MEETING OF THE BOARD OF DIRECTORS
TUESDAY 26TH JANUARY 2021
AT 1.00 P.M.

The meeting will be held via MS Teams

Governor/Public Observation:
Invitations to observe the meeting have been sent to all Governors and posted on social media and the Trust's website. Those responding will be sent instructions to join the event using MS Teams.

If you are observing the meeting please keep your microphone on mute. No questions or statements are allowed.

The timings provided in the agenda are indicative only.

Pre-Meeting Governor Session with the Chairman:
The Chairman has invited all Governors to join her for a pre-meeting question and answer session from **12.00 noon**. This provides an opportunity for them to raise any matters on the reports due for consideration during the meeting.

Joining instructions for the event have been circulated separately.

AGENDA

Standard Items (1.00 pm – 1.20 pm):

1	Apologies.	**Chairman**	**-**
2	Chairman's Introduction.	**Chairman**	**Verbal**
3	To approve the minutes the meeting of the Board of Directors held on 24th November 2020.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	To review the Board Action Log.	**-**	**Report**
6	Chairman's Report.	**Chairman**	**Verbal**
7	Chief Executive's Report.	**BK**	**To Follow**
8	BAF Summary.	**PB**	**Attached**
9	To note any matters raised by Governors.	**Board**	**Verbal**

Strategic Items (1.20 pm – 1.25 pm):

10	To approve the Trust's Strategic Framework.	**BK/SP**	**Attached**

Quality Items (1.25 pm – 2.30 pm):

11	To receive and note the report of the Freedom to Speak Up Guardian.	**Dewi Williams to attend**	**Report**
12	To receive and note the report of the Guardian of Safe Working.	**Dr. Jim Boylan to attend**	**Attached**
13	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Report**
14	To consider the Learning from Deaths Report for Quarter 3, 2020/21.	**EM**	**Attached**
15	To consider any matters of urgency arising from the meeting of the Mental Health Legislation Committee to be held on 21st January 2021.	**PH/EM**	**Verbal**

Performance (2.30 pm – 2.45 pm):

16	To consider the Performance Dashboard Report as at 31st December 2020.	**SP**	**Attached**
17	To consider the monthly Finance Report as at 31st December 2020.	**LR**	**Report**

Governance Reports (2.45 pm – 2.55 pm):

18	To consider the Gender Pay Gap Report.	**DL**	**Report**
19	Report on the use of the Trust Seal.	**BK**	**Report**

Exclusion of the Public (2.55 pm):

20	**The Chairman to move:** "That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below: *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.* *Information which, if published would, or be likely to, inhibit -* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*	**Chairman**	**Verbal**

Miriam Harte
Chairman
20th January 2021

Contact: Phil Bellas, Trust Secretary Tel: 01325 552312/Email: p.bellas@nhs.net

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 24TH NOVEMBER 2020 VIA MICROSOFT TEAMS COMMENCING AT 11.00 AM

Present:

Ms. M. Harte, Chairman
Mr. B. Kilmurray, Chief Executive
Dr. H. Griffiths, Deputy Chairman
Prof. P. Hungin, Non-Executive Director
Mr. J. Maddison, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mrs. R. Hill, Chief Operating Officer
Dr. A. Khouja, Medical Director
Mrs. L. Romaniak, Director of Finance and Information
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Commissioning, Performance and Communications (non-voting)

In Attendance:

Mrs. A. Lowery, Director of Quality Governance (non-voting)
Mr. P. Bellas, Trust Secretary
Dr. J. Boylan, Acting Freedom to Speak Up Guardian
Dr. S. Dexter-Smith, Director of Therapies
Mr. S. Johnson, Foundation Trust Governor/Membership Administrator
Ms. D. Oliver, Deputy Trust Secretary (Corporate)
Mrs. K. Ord, Deputy Trust Secretary (Membership, Involvement & Engagement)
Mrs. K. Sidhu, Deputy Chief Information Officer
Mrs. H. Warburton, Communications Manager
Mr. R. Yaldren, Head of Information Services

Observers/Members of the Public

Mrs. S. Baxter, Public Governor, Redcar & Cleveland
Mrs. M. Booth, Public Governor, Middlesbrough
Miss. G. Birchwood, Public Governor, York & Selby
Mrs. S. Brent, Appointed Governor, Sunderland University
Mr. J. Creer, Public Governor, County Durham
Mr. R. Godwin, Staff Governor, Forensics
Mr. A. Heslop, Public Governor, County Durham
Mr. M. Sani, Public Governor, Stockton
Mr. T. McGuffog, Public Governor, York
Mr. J. Preston, Public Governor, Harrogate & Wetherby
Mrs. S. Talbot-Landon, Public Governor, County Durham
Mrs. J. Wardle, Public Governor, County Durham

One member of the public.

20/75 CHAIRMAN'S INTRODUCTION

The Chairman welcomed members, those in attendance and public observers to the meeting.

20/76 APOLOGIES

Apologies for absence were received from Mrs. E. Moody, Director of Nursing and Governance and Deputy Chief Executive and Mrs. B. Reilly, Non-Executive Director.

20/77 MINUTES

***Agreed** – that the minutes of the last formal meeting held on 27th October 2020 be approved as a correct record and signed by the Chairman.*

20/78 DECLARATIONS OF INTEREST

There were no declarations of interest.

20/79 MATTERS ARISING AND PUBLIC BOARD ACTION LOG

Consideration was given to the Public Board Action Log, together with updates on matters arising from the last meeting.

The Chairman highlighted that the action log had been combined to include outstanding actions since January 2020, which had been paused due to the pandemic and those from the 27th October 2020 Board meeting.

With regard to action 20/03 (29/01/20) the Chief Executive stated that the next report of the Freedom to Speak up Guardian had been delayed and would be reported to the next formal Board meeting. Key issues and themes would be discussed with a view to reporting by exception.

Non-Executive Directors sought assurance on the ability to provide cover for the Freedom to Speak up Guardian, which was a part time role.

The Director of HR and Organisational Development stated that there were deputy arrangements in place to ensure continuity, however recognised that there were some limitations to the amount of cover that could be given. Any concerns however, could be raised via email and these would be picked up.

20/80 CHAIRMAN'S REPORT

The Chairman noted that there had been a strong focus over the last few weeks for the Board and other key stakeholders around developing the new strategic plan as well as to ensure that the Trust continued to provide and manage services under the strain of the pandemic. Staff and teams had continued to work tirelessly over the last month and it was recognised how challenging times had been in the second wave of the pandemic.

20/81 CHIEF EXECUTIVE'S REPORT

The Board received and noted the Chief Executive's Report.

The Chief Executive updated on the following matters:

(1) Further discussions that had taken place around legislation being put forward to formalise "system working". This would be part of the new governance arrangements for the NHS in England and would see the status of Integrated Care Systems (ICS) becoming statutory.

The roles of Clinical Commissioning Groups would be subject to change in order to be more strategic and Provider Collaboratives would become more prominent.

(2) Engagement with the Good Governance Institute (GGI) continued, which included plans to complete some of the work undertaken in the Governance Review by Mrs Squires that had not been completed due to Covid-19. The engagement would also include an independent well led review as required by NHSEI; the last of these being completed in 2017.
There would be a Directors' Board Seminar held on 15th December 2020 to take forward the governance review work and the well led review.

(3) Staff had shown incredible perseverance in dealing with the pandemic over the recent month. There were around four to five Covid outbreaks currently being manged through outbreak control.
(4) There would be asymptomatic twice weekly testing of staff. This would commence from mid-November and the QIS team would support the rapid roll out of the tests.
(5) The vaccine for Covid-19 was due to be released and the Director of Human Resources and OD was working on the logistics of how that would be implemented in the Trust.
On this matter it was noted that the Trust would expect all patient facing staff to be vaccinated.
The Chief Executive added that it would also be a matter for staff's own registration and standards to have the vaccine.

A member raised a query around how the Trust would stand should a patient come into contact with Covid-19 from a staff member that had not had the vaccine or was not wearing the appropriate PPE.

The Chief Executive advised that this would need to be discussed with the Trust's legal advisers. From a PPE perspective, the Trust would be taking very seriously any instances where there had been breaches with compliance, as staff had a clear duty to protect patients and colleagues.

The Director of Human Resources and OD commented on the link between the flu and Covid-19 vaccine. Currently 54% of Trust staff that had received the flu jab, however the national expectation was to reach 90% compliance.

(6) The Trust was currently reviewing its local Brexit action plan with weekly catch up meetings with key leads across the organisation to assess the implications of any new guidance that might be received.
(7) The review of Forensic Services would be reported to the December 2020 Quality Assurance Committee for oversight and scrutiny.

20/82 BOARD ASSURANCE FRAMEWORK (BAF) SUMMARY

The Board received the BAF summary as an aide memoir for consideration of the Trust's risks during the discussions at the meeting.

Mr. Bellas advised that based on the Chief Executive's report, consideration would be given to a review of the risk "impact of BREXIT" and that this matter would be discussed in more detail during the confidential Board session later in the day.

20/83 MATTERS RAISED BY GOVERNORS

The Chairman highlighted that the following areas had been raised by Governors in discussions prior to the Board meeting, most of which had been covered in the Chief Executive's Report:

1. Brexit
2. Emergency planning
3. Continuity of services

20/84 DEVELOPMENT OF THE STRATEGY FRAMEWORK AND COMMITMENTS FOR THE BUSINESS PLAN (BP) 2021-24

Board members received a report setting out the outcome of a two day business planning event, held on 10th and 11th November 2020 and proposals around the focus for the Business Plan for 2021-24.

A revised Strategic Framework was included as appendix 2 to the report.

Mrs Pickering highlighted that:

(1) At the event participants had been presented with the emerging Strategic Framework which had evolved from the Big Conversation. Consideration had also been given to the areas where there should be focus for the next three years. Following suggestions made by participants at the Business Planning event a reiterated Strategic Framework had been included as appendix 2 to the report.
(2) The Strategic Framework was a 'working draft' in anticipation of further refinement from key stakeholders.
(3) The final draft of the Strategic Framework would be presented to the January 2021 Business Planning Workshop and then to the 26th January 2021 Board meeting for final approval.

(4) There would be development around the key areas of focus that would be included in the Business Plan for the next three years. The draft Business Plan would be reported to the February 2021 Board and the final draft to the Board in March 2021 for approval. The Resources Committee would be given the opportunity to review the Business Plan before it was presented to the Board.

The Chief Executive added that:

(1) There had been healthy and challenging discussions in formulating the draft framework.
(2) There would now need to be some reflection on the Trust's ambition, together with the five areas of commitment going forward. This would be in conjunction with some pending changes to the Executive leadership team. Some thought would also need to be given to service user and carer leadership to sit alongside that at a senior level.

Members of the Board commented that:

(1) The two day Business Planning event had been very positive, a view which had also been expressed by the service users and carers who had attended and participated. The feedback noted was that there had been great progress made.
(2) In considering the description of the five areas of focus going forward some thought should be given to using a different noun to "commitment".

In response to queries Mrs Pickering advised that there would need to be a significant piece of work undertaken around embedding the values, in order to ensure that staff had taken them on board. There was significant agreement on and support for the values.

The Chief Executive added that the values linked to the goal around co-creating a great experience for colleagues as there was evidence from the Big Conversation that there had been drift from the values.

Language around the values would need to land and resonate with people in order for them to become embedded and then there would need to be discussions around how people could be supported to live them. It was a work in progress.

The Chairman stated that:

(a) There had been genuine involvement and consultation since the start of July 2020 to work up the draft Strategic Framework and thanked all those people that had participated and been part of the development, including service users and cares and also the Planning Team for their work in preparing the documentation.

(b) The Board was fully committed and engaged with the principles of the Strategic Framework and the Business Plan.

Mrs Pickering concluded the item by encouraging all Board members to attend the BP event on the 12th January 2021.

Agreed:

(i) ***That the draft Strategic Framework, subject to any further amendments from key stakeholders, be approved as a working draft.***

(ii) ***That the final draft of the Strategic Framework be reported to the January 2021 Board meeting for approval.***

(iii) ***That the further development of the areas of focus/commitments as outlined in the report for inclusion in the Business Plan 2021/22-23/24.***

(iv) ***That the draft Business Plan be reported to the February 2021 Board with the final draft to be reported in March 2021 for approval.***

20/85 REPORT OF THE GUARDIAN OF SAFE WORKING

Board members received an update report from the Acting Guardian of Safe Working.

In introducing the report, Dr Boylan, highlighted:

(1) Monitoring processes for the year had not identified any breaches to terms and conditions of service that had required the levy of a fine.
(2) Trust exception reports had mainly reflected variation in work on non-resident rotas and a new process had been implemented and would be reviewed.
(3) That processes were in place for ongoing scrutiny and review of work schedules to provide assurance of safe working environments with consideration of training and service needs.
(4) There had been extensive Junior Doctor engagement in the planning and implementation of rota changes and recording activity.
(5) How well Junior Doctors had reacted to the challenges brought about by Covid-19, the increased levels of anxiety shown in service users and to the new ways of working remotely.

(6) The following concerns:

(i) The lack of an adequately resourced on call rooms for Junior Doctors on the residential out of hour's rota at Cross Lane and Lanchester Road.
(ii) Difficulties accessing clinical results out of hours. This was sometimes due to licence access and evidence suggested it was worse in some localities than others.

The Chief Operating Officer noted that she was aware of some correspondence with the Director of Estates and Facilities on the issue of the on call rooms and this would be picked up and addressed.

Action: Mrs Hill

With regard to the lack of access to clinical results, there should be full access for clinicians out of hours and this would be discussed further to find some resolution to the problems.

Action: Mrs Hill/Dr Boylan

It was noted that with the implementation of Cito there would be integration at regional level and for specialist pathway results, which would bring greater transparency for the clinicians.

Board members complimented Dr Boylan for his informative report and considered that robust oversight on the welfare of Junior Doctors should be maintained and continued.

In response to a question, Dr Boylan provided assurance that keeping in touch with any Junior Doctors if they were away from work due to sick leave was robust.

The Chairman, on behalf of the Board, noted thanks and appreciation to the cohort of Junior Doctors that had been providing care for patients during the challenging recent months, clearly demonstrating that many had gone over and above what was expected of them.

Dr Khouja joined the meeting

Further to minute 20/09: (28/01/20), Dr Khouja thanked Dr Boylan for agreeing to continue in the role of Deputy Guardian of Safe Working for another year and provided assurance that plans were in place for a substantive appointment.

20/86 REPORT OF THE QUALITY ASSURANCE COMMITTEE

The Board received an update report on the business discussed by the Quality Assurance Committee (QuAC) including:

(1) The key issues considered at its meeting held on 5th November 2020.
(2) Notification that the Committee had returned to a formal meeting and the Board would receive a copy of the previous set of approved and signed minutes at its next meeting.
(3) The following matters were raised:

Clarification and some assurance had been sought from a Governor in the pre-Board teleconference about the two instances of mechanical restraint in Teesside MHSOP reported in the Quality Assurance Committee minutes.

The Director of Quality Governance confirmed that the two instances reported had been in relation to the same patient. There had been an error made by staff in the recording of the episodes.

Assurance was given that what had been used was termed a “mora bag”, which was a large type of bean bag used in older people’s services to help any individuals that might be recovering from anxiety or an aggressive episode.

Reassurance was provided that some training with staff was underway to avoid any repeated mistakes in categorising those kinds of episodes.

(4) Two newly developed template reports for Trust (Trust Wide Quality & Learning Report) and locality level reporting.
The purpose of the revised templates was to provide more robust assurance in the reports and would be piloted in the Tees locality for the next three months, The Lead Director for Tees, Mr Gardner, had commented that the new styled template had been helpful as it could be used as a tool for informing the locality on current issues.

(5) Notification that the Sub-Groups to QuAC would recommence reporting in to Committee, starting with the Health, Safety, Security and Fire Group in December 2020 and Research & Governance in February 2021. There would be no QuAC meeting in January due to the Christmas holidays.

The Chairman of QuAC concluded the report by stating that there were no formal matters to be raised to the Board.

20/87 IMPLEMENTATION OF CITO REPORT

The Board received and noted an update report and presentation on the implementation of Cito.

The key matters highlighted were:

(1) The clinical staff that had joined the programme would remain in post due to the delays caused by the pandemic.
(2) Plans were being developed which included combining the electronic prescribing medicines Administration (EPMA) project with the Cito programme and that rollout combined the two products where suitable. This would minimise the impact on clinical services as they would benefit from a full electronic solution. Risks and benefits of this approach would be considered in order to develop the final resourcing options. A recommendation around the options for these proposals would be reported to the Resources Committee on 19th January and Board on 26th January 2021.

Action: Mrs Romaniak

(3) A full review of resources and associated timelines would be undertaken in order to propose the funding required and the delivery options for both Cito and EPMA within a realistic, safe and achievable timescale. The long term ongoing requirements for support of the two systems would also be considered to ensure maintenance and integrity of both solutions and that future upgrades could be successfully managed.

The Chairman thanked the Deputy Chief Information Officer and the Head of Information Systems for attending the meeting and for the informative and helpful update.

The Chief Executive added that the two projects were of high strategic importance, which formed part of the transformation initiative.

He stated that:

(i) There would need to be clear steer on the ambitions and expectations, as well as the interdependencies of the two programmes, with the key priorities set out for the coming year together with some scoping into the five commitments that would form the Strategic Plan.
(ii) The timeliness of the implementation would be important and how quickly that could be done, coupled with the need for the systems to be maintained and built upon in the future.

Non-Executive Directors welcomed progress with the programme in the New Year as the implementation had been long awaited and it was clear that it would bring many benefits.

The following matters were raised:

(1) The potential challenges of resourcing the programme internally and it would be helpful to see in the future some scope around the level and cost of support required.

(2) As Cito would support clinical transformation a request was made that further information be set out on how it would support improved risk management for clinicians and formulation.

The Medical Director noted the significant culture change that would be required for those using Cito should not be under estimated and that there would need to be some re-training. Training would need to be provided to ensure the satisfactory risk assessments were undertaken.

(3) Whether Cito had been used elsewhere. It was noted that the system had been used in Acute providers but that TEWV would be tailoring it around its own clinical practices.

Mrs Romaniak concluded the item by informing members that there would be virtual road shows and the link would be shared with the Board.

Action: Mrs Romaniak

Agreed: *That the development of resourcing options for implementation including possible alignment of Cito and EMPMA and delivery timescales be supported for consideration at the 2021 Board of Directors.*

Action: Mrs Romaniak

20/88 EQUALITY DELIVERY SYSTEM (EDS 2) REPORT & STAFF EQUALITY AND DIVERSITY DATA

The Board received an update report on the Equality Delivery System (EDS2) and the publication of equality information about staff.

In introducing the report, Mr Levy drew attention to:

(1) The EDS2 was a self-assessed tool across 18 patient and workforce related outcomes.
(2) The report focused on the nine workforce outcomes only.
(3) The position was varied across the nine areas, demonstrating that staff from some, but not all of the protected groups did not fare as well as people overall.
(4) There were challenges with data completeness in respect of disabled and sexual orientation of staff groups as this was not captured in the Trust.
(5) The position had worsened since the previous year on the Trust making reasonable adjustments for staff with a disability.
(6) There was an issue with interpretation of the data from Trust level to locality level as the information could not be broken down or simply was not known.
(7) Being appointed from short list to interview data would be more meaningful from a locality perspective.
(8) There were a lot of positive initiatives going on with the reverse mentoring programme and the BAME leadership network.

Non-Executive Directors commented that they had found the information difficult to interpret and understand and were disappointed with the position around enabling disabled people to work.

The Chairman of the Resources Committee informed the Board that due consideration had been given to this report at its last meeting where the consensus had been to press for improvements around the experiences of TEWV disabled staff in 2021.

Board members:

Agreed: ***(i) That the EDS2 document be approved for publication.***
(ii) That the staff equality data be approved for publication.
Action: Mr Levy

20/89 MENTAL HEALTH LEGISLATION COMMITTEE UPATE

The Board received an update report on the business discussed by the Mental Health Legislation Committee (MHLC) including the key issues considered at its teleconference held on 21 October 2020.

As previously stated in a verbal update to the October 2020 Board meeting there had been no significant matters to escalate.

20/90 PERFORMANCE DASHBOARD AS AT 31st OCTOBER 2020

The Board received and noted the Performance Dashboard Report as at 31st October 2020.

Mrs Pickering highlighted:

(1) That the report included the standards from 2019/20 which had been carried forward, with no change to the measure. Work was ongoing to identify potential possible standards for those measures with no standards and they would be brought back in a future report.

(2) The key areas of concern were around patient experience, the achievement of benchmarks for HoNOS scores in AMH and MHSOP, delays with patient assessments and compliance with mandatory training.

In response to a query about whether there had been any change in practice to recording HoNOS scores, it was noted that due to the pandemic there had been difficulties producing the reports.

With regard to the scoring in MHSOP for HoNOS there had been a change in the model of delivery in response to NICE guidance, which meant that service users were now being transferred back to their GP earlier for ongoing monitoring and treatment. Their HoNOS score would be completed on assessment; however since they did not complete a pathway there would be no end point for comparison.

20/91 FINANCE REPORT AS AT 31st October 2020

The Board received and noted the Finance Report as at 31st September 2020.

The following matters were highlighted from the report:

(1) The Trust had moved into new financial arrangements for months 7-12 following the first six months when there had been a top up of income to enable a break even position. This was in line with national guidance to cover Covid-19 emergency planning.
(2) The Trust had submitted an updated revenue forecast that included £9,632k for future Covid-19 related expenditure and £25m growth.
(3) Each organisation in the ICS had been given a fixed allocation which provided some certainty.
(4) There had been a detailed discussion at the Resources Committee meeting held on 17th November 2020 to understand the implications of the forecasts.
(5) The outturn position for the period ending 31st October 2020 was a surplus of £1,942k and this was £2,199k ahead of the NHSI revised plan. The majority of the underspend related to a number of one off items in October 2020 that were not anticipated to be repeated in future months.

The Director of Finance and Information drew attention to:

(i) The importance of ensuring that in the remaining months of the financial year, where there had been some backlogs that there was a firm commitment to making use of the funding available.

(ii) The need for focus on the implications of the pandemic for the forward financial plan for the next 3-5 years and to link in with the new Strategic Direction which was being worked through.

(iii) The Trust income and expenditure (I&E) margin assessed against turnover, excluding impairments showed a margin of 0% due to the breakeven position linked to Covid working arrangements. This meant "on plan with a rating of two".

(iv) The I&E margin distance from plan ratio assessed the I&E margin against plan**,** excluding PSF income. This meant the "Trust I&E distance from plan was 0% and on plan rated as one".

(v) The forecast was to achieve the financial plan by the end of the year. This would of course be subject to the impact of the environment and workforce.

Following a query and comment from Board members it was noted that:

(a) The impact of the implementation of Cito had been factored into budgets.

Mrs Romaniak advised that there had been approval of five clinical posts to support the work around Cito and any further additional recurring costs would be taken through to the Resources Committee and Board for discussion and approval.

(b) It would be important to ensure that in making use of any underspend that staff welfare was paramount and that any additional resources to support them should be considered.

Mrs Romaniak concluded the discussions by drawing attention to the forward capital programme and the increased rectification costs for Roseberry Park Hospital. Discussions would take place to inform decisions around future plans for cash borrowing, which would be subject to stringent permissions and agreement from the ICS that it was their shared priority.

The Board would be kept up to date on progress around these matters through the monthly Finance reports.

20/92 BUSINESS PLAN UPDATE REPORT

The Board received the Business Plan Update for Quarter 2 – 2020/21.

In introducing the report Mrs Pickering noted that it provided focus around delivery of the 2020/21 actions since the Trust was currently reviewing the Strategic Direction which would inform the key priorities in the coming years.

The key matters highlighted were:

(1) That progress on strategic goals in Q2 had improved on Q 1. 50 out of the 60 (83%) business plan actions due to be completed by the end of Q2 had been delivered on time.

This was a very encouraging position that staff had managed to make such progress at a time of significant stretch across both clinical and corporate services.

(2) That there were changes to the Trust Business Plan set out in Appendix 1 to the report. Actions where completion was planned for beyond 2020/21 would be part of the development of the 2021/24 Business Plan.

The Chairman welcomed the inclusion of other forms of qualitative and soft intelligence to the report.

Agreed:

(i) That the changes to the Trust Business Plan as set out in Appendix 1 to the report be approved.

(ii) ***That the actions set out in Appendix 1 to the Business Plan Update report Q2, that went beyond 2020/21 be considered in the development of the 2021/24 Business Plan****.*

20/93 USE OF THE TRUST SEAL

The Board received and noted a report on the use of the Trust's seal in accordance with Standing Orders.

20/94 DATE OF NEXT MEETING

It was noted that the next provisional meeting of the Board of Directors had been held in diaries for 15th December 2020. This would be confirmed in due course.

20/95 CONFIDENTIAL MOTION

Agreed *– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*

Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.

Information which, if published would, or be likely to, inhibit -

(a) the free and frank provision of advice, or

(b) the free and frank exchange of views for the purposes of deliberation, or

(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.

Following the transaction of the confidential business the meeting concluded at 14.38pm.

Board of Directors

Public Action Log

RAG Ratings:

	Action completed/Approval of documentation
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Date for completion of action not yet reached

Date	Ref No.	Action	Owner(s)	Timescale	Status
28/01/20	20/03	An update on the outcome of discussions at the planned "away day" held on 6/12/19 to review the Trust's approach to "speaking up" to be included in the next report of the Freedom to Speak Up Guardian	F2SUG	Jan-21	See Agenda Item 11
25/02/20	20/44	Revised terms of reference for the QuAC, in regard to the representation from the LMGBs at its meetings, to be prepared and presented to the Board for approval	Chairman of QuAC/TS	~~Jan-21~~ Apr-21	To be addressed following the governance review
25/02/20	20/46	A re-assessment of the establishment reviews, by exception, to be undertaken	DoN&G	~~Dec 20~~ Mar 21	
25/02/20	20/47	The data on ethnicity in the Equality Data Document is to be aggregated to support comparison when presented to the Resources Committee	DoHR&OD	~~Jan-21~~ Mar-21	

Date	Ref No.	Action	Owner(s)	Timescale	Status
24/11/20	20/84	To note: - The version of the Strategic Framework presented to the meeting was approved as a working draft - The final version of the Strategic Framework is to be presented to the Board meeting to be held in January 2021 for approval - The areas of focus/commitments as outlined in the report were agreed for further development and inclusion in the refreshed Business Plan - The draft Business Plan is to be reported to the February 2021 Board meeting and presented for approval at the March 2021 Board meeting	DoPCPC	-	To note (See agenda item 10)
24/11/20	20/85	The lack of adequately resourced on-call rooms for Junior Doctors at Cross Lane and Lanchester Road is to be addressed	COO	Feb-21	Interim solutions will be put in place at both Hospitals in February. The provision of the fully resourced facilities will be included in the capital plan
24/11/20	20/85	Discussions are to be held to seek a resolution of the issues identified about lack of access to clinical results out of hours	COO/GoSW	Mar-21	Verbal update to be provided by the DoFI at the meeting
24/11/20	20/87	Final resourcing options for the implementation of CITO, including possible alignment with ePMA and delivery timescales, are to be presented to the Board following consideration by the Resources Committee	DoF&I	Jan-21	See Confidential Agenda Item 6
24/11/20	20/87	Links to the virtual roadshows on CITO are to be shared with Board Members	DoF&I	-	Completed
24/11/20	20/88	To note that approval was given to publish: - The EDS 2 document - The staff equality data	DoHR&OD	-	Approved

Date	Ref No.	Action	Owner(s)	Timescale	Status
24/11/20	20/92	To note: - Approval of the changes to the Business Plan as set out in Appendix 1 to the report - The actions included in Appendix 1 which extend beyond 2020/21 are to be considered in the development of the 2021/24 Business Plan	DoPCPC	-	To note

Tees, Esk and Wear Valleys
NHS Foundation Trust

Carers carter - working together

Developed by carers for ALL who support or help a person receiving care from Tees, Esk and Wear Valleys NHS Foundation Trust

Our commitment to you

We'll make sure you have a named person to contact

We'll listen and value your expert knowledge about the person you care for

We'll work with you to provide quality care

We'll include you in any decisions about the person you care for. Where this isn't possible we'll explain why

We'll support and listen to you and provide clear, accessible information to help you care

We'll respect the confidentiality of the personal information that you provide about yourself or the person you care for

We'll train our staff to understand and respect the essential role you play in the person's care and recovery

We will actively involve you in service planning and development

Please help us

Work with us to provide personalised care and treatment for the person you care for

Share your experiences and history of the person you care for to help us provide effective care

Help us understand your own needs so we can support your health and wellbeing

Trust us to share with our colleagues as necessary the personal information you provide to improve the care we give

Respect that staff will listen but may not always be able to answer personal questions about the person you care for

Use the information we provide for carers to understand your rights and how we can work together

Help us develop better integrated, more joined up services that meet the needs of everyone

If you feel your are not being listened to, or not being supported, please talk to your loved one's care team or contact our Patient Advice and Liaison Services team (PALS) on 0800 052 0219.

November 2020

Tees, Esk and Wear Valleys
NHS Foundation Trust

Carers carter - working together

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November 2020

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 7

PUBLIC

BOARD OF DIRECTORS

DATE:	**Tuesday, 26 January 2020**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	

Executive Summary:

A briefing to the Board of important topical issues that are of concern to the Chief Executive.

Recommendations:

To receive and note the contents of this report.

The Good Governance Institute (GGI) Governance Review

GGI has commenced its governance review of the Trust. To date, we have submitted our self-assessment, which was "sense-checked" by John Maddison; submitted the majority of the documentation requested; and set up interviews with Board Members and other appropriate Directors.

GGI observed the meeting of the Audit and Risk Committee held on 17 December 2020 and will also be attending a range of meetings over the coming weeks.

At present, we are working with GGI on developing communications to staff on the review and to provide a rounded picture of our arrangements, and supporting the organisation engage with key partners and stakeholders.

At present, subject to the completion of the documentation submission, the review remains on track for completion in early March.

Reforming the Mental Health Act (MHA)

On 13 January 2020, HM Government published a new white paper, *Reforming the Mental Health Act*, which sets out a package of reforms, which have been developed building from the recommendations made by Sir Simon Wessely's Independent Review of the MHA in 2018. Alongside greater choice and autonomy for patients in crisis, the reforms aim to tackle the racial disparities in mental health services, better meet the needs of people with learning disabilities and autism and ensure appropriate care for people with serious mental illness within the criminal justice system. Although there is no fixed timetable for when it will come in to law, it could be as soon as 2022. There is a consultation exercise which was launched alongside the white paper, which closes on 21 April 2021. Mel Wilkinson, Head of Mental Health Legislation and Dr Ahmad Khouja will lead TEWV's response to the consultation.

EU Transition

The Trust has undertaken the reporting requirements to inform national and regional partners about our EU transition preparation. Various checklists have been submitted and no issues of note have been identified. To date there have been no untoward impacts from the EU transition but this continues to be closely monitored.

Covid-19 Update

Outbreaks

There are currently 11 Covid-19 outbreaks as at 21 January and are being managed through outbreak control measures, all processes are in place to support clinical teams to care for patients and all reporting requirements are in place. There is a mix of both inpatient and community based infections.

Staff Testing

Following national guidance issued in November 2020 regarding healthcare workers being regularly tested for Covid-19 via a lateral flow test (LFT), a phased roll out was implemented on 25 November. The asymptomatic testing of staff via a LFT has been positively received and reporting arrangements are in place to review receipting and regular testing of staff to ensure they are adhering to the testing requirements.

Vaccine

The Trust's vaccination programme is underway and good progress has been made both at the TEWV vaccination centre at the Newberry Centre, West Lane Hospital and through partnership arrangements with five neighbouring acute Trusts

Crisis Update

Following a number of concerns about the Crisis Team which have been identified by patients, staff and stakeholders there has been a senior level review of the range of issues and concerns to understand and consider some specific actions. We have met with Unions to consider the next steps and have agreed to develop a plan which involved moving some staff to alternative roles. To communicate this plan we have offered two staff engagement sessions which have been well attended. A number of issues have been raised by the team so we are offering additional opportunities for staff to feedback. This information is being evaluated by two independent reviewers and they will consider the detail and will inform the next steps. Any plans will be considered by the Senior Leadership and Union reps during early February.

Integrated Care Next Steps

NHS England and Improvement published a document at the end of November 2020 setting out its thoughts on how building on previous commitments they can embed integrated and system working on a more statutory basis. There will be an NHS Bill developed over the coming months.

The paper sets out clearer statutory roles for Integrated Care Systems (ICS), promotes the importance of place based partnerships and integrated clinical pathways, promotes a stronger focus on data driven population health management and states Trusts will be required to be part of provider collaboratives in the future.

It is clear that the ICS will take a much more direct leadership role in the management of the system. There will be a clear role in the distribution of financial resources, direction of transformation, workforce planning and general oversight. ICSs will take on Clinical Commissioning Group functions. It is not yet clear whether there will be any sub-geographic structures between ICS (in our case at North East and North Cumbria and Humber, Coast and Vale levels).

Place level working is highly emphasised in the paper as being an important aspect. An emphasis on joining up local clinical services on the basis of improvement of population health, preventative services, supporting the vulnerable and those at risk. There is also an emphasis on the NHS participating in social and economic development at a place level.

Much of the system transformation will be delivered at a regional and place level by providers working closely in provider collaboratives. It is likely that organisations like ours will be involved in multiple provider collaboratives at a regional and local level. It is understood NHSE/I is working on the various models that might be adopted.

However, as the Board is aware we have experience of this way of working through our specialist services provider collaborative arrangements.

It is unlikely the statutory changes will be in place before April 2022. However, both ICSs are preparing to take steps from April 2021 to begin to develop and then shadow new ways of working. To this end we are working closely with the City of York on place based arrangements and developing a Memorandum of Understanding which will promote collaborative working on a number of emerging clinical priority areas. Similarly the County Durham Partnership is reviewing its governance and considering further opportunities for collaboration.

It is intended that we will indentify a Board Seminar slot in the near future to work through the key implications for the Trust and its partnerships and particularly our aspirations to be a "Great Partner".

Positive Practice in Mental Health (PPiMH)

I wanted to take the opportunity to remind Board colleagues of our involvement with the Positive Practice in Mental Health network. Through the pandemic PPiMH has reviewed its model and is now offering to work more intensively with a small number of Trusts. We are one of the Trusts they have invited to participate. PPiMH is a networking organisation set up to share good practice and use learning to improve services. We have asked PPiMH to work with us on the review of service user and carer and family involvement which is currently underway and led by the Specialty Development Group. This sits well with the work that Ahmad Khouja is leading on co-creation. PPiMH are also connecting us with other organisations on community mental health transformation and access to services in rural areas.

Director of People and Culture Appointment

I wanted to report in public that Dr Sarah Dexter-Smith has been appointed as Director of People and Culture. Sarah will take up post on 15 February. As you know, Sarah is currently our Director of Therapies and is a Clinical Psychologist. Sarah has led a number of service transformations, the development of our leadership programmes and cultural change initiatives.

Sarah will replace David Levy, who after 12 years in the role will retire as Director of Human Resources and Organisational Development. This will be David's last public Board meeting. I am sure you would wish to join me in recording the Board's thanks for David's service and to wish him our very best wishes for his next stage.

Carers Charter

The Trust is committed to the Triangle of Care and there is a very active steering group that has facilitated our accreditation in this scheme, this involves a number of carers and staff. A sub-group of the steering group has worked with carers to develop a Carers Charter. The Charter sets out expectations in relation to decision making and helping develop personalised care plans, making sure a carer's

knowledge and experience of their loved one and their condition is taken into account, and having a named contact within their loved one's care team they can talk to. The Charter can be found at Appendix 1 of this report.

Making a Difference Staff Awards

Back in March last year we were all ready to host our staff recognition awards ceremony, the Making a Difference awards. We received more than 300 nominations from colleagues which our judging panel shortlisted for the ten award categories. Unfortunately, Covid 19 put a stop to our plans.

With all the hard work during the pandemic we knew that celebrating achievements and recognising staff and volunteers who had gone above and beyond was more important than ever.

On Thursday, 17 December we were delighted to hold a virtual Making a Difference awards ceremony to recognise the work people across the Trust had delivered in 2019. Staff and volunteers were invited to the MS Teams event hosted by a local journalist and ex-editor of the Northern Echo, Peter Barron. Myself and the Trust's Chairman congratulated our winners and those who were highly commended.

2021/2022 Financial Planning Update

2020/21 Context

Julian Kelly (CFO at NHSE/I) set out the context and anticipated national financial arrangements for 2021/22 at a Finance Directors webinar on 21 January. He thanked colleagues for efforts in unprecedented times to support patient care and set out the implications of those extraordinary pressures on the NHS for national financial planning and funding flows into 2021/22.

Most systems are under spending in aggregate against their allocations for the second half of 2020/21, which are expected to be sufficient to cover quarter 4 winter- and pandemic-related pressures at a macro level. A letter circulated by NHSE/I over the Christmas period set out the key priorities; including Covid recovery, and related national framework.

2021/22 NHS Financial Planning and Revenue Settlement

Revenue related financial planning work will be deferred into quarter one of the new financial year to allow focus on ongoing operational pressures. This will be accommodated by rolling over the national block funding arrangements into April to June 2021. Plans for quarters 2 to 4 will be developed via Integrated care Systems (ICSs) between April and June 2021.

The NHS will need to consider the pace of 'recovery' in the context of the settlement, staffing and impaired resilience. Discussions with Treasury and Government to agree the NHS settlement are not expected to conclude until around mid-February.

On this basis, systems might expect to receive resource envelopes by mid-March however judgements nationally will need to remain agile in light of the pandemic.

Importantly, the £500 million Spending Review settlement for Mental Health will be available via national arrangements from April.

2021/22 Capital Settlement

The 2021/22 NHS capital settlement was confirmed in the one year Spending Review, therefore system capital resource envelopes are likely to be notified in February, with likely submissions of system-based capital plans in April. The national capital quantum is similar to 2020/21 and the basis for allocations to systems will be similar, however backlog and capital infrastructure funding will be included in ICS resource envelopes. National capital programmes will continue for some items including the eradication of mental health dormitories.

ITEM NO. 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th January 2021**
TITLE:	**BAF Summary**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Report:

The Board Assurance Framework (BAF) is a key means of providing assurance to the Board that the Trust's strategic risks are being managed effectively across the organisation.

The risks currently featuring in the BAF are provided in Annex 1 to this report.

Board Members are asked to be mindful of these risks during the discussions at the meeting.

Annex 1

Summary of Risks included in the Board Assurance Framework
Month: November 2020

Risk Title	Risk Manager	SG	Risk Description	Current Risk Grade
Consultant Recruitment	MD	1 & 3	Patient safety, quality and outcomes could be compromised due to difficulties appointing sufficient consultants to meet current and future workforce demands.	**Very High**
Cyber Security	DoF&I	1, 2, 4 & 5	Patient care could be compromised and there could be reputational damage if a cyber-attack was successful	**Very High**
West Lane Strategic Impact	CEO	All	The events at West Lane Hospital Inpatient services could have an adverse strategic impact on the Trust.	**Very High**
Maintaining Effective Governance	CEO	1 & 5	There could be repeated failures, unsafe services, regulatory action and reputational damage if we fail to put in place and maintain effective governance, risk and assurance processes.	**Very High**
Provider Collaboratives	CEO	All	The establishment of provider collaboratives might impact on the Trust's ability to deliver services particularly in regard to quality, contracting, case management and finances	**Very High**
Compliance with National Targets and Standards	CEO	5	We could be subject to regulatory action and suffer reputational damage if we fail to comply with national targets and standards	**Very High**
Coronavirus	COO	All	There could be a significant impact on the Trust's ability to deliver services arising from staff absence and access to supplies due to the Coronavirus	**Very High**
Impact of ICS/STP Development	CEO	All	The competing priorities, non-alignment of footprints and varied governance structures of integrated care systems (ICSs)/sustainable and transformation partnership (STPs) could complicate and frustrate the consistent delivery of the Trust's strategic objectives	**High**
Staff Recruitment and Retention	DoHR& OD	1 & 3	Patient safety, experience and outcomes could be compromised if we fail to recruit and retain sufficient qualified and compassionate staff	**High**
Promoting User-Focussed High Quality Care	MD	1 & 2	The recovery of patients could be compromised if we fail to maintain a culture which promotes user-focussed high quality care in all our services.	**High**
Roseberry Park Defects - Strategic Impact	DoF&I	1, 2, 3 & 5	The challenging position at Roseberry Park could undermine the delivery of the Strategic Goals and Business Plan priorities and adversely impact on the Trust's financial, reputational and regulatory standing	**High**
Impact of BREXIT	COO	All	Withdrawal from the European Union (BREXIT) could result in significant problems for the employment of nationals from other EU states, exacerbating recruitment and retention issues and for the supply of medicines	**High (subject to review)**
Reputation	CEO	All	A loss of reputation could reduce the confidence of service users and carers to engage with services and commissioners to invest in services which would impact on the Trust's ability to deliver its strategic goals	**High**
Closed Cultures	COO	1	Failure to identify and tackle closed cultures in our services will increase the risk of harm including abuse and breaches of human rights	**High**

Benefits from Information Systems	DoF&I	2 & 5	Our ability to deliver high quality, productive care could be compromised if our information systems do not deliver their intended benefits and meet the needs of services.	**Medium**
Developing Leadership	CEO	2 & 3	Our ability to deliver high quality, productive services could be jeopardised if we fail to develop leadership throughout the Trust	**Medium**

ITEM NO. 10

CONFIDENTIAL

BOARD OF DIRECTORS

DATE:	**26th January 2021**
TITLE:	**Trust Strategic Framework**
REPORT OF:	**Brent Kilmurray Chief Executive and Sharon Pickering, Director of Planning, Commissioning, Performance and Communications**
REPORT FOR:	**Approval**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

Following an initial engagement event which commenced in June 2020 the Board agreed in July 2020 that the organisation should review its Strategic Framework. It also agreed that to do this we need to undertake a significant amount of further engagement with service users, carers, staff and partners

The output from all the engagement has been considered and has resulted in a draft new Strategic Framework for approval by the Board.

By approving the Framework, the Board of Directors are stating what type of organisation TEWV wants to be and how we will get there. The Strategic Framework should drive the business of the Trust and help us focus the activities that the Trust undertakes. It will also enable a business plan to be developed which sets out actions to ensure TEWV achieves its new strategic goals.

Recommendations:

The Board of Directors are recommended to approve the new Strategic Framework and note the next steps for the production of the Business Plan 2021/22 – 23/24

MEETING OF:	**Board of Directors**
DATE:	**26th January 2021**
TITLE:	**TEWV Strategic Framework**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present the new Trust Strategic Framework to the Board for approval.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The Board of Directors considered a report on 28th July about Revising our Strategy.

2.2 At that meeting the Board agreed that we needed to review the Strategic Framework but this needed to be informed by significant engagement with service users, carers, staff and stakeholders. As a result of this we launched Our Big Conversation as a means of gather intelligence to inform our new Strategic Framework but also for testing the key messages we heard from that intelligence.

3. KEY ISSUES:

3.1 Since the Board agreed this approach further work has taken place:

- Our Big Conversation has been undertaken and the thoughts/ideas provided have been analysed. This analysis was then used to inform an emerging Strategic Framework
- A Board planning workshop was held in October 2020, where a number of external speakers outlined national and international best practice and encouraged discussion on what potential implications these could have for us
- A second Board planning workshop in November 2020 which discussed and added to the emerging new Strategic Framework and led to the identification of 5 key areas of focus for the 2021/22 – 23/24 Business Plan
- That strategic framework was then further developed by a group led by a Non-Executive Director and the Director of Planning, Performance, Commissioning and Communications
- A third Board planning workshop on 12th January then had a final review of the draft Strategic Framework. At this meeting there was also significant discussion about the emerging work being identified to take forward the key 5 areas of focus.

3.2 The new Framework (see Appendix) has been shaped by Our Big Conversation which has engaged approximately 1,700 staff and 400 service users and carers. In addition a cohort of service users and carers also attended all 3 Board planning events and provided input and challenge into the refinement of the Strategic Framework. This engagement has given the Board an ideal opportunity to listen to what people are saying about the organisation. The new framework will enable actions to be planned and implemented to address the issues revealed by the conversations.

3.3 Although the draft of the framework which was shared with participants at the Board workshop on 12th January was broadly well received, some comments have been made that the importance of listening to service users, carers and partners needs more emphasis. Therefore, as well as the existing reference to listening in the values section of the framework, the word "listen" has now been added to the statement of the kind of organisation we want to be. This is reflected in the Appendix.

3.4 There have also been comments received that the inclusion of the phrase "by 2025" in the Goals section of the framework could be interpreted as meaning that we do not intend to act quickly on these goals. However, if we were to remove that phrase, then the commitment to achieving the goals "within the next 5 years" could be misunderstood by people reading the framework in the future. Therefore we are proposing to add the words highlighted in red to provide clarity and we will ensure that the communications approach around the launch of this framework will be very clear on how the Strategic Framework will be delivered including that we will see implementation of the framework commencing on 1st April 2021 and continuing up to Spring 2026.

3.5 The approval of this Framework will facilitate the development of a new business plan which is a key tool in ensuring that that the Trust delivers the Strategic Goals from 1st April 2021.

3.6 Time limited planning groups, which include service users and carers are currently developing visions, priorities and milestones for the 5 key areas of focus which will form a critical part of the Business Plan. Early drafts of these were shared at the event on the 12th January and the groups are now reflecting the comments received in their next draft. The following are the key milestones for development of the Business Plan:

18 Jan	Commence 'warm up' communications about the next stage of Our Big Conversation (this will include sending letters to service users and carers (with option to join our big conversation online or to return views via email using a proforma)
2 Feb	Open next phase of Our Big Conversation where we will share the emerging thinking on the 5 key areas of focus and ask what is wrong, strong or missing
4 Feb	Governor business planning workshop (at which they will also be encouraged to take part in Our Big Conversation online)
16 Feb	Big Conversation closes
23 Feb	First draft Business Plan considered by the Board of Directors (please note that this first draft will be based on the proposals shared with the Big Conversation on 2nd Feb and Governors on 4th Feb)
25 Feb	Share feedback from Our Big Conversation with the planning groups
17 March	Final draft business plan submitted to Board of Directors
23 March	Board of Directors consider and approve the final draft of the Business Plan

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** This new Framework will be noted by CQC's intelligent monitoring systems when it is published and will inform their overall view of the Trust. Trust Directors will also proactively share the new Framework with the CQC.

4.2 **Financial/Value for Money:** The approval of the new framework will not increase Trust costs. However, the Strategic Change Fund and other resources will need to be realigned to ensure they fully support our plans to achieve our new goals.

4.3 **Legal and Constitutional (including the NHS Constitution):** Strategic Frameworks of this nature are generally viewed as an essential element for any well-governed organisation of TEWV's complexity and size.

4.4 **Equality and Diversity:** Work was undertaken during the big conversation to see whether issues raised by BAME staff were different from other staff in the organisation. This was not the case, but the new values categorically exclude any discriminatory behaviour relating to any protected characteristic.

5. RISKS:

5.1 The main risks connected with approval of this document are

a) That the new framework is based on a faulty understanding of the external environment or the strengths / weaknesses of the organisation. This has been mitigated by connecting the development of the framework to the Business Planning process and through Our Big Conversation (including the role of an external organisation in analysing the data)

b) That the new framework raises hopes of change which are then not realised as the organisation continues as it was before. This has already been mitigated through the commitment unleashed by the process so far, but will also be mitigated by the production of a new business plan focussed on making progress on those changes that our service users, carers, staff and partners say are most needed

6. CONCLUSIONS:

6.1 The new Trust Strategic Framework has been developed through a robust process which has involved appropriate and focussed engagement by Board members, Governors, managers, clinical leaders, staff, service users / carers and other stakeholders.

6.2 It sets out clearly:

- why we do what we do;
- what people have told us about the sort of organisation we were in 2020;
- the kind of organisation we want to be;
- our values;
- three big goals for the next five years.

6.3 The Business Plan will be the key mechanism for planning and driving change which will ensure the Trust achieves the goals in the new Framework.

7. RECOMMENDATIONS:

7.1 The Board of Directors are recommended to approve the new Trust Strategic Framework

Sharon Pickering Director of Planning, Commissioning, Performance, & Communications

Background Papers: Board Report 28th J2020

Appendix

<table>
<tr><th colspan="4">TEWV: Who we are and what we want to be</th></tr>
<tr><td>This is why we do what we do:</td><td colspan="3">We want people to lead their best possible lives.</td></tr>
<tr><td>This is what people have told us about the sort of organisation we were in 2020</td><td colspan="3">We have a lot to be proud of, yet:
We don’t always provide a good enough experience for those who use our services, their carers and their families;
Our speed of response is too slow, too often;
Too many of us are unclear about our direction;
Our partners sometimes find us tricky to collaborate with;
We don’t provide a consistently good experience for our colleagues.</td></tr>
<tr><td>This is the kind of organisation we <u>want</u> to be:</td><td colspan="3">We will co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism, involving them and their carers as equal partners. We will listen, learn, improve and innovate together with our communities and will always be respectful, compassionate, and responsible.</td></tr>
<tr><td>The most important way we will get there is by living our values, all of the time:</td><td>Respect
Listening
Inclusive
Working in partnership</td><td>Compassion
Kind
Supportive
Recognising and celebrating</td><td>Responsibility
Honest
Learning
Ambitious</td></tr>
<tr><td>We will also commit to three big goals for the next five years.
Work will start on these immediately following approval of this Strategic Framework and will continue through to 2025</td><td>Goal 1: To co-create a great experience for our patients, carers and families.
If you use our services, or care for someone who does, by 2025 you will experience:
Outstanding and compassionate care, all of the time.
Access to the care that is right for you.
Support to achieve your goals.
Choice and control.</td><td>Goal 2: To co-create a great experience for our colleagues.
If you work at TEWV, by 2025 you will feel:
Proud, because your work is meaningful.
Involved in decisions that affect you.
Well led and managed.
That your workplace is fit for purpose.</td><td>Goal 3: To be a great partner.
If you are a local, national or international partner of TEWV, by 2025 we will:
Have a shared understanding of the needs and the strengths of our communities.
Be working innovatively across organisational boundaries to improve services.
Be widely recognised for what we have achieved together.</td></tr>
</table>

ITEM NO.11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th JANUARY 2021**
TITLE:	**FREEDOM TO SPEAK UP GUARDIAN REPORT**
REPORT OF:	**THE FREEDOM TO SPEAK UP GUARDIAN**
REPORT FOR:	**INFORMATION**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	√
To continuously improve to quality and value of our work	√
To recruit, develop and retain a skilled, compassionate and motivated workforce	√
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	√
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	√

Executive Summary:

This report is for information and outlines freedom to speak up developments and challenges during the last 6 months. Reference is made to local, regional, and national issues and reflections about COVID 19 and includes data relating to numbers and types of referrals.
The nine months up to 31st December 2020 saw a decrease in the number of concerns being raised compared to the pervious reporting period. However there have been a number of Covid related enquiries which for the most part have been signposted to operations to help ensure a swift response.
A welcome increase in the number of Dignity at Work Champions has been achieved. Unfortunately I have not yet managed to fully utilise their potential in the freedom to speak role and intend to prioritise this in the coming year.
A review of our approach to the management of certain FTSU issues was held at the end of 2019 and we have since begun to adopt some new ways of working albeit further work to bring about change is needed. We intend to revisit these planned developments next month and will again be considering our response to concerns related to detriment.

Recommendations:

To note the contents of the report and to comment accordingly.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**26th JANUARY 2021**
TITLE:	**FREEDOM TO SPEAK UP GUARDIAN REPORT**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board about the last 9 months of the Freedom to Speak Up role. The report will outline developments and activity to date and discuss how we intend to further develop the role in the coming year

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 I have been in post since October 2016 and continue to work 18 ½ hours a week.

2.2 Clearly the last 9 months have proved most challenging for all. As stated above we have received a number of contacts related to a perceived inconsistency in how some staff have been asked to work during the current pandemic. Most concerns were quickly resolved through signposting and only three cases were registered that required further review. We have agreed to formalise this approach, and have agreed that any Covid related enquiries will be directed to the Director of HR&OD for consideration by Gold Command.

Two factors appear to have influenced the reduction in contacts. Last year a significant number a staff from just one service raised concerns. The other factor has been Covid. I have received many calls from staff who said they did not want to speak up at a time when they appreciated that services were stretched. We also chose to prioritise cases relating to staff or patient safety during the original lockdown. Whilst numbers have recently started to increase we remain mindful of the operational capacity to conduct requested reviews/investigations.

The grid below shows the previous three 6 monthly activity summaries provided to the Board of Directors and the 2020/21 Q3 results from the end of September to the end of December 2020.

	September 2019	March 2020	September 2020	December 2020
Total cases	28	44	27	6
Patient safety	5	16	2	3
Staff safety	0	3	8	0
Allegations of bullying	10	23	16	3
Culture systems/processes	4	2	1	0
Anonymous cases	12	25	13	1
Resolved cases	20	15	5	0

3. KEY ISSUES:

3.1 **Training**. Following the National Guardians Office recommendation to offer all staff a level of Speaking Up awareness training we developed a shortened version of the current package delivered to managers. Unfortunately like much training activity it has been suspended until the early part of 2021. In the interim staff had been asked to address their outstanding mandatory requirement by completing an on line training video from the HEE. Whilst this training was not service specific, it did offer some level of information and assessment of understanding. However this package is now out of licence. Following the training requirement guidance published by the National Guardian's Office last year, they have finally started to deliver the e-learning packages. So far we have uploaded the initial, 'all staff' training on our system, and hope to have two further packages available for middle and senior managers in the near future.

3.2 **Support networks.** Locally, Barry Speak continues to act as Deputy Freedom to Speak Up Guardian. Barry also provides a service to people who see him in his capacity as a staff psychologist working within the Employee Psychology Service. This arrangement has again proved invaluable, and despite his own work pressures, Barry has continued to support the TEWV Freedom to Speak Up service.

Our local network forum continues to meet regularly for sharing of intelligence, and peer support via MS teams. The potential to feel disconnected and out of touch whilst home working is a constant concern. Through our sharing we have been better able to coordinate action plans with teams and offer more focussed feedback to services.

Our regional network for trust guardians meets quarterly. We have a rotating chair which has recently been supported by the National Guardians Office who have appointed regional representatives to support us, keep up to date with developments, and continue the work of developing the service to ensure equity of provision.

Our National Guardians Office continues to support and become increasingly clear about what 'best practice' might look like, through a weekly newsletter, and the publication of service reviews. However the National Guardian's Office could be stretched as they are home working whilst prioritising the development of Guardians within the primary care sector.

3.3 **Development of Champions.** We currently have thirty Dignity at Work Champions, a reduction of three compared to the number stated within my last report. Progress made with developing he Dignity at Work Champions network has been understandably hampered by the current crisis.

Development of the role, and support during the initial roll out has been compromised. I intend to work with HR colleagues to develop a coordinated plan to deliver training and support to ensure that the volunteers are able to offer support, advice and training on speaking up within their respective localities from March 2021 onward. This would seem to be a good time to relaunch the Dignity at Work Champions initiative within TEWV and would support achievement of the goal of making TEWV a Great Place to Work.

3.4 **Data Management.** The collection and analysis of data is central to ensuring that we can learn from our experiences. However we have continued to have reliability issues with the original reporting system. It was intended to be a central record that captured for all cases however, the system has not proved to be reliable. The TEWV IT department is currently developing a replacement system, and I hope to start testing it shortly.

3.5 **Feedback.** It remains challenging to get feedback post involvement from people who use the service. This is also a concern nationally. We receive regular supportive messages about staff valuing our support, but few feel able to say whether they have experienced detriment, or whether they would feel confident to speak up again. Our regional guardians group is considering ways in which we could adopt practices to improve this aspect. This year we have received only two feedback comments; both positive.

3.6 **Learning from experience.** At the end of last year we had a meeting between operations, HR and myself to review our progress to date, and consider developments and improvements we could make. We shared the experience of those who had conducted investigations, and heard the reflections of some who had been investigated. We concluded that some standardisation of process would be helpful for those conducting investigations, and a review of the language used may go some way to limit the negative impact sometimes felt by teams selected for scrutiny. It was noted that some teams had felt being 'investigated,' gave a very public belief that there was already a presumption that there was fault to be found. They preferred the term service review.

3.6.1 We have also committed to developing a more flexible approach to how best to look into concerns. To date most have rigidly followed a grievance/complaint investigation model. In some instances a more rapid or informal approach may resolve the concern. We have already started using a wider range of approaches and will be actively evaluating and reviewing the outcomes. This flexible approach has resulted in quicker resolution is some instances and appears less intimidating.

3.6.1 The external investigation into concerns raised within Forensic Services concluded at the beginning of lockdown. Unfortunately a number of staff could be identified in the report so could not be shared with the wider staff group. Ruth Hill delivered two webinars to share the anonymised findings and

opportunity question the findings in the Summer. Since then there has been a comprehensive action plan and a number of initiatives to address the findings, and engage with the staff team. I have been invited to be a member of the cultural oversight group to ensure that the voices of the 27 staff who initially raised their concerns are heard. Regaining the trust of these staff in the service, and belief that the team can act fairly and impartially remains a challenge.

3.8 **Covid 19** Since the beginning of the current pandemic there has been a significant reduction in the number of contacts received. Initially there was a flurry of concern related to PPE or building facilities. Given the daily updating of advice, and prompt management action, most were addressed to staff's satisfaction. A few of those speaking up noted that they had questioned whether it was right or fair to raise concerns at the moment knowing that all services are stretched. Many guardians elsewhere have also noted reported this drop in non Covid related referrals and are concerned in case we miss cases. Initially we told staff that in line with all HR processes, we would be prioritising patient and staff safety cases, and putting some investigations on hold. However we now need to reassure staff that speaking up remains a vital responsibility, and that approaching the Freedom to Speak Up Guardian remains an option for all staff. We continue to work with the communications team to ensure we regularly remind staff of who we are and how to speak up.

3.9 Since the initial lockdown reviewing managers have managed to continue to look into concerns raised before and during the pandemic but I appreciate that this has not always been straightforward.

3.10 Immediately prior to the start of the pandemic we identified a number of potential service developments. Amongst the issues that we now wish to explore is the potential for greater use of conciliation and mediation as alternatives to investigation. The provision and communication of clearer descriptions of the roles and responsibilities of those involved within the Freedom to Speak Up process, indicative timescales to work to may also assist. Further issues include how to best inform the contents of TEWV leadership and management development programmes and the potential for a dedicated independent investigation resource.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** Having effective speaking up arrangements in place is an important way to help ensure that TEWV can meet related CQC standards.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.

4.4 **Equality and Diversity:** All TEWV staff ought to be able to access the Freedom to Speak Up Guardian regardless of job role, location or protected characteristic.

4.4 **Other implications:** None identified.

5. RISKS: None identified.

6. CONCLUSIONS:

6.1 It is difficult to draw like for like comparisons between the activity and feedback received during the last nine months and previous reporting periods due to the exceptional nature of the circumstances that were present during 2020 and which continue.

6.2 There is an opportunity to relaunch the network of Dignity at Work Champions and to refresh the role of the champions in a way that can help raise awareness amongst staff and to make the champions more effective. This will complement efforts to improve TEWV as a place to work.

6.3 Over the coming weeks we will be revisiting potential service developments identified immediately before the pandemic.

7. RECOMMENDATIONS:

7.1 To note the contents of the report and to comment accordingly

Dewi Williams
Freedom to Speak Up Guardian

Background Papers:

ITEM NO. 12

Trust Board of Directors

DATE:	**January 2021**
TITLE:	**Guardian of Safe Working Quarterly Report**
REPORT OF:	**Dr Jim Boylan, Acting Guardian of Safe Working**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

It is the responsibility of the Guardian of Safe Working to provide Annual & quarterly reports to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.
The 2016 Junior Doctor Contract was implemented for psychiatry trainees starting new contracts in February 2017. Mandated monitoring processes for the year have not identified any breaches to terms and conditions of service requiring the levy of a fine.
The Trust Exception Reports mainly reflect variation in work on non-resident rotas and a new process for this has been implemented and is under review. Processes are in place for ongoing scrutiny and review of work schedules to provide assurance of safe working environments and consideration of training and service needs. There has been extensive Junior Doctor engagement in planning & implementation of rota changes and recording activity.

Recommendations:

The Board are asked to read and note this Quarterly update report from the Acting Guardian of Safe Working.

MEETING OF:	**Trust Board**
DATE:	**January 2021**
TITLE:	**Quarterly Report by Acting Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

The Board receive Annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for Junior Doctors. This report contains both annual and quarterly data in the appendices and includes aggregated data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern. This will provide assurance to the Board and if needed, ask for approval for action to rectify a safety concern.

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours and during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.
The Guardian role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The guardian is required to levy a fine against a department(s) if a doctor works on average over 48 hours/week, works over 72 hours in 7 days or misses more than 25% of required rest breaks. The work of the guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

3. KEY ISSUES:

- The ongoing core issue of concern for all healthcare staff and managers in the current climate remains to be the delivery of high quality mental health care within the constraints placed upon us by the Covid 19 pandemic. As everyone is aware we had been placed on a high level of restriction and alert in this region prior to National Lockdown and we are all experiencing a Winter surge in cases.

- In this last quarter we noted that on Teesside there were 2 Foundation doctors who were held back from rotating to Psychiatry as expected in order to support acute services during the CoVID Pandemic, which is understandable given the Winter surge in cases.

- I continue to be very impressed and reassured by the way that our Junior Doctors within TEWV have reacted to these challenges despite understandable raised levels of anxiety and this has been helped by the supportive and reactive stance taken by the trust in the context of the organisation of clinical services, medical staffing and educational support and provision. Junior doctors appear to continue to adapt well to distance working and to support clinical services in whatever

ways they can. In this last period I am not aware of any expressed concerns about PPE availability and local arrangements for managing this across different sites appear to have clarified and settled. There have been no specific reports in this period of junior doctors being forced into inappropriately risky situations. The regular trust briefings and updates from the Medical Director continue to provide clarity and guidance as do the fortnightly webinars hosted by Medical Development.

- In November I reported concerns around the lack of adequate on call accommodation and provision for Junior Doctors in Cross Lane Hospital, Scarborough and Lanchester Road Hospital. I was heartened by the Board's prompt and decisive response and am pleased that appropriate rooms have been identified and resources ordered (beds etc). The only frustration on behalf of the Junior Doctors is the time that the ordering process seems to be taking.

- Since my last update I have had no further specific reports by Junior Doctors of concerns around excessive workload, excessive expectations around clinical competency or workplace tensions in West Park hospital. We shall of course continue to monitor the situation through the Junior Doctor Forum (JDF) and word of mouth.

- We have decided to change the process and operational structure of the JDF due to volume and pressure of business in both North and South Sectors. Moving forward we will separate the sectors and have 2 separate forums in each Quarter (One for North and one for South), except in Autumn when we will all come together have a whole day event incorporating a Trust-Wide JDF (half day) and Wellbeing Conference (half day) with internal and external speakers. We have disbanded the separate Wellbeing committee and incorporated that business into the JDF. For now the meetings will continue on a regular basis via MS Teams in addition to the fortnightly webinars and quarterly Postgraduate Boards held in the Durham / Teesside and York/ N Yorks sectors. We continue to provide availability for regular additional supervision and coaching / support sessions for junior doctors to access by phone or video-link if required. Medical development have commenced and are continuing to provide regular weekly postgraduate teaching across all localities via MS Teams.

- A detailed breakdown of Junior Doctor numbers, status, exception reporting and locum usage is contained in **Appendix 1** which incorporates data for both Durham / Teesside and York / North Yorkshire updated for the 4th quarter of 2020. There continues to be an obvious excess of exception reporting in the Teesside area over this past quarter along with a continuing excess in Guardian fines levied in the same locality. This remains much more than in either Durham or N Yorkshire and remains under scrutiny. The anonymised Guardian fines levied in the last quarter are documented along with locality totals in **Appendix 2.** As previously they are virtually all attributable to lack of 5 hours continuous rest overnight in Non Resident Rotas.

- I wanted to make the board aware of concerns expressed by Senior Registrars on call – particularly on the Teesside area about being called to make a unilateral

assessment of patients under section 136 in the Emergency Assessment (CAS) suite at Roseberry Park Hospital if they have been waiting 3 hours. In order to appropriately complete a section 136 assessment the patient should also be assessed by an Approved MH Professional (usually the duty social worker) who may not respond within the 3 hour wait limit (which I believe has been instituted on Teesside to comply with CQC guidelines) and Senior Registrars say they feel they are being pressured to attend to assess and make a unilateral decision about whether to discharge the patient or proceed to formal further assessment for admission. This is not appropriate within the MH Act code of practice which requires an AMHP and a Section 12 approved doctor to properly discharge a section 136. Our Director of Medical Education has been trying to negotiate an appropriate response and support protocol with Clinical management and has also been in contact with Dr Khouja about the issue.

- I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified and reasonable timeframes. The medical staffing department have supported doctors' supervisors to action these appropriately and maintain a log that enables trends to be spotted and reports submitted to locality forums.

- The large majority of exception reports over this quarter have been placed for additional hours of work on call – some relate to persistent extension of normal working hours in some posts, but in the main these have been adequately responded to by clinical supervisors. Higher levels of exception reports in different localities relate to the degree of variation in out of hours non-resident on call rota work and are particularly noticeable for senior registrars across specialities. We continue to utilise a non residential on-call log form' which appears to be well accepted by the trainees. I am satisfied that doctors are appropriately paid for work undertaken.

- Since my last report we have been investigating the situation and challenges for junior doctors in getting access to clinical results on-line and out of hours through the Web-Ice system for patients admitted within our trust. This is not something that the Trust can solve unilaterally as it involves multiple contracts for licences to access the clinical results service with a number of different partner acute trusts. Medical Development have been consulting with CNTW who have established a collaborative partnership through their IT department with their corresponding acute trusts IT departments - which apparently allows for the pre-allocation of licences for Junior Doctors due to rotate into Mental Health and rapid registration once they arrive. We are hoping that we can potentially replicate a similar system. In the meantime we continue to monitor and ask junior doctors to make Datix reports on each occasion that they have struggled to access results through WebIce

- Beyond the particular concerns raised in this report, from the current perspective of the Guardian of Safe Working there seems no sense in trying to make longer term strategic plans or particular recommendations for Junior doctors safety and working conditions until we eventually emerge from the real challenges of the extended Pandemic. It is evident that it will continue to have a major impact for the foreseeable future and may well have a fundamental and lasting impact in

terms of how we all work. As previously stated we will continue to monitor the situation very closely and maintain clear and co-ordinated channels of communication and update the board accordingly.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour. This report evidences maintenance of these standards.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board understands that extra costs will be incurred for additional anti-social hours work and breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to junior doctors is necessary and appropriate.

4.3 Legal and Constitutional (including the NHS Constitution):

The Learning and Development Agreement signed by the Trust with Health Education England clearly sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow junior doctors to fulfil their curriculum needs within a sound learning environment.

4.4 Equality and Diversity:

The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity has therefore been co-opted to the quarterly trustwide Junior Doctor Forum. An Equality Impact Assessment has been completed and is updated within the forum. The Champion of Flexible Working is a core member of the Junior Doctor forum and holds an additional forum / network for less that full time doctors.

4.5 Other implications:

It is important that our junior doctor colleagues continue to experience that we are supporting them in providing an appropriate and safe learning environment.

5. RISKS:

The ongoing and developing crisis with Covid 19 and adaptations required to maintain working practices and conditions as safe as possible for junior doctors.

Failure to provide adequate rest and accommodation facilities for Junior Doctors Working Out of Hours will impact upon safety and patient care and also the reputation of the trust as an employer of quality for future consultants.

It remains important to monitor the situation following major service changes as in North Yorkshire and also where work intensity appears high, such as the apparent

situation on Teessdide – and where there may be additional burdens and reduced levels of supervision for the most Junior staff due to colleague and senior doctor vacancies.

We encourage high levels of exception reporting and with current levels of negative media attention – these may be misunderstood and be reported in the media without adequate understanding of our processes – which may lead in turn to reputational risk.

Continuing difficulties in access for Junior Doctors in some localities to clinical lab results through WebIce provides potential risks in clinical safety for patients and a reputational risk for the trust.

In the context of the current requirements for social distancing our normally robust structures for Junior Doctor Forums and meetings between senior medics continue to be more challenged, although in general people have adapted well. It remains to be seen how effective these necessary adaptations will prove in the longer term but we will continue to monitor this and I am satisfied that these continuing efforts are a positive response and should provide assurance of interventions to mitigate some of the potential risks highlighted.

6. CONCLUSIONS:

Despite the continuation of an extremely challenging current environment due to the Covid19 Pandemic the organisation in the main continues to fulfil requirements of the new 2016 Junior Doctor Contract and I am encouraged by the pro-active response to recent concerns about provision of adequate on-call facilities.for Junior Doctors in the Lanchester Road and Cross Lane Hospital sites.

I was pleased to note that no further concerns have been raised by Junior Doctors on the West Park hospital site. It is clear we need to continue monitoring work intensity on Teesside and find an acceptable response to concerns raised about the pressure on Senior Registrars on call in the assessment of Section 136 patients in the CAS suite on Teesside.

Junior doctors appear to be appropriately submitting exception reports which are themselves being handled and reviewed appropriately through Medical Staffing. I am satisfied that reasonable processes continue to be in place to identify and rectify issues of safety despite the stringencies of safe distance working. Appropriate alternative measures continue to provide ongoing training and support for Junior Doctors through regular webinars and video conferencing. Careful monitoring of the effectiveness of these measures will continue through maintaining regular open channels of communication with Junior Doctors.

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7. RECOMMENDATIONS:

The Board are asked to read and note this Quarterly report from the Acting Guardian of Safe Working.

Author: Dr Jim Boylan

Title: Acting Guardian of Safe Working for Junior Doctors

Background Papers:
Appendix 1 : detailed information on numbers, exception reports and locum usage for both Durham / Teesside and York City / North Yorkshire localities - fourth quarter 2020.
Appendix 2 – Details of fines incurred and levied in fourth quarter 2020.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data – Teesside, Durham & Darlington

Number of doctors / dentists in training (total): 74

Number of doctors / dentists in training on 2016 TCS (total): 72

Amount of time available in job plan for guardian to do the role: 1.5 PAs

Admin support provided to the guardian (if any): 4 Days per quarter

Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st October 2020 up to 31st December 2020

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	7	7	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	4	4	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	21	21	0
CT1-2 –North Durham	0	0	0	0
CT1-2 – South Durham	0	0	0	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	13	13	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	3	3	0
Total	**0**	**48**	**48**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	31	31	0
Teesside & Forensic Senior Registrars	0	10	10	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
Total	**0**	**41**	**41**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	0	35	0	0
Teesside & Forensic Senior Registrars	0	13	0	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
Total	0	48	0	0

There have been no exception reports submitted from any junior doctors within the Durham and Darlington locality this quarter. Both junior doctor rotas are now resident and as the majority of exception reports submitted before were from the North Durham trainees who took part in the 8 weekly NROC monitoring period this is no longer the case.

In Teesside, there were 48 exception reports received, 41 of which were for working above the work schedule (no enhanced hours are included in the schedule, therefore trainees get paid for all work during that time when on call). The other 7 reports were from trainees working late, which the ADME is aware of and discussed with supervisors.

There have been 2 doctors on long term sick during the 3 months, plus a number of doctors who have taken emergency time off due to self-isolation. Additionally, there were 2 F2s who did not transfer into psychiatry as planned. All these shifts needed covering.

Work schedule reviews

Work schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST4 - 6	0

Work schedule reviews by locality	
Teesside & Forensics	0
North Durham	0
South Durham	0

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	14	14	0	168.5	168.5
	CT1/2/GP	11	11	0	127	127
	CT3	7	7	0	93	93
	Trust Doctor	0	0	0	0	0
	SPR/SAS	13	13	0	248	248
North Durham	F2	0	0	0	0	0
	CT1/2/GP	19	19	0	212	212
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	SPR/SAS	0	0	0	0	0
South Durham	F2	0	0	0	0	0
	CT1/2/GP	8	8	0	91.5	91.5
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	SPR/SAS	40	40	0	704	704
Total		**112**	**112**	**0**	**1644**	**1644**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	67	67	0	1011.5	1011.5
Sickness	45	45	0	632.5	632.5
Increase in workload	0	0	0	0	0

Total	**112**	**112**	**0**	**1644**	**1644**

Vacancies

Vacancies by month						
Locality	**Grade**	**October 2020**	**November 2020**	**December 2020**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	2	2	3	2.3	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	1	1	1	1	0
	Trust Doctor	0	0	0	0	0
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	3	3	3
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
South Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	12	13	12	37	37
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**16**	**13**	**21**	**43.3**	**40**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	17	£4,922
North Durham	0	£00.00
South Durham	0	£00.00
Total	**17**	**£4,922**

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
£9,840.9	**£4,922**	**£00.00**	**£14,762.9**

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data – North Yorkshire & York

Number of doctors / dentists in training (total):	58
Number of doctors / dentists in training on 2016 TCS (total):	58
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st October 2020 up to 31st December 2020

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - York	0	6	6	0
CT1-2 - Northallerton	0	4	4	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	5	5	0
CT1-2 - York	0	1	1	0
CT3/ST4-6 – Northallerton	0	1	1	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	1	1	0
CT3/ST4-6 – York	0	2	2	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	0	0	0
Trust Doctors - York	0	0	0	0
Total	**0**	**20**	**20**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton/ Harrogate/ York	0	14	14	0
Scarborough	0	6	6	0
Total	**0**	**20**	**20**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Northallerton/ Harrogate/ York	0	8	6	0
Scarborough	0	2	4	0
Total	0	10	10	0

Work Schedule reviews

Work schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST4 - 6	0

Work schedule reviews by locality	
Northallerton	0
Harrogate	0
Scarborough	0
York	0

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Northallerton/ Harrogate/ York	F2	17	17	0	236.5	236.5
	CT1/2/GP	27	26	0	169.5	157
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	ST4-6/SAS	22	21	0	416	400
Scarborough	F2	0	0	0	0	0
	CT1/2/GP	19	19	0	328	328
	CT3	0	0	0	0	0
	Trust Doctor	8	8	0	160	160
	ST4-6/ SAS	78	78	0	1410	1410
Total		**171**	**169**	**0**	**2720**	**2692**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	0	0	0	0	0
Sickness	31	29	0	519	491
Other	140	140	0	2201	2201
Total	**171**	**169**	**0**	**2720**	**2692**

Vacancies

Vacancies by month						
Locality	**Grade**	**October 2020**	**November 2020**	**December 2020**	**Total gaps (average)**	**Number of shifts uncovered**
Northallerton/ Harrogate/ York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	Trust Doctor	0	0	0	0	0

Total	**0**	**0**	**0**	**0**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Harrogate & Northallerton	1	£94.46
Scarborough	0	£00.00
York & Selby	0	£00.00
Total	**1**	**£94.46**

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£806.16	**£94.46**	**£00.00**	**£900.62**

GoSW Board Report – January 2021 - Appendix 2

Guardian Fines Levied – 4th quarter 2020 – All Localities

All Fines levied during this quarter arose from Teesside area

Teesside Senior Registrar Rota

Sen Reg (5 on calls)
Total Hours – 3.25
Guardian fine - £306.9
Dr gets - £184.21

ST4, 78604 (5 on calls)
Total hours – 4.25
Guardian - £401.46
Dr - £240.89

ST6, 78300 (5 on calls)
Total hours – 6.5
Guardian - £613.99
Dr - £368.42

ST6, 79924 (4 on calls)
Total hours – 9.5
Guardian - £897.37
Dr - £538.46

ST6, 83486 (4 on calls)
Total hours – 0.25
Guardian - £23.62
Dr - £14.17

ST6, 83154 (5 on calls)
Total hours – 0.75
Guardian - £70.85
Dr - £42.51

ST4, 82189 (3 on calls)
Total hours -1
Guardian - £94.46
Dr - £56.68

ST6, 83121 (1 on call)
Total hours – 1.5
Guardian - £141.69
Dr - £85.02

ST6, 83149 (7 on calls)
Total hours – 7.5
Guardian - £708.45
Dr - £421.10

GoSW Board Report – January 2021 - Appendix 2

Guardian Fines Levied – 4th quarter 2020 – All Localities

ST6, 83122 (5 on calls)
Total hours – 5
Guardian - £472.30
Dr - £283.40

ST6, 83116 (9 on calls)
Total hours – 16.5
Guardian - £1558.59
Dr - £935.22

SUB TOTAL for Senior Registrars - £ 5289.68

Teesside Junior Grades Doctors Rota

GP Trainee (3 on calls)
Total Hours – 0.75
Guardian fine - £55.89
Dr gets - £33.54

F2 trust doctor (4 on calls)
Total Hours – 1.5
Guardian fine - £94.485
Dr gets - £56.685

CT1 (2 on calls)
Total Hours – 4
Guardian fine - £298.12
Dr gets - £178.88

2nd GP Trainee (2 on calls)
Total Hours – 3.75
Guardian fine - £279.4875
Dr gets - £167.7

GP, 78746 (4 on calls) June 2020
Total hours – 0.25
Guardian - £18.63
Dr – £11.18

CT1, 78720 (2 on calls) June 2020
Total hours – 3.25
Guardian - £242.22
Dr - £145.34

CT3, 78495 (2 on calls) May 2020
Total hours – 0.5
Guardian – £37.27
Dr - £22.36

GP, 78467 (3 on calls) May 2020
Total hours – 2.25
Guardian - £167.69
Dr - £100.62

GoSW Board Report – January 2021 - Appendix 2

Guardian Fines Levied – 4th quarter 2020 – All Localities

CT1, 82300, (2 on calls) October 2020
Total hours – 8.75
Guardian - £652.14
Dr - £391.30

CT3, 83113 (3 on calls) October 2020
Total hours – 0.5
Guardian - £47.23
Dr - £28.34

CT1, 83114 (1 on call) October 2020
Total hours – 0.25
Guardian - £18.63
Dr - £11.18

GP, 83685 (1 on call) November 2020
Total hours – 0.5
Guardian - £37.27
Dr - £22.36

GP, 83440 (2 on calls) October 2020
Total hours – 0.5
Guardian - £37.27
Dr - £22.36

CT1, 83138 (1 on call) October 2020
Total hours – 4.5
Guardian - £335.59
Dr – £201.24

F2, 83691 (2 on calls) September 2020
Total hours – 0.5
Guardian - £31.50
Dr - £18.90

F2, 83852 (3 on calls) November 2020
Total hours – 1
Guardian - £62.99
Dr – £37.39

CT1, 84604 (4 on calls) August 2020
Total hours – 3
Guardian - £223.59
Dr - £134.16

SUB TOTAL – Junior Training Grades - £ 2602.75

TOTAL Guardian Fines Approved and Levied for 4th Quarter 2020 - £ 7892.43

Quality Assurance Committee Meeting Update

Board of Directors – 26th January 2021

Headlines

This report provides an update on the business discussed at the Quality Assurance Committee meeting held on 05 December 2020.

Common Locality Issues

- **Capacity and demand issues with increasing number of referrals to various services.**
- **Difficulties recruiting to some nursing and clinical posts.**
- **The ongoing impact of Covid-19 and lock down measures:**
  - **Implications on managing outbreaks across various wards and areas, isolating and cohorting, leave arrangements and cancellations, visiting and a higher number of falls.**
- **Staff wellbeing – growing evidence of staff fatigue, lack of safe spaces to take breaks/lunch. There is continued focus on regular briefings, including health and well-being information.**

Locality Issues: North Yorkshire and York

Top areas of concern:

- A request was made to silver command to reduce the number of beds on Danby and Esk to retain the current locum consultant who had been covering both Danby and Esk Wards. The locality medical workforce is planning how this can be resolved.
- Increased volume of child eating disorder referrals – urgent assessments are being offered by the team by flexing capacity.
- Higher incidences of falls, most likely related to Covid and cohorting plans. Training has been given by Physiotherapists and improvements made. This is being monitored closely at QuAG/LMGB level.
- Oak Rise was closed to admissions due to one covid-19 positive patient who required ECT therapy and this was being discussed at the Ethics Committee.
- During November there were no breaches with checking emergency equipment and no instances of the use of mechanical restraint or tear proof clothing.

Locality Issues: County Durham and Darlington

Top areas of concern:

- Increased waits for autism and ADHD assessments – teams are identifying trajectories to incorporate the backlog as formulations are back to March 2020 levels of 24 per week.
- Deteriorating position of care homes due to impact of Covid-19. Recruiting to enhanced CHL Hub and Care Home Wellbeing Service progressing well.
- Pressures of supporting a number of Tees patients. Bed capacity tight and acuity high, however had been able to manage staffing through flexible approaches.
- Recognition of the vulnerabilities for those with learning difficulties. Individual risk assessments will be made with reasonable adjustments offered.

During November there were no breaches with checking emergency equipment. There were no instances of the use of mechanical restraint and no episodes of the use of tear proof clothing.

Locality Issues: Teesside

The Committee received the locality update in the revised style format, which will be piloted for three months, The Quality Assurance and Learning Report. Standardising the locality reports had been one of the key recommendations following the QuAC Away Day to improve the reporting and levels of assurance provided to the Committee. The layout, centred around the CQC domains, uses SPC charts and a what, so what, now what approach as well as identifying how learning is

Quality Assurance Committee Meeting Update

Board of Directors – 26th January 2021

being used to improve. The new report was welcomed by members of the Committee as it contained a sharper more focused narrative with relevant analysis and assurance.

Top areas of concern:

- Impact of Covid-19 increased infection rates on staffing with increase in bank and agency use. Skill mix being reviewed daily.
- Ability to maintain services and bed admissions during periods of outbreaks. Daily bed management calls in place.
- Cohorting plans being reviewed due to the high levels of self-harm incidents, 22 attributable to AMH inpatient services and 13 involving a ligature. Options being looked at to provide alternative capacity to expedite ligature works.

  During November there were three instances where the resuscitation equipment had not been checked on two ward and one use of tear proof clothing.

Locality Issues: Forensics

Top areas of concern:

- Following a deep dive of cancelled leave from August to October a plan based on the findings is being developed.
- Two nurse secondments have been developed in response to pressures in Health and Justice and the high number of outbreaks.
- Issues have been raised with Spectrum, the prime provider regarding the high number of referrals to HMP Durham prison and business continuity plans have been implemented.
- A ward improvement plan has been implemented where there were concerns over staff attitude, particularly in relation to black and ethnic minority groups. Investigations are ongoing.

The Committee received the Forensic Services Culture Review Action Plan. Opportunities to share information with staff around the ongoing work within the Forensic culture plan would take place in due course.

The Committee requested a stand-alone item on progress with the action plan for the February 2021 meeting.

During November there were:

- Nine instances of using pre-authorised tear proof clothing.
- Five uses of soft restraint devices two for a general hospital appointments and three for transfer to seclusion.
- Four occasions of partially completed or not completed equipment checks meaning compliance was at 99.3%. Individual supervisions have taken place.

Trust Wide Quality & Learning Report

The Committee received for the first time this new report on Trust level Quality Assurance and Learnng Report.

- This integrated report is being developed to combine a number of individual reports into one overarching document with details around the monitoring and assurance of quality indicators.
- Members welcomed the presentation of the quality information setting out statistical process control charts for 16 of the 26 measures identified. Also, that the data is framed around the CQC headings of “safe, effective, caring, responsive and well led” and the strategic goals.
- A further update was requested on the Trust wide indicator for ‘whistleblowing alerts received by the CQC’ which was flagging as ‘much worse compared nationally’. This would report to the February QuAC meeting.
- Some of the benchmarking in the CQC Insight Report published in October 2020 revealed areas where the Trust compared better than nationally around proportion of sick days in the last 12 months for nursing associates, staff believing they have adequate material resources and staff receiving updates on patient feedback.

Quality Assurance Committee Meeting Update

Board of Directors – 26th January 2021

Quality and Patient Safety Key Indicators

The Committee considered the monthly update which included the Trust position showing three areas with no variation. Three areas were reporting special cause variation – improvement for the number of shifts worked greater than 13 hours, Serious Incidents and Head of Service Reviews). Some work will be undertaken to look at any themes across the shifts worked and whether there are particular wards affected more than others.

The locality position showed five areas with no variation and one area indicating special cause variation – improvement for number of shifts worked greater than 13 hours. (North Yorkshire & York and Teesside).

Due to the presentation of the new Trust Wide Quality and Learning Report consideration will be given to whether this report will be needed in future, due to duplication of some of the information.

CQC Action Plan

The Committee noted an update on the action plan as at 25th November 2020.

- Of the 19 actions, 9 were complete, 2 required submission of supporting evidence to facilitate sign off and 4 actions were in progress within timescale. There were 4 actions behind schedule.
- The Chairman of the Committee sought assurance on the oversight of the actions and assurance was given that there was rigorous monitoring by the Compliance Team, alongside operational services with progress reports to the Quality and Safety cell weekly.
- The Quality Compliance Group, suspended during business continuity had been reinvigorated via a webinar on 19th November 2020 to share and spread information.

Exceptions on the Key areas of Quality and Safety

Members received the monthly update, as of 19nd November 2020.
The key matters considered were around:

- Safeguarding adults and children, infection, prevention and control, learning from Covid-19 related deaths, pharmacy, and delivery of the ligature reduction programme.
- There were eight wards where the ligature reduction programme was outstanding and plans were in place for completion.
- There were no areas of concern from the information contained in the report.

Silver Command Quality & Safety (Q&S) Cell Assurance Report

This update report provided QuAC with an overview of the issues discussed by the Quality & Safety cell and the key matters of focus.

The committee recognised that there was repetition in the items covered in this report and with the introduction of the new Trust wide Quality & Learning Report consideration would be given to whether this report will be required at the February 2021 meeting.

Update from Sub-Groups:

Health, Safety, Security & Fire

Reported no risks or concerns and provided assurance around the monitoring of controls, key performance indicators and work plans.

Annual Reports were received and noted from:

- Patient Safety
- Complaints & PALS
- Positive & Safe
- Patient Experience
- Clinical Audit & Effectiveness
- Infection, Prevention & Control

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 14

FOR GENERAL RELEASE

DATE:	**26 January 2021**
TITLE:	**Learning from Deaths – Dashboard Report 2020/21**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

The Learning from Deaths Dashboard Report sets out the approach the Trust is taking towards the identification, categorisation and investigation of deaths in line with national guidance. The mortality dashboard for Q3 of the 2020/2021 financial year is included at Appendix 1 and includes 2019/2020 data for comparison.

Work continues to ensure that the numbers of deaths reported are as accurate as possible to allow us to gain maximum learning from this process. The mortality review process continues to be refined, as detailed in the main body of this report.

Recommendations:

The Board is requested to note the content of this report, the dashboard and the learning points identified.

MEETING OF:	**Trust Board of Directors**
DATE:	**26 January 2021**
TITLE:	**Learning from deaths - Dashboard Report 2020/2021**

1. INTRODUCTION & PURPOSE:

1.1 To formally report the key information on learning from deaths in line with national guidance and the Trust's 'Learning from Deaths: the right thing to do' policy (CORP 00-65).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 All NHS Trusts are required to publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis, which are in-scope of the Learning from Deaths policy, and which have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all of the deaths categorised as in scope for the learning from deaths policy are subject to an initial review before determining if they require further investigation.

The Learning from Deaths policy and the mortality review process remain under review and will be completed by the end of March 2021. New ways of working in relation to proportionate reviews of Serious Incidents continue.

3. KEY ISSUES:

3.1 Mortality Review and Learning

As previously reported, the Mortality Review Manager who was appointed in Q3 2019/2020 went off on long term sick on 23rd March 2020. Although this did not impact on cases falling within the Serious Incident Investigation criteria, it culminated in a backlog of expected and unexpected physical health deaths awaiting review under Part 1 and/or Part 2 of the Mortality Review process as described below. Those cases requiring a more in-depth review under either part 1 or part 2 of the mortality review process (Structured Judgement Review) have either been completed or are awaiting completion. There are currently 8 Structured Judgement Reviews awaiting completion.

In Q3 2020/2021, 126 cases met the criteria for a mortality review. Of those 126 reviews, 10 cases were selected for a more detailed part 2 Structured Judgement Review.

Mortality reviews are completed in-line with guidance from the Royal College of Psychiatrists and peer organisations across the region. All cases within scope have a Part 1 review which identifies any issues relating to the red flag criteria detailed below. Any issues detected relating to these red flags would necessitate a more in-depth part 2 Structured Judgment Review.

The "red-flags" to be considered during the Part 1 review are as follows:

- Family, carers or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care

- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)
- Patient had a Learning Disability. These cases will also be referred to LeDeR
- Prescribed Clozapine or high doses of anti-psychotic medication

This criterion allows for greater learning from a more suitable selection of cases reviewed.

Appendix 2 includes an overview of the cases reviewed and key learning points from the structured judgement reviews which took place during Q3. These issues were not felt to be contributory to the deaths which occurred but have all been fed back to the relevant teams and/or other organisations where appropriate.

3.2 Appendix 1: Dashboard

The learning from deaths dashboard is attached at Appendix 1 which also includes 2019/20 data for comparison.

For Q3 the dashboard highlights the following:

- A total of 670 deaths were recorded (not including LD deaths). This is all deaths (including natural expected and unexpected) in relation to people who are currently open to the Trust's caseload including Older People's Community and Memory Services.
- There were 43 STEIS reportable serious incidents resulting in death reviewed. New ways of working within the Patient Safety Team in relation to proportionate incident investigation has resulted in a back log of cases being completed during Q3
- 29 learning points * were identified from completed Serious Incident reviews
- There were 126 cases highlighted for review under the mortality review process
- 22 Learning Disability deaths were reported on Datix and were reviewed via the mortality review process. These cases have also been reported to LeDeR.
- 6 in-patients deaths were reported over this period. One death occurred in Adult Mental Health services and involved the use of a suspended ligature. This death is being reviewed through the Serious Incident Investigation process. A Rapid Patient Safety Review meeting was held within 24 hours of the incident occurring to ensure all immediate identified actions had been put in place to assure ongoing safety and to share any early lessons identified that could be actioned.
- Four deaths occurred in MHSOP services, three were COVID related and one patient died of natural causes. All four deaths were expected, and all patients were on the end of life pathway. These 4 deaths have been reviewed via the mortality review process. One death involved a person with a Learning Disability, this was a COVID-related death and is being reviewed via the Serious Incident Review process.

- In comparison for the same time frame in 2019/2020 Q3: there were 7 in-patient deaths. These were categorised as follows:

- 2 unexpected patient safety related deaths within inpatient services reviewed under the Serious Incident Investigation process
- 1 MHSOP fracture neck of femur where the patient subsequently died - reviewed under serious incident investigation process
- 4 expected deaths in MHSOP services – reviewed under the mortality review process

**For the purpose of this report the learning identified from Serious Incidents has been categorised as those which concluded with either a root cause or contributory finding meaning the outcome may have been different if different decisions had been made or different circumstances in place. Therefore there are strong opportunities to learn and potentially prevent future deaths. There may be more than one learning point identified in relation to an individual serious incident.*

Part 1 Mortality Reviews and Structured Judgement Reviews, including themes and trends, would normally be discussed at the Trust's Patient Safety Group. This group has been stood down as a result of COVID-19. An interim Mortality Review Panel has been put in place to provide assurance on the back log of mortality reviews that have been completed. The first meeting is to take place on 25/01/2021. The back log of Structured Judgment Reviews will be taken to panel either as an individual report or as part of a thematic review. It is planned that the panel will be a substantive part of governance arrangements moving forward.

3.3 Serious Incidents

For completed Serious Incident reviews in Q3 the four most common root cause or contributory findings (appendix 3) were in relation to care planning (32%) inadequate record keeping (16%) lack of involvement with families (11%) and poor communication (11%).

The Trust has a range of work streams that align to these key themes and are aimed at improvement. Some examples are care planning and documentation, the triangle of care work focusing on patient and carer experience and involvement, harm minimisation training and the ICS suicide prevention training .

The Trust is strengthening its arrangements for organisational learning with the establishment of a task and finish group. An initial focus will be in two key areas:

- Implementing pragmatic and innovative approaches for effectively sharing learning, underpinned by strong governance and assurance processes.
- Revisiting the wealth of learning we already have, taking stock of current status and quickly developing a range of activities to share lessons and improve care

.

Currently Serious Incident reports and findings are shared with services via Quality Assurance Groups. Key messages are also shared Trust wide via patient safety bulletins and where appropriate SBARD processes. Themes and trends are normally discussed at the Trust's Patient Safety Group that monitors trust wide issues, provides support and guidance to clinical services and seeks additional assurances that key issues are understood and learning is being implemented. During this period this surveillance has been undertaken by the Quality and Safety Cell and Gold Command. Through the work of the task and finish group it is anticipated that there will be opportunities for building upon these processes.

Formal action plans are in place for all incidents where a root cause or contributory findings are identified which are closely monitored by the Patient Safety Team and Commissioners.

3.4 In line with the National Quality Board (NQB) guidance for NHS Trusts working with bereaved families, we continue to support and engage families in review processes following the death of a family member. The Trust's Family Liaison Officer role is now well established and we have received extremely positive feedback from both families and staff. The Trust was due to hold its second annual family conference in March 2020; this has been put on hold due to COVID-19 and is regularly under review.

Work is currently being undertaken in relation to involving services and families more in mortality reviews of expected and unexpected physical health deaths. The mortality review process, when looking a new ways of working, will also focus on how improvements can be made in ensuring learning is shared and embedded into practice.

3.5 Figures show a reduction in the number of in-patient deaths reported as serious incidents compared with the previous year in the same period.

3.6 A strategic task and finish group has been established to provide oversight with respect to Suicide Prevention and Self Harm Reduction. The purpose of the group is to support the Trust in the coordination of activities designed to reduce the risk of suicide and frequency of suicide attempts and dissemination of learning and good practice around suicide prevention and self-harm.

4.0 IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
CQC look at a range of data to help them monitor trusts that provide mental health services. This report provides evidence in respect of Regulation 17 – Good Governance.

4.2 **Financial/Value for Money:**
There are financial and reputational implications associated with poor standards of care. A focus on learning helps the Trust to improve the quality and safety of our care services.

4.3 **Legal and Constitutional (including the NHS Constitution):**
CQC's Fundamental Standards in respect of Regulation 17 - Good Governance.

4.4 **Equality and Diversity:**
The Trusts learning from deaths reviews consider any issues relating to equality and diversity to ensure that any issues of discrimination are addressed.

4.5 **Other implications:**
No other implications identified.

5. RISKS:

There is a risk that the data published is compared by others with the data of other organisations that may not provide similar services. There is a risk that if we fail to embed key learning from deaths that patient safety and quality will be compromised.

6. CONCLUSION:

The Trust continues to refine its approach to identification, categorisation and investigation of deaths in line with national guidance. Work is ongoing to ensure the numbers of deaths reported are as accurate as possible and we continue to undertake work to improve the mortality and serious incident review processes to allow us to gain maximum learning. Unexpected deaths occurring as a result of a patient safety incident continue to be reviewed in a way that is proportionate to the circumstances of the incident with the primary aim being to learn lessons and improve the safety of the services we provide. Mortality reviews of unexpected/expected physical health deaths continue to focus on deaths where the Trust is the main care provider. COVID related in-patient deaths continue to be reviewed either under the mortality review process or the serious incident review process depending on the circumstances of the case.

7. RECOMMENDATIONS:

The Board is requested to note the content of this report, the dashboard and the learning points.

Background Papers:

Learning From Deaths Framework
https://www.england.nhs.uk/?s=Learning+from+Deaths

Southern Health Report
https://www.england.nhs.uk/2015/12/mazars/

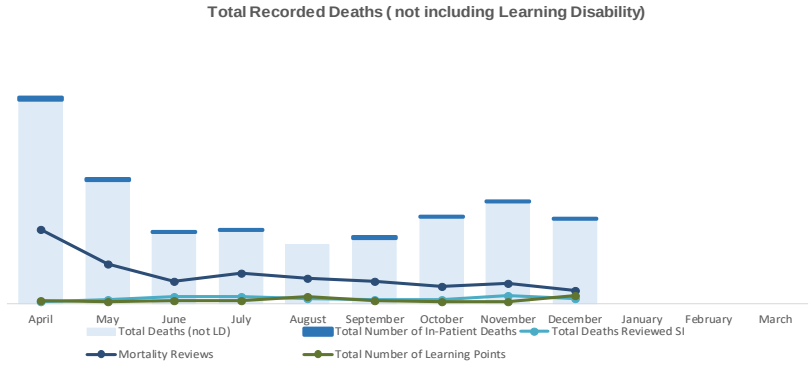
Appendix 1 Dashboard

Learning from Deaths Dashboard - Data Taken from Paris and Datix
Reporting Period - Quarter 3 - October- December 2020

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

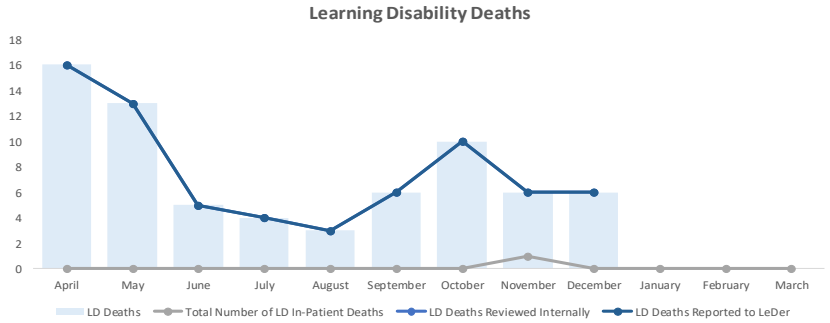
	Total Deaths (not LD)			Total Number of In-Patient Deaths			Total Deaths Reviewed SI			Mortality Reviews			Total Number of Learning Points		
	2020/21	2019/20		2020/21	2019/20		2020/21	2019/20		2020/21	2019/20		2020/21	2019/20	
Q1	979	655	↗	14	8	↗	29	32	↘	337	43	↗	18	1	↗
Q2	485	654	↘	6	6	↔	39	30	↗	191	65	↗	32	18	↗
Q3	670	769	↘	5	7	↘	43	26	↗	126	47	↗	29	23	↗
Q4		719			9			21			105			29	
YTD	2134	2797	↘	25	30	↘	111	62	↗	654	260	↗	79	19	↗



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

	LD Deaths			Total Number of LD In-Patient Deaths			LD Deaths Reviewed Internally			LD Deaths Reported to LeDer		
	2020/21	2019/20		2020/21	2019/20		2020/21	2019/20		2020/21	2019/20	
Q1	34	20	↗	0	0	↔	34	10	↗	34	10	↗
Q2	13	14	↘	0	0	↔	13	7	↗	13	7	↗
Q3	22	24	↘	1	0	↗	22	14	↗	22	14	↗
Q4		24		0	0	↔		14			11	
YTD	69	82	↘	1	0	↗	69	45	↗	69	42	↗

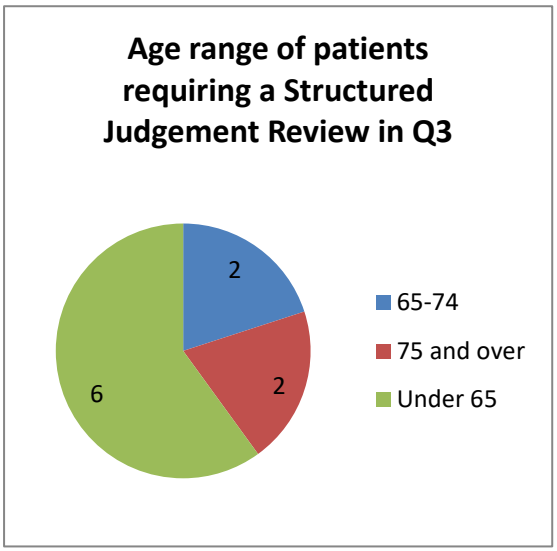


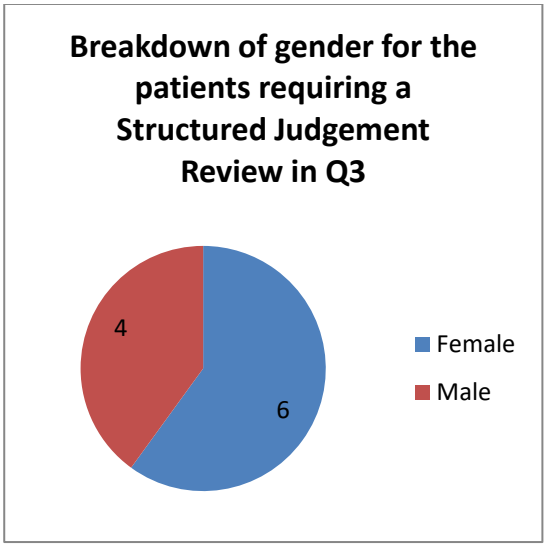
Appendix 2

Mortality Review 2020/2021

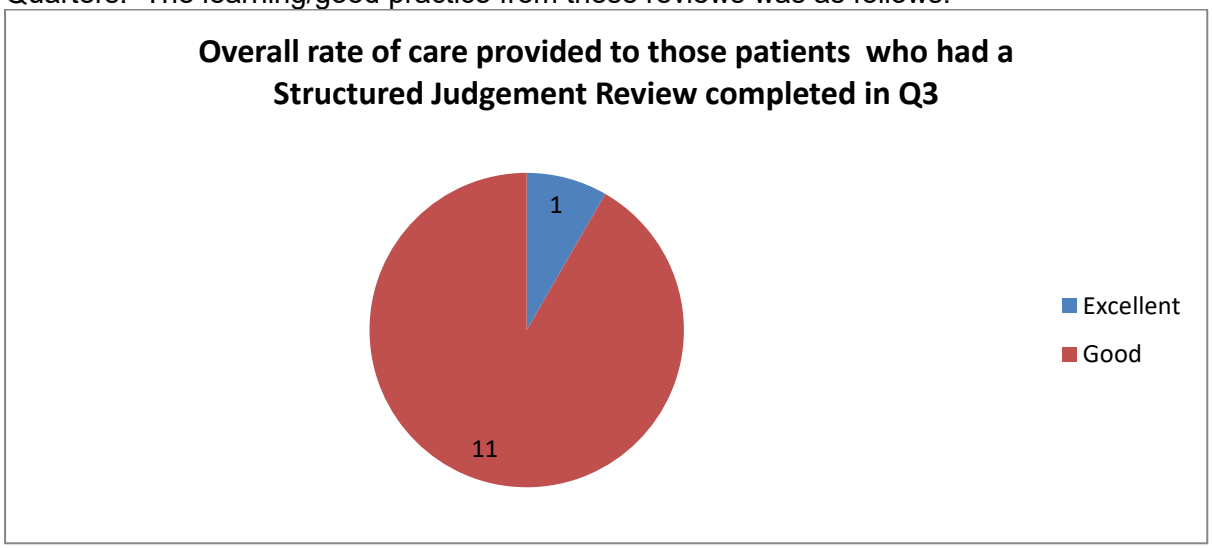
There were a total of 10 Structured Judgement Reviews requested within Q3.

Month	Total Number of Deaths which met criteria for a review	Total Number identified as requiring a Structured Judgement Review
October	42	3
November	51	3
December	33	4
Total		





There were also 12 Structured Judgement Reviews completed within Q3 from previous Quarters. The learning/good practice from these reviews was as follows:



Points of learning from unexpected and expected physical health deaths completed in Q3

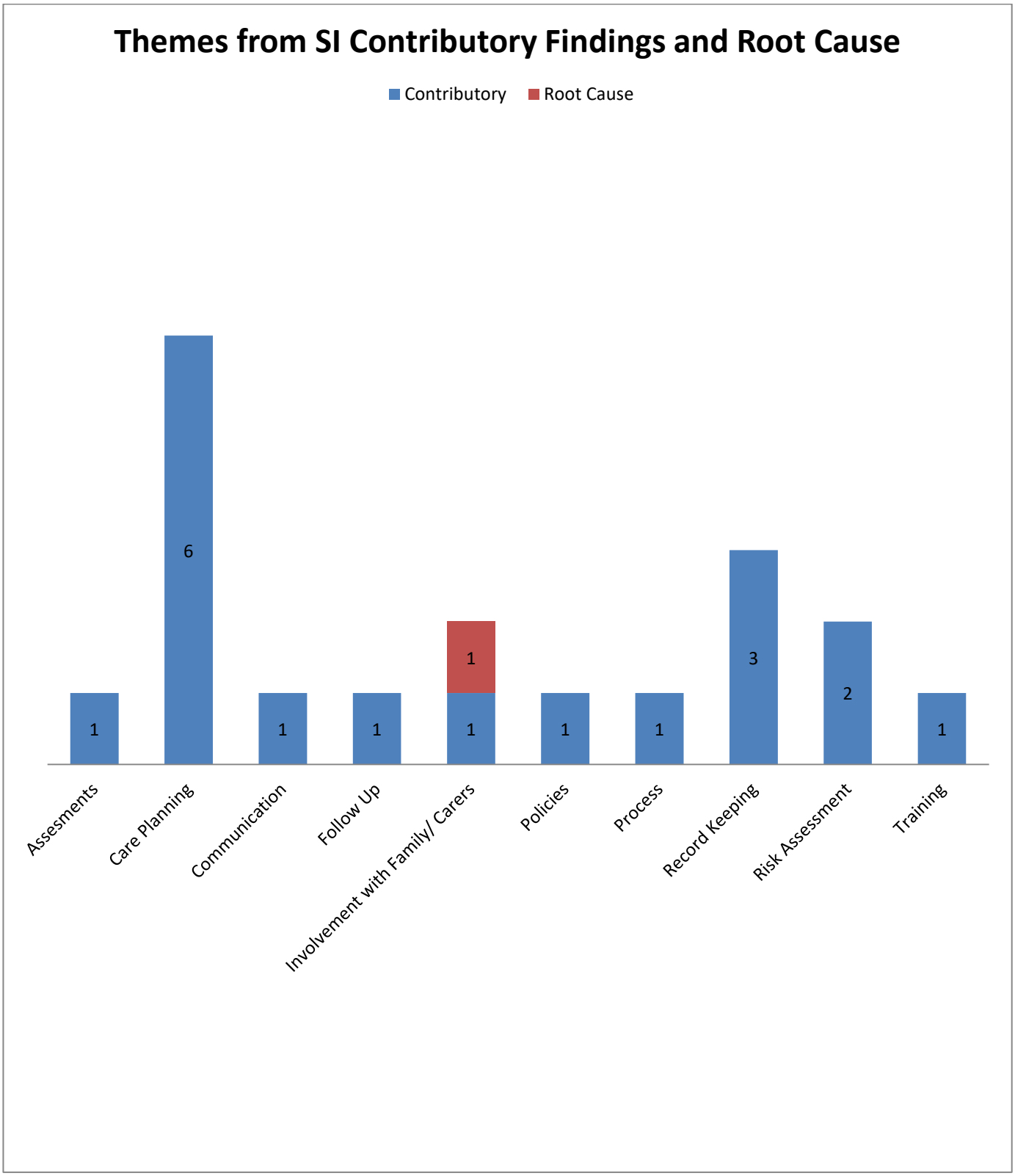
1. It is important that clinical staff are persistent in maintaining a sustained level of engagement particularly with those individuals who appear to have a high level of complexity associated with diagnosis/lifestyle and who maybe non-conforming or compliant with medical treatments suggested. This has benefits in improving both mental and physical health and wellbeing longer term.
2. Impact of social isolation; social anxiety and isolation not to be under-estimated its impact on mental wellbeing particularly under COVID restrictions. There is evidence to support the value in staff being creative with regard to ways in which contact can be maintained during these restrictions.
3. Staff to recognise the importance and value of updating the safety summary if changes in the patient's presentation have been observed, no matter how small or insignificant these may appear at the time of the assessment.
4. Where a person has a high level of complexity and/or contentiousness, there is, on occasions, a lack of objective analysis to extract the learning relating to effectiveness of interventions, particularly after the patient has been assessed as making an improvement in their mental health state and where this may be seen as unusual or out of character for that person.
5. There is evidence to support the value of staff completing and then reviewing the psychological formulation for that person particularly where a degree of complexity exists and where the team are involved with that person over longer term care.

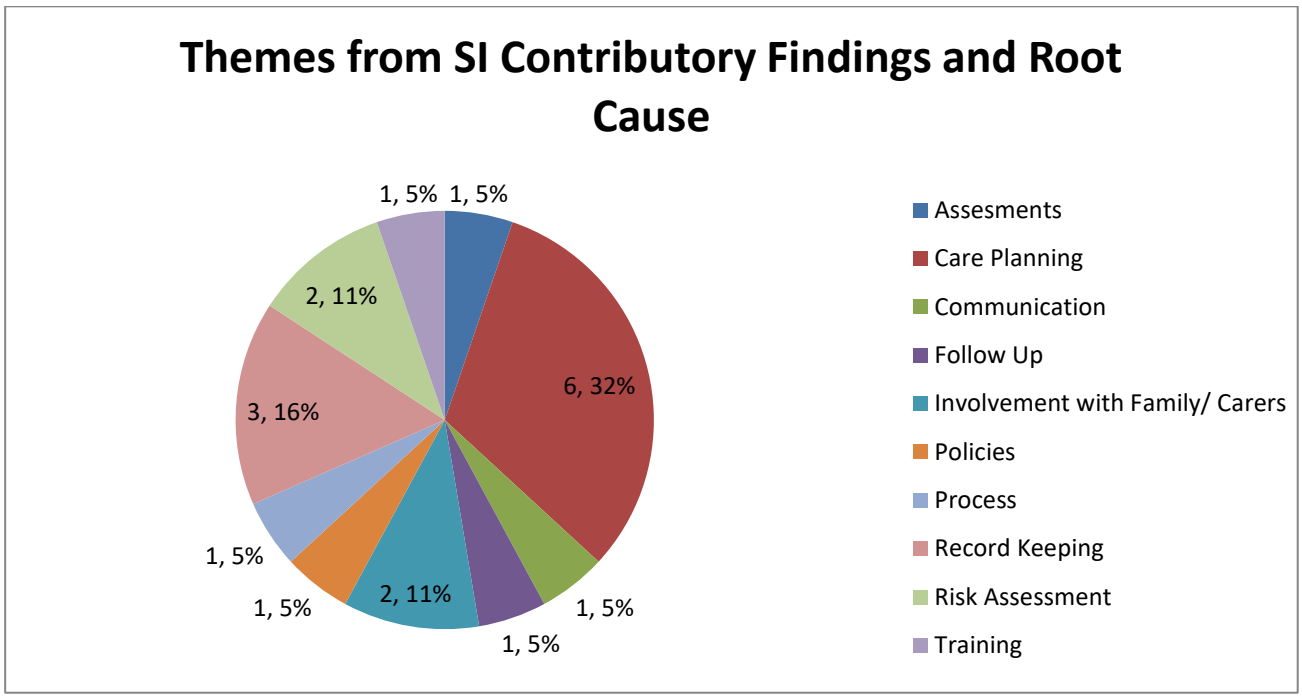
Points of good practice:

1. Proactive use of CPA reviews [process and care planning] to support patients to make informed choices relating to their care and recovery.
2. Value and recognition of psychological interventions being offered to appropriate persons in a timely manner and sustained over a longer period of time.
3. Recognition of how feeling positive about one's health can impact upon and improve mental health particularly where a patient's physical health state is impacted upon [such as chronic health conditions; obesity; cardiovascular risk].
4. Value of recording baseline physical health observations including EWS in recognising deterioration in a patient s physical health state; evidence of increased recording and analysis of physical health data.
5. Evidence that most staff are delivering compassionate care based upon being person-centred and non-judgemental and the positive influence and impact this can have on individuals.

Appendix 3

Serious Incident Review 2020/2021




Themes from SI Contributory Findings and Root Cause
1, 5%
1, 5%
2, 11%
6, 32%
3, 16%
1, 5%
1, 5%
2, 11%
1, 5%
1, 5%
Assesments
Care Planning
Communication
Follow Up
Involvement with Family/ Carers
Policies
Process
Record Keeping
Risk Assessment
Training

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th January 2021**
TITLE:	**Board Performance Dashboard as at 31st December 2020**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	✓
To continuously improve to quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	✓
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

This is the Board level Performance Dashboard for the period ending **31st December 2020**. We have been able to apply Statistical Process Control (SPC) Charts to **18** of the 21 measures. Three measures are finance related and detailed narrative has been provided for these.

Key Issues

Having reviewed the variation and assurance icons in addition to the latest financial year to date performance there has been **4** areas of concern identified and **3** areas which require additional monitoring. Details on why these areas have been highlighted are provided in the table below with further information in Appendix A. Exceptions at Locality level are also noted within Appendix A. Where discussions have taken place with Operational Services and other Corporate Departments on the key areas of concern more detailed information on these can be found in Appendix D.

Key Areas of Concern:

4)	Percentage of patients surveyed reporting their overall experience as excellent or good	This issue was first identified in the September Board Report. Whilst the SPC chart shows common cause variation (no significant change) it also shows that the standard will be met and sometimes missed due to random variation. Given that this is a key measure of quality and that the latest Year To Date (YTD) actual is also below the standard this is an area of concern

		that we need to investigate further. Appendix A provides further information on this including when the next update will be provided.
6)	% of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind	This issue was first identified in the September Board Report. This is a key outcome measure which is indicating special cause variation of particular concern and that the standard will be met and sometimes missed due to random variation. In addition the latest YTD actual is also below the standard therefore we need to investigate further. Appendix A provides further information on this including when the next update will be provided. Whilst our actual performance against the Trust measure isn't at the standard we would want it to be, from the latest data available, we are performing better from a national benchmarking perspective.
9)	The percentage of new unique patients referred with an assessment completed (2 months behind)	This issue was first identified in the September Board Report. This is a key measure of quality and effectiveness which is indicating special cause variation of particular concern and remains within the lower process limit therefore we need to investigate further. Appendix A provides further information on this including when the next update will be provided.
10)	The percentage of new unique patients referred and taken on for treatment (3 months behind)	This key measure of quality and effectiveness has continued to indicate special cause variation of particular concern, is within the lower process limit and below the mean therefore we need to investigate further. Appendix A provides further information on this including when the next update will be provided.

Measures which require additional monitoring:

2)	Percentage of patients starting treatment within 6 weeks of an external referral	The SPC is showing **special cause improvement** and the latest YTD actual is above the standard and the mean (positively). However, the SPC indicates that the standard will be met and sometimes missed due to random variation and there is now a **continuous decline** in the last 5 data points. Given this is a key measure of quality, this is an area that we are undertake additional monitoring. Appendix A and D provides further information on this.
12)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	The SPC chart for this measure first indicated **special cause improvement** in the November Board report and continues with the latest data. The latest YTD actual is below the standard (positively) and the latest data point is within the lower process limit (positively). However, the SPC indicates that the standard will be met and sometimes missed due to random variation and feedback from Operational Services is that bed pressures continue in some specific areas. Given this is a key measure of effectiveness, this is an area that we are undertaking additional monitoring.

		Occupancy is likely being supported by the special cause improvement in the number of patients occupying a bed with a LoS from admission less than 90 days (measure 13). Appendix A provides further information on the work being undertaken in relation to Bed Occupancy including when the next update will be provided.
18)	Percentage Sickness Absence Rate (month behind)	This key workforce measure is showing common cause variation (no significant change) however it also shows that the standard will be met and sometimes missed due to random variation. The latest data point is above the mean and in the upper process limit therefore this is an area that requires additional monitoring. Appendix A provides further information on this including an update on the action plan for Forensics Services.

Positive assurance:

1)	Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	This key measure of quality is providing positive assurance as indicated by the **special cause improvement** displayed within the SPC chart, although the chart indicates that there is no assurance that the standard will be delivered consistently as this stage.
13)	No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	This key measure of quality and effectiveness is continuing to provide positive assurance as indicated by the **special cause improvement** displayed within the SPC chart, although the chart indicates that there is no assurance that the standard will be delivered consistently as this stage.

Other issues to note:

16)	Percentage of staff in post with a current appraisal	This key workforce measure is indicating **special cause variation of particular concern** and that we will consistently fall short of the standard; however there has been a number of extensions to the time allowed to complete appraisal (linked to the pressures caused by the pandemic) which have been approved by Gold Command which have not been fully implemented in the measure. The work required is being impact assessed by the Information Team and an update, including timescales for this work, will be provided to the Board next month. This will then provide a more accurate reflection of the position.
17)	Percentage compliance with ALL mandatory and statutory training (snapshot)	As reported last month (as a key area of concern), this key workforce measure is indicating **special cause variation of particular concern;** however as part of the deep dive into mandatory training undertaken we identified a number of issues in relation to the accuracy of the data being reported. These issues have been investigated and accuracy

		around courses for specific staff banding corrected. There continues to be some complex changes required around Safeguarding training which are requiring investigation. In addition there has been a number of extensions to the time allowed to complete appraisal (linked to the pressures caused by the pandemic) which have been approved by Gold Command which have not been fully implemented in the measure. The work required is being impact assessed by the Information Team and an update, including timescales for this work, will be provided to the Board next month. This will then provide a more accurate reflection of the position.

NHS Oversight Framework Quarter 3 20/21

Of the 14 measures we monitor internally, we have been able to assess 12 as at the end of Quarter 3. We have failed to achieve the national standard for *IAPT Recovery* as a Trust due to not achieving the standards in County Durham and Tees Valley CCGs. Further details are contained in the NHS Oversight Framework paper being presented to Board this month.

Recommendations for 20/21 standards

Currently the standards included in the Dashboard are those from 19/20 which have been carried forward (where no change to the measure). Work has been completed for those measures where a standard has not yet been set and proposals were discussed at the Operational Delivery & Development Group and the Quality Assurance & Improvement Group (Sub-groups of the Senior Leadership Group) late November/early December. The following are the recommendations from these groups:

08	Number of unique patients referred	This is an indication of new demand coming into the Trust and it is felt we need to understand the effects of the pandemic before setting a standard. ***Recommendation:*** Not to set a standard at this stage but to review in 21/22
09	The percentage of new unique patients referred with an assessment completed (2 months behind)	Through the work we have done on the current performance against this standard where initial deep dive analysis has been started in certain localities, this has lead us to understand that for some specialties a 'higher is better' standard will not be appropriate. As we need to set a trust wide standard, we would like to continue this deep dive work but trust wide to understand the differences in more detail before a standard is agreed. ***Recommendation:*** Not to set a standard at this stage but to complete the necessary investigations and analysis to better inform what we feel it should be for 21/22.
10	The percentage of new unique patients referred and taken on for treatment	Through the work we have done on the current performance against this standard where initial deep dive analysis has been started in certain localities, this has

	(3 months behind)	lead us to understand that for some specialties a 'higher is better' standard will not be appropriate. As we need to set a trust wide standard, we would like to continue this deep dive work but trust wide to understand the differences in more detail before a standard is agreed. ***Recommendation:*** Not to set a standard at this stage but to complete the necessary investigations and analysis to better inform what we feel it should be for 21/22.
11	Number of unique patients discharged (treated only)	This is an indication of the numbers leading the Trust and it is felt we need to understand the effects of the pandemic before setting a standard. ***Recommendation:*** Not to set a standard at this stage but to review in 21/22
14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	The groups reviewed the mean (9.0%), the latest financial year to date position (9.9%) and the 19/20 actual (11.4%) recognising that the latest position has been achieved whilst operating within a pandemic which will have impacted on the position. The figure is slightly higher than the mean but takes into account the ongoing pressures connected to COVID, during which we have seen two months (not consecutively) at the highest numbers of readmissions since April 2018. ***Recommendation:*** Set a standard of 9.9%
15	Finance Vacancy Rate	This measure will be impacted by the current significant levels of recruitment within the Trust as a result of the surge planning and it is felt more appropriate to wait to set a standard until we have a more stable baseline workforce position. ***Recommendation:*** Not to set a standard at this stage but to complete the necessary investigations and analysis to better inform what we feel it should be for 21/22.

Proposal for Board Performance Dashboard for 21/22

The 20/21 Board Performance Dashboard was first reported to the Board in September 20, replacing an Interim Dashboard that had been provided since the start of the pandemic. The Board Performance Dashboard underwent significant development with the inclusion of Statistical Process Control (SPC) charts and a number of measures were revised to ensure they were more meaningful. Whilst the report is still in its infancy the feedback from the Board and NHSE&I (see below) has been extremely positive.

Discussions are underway to look at a more "integrated" approach to reporting linked to the Governance Review and the new Strategic Framework as well as the work being undertaken by the Quality Assurance & Improvement Group (Sub Group of Senior Leadership Group). It is therefore **proposed** that we carry-forward the 20/21 Board Performance Dashboard measures into 21/22 to allow the time and capacity to develop a more integrated approach and report to the Board whilst maintaining the existing Operational Dashboard in the interim. It is envisaged that this new integrated approach will be piloted in the Quality Assurance & Improvement Group in the latter part of 21/22.

Critique from NHSE &I on the Board Performance Dashboard

As part of commitment to continuously improve the Performance Management Framework, we shared the Board Performance Dashboard as at 31st October 20 for a critique with colleagues from NHS England and NHS Improvement who supported our work on the introduction of Statistical Process Control Charts within the Trust and Board Reports. The feedback was very positive ("overall a very clear report") with some suggestions that we will explore.

Appendices

- **Appendix A** is the summary dashboard showing all the measures with further detail (where appropriate)
- **Appendix B** provides the individual Trust and Locality Level SPC charts and the variation/assurance icons associated with these
- **Appendix C** provides an explanation for the symbols used in the table/SPC charts
- **Appendix D** provides detailed information on the areas of concern highlighted in this report including those subject to additional monitoring (where appropriate)

Recommendations:

It is recommended that the Board:

1. Consider the content of this paper and raise any areas of concern/query

2. Note the following recommendation within Appendix D:

    - The percentage of patients starting treatment within 6 weeks of an external referral (TD02) *To note the analysis that has taken place in Durham & Darlington and the actions being taken in relation to this measure and agree to receive an update in March 21.*

3. Note the measures providing positive assurance:

    - Percentage of patients seen within 4 weeks for a 1st appointment following an external referral (TD01)
    - No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot (TD13)

4. Discuss the recommendations outlined in this paper in relation to standards for 20/21

5. Discuss the proposal to roll forward the 20/21 Board Performance Dashboard into 21/22

6. Note the positive feedback from NHSI&E in relation to the Board Performance Dashboard

TRUST Dashboard Summary

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Quality

Measure Name	Variation Ending Dec - 2020	Assurance Ending Dec - 2020	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral			90.00%	93.46%	90.00%	
2) Percentage of patients starting treatment within 6 weeks of an external referral			60.00%	67.80%	60.00%	Durham and Darlington are demonstrating no significant change (common cause variation); however there is a continuous decline in the last 5 data points and they are now below the standard and the mean. Following initial analysis, more detailed work was completed at speciality and team level and shared with the locality to better understand their positions and whether this is an actual area of concern. Please see Appendix D for more detailed information on this.
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)			1,884	1,263	1,833	
4) Percentage of patients surveyed reporting their overall experience as excellent or good			94.00%	90.53%	94.00%	Patient Experience has been impacted by Covid in relation to the restrictions that had to be put in place as part of National Guidance; however given the SPC charts are indicating no significant change (common cause variation) at Trust and Locality Level (*with the exception of Durham and Darlington who now demonstrate Special Cause - concern) we agreed we needed to undertake a deep dive to understand the position better and what could be done to improve the position given this is a key measure of quality. The Quality & Safety Cell undertook a deep dive which was included in last month's report and an update on the actions will be provided to the Board next month.
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding			32.00%	34.88%	32.00%	
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind			60.00%	51.74%	60.00%	Tees Locality is indicating special cause variation of particular concern and needing action and that the standard will be met and sometimes missed due to random variation. The latest data point is also below the standard. North Yorkshire & York locality is also indicating special cause variation of particular concern and needing action and that the standard will be met and sometimes missed due to random variation. The latest data point is also below the lower process limit. This information was shared with both localities to better understand their positions and whether this is an actual area of concern and these have been shared with the Board previously. An update on the actions identified will be provided to the Board in March 2021.
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind			65.00%	70.10%	65.00%	

Activity

Measure Name	Variation Ending Dec - 2020	Assurance Ending Dec - 2020	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
8) Number of new unique patients referred				61,337		Forensics are indicating special cause variation with an increase in the number of new unique referrals therefore this is an area we need to investigate further. This information will be shared with the locality to better understand their position and whether this is an actual area of concern. An update on this will be included in next month's report.
9) The percentage of new unique patients referred with an assessment completed (2 months behind)				68.10%		Forensics Locality is indicating special cause variation of particular concern (low) and needing action. Having reviewed the underlying data for this we have identified that there is special cause improvement (an increase) within the denominator which is the number of new unique referrals (linked to above measure). This information was shared with the locality to better understand their position and whether this is an actual area of concern and this was shared with the Board previously. An update on the identified actions will be provided to the Board next month. North Yorkshire & York Locality is indicating special cause variation of particular concern (low) and needing action. Having reviewed the underlying data there is no indication of significant change (common cause variation) in the data. This information was shared with the locality to better understand their position and whether this is an actual area of concern and this was shared with the Board previously. The remaining action was to include telephone contacts for MHSOP and LD services trust-wide. Whilst discussions have taken place with the Information Team, a formal change will need to go to Technical Change Board in January for this to be assessed. A further update will be provided to the Board next month.

TRUST Dashboard Summary

Tees, Esk and Wear Valleys
NHS Foundation Trust

Measure Name	Variation Ending Dec - 2020	Assurance Ending Dec - 2020	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
10) The percentage of new unique patients referred and taken on for treatment (3 months behind)	L			31.51%		Tees Locality is indicating special cause variation of particular concern (low) and needing action. This information was shared with the locality to better understand their position and whether this is an actual area of concern and this has been shared with the Board previously. An update on the identified actions will be provided to the Board next month. Forensic Services are indicating special cause variation of particular concern (low) and needing action. The last 7 data points are all below the mean but within the lower process limit. This information will be shared with the locality to better understand their position and whether this is an actual area of concern. An update on this will be provided to the Board next month.
11) Number of unique patients discharged (treated only)				25,162		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	L	?	90.00%	76.58%	90.00%	Following previous deep dive work at Trust and Locality level, bed occupancy is now being monitored weekly using SPC at ward level by the Corporate Performance Team. Currently bed pressures continue to be predominantly in female beds on Tees. A Trust wide bed event is to take place across two ½ days in February and an update on this will be provided to the Board in March 2021.
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	L	?	61	40	61	
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)				10.52%		

Workforce

Measure Name	Variation Ending Dec - 2020	Assurance Ending Dec - 2020	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
15) Finance Vacancy Rate				-8.96%		
16) Percentage of staff in post with a current appraisal	L	F	95.00%	88.13%	95.00%	
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	L	?	92.00%	88.56%	92.00%	
18) Percentage Sickness Absence Rate (month behind)		F	4.30%	4.91%	4.30%	Whilst previously Forensics were indicating special cause variation of particular concern, they are now demonstrating common cause variation and the latest data point is just above the mean. An action plan was developed in June 2020 and since its implementation sickness absence rates have been closely monitored each month. All actions are now complete however monitoring will continue to ensure the desired impact is sustained. Durham and Darlington are indicating special cause variation of particular concern with the latest data point above the upper process limit. This information will be shared with the locality to better understand their position and whether this is an actual area of concern. An update on this will be provided to the Board next month.

Money

Measure Name	Plan (YTD)	Actual (YTD)	Comments
19) Delivery of our financial plan (I and E)	1,088,000	-9,026,827	The comprehensive income outturn for the period ending 31 December 2020 is a surplus of £7,938k, and is £9,026k ahead of the NHSI phase 3 plans. Income from activities is ahead of plan largely due to non-recurrent investment into North East prison services £3,000k. In addition the Trust received £1.3m additional commissioner investment for service developments, an update to its Learning Development Agreement (LDA) that allocated £0.9m retrospective funding for trainees, and £0.4m income relating to a settled contract dispute. These items were not anticipated in the revised plan. Pay expenditure is underspending against plan in month 9 due to COVID-19 related expenditure being less than anticipated (£1.5m) and continued vacancies where recruitment was expected (£0.4m). Depreciation and Financing expenditure is less than planned due to reduced PDC dividend payable there has also been delays to capital programme schemes (MIST system and Roseberry Park in particular) which has resulted in a reduced depreciation charge for the year.

TRUST Dashboard Summary

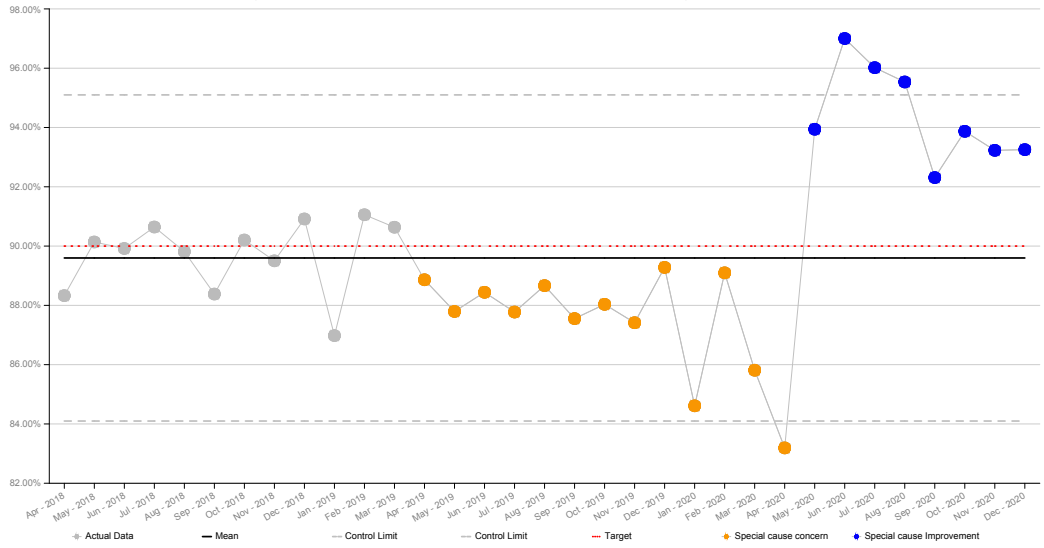
Tees, Esk and Wear Valleys
NHS Foundation Trust

Measure Name	Plan (YTD)	Actual (YTD)	Comments
20) CRES delivery	3,095,001	2,653,647.13	Identified Cash Releasing Efficiency Savings at 31 December was £2,654k and was £441k behind plan but has a number of developing schemes which once confirmed will be sufficient to meet the required target.
21) Cash against plan	66,719,000	110,076,350	The Trust's cash balance at 31 December is £110,076k; this is £43,357k ahead of the plan and is largely due to; £33,806k of income received in advance for January; and the Trust being £9,026k ahead of it's financial plan.

TRUST Indicator Details

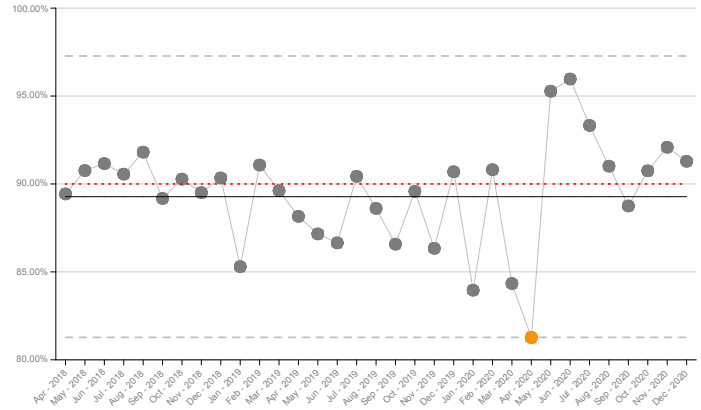
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral - TRUST

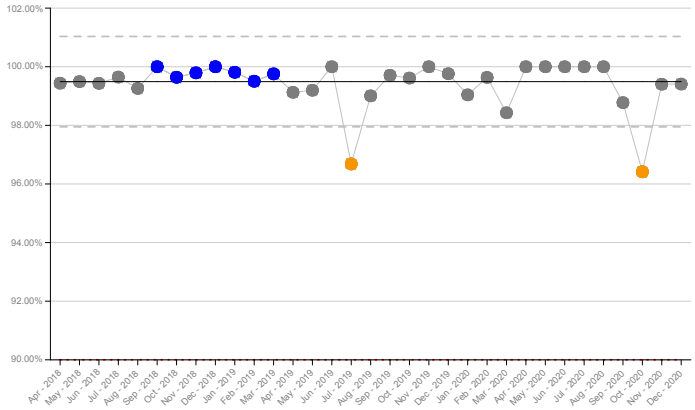


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	?	89.60%	95.10%	84.10%
DURHAM AND DARLINGTON		?	89.28%	97.28%	81.27%
FORENSIC SERVICES		P	99.49%	101.03%	97.95%
NORTH YORKSHIRE AND YORK	H	?	83.92%	91.54%	76.30%
TEESSIDE	H	?	93.12%	98.15%	88.09%

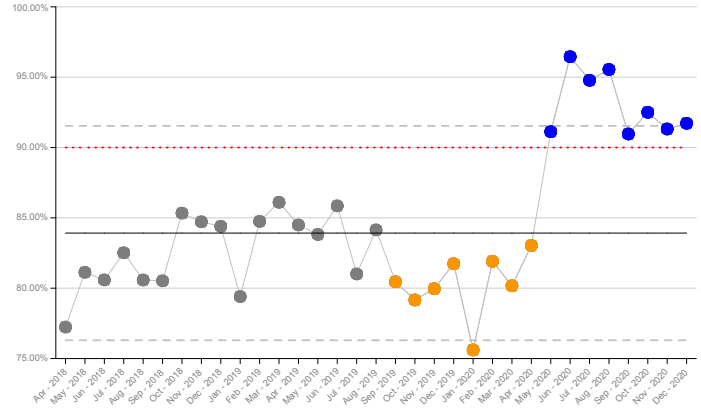
DURHAM AND DARLINGTON



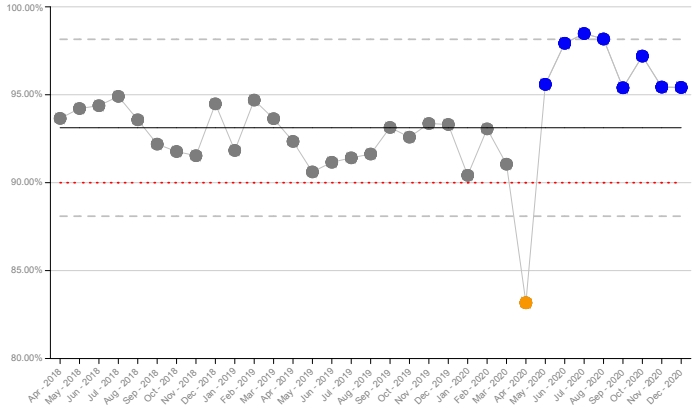
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



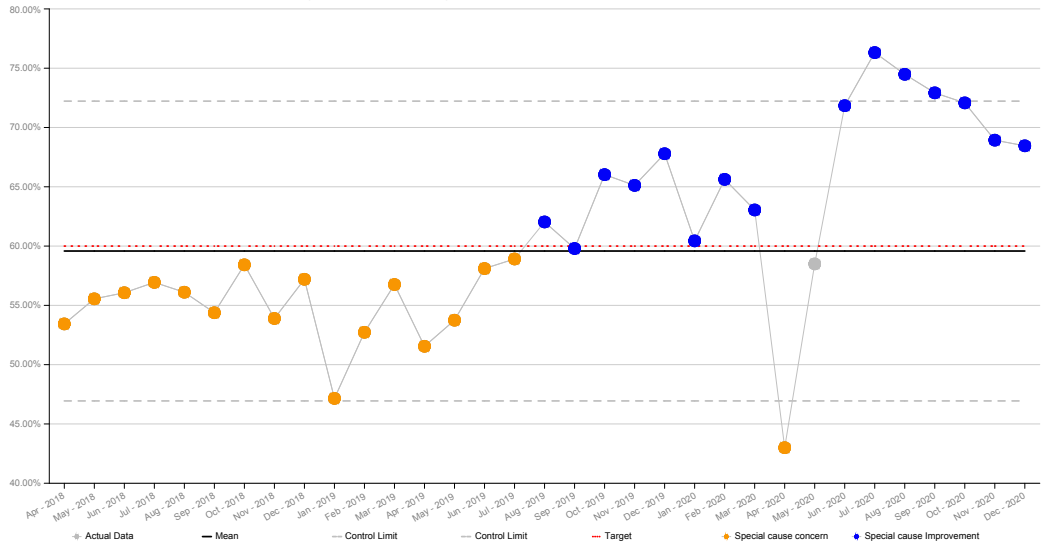
TEESSIDE



TRUST Indicator Details

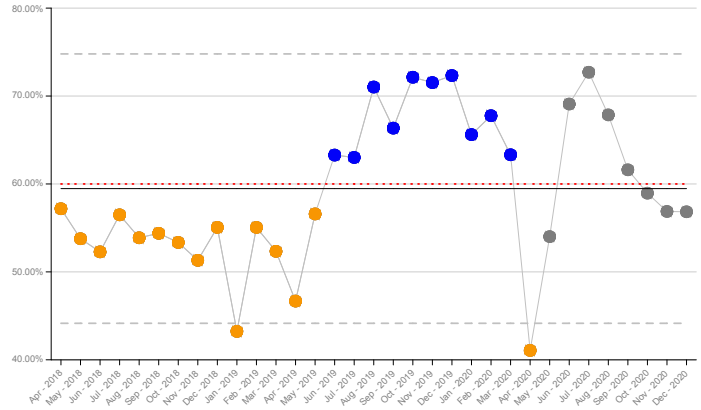
Tees, Esk and Wear Valleys NHS Foundation Trust

2) Percentage of patients starting treatment within 6 weeks of an external referral - TRUST

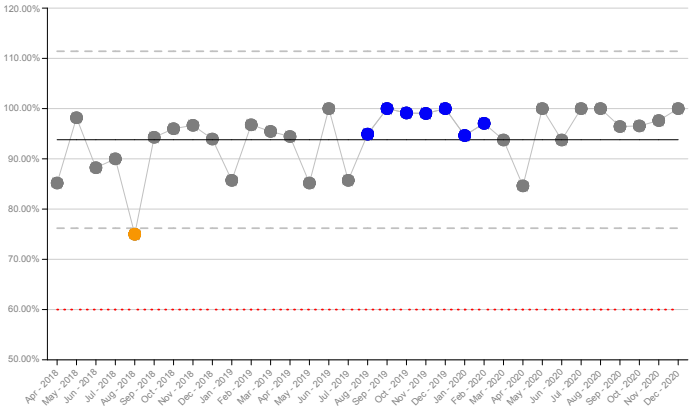


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	?	59.58%	72.22%	46.94%
DURHAM AND DARLINGTON		?	59.47%	74.79%	44.15%
FORENSIC SERVICES		P	93.80%	111.41%	76.19%
NORTH YORKSHIRE AND YORK	H	?	62.36%	75.85%	48.87%
TEESSIDE	H	?	61.21%	76.02%	46.40%

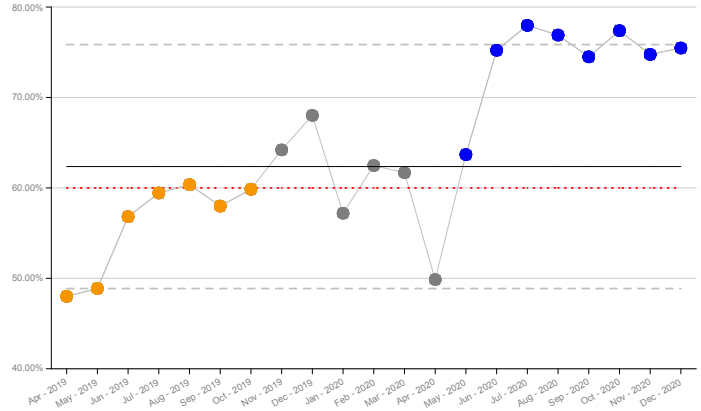
DURHAM AND DARLINGTON



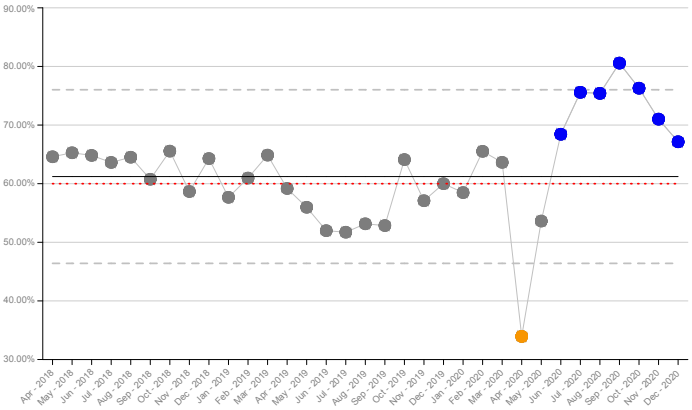
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



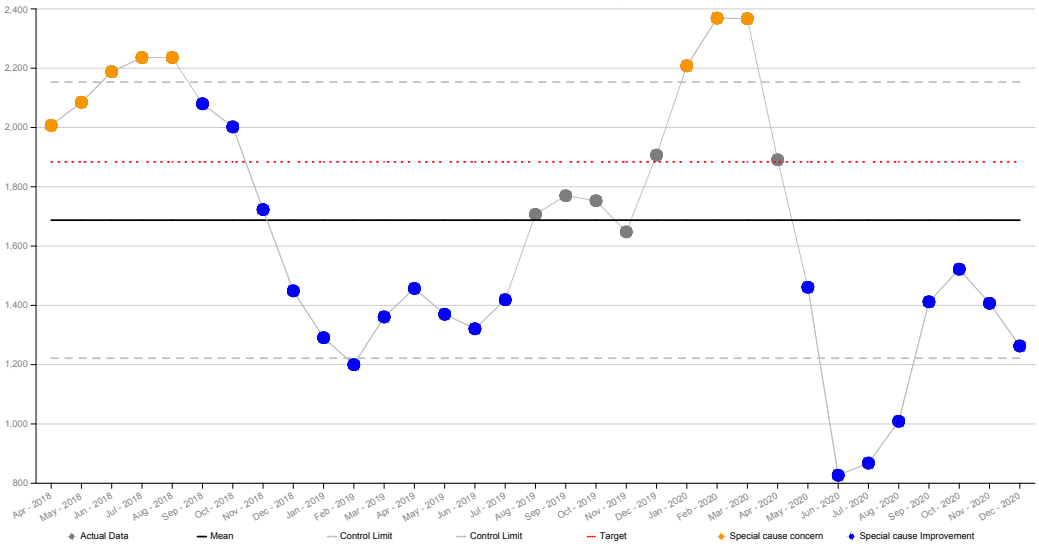
TEESSIDE



TRUST Indicator Details

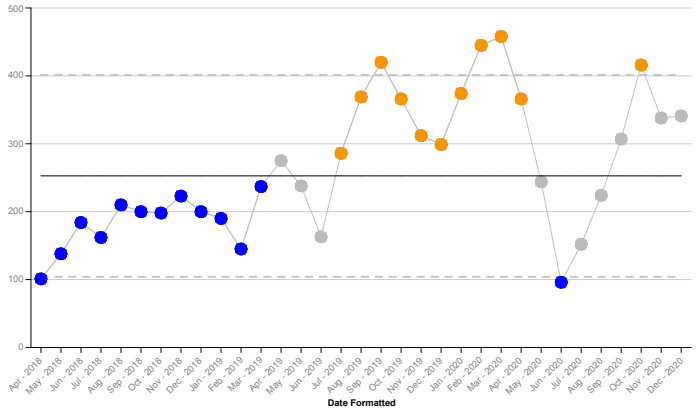
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

3) The total number of inappropriate OAP days over the reporting period (rolling 3 months) - TRUST

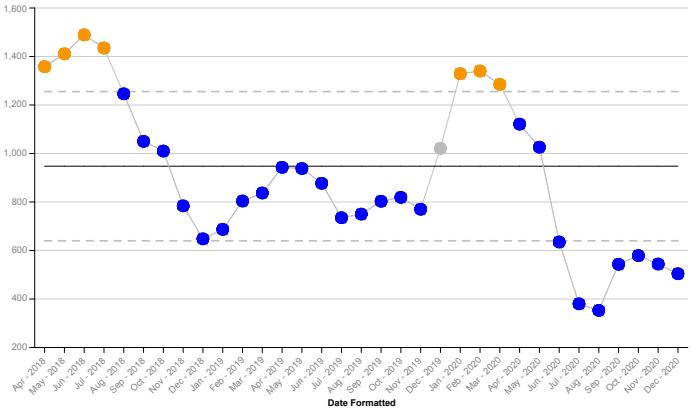


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	1,687.40	2,153.08	1,221.72
DURHAM AND DARLINGTON			252.73	401.33	104.14
NORTH YORKSHIRE AND YORK	L		947.57	1,255.30	639.83
TEESSIDE			467.83	710.44	225.22

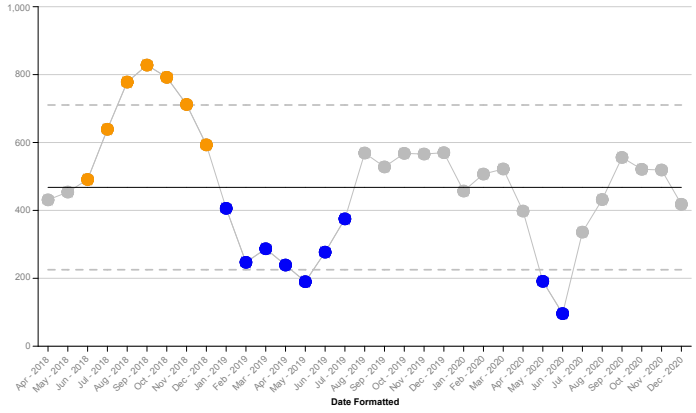
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



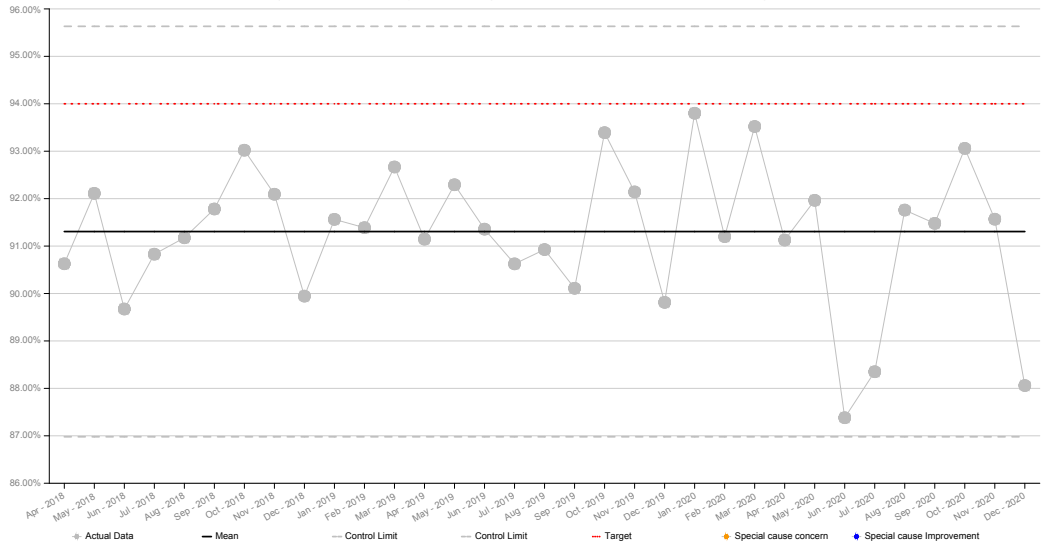
TEESSIDE



TRUST Indicator Details

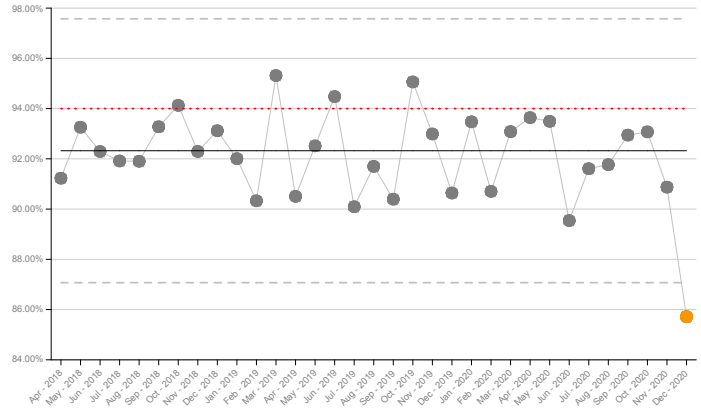
Tees, Esk and Wear Valleys NHS Foundation Trust

4) Percentage of patients surveyed reporting their overall experience as excellent or good - TRUST

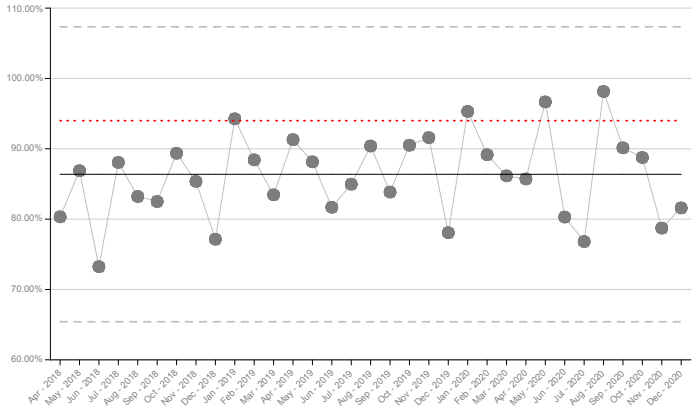


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			91.31%	95.63%	86.98%
DURHAM AND DARLINGTON	L		92.32%	97.58%	87.07%
FORENSIC SERVICES			86.37%	107.34%	65.41%
NORTH YORKSHIRE AND YORK			89.74%	98.34%	81.14%
TEESSIDE			92.91%	96.99%	88.83%

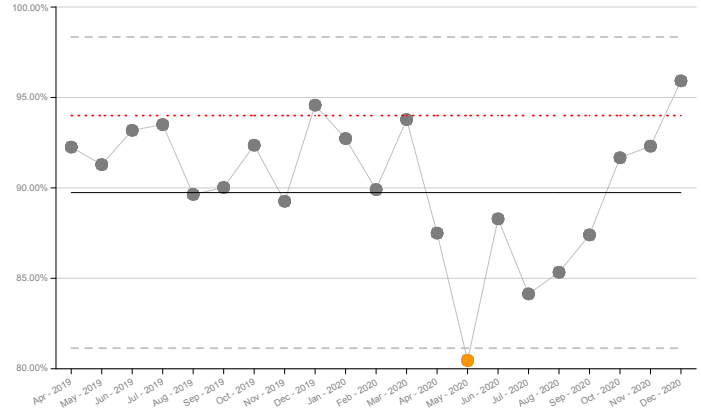
DURHAM AND DARLINGTON



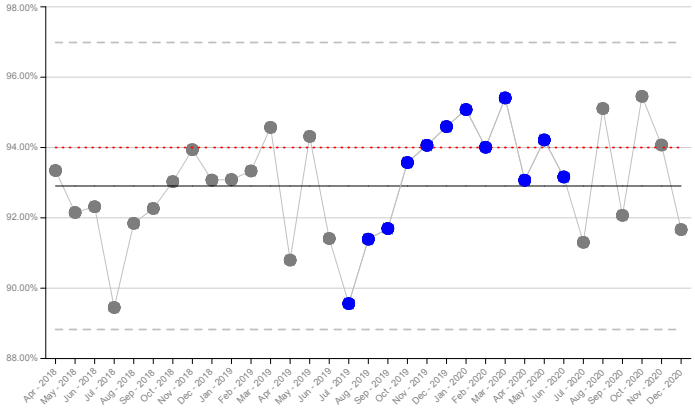
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



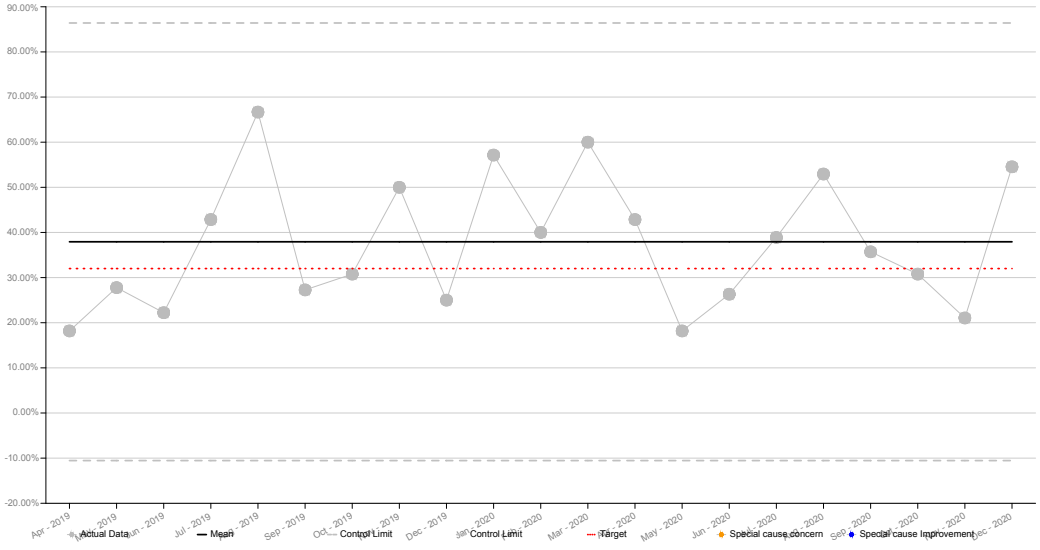
TEESSIDE



TRUST Indicator Details

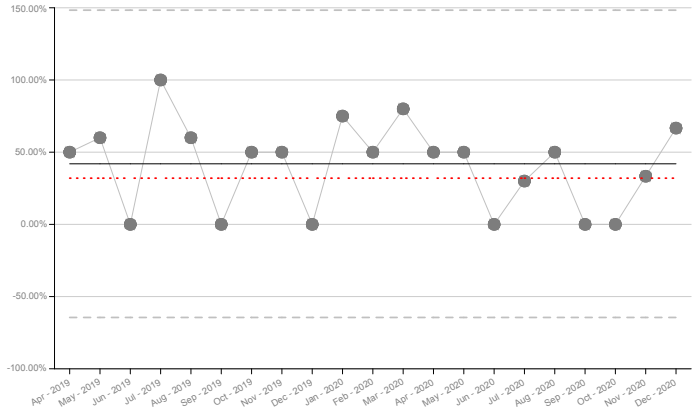
Tees, Esk and Wear Valleys NHS Foundation Trust

5) The percentage of Serious Incidents which are found to have a root cause or contributory finding - TRUST

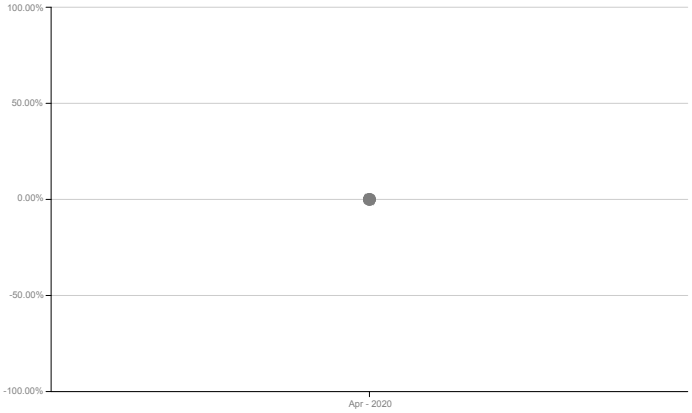


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			37.93%	86.41%	-10.54%
DURHAM AND DARLINGTON			41.94%	148.34%	-64.46%
NORTH YORKSHIRE AND YORK			44.79%	134.18%	-44.61%
TEESSIDE			29.62%	90.47%	-31.24%

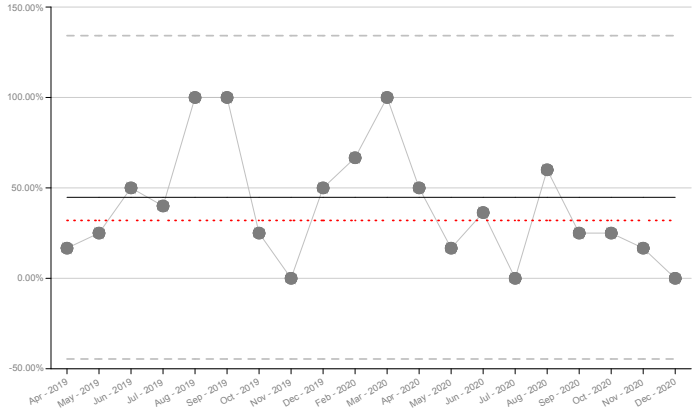
DURHAM AND DARLINGTON



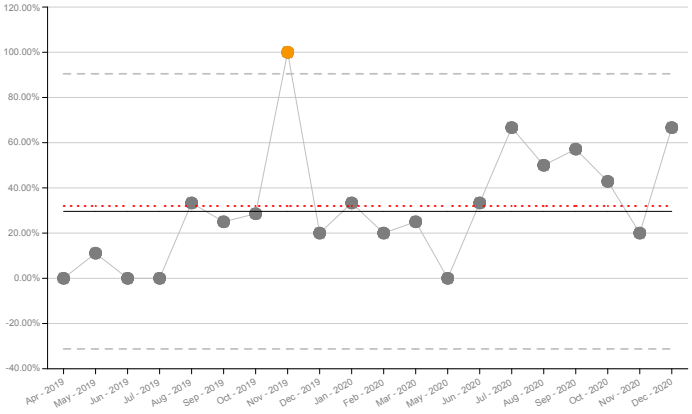
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



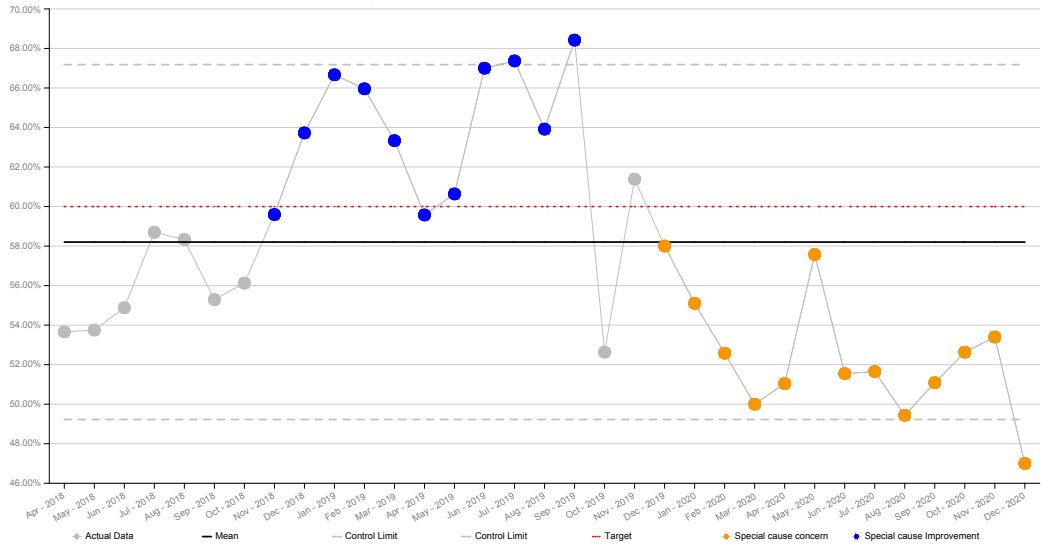
TEESSIDE



TRUST Indicator Details

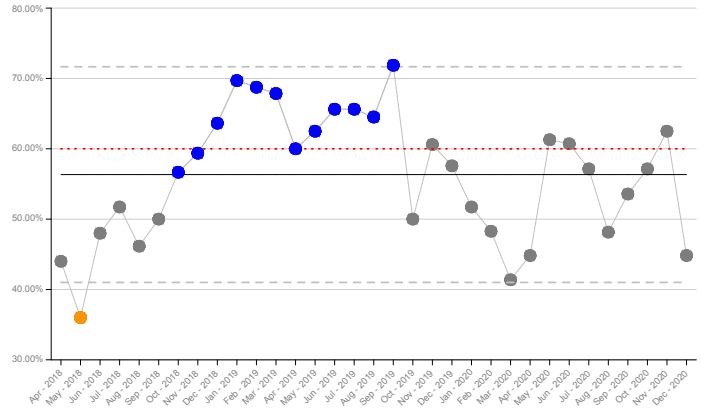
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind - TRUST

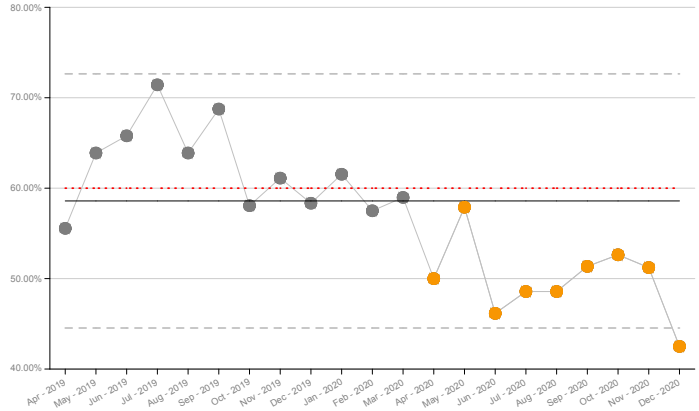


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	58.20%	67.18%	49.22%
DURHAM AND DARLINGTON		?	56.33%	71.67%	41.00%
NORTH YORKSHIRE AND YORK	L	?	58.59%	72.64%	44.54%
TEESSIDE	L	?	58.69%	76.00%	41.37%

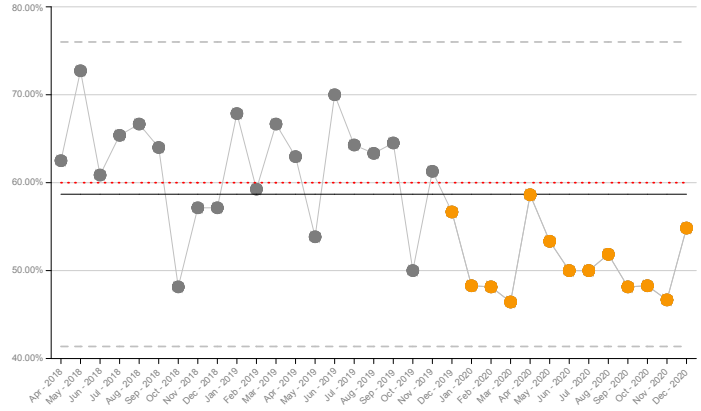
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



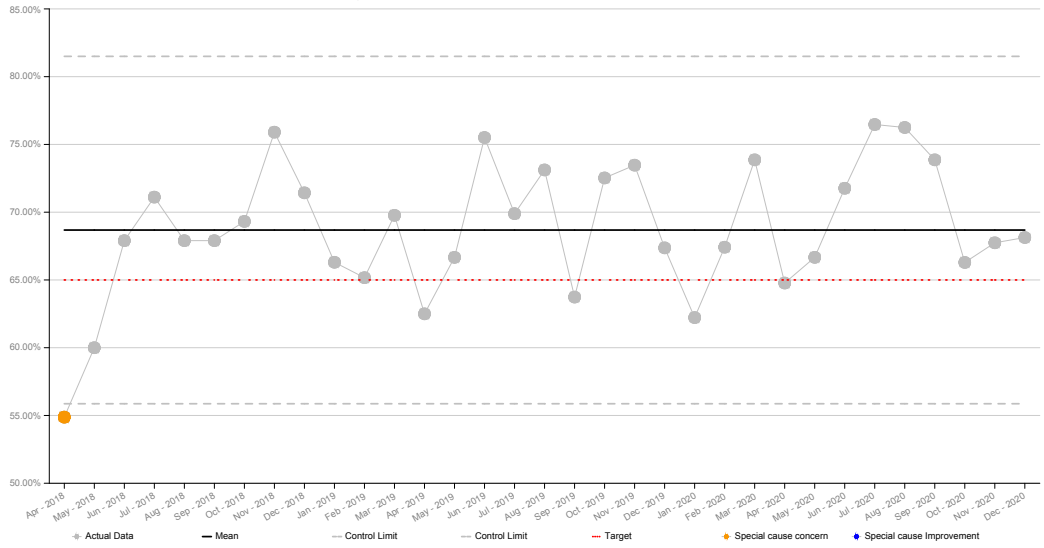
TEESSIDE



TRUST Indicator Details

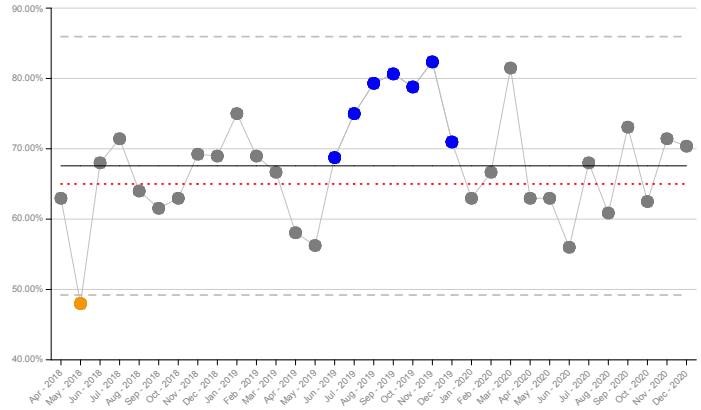
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind - TRUST

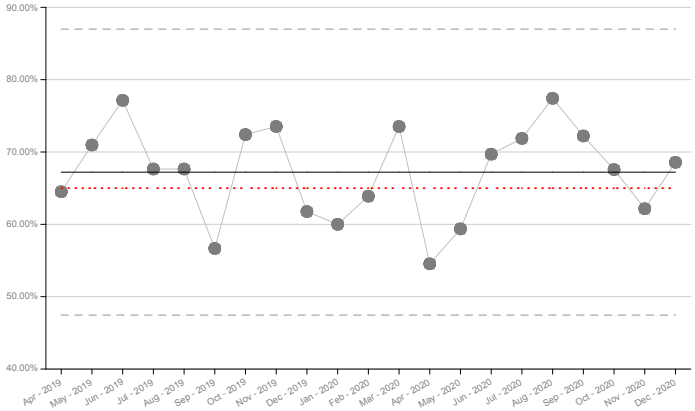


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			68.68%	81.50%	55.87%
DURHAM AND DARLINGTON			67.58%	85.95%	49.21%
NORTH YORKSHIRE AND YORK			67.21%	86.98%	47.45%
TEESSIDE			69.98%	90.67%	49.30%

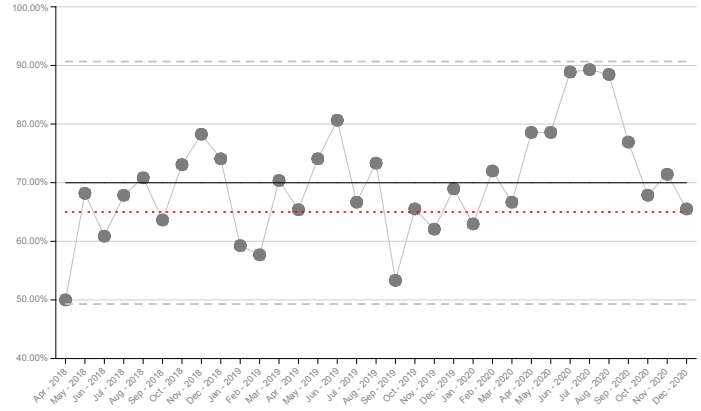
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



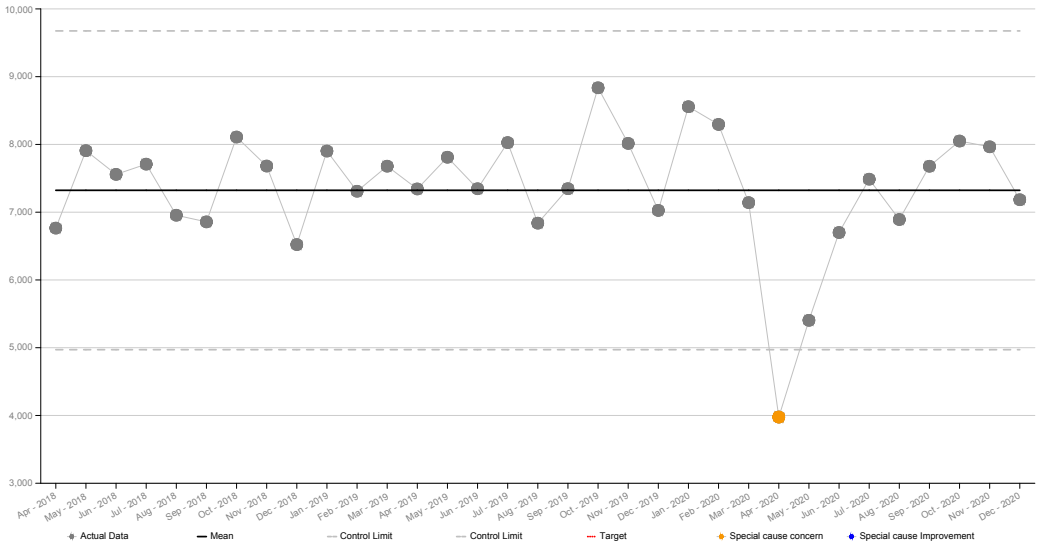
TEESSIDE



TRUST Indicator Details

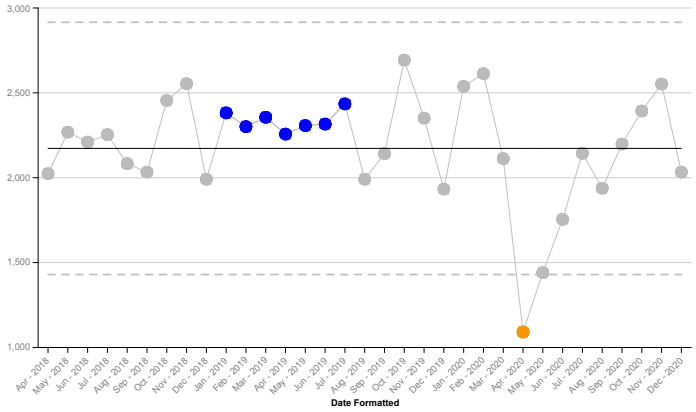
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

8) Number of new unique patients referred - TRUST

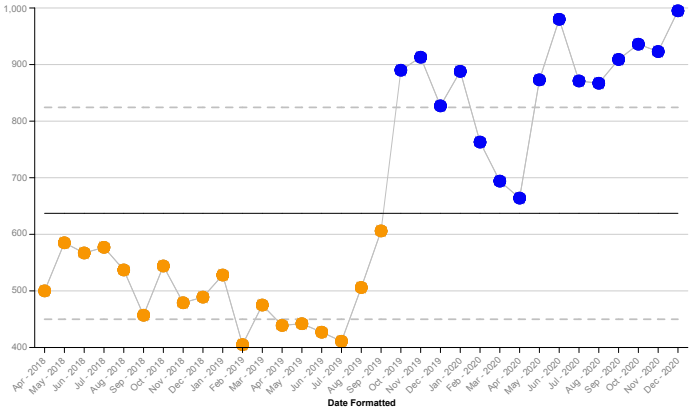


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			7,323.03	9,675.21	4,970.86
DURHAM AND DARLINGTON			2,172.80	2,915.95	1,429.65
FORENSIC SERVICES	H		637.10	824.31	449.89
NORTH YORKSHIRE AND YORK			2,087.13	2,730.30	1,443.96
TEESSIDE	L		2,425.93	3,298.41	1,553.45

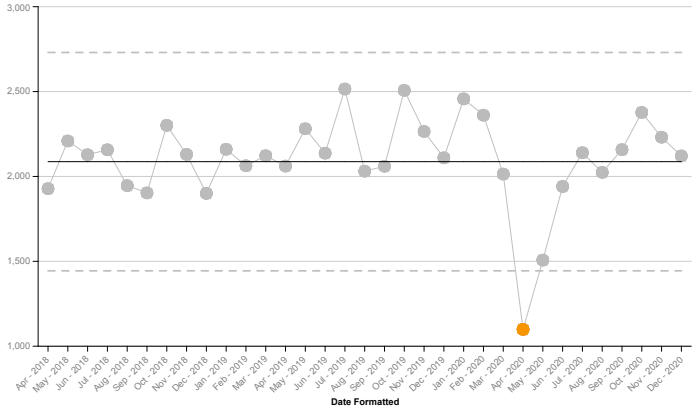
DURHAM AND DARLINGTON



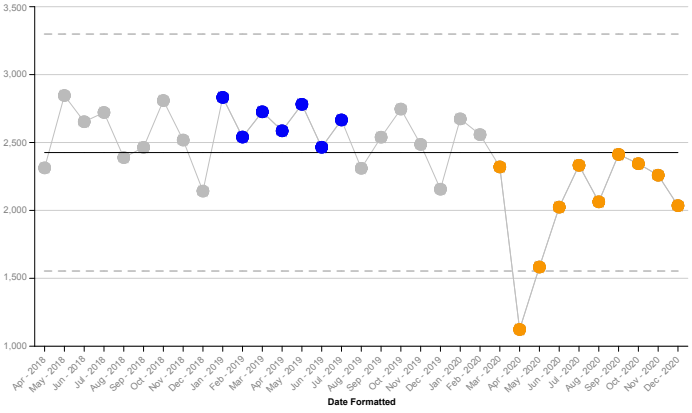
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



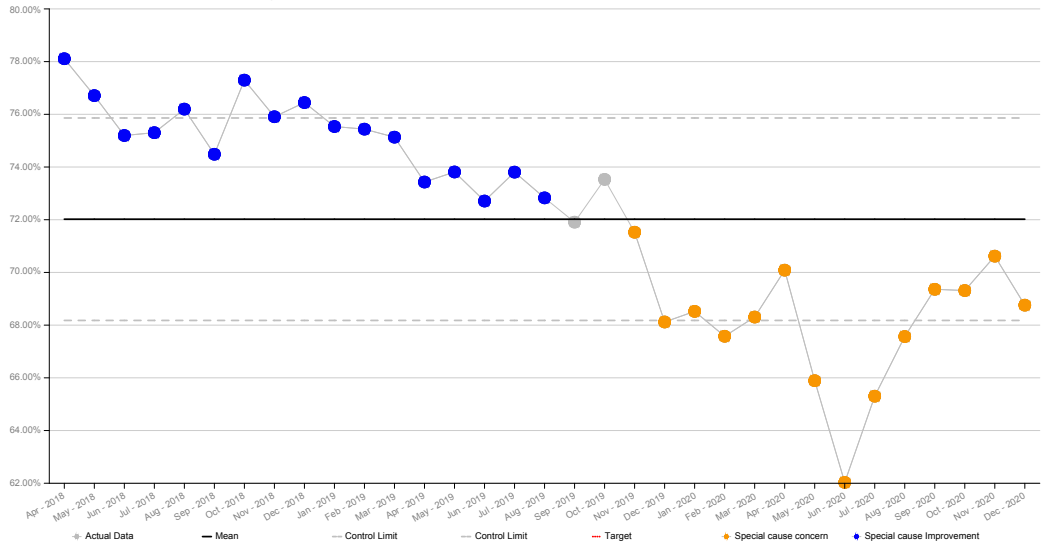
TEESSIDE



TRUST Indicator Details

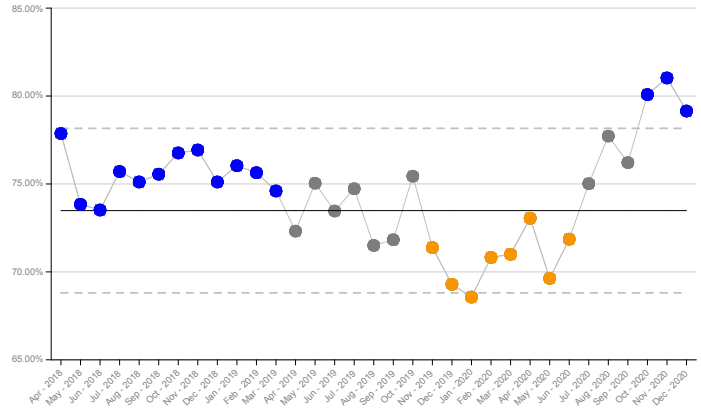
Tees, Esk and Wear Valleys NHS Foundation Trust

9) The percentage of new unique patients referred with an assessment completed (2 months behind) - TRUST

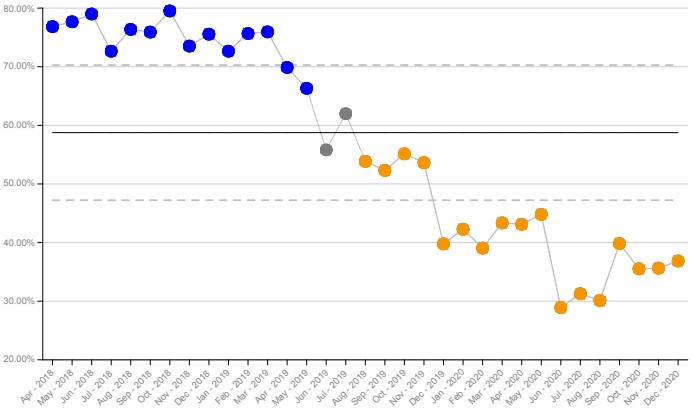


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L		72.02%	75.86%	68.18%
DURHAM AND DARLINGTON	H		73.48%	78.16%	68.81%
FORENSIC SERVICES	L		58.75%	70.28%	47.23%
NORTH YORKSHIRE AND YORK	L		72.63%	76.94%	68.31%
TEESSIDE			74.74%	79.53%	69.94%

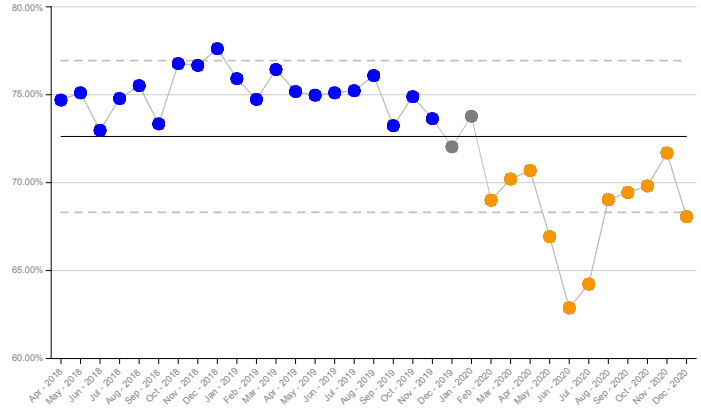
DURHAM AND DARLINGTON



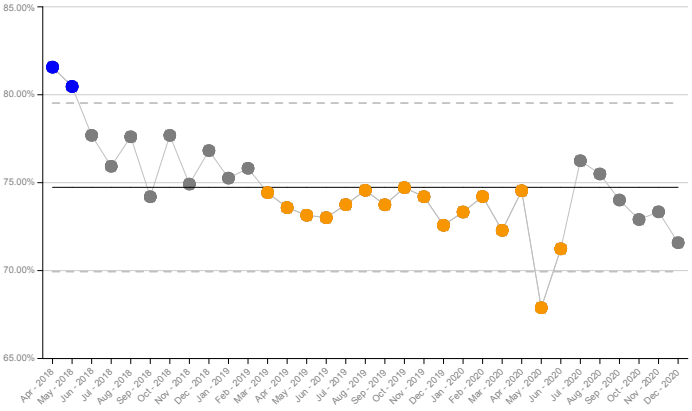
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



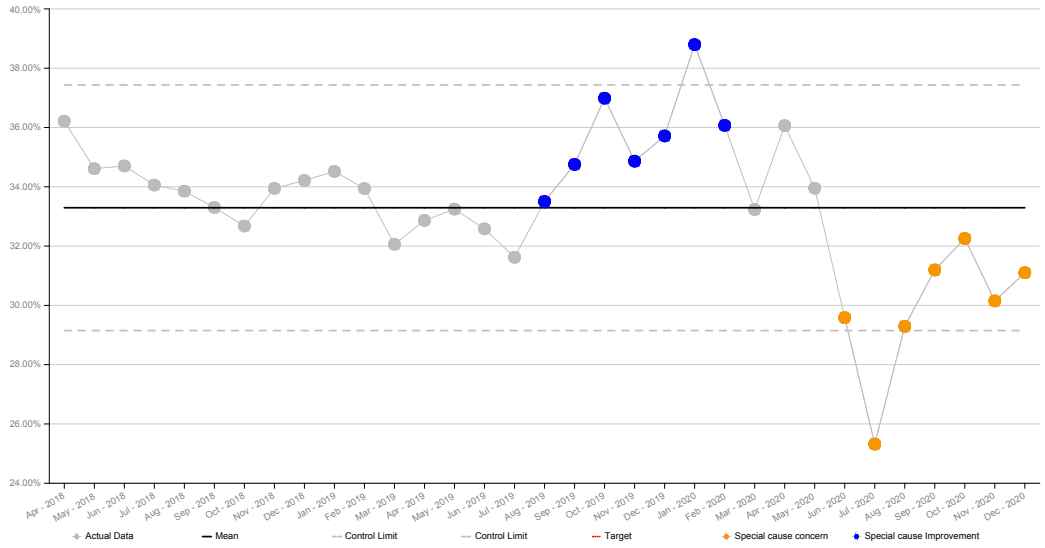
TEESSIDE



TRUST Indicator Details

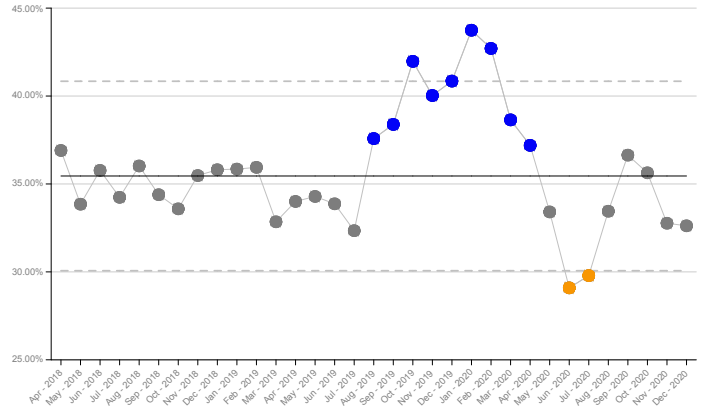
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

10) The percentage of new unique patients referred and taken on for treatment (3 months behind) - TRUST

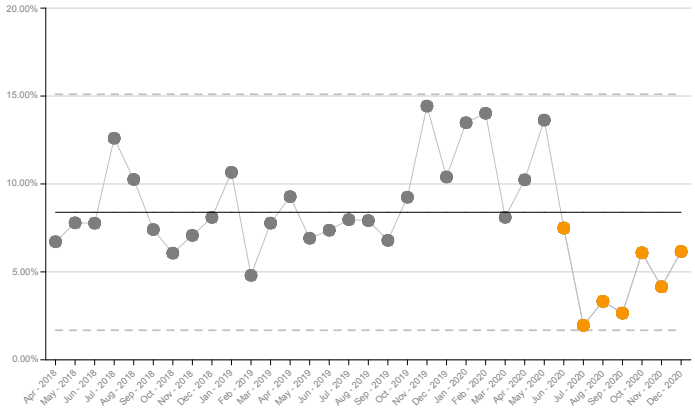


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L		33.29%	37.44%	29.15%
DURHAM AND DARLINGTON			35.45%	40.84%	30.07%
FORENSIC SERVICES	L		8.39%	15.10%	1.68%
NORTH YORKSHIRE AND YORK			40.13%	45.39%	34.88%
TEESSIDE	L		31.79%	36.04%	27.54%

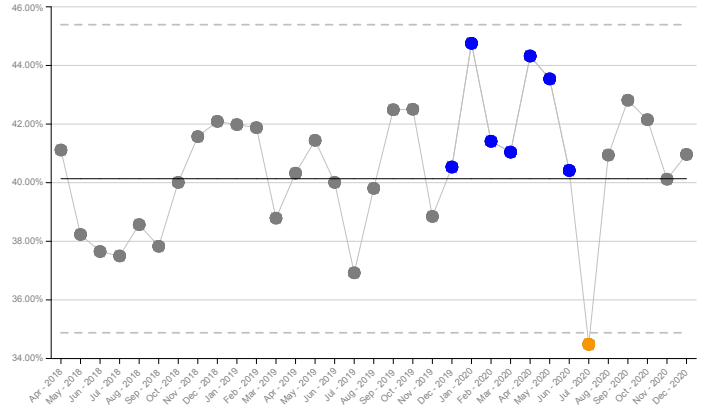
DURHAM AND DARLINGTON



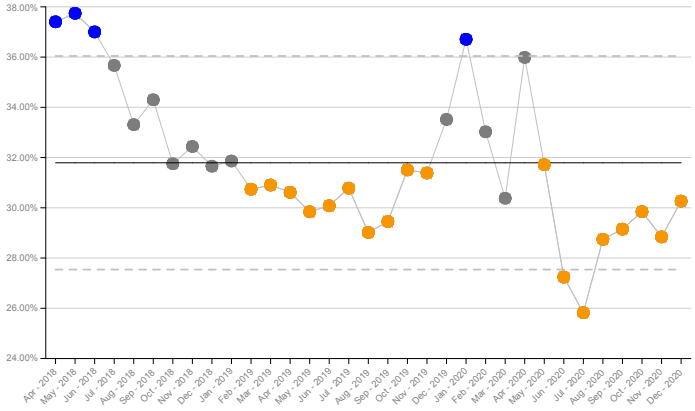
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



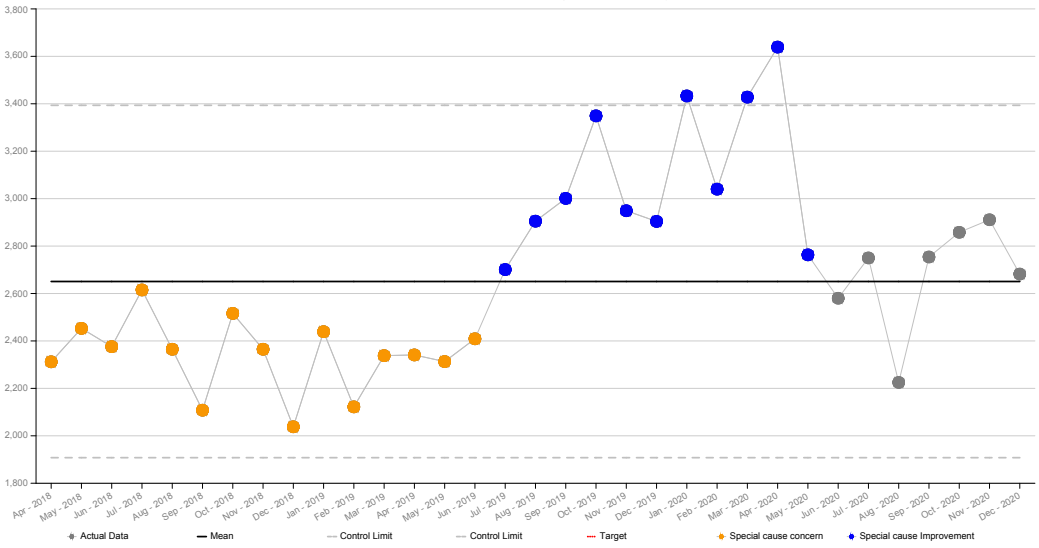
TEESSIDE



TRUST Indicator Details

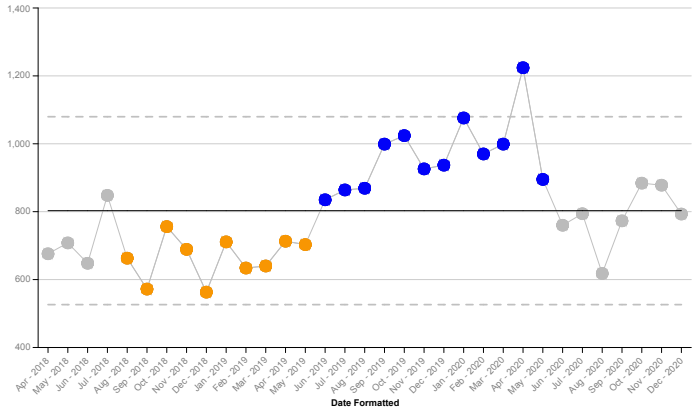
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

11) Number of unique patients discharged (treated only) - TRUST

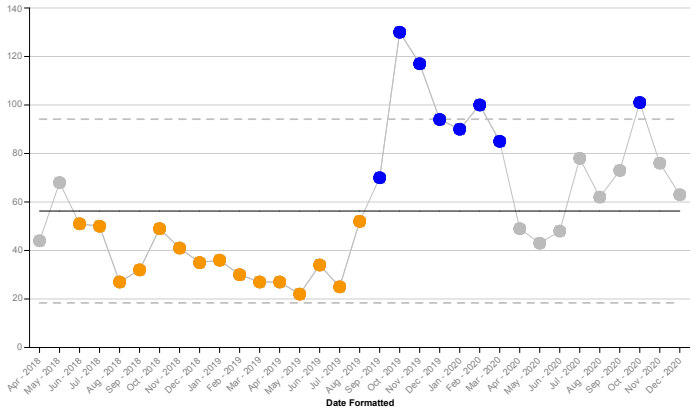


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			2,650.67	3,393.54	1,907.79
DURHAM AND DARLINGTON			802.97	1,079.70	526.23
FORENSIC SERVICES			56.27	94.15	18.38
NORTH YORKSHIRE AND YORK			908.80	1,171.04	646.56
TEESSIDE			882.63	1,171.56	593.70

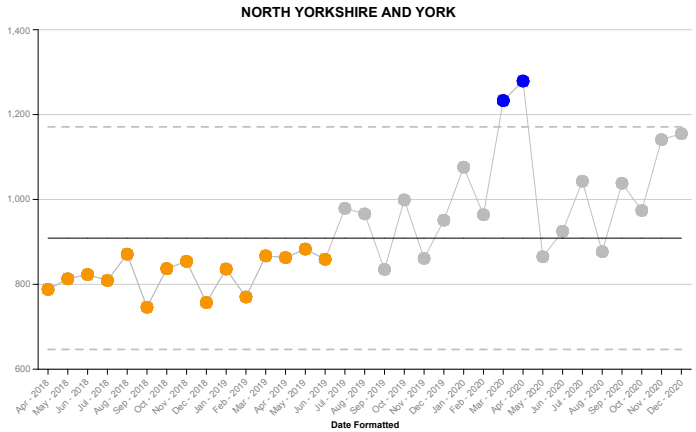
DURHAM AND DARLINGTON



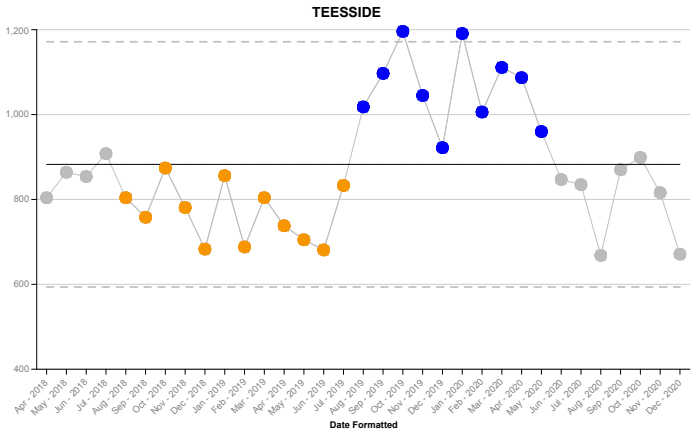
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



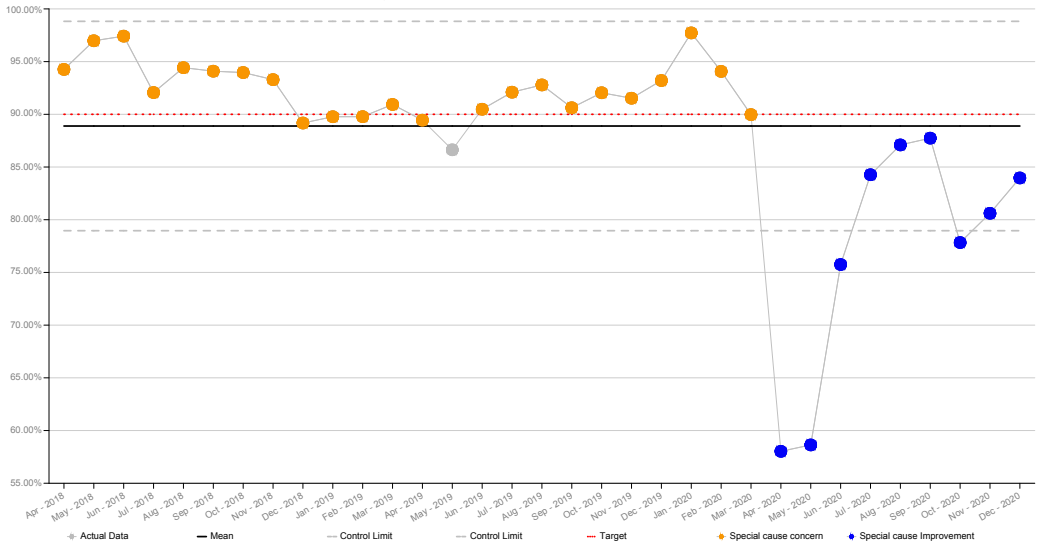
TEESSIDE



TRUST Indicator Details

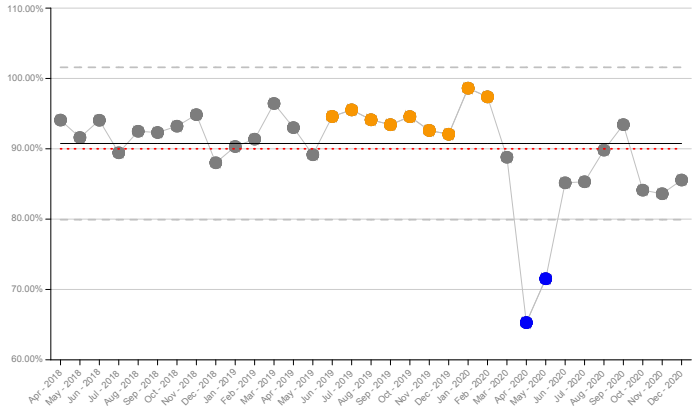
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards) - TRUST

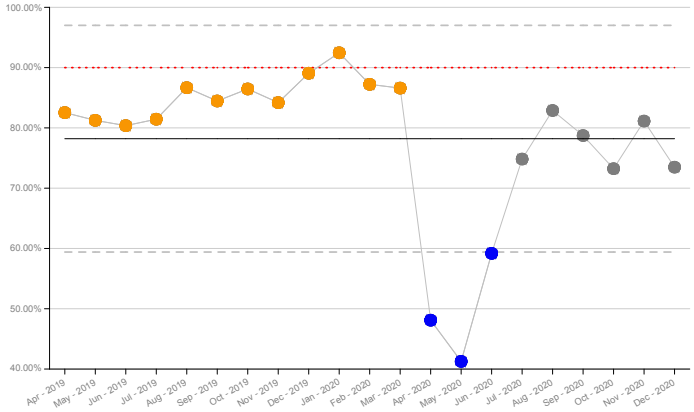


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	88.89%	98.82%	78.96%
DURHAM AND DARLINGTON		?	90.75%	101.58%	79.92%
NORTH YORKSHIRE AND YORK		?	78.21%	97.01%	59.40%
TEESSIDE	L	?	95.52%	108.70%	82.34%

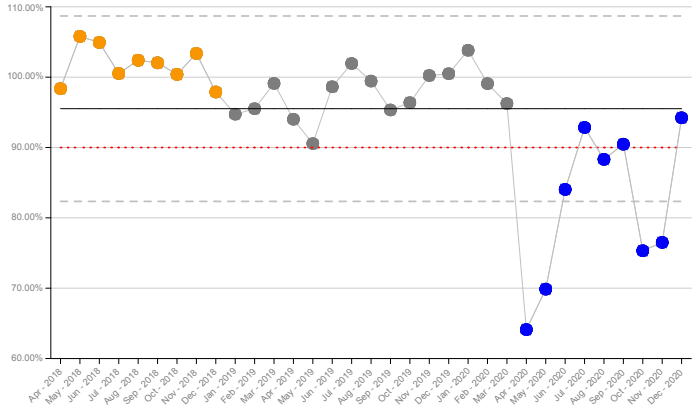
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



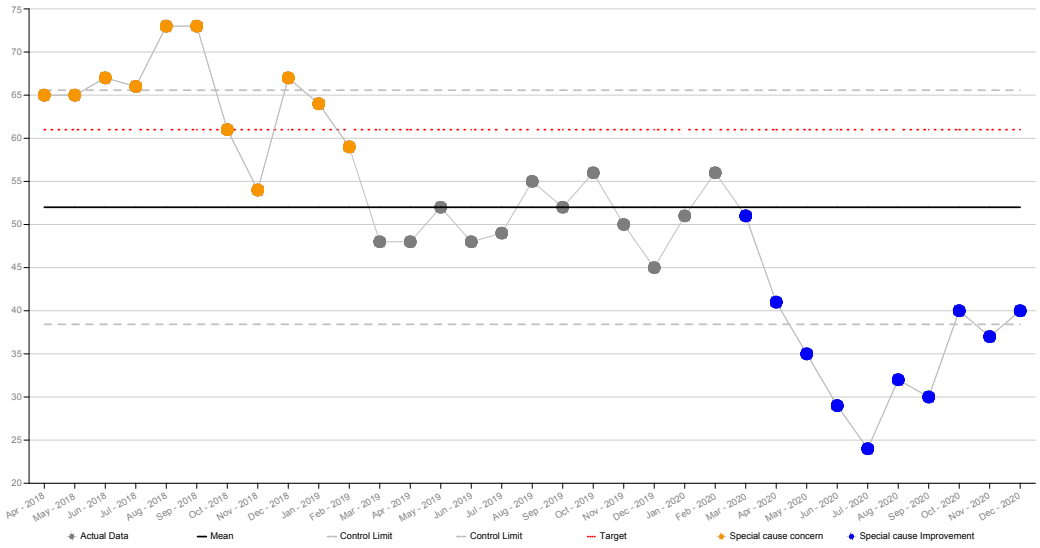
TEESSIDE



TRUST Indicator Details

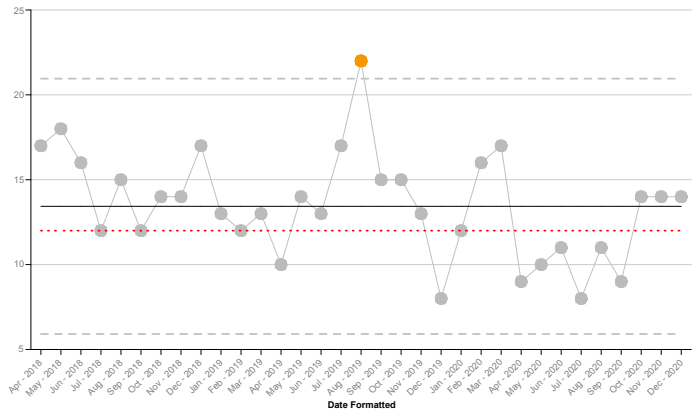
Tees, Esk and Wear Valleys NHS Foundation Trust

13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot - TRUST

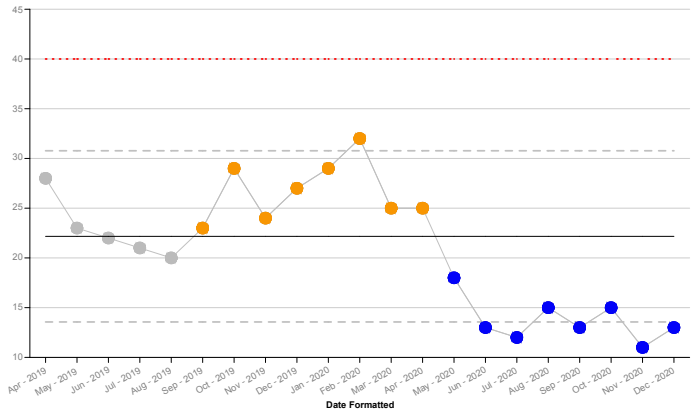


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	52.00	65.58	38.42
DURHAM AND DARLINGTON		?	13.43	20.95	5.91
NORTH YORKSHIRE AND YORK	L	P	22.17	30.77	13.56
TEESSIDE		?	9.93	15.71	4.15

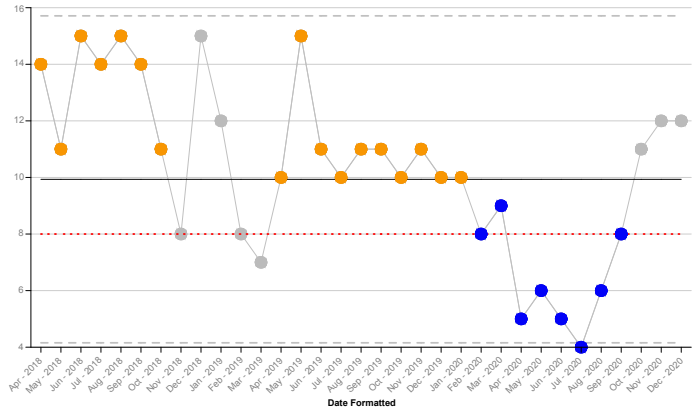
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



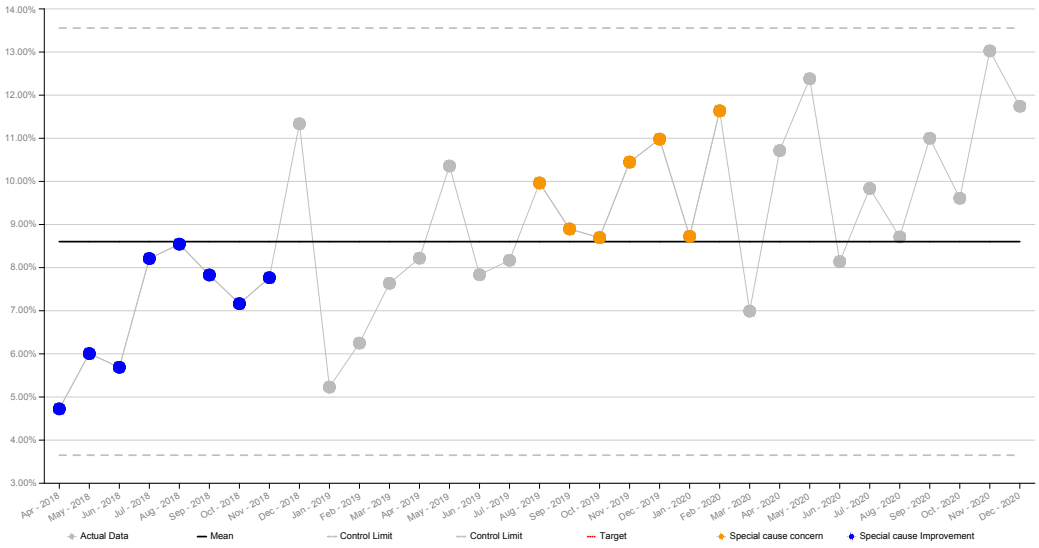
TEESSIDE



TRUST Indicator Details

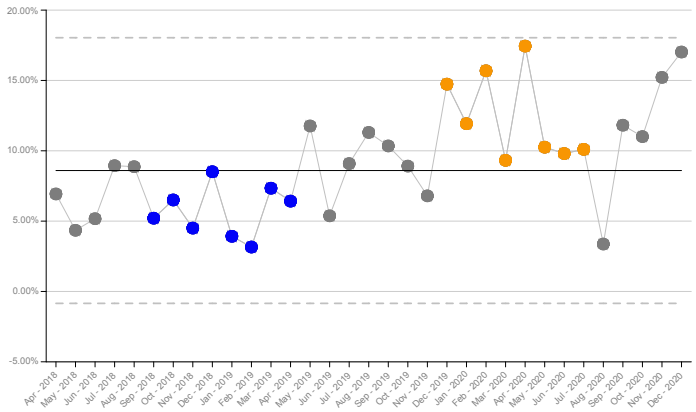
Tees, Esk and Wear Valleys NHS Foundation Trust

14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - TRUST

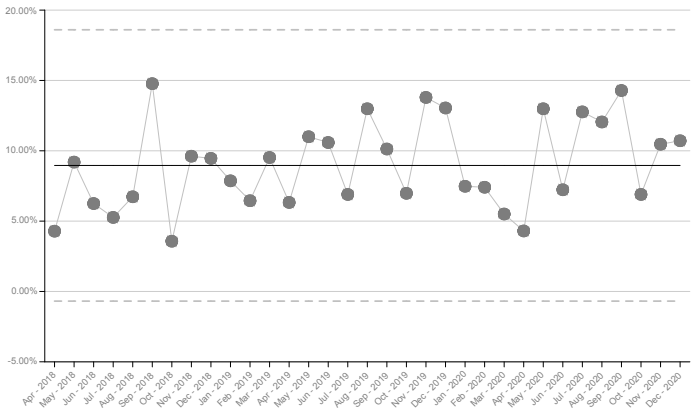


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			8.60%	13.56%	3.65%
DURHAM AND DARLINGTON			8.60%	18.04%	-0.85%
NORTH YORKSHIRE AND YORK			8.96%	18.60%	-0.69%
TEESSIDE			8.38%	19.57%	-2.82%

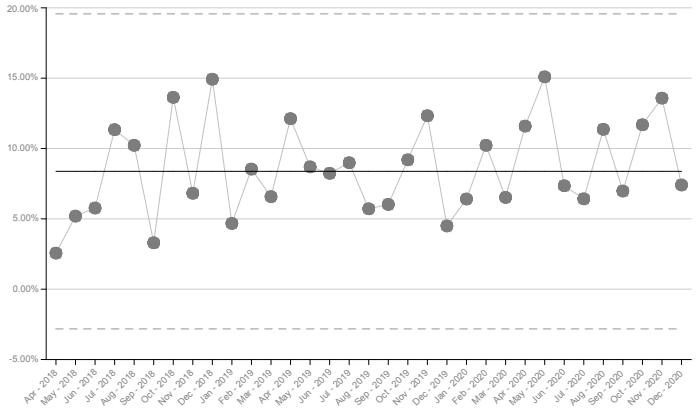
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



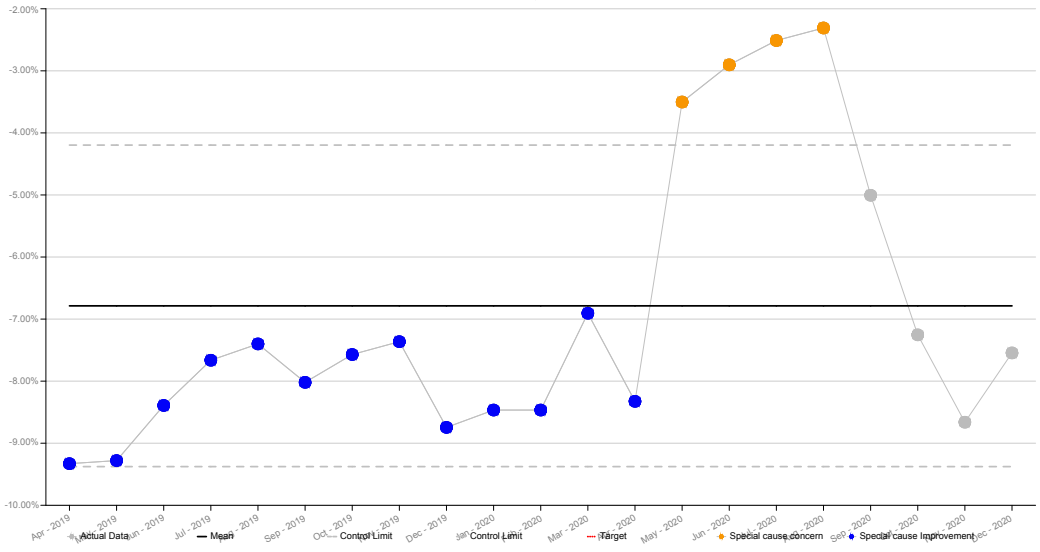
TEESSIDE



TRUST Indicator Details

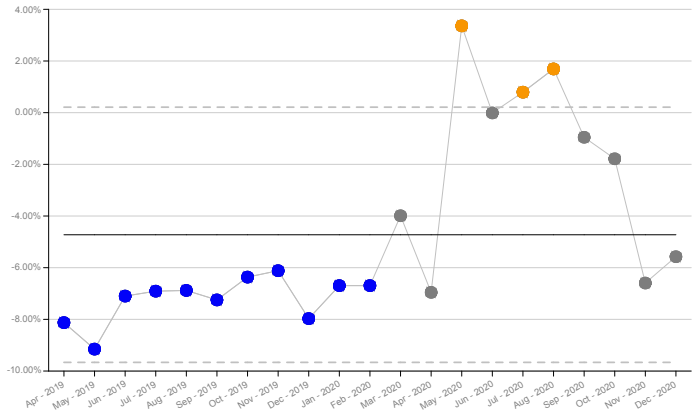
Tees, Esk and Wear Valleys NHS Foundation Trust

15) Finance Vacancy Rate - TRUST

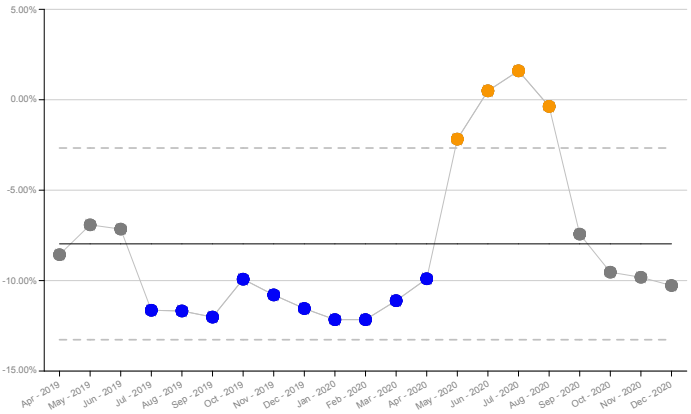


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			-6.79%	-4.20%	-9.38%
DURHAM AND DARLINGTON			-4.73%	0.21%	-9.66%
FORENSIC SERVICES			-7.97%	-2.67%	-13.27%
NORTH YORKSHIRE AND YORK	H		-6.62%	-3.58%	-9.67%
TEESSIDE	L		-6.09%	-2.94%	-9.24%

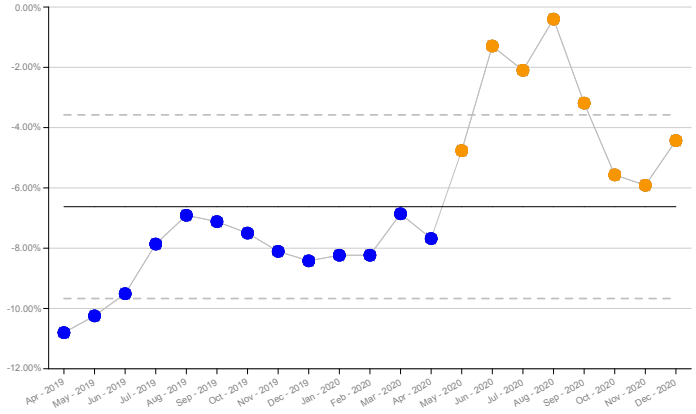
DURHAM AND DARLINGTON



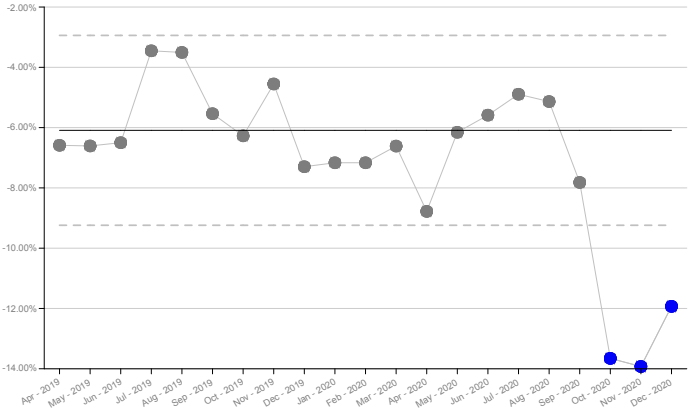
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



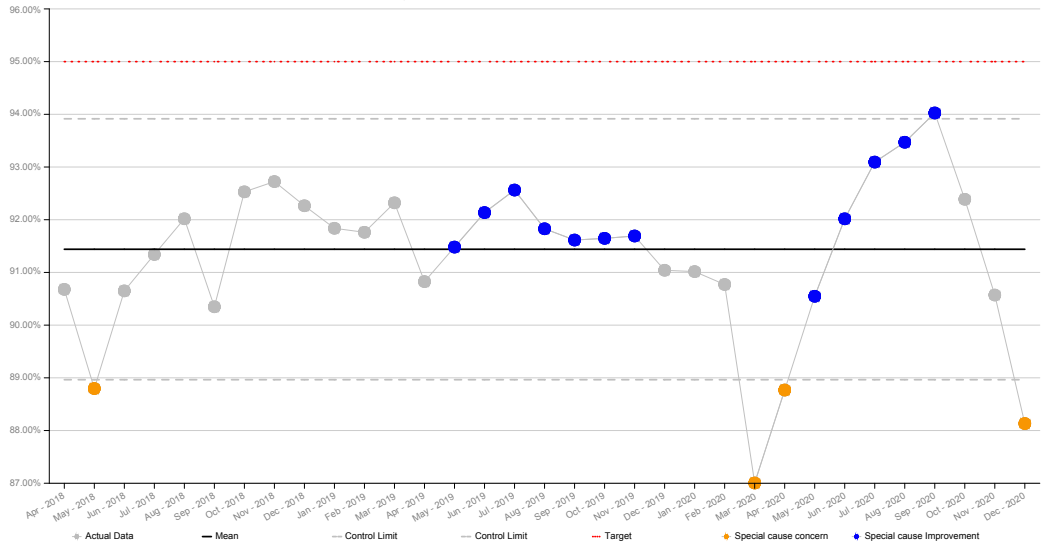
TEESSIDE



TRUST Indicator Details

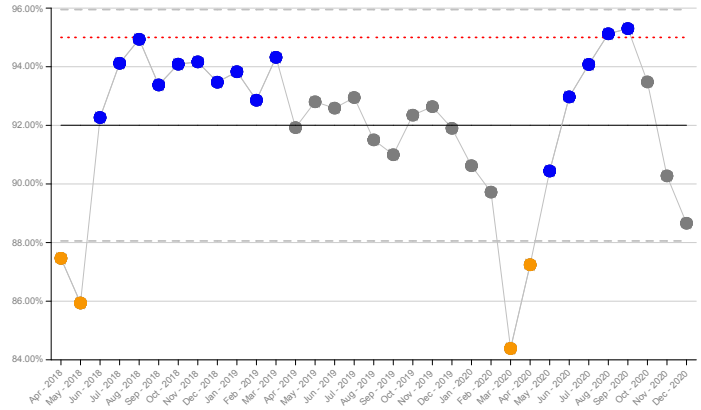
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

16) Percentage of staff in post with a current appraisal - TRUST

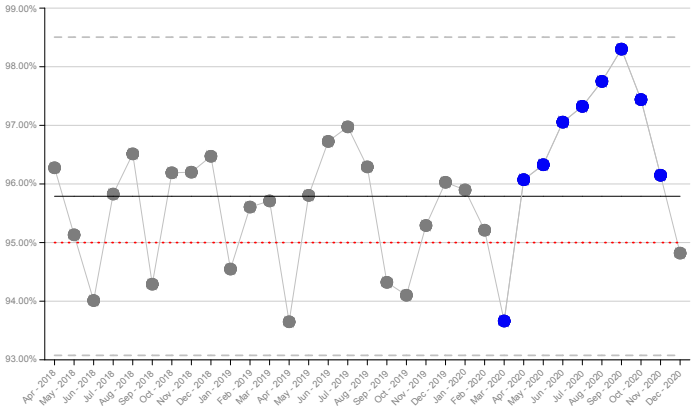


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	F	91.44%	93.92%	88.96%
DURHAM AND DARLINGTON		?	92.00%	95.95%	88.06%
FORENSIC SERVICES		?	95.79%	98.50%	93.08%
NORTH YORKSHIRE AND YORK		F	89.65%	92.84%	86.47%
TEESSIDE		?	93.23%	95.96%	90.49%

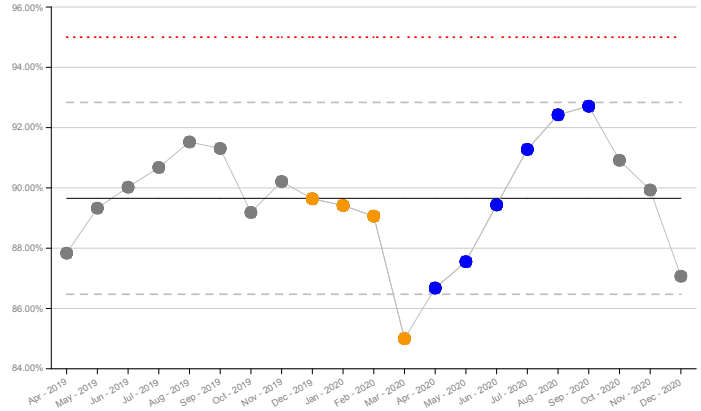
DURHAM AND DARLINGTON



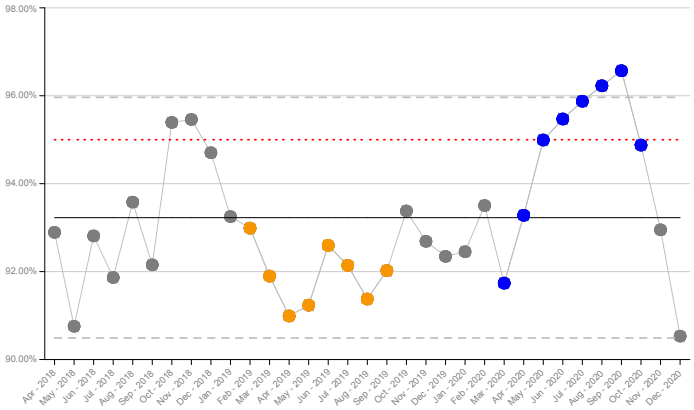
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



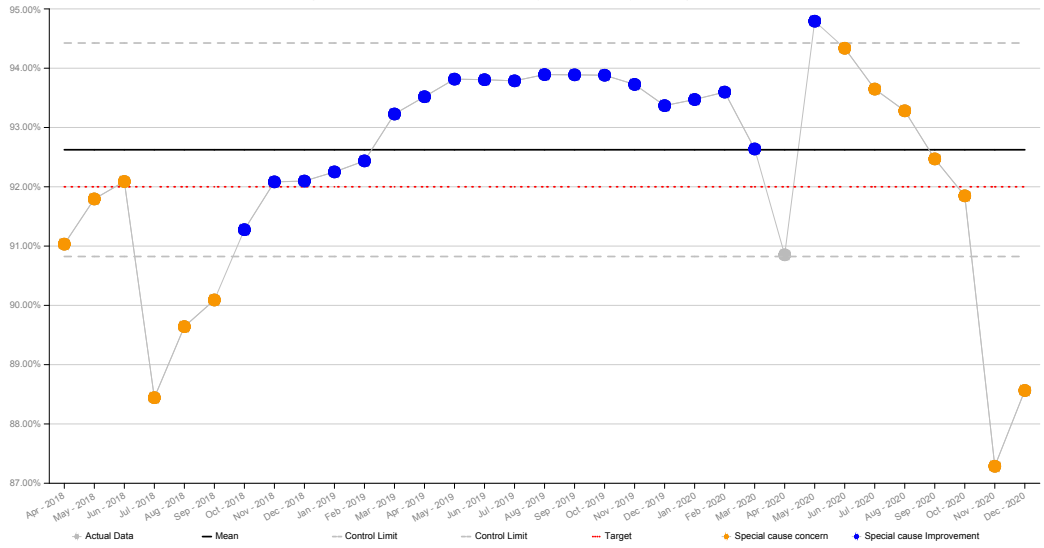
TEESSIDE



TRUST Indicator Details

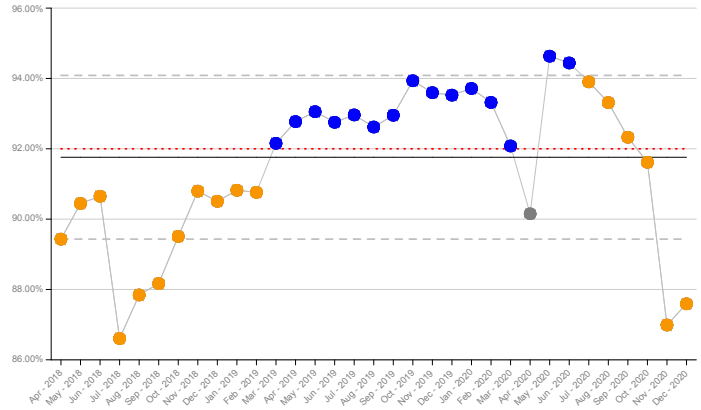
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

17) Percentage compliance with ALL mandatory and statutory training (snapshot) - TRUST

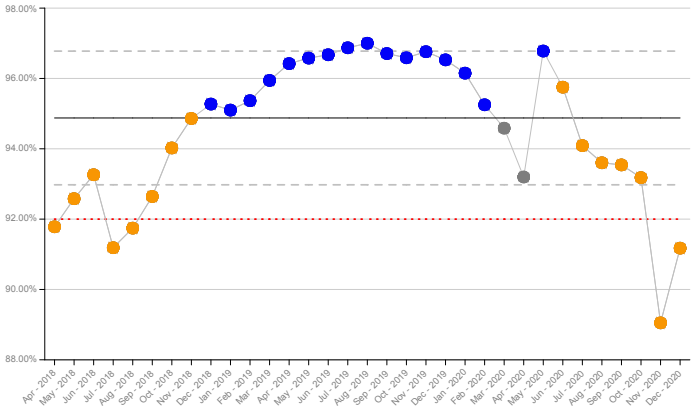


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	92.62%	94.42%	90.82%
DURHAM AND DARLINGTON	L	?	91.76%	94.09%	89.43%
FORENSIC SERVICES	L	P	94.88%	96.78%	92.98%
NORTH YORKSHIRE AND YORK	L	?	91.04%	93.28%	88.81%
TEESSIDE	L	?	93.58%	95.33%	91.84%

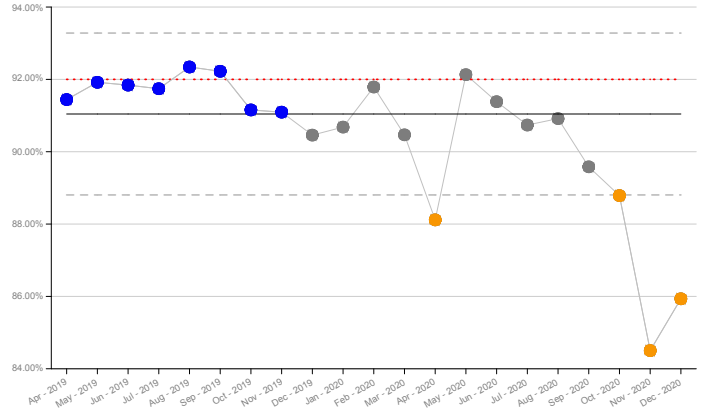
DURHAM AND DARLINGTON



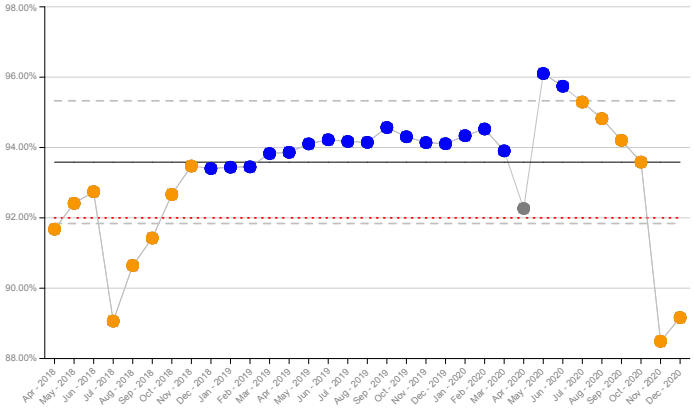
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



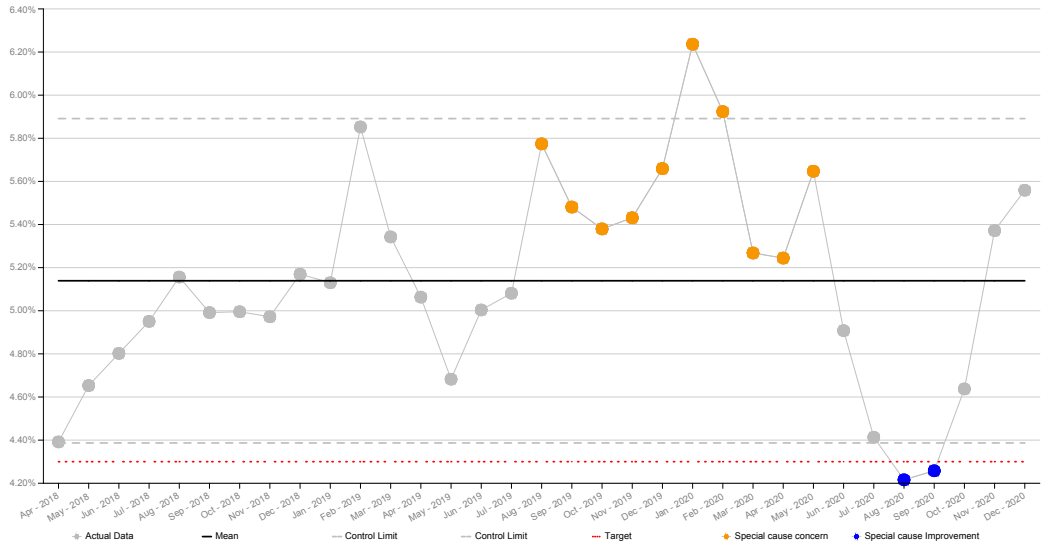
TEESSIDE



TRUST Indicator Details

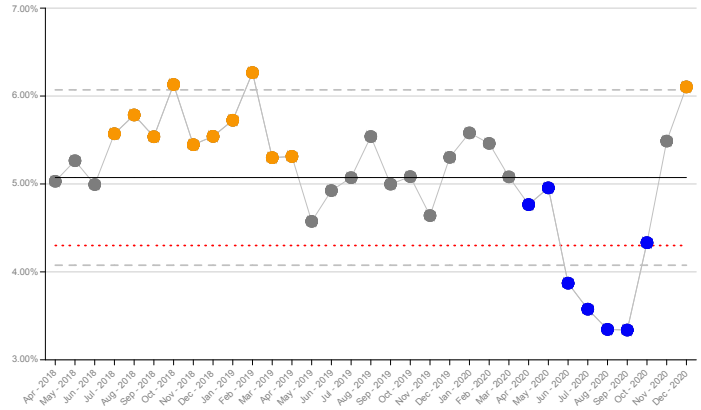
Tees, Esk and Wear Valleys NHS Foundation Trust

18) Percentage Sickness Absence Rate (month behind) - TRUST

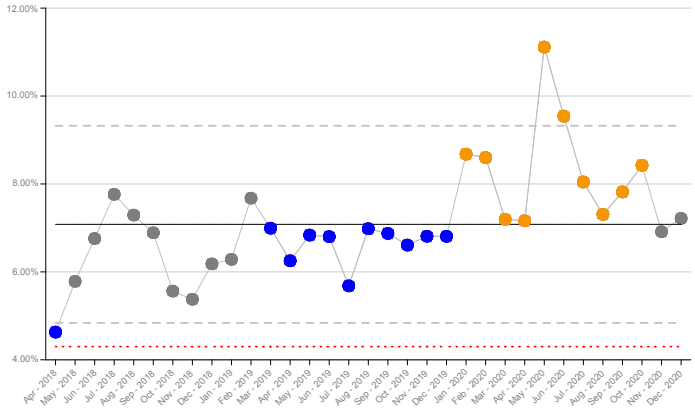


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST		F	5.14%	5.89%	4.39%
DURHAM AND DARLINGTON	H	?	5.07%	6.07%	4.08%
FORENSIC SERVICES		F	7.08%	9.32%	4.84%
NORTH YORKSHIRE AND YORK		?	4.23%	5.13%	3.32%
TEESSIDE		F	5.49%	6.58%	4.40%

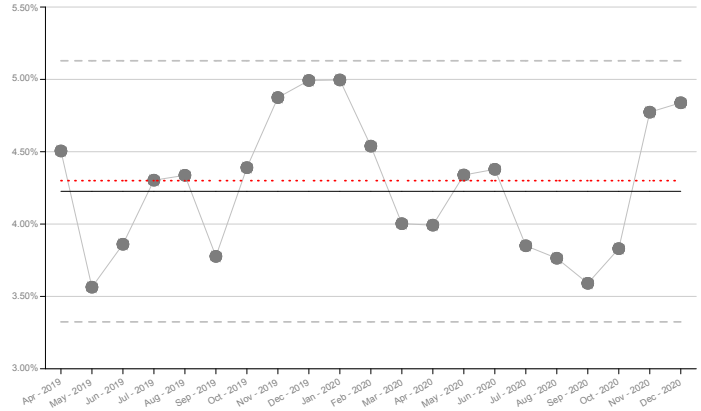
DURHAM AND DARLINGTON



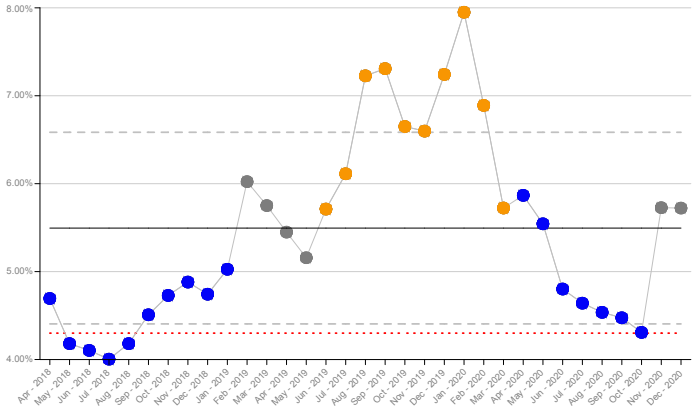
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



TEESSIDE



SPC Icon Definitions

Tees, Esk and Wear Valleys NHS Foundation Trust

Icon	Description
	1. Variation indicates inconsistently hitting, passing or falling short of the target
	2. Variation indicates consistently (F)alling short of the target
	3. Variation indicates consistently (P)assing the target
	4. Common cause - no significant change
	5. Special cause of concerning nature or higher pressure due to (H)igher values
	6. Special cause of concerning nature or higher pressure due to (L)ower values
	7. Special cause of improving nature or lower pressure due to (H)igher values
	8. Special cause of improving nature or lower pressure due to (L)ower values

Appendix D

TDB2 - Percentage of patients starting treatment within 6 weeks of an external referral – Durham and Darlington locality

TEWV is committed to ensuring that all patients referred into our services receive timely treatment, supporting patient safety, wellbeing and quality of care.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Analysis

- Durham and Darlington are displaying common cause variation; however a 5th consecutive monthly deterioration is observed and the locality reports below both the mean and the standard. Both the numerator (Number of patients starting treatment within six weeks of an external referral) and denominator (Number of patients starting treatment following an external referral) show common cause variation. AMH demonstrates special cause improvement and ALD demonstrates common cause variation neither indicating any cause for concern at this time.
- Within MHSOP, the last 6 months indicate a gradual deterioration, however common cause variation is displayed in the measure and its numerator and denominator. During the pandemic the service have had to minimise face to face contacts, which has had the effect of delaying treatment for some patients with presentations that require face to face contact (such as those who require memory assessment) beyond 6 weeks; treatment capacity has continued to be prioritised appropriately throughout this time. Durham and Chester-le-street Community team are showing special cause (concern), with 12 consecutive data points below the process mean; other teams contributing significantly to this measure are showing common cause variation and further work would be required to understand this difference.
- Within CYPS common cause variation is displayed. Both the numerator and denominator also show common cause variation; however both have regularly been below the mean throughout the pandemic. A shift from special cause improvement to common cause variation has been observed in the longer-term; feedback from the service is that incorrect use of 'governed psychological therapy' treatment intervention codes had led to a number of patients being recorded as having received treatment during their first appointment. Action was taken in Oct-19 to address this and performance has better-reflected reality since around Feb-20, with the position currently below the standard. All teams contributing significantly to this measure are showing common cause variation below the standard. A significant volume of referrals relate to neuro-developmental pathways such as for ADHD; these require face-to-face contact and thus many have been delayed since the onset of the pandemic. As these patients are treated in the coming months, this may have a negative impact on the overall specialty position as many have already waited more than 6 weeks from referral.

Conclusions

- The deterioration of performance in this measure has been mostly impacted by covid-related factors affecting the ability to see some patients in MHSOP.
- A shift from special cause (improvement) to common cause variation has been observed in CYPS in the longer-term as a result of the incorrect recording of treatment intervention codes. The current position better reflects the true performance.
- Further detailed analysis is required in both MHSOP and CYPS to understand variations at team level and to understand why Durham and Darlington locality are different to other localities within the Trust.

Actions we will take

- This measure and TD1 (percentage of patients seen within 4 weeks for a 1st appointment following an external referral) will continue to be monitored via routine monthly processes within MHSOP, supported by Corporate Performance.
- A detailed deep dive analysis is to be undertaken to identify any key areas of concern within MHSOP and CYPS, including those teams with low common cause variation. This will be supported by the Corporate Performance Team and findings shared with the Board in March 21.

Recommendations

- To note the analysis that has taken place and the actions being taken in relation to this measure and agree to receive an update in March 21.

ITEM No 17

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**26 January 2021**
TITLE:	**Finance Report for Period 1 April 2020 to 31 December 2020**
REPORT OF:	**Liz Romaniak, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	
To continuously improve to quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	✓

Executive Summary:

National financial arrangements have operated for the NHS during 2020/21 as a consequence of the Covid-19 Pandemic. In the first six months (April to September 2020) the trust followed national guidance for COVID-19 emergency planning and received a top up of income, including for recovering Covid costs, each month in order to breakeven. For the remaining months (October 2020 to March 2021) the Trust submitted an updated revenue forecast that anticipated a £1,998k deficit outturn. This was revised by agreement with NHSE/I during November, following notification of the receipt of £2,600k additional clinical income, to £602k surplus.

Forecast: Taking into account performance to the end of December, and a review of run rates, the statement of financial position, Covid and forecast costs, we project a 'probable case' forecast of £4,012k ahead of that revised required position of £602k surplus, i.e. an outturn surplus of £4,614k. The forecast takes into account projected additional Covid, IM&T, waiting list and staffing costs that have been proposed and supported by the Senior Leadership Group, the delivery of which they will oversee on a weekly basis.

Year to Date: The statement of comprehensive income for the period ending 31 December 2020 shows a surplus of £7,938k, which is £6,426k ahead of the revised required financial position (taking into account the additional £2,600k clinical income).

Performance Against Plan – year to date (3.1 / 3.2)

The Trust is currently £6,426k **ahead of** its financial plan	**Variance £000**	**Monthly Movement £000**	
	-6,426	-2,300	⬆

Cash Releasing Efficiency Savings (CRES) (3.3)

	CRES Type	Annual Variance £000	
Identified CRES schemes for the financial year are forecast to be £589k **behind** the financial plan.	Recurrent	1,343	
	Non recurrent	-1,930	
	Target	0	
	Variance	589	

	CRES Type	Annual Variance £000	
Identified CRES schemes for the rolling 3 year period were £11,182k **behind** the £15,261k CRES target.	Recurrent	11,182	

CRES delivery will be monitored by the Financial Sustainability Board (re-purposed group incorporating former Waste Reduction Programme) to ensure the Trust remains on course to deliver required recurrent CRES plans. Progress and actions will be reported into Resources Committee.

Capital (3.4)

	Variance £000	Monthly Movement £000	
The Trust is £3,786k **behind** its capital plan.	-3,786	2,406	

Capital programme expenditure to 31 December 2020 is £19,823k, and is behind plan by £3,786k. The variance arises largely due to VAT recovery for Foss Park Hospital (£4,045k) offset in part by construction projects not anticipated in the capital plan but which needed to be prioritised in-year, e.g. anti-ligature works.

Workforce (3.5)

	Variance £000	Monthly Movement £000	
The Trust is £167k **behind** its agency cap (3%)	167	76	

Agency expenditure to date is £5,867k which is £167k above the cap for the period ending 31 December 2020 with expenditure across all localities. The Trust anticipates a large increase in agency usage during quarter 4 due to increased service demand and staff shortages owing to sickness and isolation. Additional approvals were sought via the Senior Leadership Group and, where breaching related wage or price caps, will require additional Medical Director / Director of Nursing consideration, e.g. on the basis of quality or safety.

Use of Resources Risk Rating (UoRR) (3.7)

	Plan	Actual	
The Trusts UoRR is 1 which is **ahead of** plan. Ratings are awarded from 1 to 4 with 1 being good.	2	1	

The UoRR is impacted by COVID-19 and is currently suspended. However, the Trust has assessed the UoRR against its revised plan as a 1 for the period ending 31 December 2020. More detail on this is included in section 3.7 of this report.

Recommendations:
The Board of Directors is requested to: • receive the report, noting this now reflects year to date and forecast performance against the revised 2020/21 plan, • consider the issues and risks raised and any related further assurances needed, including via Resources Committee.

MEETING OF:	**Board of Directors**
DATE:	**26 January 2021**
TITLE:	**Finance Report for Period 1 April 2020 to 31 December 2020**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2020 to 31 December 2020.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to monitor the Trust's key financial duties and performance indicators which are both statutory requirements.

2.2 NHS Improvement's Use of Resources Rating (UoRR) evaluates Trusts based on their ability to service debt, liquidity, I&E margin, achievement of planned I&E margin and agency expenditure.

2.3 In the first six months of the financial year (April to September) the trust followed national NHS finance guidance to cover COVID-19 emergency planning and received a top up of income each month in order to breakeven. For the remaining months, October 2020 to March 2021 the Trust, in line with Phase 3 NHS planning guidance, submitted an updated revenue forecast and this will be the plan used to measure ongoing performance.

3.1 Key Performance Indicators

The UoRR for the Trust is assessed as 1 for the period ending 31 December 2020.

3.2 Statement of Comprehensive Income

In the first six months of the financial year (April to September) the trust followed national NHS finance guidance and received a top up of income each month in order to breakeven.

The comprehensive income outturn for the period ending 31 December 2020 is a surplus of £7,938k, and is £6,426k ahead of the NHSI phase 3 revised plan (a deficit of £1,998k increased by £2,600k to £0.6m surplus) agreed with NHSE/I following notification of the receipt of £2,600k additional clinical income in Month 8). This is summarised in table 1 below:

Table 1

	Annual Plan			Year to Date		YTD
	M1-6 £000	**M7-12 £000**	**Total £000**	**Plan £000**	**Actual £000**	**Variance £000**
Income From Activities	175,422	193,311	**368,733**	273,764	275,547	-1,783
Covid Top Up income	8,313		**8,313**	8,313	8,313	0
Other Operating Income	8,969	7,801	**16,770**	12,868	14,351	-1,483
Total Income	**192,704**	**201,112**	**393,816**	**294,945**	**298,211**	**-3,266**
Pay Expenditure	-153,727	-159,627	**-313,354**	-233,460	-231,447	-2,013
Non Pay Expenditure	-33,763	-35,730	**-69,493**	-52,183	-52,483	300
Depreciation and Financing	-5,214	-5,153	**-10,367**	-7,790	-6,343	-1,447
Surplus / (Deficit)	**0**	**602**	**602**	**1,512**	**7,938**	**-6,426**

Income from activities is ahead of plan largely due to further investment from commissioners in relation to mental health investment standards and service development funding across various clinical localities which was not anticipated in the trust's plan for October 2020 to March 2021.

Other operating income is ahead of plan following an update to the trust's Learning Development Agreement (LDA) that allocated £1.1m retrospective funding for trainees, and £0.4m income relating to a settled contract dispute. These items were not anticipated in the revised plan.

Pay expenditure is below plan in month 9 due to COVID-19 related expenditure being less than anticipated (£0.8m) and continued vacancies where recruitment was expected (£1.2m).

Depreciation and Financing costs are less than planned due to reduced PDC dividend payable (£0.9m) and depreciation (£0.5m), both largely related to delays in the completion of capital schemes.

3.2 Cash Releasing Efficiency Savings (CRES)

The Trust's performance against the 2020/21 net CRES target of £4,127k is shown in Table 2 below. The Trust is forecasting to be £589k behind its 2020/21 plan. The Financial Sustainability Board (re-purposed and incorporating the former Waste Reduction Board) will keep this situation under review and co-ordinate financial planning activities. Delays in delivery are being mitigated by non-recurrent underspends.

Table 2: Cash Releasing Efficiency Scheme Performance 2020/21	**2020/21 Target**	**2019/20 B/fwd Variance**	**2020/21 Cumulative Target**	**2020/21 Identified Recurrent Schemes**	**2020/21 Identified Non Recurrent Schemes**	**2020/21 Total Identified Schemes**	**2020/21 Variance from Target**
Locality	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Chief Operating Officer	5,129	-1,672	**3,457**	3,322	-807	**2,515**	941
Corporate and EFM	1,215	-391	**824**	678	253	**931**	-107
Total identified and approved recurrent CRES	**6,344**	**-2,063**	**4,281**	**4,000**	**-554**	**3,446**	**835**
Trust Wide Schemes							
Revaluation of Assets - Depreciation & PDC	0	-154	**-154**	607	-515	**92**	-246
Total identified non recurrent schemes	**0**	**-154**	**-154**	**607**	**-515**	**92**	**-246**
-							
Total identified and approved recurrent CRES	**6,344**	**-2,217**	**4,127**	**4,608**	**-1,069**	**3,538**	**589**

3.3 Capital

Capital programme expenditure to 31 December 2020 is £19,823k, or behind plan by £3,786k. The variance arises largely due to VAT recovery for Foss Park Hospital (£4,045k) offset in part by construction projects not anticipated in the capital plan but which needed to be prioritised in-year, e.g. anti-ligature works.

The Trust has received national confirmation during January that a £4.5 million bid for PDC (cash-) backed Mental Health capital funding has been

successful. This relates to programmed Children and Young People (CYP) services schemes i.e. Bacchus House and The Ridings, and reduces the call on the Trust's own cash balances.

As a consequence of the £4.5 million PDC funding, VAT recovery of £4.1 million and a £2m prioritised anti-ligature programme, the Trust forecasts being £6,584k underspent against its opening capital expenditure limit. Regional NHSE/I finance colleagues supported the Trust's bid to secure additional capital cash/resource for the CYP schemes.

3.4 Workforce

Table 3 below shows the Trust's performance on some of the key financial drivers identified by the Board.

Table 3	Pay Expenditure as a % of Pay Budgets						
Tolerance	Tolerance December-20	July	August	September	October	November	December
Establishment (a) (90%-95%)	92.45%	91.92%	90.06%	91.52%	91.92%	91.86%	92.45%
Agency (b)	2.60%	2.36%	2.38%	2.44%	2.46%	2.49%	2.51%
Overtime (c)	1.00%	1.22%	1.18%	1.15%	1.15%	1.19%	1.23%
Bank & ASH (flexed against establishment) (100%-a-b-c)	3.95%	2.99%	3.12%	3.29%	3.29%	3.35%	3.41%
Total	**100.00%**	**98.49%**	**96.73%**	**98.40%**	**98.83%**	**98.89%**	**99.61%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for overtime and 2.6% for agency, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For December 2020 the tolerance for Bank and ASH is (3.95%) of pay budgets.

NHS Improvement monitors agency expenditure against a capped target of £7,600k for the year (TEWV's target equates to 2.6% of pay budgets). Agency expenditure to date is £5,867k which is £167k above the cap for the period ending 31 December 2020, with expenditure across all localities.

Nursing and Medical agency expenditure accounts for 95% of total agency expenditure, and is used to support vacancies and enhanced observations with complex clients. The Trust anticipates increased agency usage during quarter 4 due to increased service demand and staff shortages owing to sickness and isolation. Additional approvals were sought via the Senior Leadership Group and, where breaching related wage or price caps, will require additional Medical Director / Director of Nursing consideration, e.g. on the basis of quality or safety

Excluding that used for agency for COVID-19 reasons, agency expenditure is lower than the cap ceiling. The Trust continues to work to improve this position on a recurrent basis.

3.5 Cash

Total cash at 31 December 2020 is £110,076k; this is £43,357k ahead of plan and is largely due:

- (£31,021k) income relating to future months; which is received early due to receiving block contracts early;
- (£2,600k) attributable to the receipt of unplanned clinical income and required improvement in plan;
- the trust being ahead of its revised financial plan (£6,426k);

- The remaining balance relates to variances within working capital.

The PDC capital support confirmation improves forecast cash balances by an equivalent £4,532k. A refreshed cash flow forecast and 5 year capital plan / financing estimate is being progressed to take into account current cash forecasts and the latest daft 5-year capital plan.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The UoRR is impacted by COVID-19 and is currently suspended for national reporting and performance purposes. However, the Trust has assessed the UoRR against its revised plan as a 1 for the period ending 31 December 2020. Table 4 below shows the performance over each of the metrics.

Table 4: Use of Resource Rating at 31 December 2020

NHS Improvement's Rating Guide	Weighting	Rating Categories			
	%	1	2	3	4
Capital service Cover	20	>2.50	1.75	1.25	<1.25
Liquidity	20	>0	-7.0	-14.0	<-14.0
I&E margin	20	>1%	0%	-1%	<=-1%
I&E margin distance from plan	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	3.47x	1	1.50x	3	
Liquidity	46.1 days	1	38.2 days	1	
I&E margin	2.7%	1	0.2%	3	
I&E margin distance from plan	2.6%	1	0.0%	1	
Agency expenditure	£5,867k	2	£5,700k	1	

Overall Use of Resource Rating	1	2	

3.7.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 3.47x (can cover debt payments due 3.47 times), which is ahead of the revised plan and is rated as a 1.

3.7.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 46.1 days; this is ahead of the revised plan and is rated as a 1.

3.7.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 2.7%, which is ahead of the revised plan and is rated as 1.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan. The Trust I&E margin distance from plan is 2.6% which is rated as a 1.

The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is £167k (3%) in breach of the capped target and is marginally behind plan and rated as a 2, however this does not generate an overriding rules breach and means the trust retains an overall UoRR of 1.

The margins on UoRR are as follows:

- Capital service cover - to reduce to a 2 a surplus decrease of £7,092k is required.
- Liquidity - to reduce to a 2 a working capital decrease of £47,578k is required.
- I&E Margin – reduce to a 2 rating an decrease in surplus of £4,956k is required
- Agency Cap rating – to reduce to a 3 an increase in agency expenditure of £1,258k is required.

4. IMPLICATIONS:

4.1 There are no direct CQC, quality, legal or equality and diversity implications associated with this paper.

5. RISKS:

5.1 There are no risks arising from the implications identified in section 4.

5.2 If the Trust does not identify and deliver robust CRES plans, the underlying position will deteriorate and impact on service delivery and/or quality.

5.3 Latest updates indicated that, to enable continued focus on the pandemic, national 2021/22 planning guidance will be issued late in Quarter 4 and national block arrangements are likely to extend into the first quarter of 2021/22. In the absence of detailed guidance and resource assumptions the ICS and trust will need to agree the approach for 2021/22 budget setting, with oversight via Resources Committee.

6. CONCLUSIONS:

6.1 For the period ending 31 December 2020 the Trust has a surplus of £7,938k, which is ahead of the revised NHSI plan by £6,426k. Following detailed work overseen by the Senior Leadership Group (SLG) the trust is forecasting costs to rapidly progress a number of key programmes including improving waiting lists (progressed via the mental health partnership board), staffing and IT equipment for remote working. The Trust anticipates a probable case forecast of £4m ahead of our revised required position of £0.6m surplus, i.e. £4.6m surplus at the end of the financial year. This will require close and ongoing review via the SLG.

6.2 The amount of CRES identified for the financial year is behind plan and any delays in delivery are being mitigated by non-recurrent underspends. Plans continue to be progressed to meet the required target in future years and will continue to be monitored by the Financial Sustainability Board.

6.3 The UoRR for the Trust is assessed as 1 for the period ending 31 December 2020 and is ahead of the revised plan.

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to:

- receive the report, noting this now reflects year to date and forecast performance against the revised 2020/21 plan,
- consider the issues and risks raised and any related further assurances needed, including via Resources Committee.

Liz Romaniak
Director of Finance and Information

ITEM NO. 18

BOARD OF DIRECTORS

DATE:	**21st January 2021**
TITLE:	**Gender Pay Gap Report**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Information and Decision**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their carers to promote recovery and wellbeing	
To continuously improve to quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	√
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	√
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefits of the communities we serve.	√

Executive Summary:

The trust is legally required to publish information about its gender pay gap each year. The latest TEWV Gender Pay Report tells us that the gap between the average hourly pay of all male and all female employees, as at 31st March 2020, has reduced compared to the previous year and is the lowest since recording began from 2017. The gender balance of the TEWV workforce has not changed since the previous report whereas in previous years there had been a small but steady increase in the proportion of the workforce that is female. Work will be undertaken with the intention of taking steps to further reduce the pay gap where this can be done. A gender pay gap must not be confused with equal pay as the two are very different measures.

Recommendations:

1) To note the contents of the report, to comment accordingly and to approve publication of the gender pay gap information in Appendix A by 30th March 2021.
2) To support the production and publication of a TEWV ethnicity pay gap report within the next three months.

MEETING OF:	**Board of Directors**
DATE:	**21st January 2021**
TITLE:	**Gender Pay Gap Report**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to share information ahead of publication about the latest available TEWV gender pay gap as part of efforts to help ensure that TEWV complies with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The report will also be shared with the Senior Leadership Group and the Joint Consultative Committee over the coming weeks.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 From March 2018 public, private and voluntary sector organisations with 250 or more employees have been required to report annually on their gender pay gap using six different measures. This report is based upon a snapshot date of 31st March 2020. The last TEWV Gender Pay Gap report (snapshot date 31st March 2019) was published in October 2019. This was shortly before the Government decided that no enforcement action would be taken against employers who did not report, or who reported late for the reporting year 2019/20 (snapshot date 31st March 2019) in recognition of the pressures due to Coronavirus. There is now a legal requirement for TEWV to publish the 2020/21 data (snapshot date 31st March 2020) on the Government Equalities Office website by no later than 30th March 2021.

2.2 Gender pay gap reporting obligations complement other equality and diversity reporting requirements for specified public bodies. These requirements include the annual publication of information to demonstrate that TEWV is meeting its Public Sector Equality Duty and the publishing of equality objectives every four years

3. KEY ISSUES:

3.1 The six gender pay gap reporting measures are:

- Mean gender pay gap – the difference between the mean hourly rate of pay of male full-pay relevant employees and that of female full-pay relevant employees

- Median gender pay gap – the difference between the median hourly pay rate of male full-pay relevant employees and that of female full-pay relevant employees

` - Mean bonus gap – the difference between the mean bonus pay paid to male relevant employees and that paid to female relevant employees

- Median bonus gap – the difference between the median bonus pay paid to male relevant employees and that paid to female relevant employees

- Bonus proportions – the proportions of male and female relevant employees who were paid bonus pay during the relevant period

- Quartile pay bands – the proportion of male and female relevant employees in the lower, lower middle, upper middle and upper quartile pay bands

3.2 Appendix A includes TEWV gender pay gap information that it is intended to publish by no later than 30th March 2021. The 2020 TEWV mean gender pay gap fell by 16.7% compared to 2018 and the median gender pay gap fell by 13.2%. These reductions follow reductions reported for the previous year.

3.3 It is understood that the reduction in the Gender Pay Gap can be attributed at least in part to the impact of the national three year Agenda for Change pay agreement which has seen some staff progress through pay bands at a faster rate than before. This development has not eliminated the pay gap between males and females but it has helped to reduce the size of the pay gap as more female staff will have benefitted from the revised pay progression arrangements. Local changes made to the TEWV Healthcare Assistant Career Framework in 2019 increased earnings amongst this predominantly female staff group and could have had an impact also.

3.4 The previously reported trend toward TEWV having an increasingly female workforce had paused as at the snapshot date of 31st March 2020.

3.5 The gender breakdown by pay band information highlights few changes in distribution between 2019 and 2020 though there has been a marked increase in the proportion of females in Band 9 and Very Senior Manager posts for a second successive year.

3.6 Only the particular gender pay gap information that is described in paragraph 3.1 will be published on the Government Equalities Office website. The additional gender pay gap information provided within Appendix A can be published on the TEWV website.

3.7 The 2020 annual staff survey results are expected to be published shortly and will provide more insight about the latest views of TEWV staff about TEWV acting fairly with regard to career progression and promotion.

3.8 The timing of this report is such that comparable gender pay gap information from many other NHS organisations is not yet available.

3.9 Consultation with the BAME Staff Network has highlighted support for the production of a TEWV ethnicity pay gap report. Though TEWV is not legally required to report about the ethnicity pay gap it is believed that producing such a report would be the right thing to do.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** None identified.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** TEWV is required to publish its Gender Pay Gap Report on the Government Equalities Office website and on the TEWV website.

4.4 **Equality and Diversity:** Publishing gender pay gap information is part of the commitment of TEWV to being open and transparent about sharing this important information, to better understanding the reasons why gender pay differences exist and to taking actions in response. Reporting encourages TEWV to strive to be more diverse and inclusive through increasing its available talent pool.

4.4 **Other implications:** None identified.

5. RISKS:

Gender pay gap information could be confused by some with information about equal pay.

6. CONCLUSIONS:

6.1 The TEWV Gender Pay Gap Report identifies that the average pay of female TEWV employees is lower than male employees by 12.16% (mean) and by 8.91% (median). This information is to be published on the Government Equalities Office website and on the TEWV website by 30th March 2021.

6.2 The gender pay gap in March 2020 was less than that in March 2019 but a gap remains and more can be done to try to identify ways in which the pay gap can be further reduced.

7. RECOMMENDATIONS:

7.1 To note the contents of the report, to comment accordingly and to approve publication of the gender pay gap information in Appendix A by 30th March 2021.

7.2 To support the production and publication of a TEWV ethnicity pay gap report within the next three months.

Beverley Vardon-Odonkor
Head of HR and Workforce Assurance

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust Gender Pay Gap Report – 2020

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures. This is the third report and is based upon a snapshot date of **31st March 2020.** We are required to publish data on the Government Equalities Office website and on the Trust website by 30th March 2021 and annually going forward.
The gender pay gap differs from equal pay in the following way. Equal pay deals with the pay differences between men and women who carry out **the same jobs, similar jobs or work of equal value**. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women.
The following report includes the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality. The Trust is committed to understanding any differences identified in the gender pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

The gender profile of the Trust is

78.0% **22.0%**

The gender profile split in the Trust has remained static in the last 12 months. There has however been a 1% increase in favour of females since we started to report in March 2017. The gender split at that time was 76.9% female and 23.1 male.

Mean and Median Gender Pay Gap

The mean gender pay gap and median gender pay gap for **all employees** is as follows:-

Mean Gender Pay Gap

12.16% less than males -
equating to £2.20 per hour less

Median Gender Pay Gap

8.91% less than males -
equating to £1.31 per hour less

The mean gender pay gap linked to the amount a female is paid per hour has decreased by 16.7% in the last 12 months. The mean gender pay gap has reduced from 14.65% to 12.16%. The median pay gap linked to the amount a female is paid per hour has decreased by 13.2% on the previously reported position. The median gender pay gap has reduced from 10.14% to 8.91%.

The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle or a lease car. The table below highlights the number of staff by gender contributing to the schemes. The majority of staff opting to participate in one or more salary sacrifice schemes are female. The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median gender pay gap and will be one of a number of contributory factors which may be causing the differences being reported. There has been a 39% reduction in the number of staff contributing to the child care voucher scheme. This is linked to changes to the existing scheme.
There has been an increase of **38.6%** in the number of staff contributing to the lease car salary sacrifice scheme compared to March 2019. Based on the average monthly sacrifice of £297 this will reduce the gross pay of a female member of staff by approximately £3,564 per annum. It is also worth noting a proportion of staff contribute to more than one salary sacrifice scheme.

March 2020

Salary Sacrifice Schemes	Child Care Vouchers	Lease Car Scheme	Cycle to Work Scheme
Female	131 (77.9%) average sacrifice per month £166	250 (76.0%) average sacrifice per month £297	49(76.6%) average sacrifice per month £45
Male	37 (22.1%) average sacrifice per month £112	79 (24.0%) average sacrifice per month £340	15 (23.4%) average sacrifice per month £61

March 2019

Salary Sacrifice Schemes	Child Care Vouchers	Lease Car Scheme	Cycle to Work Scheme
Female	212 (77.4%) average sacrifice per month £166	147 (72.8%) average sacrifice per month £285	57(67.1%) average sacrifice per month £46
Male	62 (22.6%) average sacrifice per month £145	55 (27.2%) average sacrifice per month £301	28 (32.9%) average sacrifice per month £49

The mean gender pay gap and median gender pay for those staff **employed on Agenda for Change** terms and conditions and Executive Pay shows the difference in rate to be lower.

Mean Gender Pay Gap (AfC & Executive Pay)

5.14% less than males - equating to £0.84 per hour less

Median Gender Pay Gap (AfC & Executive Pay)

6.22% less than males – equating to 0.94p per hour less.

The mean gender pay gap has decreased by 15.15% and the median gender pay gap has increased by 9.57% compared to the previous year.

The information below highlights the mean gender pay gap and median gender pay gap for those staff employed on **Medical and Dental terms and conditions**. The figures include the Clinical Excellence Awards payments that are paid to eligible medical staff, which is a section of the workforce with a higher proportion of males.

Mean Gender Pay Gap (M&D)

Median Gender Pay Gap (M&D)

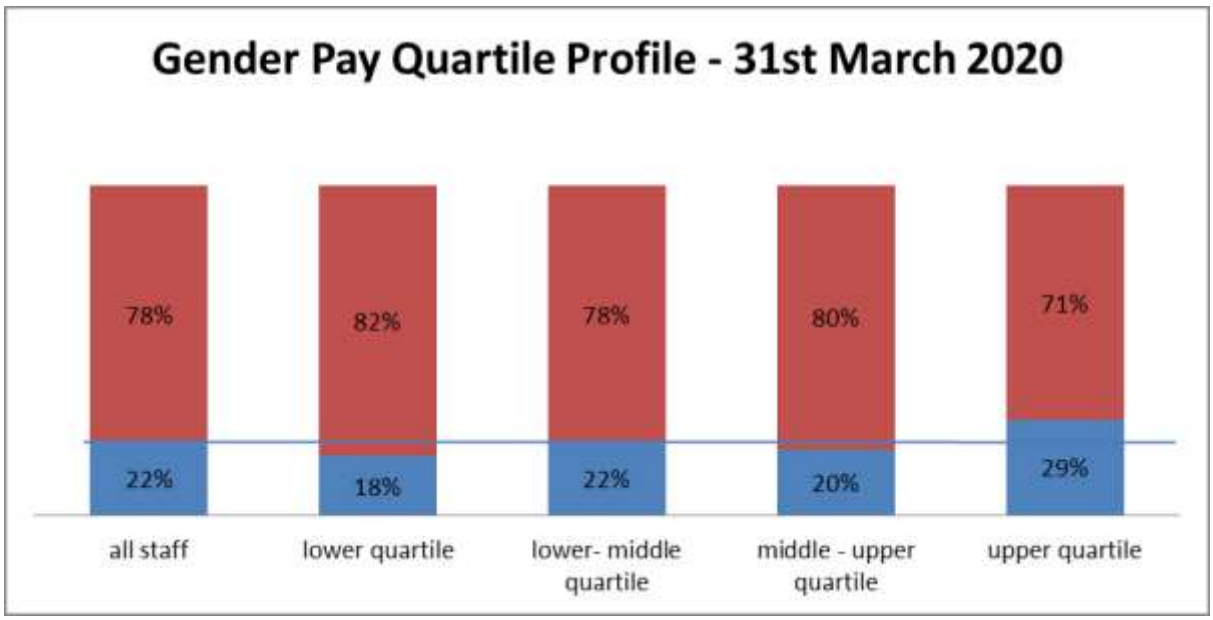
14.20% less than males -
equating to £6.34 per hour less

2.90% less than males –
equating to £1.34 per hour less

The mean gender pay gap has decreased by 7.49% which has resulted in a smaller difference in hourly pay for females based on the previous report. The median gender pay gap has also decreased by 48.94%.

Gender Pay Quartile Profile

The graph below shows the proportion of males and females in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile. 82% of employees in the lower quartile are female, compared with 71% in the upper quartile. The gender pay quartile profile has remained the same as the previous reporting period.



Bonus Payments

Under the national Medical & Dental terms and conditions Consultants are eligible to apply for Clinical Excellence Awards (CEA). These awards recognise individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role and are part of a commitment to the continuous improvement of the NHS. The table below highlights the mean and median bonus pay linked to clinical excellence awards.

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£13,608	£12,639
Female	£7,938	£7,182
Difference	£5,670	£5,457
Pay Gap %	41.6%	43.2%

At the time of reporting the Trust was operating a local clinical excellence award scheme based on the national terms and conditions. Eligible Consultants are invited to submit evidence to a panel who subsequently determined if an award would be made. Once an award had been made the Consultant continued to receive that level of award going forward. A further submission may be made the following year and as a consequence progression through the varying payment levels occurred. This may account for one of the reasons for the significant difference being reported.

Proportion of eligible Consultants receiving a CEA

66.6%

48.3%

The proportion of eligible Consultants receiving a CEA has decreased by 7.2% for males and 3.4% for females compared to the previous year.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 91 staff received an award. 73 females and 18 males received an award, equating to 80% of females which is greater than the Trust gender breakdown.

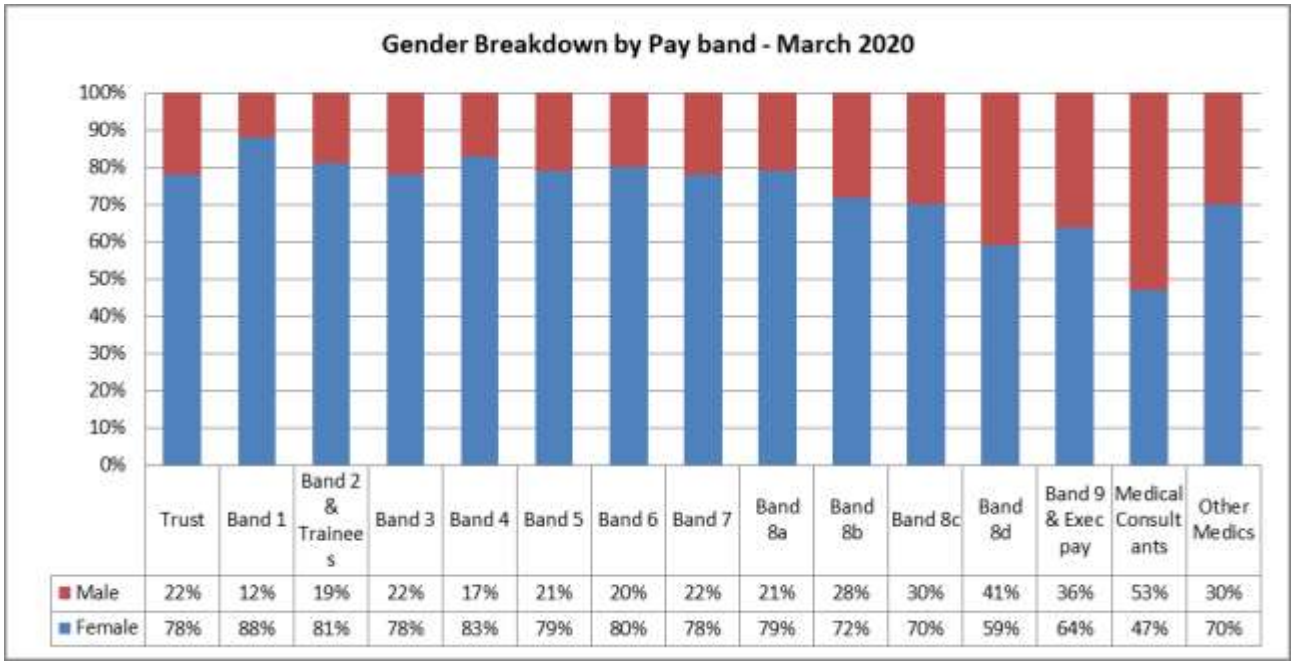
Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above. Guidance from ACAS states that such payments with a monetary value should be included. The table below provides **combined details of the clinical excellence awards and long service awards**.

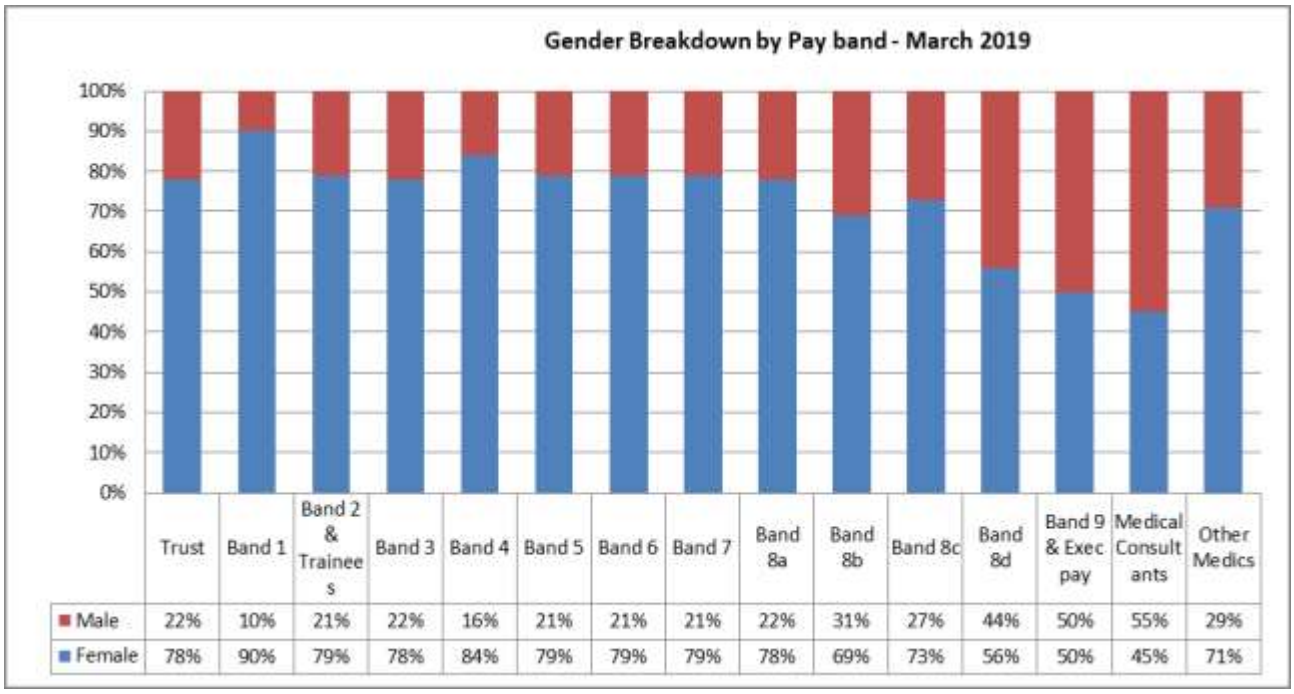
Gender	Mean Bonus Pay	Median Bonus Pay
Male	£8,255	£6,032
Female	£1,687	£100
Difference	£6,568	£5,932
Pay Gap %	79.5%	98.3%

It is important to recognise when combining the bonus awards in this way the data is skewed as long service awards are predominantly paid to women with a higher proportion of males receiving clinical excellence award payments.

Gender Breakdown by Pay Band

The following two graphs provide a gender profile breakdown by pay band as at March 2020 and March 2019. **The graphs highlight there have been changes in the profile in a number of bands, most notably in band 8b, 8d and band 9 and Executive pay.**





Gender Pay Gap by Banding

In addition to statutory requirements, we have also analysed our gender pay gap by banding. The shaded boxes below highlight the pay bands where females are paid more than males. The tables relates to those staff employed on Agenda for Change conditions and locally agreed Executive Pay.

	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6
Mean pay difference	£1,24p per hour 11.80% **more**	0.13p per hour 1.2% **less**	0.38p per hour 3.3% **less**	0.17p per hour 1.1% **less**	0.49p per hour 3.26% **less**	0.51p per hour 2.79% **less**
Median pay difference	No difference reported	No difference reported	0.58p per hour 5.17% **less**	0.26p per hour 2.19% less	0.94p per hour 6.16% **less**	£1.27 per hour 6.66% **less**

	Band 7 	Band 8a 	Band 8b 	Band 8c 	Band 8d 	Band 9 and Executive Pay 
Mean pay difference	**No difference reported**	0.34p per hour 1.37% **less**	0.21p per hour 0.71% **less**	0.21p per hour 0.60% **less**	0.56p per hour 1.35% **more**	£8.95 per hour 13.79% **less**
Median pay difference	0.12p per hour 0.58% less	0.97p per hour 3.77% **less**	£1.29 per hour 4.31% **less**	0.09p per hour **0.25% less**	£1.33 per hour **3.23% more**	0.55p per hour 0.95% **less**

The table below highlights the gender pay differences for female Medical Staff.

	Consultants 	Speciality Drs 	Speciality Registrars 	Foundation Doctors 
Mean pay difference	£2.42 per hour 4.96% less	**0.96p per hour 3.30% more**	£1.12p per hour 4.51% less	**£0.11 per hour 0.67% more**
Median pay difference	0.67p per hour 1.40% **less**	**£2.16 per hour 7.73% more**	£2.47 per hour 9.98% less	**£.0.09 per hour 0.54% more**

Update on Progress from Gender Pay Report 2019

Following the publication of the last Gender Pay Report (March 31st 2019 snapshot date) further analysis was undertaken and shared with the Resources Committee. The analysis was undertaken to better understand the reasons for the reduction in the median gender pay gap reported as at March 2019. The following summarises the findings of the analysis:-

- A review of the implications of the Agenda for Change three year pay deal was undertaken to see whether the roll out of the pay framework may have contributed to the reduction in the median gender pay gap. The analysis undertaken highlighted the implementation of the changes resulted in over 817 staff moving further up the pay band than they would normally have progressed had the changes not been implemented. 680 of the staff were female which equates to 83%. Although the changes happened on 1st April 2018 the effect would not be reported until the current report as at 31st March 2019. It is believed this change is likely to have impacted on the median gender pay gap reported. The calculation for determining the median pay rate is dividing the pay of employees by the number of employees by gender.
- Analysis was also undertaken to assess whether a greater number of female staff had reached the maximum of the pay scale between the previous reporting period and 31st March 2019. The analysis highlighted the overall rate remained on a par with the previous reported rate, in March 2018 47.6% of females were on the top of their pay band, with 46.7% in March 2019.
- The Trust operates a number of salary sacrifice schemes contributions to the schemes are deducted from the gross pay calculation. It's believed this will have an impact on the gender pay figures reported. There was a 10% increase in the number of staff contributing to the lease car salary sacrifice scheme in the reporting year. There was a 9% increase in females joining the scheme but the average monthly payment reduced by 3% which may have impacted on the figures reported. The increase in males joining the scheme was higher at 14.5%. The average monthly payment for males increased by 7.5%.

Clinical Excellence Awards

The Trust participated in a national research project with the Government Equalities Office into Clinical Excellence Awards. The research project investigated how the awards relate to the Gender Pay Gap in medicine. The research paper was published but did not provide specific recommendations that could be used locally to support the process. We await national guidance on how the LCEA's will proceed in future years.

Local Clinical Excellence Awards (LCEA) were halted this year as a result of the COVID-19 pandemic, with the award money that was due distributed equally among eligible consultants. This meant there was no formal process of application and review and instead all eligible individuals received a non-consolidated and non-pensionable payment for the 2020 year.

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th January 2021**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	
To recruit, develop and retain a skilled, compassionate and motivated workforce	
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Report:

The Board is asked to note the following use of the Trust seal in accordance with Standing Order 15.6:

Ref.	Date	Document	Sealing Officers
393	26.11.20	Lease relating to Wing A, Ground Floor, Enterprise House, Enterprise City, Spennymoor	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary
394	26.11.20	Lease relating to Units A7, A8 and A9 Green Square, Kirkleatham Business Park, Redcar	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary
395	26.11.20	Pre-emption agreement relating to Units A7, A8 and A9 Green Square, Kirkleatham Business Park, Redcar	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary
396	10.12.20	Deed of Covenant relating to Bacchus House, Link Business Park, York	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary

397	10.12.20	TP1 Form (transfer of part of registered title) relating to Bacchus House, Link Business Park, York	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary
398	17.12.20	Consultant's Collateral Warranty relating to Block 16, Roseberry Park Hospital, Middlesbrough (Hadley Industries Holdings Ltd t/a Hadley Steel Framing)	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary
399	17.12.20	Subcontractor Warranty relating to Block 16, Roseberry Park Hospital, Middlesbrough (Interserve Engineering Services Limited)	Brent Kilmurray, Chief Executive Phil Bellas, Trust Secretary

Recommendations:

The Board is asked to receive and note this report.