MEETING OF THE BOARD OF DIRECTORS
THURSDAY 29TH APRIL 2021
AT 1.00 P.M.

The meeting will be held via MS Teams

Board Members:
Board Members are asked to raise any questions for clarification on matters contained within the reports with the lead Executive Director prior to the meeting.

The 'chat' function on MS teams should not be used during the meeting.

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 – 1.15 pm):

1	Apologies.	**Chairman**	**-**
2	Chairman's Introduction.	**Chairman**	**Verbal**
3	To approve the minutes the last meeting held on 25th March 2021.	**-**	**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	To note any matters raised by Governors.	**Board**	**Verbal**

Strategic/Performance (1.15 pm – 1.45 pm):

8	Chief Executive's Report.	**CEO**	**Report**
9	To consider the report of the Audit and Risk Committee.	**Committee Chairman (JM)**	**Report**
10	To consider the Finance Report as at 31st March 2021.	**DoF&I**	**Report**
11	To consider the Performance Dashboard Report as at 31st March 2021.	**DoPCPC**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (1.45 pm – 2.35 pm):

12	To receive and note an update on the delivery of the CQC Action Plan.	**DoN&G**	**Presentation**
13	To consider the report of the Quality Assurance Committee.	**Committee Chairman (BR)/ DoN&G**	**Report**
14	To consider the Learning from Deaths Report for Quarter 4, 2020/21.	**DoN&G**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (2.35 pm – 2.45 pm):

15	To consider the Annual Report of the Guardian of Safe Working.	**Dr. Jim Boylan to attend**	**Report**

Items for Information (2.45 pm – 2.50 pm):

16	Report on the use of the Trust Seal.	**CEO**	**Report**

Exclusion of the Public (2.50 pm):

17	**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.* *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.*	**Chairman**	**Verbal**

Miriam Harte
Chairman
23rd April 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 25th MARCH MICROSOFT TEAMS COMMENCING AT 1.00 PM

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 B Reilly, Non-Executive Director
Mrs S Richardson, Non-Executive Director
Mrs R Hill, Chief Operating Officer
Dr A Khouja, Medical Director
Mrs E Moody, Director of Nursing and Governance
Mrs L Romaniak, Director of Finance and Information
Dr S Dexter-Smith, Director of People & Culture (non-voting)
Mrs S Pickering, Director of Planning, Commissioning, Performance and Communications (non-voting)

In Attendance:
Mr P Bellas, Trust Secretary
Ms D Oliver, Deputy Trust Secretary (Corporate)
Mrs K Ord, Deputy Trust Secretary (Membership, Involvement & Engagement)
Mrs S Paxton, Head of Communications

Observers/Members of the Public
Dr S Baxter, Public Governor, Redcar & Cleveland
Mrs M Booth, Public Governor,
Mr J Creer, Public Governor, County Durham
Dr A Fairbairn, Appointed Governor, Newcastle University
Mr A Heslop, Public Governor, County Durham
Mrs J Kirkbride, Public Governor, Darlington
Mr J Preston, Public Governor, Harrogate
Dr M Sani, Public Governor, Stockton on Tees
Mr J Venable, Public Governor, York and Selby
Mrs J Wardle, Public Governor, County Durham
Mrs S Baines, CQC Inspector/Relationship Owner TEWV
Ms S Liu, Research Student, University of York
Mrs K Cole, Press
Mr M Discombe, Journalist, Health Service Journal

Four members of the public.

21/41 APOLOGIES

There were no apologies for absence.

21/42 CHAIRMAN'S INTRODUCTION

The Chairman welcomed Board Members, Governors and those in attendance at the meeting.

21/43 MINUTES

***Agreed** – that the minutes of the last formal meeting held on 26th January and Special meeting held on 3rd March 2021 be approved as correct records and signed by the Chairman.*

21/44 DECLARATIONS OF INTEREST

It was noted that under item 11 of the Confidential Agenda, "recommendations arising of the Nomination and Remuneration Committee, held on 22nd March 2021" that all Executive Directors had a potential conflict of interest.

The Trust Secretary advised that Executive Directors would not be required to leave the meeting unless there was anything specific to their individual role to be discussed in detail.

21/45 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.

21/46 CHAIRMAN'S REPORT

The Chairman highlighted:

(1) That the primary focus for the organisation over the past month had been the response to the inspection of adult inpatient wards by the CQC in January 2021. The Board of Directors had been well sighted on the action plan, with the opportunity to challenge and provide support, in order that the proposed next steps be delivered.

(2) That work continued around the development of the new Trust Strategic Framework, which had been a very extensive and inclusive process, and its implementation would commence over the coming weeks.

(3) That there would need to be critical input from the Trust into the developments around integrated care systems (ICS) and any changes resulting from the publication of the White Paper 'Working together to improve health and social care for all' on 21st February 2021.

(4) That, on reflection, there had been an overwhelming amount of commitment and support shown by all staff in managing and responding over the last twelve months since the beginning of the pandemic.

Staff had worked extremely hard in often challenging times, whilst also adapting to new working environments.

There was evidence to suggest that the demand for services would continue to rise, with increased acuity due to the declining mental health of the population.

Given the levels of fatigue and concerns for staff wellbeing it had to be acknowledged that it was still unknown what the true impact of the pandemic would be on the needs of individuals for the services provided by TEWV.

21/47 CHIEF EXECUTIVE'S REPORT

The Board received and noted the Chief Executive's Report, which provided an update on the CQC inspection in January 2021, integration and innovation, the launch of the Trust Strategy, Covid 19 and the Governance Review.

The following matters were highlighted:

(1) The publication of the CQC report following the inspection in January 2021 had been delayed and was now expected on 26th March 2021. The Trust had received an embargoed copy of the report in advance.

Non-Executive Directors:

(a) Queried whether there had been any early feedback from patients and staff around how they had adapted to such significant changes in processes.

It was noted that there had been excellent clinical and non-clinical engagement with the change management processes and the Chief Executive expressed his thanks to all staff for their commitment and support.

Overall there had been a feeling of acceptance from staff on what was required in response to the inspection and positive feedback had been received.

Some early feedback from service users had been that they had welcomed the renewed emphasis and focus on risk management and they had noticed a difference.

(b) Noted that the governance arrangements for feedback to Board members, following the CQC inspection had been transparent and they had been well engaged.

(c) Highlighted the connection between the ongoing work in response to the CQC inspection and setting the tone for the 'Our Journey to Change'.

(d) Sought assurance that concerns were being addressed and whether services were currently safe.

The Director of Nursing and Governance advised that there was a range of safety and governance measures in place both on a daily and weekly basis, including direct observations and coaching to formal audits and peer audits. Information was being monitored through the weekly Trust Quality Improvement Board, chaired by the Chief Executive and attended by all Executive Directors, which would then report to the Quality Assurance Committee. A range of approaches, for individual patient focus, both at ward and team level were in place to monitor patient safety.

(e) Noted the importance of "future proofing service delivery" and the need for the right governance trail from the Practice Development Specialists (PDS) to the senior multidisciplinary teams and through to the Committees and the Board.

The Chief Executive highlighted that the PDS approach would encompass sustainability and engagement including training and development; coaching and working alongside staff with the ability to adapt and change processes as the weeks progressed.

Improvements were also being made to the flow of assurance from Ward to Board, which would encompass any recommendations taken from the outcome of the Governance Review.

The Director of Nursing and Governance highlighted that one of the issues raised at the Patient Safety Summit in February 2019 had been the need to free up time to care. It was anticipated that the proposals for additional resources, staffing and seven day administration would be the enabler to deliver that.

The Chairman made an ongoing plea for simplicity in all processes and in undertaking matters in a clear and uncomplicated way.

(2) The impact of the Health and Social Care white paper – 'Working Together to Improve Health and Social Care for All', had been considered at a recent Board Seminar. Future operating models would build on strengthening partnership working with key stakeholders.

(3) The launch of 'Our Journey to Change', the new Strategic Framework was planned for 30th March 2021.

(4) The current take up rate for the Covid vaccination was 87% and plans were being made to provide the second. There were with no concerns about acquiring sufficient supplies. Monthly Teams conversations were available to anyone with concerns about either the Covid vaccine or the upcoming flu vaccine, planned for later in the year.

(5) There was currently one live outbreak of Covid across the whole Trust.

21/48 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.

21/49 MATTERS RAISED BY GOVERNORS

The Chairman highlighted that, in discussions prior to the meeting, Governors had raised the medication errors referenced on page 6 of the Quality Assurance Committee minutes (meeting held on 4th February 2021), (minute 21/08 refers).

The Medical Director explained that the medication error, which had been reported at a recent meeting of the Quality and Safety Cell had involved the misidentification of a patient. Remedial measures were being considered, including the use of wrist bands or photo identification for patients.

Assurance was provided that no individual had been harmed, as the error had been picked up very quickly.

21/50 QUALITY ASSURANCE COMMITTEE

The Board received an update report on the business discussed by the Quality Assurance Committee (QuAC), including the key issues considered at its meetings held on 4th February and 4th March 2021.

The following matters were highlighted to the Board:

(1) Concerns around staffing, particularly in Forensic services where two wards had been temporarily closed to admissions at Roseberry Park Hospital.

Concerns were also raised around:

(a) Thistle ward, where staff had been working in business continuity arrangements.
(b) Ongoing issues with the Durham and Darlington Crisis Team.

A short briefing paper had been requested from Forensic Services and the Durham and Darlington Locality to be reported to the meeting of the Committee due to be held on 1st April 2021.

The Chief Operating Officer advised that Thistle ward had been taken out of business continuity arrangements; however, there were ongoing issues and daily huddles were supporting the ward and staff.

(2) There had been two under 18 year old individuals admitted to adult acute wards. Some reassurance had been provided that they were cared for in a slightly separate area of the PICU with CAMHS crisis staff.

It was noted that shortage of CAMHS inpatient facilities was recognised as a national concern.

The Director of Finance and Information advised that alignment of the staffing establishment and investment into inpatient facilities would be considered through the Quality Improvement Board to ensure that future needs could be met.

(3) That the Committee was keen to ensure alignment of Trust wide reporting on quality matters, including oversight of information from the Trust Quality Improvement Board and NHSEI Quality Board.

21/51 SAFE STAFFING REPORT

The Committee received and noted the six monthly Safe Staffing report.

The key matters highlighted were that:

(1) The report had been re-formatted, in line with other quality reports to include SPC charts and analysis.

(2) The report contained information for the period June to November 2020, so was recognised as being out of date.

(3) For the reporting period, the statistical analysis demonstrated that there were areas showing cause for concern around fill rates (with the exception of Registered Nurses on days which had increased due to Covid). HCA fill rates on nights had also been an issue across all four localities. This had been due to staff being deployed above establishments leading to the reliance on temporary staffing or overtime.

There had also been a decline in mandatory training compliance, which had been due to a pause during the pandemic.

(4) There had been positive news regarding the introduction of 'Aspirant nurses' during the pandemic, who had helped with staffing establishments.

Non-Executive Directors drew attention to a minor inconsistency in two of the tables contained in the report.

The analysis of the metric 'care hours per patient day' (CHPPD) for adult mental health, which had reported under the national average, was raised.

In response it was recognised that benchmarking included the Mental Health Optimum staffing tool (MHOST) and data from the 'Model Hospital', as well as looking at the balance between registered nurses and HCAs on wards at any given time.

21/52 PROPOSAL FOR STAFFING ESTABLISHMENTS

Consideration was given to a report on proposals for staffing establishments.

In introducing the report, it was highlighted that:

(1) The Board, at its meeting held on 25th February 2020 had supported in principle further investment into adult inpatient wards.

(2) In response to the pandemic the approach taken around staffing had been to over recruit using the surge funding, which had been provided from centrally.

(3) The report had been written with consideration of historic data, since a reflection of the data for the last twelve months alone would not have provided a true indicative position on staffing establishments and requirements.

(4) Two of the key aims for the proposals were to release time to care and for more support to be provided to staff.

The proposals set out in the report included:

(1) Phase 1: Adult mental health and PICU ward to be given priority to include additional staffing to enhance nursing leadership across 7 day a week roster for daytime shifts for all wards; skill mix plans to increase the registered to unregistered ratio; and to increase occupational therapy assistants and peer support. The introduction of a practice development practitioner would support the embedding of good practice, organisational learning, coaching and supervision at ward level. Seven day administrative staffing would be provided to adult mental health wards with a focus on supporting safety reporting and ward related reporting.

- The additional resources for phase 1 totalled £3,616,576.
- The total resources identified totalled £5,477,064.

(2) Phase 2: Consideration of staffing levels, taking into account the additional roles, to understand how that translated into a workable multidisciplinary roster for the different ward sites by the end of May 2021.

The Director of Finance and Information noted that there had been significant overspends each year on inpatient budgets and future spending would be about hard wiring that overspend to achieve different outcomes. The overspend for 2021 on inpatients and secure services had been £4.2m, which had increased due to Covid to £7.5m. The consequences of the overspends would be worked into the planning round.

In talking through the risks it was noted that:

(1) Insufficient staff numbers would impact on quality patient care with a continued reliance on temporary staffing and overtime.

(2) Any wards below the benchmark values there could be a negative impact on effective clinical leadership on culture within those wards below the benchmark values and mitigations would be required.

(3) The revised investment plan might not lead to a reduction in the current overspend on staffing but would reduce agency spend.

Following discussion it was noted that:

(1) The governance route for the proposals set out in the report around adult mental health had included presentation and discussion at both the Resources Committee and the confidential Board. The SLG had considered the secure inpatient services more recently and agreed with the direction of travel.

(2) The Chairman of the Resources Committee stated there were multiple reasons to support the proposals, with a slight caveat around the affordability.

(3) The Financial Sustainability Board would be considering how future investment would be managed in a sustainable way and the work plan would reflect how the strategic pressures would be managed.

The Chairman added that the drivers of the proposals were about quality and safety, getting the right staff in the right place, at the right time, rather than cost saving.

In response to a query the Director of Nursing and Governance provided an explanation of the “Zonal engagement model of care”.

She explained that the model of care was currently being piloted on Westerdale South, an organic ward in Tees for older people. There had been a reduction in the number of falls and the incidents of violence. Staff had reported having more time to spend with patients and felt they were better able to carry out their clinical duties. The formal evaluation of the pilot had been delayed due to Covid, however it was expected that the model would also work very well in secure inpatient services.

The Medical Director added that some thought would need to be given to:

(1) How the models of care demonstrated robust quality care and what that looked like. Also, how the Board would be assured around the delivery of that quality care.
(2) How the medical workforce would fit into the model of care and how they would contribute and provide additional functions within the current numbers of consultant psychiatrists.

Non-Executive Directors sought some reassurance around the ability to recruit the necessary staff to over established levels.

In response it was noted that ambitious targets had been set to over recruit and that would be achieved through various routes, including a new area of the Trust website, focussed targeted recruitment from the local communities and roles such as those within the Practice Development teams.

Agreed:

(1) that the additional funding be provided to meet the immediate (phase 1) staffing priorities for the AMH admission / PICU wards and Secure Inpatient Services as follows:

- *Adult mental health and PICU - £3,616,576*
- *Secure Inpatient Services - £1,860,488*
- *Total additional resources identified for phase 1 - £5,477,064*

(2) that the plan and timescales for further consideration of staffing establishments in the remaining inpatient ward areas (phase 2), as detailed in the above report, be approved.

Action: L Romaniak/E Moody

21/53 MENTAL HEALTH LEGISLATION COMMITTEE

The Board received an update report on the business discussed by the Mental Health Legislation Committee (MHLC), including the key issues considered at its meeting held on 21st January 2021.

The following matters were raised:

(1) The report had been re-formatted into a template. The purpose of the report was to provide the Board with a clear, concise overview of what had been considered on the agenda, matters that the Board should be alerted to, what assurances had been provided and any issues that the Board should be advised on.

(2) There were no significant matters to raise to the Board.

(3) The key areas that the Board should be alerted to were:

(a) Improvements to the provision of information to detained patients, particularly at Roseberry Park Hospital.
(b) The short consultation period for a Trust response to the reforms to the Mental Health Act, following the recommendations from the Simon Wesley report and the keen intention to try and consult with Governors, carers and service users.
(c) Improvements required to record keeping for section 17 leave forms.

Assurance was provided that mitigating actions were in place to address the issues raised.

A query was raised around the 18 occasions between January - December 2020 when there had been flaws with section 15 forms. Fourteen of those had been flaws such as unsigned applications, using incorrect forms or missing patient names.

The concern about the administration of the forms, was that the process had to be re-started should an inaccuracy be found and that clearly impacted on the patient.

The Director of Nursing and Governance provided assurance that there were robust processes in place to pick up any fundamental flaws, however agreed that any issues should be rectified in a timely way.

Non-Executive Directors welcomed the revised format of the report.

21/54 FINANCE REPORT

The Board received the Finance report for the period 1 April 2020 to 28th February 2021.

The key matters highlighted were:

(1) The statement of comprehensive income. At month 11 there was a surplus of £11.2m, which was £10.4m ahead of the revised plan. The Trust forecasted achieving a surplus of £8.2m, or being £7.6m ahead of a revised required surplus of £0.6m. There could be the potential for further improvement, subject to the national position on annual leave accruals and confirmation of provisions.

(2) Capital expenditure was £9.8m below plan with a forecast outturn of £7.0m below plan at the end of March 2021. The position reflected the £4.05m VAT rebate following completion of Foss Park Hospital; a successful bid for £4.05m backed funding for planned Children and Young People that had been received in February; and delays in construction projects.

(3) There was a cash balance of £112.6m as at 28th February 2021, including £31.8m income received in advance through national funding arrangements to support prompt supplier payments.

(4) There had been some difficulties recruiting to the surge posts identified to tackle acuity and demand, with movement of some staff across different roles.

Following discussion Board members commented that the Resources Committee had gone through in some detail the month 11 position.

21/55 BOARD PERFORMANCE DASHBOARD

The Board received the Board Performance Dashboard report as at 28th February 2021.

The key issues highlighted were:

(1) The positive assurance around three areas:

- The percentage of patients seen within four weeks for their first appointment.

- The number of patients occupying a bed with a length of stay over ninety days.
- The percentage of staff in post with a current appraisal.

(2) Following previous reporting in Q3 that the Trust had failed to achieve the national standard for IAPT recovery in County Durham and Tees Valley CCGs, for Q4, to date, there had been positive assurance from the data that Trust level achievement had been reached for all the CCGs.

(3) Areas of concern (set out in Appendix D) were in regard to:

- Patients that started their treatment within six weeks of referral - a deep dive had been undertaken in Tees with actions being progressed.
- Out of area placements – a deep dive had been undertaken in Durham and Darlington with actions being progressed.
- Achievement of the benchmarks for HoNOS in AMH and MHSOP. A deep dive had been undertaken with actions being progressed.
- Percentage of new patients referred and taken on for treatment that were three months behind. The Tees locality had an action plan in place.

Non-Executive Directors questioned whether there was any further understanding of the significant increase in the number of unique patients referred to the Trust in recent months for Forensic services.

In response it was stated that this could be checked, however the most likely cause would be the changes that had been made to the recording in LD services for this.

Action: S Pickering

The Chairman queried what the level of responses were versus normal activity and was adequate to provide a view?

In response it was noted that:

(1) The number of patient experience questionnaires returned had dropped from 1484 In January 2020 to 926 in March 2021. However, the percentage of patients stating their care had been excellent or good had not really changed and was at around 90% for both years.

A piece of work was underway by make improvements on capturing patient experience and to increase the number of responses. The questionnaires were available in the community and inpatients. More detail would be provided to the Board in due course.

Action: S Pickering

(2) During Covid the national reporting of the Friends and Family test had been stood down under national arrangements.

(3) Capturing the information was undertaken at various 'touch points' and for longer stay patients, such as Forensics, the information was captured every six months.

(4) A piece of work was underway by make improvements on capturing patient experience and to increase the number of responses. More detail would be provided to the Board in due course.

Action: S Pickering

21/56 TRUST BUSINESS PLAN UPDATE QUARTER 3

The Board:
(1) Received the Trust Business Plan update for Quarter 3 2020/21.
(2) Considered proposed changes to the Business Plan as set out in appendix A to the report:
(3) Considered the significant changes to the Business Plan in relation to the transition of children and young people to AMH services.

Agreed:
(1) that the changes to the Business plan, as set out in Appendix A to the report be approved; and
(2) that the inclusion of the significant changes to the plans for the transition of children and young people to adult MH services be included in the Business Plan be approved.

Action: S Pickering

21/57 APPOINTMENTS TO COMMITTEES

On the recommendation of the Chairman it was:

Agreed: *that from 1st April 2021:*
(1) Bev Reilly be appointed as Chair of the Quality Assurance Committee; and
(2) Prof. Pali Hungin be appointed as chairman of the Mental Health Legislation Committee.

21/58 USE OF TRUST SEAL

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

21/59 DATE OF NEXT MEETING

It was noted that the next meeting of the Board of Directors would be 29th April 2021.

21/60 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 4.28pm.

Miriam Harte
Chairman

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
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	May-21	To be addressed following the governance review
25/03/21	21/52	To note approval of: - the additional funding (£5,477,064) to meet the immediate staffing priorities for the AMH admission and PICU wards and for Secure Inpatient Services as Phase 1 of the proposals to address staffing establishments - the plan and timescales for further consideration of staffing establishments in the remaining inpatient ward areas (Phase 2)	DoF&I/DoN&G	-	To note
25/03/21	21/55	Further information is to be provided to Board Members on the reasons for the significant increase in the number of unique patients referred to Forensic Services in recent months	DoPCPC	-	Completed
25/03/21	21/55	Further information to be provided to the Board on the work being undertaken to make improvements to capturing patient experience and increase the number of responses	DoN&G/DoPCPC	May-21	

Date	Ref No.	Action	Owner(s)	Timescale	Status
25/03/21	21/56	To note the approval of: - the changes to the Business plan 2020/21 as set out in Appendix A to the report - the inclusion of the significant changes to the plans for the transition of children and young people to AMH services in the Business Plan	DoPCPC	-	To note
25/03/21	21/57	To note the appointment, from 1st April 2021, of: - Bev Reilly as the Chair of the Quality Assurance Committee - Pali Hungin as the Chairman of the Mental Health Legislation Committee	TS	-	To note

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 29 April 2021**
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.

Governance Review

The final draft of the Well Led governance review undertaken by the Good Governance Institute will be considered by the Board later today. The report is comprehensive and makes a number of recommendations across twelve headings:

- Board development
- Risk Management and Board Assurance Framework
- Embedding the Strategy
- People and Culture
- Perfomance Management and Quality Assurance

- Governance routes and structures
- Quality Improvement
- Training
- Digital
- Involvement and Engagement
- Learning
- Innovation

A mapping of the recommendations to existing business plan priorities and other activities is underway, including through the CQC action plan, has been completed. Early priorities of risk management and board development have been identified, along with governance routes and structures.

The full report and action plan will be brought back to the May Board meeting.

Integrated Care System

The Trust continues to engage in discussions regarding the development of the North East and North Cumbria and the Humber, Coast and Vale Integrated Care Systems. Interim operating models are clearer for HCV and are being implemented. Discussions are still ongoing in NENC. The Trust has been participating in workshops and meetings with regards to Provider Collaborative arrangements. There has also been considerable activity at a place level to establish opportunities for closer working and integration.

ICS discussions in recent weeks in both patches has focussed on post-Covid recovery and planning. We are well engaged in both.

York Health and Care Alliance

For some months as previously reported, the Trust has been involved in discussions with partners within the City of York regarding the creation of a Health and Care Alliance. Partners from health, social care and the voluntary and community sector are commiting to the following common aim:

> **"As Health, Care and Voluntary and Community sector partners we have chosen to come together to support each other in taking bold collective action to help make the City of York a fairer, healthier place to live."**

The focus is on collaborative working, supporting the improvement in patient outcomes, addressing health inequalities and integrating services.

Three initial areas of focus have been identified:

1. Prevention and early management of diabetes in vulnerable people, including the mental wellbeing perspectives.
2. Complex packages, including Continuing Health Care cases.

3. Learning Disabilities / Autism – physicial health and health inequalities.

These need to be agreed and refined by partners but there is a strong sense of support to take these forward.

There are also a number of areas where our work is so closely connected that it would be helpful for all of our teams to have some clarity, at least in terms of our commitment to work collaboratively. These include:

- COVID recovery
- Community Mental Health
- Dementia care and support across the whole pathway
- Loneliness, isolation and wellbeing
- Self-harm and suicide
- Childhood resilience
- Health Inequalities

Green Social Prescribing Steering Group

I have recently been asked to chair a group across the Humber, Coast and Vale ICS patch to oversee one of the six national test and learn partnerships concerning green social prescribing. The aim is to work in partnership with a range of statutory and non-statutory partners to develop plans across the 6 places in Humber, Coast and Vale to identify activities, support and resources to promote nature based activitities to help people with mental health issues reduce symptoms, activate self management approaches and improve their physical health. This will involve co-creating opportunities with service users and voluntary and community organisations. There are a range of partners from across the ICS, with Public Health England and Yorkshire Wildlife Group being key amongst them.

Covid-19 Update

In line with national trends the level of Covid within our services has significantly reduced. At the 14 April 2021 there were no cases of Covid within the inpatient services. There remains daily SITREP reporting and close monitoring of cases via IPC.

The oversight arrangements for the pandemic have been modified in light of these changes. Gold meetings have ceased and strategic Covid related issues are reviewed via the Senior Leadership Group. A number of the associated structures at Silver and Bronze level have also been modified. All of these structures can be stood up if circumstances change.

As lockdown progresses, services continue to review how they operate in line with national guidance, this includes how visiting and leaves are managed. The resilience hubs which support staff health and wellbeing across the ICSs are now fully operational. The operational arrangements in each ICS differ slightly but TEWV staff

are part of the service delivery. There has been a steady uptake of the service across the patch.

Staff who have been shielding have received new guidance and there are individual conversations around their risk assessment which are progressing, in the context of the RAG rating of the environment, to ensure that any changes around their return to work is safe and effective. However, the group of staff who have been shielding have a relatively low rate of risk assessment completion, probably due to them previously working from home and we are picking this up through ODDG and will continue to monitor. We have moved the reporting on risk assessments to fortnightly and will move to monthly from mid-May once the shielding group have returned to site and the second dose vaccines are completed.

At-risk' group breakdown (from SITREP)	Risk Assessments Requested and Completed	
BAME	271	**92%**
Over 70	19	**83%**
Pregnant, pre-maternity	62	**55%**
Males and Females, white (60-69)	469	**89%**
Health Conditions	258	**85%**
Shielding	142	**60%**

There continues to be close monitoring of service pressures which may be a consequence of Covid, These issues are being escalated to the Senior Leadership Group and our partners to progress additional plans and support where necessary.

Covid-19 Vaccines

Second dose clinics are well underway and will last through April. We will then be going back to inpatients who are experiencing a long stay with us. Any remaining staff who have not had a first dose will be referred back to GPs as per national guidance. The monthly online conversations for staff who are still concerned about the vaccine are all in place. There will be a mop up second dose clinic in May.

Latest figures for dose 1 vaccinations are noted on page 5.

The Trust has ordered enough flu vaccines for all of those who are deemed frontline healthcare workers in the Trust if they want one. We plan to then try to streamline flu and Covid clinics for Autumn if the national direction allows.

Total Frontline Staff				
Total Frontline Staff Headcount	**Total Frontline Staff** Vaccinated	**Total Frontline Staff** Offered	**Total Frontline Staff** Declined	**Total FrontlineStaff** Exempt
6380	5492	6380	104	39

Substantive Staff				
Substantive Staff Headcount	**Substantive Staff** Vaccinated	**Substantive Staff** Offered	**Substantive Staff** Declined	**Substantive Staff** Exempt
7949	6895	7949	104	49

Bank Staff				
Bank Staff Headcount	**Bank Staff** Vaccinated	**Bank Staff** Offered	**Bank Staff** Declined	**Bank Staff** Exempt
404	404	404		

Agency Staff				
Agency Staff Headcount	**Agency Staff** Vaccinated	**Agency Staff** Offered	**Agency Staff** Declined	**Agency Staff** Exempt
81	81	81		

BAME Staff				
BAME Staff Vaccinated	**BAME Staff** Headcount	**BAME Staff** Offered	**BAME Staff** Declined	**BAME Staff** Exempt
280	404	404	11	4

CEV STAFF				
CEV Staff Vaccinated	**CEV Staff** Headcount	**CEV Staff** Offered	**CEV Staff** Declined	**CEV Staff** Exempt
92	111	111	3	2

Committee Key Issues Report

Report Date: 29th April 2021		**Report of: The Audit and Risk Committee**
Date of last meeting: 18th March 2021		**Membership Numbers: 3** Quoracy met - 100% attendance including the Chairman
1	**Agenda**	The Committee considered an agenda which included the following: • The Clinical Audit Programme 2021/22. • The BAF and Corporate Risk Register. • An update on the strengthening of controls relating to patient property, money and valuables (PPMV). • An update on counter fraud activities including the draft Work Plan for 2021/22. • Internal Audit matters including an update on the progress being made on delivering the Audit Plan for 2020/21; the refreshed Internal Audit Charter; and the draft Audit Plan for 2021/22. • External Audit matters including a progress report; the three-year Strategic Plan; the Audit Strategy Memorandum; the annual TCWG request; and the External/Internal Audit Protocol for Liaison. • The 'Going Concern' Report. • A report on year-end processes. • A report on tender waivers. • A report on the registration of conflicts of interest including gifts and hospitality. • Losses and special payments for write off. • The performance of the External Auditors in connection with the extension of their contract with the Trust.
2a	**Alert**	The Committee wishes to alert members of the Board that: • Work to provide assurance on compliance with the Internal Auditors' recommendations on PPMV has been deferred due to the Covid-19 pandemic and the focus on patient safety • The deferral of four Internal audit Assignments was agreed: PPMV; infection prevention (antimicrobial stewardship); mortality reporting (follow up); and right staffing (follow up). This was due to the Covid-19 pandemic and changes to procedures. The assignments will feature in future audit plans. There will be no impact on the robustness of the Head of Internal Audit's Annual Opinion for 2020/21. • The new Code of Audit Practice has changed the way in which the External Auditors will report on value for money. It will now be in the form of a commentary in the Audit Report covering financial sustainability, governance and improving economy, efficiency and effectiveness. For the 2020/21 Audit two key considerations will be financial sustainability and the implications of the regulatory action taken by the CQC. • The registration of conflicts of interest by decision-making staff, through the new online system, has been disappointing but follow ups are continuing to improve compliance.
2b	**Assurance**	The Committee wishes to assure members of the Board that: • The Clinical Audit Programme for 2021/22 is aligned to the needs of the Trust and there is sufficient capacity, in place, for its delivery

		• No fraud was detected from the proactive review of purchasing cards • No issues had been identified that might significantly impact upon the Head of Internal Audit's Annual Opinion. • The Internal Audit Plan 2021/22 is sufficient to provide a robust Head of Internal Audit Annual Opinion; is aligned to the Trust's Strategic Objectives and risks; and it adequately resourced. • There are no material uncertainties that might cast significant doubt about the Trust's ability to continue as a 'going concern'. • Robust plans are in place for the preparation, sign-off and submission of the Annual Report and Accounts. • No issues were identified which might preclude the extension of the External Auditors' contract with the Trust (as permitted).		

2c	**Advise**	The Committee wishes to advise members of the Board that:
		• The refreshed Procurement Strategy is due to be presented to the Committee at the end of Quarter 2.
		• The following documents were reviewed and approved:
		  • Counter Fraud Work Plan 2021/22
		  • The Internal Audit Plan 2021/22
		  • The AuditOne Internal Audit Charter
		  • The Internal/External Audit Protocol for Liaison
		• The draft Head of Internal Audit's Annual Opinion 2020/21 is due to be present to the Committee's next meeting.
		• There has been a significant increase in the registration of gifts and hospitality over the last 12 months but, given Covid-19, it is difficult to gauge what the usual level of reporting should be. This will be kept under review.
		• Retendering of the contract for external audit services will commence in early 2022.		

2d	**Review of Risks**	• As reported to the last Board meeting:
		  • No new risks were identified for inclusion in the BAF
		  • The Senior Leadership Group was considering a potential strategic risk posed from legal decisions relating to staff and terms and conditions regarding the legal cases of 'Flowers' and 'McCloud'
		  • Appropriate amendments had been made to the BAF in relation to Roseberry Park and the regulatory action being taken by the CQC		

3	**Actions to be considered by the Board**	• None at this time. The Committee's recommendation that the Trust should be considered as a 'going concern' and that the year-end accounts should be prepared on that basis was approved by the Board at its last meeting (minute 21/C/68 refers)		
4	**Report compiled by**	*John Maddison* *Chairman of Committee* *Phil Bellas* *Trust Secretary*	**Minutes available from**	*Angela Grant* *Senior Administrator*

Item 10

BOARD OF DIRECTORS

DATE:	**29th April 2021**
TITLE:	**Finance Report for Period 1 April 2020 to 31 March 2021**
REPORT OF:	**Liz Romaniak, Director of Finance, Information and Estates**
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:

Statement of Comprehensive Income: The Trust's unaudited draft accounts for 2020/21, before impairments, show a surplus of £9.2m, equivalent to 2.2% of the Trust's annual turnover and £8.6m ahead of the revised targeted year end surplus of £0.6m. This is £1m better than forecast at month 11, but now incorporates "potential" national upsides highlighted last month. After adjusting for fixed asset impairments of £25.5m the Trust's annual accounts show a technical accounting deficit of £16.3m. (These adjustments are excluded when measuring Trust financial performance).

Capital Programme: The outturn position for the 2020/21 financial year was largely as projected, being £6.1m below plan and reflects the following as previously reported:

- The benefit from a (£4m) VAT rebate following completion of Foss Park Hospital;
- A bid for (£4.5m) national funding for planned capital costs (received in February);
- Slippage on construction projects offset by an agreement to defer an asset disposal into 2021/22 and by the cost of fast-tracked (unplanned) anti-ligature inpatient work.

Cash: Closing cash balances were £80.9m as at 31st March and reflected the anticipated cessation of national arrangements to support advance block payments to ensure prompt payment of suppliers. Whilst cash levels have consequently decreased in-month, they remain ahead of plan with further detail at paragraph 3.7 below.

2021/22 Plan: Financial planning for the first 6 months is now underway, with the Trust needing to agree Mental Health (MH) income and associated Partnership investment priorities by 6th May 2021. The Board approved an interim 2021/22 budget in March, pending receipt of deferred national guidance, CCG and System funding envelopes and abridged plan requirements. Progress has included preparatory run-rate analysis, cost pressures and an assessment of the national financial framework and various funding streams, including with system partners. Discussions with MH Partnership Board partners are progressing at pace to service the tight 6th May deadline and will include discussion of options to fund adult acute inpatient staffing investments approved by the Board in March.

Recommendations:

The Board of Directors is requested to:

- Receive the report, consider the issues and risks raised and any related further assurances needed and
- Note the ongoing 2021/22 planning activities to service the agreement of final operating budgets for the first six months and full year Mental Health Investment priorities for 2021/22.

MEETING OF:	**Board of Directors**
DATE:	**29th April 2021**
TITLE:	**Finance Report for Period 1 April 2020 to 31 March 2021**

1. INTRODUCTION & PURPOSE:

This report sets out the unaudited financial position for the twelve months ending 31 March 2021.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to monitor the Trust's key financial duties and key performance indicators (KPIs) which are both statutory requirements. Appendix 1 provides an overview of the Trust's KPIs for the year to date and unaudited outturn performance to 31st March 2021.

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

2.3 National financial arrangements have operated throughout 2020/21 to support the NHS in responding to the Covid-19 Pandemic. In the first six months (to September 2020), the Trust followed national guidance for Covid-19 emergency planning and received a top up of income, including for recovering Covid-19 costs, each month in order to break-even. For the remaining months (to March 2021) the Trust submitted an updated revenue forecast of a £2.0m deficit outturn in the Autumn. This became the Trust's planned deficit for 2020/21. The Trust's forecast surplus was revised, by agreement with NHSE/I during November, following notification of the receipt of £2.6m additional clinical income, to a £0.6m surplus. This is the surplus against which we now therefore track performance.

3.1 <u>Key Performance Indicators</u>

The UoRR for the Trust is assessed as 1 for the period ending 31 March 2021, representing the lowest assessment of risk.

Appendix 1 provides a summary of all KPIs for the period ending 31 March 2021 and forecast year end outturn position.

3.2 <u>Statement of Comprehensive Income – Year to date</u>

The Trust's outturn financial position for the 2020/21 financial year, excluding adjustments for impairments, was a surplus of £9.2m, being £8.6m ahead of the revised targeted surplus of £0.6m. Impairments are technical accounting adjustments and are excluded when assessing Trust financial performance. However, for annual accounts purposes, the Trust needs to account for fixed asset impairments of £25.5m, relating to the revaluation of Roseberry Park Hospital, driving a 2020/21 reported deficit of £16.3m as is summarised in Table 1 below:

Table 1 - including Impairments	Annual Plan			Year to Date		YTD
	M1-6	M7-12	Total	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income From Activities	175,422	193,311	**368,733**	369,122	392,087	22,965
Covid Top Up income	8,313		**8,313**	8,313	7,760	-553
Other Operating Income	8,969	7,801	**16,770**	16,739	24,233	7,494
Total Income	**192,704**	**201,112**	**393,816**	**394,174**	**424,079**	**29,906**
Pay Expenditure	-153,727	-159,627	**-313,354**	-313,246	-324,288	-11,042
Non Pay Expenditure	-33,763	-35,730	**-69,493**	-70,292	-83,610	-13,318
Depreciation and Financing	-5,214	-5,153	**-10,367**	-10,034	-32,466	-22,432
Surplus / (Deficit)	**0**	**602**	**602**	**602**	**-16,285**	**-16,887**

Income received during 2020/21 was more than plan by £29.9m including the following key items:

- £2.6m mental health investment standard & service development funding
- £1.5m non-recurrent investment in prison services
- £2.2m relating to various locality and non-recurrent income streams
- £1.7m received for additional trainee funding including a revised updated Learning Development Agreement.

Unplanned income also reflected the following national adjustments (which have equal and opposite expenditure entries in the Trust's accounts).

- £12.4m central adjustment for employer pension contributions
- £9.5m other central adjustments including to account (within the Trust's income and expenditure) for nationally procured and supplied Personal Protective Equipment and for estimated untaken annual leave accruals.

Pay expenditure was £11m more than plan at the end of the year, with key variances including:

- £12.4m central adjustment for employer pension contributions
- (£3.8m) relating to vacancies and staffing turnover.
- £2.3m increased level of untaken annual leave. Exceptional national arrangements are operating through the pandemic, to support the NHS response and permit a level of leave to be carried forward into the next 2 financial years.

Non Pay Expenditure was £13m more than plan, reflecting the following significant items (supplemented by a number of other smaller variances):

- £3.9m DHSC donated PPE
- £4.4m costs to fast-track 'Build Back Better' programme priorities and to address backlog and other pressing and/or Covid-19 issues. This expenditure was agreed as part of slippage on Covid cost projections.

Depreciation and Financing expenditure was £22.4m more than plan with the following main variances:

- £25.5m impairments relating to asset revaluation.
- (£2.5m) reduced PDC dividend payable (including the benefit from elevated in-year cash balances linked to advance block payments).
- (£0.8m) reduced depreciation, including impacts from capital expenditure slippage.

3.3 Cash Releasing Efficiency Savings (CRES)

Performance against the 2020/21 CRES target is shown in Table 3 below, with delivery being £589k behind plan at the end of the financial year. The Trust's Finance Sustainability Board will keep this situation under review and co-ordinate through 2021/22 financial planning activities in advance of a return to normal financial arrangements. Delays in delivery have been non-recurrently offset.

Table 2: Cash Releasing Efficiency Scheme Performance 2020/21	**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**
Chief Operating Officer	**3,457**	3,322	-807	**2,515**	941
Corporate and EFM	**824**	678	253	**931**	-107
Total identified and approved recurrent CRES	**4,281**	**4,000**	**-554**	**3,446**	**835**
Trust Wide Schemes					
Revaluation of Assets - Depreciation & PDC	**-154**	607	-515	**92**	-246
Total identified non recurrent schemes	**-154**	**607**	**-515**	**92**	**-246**
-					
Total identified and approved recurrent CRES	**4,127**	**4,608**	**-1,069**	**3,538**	**589**

3.4 Capital

The outturn position for the 2020/21 financial year was largely as projected, being £6.1m below plan and reflects the following as previously reported:

- Benefits of a (£4m) VAT rebate following completion of Foss Park Hospital;
- A successful bid for (£4.5m) national funding for planned Children and Young People scheme costs (received during February); and
- Slippage on construction projects offset by a deferred asset disposal into 2021/22 and by costs of fast-tracked (unplanned) anti-ligature work.

3.5 Workforce

Table 3 below shows performance on some of the key workforce performance indicators.

Table 3	**Pay Expenditure as a % of Pay Budgets**						
Tolerance	Tolerance March-21	October	November	December	January	February	March
Establishment (a) (90%-95%)	94.17%	93.43%	93.37%	93.98%	93.05%	94.89%	94.17%
Agency (b)	2.60%	2.46%	2.49%	2.51%	2.53%	2.60%	2.69%
Overtime (c)	1.00%	1.15%	1.19%	1.23%	1.22%	1.27%	1.33%
Bank & ASH (flexed against establishment) (100%-a-b-c)	2.23%	3.29%	3.35%	3.41%	3.43%	3.40%	3.41%
Total	**100.00%**	**100.34%**	**100.40%**	**101.13%**	**100.22%**	**102.16%**	**101.60%**

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 March 2021 the tolerance for Bank and ASH is 2.23% of pay budgets.

Prior to the Pandemic, NHS Improvement monitored agency expenditure against a capped annual target of £7.6m (or 2.6% of pay budgets). Agency expenditure to date is £8.42m which is £0.8m, or 10.8% above the cap for the period ended 31 March 2021, with expenditure across all localities. However this reflects elevated temporary staffing requirements as indicated below.

Whilst flexible staffing costs have increased in quarter 4 and would exceed the pre-Covid agency cost cap, expenditure is not as high as had previously been expected. The Trust has benefited from recruitment of 83 students undertaking paid placement arrangements in support of the Covid-19 response; this explains the increase in the establishment metric in table 3.

Nursing and Medical agency costs account for 96% of total agency expenditure, with additional staffing used to cover vacancies, sickness and isolation and support enhanced observations and complex needs.

Excluding that used for Covid-19 related activities, agency expenditure is below the agency expenditure cap. The Trust continues to work to improve this position on a recurrent basis.

3.6 Statement of Financial Position

The following key issues impact the Trust's Statement of Financial Position for the period ending 31 March 2021.

Total **cash** held at 31 March 2021 was £80.9m which is £20.2m ahead of plan and includes:

- Additional income supporting the agreed change from a planned £1.998m deficit to £0.6m surplus (£2.6m);
- Better than planned revenue position (£8.6m);
- Successful bid for PDC-backed national capital funding (£4.5m);
- Receipt of a VAT rebate linked to Foss Park Hospital (£4.0m); and
- Remaining movements relate to changes in working capital.

A refreshed cash flow forecast and financing estimate is being progressed to take into account current cash forecasts and ongoing work to assess draft 5-year capital programme priorities (in advance of the expected 3-year Comprehensive Spending Review and an anticipated national Health Infrastructure Plan refresh).

Accounts Receivable (amounts owed to the Trust) include total debts of £4.1m with 17.4%, or £0.8m being over 90 days.

The overall aged debt position has significantly improved in March. Of the £4m reduction, £3.7m related to payment by Spectrum Community Health. The remaining balance largely relates to receipts from NHS organisations with whom outstanding balance issues have been resolved as part of the national NHS 'Agreements of Balances' exercise.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The UoRR is impacted by Covid-19 and related national financial arrangements, with national monitoring suspended throughout 2020/21. However the Trust has continued to assess the UoRR and achieved a rating of '1' for the period 31 March 2021. Table 4 below shows the performance over each of the metrics.

Table 4: Use of Resource Rating at 31 March 2021

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%

Actual performance 31 March 2021	Actual		YTD Revised Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	4.00x	1	1.66x	2	
Liquidity	43.4	1	31.98	1	
I&E margin	2.2%	1	0.2%	2	
I&E margin distance from plan	2.0%	1	0.0%	1	
Agency expenditure (£000)	£8,421k	2	£7,600k	1	
Overall Use of Resource Rating		**1**		**1**	

Agency expenditure breached the expenditure cap by £0.8m (or 10.8%) inclusive of Covid-19 related costs and this individual metric was behind plan and rated as a '2'.

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 To enable continued focus on the pandemic, annual financial planning activities for 2021/22 were suspended nationally during 2020/21. Guidance, and details relating to rolled forward national block funding arrangements that will operate in the first 6 months of the new financial year, was received during April. Abridged national planning requirements for systems and specific to Mental Health investments are due to complete in two stages on 6th May and during June 2021.

In the absence of detailed guidance and resource assumptions, high level 'run rate' financial forecasts were shared with the Integrated Care System finance team during March, to inform initial resource requirements. Trust forecasts were reviewed by the Senior Leadership Group and Resources Committee to support consideration, and approval by the Board, of a 'preliminary' Trust Financial Plan when it met in Private in March 2021. Final plans for the first 6 months (H1) of 2021/22 will be reviewed and submitted for Board

consideration during quarter one. Financial arrangements beyond H1 have not yet been confirmed and will likely depend, to some extent, on the ongoing impacts from the Pandemic.

5.3 The Trust outturn position is subject to external audit review and any findings may alter the financial outturn position and associated financial risk rating indicators.

6. CONCLUSIONS:

6.1 The Trust's unaudited draft accounts for 2020/21, before adjusting for impairments, show a surplus of £9.2m, equivalent to 2.2% of the Trust's annual turnover and £8.6m ahead of the revised targeted year end surplus of £0.6m. This is £1m better than had been forecast at month 11 but incorporates potential (now realised) upsides that were highlighted last month. After adjusting for fixed asset impairments of £25.5m the Trust's annual accounts show a technical accounting deficit of £16.3m. (These adjustments are excluded when measuring Trust financial performance).

The Trust took the opportunity afforded by receipt of Covid-19 and growth funding allocated via the ICS to fast-track some of the Build Back Better programme priorities, address backlog and other pressing and/or Covid-19 issues.

6.2 The amount of CRES identified for the financial year was behind plan due to the need to focus on the Pandemic response. Delays in delivery have been mitigated by non-recurrent underspending. Plans to meet the required target in future years will be monitored by the Trust's Finance Sustainability Board as planning activities recommence.

6.3 Financial planning activity for 2021/22 was delayed and has been abridged nationally to allow continued focus across the NHS on the vital pandemic response. Funding allocations for national financial arrangements that will now extend to cover the first half of 2021/22 (H1) were received during April 2021 with system and organisation-level plans now being developed.

6.4 The UoRR for the Trust is assessed as 1 for the period ending 31 March 2021 and is in line with plan.

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to receive the report, consider the issues and risks raised and any related further assurances needed.

Liz Romaniak
Director of Finance, Information and Estates

Appendix 1 – Key Performance Indices

Key Financial Indicators for the period ending 31 March 2021

Surplus variances are shown as negative	Year to date Plan	Actual	Variance	RAG	Prior Month Variance	RAG
I&E (Surplus) / Deficit £m	-0.6	16.3	16.9	◆	-10.4	●
EBITDA £m	-11.0	-16.2	-5.2	●	-7.8	●
Net Surplus Ratio %	0.2%	-3.8%	4.0%	◆	-2.8%	●
EBITDA Margin %	2.8%	3.8%	-1.1%	●	-2.1%	●
Income £m	-394.2	-424.1	-29.9	●	-5.9	●
Pay Expenditure £m	313.3	324.3	11.0	◆	-3.5	●
Non Pay Expenditure £m	69.9	83.6	13.7	◆	1.6	◆
Non Operating Expenditure £m	10.4	32.5	22.1	◆	-2.6	●
Capital Expenditure £m	34.1	28.0	-6.1	●	-9.8	◆
Capital Service Cover	1.66x	4.00x	-2.34x	●	-2.76x	●
Liquidity Days	32.0	43.4	-11.4	●	-19.4	●
I&E Margin	0.2%	2.2%	-2.0%	●	-2.9%	●
Variance from I&E Margin plan	0.0%	2.1%	2.1%	◆	2.8%	●
Agency Expenditure £m	7.6	8.4	0.8	◆	0.5	◆
CRES £m	4.1	3.5	0.6	◆	0.6	◆
Cash Balances £m	60.7	80.9	-20.2	●	-50.5	●
Total debt over 90 days	5.0%	17.4%	12.4%	◆	26.2%	◆
BPPC NHS invoices paid < 30 days	95.0%	93.5%	1.6%	◆	-5.0%	●
BPPC Non NHS invoices paid < 30 days	95.0%	96.2%	-1.2%	●	-0.2%	●

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 11

FOR GENERAL RELEASE

MEETING OF THE BOARD OF DIRECTORS

DATE:	**29th April 2021**
TITLE:	**Board Performance Dashboard as at 31st March 2021**
REPORT OF:	**Sharon Pickering, Director of Planning, Commissioning, 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 March 2021**. 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 **5** areas of concern identified and **4** 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:

3)	The total number of inappropriate OAP days over the reporting period (rolling 3 months)	Whilst this key measure of quality is now indicating common cause variation (no significant change) it was previously indicating special cause improvement. This has been included as an area of concern for the first time this month due to the ongoing concern in Durham & Darlington Locality and because the

		national standard we agreed with NHSE, has been exceeded. Appendix A provides further information on this and Appendix D provides an update on the actions identified for the Durham & Darlington Locality.
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 noting a further update on the actions identified is due next month.
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 and Appendix D provides an update on the actions identified for all 3 geographical localities. Whilst our actual performance against the Trust measure isn't at the standard we would want it to be, from the latest data available (on the number of paired measures (as opposed to the amount of change made), we are continuing to perform better from a national benchmarking perspective.
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 and is now below the lower process limit therefore we need to investigate further. Appendix A provides further information on this and Appendix D provides an update on the actions identified for Durham & Darlington, Tees and Forensic localities.
18)	Percentage Sickness Absence Rate (month behind)	This key workforce measure is continuing to indicate special cause variation of particular concern with the latest data point within the upper process limit. It also indicates that we will consistently fall short of the standard therefore we need to investigate further. Appendix A provides further information on this and

		Appendix D provides an update on the actions identified for Durham & Darlington and North Yorkshire localities.

Measures which require additional monitoring:

2)	Percentage of patients starting treatment within 6 weeks of an external referral	The SPC is continuing to showing special cause improvement; that the standard will be met and sometimes missed due to random variation and the latest YTD actual remains above the standard (positively). However Durham & Darlington and Tees localities are within common cause variation (no significant change); and are below the standard and the mean. Given this is a key measure of quality this is subject to "additional monitoring". Appendix A provides further information on this and Appendix D provides an update on the actions identified for both of the localities.
5)	The percentage of Serious Incidents which are found to have a root cause or contributory finding	Whilst this key measure of quality is indicating common cause variation (no significant change) within the SPC chart, the chart also indicates that there is no assurance that the standard will be delivered consistently as this stage. There is also special cause variation of particular concern in Tees Locality therefore this is subject to additional monitoring. Appendix A provides further information on this.
12)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	The SPC chart is indicating common cause variation (no significant change) previously special cause improvement. The latest YTD actual is below the standard (positively); however the latest data point is above the standard and the mean. The SPC chart also 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 continuing to undertake additional monitoring. Appendix A provides further information on this including when a more detailed update will be provided. 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).

17)	Percentage compliance with ALL mandatory and statutory training (snapshot)	This key measure of workforce is showing special cause variation of particular concern and that the standard will be met and sometimes missed due to random variation; however the latest data point is above the standard. There is visible improvement across the Trust and localities however this will be subject to additional monitoring in the short term. Appendix A provides further information on this. As previously reported, there have been a number of extensions to the time allowed to complete mandatory and statutory training (linked to the pressures caused by the pandemic) which were approved by Gold Command which have been implemented in the measure.

Positive assurance:

1)	Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	This key measure of quality 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.
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.
16)	Percentage of staff in post with a current appraisal	This key workforce measure is continuing to provide positive assurance as indicated by the special cause improvement displayed within the SPC chart, although the chart indicates that we will consistently fall short of the standard. As previously reported, there have been a number of extensions to the time allowed to complete appraisal (linked to the pressures caused by the pandemic) which were approved by Gold Command which have been implemented in the measure.

Other issues/points to note:

9)	The percentage of new unique patients referred with an assessment	This issue was first identified in the September Board Report as an area of concern; however the SPC is now indicating common cause variation (no

	completed (2 months behind)	significant change). There is one locality subject to an ongoing deep dive (Forensics). Appendix A provides further information on this and Appendix D provides an update on the actions identified for the relevant locality.

NHS Oversight Framework

The majority of national standards within the NHS Oversight Framework have been achieved for Q4; however there are 2 exceptions to this which are:

- *Admissions to adult facilities of patients who are under 16 years old* - There was one Tees Valley CCG patient under the age of 16 admitted to an adult ward in February 21. The patient was admitted under section because no CAMHS PICU beds were available nationally; they spent one night in a Trust AMH unit but in a specific area separated from the main adult ward under 2:1 observations. The child did not therefore come into contact with any of the AMH service users on the main part of the ward.

- *Inappropriate out of area placements for adult mental health services* – This measure is contained within the Board Performance Dashboard (measure 3) please see the area of concern highlighted earlier in this report for further details.

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 discuss how assured it is that we have identified all the areas of concern and whether the information provided in this report provides sufficient assurance that we are addressing these areas.

2. Note the recommendations within Appendix D and discuss whether any further actions are required at this stage.

3. Discuss whether the information provided in this report supports the following areas identified as positive assurance:

a. Percentage of patients seen within 4 weeks for a 1st appointment following an external referral) (TD01)

b. No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot (TD13)

c. Percentage of staff in post with a current appraisal (TD16)

4. Note the overall positive Q4 position in relation to the NHS Oversight Framework measures and discuss whether the information provided in this report provides sufficient assurance that we have addressed/or are addressing the standards that were not achieved.

TRUST Dashboard Summary

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Quality

Measure Name	Variation Ending Mar - 2021	Assurance Ending Mar - 2021	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%	93.93%	90.00%	
2) Percentage of patients starting treatment within 6 weeks of an external referral			60.00%	66.51%	60.00%	Durham and Darlington are demonstrating no significant change (common cause variation) and they are below the standard and the mean. Identified as an area of concern in the January report (data ending December 20); this information was shared with the locality to better understand their position and whether this is an actual area of concern and update on this is included in Appendix D. Tees are demonstrating no significant change (common cause variation) and they are below the standard and the mean. Identified as an area of concern in the February report (data ending January 21); this information was shared with the locality to better understand their position and whether this is an actual area of concern and update on this is included in Appendix D.
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)			1,833	2,061	1,833	Durham and Darlington are demonstrating special cause variation of particular concern therefore this was an area we needed to investigate further. The latest position is significantly above the mean and is the highest since April 18. This information was shared with the locality to better understand their position and whether this is an actual area of concern and update on this is included in Appendix D.
4) Percentage of patients surveyed reporting their overall experience as excellent or good			94.00%	90.71%	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, 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 shared with the Board previously and an update on the actions identified was shared with the Senior Leadership Group in February. A further update on progress against the identified actions will be provided next month.
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding			32.00%	36.94%	32.00%	Tees are demonstrating special cause variation of particular concern therefore is an area we needed to investigate further. This information was shared with the locality and Patient safety team to better understand their position and whether this is an actual area of concern and update on this is included in Appendix D.
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind			60.00%	49.43%	60.00%	Durham and Darlington Locality is continuing to indicate no significant change (common cause variation) and that the standard will be met and sometimes missed due to random variation/ The latest data point is now just below the standard but above the mean. Identified as an area of concern in the January report, this information was shared with the locality to better understand their position and whether this is an actual area of concern and an update on this is included in Appendix D. 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 below the standard and close to the lower process limit. 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. 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 for both localities are included in Appendix D.
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind			65.00%	67.59%	65.00%	

Activity

Measure Name	Variation Ending Mar - 2021	Assurance Ending Mar - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
8) Number of new unique patients referred				84,333		Forensic Services is indicating special cause improvement (increase) with 11 consecutive data points above the upper process limit. Identified as an area of concern in the January report (data ending December 20); this information was shared with the locality previously to better understand their position and whether an increase in referrals is an area of concern. The findings concluded that the increase is as a result of referrals into the Liaison & Diversion (L&D) Services. Following the Board requesting further assurance last month an email was sent out that gave further information on the reason for the increase. This confirmed that in fact the increase was not an area of concern.

TRUST Dashboard Summary

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Measure Name	Variation Ending Mar - 2021	Assurance Ending Mar - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
9) The percentage of new unique patients referred with an assessment completed (2 months behind)				72.33%		Forensics Locality is continuing to indicate no significant change (common cause variation. 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). Identified as an area of concern in the September report (data ending August 20); this information was shared with the locality to better understand their position and whether this is an actual area of concern this was shared with the Board previously. An update on the actions identified is included in Appendix D. North Yorkshire & York Locality are now indicating no significant change (common cause variation) previously 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 was shared with the Board previously. The remaining action was to include telephone contacts for MHSOP and LD services trust-wide. This change has been made and is reflected in this month's report giving us assurance that no further actions are required at the current time.
10) The percentage of new unique patients referred and taken on for treatment (3 months behind)	L			32.40%		Durham and Darlington 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 an update is provided in Appendix D. Tees Locality is continuing to indicate 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. A further update on the actions identified is included in Appendix D. Forensic Services are continuing to demonstrate no significant change (common cause variation). Identified as an area of concern in the January report (data ending December 20); 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. A further update on the actions identified to provide assurance is included in Appendix D.
11) Number of unique patients discharged (treated only)				33,485		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		?	90.00%	79.07%	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 there are areas of concern highlighted on one male ward and one female ward in all three localities. The remaining female wards are demonstrating no significant change (common cause variation), however are all above the mean and standard. Work is underway between the Programme Manager right care right place, the Business Analytics team and the Corporate Performance Team to undertake some analysis work around the demands on the Inpatient provision as well as some future forecasting work. Findings from this will be shared with the Board once the analysis is completed and any actions are identified. A Trust wide bed event was planned to take place across two ½ days in February, however this has been postponed due to pressures within the Trust in relation to the Pandemic. Once a new date is confirmed and update will be provided to the Board.
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	L	?	61	37	61	
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)		?	9.90%	10.48%	9.90%	Durham and Darlington Locality is indicating special cause variation of particular concern (high) and needing action. This information will be shared with the locality to better understand their position and whether this is an actual area of concern. An update will be included in next month's report.

Workforce

Measure Name	Variation Ending Mar - 2021	Assurance Ending Mar - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
15) Finance Vacancy Rate				-5.83%		
16) Percentage of staff in post with a current appraisal	H	F	95.00%	96.83%	95.00%	As previously reported, there have been a number of extensions to the time allowed to complete appraisal (linked to the pressures caused by the pandemic) which were approved by Gold Command. The extensions have been implemented in the measure and the data has been refreshed for the relevant time period. The data being reported is now a more accurate reflection of the position.

TRUST Dashboard Summary

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Measure Name	Variation Ending Mar - 2021	Assurance Ending Mar - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
17) Percentage compliance with ALL mandatory and statutory training (snapshot)			92.00%	92.46%	92.00%	There have been a number of extensions to the time allowed to complete appraisal (linked to the pressures caused by the pandemic) which were approved by Gold Command. The extensions have been implemented in the measure and the data has been refreshed for the relevant time period. The data being reported is now a more accurate reflection of the position. All localities with the exception of Forensic Services demonstrate special cause variation of particular concern (low), however the latest positions are an improvement across the last 3 consecutive data points. These positions will continue to be monitored.
18) Percentage Sickness Absence Rate (month behind)			4.30%	5.14%	4.30%	Durham and Darlington are continuing to demonstrate no significant change (common cause variation) with the latest data point within the lower process limit. Identified as an area of concern in the January report (data ending December 20); this information was shared with the locality to better understand their position and whether this is an actual area of concern and an update was provided previously to the Senior Leadership Group. An update on the actions identified is provided in Appendix D. Forensics are continuing to indicate special cause variation of particular concern with the latest data point above the upper process limit. An action plan was developed in June 2020 and since then sickness absence rates have been closely monitored each month. Within the service there has been a reduction in COVID related sickness, following the highest levels of absence in January. The overall number of episodes of sickness not related to COVID is also high with an increase in long term sickness with an equal number related to physical health and mental health. HR sickness clinics with managers have been reinstated from April 2021 along with the development of more sickness absence reporting to enable the locality to understand the position in more detail. Alongside this a revised action plan is in development and a summary of progress against the action plan will be included in this report each month until the actions have had the desired impact. North Yorkshire and York are now indicating no significant change (common cause variation) previously special cause variation of particular concern with the latest data point above the mean and standard. This information was shared with the locality to better understand their position and whether this is an actual area of concern and an update is provided in Appendix D. Further analysis at trust level has been undertaken including a discussion with HR colleagues to understand the current sickness levels in more detail and whether any additional actions are required at this time. This work has concluded that there are no areas of concern and no further work required in addition to that in the specific three localities detailed above.

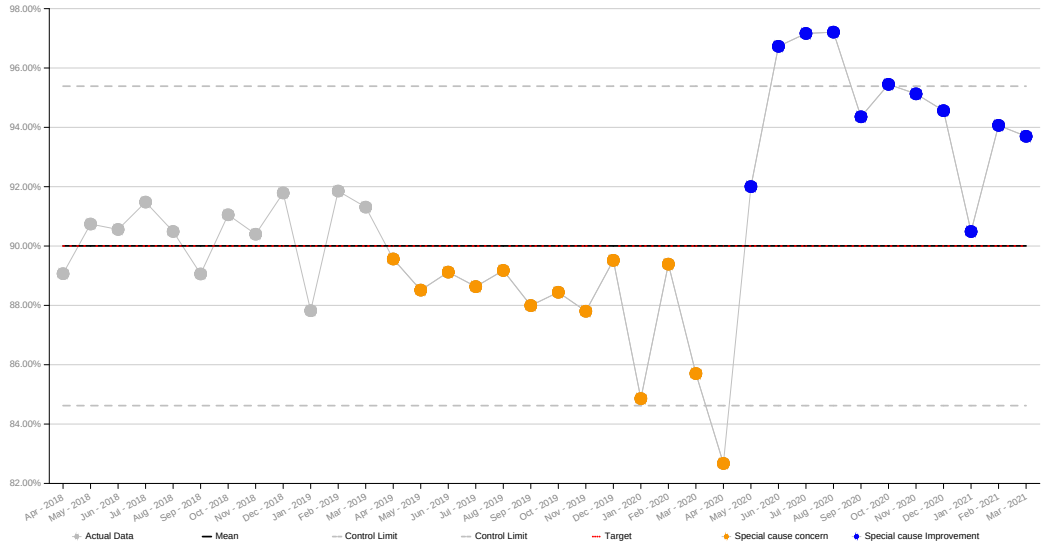
Money

Measure Name	Plan (YTD)	Actual (YTD)	Comments
19) Delivery of our financial plan (I and E)	-602,000	16,594,501	The trusts outturn financial position for the 20/21 financial year, after adjustments for impairments, was a deficit of £15,993k, representing 4.1% of the Trust's turnover, and was £16,595k ahead of the NHSI phase 3 financial plan. For annual accounts purposes the Trust reported a surplus of £9,482k as it includes a modern equivalent asset revaluation (MEA) impairments of £25,475k which relates to a revaluation of Roseberry Park Hospital. This is a technical accounting adjustment and is excluded when measuring control total performance.
20) CRES delivery	4,126,668	3,538,192.87	Identified Cash Releasing Efficiency Savings as at 31 March 2021 was £3,538k and was £589k behind plan. The Trusts Finance Sustainability Board will keep this situation under review and co-ordinate through 2021/22 financial planning activities. Delays in delivery were mitigated by non-recurrent underspends.
21) Cash against plan	60,972,000	80,935,995	Total cash at 31 March 2021 is £80,936k; this is £19,964 ahead of plan and is largely due to the required improvement in plan (£2,600k), the favorable revenue position (£8,880k), the receipt of PDC (cash) backed national Mental Health Programme capital funding for Children and Young People (£4,505k), the receipt of £2,556k NHSE funding relating to an annual leave provision and the remaining balance relates to movements in working capital.

TRUST Indicator Details

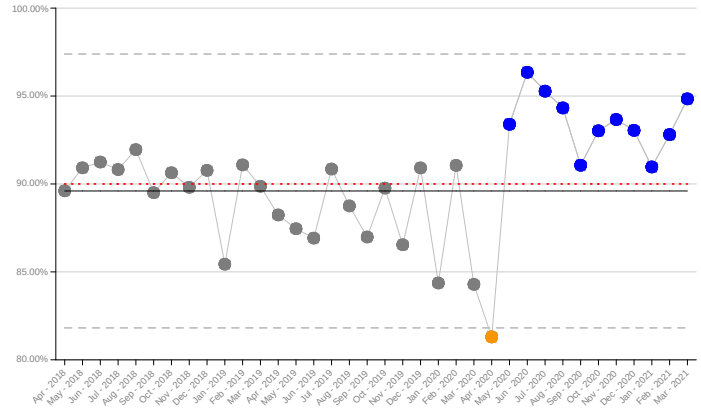
Tees, Esk and Wear Valleys NHS Foundation Trust

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

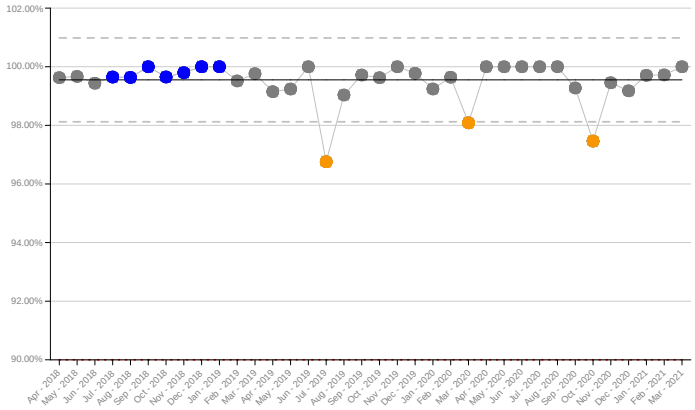


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	?	90.00%	95.39%	84.62%
DURHAM AND DARLINGTON	H	?	89.60%	97.39%	81.82%
FORENSIC SERVICES		P	99.55%	100.98%	98.12%
NORTH YORKSHIRE AND YORK	H	?	84.83%	92.32%	77.34%
TEESSIDE	H	?	93.28%	98.05%	88.51%

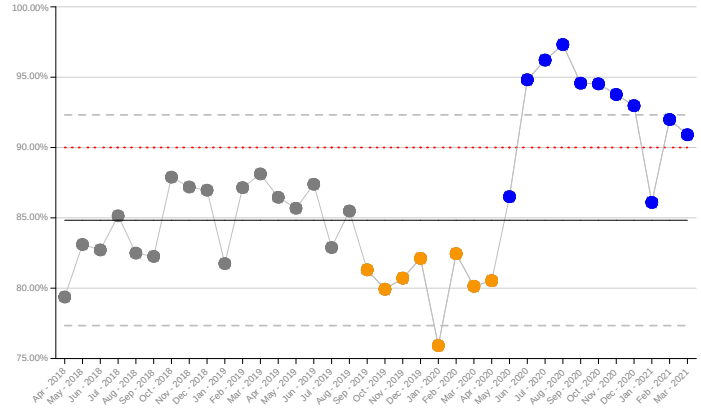
DURHAM AND DARLINGTON



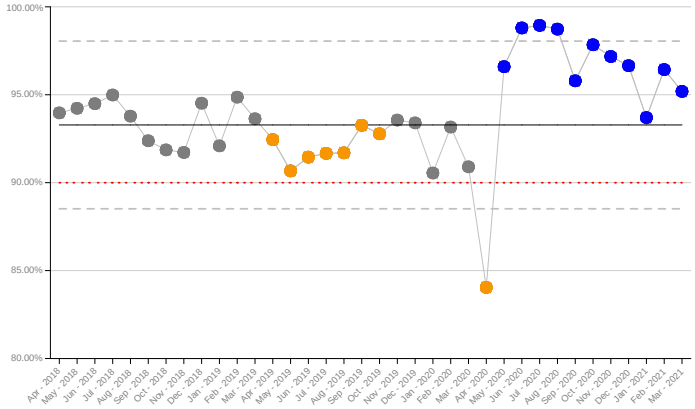
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



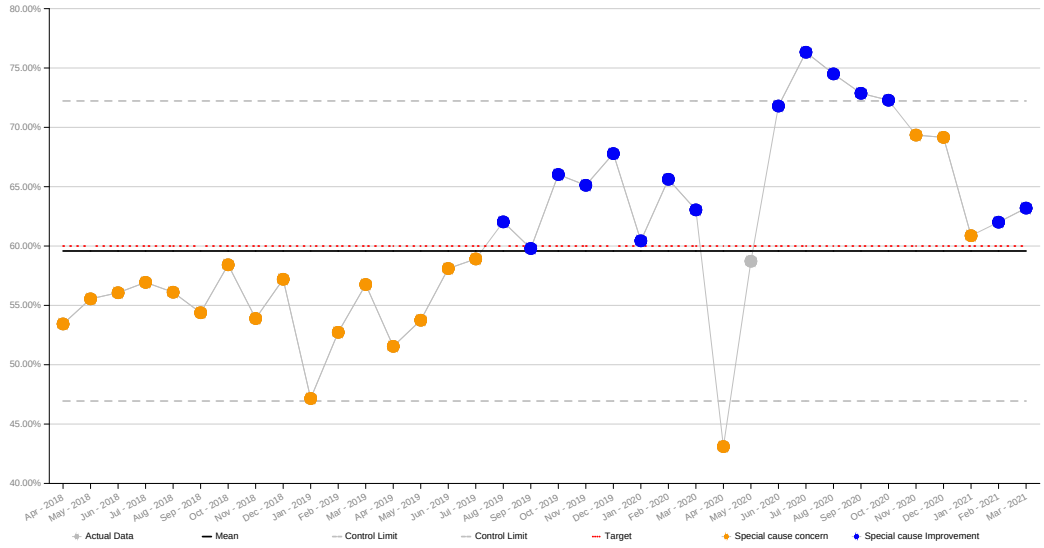
TEESSIDE



TRUST Indicator Details

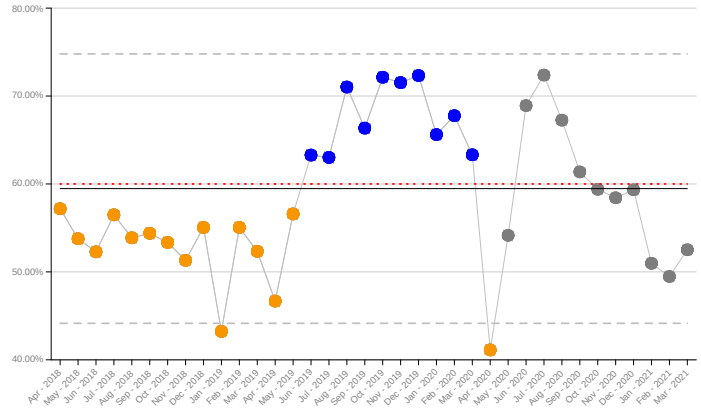
Tees, Esk and Wear Valleys NHS Foundation Trust

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

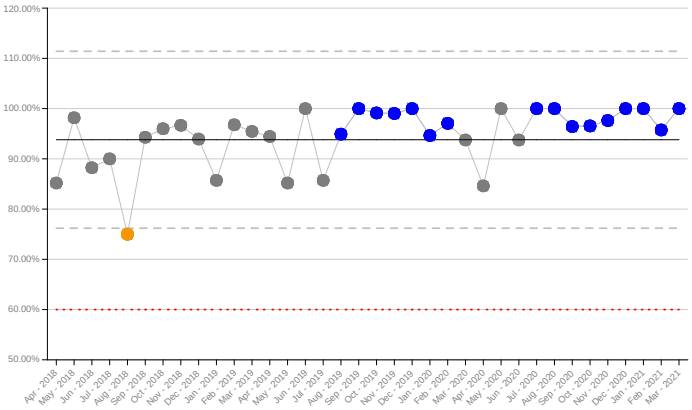


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	?	59.58%	72.22%	46.94%
DURHAM AND DARLINGTON		?	59.47%	74.79%	44.15%
FORENSIC SERVICES	H	P	93.80%	111.41%	76.19%
NORTH YORKSHIRE AND YORK	H	?	62.36%	75.85%	48.87%
TEESSIDE		?	61.21%	76.02%	46.40%

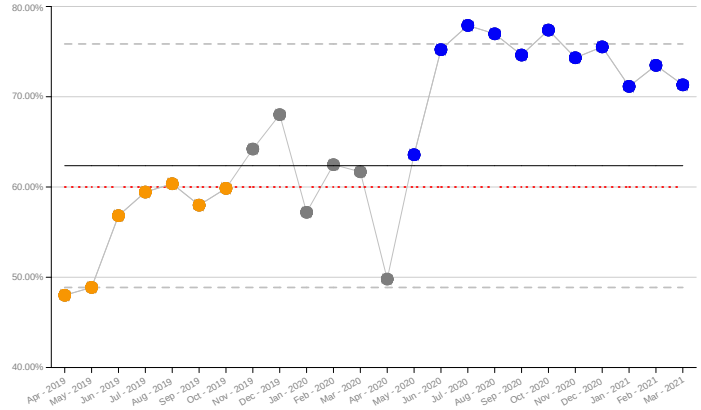
DURHAM AND DARLINGTON



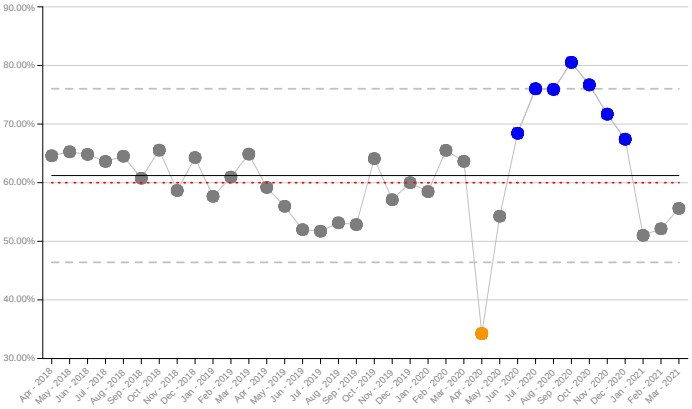
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



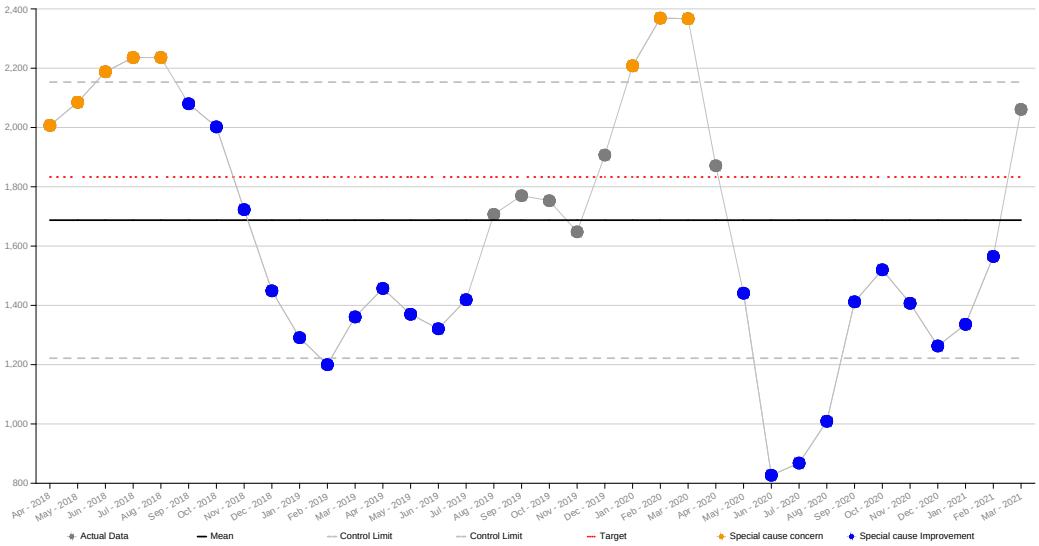
TEESSIDE



TRUST Indicator Details

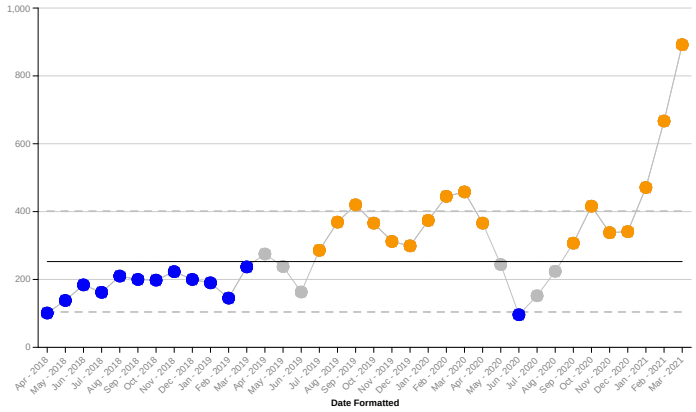
Tees, Esk and Wear Valleys NHS Foundation Trust

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

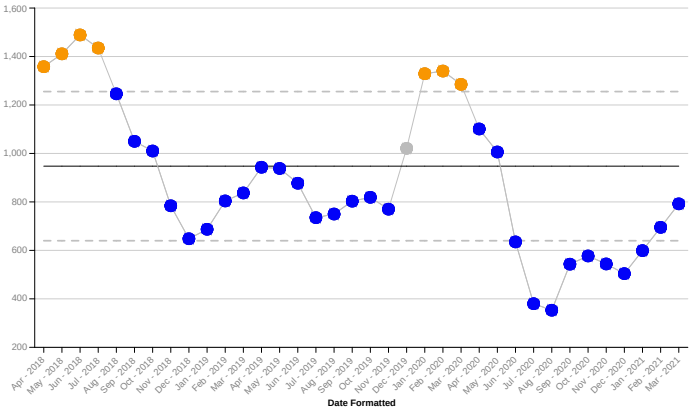


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			1,687.40	2,153.08	1,221.72
DURHAM AND DARLINGTON	H		252.73	401.33	104.14
NORTH YORKSHIRE AND YORK	L		947.57	1,255.30	639.83
TEESSIDE			467.83	710.44	225.22

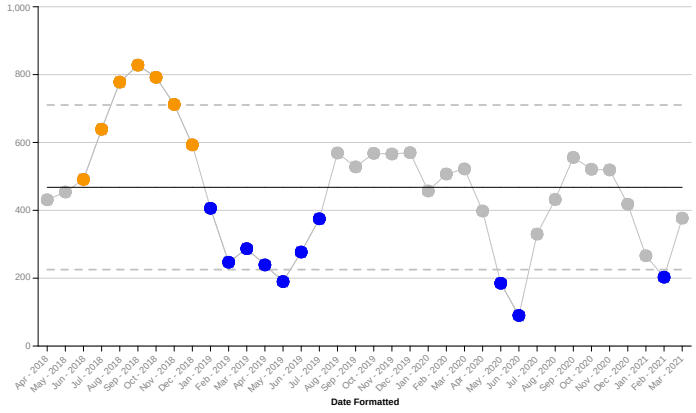
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



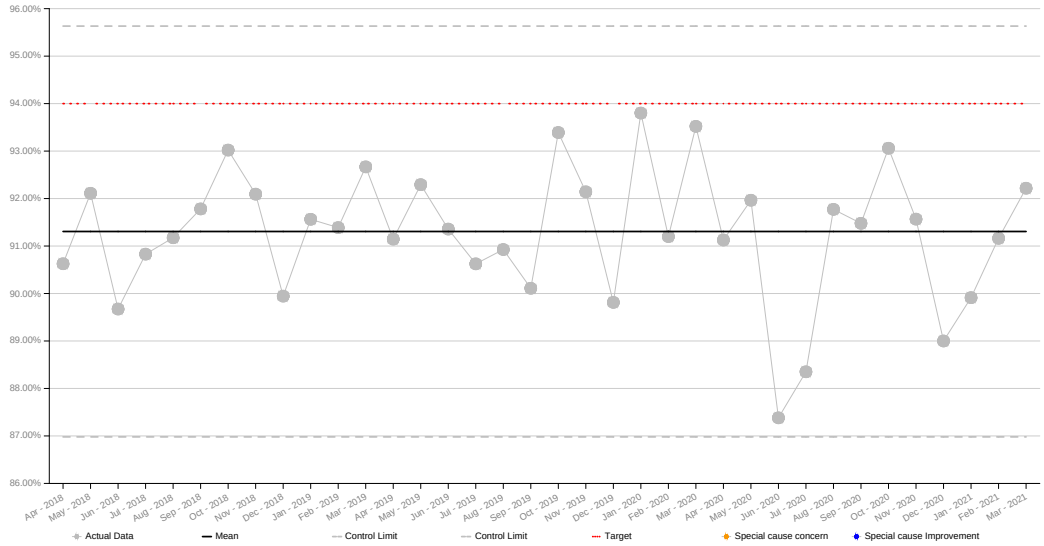
TEESSIDE



TRUST Indicator Details

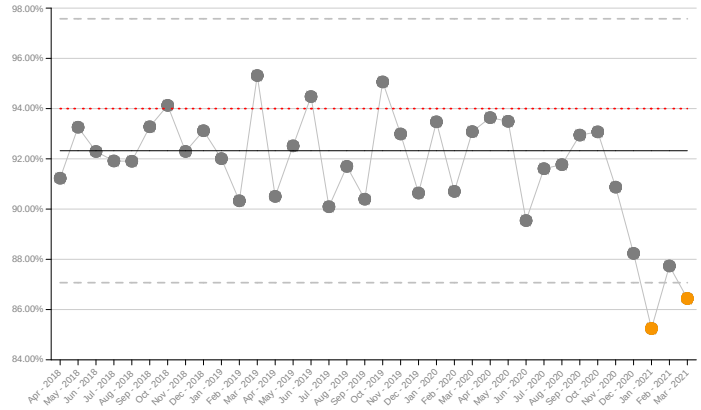
Tees, Esk and Wear Valleys NHS Foundation Trust

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

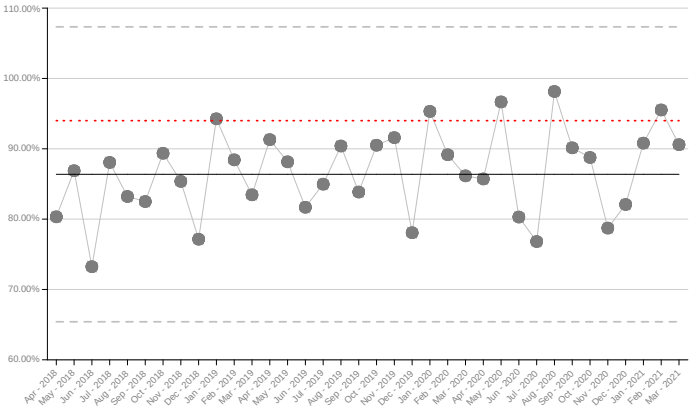


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			91.31%	95.63%	86.98%
DURHAM AND DARLINGTON	L		92.32%	97.58%	87.07%
FORENSIC SERVICES			86.37%	107.34%	65.41%
NORTH YORKSHIRE AND YORK			89.74%	98.34%	81.14%
TEESSIDE	H		92.91%	96.99%	88.83%

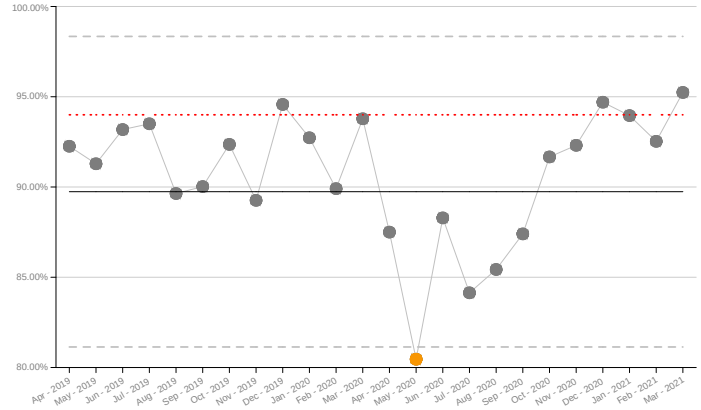
DURHAM AND DARLINGTON



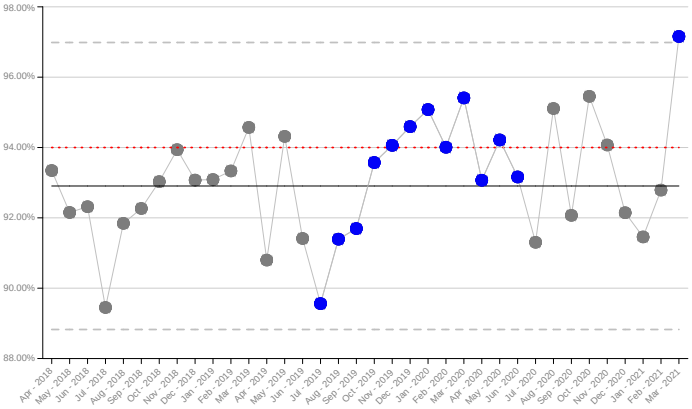
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



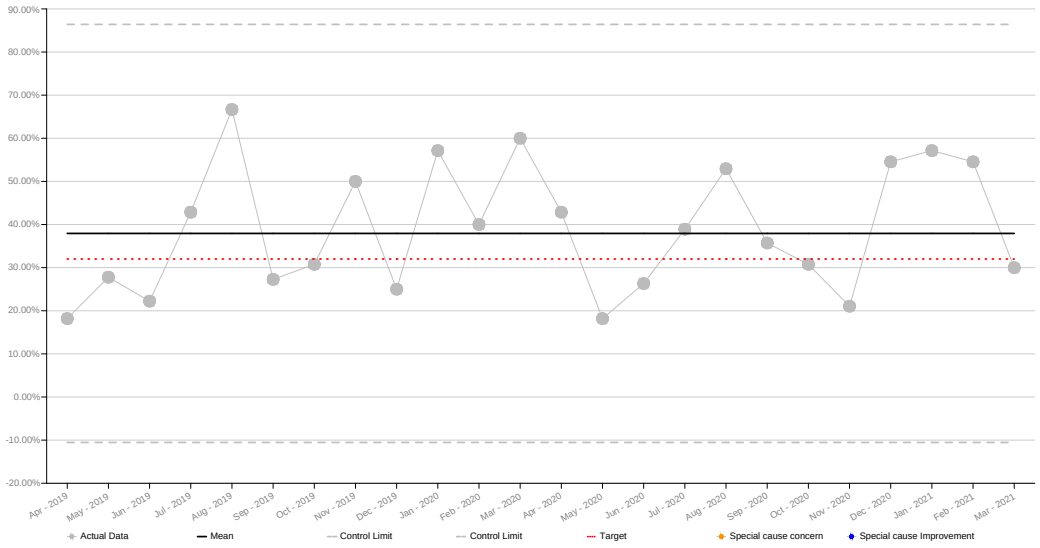
TEESSIDE



TRUST Indicator Details

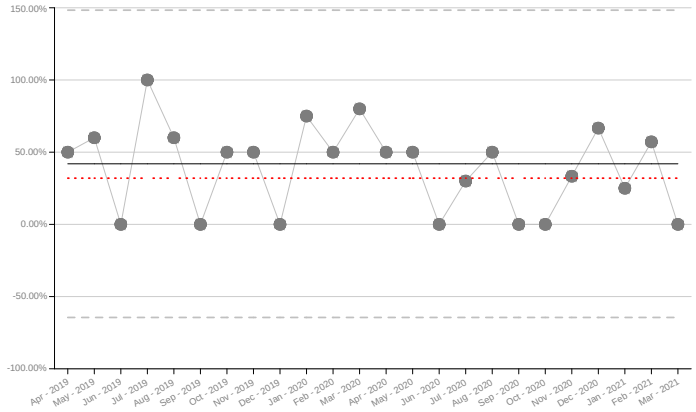
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

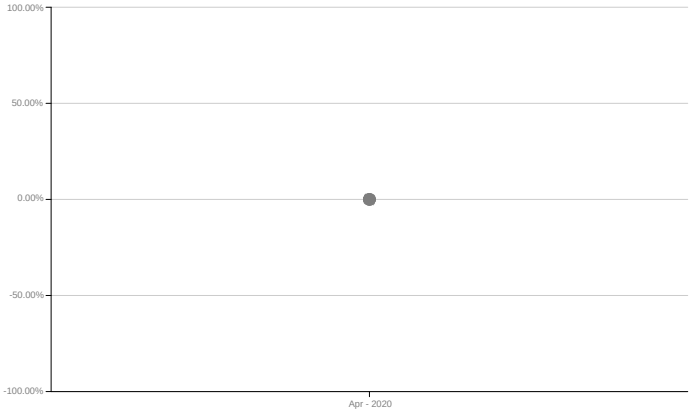


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			37.93%	86.41%	-10.54%
DURHAM AND DARLINGTON			41.94%	148.34%	-64.46%
NORTH YORKSHIRE AND YORK			44.79%	134.18%	-44.61%
TEESSIDE	H		29.62%	90.47%	-31.24%

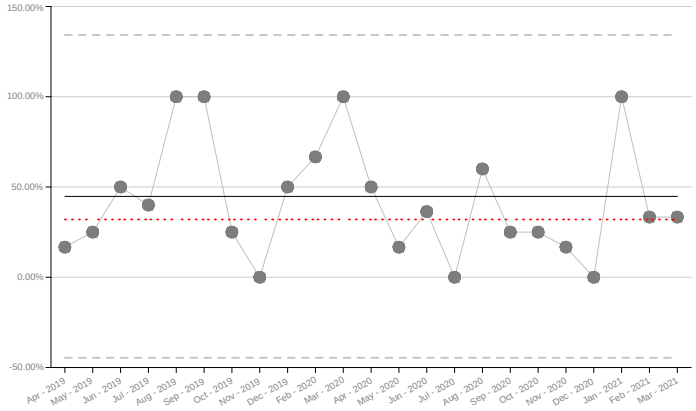
DURHAM AND DARLINGTON



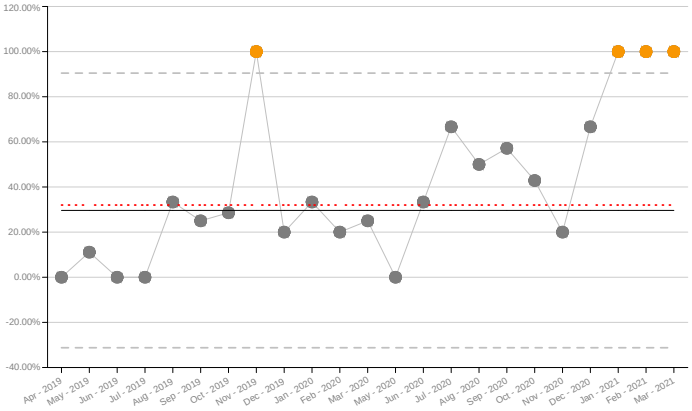
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



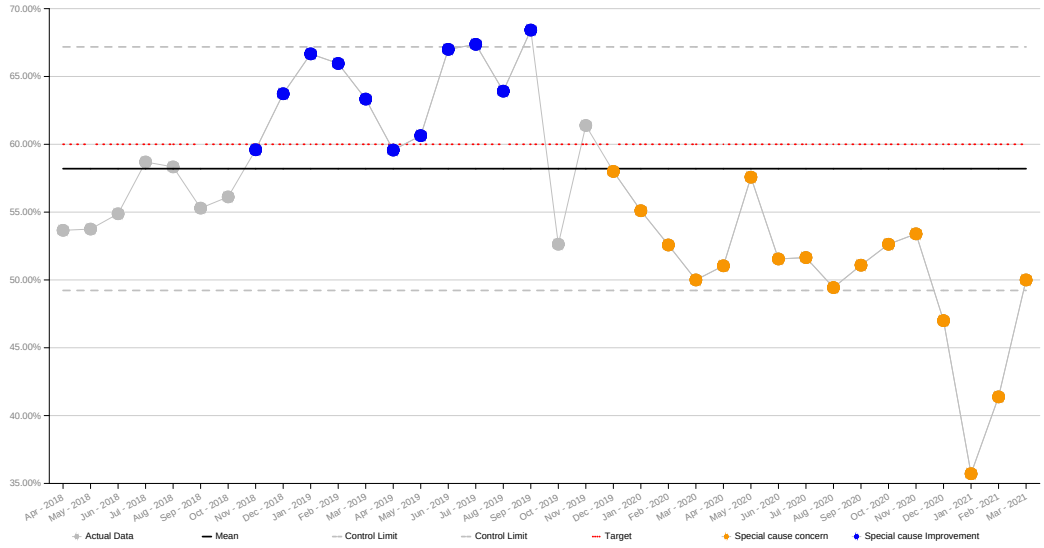
TEESSIDE



TRUST Indicator Details

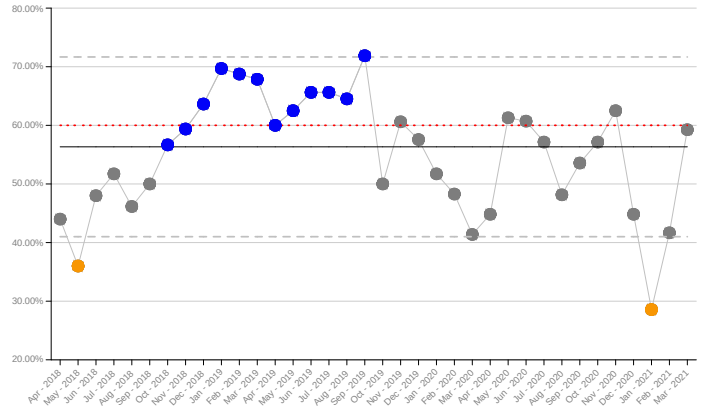
Tees, Esk and Wear Valleys NHS Foundation Trust

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

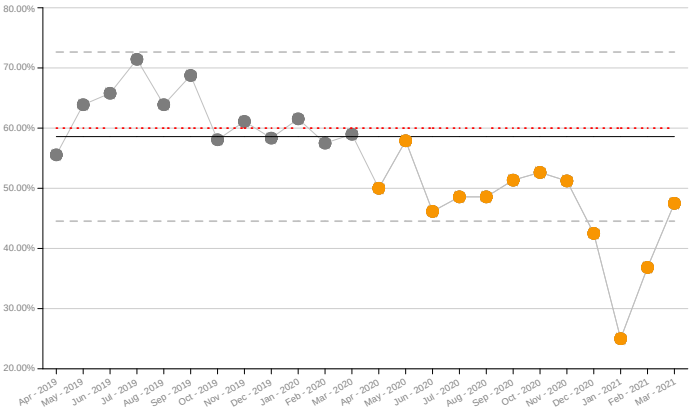


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			58.20%	67.18%	49.22%
DURHAM AND DARLINGTON			56.33%	71.67%	41.00%
NORTH YORKSHIRE AND YORK			58.59%	72.64%	44.54%
TEESSIDE			58.69%	76.00%	41.37%

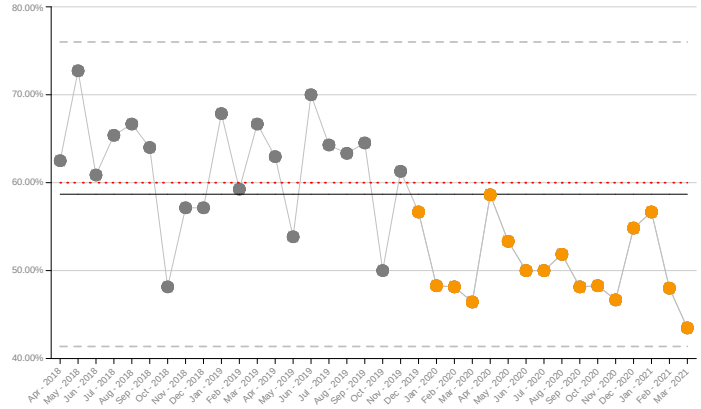
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



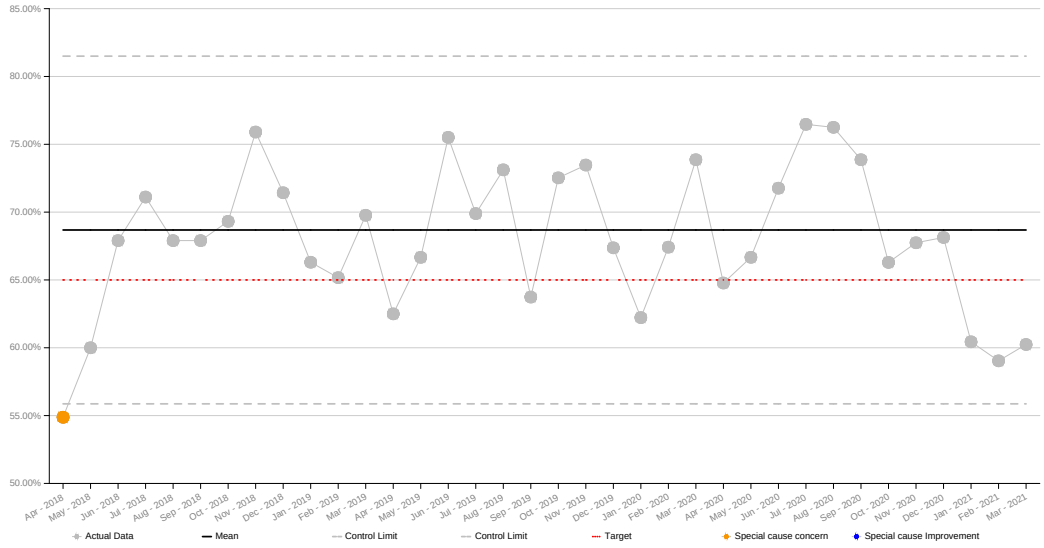
TEESSIDE



TRUST Indicator Details

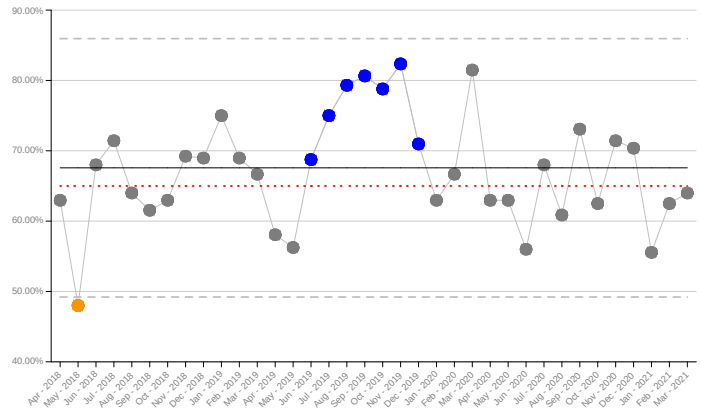
Tees, Esk and Wear Valleys NHS Foundation Trust

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

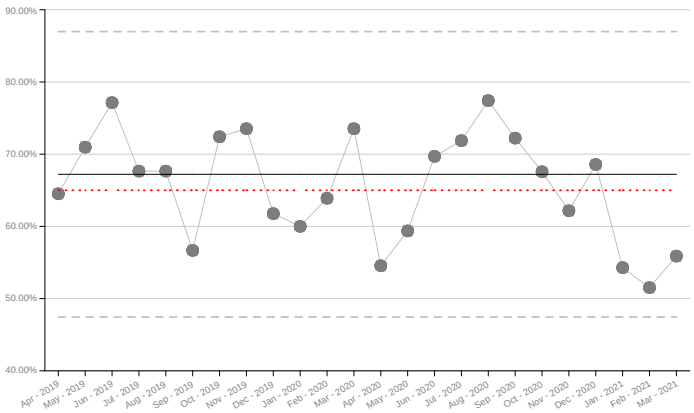


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			68.68%	81.50%	55.87%
DURHAM AND DARLINGTON			67.58%	85.95%	49.21%
NORTH YORKSHIRE AND YORK			67.21%	86.98%	47.45%
TEESSIDE			69.98%	90.67%	49.30%

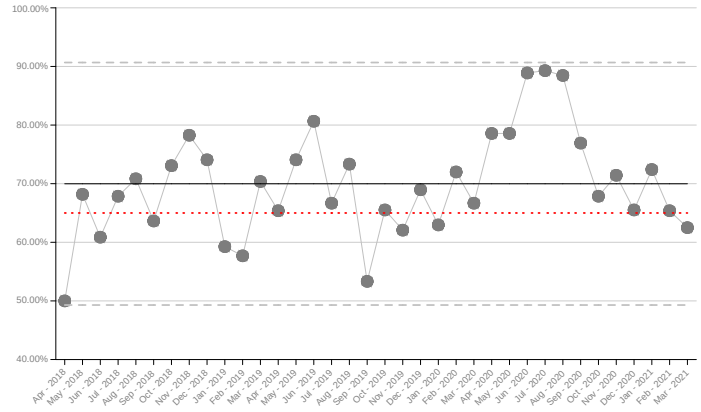
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



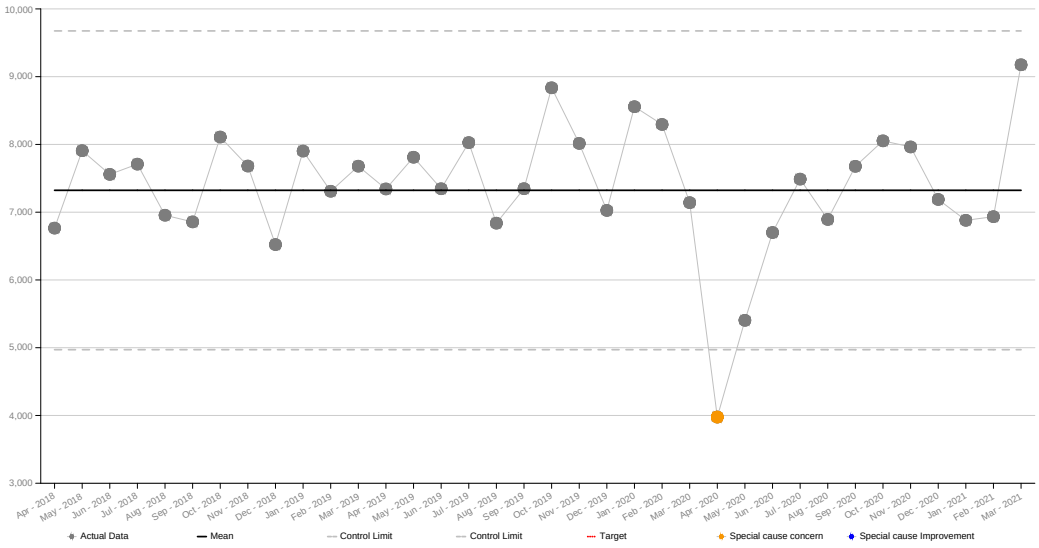
TEESSIDE



TRUST Indicator Details

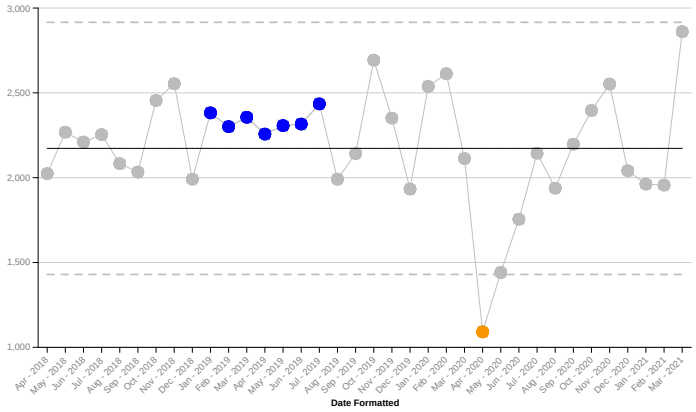
Tees, Esk and Wear Valleys NHS Foundation Trust

8) Number of new unique patients referred - TRUST

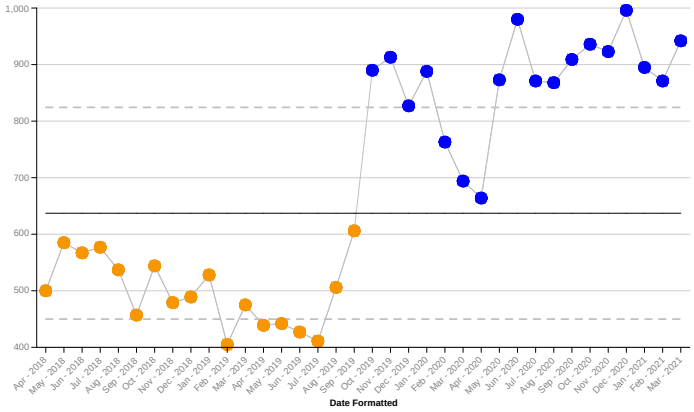


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			7,323.03	9,675.21	4,970.86
DURHAM AND DARLINGTON			2,172.80	2,915.95	1,429.65
FORENSIC SERVICES			637.10	824.31	449.89
NORTH YORKSHIRE AND YORK			2,087.13	2,730.30	1,443.96
TEESSIDE			2,425.93	3,298.41	1,553.45

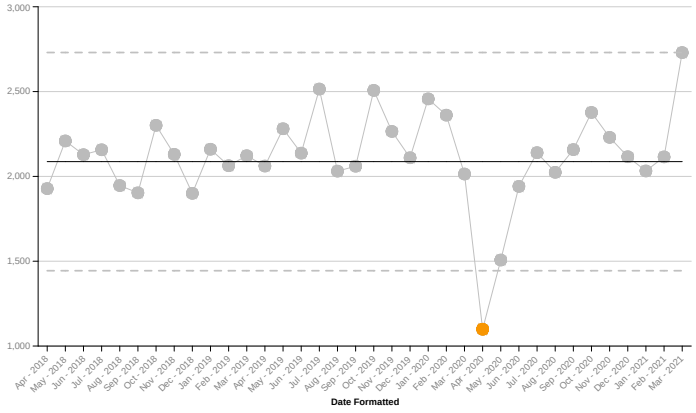
DURHAM AND DARLINGTON



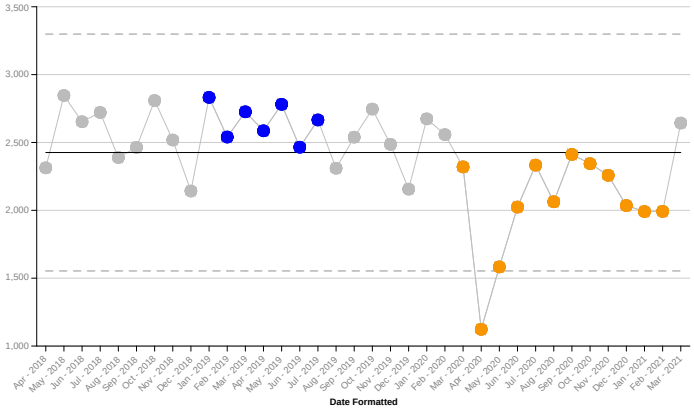
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



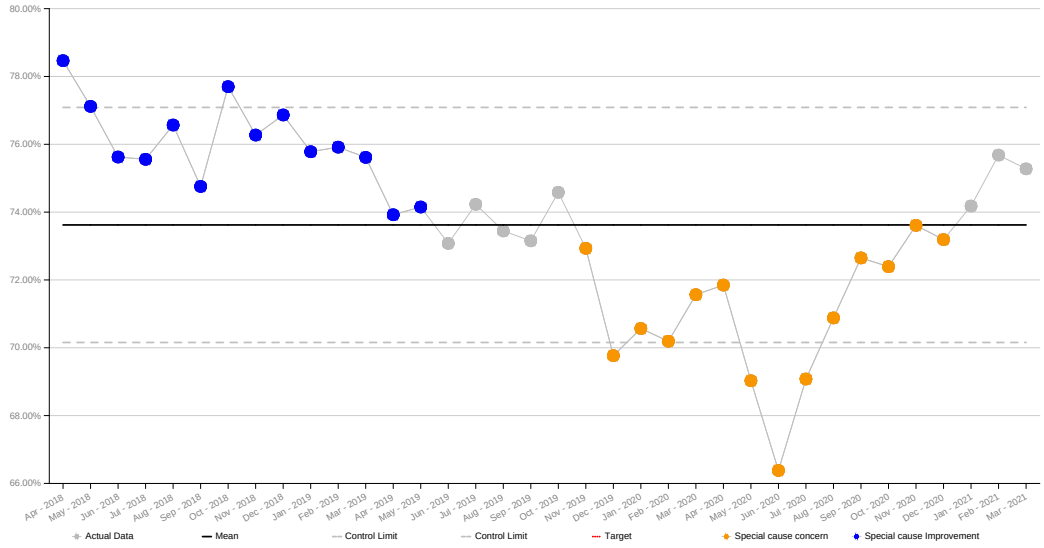
TEESSIDE



TRUST Indicator Details

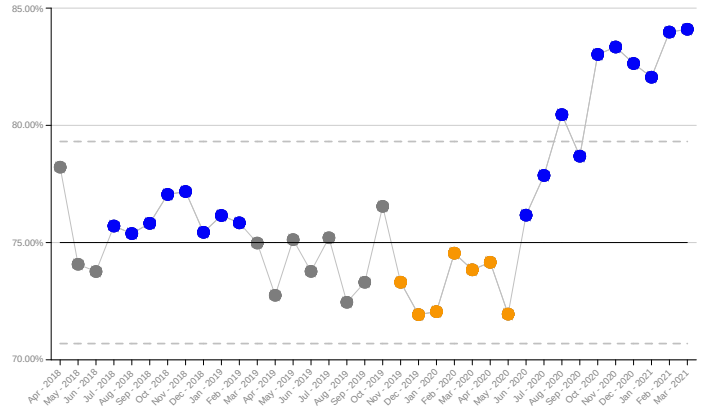
Tees, Esk and Wear Valleys NHS Foundation Trust

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

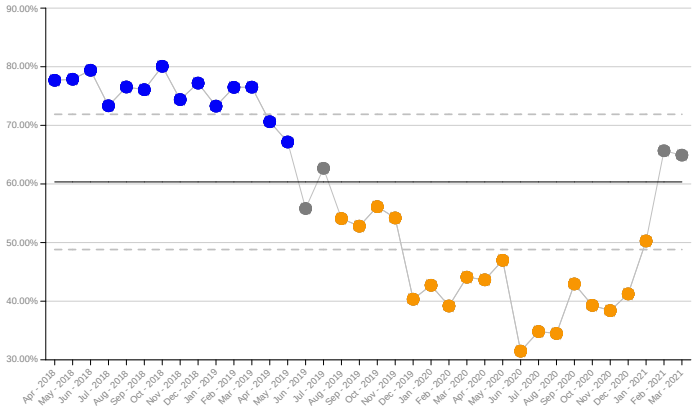


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			73.62%	77.09%	70.16%
DURHAM AND DARLINGTON	H		75.00%	79.31%	70.69%
FORENSIC SERVICES			60.35%	71.88%	48.81%
NORTH YORKSHIRE AND YORK			74.86%	78.96%	70.76%
TEESSIDE			75.85%	80.42%	71.27%

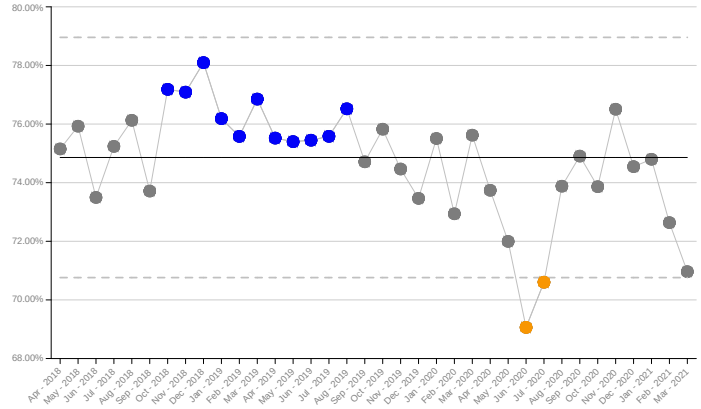
DURHAM AND DARLINGTON



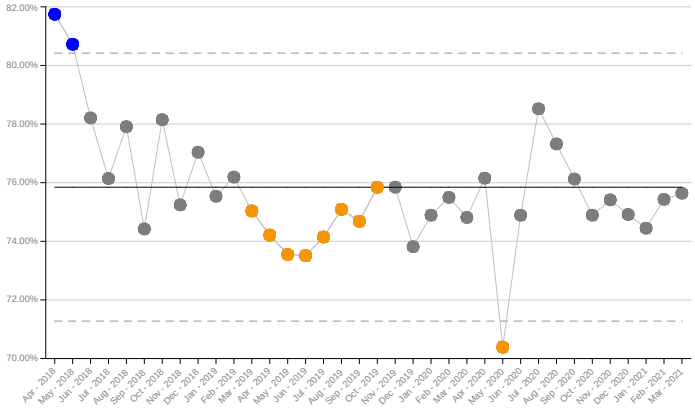
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



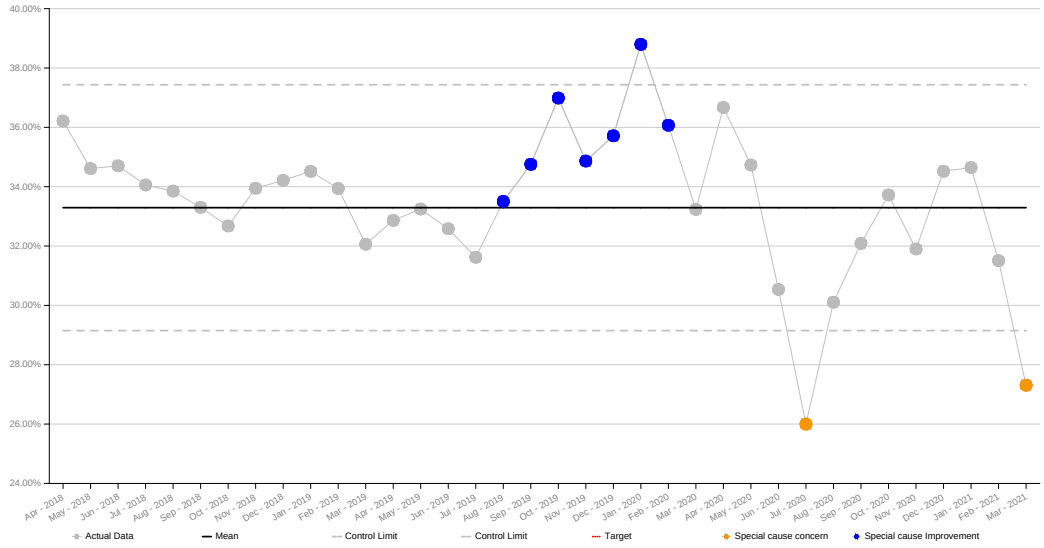
TEESSIDE



TRUST Indicator Details

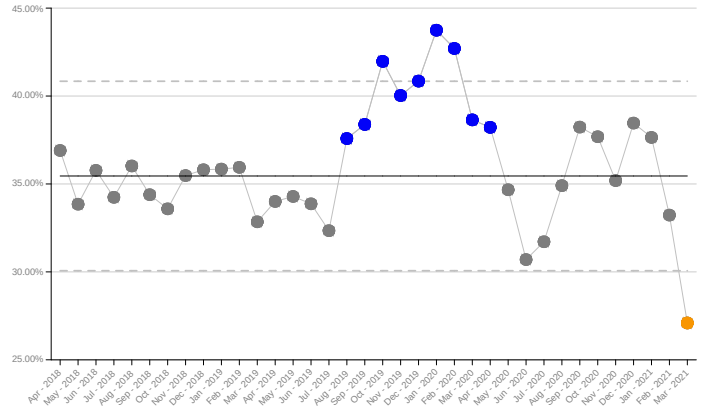
Tees, Esk and Wear Valleys NHS Foundation Trust

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

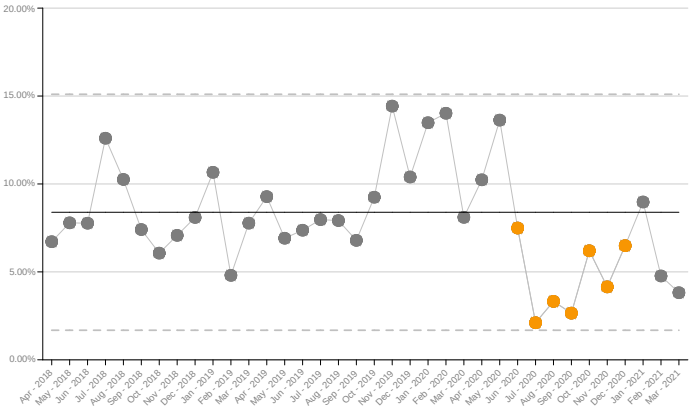


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			33.29%	37.44%	29.15%
DURHAM AND DARLINGTON			35.45%	40.84%	30.07%
FORENSIC SERVICES			8.39%	15.10%	1.68%
NORTH YORKSHIRE AND YORK			40.13%	45.39%	34.88%
TEESSIDE			31.79%	36.04%	27.54%

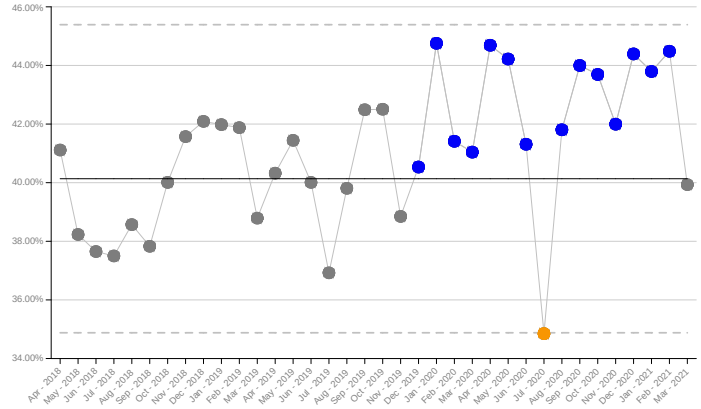
DURHAM AND DARLINGTON



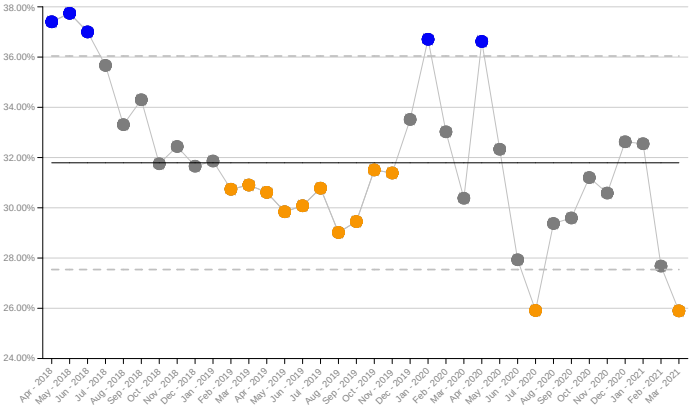
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



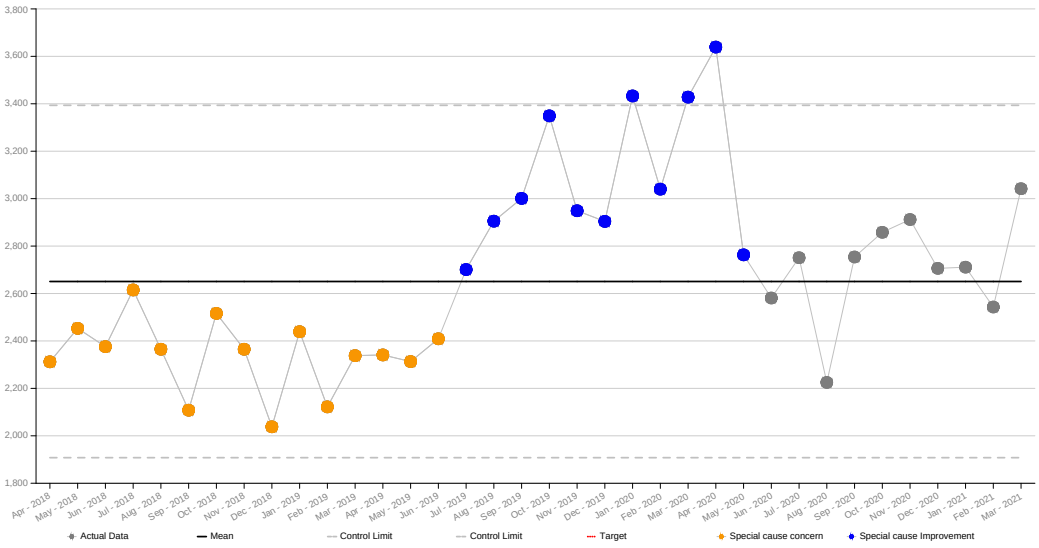
TEESSIDE



TRUST Indicator Details

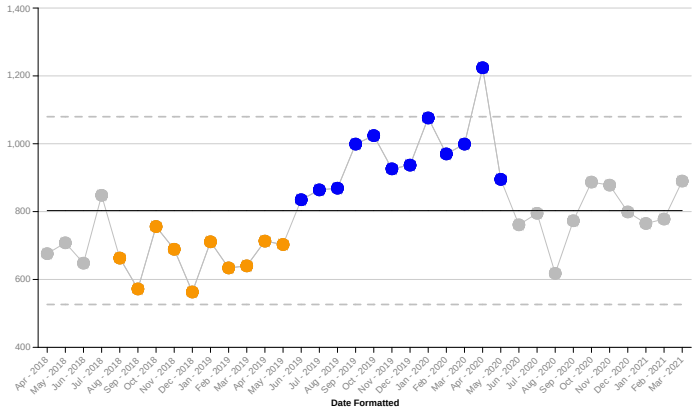
Tees, Esk and Wear Valleys NHS Foundation Trust

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

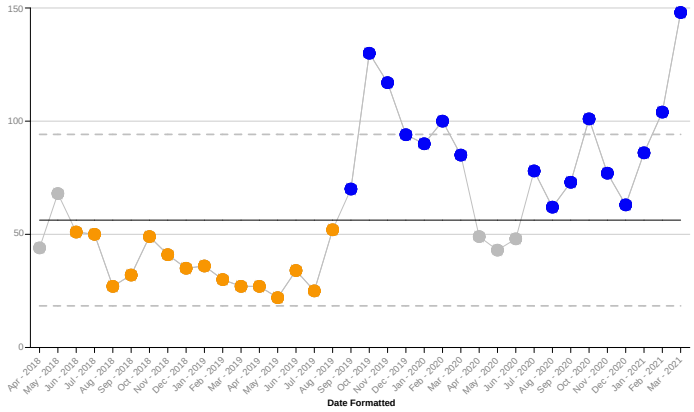


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			2,650.67	3,393.54	1,907.79
DURHAM AND DARLINGTON			802.97	1,079.70	526.23
FORENSIC SERVICES	H		56.27	94.15	18.38
NORTH YORKSHIRE AND YORK	H		908.80	1,171.04	646.56
TEESSIDE			882.63	1,171.56	593.70

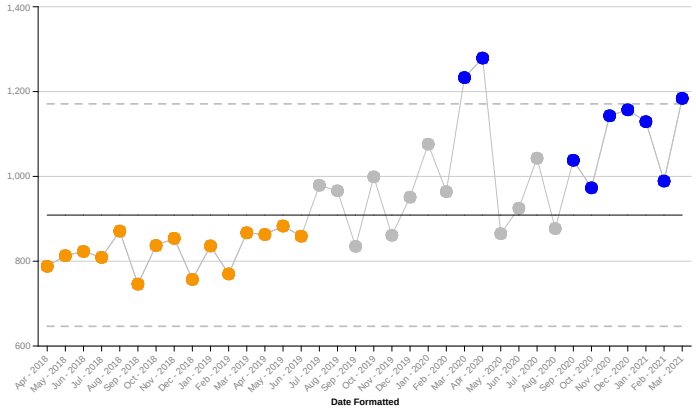
DURHAM AND DARLINGTON



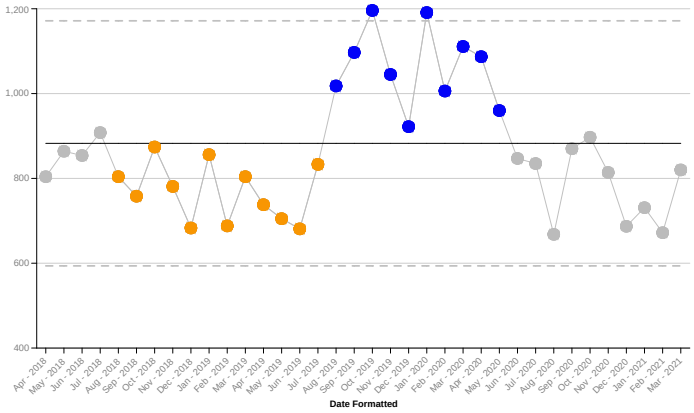
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



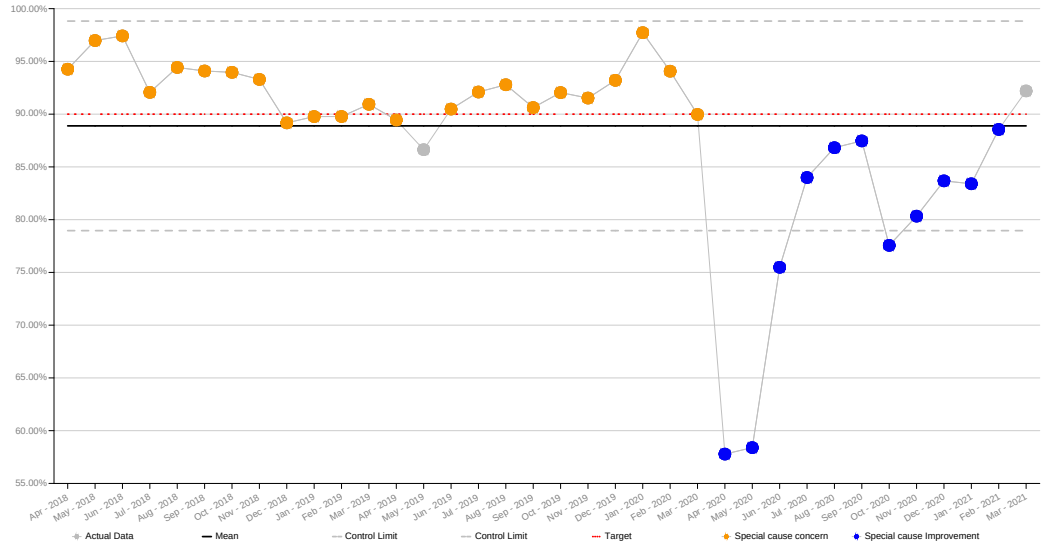
TEESSIDE



TRUST Indicator Details

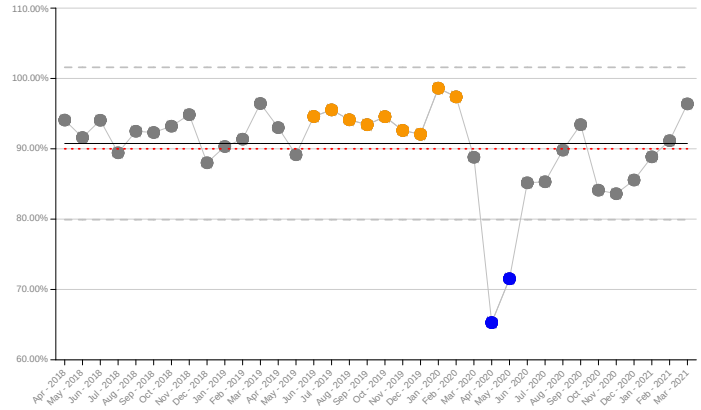
Tees, Esk and Wear Valleys NHS Foundation Trust

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

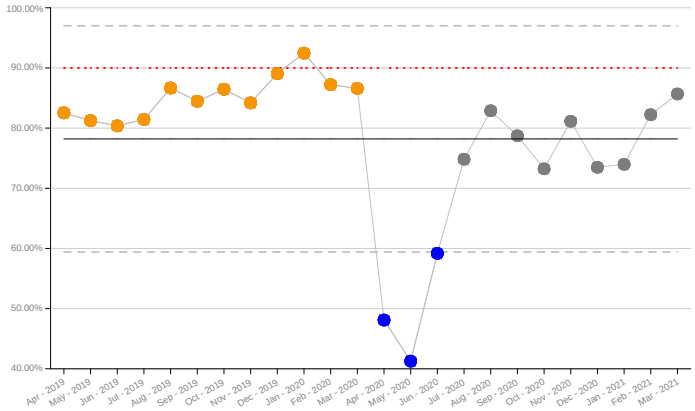


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			88.89%	98.82%	78.96%
DURHAM AND DARLINGTON			90.75%	101.58%	79.92%
NORTH YORKSHIRE AND YORK			78.21%	97.01%	59.40%
TEESSIDE			95.52%	108.70%	82.34%

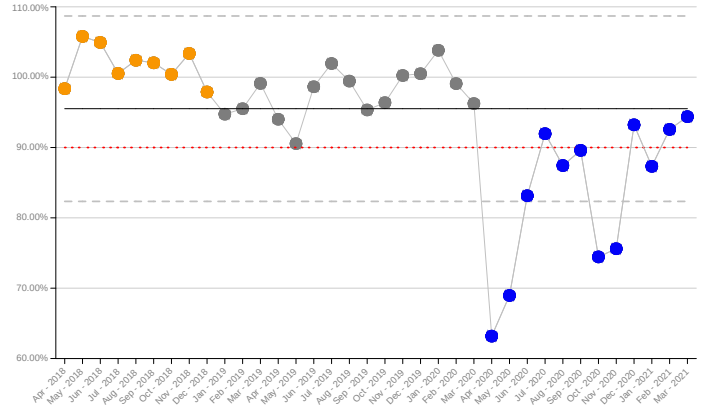
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



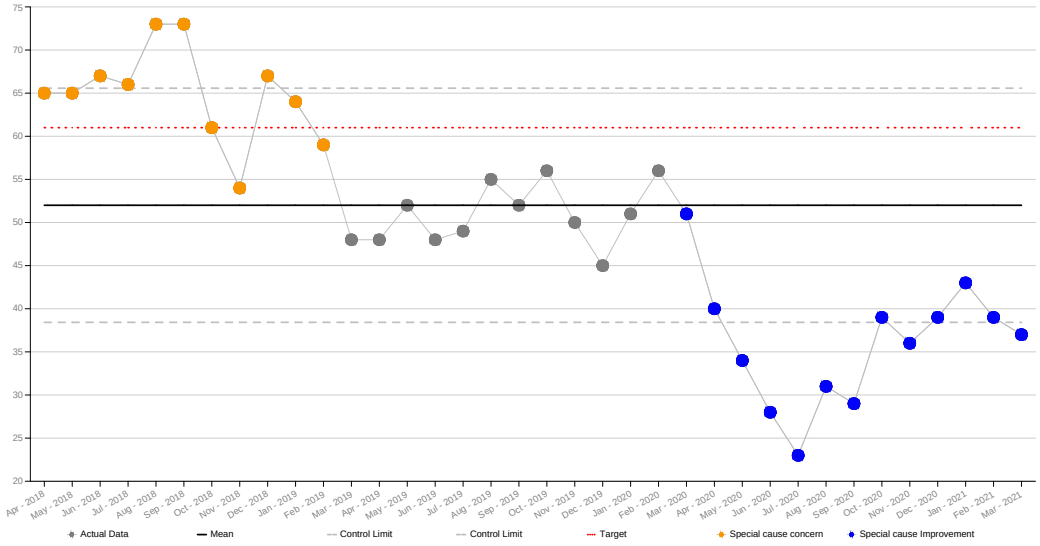
TEESSIDE



TRUST Indicator Details

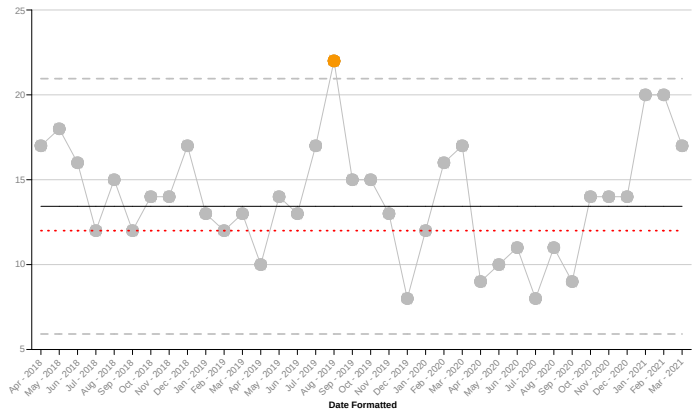
Tees, Esk and Wear Valleys NHS Foundation Trust

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

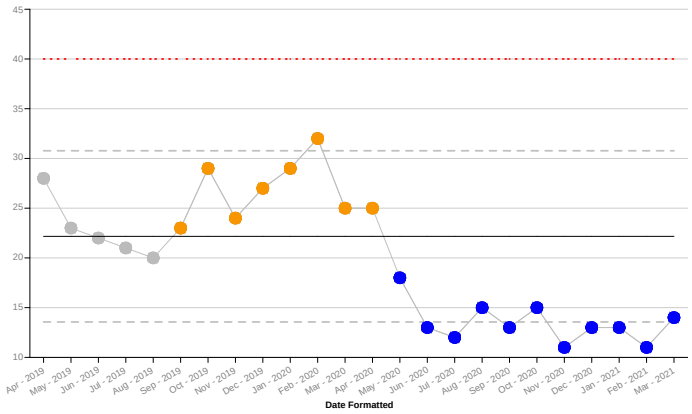


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	52.00	65.58	38.42
DURHAM AND DARLINGTON		?	13.43	20.95	5.91
NORTH YORKSHIRE AND YORK	L	P	22.17	30.77	13.56
TEESSIDE		?	9.93	15.71	4.15

DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



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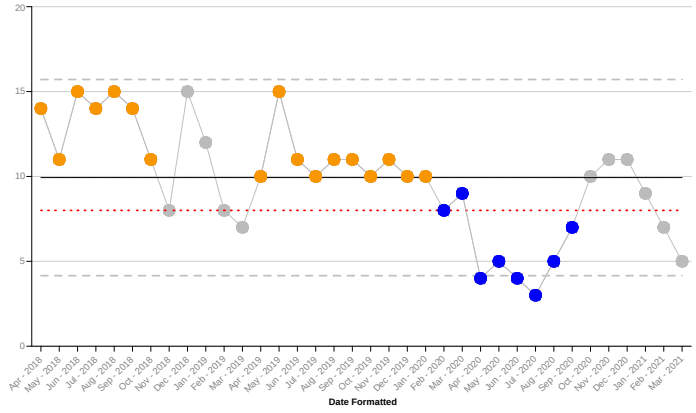
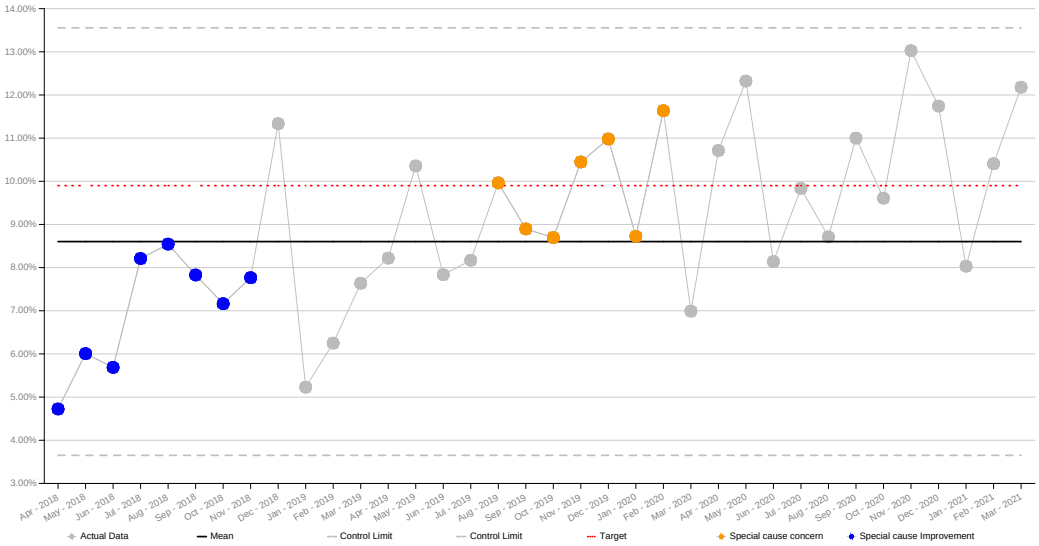


TRUST Indicator Details

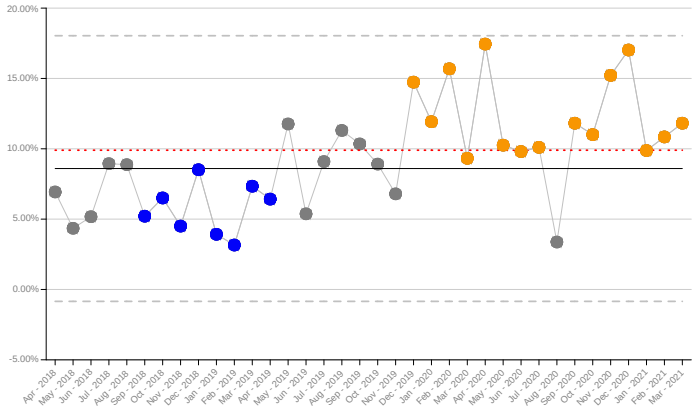
Tees, Esk and Wear Valleys NHS Foundation Trust

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

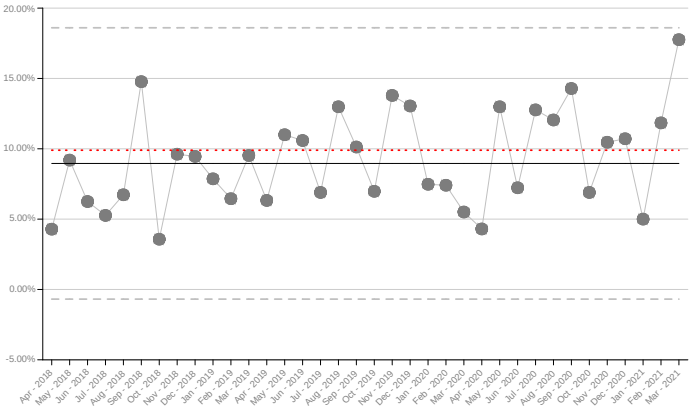


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			8.60%	13.56%	3.65%
DURHAM AND DARLINGTON	H		8.60%	18.04%	-0.85%
NORTH YORKSHIRE AND YORK			8.96%	18.60%	-0.69%
TEESSIDE			8.38%	19.57%	-2.82%

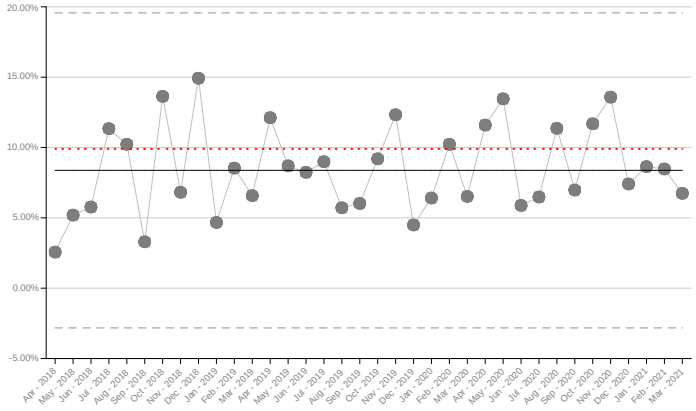
DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



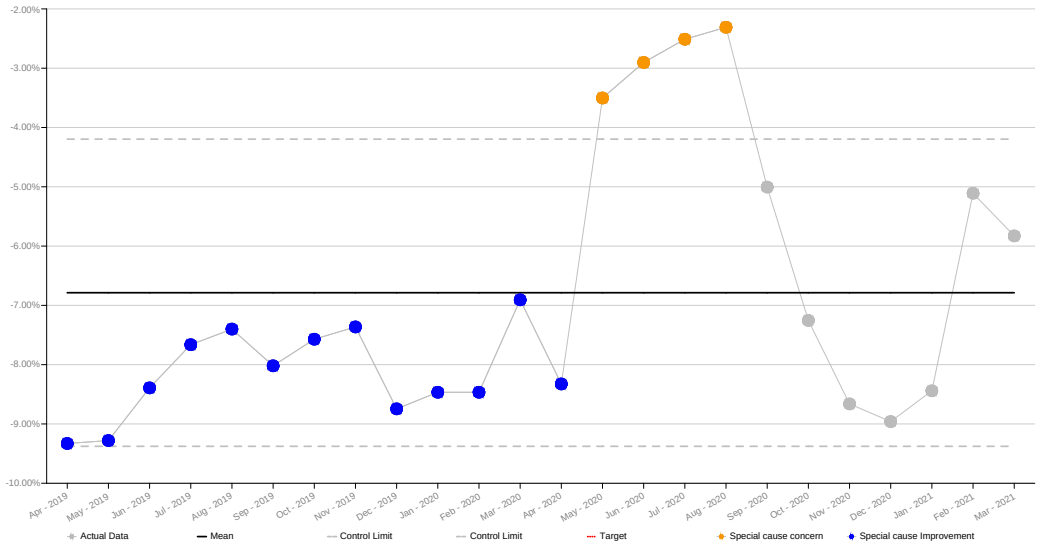
TEESSIDE



TRUST Indicator Details

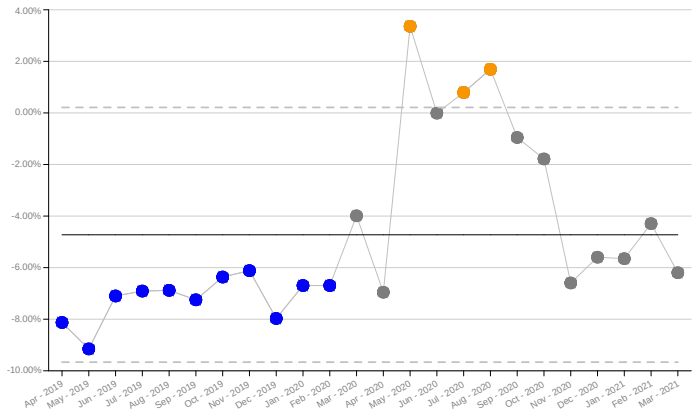
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

15) Finance Vacancy Rate - TRUST

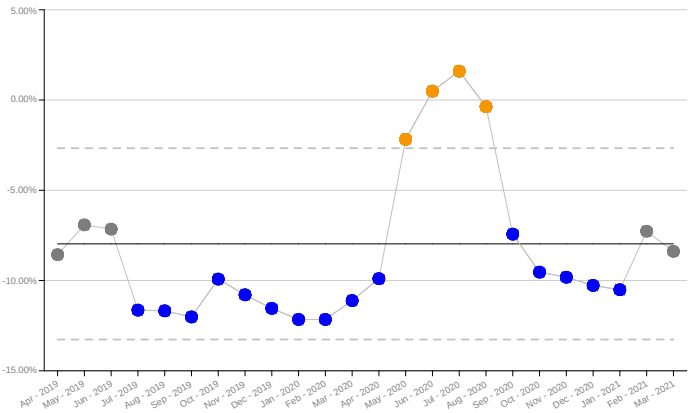


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			-6.79%	-4.20%	-9.38%
DURHAM AND DARLINGTON			-4.73%	0.21%	-9.66%
FORENSIC SERVICES			-7.97%	-2.67%	-13.27%
NORTH YORKSHIRE AND YORK			-6.62%	-3.58%	-9.67%
TEESSIDE			-6.09%	-2.94%	-9.24%

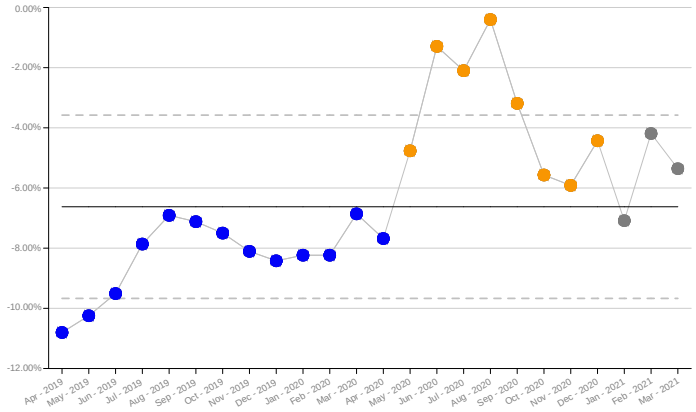
DURHAM AND DARLINGTON



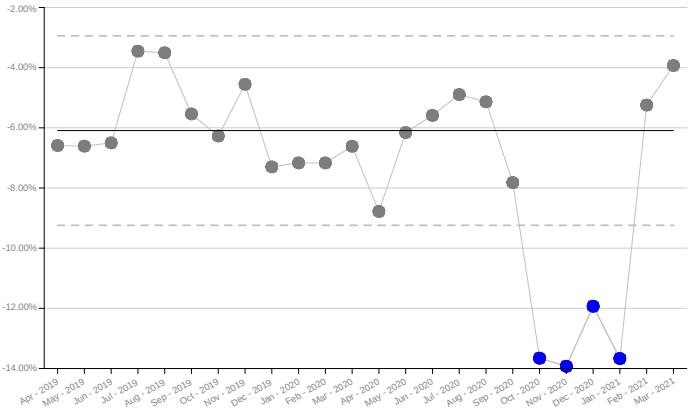
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



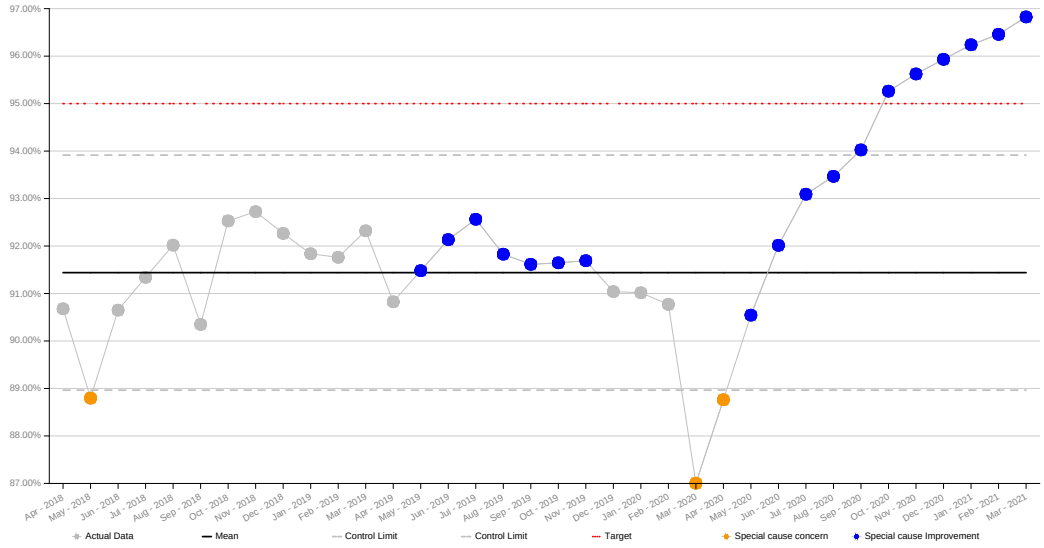
TEESSIDE



TRUST Indicator Details

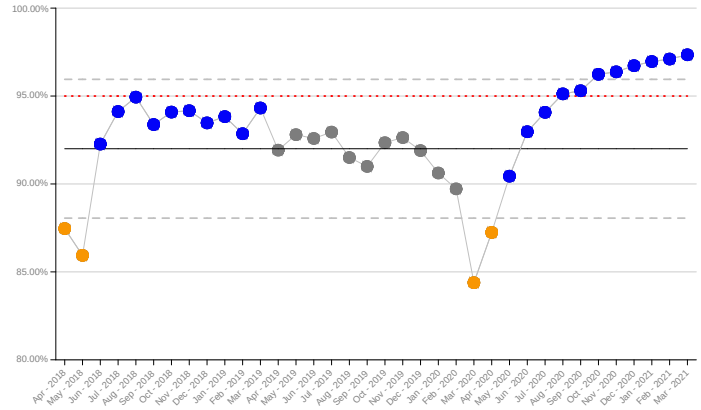
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

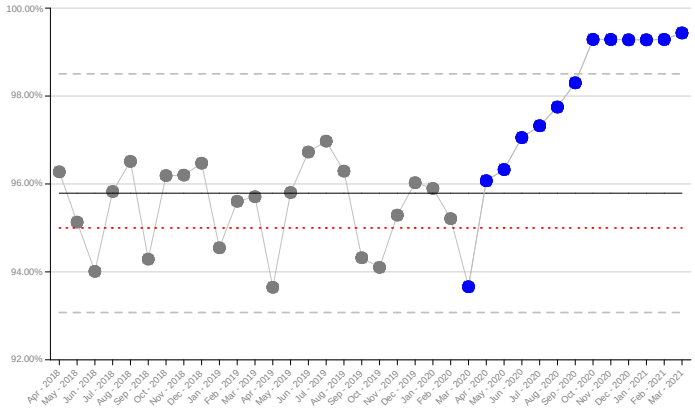


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	F	91.44%	93.92%	88.96%
DURHAM AND DARLINGTON	H	?	92.00%	95.95%	88.06%
FORENSIC SERVICES	H	?	95.79%	98.50%	93.08%
NORTH YORKSHIRE AND YORK	H	F	89.65%	92.84%	86.47%
TEESSIDE	H	?	93.23%	95.96%	90.49%

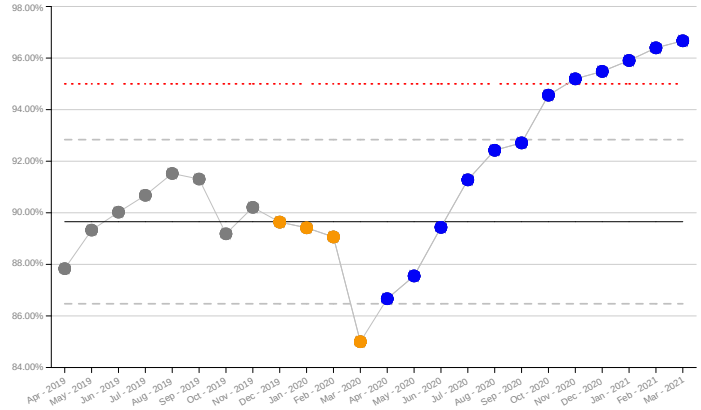
DURHAM AND DARLINGTON



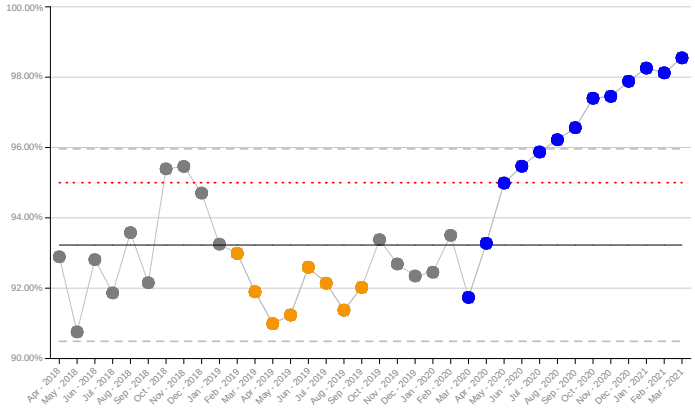
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



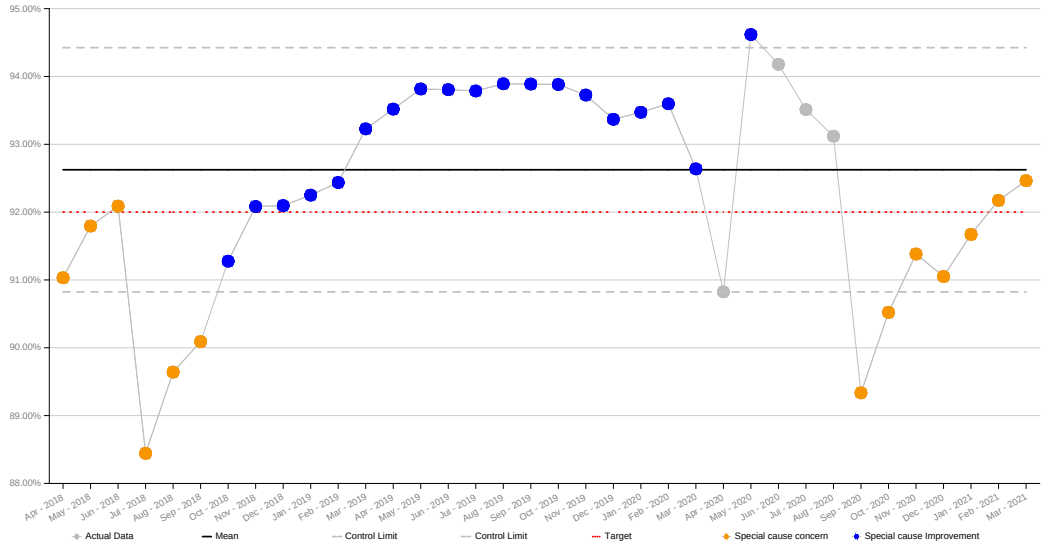
TEESSIDE



TRUST Indicator Details

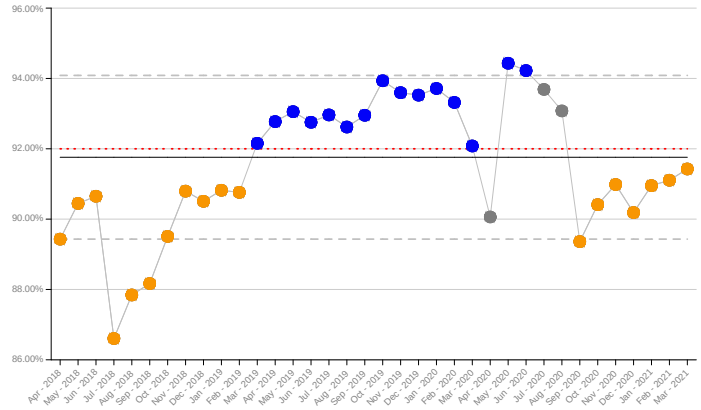
Tees, Esk and Wear Valleys NHS Foundation Trust

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

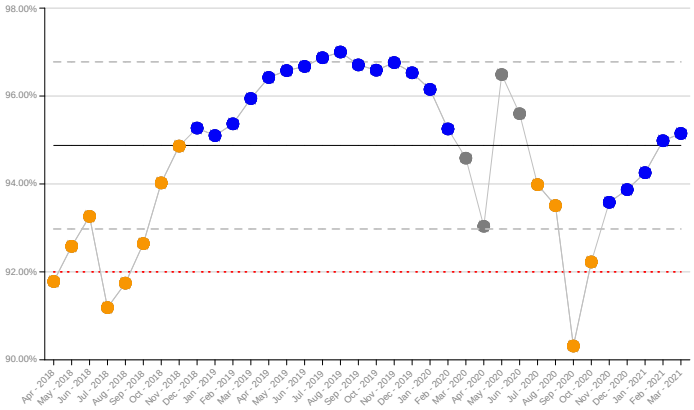


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	L	?	92.62%	94.42%	90.82%
DURHAM AND DARLINGTON	L	?	91.76%	94.09%	89.43%
FORENSIC SERVICES	H	P	94.88%	96.78%	92.98%
NORTH YORKSHIRE AND YORK	L	?	91.04%	93.28%	88.81%
TEESSIDE	L	?	93.58%	95.33%	91.84%

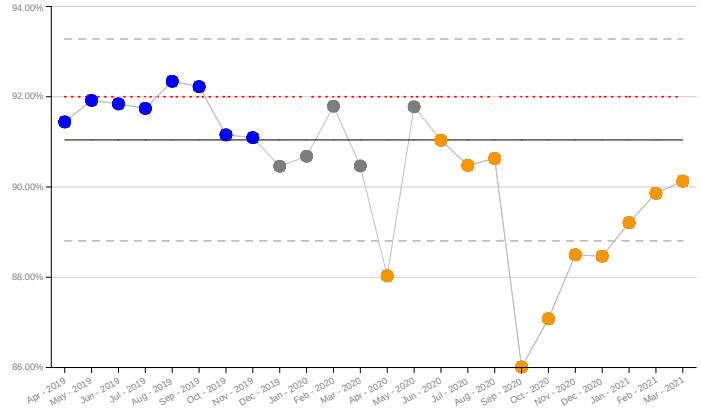
DURHAM AND DARLINGTON



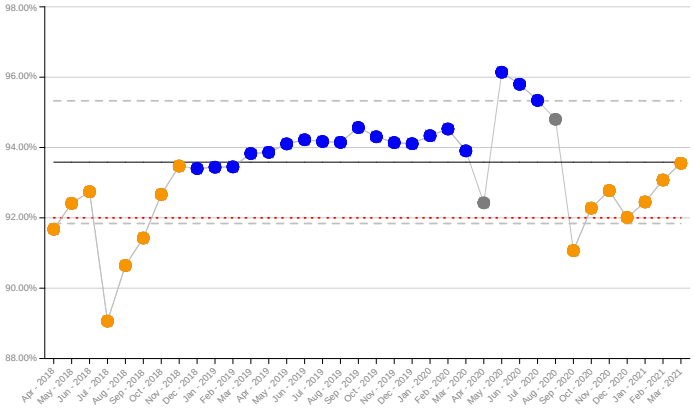
FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



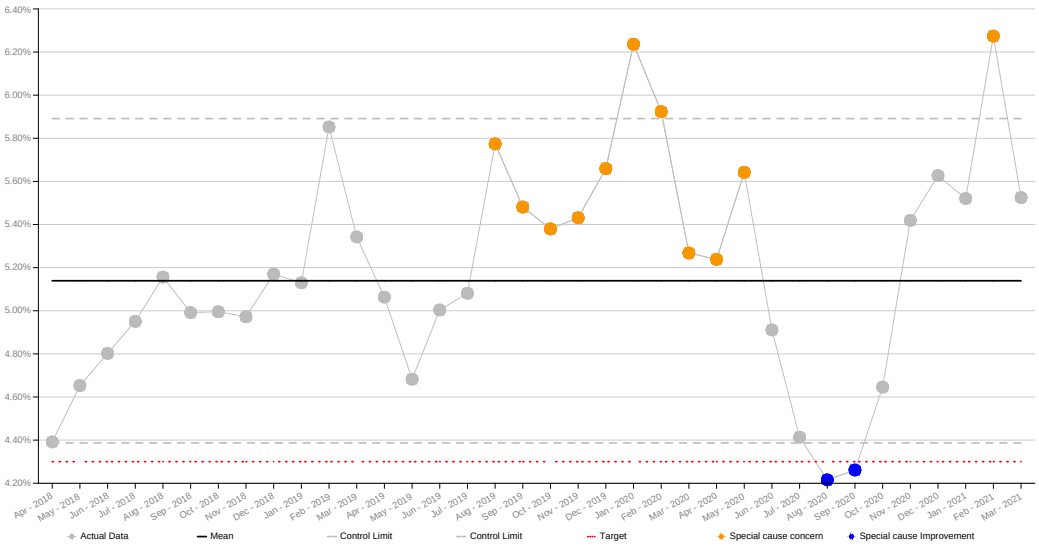
TEESSIDE



TRUST Indicator Details

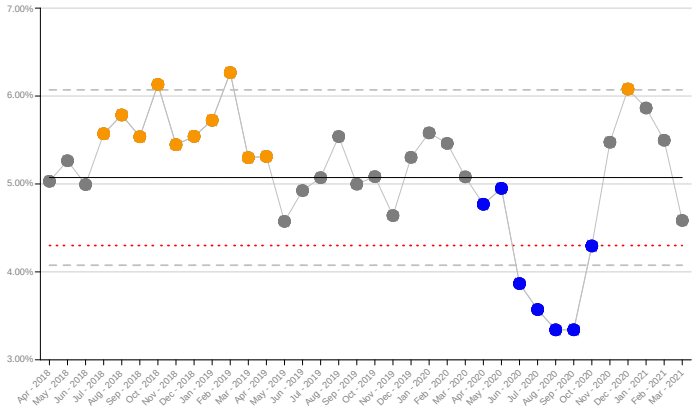
Tees, Esk and Wear Valleys NHS Foundation Trust

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

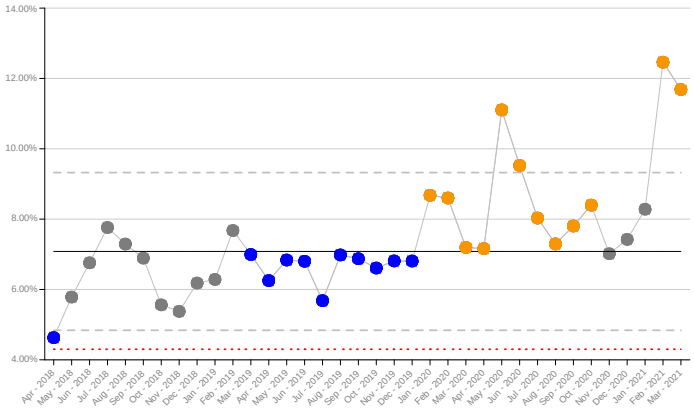


Level	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST		F	5.14%	5.89%	4.39%
DURHAM AND DARLINGTON		?	5.07%	6.07%	4.08%
FORENSIC SERVICES	H	F	7.08%	9.32%	4.84%
NORTH YORKSHIRE AND YORK		?	4.23%	5.13%	3.32%
TEESSIDE		F	5.49%	6.58%	4.40%

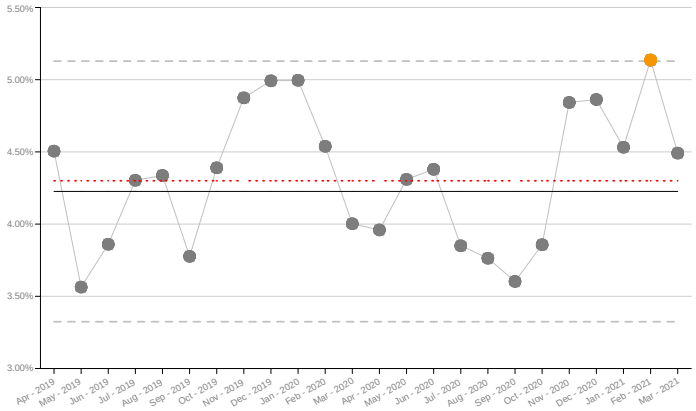
DURHAM AND DARLINGTON



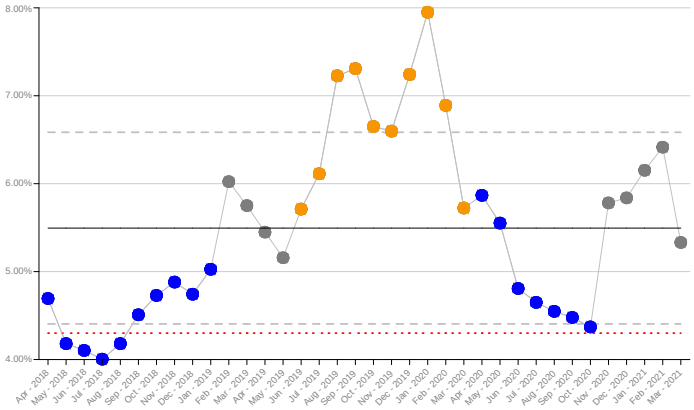
FORENSIC SERVICES



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

TD02) Percentage of patients starting treatment within 6 weeks of an external referral – Durham & 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

Key Conclusions to date

- The deterioration in this measure had 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 had been observed in CYPS in the longer-term as a result of incorrect recording of treatment intervention codes. The current position better reflects true performance.

Actions we said we would take

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

Update on actions including assurance (where known)

- This measure and TD1 (percentage of patients seen within 4 weeks for a 1st appointment following an external referral) have continued to be monitored via routine weekly processes within MHSOP. No notable change has been observed so far but monitoring and discussions will continue.
- A detailed deep dive analysis has been undertaken to identify any key areas of concern within CYPS and MHSOP, including those teams with low common cause variation.
  - The CYPS position now demonstrates special cause (concern). This position is most influenced by performance in community teams; despite all showing common cause, all teams perform considerably below the standard. During lockdown in summer 2020, community teams appropriately prioritised treatment based on clinical need and risk; as the service has now increased the number of treatment appointment they have started to provide treatment to patients not initially given highest priority, performance has declined, as many had waited longer than 6 weeks by that time; this continues to impact on February's position. Additionally, vacancies have affected the North Durham, South Durham and Easington teams, with 6 posts currently not filled; 4 of these (x3 Band 6, x1 Band 7) having been advertised unsuccessfully multiple times since summer 2020. The service has chosen alternative configurations of these posts in order to fill long-standing vacancies; of these, 1 has been appointed to but not yet started, and the remaining 3 will go out to advert in April. CYPS are to investigate further into the Darlington team to explore whether any factors other than patient prioritisation during lockdown have impacted the position. CYPS is fully engaged with utilising the new IIC dashboards weekly to proactively manage waits for both assessment and treatment, and to identify and correct data quality issues.
  - The MHSOP position shows common cause variation and is above both the mean and the standard. Durham Chester-le-street Community team are demonstrating cause for concern, with 14 points below both the standard and mean. A sample of patients have been investigated, which indicates that recording of treatment intervention codes has not been accurate, and that genuine performance against this measure is higher than currently shown. CPT are working with the service to improve understanding of treatment recording requirements and to identify and rectify historical data quality issues; reminders of the intervention codes representing 'treatment' have been re-shared across all community teams. Other teams contributing significantly to this measure demonstrate common cause variation; Derwentside are above the standard, whilst the remainder are below, which the service believe is related to failure to record treatment accurately.

Actions being taken to provide assurance

A number of actions will take place in CYPS including:

- CYPS will progress their recruitment with posts going out to advert by end of April 21.
- CYPS to complete further analysis into the Darlington team. An update will be provided in May 21.
- MHSOP to work with the Corporate Performance Team to complete a validation exercise to ensure historic recording of interventions is accurate. This will be complete by the end of May 21.

Recommendations

To note the detailed analysis undertaken, and further actions in place to improve. A further update on this will be provided next month.

TD02) Percentage of patients starting treatment within 6 weeks of an external referral – Teesside 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 Foundation Trust

Key Conclusions to date

Cause for concern is identified for both CYPS and AMH, with consecutive deteriorations in both services being observed. Further detailed analysis is required in AMH and CYPS to better understand the underlying reasons for this.

Actions we said we would take

- A detailed deep dive analysis is to be undertaken to identify key areas of concern within CYPS and AMH. This will be supported by Corporate Performance and initial update provided in April 21 with the review being completed and findings fully reported to Board in May 21.
- This measure will continue to be monitored via routine monthly processes within MHSOP and LD, supported by Corporate Performance.

Update on actions including assurance (where known)

A detailed deep dive analysis is being undertaken to identify any key areas of concern within CYPS and AMH and to support this initial analysis has been undertaken to identify key areas of concern and variances within these specialities.

- Within CYPS, January 2021 the SPC indicated a change from special cause improvement to special cause concern. Team level data analysis identified the CYPS generic community teams as key areas of concern with variances in performance across the teams. Hartlepool Community reflected the speciality position reporting a change from special cause improvement to special cause concern, with concern visible in both the numerator (number of patients who have received treatment in 6 weeks) and denominator (number of patients who have received treatment). Middlesbrough, Stockton and Redcar & Cleveland community teams all reported common cause variation with activity below the mean. The initial analysis indicates that the changes in activity may be linked to a change in coding practice; however this cannot be confirmed until the patient level deep dive has been completed. That work will also provide an understanding of any further factors impacting on performance across the teams. The SPC for data ending February 2021 is now indicating common cause variation (no significant change) at speciality level however is below both the standard and the mean.
- Within AMH common cause variation with data below the mean has been visible for 4 consecutive months. Initial analysis has identified the Access teams as key areas of concern, with variances in performance across the teams. Common cause variation is visible for the Hartlepool, Middlesbrough and Redcar & Cleveland Access Teams, the data indicating that the Hartlepool team is driving the concern with data reporting at the lower process limit; however the upper and lower process limits within the Middlesbrough and Redcar & Cleveland teams are wider than the other teams. Stockton Access team reports special cause improvement and we need to understand why the activity for this team is different to that of the other access teams. Initial analysis indicates this may be linked to Covid outbreaks impacting on staff capacity; however this cannot be confirmed until the patient level deep dive has been completed. That work will also provide an understanding of any further factors impacting on performance across the teams. Further work needs to be undertaken with the service to understand their model and the circumstances under which the Access teams will deliver treatment.

Routine monthly monitoring of MHSOP and LD activity continues and to date no concerns have been identified within those specialities. This monitoring will continue as part of standard procedure and only reported to Board should any concerns be identified.

Actions being taken to provide assurance

- A patient level deep dive analysis within CYPS and AMH will be completed and findings reported in May 21.

Recommendations

To note the analysis undertaken so far and that a patient level deep dive will be completed and will be reported in May 21.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD03 – The total number of inappropriate OAP days over the reporting period (rolling 3 months) – Durham and Darlington - *The Trust is committed to ensuring that all patients are treated in a location that helps them to retain contact with family, carers and friends, and to feel as familiar as possible with the local environment.*

Key conclusions to Date

- The current D&D position had been mostly impacted by inappropriate OAP days in AMH services.
- Further detailed analysis is required to better understand the areas of concern in AMH and MHSOP.

Actions we said we would take

More detailed analysis will be undertaken to identify the key areas of concern and any possible actions that could be taken to improve the position within AMH and MHSOP. This work will be supported by the Corporate Performance Team, working in collaboration with the operational services and would be shared next month.

Update on actions including assurance (where known)

- As detailed last month, AMH report an increase in acuity that has particularly affected female wards , resulting in increased lengths of stay and higher bed occupancy, which has led to more female patients requiring placement out of area. More detailed analysis has been undertaken which has identified the following:
  - One patient with a long ongoing inpatient stay should not be classed an inappropriate as they were admitted, by choice, to the hospital closest to their home following a relocation, however they have not changed their GP. Ward staff have just commenced looking for accommodation to support this patients discharge.
  - As reported last month, the closure of Elm ward due to a covid outbreak in February reduced the capacity of female beds within the locality. During this period there were 11 unoccupied beds on Elm unavailable for admission, whilst 9 D&D patients had to be admitted elsewhere, accounting for 83 of February's OAP bed days.
  - In addition, Bransdale – a female ward in Tees – was also closed in February due to a covid outbreak and during this period 5 patients were admitted to D&D from elsewhere, occupying 81 bed days during February and reducing the availability of beds for local patients. Six D&D patients were admitted out of area during this time accounting for 43 OAP bed days in addition to those 83 detailed above. Both wards are now operating at their full capacity and covid outbreaks continue to be managed in line with Trust procedures.
  - D&D (and Teesside) do not have the facility to utilise swing beds, so are not able to flex AMH female and male bed capacity to respond to demand, in the same way NYY are able to and as a result, where beds are not available patients need to be placed in a bed outside of their local area. Pressure remains on AMH female beds and admissions continue to be co-ordinated pro-actively across the locality and repatriated where possible.
- Within MHSOP, more detailed analysis has identified the following:
  - During February, bed capacity was reduced as a result of the closure of Ceddesfeld ward to admissions due to a covid outbreak. During this time there were 12 unoccupied beds on Ceddesfeld, whilst 4 D&D patients had to be admitted elsewhere, which accounted for 79 of February's OAP bed days. Ceddesfeld are now operating all 15 beds and any additional covid outbreaks in MHSOP will be managed in line with Trust procedures.
  - Further analysis and discussion with the service highlighted that 1 patient, accounting for 31 days was mistakenly admitted out of area. There had been bed availability in D&D at the time and the patient has since been offered repatriation but has chosen to remain on Westerdale South, where their stay is ongoing. This has been discussed with the relevant services to ensure learning is in place to prevent a reoccurrence.
  -

Actions to be taken to provide assurance

- The Corporate Performance Team, working with the locality will complete further analysis at patient level to understand the position in more detail. This will be completed and reported back in next months report.
- The D&D AMH Acute Locality Manager will review the structure of their daily sitrep meeting to place increased focus on out of area placements and ensure there is oversight of this measure at senior management level, including introducing a OAP visual control board; this will be completed by the end of April.
- Corporate Performance Team to complete ward level analysis of all inpatient measures and share this with the Business Analytics team by the end of April 21 for the next stage of the analysis work to commence. Any actions identified as a result of this analysis work will be included in this report.

Recommendations

To note the further analysis undertaken and to receive an update next month on the additional actions identified.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD05 - The percentage of Serious incidents which are found to have a root cause or contributory Finding– <u>TEES Locality</u>- *TEWV is committed to ensuring that all patients in our care are safe and when serious incidents have occurred, we understand these and learn from them to prevent the likelihood of them happening again.*

Analysis based on data ending March 21

Tees Locality demonstrate special cause variation – cause for concern, above the standard, mean and upper process limit. The numerator (the number of completed Serious Incidents reported to Panel in the reporting period) and denominator (the number of Serious Incidents which are found to have a root cause or contributory finding) both demonstrate common cause variation and are below the mean.

Further investigation shows that there was 1 incident reported to SI Review Panel in January, 1 incident in February and 2 incidents in March, all of which had contributory findings.

The analysis of the Serious Incident Review findings has identified the following areas of learning:

- Risk Assesment and safety planning
- Liaison with the Acute Hospital
- The quality of clinical record keeping in relation to the Care Programme Approach

Conclusions

Within the Tees locality the SPC chart indicates special cause variation – cause for concern. There has been a number of areas of learning and opportunities for improvement identified. Whilst we had improvement work in place such as the that focusing on careplanning , this has been significantly strenghthed following the recent CQC Focused Inspection to Adult Mental Health Inpatient Wards and the associated programme of improvement work. the Trust is undertaking. A protocol has been developed to enable effective liaison with Acute Hospitals when someone is admitted as an inpatient and this has been agreed in principle.

Actions being taken to provide assurance

The improvement progamme is underway and progress is being monitored through the Quality Improvement Board and Quality Governance processes. A comprehensive assurance programme has been established and significant progress has been made and we are currently focusing on embedding the expected standards. A further source of assurance will be received through the SI action plan monitoring process. In the future it is envisaged that the organisational learning group will identify any repeated themes. Therefore no additional actions are required at this stage.

Recommendations

To note the analysis undertaken and the assurance provided in relation to the actions already underway within the Trust, therefore no further action is required at this point.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD06) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) – Durham & Darlington Locality - *TEWV is committed to making a difference to people's lives and supports the use of Routine Outcome Measures, which add to the quality of the work we do and are meaningful to both service users and clinical staff. Used effectively, outcomes can significantly enhance the therapeutic alliance between service users and clinicians and lead to improvements for both.*

Key conclusions to date

- The current position within the locality is mostly impacted by performance of AMH against this measure. However MHSOP are now within the lower process limit.
- Further detailed analysis is required to better understand the areas of concern at speciality and team level and the possible actions that could be taken to improve the position

Actions we said we would take

- A more detailed analysis would be undertaken by Corporate Performance, alongside discussions with the locality, to identify areas of concern within AMH and MHSOP community teams, including those teams with a low common cause variation. This would be completed by the end of March 21.
- A trust-wide meeting between Corporate Performance Team, Service Development Managers and Clinical Leads would take place during March to outline the work completed around this measure to date and agree on the most appropriate way to take this forward in an integrated way in order to improve performance in this area.

Update on actions including assurance (where known)

- Further analysis has been undertaken by Corporate Performance Team and discussions have taken place with Operational colleagues to attempt to identify areas of concern. Analysis of data to February 21 has indicated the following:
  - Within AMH, 5 teams showed special variation -cause for concern, those were Derwentside and Chester-le- Street, Easington Affective, Sedgefield Affective, South Durham EIP and Darlington Affective.
  - Within MHSOP, 3 teams showed special variation –cause for concern, those were Durham Chester-le-street community, Easington community and Auckland Park Inpatient team.

  Discussions regarding the issues in these teams are to take place with the locality

- A meeting took place between Corporate Performance Team and the AMH Service Development Manager in March to discuss the work completed on this measure, the reinstatement of the clinical outcome reports (outlined below) and to agree to how to support the locality together to better understand their position. This will help inform our understanding of the Locality's performance against this measure, where improvement is needed and how this could be delivered. In addition to this:
  - Clinical outcomes report was reinstated at the end of January. The reports includes data at team and patient level enabling the AMH and MHSOP services to have a better understanding of their position and will help inform our understanding of the performance against this measure and where improvement is needed.
  - The Clinical Outcomes Steering Group meeting was reinstated in March 21 and work has now commenced to re-establish processes to monitor and improve Clinical Outcomes. Speciality Sub Groups require reinstating which the Speciality Service Development Managers (SDM) will action during April.

Actions being taken to provide assurance

- The service, with the support from the Corporate Performance lead, will conduct a more detailed analysis at team level to identify areas of concern and findings will be discussed at with the service in May with an update being provided in June 2021.
- A request will be made to the Business Intelligence & Clinical Outcomes Team for staff training and the development of staff webinars; an update on this will be provided next month.
- The Clinical Outcomes Group will be asked to review and agree their Terms of Reference and consider whether the group can support the improvement and implementation of outcomes within operational services. An update on this will be provided next month.

Recommendation

To note the detailed analysis undertaken and that conversation will take place to agree a way forward which will be provided in next month's report.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD06) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - North Yorkshire & York Locality - *TEWV is committed to making a difference to people's lives and supports the use of Routine Outcome Measures, which add to the quality of the work we do and are meaningful to both service users and clinical staff. Used effectively, outcomes can significantly enhance the therapeutic alliance between service users and clinicians and lead to improvements for both.*

Key conclusions to date

MHSOP services are the area of concern which is impacting on the achievement of this measure. Memory Services have been further impacted by delays with scans and difficulties in seeing patients face to face which impacts on patient outcomes.

Actions we said we would take

- A more detailed deep dive analysis is to be undertaken to identify key areas of concern within MHSOP community teams.
- Progress will be monitored by the Locality supported by the Corporate Performance Lead from December 2020 to identify if there are any further concerns or if any improvement is shown and what learning could be taken from this.
- Clinical Outcomes reporting will be reinstated from January 2021 enabling the locality a better understanding of their positions.
- Clinical Outcomes Steering Group would be formally reinstated from January 2021 to help in supporting implementation and improvement in clinical outcomes.

Update on actions including assurance (where known)

- An initial deep dive took place at the beginning of March to look at data at Speciality level - MHSOP. The position is displaying special cause variation - concern with 8 consecutive data points below the mean. At team level, memory services demonstrate special cause variation – concern whilst all community teams display common cause variation (no significant change) although positions are below the mean. A random sample of 11 patients across teams has been undertaken and has identified the following issues:
  - Incorrect and/or missing score at assessment and or discharge attributable to user error
  - Transfer of patient's to acute trust and discharge from the acute hospital
  - Untimely or no paired score impacting on the number of in-scope teams pulling through with HoNOS completed.

  The above has highlighted a need for further staff training within the Service and proposals are being considered with the outcomes team for the development of staff webinars. Speciality level findings have been discussed at the operational management meeting on the 19th March and it has been agreed that a deep dive into cases in each team ~~s~~will now be completed in May.

- A meeting took place between Corporate Performance Team and the AMH Service Development Manager in March to discuss the work completed on this measure, the reinstatement of the clinical outcome reports (outlined below) and to agree to how to support the locality together to better understand their position. This will help inform our understanding of the Locality's performance against this measure, where improvement is needed and how this could be delivered.
- Clinical outcomes report was reinstated at the end of January. The reports includes data at team and patient level enabling the AMH and MHSOP services to have a better understanding of their position and will help inform our understanding of the performance against this measure and where improvement is needed.
- The Clinical Outcomes Steering Group meeting was reinstated in March 21 and work has now commenced to re-establish processes to monitor and improve Clinical Outcomes. Speciality Sub Groups require reinstating which the Speciality Service Development Managers (SDM) will action during April.

Actions being taken to provide assurance

- The service, with the support from the Corporate Performance lead, will conduct a more detailed analysis at team level to identify areas of concern and findings will be discussed at the operational management meeting in May with an update being provided in June 2021.
- A request has been made to the Business Intelligence & Clinical Outcomes Team for staff training and the development of staff webinars an update on this will be provided next month.
- The Clinical Outcomes Group will be asked to review and agree their Terms of Reference and consider whether the group can support the improvement and implementation of outcomes within operational services. An update on this will be provided next month.

Recommendation

To note the analysis that has taken place, the further actions we will take in relation to this measure and to agree to receive an update in June 2021.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD06) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) – Tees Locality

TEWV is committed to making a difference to people's lives and supports the use of Routine Outcome Measures, which add to the quality of the work we do and are meaningful to both service users and clinical staff. Used effectively, outcomes can significantly enhance the therapeutic alliance between service users and clinicians and lead to improvements for both.

Key conclusions to date

More detailed analysis and discussions with the services took place to further understand the issues within AMH and MHSOP, however further work is required with support from the Outcomes team to understand the reasons why

Actions we said we would take

- Clinical Outcomes reporting will be reinstated from January 2021 enabling the locality a better understanding of their positions.
- Clinical Outcomes Steering Group would be formally reinstated from January 2021 to help in supporting implementation and improvement in clinical outcomes.

Update on actions including assurance (where known)

- Clinical Outcome reporting was reinstated at the end of January. The reports include data at team and patient level enabling the service to have a better understanding of their position and will help inform our understanding of the performance against this measure and where improvement is needed.
- The Clinical Outcomes Steering Group was reinstated in March 2021 and work has now commenced to re-establish processes to monitor and improve Clinical Outcomes. Speciality Sub Groups require reinstating and speciality Service Development Managers will action this during April.
- A meeting took place between Corporate Performance Team and the AMH Service Development Manager in March to discuss the work completed on this measure, the reinstatement of the clinical outcome reports (outlined below) and to agree to how to support the locality together to better understand their position. This will help inform our understanding of the Locality's performance against this measure, where improvement is needed and how this could be delivered.
- Work has continued within the Corporate Performance Team to analyse and monitor the position on this measure, with the locality continuing to demonstrate special cause variation -cause for concern, below the mean and standard. Findings from additional analysis highlights:
  - AMH demonstrate common cause variation, below the mean and standard. Whilst variance is visible at team level, the following teams demonstrate special cause variation cause for concern:
    - Hartlepool Crisis team
    - Redcar and Cleveland Psychosis
    - Stockton Psychosis
    - All affective disorder teams

    Further analysis is required to understand these positions more detail and whether they are actual areas of concern.

  - MHSOP demonstrate special cause variation cause for concern, below the mean and standard. Previous analysis identified that this measure is impacted by the change in service for dementia patients; it is important to note this change was established to ensure patients received the right care in the right place. However variance is visible at team level with all teams showing common cause variation, above the mean with the exception of Hartlepool community team who demonstrate special cause variation – concern, further analysis is required to understand this better.

Actions being taken to provide assurance

- The service, with the support from the Corporate Performance lead, will conduct a more detailed analysis at team level to identify areas of concern and findings will be discussed at with the service in May with an update being provided in June 2021.
- A request will be made to the Business Intelligence & Clinical Outcomes Team for staff training and the development of staff webinars; an update on this will be provided next month.
- The Clinical Outcomes Group will be asked to review and agree their Terms of Reference and consider whether the group can support the improvement and implementation of outcomes within operational services. An update on this will be provided next month.

Recommendations

To note the detailed analysis undertaken and that conversation will take place to agree a way forward which will be provided in next month's report.

TD09) Percentage of new unique patients referred with an assessment completed (2 months behind) – Forensics Services *The Trust is committed to ensuring that all patients referred into our services receive a timely assessment, supporting patient safety, wellbeing and quality of care.*

Tees, Esk and Wear Valleys NHS Foundation Trust

Key Conclusions to date

It was established that the L&D sub-contractors, Humankind and Spectrum, did not record their contacts as assessments on PARIS; they were capturing these under the activity code for screening. There was a misunderstanding that the assessment activity codes only applied to those staff undertaking mental health assessments.

Actions we said we would take

- The Service, with support from the Corporate Performance Lead, will continue enhanced monitoring of progress during February and March, to allow time to address any inconsistencies across the L&D teams. This includes understanding the specific issues in the North Yorkshire team.
- Supporting Users to provide further support to the North Yorkshire team, providing guidance with data capture
- A further meeting will be held in April 2021 between the Service and corporate leads to determine whether the agreed actions have had the desired impact.

Update on actions including assurance (where known)

- Monitoring of this measure has continued and Forensic services is now reporting common cause variation with data ending February reporting above the mean and showing an overall improvement (increase) in the number of unique patients with an assessments, indicating the work undertaken to address inconsistencies in recording assessments has had a positive impact. All three L&D teams are reporting an improvement with the Durham team transitioning to special cause improvement and Cleveland to common cause variation. The North Yorkshire team is now reporting common cause variation but improvement is significantly lower than within the other two areas indicating that further time is required to embed the improvements. Enhanced monitoring will continue throughout April 2021.
- Supporting Users offered further support to the North Yorkshire team in relation to guidance and data capture however, initially the service was confident that peer support within the team was sufficient as this was being provided via training sessions and 1:1s with all staff. As improvements within this area are still required, the service will be linking in with Supporting Users during April to support further progress.
- A further meeting was held in April between the service and corporate leads and it was agreed that whilst there had been a positive impact, further improvements are required within the North Yorkshire L &D team. There is a number of new staff within the team who require Paris training and this is now underway. It was also agreed a further snapshot audit of referrals into this team would be undertaken to provide assurance regarding consistency of recording. This will be completed in April.

Actions being taken to provide assurance

The North Yorkshire team will link in with Supporting Users for further support and will undertake an audit of referrals to provide assurance to the Board that they are being recorded consistently. This will be undertaken in April with progress monitored by the Service and Corporate Performance Lead, and the results reported in May 2021.

Recommendation

To note the progress made against the actions so far, including the assurance provided that significant improvements have been made to date and that further improvement work will be undertaken by the North Yorkshire team during April and will be reported in May 21.

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TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) – <u>Durham & Darlington Locality</u> *The Trust is committed to ensuring that all patients referred into our services receive timely treatment, supporting patient safety, wellbeing and quality of care.*

Analysis based on data ending February 21

- Durham and Darlington are displaying special cause (concern), with the latest position below the lower process limit. The numerator (number of new unique patients referred, 3 months behind, who have been taken on for treatment) shows common cause variation (no significant change) but below the mean, while the denominator (number of new unique patients referred, 3 months behind), indicates common cause but is above the mean.
- Within CYPS, special cause (concern) is showing, with the position below the lower process limit. The numerator and denominator both show common cause variation. At team level:
    - The North and South Durham teams show special cause (concern) and the Easington team, whilst showing common cause, is near the lower process limit. Vacancies have affected these teams, with 6 posts currently not filled; 4 of these (x3 B6, x1 B7) have been advertised unsuccessfully multiple times since summer 2020. Please refer to the TD02 briefing for further information on factors impacting performance against this measure.
    - The ASD team reports special cause (concern). This team is commissioned only for assessment, therefore the position is influenced by subsequent treatment within other teams (within the same journey); further analysis is required to understand this.
- Within ALD, common cause variation is shown. The numerator shows common cause variation, whilst the denominator shows special cause (concern). Each team shows common cause variation within the measure, numerator and denominator; however when the Durham Integrated Community teams are combined, the findings reflect the specialty (special cause concern within the denominator). Further investigation is required to understand this.
- Within AMH, common cause variation is shown. The numerator and denominator both show special cause (improvement), near the upper process limit. This position is mainly influenced by the Access team's position, with the SPC observations reflecting that of the specialty. Further team-level analyses demonstrate common cause variation in the measure, numerator and denominator and do not give any indication of teams to be concerned about; as a result, further analysis is not required at this stage.
- Within MHSOP, the measure, numerator and denominator all show common cause variation and below the mean, this is also observed at team level and as a result is not an area of concern at this time. Further analysis is not required at this stage

Actions we will take to provide assurance

- CYPS will progress their recruitment with posts going out to advert by end of April 21.
- Further investigation will be undertaken by Corporate Performance to understand the CYPS ASD team's position and the special cause variation with the ALD denominator; this will be completed by the end of April and shared with the service for discussion

Conclusions

- The cause for concern at Locality level has been mostly impacted by CYPS, primarily the North Durham and South Durham community teams.
- The performance of the CYPS ASD team is linked to the delivery of treatment within other teams.
- Further investigation is required to understand the special cause variation within ALD services.

Recommendations

To note the detailed analysis undertaken, and further actions in place to improve. A further update on this will be provided next month.

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) – Forensics Services *The Trust is committed to ensuring that all patients referred into our services receive a timely assessment, supporting patient safety, wellbeing and quality of care.*

Tees, Esk and Wear Valleys NHS Foundation Trust

Conclusions we arrived at to date

Performance within Forensics Services is being driven by the sustained special cause for concern within L&D services. There are two main issues which are contributing towards this:

- In line with the national specification, there are a number of referrals that do not result in treatment.
- There is also an issue with the recording and use of treatment codes.

Actions we said we would take

- The Head of Corporate Performance will discuss the use and recording of assessment codes with Clinical Leaders Board in March 21 (date tbc)
- The list of treatment codes available to Liaison & Diversion Services will be restricted to only those relevant to the service, thereby minimising recording errors. A Paris change request is to be submitted by the Supporting Users team by March.
- The Service, with support from the Corporate Performance Lead, will continue enhanced monitoring of progress during February and March, to obtain assurance that the actions have had the desired impact.
- The Service, with support from Corporate Performance and the Business Intelligence & Clinical Outcomes Team, is to undertake an audit on referrals. This work will be completed in March 2021 and reported to Board in April.

Update on actions including assurance (where known)

- The Head of Corporate Performance has discussed the use and recording of assessment codes with clinical leads involved in the development of CITO (as opposed to the original action with Clinical Leaders Board) which is a hub that will integrate with systems such as PARIS, our patient system. CITO follows the patient journey which will make it easier for clinical staff to record relevant information at the right time. It is agreed that this is a better solution to support improvements in this measure going forward. Further work will be undertaken in collaboration with the clinical services to develop what information is required. An update on this will be provided in June.
- A change request has been submitted by the Supporting Users team to restrict the list of treatment codes on PARIS available to Liaison & Diversion Services to only those relevant to the service; timescales for implementation on Paris are to be confirmed.
- Monitoring of this measure has continued and no further issues identified; however as the data for referrals taken on for treatment is 3 months behind, it will not be possible to understand if the actions have had the desired impact until full analysis of March 2021 data is undertaken.
- The Service has undertaken an audit on a sample of referrals and the findings showed a number of referrals with treatment recorded were not included within the measure. Further investigations are being undertaken during April by the Business Intelligence & Clinical Outcomes Team to identify the underlying cause.

Actions being taken to provide assurance

- The Head of Corporate Performance will work with the Clinical Leads for CITO to support improvements in this measure going forward. An update will be provided in June.
- The Supporting Users team to confirm the implementation date for the Paris system changes and report back in May.
- The Service, with support from the Corporate Performance Lead, will continue enhanced monitoring of progress during April, to obtain assurance the actions have had the desired impact.
- The Business Intelligence & Clinical Outcomes Team will undertake investigations into the data discrepancies identified during April 2021 and report in May 2021.

Recommendation

To note the progress update in relation to the actions we are taking and that a further update will be provided in May 2021.

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) – Tees Locality

The Trust 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 Foundation Trust

Appendix D

Key Conclusions to date

- CYP are moving to a new service model which means a more integrated approach with partners and involves supporting the signposting of referrals to enable the right level of treatment to meet individual needs. This means a proportion of CYP will not be taken on for treatment. Since the start of the pandemic, referrals to the CAMHS Crisis Service have reduced and for those referrals received, a greater proportion are for telephone advice or signposting to partners to provide a more appropriate level of care. As a result there has been a reduction in the number of referrals taken on for treatment; however all receive the level of intervention required.
- MHSOP services also have a service model which supports signposting to alternative more appropriate services however there is some variation in performance across the teams.
- LD Services receive a number of referrals which are either inappropriate or are for dementia screening and do not require treatment. Inaccurate recording of rejected referrals was identified within one team, which has now been addressed.
- This measure may not be fit for purpose as it includes all patients that have been referred and not necessarily assessed and accepted for service.

Actions we said we would take

- The Service Development Manager MHSOP will complete further work to identify underlying issues and mitigating actions to improve performance. An update will be provided in June.
- The Service, with support from the Corporate Performance Lead, will continue enhanced monitoring of progress during March and April, to ensure rejected referrals within the LD North Community team are being recorded correctly.
- The Head of Corporate Performance will work with the Clinical Leads for CITO to support improvements in this measure going forward. An update will be provided in June.
- Given this issue has been a cause for concern since September 2021, the Corporate Performance Lead will repeat the analysis at service and team level to identify if there are any new issues. An update will be provided in June.

Update on actions including assurance (where known)

- Enhanced monitoring of progress within Learning Disability Services continues and the supporting measure that forms the denominator for this (TD08 Number of Unique referrals) shows that rejected referrals are now being recorded correctly by the North Community team. It is important to note, however, that the expected impact will not reduce the proportion of patients that go on to receive treatment as the number of referrals (denominator) will increase. The service are assured that the measure accurately reflects the data for the LD teams; however the service model reflects a high number of patients do not move on to treatment because they were either not appropriate for service or were for dementia screening and did not require treatment.
- The analysis for MHSOP has been repeated and the following has been identified:
  - At the time of initial escalation, the teams showing cause for concern within MHSOP were the generic Community Teams for Redcar & Cleveland, Hartlepool and Stockton. The SPC for Redcar and Cleveland now indicates a transition from special cause concern to common cause variation (no significant change) in the measure; that is visible in both the numerator and denominator. Although the SPC for the Hartlepool team is now indicating common cause variation in the measure, the numerator (number entering treatment) has been below the mean since February 2020. The SPC for Stockton continues to show special cause concern, which is also visible within the numerator. The SPC for Middlesbrough continues to displays common cause variation, however it currently shows two consecutive data points below the mean, which is attributable to the numerator.
  - Whilst the SPCs for the Liaison teams indicate common cause variation, South Tees Liaison services indicates special cause for concern in the numerator. Previous investigations have identified this is attributable to the service model. The Liaison teams do not hold caseloads for a long period of time, their role being to signpost/refer patients to the most appropriate care thereby ensuring that service users access the right service to meet their needs.

Actions being taken to provide assurance

- The Service Development Manager MHSOP will complete further work to identify underlying issues and mitigating actions to improve performance. The scope of this work will now include Middlesbrough community team. An update will be provided in June.
- The Head of Corporate Performance will work with the Clinical Leads for CITO to support improvements in this measure going forward. An update will be provided in June.
- The Corporate Performance Lead will repeat the analysis for the remaining services, including team level, to identify if there are any new issues. This will be completed and reported back in June.

Recommendations

To note the further progress in relation to this deep dive including the assurance relating to recording of referrals in LD Services and the further actions that will be completed and reported back in June 21.

TD18) Percentage Sickness Absence Rate (month behind) – Durham and Darlington locality

TEWV is committed to ensuring that we support individuals' wellbeing and help people feel well enough to come to work

Tees, Esk and Wear Valleys NHS Foundation Trust

Key Conclusions to date

- The current position has been mostly impacted by sickness levels in AMH (primarily), MHSOP and ALD services.
- Further detailed analysis is required to better understand the areas of concern at team and ward level and the possible actions that could be taken to improve the position.

Actions we said we would take

More detailed analysis would be undertaken to identify any key areas of concern within AMH, MHSOP and ALD. This work would be supported by the Corporate Performance Team and findings shared with the Board.

Update on actions including assurance (where known)

Further analysis has been undertaken to identify any key areas of concerns within AMH, MHSOP and ALD.

- Within AMH, sickness levels continue to indicate cause for concern, with the position above the standard and the upper process limit. SPC analysis has been undertaken on the 10 teams that contribute most to the specialty position; of those, the following 4 teams have been identified as a cause for concern and are above the standard and mean:
  - Derwentside CLS Affective team have 5 staff are experiencing long term sickness, including 1 that is covid-related. Return dates are not known at this stage but all sickness is being managed in line with Trust policy.
  - D&D Crisis team reports have 9 staff are currently on long-term sick leave and are being managed in line with Trust policy.
  - D&D Access team have 4 staff experiencing long term sickness; 2 have returned to work (including 1 covid-related), whilst 2 remain off with no known return dates (including 1 covid-related). The team also experienced 5 episodes of short-term sickness, 4 of which were related to covid vaccination side effects.
  - Tunstall ward have 4 staff experienced long term sickness; 2 have returned to work, whilst 1 remains off with no known return date. The ward also experienced 4 episodes of short-term sickness.
- Within MHSOP, sickness levels continue to indicate common cause variation but now report below the standard and mean (positively). The position in January had largely been impacted by Ceddesfeld ward, which had 18 staff affected by a covid outbreak; all staff have now returned to work and the ward is now reporting common cause variation.
- Within ALD, sickness levels continue to indicate common cause variation, with the position above the standard and the mean. The North and South Durham Integrated teams both report cause for concern above the standard and upper process limit, which is attributable to a member of staff in each team. Both staff members have returned to work (one on a gradual return) and both episodes were managed in line with Trust policy.

The Durham and Darlington position is now within common cause variation but remains above the mean and standard. There is assurance that this has been and continues to be impacted by long term sickness, although there has been a considerable reduction in long term episodes since January with 15% of remaining cases having a return to work date arranged. All instances of long term sickness are managed in line with Trust policy.

Actions being taken to provide assurance

No further actions are required at this point. Durham and Darlington are now within common cause variation and sickness will continue to be monitored through routine performance management processes

Recommendations

To note the detailed analysis undertaken, including the assurance provided by the latest position and that no further action is required at this point

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD18 - Percentage Sickness Absence Rate (month behind) – North Yorkshire and York locality *-TEWV is committed to ensuring that we support individuals' wellbeing and help people feel well enough to come to work*

Analysis

North Yorkshire and York are displaying common cause variation, above the standard and close to the upper process limit. The numerator (number of days lost to staff sickness) shows special cause concern. Initial analysis has been undertaken at Speciality and team level which has identified:

- Within AMH the SPC charts indicate common cause variation, with the position above the standard and close to the upper process limit. Special cause concern is indicated within the numerator. Analysis has been completed at team/ward level; the following teams demonstrate concern and need further investigation to establish whether they are true areas of concern.
  - Inpatient services Danby, Ebor and Esk wards
  - For community services:
    - EIP services in HHR & SWR
    - Ripon, Scarbourgh & South and West York Community teams
  - For Crisis Services: Both HRW & HRD Crisis teams
  - SWR Medical staff
  - NYY AMH Management team

- Within CYPS, the position displays special cause concern for both the measure and the numerator. The latest data point for both the measure and numerator is just above the upper process limit and the actual position is above the standard. Analysis has been completed at team/ward level; the following teams demonstrate concern and need further investigation to establish whether they are true areas of concern.
  - Scarborough community team
  - Selby community team
  - Northallerton Community team

- Within MHSOP both the measure and the numerator show common cause variation with the position below the upper process limit however are above the mean and the standard therefore a cause for conern. Analysis has been completed at team/ward level; the following teams demonstrate concern and need further investigation to establish whether they are true areas of concern.
  - Inpatient services: Rowan Lea, Springwood, Wold View and Moor Croft wards
  - Community services:
    - HRW, Ryedale and Harrogate Memory service.
    - York South and West and Harrogate Community teams
    - Acute Liaison Service: Harrogate and HWR Acute Liaison team.
    - Harrogate Vanguard community team.

- Within ALD both the measure and the numerator show common cause variation; the speciality has been below the standard for 6 consecutive months therefore there is currently no cause for concern.

Conclusion

- The current postion within the locality has been mostly impacted by CYP services which is displaying cause for concern for the measure and the numerator.
- There are also teams in other specialities, particularly AMH, where further investigation is required to understand their positions in more detail.

Actions being taken to provide assurance

More detailed analysis will be undertaken within CYP, AMH, MHSOP and Management to understand whether these are actual areas of concern. This work will be supported by the Corporate Performance Team by working collaboratively with HR and findings shared next month.

Recommendations

To note the analysis that has taken place, the further actions we will take and to agree to receive an update next month.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item no 13

Quality Assurance Committee: Key Issues Report

Report Date: 29/04/21		**Report of: Quality Assurance Committee**
Date of last meeting: 01/04/21		**Membership Numbers: 4** Quoracy was met. Apologies: 1 **Summary of key issues:** This report captures the key issues and risks that were brought to the attention of the Committee. In summary these were: • Concerns over the safety, health, wellbeing and morale of our staff. This was a common theme throughout the meeting, with some concerning examples articulated. • The Durham and Darlington Crisis Team has been an unsettled team for some time. The Committee received a comprehensive update on the action plan that is being implemented. A thematic review has been commissioned, involving independent reviewers. The review report is due to be received. • The Board is familiar with the issues raised on Thistle Ward in Forensics Services. Our internal Heads of Service reviews have been helpful in identifying initial areas of concerns for further exploration and as a consequence an external review was commissioned. The Committee received an update on the actions being taken. • Increasing pressures in Learning Disabilities services was also an identified theme, with a particular insightful risk (with excellent risk management) provided by the Director of Operations for Teesside.
1	**Agenda**	**The Committee meets monthly (except Aug/Jan). The Committee considered an agenda, which included the following:** • Minutes of previous meeting, 4th March 2021 • Trust Level Quality & Learning Report. • Locality updates from Forensics, Durham & Darlington, Tees, North Yorkshire & York • Exception report of Quality and Safety. • An update on progress in response to CQC Inspection, January 2021. • Positive and Safe Mid-point review, for period 1st April to 30th September 2020. • The Quality Improvement Proposals for 2021/22.
2a	**Alert (by exception)**	**The Committee alerts members of the Board on the following:** **Cross Locality Issues:** • Staffing pressures due to the challenges around recruitment and retention, with difficulties attracting candidates to certain posts and a lack of resource pool in the surrounding communities. • Increased acuity and complexity, particularly in LD. • Staff well-being and low morale. • Higher bed occupancy. • Lower levels of compliance with Basic Life Support (BLS) due to no face to face training. E-learning packages are available for the current time.

		• Increasing levels of violence, aggression and assaults against staff by patients. **Durham & Darlington** • There are ongoing and increasing concerns for the Durham & Darlington (D&D) crisis team, due to shortages of staff linked to the pandemic and the HR review that is underway. The Committee received an update on actions being taken. A thematic review with independent participation is due to report to the next meeting. • Staff morale is low in D&D inpatient services, due to a combination of issues, including staff assaults, injuries, social media comments and general issues covering other areas in the Trust. The locality is considering adding this to the risk register. The Health & Wellbeing Coordinator is working with staff. **Teesside** • Increase in falls linked to physical health problems. • AMH Increase in level 4 Heads of Service Reviews, with three incidents involving a ligature • Some significant challenges in Bankfields ALD due to heightened acuity. This has been added to the locality risk register and has prompted a Trust wide Review of the service. **North Yorkshire & York** • Increasing referrals to eating disorders, with breaches for access and waiting times. • An increase in Serious Incidents and Head of Service Reviews on Ebor Ward. Further work is being undertaken to identify any key themes and areas of learning as well triangulation with other quality and safety information. An update will be provided at the next meeting. **Forensics** • Waiting times at Holme House Prison give cause for concern with current waits (note: waiting times have now reduced significantly) • Thistle Ward is under review following a number of concerns. The Committee received a briefing update on actions being taken. The review includes members external to the service. • Whilst the locality has exited business continuity mode, the concerns over staffing levels remain. A plan remains in place to mitigate risks. • Culture Review Delivery Plan continues to be monitored by the Oversight Group. **Positive and Safe Six Monthly Report (April – Sept 2020)** • At locality level and following review of individual wards, Sandpiper (use of supine and self-harm incidents) and Clover/Ivy (self-harm incidents) raised concerns. On triangulation of the data caring for the needs of an individual who was acutely unwell for a long period of time had contributed to the increased levels. An update was requested for inclusion in the next quarterly report.

2b	**Assurance**	**The Committee assures members of the Board that:** • The Committee received a progress report on the Trust CQC action plan and the Trust Quality Improvement Board. It should be noted that given the significance of this matter, members were assured that they were receiving assurance, governance briefings and updates. • For each of the alerts to be noted by the Board, there is a narrative to the Committee from the appropriate Director or Executive Director advising of what actions are being taken to mitigate or reduce the risk and ensure the safety of staff and our service users in our care. • **In the Positive and Safe Six Monthly report,** of the eight measures where statistical control process could be applied, all metrics were reporting within a normal variation (no concerns). • At the end of every meeting, members collectively review and agree matters that the Board should be sighted on.
2c	**Advise**	The Committee advises the Board of some concerns, in particular that they should be aware of, accepting that the assurance on reducing risk and appropriate actions at this stage, have been provided to the Committee. **Quality Account Proposals 2021/22** • The Committee approved the Quality Account Improvement Priorities which are: Care Planning, Safer Care and Compassionate Care • Supported the plans to review the Quality Metrics reported as part of the Quality Account and the proposed timescales in relation to circulation to stakeholders.

Recommendation: The Board is asked to:

- Note the Key Issues report following the Committee meeting held on 1st April 2021.

3	**Actions to be considered by the Board**	There are no action to be considered by the Board		
4	**Report compiled by**	Bev Reilly, Chair of Committee Donna Oliver, Deputy Trust Secretary, (Corporate) Avril Lowery, Director of Quality Governance	**Minutes available from**	Donna Oliver, **Deputy Trust Secretary (Corporate)**

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 14

FOR GENERAL RELEASE

DATE:	**29/04/2021**
TITLE:	**Learning from Deaths – Dashboard Report 2020/21**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information and 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 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 Q4 of the 2020/2021 financial year is included at Appendix 1 and includes 2019/2020 data for comparison.

32 serious incidents resulting in death were reported on STEIS throughout the period.

21 completed Serious Incident reviews were undertaken in Q4. The four most common root cause or contributory findings were in relation to risk assessment, care planning, inadequate record keeping and poor communication. The report sets out extensive work that is underway to address these themes across community and inpatient services as well as the increased focus on assurance linked to the Trusts most recent CQC report that highlighted these concerns within adult mental health inpatient wards.

Despite the pressures of Covid 19, good progress has been made to improve both the quality and the number of Serious Incident and Mortality reviews completed over the year, notably the number of Learning Disability Deaths that have been reviewed internally and reported to LeDeR.

New structures and processes for learning from deaths are included. This work will help us to strengthen and demonstrate how we are capturing, acting and sharing learning to improve care for our service users and their families.

Recommendations:

The Board is requested to note the content of this report, the dashboard and the learning points and consider any additional actions to be taken.

Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF:	**Trust Board of Directors**
DATE:	**29th April 2021**
TITLE:	**Learning from deaths - Mortality Report 2020/2021**

1. INTRODUCTION & PURPOSE:

1.1 The national guidance on learning from deaths requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period of January-March 2021.The Board is receiving the report for information and assurance of the Trusts approach.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is expected that when people die in our care that the Trust reviews practice and works with families and others to understand what happened and what can be learned from the death to prevent reoccurrence where possible. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon (National Quality Board, 2017). 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 have remained under review but have encountered some delays due to staffing/capacity issues and the impact of covid 19 pressures. New ways of working in relation to proportionate reviews of Serious Incidents continue and are due for review at a learning event in May 2021.

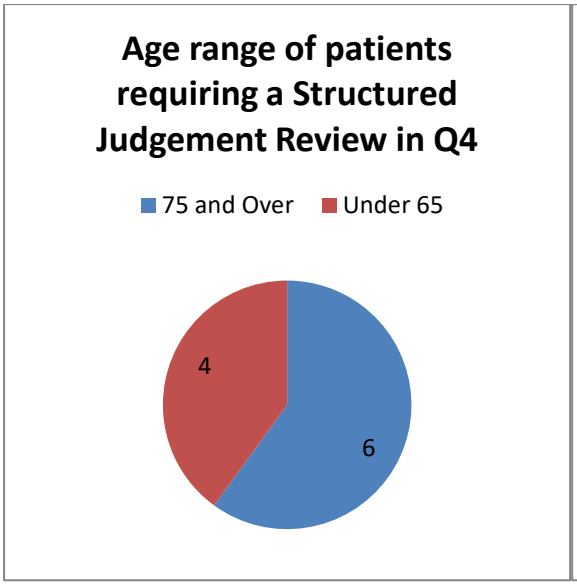
3. KEY ISSUES:

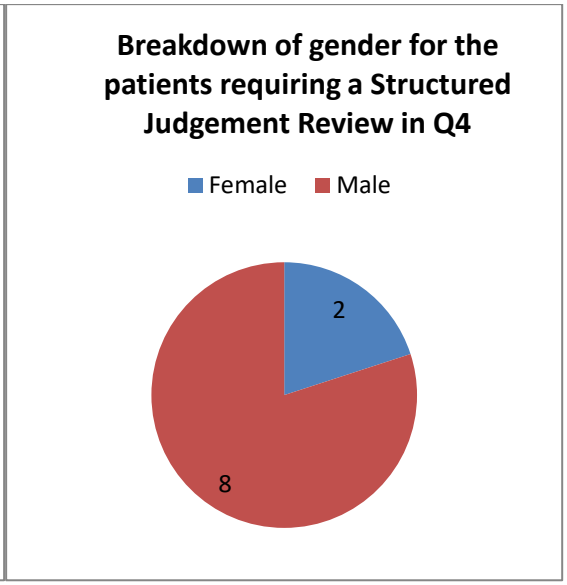
3.1 Mortality Review and Learning

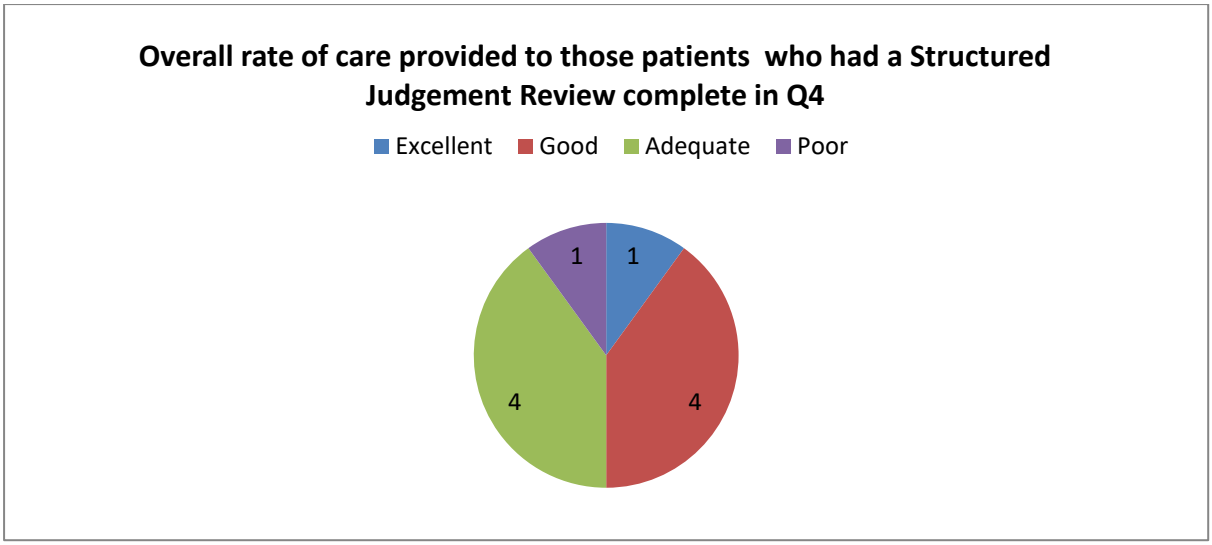
Further detail and criteria for Mortality reviews can be seen at Appendix 2.

There were a total of 10 Structured Judgement Reviews requested within Q4.

Month	Total Number of Deaths which met criteria for a review	Total Number of Deaths which have been reviewed under locally agreed criteria.	Total Number identified as requiring a Structured Judgement Review
January	105	33	1
February	129	35	6
March	87	30	3
Total	**321**	**98**	**10**







*Further analysis of these findings will be undertaken at the Mortality Review Panel in order to identify any significant learning.

Mortality Review 2020/2021

Points of learning from unexpected and expected physical health deaths completed in Q4

1. Prescribing and monitoring of psychotropic medication – emphasis on management of obesity and physical health checks.

2. Consideration of prescribing and monitoring of medication for those patients who are known to access 'street drugs' or medications from the internet in addition to prescription drugs.

3. Clinical/management supervision–to help clinicians to manage difficult to engage patients/focus on appropriate interventions and to escalate cause for concerns when caseload numbers impact of the quality of patient contacts.

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. 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].
3. 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.
4. 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.

3.2 Learning from deaths and Serious Incidents

21 completed Serious Incident reviews were undertaken in Q4. The four most common root cause or contributory findings were in relation to risk assessment, care planning, inadequate record keeping and poor communication. Formal action plans are in place for all incidents where a root cause or contributory findings are identified which are actioned by services, closely monitored by the Patient Safety Team and Commissioners. Serious incidents and findings are shared with services via Quality Assurance Groups, however a number of wider, trust wide pieces of work have been identified to address learning based on key themes and are detailed below although this is not an exhaustive list:

- In January 2021 following the CQC focussed inspection, the Trust held a Quality Improvement event to ensure that robust systems were in place to comprehensively assess and mitigate patient risk. This improvement work has encompassed and enhanced ongoing actions to address the four most common root cause or contributory findings as detailed above. Work has included providing detailed guidance on clinical risk assessment and management to clinical staff to support practice in line with the Trusts Harm Minimisation policy as well as simplifying related documentation on the electronic patient record in the form of the safety summary and safety plan, leave and observation care plan. Harm minimisation training and suicide prevention training content and delivery has also been reviewed to bring greater clarity on standards and expectations as well as more detailed focus on clinical risk assessment aligned to particular patient needs.

- Extensive work continues in seeking assurance that expected standards are being embedded into practice, which is being reported on through the Trusts CQC action plan. Improvements to date have been communicated, reinforced and tested out through MS team webinars, training sessions, Multi-Disciplinary Team walkabouts and Directors visits. Further quality improvement work is planned throughout April on reviewing care-planning and observation policy and practice.

- In order to embed and sustain improvements in relation to the four themes highlighted above, supporting actions and work-streams have been established around collective leadership and clinical supervision, relating to the importance of a high functioning multi-disciplinary team. The Trusts Head of Organisational Development has been undertaking development work on collective leadership across inpatient teams and has been revisiting the "super cell" development work previously done within community teams.

- It is recognised that team development and skilled staff are key to the delivery of high quality, safe care and high functioning teams to minimise the risk of incidents occurring. Progress is being made to enhance senior clinical leadership with recruitment to new Community Matron roles, Practice Development Practitioners and Peer Workers to support co-creation, recovery and involvement.

- The Trust is undertaking an extensive programme of estates works to reduce potential ligature points within inpatient services to address learning from inpatient deaths and an increase in fixed ligature incidents. Phase 1 of the programme has focused on the replacement of sinks, taps, toilets, shower controls and soap dispensers to standardise these with anti-ligature fittings in en-suite bathrooms and agreed standards for assisted bathrooms which are recognised as high risk areas for patients. In addition, 11 wards have now been prioritised for installation of Oxehealth digital care assistant which is assistive technology that has been proven to reduce harm within in-patient services. The Environmental Risk Group, chaired by the Director of Nursing and Governance has oversight of these safety measures and receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm.

- Information sharing and involvement in care with families are two key areas of learning that remain a theme in Serious Incidents. On a trust-wide basis, this is being taken forward through the Triangle of Care Steering Group. The Carers Charter developed by carers, for carers was signed off at the last Trust Board meeting and is being formally launched next week. This sets out standards, principles and expectations for working with families. A carers working group will measure progress and impact of the charter.

- In line with ICS priorities around physical health and learning from deaths, the Trust has identified 'Making Every Contact Count' leads within services and are incorporating the principles of this, which include making healthy changes such as, stopping smoking, improving diet, increasing physical activity, losing weight and reducing alcohol consumption into daily practice. These can help people to reduce their risk of poor health significantly. Additionally weekly webinars are in place from the physical health lead to support teams in the application and ongoing implementation of the Lester Tool.

- There have been 11 Patient Safety Briefings disseminated to wards and teams from January to April 2021 to support early learning from incidents. These have covered issues and information including: Assessment and management of risks including updates on clinical risk management improvements to record keeping and environmental risk awareness; management of ligature risks in assisted bathrooms and toilet areas; risks to patients from plastic bags; defibrillation battery indicators; identification of potential anchor points for ligatures and keeping patients safe

through carrying out of care rounds and supportive observations. Staff awareness of these briefings has been enhanced through improved ward communication structures and the inpatient practice development team.

- 1 SBARD has been disseminated in the quarter relating to a risk of potential ligature points on a window.

3.3 Structures to support and embed learning

- The Trust is strengthening its arrangements for organisational learning with the establishment of the Organisational Learning Group, chaired by the Director of Quality Governance. Work streams include the development of effective systems for rapid dissemination of urgent safety messages, sharing early learning and establishing and maintaining a Learning Library.
- An improvement event is planned for the serious incident review process in May 2021. Part of the focus at this event will consider how we can improve involvement with families to facilitate a more equal partnership in the serious incident investigation process. The Trust's Family Liaison Officer Role is now well established and has received 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.

- A rapid patient safety review meeting has been introduced for unexpected inpatient deaths, usually to be held within 48 hours of the incident occurring. Ensuring all immediate identified actions have been put in place to maintain patient safety and share any early learning identified.

- Prior to COVID, Part 1 Mortality Reviews and Structured Judgement Reviews, including themes and trends, would normally be discussed and reviewed at the Trust's Patient Safety Group. This group was stood down as a result of COVID-19. An interim Mortality Review Panel was put in place to review the back log of Structured Judgment Reviews that had been completed. In Q4, 47 historical cases were reviewed; a further 24 cases from the backlog will be discussed in Q1 2020/21. Themes from these historical cases are currently being analysed and will be reported into the Quality Improvement and Assurance meeting.

- The Suicide Prevention and Self Harm Reduction Group, chaired by the Medical Director continues to develop a framework to ensure that the Trust is supported in coordinating activities designed to reduce the risk of suicide and frequency of suicide attempts. The group will also focus on dissemination of learning and good practice around suicide prevention and self-harm.

- Trust Suicide Prevention Leads continue to build up and maintain effective partnership working with the suicide prevention taskforces/alliances and other agencies.

3.4 Learning from Deaths Dashboard

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

For Q4 the dashboard highlights the following:

- A total of 641 deaths were recorded (not including LD deaths). This is all deaths (including natural expected and unexpected) in relation to people who were currently open to the Trust's caseload including memory services.

- 21 STEIS reportable serious incidents resulting in death were reviewed in the period.

- 9 cases were identified to have learning points* from the 21 completed Serious Incident reviews.

  **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.*

- 32 serious incidents resulting in death were reported on STEIS throughout the period.

- 321 deaths were signposted down the mortality review process. Of those 321 deaths, based on the criteria in Appendix 2, 98 cases had a part 1 review. 10 of those cases were selected for a more detailed Part 2 Structured Judgement Review.

- 37 Learning Disability deaths were reported on Datix. All 37 were reviewed either by the mortality review process (35 in total) or serious incident process (2 in total). One of these serious incident reviews was an unexpected in-patient death. A Rapid Patient Safety Review meetings was held within 48 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. All 37 of these cases have been also been reported to LeDeR. Discussions have taken place at the Learning Disability Service Development Group in relation to Trust-wide learning and learning from LeDeR reviews in relation to a greater focus on actions and learning. Further analysis is required to identify if there are any recurring themes in relation to the increase in LD deaths. This will be carried out in Q1 2020/21.

- 6 in-patients deaths were reported over this period. Two of the deaths are unexpected and are being reviewed through the Serious Incident Investigation process. Rapid Patient Safety Review meetings were held within 24 hours of the incidents occurring to ensure all immediate learning was identified and to share any early lessons that could be actioned. Four natural, expected deaths occurred in MHSOP services and are being reviewed via structured judgment reviews as part of the mortality review process.

- Figures show a reduction in the number of in-patient deaths reported as serious incidents compared with the previous year in the same period. In Q4 2019/20 there were 9 inpatient deaths of which 3 were reported as serious incidents.

3.5 **Suicide Prevention and Self Harm Reduction**

4.0 IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
The learning from deaths processes outlined will support the Trust to demonstrate the delivery of high quality, safe patient care in line with CQC Fundamental standards. The paper outlines how the Trust is strengthening its arrangements for organisational learning and the provision of assurance in the context of learning from deaths and embedding these to improve patient safety.

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 if we fail to embed key learning from deaths that patient safety and quality will be compromised.

There is a risk that the data published is used or interpreted without context as there is no current national benchmarking or methodology within mental health and learning disability services for mortality.

6. CONCLUSION:
The paper sets out the Trusts approach to Learning from Deaths in line with national NQB guidance, themes identified and how these are being addressed to drive improvements in the quality and safety of patient care. Despite the pressures of Covid 19, good progress has been made to improve both the quality and the number of Serious Incident and Mortality reviews completed over the year.
The new organisational learning group and revised governance reporting and structures will enable greater triangulation and understanding of the impact of actions put in place to address learning. Structures to support and embed learning are highlighted for information as the Trust acknowledges the need to further develop its processes for capturing and sharing learning in order to support and embed a learning culture within the organisation.

7. RECOMMENDATIONS:
The Board is requested to note the content of this report, the dashboard and the learning points and consider any additional actions to be taken.

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/

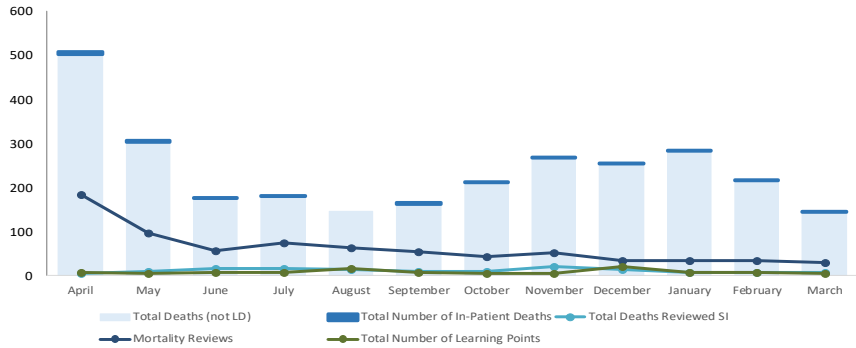
Appendix 1 Dashboard

Learning from Deaths Dashboard - Data Taken from Paris and Datix
Reporting Period - Quarter 4 - January- March 2021

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)

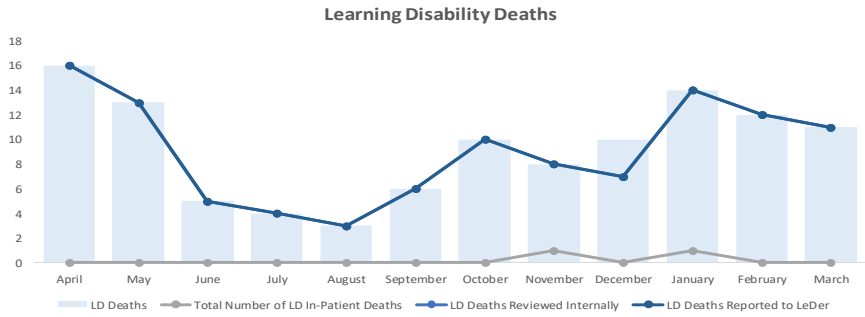
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20	2020/21	2019/20
Q1	979	↗ 655	14	↗ 8	29	↘ 32	337	↗ 43	18	↗ 1
Q2	486	↘ 654	6	↔ 6	39	↗ 30	191	↗ 65	32	↗ 18
Q3	731	↘ 769	5	↘ 7	43	↗ 26	126	↗ 47	29	↗ 23
Q4	641	↘ 719	6	↘ 9	21	↔ 21	98	↘ 105	18	↘ 29
YTD	2837	↗ 2797	31	↗ 30	132	↗ 109	752	↗ 260	97	↗ 71



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	28	↗ 24	1	↗ 0	25	↗ 24	25	↗ 24
Q4	37	↗ 24	1	↗ 0	37	↗ 14	37	↗ 11
YTD	112	↗ 82	2	↗ 0	109	↗ 55	109	↗ 52



*The learning identified on the above dashboard is for both Serious Incident reviews (which refer to Root Cause and Contributory findings) and Mortality Reviews.

Appendix 2

Mortality reviews are completed in-line with guidance from the Royal College of Psychiatrist and peer organisations across the region.
The mortality review tool used consists of a Part 1 and Part 2 review.
Part 1 is a review of the care records, if any red flags or concerns are noted a Part 2 (Structured Judgement Review) will be carried out.

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. In order to prioritise the most significant cases for learning from unexpected and expected physical health deaths throughout Q4, taking into consideration capacity issues, the following actions have been taken for those deaths reported on datix:

- All in-patient deaths have either had a Structured Judgement Review completed or are in the process of having one completed.
- All LD deaths have either been reviewed or are being reviewed under Part 1 of the mortality review process. Where any concerns are identified a Structured Judgment Review has been, or will be requested. All these cases have also been referred to LeDeR for review.
- All community deaths for patients aged 64 and under have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested.
- 20% of community deaths for patients aged between 65 and 75 have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested. This 20% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.
- 10% of community deaths for patients aged between 76 onwards have been reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review has been requested. This 10% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 15

Trust Board of Directors

DATE:	**April 2021**
TITLE:	**Guardian of Safe Working Annual Report 2020-2021**
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. I am satisfied that the Trust continues to fulfil the spirit and terms of the contract and that the Trust board has been attentive and supportive of the concerns and wellbeing of Junior Doctors over the past year.

There has been a major impact on working conditions by the CoVID 19 pandemic for all staff, including Junior Doctors, over the past year and both the Trust and the Junior Doctors have worked constructively and diligently together to try to maintain the delivery of effective care and a safe workforce.

The Junior Doctor Exception Reports and particularly Guardian fines levied over the past year mainly reflect variation in work intensity on non-resident rotas and the breach of the 5 hours continuous rest rule. There is a continuing review of the process for exception reporting to try to ensure timely reporting by Junior Doctors and accurate intelligence of work intensity across all localities. Processes are in place for ongoing scrutiny and review of work schedules and Junior Doctor working experiences in all localities to provide assurance of safe working environments and consideration of training and service needs. There continues to be extensive Junior Doctor engagement in planning & implementation of rota changes and recording activity.

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

MEETING OF:	**Trust Board**
DATE:	**29th April 2021**
TITLE:	**Annual 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 Junior Doctor :-

- works on average over 48 hours/week
- works over 72 hours in 7 days
- misses more than 25% of required rest breaks
- on non-residential on call (NROC) does not have a minimum of continuous rest for 5 hours between 22:00 and 07:00
- does not have the minimum 8 hours total rest per 24 hour NROC shift
- has more than the maximum 13 hour residential shift length
- does not have the minimum 11 hours rest between resident shifts

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:

- At this stage I continue as Acting Guardian of Safe Working but it is anticipated that the substantive role will be advertised within the next few months.

- I was extremely pleased to see the appointment of Dr Jenny Forge as Champion of Less than Full Time Working and Deputy Guardian of Safe Working within the last few months and we have already started to work closely together on a range of issues.

- Over the past year working practices of all staff within the Trust have been fundamentally altered by the continuing impact of the CoVID 19 pandemic. This has obviously posed major adaptive challenges for us all but I have been particularly proud of the way that our Junior Doctor workforce have risen to this challenge despite the clear escalation in anxiety levels – like all staff in the NHS of course. I have not received any specific reports of junior doctors being forced into inappropriately risky situations and the Trust has been mindful and supportive of their (and other staffs') safety with such things as the provision of adequate PPE and a very well organised and pro-active vaccination programme. The regular trust briefings and updates from the Medical Director have also helped to provide clarity and guidance. Throughout this last year I am pleased to say that we have not experienced any significant impact from depletion of our junior doctor workforce through redeployment into acute services – with the exception of some 3 or 4 Foundation doctors who were retained in acute services rather than rotate into Psychiatry placements.

- Medical Development have continued to deliver a fortnightly webinar meeting for all Junior doctors to provide updates and support. I link in with this and along with other senior medical staff am making myself available for regular supervision and coaching / support sessions for junior doctors to access by phone or video-link.

- We have reviewed the format of the Junior Doctors Forum (JDF) and In order to allow proper time for discussion and planning we have decided to divide it into North and South sector meetings every quarter (instead of one trust-wide meeting each quarter) with one of the meetings each year (in June) to remain combined as a trust-wide meeting in the morning followed by a wellbeing conference for Junior Doctors in the afternoon with outside speakers and workshops. We had our first divided JDFs in March 2021 and it was clear to me that this was a better arrangement with more time to discuss pertinent locality issues.

- I am pleased to report the recent appointment of 2 Junior Doctor Wellbeing Reps (1 each in the North and South sectors) who will be regular attenders at the JDFs and have already been pro-active in organising the Wellbeing conference in June 2021.

- **Appendix 1** to this report provides a summary of Junior Doctor vacancies and rota gaps over the last year and I am pleased to note excellent fill rates with few uncovered shifts despite the challenges posed by CoVID 19. **Appendices 2 and 3** provide more details for North (Durham & Teesside) and South (York and North Yorks) sectors respectively for the quarter January to March (inclusive) 2021 with a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendices are shared with the corresponding Health Education England body for the different sectors.

- 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 majority of exception reports over the year have been placed for additional hours of work. Higher levels of exception reports in different localities relate to the degree of variation in out of hours non-resident on call rota work. We continue to utilise a non residential on-call log form which appears to be well accepted by the trainees and the continuing effectiveness of this system is under review. I am satisfied that Junior Doctors are appropriately paid for work undertaken. As can be seen from **Appendices 2 and 3** the internal locum system appears to be working effectively and has effectively reduced the use of agency locums to zero.

- During the course of the last year it has been necessary to continue to levy fines on the trust for technical breaches of the contract (detailed and summarised in **Appendix 1**). The total sum of fines levied over the past year was just under £17,200 with about 77% of these arising in the Teesside locality and 23% in York and Scarborough. As was the case for the preceding year it is the one threshold of doctors on a non-residential on call rota requiring a minimum of 5 hours continuous rest between 10pm and 7am which has resulted in the all of the fines levied at this point. A significant proportion of the fines levied on Teeside arise from Higher trainees on NROC rotas working as first on call for Consultant rotas. **Appendix 1** also provides a summary of additional spending through the course of the past year on resources to improve Junior Doctors working conditions, which has been partly funded from the monies levied through the fines system.

- The Trust continues to monitor and provide compensatory rest arrangements that exceed requirements set out in the contract.

- During the course of this year a residential on-call rota was successfully introduced for Junior Doctors in North Durham which has significantly reduced exception reporting in that locality.

- Over the past year concerns were expressed about the provision of adequate on call and rest facilities for Junior Doctors on both the Cross Lane Hospital (Scarborough) and Lanchester Road Hospital (Durham) sites. I very recently met with the Trust Director of Estates at Cross Lane Hospital and I was pleased and reassured to see that progress has been made with the provision of rest facilities and also excellent plans for upgrading of those and a Junior Doctors meeting room and learning space at the same site by the end of Summer. The director assured me that a similar kind of arrangement for upgrade of facilities can be made at the Lanchester Road Hospital site.

- Over the course of the last year there have been major changes to mental health services across York and North Yorkshire including the opening of Foss Park hospital in York city in April 2020 and the closing down of inpatient services in Harrogate. The establishment of a residential rota in York with a non resident rota covering the community services across Harrogate/ Hambleton & Richmond /Northallerton. These major changes took some time to settle down and Junior Doctors have been helpful and supportive in making these new arrangements functional. We continue to monitor the workload intensity and exception reporting carefully across the locality.

- There appears to be progress on the issue of junior doctors access to the WebIce clinical results on-line service. This has been a long running problem and is related to the fact that access has to be individually licensed to the Junior Doctors themselves by our surrounding acute trusts who hold the licenses and when new doctors join the trust on rotation there has been a delay of some weeks in some instances before they have received a licence for access. An attempt to organise a single conduit of access for our trust via IT links with the acute trusts clinical results services was not fruitful. Our Medical staffing department has been working to expedite the process of the allocation of licences on arrival of new Junior Doctors and my understanding is that access has now improved overall across the localities. This is encouraging but we shall have to maintain ongoing monitoring of the situation.

- At this time it remains difficult to make clear longer term strategic plans or particular recommendations for Junior doctors safety and working conditions until we eventually emerge from the current pandemic and see the effects of society opening up once again. It is evident that it will continue to have a major impact for the foreseeable future and we will continue to monitor, listen and review the situation closely and maintain clear and co-ordinated channels of communication with the Junior Doctor workforce 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 invited to the quarterly trustwide Junior Doctor Forum. An Equality Impact Assessment has been completed and is updated within the forum. The Champion of Less Than Full-time Working is a core member of the Junior Doctor forum and holds an additional forum / network for less than full time doctors.

4.5 **Other implications:**
It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.

5. RISKS:

The ongoing and developing situation with Covid 19 including adaptations required to maintain working practices and conditions as safe as possible for junior doctors while anticipating the impact of easing of social restrictions.

Failure to anticipate the impact on Junior Doctors working situations of any major service changes remain a generic risk for a large and dispersed organisation such as the Trust and may lead to a Junior Doctor being placed in an unsafe situation.

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

If there remain any continuing difficulties in access for Junior Doctors in some localities to clinical lab results through WebIce licensing issues this could provide 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 are potentially more challenged, although there is continuing evolution in the availability and use of technology for remote linkage.

6. CONCLUSIONS:

Despite the extreme challenges of the Covid19 Pandemic throughout the past year the Trust continues to fulfil the requirements of the 2016 Junior Doctor Contract and the Executive Board have been attentive and supportive of the different agendas for Junior Doctors working conditions and wellbeing. Junior Doctors are appropriately submitting exception reports but continuing review of how to maintain and improve the efficiency of this process is important. Medical staffing are processing the exception reports in an appropriate and fair way. 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 be taken to provide ongoing training and support for Junior Doctors through regular webinars and video conferencing. Careful monitoring of the effectiveness of these measures needs to continue through maintaining regular open channels of communication with Junior Doctors and I believe the new structures now in place for the Junior Doctor Forums is a step forward in this regard.
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7. RECOMMENDATIONS:

The Board are asked to read and note this Annual 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: Annual summary of fill rates, vacancies and rota gaps – also Guardian fines levied and use of monies for Junior Doctors wellbeing
Appendices 2 & 3: detailed information on numbers, exception reports and locum usage- first quarter 2021.

TEWV QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING – 01/01/21 – 31/03/21

High level data

Number of doctors in training (total): 95

Number of doctors in training on 2016 TCS (total): 95

Amount of time available in job plan for guardian to do the role: 1PA

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 January 2021 up to 31st March 2021

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	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	3	3	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	10	10	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	6	6	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	3	3	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	2	2	0
Total	**0**	**24**	**24**	**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	15	15	0
Teesside & Forensic Senior Registrars	0	6	6	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	2	2	0
North Durham Senior Registrars	0	0	0	0
D&D CAMHS Senior Registrars	0	1	1	0
Total	**0**	**24**	**24**	**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	2	13	0
Teesside & Forensic Senior Registrars	1	0	5	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	2	0
North Durham Senior Registrars	0	0	0	0
D&D CAMHS Senior Registrars	0	0	1	0
Total	**1**	**2**	**21**	**0**

In Durham and Darlington, there were 3 exception reports raised from Senior Registrars who are involved in the NROC 8 weekly monitoring period and had worked above the hours stated on their work schedule.

In Teesside, there were 21 exception reports received, 20 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 report was from a trainee working on their portfolio, which had been agreed with the DME. The number of exceptions is much less than the last report and this is largely due to the NROC 8 weekly period overlapping meaning trainees haven't yet submitted their exceptions from mid-Feb to the end of March.

There have been 3 doctors on long term occupational health restrictions during the 3 months, 2 vacancies from doctor's who left mid-rotation, 1 doctor who had a month off the rota agreed following an assault on the ward, plus 2 F2s who did not transfer into psychiatry as planned. All these shifts needed covering. From April, the 2 F2 vacancies will be filled, plus 3 new trust doctors which hopefully will join the rota and fill in some of the gaps. On the senior registrar, there is 1 doctor on long term sick (works in CNTW but does on calls in Teesside).

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	0	0	0	0	0
	CT1/2/GP	40	40	0	574.5	574.5
	CT3	12	12	0	143.5	143.5
	Trust Doctor	11	11	0	137.5	137.5
	SPR/SAS	14	14	0	237.5	237.5
North Durham	F2	2	2	0	8	8
	CT1/2/GP	14	14	0	124	124
	CT3	8	8	0	87.5	87.5
	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	10	10	0	91	91
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	SPR/SAS	40	40	0	727	727
Total		**151**	**151**	**0**	**2130.5**	**2130.5**

In South Durham, there is 5 Senior Registrars on the middle tier rota, the 40 locum shifts have been covered by senior registrars or SAS doctors as part of the middle tier rota pilot.

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	21	21	0	269.5	269.5
Sickness	40	40	0	479.5	479.5
Special leave	9	9	0	157.5	157.5
On call cover	63	63	0	984.5	984.5
COVID 19	18	18	0	239.5	239.5
Increase in workload	0	0	0	0	0
Total	**151**	**151**	**0**	**2130.5**	**2130.5**

Vacancies

Vacancies by month						
Locality	**Grade**	**January 2021**	**February 2021**	**March 2021**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	2	2	2	2	0
	CT1	0	0	1	0.3	4
	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	1	0.3	3
North 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	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	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**2**	**2**	**4**	**2.6**	**7**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	7	£3586.41
North Durham	0	£0.00
South Durham	0	£0.00
Total	**7**	**£3586.41**

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
£11415.03	**£3586.41**	**£00.00**	**£15001.44**

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS IN TRAINING

Annual data summary from 1st April 2020 to 31st March 2021

Vacancies

***Northallerton, Harrogate and York Rota merged from Q2.

Locality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average wte)	Number of shifts uncovered (over the year)
North Durham	F1	0	0.3	0	0	0.075	0
	F2	0	0	0	0	0	0
	CT1	0	1	1	0	0.5	0
	CT2	0	0	0	0	0	0
	CT3	0	0	0	0	0	0
	ST4 -6	0	0.3	0	0	0.075	0
	GP	0	0.6	0	0	0.15	0
	Trust Doctor	0	0.6	0	0	0.15	0
South Durham	F1	0	1	0	0	0.25	0
	F2	0	0.3	0	0	0.075	0
	CT1	0	0.3	1	0	0.325	0
	CT2	0	0.3	0	0	0.075	0
	CT3	0	0	0	0	0	0
	ST4 -6	0	1.3	0	0	0.325	0
	GP	0	1.6	0	0	0.4	0
	Trust Doctor	1	0	0	0	0.25	0
Teesside & Forensics	F1	0	1.3	0	0	0.325	0
	F2	0	0	2.3	2	1.075	0
	CT1	0	0	0	0.3	0.075	4
	CT2	0	0	0	0	0	0
	CT3	0	0	0	0	0	0
	ST4 -6	0	0	0	0	0	0
	GP	0	0	1	0	0.25	0
	Trust Doctor	0	0	0	0.3	0.075	3
Northallerton, Harrogate & York	F1	n/a	0	0	0	0	0
	F2	n/a	0	0	0	0	0
	CT1	n/a	0.3	0	0	0.075	0
	CT2	n/a	0	0	0	0	0
	CT3	n/a	0	0	0	0	0
	ST4 -6	n/a	0	0	0	0	0
	GP	n/a	0	0	0	0	0
	Trust Doctor	n/a	0	0	0	0	0
Scarborough	F1	0	0	0	0	0	0
	F2	0	0	0	0	0	0
	CT1	0	0	0	0	0	0
	CT2	0	0	0	0	0	0

Locality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average wte)	Number of shifts uncovered (over the year)
	CT3	0	0	0	0	0	0
	ST4 -6	0	0	0	0	0	0
	GP	0	0	0	0	0	0
	Trust Doctor	0	0	0	0.5	0.125	0
Harrogate	F1	0	n/a	n/a	n/a	0	0
	F2	0	n/a	n/a	n/a	0	0
	CT1	0	n/a	n/a	n/a	0	0
	CT2	0	n/a	n/a	n/a	0	0
	CT3	0	n/a	n/a	n/a	0	0
	ST4 -6	0	n/a	n/a	n/a	0	0
	GP	0	n/a	n/a	n/a	0	0
	Trust Doctor	0	n/a	n/a	n/a	0	0
York	F1	0	n/a	n/a	n/a	0	0
	F2	0	n/a	n/a	n/a	0	0
	CT1	0	n/a	n/a	n/a	0	0
	CT2	0	n/a	n/a	n/a	0	0
	CT3	0	n/a	n/a	n/a	0	0
	ST4 -6	0	n/a	n/a	n/a	0	0
	GP	0	n/a	n/a	n/a	0	0
	Trust Doctor	0	n/a	n/a	n/a	0	0
Northallerton	F1	0	n/a	n/a	n/a	0	0
	F2	0	n/a	n/a	n/a	0	0
	CT1	0	n/a	n/a	n/a	0	0
	CT2	1	n/a	n/a	n/a	0.25	0
	CT3	0	n/a	n/a	n/a	0	0
	ST4 -6	0	n/a	n/a	n/a	0	0
	GP	0	n/a	n/a	n/a	0	0
	Trust Doctor	0	n/a	n/a	n/a	0	0
Total		2	9.2	5.3	3.1	4.9	7

Fines

Locality	Quarter 1 Number of fines levied	Quarter 2 Number of fines levied	Quarter 3 Number of fines levied	Quarter 4 Number of fines levied	Annual Total
North Durham	0	0	0	0	**0**
South Durham	0	0	0	0	**0**
Teesside & Forensics	10	12	18	7	**47**
Northallerton & Harrogate	0	0	1	0	**1**
Scarborough	1	1	0	0	**2**
York	0	2	0	9	**11**
Total	**11**	**15**	**19**	**16**	**61**

Locality	Quarter 1 Value of fines levied	Quarter 2 Value of fines levied	Quarter 3 Value of fines levied	Quarter 4 Value of fines levied	Annual Total
North Durham	£0.00	£0.00	£0.00	£0.00	**£0.00**
South Durham	£0.00	£0.00	£0.00	£0.00	**£0.00**
Teesside & Forensics	£2,758.55	£3,545.56	£5,110.92	£3,586.41	**£15,001.44**
Northallerton & Harrogate	£0.00	£0.00	£94.46	£0.00	**£94.46**
Scarborough	£111.79	£130.42	£0.00	£0.00	**£242.21**
York	£0.00	£60.88	£0.00	£1796.25	**£1,857.13**
Total	**£2,870.34**	**£3,736.86**	**£5,205.38**	**£5,382.66**	**£17,195.24**

The following has been spent within the past year:

- Junior Doctors Travel Taxi's - £4,361
- Fit out of Junior Doctors Office at Foss Park including TV, Fridge, Chairs, Table, Chair bed and lockers - £2,544.67
- Bed's purchased for Cross Lane, Lanchester Road and Foss Park - £1,335
- Blinds' purchased for Cross Lane and Lanchester Road - £1,394
- Food Provisions approximately £100 per month
- Wellbeing Days booked at Camp Hill for Core Trainees and SPRs - £11,592
- Sofa purchased for Lanchester Road - £512.95
- Heater purchased for Lanchester Road - £34.65
- 135 laptops purchased for all trainees at a cost of £860 per laptop and 85 Mobile Phones purchased at a cost of £113 per mobile totaling - £150,846

TEWV QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING – 01/01/21 – 31/03/21

High level data

Number of doctors in training (total): 62

Number of doctors in training on 2016 TCS (total): 62

Amount of time available in job plan for guardian to do the role: 1 PA

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 January 2021 up to 31st March 2021

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	4	4	0
CT1-2 - Northallerton	0	0	0	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	16	16	0
CT1-2 - York	0	6	6	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	5	5	0
CT3/ST4-6 – York	0	13	13	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	11	11	0
Trust Doctors - York	0	0	0	0

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Total	**0**	**55**	**55**	**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	23	23	0
Scarborough	0	32	32	0
Total	**0**	**55**	**55**	**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	13	10	9	0
Scarborough	14	7	2	0
Total	27	17	11	0

All exception reports from the NY&Y rotas relate to on call work. Exceptions from doctors on the middle tier rota have been a mixture of claiming additional payments following submission of the NROC forms and reporting instances of not getting 5 hours continuous rest between 10pm and 7am. Exceptions from junior doctors have been to claim additional payments following submission of the NROC forms.

The majority of exception reports from doctors working in Scarborough have been for early starts or late finishes to the normal working day. There has been a marked increase in these since the start of the new rotation in February. The remainder have been to claim additional payments following submission of the NROC form.

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	15	15	0	191.5	191.5
	CT1/2/GP	24	24	0	222.5	222.5
	CT3	1	1	0	16	16
	Trust Doctor	0	0	0	0	0
	ST4-6/SAS	12	12	0	240	240
Scarborough	F2	1	1	0	16	16
	CT1/2/GP	10	10	0	208	208
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	ST4-6/ SAS	79	79	0	1463	1463
Total		**142**	**142**	**0**	**2357**	**2357**

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	91	91	0	1600.5	1600.5
Sickness	17	17	0	234.5	234.5
Other	34	34	0	522	522
Total	**142**	**142**	**0**	**2357**	**2357**

Vacancies

Vacancies by month						
Locality	**Grade**	**January 2021**	**February 2021**	**March 2021**	**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	1.6	0	0.5	0
Total		**0**	**1.6**	**0**	**0.5**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Harrogate & Northallerton	0	£0
Scarborough	0	£0
York & Selby	9	£1796.25
Total	**9**	**£1796.25**

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£397.55	**£1796.25**	**£00.00**	**£2193.8**

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th April 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
401	30.03.21	Collaboration Agreement for use of space at the Clinical Research Facility at Foss Park Hospital, York (University of York)	Liz Romaniak, Director of Finance and Information Phil Bellas, Trust Secretary
402	30.03.21	Variation of the Restaurant and Hospitality Services Agreement relating to Roseberry Park, Hospital, Middlesbrough (Starr & Style Ltd trading as Bon Appetit 1995)	Liz Romaniak, Director of Finance and Information Phil Bellas, Trust Secretary
403	30.03.21	Restaurant and Hospitality Services Agreement relating to Roseberry Park, Hospital, Middlesbrough (Starr & Style Ltd trading as Bon Appetit 1995)	Liz Romaniak, Director of Finance and Information Phil Bellas, Trust Secretary

Recommendations:
The Board is asked to receive and note this report.