MEETING OF THE BOARD OF DIRECTORS
THURSDAY 29TH JULY 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 of the special meeting held on 24th June 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 Items (1.15 pm – 1.50 pm):

8	Chief Executive's Report.	**CEO**	**Report**
9	To receive and note a progress report on the development of the integrated approach to assurance performance reporting	**DoPCPC**	**Report**
10	To consider the Finance Report as at Quarter 1, 2021/22.	**DoF&I**	**Report**
11	To consider the Performance Dashboard Report as at Quarter 1, 2021/22.	**DoPCPC**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (1.50 pm – 2.45 pm):

12	To consider the public report of the Quality Assurance Committee.	**Committee Chairman (BR)/ DoN&G**	**Report**
13	To receive and note the report of the Freedom to Speak Up Guardian.	**Dewi Williams to attend**	**Report**
14	To receive and note the six monthly Nurse Staffing Report (1st December 2020 to 31st May 2021).	**DoN&G**	**Report**
15	To consider the Learning from Deaths Report as at Quarter 1, 2021/22.	**DoN&G**	**Report**
16	To consider the report of the Mental Health Legislation Committee.	**Committee Chairman (PH)/ MD**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (2.45 pm – 3.10 pm):

17	To consider the Annual Report of the Guardian of Safe Working.	**Dr. Jim Boylan to attend**	**Report**
18	To consider the Annual Report of the Responsible Officer on Medical Revalidation.	**MD**	**Report**
19	To approve the Workforce Race Equality Standard and Workforce Disability Equality Standard. *(Note: The recommendations of the Resources Committee will be provided verbally at the meeting)*	**DoPC**	**Report**

Exclusion of the Public (3.10 pm):

20	**The Chairman to move:** *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.* *Information which, if published would, or be likely to, inhibit -* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.* *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 July 2021

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

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 24TH JUNE 2021 COMMENCING AT 1.00 PM

The meeting was held via MS Teams

Present:
Ms M Harte, Chairman
Mr B Kilmurray, Chief Executive
Dr H Griffiths, Deputy Chairman
Prof P Hungin, Non-Executive Director
Dr A Khouja, Medical Director
Mr J Maddison, Non-Executive Director
Mr P Murphy, Non-Executive Director
Mrs B Reilly, Non-Executive Director
Mrs S Richardson, Senior Independent Director
Mrs R Hill, Chief Operating Officer
Mrs E Moody, Director of Nursing and Governance
Mrs L Romaniak, Director of Finance and Information
Dr S Dexter-Smith, Director of People and Culture (non-voting)
Mrs S Pickering, Director of Planning, Commissioning, Performance and Communications (non-voting)

In Attendance:
Mr P Bellas, Trust Secretary
Mrs W Johnson, Team Secretary
Ms D Oliver, Deputy Trust Secretary (Corporate)
Mrs S Paxton, Head of Communications

Observers/Members of the Public

Mrs M Booth, Public Governor, Middlesbrough
Mr J Creer, Public Governor, Durham
Ms H Griffiths, Public Governor, Harrogate and Wetherby
Mrs J Kirkbride, Public Governor, Darlington
Ms S Liu, Research Student, University of York
One member of public

21/127 APOLOGIES

There were no apologies for absence.

21/128 MINUTES

***Agreed** – that the minutes of the last meeting held on 27th May 2021 be approved as a correct record and signed by the Chairman.*

21/129 DECLARATIONS OF INTEREST

There were no declarations of interest.

21/130 PUBLIC BOARD ACTION LOG

The Board noted that there were no actions outstanding on the log.

21/131 CHAIRMAN'S REPORT AND MATTERS RAISED BY GOVERNORS

The Chairman reported that:

(1) The main purpose of the Special Board meeting was to approve the Annual Report and Accounts 2020/21 and the Quality Account 2020/21.

(2) It had been difficult, due to the current pressures on staff time and resources to distribute the relevant papers on the agenda in a timely manner and apologies were offered for any inconvenience this may have caused.

This had been particularly the case for the Quality Account 2020/21, which had been impacted by the pandemic and changing national guidance about its submission.

(3) One matter that had been raised by Governors, at the pre-Board session was about the receipt of an 'all staff email' received over the previous weekend regarding staffing concerns in Forensic services.
It was noted that any of the Governors, who used their NHS Email accounts would have been included in the circulation of the email. It was confirmed that the issue around staffing had been resolved and the wards in Forensics had been safety rostered.

(4) This was Dr Griffiths's last Board meeting. His term of office for more than six years would come to an end in June 2021. He had served the Board in various roles including Non-Executive Director, Associate Non-Executive Director, Vice Chairman and Chairman of the Quality Assurance Committee, over that time and had kindly stayed on for an extra six months at the end of the term to support with the recent challenges being faced by the Trust.

The Board were extremely grateful for Dr Griffith's support, diligence and commitment that he had shown in supporting the Trust and wished him well for the future.

21/132 CHIEF EXECUTIVE'S REPORT

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

In regard to the Care Quality Commission, Mr. Kilmurray reported that:

(1) Good progress continued to be made on the delivery of actions in the extensive programme of work to address the concerns received from the regulator.

(2) Following the rating of inadequate the adult mental health inpatient services and PICUs the CQC had returned to the Trust in June 2021 and a letter of response had been received on 8th June 2021 with some initial high level feedback.

(3) The CQC had found improvements around the documentation of patient safety incidents, learning from serious incidents, staff being supported throughout the change process and completion of the Trust wide ligature reduction programme.

(4) They also found examples where further improvements were needed. These included finding that not all risks were reflected in safety summaries, there had been an incident regarding sexual safety which had not been recorded in the records. Inspectors had raised concerns around the lack of seclusion facilities and a ligature risk had been found with an unlocked window.
On the matter of the sexual safety incident Mrs. Reilly (the Chairman of the Quality Assurance Committee) updated the Board that there would be a report presented on this matter to its next meeting on 1st July 2021.

(5) It was expected that the final CQC report would be published within approximately a 50 day timescale.

(6) The CQC had also commenced a Well Led and Core Services inspection of the Trust, with the former taking place on 28th and 29th July 2021. Requests for various pieces of information were well underway.

(7) The Council of Governors had been informed about the Well Led Review.

Non-Executive Directors:

(a) Highlighted the significant amount of progress that had been made over the last three to four months with regard to making changes in response to the CQC inspection and that it was heartening to see how well staff had responded.

(b) Sought clarity on the reference to the concerns found by the CQC that not all risks had been reflected in safety summaries and whether it was known how widespread the issue might be.

Mr. Kilmurray noted that these occurrences were in small numbers.

(c) Stated that there appeared to be a contradiction in the reported findings of the CQC, regarding patient safety incidents being pulled through into the patient overview sections.

Mr. Kilmurray advised that whilst the CQC was seeing good progress, the issue was more about ensuring that processes were embedded.
Dr. Khouja added that there had been some redesign work undertaken on the Trust information system Paris to ensure that the safety incidents would be documented correctly 100% of the time.

In addition to the report Mr. Kilmurray noted that Forensic services had been placed under business continuity arrangements. Governors who were using NHS email accounts had received an ‘all users’ message about staffing pressures at the weekend and he reaffirmed that the matter had been safely addressed with enough cover provided on the Forensic wards.

The Chairman added that staff had continued to go over and above their required level of duties and expressed on behalf of the Board a big thank you to each and every member of the organisation.

21/133 AUDIT AND RISK COMMITTEE

The Board received and noted a report on the business transacted and matters arising from the meetings of the Audit and Risk Committee held on 10th June 2021 (ordinary) and 18th June 2021 (special).

Mr. Maddison, the Chairman of the Committee:

(1) Informed the Board of the matters considered at the meetings.
(2) Advised the Board of the positive assurances around:

- The Audit Opinion for 2020/21 from the Head of Internal Audit.
- External Auditors opinion on the financial statements as at 31st March 2021.
- The Trust was not an outlier in regard to ratings in the Counter Fraud Functional Standards Return,
- There was nothing to cast doubt on the Trust's ability to continue as a 'going concern',
- There was nothing to report in regard to the Annual Governance Statement.
- There were no concerns around the Data Security & Protection toolkit.

(3) Alerted the Board on the following matters:

- An assignment undertaken by the Internal Auditors had revealed some potential issues with staff attitude towards Whistleblowing and Freedom to Speak Up Guardian procedures. This was being followed up.

  Non-Executive Directors sought further assurances on how this matter would be addressed.

  The Director of People and Culture advised that a quality improvement process had already started and an additional member of staff had been recruited to support the Freedom to Speak Up Guardian. Other actions included a review of all Trust policies, including the Whistleblowing Policy. The newly established People and Culture Committee would be the monitoring the governance for such matters which would be kept under close review.
  It was also highlighted that Mr. Maddison would be taking up the role of Non-Executive Director lead on Freedom to Speak Up.

(4) Recommended to the Board that:

- The Annual Report and Accounts 2020/21 be approved for submission to NHSEI and Parliament.
- Subject to any amendments, that the Quality Account 2020/21 be approved for submission to the Department of Health and Social Care.

21/134 NHS FOUNDATION TRUST ANNUAL REPORT AND ACCOUNTS 2020/21

Consideration was given to the approval of:

(1) The draft Annual Report and Accounts 2020/2021
(2) The Letter of Representation
(3) The submission of the Annual Report and Accounts to NHSEI and Parliament.

In regard to the above matters Board members took into account:

(i) The External Auditor's Audit Completion Report and update letter. This provided assurance that the External Auditors intended to issue an unqualified opinion on the accounts.
(ii) The report of the Director of Finance and Information noting that in approving the documentation each Board member would be confirming that, as far as they were aware, there was no relevant information of which the Trust's External Auditors were unaware.
(iii) That the members of the Audit and Risk Committee had considered the Annual Report and Accounts and the External Auditor's reports on them at its meeting held on 18th June 2021 and supported their approval and submission.

Non-Executive Directors:

(1) Complimented the very well written Annual Report, which set the right tone and offered congratulations to the team in their hard work preparing and finalising it.
(2) Sought clarification on the final outturn position.

Mrs. Romaniak advised that the bottom line deficit position for the Trust was £16.741m with a residual surplus of £9.1m and explained how the position had been affected by the national financial arrangements and the impact of additional monies received by the Trust due to Covid-19 and funding from Health Education England.

On behalf of the Board, the Chairman thanked all those who had contributed to the preparation of the Annual Report and the Annual Accounts.

Board members,

Agreed:

(i) *That the Annual Report 2020/21 be approved;*

(ii) *That the Annual Accounts 2020/21 be adopted;*
(iii) *That the Letter of Representation 2020/21 be approved;*
(iv) *That the Chairman, Chief Executive and Director of Finance and Information as appropriate be authorised to sign off the Annual Report, the Accounts, the Performance Report, the Accountability Report, the Remuneration Report, the Annual Governance Statement, the Statement on the Accounting Officer's Responsibilities, the Foreword to the Accounts, the Statement of Financial Position and any other necessary statements and certifications.*

Action: Ms Harte, Mr Kilmurray and Mrs Romaniak

(v) *That the Modern Slavery Act 2015 statements included in the Annual Report be confirmed.*

(vi) *The submission of the Annual Report 2020/21 including the Annual Accounts to NHSEI and Parliament.*

Action: Mrs Romaniak and Mr Bellas

21/135 QUALITY ACCOUNT 2020/21

The Board received and noted the Quality Account for 2020/21.

Mrs. Pickering highlighted that:

(1) The development process for the Quality Account had been impacted by Covid-19 and the consequences of both limited national guidance and local capacity.
(2) The Trust would be publishing the Quality Account to the legal deadline which had meant having a shorter time to take comments from stakeholders.
(3) The three quality improvement priorities for 2021/22 were linked to what the Trust data had revealed and had been developed with Clinical input.
(4) The Quality Assurance Committee at its meeting held on 3rd June 2021 had approved the Quality Account priorities.

Agreed:

(i) *That the Quality Account 2020/21 be approved;*
(ii) *That the document be authorised and signed off;*
(iii) *That the Quality Account 2020/21 be submitted to the Department of Health and Social Care.*

Action: Mrs. Pickering

21/136 DATA SECURITY AND PROTECTION TOOLKIT

The Board received and noted a report on the Trust's compliance with the Data Security and Protection Toolkit.

In introducing the report Mrs. Romaniak highlighted:

(1) That the Toolkit was a self-assessment tool that allowed organisations to measure their performance against the National Data Guardian's 10 data security standards.
(2) Organisations using NHS patient data and systems were required to use the toolkit in order to provide assurance that they were practicing good data security and that personal information was handled correctly.
(3) Following collation of evidence it had been found that the organisation met the standards apart from in four areas. These were privacy by design, policy for retention of audit logs, back up kept off site or in cloud and verification of supplier certification annually.
On this matter it was noted that an action plan had been formulated with all measures to be in place by November 2021.

Non-Executive Directors:

(a) Questioned how well protected the Trust was from cyber security threats.

Mrs. Romaniak advised that:
(i) There were multilayers involved in the defence against cyber security threats and that whilst the Trust had gone some way to install protective measures across the infrastructure, it was not possible to determine that the organisation was completely secure.
(ii) This was an ongoing challenge, not only for the Trust but for all large organisations and the risks would be managed closely. One of the most important risks to manage was Trust staff and providing the right kind of education and training to ensure that staff would not be caught out by opportune hackers and other cyber-attacks.

(b) Sought assurance that the risks identified in 3.4 of the report, 'top four issues for the Information Governance Team' were being addressed and monitored.

In response it was noted that there were risks with regards to the small team working in the Data Protection Office around the ability to meet the deadlines for subject access requests, which could lead ultimately to a fine from the ICO. Assurance was provided that EMT, prior to the pandemic had agreed to some non-recurrent resources to support the staff in order to be able to respond to subject access requests. The number of responses outstanding had declined, however there still remained a high volume of work.

(c) Highlighted that there would need to be close monitoring of the impact and effectiveness of the pilots of body worn cameras on wards across the Trust as there was already a significant amount of resources required to deal with complaints and investigations about CCTV.

Mrs Moody explained that the two systems, body worn cameras and CCTV were quite different. With CCTV once an incident had occurred it was important that the matter was escalated and Duty Managers and Ward Matrons were aware of the processes in place for that. There was a Trust policy for CCTV, however it was important that the policy was embedded with the appropriate staff.

In response to a query about CCTV being turned off, it was noted that this would only be in extreme circumstances, for example for essential maintenance works.

Agreed:

(i) That the Data Security and Protection Toolkit be approved for publication, as at 30th June 2021, with all evidence in place except four outstanding actions.

(ii) That monitoring of the Trust's actions in response to Data Security and Protection would be through the Strategy and Resources Committee.

Action: Mrs Romaniak

21/137 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 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.

Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.

Following the transaction of the confidential business the meeting concluded at 3.35 pm.

Miriam Harte
Chairman
29th July 2021

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
24.06.21	21/134	To note: - Approval to the Annual Report - Adoption of the Annual Accounts - Approval of the Letter of Representation - Approval to sign off the above documents and related certificates - Confirmation of the statements in the Annual Report in regard to the Modern Slavery Act	Chairman CEO DoFI	-	To note
24.06.21	21/134	To submit the Annual Report and Accounts to NHS E/I and Parliament	DoFI Co Sec	Sep-21	The Annual Reports and Accounts (and other required documentation) was submitted to NHS E/I on 29/6/21 (within deadline) Clarity awaited on the arranagements for submitting the Annual Report and Accounts to Parliament
24.06.21	21/135	To note approval of the Quality Account 2020/21 and authority to sign off the document	DoPCPC	Jun-21	To note

Date	Ref No.	Action	Owner(s)	Timescale	Status
24.06.21	21/135	To submit the Quality Account 2020/21 to the DoH&SC and to publish the document on the Trust's website	DoPCPC	Jun-21	Completed

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 29 July 2021**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Information**

This report supports the achievement of the Strategic Goals:	
To co-create a great experience for our patients, carers and families	✓
To co-create a great experience for our colleagues	✓
To be a great partner	✓

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.

Business Continuity

After having made the decision to re-establish a large part of our pre-pandemic business management arrangements we moved Gold Command meetings to once a week within our Senior Leadership Group. This was an attempt to support the restoration of the business as usual approach to leading the organisation and decision making. This was always done on the basis that we could re-establish command and control arrangements quickly should the need arise. In the last week of June that need was presented as it became clear that the increase in community infection rates of the Delta variant of Covid were starting to have an increasing impact on staffing.

This has meant that we now have three Gold Command meetings during the week and have a number of operational huddles that now operate as Silver Command. Re-establishing these arrangements means that we have a real embedded set of expectations on escalation, a routine detailed overview on specific operational challenges and a regular drumbeat of opportunities for decision making.

At the time of writing we have an absence rate of 7.9% and 205 staff who are isolating or have childcare due to children isolating from school. This has started to cause some significant pressures in some service areas. All operational services are considering their clinical and operational priorities, however three services are formally escalating into their business continuity plans. They are:

- **Durham and Darlington Crisis and Intensive Home Treatment Team** – This service has been escalated for some weeks linked to the recent review, however the situation increased due to Covid absences. All services remain operational, however the team is pulling staff from local community mental health teams to cover shifts. There is Gold Command oversight of staffing and to date we have received positive assurance that all shifts have been covered and the service is operating safely.

- **Tees Learning Disability Inpatient Services** – The service at Bankfields Court in Middlesbrough is fully occupied with highly complex packages of care for people with learning disabilities and autism. The service has had a sustained period of pressure caused by staff absences, some vacancies that are being filled and staff are yet to arrive and increased acuity requiring more staff to meet specific patient needs. The service is also in business continuity and is working through ensuring that there are the right skills and numbers for every shift. Gold Command took the decision on 13 July that there should be some urgent engagement with families to reduce the respite service temporarily by two thirds freeing up an additional 7.9 wte staff with the right skills and knowledge of the service. The engagement with families was positive and we are now moving to implement these changes. This will mean that a reduced service will continue in order that we can honour some commitments we have made over the coming weeks. The team continues to report their staff situation through to Gold Command twice a week and to date have positively assured us that services are safe.

- **Forensics Specialist Inpatient Services** – Staffing challenges have been a long term concern for the Trust. Previous reports have highlighted some of the issues here, and the Board has supported additional investment in recruitment. This is well underway, however a good proportion of these staff will not arrive until September. There have been times when managers have had to re-prioritise activities and take measures to consolidate staff to ensure the safety of the service. All changes are quality impact assessed and the key considerations are on the patient experience and staff wellbeing. Given that these considerations are site wide across 17 wards this has largely been a matter of re-prioritisation, rather than cancellations as we have been able to move staff across the site. Since the work undertaken in mid June on site co-ordination has been limited to staff moving within their pathway, onto wards that they know as much as possible. On 9 July the decision was taken to temporarily merge some wards – Jay, Harrier Hawk, Thistle and Kingfisher. Additionally, on 16 July Oakwood was merged into Langley Ward temporarily. This was done on the basis of individual risk assessments of each patient and any necessary adjustments to their care plans, consideration of the mix of

patient in each environment and the legal status of their admission. In some cases this has required Ministry of Justice approval. This temporary series of moves has allowed consolidation of staffing and whilst there are daily pressures, the team has been able to assure Gold Command that activities such as medical appointments, leave and visiting have been facilitated, even if some have had to be delayed or rescheduled. Some staff have raised concerns, with some having contacted the CQC. The team have sought to address any concerns and we continue to promote the staff wellbeing support.

I am very grateful for the ongoing support and commitment of staff and to the patience of patients, carers and their families during these difficult times. Their wellbeing and safety is our prime concern. In line with our commitment to co-create great patient, carer and family experience and colleague experience we will continue to proactively communicate and where we can involve people in decision making even though we are in business continuity mode. These local arrangements and the ongoing situation across the Trust is regularly reviewed and we will continue to make decisions with these interests in mind. We will look to stand down these arrangements as soon as possible.

Care Quality Commission (CQC)

The CQC are continuing their Well Led inspection and as part of this interviews with the Executive and Non-Executive Directors will take place on 3 and 4 August. They have inspected 4 core services as part of this inspection. They asked for further details relating to staffing in Forensics, which we have provided. We anticipate the report will be ready for factual accuracy checking in September. Actions relating to previous inspections including the Section 29A letter and the 2019 inspection are now all completed but we are still awaiting feedback from the CQC as to whether any further action is required. Throughout the inspection the CQC has requested an unprecedented volume of information from the Trust, which has been provided where possible. We have made representation to the CQC about the disruption that this has caused to our staff as it has prevented some internal assurance activity taking place.

Structures

Work is progressing with the new structures. We have extended the time for informal discussion with local services regarding options and in the meantime have agreed with staff side colleagues that the organisation will go out to recruit the two Managing Director posts. Through August we have support from the regional improvements board to ensure we align clinical need, operational structures and governance flow across our geographical footprints.

Covid-19 Update

Increased transmission in the community has translated into increased admissions at acute hospitals. As at 21 July the Trust had one open outbreak and four Covid positive patients were being cared for within inpatient services.

Due to increased levels of staff sickness three services are formally in business continuity to ensure active monitoring for patient care. Gold Command has been stepped up to oversee arrangements. On the 23 July the Trust formally invoked Opel L4 which means that the Trust has now set up its incident room and there are formal requests to the wider system for support. All non-essential work is being assessed and may be stopped, for example some meetings, certain training courses, project work etc. We are working on plans to address the issues and reduce the pressures on our services to enable us to move out of Opel 4 as soon as possible.

The Trust is applying national guidance to reinforce IPC control measures and ensure as many staff as possible are able to attend work.

Staff now report lateral flow test results via the national system. The remaining kits received from NHS England have been sent to localities for distribution.

Covid Vaccines Update

Final submission of the Trust's Immunisation uptake report was submitted on 9 July 2021, confirming the following data:

Staff Category	Total	Dose 1	Uptake	Dose 2	Uptake
Medic	284	249		212	
Nurses	2508	2181		1958	
AHP / ST&T	1059	917		820	
Clinical Support	2535	2189		1962	
Total Staff Included	**6386**	**5536**	**86.7%**	**4952**	**77.5%**

Summary of last year's Flu Vaccine Programme

We were below average on our vaccinations last year although this was compounded by the impact of Covid meaning we had to cut short our campaign.

- We achieved 71.5% vaccination of frontline staff
- Average for Mental Health Trusts was 74.5% frontline staff
- Average for North East and Yorkshire Commissioning Group (our region) was 78.1% frontline staff

We are hoping that this year the message about being vaccinated has permeated more deeply and more people will come forward (for flu as well as Covid vaccination). We are on track with our flu campaign and have ordered doses in line with national guidance for different groups and prepared the communications for this. We are coordinating our Covid booster and flu campaigns as much as possible and it looks likely that this will be the national approach, We are also talking with our acute colleagues about mirroring the partnership approach to Covid vaccines for dose 1 and 2.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO.9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	29th July 2021
TITLE:	Progress update on the development of an Integrated Assurance Report for the Board of Directors
REPORT OF:	Sharon Pickering, Assistant Chief Executive
REPORT FOR:	Discussion and agreement

This report supports the achievement of the following Strategic Goals:	✓
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

This report provides a progress update on the development of the Integrated Assurance Report for the Board of Directors including the deployment of a member of staff full-time to this work and the submission of initial proposals for each Board Sub Committee.

This report also highlights the current context this work is operating within including the significant developments resulting from our new Strategic Framework and the Good Governance Institute Report and the next steps pertaining to this development work.

Recommendations:

The Board of Directors are asked to:

1) Receive this progress update on the development of the Integrated Board Assurance Report
2) Support the recommendation for a collective discussion of the Board in September in order to agree the first set of Board measures.
3) Discuss and feedback their views in relation to the reporting and assurance flow required from the Commissioning and Audit & Risk Committees.

MEETING OF:	Board of Directors
DATE:	29th July 2021
TITLE:	Progress update on the development of an Integrated Assurance Report for the Board of Directors

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide a progress update on the development of the Integrated Assurance Report for the Board of Directors; to highlight the current context this development work is operating within and the planned/proposed next steps. There are also a small number of recommendations pertaining to this development work that we are asking the Board to consider.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 As part of the continuous improvement of the Trust's Performance Management Framework we identified a need for a more integrated approach to quality and performance assurance and improvement across the Trust. In June 2020 we then received the draft report from the Good Governance Institute following their review of our Governance processes which identified a number of areas for improvement and set out a range of recommendations including:

- *The board must consider whether it feels it is able to give sufficient time to the performance dashboard as a means of understanding active issues. If not, it should consider delegating this to one of the board assurance committees.*
- *The Board should consider creating a more comprehensive integrated performance report that addresses the live tensions in the organisation as well as its mandated performance targets and that this should be placed early in the agenda followed by the more detailed narrative reports.*

2.2 A paper was taken to the Resources Committee in March 21, outlining the proposal for the development of an Integrated Board Assurance Report which was supported and then approved by the Board of Directors in March 21. As outlined in that paper the plan is that the Integrated Board Assurance Report would include an Integrated Board Dashboard supported by a series of reports from each individual Board Sub Committee – see Appendix for further details on this. Each Board Sub Committee would then have a suite of standard measures and reports to assure itself that it is meeting the delegated responsibilities from the Board.

3. KEY ISSUES:

Current Context

3.1 In addition to the above progress, since March 21 there have been a number of significant developments which require the integrated approach to be closely aligned for it to have the desired outcome. The following developments reflect our new Strategic Framework and a number of the recommendations within the Good Governance Institute Report which need to be taken into consideration with this work:

- The deployment of our new Strategy *Our Journey to Change* and the work plans associated with this
- The undertaking of a Board Development Programme
- A review and revision of the Board Assurance Framework (BAF)
- A review and revision of the Governance Framework
- The emerging structures in relation to potential changes to Clinical Service Delivery which are required to support *Our Journey to Change*

It is therefore imperative that the development of the integrated approach to assurance aligns to the work and timescales of the above developments to ensure there is a successful outcome.

Progress Update

3.2 Following agreement of the approach by the Board of Directors in March 21, it was recognised that the development of the new Integrated Board Assurance Report was a significant piece of work which required dedicated time in order to engage with the various sub committees and Board members to establish what key metrics each sub-committee requires to give it assurance and which of these need to be routinely reported to the Board. It was therefore agreed that the Head of Corporate Performance would focus solely on the development work with effect from the 1st June 21.

3.3 To date there have been individual meetings with each Chair* and Executive lead of the sub committees that form part of the integrated approach (*where appointed). There has been really good engagement and support in the identification of measures for each sub-committee with initial proposals being submitted at the end of June. The main feedback from the discussions to date has been that the chairs would welcome a collective discussion by the Board in relation to the development and agreement of the measures that will be used from the sub-committee reports to form the Integrated Board Assurance Dashboard.

Next Steps

3.4 Whilst being cognisant of the significant developments outlined in 2.3, work has commenced with each sub-committee to start identifying the measures they feel should be included in the new Integrated Board Dashboard that

would meet the needs of the Board and, where appropriate, align to the new Board Assurance Framework. The timescale for completion of this work is the 4th August. The intention is to collate these proposals and have an initial discussion within the Executive Team on the 9th August and then have a **collective discussion of the Board in September, as requested by the Chairs and Executive leads of the sub-committees, in order to agree the first set of Board measures.** As part of this work, we will be looking to complete an initial assessment of the viability of the proposed measures in order to aid the Board discussion. For example is the measure already one we use, is the measure clearly defined, do we have existing data collection processes etc.

3.5 In addition to work outlined above, we are continuing to work with each Chair and Executive Lead to review and refine their initial proposals for their respective sub committees by sharing the collated information and some of the questions that have arisen (e.g. where does x sit in terms of assurance?). This clearly will have a longer lead in time whilst we prioritise the development of the Board Integrated Dashboard.

3.6 We will also be looking to establish an assurance flow (linked to the new Governance Framework), a reporting schedule and options for the presentation of the new Integrated Board Assurance Report in the coming months.

Other points for discussion

3.7 As part of the work to date, there has been some further thinking about whether the Commissioning Committee should be part of the integrated approach or reported separately given the nature of this new committee and the need to have delineation between the provider and commissioner functions including assurance. **The Board are asked to discuss and feedback their views on this.**

3.8 In addition to the above point, there has also been a query in relation to the Audit & Risk Committee and how the Board will get its assurance from this committee. In the initial proposal (within the Integrated Approach) approved by Board in March 21, there was a note to say this will need to report separately as it fulfils a different function (i.e. across all the sub committees and controls); however in light of the query **the Board are asked to discuss and feedback their views on this.**

4. RECOMMENDATIONS:

4.1 The Board of Directors are asked to receive this progress update in relation to the development of the Integrated Board Assurance Report.

4.2 The Board of Directors are asked to support the recommendation for a collective discussion of the Board in September in order to agree the first set of Board measures.

4.3 The Board of Directors are asked to discuss and feedback their views in relation to the reporting and assurance flow required from the following two committees:

- Commissioning
- Audit and Risk

Sarah Theobald, Head of Corporate Performance

Tees, Esk and Wear Valleys
NHS Foundation Trust

Appendix A

Integrated Board Assurance Report – Draft Contents

Chapter 1 Executive Summary

- This summary will include the key areas of concern including the triangulation with any other relevant information from both the Integrated Dashboard as well as the reports from the Board Sub Committees (via an Executive discussion)

Chapter 2 Integrated Dashboard

- A set of agreed measurse from each of the sub committee reports which will be structured around a set of domains to be agreed *(e.g. sub committees, CQC domains, our journeys to x)*
- The Integrated Dashboard will be underpinned by the SPC methodology and will include “deep dives” for any areas of concern that have been highlighted.

Chapter 3 Reports from Board Sub Committees

- These reports will include other key information, issues and risk not already included in the Integrated Dashboard but which the sub-committee wishes to escalate to the Board.
  - Mental Health Legislation
  - Quality Assurance
  - People, Culture & Diversity
  - Strateggy & Resources
  - Commissioning (tbc)
  - Audit & Risk (tbc)

Item 10

BOARD OF DIRECTORS

DATE:	**29th July 2021**
TITLE:	**Finance Report for Period 1 April 2021 to 30 June 2021**
REPORT OF:	**Liz Romaniak, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

The Month 3 2021/22 report reflects performance within the context of national financial arrangements supporting the NHS to respond to the Coronavirus Pandemic. Revenue funding arrangements have been confirmed for the first half (or H1) of 2021/22 and detailed plans, including budgets and workforce implications are in line with these arrangements. Capital envelopes have been confirmed at ICS, and were subsequently agreed at organisation, level for the 2021/22 financial year.

- **Statement of Comprehensive Income:** The financial position to 30 June 2021 is a surplus of £3.7m. This reflects performance within national financial arrangements, and is £0.3m ahead of run rate trajectories prepared to support the ICP / ICS submission. The Trust's H1 plan (April to September) is a £4.7m surplus.
- **Capital Programme:** 2021/22 capital funding requests have been prioritised to establish a 2021/22 Capital Programme that is deliverable within the Trust's agreed ICS capital departmental expenditure limit (CDEL) allocation of £13.6m. Schemes that were not affordable within the allocation were impact assessed, leading to a re-prioritisation. The month 3 report shows that capital expenditure is exceeding plan by £0.3m largely due to a number of small schemes that did not complete as planned during 2020/21. In addition the sale of a trust property was not finalised in June as planned (£1.5m), but is expected to complete during July. The Trust expects to fully expend within the £13.6m annual limit and have a breakeven forecast position by the end of the financial year. However, should additional capital become available due to ICS slippage, the Trust has a number of schemes identified to commence during 2021/22.
- **Cash:** The Trust's cash balance is £78.4m as at 30 June 2021 which is £0.3m ahead of plan. More detail can be found in section 3.7.

The Trust has developed detailed draft budgets and workforce plans for H2. These are consistent with H1 allocations but assume a proposed 'waste reduction' ask of 3%, and will continue to review in light of any H2 (October-March) planning guidance and ICP/ ICS requirements once released (expected in September).

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**29th July 2021**
TITLE:	**Finance Report for Period 1 April 2021 to 30 June 2021**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for month 3 of 2021/22; 1 April 2021 to 30 June 2021, and based on a draft plan submission for the first half (H1) of 2021/22, of £4.7m surplus.

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.

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 operated throughout 2020/21 and H2 block funding mechanisms have continued into H1 2021/22 to support the NHS in responding to the Covid-19 Pandemic. The Trust has supported the submission of high level ICP/ICS system(s) plans for H1 that would deliver a H1 surplus of £4.7m for the Trust and a breakeven plan for the ICP/ICS. It is important however to note that the Trust's H1 funding incorporates £9.1m net (of £3m required minimum surplus) non-recurrent income allocated at 'place' level for growth and Covid costs, meaning an underlying recurrent deficit position for the same period. This is largely due to the pump priming of inpatient staffing investment; however the Trust continues to work within Partnership Boards to agree immediate and future investment priorities which would in turn mitigate this to a closer to break even position.

2.4 The North East and North Cumbria ICS one year 2021/22 capital departmental expenditure limit (CDEL) was received at the end of March 2021. The ICS envelope of £185m was less than the sum of organisations' composite 'aspirational' plans. Individual plans were re-visited and prioritised on a more consistent 'pre-commitment' and 'safety' basis, to inform envelopes to individual organisations. The Trust's capital funding envelope on this basis is £13.6m.

3.1 <u>Key Performance Indicators</u>

Appendix 1 provides a summary of all KPIs for the period ending 30 June 2021.

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

The Trust is reporting a year to date surplus of £3.7m for month 3, which is £0.3m ahead of its draft plan, with performance is summarised in table 1:

Table 1	H1 Plan	Year to Date		YTD	YTD
	M1-6	Plan	Actual	Variance	Last Month Variance
	£000	£000	£000	£000	£000
Income From Activities	191,783	95,880	96,620	-740	-524
Other Operating Income	9,803	4,872	4,967	-95	-27
Total Income	**201,586**	**100,752**	**101,587**	**-835**	**-551**
Pay Expenditure	-159,158	-78,149	-79,330	1,181	825
Non Pay Expenditure	-34,016	-17,441	-16,810	-631	-716
Depreciation and Financing	-3,692	-1,790	-1,790	0	0
H1 Surplus / (Deficit)	**4,720**	**3,372**	**3,657**	**-285**	**-442**

Income from activities is (£0.7m) ahead of plan due to additional income received not in the plan.

Pay expenditure is higher than planned by £1.2m due to:

- £0.9m higher than planned agency and bank spend, largely relating to the Trust's decision to approve recurrent investment in adult inpatient services and commence recruitment linked to increased investment.
- £0.3m higher than planned trainee medical grade staff, due to the Trust being successful in recruitment within the latest medical rotation.

Non Pay expenditure is lower than plan by (£0.6m); the following expenditure accounts for the majority of the reduced spend:

- (£0.8m) Premises and fixed plant – there is general underspending against utilities, furniture and IT equipment estimates assumed in run rates; which is reflective of fast-tracking expenditure during 2020/21 to mobilise 'Smart' and / or home working.
- (£0.2m) General supplies and services – arises as a result of a delay in moving to a new Trust property; for which the trust had planned dual running costs.
- £0.4m Increased final pension pay control charges the trust has incurred.

3.4 Cash Releasing Efficiency Savings (CRES)

Detailed full year financial plans are being developed internally and will be assessed against any updated H2 planning guidance publication, and will include the Trust's CRES framework and targets for 2021/22 and planning assumptions for the twelve months beyond. Recent national NHS England communications suggest a likely second half efficiency ask of around 3%. In preparation the Trust will step up activities to identify and consider schemes to deliver future requirements and will include quality impact assessments (QIA) where schemes have been identified and due to commence. QIAs will also be revisited for any schemes that were delayed and / or stood down during the pandemic.

3.5 Capital

The month 3 report shows that capital expenditure is £4.3m as at 30 June and is over plan by £0.3m due to various schemes being slightly delayed during

2020/21. In addition the sale of a trust property was not finalised during June as anticipated, deferring a £1.5m capital receipt into quarter two. Composite over spending against quarter 1 CDEL was therefore £1.8m. The disposal is progressing, finalising additional legal and overage aspects relevant to the transaction and is now expected to conclude by the beginning of August.

3.6 Workforce

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for overtime, 2.4% for agency (based on NHSI cap metric), and are flexed in correlation to staff in post for bank and additional standard hours (ASH).

The NHSI agency cap has not applied during the pandemic, but it would equate to a cost cap equivalent to £3.8m for H1. Agency expenditure to date is £2.4m; which is £0.5m above the indicative cap for the period ending 30 June 2021. Expenditure is across all localities and reflects current operational and business continuity staffing pressures currently being experienced as a result of rising community infection rates and the impacts of test and trace on staffing levels. Teams have been asked to review their likely agency spend to inform financial forecasts as current levels are also £0.9m ahead of anticipated run rates for this expenditure category.

Nursing and Medical expenditure headings account for 96% of total agency expenditure; cover is required to maintain essential services and to cover vacancies, sickness, increased test and trace isolation levels and to support enhanced observations with complex clients.

3.7 Statement of Financial Position

Cash balances are £78.1m as at 30 June 2021 and are £0.3m ahead of the H1 plan, largely due to differences in working capital offset by the delayed capital disposal.

Accounts Receivable (amounts owed to the trust) in June 2021 totalled £6.3m (May - £3.1m), with 1.7% (£0.1m) being more than 90 days overdue (May– 2.9% £0.1m). The £3.2m increase arising in month was due to finalising the new 2021/22 Provider Collaborative billing arrangements and balances have since been paid in full.

3.8 Use of Resources Risk Rating (UoRR) and Indicators

3.8.1 The UoRR is impacted by Covid-19 and national monitoring is currently suspended. However, the Trust will continue to assess the UoRR based on run rate assumptions approved for H1. Detail can be found in table 2 below.

Table 2: Use of Resource Rating at 30 June 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 30 June 2021	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	4.10x	1	3.37x	1	
Liquidity	45.8	1	39.5	1	
I&E margin	3.6%	1	3.3%	1	
I&E margin distance from plan	0.3%	1	0.0%	1	
Agency expenditure (£000)	£2,428k	3	£1,893k	1	
Overall Use of Resource Rating		**1**		**1**	

3.8.2 The **capital service capacity** metric assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 4.10x (can cover debt payments due 4.10 times), which is ahead of plan and is rated as a 1.

3.8.3 The **liquidity** metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 45.8 days; this is ahead of plan and is rated as a 1.

3.8.4 The **Income and Expenditure (I&E) margin** metric assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 3.6%, this is ahead of plan and is rated as 1.

3.8.5 The **I&E margin distance from plan ratio** metric assesses the I&E surplus/deficit relative to planned performance. The Trust I&E margin distance from plan is 0.3% which is rated as a 1 and is in line with plan.

3.8.6 The **agency expenditure** metric assesses agency expenditure against a capped target for the Trust. Agency expenditure of £2,428k is in breach of the capped target by £535k (28%) and is more than plan and rated as a 3.

3.8.7 The 'headroom' margins on the individual metrics are as follows:

- Capital service cover - to deteriorate to a 2 rating the Trust's financial position would have to decrease by £2.3m.
- Liquidity - to deteriorate to a 2 rating the Trust's working capital position would have to decrease by £48.4m.
- I&E Margin – to deteriorate to a 2 rating the Trust's financial position would have to decrease by £2.6m.
- Agency Costs – to deteriorate to a 4 rating the Trust's agency expenditure would have to increase by £0.4m.

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 The extension of national funding arrangements; which includes the roll forward of block allocations covers H1 2021/22. This provides short term assurance on net income and expenditure run rates position; however, not knowing the impact of H2 funding arrangements / allocations and regulation gives less certainty for longer term recurrent funding streams and any potential budget and funding shortfalls in delivering longer term plan priorities. Discussions are continuing with the MH Partnership Boards to agree immediate and future investment priorities and will be updated as part of the detailed budget setting work which is under discussion and is to be confirmed.

5.3 Delays in delivery of CRES are mitigated by non-recurrent underspending in H1. Plans to meet the required target in H2 and future years will be monitored by the Trust's Finance Sustainability Board (FSB) as planning activities recommence. Nationally, indications are that a more challenging 'waste reduction' ask; equivalent to around 3%, will likely apply from H2. It is important therefore that the FSB and imminent Business Planning work takes this likely 'downside' view into account and the Trust begins to formulate plans.

6. CONCLUSIONS:

6.1 For the period ending 30 June 2021 the Trust outturn is a surplus of £3.7m which is £0.3m ahead of the high level run rate planning for H1.

6.2 The Trust anticipates a forecast surplus of £4.7m at the end of H1, which is in line with information shared to inform ICP / ICS plans.

6.3 The CRES framework is yet to be agreed for 2021/22 but indications are that a national 'waste reduction' target of around 3% may apply from H2. The Trust is stepping up work to identify schemes to deliver requirements and will provide an update in due course.

6.4 To enable continued focus on the pandemic, annual planning activities for 2021/22 were deferred nationally; initially into the first half of 2021/22. H2 planning and NHS financial settlements are not now anticipated until H2.

6.5 The UoRR for the Trust is assessed as 1 for the period ending 30 June 2021 and is broadly 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 of Information

Appendix 1

Key Financial Indicators for the period ending 30 June 2021

Surplus variances are shown as negative	Year to date Plan	Actual	Variance	RAG	Prior Month Variance	RAG	H1 Plan	Actual	Variance	RAG
I&E (Surplus) / Deficit £m	-3.4	-3.7	-0.2	🟢	-0.4	🟢	-4.7	-4.7	-0.0	🟢
Income £m	-100.8	-101.6	-0.8	🟢	-0.5	🟢	-201.0	-203.7	-2.7	🟢
Pay Expenditure £m	78.2	79.3	1.1	🔴	0.8	🔴	159.0	161.2	2.2	🔴
Non Pay Expenditure £m	17.4	16.8	-0.6	🟢	-0.7	🟢	34.0	34.1	0.1	🔴
Non Operating Expenditure £m	1.8	1.8	0.0	🟢	0.0	🟢	3.7	3.7	0.0	🟢
Capital Expenditure £m	2.9	4.7	1.8	🔴	0.3	🔴	6.8	6.8	0.0	🟢
Capital Service Cover	3.37x	4.10x	-0.73x	🟢	-1.12x	🟢	3.7	3.7	-0.93x	🟢
Liquidity Days	39.5	45.8	-6.3	🟢	-8.0	🟢	39.6	39.6	0.0	🟢
I&E Margin	3.35%	3.60%	-0.25%	🟢	-1.8%	🟢	2.3%	2.3%	0.0%	🟢
Variance from I&E Margin plan	0.0%	0.3%	-0.25%	🟢	-1.8%	🟢	0.0%	0.0	0.0%	🟢
Agency Expenditure £m	1.9	2.4	0.5	🔴	0.3	🔴	3.8	4.3	0.5	🔴
Cash Balances £m	78.1	78.4	-0.3	🟢	-4.0	🟢	83.0	83.0	0.0	🟢
Total debt over 90 days	5.00%	1.79%	-3.21%	🟢	-2.1%	🔴	5.0%	5.0%	0.0	🟢
BPPC NHS invoices paid < 30 days	95.00%	94.29%	0.71%	🔴	0.8%	🔴	95.0%	94.3%	0.7%	🔴
BPPC Non NHS invoices paid < 30 days	95.00%	95.77%	-0.77%	🟢	-0.9%	🟢	95.0%	95.8%	-0.8%	🟢

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 11

FOR GENERAL RELEASE

MEETING OF THE BOARD OF DIRECTORS

DATE:	**29th July 2021**
TITLE:	**Board Performance Dashboard as at 30th June 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 co create a great experience for our patients, carers and families.	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

This is the Board level Performance Dashboard for the period ending **30th June 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.

**This is an analytical tool that plots data over time; it helps understand variation in data and in doing so guides when and where it is appropriate to take action.*

Key Issues

Having reviewed the latest performance data there have been **4** areas of concern identified and **5** areas which require additional monitoring. Details on why these areas have been identified are summarised 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 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)	We first identified that we may not be treating as many people in their local hospital as we would like in the April 21 Board report. We can now see that the number of days that someone stays in a hospital that is not their local one is at its highest level since April 2019. This is a concern to us as it means that patients who need to stay in one of our hospital are potentially separated from their friends, families and

		support networks for longer than we would want, which can impact on both their experience but also potentially their recovery. Appendix A provides further information on this. A key action that has been agreed is the need to undertake some Trust wide work on the use of inpatient beds. The Executive Team has agreed that we need some external support to help with this and is currently in the process of developing a specification to commission this support
4)	Percentage of patients surveyed reporting their overall experience as excellent or good	We first identified that feedback from patients is not as positive as we would like it to be in the September 20 Board Report. Whilst the charts show us that performance has not changed significantly over a number of months our feedback surveys shows that fewer patients are telling us their experience was excellent or good than we would like. This is a concern to us as we want to deliver high quality services a key element of which is patients having a great experience. Appendix A provides further information on this and Appendix D provides an update on the actions identified by the Trust.
6)	% of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind	HoNOS is a measure of health and social functioning and we use it to indicate whether our patients have demonstrated an improvement in their outcomes from when they first enter our services to when they are discharged/reviewed. This helps us understand whether our care and treatment is supporting people to recover. We continue to see a decline in the position and we are not reaching the standards that we would hope to both of which are a concern to us. Appendix A provides further information on this at locality level and an update on progress against agreed actions.
12)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	We first identified that the use of our inpatient beds was increasing to levels of concern in August 20 and this was supported by our clinical services raising concerns that there were pressures on beds across the Trust which were impacting on both patients and staff. The use of beds is now of concern as it is above a level where we would like it to be. We know that this is not ideal as it means that wards are very busy,

		which can impact on the quality of care that can be delivered and can mean that patients are admitted to a hospital that is not local to where they live as a result of this pressure. It can also have a negative impact on staff working on those wards. Appendix A provides further information on this including when a more detailed update will be provided. The key action described for measure 3, the need to undertake some Trust wide work on the use of inpatient beds, will also incorporate this measure.

Measures which require additional monitoring:

2)	Percentage of patients starting treatment within 6 weeks of an external referral	We want our patients to begin their treatment at the earliest opportunity to improve their experience and outcomes and also to reduce the risk of a deterioration of their condition and the potential need for admission. We put in place additional monitoring of this indicator in January 21 when it became clear that in some localities the number of patients that were not receiving treatment within 6 weeks was higher than we would like it to be. We will continue to monitor this measure to minimise the risk of this becoming a concern. Both the Durham & Darlington and Tees localities are not achieving the standard we would like and as a result we have completed further work to understand why this is the case. Appendix A provides further information on this and Appendix D provides an update on the actions identified for both of the localities.
10)	The percentage of new unique patients referred and taken on for treatment (3 months behind)	Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery. We put in place additional monitoring of this indicator in August 20 when it became clear that in some localities the number of patients being taken on for treatment were lower than we would like them to be and we needed to understand the reasons for this. We will continue to monitor this measure to minimise the risk of this becoming a concern.

		Durham & Darlington, Tees and Forensic localities have all been subject to further analysis. Appendix A provides further information on this and Appendix D provides an update on the actions identified for Tees and Forensic Localities. For Durham & Darlington, the key areas impacting this measure also apply to TD 02 (Percentage of patients starting treatment within 6 weeks of an external referral) and so further details and updates on the actions can be found in that section of Appendix D.
13)	No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	We want to ensure that our patients do not stay in hospital longer than they clinically need to as we know that this can affect their transition back into the community and their recovery. In addition we want to ensure that we use our inpatient beds as effectively as possible to meet the needs of everyone who needs to be admitted. We started to monitor this more closely in May 21 when we started to see the numbers of patients staying in beds longer than 90 days increasing, particularly in Durham & Darlington. Given we have not seen any significant improvement we will continue to monitor this measure to minimise the risk of this becoming a concern. Appendix A provides further information on this and outlines plans to continue to progress this work.
17)	Percentage compliance with ALL mandatory and statutory training (snapshot)	Ensuring that our staff having the appropriate levels of training to maintain their skills is vital if we are to provide high quality and safe services. We have been monitoring this indicator more closely since March 21 when it was clear we were not achieving the standard we have set ourselves. Whilst we are beginning to see some positive progress across the Trust it has not yet reached a level that is statistically a real improvement and therefore we will continue to monitor it closely to minimise the risk of this becoming a further concern. 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. These will come to an end in September 21 and the data indicates that there is currently a high number of staff with training outstanding. It is important that steps are taken now to ensure all staff are up to date with their training to minimise the risk

		of this becoming a concern once the grace period ends.
18)	Percentage Sickness Absence Rate (month behind)	As part of us wanting to create a great experience for our colleagues we want to ensure that we support them to maximise their health and wellbeing. This measure has been monitored closely since August 20 as sickness levels for staff are higher than we would like them to be, which can impact on both service user and staff experience. We will continue to monitor this measure to minimise the risk of this becoming a concern. Appendix A provides further information on this.

Positive assurance:

16)	Percentage of staff in post with a current appraisal	Evidence shows that when colleagues feel engaged in the organisation they provide higher quality care, and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. It also provides an opportunity to look at how they can develop their skills/role further within the organisation. This measure shows a positive achievement for the Trust as the percentage of our staff who have a current appraisal is higher than the standard we have set ourselves and is the highest position achieved to date. 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. These are planned to come to an end in September 21 and the data indicates that there is currently a high number of staff with an appraisal outstanding. It is important that steps are taken now to ensure all staff are up to date with their appraisals to minimise the risk of this becoming a concern once the grace period ends.

Other issues/points to note:

9)	The percentage of new unique patients referred with an assessment completed (2 months behind)	Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

		Whilst at Trust level, achievement of this measure has not changed, Tees locality is not assessing the same level of patients as they have been previously. We therefore need to understand the reasons for this. Appendix A provides further information on this and Appendix D provides an update on the actions identified by the Tees Locality.
11)	Number of unique patients discharged (treated only)	Understanding the levels of patients that are discharged from our services is important as it demonstrates that our patients are recovering and allows us to ensure we can maintain sufficient capacity to take on new patients. Whilst at Trust level, achievement of this measure has not changed Tees locality is not discharging the same level of patients as they were previously, suggesting that patients may not be being discharged in a timely manner so that they can continue their recovery journey independently. We therefore need to understand the reasons for this. Appendix A provides further information on this s and Appendix D provides an update on the actions identified by the Tees Locality.

NHS Oversight Framework

The majority of national standards within the NHS Oversight Framework have been achieved for Quarter 1 2021/22; however there are 2 exceptions to this:

- *Admissions to adult facilities of patients who are under 16 years old* – There was one Vale of York CCG patient under the age of 16 admitted to an adult ward in May 21. The patient was admitted under the Mental Health Act because no CAMHS PICU beds were available; NHSE were involved in the discussions to identify a secure bed. The patient spent three nights in a Trust AMH unit under 3:1 observations and throughout their stay were supported by a combination of adult staff, CAMHS staff and specialist CAMHS/LD staff from his local care team in the community.

- *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.

It should be noted that a new System Oversight Framework was released in June 2021, which sets out NHS England and NHS Improvement's (NHSE/I) approach to the oversight of integrated care systems, CCGs and trusts, with a focus on system-led delivery of care. Work is currently underway to identify the requirements and the work

that needs to be undertaken to establish internal assurance mechanisms within the Trust; a briefing paper will be submitted to the Senior Leadership Group this month. The first submission to Trust Board of performance against the System Oversight Framework will be in October 2021, covering performance for quarters 1 and 2 of this financial year.

Data Quality Assessment.

The Data Quality Assessment for the new dashboard indicators is attached in Appendix E. This data quality assessment tool focusses on 4 key elements of data: data source, data reliability, construct/definition, and when each measure was last amended/tested. All of the measures score 80% or above, which is extremely positive and reflects the improvements made in our processes. Seven measures scored 100% whilst a further 6 scored 90% or more. Lower scores are due to data testing requiring update and plans are in place to address this. Also some measures are subject to a manual process prior to reporting and where possible this is being addressed to eliminate the manual process and therefore improve the scoring.

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)
- **Appendix E** is the Data Quality Assessment of the dashboard measures.

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 staff in post with a current appraisal (TD16)

4. Note the overall positive Q1 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.

5. Note the positive assurance provided by the Data Quality Assessment of the measures included in the report and the work that is being undertaken to improve the scores further.

TRUST Dashboard Summary

Tees, Esk and Wear Valleys NHS Foundation Trust

Quality

Measure Name	Variation Ending Jun - 2021	Assurance Ending Jun - 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%	89.66%	90.00%	
2) Percentage of patients starting treatment within 6 weeks of an external referral			60.00%	60.72%	60.00%	Durham & Darlington are continuing to indicate a concern and are below the standard. 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 continuing to indicate no significant change and they are just above the standard. 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	2,892	1,833	Durham & Darlington are continuing to indicate a concern. Identified as an area of concern in the March report (data ending February 21); this information was shared with the locality to better understand their position and whether this is an actual area of concern. Tees are continuing to indicate a concern. Identified as a concern in the June report (data ending May 21) and as updated in that report; this information was shared with the locality to better understand their position and whether this is an actual area of concern. North Yorkshire & York are now indicating a concern (previously no significant change). It was identified previously that it would be more beneficial to have a Trust wide discussion on out of area placements and the wider impact on our current inpatient pressures. These discussions commenced in May and a suite of measures, including OAPS have been identified for analysis in more detail, including the use of forecasting tools. The Executive Team has agreed that we need some external support to help with this and is currently in the process of developing a specification to commission this support. A further update on the analysis undertaken to date will be provided next month.
4) Percentage of patients surveyed reporting their overall experience as excellent or good			94.00%	88.64%	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 at Trust and Locality Level, with the exception of Durham & Darlington Locality where this is identified as an area of concern, we agreed we needed to undertake a deep dive to understand the position better and what could be done to improve the position given this is a key measure of quality. The Quality & Safety Cell undertook a deep dive which was shared with the Board previously. An update on the actions identified was also shared with the Quality Assurance and Improvement Sub Group in May and patient experience remains a standing agenda item for discussion within that group. A further update on progress against the identified actions is provided in Appendix D.
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding			32.00%	52.78%	32.00%	
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind			60.00%	48.90%	60.00%	Durham & Darlington Locality is continuing to indicate no significant change. Identified as an area of concern in the January report (data ending February 21), this information was shared with the Locality to better understand their position and whether this is an actual area of concern. North Yorkshire & York Locality is continuing to indicate no significant change. Identified as an area of concern in the November report (data ending October 20), this information was shared with the Locality to better understand their position and whether this is an actual area of concern. Tees Locality is continuing to indicate no significant change. 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 and this has been shared with the Board previously. Work is progressing on the actions outlined in the update shared last month in all Localities; however due to current pressures on the services in terms of clinical need and staffing shortages due to sickness or staff isolating due to covid, this has not progressed as quickly as planned but continues to be a focus. A further update will be provided in September 21.
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind			65.00%	68.92%	65.00%	

Activity

TRUST Dashboard Summary

Tees, Esk and Wear Valleys NHS Foundation Trust

Measure Name	Variation Ending Jun - 2021	Assurance Ending Jun - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
8) Number of new unique patients referred				25,761		Forensic Services is continuing to indicate an improvement (increase). 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 was an area of concern. The findings concluded that the increase is a result of referrals into the Liaison & Diversion (L&D) Services. Following the Board requesting further assurance in March, it was confirmed that the increase was not an area of concern as the key to providing a high quality L&D Service is pro-actively engaging with potential clients.
9) The percentage of new unique patients referred with an assessment completed (2 months behind)				76.19%		Tees Locality are continuing to indicate a concern. Identified as an area of concern in the June report (data ending May 21); 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 the actions identified is provided in Appendix D.
10) The percentage of new unique patients referred and taken on for treatment (3 months behind)				30.32%		Durham & Darlington Locality are now indicating a concern (previously no significant change). First 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. All factors affecting performance are being addressed as part of the TD02 (Percentage of patients starting treatment within 6 weeks of an external referral) briefings (see Appendix D). The measure will continue to be monitored through routine performance management processes and should the improvements that we would expect to see not have the desired affect further investigations will be initiated. Tees Locality is continuing to indicate a concern. 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 and an update on the actions identified is included in Appendix D. Forensic Services are continuing to indicate no significant change. 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 on the actions will be provided in next month's report.
11) Number of unique patients discharged (treated only)				8,780		Tees Locality are continuing to indicate a concern. Identified as an area of concern in the June report (data ending May 21); 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 the actions identified is provided in Appendix D.
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)			90.00%	96.80%	90.00%	Durham & Darlington Locality is continuing to indicate a concern. Identified as a concern in the June report (data ending May 21) this information is forming part of the further analysis work outlined in measure 3 and additional details below. Whilst the remaining Localities are mirroring the Trust and indicating no significant change there is an observed increase in bed occupancy Trust wide which supports the concerns raised from services about pressure on beds. Further discussions have begun to take place at locality level through the Locality Quality Assurance and Improvement Groups and have been brought together through discussions with the Chief Operating Officer but some further analysis work is required to understand the demands on inpatient provision. This will encompass some future forecasting work and analysis of OAPs (TD03), length of stay greater than 90 days (TD13), admissions and referrals to community teams, as well as investigations to understand the impact from staffing measures including sickness. Further discussions will take place and as outlined above in the TD03 OAPs narrative, an update will be shared next month.
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot			61	56	61	Durham & Darlington Locality are continuing to indicate a concern. Identified as an area of concern in the May report (data ending April 21); this information was shared with the Locality and this data now forms part of the work outlined in TD03 (total number of inappropriate OAP days) and TD12 (bed occupancy). A further update will be provided in next month's report.
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)			9.90%	8.29%	9.90%	

Workforce

Measure Name	Variation Ending Jun - 2021	Assurance Ending Jun - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
15) Finance Vacancy Rate				-4.20%		
16) Percentage of staff in post with a current appraisal			95.00%	97.62%	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

Tees, Esk and Wear Valleys NHS Foundation Trust

Measure Name	Variation Ending Jun - 2021	Assurance Ending Jun - 2021	Standard (YTD)	Actual (YTD)	Annual Standard	Comments
17) Percentage compliance with ALL mandatory and statutory training (snapshot)			92.00%	93.11%	92.00%	There have been a number of extensions to the time allowed to complete mandatory & statutory training (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 Durham & Darlington now indicate no significant change; Durham & Darlington indicate concern. Tees, Durham & Darlington and Forensics Localities are above the standard of 92% whilst North Yorkshire & York are just below at 91.40%. These positions will continue to be monitored.
18) Percentage Sickness Absence Rate (month behind)			4.30%	5.30%	4.30%	Forensics are now indicating no significant change (previously a concern). Since the implementation of the action plan in June 2020, sickness absence rates within Forensic Services have been closely monitored each month with a number of actions being implemented to address this. However, the absence rates for the service remain high and the action plan has therefore been revised to reflect actions considered appropriate in the current circumstances. There are 6 actions within the action plan with two now complete (closer monitoring and analysis of long term sickness episodes and working with HR more effectively to support staff with long term health conditions). Remaining actions are progressing to plan and are due to be completed by September 21; updates will continue to be provided in this report.

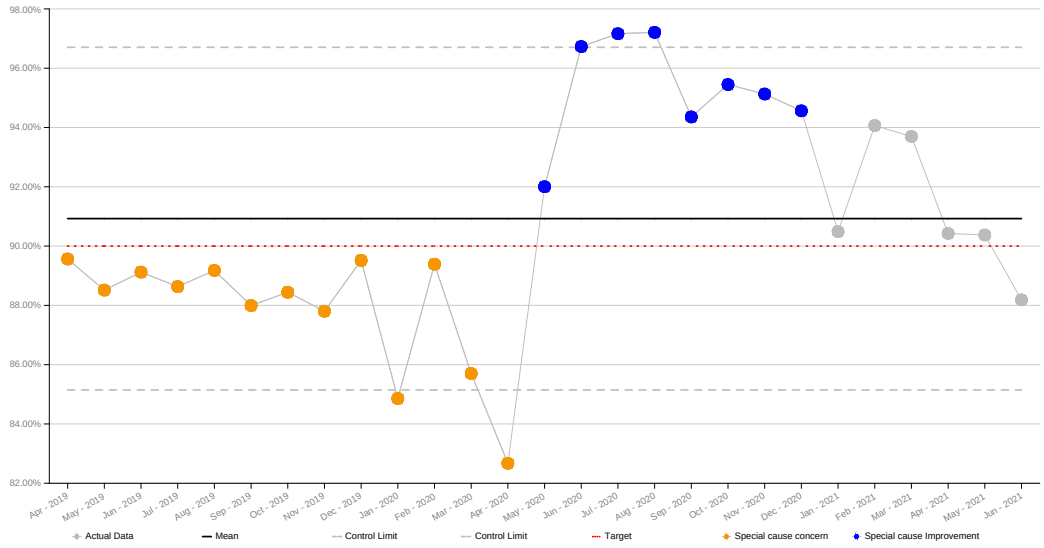
Money

Measure Name	Plan (YTD)	Actual (YTD)	Comments
19) Delivery of our financial plan (I and E)	-3,372,000	-3,681,318	The financial position to 30 June 2021 is a surplus of £3.7m. This reflects performance within national financial arrangements, and is £0.3m ahead of run rate trajectories prepared to support the ICP / ICS submission. The Trust's draft H1 plan (April to September) is a £4.7m surplus.
20) CRES delivery	0	0	Detailed full year financial plans are being developed internally and will be assessed against updated H2 planning guidance and will include the Trust's CRES framework and targets for 2021/22. In preparation the Trust continues to identify and consider schemes to deliver future requirements and will include quality impact assessments (QIA's) where schemes have been identified and due to commence.
21) Cash against plan	78,107,000	78,448,339	Cash balances are £78.4m as at 30 June 2021 and is £0.3m ahead of the H1 plan which is largely due to differences in working capital. The change in-month with the cash position is due to the trust aged debt (61-90 day category) increasing throughout June, work is currently being undertaken to review this position.

TRUST Indicator Details

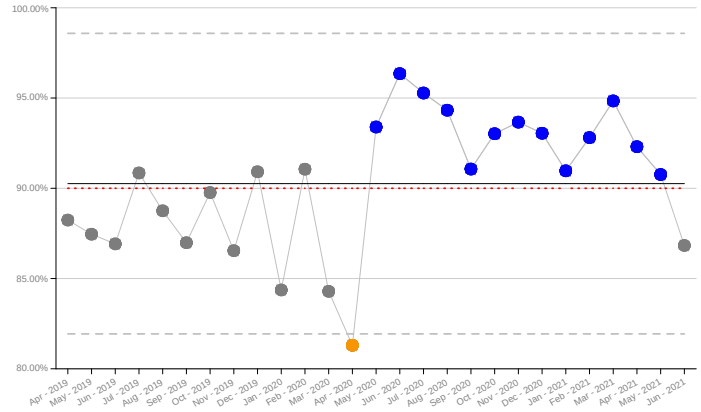
Tees, Esk and Wear Valleys NHS Foundation Trust

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

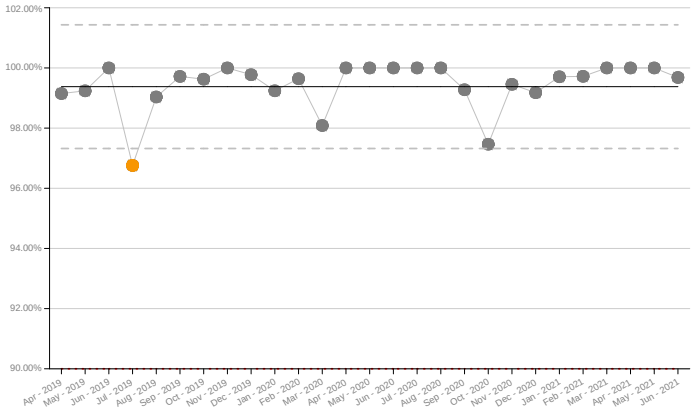


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			90.93%	96.71%	85.15%
DURHAM AND DARLINGTON			90.26%	98.58%	81.93%
FORENSIC SERVICES		P	99.38%	101.43%	97.32%
NORTH YORKSHIRE AND YORK			87.11%	94.95%	79.28%
TEESSIDE			93.98%	99.60%	88.36%

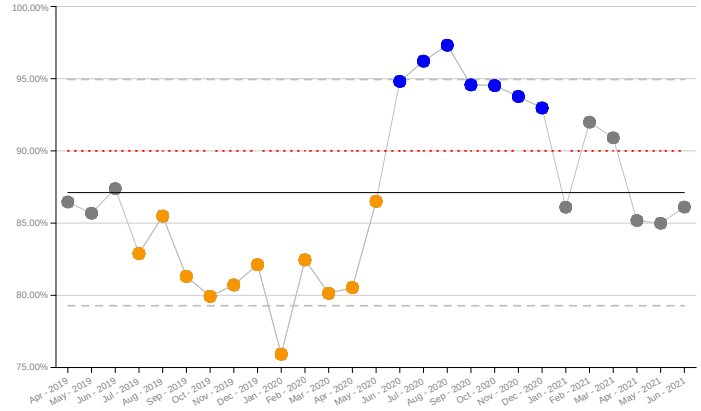
DURHAM AND DARLINGTON



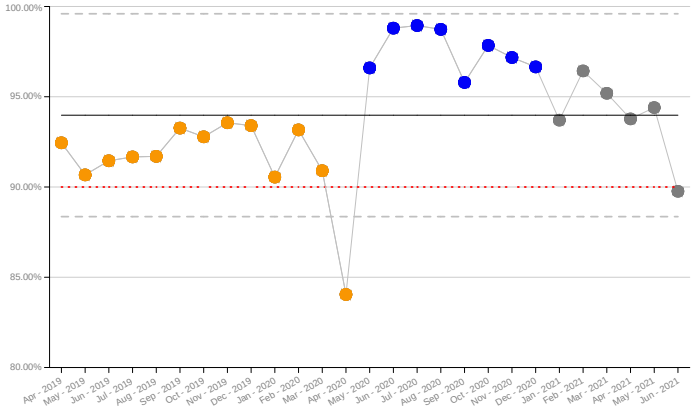
FORENSIC SERVICES



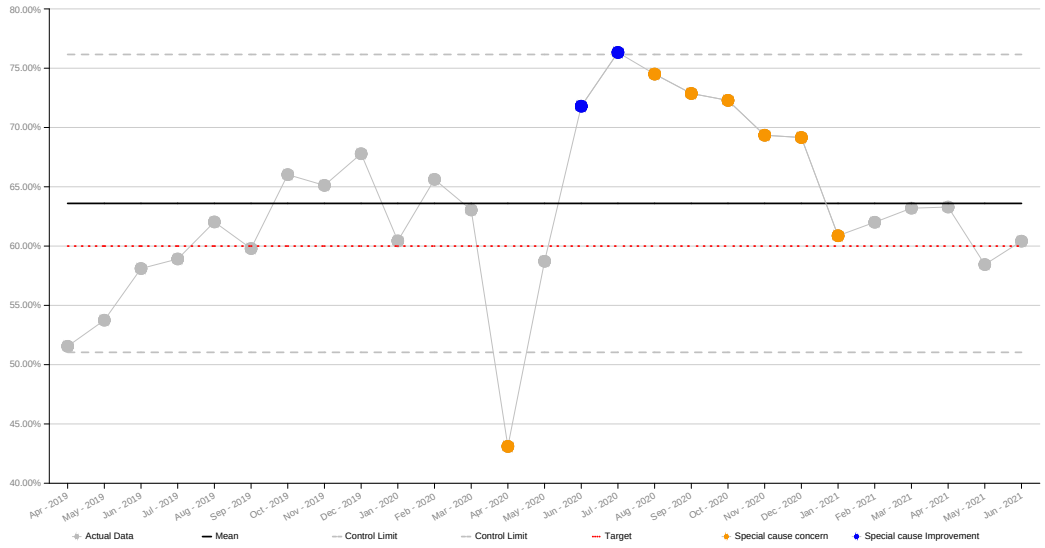
NORTH YORKSHIRE AND YORK



TEESSIDE

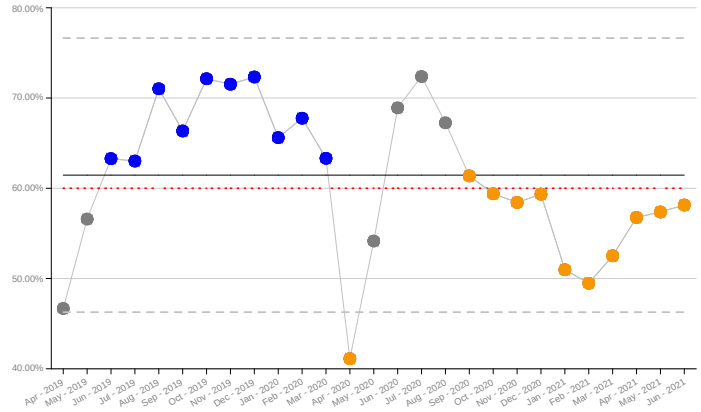


2) Percentage of patients starting treatment within 6 weeks of an external referral - TRUST

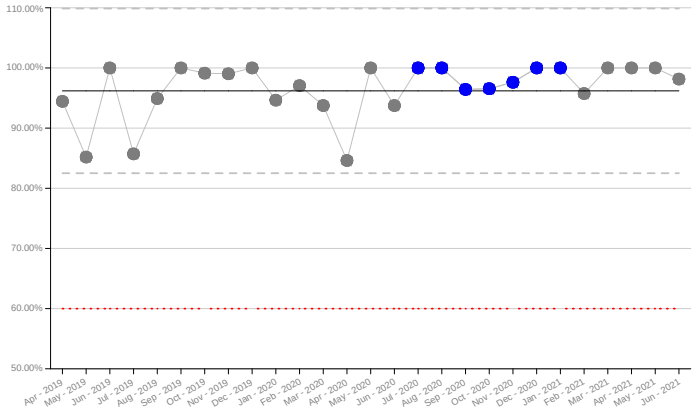


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			63.60%	76.16%	51.04%
DURHAM AND DARLINGTON	L		61.46%	76.64%	46.27%
FORENSIC SERVICES		P	96.19%	109.88%	82.50%
NORTH YORKSHIRE AND YORK			65.26%	76.92%	53.60%
TEESSIDE			60.74%	78.18%	43.29%

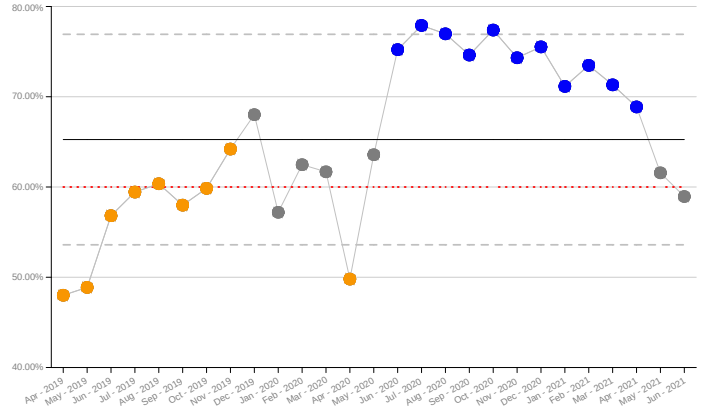
DURHAM AND DARLINGTON



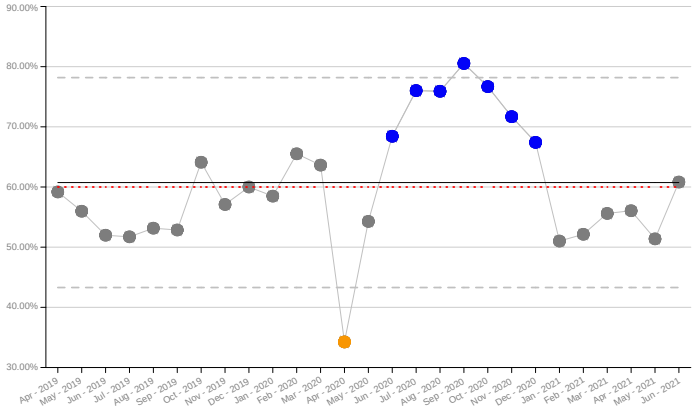
FORENSIC SERVICES



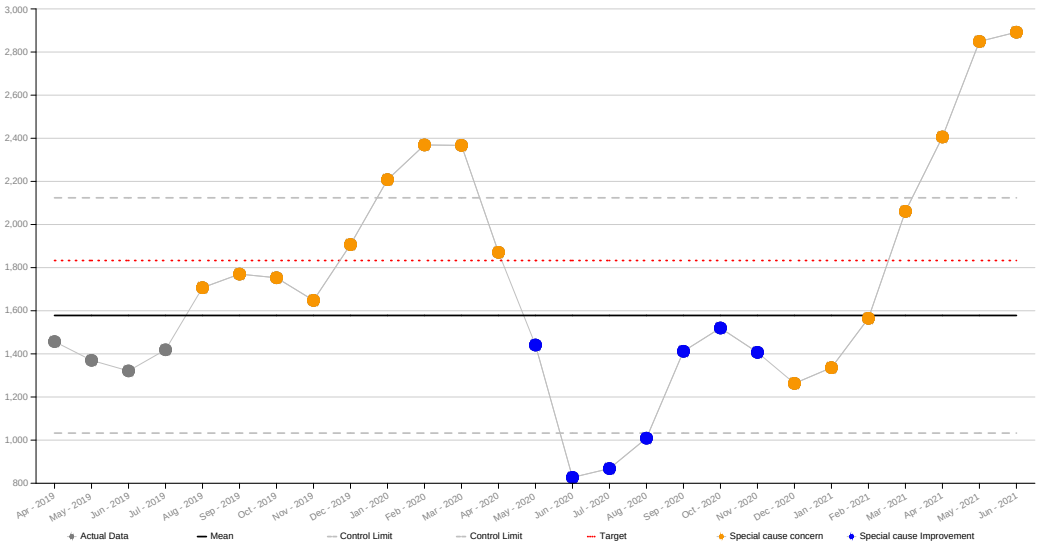
NORTH YORKSHIRE AND YORK



TEESSIDE

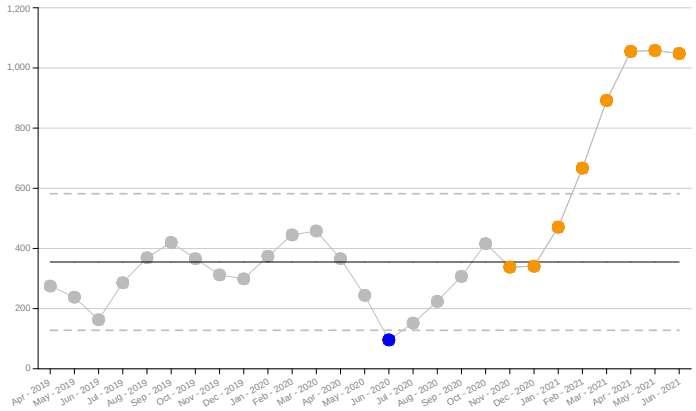


3) The total number of inappropriate OAP days over the reporting period (rolling 3 months) - TRUST

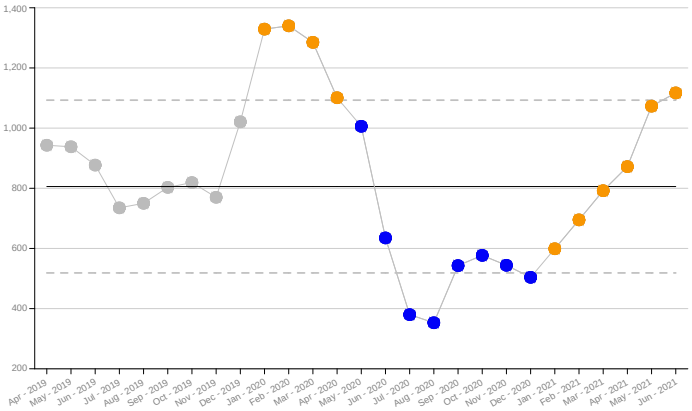


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	?	1,578.17	2,123.81	1,032.52
DURHAM AND DARLINGTON	H		354.96	581.98	127.93
NORTH YORKSHIRE AND YORK	H		805.79	1,092.96	518.63
TEESSIDE	H		402.63	647.58	157.67

DURHAM AND DARLINGTON



NORTH YORKSHIRE AND YORK



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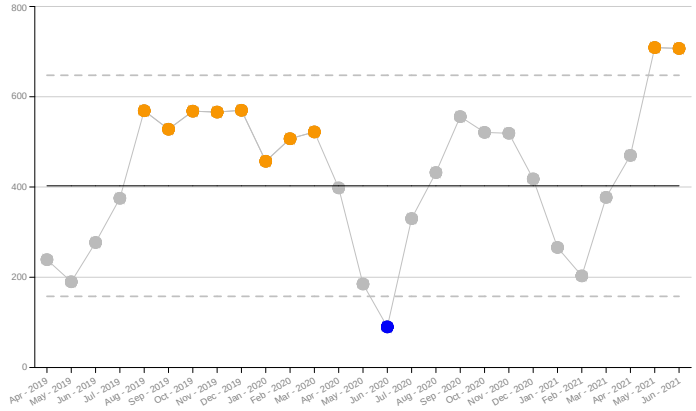
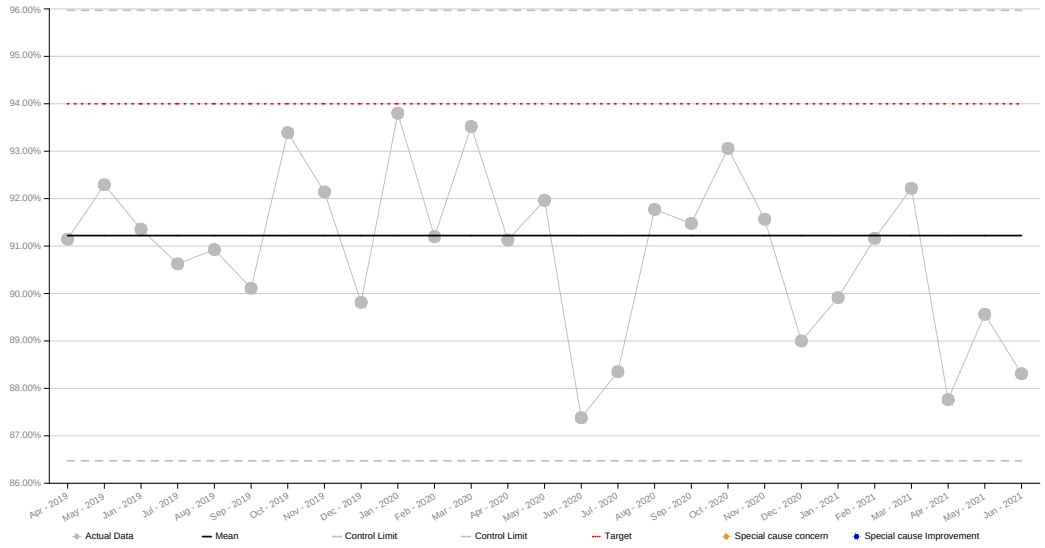
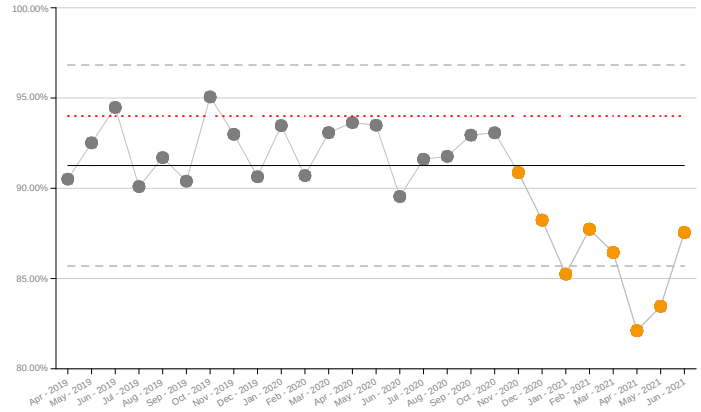


4) Percentage of patients surveyed reporting their overall experience as excellent or good - TRUST

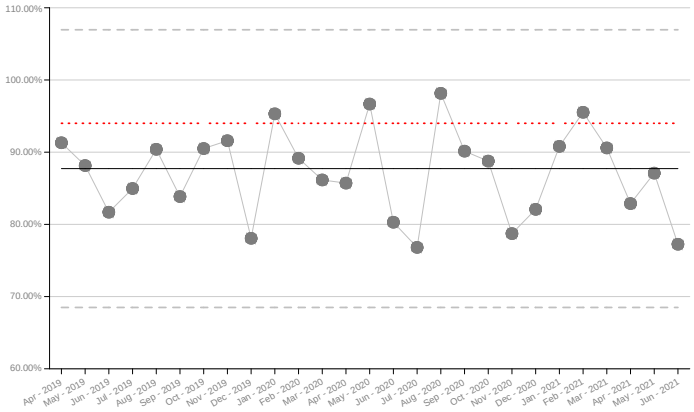


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			91.22%	95.97%	86.47%
DURHAM AND DARLINGTON	L		91.26%	96.83%	85.69%
FORENSIC SERVICES			87.72%	106.96%	68.49%
NORTH YORKSHIRE AND YORK			90.67%	98.47%	82.87%
TEESSIDE			93.25%	98.17%	88.32%

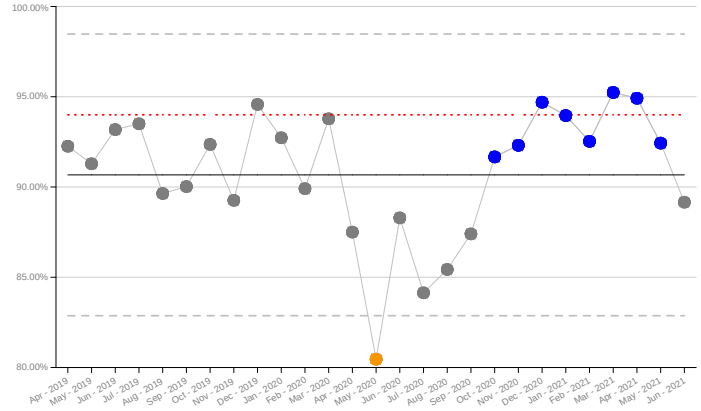
DURHAM AND DARLINGTON



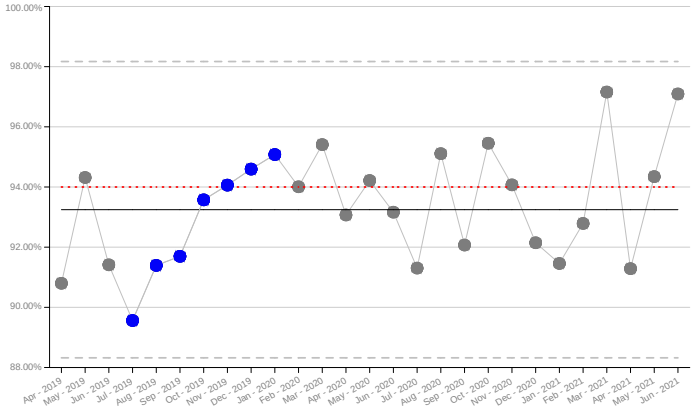
FORENSIC SERVICES



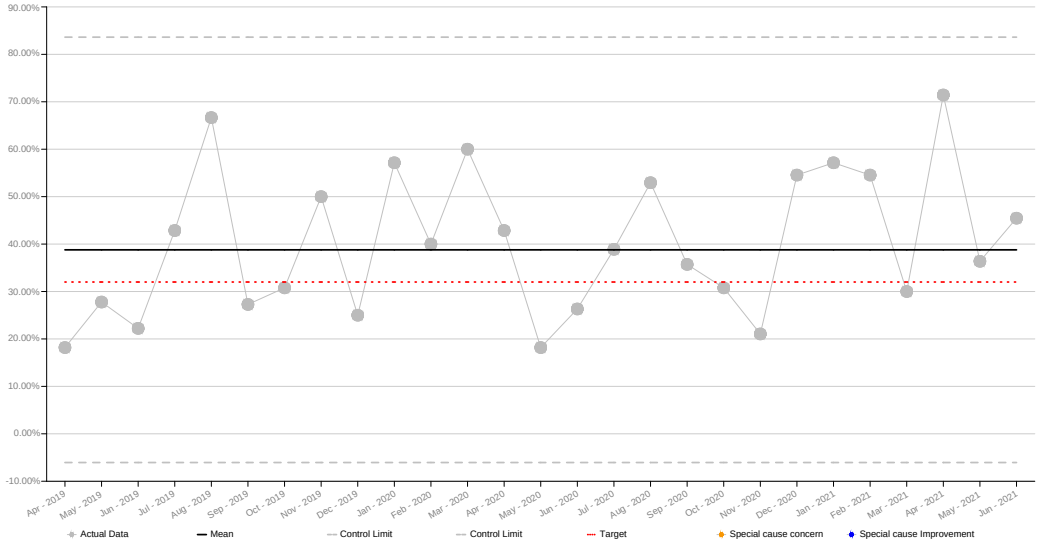
NORTH YORKSHIRE AND YORK



TEESSIDE

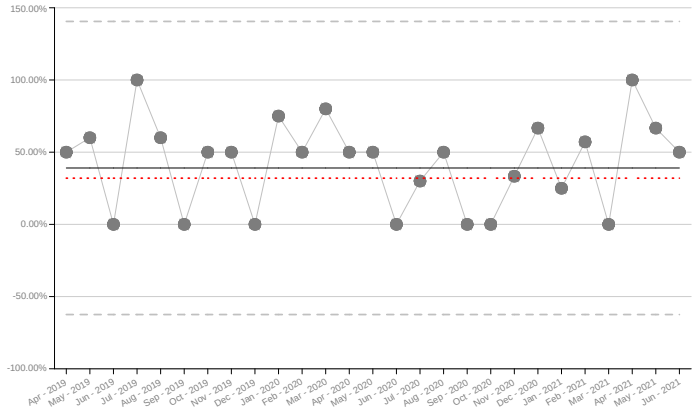


5) The percentage of Serious Incidents which are found to have a root cause or contributory finding - TRUST

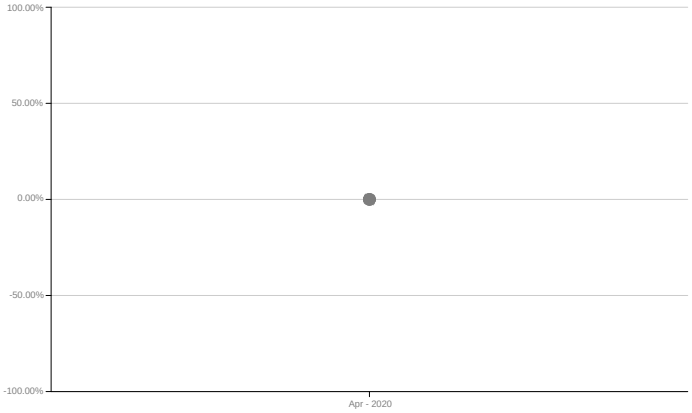


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			38.79%	83.62%	-6.05%
DURHAM AND DARLINGTON			39.05%	140.55%	-62.45%
NORTH YORKSHIRE AND YORK			42.16%	130.35%	-46.03%
TEESSIDE			40.57%	98.99%	-17.85%

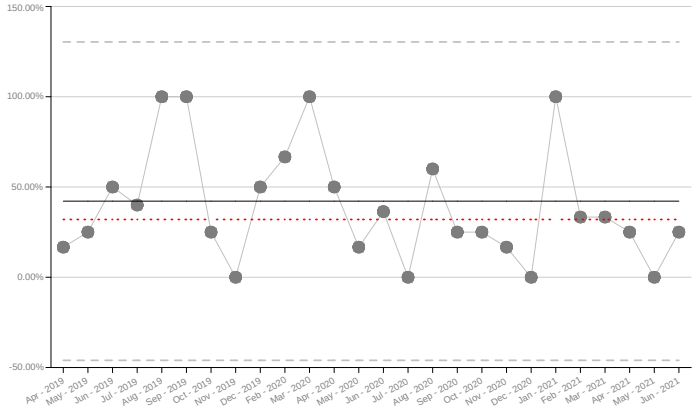
DURHAM AND DARLINGTON



FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



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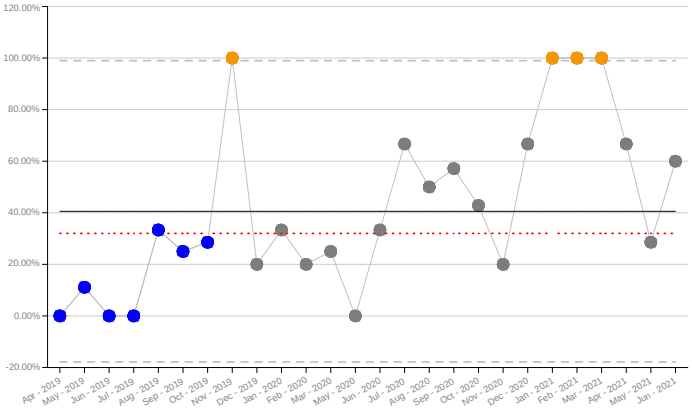
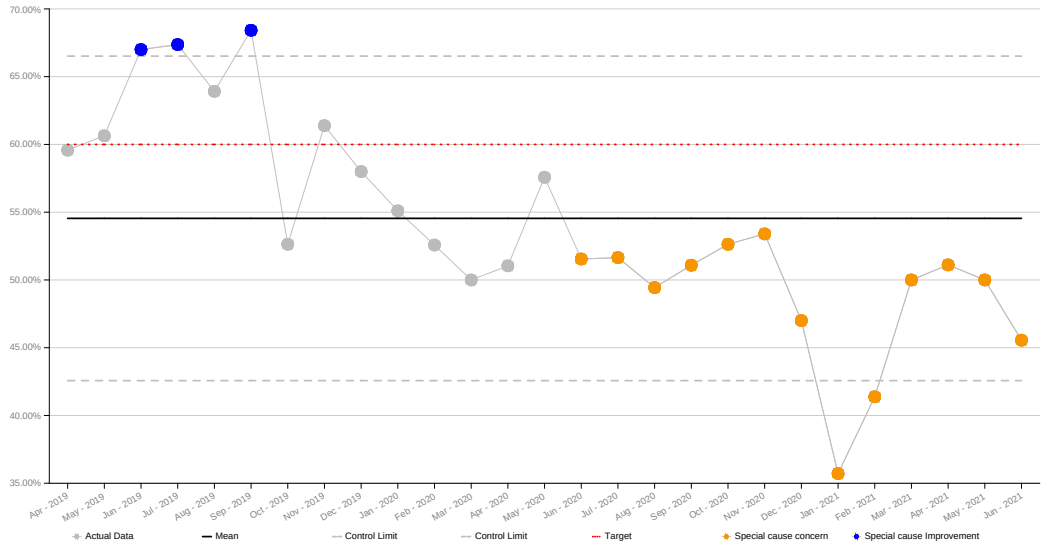
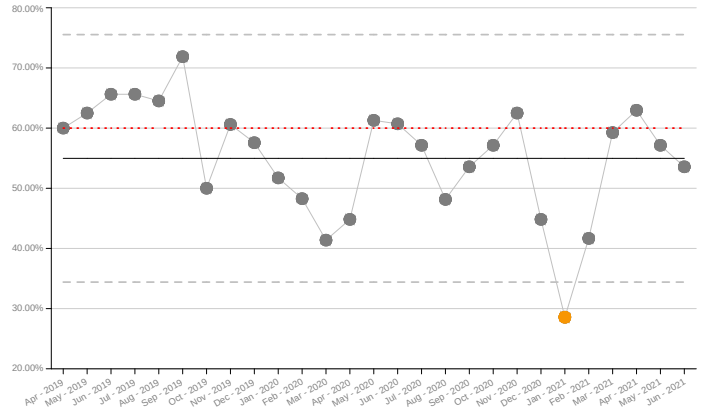


6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind - TRUST

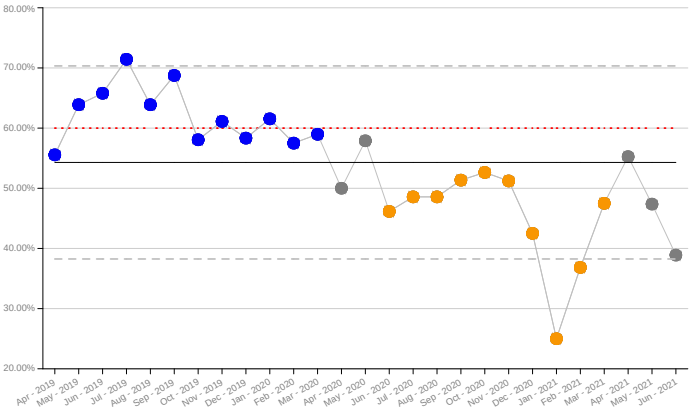


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			54.54%	66.52%	42.57%
DURHAM AND DARLINGTON			54.97%	75.54%	34.41%
NORTH YORKSHIRE AND YORK			54.29%	70.34%	38.25%
TEESSIDE			54.15%	68.62%	39.69%

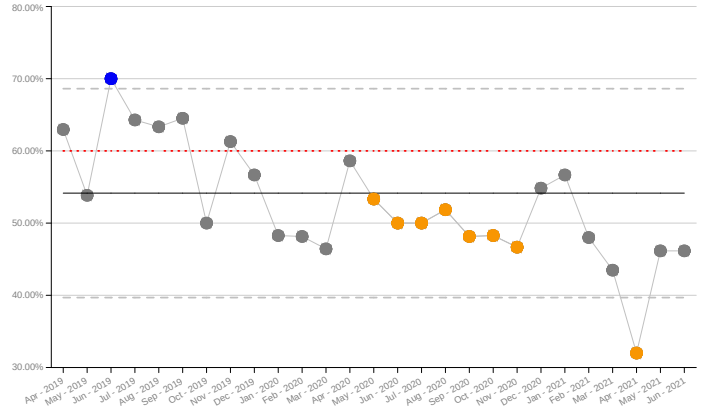
DURHAM AND DARLINGTON



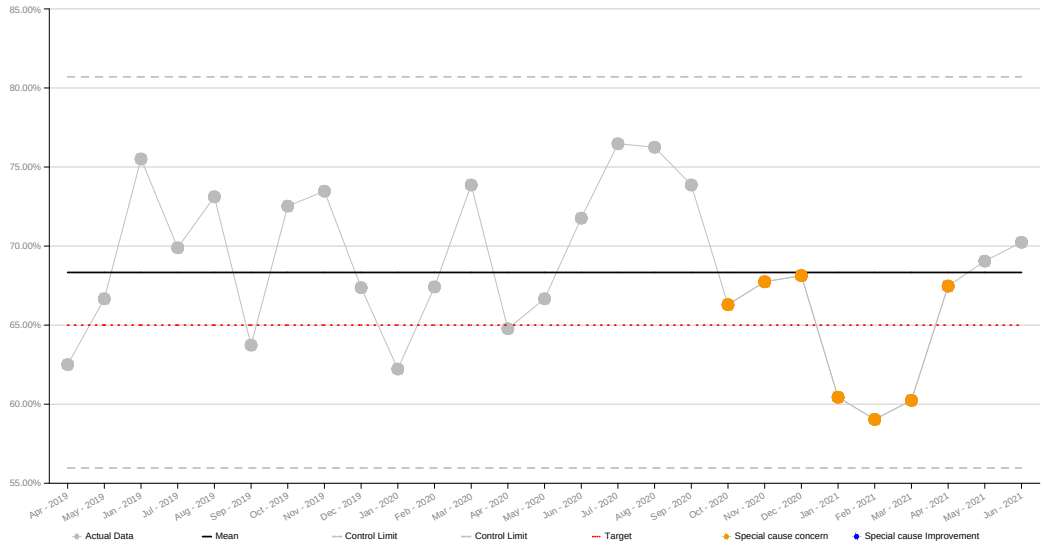
NORTH YORKSHIRE AND YORK



TEESSIDE

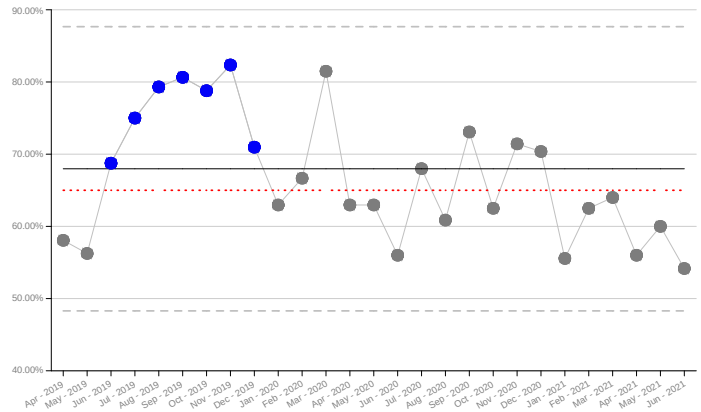


7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind - TRUST

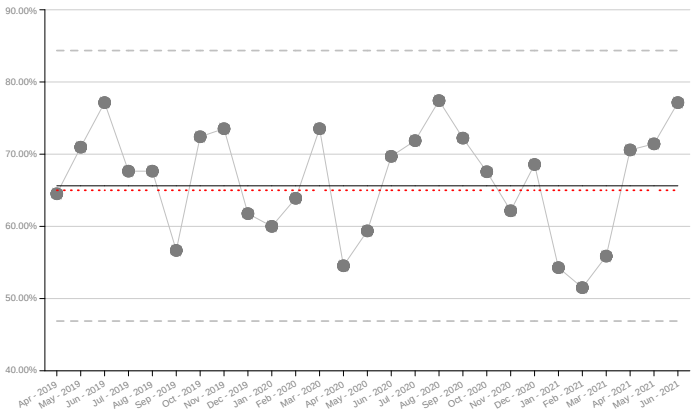


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			68.33%	80.70%	55.96%
DURHAM AND DARLINGTON			67.98%	87.66%	48.30%
NORTH YORKSHIRE AND YORK			65.62%	84.35%	46.89%
TEESSIDE			71.56%	91.12%	52.00%

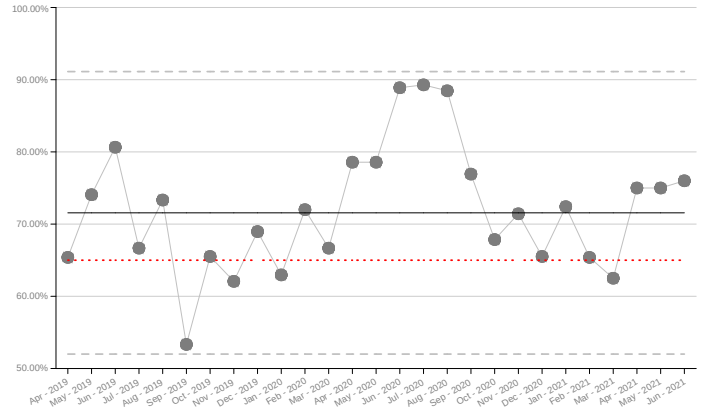
DURHAM AND DARLINGTON



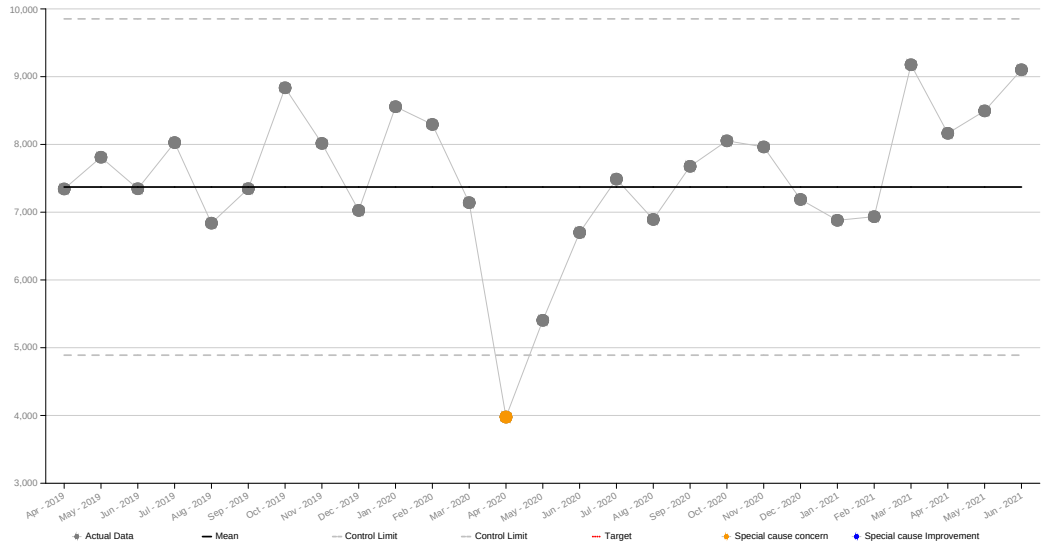
NORTH YORKSHIRE AND YORK



TEESSIDE

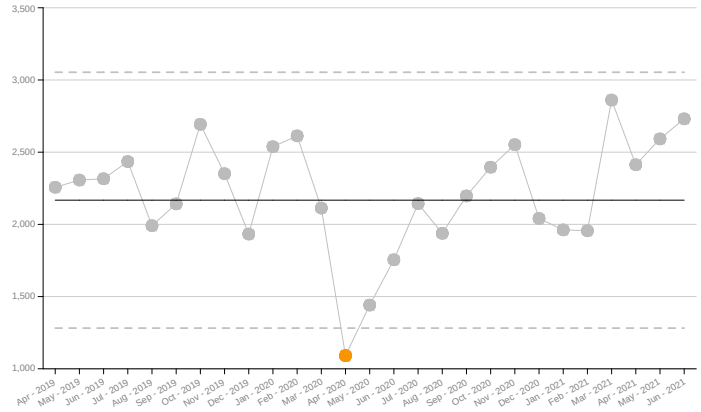


8) Number of new unique patients referred - TRUST

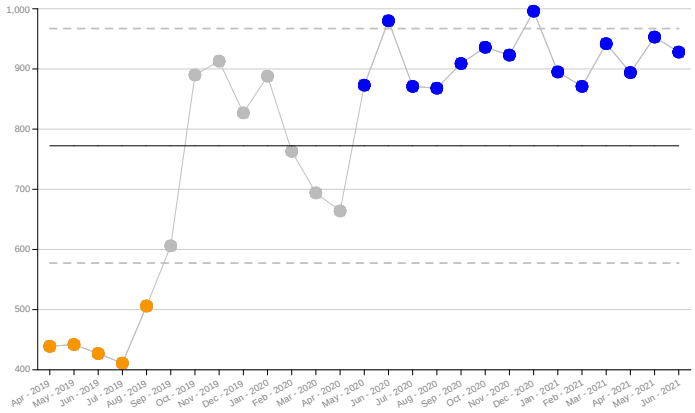


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			7,371.46	9,853.01	4,889.91
DURHAM AND DARLINGTON			2,167.62	3,053.52	1,281.73
FORENSIC SERVICES			772.25	967.12	577.38
NORTH YORKSHIRE AND YORK			2,136.17	2,871.37	1,400.97
TEESSIDE			2,295.33	3,112.42	1,478.25

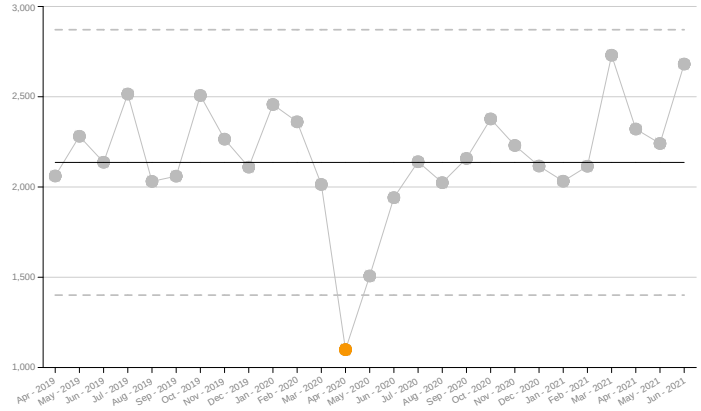
DURHAM AND DARLINGTON



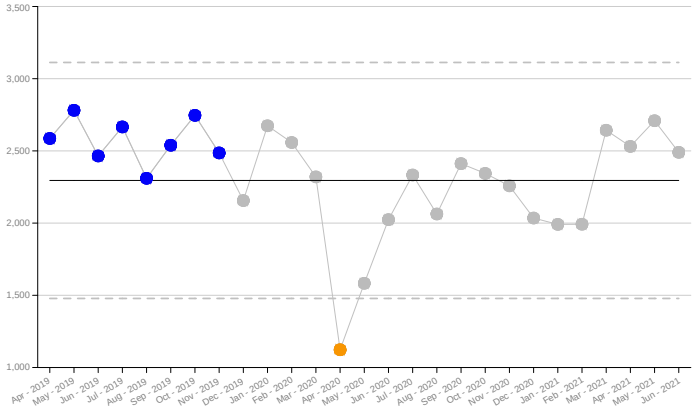
FORENSIC SERVICES



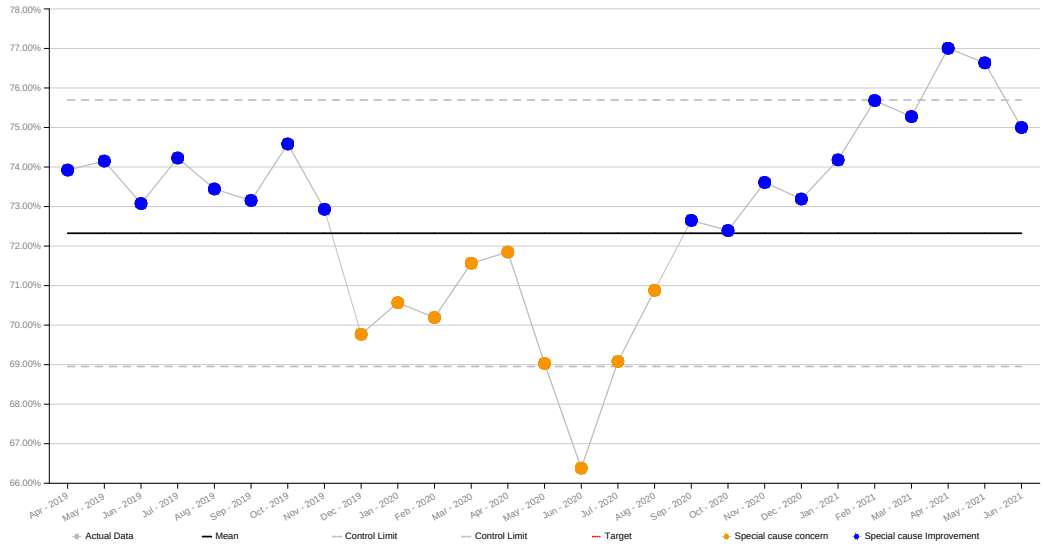
NORTH YORKSHIRE AND YORK



TEESSIDE

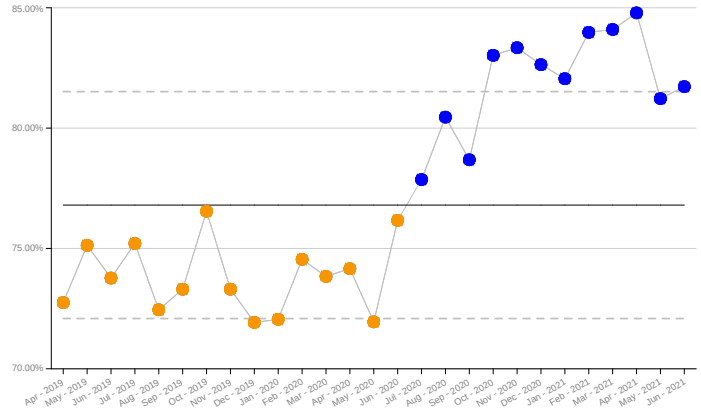


9) The percentage of new unique patients referred with an assessment completed (2 months behind) - TRUST

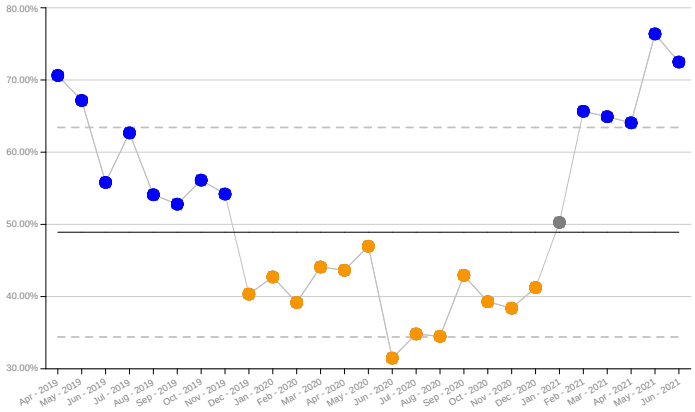


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H		72.32%	75.69%	68.95%
DURHAM AND DARLINGTON	H		76.80%	81.52%	72.09%
FORENSIC SERVICES	H		48.91%	63.42%	34.40%
NORTH YORKSHIRE AND YORK			74.10%	78.26%	69.95%
TEESSIDE	L		75.00%	78.45%	71.55%

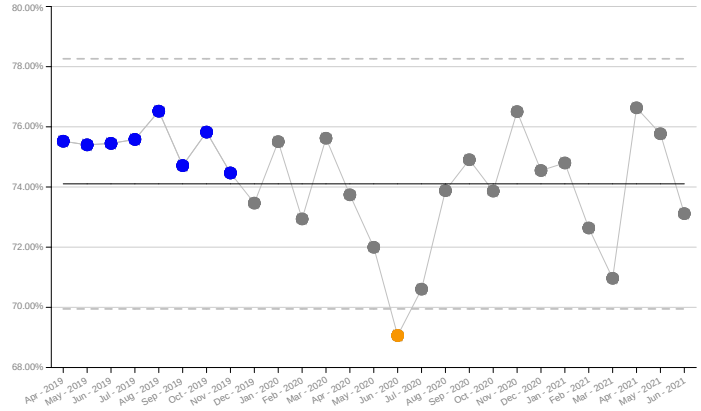
DURHAM AND DARLINGTON



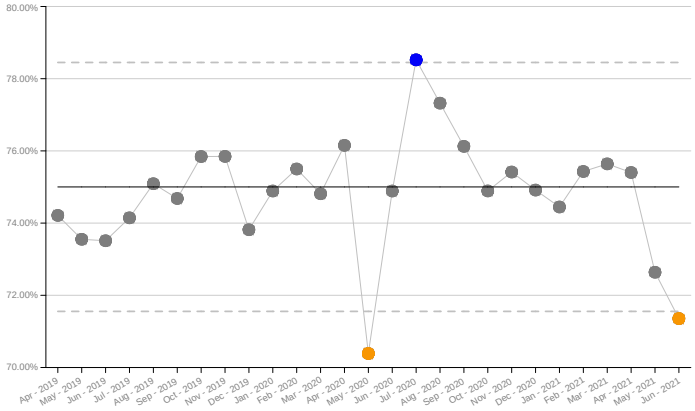
FORENSIC SERVICES



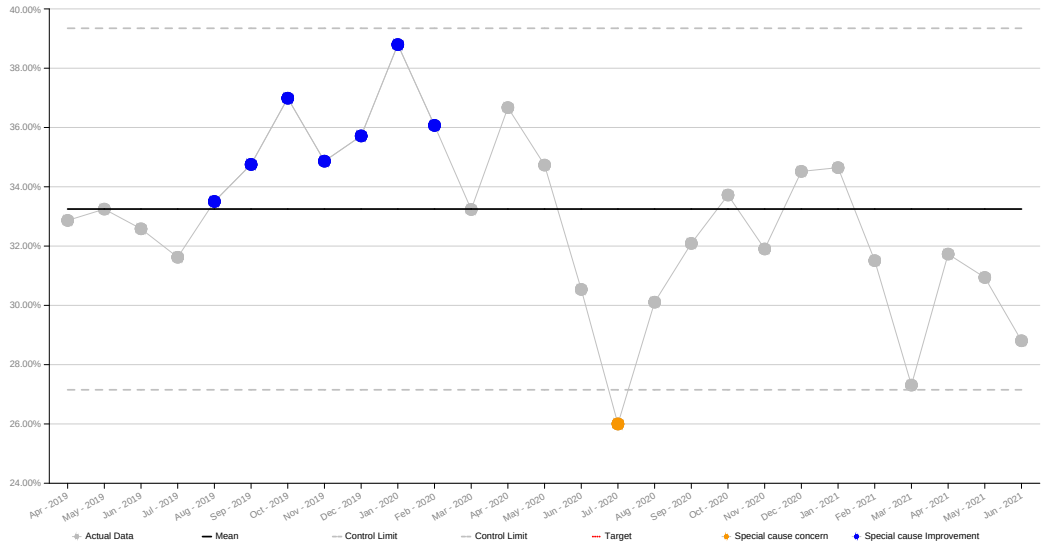
NORTH YORKSHIRE AND YORK



TEESSIDE

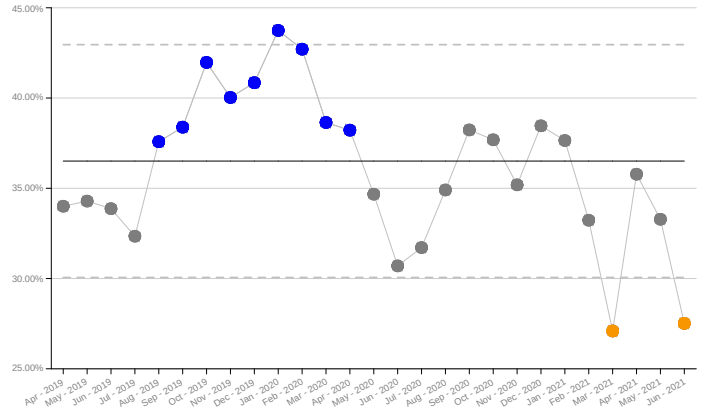


10) The percentage of new unique patients referred and taken on for treatment (3 months behind) - TRUST

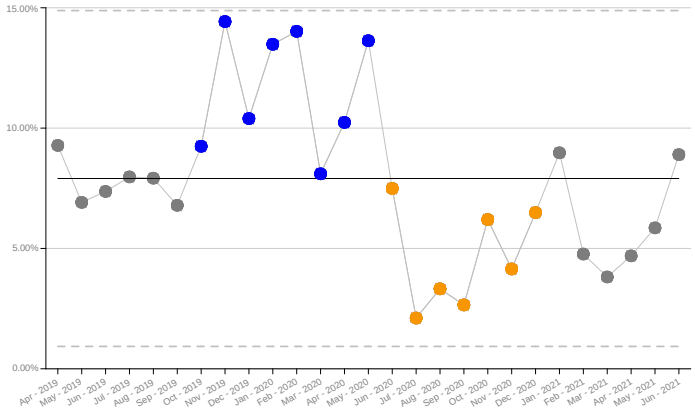


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			33.25%	39.35%	27.15%
DURHAM AND DARLINGTON	L		36.51%	42.96%	30.06%
FORENSIC SERVICES			7.91%	14.88%	0.93%
NORTH YORKSHIRE AND YORK			41.64%	48.27%	35.00%
TEESSIDE	L		30.78%	36.49%	25.07%

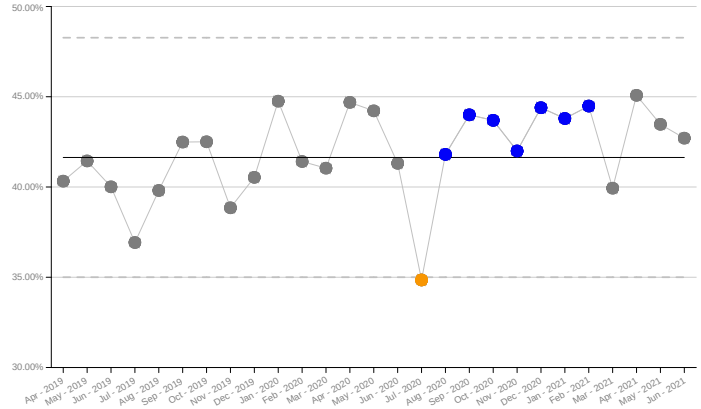
DURHAM AND DARLINGTON



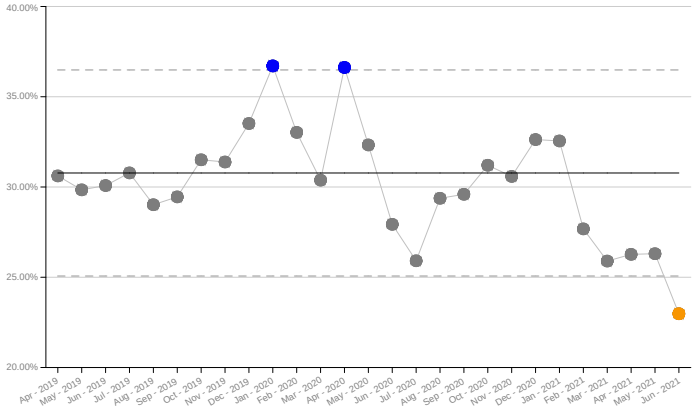
FORENSIC SERVICES



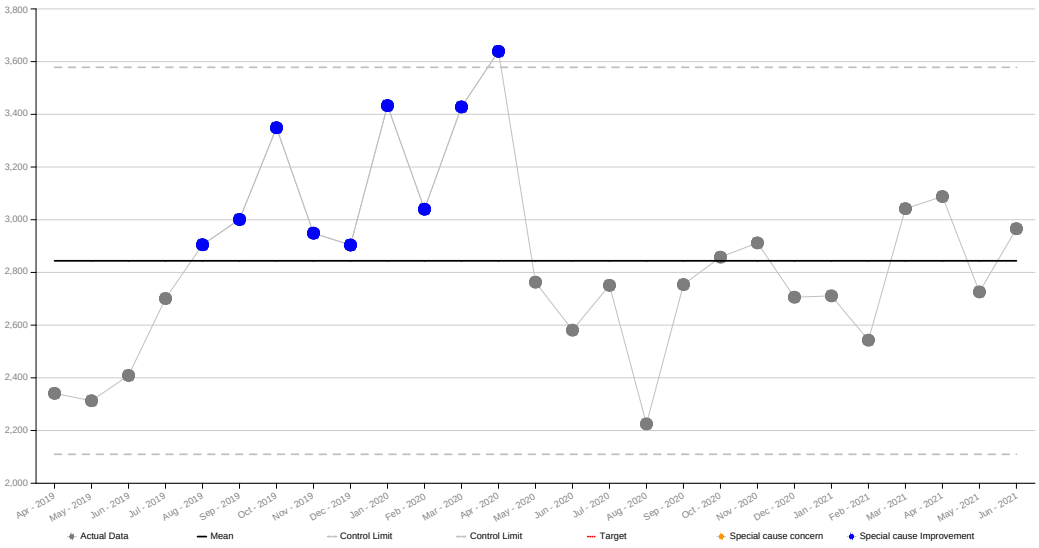
NORTH YORKSHIRE AND YORK



TEESSIDE

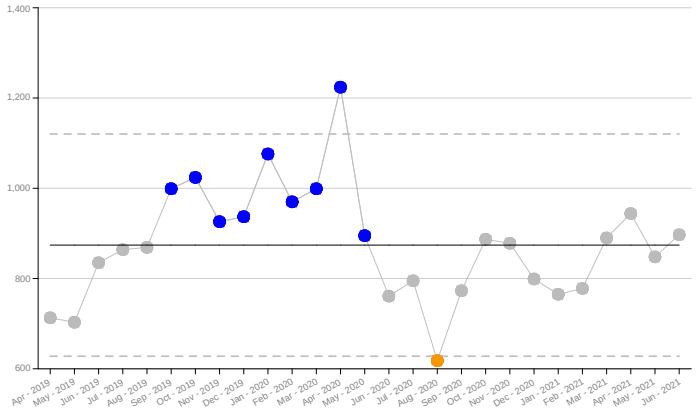


11) Number of unique patients discharged (treated only) - TRUST

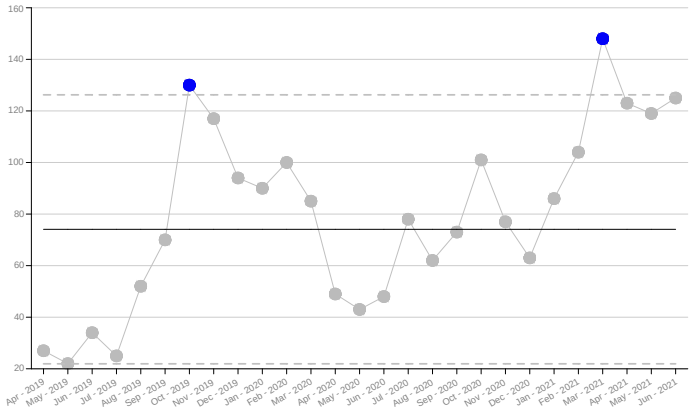


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			2,844.08	3,578.36	2,109.81
DURHAM AND DARLINGTON			874.08	1,120.31	627.86
FORENSIC SERVICES			74.08	126.24	21.92
NORTH YORKSHIRE AND YORK			1,002.96	1,324.82	681.10
TEESSIDE	L		892.96	1,186.48	599.43

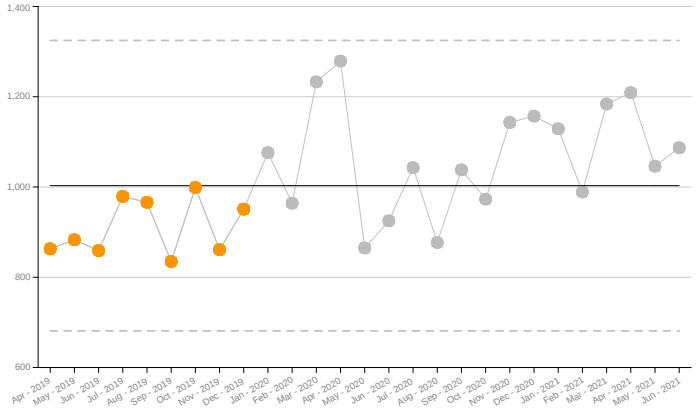
DURHAM AND DARLINGTON



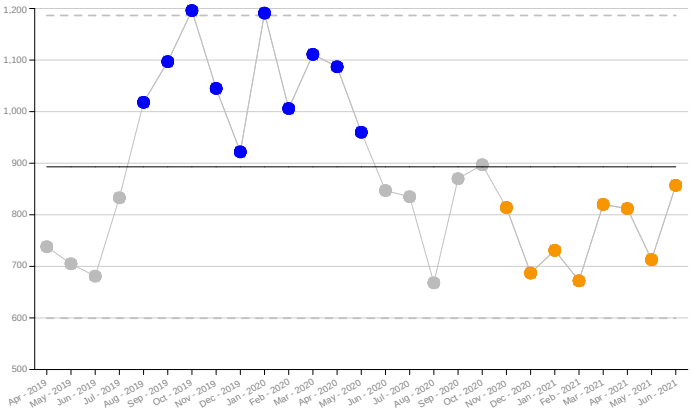
FORENSIC SERVICES



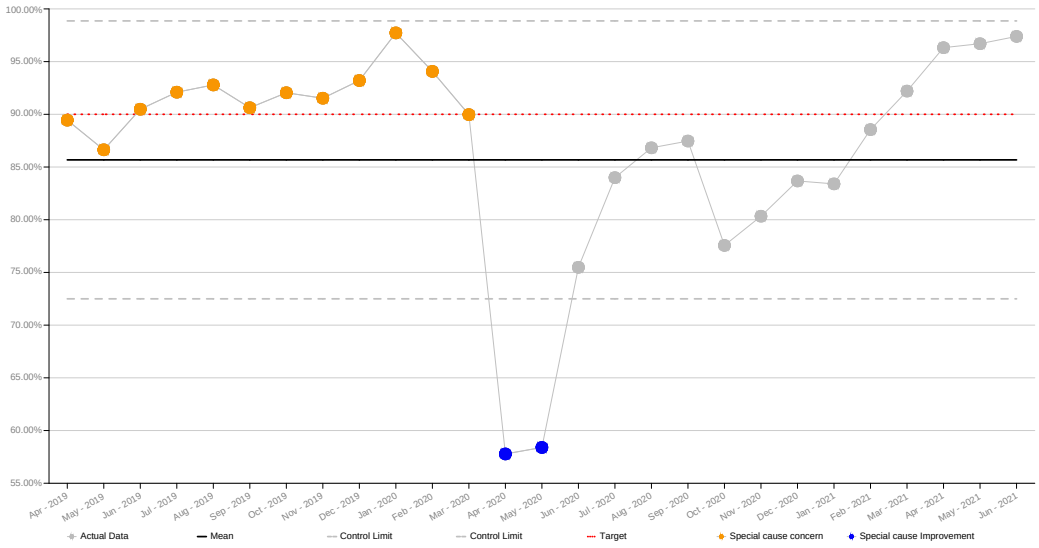
NORTH YORKSHIRE AND YORK



TEESSIDE

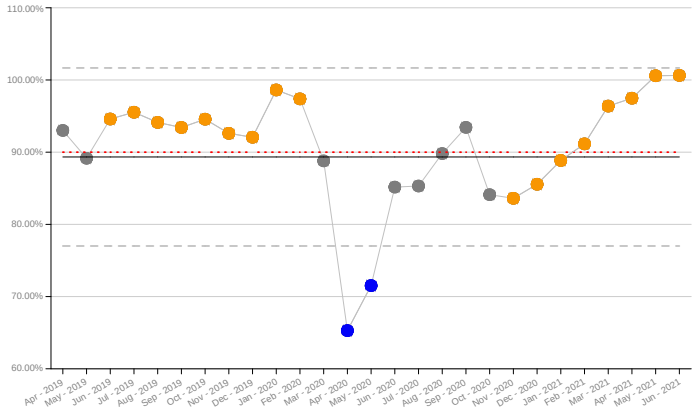


12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards) - TRUST

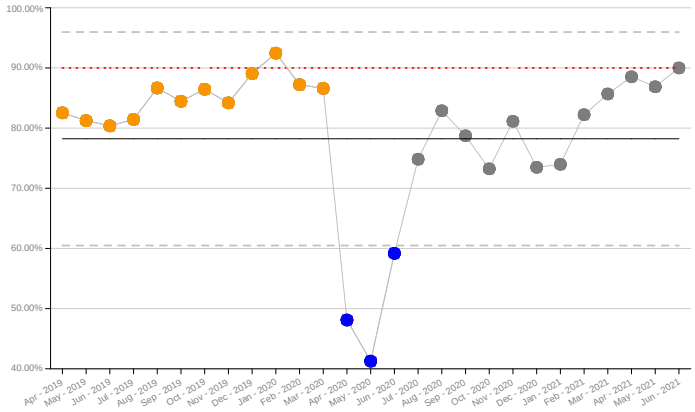


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			85.68%	98.86%	72.49%
DURHAM AND DARLINGTON	H		89.34%	101.67%	77.01%
NORTH YORKSHIRE AND YORK			78.23%	95.97%	60.49%
TEESSIDE			90.75%	108.44%	73.07%

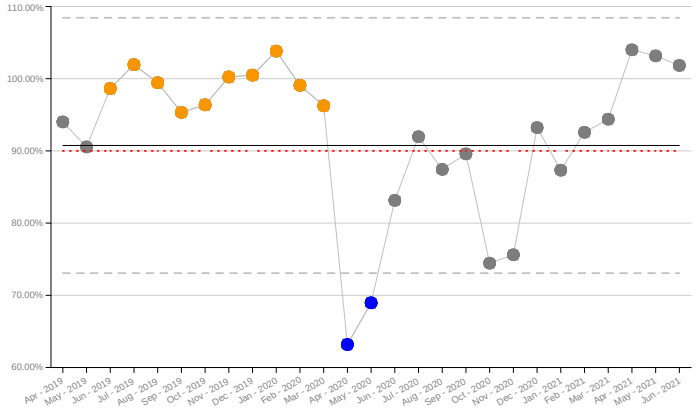
DURHAM AND DARLINGTON



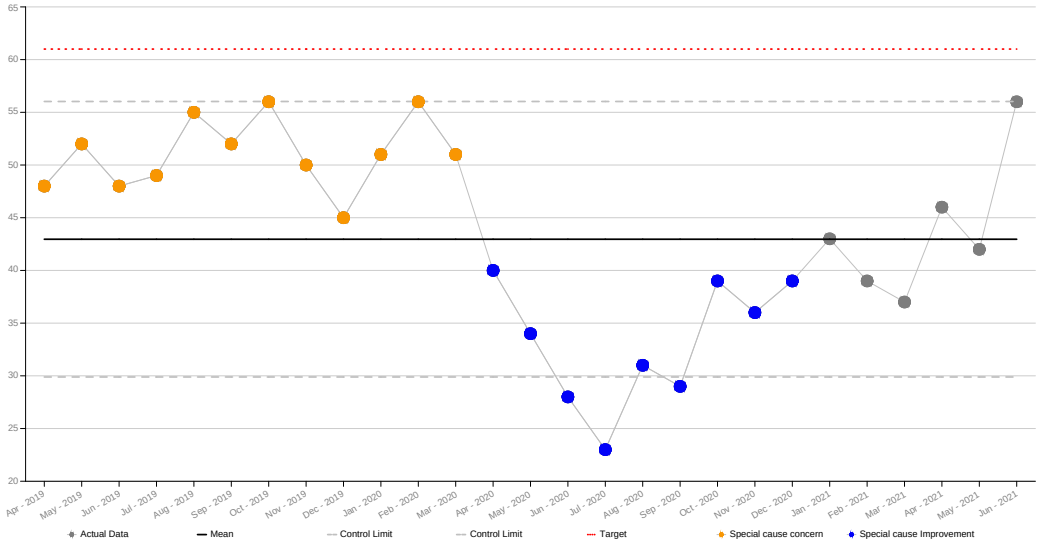
NORTH YORKSHIRE AND YORK



TEESSIDE

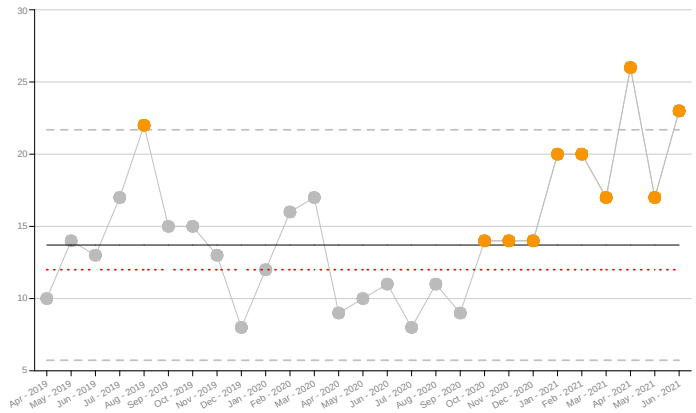


13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot - TRUST

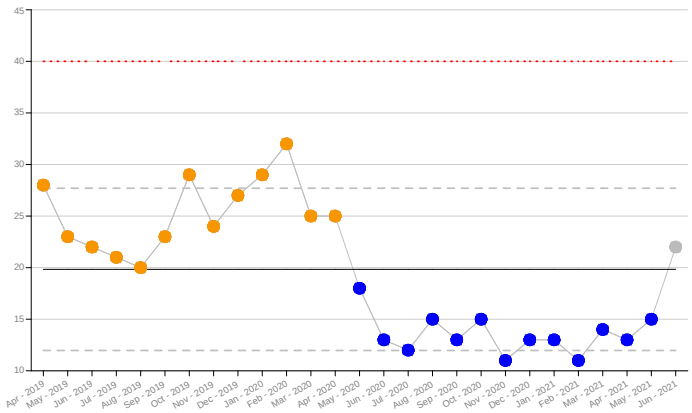


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST		P	42.96	56.03	29.89
DURHAM AND DARLINGTON	H	?	13.71	21.69	5.73
NORTH YORKSHIRE AND YORK		P	19.83	27.70	11.97
TEESSIDE		?	8.62	13.14	4.11

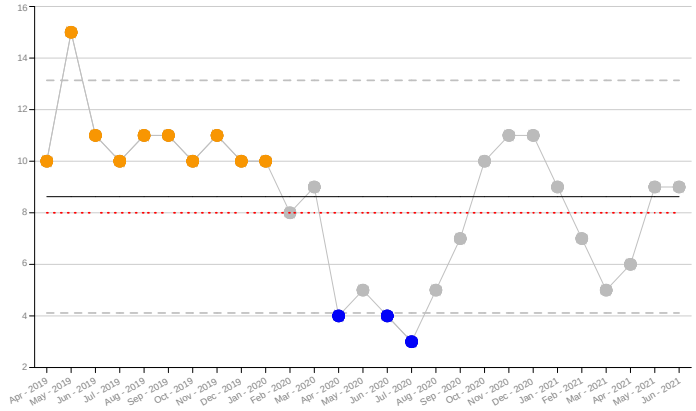
DURHAM AND DARLINGTON



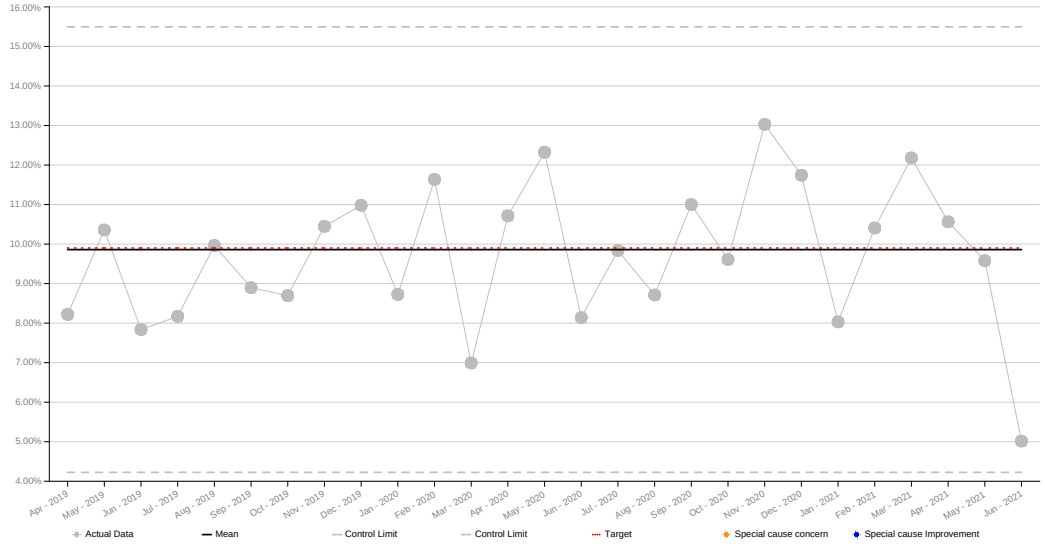
NORTH YORKSHIRE AND YORK



TEESSIDE

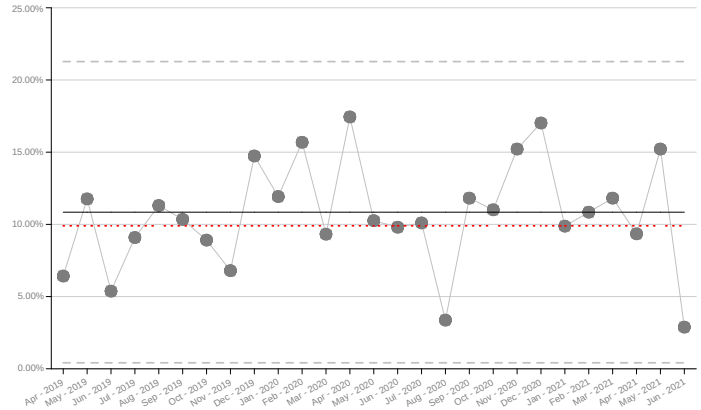


14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - TRUST

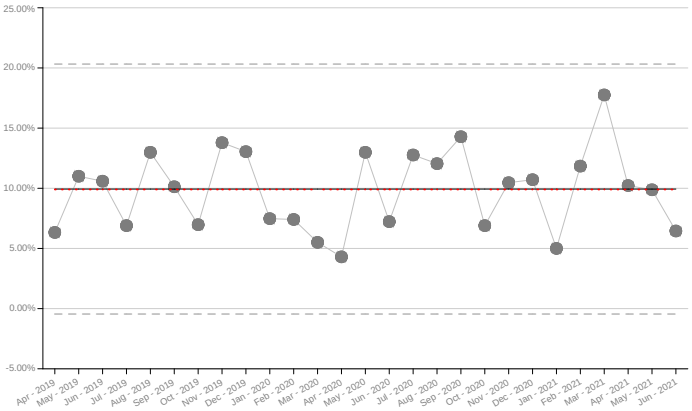


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			9.86%	15.50%	4.22%
DURHAM AND DARLINGTON			10.84%	21.27%	0.41%
NORTH YORKSHIRE AND YORK			9.93%	20.32%	-0.45%
TEESSIDE			8.80%	17.14%	0.46%

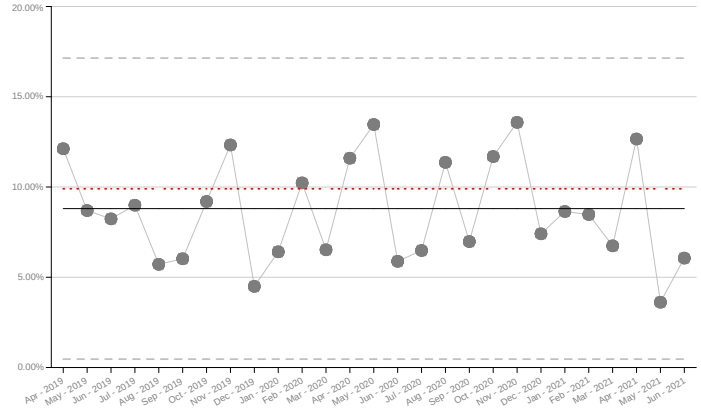
DURHAM AND DARLINGTON



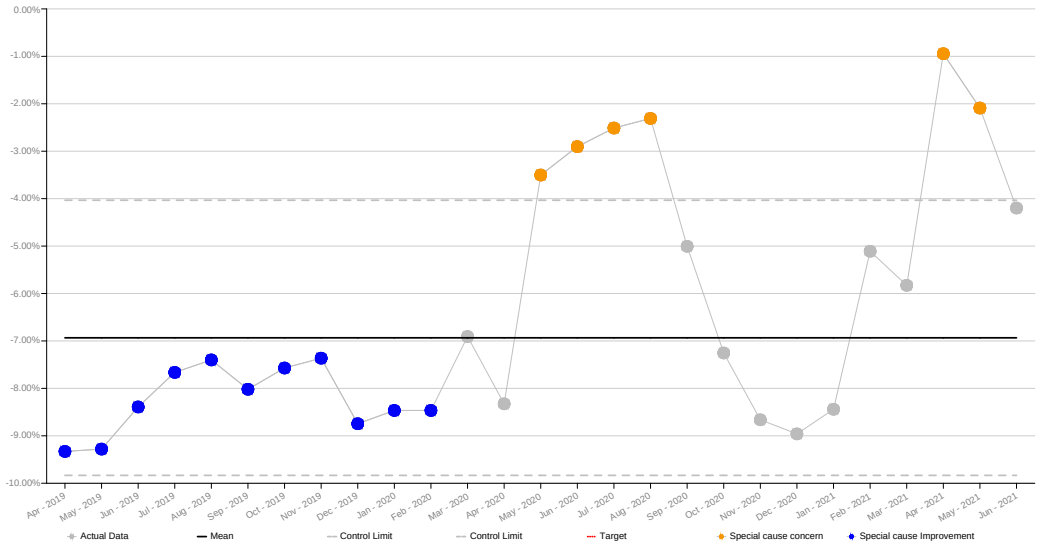
NORTH YORKSHIRE AND YORK



TEESSIDE

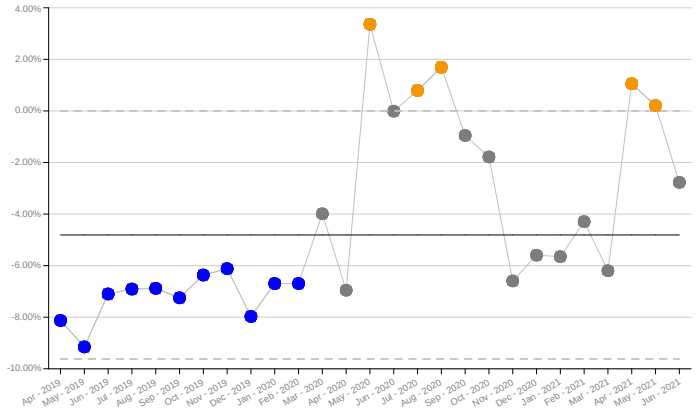


15) Finance Vacancy Rate - TRUST

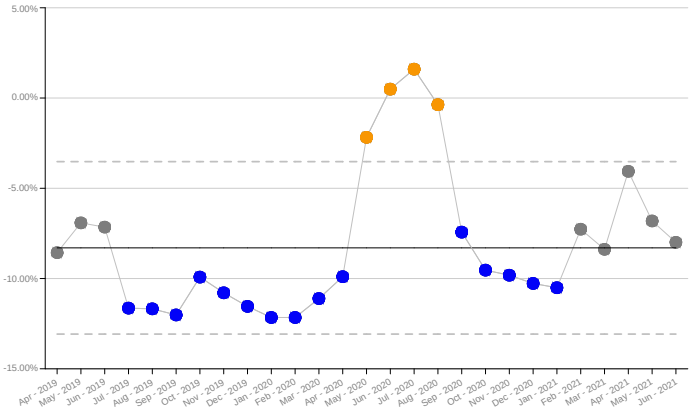


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			-6.93%	-4.03%	-9.83%
DURHAM AND DARLINGTON			-4.81%	0.00%	-9.62%
FORENSIC SERVICES			-8.30%	-3.52%	-13.08%
NORTH YORKSHIRE AND YORK			-6.32%	-2.81%	-9.84%
TEESSIDE			-7.17%	-2.57%	-11.76%

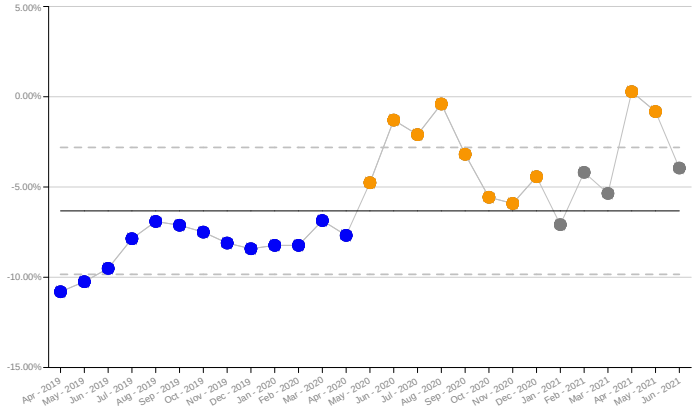
DURHAM AND DARLINGTON



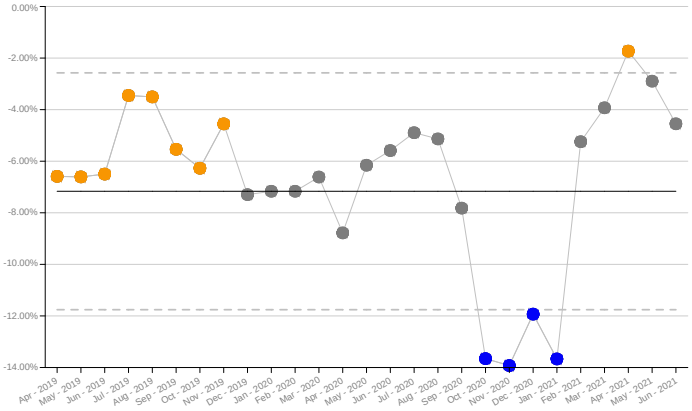
FORENSIC SERVICES



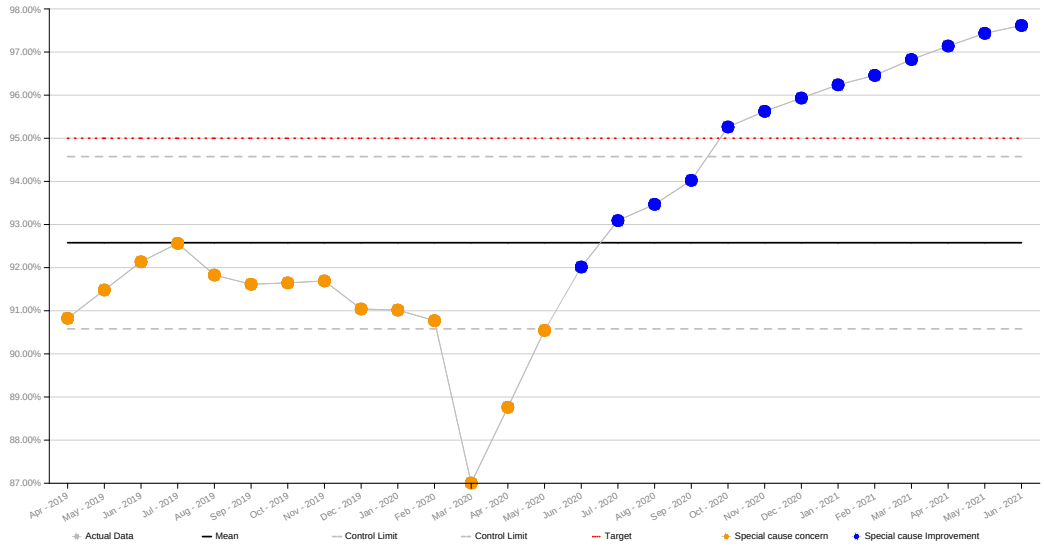
NORTH YORKSHIRE AND YORK



TEESSIDE

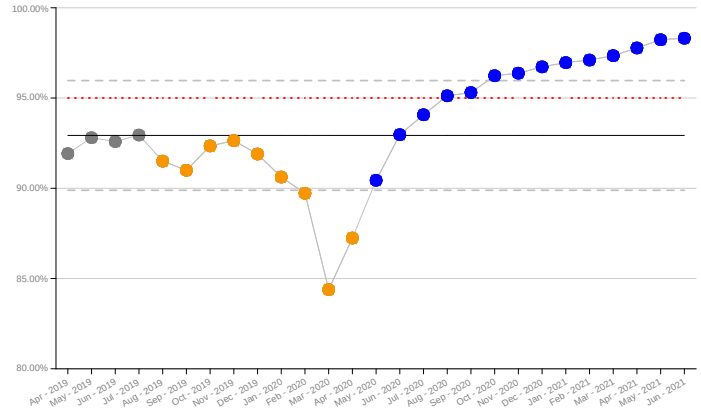


16) Percentage of staff in post with a current appraisal - TRUST

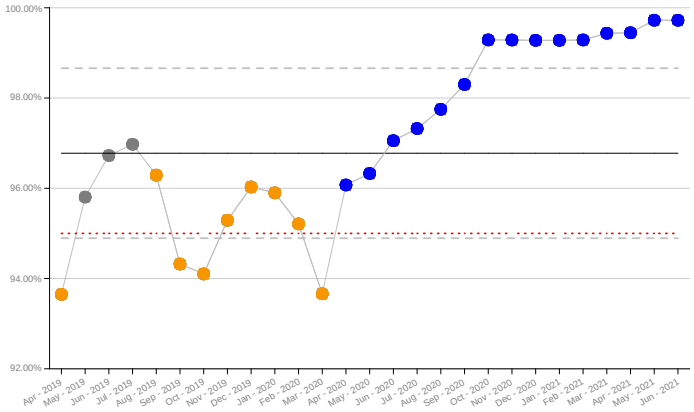


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST	H	F	92.58%	94.58%	90.58%
DURHAM AND DARLINGTON	H	?	92.93%	95.97%	89.89%
FORENSIC SERVICES	H	?	96.78%	98.66%	94.89%
NORTH YORKSHIRE AND YORK	H	F	91.14%	93.91%	88.38%
TEESSIDE	H	?	94.44%	96.27%	92.60%

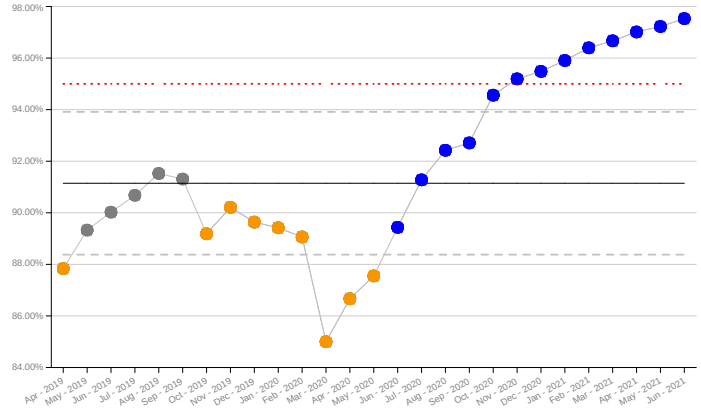
DURHAM AND DARLINGTON



FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



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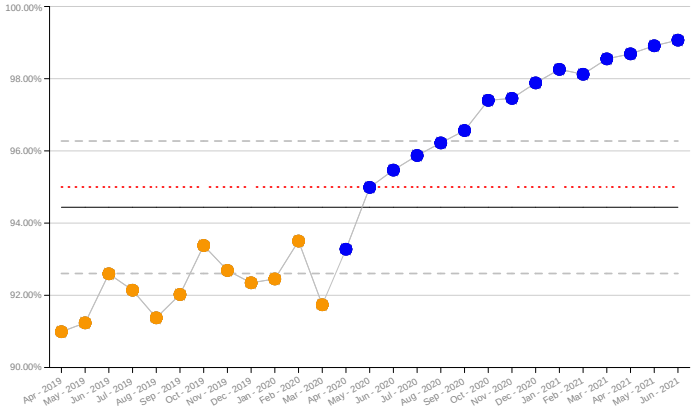
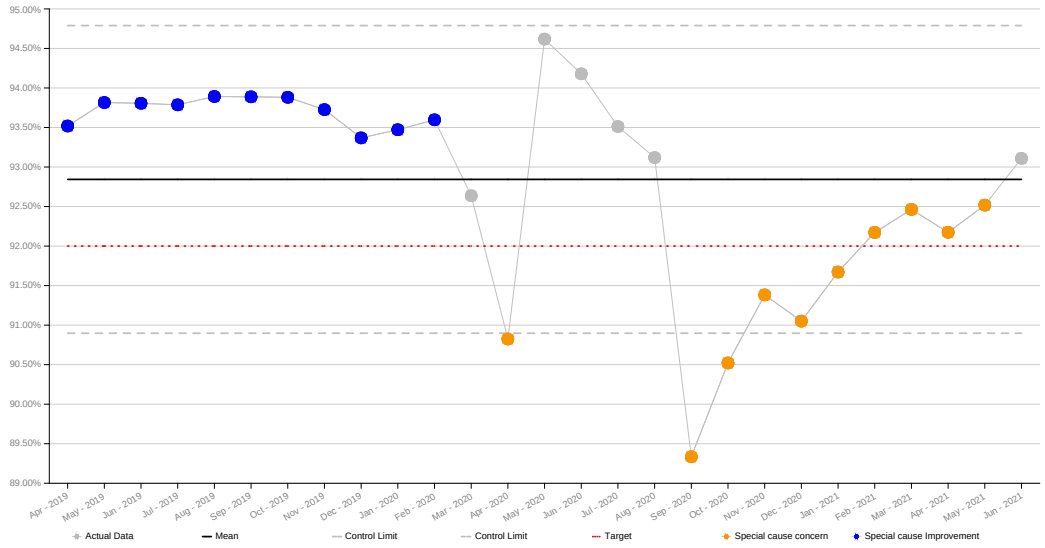
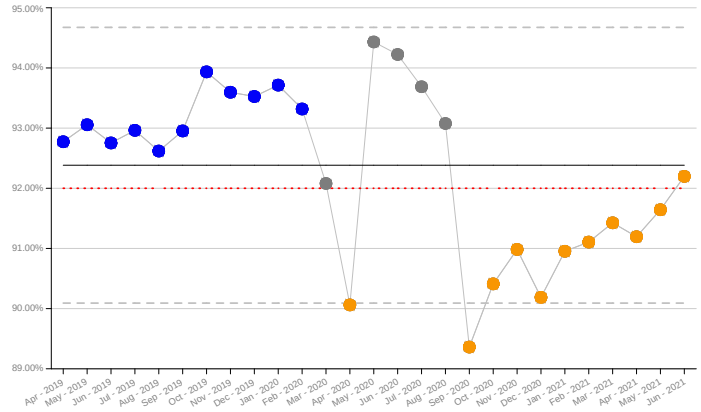


17) Percentage compliance with ALL mandatory and statutory training (snapshot) - TRUST

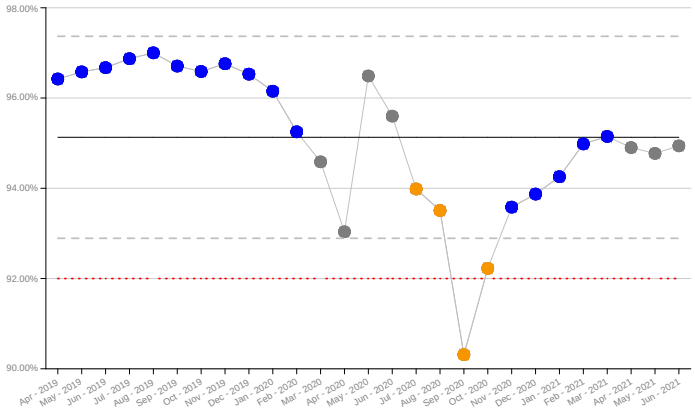


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST			92.84%	94.79%	90.90%
DURHAM AND DARLINGTON	L		92.38%	94.67%	90.09%
FORENSIC SERVICES		P	95.13%	97.37%	92.89%
NORTH YORKSHIRE AND YORK			90.35%	92.92%	87.78%
TEESSIDE			93.84%	95.76%	91.91%

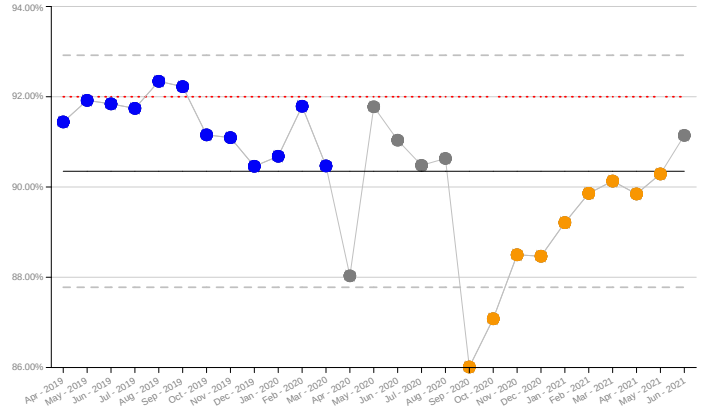
DURHAM AND DARLINGTON



FORENSIC SERVICES



NORTH YORKSHIRE AND YORK



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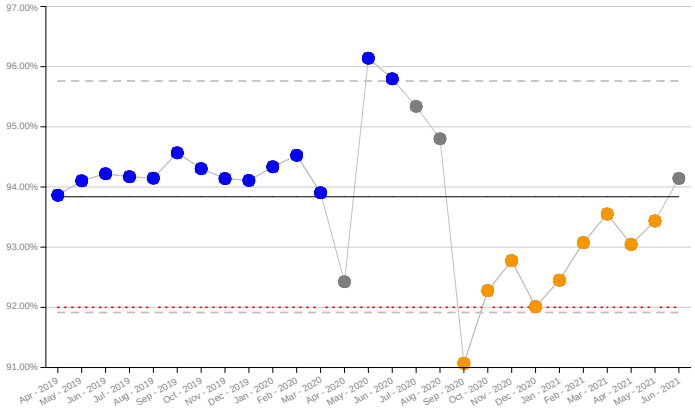
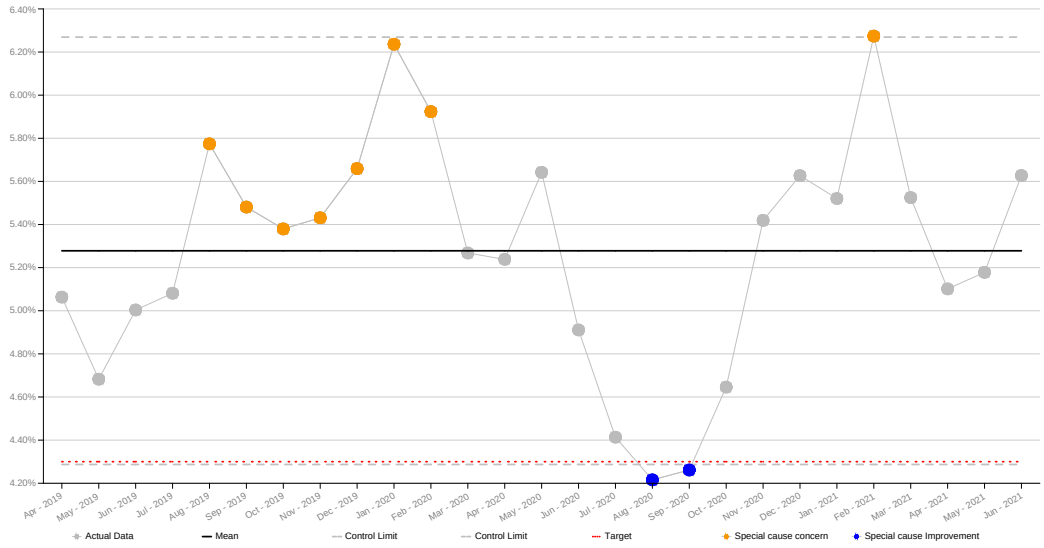
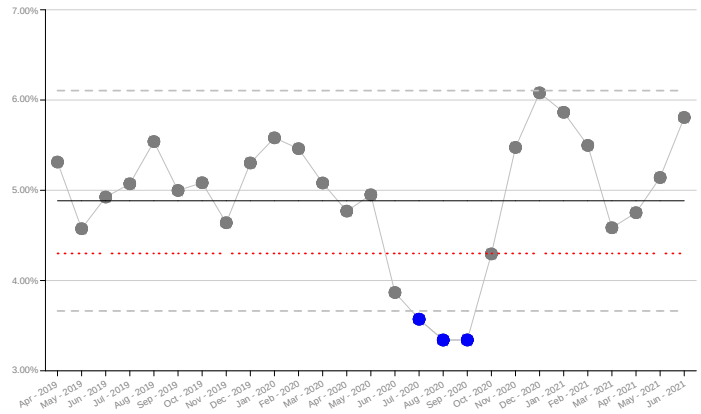


18) Percentage Sickness Absence Rate (month behind) - TRUST

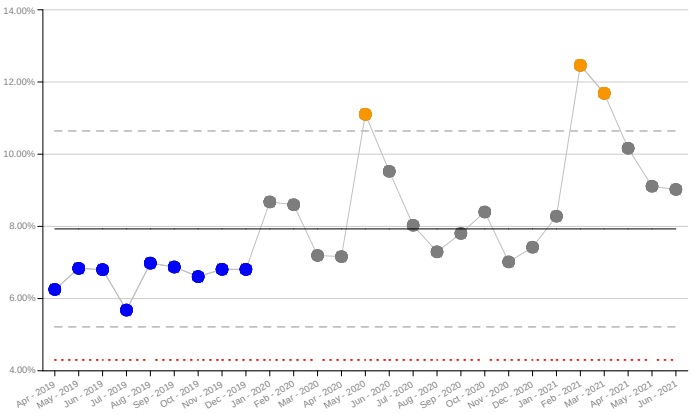


Locality	Variation	Assurance	Mean Observation	Upper Control Limit	Lower Control Limit
TRUST		?	5.28%	6.27%	4.29%
DURHAM AND DARLINGTON		?	4.88%	6.10%	3.66%
FORENSIC SERVICES		F	7.93%	10.64%	5.22%
NORTH YORKSHIRE AND YORK		?	4.32%	5.31%	3.33%
TEESSIDE		F	5.91%	7.24%	4.58%

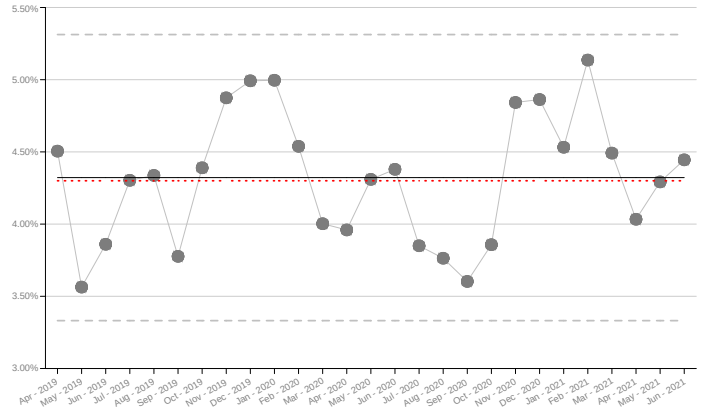
DURHAM AND DARLINGTON



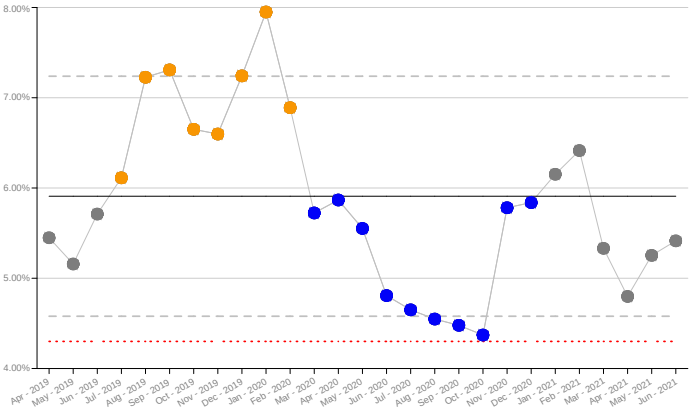
FORENSIC SERVICES



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
An Asterisk (*) at the end of a Measures name indicates that it is not up to date for the currently selected Report Period	

Appendix D

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD02) Percentage of patients starting treatment within 6 weeks of an external referral – Durham & Darlington locality – *We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and treatment is timely as we know this supports patient safety, wellbeing and quality of care.*

Key Conclusions to date

- The deterioration in this measure is now mostly impacted by CYPS, whose position has been impacted by staff vacancies.
- The CYPS position is impacted by a significant proportion of patients on a neurological pathway, whose waits to commence treatment are typically extended beyond 6 weeks due to the complexity of assessment.
- A further impact has been in relation to covid-related factors affecting the ability to see some patients in MHSOP.

Actions we said we would take

- A progress update will be provided by the speciality on the CYPS Recruitment, including the Darlington Team in July.
- CYPS to work with the Information and Corporate Performance Teams to understand any data quality issues around the recording of treatment codes in the Darlington team and the extent to which these impact on this measure and put actions in place to correct any historic inaccuracies, with an update on the timescales around this work provided in July.
- Corporate Performance Team, with support from the Service Manager, to identify the impact of the NBG coding interventions on this measure; an update to be provided in July.
- The service, with support from the Corporate Performance Team will provide an update in July on the work relating to patients on the Neurological pathway

Update on actions including assurance (where known)

The SPC chart for Durham and Darlington continues to indicate a cause for concern with the latest data point below the mean; this also continues to be reflected in the chart for CYPS. At team level, North Durham, South Durham, Easington and Darlington Community teams continue to indicate special cause concern.

- Previous analysis had concluded that performance has been impacted by vacancies within the North Durham, South Durham and Easington teams and updates regarding vacancies were provided; however recent discussions have identified there may have been additional vacancies impacting performance that have not been identified previously and further work is required to understand this. A full update will be provided in next month's report. The Darlington Team Manager vacancy continues to impact on management capacity and the post is currently being re-advertised following unsuccessful recruitment.
- Patient level analysis of long-term waiters had previously identified data quality issues associated with the recording of treatment intervention codes within the Darlington team and further analysis into the impact of this within this team and the other three generic community teams has taken place. The findings demonstrated data recording issues across all 4 generic community teams; those identified have been corrected. To minimise the recurrence of future data quality issues, the CYPS Head of Service is to contact all staff to remind them of current treatment intervention recording requirements. Senior leadership will also identify new ways to improve awareness of and adherence to those requirements, including the consideration of new visual aids and any additional forums or staff groups that could adopt a lead in conveying messages around the importance and value of accuracy in this area. Progress will be monitored to ensure these issues do not recur.
- Additional analysis has shown that all community teams have patients on their caseload who are on a neurological pathway, accounting for 51% of those currently waiting for treatment. These patients' waits to commence treatment are typically extended beyond 6 weeks due to the complexity of the assessments required, which involve multiple agencies. CYP Services are currently undertaking validation work on the treatment waiting list and the Service Development Group will meet in August to the discuss findings and proposals for monitoring this cohort of patients. An update will be provided in September.
- In June 2020 CYP Service Development Group agreed a new standard for coding treatment and intervention aligned to Needs Based Groupings (NBG); a number of those agreed intervention codes are not currently recognised by this measure as 'commencing treatment'. Due to pressures within the service, the analysis to identify the impact of these was not able to be completed; however a change request has been submitted to amend the construction of this measure to ensure that all Needs Based Grouping treatment interventions are captured. That is now being progressed in line with Technical Change Board processes. Performance against this measure will continue to be monitored to ensure the changes made have the desired impact.

All other specialities are displaying common cause variation (no significant change) and are therefore not a concern at this point in time.

Actions being taken to provide assurance

- Service Managers to undertake analysis on the impact of recruitment issues on performance against this measure and an update will be provided in September.
- The Corporate Performance team to provide an update in September on the progress of the amendment to the measure to capture all agreed treatment interventions.
- The Service Development Group to complete an analysis of findings on the inclusion of patients on the neurological pathway in this measure. An update will be provided in September.

Recommendations

To note the assurance provided in respect of data quality issues and the further actions to be taken and that a further update will be provided in September.

Appendix D

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD02) Percentage of patients starting treatment within 6 weeks of an external referral – Teesside locality - *We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and treatment is timely as we know this supports patient safety, wellbeing and quality of care.*

Key Conclusions to date

Cause for concern was identified for both CYPS and AMH, with consecutive deteriorations in both services being observed. Further analysis within CYPS highlighted the generic community teams as key areas of concern and this may be linked to a change in coding practice. Within AMH the Access teams were identified as a key area. Further analysis has been undertaken to understand the underlying reasons for this.

Actions we said we would take

A deep dive analysis was to be undertaken to identify key areas of concern within CYPS and AMH. An initial update was provided in April and May 21.

AMH Access Team Managers have completed a process review into the access to medical staff. Findings were reported in June 2021.

Corporate Performance Team, with support from the Service Manager, to identify the impact of the NBG coding interventions on this measure; an update to be provided in July.

AMH Associate Clinical Director, supported by the Corporate Performance lead, to complete analysis to improve understanding of key areas of pressure in terms of demand and findings will be reported in July 21.

Update on actions including assurance (where known)

- Within CYPS, the SPC at speciality level continues to show common cause variation. In June 2020 CYP Service Development Group agreed a new standard for coding treatment and intervention aligned to Needs Based Groupings (NBG); a number of those agreed intervention codes are not currently recognised by this measure as 'commencing treatment'. 13 out of 40 patients reviewed in May had a Needs Based Groupings recorded that were not captured on the TD02 measure. A change request has been submitted to amend the construction of this measure to ensure that all Needs Based Grouping treatment interventions are captured. That is now being progressed in line with Technical Change Board processes. Performance against this measure will continue to be monitored to ensure the changes made have the desired impact and an update will be provided in September.
  Previous analysis has identified delays being experienced due to the assessment process within the Single Point of Contact team; the Service review of processes to improve efficiency and quicker throughput to teams continues.

- Within AMH, the SPC data ending June 2021 continues to show common cause variation, the standard continues to be achieved and activity is above the mean. The Associate Clinical Director has completed further analysis on the data. That has confirmed that performance against this measure had been impacted by data quality issues in respect of the recording of patients waiting for medic appointments. The deep dive confirmed that all patients had received treatment and provided assurance that there was no concern in respect of medic capacity. Clarification of process and training has been provided to ensure that these issues are prevented and the latest data provides assurance that this has had the desired impact. Initial variances seen across the Access teams are no longer visible with all four teams now indicating common cause or special cause improvement.

Actions being taken to provide assurance

- CYP Service Managers are to develop a standard and flow chart clarifying the correct coding processes for sharing with teams. This will be completed by the end of July and an update will be provided in August.
- CYP Service Managers are to review the Single Point of Contact processes to improve efficiency. This will be completed by the end of July and an update will be provided in August.
- The Corporate Performance team to provide an update in September on the progress of the amendment to the measure to capture all agreed treatment interventions.

Recommendations

To note the assurance provided in respect of AMH services and the progress undertaken to date within CYPS including the further actions that will be undertaken.

TD04) Percentage of patients surveyed reporting their overall experience as excellent or good - *We are all committed to co creating a great experience for patients, and carers and families by ensuring we are providing outstanding and compassionate care and that people tell us this is the case from their experience.*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Conclusions to date

- The SPC Charts at Trust and Locality level indicated special cause variation of particular concern (decline) for both the numerator (number of patients who have scored "excellent" or "good" for the overall experience in the patient survey) and the denominator (Number of patients who have responded to the overall experience question in the patient survey).
- From the analysis of the narrative provided by our patients and carers we identified a range of areas that patients had expressed dissatisfaction for example waiting times, access to services, activities and feeling safe
- It was decided that further work was required to assure the board that key areas of learning had been addressed through implementing locality improvement plans.

Actions we said we would take

Step 1b Insight:

- PaCE Team to continue to work with individual locality leads to develop improvement plans by 30th June 2021.
- PaCE Team will monitor progress against the improvement taking into account operational pressures. A further update will be provided by 30th July 2021.
- PaCE Team will analyse National Benchmarking information once it's made available

Step 2 Involve:

- Ensure a range of stakeholders are involved in determining areas of patient experience for improvement.

Step 3 Improve:

- Agree and implement most appropriate quality improvement approaches with process and outcome measures where appropriate and link to overarching patient rating. (Timescale will be confirmed once actions 1-3 are complete)

Step 4 Inspire:

- Share key success and learning at relevant points in the journey. Timescale will be confirmed once actions 4 are complete.

Update on actions including assurance (where known)

Step 1b Insight:

- The PaCE team have worked with all localities across the trust to develop service improvement plans linked to Patient Experience as follows:

  Durham & Darlington – from the deep dive exercise the locality have identified 3 key areas of the patient experience for improvement: waiting times, feeling safe and communication. In addition there will be a focus on improving response rates and having better oversight of the patient experience data, as well as evaluating a semi structured interview pilot. The improvements undertaken by the service will be measurable through an increase in the number of responses and the overall satisfaction scores.

  Teesside - Within Tees the deep dive exercise highlighted areas of improvement related to feeling safe which the initial improvement plan has focussed upon and will later be expanded to include communication and waiting times. We will measure the impact of these specific pieces of work by monitoring the feeling safe measure within the Quality Strategy Scorecard and the narrative comments. Improvements include re-establishing the violence and aggression task & finish group; seeking to increase activity equipment for patients and; create more therapeutic spaces.

  Forensic Services - the deep dive highlighted insufficient staffing as a key area for improvement in the context of the patient experience. A detailed plan has been developed. A further area highlighted from analysis of the data related to patients not feeling safe on our wards, and this will be the next area for improvement. The improvements undertaken by the service will be measurable through the number of staff available metric, the narrative feedback received and the safe staffing measures.

  - **North Yorkshire and York** – the deep dive highlighted the following key areas for improvement: increasing low response rates and the environment which the initial improvement plan has focussed upon and will later be expanded to include the other areas in relation to feeling safe and the number of staff. The improvements undertaken by the service will be measurable through an increase in the number of responses, the overall satisfaction scores and the narrative feedback. Promoting the use of alternative technology to improve response rates and Modern Matron Plans have been initiated and include responding to service user feedback, recruitment to new roles e.g. activity co-ordinators.

- The national benchmarking data has been analysed and has highlighted TEWV as having the highest number of responses when compared to other MH Trusts and that 91% of patients rated the service as 'very good' or 'good' (above the national average). The benchmarking data will continue to be monitored and any concerns will be raised should they arise.

Step 2 Involve:

The Locality Patient Experience groups (where established) currently consist of TEWV staff. This will be expanded to include key stakeholders. The PaCE team will work with locality patient experience groups to ensure that they are involving service users and carers where possible to ensure that identified actions for the service are co-created with families and patients.

Actions being taken to provide assurance

- NYY and Forensic Services to establish their patient experience groups in September 2021
- Ongoing monitoring of the implementation and impact of localities Patient Experience Improvement Plans will take place monthly until further notice. Monthly updates provided to the Quality Assurance and Improvement Group
- The membership of the Patient Experience groups to be expanded to include key stakeholders. An update will be provided in September 2021.

Recommendations

To note the progress that has been made to date within all localities and to receive a further update in September 2021.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) – <u>Teesside locality</u> – *We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and receive a timely assessment as we know this supports patient safety, wellbeing and quality of care.*

Analysis based on data ending May 21

At locality level, the SPC for Tees displays special cause concern with the latest data point below the lower process limit. Initial analysis has taken place at speciality and team level which has identified the following:

- Within CYP, the SPC chart indicates special cause concern with the latest data point below the lower process limit. Initial analysis at team level identified:
  - The SPC charts for all CYP teams display common cause variation (no significant change), with the exception of that for Stockton LAC which is displaying special cause improvement.
  - For the denominator (the number of new unique patients referred from 2 months prior to the reporting period), all team-level SPCs charts display common cause variation.
  - For the numerator (the number of new unique patients referred with an assessment completed at any point in the patient journey to date), all team-level SPCs display common cause variation with the latest data point above the mean or near the upper process limit with the exception of the Hartlepool and Stockton generic community teams, the SPC charts for which show common cause variation with the latest data point below the mean. This suggests that performance against this measure may be impacted by activity within these two teams and further detailed analysis with the service is required to understand whether this is a cause for concern.
  - CYP HAST ASD Team do not have enough data points to plot an SPC chart; however their position in May is significantly lower than that reported in April. Analysis of the underlying data indicates an increase in children referred requiring an assessment and further investigation is required to establish whether this is an area of concern.
- Within ALD, the SPC charts display common cause variation at both specialty and team level. Therefore this is not an area of concern which we need to investigate further at this point.
- Within AMH, the SPC charts display special cause improvement at both speciality and team level. Therefore this is not an area of concern which we need to investigate further at this point.
- Within MHSOP, the SPC charts display common cause variation at both specialty and team level. Therefore this is not an area of concern which we need to investigate further at this point.

Conclusions

The current position within the Locality has been impacted by CYP services which is displaying cause for concern for the measure. Initial analysis has indicated this may be driven by performance within the Hartlepool and Stockton generic community teams; however, further investigation at team level is required to understand their positions in more detail.

Actions we will take

More detailed analysis will be undertaken by the Corporate Performance Team for the teams identified through initial analysis of CYP data to understand whether these are actual areas of concern. This work will be completed collaboratively with the Service Manager and findings shared in September.

Recommendations

To note the analysis that has taken place to date, the further actions we will take and to agree to receive an update in September 21.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) – Forensics Services - *We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding how many people receive treatment will help us understand if this is the case.*

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 work with the Clinical Leads for CITO to support improvements in this measure going forward. An update will be provided in June.
- The Head of Health and Justice Services to raise the appropriateness of telephone contacts as a treatment method at the Forensics Service Development group on the 17 June 2021. An update will be provided in July 2021.

Update on actions including assurance (where known)

- The Head of Corporate Performance has met with the Clinical Leads for CITO and requested the recording of assessment codes be facilitated within the project. This is a significant development for the Trust and these changes will be incorporated within the project plan however it should be noted that implementation of this will not be achieved until CITO goes live in August 2022.
- Monitoring of this measure has continued; however no improvements have been evidenced in the number of patients taken on for treatment.
- The Forensics Speciality Development Group (SDG) agreed telephone contacts as an appropriate method for delivering treatment at its June meeting; however further assurance to understand the rationale and impact upon patient care has been requested by the Quality Assurance and Improvement Sub Group. Patient-level analysis is to be undertaken to review the level of telephone contacts that have taken place to understand the reason, focus and appropriateness. This will be presented back to the Sub-group for further discussion.

Actions being taken to provide assurance

- The Service, with support from the Corporate Performance Lead, to undertake a patient level analysis into the use of telephone contacts. An update to be provided in September.

Recommendation

To note the progress made against the actions and receive an updated position in September 2021

Appendix D

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) – <u>Tees Locality</u> *We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding how many people receive treatment will help us understand if this is the case.*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 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
- AMH Services have seen a decrease in the number of patients entering treatment, particularly in Redcar & Cleveland Access Team.
- 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 review the data quality issues to identify the underlying causes and any mitigating processes that need to be put in place. An update will be provided in July
- The Head of Corporate Performance to work with the Clinical Leads for CITO to support improvements in this measure going forward. An update was provided in June and improvements will be taken forward as part of that project.
- The Corporate Performance Lead will support the Redcar and Cleveland Access team manager in a patient level deep dive. An update of findings will be provided in August.

Update on actions including assurance (where known)

- Within MHSOP the SPC chart remains in special cause concern (low) with those for the North Tees Liaison Service and South Tees Frailty Team both indicating special cause concern, which is attributable to their service model which facilitates the signposting of patients to the most appropriate service for their clinical care. The Service Development Manager has reviewed the instances where treatment codes were not recorded correctly and has determined:
  - a number instances where care co-ordination and assessment codes have been used instead of treatment code; these have subsequently been resolved.
  - a number of instances where staff have used the wrong section on the patient information system (Paris) to record activity
  - a number of duplicate referrals opened on Paris; these have now been resolved.

  The MHSOP Service Development Manager has provided assurance that all patients reviewed have been seen and are receiving treatment. To minimise the risk of future recurrence, the Service Development Manager is to develop a poster to highlight common issues and how to correct them. This will be completed by the end of July and shared with staff. They are also linking in with team managers to ensure that staff have the training and support required. Monitoring of this measure will continue to confirm whether the actions taken have had the desired impact.

- Within AMH services, the SPC charts continue to demonstrate common cause, however those for the numerator and denominator both display special cause concern and below the mean. At team level the SPC chart for Redcar & Cleveland Access Team remains special cause concern and a patient level deep dive is being undertaken to identify underlying reasons. Findings will be reported in August.

Actions being taken to provide assurance

- The MHSOP Service Development Manager, with support from the Corporate Performance team will monitor the MHSOP activity to ensure the actions taken have had the desired impact. An update will be provided in September.
- The Corporate Performance Lead will support the Redcar and Cleveland Access team manager in a patient level deep dive. An update of findings will be provided in August.

Recommendations

To note the further actions that will be completed within MHSOP and AMH and reported back in September and August 21 respectively.

Appendix D

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

TD11) Number of unique patients discharged (treated only) – Teesside locality – *We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and treatment, followed by an appropriate and timely discharge from our services as we know this supports patient safety, wellbeing and quality of care.*

Analysis based on data ending May 21

At locality level, the SPC for Teesside is displaying special cause concern with the latest data point near the lower process limit. Initial analysis has taken place at speciality and team level which has identified the following:

- Within CYP, the SPC charts display special cause concern with the latest data point near the lower process limit. The SPC charts for most teams display common cause variation (no significant change) with the latest data point near or above the mean with the exception of the following teams, which display special cause concern:
  - CYP Middlesbrough Community
  - CYP Redcar and Cleveland Community
  - CYP Stockton Community

  In addition, the SPC chart for the CYP Hartlepool Community displays common cause variation with the latest data point near the lower process limit. Further detailed analysis with the service is required to understand whether there is a cause for concern within these teams.

- Within MHSOP, the SPC charts display special cause concern with the latest data point just below the mean. The SPC charts for most teams display common cause variation with the latest data point near or above the mean with the exception of that for Tees Intensive Community Liaison which displays cause for concern. In addition, the SPC chart for the North Tees Liaison Psychiatry team displays common cause variation with the latest data point near the lower process limit. Further detailed analysis with the service is required to understand whether there is a cause for concern within these teams.

- Within AMH, the SPC charts indicate common cause variation with the latest data point just below the mean. The SPC charts for most teams display common cause variation with the latest data point near or above the mean with the exception of that for Redcar and Cleveland Access team which displays special cause concern. Further detailed analysis with the service is required to understand whether this is a cause for concern.

- Within ALD, the SPC charts indicate common cause variation with the latest position just below the mean. The SPC charts for all teams indicate common cause variation with the latest data point near or above the mean, this is therefore not currently an area of concern which requires further investigation.

Conclusions

The current position within the Locality has been mainly impacted by CYP and MHSOP services which are displaying cause for concern for the measure. However, further investigation is required to understand their positions in more detail and establish whether this is an actual area of concern.

Actions we will take

More detailed analysis will be undertaken by the Corporate Performance Team for the teams identified through initial analysis of CYP, MHSOP & AMH data at team level to understand whether these are actual areas of concern. This work will be completed collaboratively with the Service Managers for CYP and MHSOP and Redcar & Cleveland Access Team Manager for AMH; findings will be shared in September.

Recommendations

To note the analysis that has taken place to date, the further actions we will take and to agree to receive an update in September 21.

		Data Source					Data Reliability					Construct/Definition					Measure Amended / Tested							Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1			
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Tested within last 12 months and all associated risks identified on proforma have been accepted or mitigated or there were no risks	Tested within last 12 months and all associated risks identified on proforma	Tested within last 12 months	Tested between 12 and 24 months ago	Tested over 24 months ago	Total Score	Total Score as %	
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	5					5					5					5					20	**100%**	
2	Percentage of patients starting treatment within 6 weeks of external referral	5					5					5								2		17	**85%**	**Testing -** This measure is to be subject to testing by 14th July 21
3	Total number of inappropriate OAP days over the reporting period (rolling 3 months)		4					4				5					5					18	**90%**	**Data Source** Data is extracted electronically and reuploaded into the system as manual validation work was completed around this measure to indicate whether the OAP was appropriate or not. Work was underway to amend PARIS to enable this to be recorded completely on the system but further discussions are now required as to whether this is required and if it is how this should be progressed. Details recorded in the DQAT action plan. **Data Reliability** National standards suggest that when a patient is offered an in area bed however refuses this, then this change to 'patient choice' should be reflected in a change from inappropriate to appropriate OAP during the stay. This means we are currently potentially overstating our OAP inappropriate days.
4	Percentage of patients surveyed reporting their overall experience as excellent or good.		4				5					5					5					19	**95%**	**Data Source -** Data is collected via electronic devices for inpatient areas, on paper surveys for community teams as well as via kiosks in team bases where there are large footfalls. There is also a phone application where clinicians can send the survey to patients and carers phones via email or SMS. Data is automatically fed into the meridian software and this feeds the IIC system with some manual intervention to format the data so the system can analyse this correctly. It is not possible to transfer the data directly via an electronic transfer.
5	The percentage of Serious Incidents which are found to have a root cause or contributory finding				2		5					5					5					17	**85%**	**Data Source -** Data is collated onto excel for manual process after retrieval from the Dataix system. An electronic transfer is not possible for this measure.
6	The percentage of teams achieving the agreed improvement benchmarks for HoNOS total score		4				5					5					5					19	**95%**	**Data Source -** Data is collated onto excel for manual calculations to take place after retrieval of patient/team level data from the PARIS system. An electronic transfer is not possible for this measure.

Data Quality Scorecard 2021/22

		Data Source					Data Reliability					Construct/Definition					Measure Amended / Tested							Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1	Total Score	Total Score as %	
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Tested within last 12 months and all associated risks identified on proforma have been accepted or mitigated or there were no risks	Tested within last 12 months and all associated risks identified on proforma	Tested within last 12 months	Tested between 12 and 24 months ago	Tested over 24 months ago			
7	The percentage of teams achieving the agreed improvement benchmarks for SWEMWBS total score		4				5					5					5					19	**95%**	**Data Source -** Data is collated onto excel for manual calculations to take place after retrieval of patient/team level data from the PARIS system. An electronic transfer is not possible for this measure.
8	Number of new unique patients referred	5					5					5					5					20	**100%**	
9	The percentage of new unique patients referred with an assessment completed (2 months behind)	5					5					5					5					20	**100%**	
10	The percentage of new unique patients referred and taken on for treatment (3 months behind)	5					5					5					5					20	**100%**	**Additional Information-** Within all localities, it has been identifed that this measure may not be fit for purpose at it includes all patients that have been referred and not necessarily assessed and accepted for service. Detailed actions in place are documented in the DQAT action plan
11	Number of unique patients discharged (treated only)	5					5					5								2		17	**85%**	
12	Bed Occupancy (AMH & MHSOP A&T wards)	5					5					5								2		17	**85%**	**Measure amended/Tested -** This measure is to be subject to testing by 4th August 21
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards)	5					5					5					5					20	**100%**	
14	Percentage of patients readmitted to Assesement and treatment wards within 30 days	5					5					5								2		17	**85%**	**Measure amended/Tested** - This measure will be subject to testing by 25th August 21

		Data Source					Data Reliability					Construct/Definition					Measure Amended / Tested							Notes
		A (5)	B (4)	C (3)	D (2)	E (1)	5	4	3	2	1	5	4	3	2	1	5	4	3	2	1			
		Direct Electronic transfer from System	Data extracted from Electronic System but data is then processed manually	Other Provider System	Access database or Excel Spreadsheet	Paper or telephone collection	Always reliable	Mostly reliable	Sometimes reliable	Unreliable	Untested Source	KPI is clearly defined	KPI is defined but could be open to interpretation	KPI is defined but is clearly open to interpretation	KPI construction is not clearly defined	KPI is not defined	Tested within last 12 months and all associated risks identified on proforma have been accepted or mitigated or there were no risks	Tested within last 12 months and all associated risks identified on proforma	Tested within last 12 months	Tested between 12 and 24 months ago	Tested over 24 months ago	Total Score	Total Score as %	
15	Finance Vacancy Rate				2			4				5					5					16	**80%**	**Data Source** Data extracted elecronically but processed manually. **Data Reliability** A working group will need to be established to look at the way the Trust record vacancies within the finance system as due to the way funding is managed in the system it is allocated to cost centres before vacancies are often agreed. As a result an over reporting of vacancies can occur.
16	Percentage of staff in post more than 12 months with a current appraisal	5					5					5					5					20	**100%**	**Additional Information -** A number of changes to courses and compliances have taken place over the last few months and there have been a number of extensions to the time allowed to complete training (linked to the pressures caused by the pandemic). The extensions have been implemented and the data has been refreshed for the relevant time period.
17	Percentage compliance with ALL mandatory and statutory training	5					5					5					5					20	**100%**	**Additional Information -** A number of changes to courses and compliances have taken place over the last few months and there have been a number of extensions to the time allowed to complete training (linked to the pressures caused by the pandemic). The extensions have been implemented and the data has been refreshed for the relevant time period.
18	Percentage Sickness Absence Rate (month behind)	5					5					5								2		17	**85%**	**Measure amended/Tested-** This measure will be subject to testing by 15th September 21
19	Delivery of our financial plan (I and E)		4				5					5					5					19	**95%**	**Data Source** Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation. Work is being progressed to improve this process to enable direct system transfer to the IIC. However, due to the challenges with the pandemic during 20/21 and other priorities identified by the Managing the Business group no date has been agreed for the finance development
20	CRES Delivery				2		5					5					5					17	**85%**	**Data Source** Data is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation. An electronic transfer is not possible for this measure.
21	Cash against plan		4				5					5					5					19	**95%**	**Data Source** An extract is taken from the system (Oracle Cloud) then processed manually to obtain actual performance. Work is being progressed to improve this process to enable direct system transfer to the IIC. However, due to the challenges with the pandemic during 20/21 and other priorities identified by the Managing the Business group no date has been agreed for the finance development

Quality Assurance Committee: Key Issues Report		
Report Date: 29th July 2021		**Report of: Quality Assurance Committee**
Date of last meetings: **3rd June** **14.00 – 17.00hrs** **1st July** **14.00 – 16.30hrs**		**Membership** Quoracy was met at both meetings. Apologies: June – 3, July – 0. **Summary of key issues:** This report captures the key issues and risks that were brought to the attention of the Committee.
1	**Agenda**	**The Committee continues to meet monthly (August exception) with a revised meeting schedule planned for 2022 to include a minimum of 4 meetings and 2 developmental sessions.** The Committee considered agendas: **3rd June 2021:** • Update on progress in response to CQC Inspection and updates from NHSE/I and TEWV Quality Boards • Trust Level Quality Assurance & Learning Report • Locality updates from Forensics, Durham & Darlington, Teesside and North Yorkshire & York • Exception Report of Quality and Safety • The Six Monthly Safeguarding Report • Draft Quality Account 2021/22 **1st July 2021**: • Update on progress in response to CQC Inspection and updates from NHSE/I and TEWV Quality Boards • Trust Level Quality Assurance & Learning Report • Locality Updates from Forensics, Durham and Darlington, Teesside and North Yorkshire and York • Sexual Safety Strategy Review • Impact and Effectiveness of Body Worn Cameras • Positive & Safe Annual Report • Monthly Safe Staffing Exception Report • Six Monthly Update on Health, Safety, Security and Fire
2a	**Alert (by exception)**	**The Committee Members alerts the Board to the following:** **Cross Locality Issues:** • Increasing levels of admissions with complexity and acuity. • There remain some ongoing challenges meeting the pace of changes and improvements being undertaken following the CQC inspection in January 2021. • Staff health, wellbeing and safety continues to be a growing

		concern over the last two months, with fatigue and burn out across all specialties, localities together with increasing numbers of staff needing to isolate. Board members are aware of this from previous reports. • Pressure on ALD Beds Trustwide. • Increased bed occupancy Trustwide. • Increase in self harm, particularly in our AMH female patients. **Durham & Darlington** • The Durham and Darlington Crisis Team continue to operate in business continuity mode with additional leadership capacity sourced along with support from other specialties. The Committee received a Crisis Team Report and Action Plan as part of our assurance processes. However this situation remains fragile with careful monitoring by the LMGB. • On Bek Ramsay, staff felt that they needed higher visible leadership support during a particularly challenging period. • In June, Elm Ward were highlighted as a cause for concern due to increased patient safety incidents, alongside an increase in bed occupancy and patient acuity. This led to a desk top review with positive feedback. **Teesside** • Bankfields Court was placed in business continuity measures on 29th June 2021 due to staffing, levels of acuity, sickness absence, maternity leave and the increasing number of staff in isolation. **North Yorkshire & York** • The Locality is seeing an increase in AMH teams requesting support through "stop the line" process due to inability to deliver service expectations due to staffing issues and increase in referrals. Regular monitoring meetings are in place with senior nurse leadership input and oversight. • Significant challenges in CAMHS single point of access due to recruitment gaps and demand to access services. The Locality advised the Committee of the "keeping in touch process" that has been put in place to monitor CYP whilst they access services. **Forensics** • The Locality had previously raised concerns in relation to Thistle Ward. The Committee received an assurance update report of the concerns, actions taken and next steps following internal and external reviews. • In June 2021, the CQC visited the inpatient services and highlighted some key safety concerns, in particular staffing.

		The service has moved back into business continuity mode and immediate measures have been taken to reduce risk and increase patient safety. The Committee had a private meeting on 1st July to discuss this in more depth. **CQC Update** The Committee received presentations in June and July 2021 on updates around the actions in response to the CQC inspection to adult IP and PICU wards in January 2021. Assurance was provided that all the actions had been completed to address the concerns raised in the S29A letter received by the regulators. However the challenge remained in embedding the changes. The Committee agreed to hold a private session to discuss concerns raised about Forensic services, in particular staffing. The 28th and 29th July 2021 were confirmed as the dates for the Well-Led inspection of Trust Services by the CQC.
2b	**Assurance**	**The Committee assures members of the Board on the following matters:** **Sexual Safety** The Committee received an update in relation to the Trust's Sexual Safety Strategy and recommendations to embed work carried out by the Trust, in conjunction with the National Sexual Safety Collaborative, in all in-patient units, both mixed sex and single sex, (commencing in mixed sex areas). • A Sexual Safety Collaborative has been established in response to the CQC report on Sexual Safety on Mental Health Wards. The Collaborative is part of a wider Mental Health Safety Improvement Programme (MHSIP) which was established by NHS improvement in partnership with the CQC in response to a request by the Secretary of State. • The Sexual Safety Collaborative aims to increase the percentage of service users, staff and visitors who feel safe from sexual harm within mental health and learning disability in-patient pathways. • Members approved the proposals outlined in the existing sexual strategy paper noting that a more detailed plan will be produced with timescales and action owners, which will be monitored through QAIB. • Members requested **a** six monthly assurance report to be presented to the Committee. • Learning will be shared from the collaborative work and the learning from the two recent sexual safety incidents Trust-wide. • There are no matters for the Board to consider. Assurance will continue to be monitored by the Committee

		Six Monthly Safeguarding Report The Committee is now receiving pre Covid reports as usual from the Safeguarding and Public Protection Group. • The Committee noted that there have been an increase in complex cases presenting to the Trust, which is impacting on services. • The Trust continue to monitor compliance with level three training for safeguarding children which has increased over the past three months across the Trust as a whole and training is being successfully delivered through Microsoft Teams and e-learning. • The Trust has not been involved in any safeguarding inspections over the last 6 months. There are no matters for the Board to consider. Assurance will continue to be monitored by the Committee. **Update on the Impact of Body Worn Cameras** The Committee had requested an update on the impact and effectiveness of the wearing of body cameras on wards. The Board is to note that the use of cameras is emerging as a positive intervention within the National Agenda to reduce Restrictive Interventions. • The initial feasibility study has revealed that the cameras were implemented with little issue and have widely been regarded as having a positive impact. • Data on the effectiveness of the cameras, particularly in relation to reducing restrictive intervention, remains inconclusive. It's possible that the services need longer to embed and utilise the potential benefits and the pilot has been extended for a further 6 months and will include 6 additional wards. • Some positive themes from the initial pilot include staff feeling safer when cameras are available. Patients reported that whilst they may have had some initial concerns, once staff provided further explanation and information they had no further concerns. A number of patients across wards have reported that they felt safer with staff wearing cameras. • The Committee were assured that the ongoing governance arrangements were being considered along with additional associated costs. From the patient perspective anyone not consenting to the cameras being switched on was being managed on an individual basis. There are no matters for the Board to consider. The Committee will monitor progress appropriately.

		Positive & Safe Annual Report 2020/21 The Committee received a detailed and informative report. Of the 8 restrictions identified, SPC was applied to all of these measures from 1st April 2020 – 31st March 2021. Board Members should note the following: • At the end of the reporting period, all metrics are reporting within normal variation. However at locality level the following are noting a cause for concern: • Use of supine across all services. A review of incidents utilising supine restraints were of a high acuity at Bankfields Court and Sandpiper and Thistle wards in secure services. • There is continuous liaison with all of these services to reduce and/or minimise the use of supine restraints and a focus placed on Behavioural Support Plans. The Annual Report highlighted many areas of positive practice and learning. The Committee were assured that the report demonstrated good progress and improvement and supported the Positive and Safe Action Plan for 2021/22. There are no matters for the Board to consider but it would be pertinent for Board Members to view the Annual Report for information. The Committee will continue to receive assurance reports. **Health, Safety, Fire & Security** The Committee received the required assurances from the monitoring of controls, key performance indicators, management of risk and work plans. There are no matters for the Board to consider. The Committee will continue to receive assurance reports on a quarterly basis. **Monthly Safe Staffing Exception Report** The Committee received a monthly exception report in relation to April 2021 data, to highlight any issues or concerns. This is in addition to the Six Monthly Board. • There are a number of areas that have high levels of clinical activity, necessitating increased observation and engagement levels with patients in addition to sickness and vacancies. This has resulted in some wards not meeting their planned staffing levels. In some areas, this has resulted in the use of high levels of agency and Bank HCAs. Leave has been cancelled in secure in patient services on occasions as a short term measure to maintain safe staffing levels. • The risks relating to the Trusts ability to meet planned staffing levels on a daily basis have been escalated to the Trust Risk

		Register. Risks are being managed and mitigated through operational services and the work being undertaken by the Right Staffing work streams. • Secure inpatient services had been using Business Continuity Plans up to 23rd April due to staffing deficits, contributed to by patient acuity, need, vacancies and sickness. This had impacted on patient leave and activities. • The Board is advised that assurance was provided that safely staffing wards is being managed at times, on an hour by hour, shift by shift basis in some areas and that many initiatives are in place in relation to recruitment as well as the need to focus on retention, and health and wellbeing. The Board should note that the data period is April 2021. The Committee can provide the Board with assurance that there are significant plans in place to address our staffing position and it is closely monitored by the Executive Team. The Committee will escalate concerns to Board as required. The Committee advises the Board that in reviewing and considering the reports and updates presented to the meetings (including the matters of alert), assurances were provided that actions were being progressed in order to improve and enhance patient safety and quality care.
2c	**Advise**	**The Committee would like to advise the Board of the following matters for information:** **Draft Quality Account (QA) 2021/22** Members agreed that the Draft Quality Account 2020/21 be presented to the Board of Directors for approval on 25th June 2021, subject to the correction of some typographical errors and amendment to the glossary definition of 'harm minimisation. **Exception Report on Quality & Safety (Q&S)** The Board are to note that this report, which was introduced during agile working for the Committee, had reduced in size as we have stepped back up our sub groups. The Committee agreed that the report in this format is no longer needed.

Recommendation: The Board is asked to:

- Note the Key Issues report following the Committee meetings held on 3rd June 2021 and 1st July 2021

3	**Actions to be**	There are no action to be considered by the Board

	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)

ITEM NO. 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**July 2021**
TITLE:	**FREEDOM to SPEAK UP GUARDIAN REPORT**
REPORT OF:	**DEWI WILLIAMS, FREEDOM TO SPEAK UP GUARDIAN**
REPORT FOR:	

This report supports the achievement of the following Strategic Goals:	✓
To co-create a great experience for our patients, carers and families	✓
To co-create a great experience for our colleagues	✓
To be a great partner	

Executive Summary:

This report is for information and outlines developments within the Freedom to Speak Up role over the last 6 months.

It discusses local, regional and national developments, includes details of numbers and types of referrals, and concludes with reflections from recent cases.

The last report which covered 9 months, described the reduction in people coming forward and presumed the pandemic had been a significant factor. However numbers are back to previous levels and have been increasing over the last quarter.

When the post was established in 2016 it was for one day a week and was only to respond directly to concerns. It quickly became 18 ½ hours a week to enable us to develop communications, training, and speed up response times. However, recently there has been concern internally, through audit, and from the CQC that we need to have a response capacity 5 days a week to cope with both pace and volume. In the short term I have increased hours to full time for two months. We have commenced QI work to map and address issues of process and oversight. It is important to acknowledge that the trust in the FTSUG is still strong amongst our colleagues.

I would like to take this opportunity to thank Hugh Griffiths who has been the NED for speaking up since I took up the post. He has been an invaluable and steadying influence, and I am happy to welcome John Maddison, as the new NED.

Recommendations:

To note the contents of the report and comment accordingly.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**July 2021**
TITLE:	**FREEDOM TO SPEAK UP GUARDIAN REPORT**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board about the last 6 months of the Freedom to Speak Up role. The report will outline developments and activity to date and discuss how we intend to further develop the role in the coming year.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The FTSUG has been in post since October 2016 and is currently working full time.

2.2 There has been a steady return to pre pandemic contact numbers. Table 1 displays the figures for the last 6 months, and includes the previous reports for comparison. We will produce the report again in September 2021 to align the data for comparison ahead of the new Board dates.

Table 1

	September 2019	March 2020	September 2020	December 2020	June 2021
Total cases	28	44	27	6	40
Patient safety	5	16	2	3	12
Staff safety	0	3	8	0	8
Allegations of bullying	10	23	16	3	19
Culture systems/processes	4	2	1	0	1
Anonymous cases	12	25	13	1	15
Resolved cases	20	15	5	0	17

3. KEY ISSUES

3.1 Training

The mandatory ½ day training for band 7s and above stopped during the pandemic. It has now been replaced by an e-learning package called ‘Speaking up’, developed jointly between the National Guardian’s office and NHSE/I. They are developing two further tools called ‘Listen up,’ and Follow up,’ Listen up’ is for all staff with supervisory responsibilities, and ‘Follow up will be for senior leaders, and should be available in the Autumn.

The FTSUG is working with the training department to develop the competency framework to further clarify who should be undertaking which course.

3.2 Capacity

Barry Speak (lead for the Employee Psychology Service) continues to act as deputy FTSUG.

We have agreed to appoint a support member of staff within HR to enable the improvement work to be developed and implemented without any impact on the FTSUG response capacity. A new JD has been evaluated and we will go out to advert early next month.

3.3. Support networks

Our Trust raising concerns group continues to meet regularly for sharing of intelligence and peer support. We are reviewing our terms of reference as there is a growing acknowledgement of the importance of hearing shared intelligence early. The Director for People and Culture will chair the formal part of this meeting and it will report into the Workforce subgroup of SLG and the new People Culture and Diversity Committee as appropriate.

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

Our National Guardians office continues to support and become increasingly clear about what 'best practice' might look like, through a weekly newsletter and the publication of their Services reviews.

3.4 Development of Champions

Development of this function has been slowed by the pandemic. Work is in progress with Nicola Rutherford, acting Head of HR and Workforce Supply, to review progress to date, their confidence and skills and relaunch this role and the support we provide to the Dignity at Work Champions, using the recently published support guidance and training developed by the NGO.

3.5 Data Management

We have designed a single replacement oversight tool and will be doing further work through the QI process to ensure it meets all service requirements.

3.6 Feedback

It remains challenging to get feedback post involvement from people who use the service. This is also a concern nationally. We receive regular supportive messages about their valuing our support, but few feel able to say if they

experienced detriment, or would feel confident to speak up again. Our regional group are considering ways we could adopt to improve this aspect.

3.7 Learning from experience

In December 2019 we held an improvement event to evaluate our service, and review our processes. As a result we

- standardised some of our processes
- now call our investigations 'reviews'
- developed a more flexible approach to commissioning reviews, which may just involve an independent manager meeting with the staff member who is speaking up, and then deciding the best next step. This has speeded up the process in some cases.

However timeliness remains a concern. In light of feedback from the Big Conversation and the internal audit we have reviewed and updated the FTSU policy and introduced new timescales. We have also committed to more regular contact with people who have raised a concern, even when there is no change to progress.

Learning lessons after a review remains challenging. The independent managers conducting the reviews are asked to identify learning opportunities, but they often report that after removing identifiable information there is little left. Given the value of learning, we will be considering this in the upcoming review and how we can work with colleagues in eg patient safety to maximise the learning that we can share across services.

3.8 Covid 19

At the beginning of lockdown there was a very significant reduction in contacts. Of the few that did come forward most said they had thought long and hard due to the extraordinary pressures the service was under. We confined our reviews predominantly to cases that involved an element of patient safety. As the figures demonstrate this last quarter, this has now returned to more typical levels.

4. IMPLICATIONS

4.1 Compliance with the CQC Fundamental Standards:
Potential impact on CQC standards should be addressed with the actions outlined above

4.2 Financial/Value for Money:

The actions outlined represent good value for money for a trust of this scale

4.3 Legal and Constitutional (including the NHS Constitution):

None

4.4 Equality and Diversity:

None

4.4 Other implications:

None

5. RISKS

There is a risk that numbers continue to rise and exceed the capacity of the FTSUG even with increased hours. However, the new support staff member should mitigate this.

Our key risk is that process issues of responsiveness and ensuring staff know what has happened/ been learned undermines the confidence of the FTSUG.

6. CONCLUSIONS

The FTSU service is well trusted but has some process and oversight issues that need resolving. A Quality Improvement approach to this is already underway and will be complete by the end of the year. In the meantime, the increase in provision to full time, further support of the Dignitity at work champions, changes to the other formal HR processes and the employment of a support member of staff should help mitigate these issues.

7. RECOMMENDATIONS

To note the contents of the report and to comment accordingly

Author, Dewi Williams
Freedom to Speak Up Guardian

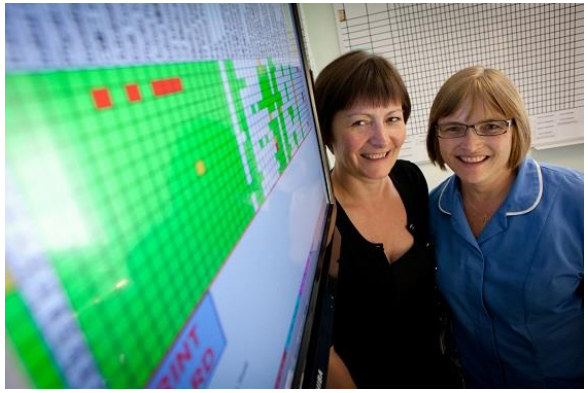
Background Papers:

6 Month Safe Staffing Report

Tees, Esk and Wear Valleys
NHS Foundation Trust



Trust Level Report


Purpose

Appropriate staffing is fundamental to the delivery of safe and effective care. Safe staffing must be matched to patients' needs and is about skill-mix as well as numbers. The purpose of the report is to advise the Board of a 6 monthly review (1st December 2020 to 31st May 2021) in relation to nurse staffing (inpatients) as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review, 2014) and in line with the NQB Guidance (NHS, 2016) and compliance with Developing Workforce Safeguards (NHSI, 2018).

The report aims to provide the Board with assurance on the key areas of Safe Staffing at a trust level. Statistical process Control (SPC) and triangulation with quality metrics has been used where appropriate to alert the Board to situations and areas where that are of concern, improving or deteriorating.

The data contained within the 6 Month Safe Staffing Report is correct as at 31st of May 2021. Of the 12 measures identified we have been able to apply Statistical Process Control (SPC) Charts to 14 of these for the period of **1st December 2020 to 31st May 2021**. The narrative is reflective to date.

Summary areas identified for action and further development

- Secure Inpatient Services and Bankfields Court are in Business Continuity Planning due to staffing shortages.
- Gold Command has been re-instated to have oversight of safe staffing due to covid pandemic pressures.
- North Yorkshire and York continue to hold stop the line meetings to oversee safe staffing.
- The removal of covid extensions to training dashboards and the provision of Mandatory training at sufficient capacity is a risk for 21/22 and 22/23.
- The skill mix of registered to unregistered staff has been progressed through the establishment review programme of work and staff recruited to the additional posts in AMH acute and Secure Inpatient Services (SIS).
- Further work is underway in MHSOP and LD services to review establishments and agree additional staffing requirements.
- Further embedding of roster efficiency across inpatient areas including roster awareness training continues to ensure best use of resources and accurate reporting.
- Continued focus on the delivery of a workforce plan to positively support the retention of staff and recruitment strategies.
- Continued work in line with regional and national strategy to address staffing concerns e.g. Zero HCSW vacancies, International Recruitment, RN apprenticeships and work with Prince's Trust.
- A review of the trusts 'headroom' is underway to ensure budgets correctly account for time in relation to mandatory training, maternity leave etc.
- Staff wellbeing will be a key feature of the 'Great Place to Work' special interest groups and information from this will report will be used in that group.
- 1st Wave Surge recruitment is completed in line with projected increases to help support post covid acuity and demand for mental health services.
- Review of actions to support patients feeling safe on wards and related actions to improve patient safety continue to be informed form the data within this report.

Recommendations

That the Board of Directors note the outputs of the report and the issues raised for further action and development.

Included in this Report

Please note that the data in this report is accurate at the time of production. The issues highlighted may change due to additional information being made available following investigation, resulting in issues being re-categorised.

Triangulated Approach to Staffing Decisions	4	• Staffing Establishments	
Right Skills	5	• Mandatory Training Compliance	
Right Place and Right Time	6 - 9	• Fill Rates RN Days and Nights • Fill Rates HCA Days and Nights • Additional Duties	• Bank Usage • Agency Usage • Overtime Usage
Patient Outcomes, People Productivity and Financial Sustainability	10 - 14	• Triangulation with Quality Indicators • Triangulation with Safe Indicators • Breaks not Taken	
Reporting, Investigating and Acting on Incidents	15	• Incidents Citing Staffing Levels	
Patient, Staff and Carer Feedback	16 - 17	• Patient and Carer Feedback • Staff Experience – In our Shoes	
Care Hours per Patient Day	18	• CHPPD	

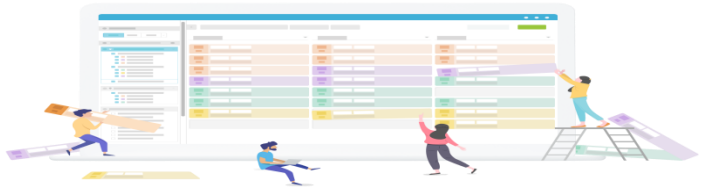
Summary Dashboard

Assurance				Variation				Caution
P	Consistently hit target	?	Hit and miss target randomly	F	Hit and miss target randomly	H / L	Special Cause Concern	H / L	Special Cause Improvement	Common Cause	The data in this chart is not normally distributed. The SPC chart should be interpreted with caution!

Latest Reporting Month: May 2021		Variation	Assurance	Target	Numerator	Denomenator	Rate/%
Additional Duties - Enhanced Observations				-	1507	-	1507.00
Bank Usage	!		P	25%	89931	441097	20.39%
Agency Usage	!		F	4%	38937	441097	8.83%
Overtime (inc AHPs)			?	4%	6105	224128	2.72%
Fill Rates - RN Day	!		?	90%	45872	45845	100.06%
Fill Rates - RN Night	!		F	90%	23345	22406	104.19%
Fill Rate - HCA Day	!		F	90%	80611	66389	121.42%
Fill Rate - HCA Night	!		F	90%	70841	44852	157.94%
Shifts without a break	!		F	0	16	54	0.30
Staffing Incidents				-	19	-	19.00
Overall CHPPD	!			-	221578	19180	11.55
RN CHPPD	!			-	70247	19180	3.66
HCA CHPPD	!	H		-	151331	19180	7.89
IIC982: Mandatory Training	!	L	F	95%	-	-	92.47%
% Feel Safe on the Ward			F	88%	97	148	65.54%

Triangulated Approach to Staffing Decisions:

Staffing Establishments



Actions we are taking

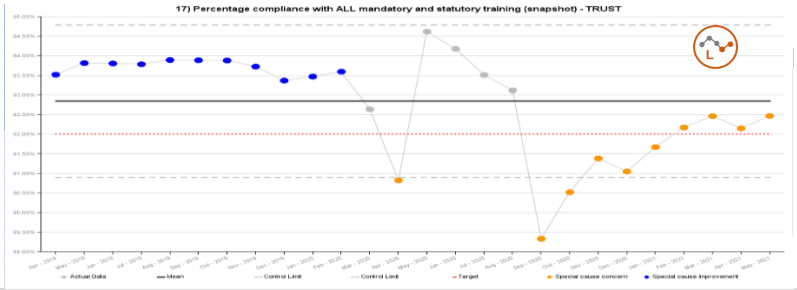
- The staffing establishment review and report was presented to the Finance Sustainability Board and Senior Leadership Group in February and March 2021. Funding was agreed with the initial priorities regarding staffing establishment numbers, skill sets and the skill mix (registered practitioners to support worker ratio) within the AMH and SIS inpatient environments.
- This report was further presented to the Trust Board 24th March 2021 where it received approval to support the building of a safe, high quality and sustainable staffing establishment to meet national guidelines and benchmark figures.
- Increased staffing requirements for establishment setting needs have been considered for AMH and SIS wards to improve patient safety, patient experience and clinical effectiveness. This is a phased approach with the initial investment aiming to align CHPPD with benchmark peer Trust median values as evidenced in the Model Hospital. To date we have recruited:-
    - 10/25 Clinical Leads
    - 12/12 Practice Development Practitioners
    - 15/20 Activity coordinators
    - 12/12 clinical team administrators
    - Recruitment is underway for Peer Support Workers
    - Recruitment is ongoing to the remaining posts
- The phased approach to reviewing staffing establishments continues within MHSOP and LD inpatient services, and each inpatient area will progress with subsequent phases over the year following intermediate reviews.
- Recent MHOST and LDOST outputs have been considered, but the data collections have been impacted by COVID-19, and as such the quality of results may produce incomplete outcomes. It is anticipated that these evidence-based figures will increase in validity as wards resume normal functioning. The evidence-based tools will continue to be utilised as required by NHSE/I, and further support and training for staff continues to embed practice and compliance. All decisions will be based on available data and triangulation within a professional judgement model.
- Initial discussions with MHSOP and LD clinical services suggest that the additional staff to extend the zonal observation pilot and increase physical health practitioners will be most beneficial to support quality and patient safety.
- The trust went at risk to recruitment based on the forecasting work undertaken, the initial phase of surge recruitment is almost completed we have recruited:-
    - 9 Pharmacy staff

- 14 Community modern matrons)
- 49 Psychology staff
- 4 Dietetic staff
- 3 Social work staff
- 6 SALT
- 6 Physiotherapy staff
- 44 Trainee Nursing Associates
- 4 Chaplains

These appointments are to support increased clinical activity following the pandemic.

- Safecare is an acuity-based roster software product it is being implemented into Secure Inpatient Services (SIS) to support the management of daily staffing levels, escalation of issues and the dynamic redeployment of staff within the service. Future implementation and use of SafeCare across the trust will follow after initial successes in SIS. A review of the implementation within SIS will inform ongoing rollout across the trust.
- Evidence based tools for the community services are to be considered to support a broader understanding of acuity levels within the community-based services.
- Evidence based tools are a key aspect to delivering safe quality care, however this is required to be triangulated with other workforce data and patient outcomes to support professional judgment discussions. Further embedding and understanding of the acuity and dependency model is required in developing and evolving the establishment setting process in the Trust. The establishment review process is under review to provide a more expedient timeline following evaluation of the previously developed process.
- Recruitment is also underway to support the Community Mental Health Framework in community services this will be overseen by the workforce Senior leadership group.

Right Skills



Level	Durham & Darlington	Forensic Services	North Yorkshire & York	Teesside
Variation	L		L	L
Assurance	?	P	?	?

Analysis (so what)

- The SPC Charts are reporting this measure as a cause for concern at trust and locality level (excluding Forensic Services).
- The COVID extensions for statutory and mandatory training come to an end in September. This will impact significantly on compliance
- which will pose a significant risk to the trust. The actions detailed below will be monitored through the Workforce SLG.

Key Learning and how we are using this

This is an area of concern for the trust as we move reporting outside of covid extensions of statutory and mandatory training as the level of compliance will be significantly reduced. Especially for PAT, Resuscitation and moving and handling.

Actions we are taking (now what)

- The Head of Workforce supported by the Deputy Director of Nursing, is leading a task and finish group with localities to agree a trajectory of compliance and delivery of training based on a risk assessed approach.
- Senior Leadership Group have discussed and approved the proposed change to bring the resuscitation officer and training in house. The necessary steps are underway to have this place in quarter 3 21/22. This change will increase capacity and enable us to deliver a more flexible service across 7 days assisting to meet the trajectory set. This continues to be progressed.
- The deep dive of positive approaches training highlighted the significant shortfall of compliance with training after the removal of the covid extensions. The planning to address shortfall will form part of a task and finish group to recommend trajectories, offer to increase capacity and the requirements of localities to release staff.
- As previously reported review of the headroom is underway to ensure that the correct allocation of time is provided for statutory and

mandatory training requirements to be met. Also considered within this review of headroom is the allocation of protected time for registered professional staff to attend to their required training needs for revalidation of their registration. This draft report is still awaiting review prior to approval at the relevant groups and is expected at the end of Quarter 2 21/22.

- Work has begun on the Workforce Development intranet pages to help staff find current information linked to training and staff booking directly onto available courses.
- Workforce Development Team are running weekly reports to understand the overbooking problem. Employees who double book will be notified and places will be released back into the numbers increasing capacity of training.
- The Workforce Development Team have developed a pilot "block" approach to some key elements of face to face statutory and mandatory training to support the capacity and demand in the short term, longer term it is envisaged this will develop into a block Induction for clinical staff.
- Workforce Development have agreed with Humber Coast and Vale colleagues to passport Mandatory Training as is in place in the North ICS.

Nurse Development and Initiatives

We are working in partnership with 4 other Mental health trusts, led by South West Yorkshire Foundation Trust, to begin the journey of international recruitment. The focus is on recruitment of candidates who can quickly be supported to join the NMC register. We have agreed to try and recruit 20 staff. This work continues to progress and we will hopefully be interviewing international nurses in the Autumn to commence their journey to NMC registration.

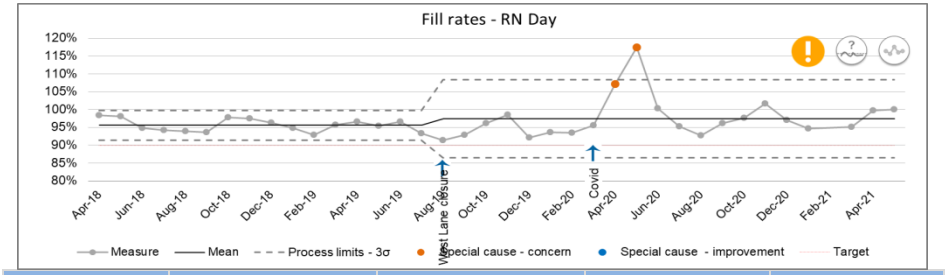
We are working in partnership with Indeed digital recruitment agency and NHSE regional office to be part of the national initiative to have zero HCSW posts by 31.3.2021. In financial terms at a Trust level, we have no actual HCSW vacancies against base line establishments but we have set an ambitious target to over-recruit. This is fast paced work; we have commenced in NY&Y and are offering 12 posts across the locality. We are now working with the other 3 areas of the trust. This pilot has been extended until end of September 2021, we have successfully recruited and additional 47 HCSW with the support of Indeed, these posts are largely on an over recruitment basis.

We have recruited over 90 newly qualified registered nurses into the trust, they will commence in September.

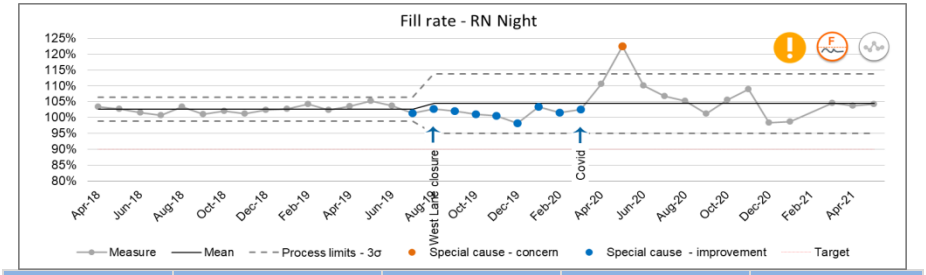
We are consistently striving to engage with any new initiatives that support recruitment and the local community; we have therefore joined with The Prince's Trust to complete targeted recruitment for new staff to join our organisation. These come from a number of different backgrounds and offer a wide range of different approaches that can potentially enhance service delivery. The Prince's Trust prepare and support the candidate's pre and post-employment.

Right Place and Right Time

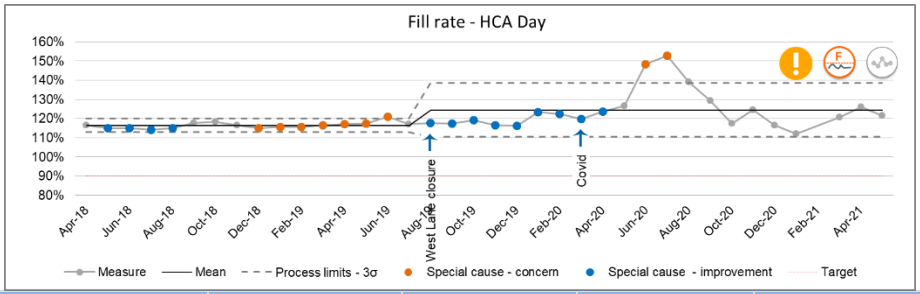
Staffing Fill Rates



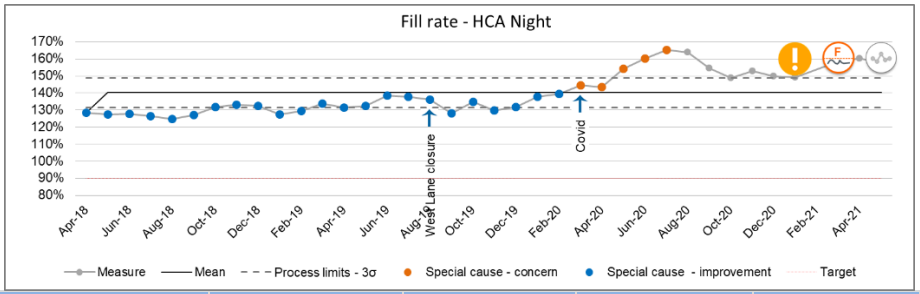
Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				
Assurance	F	?	?	F



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				
Assurance	F	F	F	F



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				
Assurance	F	F	F	F



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				
Assurance	F	F	F	F

Right Place and Right Time Continued…

Analysis (so what)

- The SPC charts at Trust and Locality Level are all reporting within a normal variation and the Trust's tolerance of 89.9%
- The 6 monthly position in terms of the average fill rates for RN's shows that there were 19 (30%) fill rates of less than 89.9%for registered nurses on daytime shifts, largely due to the roster having an additional registered nurse aligned to it that was not essential and 8 (13%) for registered nurses on nights. The 6 monthly position in terms of the average fill rates for HCA's shows that there were 8 (13%) fill rates of less than 89.9% for HCA on daytime shifts and 2 (3%) for HCA on nights.
- This shows that although the trust usually meets its planned staffing numbers there is, on occasion, a deficit of the planned skill mix from registered to non-registered. This presents risks as it limits the quality of interventions that can be offered from a registered nursing perspective.
- Secure Inpatient Services have the highest number of red occurrences (9 wards) across the reporting period for RN on days and for HCA on days (5 wards).
- Further analysis of the data is linked to the 2nd wave of covid. SIS had increased sickness due to covid outbreaks in January and February this is showing an improving picture from March.
- Focussing on the top 3 lowest average fill rates these were in relation to Newtondale for RN on Nights equating to 66%; Westerdale South in relation to RN on Nights equating to 73.2% and Clover/Ivy in relation to RN on Days equating to 74.7%. This is due to the areas been established to have 2 registered nurses on duty at night but only 1 is usually required, so it appears as a low fill rate. Clover/Ivy
- The highest average fill rates were in relation to Bedale Ward for HCSW on Nights equating to 300.8%; Cedar for HCA on Days equating to 296.6% and Overdale for HCSW on Nights equating to 275.4%. Bedale and Cedar are the PICU wards and have required additional HCSW due to increased acuity, seclusion and observation requirements. Overdale also had increased observation requirements.

Key Learning and how we are using this

- This metric helps the Trust determine whether its planned staffing is sufficient to meet clinical need and demand. Along with CHPPD, it can indicate where additional investment in staffing establishments may be required. The analysis indicated that we continue to need to increase the number of registered nurses available to ensure an effective skill mix and the availability of HCSW to support care delivery.

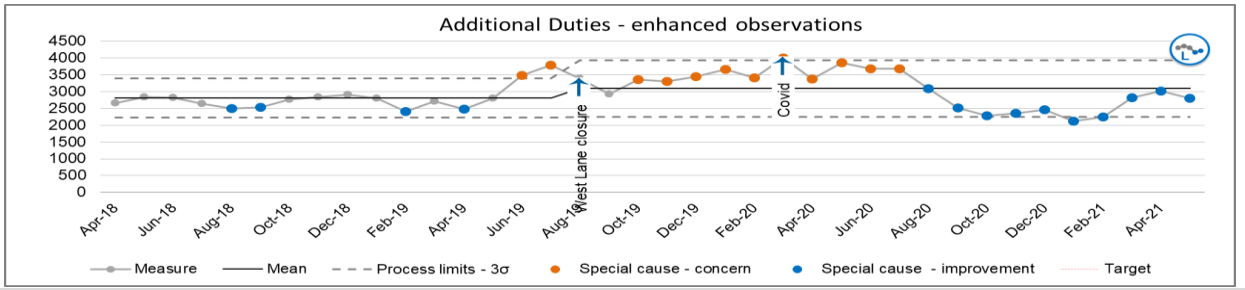
Actions we are taking (now what)

- Establishment work is underway for MHSOP and LD inpatient services considering skill mix.
- The staffing establishment setting process will continue to develop to consider and include community based teams.
- We are continuing to improve the skill mix with ongoing investment and recruitment for registered nursing posts. Work has commenced to ensure we can capture the essential contribution of the MDT team is in the skill mix figures and roster.
- A paper is been developed to go to Workforce SLG to share and consider over recruitment to HCSW and registered nurse posts to reduce the reliance on agency overtime and bank.

- We continue to work with the national initiative for zero vacancies for HCSW.
- Working with Indeed we are doing targeted campaigns to attract registered staff nurses, although we have only recruited to 1 staff nurse vacancy so far Indeed suggest that this area needs further consideration to increase our welcome offer, our recruitment lead is exploring other local trusts offers.
- We are working with Indeed and the national programme to recruit HCSW.
- We are working with Princes' Trust to recruit young people who have no healthcare experience but display values and behaviours we would want to see. To date we have recruited 11 candidates into various roles across the trust.
- The staffing escalation process has been re circulated to ensure it is readily available to support ward staff re actions and escalation process. The heads of nursing have oversight of escalations and associated actions taken.

Right Place and Right Time Continued…

Additional Duties



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation		H	L	

Analysis (so what)

- This measure is looking at the number of additional duties that have been created over and above the budgeted establishment with a reason of 'enhanced observations, business continuity, seclusion, high acuity and escort of a patient '.
- The SPC chart at trust level is reporting this measure within a special cause variation (improvement).
- At locality level the improvement can be seen in relation to North Yorkshire & York.
- A cause for concern has been highlighted in relation to Secure Inpatient Services and is likely to be linked to the current staffing pressures as a result of an increased patient acuity and a number of staff absences.

- The number of trustwide additional duties created linked to enhanced observations, business continuity, seclusion, high acuity and escort of a patient ranges from 1,910 to 2,851 duties a month over the 6 month period. In total 14,474 hours were created which would equate to 1,206 12 hour shifts.
- The highest creators of additional duties were Kestrel/Kite (Secure Inpatient Services), Bankfields Court (Learning Disability Teesside) and Birch Ward (Eating Disorder ward Durham & Darlington)

Key Learning and how we are using this

- The analysis indicates a shortfall of staff in SIS and Bankfields Court as they are requesting additional staff to meet patient safety and need.
- We are using this information to have an oversight of patient safety and quality and currently these areas are in BCP arrangements to monitor and oversee staffing at a trust level.
- Birch ward require additional duties to support the well-being of patients at mealtimes.

Actions we are taking (now what)

- SIS and Bankfields Court are currently in BCP arrangements to ensure effective oversight and monitoring of staffing. They have a minimum of a daily review of staffing across the site and re-allocation of staff to meet patient need. This includes ward managers, matrons, and clinical leads been in the staffing numbers the use of senior staff and MDT colleagues to ensure patient safety and support activities and breaks on the wards.
- Non-essential meetings are postponed to ensure the focus of all is on the front line delivery of clinical care.
- The Zonal model of care, used at Westerdale is reported to continue to provide positive quality and safety benefits. As a result of this MHSOP services in their initial discussions about their establishments reviews are considering adopting this model service wide.
- Ongoing roster awareness training to support correct and ensure effective rostering
- North Yorkshire and York locality continue to have staffing needs across services and a stop the line meetings are in place to ensure oversight and escalation.
- Gold command has been reinstated to ensure senior leadership oversight and support is available to those areas in greatest need.

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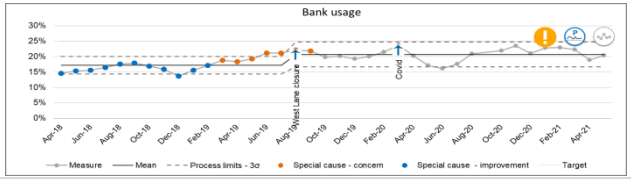
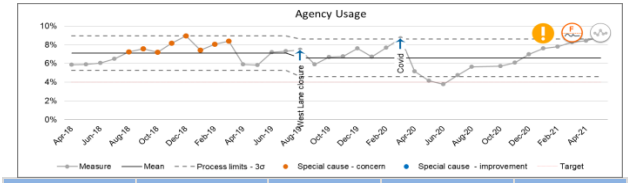
Right Place and Right Time Continued…

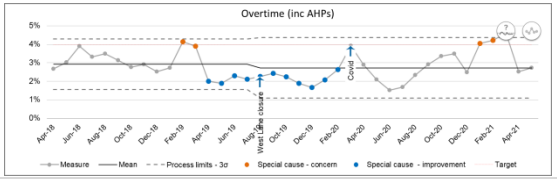
Bank, Agency and Overtime Usage



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				
Assurance	P	?	P	P



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				
Assurance	?	P	F	?



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation		H		
Assurance	?	?	?	?

Analysis (so what)

- The SPC charts for Bank, agency and overtime show the exception is Forensic Services who are reporting a special cause variation (cause for concern) in relation to Overtime.
- The highest users of bank as a proportion of the actual hours worked (over 25% usage) were Kingfisher Ward (44.7%) (this ward has a single occupancy placement package in place that utilises bank to deliver this; Harrier/Hawk (38.2%) in SIS and Birch Ward D&D (36.1%). Birch ward have registered general nurse as part of their establishment, if they are the only R/N on duty they need to have a registered mental health nurse on duty to take charge of the ward, as well so request additional staff to fulfil this requirement.
- There are risks in high use of bank staffing, these are mitigated by the use of regular bank staff who know the clinical areas, through previous regular bank work, being permanent staff working extra hours or previously employed staff/students.
- The highest users of agency as a proportion of the actual hours worked (over 4%) were Wold View (32.3%); Tunstall Ward (20.8%) and Overdale (20.7%). All of these wards report vacancies and clinical acuity as the reason for agency use.
- There is a noticeable higher use of agency in the North Yorkshire and York locality, it is recognised that this impacted on by the ability to recruit generally in that area as well as the limited availability of bank staff.
- The highest users of Overtime (over 4%) of the actual hours worked were Moor Croft (7.8%); Linnet (7.3%) and Swift (6.8%). Secure Inpatient Services are using the most overtime (13,111 hours) whilst North Yorkshire & York are using the least (9,426 hours).
- A total of 48 wards have utilised bank, agency and overtime within the reporting period, which is an increase of 17 from last report.
- There is an upward trajectory of increased use of Agency.

Key Learning and how we are using this

- The increased levels of patient acuity require increased levels of staff available to maintain patient safety.
- This information highlighting use of bank agency and overtime has been used to support and inform the staffing establishment review process to understand and agree the future staffing levels moving forward and informed actions to be taken,

Actions we are taking (now what)

- The localities continually review the use of bank and agency usage as part of their ongoing roster management and any concerns are escalated through to their daily huddles and to their governance groups.
- As noted earlier a paper is going to Workforce SLG to propose a model of over recruitment of permanent staff.
- The window to buy back annual leave has been extended to enable as many staff as possible to consider this an option to support staffing.
- Nursing and Governance staff are working collaboratively with operational services supporting with Bank & substantive staff interviews.
- Ongoing discussions with Bank staff re availability over holiday periods to understand their availability to support staffing
- Staff who were appointed on a fixed term contract are been offered a permanent contract.
- Work continues to align the planned / budgeted staffing levels to meet patient need and therefore reduce the demand on temporary staffing services.
- Continue to build the bank staff capability hosted within the trust which in turn would minimise the requirement for agency and overtime in the future.
- Work continues to support managers to ensure that the budgeted establishments within the electronic system are up to date and are accurate.

Patient Outcomes, People Productivity and Financial Sustainability

Triangulation with Quality Indicators

Quality Indicator				Ward Name	Bank Usage	Agency Usage	RN Days	RN Nights	HCA Days	HCA Nights
SI's	L4	L3	Complaints							
2	2	5	0	Thistle	31.0%	4.7%	95.5%	124.0%	109.3%	141.7%
2	1	4	0	Tunstall Ward	27.6%	20.8%	109.2%	105.4%	196.7%	269.5%
1	0	1	3	Bedale Ward	33.8%	15.1%	89.0%	88.0%	179.5%	300.8%
1	2	2	1	Cedar	27.3%	15.5%	111.5%	103.9%	296.6%	240.2%
1	1	0	0	Bilsdale	19.3%	11.9%	107.5%	98.9%	162.8%	206.8%
1	1	0	0	Ceddesfeld	11.1%	1.4%	98.4%	101.6%	122.7%	167.1%
1	0	0	1	Danby Ward	15.8%	2.3%	101.1%	96.3%	173.5%	159.6%
1	0	0	0	Mallard	21.8%	1.3%	119.6%	103.8%	117.9%	132.1%
1	0	0	1	Nightingale	16.0%	0.8%	88.7%	106.0%	107.0%	104.6%
1	0	0	0	Oak Ward	12.4%	6.4%	96.6%	102.2%	105.1%	128.7%
0	0	7	1	Ebor Ward	25.5%	19.5%	111.3%	145.3%	138.2%	217.9%
0	0	6	2	Esk Ward	12.4%	3.0%	89.5%	100.2%	174.5%	153.7%
0	0	3	4	Elm Ward	30.2%	11.4%	107.2%	122.5%	164.3%	208.1%
0	0	3	0	Bransdale	25.6%	15.6%	96.7%	106.1%	153.6%	221.6%
0	0	3	0	Swift Ward	19.3%	1.8%	87.0%	100.5%	80.0%	96.0%
0	0	1	0	Farnham Ward	29.0%	12.6%	94.4%	98.5%	161.8%	226.5%
0	0	1	1	Minster Ward	28.8%	18.2%	113.6%	205.6%	137.8%	214.2%
0	0	1	2	Overdale	21.1%	20.7%	111.2%	103.4%	203.8%	275.4%
0	0	1	0	Sandpiper Ward	15.4%	0.5%	88.0%	77.9%	90.4%	117.6%
0	0	0	2	Harrier/Hawk	38.2%	3.3%	85.0%	101.9%	100.5%	173.2%
0	0	0	2	Kestrel/Kite	35.4%	1.6%	95.1%	106.9%	162.4%	225.7%
0	0	0	2	Maple	28.8%	11.1%	90.2%	112.1%	171.9%	196.5%
0	0	0	2	Stockdale	26.4%	15.2%	114.1%	102.6%	161.0%	185.8%
0	0	0	1	Lustrum Vale	27.6%	0.3%	108.8%	147.3%	129.1%	116.9%
0	0	0	1	Moor Croft	12.1%	16.4%	103.3%	98.4%	128.3%	188.5%
0	0	0	1	Roseberry Wards	16.5%	4.1%	104.9%	104.5%	108.9%	116.3%

Analysis (so what)

This section explores all serious incidents, severe harm incidents (L4); self-harm incidents of moderate harm (L3) and all complaints raised within the 6 month reporting period. There were no incidents recorded from Harrier/Hawk, Kestrel/Kite, Lustrum Vale, Maple, Roseberry Ward and Stockdale Ward.

- The Patient Safety investigation team have been asked to specifically consider staffing levels and skill mix in relation to their investigation of inpatient SI's to support more robust triangulation of staffing data and aid root cause analysis. A review of those cases reviewed at Directors Panel during the reporting period did not identify lack of staffing or skill mix as a potential lapse in care, however, we are aware that the ongoing challenges of the pandemic and staff vacancies have affected staffing levels and skill mix on occasions.
- It is also clear from the recent staffing establishment review (professional judgement approach) that whilst staffing levels may not have been seen to directly contribute to a patient safety incident that patient acuity, complexity and bed occupancy is felt to be a pressure in relation to clinical activity and the delivery of quality care across a number of unit.
- None of the complaints raised cited issues with staffing levels or skill mix. There was 1 complaint received in relation to Nursing Staff's Attitude being negative (Elm Ward, Durham & Darlington).
- Senior staff visited SIS we heard directly from patient's that leaves could not always be undertaken as planned which caused them distress.
- PICU and adult acute wards especially, continue to have patients who have very complex and on occasion's different presentations, this is continuing to be a cause for requests for additional staff.

Key Learning

- As reported in last report there continues to be an ongoing need to increase staffing to cover staff absences and increase in patient acuity. This information informs staffing establishment reviews.

Actions we are taking (now what)

- Wider themes relating to serious incidents and complaint data are analysed further through the monthly Quality Assurance and Improvement Sub Group along with any actions needed for further investigation
- The staffing skill mix will be reviewed where we are reporting below the tolerance of 89.9% and will be included in the staffing review analysis.
- Analysis and triangulation take place within the localities to identify and themes or areas of learning that need to be actioned key risk and actions to are then reported to QUAC for trustwide consideration, learning and action if required.
- In order to free up staffs time to care and focus on a safety culture, establishment reviews have focussed on additional roles to support inpatient clinical activity, such as ward team administrators and activity coordinators and improve the RN/HCSW skill mix ratio.
- Following a number of incidents and complex clinical situations Thistle ward has had an independent review undertaken and a subsequent action plan developed. This is reviewed and monitored in weekly calls attended by the service and director of nursing and chief operating officer.

Patient Outcomes, People Productivity and Financial Sustainability Continued…

Triangulation - Safe Indicators

Quality Indicator			Ward Name	Bank Usage	Agency Usage	Actual Staff Rostered			
Falls Harm	Pressure Ulcers	Medication Errors				RN Days	RN Nights	HCA Days	HCA Nights
1	0	3	Ceddesfeld	11.1%	1.4%	98.4%	101.6%	122.7%	167.1%
0	2	2	Aysgarth	1.3%	0.0%	136.1%	121.1%	106.1%	116.0%
0	1	2	Cedar	27.3%	15.5%	111.5%	103.9%	296.6%	240.2%
0	1	4	Hamsterley	14.1%	3.4%	111.2%	104.4%	150.5%	203.5%
0	1	9	Moor Croft	12.1%	16.4%	103.3%	98.4%	128.3%	188.5%
0	1	2	Ramsey/Talbot	13.3%	19.0%	80.9%	115.3%	114.3%	153.5%
0	1	4	Roseberry Ward	16.5%	4.1%	104.9%	104.5%	108.9%	116.3%
0	4	8	Springwood	20.3%	14.8%	76.9%	100.4%	209.7%	239.1%
0	1	12	Wold View	13.2%	32.3%	86.0%	86.6%	134.0%	193.8%
0	0	19	Brambling	29.4%	2.7%	83.6%	113.2%	130.8%	131.3%
0	0	19	Elm	30.2%	11.4%	107.2%	122.5%	164.3%	208.1%
0	0	18	Ebor	25.5%	19.5%	111.3%	145.3%	138.2%	217.9%
0	0	15	Lark	13.9%	0.9%	91.9%	110.5%	85.3%	94.2%
0	0	12	Thistle	31.0%	4.7%	95.5%	124.0%	109.3%	141.7%
0	0	10	Newtondale	16.2%	0.5%	98.4%	66.0%	90.6%	111.6%
0	0	9	Westerdale North	14.0%	12.0%	123.8%	116.2%	99.2%	150.2%
0	0	8	Harrier/Hawk	38.2%	3.3%	85.0%	101.9%	100.5%	173.2%
0	0	8	Maple	28.8%	11.1%	90.2%	112.1%	171.9%	196.5%

Analysis (so what)

- There was 1 incident recorded as a fall that resulted in significant harm within inpatient services. The fall occurred within older people's service.
- There were 12 incidents reported in relation to pressure ulcers. Again the majority of these occurred within older people's service.
- 8 were present on admission and 4 were further downgraded when reviewed by the tissue viability service.
- There were 304 incidents of medication errors reporting within the reporting period across 58 wards. The top 10 wards for medication errors are listed within the data set above Analysis of medication incidents indicated that wrong patient administration errors and administration of the wrong drug due to similar drug names been confused were the areas that needed actions putting in place.

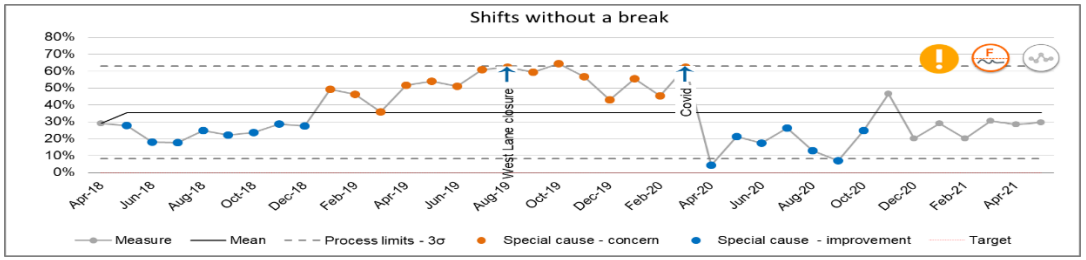
Key Learning and how we are using this

- Pharmacy are working with clinical services to implement different ways of working in relation to above areas.
- Following a recent SI for a pressure ulcer the learning from this identified the need to implement training on pressure ulcer prevention and how to complete the Waterlow Pressure Ulcer Risk Assessment chart and body map skin assessment chart. The tissue viability team produced a pressure ulcer equipment protocol and a wound infection algorithm to help staff to identify when to order pressure relieving equipment and how to manage wound infections/suspected wound infections.

Actions we are taking (now what)

- Commencement of the introduction of photographic identification of patients onto prescription and administration records on admission as the first choice option with wristband identification being the second choice option has been made.
  Early feedback suggests further work is required to ensure standardisation of application and adoption of the process
- Tallman lettering has been introduced successfully and we are continuing to add to our catalogue of drugs we are using this lettering on. We have shared this work regionally as it is recognised there is no standardised list of agreed lettering. This is to be taken to a national Medication Safety meeting in September for further discussion.
- The Tissue Viability Service has recently had a new member of staff join the team which will increase expertise within the Trust. Pressure ulcer prevention and management training has been delivered throughout the year on a bespoke basis which incorporates how to complete the Waterlow Pressure Ulcer Risk Assessment chart and body map/ skin assessment chart. Tissue viability is planning to restart their training programme from January 2022.
- Tissue viability service have led head of service review in 1 case, learning has been shared.

Breaks not Taken



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation		L		
Assurance		F		

Analysis (so what)

- The SPC Chart is reporting within a normal variation at trust and locality level with the exception of Secure Inpatient Services). An increase in staff breaks has coincided with an increase in bed occupancy and patient activity. There were 1,857 shifts worked within the reporting period where breaks were not taken
- The top 5 wards were Elm Ward (132 shifts); Kestrel/Kite (123 shifts); Tunstall Ward (116 shifts); Brambling Ward (101 shifts) and Bedale Ward (100 shifts).
- The majority of shifts where breaks were not taken occurred on day shifts and are reported by the services as being due to periods of high clinical activity or staffing shortfalls to meet demand.

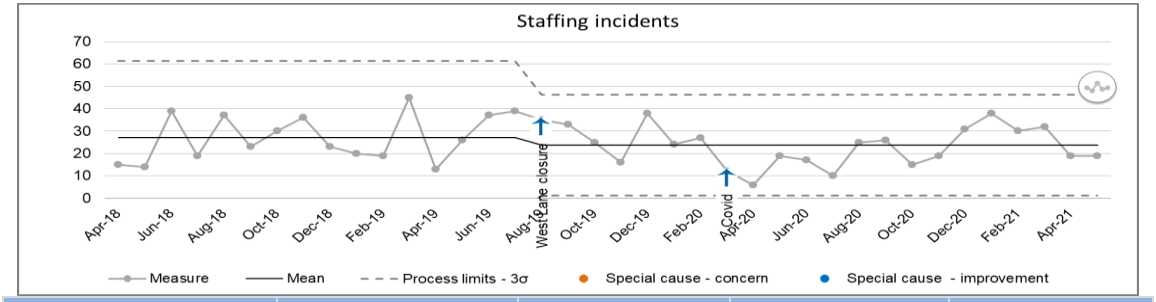
Key Learning and how we are using this

- Breaks are essential to maintain well-being at work and all efforts should be made to support staff to take breaks.

Actions we are taking (now what)

- The absence of breaks is monitored by localities in order to reinforce locally and responsively the importance of ensuring breaks are taken during the course of a shift. Also ensuring there is appropriate escalation in place and using additional staffing and MDT to support breaks to be taken
- Continued education with regard to ensuring the staff Health Roster is properly maintained and updated to record all occurrences of missed breaks and the reasons why breaks are not being taken.
- Triangulation with other metrics to identify wards with high acuity and staffing pressures Staff wellbeing aspects are being fed into the “Great Place to Work” Special Interest Groups for consideration.

Reporting, Investigating and Acting on Incidents Citing Staffing Levels



Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation				

Analysis (so what)

- The SPC Charts are reporting this measure within a normal variation at trust and locality level.
- There were 161 incidents raised citing issues with staffing. This is an increase of 53 when compared to the previous 6 month report.
- Of the total incidents reported 55 were in relation to day shifts and 106 were reported in relation to nights from 25 teams across the Trust
- 67% (108) of all staffing incidents reported involved the Secure Inpatient Services Wards at Roseberry Park the majority of these were reported retrospectively.
- 140 incidents were reported for inpatient areas whilst there were 21 reported involving community services.
- Themes include – Enhanced observations increasing staffing requirements, insufficient FFP3 trained staff on duty to provide Covid response, wards not running on required staffing levels/skill mix, staff sickness (long and short term), Covid related absence (sickness, isolation and quarantine), staff moved from ward to ward causing lack of staff continuity, high acuity, imbalance of agency/bank staff to permanent staff, lack of capacity to meet increasing demand of the service and service delivery. In all cases remedial actions were able to be put in place to maintain patient safety.

Key Learning and how we are using this

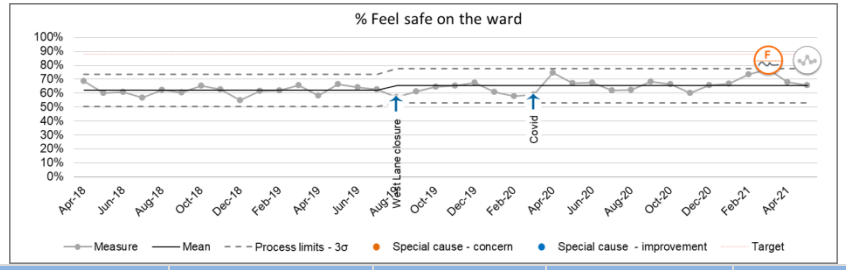
- The incidents raised in SIS were reported retrospectively due to staff not always escalating staffing concerns through datix.

Actions we are taking (now what)

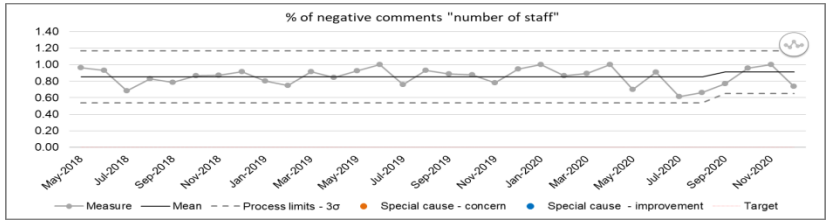
- Using the establishment review process and focus on recruitment to increase the registered practitioner to support worker skill mix on AMH acute and Secure Inpatient Service wards to meet recommended levels as detailed by evidence based staffing tools, professional judgement and benchmarking.
- Gold command is in place to have an oversight of and support staffing.
- Actions have been taken to support staff to report staffing issues using datix, through the re circulation and education of the staffing escalation protocol.

Patient, Staff and Carer Feedback

Patient and Carer Feedback



Level	Durham & Darlington	Forensic Services	North Yorkshire & York	Teesside
Variation				H
Assurance	F	?	?	F



Level	Durham & Darlington	Forensic Services	North Yorkshire & York	Teesside
Variation			L	L

Analysis (so what)

- 246 comments were received from our patient experience surveys that suggested improved staffing was required within our inpatient wards due to patients saying additional staff were required to support further activities including supporting leave, continuity of care and diversional activities.
- From the total number of 112 compliments, there was nothing highlighted that was specific to staffing levels, although patients were very complimentary about nursing staff.
- The SPC chart at trust level in relation to feeling safe is reporting this metric within a normal variation however; the target of 88% consistently fails to be achieved. At locality level Teesside are reporting within a special cause variation (improvement) whilst the other localities are reporting within a normal variation. The reasons given by the patients were "*having witnessed incidents and being attacked by other patients, unfamiliar surroundings, under staffed, patients were shouting and arguing, unpredictability of the ward, not feeling listened to, probably mainly due to my mental health*"
- 78% of the comments relating to the number of staff available were negative (community and inpatient). The SPC chart at trust level is reporting this within a normal variation and at locality level North Yorkshire & York reporting an improvement. An example of the comments received by patients included *"Increase amount of staff so patients can get out more; Services are so stretched I had to fight to even be seen, once I was, I am very happy with it.; More staff needed, long waiting list.; Better communication as see different people all the time, some are good some aren't." "Staff are very busy we need more staff so we can go out more ".*

Actions we are taking (now what)

- This feedback informed and informs staffing establishment setting exercises
- Feeling safe has been identified as a priority within the Trust's Quality Account. A range of work is being undertaken to address these concerns where this is possible across localities. During 2021/22 we aim to:
    - Work proactively within the newly formed Regional Patient Experience network maximising opportunities for benchmarking patient experience data.
    - Seek ideas as part of the 'mutual help' meetings that take place on the wards on what we can do to make patients feel safe. Review current 'ward orientation' process for patients being admitted onto our wards and incorporate into personal safety plans.
    - Continue the existing pilot of body cameras to a further 6 wards and an additional 60 cameras.

Key Learning and how we are using this

- Feedback outcomes into Special Interest Groups, such as "A Great Place to Work", and the Trust Workforce sub-group of SLG to support future strategic planning regarding staffing and workforce.
- Triangulation in workforce planning and establishment reviews.
- Work has been undertaken to improve liaison with the Police, this work is becoming embedded as business as usual.
- We piloted body cameras on 3 wards, early feedback from staff and patients so this has been was positive to a further 12 wards.

Patient, Staff and Carer Feedback Continued…

Staff Experience – in our shoes

The staff team from Bankfields Court were asked to share their experience of working during Covid:

I was expecting the patients to struggle with staff wearing masks but I feel it has been okay.

It was sad when we couldn't sit and eat with the patients as that is what they are used to and it is good for them.

Wearing the PPE was hard at first and took some adjusting to but now it is okay and I am used to it.

At first it was very nerve racking coming to work daily knowing that I was going home and putting my family at risk. I battled with guilt thinking I am putting my family at risk.

It was sometimes hard to keep up with the guidance changing but there was always someone that found out what was happening and what we were supposed to be adhering to.

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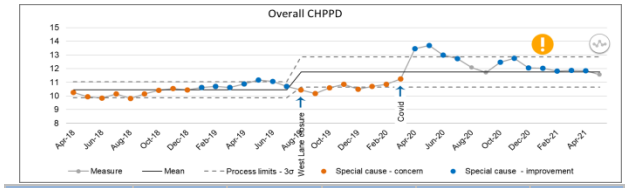
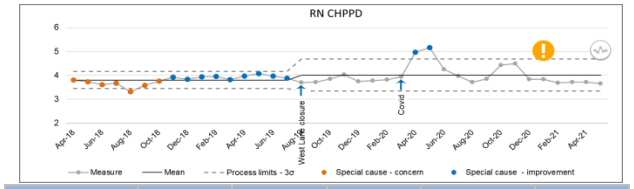
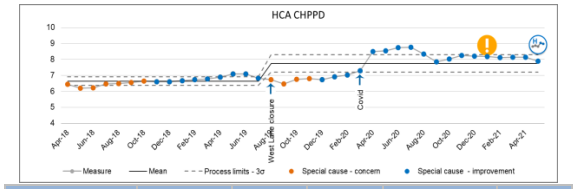
Care Hours per Patient Day (CHPPD)



Level	AMH	CYP	LD	MHSOP	SIS
Variation	H		H	L	



Level	AMH	CYP	LD	MHSOP	SIS
Variation			H	L	



Level	AMH	CYP	LD	MHSOP	SIS
Variation	H		H	H	H

Analysis (so what)

- This metric tracks the total number of direct nursing care hours compared to the number of patients as a count at midnight. The average CHPPD across all inpatient areas was 11.69 WTE (3.53 WTE registered nurses; 7.82 WTE healthcare assistants; 0.08 registered nursing associates, 0.08 non-registered nursing associates, 0.10 WTE registered AHP; 0.08 WTE unregistered AHP).
- The SPC Chart is reporting the overall CHPPD within a normal variation at trust level. A review at speciality level has taken place and highlights a cause for concern in relation to MHSOP, an improvement in relation to AMH and LD Services whilst the others are reporting within a normal variation. 1 ward had a significant drop in CHPPD which has adversely affected the report, this is been reviewed in the locality.
- The RN CHPPD is reporting at trust level within a normal variation. A review at speciality level highlights MHSOP who are reporting a cause for concern whilst LD are reporting an improvement. All other specialities are reporting within a normal variation.
- The HCA CHPPD is reporting at trust level within a special cause variation (improvement), this is reflected also at speciality level in relation to AMH, LD, MHSOP and SIS whilst CYP are reporting within a normal variation.

Key Learning and how we are using this

- Within the MHSOP establishment review consideration needs to be given to ration of RN/HCSW
- We are maintaining a satisfactory number of CHPPD as per SPC chart.

Actions we are taking (now what)

- This information is incorporated into establishment review reports for all inpatient services to support triangulation for increasing staffing establishments.
- Develop a briefing/teaching document for all ward based staff regarding CHPPD to increase its visibility and uses, including access to Model Hospital.

- Local TEWV dashboard is available on IIC for CHPPD so teams can understand how best to deliver care within their resource available. The fill rates are monitored locally on a monthly basis and reported to NHSE as per national requirements
- Benchmarking against peer and national Trusts using Model Hospital
- Benchmarking against local wards of same speciality / sub-speciality
- Variation between wards within a speciality needs to be reviewed at a more granular level.

Conclusions

We continue to work in unprecedented times. The management of the pandemic continues to present challenges in relation to staffing. At the beginning of 2021 we had a significant number of covid outbreaks which impacted on staffing and the wellbeing of staff and patients. Currently parts of the trust have the highest incidence of covid nationally which again is impacting on staffing.

Additionally we are seeing the expected clinical surge post wave 1 and 2 of the pandemic with different presentations of patients, new patients presenting and an increased level of acuity. These presentations are placing pressure on our staffing resource.

Localities have oversight of staffing and the pressures and seek to find local solutions to manage needs of patients, SIS and Bankfields have moved into BCP and are receiving additional support from gold command to deliver their services safely. There is daily oversight of staffing across services. Gold command seeks assurances that services are safe and supports changes to services to ensure what we deliver is safe. We are striving to improve our staffing establishments working creatively with partners to recruit qualified and HCSW to ensure we continue to be able to deliver quality services to patients.

Appendix 1

SPC Symbols

Variation:

Special cause variation – cause for concern
(indicator where high is a concern)

Special cause variation – cause for concern
(indicator where low is a concern)

Special cause – improvement
(indicator where high is good)

Special cause variation – improvement
(indicator where low is good)

Common cause variation

The data does not meet the assumptions of the normal distribution and the SPC chart should be interpreted with caution

Assurance:

Consistently hit target

Hit and miss target randomly

Consistently miss target

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 15

FOR GENERAL RELEASE

DATE:	**29 July 2021**
TITLE:	**Learning from Deaths – Dashboard Report 2021/22**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

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 Q1 of the 2021/2022 financial year is included at Appendix 1 and includes 2020/2021 data for comparison.

31 serious incidents resulting in death were reported on StEIS and 23 serious incident reviews were completed. The three most common root cause or contributory findings were in relation to care planning, policies not being followed and medication issues. Actions that are being taken to address these are in the report.

301 cases met the criteria for a mortality review. Of those 301 reviews, 78 reviews have had a part 1 review. 12 of those cases were selected for a more detailed Part 2 Structured Judgement Review.

New structures and processes for learning from deaths continue to be developed with the most recent event for serious incidents being held on 06/07/2021. This work is helping 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:	**29 July 2021**
TITLE:	**Learning from deaths - Dashboard Report 2021/2022**

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 April – June 2021.The Board is receiving the report for information and assurance of the Trusts approach.

2. BACKGROUND INFORMATION AND CONTEXT:

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

The Learning from Deaths policy and the Mortality Review process remain under review. From September there will be a full-time mortality reviewer in place to continue to develop and take new processes forward as well as a 0.2 WTE band 7 from MHSOP services who continues to assist with Structured Judgement reviews. New ways of working in relation to proportionate reviews of Serious Incidents continue and were reviewed at a learning event in July 2021. In keeping with the Trusts Journey to Change, part of the event focused on how we can work in partnership with patients and families if aspects of the care we provide goes wrong.

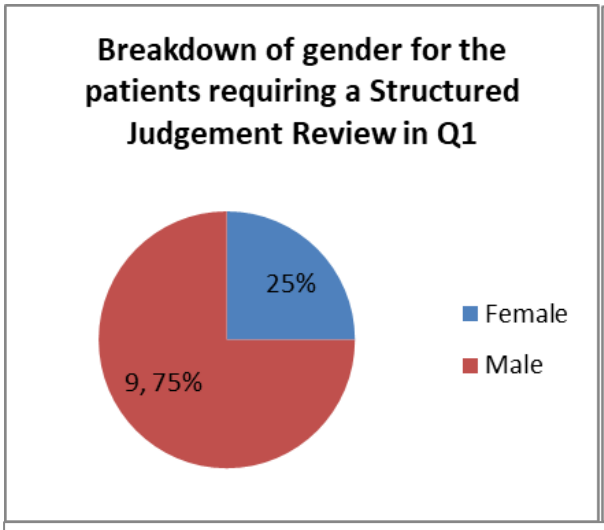
3. KEY ISSUES:

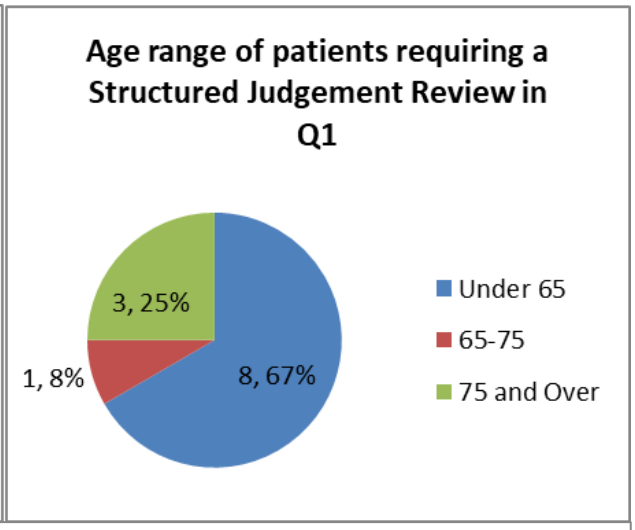
3.1 Mortality Reviews and Learning

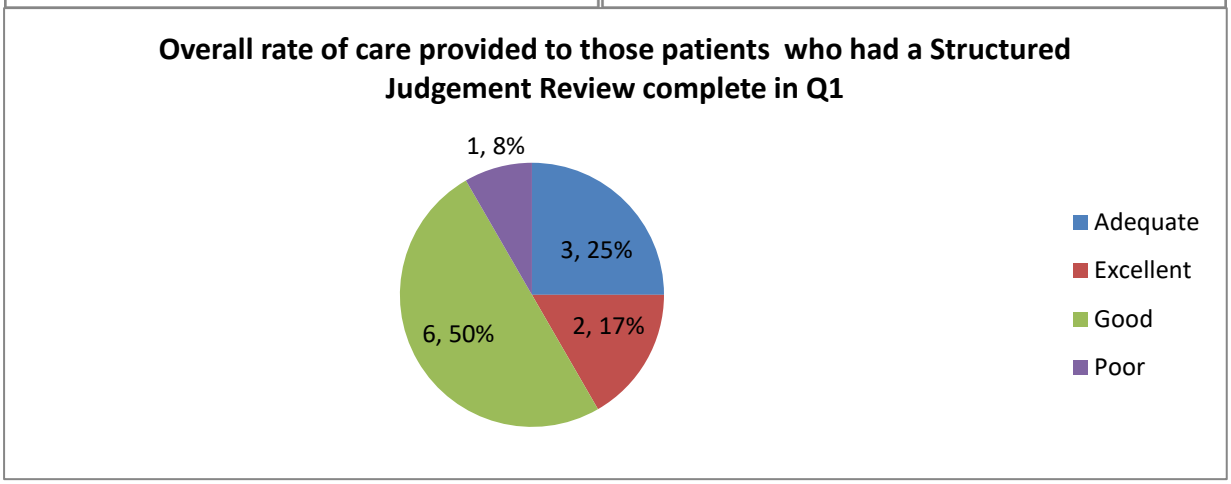
Further detail and criteria for Mortality reviews can be found in Appendix 2.

Mortality Review 2021/2022
In quarter 1 2021/2022, 301 cases met the criteria for a mortality review. Of those 301 reviews, 78 reviews have had a part 1 review. 12 of those cases were selected for a more detailed Part 2 Structured Judgement Review.

Month	Total Number of Deaths which met criteria for a review	Total Number of Deaths which has been reviewed under locally agreed criteria.	Total Number identified as requiring a Structured Judgement Review
April	116	28	3
May	114	17	2
June	71	33	7
Total	**301**	**78**	**12**







Mortality Reviews

Points of learning from unexpected and expected physical health deaths reviews completed in quarter 1

- Prescribing and monitoring of psychotropic medication – more emphasis is required on the management of obesity and physical health checks.
- Consideration of prescribing practice and increased monitoring of medication for those patients who are known to access street drugs or medications from the internet in addition to prescription drugs.
- There is a lack of medication reconciliation between GPs and community mental health services.
- There is a recurrent theme of lack of compliance with the Did Not Attend/Was Not brought policy in particular for those patients who are difficult to engage.
- There is a need to increase multi-agency communication and responses to patients with a dual diagnosis.

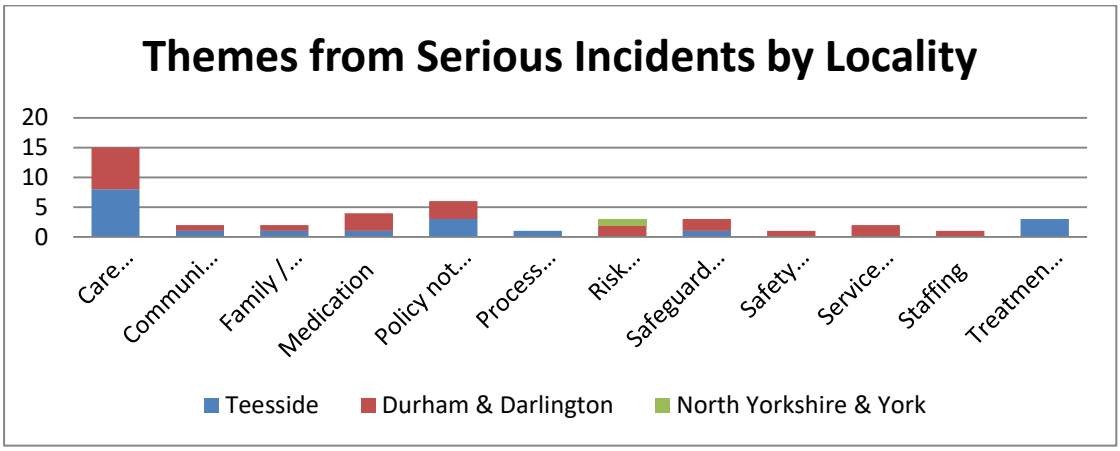
Points of Good Practice

- Collaboratively working with other services/external agencies
- Individualised compassionate care.

- Detailed and personalised care plans to meet identified needs
- Carers assessments which provide the opportunity for relatives to share concerns
- Evidence informed, compassionate and person centred care that enabled patients to experience a reasonably independent quality of life and a dignified death.
- Care based upon recovery principles despite poor prognosis which supported a positive and continuous therapeutic relationship.
- Care plans were objective and provided clear goals and outcomes

3.2 Learning from deaths and serious incidents

31 serious incidents resulting in death were reported. This included 8 in-patients deaths, 7 were due to either expected or unexpected physical health deaths, 1 was as a result of a patient safety incident. 23 STEIS reportable serious incidents resulting in death were reviewed. The key learning themes are summarised in the table below which illustrates the three most common root cause or contributory findings being care planning (35%), policy not being followed (14%) and medication (9%).



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 reports and associated 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. All work streams that align to these key themes are aimed at improvement.

3.3 Structures to support and embed learning

- The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group. During Q1 the group has been focusing on implementing approaches to ensure effective sharing of learning that are underpinned by strong governance and assurance processes. The learning library is now in place where safety briefings and learning bulletins can be found. This area will develop significantly over the

coming months. Over the reporting period learning from patient safety events has been shared through a range of mechanisms.

Three Patient Safety Briefings were issued:

- one in relation to in-patients who self-medicate and highlighted the trust practice procedure
- one raised awareness of the types of clinical presentation that should be taken into account when considering a referral for assessment to perinatal services
- one reminded staff of how to get support from the Trusts safeguarding team in identifying safeguarding issues .

- Seven Learning from Serious Incidents Bulletins' have been distributed across the trust, that have shared key learning and good practice highlighted in serious incident reports presented at the Directors Assurance Panel.

- There have also been two further Trust-wide communications in Q1 in relation to how we are improving patient care which included information about the roll out of suicide prevention training and the use of patient monitoring technology (oxyhealth) as well as a communication on how we are continuing to improve safety and patient experience.

- Senior clinical leadership continues to be further enhanced to support and embed learning as newly appointed Community Matrons, Practice Development Practitioners and Peer Workers commence in their new roles.

- We are committed to supporting and engaging families in the review processes following the death of a family member, however opportunities for improving the quality of communication and involvement in the review process continue to be highlighted and views from families have been actively sought as part of quality improvement. In response to this, the Director of Quality Governance commissioned an improvement event to focus upon this feedback. The event took place on 06/07/2021, facilitated by Trust QI colleagues and NHSE/I colleagues currently supporting the Trust. A range of staff attended to share their experiences and ideas for change. The outputs from the event are being pulled together to inform a number of recommendations will be made regarding future approaches. We are also considering how we can involve services and families more in mortality reviews of patients who die from a physical health cause.

- Work continues in relation to improving the physical health of people with mental health problems in keeping with ICS priorities when learning from deaths. This has included the appointment of physical health practitioners to support wards and teams as well as training. It is envisaged that the themes collated from Structured Judgement Reviews will identify areas which will enhance further developments and improvements in this area in particular with those patients who are difficult to engage and those who have a dual diagnosis. This analytical work will be undertaken in Q2.

- Suicide prevention and self-harm reduction is one of the Trusts key patient safety priorities in 'Our Journey to Safer Care'. The Suicide Prevention and Self Harm Reduction Group is developing a framework and work programme aimed at reducing 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. A task and finish group is currently working on the Trusts Suicide prevention Strategy

and it is anticipated that this will be launched on World Suicide Prevention Day on 10th September 2021.

- Working in collaboration with the 'Connecting with People' initiative, an organisational response to addressing suicide and self-harm, 25 staff have been trained to deliver this training to all registered staff within the Trust.

- The Trust plans to do some collaborative work with NY&Y CCG focusing on the learning gained from SI's related to safeguarding practices and opportunities for improvement. A meeting scheduled for September will develop the detail of the work plan.

- The Trust is part of a regional collaborative working with the Academic Health Science Network for the North East and North Cumbria across a range of patient safety priorities. This network will enable the sharing of a range of patient safety improvement approaches and enable benchmarking of process and outcome measures.

- We continue to utilise a range of methods to gain assurance on the quality of clinical risk assessment, care planning and documentation, a key area for improvement identified through serious incident reviews , complaints and external inspections. This is proving a high level of assurance regarding patient safety. We will continue to review and broaden our assurance programme over the coming months to ensure this adequately covers the 3 domains of quality.

- A task and finish group has been reviewing actions and progress around care-planning with a view to simplifying documentation and reducing the amount of intervention plans in place. This work is a quality priority for 2021/22.

- Further work to understand why key policies are not always adhered to and how we can use quality improvement methodology such as visual controls to strengthen this is underway.

3.4 The Learning from Deaths Dashboard

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

For Q1 the dashboard highlights the following:

- A total of 467 deaths were recorded (not including LD deaths). This is all deaths (including natural expected and unexpected) in relation to people who are currently open to the Trust's caseload including Older People's Community and Memory Services.
- There were 23 STEIS reportable serious incidents resulting in death reviewed and 31 STEIS reportable serious incidents resulting in death reported.
- 43 learning points were identified from completed Serious Incident reviews.
- There were 78 cases reviewed under the mortality review process, 301 reviews were identified as meeting the mortality review criteria. The 78 cases reviewed meet the local agreement due to capacity (see appendix 2).
- 29 Learning Disability deaths were reported on Datix. All 29 were reviewed via the Trust mortality review process and have been reported to LeDeR.

- 8 in-patients deaths were reported over this period. Six deaths occurred in MHSOP services of these deaths, 3 were expected physical health deaths with one patient being on the End of Life pathway. The other 3 deaths were unexpected physical health deaths. All of these deaths have been or are being reviewed via structured judgment reviews via mortality review process. 2 of the in-patient deaths during Q1 occurred in Forensic services. One was an expected physical health death; the patient was on the end of life pathway. This death will be reviewed via a structured judgment review. The other death was as a result of a patient safety incident and has been reviewed via the serious incident investigation process.
- In comparison for the same time frame in 2020/2021 Q1: there were 14 in-patient deaths. These deaths were all either expected or unexpected physical health deaths and were reviewed via the mortality view process.
- Figures show an increase of 1 in the number of in-patient deaths reported as a serious incident compared with the previous year in the same period.

4.0 IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
Improvements in 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. The organisational learning group and revised governance reporting and structures has enabled 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/

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NHS Foundation Trust

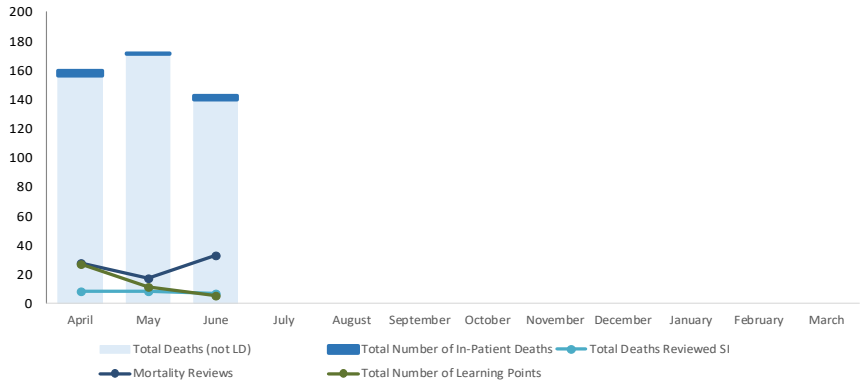
Appendix 1 Dashboard

Learning from Deaths Dashboard - Data Taken from Paris and Datix
Reporting Period - Quarter 1 -April- June 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	
	2021/22	2020/21	**2021/22**	2020/21	**2021/22**	2020/21	**2021/22**	2020/21	**2021/22**	2020/21
Q1	**467**	↘ 979	**8**	↘ 14	**23**	↘ 29	**78**	↘ 337	**43**	↗ 18
Q2		486		6		39		191		32
Q3		731		5		35		126		29
Q4		691		7		22		98		18
YTD	**467**	↘ 2887	**8**	↘ 32	**23**	↘ 125	**78**	↘ 752	**43**	↘ 97



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	
	2021/22	2020/21	**2021/22**	2020/21	**2021/22**	2020/21	**2021/22**	2020/21
Q1	**29**	↘ 34	**0**	↔ 0	**29**	↘ 34	**29**	↘ 34
Q2		13		0		13		13
Q3		28		1		25		25
Q4		32		1		36		36
YTD	**29**	↘ 107	**0**	↘ 2	**29**	↘ 108	**29**	↘ 108

Mortality Reviews 2021/2022

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 Q1, 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.

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ITEM NO.16

Mental Health Legislation Committee: Key Issues Report		
Report Date: 29 July 2021		**Report of: Mental Health Legislation Committee (MHLC)**
Date of last meeting: 22 July 2021		The meeting was quorate, there were no apologies for absence Joanne Allot, CQC Mental Health Act Reviewer observed the meeting
1	**Agenda**	**The Committee considered the following agenda items during the meeting:** • Revised MHLC Terms of Reference • Board Integrated Assurance Dashboard • Discharges from Detention Quarterly Report • Section 136 Quarterly Report • Section 132 b Quarterly Report • Seclusion Report • Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DoLS) Report • Care Quality Commission (CQC) Quarterly Report • Assurance Hospital Managers Report • Internal Audit Report: Tees Esk and Wear Valley 2020 – 21/24 Mental Health Act (Tribunals) • Annual Committee Scheme of Delegation • Case Study
2a	**Alert**	**The Committee alerts members of the Board that:** **Outcome of CQC Inspections** A number of issues were raised particularly on Harriet/Harker ward. These included, amongst others, negative patient feedback, staffing numbers and attitudes, communication and physical environmental problems around patient observations. **Flexible Segregation Policy** Following the implementation of the new Flexible Segregation Policy a number of concerns had been raised with regards to its application. Work is currently taking place to compare with policies in place at other NHS Mental Health Trust providers to identify any improvements that can be made. **Seclusion Report** There had been a marginal increase in the seclusion of patients during April to June 2021 with 52 episodes of seclusion in comparison to 50 in the previous quarter; 4 episodes of segregation in comparison to one in the previous quarter; and there were multiple episodes of seclusion for 11 patients. No seclusions related to Covid.
2b	**Assurance**	**The Committee assures members of the Board that:** **Revised MHLC Terms of Reference** Following the Independent Well-led review carried out by the Good Governance Institute, the Committee's Terms of Reference had been updated and approved

		by the Board at its 27 May 2021, to come into effect from September 2021. The Committee received, noted and accepted the updated Terms of Reference. **Discharge from Detention Quarterly Report** Processes are in place following Tribunal discharges, which include the patient's care package being monitored by the Trust's MHL Department and the Hospital Managers are required to identify any common themes or trends including the reasons for discharge from the same team. The number of patients returned to the community following admission to Roseberry Park hospital was highlighted. A further review is planned to take place to gain a greater understanding and to provide assurances to the Committee on remedial actions in place. **Section 136** There is a process in place, which includes the maintenance of electronic records for the use of Section 136 and the Trust's 'Places of Safety'. Work continues to embed the process to ensure patients are informed of their rights when detained under the Mental Health Act. The escalation process in place is overseen by the MH Legislation Team to ensure completion of paperwork within the required timeframe. **Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) Report** The reduction in reportable DoLS cases was attributable to the reduction of Respite patients during the Covid pandemic. **Internal Audit Report** **(TEWV 2020 – 2021/24 Mental Health Act (Tribunals))** The internal audit report provided assurance that any risks identified are managed effectively within the control framework. **Scheme of Delegation Annual Report** There is a Scheme of Delegation in place in response to the Mental Health Act 1983 as amended by the Mental Health Act 2007 (Code of Practice, 37.9).
2c	**Advise**	**The Committee advises the Board that:** **Seclusion Clinical Audit** A Seclusion Clinical Audit was agreed to be arranged with the Scope and timeline of the audit provided to the next meeting. **Annual Clinical Audit Plan** The Annual Clinical Audit Plan was agreed to be provided to the next meeting to provide assurance that quality and patient safety; and legal and regulatory requirements are included. **Future Section 136 of the Mental Health Act Committee Reports** An addendum to the Section 36 Report was agreed to be provided to the Committee in future, which will include the number of individuals under the age of 16. **Integrated Board Assurance Dashboard** Proposed measures for inclusion within an Integrated Board Assurance Dashboard were considered as part of developing an integrated approach to assurance to align with 'Our Journey to Change' and the Board Assurance

		Framework. The Committee agreed to confirm what quantitative measures it recommended for inclusion within the Dashboard. **Associate Hospital Managers (AHMs) Report** There are arrangements in place for hearings to continue to take place. Virtual meetings had been held since the onset of the Covid-19 pandemic and despite a reduction in AHMs all planned hearings had taken place. **CQC Quarterly Report** During quarter one, seven CQC inspections had been carried out across the Trust. Six of the seven inspections were carried out remotely with one face to face inspection carried out on the Harrier/Hawk ward. At the time of the Committee meeting the Trust had received feedback from the CQC for five inspections: Linnet, Cedar, Oakwood, Newtondale and Harrier/Hawk wards. Due to the number of concerns raised on Harrier/Hawk ward it was agreed this would be escalated to the Board at its 29 July 2021 meeting. **Case Study** A Case Study report was received on a patient's seclusion episode. The Committee noted that the patient had a complex background and that seclusion is used as a last resort. The decision to invoke the seclusion arrangement was made to safeguard the patient.		
2d	**Review of Risks**	There were no new risks that were identified during the meeting for inclusion on risk registers or the Board Assurance Framework.		
Recommendation: The Board is asked to note the contents of this report.				
3	**Actions to be considered by the Board**	There are two matters that were agreed to be escalated to the Board: **1. Harrier/Hawk ward** The number of concerns raised by the CQC following their face to face inspection on the Harriet/Hawk ward on 2 June 2021. As this is a setting from where these issues had not been previously highlighted the Board needs to be aware of this. 2. **Flexible Segregation Policy** Application concerns regarding the new Flexible Segregation Policy have been raised across the Trust. Work is underway, led by the Director of Nursing and Governance team to compare the Trust's current policy against other NHS Mental Health Trust providers to identify any improvements that can be made to update the Trust's policy.		
4	**Report compiled by:**	Lynn Hughes ***Interim Corporate Governance Advisor*** Pali Hungin ***Non-executive Director (Committee Chairman)*** Ahmed Khouja **Medical Director**	**Minutes are available from:**	Lynn Hughes ***Interim Corporate Governance Advisor***

Trust Board of Directors **ITEM NO. 17**

DATE:	**21st July 2021**
TITLE:	**Guardian of Safe Working Quarterly Report July 2021**
REPORT OF:	**Dr Jim Boylan - Guardian of Safe Working**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
A great experience for patients, carers and families	
A great experience for staff	✓
A great experience for partners	✓

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.

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 more recently a significant escalation of positive cases has meant an increase in the number off work due to self isolation or sick leave.

An issue that has recently been identified which is being actively investigated and assurances sought is around adequate staff being available in the 136 suites. As previous reports have also identified other junior doctor concerns regarding section 136 assesments, the medical director is pursing a Trust-wide quality improvement event to obtain baseline data and develop standard operating procedures to ensure the quality and staff / patient safety.

There continue to be a notable number of exception reports emanating from the Scarborough (in particular) and Teesside localities where there are Non-Residential On Call Rotas. These have persisted over several months and indicate the elevated work intensity in these areas which continues to give rise to an excess of Guardian Fines levied upon the trust – largely due to the breach of the 5 hours continuous rest rule.

We continue to monitor and review the process for exception reporting to try to ensure timely reporting by Junior Doctors and accurate intelligence of work intensity across all localities.

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 July 2021**
TITLE:	**Quarterly Report by 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:

- Since the Annual report to the board in April 2021 I am pleased to say that I was interviewed and appointed in a substantive capacity as Guardian of Safe Working for the Trust.

- During May 2021 the Guardian Role was subject to a detailed audit conducted by Audit 1 North East – the final report is attached for information as **Appendix 1.** I

am pleased to say that the audit gave the functioning of the role within TEWV a clean bill of health, with only 2 low level recommendations around the specific timing of exception report records and inclusion of specific details of expenditure from the Guardian fund on Junior Doctor's wellbeing. These have both been actioned.

- **Appendices 2 and 3** provide more details for North (Durham & Teesside) and South (York and North Yorks) sectors respectively for the quarter April to June (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.

- From these appendices the data is clear that there remain concerns about the continuing level of exceptions being reported particularly in the Scarborough locality which has had the highest number of exceptions reported by some margin (60 in this quarter) and also in York (26) and Teesside (30). All of these are related to Non-Residential On Call Rotas. The trainees in Scarborough report regular very intense workloads on call – mostly related to out of area admissions, which is a particular issue at Weekends. Monitoring during this quarter has demonstrated this escalated work intensity in Scarborough and discussions have been underway with Junior Doctors and medical staffing to find an acceptable solution. A split weekend system with allocated days rest is the currently preferred model.

- Over the past quarter we have witnessed the continuing impact of CoVID 19 in the workplace and a national upsurge in new cases as relaxation of distancing measures has occurred. This has caused an escalation of staff absences in TEWV through infection and the need for self isolation, which can impact on staffing levels.

- I am concerned about reports from Junior doctors (and Consultants) regarding a reduced availability of Crisis Team staff, and therefore available support for the Section 136 suites during out of hours assessments in County Durham. There are particular staffing pressures for the Durham and Darlington Crisis Team (which is currently being managed through business continuity arrangements) – leaving duty doctors alone with only the Police and patient in attendance on a number of occasions. This represents a concerning issue during these out of hours acute assessments by Junior Doctors which requires immediate rectification and assurance that the steps have had the desired impact. This is of particular concern on the Lanchester Road site where the 136 suite is relatively isolated but is also a concern at West Park – although there is an admission ward nearby in that case from where staff will respond from in an emergency. This has recently been raised to me by Junior doctor representatives but also in the LNC by consultant colleagues, and I believe the situation has persisted for some time, and has been escalated within the locality. I am currently gathering further evidence as to the junior doctor experience, and will feed this back to the Medical Director and the Director of Medical Education.

- The other area of concern around 136 assessments out of hours is the reports of pressure that Higher Trainees on call feel under to assess and potentially

discharge a patient within the 3 hours period stipulated by the CQC, despite the lack of attendance by an AMHP within that timeframe. This practice goes against the spirit of the Mental Health Act Code of Practice for 136 assessments and reduces the level of assurance for safe patient management and potentially increases the level of professional risk for the Junior Doctor.

- Both these matters regarding section 136 assessments have been escalated to the Medical Director, in order for the immediate concerns to be addressed as well as consideration as to how quality and safety can be assured going forward.

- Medical Development have continued to deliver a fortnightly webinar meeting for all Junior doctors to provide updates and support and also regular on-line teaching sessions. I link in with this when possible and try to make myself responsive and available for requested consultation and coaching / support sessions for junior doctors to access by phone or video-link.

- We continue to review the new format of the Junior Doctors Forum (JDF) which appears to be acceptable to most and working reasonably well at this time .
- Over this quarter 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.

- There have been no evident rota gaps of concern during this quarter and the internal locum system appear to function well with minimal use of Agency locums.

- I have not received any concerns about the quality of on-call accommodation and facilities for Junior Doctors during this quarter.

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

- 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 and the recent escalation of cases resulting in staff vacancies and shortages in key areas has compromised safety for Junior Doctors in some localities for urgent out of hours assessments.

Pressure upon Junior doctors to assess section 136 patients without the presence of an AMHP does not constitute best practice and may compromise the level of assurance for decisions made about these patients and pose a professional risk for Junior Doctors.

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.

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:

The continuing challenges of the Covid19 Pandemic manifested more recently through staff shortages have impacted upon safe working practices for Junior Doctors in acute out of hours situations in some parts of the trust. There is a need to further assess and respond to this situation pro-actively.

There continue to be issues around work intensity in Non-Residential Rotas around the trust and this is of most concern in the Scarborough locality. Draft measures are underway to alleviate work pressure on Junior Doctors, particularly at weekends in this locality.

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.
.

7. RECOMMENDATIONS:

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

Author: Dr Jim Boylan
Title: Guardian of Safe Working for Junior Doctors

Background Papers:
Appendix 1: Final Report of Audit of Guardian of Safe Working – TEWV – June 2021
Appendices 2 & 3: detailed information on numbers, exception reports and locum usage- North and South Sectors respectively - second quarter 2021.

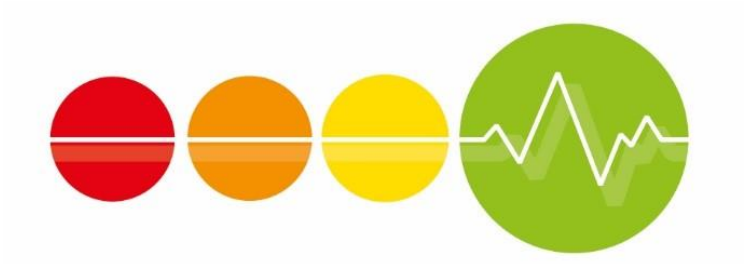
INTERNAL AUDIT REPORT

TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

GUARDIAN OF SAFE WORKING (TEWV 2020-21/26)

auditone
assurance . counter fraud . advisory

REPORT REFERENCE:	TEWV 2020-21/26
REPORT STATUS:	Final
ASSURANCE RATING:	SUBSTANTIAL



Governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.

DATE:	7th June 2021
AUDIT TEAM:	Carl Best, Director of Internal Audit Lesley Lawton, Acting Group Audit Manager Joanne Kimmitt, Senior Auditor
CLIENT SPONSOR:	Ahmad Khouja, Medical Director
DEBRIEF MEETING:	N/A
DRAFT REPORT ISSUED:	21st May 2021
REPORT DISTRIBUTION:	<u>Draft Report</u> Dr Jim Boylan, Acting Guardian of Safe Working Ahmad Khouja, Medical Director Liz Romaniak, Director of Finance & Information <u>Final Report</u> Brent Kilmurray, Chief Executive Officer Phil Bellas, Trust Secretary Joanne Greener, Senior Manager (Mazars) Karen Wass, Technology Risk Assurance Manager (AuditOne) Kathryn Wilson, Counter Fraud Specialist (AuditOne)

The matters raised in this report are only those which came to our attention during our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist, or of all the improvements that may be required. Whilst every care has been taken to ensure that the information in this report is as accurate as possible, based on the information provided and documentation reviewed, no complete guarantee or warranty can be given with regards to the advice and information contained herein. Our work does not provide absolute assurance that material errors, loss or fraud do not exist. This report is prepared solely for the use of the Board and senior management of Tees, Esk and Wear Valleys NHS Foundation Trust. Details may be made available to specified external agencies such as external auditors, but otherwise this report should not be quoted or referred to in whole or in part without prior consent. No responsibility to any third party is accepted as the report has not been prepared and is not intended for any other purpose.

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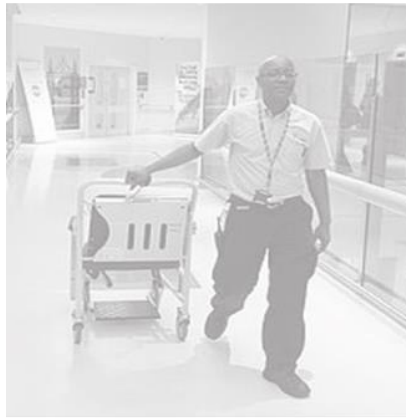
CONTENT



1. Introduction

In accordance with the Operational Internal Audit Plan for 2020/21, we have undertaken a compliance audit regarding the role of the Guardian of Safe Working. This internal audit was approved by the Trust's Audit & Risk Committee under Appendix B of the plan (Additional Assurance & Advisory - Quality and Clinical Governance).

Background

The contractual limits on working hours and protected rest periods for doctors in training are vital for ensuring the safety of patients and junior doctors. In relation to this, employers must have a Guardian of Safe Working Hours, and this role is outlined in schedule 6 of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, i.e., the Junior Doctor Contract.

2. Scope of the Audit

The scope of this compliance review was to provide assurance on the correct application of Trust processes in relation to the role of the Guardian of Safe Working, to evaluate how effectively the remit of the Guardian of Safe Working is being discharged, including the accurate and timely reporting of Junior Doctor Contract breaches. Our testing of key controls was undertaken on a sample basis covering the period April 2020 to February 2021 and our work was limited to the evaluation of compliance with the following requirements of the role as specified in Schedule 6, of the Junior Doctor contract:

Schedule / Paragraph	Requirement of the Guardian
Schedule 06, para 10 (Role of the Guardian of Safe Working)	Provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe an in compliance with Schedules 3, 4 and 5 of the terms and conditions of service.
	Receive copies of all exception reports in respect of safe working hours. This will allow the guardian to record and monitor compliance with the terms and conditions of service.
	Escalate issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.
	Require intervention to mitigate any identified risk to doctor or patient safety in a timescale commensurate with the severity of the risk.
	Require a work schedule review to be undertaken, where there are regular or persistent breaches in safe working hours, which have not been addressed.
	Have the authority to intervene in any instance where the guardian considers the safety of patients and/or doctors is compromised, or that issues are not being resolved satisfactorily.
	Distribute monies received as a consequence of financial penalties to improve the training and service experience of doctors.

Schedule / Paragraph	Requirement of the Guardian
Schedule 06, para 11 (Reporting)	The Board (directly or through a nominated committee) must receive a Guardian of Safe Working Report no less than once per quarter, which includes data on all rota gaps on all shifts
	A consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account.
Schedule 06, para 13 (Liaison with doctors)	Each Guardian and Director of Medical Education shall jointly establish a Junior Doctors Forum to advise them. The junior doctors' forum or a sub-group it establishes will take part in the scrutiny of the distribution of income drawn from fines.

3. Limitations to the scope of the audit

The following limitations were agreed in advance of the audit:

As per the scope described above.

4. Corporate significance & risk profile

Capacity and recruitment issues are mentioned as factors in several high-rated risks in the Trust's Corporate Risk Register (references 205, 682, 788 and 1017). On-going issues regarding difficulties with recruitment and capacity increase the risk that junior doctors may breach, albeit inadvertently, their terms and conditions regarding safe working if they must cover for vacancies and capacity gaps.

5. Key findings

The following section sets out the key finding from this audit. Details of our full audit findings are available at Appendix A.

Design of the control framework

We reviewed the report of exceptions used by the Guardian to establish whether the exceptions included the information detailed in schedule 5 paragraph 5 of the Terms & conditions of service for Doctors. We noted exception reports did not specifically include the time of the exception; however, times were occasionally recorded in the description column. We queried this with medical staffing, and we were informed there was no requirement for the time to be entered by a Doctor when submitting an exception report. This contradicts the terms and conditions, which state at para 5(c) that exceptions reports should include "the dates, times and duration of exceptions". If required details are not included, there is an increased risk that the exception reports recorded by the Trust do not comply with the terms and conditions of service requirements, which could lead to censure.

Compliance with the control framework

We noted that Doctors had been advised via the quarterly Junior Doctors forum (JDF) of the value of fines, with further discussion required on how the income from fines would be spent. However, we noted that records of JDF meetings did not include evidence that the details of actual items purchased, as reported in appendix 1 of the annual report for to the year ending 31 March 2021 had been reported to the JDF. We were advised by the Guardian that the value reported in the annual report included the Guardian's fund and additional spending on Junior Doctors. We have made a low-grade recommendation that income raised from fines and the expenditure of that income should be recorded separately from any additional spending on junior doctors to help ensure that doctors can be included in decisions on how to use the income and that the Trust can easily demonstrate that all monies raised from contract breach fines have been spent appropriately and in full for the benefit of junior doctors.

6. Good practice identified

- Quarterly reports are presented to the Trust Board and to the Junior Doctors Forum. The reports provide assurance that the safe rostering of junior doctors is monitored and controlled and detail any exceptions such as gaps in rotas and response time for dealing with exceptions.
- The Quality Account for the year 2019/20 included information on reducing gaps in rotas and the plan for improvement to reduce gaps. Discussions on issues had taken place and additional staffing put in place where possible.
- From a sample of five exception reports, we noted that all issues had been addressed at departmental level and therefore, did not require to be escalated further. All exceptions had been dealt with by way of time off in lieu, additional payments or had been evaluated through investigation as no further action required.
- We checked a sample of five regular or persistent breaches in safe working hours and sought evidence that the Guardian had undertaken a work schedule review to address those issues. We noted that following review and evaluation by the Guardian, the work schedules had been discussed, deemed appropriate and therefore, were not amended.
- We sought evidence of examples of intervention by the Guardian when it was believed the safety of Doctors or patients was at risk of being compromised or that issues were not being resolved satisfactorily. From the details recorded in the exception reports from April 2020 to February 2021 no intervention was required as issues had been addressed appropriately.
- Monies raised during 2020/21 from fines levied on Trust Localities where breaches of the junior doctors' contract had occurred had been spent appropriately to improve the training and service experience of doctors.

7. Recommendation summary

	High	Medium	Low
Design of the control framework	0	0	1
Compliance with control framework	0	0	1
Total	0	0	2

8. Acknowledgment

We would like to thank management and staff for their help and cooperation during this audit.

Appendix A – Full audit findings

This report has been produced by exception. Therefore, we have included in this section only those areas of non-compliance identified from our testing and not the outcome of all testing undertaken. The prioritisation of our recommendations is explained at Appendix C.

Exceptions noted regarding compliance with Schedule 06, para 10 (Role of the Guardian of Safe Working)

Actual control	Design Adequate (Y or N)	Test result and implication	Rec Ref	Priority
Provide assurance to doctors and employers that doctors are safely rostered and enabled to work hours that are safe and in compliance with Schedules 3, 4 and 5 of the terms and conditions of service. The Guardian receives copies of all exception reports in respect of safe working hours. This will allow the guardian to record and monitor compliance with the terms and conditions of service. To comply with Schedule 5 para 5 - exception reports should include: a - name, specialty, Drs grade b - the identity of the educational supervisor c - the dates, times, and durations of exceptions d - the nature of the variance from the work schedule e - an outline of the steps the Dr has taken to resolve matters before escalation (if any)	N	We examined copies of exception reports and noted the reports did not include a column to record the time that an exception took place. Times were occasionally recorded in the description column, although this was not consistent for all entries in the reports. We queried this with Medical staffing, and we were informed there was no requirement for the time to be entered by a Doctor when submitting an exception report. We were provided with a screenshot of the details to be completed when inputting an exception report which did not include a data field to record the relevant times. If details to be recorded are not in accordance with the requirements of Schedule 5, para 5 of the terms and conditions of service, there is an increased risk that the Trust could be found to be non-compliant, leading to censure. Although in this case we consider that the risk is minimal given all other key information is recorded.	1.1	**Low**
Each Guardian and Director of Medical Education shall jointly establish a Junior Doctors Forum. The junior doctors' forum or a sub-group it establishes will take part in the scrutiny of the distribution of income drawn from fines.	**Y**	We examined the agendas and minutes of the quarterly Junior Doctors Forum (JDF) meetings held during 2020/21 and noted that the JDF minutes dated 9th March 2021 stated there was £24,000 to be spent by 31st March 2021. However, we noted that appendix 1 of the Annual Report on Rota Gaps and Vacancies: Doctors in Training for the year ending 31st March 2021 did not report this cash balance.	1.2	

Actual control	Design Adequate (Y or N)	Test result and implication	Rec Ref	Priority
		The annual report for 2020/21 recorded a total value of fines levied during the year as £17,195.25 and expenditure of £172,720.27, which included £150,846 on laptops and mobile phones for all trainees. We were advised by the Guardian that the expenditure reported in appendix 1 of the annual report included the use of the Guardian's fund and additional spending on the Junior Docs over the time period in addition to use of the income raised from fines levied. Furthermore, although the items purchased, as listed in the annual report, seemed appropriate regarding improving the training and service experience of junior doctors, the minutes of JDF meetings did not evidence that the proposed items had been discussed at that forum to help demonstrate input from the doctors themselves into use of the income raised. Lack of separate recording of the use of the income levied from fines increases the risk that the Trust may not be easily able to demonstrate that monies have been used appropriately or in full.		

Appendix B – Action Plan

Ref	Recommendation	Priority	Accepted	Management response	Target implementation	Manager responsible
1.1	To comply with the terms and conditions of service for Doctors Schedule 5 paragraph 5c - exception reports should include the time the exception took place.	**Low**	Y	This will necessitate a discussion with the current external exception reporting system providers (DRS) to build in facility within the software package for the recording of the time of the exception report or finding an acceptable alternative method of recording the time specifically in addition to the date.	31st August 2021	Acting Guardian of Safe Working
1.2	The expenditure of income drawn from fines imposed as a result of breaches should be reported separately from any additional spending for Junior Doctors.	**Low**	Y	Future update reports provided to the Trust Board and also records within the Junior Doctor Forum minutes will indicate specifically the items of expenditure and remaining balance of the GOSW Junior Doctors fund on an ongoing basis.	31st July 2021	Acting Guardian of Safe Working

Appendix C – Findings' prioritisation and assurance definitions

Findings Prioritisation

High	A fundamental weakness in the system that puts the achievement of the systems objectives at risk and / or major and consistent non-compliance with the control framework requiring management action as a matter of urgency.
Medium	A significant weakness within the system that leaves some of the systems objectives at risk and / or some non-compliance with the control framework.
Low	Minor improvement to the system could be made to improve internal control in general and engender good practice but are not vital to the overall system of internal control.

Assurance Definitions

Substantial	Governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.
Good	Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place. Minor remedial action is required.
Reasonable	Governance, risk management and control arrangements provide reasonable assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required.
Limited	Governance, risk management and control arrangements provide limited assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place. Immediate and fundamental remedial action is required.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RESPECT
For one another and our clients
INNOVATION
Always looking to improve
QUALITY
At the heart of everything we do

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

High level data

Number of doctors / dentists in training (total):	74
Number of doctors / dentists in training on 2016 TCS (total):	72
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st April 2021 up to 30th June 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	8	8	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	9	9	0
CT1-2 –North Durham	0	1	1	0
CT1-2 – South Durham	0	0	0	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	11	11	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	2	2	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**	**33**	**33**	**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	22	22	0
Teesside & Forensic Senior Registrars	0	6	6	0
North Durham Juniors	0	1	1	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	2	2	0
Total	**0**	**31**	**31**	**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	3	11	12	0
Teesside & Forensic Senior Registrars	1	4	2	0
North Durham Juniors	0	1	0	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	1	0	1	0
Total	**5**	**16**	**15**	**0**

Narrative for Exception Reports

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	1	0	0	16
	CT1/2/GP	0	41	0	0	519
	CT3	0	3	0	0	44.5
	Trust Doctor	0	7	0	0	55.5
	SPR/SAS	0	14	0	0	264
North Durham	F2	2	2	0	0	25
	CT1/2/GP	10	10	0	0	108
	CT3	17	17	0	0	170
	Trust Doctor	0	0	0	0	0
	SPR/SAS	0	0	0	0	0
South Durham	F2	1	1	0	0	12.5
	CT1/2/GP	4	4	0	0	24.5
	CT3	4	4	0	0	80
	Trust Doctor	0	0	0	0	0
	SPR/SAS	41	41	0	0	792
Total		**79**	**145**	**0**	**0**	**2111**

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**
Compassionate Leave	6	6	0	80	80
COVID isolation	5	5	0	66	66
Maternity leave	2	2	0	40	40
On call cover	102	102	0	1,591.5	1,591.5
Vacancy	8	8	0	85.5	85.5
Sickness	28	28	0	340.5	340.5
Increase in workload	0	0	0	0	0
Total	**151**	**151**	**0**	**2203.5**	**2203.5**

Vacancies

Vacancies by month						
Locality	**Grade**	**April 2021**	**May 2021**	**June 2021**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	1	1	2	2	0
	CT1	2	2	2	2	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	1	1	1	1	0
	Trust Doctor	0	0	0	0	0
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	2	2	2	2	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	2	2	2	2	0
	GP	1	1	1	1	0
	Trust Doctor	0	0	0	0	0
Total		**9**	**9**	**10**	**10**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	9	£3,693
North Durham	0	£00.00
South Durham	0	£00.00
Total	**0**	**£3,693**

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
£00.00	**£3,693**	**£00.00**	**£3,693**

Purchases

X3 Aromatherapy Oil Diffuser for WPH, LRH and RPH = £161.88

Kettle for West Park Junior Doctors Office = £23.82

NARRATIVE

The majority of exception reports in Teesside were for work done above the schedule during non-resident on calls. The 9 fines were due to breaching the 5 hours continuous rest during these on calls.

The majority of locum shifts were classed as ‘on call cover’ – this is because the doctor is present at work but is exempt from on call due to occupational health issues (2), individual learning plans (2), pregnant (1), issues following return from maternity leave (1) – patchwork does not have a category to define these locum requests.

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

High level data

Number of doctors / dentists in training (total):	61
Number of doctors / dentists in training on 2016 TCS (total):	61
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st April 2021 up to 30th June 20201

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	1	1	0
F1 - York	0	0	0	0
F2 - York	0	1	1	0
CT1-2 - Northallerton	0	2	2	0
CT1-2 - Harrogate	0	1	1	0
CT1-2 - Scarborough	0	28	28	0
CT1-2 - York	0	10	10	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	1	1	0
CT3/ST4-6 – Scarborough	0	1	1	0
CT3/ST4-6 – York	0	12	12	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	30	30	0
Trust Doctors - York	0	3	3	0
Total	**0**	**90**	**90**	**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	61	61	0
Scarborough	0	29	29	0
Total	**0**	**90**	**90**	**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	8	22	0	0
Scarborough	25	35	0	0
Total	**33**	**57**	**0**	**0**

Narrative around Exception Reports

The majority of exceptions in both localities relate to the information contained in the Out of Hours Monitoring Forms whereby the hours in the work schedules have been exceeded – usually when on non-resident on-call. Two doctors in Scarborough regularly submit exceptions as they have either started work early or finished late.

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	14	14	0	208	208
	CT1/2/GP	18	18	0	212	212
	CT3	1	1	0	4	4
	Trust Doctor	0	0	0	0	0
	ST4-6/SAS	12	12	0	216	216
Scarborough	F2	0	0	0	0	0
	CT1/2/GP	0	0	0	0	0
	CT3	1	1	0	16	16
	Trust Doctor	4	4	0	80	80
	ST4-6/ SAS	81	81	0	1488	1488
Total		**131**	**131**	**0**	**2224**	**2224**

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	50	50	0	820	802
Sickness	4	4	0	64	64
Other	77	77	0	1340	1340
	131	**131**	**0**	**2224**	**2224**

Vacancies

Vacancies by month						
Locality	**Grade**	**April 2021**	**May 2021**	**June 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	2	1	1	1.3	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	1	1	1	1	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**3**	**2**	**2**	**2.3**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	4	£540.34
North Yorkshire & York	10	£1,785.20
Total	**5**	**£2,325.54**

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£00.00	**£2,325.54**	**£00.00**	**£2,325.54**

Purchases

X2 Aromatherapy Oil Diffuser for CLH & FPH = £107.92

Desk Lamp for FPH = £18.95

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 18

FOR GENERAL RELEASE

Board Of Directors

DATE:	**29th July 2021**
TITLE:	**Annual appraisal and revalidation board report and statement of compliance.**
REPORT OF:	**The Board**
REPORT FOR:	**Information and Decision**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

The Framework of Quality Assurance for Responsible Officers and Revalidation (FQA) is requested by NHS England each year and has been designed to assist responsible officers in providing assurance to their organisation's board that the doctors working in their organisations remain up to date and fit to practice. It highlights compliance rates for appraisal and revalidation amongst our doctors for the previous appraisal year and the supporting narrative explains the processes we have in place.

Due to the Covid 19 pandemic, NHS England wrote to us to say that all medical appraisals could be cancelled between April-September 2020 to focus on the pandemic. We re-started our appraisals in October 2020 along with revalidation.
All responsible officers are asked to present an annual report to their Board or equivalent management team. The template has been redesigned this year and has been combined with the statement of compliance for efficiency and simplicity. The statement of compliance should be signed off by the Chief Executive or Chairman (or executive if no board exists) of the designated body's Board or management team and submitted to NHS England by 29th October 2021.

The statement of compliance is slightly different this year in that question 2b has been added which asks for appraisal data from the last year. This is normally detailed in the Annual Organisational Audit (AOA) however this was not required for the last year as many appraisals were cancelled due to the Covid 19 pandemic.
The questions ask for comments to support our answers and an explanation of actions we propose to take for the next year.

Recommendations:

The report covers the last appraisal year (2020-21) therefore we are taking a retrospective approach. Our plans for the next year include,

- To review our medical appraisal and revalidation policy & procedure and update where necessary.

CONFIDENTIAL

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

REVALIDATION / APPRAISAL ANNUAL REPORT
1st April 2020 – 31st March 2021

Management of Appraisal and Revalidation

Responsible Officer:	Dr Ahmad Khouja
Associate Responsible Officer:	Dr Lenny Cornwall
Medical Development and	Mr Bryan O'Leary
Medical Management:	Mrs Elaine Corbyn
	Miss Chloe Cooper
	Dr Tolu Olusoga (DMD – North Yorkshire & York)
	Dr Mark Speight (DMD – Forensic Services)
	Dr Suresh Babu (DMD – Durham & Darlington)
	Dr Kirsty Passmore (DMD – Teesside)
	Dr Hany El Sayeh (Director of Medical Education)

Activity Levels

Number of doctors that TEWV are responsible body	Consultant		SAS		Trust Doctors/MTI	
	2019–20	2020–21	2019-20	2020–21	2019-20	2020–21
Adult Mental Health	68	64	21	27	12	9
Mental Health Services for Older People	29	30	17	13	2	2
Child and Young Person's Services	38	40	5	7	2	1
Learning Disabilities	10	11	2	2	0	0
Forensic Services	16	16	5	3	3	1
Total:	**161**	**161**	**50**	**52**	**19**	**13**

Comments: We had 226 doctors in total with a prescribed connection to TEWV as at 31st March 2021.

Number of doctors who were due for an appraisal	Consultant		SAS		Trust Doctors/MTI	
	2019-20	2020–21	2019-20	2020–21	2019-20	2020–21
Adult Mental Health	64	60 (36)	18	22 (19)	3	9
Mental Health Services for Older People	27	27 (18)	15	13 (10)	0	2
Child and Young Person's Services	35	39 (28)	4	6 (6)	0	1
Learning Disabilities	10	10 (6)	1	2 (2)	0	0
Forensic Services	15	15 (10)	4	3 (3)	0	1
Total	**151**	**151 (98)**	**42**	**46 (40)**	**3**	**13**

Comments:
The above table shows the number of doctors that were due an appraisal with us in the last appraisal year 2020/21. The figures in black, show the number of doctors who would have been due, had a number of appraisals not been cancelled following guidance from NHS England in response to the Covid 19 pandemic.

The reasons why people might not be due an appraisal in normal circumstances are that they have already had one in this appraisal year with a previous organisation before joining TEWV, or they might not have worked with us for the minimum time period required to have

an appraisal. These account for the difference of 10 in the consultant figure, as we had 10 new consultants join throughout the year who were not due an appraisal with us yet and 6 new SAS doctors joined.

The figures in red show the number of doctors that were due for an appraisal between October 2020-March 2021, as we excluded those appraisals that were due between April-September 2020 as these were cancelled due to the pandemic. A total of 59 consultant and SAS doctor appraisals were cancelled between this period.

Number of doctors who have been appraised in the appraisal year	Consultant		SAS		Trust Doctors/MTI	
	2019-20	2020–21	2019-20	2020–21	2019-20	2020–21
Adult Mental Health	62	36	15	18	3	8
Mental Health Services for Older People	26	18	15	9	0	2
Child and Young Person's Services	34	27	3	6	0	0
Learning Disabilities	10	6	1	2	0	0
Forensic Services	15	10	3	3	0	1
Total	**147 (97%)**	**97 (99%)**	**37 (88%)**	**38 (95%)**	**3 (100%)**	**12 (92%)**

Comments:
The figures in the table above show the number of doctors that have had an appraisal, based on the figures after we excluded those appraisals that were cancelled between April-September.

The consultant figure shows a difference of 1, this was due to one CYPS consultant on long term sick.

The SAS doctor figure shows a difference of 2, this was due to one doctor on long term sick and one doctor who retired but has a zero hours contract with us, however she was unable to work due to the pandemic so did not have sufficient evidence for an appraisal before 31st March. We agreed she could have her appraisal later in 2021.

The Trust doctor figure shows a difference of 1, this was due to one doctor who did not complete a 'priming appraisal' prior to 31st March as she has been absent from the UK for an extended period of time. She has since left the Trust.

Exceptions

The table below shows the 'approved missed or incomplete appraisals'. These are doctors that could not complete their appraisal in the appraisal year for a reason that was accepted and signed off by the Associate Responsible Officer on behalf of the Responsible Officer.

For an appraisal to be an 'approved missed or incomplete', the trust needs to be able to produce documentation to show they have agreed the postponement as being reasonable. These are requirements set out by NHS England.

Number of 'approved missed or incomplete appraisals'	Consultant	SAS	Trust Doctors/MTI
Adult Mental Health	0	1	0
Mental Health Services for Older People	0	1	0
Child and Young Person's Services	1	0	1
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	**1**	**2**	**1**
Comment: We had one consultant and one SAS doctor both on long term sick and one SAS doctor who retired but didn't do any work due to the pandemic therefore we agreed to delay her appraisal until later in 2021. The trust doctor exception is due to this doctor being absent from work for an extended period of time and not completing a 'priming' appraisal before 31st March.			

The table below shows the 'unapproved missed or incomplete appraisals'. These are doctors that have not completed their appraisal in the appraisal year however; they have not sought any agreement of this from the Associate Responsible Officer. As you can see, none of our doctors fall into this category.

Number of 'unapproved missed or incomplete appraisals'	Consultant	SAS	Trust Doctors/MTI
Adult Mental Health	0	0	0
Mental Health Services for Older People	0	0	0
Child and Young Person's Services	0	0	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	**0**	**0**	**0**
Comments:			

Revalidation

Number of doctors completing revalidation cycle	Consultant		SAS		Trust Doctors	
	2019-20	2020–21	2019-20	2020–21	2019-20	2020–21
Adult Mental Health	17	8	7	2	0	0
Mental Health Services for Older People	7	5	3	0	0	0
Child and Young Person's Services	10	6	1	0	0	0
Learning Disabilities	3	0	0	0	0	0
Forensic Services	3	3	1	0	0	0
Other	0	1	0	0	0	0
Total	**40**	**23**	**12**	**2**	**0**	**0**

Number of doctors receiving revalidation recommendations	Consultant		SAS		Trust Doctors	
	2019-20	2020–21	2019-20	2020–21	2019-20	2020–21
Adult Mental Health	17	8	7	2	0	0
Mental Health Services for Older People	7	5	3	0	0	0
Child and Young Person's Services	10	6	1	0	0	0
Learning Disabilities	3	0	0	0	0	0
Forensic Services	3	3	1	0	0	0
Other	0	1	0	0	0	0
Total	**40**	**23**	**12**	**2**	**0**	**0**
Comments: All doctors who were due for revalidation in the 2020/21 had their revalidation date pushed back one year by the GMC in response to the Covid 19 pandemic. It was however optional whether we wished to still revalidate in the 2020/21 year, hence we decided to re-start revalidation from September for those doctors who were revalidation ready, so that we didn't have so many doctors to revalidate the following year.						

Performance Review, Support and Development of Appraisers

Training of Appraisers

	Consultant		SAS	
	2019-20	2020-21	2019-20	2020-21
Number of enhanced appraisers	58	52	5	5
Number of enhanced appraisers carrying out appraisals in appraisal year	52	50	3	5

Support and Development of Appraisers

Update/Support Sessions	**Update/Support Sessions**
20th May - cancelled	18th November 2020
23rd September 2020	3rd March 2021
Comment: We normally run 4 sessions each year, however the May session was cancelled due to the pandemic, as appraisals were suspended between April-September 2020.	

Performance Review of Appraisers

Each appraiser's performance is reviewed by their appraisee after every appraisal that they complete. A set of standardised questions are sent to each appraisee of which they answer them on a scale from 'strongly agree' to 'strongly disagree'. On a yearly basis the feedback is anonymised, collated and fed back to the appraisers. We also have a form which allows the appraiser to reflect on the information fed back to them and include it in their own appraisal to contribute to any development discussions and/or PDP objectives.

Quality Assurance of Appraisals

All of the appraisal summaries from those doctors who were due for revalidation in 2019/20 were anonymised and then 12 appraisers were randomly selected to rate 8 summaries each as part of a quality improvement exercise. We asked for volunteers from our appraisers as well as our medical management structure and those who were not picked this year will be used next year. Each summary was rated by two different appraisers. Feedback from this was provided to the appraisers at our appraiser update sessions in November and February. We plan to repeat this exercise in the summer for the 2020/21 revalidated doctors.

Responding to Concerns about doctors in TEWV

Total Number of All doctors who were managed under 'Responding to Concerns' (includes 'Low Level' and 'Investigations')	Consultant				SAS				Trust Doctors/MTI			
	2019/20		2020/21		2019/20		2020/21		2019/20		2020/21	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	1	1	0	0	0	1	1	0	0	0	0	0
Durham & Darlington	0	1	1	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	1	0	1	0	0		0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	1
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	2	1	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	1	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**3**	**4**	**1**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**1**

Comments: The following is the demographic information relating to all doctors detailed above.

Code	Ethnicity	No. of Doctors 2020/21 Only
SE	Other Specified	(1)
C	White – Any other white background	(1)
CQ	CQ White ex USSR	(1)
N	Black or Black British – African	(1)
L	Asian or Asian British – Any other Asian background	(1)
H	Asian or Asian British - Indian	(2)

Age Range of All Doctors – 2020/21				
	Aged 30-40	Aged 41-50	Aged 51-60	Aged 61-70
Male Consultants		3	1	
Female Consultants			1	
Male SAS Doctor			1	
Female SAS Doctor				
Male Trust Doctor				
Female Trust Doctor	1			

Total Number of doctors spoken to under 'Low Level Concerns'	Consultant				SAS				Trust Doctors/MTI			
	2019/20		2020/21		2019/20		2020/21		2019/20		2020/21	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	1	0	0	0	0	1	1	0	0	0	0	0
Durham & Darlington	0	1	1	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	1	0	1	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	2	1	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	1	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**2**	**4**	**1**	**1**	**1**	**1**	**0**	**0**	**0**	**0**	**0**

Comments:

Low level concerns are dealt with by clinical managers or relevant managers having a meeting with the individuals to discuss the issues that have been raised or that might be causing some concern and which they would like to address before those issues become a more serious problem. There is a low level concern form that managers complete and a copy is given to the doctor who has been spoken to and another copy returned to Medical Development for recording purposes.

The purpose of the low level concern forms is to allow concerns to be documented and monitored so that should there be future concerns raised there are records to show that actions had already been taken before making the matter more formal.

An example of concerns raised may be comments made by colleagues in relation to a doctor's behaviour or how they communicate with others etc.

2020/21 has seen an increase of one extra case from five last year to six this year. The reasons behind the low level concerns being raised include issues or concerns raised by colleagues, record keeping, accessing records inappropriately and a case of inappropriate attire being worn.

Total Number of doctors where investigation was necessary 'More Serious Concerns'	Consultant				SAS				Trust Doctors/MTI			
	2019/20		2020/21		2019/20		2020/21		2019/20		2020/21	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	1	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	1	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	1
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	1	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**

Comments:

During 2019/20 there was only one formal investigation. The outcome of that investigation led to a formal Remediation Action Plan being implemented and this was monitored and was completed in June 2021.

There has again been one formal investigation during 2020/21. The outcome of this investigation was a reflection on the incident and to be reported in the doctor's appraisal and to undertake a repeat of the Information Governance training, which has now been completed.

Ongoing Actions

Responding to Concerns – Remediation/Disciplinary

Our Responsible Officer, Associate Responsible Officer and Associate Director of Medical Development attend regular sessions with our GMC representative throughout the year. These sessions allow for any concerns to be raised and advice to be given from a GMC perspective – additionally to these sessions the representative from the GMC is always available to be contacted with any other queries throughout the year.

The Medical Remediation/ Disciplinary policy was reviewed last year, and whilst no significant changes to content were required, there has been an opportunity to look at further developing local processes for responding to concerns and how these are classified / escalated and dealt with.

Electronic IT System

SARD JV continues to be used as the electronic system for appraisals and revalidation. All doctors in TEWV now use SARD for completing appraisal. Last year, our Associate Responsible Officer put together a plan of how we can make SARD simpler to use and abandon some sections were there is duplication between the portfolio and the form used for appraisal. These changes were agreed at our medical directorate meetings and by our corporate services team who worked to implement the changes during 2019/20.

In 2020/21, our Associate Responsible Officer also began delivering training sessions on how to use SARD for the purpose of appraisal and job planning for all new Consultant and SAS doctors that join TEWV. Training sessions are run on a quarterly basis.

We also implemented a new, simpler appraisal process for Trust doctor appraisals from August 2020, whereby they are given access to HORUS training E-portfolio upon joining us and then they can attach this portfolio to SARD for their appraisal, as HORUS is more focused at foundation grade doctors. Trust doctors now have a priming appraisal in the first two months of joining us, where they agree a PDP with their appraiser for the year ahead. They then have their full appraisal around month 10 if they remain in post that long.

Last year we moved to using the 360 MSF module on SARD JV for the production of patient and colleague feedback as this is. The format of the feedback forms mirrors the structure of questionnaires in use by the GMC. Appraisers have been asked to provide feedback on the forms in order to ensure all questions reflect practices in psychiatry and can accommodate responses from a range of service users, to include those with learning disabilities. We are still in the process of agreeing upon a recommended tool for MSF and have been having discussions with the appraisers at our appraiser update sessions this year.

Following a successful pilot of the SARD JV e-Job Planning module with medical managers in mid-2019 we then moved to implement this functionality in early 2020. However due to the pandemic the majority of job plans were put on hold in 2020, so most of our medics have experienced using SARD job planning for the first time from January 2021. The form aims to consider job planning as a process, taking stock of commitments in each year and their appropriateness, alongside developing continuity between years ensuring amendments to work practices and financial impact are accurately captured and can be reviewed when needed. The system will also have a key role in ensuring all quality improvement requirements of NHSE&I can be achieved for job planning. We have 5 job plan consistency panels for each specialty which began in May 2021 and it is hoped these meetings will help identify areas which we need to deliver further training on later in the year, before the 2022 job planning round.

The contract with SARD JV was therefore renewed in October 2019 on a contractual model of 3+1+1 years. There are no immediate tendering exercises planned for the future for this system with a view instead to further develop the existing modules and explore additional items that could be incorporated into the contract such as managing E- Annual Leave. We are currently piloting e-leave with the Forensic Team and the future use of this module will depend upon the evaluation of the pilot scheme.

Learning from Revalidation

We continue to have a robust electronic system and team in place to help manage revalidation, which ensures the process runs efficiently.

The third cycle of revalidation is now underway for a number of our doctors , despite revalidation being postponed by the GMC during most of the 2020/21 year. Any medics due revalidation during the last year had their revalidation date pushed back by one year, however we do still have the ability to revalidate these medics if we wish, so we have been revalidating those who are ready.

Other Information:

Appraisal policy and procedure was updated in 2018/19.

SARD Guidance has been updated to reflect new system layout following the implementation of the e- job planning form. The Associate Responsible Officer has also produced local guidance for doctors to help with using the new system for the first time and adapting to the new layout. Presentations have also been delivered to medical colleagues at the TEWV Senior Medical Staff Committee with further sessions to be held with specific groups at similar local events and departmental meetings with specific clinical teams.

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The board of Tees Esk and Wear Valleys NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: N/A Comments: Yes. Dr Ahmad Khouja, Medical Director, was appointed Responsible Officer on 1st April 2018. Action for next year: No change expected.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes. TEWV as the designated body is supported by the medical development department with dedicated members of admin and an Associate Responsible Officer, to support the Responsible Officer. Action from last year: N/A Comments: The Trust ensures we have the funds and staffing to support the role of RO. Action for next year: Not change expected.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/A Comments: Yes, this is done by the Medical Development team under the management of Dr Ahmad Khouja. Names are recorded via GMC Connect. Action for next year: This process is ongoing as described above.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A Comments: Yes, these are reviewed every 3 years. They were last updated on 16/01/19. Action for next year: To be updated in January 2022.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year To undertake a peer review of a selection of appraisal summaries to review their quality. Comments: This exercise is currently in its third year of being carried out. Whilst we don't have the results for this year just yet, we have seen an improvement in the quality of our appraisal summaries last year, compared to the previous year. We provide feedback of the results at our appraiser networks which we run 4 times a year. Action for next year: To continue to undertake a peer review of a selection of appraisal summaries to review their quality.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: N/A Comments: We provide exit reports for all locum doctors upon leaving the Trust which states details of any leave / sickness / complaints / investigations and comments from line managers. Longer term locums are provided with time to complete the CPD. We provide supporting info to all our doctors (including those not prescribed to us) to enable them to input into their appraisal. For TEWV employed doctors they are provided with software to access appraisals, coaching, CPD etc. Action for next year: To continue with the above process.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change.

Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: Comments: As a Trust we decided not to use the Appraisal 2020 model, we continued with our normal process for collecting evidence for appraisal. Action for next year: To continue as above.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Comments: We have an appraisal policy and procedure in place which is followed in this instance. Action for next year: No action identified.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Comments: Yes. The appraisal policy and procedure were approved at the Medical Directorate meetings and ratified at the Executive Management Team (EMT). The policy and procedure follows national guidance. Action for next year: Our policy will be reviewed in 2022.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Comments: Yes. There were 55 appraisers for 226 doctors in 2020/21. Action for next year: To continue to monitor the number of appraisers to ensure we always have enough to cover the appraisal cycle.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal

network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year:
Comments: Yes, there are normally four training sessions a year, of which appraisers must attend at least two. Due to Covid 19 our May 2020 session was cancelled, so we ran three sessions last year.
Action for next year:

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Comments: We follow a process whereby a group of appraisers undertake a peer review of appraisal summaries, the findings are then fed back to the medical directorate group and our appraiser group. Our appraisal process is quality assured through the use of feedback questionnaires following appraisal and then a report is collated for each appraiser at the end of the appraisal year. Action for next year:

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	226
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	163
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	63
Total number of appraisals cancelled due to Covid 19	59
Total number of agreed exceptions	4

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:

Comments: Yes. Good communications exist with no concerns raised from either side. In addition regular meetings occur between the Responsible Officer and the GMC's ELA which are minuted – these allow for ongoing concerns and low level concerns to be regularly reviewed.

Action for next year:

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:

Comments: Yes, letters are sent to doctors following recommendations from the RO and if unable to make recommendation the doctor is contacted immediately.

Action for next year:

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:

Comments: There are effective and well established processes in place for pre-employment checks, medical appraisal and revalidation, and responding to concerns. Within this, roles and responsibilities are clearly defined. The medical directorate has dedicated expertise and is adequately resourced to carry out its function.

Action for next year:

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:

Comments: There is a disciplinary policy for maintaining high professional standards. Issues around conduct and performance can be identified from

multiple sources, including formal complaints, SUIs, Guardian of Safe Working, and the Freedom to Speak up Guardian, Monitoring of any conduct and performance issue is undertaken within the medical development department. Processes are in place to allow this to be done under a variety of different formats, depending on the seriousness of the concern e.g. low level concerns and disciplinary investigations. The department receives PALS/Complaints and SUI reports each month and this is documented on the supporting information which is sent to doctors ahead of their appraisal. All doctors have a line manager who monitors performance.

Action for next year:

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

Comments: We have a medical remediation and disciplinary procedure for dealing with all concerns, including low level concerns, which is monitored.

Action for next year:

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: Last year in our annual report to the Board, we introduced an analysis of the number of disciplinary cases/low level concerns, type, outcome as well as an analysis of the protected characteristics of the doctors.

Comments: We now have a quality assurance process in place, though no concerns have been raised and no appeals have been made regarding either process of outcome when we have responded to concerns.

Action for next year:

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year:
Comments: We complete an MPIT form for doctors who work for us and are connected to us to pass to a doctor's new organisation. Medical development inform the RO of any concerns, who would then directly contact the doctor's new Designated Body. If there are issues concerning agency doctors, we would contact the agency and ask that our concerns are discussed with their RO. If they wanted to discuss with our RO we would arrange this.
Action for next year:

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:
Comments: All doctors have clinical manager supervision, annual appraisal and annual job planning. Quality assurance systems are in place checking our processes. The medical revalidation group meet quarterly to discuss and agree issues in relation to appraisals and revalidation. All doctors are treated equally and any issues would be dealt with following our procedures. We have a PALS/complaints team and a dedicated medical development team that deal with all issues/concerns as they arise.
Action for next year:

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: Comments: Yes, we ensure that all six NHS pre-employment check standards are completed. This is done by medical staffing. Action for next year:

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**

Last year's action was to introduce a tailored approach for doctors who are on short term contracts and new to the appraisal process and include a priming appraisal.

We have therefore implemented a simpler appraisal process for Trust doctor appraisals, whereby they are given access to HORUS training E-portfolio upon joining us and then they can attach this portfolio to SARD for their appraisal, as HORUS is more focused at foundation grade doctors. Trust doctors now have a priming appraisal in the first two months of joining us, where they agree a PDP with their appraiser for the year ahead. They then have their full appraisal around month 10 if they remain in post that long.

In the last year our Associate Responsible Officer has began delivering training sessions on how to use SARD electronic system for the purpose of appraisal and job planning for all new Consultant and SAS doctors that join TEWV. Training sessions are run on a quarterly basis.

- **Actions still outstanding**

None

- **Current Issues**

- **New Actions:**

Review our appraisal policy and procedure in 2022.

Overall conclusion:

Governance arrangements and assurance processes for doctors employed within TEWV remain robust and fit for purpose.

Appraisals for 2020/21 were cancelled between April-September following guidance from NHS England, however they re-started from October 2020.

Despite revalidation being postponed by the GMC during the 2020/21 year, we also re-started revalidation from September 2020 for any medics that were ready to be revalidated so that we didn't have a large number to revalidate in the following year.

Section 7 – Statement of Compliance:

The Board of Tees Esk and Wear Valleys NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Tees Esk and Wear Valleys NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
Skipton House
80 London Road
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Publication approval reference: PAR614

BOARD OF DIRECTORS
FOR GENERAL RELEASE **Item No. 19**

DATE:	**28th July 2021**
TITLE:	**To consider the Trust's 2021 Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard submissions and associated action plans and The Publication of Information**
REPORT OF:	**Sarah Dexter- Smith Director of People and Culture**
REPORT FOR:	**Information and Decision**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

This report provides the key themes from the WRES, WDES, SOWES, the Publication of Information, the Model Employer trajectory update, the BAME disparity ratios action plan and the overhauling recruitment and selection action plan.

The Trust is required to publish the WRES and WDES information sets and action plans and the Publication of Information. Ratification by the Board of Directors is required prior to publication.

Recommendations:

- To note the contents of the report and to comment accordingly.
- To agree to the publication of the WRES, WDES, SOWES action plans and the Publication of Information.

MEETING OF:	**Board of Directors**
DATE:	**28th July 2021**
TITLE:	**To consider the Trust's 2021 Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard submissions and associated action plans and the Publication of Information (staff)**

1.0 INTRODUCTION & PURPOSE:

The purpose of this report is to ask the Board to ratify and agree to the publication of the following documents following the recommendation of the Resources Committee at their meeting on 20th July 2021. The documents are:

- 2021 WRES (Workforce Race Equality Standard) action plan
- 2021 WDES (Workforce Disability Equality Standard) action plan
- 2021 SOWES (Sexual Orientation Workforce Equality Standard) action plan
- The Publication of Information (staff)
- The Model Employer trajectory update
- The overhauling recruitment and selection action plan

The Board is also asked to note the BAME disparity ratios action plan.

A summary report of the key themes from the requirements is available in Appendix 1.

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The WRES and the WDES are both mandated in the NHS standard contract. The Trust is required to publish its latest WRES by 31st August 2021 and latest WDES by 30th September 2021 following ratification by the Board of Directors.

2.2 The SOWES is not mandatory but helps the Trust to identify and address any inequalities experienced by LGB staff.

2.3 The Trust must publish information to meet the Equality Act Public Sector Equality Duty; this information must include information relating to staff who share a relevant protected characteristic who are affected by its policies and practices. Information relating to service users is published separately.

2.4 The NHS EI Model Employer trajectories sets aspirational goals for each organisation to increase BAME representation at leadership levels (8a and above).

2.5 The national WRES Programme created the Race Disparity Ratio to support organisation to understand if BAME staff are as likely to progress in the organisation as White staff. It is not yet clear whether this needs to be published, but is included for the Board's information.

2.6 NHS EI has requested NHS trusts to develop action plans to 'overhaul recruitment and selection processes' directly connected to equality, diversity and inclusion.

3.0 KEY ISSUES:

3.1 Areas of immediate concern

3.1.1 Indicator 2 on the WRES show that White people are 1.71 times more likely to be appointed from shortlisting compared to BAME people; this is higher than in previous years. The WDES shows that Non-disabled staff are 1.29 times more likely to be appointed from shortlisting compared to staff with disabilities. Despite interventions these figure remain consistent with previous years.

Actions:

- Develop a staff mid-career leadership programme for staff from protected characteristics.
- Widen centralised recruitment/ bulk recruitment to more posts.
- Explore other selection methods outside of interview process.
- Training for all recruitment chairs and panel members.
- Develop work with Princes Trust, Girls Network and the trust's voluntary services employability course to encourage people from our diverse communities to apply for posts.

3.1.2 The Race Disparity Ratio shows the difference for TEWV's BAME nursing staff is considerably higher than the Trust's overall ratios. The data suggests that BAME nursing staff are less likely to progress through the organisation, White nursing staff are 7.34 more likely to progress from lower band (1-5) to upper bands (8a and above) than BAME nursing staff.

Actions:

- Actions as detailed in paragraph 3.1.1.
- Hold an event for BAME nursing staff and senior leaders/HR to discuss progression within the organisation.

3.1.3 BAME staff, staff with disabilities and LGB staff all report higher levels of bullying, harassment, abuse and discrimination compared to other colleagues. This is an area remains a concern for the organisation.

Actions:

- Roll out a violence and aggression campaign.
- Relaunch Dignity at Work Champions.
- Deliver BAME awareness training.

3.1.4 The percentage of staff with a disability saying that their employer has made adequate adjustment(s) to enable them to carry out their work was 81%, although this has improved from last year it still shows that 19% of people who require workplace adjustments do not have these in place.

Actions:

- Implementation of Workplace Adjustments Procedure and process to record and report.
- Reverse mentoring programme for staff with long term health conditions.
- Develop a Trust wide process to record and report on Workplace Adjustments.

3.2 Areas of concern

3.2.1 20% of staff have not declared if they have a disability or not and 13% of staff have not declared their sexual orientation, therefore the Trust does not have reliable data to fully understand the experiences of staff.

Action:

- A campaign has been developed which will include a review process to ensure that staff know the importance of why demographic data is collected on ESR.

3.2.2 From the staff survey results 28.8% of people who completed the survey said they had a physical or mental health condition or illness lasting or expected to last for 12 months or more. Therefore it is likely that the 6% of staff with disabilities recorded on ESR is not an accurate reflection the true number of staff who have a disability or long term health condition.

Action:

- As detailed in paragraph 3.2.1

3.2.3 The Model Employer trajectories show the Trust is above or on track with the 2021 trajectories except for band 8c where we are below our trajectory. The trust needs to retain its existing BAME staff along with recruiting a further 6 BAME senior staff members by 2028.

Action:

- Develop a staff mid-career leadership programme for staff from protected characteristics

3.3 Areas of progress

3.3.1 BAME staff, staff with disabilities and LGB staff are no more likely to enter the Trust's formal disciplinary and capability processes than their colleagues; this remains a positive continuation from last year's data.

3.3.2 The BAME reverse mentoring programme has successfully raised awareness with the SLG of the challenges that BAME staff face and has encouraged the SLG to identify actions to improve race inequalities within TEWV.

3.3.3 The BAME, LGBTQ+ and Long Term Health Conditions (LTHC) staff networks have all positively developed which has led to increased attendance and engagement. They provide an important mechanism for the organisation to engage with staff from these protected characteristic groups.

3.3.4 The Workplace Adjustments Procedure has been developed, with consultation from the LTHC staff network, and is being launched within the organisation.

3.3.5 The LGBTQ+ training has received positive feedback from staff for raising awareness of Trans and sexual orientation issues. Along with this the LGBTQ+ staff network ran an extremely successful PRIDE week within the organisation.

4.0 IMPLICATIONS:

4.1 Compliance with the CQC fundamental Standards:

4.1.1 It is a requirement of the CQC that the Trust acts to improve the outcomes and experience of staff and service users from protected groups. The WRES, SOWES and WDES and associated action plans support this.

4.2 Financial/Value for Money:

4.2.1 Financial penalties can be incurred for non- compliance with the legislative requirements of the Equality Act. This may result in reputation loss for the Trust. The WRES, WDES, and SOWES support the trust in meeting its duties under the Equality Act.

4.3 Legal and Constitutional (including the NHS Constitution):

4.3.1 The Trust is required to publish information demonstrating its compliance with the general public sector duties of the Equality Act 2010. The WRES, WDES and SOWES documents will meet that legal requirement and as Equality Act compliance is a pre-requisite of Care Quality Commission registration will maintain Trust registration. The Publication of Information must be published to demonstrate the Trusts compliance with the general equality duty.

4.4 Equality and Diversity:

4.4.1 The Trust must demonstrate compliance with statutory and contractual equality requirements. Failure to do so may result in legal action and subsequent financial penalties and damage to the Trust's reputation.

4.5 Other implications:

4.5.1 None have been identified.

5.0 RISKS:

5.1 There is a reputational and a legal risk if the trust is unable to provide timely and adequate workplace adjustments for its staff with long term health conditions.

5.2 There is a risk of reputational damage if TEWV does not work to improve the outcomes of BAME staff, staff with disabilities and LGB staff. Such information could impact upon the ability of TEWV to recruit and retain staff.

6.0 CONCLUSIONS:

6.1 There are number of immediate concerns identified in section 3.1, actions to address these are in place and will be closely monitored.

6.2 There are actions in place to address demographic completion and to maintain and improve the Model Employer trajectory rates; both of these will be closely monitored.

6.3 The Board is asked to note the positive progress made in the areas outlined in section 3.3.

7.0 RECOMMENDATIONS:

7.1 To note the content of the report and to comment accordingly.

7.2 To approve the publication of the 2021 WRES, WDES, SOWES, the overhauling recruitment and selection plan and the publication of staff information.

Sarah Dexter- Smith Director of People and Culture
Sarah Dallal Equality, Diversity and Human Rights Lead
Lisa Cole, Voluntary Services and Equality, Diversity and Human Rights Manager

Background Papers:

APPENDIX ONE

Summary Report

1. INTRODUCTION

This summary report outlines the key themes and actions from the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), the Sexual Orientation Equality Standard (SOWES), the publication of information that is required to meet the public sector equality duties, the Model Employer trajectory update, BAME disparity ratios action plan and the BAME overhauling recruitment action plan.

WORKFORCE AND TRUST BOARD

2.2 RACE

- There is an increase in the percentage of BAME staff within the trust from 4.4% (311 staff members) in 2020 to 4.7% (359 staff members) in 2021.
- The Model Employer trajectories set aspirational goals for each organisation to increase BAME representation at leadership levels. The trust is above or on track with the 2021 trajectories except for band 8c where we are below our trajectory. The trust needs to retain its existing BAME staff along with recruiting a further 6 BAME senior staff members by 2028.

2.3 DISABILITY

- There has been an increase in staff recording if they have a disability this year, 20% not declare compared to 24% not declared in 2020.
- From the staff survey results 28.8% of people who completed the survey said they had a physical or mental health condition or illness lasting or expected to last for 12 months or more. Therefore it is likely that the 6% of staff with disabilities recorded on ESR is not an accurate reflection.
- 67% of the Trust Board has not declared if they have a disability or not therefore we cannot accurately measure if the Board is representative, in terms of disability, to the overall workforce.

2.4 SEXUAL ORIENTATION

- 13% of staff have not declared their sexual orientation, in order to fully understand the experiences of LGB staff the organisation must continue to focus on increasing the demographic data for sexual orientation.

2.5 GENDER

- 43% of the Trust Board is male compared to 21% of the workforce being male.

2.6 KEY ACTIONS

- A campaign has been developed which will include a review process to ensure that staff know the importance of why demographic data is collected on ESR.
- Develop a staff mid-career leadership programme for staff from protected characteristics

3. RECRUITMENT SELECTION AND PROMOTION

3.1 RACE

- White people are 1.71 times more likely to be appointed from shortlisting compared to BAME people, this is higher than in previous years.
- BAME staff are less likely to believe the Trust provides equal opportunities for career progression or promotion - White staff: 90% BAME staff: 81%
- Race Disparity Ratio is the difference in proportion of BAME staff at various AfC bands in a Trust compared to proportion of White staff at those bands. The difference for TEWV's BAME nursing staff is considerably higher than the Trust's overall ratios, the data suggests that BAME nursing staff are less likely to progress through the organisation.

3.2 DISABILITY

- Non-disabled staff are 1.29 times more likely to be appointed from shortlisting compared to staff with disabilities.
- Staff with disabilities are less likely to believe the Trust provides equal opportunities for career progression or promotion - Disabled 84% Non-disabled 91%

3.3 SEXUAL ORIENTATION

- Bisexual staff are less likely than gay men, gay women and heterosexual staff to believe that the Trust provides equal opportunities for career progression or promotion: Gay Man or Gay Woman (Lesbian) 90.2%, Bisexual 81%, Heterosexual (straight) 90%.

3.4 GENDER

- Men and women are equally likely to be appointed from shortlisting.

3.5 KEY ACTIONS:

- Develop a staff mid-career leadership programme for staff from protected characteristics
- Hold an event for BAME nursing staff and senior leaders/HR to discuss progression within the organisation.

- Widen centralised recruitment/ bulk recruitment to more posts.
- Explore other selection methods outside of interview process.
- Training for all recruitment chairs and panel members and video refresher and develop pack for recruiting managers.
- Develop work with Princes Trust, Girls Network and the trust's voluntary services employability course to encourage people from our diverse communities to apply for posts.

4. DISCIPLINARY AND CAPABILITY PROCESSES

Below identifies any differences of staff from protected characteristic groups entering formal disciplinary or capability processes, this indicator has improved over the last two years.

4.1 RACE

- For the last two years BAME staff are less likely than White staff to enter disciplinary.

4.2 DISABILITY

- Staff with disabilities are less likely than non-disabled staff to enter the formal capability process.

4.3 SEXUAL ORIENTATION

- LGB staff are 1.11 times more likely to enter disciplinary than heterosexual, this has reduced from the previous two years of reporting.

5. BULLYING, HARRASSMENT, ABUSE AND DISCRIMINATION

Below details the responses to the national staff survey questions in relation to bullying and harassment. BAME staff, staff with disabilities and LGB staff all report higher levels compared to other colleagues.

5.1 RACE

BAME staff report that they are more likely to experience bullying, abuse, harassment and discrimination than white staff:

- From patients, relatives or public - White staff: 24% BAME staff: 29%
- From staff – White staff: 20% BAME staff: 25%
- From manager/team leader or colleague – White staff: 6% BAME staff: 15%

5.2 DISABILITY

Staff with disabilities report that they are more likely to experience bullying, abuse, harassment and discrimination than non-disabled staff:

- From patients, relatives or public - disabled staff: 29% non-disabled staff: 22%
- From staff – disabled staff: 23% non-disabled staff: 13%
- From manager/team leader or colleague – disabled staff: 15% non-disabled staff: 8%

5.3 SEXUAL ORIENTATION

LGB staff report that they are more likely to experience bullying, abuse, harassment and discrimination than heterosexual staff:

- From patients, relatives or public – Gay Man or Gay Woman (Lesbian), 32.4% Bisexual 33.3%, Heterosexual (straight) 23.7%
- From staff – Gay Man or Gay Woman (Lesbian) 17.6%, Bisexual 30%, Heterosexual (straight) 15.2%
- From manager/team leader or colleague – Gay Man or Gay Woman (Lesbian), 5.4% bisexual 23.3%, Heterosexual (straight) 6%

5.4 KEY ACTIONS:

- Roll out a violence and aggression campaign.
- Relaunch Dignity at Work Champions.
- Deliver BAME awareness training.

6. STAFF WITH DISABILITIES AND/OR LONG TERM HEALTH CONDITIONS

The WDES includes specific indicators around the health and wellbeing of staff with disabilities. The indicators show that disabled staff are having a worse experience in regards to their health and wellbeing compared to staff without a disability.

- Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties: Disabled staff 26% Non-disabled staff 19%
- Percentage of staff saying that they are satisfied with the extent to which their organisation values their work: Disabled staff 45%, Non-disabled staff 57%
- Percentage of staff with a disability saying that their employer has made adequate adjustment(s) to enable them to carry out their work: 81% (19% do not have these in place)

KEY ACTIONS:

- Implementation of Workplace Adjustments Procedure and process to record and report.
- Reverse mentoring programme for staff with long term health conditions.

- Develop a Trust wide process to record and report on Workplace Adjustments.