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| NHS Equality Delivery System 2022 |
| EDS Reporting Template |
| Third Version  Tees, Esk and Wear Valleys NHS Foundation Trust – 2023/24 |
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| Classification: Official |
| Publication approval reference: |

Contents

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## Equality Delivery System for the NHS

***The EDS Reporting Template***

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at [www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/](http://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/)

The EDS is an improvement tool for patients, staff and leadersof the NHS.It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Reportis a template which is designed to give an overview of the organisation’s most recent EDS implementation and grade. Once completed, the report should be submitted via [england.eandhi@nhs.net](mailto:england.eandhi@nhs.net) and published on the organisation’s website.

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| **Name of Organisation** | | Tees Esk and Wear Valleys NHS Foundation Trust | **Organisation Board Sponsor/Lead** | | |
| Sarah Dexter-Smith | | |
|  |  |  |
| **Name of Integrated Care System** | | North East & North Cumbria ICB &  Humber & North Yorkshire ICB |
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## NHS Equality Delivery System (EDS)

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| **EDS Lead** | | Sarah Dallal | | **At what level has this been completed?** | | | |
|  | |  |  |  | | **\*List organisations** | |
| **EDS engagement date(s)** | | Circulated to JCC and staff network chairs.  People, Culture & Diversity Committee – 30.11.23  Exec PC&D – 10.11.23  QAIG Care Group – 14.12.23 | | **Individual organisation** | | Tees Esk and Wear Valleys NHS Foundation Trust | |
|  | |  |  | **Partnership\* (two or more organisations)** | | County Durham and Tees Valley Mental Health, Learning Disability and Autism Partnership | |
|  | |  |  | **Integrated Care System-wide\*** | | Reviewed by Cumbria, Northumberland, Tyne and Wear Foundation Trust | |
| **Date completed** | 23.11.2023 | | | | **Month and year published** | | February 2024 |
|  |  | | | |  | |  |
| **Date authorised** | 08.02.2024 | | | | **Revision date** | |  |

## EDS Rating and Score Card

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| Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly  Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance with scores are below | |
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| **Undeveloped activity** – **organisations score out of 0** for each outcome | Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** |
| **Developing activity** – **organisations score out of 1** for each outcome | Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** |
| **Achieving activity** – **organisations score out of 2** for each outcome | Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** |
| **Excelling activity** – **organisations score out of 3** for each outcome | Those who score **33,** adding all outcome scores in all domains, are rated **Excelling** |

## Domain 1: Commissioned or provided services

**Summary Domain 1 – Please see detailed ratings and evidence for the three services chosen**

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| **Domain** | **Outcome** | **Evidence** | **Rating** | **Owner (Dept/Lead)** |
| ***Domain 1: Commissioned or provided services*** | 1A: Patients (service users) have required levels of access to the service | **Some of the Evidence Reviewed**  **Kestrel Kite: Score 2**  All patients are referred to a speech and language therapist upon admission.  Easy read formats are available.  Patients have option to have communication profiles and passports.  Interpretation services are available when required.  Sensory profiles are completed by occupational therapy.  Some staff are trained to support service users with visual or auditory impairments.  Multi-agency working to ensure good communication is maintained.    **Scarborough CAMHS: Score 2**  Protected characteristics are reported on Paris.  Initial assessment explores needs related to protected characteristics.  Sensory and communication needs are flagged as an alert in Paris.  Access to interpreter and translation services are available as required.  Support is available for families with regards to referrals to other agencies  Individual needs are assessed during admission assessment.  Key workers are available to advocate if required.  Flexible appointment times are available if required due to i.e., religious / cultural festivals.  Reception / waiting areas displays information relating to local LGBTQ+ groups and the Pride Flag  Promotion of local charitable services that help families in need.  **Bedale: Score 2**  Access to service is 24 hrs per day 7 days per week.  Can take direct admissions from the community or other wards.  Dedicated MDT to respond to individual needs of patients.  Over establishment of HCA’s to increase clinical capacity  Access to support from MHSOP colleagues when supporting older patients.  No age restrictions, admissions 18 years old upwards  Reasonable adjustments process in place with links to autism team. | 2  2  2  **Average Score - 2** | Jody Buxton (Modern Matron)  Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)  Rebecca Stephenson (Modern Matron) |
| 1B: Individual patients (service users) health needs are met | **Some of the Evidence Reviewed**  **Kestrel Kite: Score 3**  Meeting needs of people from protected characteristic groups.  Access to interpretation/translation services  Accessible environment for wheelchair users  OT and Physio support  Access to support aids delivered within 24 hours.      **Scarborough CAMHS: Score 2**  Accessible building no steps, all rooms are on the ground floor, access to disabled toilets, lift available.  Personal alarm system available where additional support is required.  Environmental risk assessment is carried out at 3-month intervals.  Concerns are highlighted in safety plans.  Home visits can be provided for families who are unable to access the service.  Referrals to perinatal services fare made where required.  **Bedale: Score 2**  Access to interpreter and translation service  Accessible single-story building  Bedrooms adapted and reasonable adjustments made where required.  Daily meetings with patients about improving the environment.  Comprehensive risk assessment are undertaken and maintained throughout the patient journey  Documented PC’s and individual requirements in safety plans  Alerts relating to safety are recorded.  Patients have access to independent MH Advocates | 3  2  2  **Average score: 2** | Jody Buxton (Modern Matron)  Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)  Rebecca Stephenson (Modern Matron) |
| 1C: When patients (service users) use the service, they are free from harm | **Some of the Evidence Reviewed**  **Kestrel Kite: Score 3**  Early learning reviews completed with 72 hours for any incidents graded low to moderate.  Safe wards framework used on ward.  Individual risk documentation in place i.e., safety summary, safety plans  ‘Safe care system is embedded to review any daily risks with regards to staffing resources.  Safeguarding alerts forms within Paris.  Datix incidents are completed for all incidents.    **Scarborough CAMHS: Score 2**  Protected characteristics are reported when logging an incident.  Incidents deemed to be ‘medium to high’ level of harm will be followed up with an early learning review report which provides an opportunity to consider individual needs and PC’s.  These reports are then reviewed by Patient Safety where further consideration around individual needs & PC’s are considered  Formal complaints are received vial PALS.  Complaints received linked to PC’s are specifically addressed.  Complaints are used to improve clinical practice and service improvement.  **Bedale: Score 2**  Complaints received have not related to patients protected characteristics.  Work taking place to look at reducing restrictive practices.  Clear process in place to manage patient to patient discrimination on the ward.  Mutual help meetings have been used, can include police liaison officer where incidents of discrimination have taken place.  Incidents of discrimination are reported to the police. | 3  2  2  **Average Score: 2** | Jody Buxton (Modern Matron)  Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)  Rebecca Stephenson (Modern Matron) |
| 1D: Patients (service users) report positive experiences of the service | **Some of the Evidence Reviewed**  **Kestrel Kite: Score 2**  Patient experience surveys offered 6 monthly.   PREOMS surveys offered 6 monthly (alternate to pt experience to allow for quarterly surveys)  Local issues resolution monitoring is being piloted on the ward.  Friends and Family Test  Freedom to speak guardian accessible.  Advocates and IMHA offered to all service users.  CQC, PALS & Complaints contact details / posters are visible on the ward. Timescales in place to resolve any complaints efficiently and effectively.  **Scarborough CAMHS: Score 2**  Act upon FFT feedback  FFT Experience Sept 23 100%  Scores are displayed for patients to review.  Examples of compliment received: ‘Very centred on the young person’s needs.  ‘You said we did’ board in reception – listing actions taking in response to feedback given.  PALS, Complaints & CQC information is displayed in reception / waiting room area.  **Bedale: Score 2**  The patient experience information for the ward is provided below. This is reviewed monthly and also displayed for patients to review.  Since January 2022, there have only been 3 complaints submitted for Bedale ward, none of which relate to a protected characteristic.  PALS, complaints and CQC information is available on the ward and is available in different formats and languages. This is included in the ward welcome booklet. | 2  2  2  **Average Score: 2** | Jody Buxton (Modern Matron)  Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)  Rebecca Stephenson (Modern Matron) |
| **Domain 1: Commissioned or provided services overall rating** | | | **8** |  |

## Domain 2: Workforce health and well-being

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| **Domain** | **Outcome** | **Evidence** | **Rating** | **Owner (Dept/Lead)** |
| ***main 2:***  ***Workforce health and well-being*** | 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions | * Occupational Health Service Provision * Employee Support Service/Employee Psychology Service (including support groups such as Burnout group/Reliance) * VIVUP wellbeing platform (includes Counselling service for staff) * Long Term Health Conditions staff network and numerous other support network groups which meet regularly * Achieved Better Health at Work bronze level, in 2023 working towards Silver level (assessment October 2023 – campaigns have included financial wellbeing, better sleep, risky alcohol & substance use and workplace wellbeing environments/basic wellbeing needs (including nutrition and healthy eating). * Long term sickness absence team * Health and Wellbeing Strategic Group * Nutrition and weight management programmes * Over 300 Health & Wellbeing (H&W) champions * Staff led Health Council meets every two months * H&W pages on the staff Intranet * Smarter Working initiative * Reasonable adjustments – Central Team * Working carer support - network * Staff Mindfulness Programme * Bereavement Support * Central staff Health and Wellbeing team (4 wte’s) * Bi-monthly Strategic Health & Wellbeing Group which meets made up of MDT staff and Services. * H&W coordinator (Durham & Darlington Locations) * Health & Wellbeing Conversations training programme to be rolled out across the Trust from Autumn 2023 | 2 | Sarah Dallal |
| 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | * Violence Reduction strategy development * Verbal & Physical Aggression procedure * Indicator 5 WRES – Staff experiencing harassment, bullying or abuse from patients, relatives, public. * Indicator 6 WRES - Staff experiencing harassment, bullying or abuse from staff. * Indicator 4 WDES * Indicator 5 SOWES * Indicator 6 SOWES * Publication of information Staff survey results (harassment, bullying & abuse) - Age and Gender * WRES/WDES/SOWES action plans * Equality objectives (include verbal & physical aggression actions) * Disciplinary data * Support offered after Datix. * Hate crime campaigns. * Staff Council * Staff Support – Speak Up Guardian, ESS, EPS * Training available including in leadership programmes * Domestic violence work | 1 | Sarah Dallal |
| 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | * The Trust has a EDIHR Team * 8 active staff networks * Freedom to Speak Up Guardian embedded & increase in capacity for Freedom to Speak Up with the FTSU Officer * Employee Support Service, VIVUP platform (including Counselling service), Employee Psychology Service * Actively work with Unions * Work agreed in partnership with Unison as part of their ‘Year of Black workers’ to provide co developed training. * Equality Impact Assessments completed on all policies/procedures. * WRES/WDES/SOWES & Publication of Information data led to actions. * Chaplaincy Team * A relaunch of the Speaking Up Ambassadors * Speaking Up policy and includes information on how workers can access support for their wellbeing and Equality Impact Assessments these are also applied to other related policies. * Staff Survey Q21c & Q21d – Age, Ethnicity, Gender, LTHC, Sexual Orientation. * Overall recommend as a place to work: 54.4% * Overall happy for friend or relative to be cared for: 51.6% * Reasons for leaving data broken down by demographics. * Disciplinary data broken down by demographics. * Recruitment data by demographics | 2 | Sarah Dallal |
| 2D: Staff recommend the organisation as a place to work and receive treatment | * Staff Survey Q21c & Q21d – Age, Ethnicity, Gender, LTHC, Sexual Orientation. * Overall recommend as a place to work – 54.4% * Overall happy for friend or relative to be cared for 51.6% * Reasons for leaving data broken down into demographics. * Disciplinary data broken down into demographics. * Recruitment data broken down into demographics | 1 | Sarah Dallal |
| **Domain 2: Workforce health and well-being overall rating** | | | **6** |  |

## Domain 3: Inclusive leadership

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| **Domain** | **Outcome** | **Evidence** | **Rating** | **Owner (Dept/Lead)** |
| ***Domain 3:***  ***Inclusive leadership*** | 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities | * Brents/Senior staff Blogs/Vlogs include EDI. * BoD & committees – EDI & Health Inequalities discussed (minutes) * Board members & senior leaders sponsor & attend staff networks. * EDI Lunch & Learn sponsorship from BoD and Senior Leaders. * Significant increase in board declarations of EDI characteristics and over representation of some characteristics at board compared to community. * Commitment to review the new structure brought in April 2022 to check impact on protected characteristics. * All execs have EDI specific objective. | 1 | Sarah Dexter-Smith |
| 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | * EDI & Health inequalities are discussed at BoD (minutes) * BAME staff risk assessments were completed during the pandemic. * EIA’s are complete for policies & procedures and projects | 2 | Sarah Dexter-Smith |
| 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | * BoD and committees monitor Gender Pay Gap, WRES (including Model Employer), WDES & SOWES, EDS, leavers information. * Executive clinical lead identified to oversee EDI data related to patient care. | 2 | Sarah Dexter-Smith |
| **Domain 3: Inclusive leadership overall rating** | | | **5** |  |

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| **Third-party involvement in Domain 3 rating and review** | |
| **Trade Union Rep(s): JCC approval** | **Independent Evaluator(s)/Peer Reviewer(s): Chris Rowlands CNTW** |

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| EDS Organisation Rating (overall rating): 19 |
| Organisation name(s): Tees, Esk and Wear Valleys NHS Foundation Trust |
| Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**  Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**  Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**  Those who score **33,** adding all outcome scores in all domains, are rated **Excelling** |

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| **EDS Action Plan** | |
| **EDS Lead** | **Year(s) active** |
| Sarah Dallal | 2024/25 |
| **EDS Sponsor** | **Authorisation date** |
| Sarah Dexter-Smith |  |

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| **Domain** | **Outcome** | **Objective** | **Action** | **Completion date** |
| **Domain 1: Commissioned or provided services.** | 1A: Patients (service users) have required levels of access to the service | Understand the demographics of people who access services at TEWV and their experiences | Design data reports for Care Groups to understand the needs of the population they serve. |  |
| 1B: Individual patients (service users) health needs are met | Understand and improve the access and experiences of Trans people & the Gypsy Romany Traveller Community | As detailed in the Equality Objectives  Continue to achieve our goal to co-create a great experience for our patients, carers and families |  |
| 1C: When patients (service users) use the service, they are free from harm | Care is delivered in a way that minimises things going wrong, reduces risk and empowers and supports people to make safe choices. | Continue with the Journey to Change Quality & Clinical Journey Strategies to ensure we deliver safe and effective services |  |
| 1D: Patients (service users) report positive experiences of the service | To offer all patients the opportunity to provide feedback about their experiences | Continue to review patient experience and FFT user surveys |  |

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| **Domain** | **Outcome** | **Objective** | **Action** | **Completion date** |
| **Domain 2:**  **Workforce health and well-being** | 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions | To promote and provide innovative initiatives for work-life balance, healthy lifestyles, encourages and provides opportunity to exercise. | The Health and Wellbeing Team will continue to run specific wellbeing campaigns on specific conditions such as COPD, Asthma and weight management, financial wellbeing, better sleep, risky alcohol & substance use and workplace wellbeing environments/basic wellbeing needs (including nutrition and healthy eating), (obesity) in the coming year (2024). | Ongoing |
| 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source | Ensure we support and respond to staff who experience verbal & physical aggression and proactively reduce the number of incidents of verbal & Physical aggression from service users, carers, and members of the public towards staff. | To follow the actions detailed in the objective set in 2023 as one of the Trust’s 2023-2026 Equality Objectives.  Continue to Promote Procedure for Addressing Verbal & Physical Aggression Towards Staff by Patients, Carers Relatives | Ongoing |
| 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source | Ensure staff are aware of the protected time offered to them to attend 4 staff networks of their choice annually. | Launch & promote the Staff Networks documented Communications plan to target managers about the importance of staff networks and the Trusts commitment to support staff to attend. | March 24 |
| 2D: Staff recommend the organisation as a place to work and receive treatment | To improve the % of staff reporting that they would recommend the organisation to work or receive treatment. | Continue to link this objective to The Great Place to Work workstream and actions. | Ongoing |

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| **Domain** | **Outcome** | **Objective** | **Action** | **Completion date** |
| **Domain 3:**  **Inclusive leadership** | 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities | To implement the trust approach to Health Inequalities | BoD to work with Health Inequalities Lead in the Trust approach to Health Inequalities |  |
| 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed | To implement the NHS Oversight and Assessment Framework | BoD to implement the framework and use this to develop approaches and build strategies for equality and health inequalities related impacts. |  |
| 3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients | For Board members and senior leaders to monitor the trusts approach to Health Inequalities. | BoD to implement the NHS Oversight and Assessment Framework.  To review that all the following are monitored: WRES (including Model Employer), WDES, NHS Oversight and Assessment Framework, Impact Assessments, Gender Pay Gap reporting, staff risk assessments (for each relevant protected characteristic), SOM, end of employment exit interviews, (EDS subject to approval), Accessible Information Standard, partnership working – Place Based Approaches. |  |

**Domain 1 - detailed ratings & evidence**

**Kestrel Kite**

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| **Domain** | **Outcome** | **Evidence** | **Rating** | **Owner (Dept/Lead)** |
| ***Domain 1: Commissioned or provided services*** | 1A: Patients (service users) have required levels of access to the service | Patients are referred to the service when their learning disability and/or autism needs is impacting on risk.  The ward abides by the Privacy and Dignity Policy.  All patients referred to speech and language therapist upon admission to service. If a communication need is identified on referral form or during assessment for admission, then SLT can be involved from those initial stages.  Easy read formats are available for MHA rights, medication for example with other easy read materials being available on an individual basis. For example, the ward has completed social stories, comic strip stories and have facilitated individual needs such as writing care documents in specific fonts, sizes or capitals and also pictorial forms. This is documented in care plans.  Patients have the opportunity to have communication profiles and passports.  There is also a statement of involvement from patients and carers included within care plans and risk documents.  Interpretation services are available when required.  Sensory profiles are completed by occupational therapy however sensory support is limited due to resource of sensory integration trained staff within the service / trust wide.  The ward has staff in the process of completing this training with a view to complete in Summer 2024.  The ward has a few staff trained to support service users with visual or auditory impairments where required.  Information is shared with other agencies as and when required to ensure that communication is maintained at level appropriate for the service users’ needs and wishes. | 2 | Jody Buxton (Modern Matron) |
| 1B: Individual patients (service users) health needs are met | Ward is all on one level and accessible with wider doors if a service user had a physical disability and required use of a wheelchair. Accessible bedrooms and bathrooms are available where required.  Occupational therapy and physio are available to assess, recommend and support with any physical health care needs and have provided equipment such as chair shower aids, walkers, chairs etc. There is also access to external services who can have equipment supplied to the ward within 24hours.  Staff support with medical and health appointments to ensure that information is communicated.  Impact of LD and autism is considered individually for all service users, with further consideration and adjustments to sensory needs, processing times, dietary requirements.  Autism focussed formulations are provided to increase understanding of the impact of LD and / or autism for each service user. The staff team report this is a good opportunity to review the service users’ holistic needs and inform care and treatment.  Robust transition plans are developed.  Historically the ward has provided training, formulations and worked alongside new providers to ensure smooth transition, with good outcomes.  The ward has also been able to have input into environmental needs of services users to ensure sensory needs are considered when supporting service users to move on.  In addition, the ward works alongside SOT (secure outreach and transition team) and also FOLs (forensic outreach and liaison service) to ensure a smooth transition into the community from secure care. | 3 | Jody Buxton (Modern Matron) |
| 1C: When patients (service users) use the service, they are free from harm | Safeguarding training is completed for all staff.  1:1 support with safeguarding lead nurse for all RNs.  Local authority awareness for all RNs.  Trustwide safeguarding support from a designated team.  Safeguarding alert forms within the electronic care record.  HR processes available and followed for any staff related concerns.  Complaints process in place with all complaints investigated. Local issues resolution monitoring is being piloted for all ward-based complaints monitoring along with more formal processes such as PALS and CQC  Incident recording and monitoring is well embedded with oversight from senior leaders and discussed in governance meetings.  Datix forms / incident reports are completed for all incidents.  Early learning reviews completed with 72 hours for any incidents graded low to moderate severity.  Serious incident investigations completed for any serious incidents.  Positive and safe dashboard is in place and themes and learning are discussed at ward level, as well as within service and trust wide governance meetings. Learning is shared.  Ward safety drill and ward safety file which highlight and communicate risks and mitigations is well established on the ward.  De-brief and safety bulletins are sent out to all staff.  Safewards framework used on the ward.  Individual risk documentation in place such as safety summary to highlight risk and safety plans to identify and evidence mitigation, which is reviewed as and when required, fortnight lightly by MDT, following significant change or review of care.  Environmental ligature audit is kept up to date and reviewed as and when required with a minimum of yearly.  Community meetings held fortnightly or minimum of monthly.  “Safe care” system is embedded to review any daily risks with regards to staffing resources. Patient related issues including safeguarding are also discussed within his meeting and resolution is sought before meeting can be concluded.  Observation and engagement procedure in place and staff training compliance is monitored with regards to this  Individual training to increase safety can be sourced / provided where required for example the positive and safe team have recently provided bespoke training upon request of the ward.  Autism formulations are facilitated to understand the impact of the autism on each service user which provides greater insight into risk and mitigations.  Equality diversity training is completed by staff on the ward.  The Oliver McGowan training tier 1 is 100% compliant.  Tony Attwood talk is 91%  Face to face autism training compliance is 66% (due to new starters who are booked on this training)  The ward works closely with local authority safeguarding teams, MAPPA and other organisations / agencies to support the safety of service users and members of the public both during their hospital stay or when planning for discharge.  Disclosures have been made to public institutions such as colleges to promote community participation, meaning activity etc for service users on discharge pathways.  Local authorities are also consulted when looking for appropriate placements. | 3 | Jody Buxton (Modern Matron) |
| 1D: Patients (service users) report positive experiences of the service | Patient experience surveys offered 6 monthly.  PREOMS surveys offered 6 monthly (alternate to pt experience to allow for quarterly surveys)  Local issues resolution monitoring is being piloted on the ward.  PALS - contact details / posters are visible on the ward. Close links with PALS are maintained to resolve any complaints efficiently and effectively.  CQC - contact details / posters are visible on the ward. Timescales are in place to resolve any complaints efficiently and effectively.  Friends and Family Test  Freedom to speak guardian accessible.  Advocates and IMHA offered to all service users.  ESSENCES is a psychology led short survey open to all stakeholders. It has a focus on safety and culture within a forensic setting. – offered to all service users, carers and staff.  Quality improvement events for service users and staff on the ward to explore how to improve the therapeutic culture and environment and enhance the day-to-day organisation of the ward.  Carers open days have taken place.  Carer link staff identified for the ward.  Pearls in the teacup video – the carers perspective of being a carer of someone detained in hospital portrayed by a theatre organisation was shown to staff, service users and families.  A video named Diamonds in the rough was also produced by the same theatre organisation to represent the being detained in hospital from a service users’ perspective. These have been highly acclaimed by stakeholders.  Contact with family was maintained during COVID when physical contact and visits was reduced. This included the increased use of digital support such as skype tablets.  United voices group attendance and feedback – service user led group which feeds into governance structures.  Community meetings  1:1 discussion with lead nurse and key workers  Daily engagements with staff  Collaborative working and involvement in all care and treatment plans where possible. | 2 | Jody Buxton (Modern Matron) |
| **Domain 1: Commissioned or provided services overall rating** | | | **10** |  |

**Bedale**

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| **Domain** | **Outcome** | **Evidence** | **Rating** | **Owner (Dept/Lead)** |
| ***Domain 1: Commissioned or provided services*** | 1A: Patients (service users) have required levels of access to the service | Access to the service is 24 hours per day, 7 days a week as is an inpatient ward. The ward can take either direct admissions from the community or transfers from other wards were felt necessary and has access to 10 beds and a seclusion suite.  The service has expanded their staffing to provide a dedicated MDT to respond to the individual needs of each patient on the ward, this includes nurses, HCA’s, medics, psychology, physical healthcare practitioner, SALT, OT, physio, STR worker, activity coordinator, gym instructor and access to many other services if required. This includes an over establishment of HCA posts to support greater levels of staffing on the ward and increase and maximise clinical capacity.  Chaplaincy services are accessible on the ward.  Voluntary workers are available on the ward.  Individual risk assessments are undertaken with patients to determine safe access to community services.  There are no age restrictions on the ward, admissions are from 18 years.  The access to PICU is based purely on risk and patient needs for their mental health at that time. Access to the service is determined via the PICU Pyramid and has no protected characteristic as an exclusion criterion. Any needs that need to be met following being accepted, would be done on an individual basis.  The ward has access to support from MHSOP colleagues when caring for elderly patients, this includes support such as the falls team and moving and handling team.  The service has developed closer relationships with inpatient and community ALD teams to support with training and guidance for greenlight admissions which has involved increased training on PBS by external trainers to the service and understanding of the CTR process.  The PICU are currently working towards being a single sex environment in line with the requirements of the privacy and dignity policy.  Any individual needs would be assessed during admission assessment, and these would be recorded in the safety plans for the patient which is accessed by all individuals involved in their care.  Complaints received since 2022 have not related to service users protected characteristics.  Interpreter services are accessed when required.  As part of the patient admission information, the ward document and record any identified disability, communication / language preferences. This is recorded in safety plans and where required the Dialog Plan for individual patients. The ward would also record this as an alert on the electronic care system. This information is used to inform plans of care and to use when discharge planning.  The ward share safety plans which contain information about communication preferences with family, other NHS agencies and any other care providers involved in a patients care.  The trust has access to an Autism team and work is ongoing regarding Reasonable Adjustments on the ward. The ward use checklists to screen for these and can work without colleagues in the Specialist Health Team regarding solutions for identified issues including the environment.  Communication passports are used and devised where needed with patients as well as being shared with other care providers.  The trust intranet has access to information regarding legal status, medication, and diagnosis information in different languages. They also have access to sign language services in different languages and tactile writing systems.  All patients are referred for an Independent Mental Health Advocate and Independent Capacity Advocate, this information is available on display in the ward and is in the welcome packs for the ward. | 2 | Rebecca Stephenson (Modern Matron) |
| 1B: Individual patients (service users) health needs are met | The organisation has an interpreter service which is accessed directly via the ward and works within the required policy.  The ward is a single-story building with no access issues i.e., ramps required, and bedrooms would be adapted with hired beds if required for individual physical health needs.  If a patient had additional needs identified, the supportive observations and engagement policy would be used to assess needs and how these would be supported.  The bathroom has the ability for assisted grab rails to be fitted by estates as required.  The ward has access to OT staff to assess for the need of aids in relation to mobility and personal care.  The ward has access to hoists on site and manual handling training.  The doorways on the ward are large enough to accommodate a wheelchair.  The ward holds daily meetings with all patients that want to be involved on how they can improve the environment.  A comprehensive risk assessment is undertaken and maintained throughout the patient journey.  The ward work closely with multiple agencies from across the system to ensure comprehensive care planning.  As part of the patient admission information, the ward document and record any identified disability, communication / language preferences. This is recorded in safety plans and where required the Dialog Plan for individual patients. The ward would also record this as an alert on the electronic care system.  The ward share safety plans which contain information about communication preferences with family, other NHS agencies and any other care providers involved in a patients care.  The trust has access to an Autism team and work is ongoing regarding Reasonable Adjustments on the ward.  The ward use checklists to screen for these and can work without colleagues in the Specialist Health Team in regard to solutions for identified issues including the environment.  Communication passports are used and devised where needed with patients as well as being shared with other care providers.  Our trust intranet has access to information regarding legal status, medication, and diagnosis information in different languages. The ward also has access to sign language services in different languages and tactile writing systems.  All patients are referred for an Independent Mental Health Advocate and Independent Capacity Advocate, this information is available on display in the ward and is in the welcome packs for the ward. | 2 | Rebecca Stephenson (Modern Matron) |
| 1C: When patients (service users) use the service, they are free from harm | Since January 2022, there have only been 3 complaints submitted for Bedale ward, none of which relate to a protected characteristic.  The ward has been working to reduce their restrictive interventions on the ward and meet monthly to discuss initiatives and how these are personalised.  If a patient was to be subject to discrimination on the ward from a fellow patient, the ward would follow the appropriate VA policy.  Mutual help meetings have been used to discuss where we have seen incidences of discrimination to discuss the impact of this on the patient’s emotional wellbeing and to discuss criminality in relation to discrimination, Police liaison officer is available to attend these meetings. Discrimination is reported to the police.  All patients are referred for an Independent Mental Health Advocate and Independent Capacity Advocate, this information is available on display in the ward and is in the welcome packs for the ward. |  |  |
| 1D: Patients (service users) report positive experiences of the service | The patient experience information for the ward is provided below. This is reviewed monthly and also displayed for patients to review. This information is gathered monthly from the patients and carers.  Since January 2022, there have only been 3 complaints submitted for Bedale ward, none of which relate to a protected characteristic. This is monitored by the complaints team. All complaint responses are taken via our governance routes for discussion.  PALS, complaints and CQC information is available on the ward and is available in different formats and languages. This is included in the ward welcome booklet.  If a patient was to be subject to discrimination on the ward from a fellow patient, the ward would follow the appropriate VA policy.  Mutual help meetings have been used to discuss where we have seen incidences of discrimination to discuss the impact of this on the patient’s emotional wellbeing and to discuss criminality in relation to discrimination, Police liaison officer is available to attend these meetings.  Discrimination is reported to the police. | 2 | Rebecca Stephenson (Modern Matron) |
| **Domain 1: Commissioned or provided services overall rating** | | | **8** |  |

**Scarborough CAMHS**

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| **Domain** | **Outcome** | **Evidence** | **Rating** | **Owner (Dept/Lead)** |
| ***Domain 1: Commissioned or provided services*** | 1A: Patients (service users) have required levels of access to the service | Most Children and Young People (CYP) access CAMHS through a referral to the Single Point of Access (SPA) Team. The SPA team document CYP protected characteristics on Paris. SPA complete a telephone assessment, in which they explore reason for referral. All CYP up until 18 years are able to be referred to CAMHS. Some CYP will access CAMHS through contact with CAMHS Crisis (24 hour service) or as a transfer from another NHS Trust; all CYP will have their protected characteristics recorded on Paris.  Within the access call / initial assessment, CAMHS clinicians will explore if there are any additional needs related to protected characteristics. There are specific questions around sensory and communication needs, these are clearly documented within the assessment and are also flagged as an alert on Paris.  CYP and families have access to a translator service if this is required. This will be booked by the access team to ensure the service is available for the assessment. Documents / Letters can be translated through this service also.  CAMHS Clinical staff support CYP / Families in referrals to other agencies if it is identified they require additional support to meet their needs – for example, the service complete referrals for autism assessments – with the child and family.  Any individual needs would be assessed during admission assessment, and these would be recorded in the safety plans for the patient which is accessed by all individuals involved in their care.  Service users with an autism diagnosis and/or learning disability, the service can make referrals to the Dynamic Support Register (DSR), which is a multi-professional group that tried to ensure appropriate care and support is in place for CYP with additional needs.  This service can also provide a key worker service, which advocates for CYP in multi-agency meetings.  The service is able to refer CYP to the National Youth Advocacy Service, who provide a range of services to support, safeguard and empower CYP  Our trust has access to sign language services in different languages and tactile writing systems.  Evidence to demonstrate adjustments the service makes with regards to race/religion/culture:   * CAMHS have attended multi agency meetings with local MH and CSC services for asylum seeking families based in Scarborough; trying to improve access to services. * CAMHS can be flexible with appointments for CYP if they require this due to religious/cultural periods (e.g., fasting periods)   Within reception / waiting room area there is information for local CYP LBTQI+ groups and celebration of Pride flags.  Scarborough has a high level of deprivation, so as a team promotion of local charitable services that helps families in need takes place. An example being the service created a poster that clearly shows all local food collection services.  At Christmas the team also have a collection during which time we bring in toys / food and then take this to the local community support centre who distribute this to families.  The service also have a CYP book collection in reception, with a sign that children are able to take a book home if they see one they would like to read. | 2 | Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager) |
| 1B: Individual patients (service users) health needs are met | Lake House is accessible – all rooms for children and young people are on the ground floor. There are no steps to access the building or on the ground floor. There is a lift to the first floor if visitors / staff are unable to use the stairs. There is access to a disabled toilet on the ground floor. There are emergency cords in all bathrooms if anyone needs support / assistance, as these are linked to a building-wide alarm and response system.  An environmental risk assessment is conducted very three months.  If any CYP have additional health needs that may require urgent response / additional support, staff have access to a personal alarm system which are taken into sessions – which will alert the team to attend the room if required.  Any significant health issues would be highlighted as an alert in Paris.  Concerns around risk are clearly highlighted within safety plans.  CYP and families have access to a translator service if this is required. This will be booked by the access team to ensure the service is available for the assessment. Documents / Letters can be translated through this service also.  CAMHS will provide home visits if CYP / families are unable to access Lake House – those with physical disabilities can struggle to attend if families do not drive as Lake House is on the outskirts of the town and is not on a bus / train route, and we recognise that some families cannot afford regular taxi fares.  If CYP are pregnant and in service, we will liaise and refer to the perinatal mental health team if appropriate. | 2 | Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager) |
| 1C: When patients (service users) use the service, they are free from harm | When reporting an incident, information relating to protected characteristics is documented.  If the incident is deemed to be ‘medium to high’ level of harm, then an early learning review report is completed, within which is specifically asks about their age and gender, and preferred pronouns.  This report also provides opportunity to consider if there any additional needs linked to protected characteristics. The reports are reviewed by the Patient Safety Team, who would also have opportunity to consider if there are needs that have not been appropriately addressed and if any actions need to be taken in respect of the CYP protected characteristics.  Formal complaints are received through the Patient Advice and Liaison Service (PALS); who are in place to support families to complain about the service. CAMHS have a statutory duty to respond to all complaints. If there are any concerns raised that are linked to CYP protected characteristics, these will need to be specifically addressed. If there are concerns regarding the provision of support from CAMHS, an apology would be provided (principle of Duty of Candour) and this would be opportunity for lessons learnt within the team.  Complaints are used to help in the development of clinical practice and to understand areas which need to be improved. |  | Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager) |
| 1D: Patients (service users) report positive experiences of the service | The patient experience is reviewed monthly and also displayed for patients to review.  This information is gathered monthly from the patients and carers.  Examples of compliments from FFTs demonstrating good practice include:   * Very centred on the young person’s needs * I was made to feel very comfortable. * (Worker) is a knowledgeable, kind, patient and comes across as genuinely caring.   There is a ‘you said we did’ board in reception that highlights comments made by CYP / families and what actions we have taken to evidence we are incorporating their views within changes to practice / environmental changes.  An example of these are as follows:  You Said-  We did not have a choice of where our appointments were held.  We did-  A sign in reception informing that we can offer appointments in a variety of settings including children centres and within school and this can be discussed with the CYP clinician.  There have been occasions CYP have struggled to attend Lake House – reasons have included poor physical health, feeling overwhelmed due to sensory issues. We have then offered alternative locations, including attending the home.  PALS, complaints and CQC information is available in reception / waiting room in poster form and is available in different formats and languages.  Staff complete Equality and Diversity and Human Rights Training as part of their mandatory / statutory training requirements. | 2 | Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager) |
| **Domain 1: Commissioned or provided services overall rating** | | | **8** |  |

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