AGENDA FOR THE MEETING OF THE BOARD OF DIRECTORS TUESDAY 25TH FEBRUARY 2020 VENUE: THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 9.30 A.M.

Apologies for Absence

Standard Items (9.30 am)

Item 1	To approve the public minutes of the last meeting held on **28th January 2020.**		**Attached**
Item 2	Matters Arising.		**-**
Item 3	Public Board Action Log.		**Attached**
Item 4	Declarations of Interest.		**-**
Item 5	Chairman's Report.	**Chairman**	**Verbal**
Item 6	Chief Executive's Report.	**CM**	**Attached**
Item 7	To consider any issues raised by Governors.	**Board**	**Verbal**

Quality Items (9.50 am)

Item 8	To consider the report of the Quality Assurance Committee.	**HG/EM**	**Attached**
Item 9	To receive and note the monthly safe staffing report.	**EM**	**Attached**
Item 10	To consider the outcome of the Establishment Review.	**EM**	**Attached**
Item 11	To receive and note the Learning from Deaths report.	**EM**	**Attached**
Item 12	To consider the publication of information in compliance with the public sector duty under the Equality Act.	**DL**	**Attached**
Item 13	To consider the report of the Mental Health Legislation Committee.	**PM/EM**	**Attached**

Performance (11.30 am)

Item 14	To consider the Finance Report as at 31st January 2020.	**PMc**	**Attached**
Item 15	To consider the Trust Performance Dashboard as at 31st January 2020.	**SP**	**Attached**
Item 16	To consider the Strategic Direction Performance Report for Quarter 3, 2019/20.	**SP**	**Attached**

Items for Information (12.00 noon)

Item 17	To receive and note a report on the use of the Trust's Seal.	**CM**	**Attached**
Item 18	Policies and Procedures ratified by the Executive Management Team.	**CM**	**Attached**

Item 19 To note that the next meeting of the Board of Directors will be held at 9.30 am on **Tuesday 31st March 2020** in the Boardroom, West Park Hospital, Darlington.

Confidential Motion (12.05 pm)

Item 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 relating to the financial or business affairs of any particular person (other than the Trust).

Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

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.

The meeting will adjourn for a refreshment break

Miriam Harte
Chairman
19th February 2020

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 28TH JANUARY 2020 IN THE DURHAM CENTRE, BELMONT INDUSTRIAL ESTATE, DURHAM COMMENCING AT 9.30 AM

Present:
Ms. M. Harte, Chairman
Mr. C. Martin, Chief Executive
Dr. H. Griffiths, Deputy Chairman
Mr. M. Hawthorn, Senior Independent Director
Prof. P. Hungin, Non-Executive Director
Mr. D. Jennings, Non-Executive Director
Mr. P. Murphy, Non-Executive Director
Mrs. B. Reilly, Non-Executive Director
Mrs. S. Richardson, Non-Executive Director
Mrs. R. Hill, Chief Operating Officer
Dr. A. Khouja, Medical Director
Mr. P. McGahon, Director of Finance and Information
Mrs. E. Moody, Director of Nursing and Governance and Deputy Chief Executive
Mr. D. Levy, Director of HR and Organisational Development (non-voting)
Mrs. S. Pickering, Director of Planning, Performance and Communications (non-voting)

In Attendance:
Mrs. J. Illingworth, Director of Operations for County Durham and Darlington (minute 20/08 refers)
Mr. P. Bellas, Trust Secretary
Mrs. S. Paxton, Head of Communications

20/01 APOLOGIES

Apologies for absence were received from Mr. J. Maddison, Associate Non-Executive Director.

20/02 MINUTES

***Agreed** – that, subject to the inclusion of "… as this might arise from underlying problems" at the end of the first paragraph under (2) of minute 19/297, the minutes of the last ordinary meeting held on 26th November 2019 and the special meeting held on 17th December 2019 be approved as correct records and signed by the Chairman.*

20/03 MATTERS ARISING AND PUBLIC BOARD ACTION LOG

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

(1) In response to questions:
  (a) Further to minute 19/303 (26/11/19) Dr. Khouja advised that:
    - The environmental issues at Lanchester Road Hospital, which had contributed to 33% of consultants strongly disagreeing that they

enjoyed their trainer role, related to the quality of the teaching environment and not the overall Hospital.

- He was satisfied that improvements to the teaching environment were being progressed.

(b) It was noted that the planned "away day" to review the Trust's approach to supporting "speaking up", including to consider the concerns raised under minute 19/296 (26/11/19) about the managers' reporting tool and the training of investigators, had been held on 6th December 2019 and an update would be provided in the next report of the Freedom to Speak Up Guardian.

Action: Mr. Williams

(c) It was noted that the issues raised by the Guardian of Safe Working, in regard to the provision of an out of hours switchboard for on-call doctors and the level of information on the rota provided to the Tees crisis team who, at present, supported the arrangements (minute 19/296 – 26/11/19 refers), had been considered by the Executive Management Team (EMT).

Mr. Martin considered that the issues had been found not to be as significant as they first appeared and undertook to provide Board Members with a note on the outcome of the EMT's discussions.

Action: Mr. Martin

(2) The Chairman drew attention to the note provided by Mr. Levy, in accordance with minute 19/266 (29/10/19), which confirmed that the number of recruitment episodes where TEWV candidates were considered to be 'above the line' following interview, for posts at Band 7 and above, had increased during the period July to December 2019 compared to the previous six months.

(3) Further to minute 19/325 (26/11/19) the Non-Executive Directors were asked to contact Mrs. Gilderdale (Programme Director) if they would be attending any of the reconnection days with staff from West Lane Hospital.

20/04 DECLARATIONS OF INTEREST

There were no declarations of interest.

20/05 CHAIRMAN'S REPORT

The Chairman:

(1) Updated the Board on the progress being made on the recruitment of a new Chief Executive.

It was noted that:

(a) The advertisement/search period had commenced during the previous week.

(b) An advertisement for the position had been placed in the Health Service Journal but not on NHS Jobs as this was not allowed unless candidates applied through the website.

(c) Mr. Dixon, the recruitment consultant, was undertaking an extensive search.
(d) All suggestions received about potential candidates were being signposted to Mr. Dixon.

(2) Reported on her visit to services in York including to Systems House to present a "Living the Values" Award; to Oak Rise; and to Cherry Tree House where the discussions had focussed on the success of the team in recruiting new staff.

20/06 CHIEF EXECUTIVE'S REPORT

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

Mr. Martin drew attention to the following matters contained in the report:

(1) The Government's decision, as reported in the NHS England/Improvement (NHS E/I) "Provider Bulletin", to step down preparations for a "no-deal" exit from the European Union.

It was noted that:
(a) The Department of Health and Social Care had informed NHS E/I that this meant that preparations by health and care systems should cease.
(b) NHS organisations were required to retain a key point of contact (the Director of Finance and Information in the Trust) and to support the embedding of agreed legacy items.
(c) Based on the guidance the rating of the relevant risk in the Board Assurance Framework had been reduced to "low"; however, this would be kept under review in case there were delays to reaching agreement with the EU that could have operational impacts.

(2) The revised version of the West Yorkshire and Harrogate ICS Memorandum of Understanding (circulated under separate cover) which was presented to the Board for approval.

He advised that, overall, only a few changes to the MoU were being proposed and these included revisions to the ICS's governance arrangements; recognition of the establishment of primary care networks; and the development of the long term plan.

(3) The appointment of Dr. Mani Santhanakrishnan as the new Senior Clinical Director for MHSOP, succeeding Dr Tolu Olusoga.

(4) Further to the discussions under minute 19/295 (26/11/19), the successful bid for additional financial resources in response to challenges faced by the health service team at HMP Durham following its designation as a Reception prison and the significant increase in prisoner flows.

It was noted that there had been a ministerial visit to the prison during the previous week.

(5) The circulation of the letter from Simon Stevens, Chief Executive, NHS England on the pension tax arrangements in 2019/20 to all relevant staff.

In response to a question on the impact of the pension tax, it was noted that:

(a) Concerns had been raised by only half a dozen staff in the Trust.

(b) There appeared to have been no impact on the willingness of senior clinical staff to apply for leadership and management roles; however, the issue was on people's minds and added to the stress and pressure on them at work.

(c) The results of a survey undertaken by NHS Providers and comments from other Chief Executives in the region suggested that the approach, as set out in the above letter, had not had as positive an impact as was expected.

Agreed *– that the revised Memorandum of Understanding of the West Yorkshire & Harrogate Partnership be supported.*

Action: Mr. Martin

20/07 GOVERNOR ISSUES

The Chairman:

(1) Highlighted the need for an update to be provided to Governors on IAPT services following the discussions at the meeting of the Council of Governors held on 21st November 2019.

(2) Advised that there were no matters to bring to the Board's attention from the Governor Development Day held on 23rd January 2020.

20/08 LOCALITY BRIEFING – COUNTY DURHAM AND DARLINGTON

Mrs. Illingworth (Director of Operations) gave a presentation on the key issues facing the County Durham and Darlington Locality.

A copy of the slides used in the presentation is attached as Annex 1 to these minutes.

Arising from the presentation, the Board noted the challenges being experienced on Elm Ward and the work being undertaken to address them.

Clarity was sought on:

(1) The point at which a judgement would be made on the capability of the ward to deliver the improvements required.

The Board was advised that the Trust had a formal process, overseen by the EMT, for the provision of support to wards and teams. If, based on monitoring, the required changes were not delivered, there would need to be further discussions by the EMT and the Board would be advised accordingly.

(2) The potential contribution of bed occupancy levels to the challenges being experienced on the ward.

Whilst noting that the number of beds on the ward had been reduced from 18 to 16, Mr. Martin considered that further work was needed to ease the pressure on the staff arising from the high levels of both patient flow and complexity.

(3) How the Trust would know if similar issues were being experienced elsewhere.

The Chairman emphasised the need for the Trust to be proactive in its approach to identifying teams requiring support.

(4) The Trust's ability to measure the impact of the actions taken to deliver cultural change.

In regard to this matter:

(a) The Non-Executive Directors suggested that soft intelligence, including that based on additional Directors' visits and feedback provided by volunteers and peer support workers, could be used to build a framework around hard metrics.

(b) Mr. Martin advised that, in his conversations with relatives, the clinical leadership on the ward had been praised and no issues had been raised about the quality of care.

(c) Mrs. Reilly also observed that her visit to the ward, and discussions with the ward manager and staff, had been very positive.

Mr. Levy suggested that, as part of the Investors in People assessment due to be undertaken in March 2020, the Assessor could be asked to focus on Elm Ward and, in particular, the actions taken to promote staff wellbeing.

This was supported.

Action: Mr. Levy

In addition, Board Members:

(1) Sought clarity on the Namaste project.

Mrs. Illingworth explained that the project, which was being undertaken in partnership with St Cuthbert's Hospice, sought to provide staff with the skills to manage end of life care including within a patient's own home and in care homes.

(2) Considered that the key issue about patient flow in the Locality related to it being a nett recipient of out of locality admissions, generally, rather than due to the closure of beds in Hambleton and Richmondshire as, in the latter case, those patients occupying beds were broadly in line with the modelling undertaken.

(3) Highlighted the significant presence of corporate services on the Lanchester Road Hospital site and the importance, if there were potential impacts from the work being undertaken on estates optimisation, of them being represented on the Locality's Estates Board.

Mrs. Illingworth took this on board.

Action: Mrs. Illingworth

20/09 GUARDIAN OF SAFE WORKING

Dr. Khouja reported that:

(1) Dr. Whaley had stepped back from his role as the Guardian of Safe Working (GOSW) as he wished to focus on his clinical duties.

(2) Dr. Jim Boylan would be acting as the GoSW, temporarily, for a three month period.

(3) Dr. Whaley might wish to return to the role but, if not, substantive alternative arrangements would need to be put in place.

It was noted that Dr. Khouja hoped to be in a position to advise the Board on the longer term position at its next meeting.

Action: Dr. Khouja

(4) From the data provided to him:

- (a) There had been no breaches to the terms and conditions of service set out in the 2016 Junior Doctors Contract, during the last quarter, which required the levy of a fine; however, as discussed under minute 19/296 (24/11/19), the risk of fines was now more likely following the 2018 revisions to the Contract particularly for non-residential rotas.
- (b) The organisation continued to fulfil the requirements of the new 2016 Junior Doctor Contract and junior doctors were appropriately submitting exception reports which were being handled appropriately.
- (c) He was satisfied that processes were in place to identify and rectify issues of safety.

In response to a question, it was noted that, whilst Dr. Whaley had found the role of GOSW to be rewarding, he wished to concentrate on his substantive clinical role as a consultant psychiatrist in the North Yorkshire and York Locality.

Board Members asked for their gratitude to be passed on to Dr. Whaley for his work as the Guardian of Safe Working.

Action: Dr. Khouja

20/10 NURSE STAFFING REPORT

The Board received and noted the revised six monthly review report, for the period 1st June 2019 to 30th November 2019, in relation to nurse staffing as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire NHS Foundation Trust ("Francis Review") and in line with National Quality Board (NQB) guidance and compliance with Developing Workforce Safeguards (NHSI, 2018).

The Non-Executive Directors welcomed the insight into the Trust's staffing position provided by the report but sought clarity on the correlation between staffing levels and quality and safety and how this informed the Trust's understanding of risk.

Mrs. Moody observed that:
(1) The issue was multifaceted.
(2) It was, generally, accepted that a good, well-functioning multi-disciplinary team and consistency in staffing provided a better environment for both patients and staff.
(3) Risks arose due to difficulties in recruitment (e.g. North Yorkshire) or through other pressures (e.g. the challenges being experienced on Elm Ward) but their mitigation required different approaches.

It was considered that, from a regulatory perspective, there would be benefits in developing an overall picture, by way of a narrative, which recognised the different pressures faced by services; the factors which played into them; and their implications in terms of quality and safety.

In response Mrs. Moody considered that the report:
(1) Sought to provide this approach taking into account a broad range of data, including incidents; soft intelligence from the perspectives of both Localities and Specialties; and special circumstances, for example, whilst self-harm had been identified as an issue on female assessment and treatment wards there was a greater incidence on Elm Ward than Bransdale Ward.
(2) Enabled Board Members to triangulate the information and to identify potential correlations.

The Non-Executive Directors recognised that, since its introduction, reporting had evolved and, whilst it was not always possible to understand the reasons for particular issues, the reports now provided the Board with a vehicle to have a meaningful discussion not only on staffing but on other issues related to it.

Mr. Levy advised that, in regard to the issues in North Yorkshire (see above), work was being undertaken on developing a bespoke recruitment and retention plan which was aligned to the Right Staffing Programme and supported by the HR team.

Board Members also raised the following matters:
(1) The position on the development of the ward dashboard of quality nursing indicators.

Mrs. Moody explained that:
(a) Work on the quality nursing indicators had commenced but was, at present, on hold due to the development of CITO and the IIC.
(b) The Trust was developing its own indicators as, although there were some national ones which could be applied, there were none specifically for mental health.
(c) Once in place the dashboard would enable services to use the information in real time based on exception reporting.
(d) It was not practicable, at this time, to provide a timescale for the introduction of the dashboard.

(2) The challenges and feedback received from regulators about the Trust's staffing position.

It was noted that the regulators recognised that:

(a) Quality issues could arise from the Trust's staffing position but services were not unsafe.

(b) Whilst the Trust could prove that it provided the right numbers of staff it did rely on temporary staffing.

(3) The position in North Yorkshire and York where, although there were difficulties in recruiting staff in some areas and a high usage of agency staff, the Locality's performance on the Care Hours Per Patient Day (CHPPD) metric at 22.8 hours was well in excess of the Trust average of 10.7 hours.

It was noted that the factors which contributed to the Locality's position on the CHPPD metric included wards having 12 beds but the same staffing establishment of those with 18 beds elsewhere; lower levels of occupancy and out of area admissions; and admissions to Cedar Ward being capped.

Mrs. Moody offered to undertake a further analysis of the position in the Locality but this was not sought.

(4) The positive early feedback from the pilot of zonal 'observation' on Westerdale South and whether this was due to the approach, itself, or as a result of the establishment of the ward being increased.

Mrs. Moody advised that:

(a) Previously the ward had been 200% over establishment which was more than the number of additional staff recruited to support the pilot.

(b) In addition to providing a view on the appropriateness of 'zonal observations' the pilot would also inform the Trust's understanding of the importance of the number of registered nurses in a team and guide its future approach on this matter.

(5) Whether the findings of the establishment review were being taken into account in financial planning and whether the report on its findings, due to be presented to the Board meeting to be held on 25th February 2020, would include recommendations for future investment.

It was noted that:

(a) Discussions were being held on this matter.

(b) Historically the Trust operated above its establishment but the key issue was how far above this level was appropriate. This was being explored taking into account the position at the nine other comparator trusts in the Region and data provided by the MHOST tool.

(c) The exercise undertaken over the last year had been based on more meaningful engagement with inpatient and community services.

(d) Of the 10 highest priority areas identified by the establishment review only one was an inpatient ward with the remainder being community teams.

(e) Although the aim of the report on the establishment review was to provide a guide to future investment, further understanding was required and other mitigations might be appropriate.

Mr. McGahon advised that any additional investment would need to be funded through reserves or further cost savings.

(6) Whether any feedback had been received on the external opinion exercise in regard to forensic services (minute 19/295 – 24/11/19 refers).

Mrs. Hill reported that:

(a) The final report was due to be received by the end of the month with discussions on its findings planned to be held by the Locality's leadership team during February 2020.

(b) The initial feedback received was that the challenges in the services related to cultural issues (e.g. staff not feeling heard and valued) rather than staffing pressures.

Mr. Levy considered that this suggested the issues could link to sickness absence rather than recruitment.

Consideration was given to the timescale for the provision of the report, together with the Trust's response to its findings, to the Board.

Noting that the report would need to be considered, initially, by the Freedom to Speak Up Guardian, it was agreed that it should be presented to the Board meeting to be held on 31st March 2020.

Action: Mrs. Hill

(7) The position on the recruitment of peer support workers (PSWs) and whether there were plans for them to be rolled out across all services.

Dr. Khouja advised that:

(a) At present there were between 12 and 18 PSWs.

(b) Recruitment of them had been paused to ensure they received appropriate levels of support and that the services were ready to receive them.

(c) Plans were in place to have 120 PSWs in three years' time but this would still mean that there would be less than one per team.

(d) Work was also being undertaken on the implications of PSWs for the structure of teams and how they would be engaged e.g. as part of or aligned to a team or some form of blended approach.

(e) These matters were being further explored through a deep dive conducted by the EMT.

(8) The need to keep the staffing position at Springwood under review.

(9) That clarity should be provided in the Executive Summary of the report that the reason for the decrease in registered nurses and HCAs, in the reporting period, was due to ward closures rather than staff having left the Trust.

Mrs. Moody undertook to amend the report, accordingly, and provide a revised version for the Trust's website.

Action: Mrs. Moody

20/11 REPORT OF THE QUALITY ASSURANCE COMMITTEE

The Board received and noted the report of the Quality Assurance Committee (QuAC) including the key issues considered at its meeting held on 5th December 2019.

Dr. Griffiths, the Chairman of the Committee, highlighted the coaching day to be held on 20th February 2020, as part of the ongoing development of the Committee, which would be focused on improving assurance, including through increasing the standardisation and consistency of reporting and the use of soft intelligence, and build on the enhancements introduced approximately four years ago.

Questions were raised about the timing of the event in the context of the governance review which was due to take place over the next couple of months.

In response it was noted that:
(1) The event was due to review reporting, particularly from the LMGBs, and not the overall quality governance structure.
(2) Lorna Squires, the Head of Quality Governance at NHS E/I, who would be undertaking the governance review, was aware of the event and it would be helpful for her to observe the discussions.

In addition, the Chairman highlighted the Committee's discussions on a wheelchair user being unable to attend an appointment as the building was not accessible.

Mr. Levy provided advised that:
(1) The Trust undertook audits of accessibility to its buildings.
(2) In this case, the relevant room was inaccessible as it was on the first floor and a lift was not provided.
(3) As part of the response to the incident, the standard appointment letters would be amended to ask service users to raise any accessibility requirements.

The Chairman considered that, as a matter of principle, the Trust should not use buildings that were inaccessible.

20/12 EQUALITY, DIVERSITY AND HUMAN RIGHTS STRATEGY

On the recommendation of the Resources Committee, consideration was given to the revised Equality, Diversity and Human Rights Strategy.

Board Members:
(1) Welcomed the Strategy noting the improvements to the original version presented to the Committee and on its predecessor.
(2) Noted some typographical errors in the Strategy which they agreed to provide to Mr. Levy outside the meeting.

(3) Considered that more could be done to join up the objectives of the Strategy with the work of the Board's Committees, for example, in supporting the Mental Health Legislation Committee understand the impact of detentions, etc. by protected characteristic.

(4) Questioned the inclusion of the statement "The ideal future state would be that TEWV is an inclusive employer and service provider in which diversity is welcomed and valued, where all staff are able to achieve their full potential and where service users are able to access person-centred care which supports them to lead meaningful and satisfying lives. However it is accepted that there are societal and other barriers which mean that this cannot be fully achieved by 2023" in the Executive Summary to the Strategy as the Trust could not know whether the aspiration had been achieved.

Mr. Levy undertook to remove the statement from the Strategy.

Action: Mr. Levy

(5) Considered that objective 2, in regard to verbal aggression directed against staff, was not specific to the protected characteristics and needed to be linked to the strategic approach to tackling abuse directed at staff generally.

Board Members considered that the launching of the Strategy should be considered by the EMT in view of its importance and positive message.

Mr. Martin recognised the work of the Equality and Diversity Lead and others in producing the Strategy.

***Agreed** – that the Equality, Diversity and Human Rights Strategy, as amended, be approved.*

Action: Mr. Levy

20/13 AGENCY USAGE

Further to minute 19/208 (17/9/19), the Board received and noted a report on the ongoing work to reduce the Trust's agency expenditure during 2019/20.

Clarity was sought on the reasons for the difference in the contracts of medical agency workers (based on the provision of 10 sessions of clinical work per week) and substantive medical consultant staff generally (based on the provision of 7.5 clinical sessions and 2.5 sessions to support professional activities) in the context of the Trust's agency cap.

In response it was noted that:

(1) The contractual arrangements were designed to provide value for money and, as agency workers were more expensive than substantive consultant medial staff, to make best use of their time.

(2) The regulators were aware that the Trust would not meet its agency cap in 2019/20 from the quarterly financial returns and the contractual position of medical agency workers was not used in projections of future demand.

The Chairman considered that, if the medical agency workers wanted support for professional activities, they could move to substantive contracts.

Board Members also sought clarity on the position in forensic services which had low staffing fill rates and high levels of additional duties but low levels of agency expenditure.

Mrs. Hill advised that agency usage tended to be comparatively very low in forensic services with temporary staffing needs being met through bank usage and overtime due to training requirements.

20/14 DEVELOPING MENTAL HEALTH SERVICES FOR ADULTS AND OLDER PEOPLE IN HARROGATE AND RURAL DISTRICT AND WETHERBY AND ITS SURROUNDING AREA

Further to minute 18/C/300 (30/10/18) consideration was given to the report and action plan which had been prepared in response to feedback received from the public engagement on the development of mental health services for adults and older people in Harrogate and Rural District and Wetherby and its surrounding areas.

Mrs. Pickering advised that, as a Commissioner led process, the Board's views should be provided to Harrogate and Wetherby CCG and Leeds CCG but the way forward was a matter for them to determine.

Notwithstanding the action plan being omitted from the papers of some of the Non-Executive Directors the Board agreed that it could be considered.

In regard to the key themes which had been raised throughout the engagement, as listed in the covering report, clarity was sought on:

(1) How well the Trust provided services to people close to their homes.

It was noted that that there were benefits, where practicable, in providing services in a person's own home and, as part of the proposed service changes, there had been a lot of discussion about avoiding admissions and further developing home treatment and community delivery.

(2) The availability of volunteer drivers to support access to services in North Yorkshire, particularly Wetherby.

Mrs. Hill advised that there were volunteer drivers in the Trust but the number of them in the Locality needed to be expanded in response to the service changes.

The Chairman highlighted that the charity, "Daft as a Brush", based in Gosforth provided free patient transport services and it, or similar organisations, might be able to provide support in the Locality.

Board Members also noted that there had been significant engagement with the Governors for the Harrogate and Wetherby Constituency on the future of mental health services in the area.

Agreed – *that Harrogate and Rural District CCG and Leeds CCG be informed that the Trust supports the engagement report and the engagement response action plan on the development of mental health services for adults and older people in Harrogate and Rural District and Wetherby and its surrounding areas.*

Action: Mrs. Hill

20/15 MENTAL HEALTH LEGISLATION COMMITTEE

Mr. Murphy, the Chairman of the Mental Health Legislation Committee, confirmed that there were no matters of urgency arising from its meeting held on 22nd January 2020.

20/16 FINANCE REPORT AS AT 31ST DECEMBER 2019

The Board received and noted the Finance Report as at 31st December 2019.

Mr. McGahon advised that there were concerns about cost pressures arising from increases in injury benefits provision (£750k for the Trust). These had been raised with NHS E/I and, although it was anticipated that the Control Total would be reduced to offset the increase, confirmation of this approach was still awaited.

In response to questions it was noted that:

(1) In regard to Control Totals for systems:
   (a) These were generally set at the ICP level with the Trust nominally part of the Tees ICP.
   (b) Any contributions made by the Trust to the ICP's Control Total were being offset by the financial positions of other providers.
   (c) Therefore, whilst part of the process being developed by NHS E/I, the Trust was focussing on the delivery of its own Control Total.

(2) The delays in the purchase of Kings Park and Bacchus House were due to legal processes taking longer than anticipated and there were no issues of concern.

20/17 PERFORMANCE DASHBOARD AS AT 31ST DECEMBER 2019

The Board received and noted the Performance Dashboard Report as at 31st December 2019.

Further to the discussions at the meeting of the Council of Governors held on 21st November 2019, and noting concerns that the IAPT recovery standard, as included in the NHS Oversight Framework, had not been achieved for some months, Board Members questioned whether the detailed action plan, agreed with Commissioners, included a change to the number of sessions provided to service users, which it was understood had been reduced from 12 to 7, as, if not, there could be a false economy in discharging people only for them to be re-referred.

Mrs. Pickering explained that:

(1) Although a limit of seven sessions appeared to have been applied, the actual agreement allowed for additional sessions to be provided, over and above that number, in response to clinical need.

(2) The average number of sessions provided to service users, before the limit was applied was, on average, eight.
(3) The action plan agreed with Commissioners focussed on reducing waiting times as it was recognised that long waiting times could have a detrimental impact on an individual's recovery.
(4) Whilst limits had been placed on the number of sessions as a means of rebalancing the service, following a period of instability, there had never been an absolute rule that only seven sessions would be allowed.

In response to questions on this matter it was noted that:
(1) The approach had been based on advice received from the Clinical Lead for IAPT and took into account its use by other organisations e.g. Mental Health Matters.
(2) A triage system was used but priority would always be given to the person with the greatest clinical need.
(3) Addressing the number of vacancies and high turnover in the team was a key part of the action plan.

20/18 NHS OVERSIGHT FRAMEWORK

The Board received a report which examined the Trust's positon against the five themes included in the NHS Oversight Framework (NOF) as at Quarter 3, 2019/20.

Mrs. Pickering advised that, in Annex 3 to the report (Leadership and Workforce metrics) the sickness absence rate, as per the Trust assessment (5.61%) was correct and that in the Finance Return (7.96%) was subject to an error.

20/19 NON-EXECUTIVE DIRECTOR MEMBERSHIP OF THE BOARD'S COMMITTEES

On the recommendation of the Chairman it was:

Agreed –
(1) that, with immediate effect, Mr. Murphy be appointed as a member of the Resources Committee in place of Mrs. Richardson; and
(2) that, from 1st April 2020, the Non-Executive Chairmanship and Membership of the Board's Committee and Serious Incident Panels be as set out in Annex 2 attached to these minutes.

Action: Mr. Bellas

20/20 COMPOSITION OF THE COUNCIL OF GOVERNORS

The Board reviewed the organisations eligible to appoint Governors of the Foundation Trust as set out in Annex 4 to the Constitution.

It was noted that, in accordance with the Constitutional change process, any amendments to Annex 4 of the Constitution would also require the approval of the Council of Governors.

The Board:

(1) Whilst noting attendance had been variable, considered that it was crucial for the CCGs to continue to be represented on the Council of Governors; however, it was recognised that Annex 4 to the Constitution would need to be amended to reflect the mergers which were due to come into effect on 1st April 2020.

It was considered that, as a consequence of the change, it would be helpful to write to the CCGs to ask for their Governors to seek an introductory meeting with the Chairman.

Action: Mr. Bellas

(2) Supported the removal of the seat on the Council of Governors for the Northern Specialised Commissioning Group in view of it having been vacant since it was provided and due to the establishment of the New Care Models and Provider Collaboratives.

(3) Considered that the University of Durham should be replaced as an Appointing Organisation by the University of Sunderland in view of the latter's Nursing School and its recently established Medical School.

Board Members also asked for a letter of appreciation to be sent to the Vice-Chancellor of the University of Durham in recognition of its support since the establishment of the Foundation Trust.

Action: Mr. Bellas

Agreed –

(1) that Annex 4 of the Constitution be amended as set out in Annex 3 to these minutes;

(2) that any consequential amendments to the Constitution, arising from the changes under (1) above, be approved; and

(3) that approval of the changes to the Constitution be sought from the Council of Governors.

Action: Mr. Bellas

20/21 USE OF THE TRUST SEAL

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

20/22 DATE OF NEXT MEETING

It was noted that a special meeting of the Board of Directors was due to be held at 9.30am on **Tuesday 25th February 2020** in the Boardroom, West Park Hospital, Darlington.

20/23 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 relating to the financial or business affairs of any particular person (other than the Trust).

The amount of any expenditure proposed to be incurred by the Trust under any particular contract for the acquisition of property or the supply of goods or services.

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.

The meeting adjourned for lunch between 12.25 pm and 1.00 pm.

Mr. Jennings left the meeting during the adjournment.

Following the transaction of the confidential business the meeting concluded at 2.47 pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

County Durham and Darlington

Jennifer Illingworth
Director of Operations

making a difference together

Locality Context

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Changes to leadership team
- Continued development of TAPs and Care Hubs
- Managing TEWV/LA relationship – integrated team reviews
- IAPT and secondary care interface
- Developing Mental Health and Learning Disabilities Partnership
- Right Care Right Place work

making a difference together

Excellent services

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Enhanced focus on Patient Safety and Quality
- Crisis Service for Adults, Older People and Children
- 7-day flow in Adult Mental Health Acute Inpatients
- Talking Changes (IAPT)
- Carers support for Dementia
- Positive Approaches to Care training
- Children's Trailblazers
- Thrive model in Children's Community Services
- Further development of children's ASD
- Learning Disabilities Enhanced Community Infrastructure
- STOMP

To provide excellent services, working with the individual users of our services and their carers to promote recovery and wellbeing

making a difference together

Continuous improvement

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

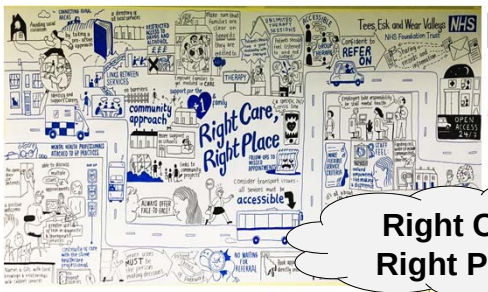
- Physical Health Practitioners Inpatients
- GP Aligned Professionals
- Community Rehab
- Persistent Physical Symptoms (PPS)
- Intermediate Care
- End of Life and Carers support –Namaste project
- Enhanced Community Services for Child LD and/or Autism
- Autism Assessment in AMH
- AHPs in Learning Disability inpatient areas
- Case management work

To continuously improve the quality and value of our work

making a difference together

Continuous improvement

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust



Vision for Durham

Right Care
Right Place

Vision for Darlington

making a difference together

JM1

Workforce

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Recruitment and retention
- Health and Wellbeing of Staff
- Coaching
- AMH and C&YP Community and Access
- Peer support workers
- Support from Organisational Development

To recruit, develop and retain a skilled, compassionate and motivated workforce

making a difference together

Partnership Working

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Durham, Darlington and Teesside NHS Mental Health and Learning Disability Partnership
- Crisis Concordat
- Trailblazers
- Voluntary sector
- Right Care Right Place
- Health and Wellbeing Boards

To have effective partnerships with local, national and international organisations for the benefit of our communities

making a difference together

Well Governed / Resources

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Daily Lean management
- Estate Optimisation
- Supporting independent providers
- Managing impact of H&R bed closures
- Corporate enabling work

To be recognised as an excellent and well governed foundation trust that makes best of its resources for the benefit of our communities

making a difference together

Our key challenges

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Elm Ward

- To ensure that the ward team are delivering safe and effective care and treatment in line with Trust policies and the clinical evidence base
- To ensure the ward is well led and that senior clinical leaders work collectively
- To ensure the processes that staff follow can evidence that the ward is providing safe and effective care
- To ensure we provide staff sufficient support to maintain their wellbeing

making a difference together

JM2

Our key challenges

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

- Acting upon the findings/outcomes of CQC inspection
- Demand/pace of workload plus patient acuity/risk behaviours
- Focus on patient experience, listening to patients/carers and increasing areas of co-production
- Enabling more recovery focused, trauma informed care
- Recruitment and retention
- Achieving Business Plan and CRES
- Compliance with Key Performance Indicators

making a difference together

Last but not least.....!

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

In 2019, John Savage – our Head of Nursing – was one of the first people in the country to receive the Chief Nursing and Chief Midwifery Officer Silver Award.

making a difference together

Questions?

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Annex 2

Non-Executive Director/Associate Non-Executive Director Committee and SUI Panel Membership from 1st April 2020

	Audit Committee	Resources Committee	Mental Health Legislation Committee	Quality Assurance Committee	West Lane Project Committee	SUI Panel
Maximum Number of Non-Executive Director seats (excluding Chair of the Committee and Ex Officio Members)	3	2	2	3	1 (plus 1 Deputy)	-
Miriam Harte		**Ex Officio Member**	**Ex Officio Member**	**Ex Officio Member**		**Ex Officio Member**
Dr. Hugh Griffiths	✓			**Chair**		✓
Prof. Pali Hungin			✓	✓		✓
David Jennings	**Chair**	✓			✓	✓
Paul Murphy	✓	**Chair**				✓
Shirley Richardson				✓	**Chair**	✓
Bev Reilly			**Chair**	✓		✓
John Maddison	✓	✓			**Deputy**	

(Note: All Non-Executive Directors are members of the Board Nomination and Remuneration Committee)

Annex 3

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

(Paragraphs 11.2 and 11.3)

COMPOSITION OF THE COUNCIL OF GOVERNORS		
Constituency		**Number of Governors from 1/4/20**
Public	Stockton-on-Tees	3
	Hartlepool	2
	Darlington	2
	Durham	8
	Middlesbrough	2
	Redcar & Cleveland	2
	Scarborough and Ryedale	3
	Hambleton and Richmondshire	2
	Harrogate and Wetherby	3
	City of York	3
	Selby	2
	Rest of England	1
Staff	Corporate	1
	Forensic	1
	County Durham and Darlington	1
	Teesside	1
	North Yorkshire and York	1
Appointed Governors	Durham County Council	1
	Darlington Borough Council	1
	Hartlepool Borough Council	1
	Stockton-on-Tees Borough Council	1
	Middlesbrough Borough Council	1
	Redcar & Cleveland Borough Council	1
	North Yorkshire County Council	1
	City of York Council	1
	University of Teesside	1*
	University of Sunderland	1*
	University of York	1*
	University of Newcastle	1*
	NHS County Durham CCG	1*
	NHS Tees Valley CCG	1*
	NHS North Yorkshire CCG	1*
	NHS Vale of York CCG	1*
TOTAL		**54**

(Notes:

1 Except for the relevant appointing organisations, the terms of Governors holding office on 1st April 2020 are unaffected by the amendments to the Constitution which come into force on that day.

2 The appointing organisations marked (*) in the above schedule are specified for the purposes of sub-paragraph 9(7) of Schedule 7 for the 2006 Act (as amended).

ITEM NO. 3

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th February 2020**
TITLE:	**Board Action Log**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information/Assurance**

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

Executive Summary:

This report allows the Board to track progress on agreed actions.

Recommendations:

The Board is asked to receive and note this report.

Board of Directors 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

	Minute No.	Action	Owner(s)	Timescale	Status
26/03/2019	19/66	The response from the DWP to the letter highlighting concerns about the impact of benefit cuts on some vulnerable service users to be provided to Governors via the Governor Briefing	AK	-	Timing dependent on the receipt of the response from the DWP
18/07/2019	19/185	Discussions on AHPs and their future role in delivering care to be included in a future nurse staffing report or as part of an update on the Right Staffing Programme to a Board Seminar	EM	Feb-20	See agenda item 10
29/10/2019	19/266	The report on the gender pay gap, to be presented to the Resources Committee, to include a futher analysis of the statistics and details of actions planned by the Trust to close it	DL	Mar-20	
17/12/2019	19/326	To consider undertaking an analysis of the opportunity costs relating to the flu campaign	DL	Apr-20	
28/01/2020	20/03	An update on the outcome of discussions at the planned "away day" held on 6/12/19 to review the Trust's approach to "speaking up" to be included in the next report of the Freedom to Speak Up Guardian	Dewi Williams	May-20	

	Minute No.	Action	Owner(s)	Timescale	Status
28/01/2020	20/03	A note on the EMT's discussions about the provision of an out of hours switchboard for on-call doctors and the level of information on the rota provided to the Tees crisis team to be circulated to Board Members	CM	Mar-20	
28/01/2020	20/06	To note the Board's support for the revised Memorandum of Understanding of the West Yorkshire & Harrogate Partnership	CM	-	To note
28/01/2020	20/08	The Assessor for the forthcoming Investors in People assessment is to be asked to focus on Elm Ward and, in particular, on whether the actions taken to support staff wellbeing have been helpful	DL	Feb-20	Completed
28/01/2020	20/08	Arrangements to be made to enable the representation of corporate services, on the Lanchester Road site, on the CD&D Estates Board	RH (JI)	-	Completed
28/01/2020	20/09	Advice to be provided on the longer term provision of the role of Guardian of Safe Working	AK	Mar-20	
28/01/2020	20/09	The gratitude of the Board, for his work as the Guardian of Safe Working, to be passed on to Dr. Whaley	AK	-	Completed
28/01/2020	20/10	The outcome on the external opinion exercise, in regard to forensic services, to be reported to the Board	RH	Mar-20	
28/01/2020	20/10	A revised version of the Nurse Staffing Report, following changes to its Executive Summary, is to be published on the Trust's website	EM	-	Completed
28/01/2020	20/12	The arrangements for launching the Equality, Diversity and Human Rights Strategy are to be considered by the EMT	CM	Mar-20	
28/01/2020	20/12	To note approval of the Equality, Diversity and Human Rights Strategy	DL	-	To note

	Minute No.	Action	Owner(s)	Timescale	Status
28/01/2020	20/14	The relevant CCGs are to be informed that the Trust supports the engagement report and the engagement response action plan for developing mental health services for adults and older people in Harrogate and Rural District and Wetherby and its surrounding areas	RH	-	Completed
28/01/2020	20/19	To note the changes to the Non-Executive Directors' Chairmanship and Membership of the Board's Committees	PB	-	To note
28/01/2020	20/20	To note the approval of changes to Annex 4 to the Constitution (Composition of the Council of Governors) and consequential amendments	PB	-	Completed
28/01/2020	20/20	The approval of the Council of Governors is to be sought to the changes to Annex 4 of the Constitution (Composition of the Council of Governors) and the consequential amendments agreed by the Board	PB	-	Completed
28/01/2020	20/20	That subject to the joint approval of the amendments to Annex 4 of the Constitution (Composition of the Council of Governors): - The Governors appointed by the CCGs to be asked to attend introductory meetings with the Chairman - A letter of appreciation be sent to the Vice Chancellor of the University of Durham in recognition of its support since the establishment of the Foundation Trust	PB	Mar-20	

ITEM NO 6

PUBLIC

BOARD OF DIRECTORS

DATE:	**Tuesday 25 February 2020**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Colin Martin, Chief Executive**
REPORT FOR:	**Information**

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

Executive Summary:

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.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday 25 February 2020**
TITLE:	**Chief Executive's Report**

1. NHS operational Planning & Contracting Guidance

NHS England and NHS Improvement (NHSE/I) published the operational planning and contracting guidance for 2020/21 on 30 January. This overarching document sets the delivery task for both NHS providers and commissioners for the coming financial year, covering system planning, finances, operational performance, and workforce.

The guidance says:

- Systems are required to improve urgent and emergency care performance next year, cutting acute bed occupancy by expanding bed capacity and providing more community care.
- Elective care waiting lists should be reduced, while 52 week waits for planned care should be eliminated. Performance against cancer standards should also improve. At least 70% of people should receive a cancer diagnosis within 28 days, under a new standard being introduced in 2020/21.
- Half of all financial recovery fund payments will depend on system-wide financial performance.
- A "system by default" model is being introduced to strengthen system working, in preparation for all areas to become integrated care systems by April 2021.
- An additional £1.44bn is to be invested in primary medical and community services, while 100% of the population should have access to online GP consultations.
- In mental health services, improved access to psychological therapies (IAPT) should expand by 14%, while commissioners are again expected to increase the share of their allocation spent on mental health, as required by the mental health investment standard (MHiS).
- In line with the recently published community mental health framework, all providers of community mental health services for adults and older adults should put in place arrangements with local PCNs by March 2021 to work together to organise and deliver services.

National deliverables for people with a learning disability, autism or both include:

- Engagement with emerging provider collaboratives to develop discharge pathways and community alternatives to inpatient provision;
- 8 week visits for all adults and 6 week visits for all children and young people in inpatient settings out of area;
- Establishing arrangements for 'host commissioner' oversight of local inpatient facilities.

2. Financial support for Student Nurses

It was announced in December that all student nurses, as of September 2020, would receive a £5,000 annual maintenance grant that they would not have to pay back. At the time of the announcement, the government said an extra £3,000 per academic year would also be available for students in specialisms or regions struggling to recruit. It has now been confirmed that mental health and learning disability nursing students will receive £1,000 per year from this additional funding allocation.

3. 2019 Staff Survey

The 2019 staff survey results of all trusts, including TEWV, were published by NHS England/Improvement on 18 February. The increase in the TEWV response from 30.5% in 2018 to 45% in 2019 is most welcome. This equates to hearing the views of approximately 1,000 more TEWV staff than last year.

Out of the eleven key themes covered by the survey TEWV results were better than average compared to other mental health and learning disability trusts for three themes (equality, diversity and inclusion, health and wellbeing and bullying and harassment), average for five themes and below average for three themes (quality of appraisals, quality of care and immediate managers). Overall, there is a decline in the results for TEWV in 2019 when compared to 2018 which is concerning and reflects some of the pressures and issues experienced by the Trust in the last year. Whilst the Trust has a number of programmes and actions in place to support staff it is important that the latest results are reviewed to ensure that these plans remain relevant to the needs of staff.

Recently received analysis of the TEWV localities are currently being examined by the Executive Management Team, and the Resources Committee will receive a report including further information and analysis at its meeting on 3 March. The Joint Consultative Committee will also consider the results at its meeting on 7 March.

4. Making a Difference Awards

Next month we will be celebrating the dedication, achievements and successes of our staff, teams and volunteers at our annual Making a Difference Awards.

We received a record 314 nominations this year, highlighting the fantastic work that takes place across this Trust every single day. We also received a record-breaking 2,536 votes for our People's Choice Award. This Award recognises people who have gone the extra mile and the winner voted for by the public. All winners will be announced at the Making a Difference Awards event on Friday 20 March.

5. Achievements and Awards section from Sarah

Paula Swift, Trustwide lead for social work who has been awarded a three year National Institute for Clinical Excellence (NICE) fellowship, starting in April 2020. The purpose of this is to be an ambassador at a regional and national level and to build an influential network that helps NICE implement their guidance. Only 10 of these are awarded a year in England.

Colin Martin
Chief Executive

ITEM NO 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 25 February 2020**
TITLE:	**Assurance report of the Quality Assurance Committee**
REPORT OF:	**Dr Hugh Griffiths, Chairman, Quality Assurance Committee**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to update the Board of Directors on any current areas of concern in relation to quality and to provide assurance on the systems and processes in place.

Assurance statement pertaining to the QuAC formal meeting held on 06 February 2020

The Quality Assurance Committee has consistently reviewed all relevant Trust quality related processes, in line with the Committee's Terms of Reference.
Key matters considered by the Committee were:

- The top concerns for Tees and Durham and Darlington Services
- Compliance with CQC
- Patient Safety
- Safeguarding & Public Protection
- Drug & Therapeutics
- Learning from Inpatient Deaths and Independent Thematic Review of Serious Incidents
- Quality Account Progress Report Q3

Recommendations:

That the Board of Directors:

- Receive and note the report of the Quality Assurance Committee from its meeting held on 06 February 2020.
- Note that the confirmed minutes of the meetings held on 07 November and 05 December 2019 are attached as appendix 1.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday 25 February 2020**
TITLE:	**Assurance report of the Quality Assurance Committee**

1. INTRODUCTION & PURPOSE

The purpose of this report is to advise the Board of Directors of any concerns and exceptions, together with levels of assurance in meeting the CQC fundamental high quality questions.

2. BACKGROUND INFORMATION AND CONTEXT

This report makes reference to the regular assurance and exception reports from the working groups of the Quality Assurance Committee, the localities and compliance with the Care Quality Commission regulatory standards.

3. KEY ISSUES

4 ARE OUR SERVICES WELL LED? *How do we gain assurance from each locality that they have effective systems and processes in place to ensure standards of care, compliance with relevant standards, quality, risk and assurance arrangements?*

4.1 Durham and Darlington Locality

The key concerns highlighted from the locality included:

1. Elm Ward
   An improvement plan will be monitored weekly to address some issues on this 18 bed ward where acuity is high with the support of Organisational Development to focus on collective leadership and accountability. This will be monitored by updates to the EMT through the teams in need of additional support process.

2. Staffing
   A continued issue for the locality is difficulties with recruitment and retention linked to recent MH investment and crisis transformation funding which has created some internal opportunities for existing staff. The impact of internal movement of some staff has meant that only one of nine newly funded vacancies for the crisis team were filled. Elm Ward staffing is of particular concern, however the Consultant Psychiatrist post has recently been filled.

3. Ward environment (Learning Disabilities)
   A review will be undertaken of the environment following significant damage to wards by a patient who is awaiting a medium secure bed and has presented some challenges regarding maintaining safety. The seclusion room in AMH services has also been damaged linked to the same patient. This has reinforced the need to review how robust the infrastructure on some wards is as well as the impact on staff.

Assurance was given to the Committee that resuscitation bags were being checked daily, in line with policy with one exception in November on Roseberry Ward.

There have been no reported episodes of the use of mechanical restraint or tear proof clothing during the reporting period November 2019 to January 2020.

4.2 Tees Locality

The key concerns highlighted from the locality included:

1. High levels of bed occupancy
   This is a concern regarding bed occupancy for adult mental health services and for older people's services. Sickness absence rates, particularly in inpatient services have added to these pressures. It is anticipated that the Trust wide bed management processes and implementation of the Trust bed plan will alleviate some of the difficulties. Heads of service are reviewing the sickness absence with Human Resources to look at any trends.

2. Activity levels in AMH Community Services and CYPS
   A deep dive is underway within the Stockton Affective Team to understand the detail and processes are in place to ensure that all moderate/high risk young people are being seen in a timely way. The matter is also being raised through the Learning Disability Commissioning Group to highlight the capacity gap between budgeted clinical workforce and the national model for HAST CCG.

3. Physical interventions
   Within adult learning disabilities acuity remains high and there has been more use of physical interventions including supine restraint; however the levels did reduce during November and December 2019. Generally however the use of restraint continues to show an improving trend across Tees.

   There were four episodes of tear proof clothing for the reporting period September to December 2019, however there is some discrepancy between reporting and double counting on Paris and Datix, which is being reviewed.

   Assurance was given to the Committee that all resuscitation bags were compliant with the exception of four across two wards. Tees LMGB are following this up to identify improvement actions.

4.3 Compliance with CQC Requirements

The Committee received the monthly update on compliance with CQC registration requirements.

The Board is to note:

- CQC feedback is awaited following the submission of factual accuracy comments by the Trust on the 14 January 2020, following receipt of the draft inspection report.
- All conditions relating to the CAMHS core service inspection at West Lane Hospital have been removed with the exception of, "The Registered Provider must not provide CAMHS (Child and Adolescent MH Services) inpatient services at West Lane Hospital (specifically Westwood, Newberry and Evergreen Centres)".
- Common themes re-occurred following Mental Health Act inspections, including reading patients their rights.
- A Provider Information Request (PIR) was received from the CQC 04 December 2019 for 367, Thornaby Road which is registered with the CQC as an Adult Social Care provider. The Registered Manager was supported by the Head of Service and Locality Manager to complete this return. The submission was completed 10 January 2020. Following review of the PIR by the CQC the service will receive a full unannounced inspection.

- The CQC and Her Majesty's Chief Inspector of Prisons (HMIP) commenced a 2 week inspection on all services at HMP Frankland on 13 January 2020. Verbal feedback appeared to be largely positive.
- In this reporting period there have been 5 CQC MHA inspections.

5 ARE OUR SERVICES SAFE? *Are lessons learned and improvements made when things go wrong?*

5.1 Patient Safety Group

The Committee received an assurance report from the Patient Safety Group and the Patient Safety Report for the period April – September 2019/20.

The key points for the Board to note are:

- Updates were provided on the Patient Safety Bulletin, the Blanket Restriction policy and the Niche Assurance Review and actions that have been completed.
- The issue of ensuring objectivity for Director's Panels will be monitored to prevent any conflict of interest if a member of the panel has clinical responsibility.
- The key performance indicators as at December 2019 showed that compliance around 60 day completion of Serious Incident reports was now at 18% which related to capacity issues within the Patient Safety team and the current volume of serious incidents. Also the complexity of these incidents and the lack of extension requests granted by CCG's. EMT are monitoring this closely. Two additional reviewers have been recruited and training in line with the new proposed safety guidance is taking place in March 2020 which is anticipated will reduce the backlog.
- There were 72 serious incidents reported for the period April to September 2019/20 which is a decrease of 4 on the previous year, with the most common themes being inadequate risk assessment, communication/information sharing and multi-agency working.

5.2 Safeguarding and Public Protection

The Committee received an exception report and the six monthly report for Safeguarding and Public Protection.

The Board is to note:

- There are no exceptions to raise from the 13 serious case reviews for children with five waiting publication, five serious adult reviews, including one to be published for North Yorkshire in the middle of February 2020, five domestic homicide reviews and one MAPPA serious case review.
- Middlesbrough Local Authority has received an inadequate rating from OFSTED in relation to an inspection in December of its children's services. There will be Trust representation on the Multi-agency Improvement Board from the Trust in response to the report.

5.3 Drug & Therapeutics

The Board is to note that the Committee approved the revised terms of reference for the Drug and Therapeutics Committee. The key points discussed were around the process to rationalise medication available through the Trust pharmacies using cost effective substitutes and a full review of safe transfer of prescribing guidance which will discussed at LMGB level as transfer issues are typically locality based rather than specialty.

5.4 Learning from Inpatient Deaths – Independent Thematic Analysis of Serious Incidents

The Committee considered a presentation on Learning from Inpatient Deaths following an independent review.

The Board is to note:

- The Committee received and supported the draft report and recommendations following the commissioned review into a number of unexpected deaths relating to adult/older adult inpatient MH services for the period December 2017 to July 2019
- The independent review did not include the two deaths that occurred at West Lane Hospital as they will be considered in the NHS England investigation.
- Work already undertaken by the Trust in advance of the thematic review included removal of en-suite doors from adult MH and psychiatric intensive care unit wards, assessment of wards for low-lying ligatures with plans in place to provide anti-ligature taps and an updated environmental risk audit for every ward.

- The five recommendations emerging from the thematic review are:

  (1) An assurance review of the effectiveness of the revised risk assessment tool and associated training;
  (2) To include in the clinical audit plan for 2020/21 compliance around policies for clinical observation, physical healthcare and leave;
  (3) Clinical supervisors to include family and carers in the clinical supervision process;
  (4) To Issue a Safety Bulletin to clinical staff around communication;
  (5) Investigating officers to consider compliance with NICE guidelines in respect of prescribed medication as well as staffing levels within the investigatory process.
- The recommendations will be discussed at the Patient Safety Summit on 18 February 2020.

6 ARE OUR SERVICES EFFECTIVE? – Outcomes for people who use services are consistently better than expected when compared with other similar services

6.1 Quality Account Quarter 3

The Board is to note:

- That good progress has been made in terms of the quality metrics with four out of ten reporting as green, which is the same position as Quarter 2.
- The number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) for inpatients has steadily improved over the last two years, with three out of four localities showing green in the quality metric and only North Yorkshire and York slightly missing the target.
- Patients' not feeling safe on the wards in Q3 showed a result of 66% against the target 88%, which the Committee noted was a top priority.
- Caution was expressed by Committee members around reporting conflicting information around "reducing the number of preventable deaths" as "all actions for this priority are currently on track" when there are key recommendations for the Trust to undertake following the independent review into inpatient deaths.

6.2 Trust Risks – Board Assurance Framework

The Committee discussed the risks set out on the Board Assurance Framework (BAF) and considered whether there are any strategic risks around deaths that should be included in the Board

Assurance Framework which are not already covered under the present risks, for example Reputation.

7 IMPLICATIONS

8 Quality

One of the key objectives within the QuAC terms of reference is to provide assurance to the Board of Directors that the organisation is discharging its duty of quality in compliance with section 18 of the Health Act 1999. This is evidenced by the quality assurance and exception reports provided, with key priorities for development and actions around any risks clearly defined.

9 CONCLUSIONS

The Quality Assurance Committee considered the corporate assurance and performance reports during the meeting.

10 RECOMMENDATIONS

That the Board of Directors is asked to:

(i) Note the issues raised at the Quality Assurance Committee meeting held on 06 February 2020.

(ii) Note that the confirmed minutes of the meetings held on 07 November and 05 December 2019 (attached as appendix 1)

Dr Hugh Griffiths
Chairman of Quality Assurance Committee
25 February 2020

Item 1

NOTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 07 NOVEMBER 2019, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Ms Miriam Harte, Chairman of the Trust
Mr Colin Martin, Chief Executive
Dr Hugh Griffiths, Chairman of the Committee
Mrs Shirley Richardson, Non-Executive Director
Dr Pali Hungin, Non-Executive Director
Mrs Bev Reilly, Non-Executive Director
Dr Ahmad Khouja, Medical Director
Mrs Ruth Hill, Chief Operating Officer
Mrs Elizabeth Moody, Director of Nursing & Governance

In attendance:
Mrs Karen Agar, Associate Director of Nursing
Dr Suresh Babu, Deputy Medical Director for Durham and Darlington
Mr Stephen Davison, Lead Nurse, Positive and Safe (for minute 19/154)
Mrs Sharon Pickering, Director of Planning, Performance & Communications (for minute 19/158)
Mrs Jo Nadkarni, Consultant Applied Psychologist, Durham and Darlington
Mrs Emma Haimes, Head of Data Quality & Patient Experience, Nursing and Governance (for minute 19/153)
Mrs Naomi Lonergan, Director of Operations, North Yorkshire
Ms Donna Oliver, Deputy Trust Secretary (Corporate)
Mrs Ann Marshall, Deputy Director of Nursing
Mr John Savage, Head of Nursing, Durham & Darlington (for minute 19/151)
Dr Steve Wright, Deputy Medical Director, NY&Y (for minute 19/155)
Mr Alan Williams, Public Governor – Redcar
Mrs Sarah Theobald, Head of Corporate Performance, Observer

19/148 APOLOGIES FOR ABSENCE

Apologies for absence were received from Mrs Jennifer Illingworth, Director of Quality Governance.

19/149 MINUTES OF THE PREVIOUS MEETINGS

The minutes of the meeting held on 05 September and 03 October 2019 were accepted as a true recording of the discussion and signed by the Chairman, subject to the addition of apologies from Mrs S Richardson, Non-Executive Director to the October 2019 meeting.

A Non-Executive raised the matter of the large volume of information contained in the papers for the Quality Assurance Committee meeting and queried whether the amount of paperwork was really essential.

The Chairman noted that as part of the annual performance assessment for the Committee and ongoing improvements, consideration would be given to increasing the standardisation of reports and seeking to make them more concise would be one of the main focus areas. In particular, the locality reports would be considered and the key pieces of information the Committee requires in order to gain levels of assurance and any matters of exception and concern.

There would be a meeting to take this work forward for key members of the Quality Assurance Committee on 27 November 2019 and Non-Executive Directors were welcome to attend.

19/150 ACTION LOG

The Committee received and noted the QuAC action log.

The following updates were noted:

18/166 Patient Safety Group Report: benchmarking with other Trusts who provide nasogastric feeding and other interventions.
This work would be incorporated into the programme board and model of care project currently underway.

18/170 Report on automated defibrilators.
This matter would be put on hold and discussed again in the New Year due to there being no immediate life support issues.

19/61a Positive and Safe Report: assurance required that the ethnicity of patients receiving restrictive interventions is known and understood so analysis can be undertaken to look at proportionality.
This matter was covered under agenda item number five (minute refers).

19/100 Positive and safe report: to include six month summary position of dashboards.
This matter was covered under agenda item number five (minute 19/refers).

19/100b All localities to include in LMGB reports dashboards with narrative and analysis.
These were now being included into LMGB reports.

Completed

19/112 All localities to review section four of LMGB reports in the covering paper: Implications from CQC standards.
This had been covered under agenda item number three.

Completed

19/114 Scope out for Maple and Elm wards issues in relation to significantly higher levels of self-harm, in order that consideration could be given to any ongoing cultural and leadership issues.

The Director of Nursing advised that some immediate action had been taken to look at the pressures around beds on the wards and this work was being led by the Director of Operations – an update would be brought back to the Committee on the timescales for completion of this work in due course.

Action: Mrs R Hill

19/114b Initiate a deep dive into multiple physical intervention incidents for an individual who is an IP on CYPS. Look at triggers and process and consider whether patients feel safe. Can anything be learned?
The Director of Nursing advised that this matter had now been superseded as it had been in relation to one individual and was now being picked up in terms of a wider programme of work.

Completed

19/136 CQC following a number of patient safety and safeguarding incidents raised across MHSOP – Trust wide to be included as an appendices to the next Patient Safety Report.

Completed

19/138 Tier 4 deep dive report to come through to the Committee next month (November 2019).

19/138b Just Culture Framework – should NEDs be undertaking training around this?
Consideration to be given to SI panels being attended by front line staff?
This was discussed and Non-Executive Directors agreed that this was already covered.

Completed

19/140 Find out the geographical spread of serious case reviews and feed back to Ms Harte.

Completed

19/151 DURHAM AND DARLINGTON LMGB REPORT

The Committee received and noted the Durham and Darlington LMGB Report.

Arising from the report it was highlighted that the top concerns to note were:

(1) The admissions of under 18s to adult mental health beds, (five since mid-September 2019). Work is being undertaken to develop alternatives to Tier 4 admissions including developing the community infrastructure.

(2) Medical recruitment – consultant vacancies, some of which are being covered by locums in MHSOP. CYPS were struggling, temporary cover was being provided however they were still not at full complement. There were difficulties filling the post of Dietician in Adult LD. These pressures were impacting on services.

(3) The impact of West Lane Hospital temporary closure, on the children's services in the locality. This related to the ability to provide safe and effective home treatment for young people within the current resources – this had been escalated to EMT and the locality was committed to supporting the development of the new service model.

Assurance was provided to the Committee that there had been no incidents of the use of tear proof clothing in the period August to October 2019; all resuscitation bags had been checked daily, in line with policy. There had been a single incident of the use of mechanical restraint in LD services due to a patient wanting to use a harness in a vehicle. This had been written into the care plan and the risk assessment for this individual.

Following discussion members:

(a) Requested that the report be amended where it detailed an individual who had suffered a cardiac arrest whilst eating a meal to reflect that this was not a choking incident.

Action: Mr J Savage

(b) Considered that in order to monitor the performance around the impact of the closure of West Lane and under18 year olds being admitted to adult wards that this could be added to the performance wall and managed by the Directors of Operations. Any matters of safeguarding could then be escalated immediately to EMT.

Action: Directors of Operations

19/152 NORTH YORKSHIRE AND YORK LMGB REPORT

The Committee received and noted the North Yorkshire LMGB Report.

Arising from the report it was highlighted that the top concerns to note were:

- Staffing – with issues across nursing and medical staff and prevalent across specialties.
- Access to services and the ongoing pressures in the Memory Service in relation to waiting times, linked with consultant retirements, sickness absences and an increase in referrals from York.
- Inpatient provision and bed management in adult mental health with challenges around recruitment and staff absences, which was impacting on all four crisis home treatment teams. On this matter it was noted that a locality wide approach was in place to maintain Cedar Ward, Harrogate operating with safe staffing levels and this has been discussed at EMT for further support for the ward and to maintain patient safety and quality until the transformation in April/May 2020.

Assurance was provided to the Committee that resuscitation bags had been checked daily in line with policy, there had been no instances of tear proof clothing required and no instances of the use of mechanical restraint.

19/153 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received and noted an update report on Compliance with CQC Registration Requirements.

The following key matters were highlighted from the report:

- Early feedback from the CQC following the core and recent well led inspection had been felt to be largely positive, with the first report due late December or early January 2019 for the Trust to check for accuracy.
- There has been a number of Mental Health Act inspections since August 2019 with a total of 11 wards and areas included, some of which had included some immediate feedback and actions to be picked up around restrictive practices. Themes for these inspections were detailed for the quarter.

Following discussion it was noted that:

(a) Following a MHA inspection to Mandarin forensics IP services it had been found that staff did not appear to understand the concept of long term segregation.
Work around segregation was currently being undertken by the Mental Health Legislation team and future implications around changes to the Code of Practice would be reported through to the Mental Health Legislation Committee to its January 2020 meeting.
(b) A solution to the issue of bathroom doors being removed from en-suite bedrooms for safety reasons would be going to EMT in the coming week.
(c) From the themes and trends identified in the CQC MHA inspections it had been identified that care plans were still the highest issue in the top five themes, however informal feedback from the inspectors had been that they could see evidence of a lot of work that had been done to make improvements.
(d) The recent team inspectors, Mrs Jayne Lightfoot and Mr Chris Watson would be leaving with new inspectors due to take up post and the first engagement meeting would be held with them in the coming weeks.
(e) There was an error in the report detailing the MHA inspections at Harland and Hamsterley ward with repetition around one patient that was “described as “unsteady on her feet” in the notes and had had a fall in her bedroom….”.
This was thought to be a copy and paste error that would be rectified.

Action: Mrs J Illingworth

The Trust continued to maintain full registration with the CQC however with a current condition of registration following the closure of West Lane Hospital.

19/154 POSITIVE AND SAFE UPDATE REPORT

The Committee received and noted the Positive and Safe Update Report.

In introducing the six monthly update Mr Davison highlighted:

- Overall Trust-wide progress had been positive with an improving downward trend in the use of restraint and rapid tranquilisation, evidenced in the review of the dashboard highlights.
- Whilst Durham and Darlington had reported a concerning escalating trend in the use of mechanical restraint in July 2019, this was thought to be due to a reporting issue and linked to police using handcuffs to transport patients to alternative placements or hospital for medical treatment.
- Forensic services had seen significant improving downward trends in the use of both prone and supine restraints.
- Learning disabilities had reported significant increases throughout the reporting period in both restraints and supine restraints.
- York and North Yorkshire were reporting significant reduction in episodes of self-harm.
- An area for further work following a publication by the CQC on their thematic review of restrictive interventions would be to look at the use of segregation in services.
- Overall the use of tear-proof clothing had reduced since escalation processes had been introduced in September 2018.
- Work on segregation would be a key piece of work going forward, as part of the national positive and safe agenda.

Assurance was provided to the Committee that:

(a) There would be opportunities for higher education training in PBS and Restrictive intervention reduction in the future being explored in partnership with CNTW.

(b) Following an action in June 2019, (minute 19/06/19 refers), further consideration had been given to ensuring that patients had equal access to services and that approaches were carried out fairly and consistency across IP settings It had been reported that 67% of patients involved in restrictive interventions were female, 22% male and 10% gender neutral. Of the patients involved 93% were categorised as white with 7% from BAME communities.

Members of the Committee requested that these characteristics be expanded further to include LGBT, however it was acknowledged that this was a complicated area for data collection, however one that would need to be considered.

(i) Non-Executive Directors raised a query around the feasibility study for a pilot of body worn cameras for staff, seeking assurance that the appropriate governance processes would support this.

(ii) The Director of Nursing mentioned the positive evaluation that had been completed by a Trust in West London that had implemented body worn cameras and agreed to share it with members for information.

Action: Mrs E Moody

(iii) The Chief Executive added that the Trust had previously approved the use of a body worn camera in North Yorkshire to reduce violence from a single patient with learning difficulties and to use it as a method of observation and reflection.

(iv) The Chairman welcomed the addition of SPC charts to the report, which demonstrated the positive and safe dashboard position for all areas.

19/155 PATIENT SAFETY GROUP REPORT

The Committee received and noted the Patient Safety Group Report

The key matters highlighted from the report were:

(1) Appointments had been made to recruit a Family Liaison Officer and a Mortality Review Coordinator as part of the actions and gap analysis following the NQB Learning From Deaths guidance.
(2) The patient safety key performance indicator for 72 hour report compliance had been 94% this related to one report and the 60 day report compliance was 38%, this related to 10 reports where extension requests were not being supported by the CCGs.
(3) It was noted that unfortunately at director serious incident panels, which Non-Executive Directors take part in there was not always representation by all CCGs. Verbal feedback had been received that this provided a good level of assurance where attended.
(4) A draft plan 10 step zero suicide plan had been presented to the Group; this focused on the steps outlined in the National Confidential Inquiry (NCI). There were elements around business as usual and a number of outstanding actions due to internal capacity that needed to be taken forward. It was agreed to propose to EMT a suicide prevention lead to take this work.

Following discussion:

(i) Members requested close monitoring of the concerns raised at Bankfields Court around the increased use of restraint, the committee noted the high level of complexity of this group and that there was a new patient that staff had been working positively with. The PBS team would also be doing some additional work with the team at Bankfields Court.
(ii) The Director of Planning and Performance suggested that following the positive feedback from the CQC about the good assurances provided in the MHSOP report on the Governance and Assurance Structure that this should be replicated in other areas and this would be taken to Clinical Leaders for sharing.

Action: Mrs E Moody

19/156 SAFEGUARDING AND PUBLIC PROTECTION EXCEPTION REPORT

The Committee received an exception report for Safeguarding and Public protection,

The following matters were raised:

- There were five cases currently under the LADO, two waiting for the outcome of internal investigations, one waiting for the outcome from the police investigation before it could be taken forward by the Trust and two waiting from the outcome for the police, in relation to a bank member of staff and an agency member of staff. The delays by the Police were being chased.
- There were no exceptions to raise from the 11 serious case reviews for children, 5 serious adult reviews and six domestic homicide reviews.
- Further scrutiny would take place to consider if there were multi agency concerns that may require a multi-agency review following the community patient in Redcar that subsequently died.

Assurance was provided in the report that the Trust was compliant with the safeguarding regulations as set out in Working Together (2018) and the Care Act (2014).

19/157 PATIENT EXPERIENCE GROUP REPORT

The Committee received and noted the assurance report of the Patient Experience Group.

The key matters highlighted from the report were:

- The report had undergone some improvements in terms of demonstrating the key information around complaints and PALs with the use of SPC charts, which members welcomed.
- The performance around complaints, PALS, friends and family test and Triangle of Care for Quarter 2.

Following discussion members raised the following matters:

(i) The increasing number of PALs and how this compared to other Trusts.
On this matter it was noted that a large number of PALS were telephone calls seeking advice and guidance on a variety of queries, including signposting.

It was agreed that it would be helpful to think about other ways of making the advice and signposting available, ie through the Trust Website.
Assurance was provided to the Committee that there was a key performance indicator monitoring this data, however it was something that could be improved.

Assurance was provided that a task and finish group was currently exploring the learning from both complaints and PALS.

(ii) The negative comments recorded around the number of staff available for Q2 which had been 85% as this was the second month where it had been higher than feeling safe (78%).
It was agreed it would be useful to understand this further.

Action: Dr S Wright

19/158 PROGRESS REPORT QUALITY ACCOUNT QUARTER 2

The Committee received and noted the progress report on the Quality Account for Quarter 2.

The main points highlighted from the report were:

(1) Progress in Quarter 2 had been good with 49/56 actions either completed or on track. The most significant delays were for personalised care planning and the transition priorities.
(2) For the quality metrics four out of 10 were green (40%) with six reported as red (60%). Three of those had seen significant improvement from Q1 (the percentage treated with respect, rates of physical restraint/intervention in MHSOP average length of stay). The other three metrics remained static.

19/159 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception raised.

19/160 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no other issues that required escalation.

19/161 ISSUES DISCUSSED THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS

The Committee discussed the risks set out in the Board Assurance Framework (BAF).

The key area considered was the need to ensure that any risks following the closure of West lane Hospital were adequately captured in the BAF, such as potential bed shortages for those patients aged under 18 years.

(The BAF was due to be discussed at the Audit Committee on the 12 December 2019 and then any recommended changes would go to the Board of Directors, at its meeting to be held on 17 December 2019).

19/162 COMMITTEE EVALUATION

Members expressed no concerns around the meeting, agenda and reports.

19/163 ANY OTHER BUSINESS

There was no other business to discuss.

19/164 DATE AND TIME OF NEXT MEETING

The next meeting of the Quality Assurance Committee will be held on Thursday 05 December 2019, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

Item 1

MINUTES OF THE FORMAL MEETING OF THE QUALITY ASSURANCE COMMITTEE, HELD ON 05 DECEMBER 2019, IN THE BOARDROOM, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Dr Hugh Griffiths, Chairman of the Committee
Mrs Shirley Richardson, Non-Executive Director
Mrs Bev Reilly, Non-Executive Director
Dr Ahmad Khouja, Medical Director
Mrs Elizabeth Moody, Director of Nursing & Governance
Mrs Jennifer Illingworth, Director of Quality Governance.

In attendance:
Mrs Karen Agar, Associate Director of Nursing (for minutes 19/174/175)
Dr Pratish Thakkar, Deputy Medical Director for Forensic Services
Mrs Lisa Taylor, Director of Operations, Forensic Services, (for minute 19/168)
Mrs Rachael Weddle, Head of Nursing, Forensic Services, (for minute 19/168)
Mrs Sharon Pickering, Director of Planning, Performance & Communications
Ms Donna Oliver, Deputy Trust Secretary, (Corporate)
Mrs Ann Marshall, Deputy Director of Nursing
Mr Keith Marsden, Public Governor, Scarborough
Professor David Ekers, Clinical Director for Research and Development, (for minute 19/170)
Mrs Helen Cunningham, Health and Safety Manager (for minute 19/178)

19/165 APOLOGIES FOR ABSENCE

Apologies for absence were received from Ms Miriam Harte, Chairman of the Trust, Mr Colin Martin, Chief Executive, Mrs Ruth Hill, Chief Operating Officer and Dr Pali Hungin, Non-Executive Director.

19/166 MINUTES OF THE PREVIOUS MEETINGS

The minutes of the meeting held on 07 November 2019 were deferred to the 06 February 2020 Quality Assurance meeting for approval.

19/167 ACTION LOG

The Committee received and noted the QuAC action log.

The following updates were noted:

19/170 Placing automated defibrillators in non clinical settings.
This matter was discussed and members agreed that due to there being no immediate life support issues this would be placed on hold with a date to be set at the February 2020 meeting.

19/30 Clinical audit and effectiveness report: include in next report further details around red audits and comparisons with previous year.
This matter was covered under agenda item number 14 (minute 19/180 refers).
Completed

19/138 Tier 4 deep dive report to come through to the Committee in November 2019.

This matter was covered under agenda item number 8 (minute 19/173 refers).

Completed

19/151a SPC charts and trends, common variations and themes. Discuss in QuAC review meeting on 27 November 2019.
The Chairman noted that at the meeting held on 27 November members had agreed to hold a coaching day in February 2020 for the Committee and lead Directors to work through any improvements that could be made to the reports and levels of assurance.

Completed

19/151b Add to the EMT performance wall any under 18 year olds admitted to adult wards for monitoring and management by Directors of Operations.

Completed

19/154 Positive and Safe: circulate evaluation conducted by West London on the implementation of body cameras.
This had been circulated following the meeting.

Completed

19/155 Patient Safety Group report: MD to take to Clinical Leaders suggestion to replicate the CQC assurance report written in MHSOP detailing performance of key quality metrics, compliance and a summary of SIs.
This matter was pending for Clinical Leaders in January 2020 and the Medical Director would report back to the 06 February 2019 QuAC meeting.

19/168 FORENSIC LMGB REPORT

The Committee received and noted the Forensic LMGB Report.

Arising from the report it was highlighted that the top concerns were:

(1) Restrictive practice.
A serious incident resulting in a patient death within the service had highlighted some gaps in the consistency of monitoring restricted items. The Trusts Serious Incident Review highlighted a number of areas for learning and both a root and contributory cause.
The root cause was a lack of clarity within the service as to whether there was a blanket restriction relating to the use of plastic bags in patient accessible areas in both low and medium secure services.
The service identified that the restrictive practice processes at service and ward level had a review process for the items listed on the grid in place at the time but that plastic bags were not listed so had therefore not been reviewed. Work was undertaken to ensure that all prohibited / restricted items are identified and consistently recorded and reviewed. Additional actions included the implementation of hourly care rounds.

(2) Staffing.
Ongoing nursing staff pressures continued and all teams within Forensic services were currently completing a staffing establishment review in line with Trust process. Within Health and Justice in HMP Durham, due to the increased level of referrals to the MH team the demand on staff had become unsustainable, having a detrimental impact on wellbeing, leading to difficulties with staff retention and recruitment.
This matter had been raised by the Director of Operations to Commissioners, leading to a bid for additional funding to the National Commissioning Team. The outcome was awaited.
Ongoing work continues to address inpatient staffing pressures.

(3) Substance misuse issues within the low secure rehabilitation ward Newtondale which had resulted in the need for patient transfer to the Acute Hospital where the individual needed intensive care and high dependency intervention. The police have been involved and the incident investigated since medication not prescribed for them had been secreted onto the ward leading to the patient consuming non prescribed medication.

(4) Further work was taking place supported by the Recovery and Outcomes team around feeling supported by staff to feel safe, (average rating of 56%) and do you feel listened to and heard by staff? (average rating of 60%).

(5) There had been 10 uses of soft restraint devices and 20 uses of tear proof clothing during the two month reporting period. Emergency Response Belts and cuffs had been used to transfer a patient to seclusion in one instance, the other nine uses were cuffs only. Of these: Three were to support relocation from one seclusion room to another , three were to support acute hospital transfers, two were to support a service user accessing outdoor space from seclusion and one was for a court escort. Resuscitation equipment had been checked in line with policy and actions taken immediately if any compliance issues.

Non-Executives raised the following:

(1) Additional resources for HMP Durham

An issue had been raised at the recent Board of Directors meeting held on 26 November 2019 around the contract with HMP Durham prison and some additional funding and resourcing.
On this matter it was noted that TEWV would be reviewing the current model of care and staffing levels with a view to looking towards some secondment arrangements.

Assurance was provided that whilst the risk of staffing remained at the current time until people were in post, this was manageable.

(2) External review of Forensic Services

Following some concerns raised by staff through the freedom to speak up guardian, four ward areas in Forensics, Merlin, Jay, Kestrel and Kite would go through an indepdent review, undertaken by Mr David Ashford

Members questioned why it had been felt by the patient that they wanted to express their concerns to the CQC rather than the Trust.
The particular concern from the individual had related to them wanting a stand alone unit, such as that which had been provided to another individual on Eagle Ward, however the two patients had significant differences in their care needs.

(3) The Director of Performance questioned the scoring of risk 225: “There is a strong possibility that some of our service users will seek to ‘spark up’ from the mains electricity supply whilst covertly smoking….”

The Medical Director suggested that this was no longer a risk but an ongoing issue which had to be dealt with in order to reduce the risk of fire and that the risk would be better described with the inclusion of some mitigating actions to show any progress against it.

Action: Mrs L Taylor

19/169 COMPLIANCE WITH CQC REGISTRATION REQUIREMENTS

The Committee received and noted an update report on Compliance with CQC Registration Requirements.

The following key matters were highlighted from the report:

(1) The draft report following the CQC responsive inspection for 2019 would be released to the Trust for factual accuracy by the end of December 2019.
(2) There was an error on page 5 of the report which should have stated Willow Ward, Durham and Darlington, not Forensics.
(3) The themes and trends from the MHA inspections for 2019/20 continued to present frustrating outcomes around the common themes of care plans and section 17 leave forms as the top issues. Getting to the bottom of these would be key for 2020 and would be part of the CQC action plan.

19/170 RESEARCH GOVERNANCE REPORT

The Committee received and noted the Research Governance Report.

In introducing the six monthly update Professor Ekers highlighted:

(1) That there had been two data breaches, once concerning an out of range fridge temperature potentially affecting medication for Alzheimer's disease and the other around the release of personal information linked to a research study.
Assurance was provided to the Committee that these been followed up and actions taken to prevent such matters occurring again.
(2) That there had been recent changes within the Research team and assurance was provide that the governance arrangements around research studies were robust.
(3) Engagement was underway with commercial companies to try to secure further commercial research studies to provide interventional research opportunities to service users.
(4) The consultation process around preparing the next five year Research and Development Strategy would commence in May 2020. A key part of this would be in liaison with the involvement and engagement team and service users, whose contribution was always very helpful.

Following discussion members raised a query around the strategic scorecard which showed metric 3.2 as red: the increase in research funding which is Trust hosted and attracts RCF.
This would be corrected for the next report as the funding had increased for 2020/21 and the scorecard in general, for matters of accuracy would be updated.

Action: Professor D Ekers

19/171 PATIENT SAFETY GROUP REPORT

The Committee received a verbal update on the Patient Safety Group and it was noted that due to unforeseen circumstances the Group had not been able to meet on the usual date. A full report would therefore be provided for the 04 February 2020 Quality Assurance Committee meeting.

19/172 INFECTION, PREVENTION AND CONTROL REPORT, QUARTER 2

The Committee received and noted the Infection, Prevention and Control for Quarter 2.

The key areas highlighted included:

(1) That there had been little feedback from the CQC in terms of IPC issues, which was encouraging.
(2) A further mattress audit would be undertaken in Quarter 3 and the audit tool had been revised to include questions relating to pressure damage as well as breaches in the mattress and cleanliness of pillows and duvets. All areas, would be included.
(3) The IPC environmental audits had revealed some lower scores in relation to community services, Parkside, Billingham and Kilton View, which had failed and a lot of the audit scores reflected out of date, out of use or dirty equipment lying around in different locations. These matters had been escalated to Estates and the head of nursing to address concerns.

Members considered how the problem of old equipment lying around could be improved and the Director of Nursing undertook to discuss this further with the Head of Estates and Faciliites.

Action: Mrs E Moody

19/173 TIER 4 DEEP DIVE SELF HARM REPORT

The Committee received an update report on a piece of work to look at self harm withinTier 4 services.

The following matters were raised:

(1) The report highlighted the levels of self-harm from 1 January 2018 to 31 August 2019 for Tier 4 services and had been provided for the Committee following an action at the 03 October 2019 meeting (action 19/138 refers).
(2) The information provided was around three Teir 4 wards at West Lane Hospital where there had been an average of 206 incidents reported each month.
(3) From September 2018 to March 2019 there had been a significant improvement in the figures, however from April to July 2019 the numbers increased to the highest levels across the reporting period.
(4) Evergreen Ward reported a huge increase in the number of self-harm incidents going up from an average of 53 per month to 232, with the majority of incidents attributed to two patients.
(5) Westwood showed a similar picture with a significant increase in March, which remained high until it reduced in August 2019 when the unit was closed.
(6) A new dashboard was being developed using SPC charts that would include all self-harm incidents in future which would help to identify any statistically significant trends.

Members discussed how it was difficult to pick up problems from the hard data as the information looked quite unremarkable other than the closure of the West Lane Hospital and acknowledged the need to look further into the softer intelligence.

19/174 SAFEGUARDING AND PUBLIC PROTECTION EXCEPTION REPORT

The Committee received and noted the exception monthly report for Safeguarding.

The following key matters were highlighted:

(1) The Trust was involved in 11 serious case reviews, five waiting publication, five serious adult reviews, including a new one for North Yorkshire, six domestic homicide reviews and one MAPPA serious case review.
(2) The previous concern in Redcar regarding a community patient that had died was discussed at the Safeguarding Adult Board in Tees and would now require a multi-agency learning lessons review, rather than a SI review by the Trust and South Tees Hospital.
(3) The new Safeguarding Partnerships could potentially mean that TEWV would be limited in their influencing decisions that could impact on multi-agency working and keeping children safe. These new arrangements would be monitored closely.

Assurance was provided to the Committee that the Trust currently met the safeguarding requirements as set out in the Care Act 2014 and Working Together 2018.

19/175 SAFEGUARDING AND PUBLIC PROTECTION SUB GROUP SIX MONTHLY REPORT

The Committee received and noted the six monthly update report from the Safeguarding and Public Protection Sub Group.

The following key areas were highlighted from the report:

(1) The Intercollegiate documents regarding safeguarding training/competencies had been published for adult and children. A paper would be completed to consider the options for training across the Trust.
(2) The South Tees Children's Hub had been working since June 2019 and the impact of this and other Hub's/MASH would be monitored.
(3) Within the period there had been no specific safeguarding inspections. All areas were preparing for the Joint Targeted area inspections which would focus on mental health and particularly how local services respond to children living with mental ill health.
(4) There had been an 8% increase in the number of contacts with the Safeguarding Adults team between Q3 and 4 of 2019/20, compared to a previous 11% decrease. Future reporting would include activity across the Trust, rather than only contacts with the team.
(5) There had been a 25% increase in the number of contacts with the Safeguarding Children's team, compared to the previous six months.
(6) Safeguarding level three training had increased in compliance by 11% in the six month period with Forensics up to 96%.

Non-Executives raised a query around the allegations against staff which detailed themes including "assault outside of work".

The Associate Director of Nursing for Safeguarding described this as when a member of staff got into an altercation outside of work.

Mrs H Cunningham joined the meeting

19/176 HEALTH, SAFETY, SECURITY AND FIRE GROUP REPORT

The Committee received and noted the six monthly report of the Health, Safety, Security and Fire Group.

Mr David Levy joined the meeting

The key matters highlighted from the report were:

(1) The number of incidents of violence and aggression had gone down from 460 in Q1 to 449 in Q2, however for the same period Q1 and 2 in 2018/19 the total had been 600, compared to 909 in 2019/20. It had been found, after some initial investigation that the increase in numbers could be attributable to a change in practice around reporting incidents, which had led to one incident being reported a number of times if multiple staff were involved.

Members requested that in future reports it would be worthwhile to look at the number of physical assaults against Trust staff in more detail to establish whether the increase was around the client group or multiple reporting and the use of SPC charts would be helpful.

Action: Mrs L Parsons

(2) Of significance was the numbers reported to the police which had gone down from 19 in Q1 to six in Q2.
On this matter it was noted that it was down to individuals to report incidents to the police and EMT had considered how this might be influenced. CNTW Trust had created a post with the role of Police Liaison Officer which was something that TEWV might wish to consider in the future.

Following discussion members raised the numbers of lone working incidents, which was reported as 16 in Q1 and 2 for 2019/20.
It was noted that there was no particular pattern to the reported incidents and none had resulted in injury, however it was agreed that it would provide further assurance to the Committee if further detail was included in future reports.
Mrs Cunningham undertook to include this in the next update.

Action: Mrs L Parsons

19/177 DRUG AND THERAPEUTICS

The Committee received and noted the Drug and Therapeutics Report.

The main points highlighted from the report were:

(1) There had been some significant delays in the procurement process for the new IT dispensing system and the training and build of the system was still underway as it went live.
(2) There were significant issues with the procurement of medicines from the wholesalers in the first two weeks, despite forward planning and this was being resolved.
(3) There were issues with the long term supply of the drug Phenelzine and most if not all patients referred to the Trust had been able to continue treatment using an unlicensed imported supply.

Members acknowledged the impact on delays to medicines during the changes to the new dispensing system and thanked staff for their support.

19/178 CLINICAL RE-AUDIT OF EMERGENCY RESPONSE BAGS

The Committee received and noted the Trust wide clinical audit of emergency Equipment and review of resuscitation Council UK Quality Standards.

The following key issues were noted:

(1) The audit had demonstrated significant practice improvments compared to the previous 2017 Trust wide results.
(2) Any areas of non-compliance had been mitigated with immediate follow up and assurance provided to the Clinical Audit and Effectiveness team.

Following discussion the following was raised.

(1) Standard 9a seemed to lack consistency in the description as sometimes it was referred to as 4:8 and someimtes 4:7. This would be corrected for factual accuracy.
(2) Reference 9a: set of adult and child supraglottic airways had scored 57% in the audit and this would be checked to understand whether this was of any significant concern.
(3) Whether the audit of the emergency response bags should be repeated again and at what interval. On this matter members emphasised the importance of repeat audits as even areas that had scored 100%, such as Forensics could decline in compliance at a later date.
(4) That a further solution to ensuring 100% compliance would be to have the emergency bag sealed to prevent staff dipping into the bag for one off items. This would be given further consideration.

It was agreed that the audit should be repeated on an annual basis and added to the action log for December 2020.

Action: Ms D Oliver

19/179 EQUALITY AND DIVERSITY SIX MONTHLY REPORT

The Committee received and noted the six monthly update report from the Quality, Diversity and Human Rights Steering Group.

The key matters highlighted from the report were:

(1) There had been no key issues of immediate concern that the Group felt should be escalated to the Quality Assurance Committee.
(2) Through monitoring of the key performance indicators the data had shown that the number of incidents around discriminatory behaviour had gone up in the first quarter of 2019/20, however dropped in Q2.
(3) Interpretation services Trust wide would now be provided by Everyday Language Solutions.
(4) A number of themes had emerged following the Chairs meeting with 28 BAME staff and one action that had been identified included raising awareness of the procedure for addressing verbal aggression and local based BAME network meetings would be trialled.
(5) There had been an incident raised as a PALS report around a wheelchair user that could not attend an appointment as they had been unable to access the building. The E&D Steering Group considered that the apppriate information should be included in appointment letters Trust wide asking service users to inform the Trust should they have any access needs.

    Members supported this approach which should be taken to the Operational Management Team.

The Medical Director suggested that within the strategy there could be greater emphasis on meeting the equality and diversity needs of patients.

Mrs S Pickering left the meeting

19/180 CLINICAL AUDIT AND EFFECTIVENESS GROUP REPORT

The Committee received and noted the quarterly report on Clinical Audit and Effectiveness.

The following was highlighted from the report:

(1) The current 2019/20 clinical audit comprogramme was running at 41% complete. A further 21 projects were scheduled for completion beyond March 2020 and the completion rates remained consistently high with a 3.8% improvement on the previous year.
(2) There was a risk around the implementation of NICE guideline 93, LD and Behaviour that Challenges in that there are not enough staff formally traind as PBS 'specialists' in CAMHS and some funding from Health Education England would be pursued.
    On this matter the Director of Nursing advised that the Trust had been working in liaison with CNTW Trust and a course had been approved at Northumbria University where 12 individuals would be trainined to masters level in PBS in order to cascade training in-house. The Trust also had a Nurse Consultant that specialised in PBS.
(3) There was another area of exception in the National Clinical Audit of Anxiety and Depression (NCAAD) standard 13 and standard 9, which related to evidence of HoNOS completion and data collection and all Paris fields would be reviewed and data collectors will undergo further Paris training.

19/181 EXCEPTION REPORTING (LMGBS, QUAC SUB-GROUPS)

There were no matters of exception raised.

19/182 ISSUES DISCUSSED THAT REQUIRE ESCALATION TO THE BOARD

There were no other issues that required escalation.

19/183 ISSUES DISCUSSED THAT MIGHT IMPACT ON THE TRUST'S STRATEGIC OR KEY OPERATIONAL RISKS

The Committee discussed the risks set out in the Board Assurance Framework (BAF) and considered that there was nothing pertaining to the meeting that would affect the current status of the Trust's strategic or key operational risks.

19/184 COMMITTEE EVALUATION

Members expressed no concerns around the meeting, agenda and reports.

19/185 ANY OTHER BUSINESS

Quality Assurance Planning Meeting

The Chairman briefed members on the outcome of a recent meeting held on 27 November 2019.

It had been agreed that there would be a coaching day held some time in February 2020 to work with members of the Committee and lead Directors from the localities and sub groups in order to improve standardisation of report writing and levels of assurance provided to the Committee.

It would also be considered if all the localities should attend each QuAC meeting with either the Director or a nominated deputy to provide greater consistency of information provided Trust wide each month.

19/186 DATE AND TIME OF NEXT MEETING

The next meeting of the Quality Assurance Committee will be held on Thursday 06 February 2020, 2.00pm – 5.00pm in the Board Room, West Park Hospital.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25 February 2020**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

This report is an exception report for the Trust Board, regarding the monthly staffing of in-patient wards across the Trust.

Assurance Statement:

The Trust is meeting its requirements for safe staffing within the current legislative framework as set out in section 2.

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**25 February 2020**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report**

1. INTRODUCTION & PURPOSE:

1.1 This report is to provide a monthly written exception report to the Trust Board to highlight any issues of note or concern.

1.2 This is in addition to the report required by the Board on a six monthly basis. This report refers to January 2020 data.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The monthly reporting of daily staffing levels is a requirement of NHSE and the National Quality Board in order to appraise the Trust Board and the public of staffing levels within inpatient wards.

2.2 The commitments set by the DH response to the Francis Report (Hard Truths, November, 2013 and subsequent update of the NQB guidance in 2016) are for NHS providers to address specific recommendations about nursing staff. The Trust has met these directives as required including the publication of this report and a dedicated web page on nurse staffing. (Nurse staffing - Tees Esk and Wear Valleys NHS Foundation Trust).

3. EXCEPTIONS

3.1 Staffing related to inpatient units have been coordinated during January, through the participation of inpatient services in daily huddles to review and understand staffing levels across sites and specialties. This has allowed for the staffing resource to be used in the most effective way to ensure high quality, patient centred care continues to be delivered safely across all inpatient units.

3.2 Themes remain consistent with previous issues that the Board have been appraised of with planned staffing not always met due to sickness, vacancies and high levels of patient acuity.

3.3 Where green fill rates were not achieved, patient safety on in-patient wards was maintained by nurses working additional unplanned hours, staff cross covering across wards, temporary staffing, the multi-disciplinary team and ward manager supporting nursing staff in the delivery of planned care and patient care being prioritised over non-direct care activities. Specific exceptions where safety concerns have arisen have been reported through Datix and escalated through operational management to action.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

There are a number of areas that have had high levels of clinical activity necessitating increased observation and engagement levels with patients in addition to sickness and vacancies. This has resulted in difficulties in some wards meeting their planned staffing levels particularly with regard to registered nursing staff fill rates on days. In some ward areas this has resulted in high levels of agency and bank HCA's. This issue has been highlighted as a concern by the CQC in our recent inspection report and poses a risk to compliance under the safe domain.

4.2 Financial/Value for Money:

It has been identified that there is little spare capacity in nursing establishments as they have been planned for maximum efficiency – it is therefore implied that the workforce deployment needs closer scrutiny to ensure those efficiencies do not constitute risks. This work is being progressed and will be a feature of this financial year's Right Staffing work stream referred to above.

4.3 Legal and Constitutional (including the NHS Constitution):

The Care Quality Commission and NHS England have set regulatory and contractual requirements that the Trust ensures adequate and appropriate staffing levels and skill mix to deliver safe and effective care. Inadequate staffing can result in non-compliance action and contractual breach.

The March 2013 NHS England and CQC directives set out specific requirements that will be checked through inspection and contractual monitoring as they are also included in standard commissioning contracts. The Trust has complied with these directives to date. The 2016 NQB guidance has also been taken into account in the Trust approach

4.4 Equality and Diversity:

Ensuring that patients have equal access to services means staffing levels should be appropriate to demand and clinical requirements.

4.5 Other implications:

From the data presented it is essential that a consistent reporting framework is maintained in particular the assigning of severity ratings.

5. RISKS:

5.1 Safe staffing and the risks regarding the Trusts ability to meet planned staffing levels on a daily basis have been escalated to the Trust Risk Register. Risks are managed and mitigated through operational services and the work being undertaken as highlighted within the Right Staffing work streams.

6. CONCLUSIONS:

6.1 The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments and continues to develop the data collation and analysis to monitor the impact of nurse staffing on patient safety, clinical effectiveness and experience.

7. RECOMMENDATIONS:

7.1 That the Board of Directors notes the exception report and the issues raised within the attached Safe Staffing Report for further investigation and development.

Emma Haimes
Head of Quality Data and Patient Experience
February 2020

Appendix 1

Safe Staffing Report – January 2020:

Safe Staffing
February Report usin

Safe Staffing – January 2020

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

"To be a compassionate, fair and just organisation where all staff want to work and excel and where patients have choice and confidence in working with the right staff having the right skills at the right place and time to receive outstanding care and treatment".

Six workstreams exist to provide a framework to support the implementation of the Right Staffing Programme - based on the NQB Guidance

Safe Staffing Fill Rates January 2020:

- The number of rosters equated to 63 inpatient wards in January.
- The highest number of red fill rate indicators relate to Registered Nurses on day shifts. This equated to 23 in January 2020, which is the same as December 2019.
- The top 3 inpatient areas where a low staffing fill rate has been reported are:
  - Jay Ward (FMH) – 68.4% RN on Days – the low fill rate was due to shifts not been filled by bank (unfilled shifts in relation to maternity, sickness and a vacancy)
  - Lustrum Vale (AMH) – 71.8% RN on Days – the low fill rate is in relation to the transition from Kirkdale to Lustrum Vale.
  - Harrier/Hawk (FLD) – 73.2% RN on Days – the low fill rate was due to sickness, maternity and vacancies.
- There were 63 fill rate indicators that had staffing in excess of their planned requirements to address specific nursing issues.
- The top 3 inpatient areas where a high staffing fill rate has been reported are:
  - Westerdale South (MHSOP) – 477.5% HCA on Nights and 310.5% HCA on Days - the increase was due to high levels of bank/agency to enable enough staffing to implement the Zonal Engagement Model of Care. The ward are currently recruiting (16 appointed in July of which 9 are in post).
  - Bedale (AMH) – 256.2 HCA on Nights and 175.2% HCA on Days – the high fill rates are in relation to seclusion, continuous observations of 1 patient; and high acuity.
  - Springwood (MHSOP) – 246.8% HCA on Nights and 168.8% HCA on Days – the increased staffing was necessary to meet the needs of 3 patients on 1:1 observations. All patients require a level of support with personal care.

Bank Usage:

- Bank usage across the trust equated to 20% in January, which is an increase of 0.7% when compared to December.
- Eagle (enhanced single occupancy care package) FLD had a bank usage rate of 88% of the actual hours worked in January and were the highest users of bank. This relates to the agreed package of care provided.
- There were 19 wards that reported greater than 25% bank usage.

Agency Usage:

- The agency usage across the trust equated to 6.7% in January, which is a decrease of 0.9% when compared to December.
- Meadowfields remains the highest user of agency (153 shifts) followed by Westerdale South.
- Rowan Ward (MHSOP) requested the highest agency shifts in January equating to 35% of the total hours worked.
- Cedar (NY) has reduced to below 100 shifts for the first time.
- Bedale (PICU) agency demand has doubled.
- All shifts used were below cap.
- HCA spend accounts for 78% of total monthly spend however following the transition to cluster rates for HCA supply, a reduction of £57k spend in January with a 13% average saving on HCA shifts.
- Those wards reporting 4% or more agency usage in January equated to 17 wards.

Missed Breaks:

- There were 373 shifts in January where an unpaid break had not been taken. This is an

Produced: 14th February 2020

The purpose of this document is to present to the Board by 'exception' the monthly safe staffing information as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review). This report refers to July 2019 data.

increase of 37 shifts when compared to December 2019.

- 306 shifts where breaks were not taken were attributable to day shifts; and 67 attributable to night shifts.
- A breakdown by locality is as follows:
  - Teesside = 110 shifts with no breaks (Bedale had the highest with 29)
  - Forensics = 139 shifts with no breaks (Northdale had the highest with 33 shifts)
  - Durham & Darlington = 78 shifts with no breaks (Farnham had the highest with 20 shifts)
- North Yorkshire & York = 46 shifts with no breaks (Minster had the highest with 9 shifts)
- This information is being monitored daily as part of the operational services huddle process.

Incidents Raised Citing Staffing Levels:

There were 24 incidents reported in January 2020 citing issues with staffing covering both inpatient and community services. The majority were received from Secure Inpatient Services.

Issues reported were as follows:

- Staff feeling unsafe due to staffing shortages and mix of temporary staffing
- Difficulties in carrying out planned care
- Lack of staff available to respond in emergency
- The incident forms are reviewed by Heads of Nursing on a monthly basis to identify themes and provide assurance that relevant action has been taken to minimise associated risks.

Severity Rating:

- Using a severity rating scale to identify potential outliers, the top 5 is as follows:
  - Bedale – 12 points awarded
  - Westerdale South – 8 points awarded
  - Sandpiper – 8 points awarded
  - Birch Ward – 8 points awarded
  - Rowan Ward – 8 points awarded
- Using the YTD score (January 2019 to January 2020) the following appear in the top 5:
  - Elm Ward – 107 points awarded
  - Westerdale South – 95 points awarded
  - Birch Ward – 93 points awarded
  - Bedale Ward – 90 points awarded
  - Rowan Ward – 89 points awarded
- Care Hours per Patient Day
  Using standard deviation (January 19 to January 20) the following appear as positive outliers:
  - The Lodge – registered nurses
  - Jay Ward – registered nurses

Conclusion:

- The Trust continues to comply with the requirements of NHS England and the CQC in relation to the Hard Truths commitments.
- Staffing pressures remain across Forensic Services and demand for temporary staffing is high particularly across MHSOP wards in relation to vacancies and clinical activity.
- Pressures are managed operationally on a daily basis through daily huddles and the use of temporary staffing to minimise risks to patient safety and quality. Escalation of staffing concerns is actively encouraged in order to identify themes and address patterns of concern.
- The trust-wide establishment review aims to highlight areas where staffing shortfalls or skill mix is impacting on the delivery of care and may need to be addressed more strategically.

Key links to documents & guidelines:

Monthly and Daily Staffing Report – January 2020

NQB Guidance July 2016

For more information on the content of this report please contact elizabeth.moody1@nhs.net

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 10

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**Tuesday, 25 February 2020**
TITLE:	**Annual Staffing Establishment Review**
REPORT OF:	**Elizabeth Moody, Executive Director of Nursing & Governance**
REPORT FOR:	**Information**

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

Executive Summary:

This report details the outputs and key findings from the Trusts annual staffing establishment review undertaken across inpatient and community services.

The Trust has used the inpatient Mental Health Optimum Staffing Tool (MHOST) to provide an evidence base with which to triangulate workforce data and professional judgement discussion. The initial ward results are viewed alongside aligned benchmarked results to support validation and verification. The report highlights that acuity scores aligned to the national benchmarking values can be considered as a minimum standard or reference point until there is sufficient assurance that the ward's data on its own is sufficiently robust.

Whilst it is useful to remember it is a tool that supports professional judgement of staffing requirements, the analysis from the MHOST results has highlighted key areas for the Trust to consider, which include:

- Registered Practitioner to Support Worker ratios are significantly below national benchmark figures. The Trust will need to consider its approach to addressing this particular area of concern.
- Areas that show results from MHOST indicating that the ward is overstaffed require further exploration before making decisions based upon these results; particularly so for SIS LSU, Rehab and MHSOP wards.

- AMH Durham and Darlington and Teesside wards and benchmark results show a staffing short fall when comparing recommend staffing against budgeted staffing.
- Eating Disorders (Birch Ward) shows a staffing short fall when comparing recommend staffing against budgeted staffing, with consistent results in ward and benchmark data.
- Secure Inpatient Services (SIS) MSU ward and benchmark results show a staffing short fall on Linnet, Mandarin and Nightingale wards when comparing recommended staffing against budgeted staffing.
- MHSOP ward and benchmark results show a staffing short fall on Cherry Tree and Westerdale North (functional MHSOP wards) when comparing recommended staffing against budgeted staffing.

An evidence based tool is still required for community teams to support analysis. The current pilot will be evaluated and consideration will be given to roll out to all community teams. The aim is to achieve the same level of detail regarding staffing in the community as that of the inpatient wards.

The areas of concern and issues taken from the ward and team manager reports will be communicated and discussed with the relevant programmes, workstreams and services to consider how these issues may be progressed.

Recommendations:

- For EMT to consider the report and agree further actions required in relation to staffing resources and mitigation of key issues raised.

MEETING OF:	**Board of Directors**
DATE:	**Tuesday, 25 February 2020**
TITLE:	**Report following the Trusts annual Staffing Establishment Review**

1. INTRODUCTION:

1.1. The delivery of safe, high quality care to achieve the best possible patient outcomes is dependent upon having the "right staff with the right skills in the right place and at the right time. Effective workforce planning and deployment of staff is critical to this process. This also needs to be realistically affordable, and so we can extend our statement to include "at the right cost and on the right contract" to deliver the short and long term objectives both of the Trust and the NHS. Developing Workforce Safeguards (DWS) (2018) specifically looks at workforce planning and deployment across all staff groups to support NHS organisations in achieving safe staffing within each NHS Trust.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1. The National Quality Board (NQB) (2016, 2018) defined a set of guidelines to support recommendations set out in the Francis report (2013) and Hard Truths Report (2014) by providing a set of expectations to deliver "safe, effective, caring responsive and well led care". DWS builds upon these guidelines and provides a set of recommendations required to be formally delivered upon by NHS Trust Boards, where it set out to ensure a consistent approach to safe staffing by describing good practice for:

- Effective workforce planning
- Deployment of staff by using evidence based tools
- Governance considerations when redesigning roles/skills mix

2.2. Responsibilities are clearly laid out and will support defining the local Trust picture against a standardised set of requirements to determine a true picture of the workforce status and achieve the assurance of achieving a safe and effective workforce.

2.3. The Trust will be assessed for compliance against the DWS framework of best practice via the Single Oversight Framework assessment and annual governance statement whereby Trusts must formally ensure NQB's 2016 guidance is embedded; this will also achieve compliance with other regulatory and advisory bodies such at the CQC and NICE.

3. PURPOSE

3.1. The purpose of this report is to present an update to the Trust Board on the Trust wide establishment review process, including the data collection of acuity and dependency assessment scores of the Mental Health Optimal Staffing Tool (MHOST), and the respective outcomes and results; this will work towards to achieving this goal.

Staffing establishment reviews within the Trust have mostly been on an as required basis following planned service changes, escalation of issues, and the ongoing processes of local and trust wide governance and assurance reporting.

3.2. The aims of the annual evidence based staffing establishment review process are to:

- Strengthen assurance and accountability for safe, sustainable and productive staffing across all staff groups in the delivery of high quality care
- Promote a consistent, systematic and proactive approach to staffing decisions which supports CQC fundamental standards
- Improve governance processes from ward to board regarding workforce and staffing
- Increase staff awareness, engagement and participation in workforce solutions
- Support stronger Board engagement with workforce challenges and issues
- Ensure compliance with NHSE/I requirements
- Improve staff welfare, morale and well being
- Support a reduction in temporary staffing usage, particularly the use of agency staff.

3.3. The methodology and approach to implementing the review process is summarised in Appendix 1, together with the background and details regarding the evidence based tool used – the Mental Health Optimal Staffing Tool (MHOST).

4. SERVICE REPORTS

4.1. There were 256 clinical teams involved in the Trust establishment review process, 196 community teams (77%) and 60 inpatient teams (23%). Of these 256, 186 ward and team managers were required to complete a report on the standard format; this form had been pre-populated with key workforce and patient related data identified during the Kaizen events, for managers to add context to the data and provide professional judgement discussion regarding their teams ability to deliver safe and high quality care and provide a RAG rating accordingly.

4.2. The remaining 70 teams were assessed by professional judgement discussion only, by the team and the clinical reference group which included the Head of Service and Clinical Director; the rationale of approach for these 70 teams may be predicated

upon the amount or significance of specific workforce data for a team with very small number of staff in the team, for example. All teams are referenced in the Service Reports below with exception of IAPT (Trust wide), Durham & Darlington Perinatal and Teesside Perinatal were it was agreed they would not be in scope for this initial exercise.

4.3. These reports were provided to respective Heads of Service to compile a summary service level report to be presented at QuAG, then to be added to with feedback from SDG/SDM and LMGB. RAG ratings had the potential to be updated along by Head of Service, QuAG or LMGB as appropriate, whilst retaining the original team manager rating.

4.4. All locality and speciality reports, providing drill down access to the individual team/ward manager reports, are available in Appendix 2.

5. KEY FINDINGS

5.1. Data collection was done via Right Staffing from central sources (IIC, Health Roster and Quality Data) to reduce the burden upon the teams; issues encountered related mainly to split coding of teams on ESR and naming conventions; the main issue being that cost centres were used to drive the reports which subsequently led to issues as staff were not always aligned to cost centres, or sit across multiple teams but provide care, and so skewed the figures. Feedback indicated that some elements of the data were not correct, e.g. average caseload per WTE from IIC included non-clinical staff as well as clinical and therefore provided incorrect results. There were some further challenges faced in data alignment and the impact of recent service changes hindered the ability to review the previous 6 months data.

5.2. The final team RAG ratings from the establishment reviews are shown in Appendix 3, which are summarised in Table 1a; 77% of the teams reviewed are community based teams; 8% of community teams and 1.9% of inpatient teams have RAG rated themselves as Red and Amber/Red, roughly proportional to the ratio of community teams to inpatient teams.

	Red	Amber Red	Amber	Amber Green	Green
Community	3.8%	4.2%	18.2%	17.0%	34.1%
Inpatient	0.4%	1.5%	4.9%	10.2%	5.7%
Total	4.2%	5.7%	23.1%	27.3%	39.8%

Table 1a: Distribution of RAG rating over all clinical teams

5.3. Table 1b shows the RAG rating criteria used, and Table 1c highlights the teams that rated themselves as Red and Amber Red, with updated actions and mitigations.

RED	RED / AMBER	AMBER	AMBER / GREEN	GREEN
Not Safe Major adjustment required Not Safe and poor quality	**Partially Safe** Significant adjustment required Partially Safe and concerns about quality	**Safe** Although moderate adjustments required Safe and Satisfactory quality	**Safe** Although minor adjustments required Safe and good quality	**Safe** No changes required Safe and High quality

Table 1b: RAG rating criteria

IP / CMHT	Loc	Spec	Team	RAG Oct 2019	Actions and mitigations - Feb 2020
InPt	D&D	AMH	Elm Ward	**Red**	Action plan in place. There has been a reduction in incidents linked to discharge of one patient however concerns remain around how they manage EUPD presentations – there is work aligned to the action plan to look at the model and intervention provided to this client group.
CMHT	D&D	AMH	Easington Access	**Red**	RPIW and Single Point Of Access model to address issues – this will be operational by March 2020.
CMHT	D&D	AMH	Tertiary Pyschosis	**Red**	20/21 service plan addressing requirements. An identified piece of work aligned to the business plan to review the function/need of the team current thinking is that the resource needs to be embedded in the teams.
CMHT	NYY	AMH	Scarborough Community	**Red**	Have been without Psychology post for close to a year, post now recruited to, commenced Feb 2020. NYCC funding removed for dual diagnosis, however locality actions from the Trust have been able to maintain level of funding into team for the short term; post remains at risk. Still require additional means to secure a B6 nurse. NYCC have secured funding for B7 homeless worker to support for 12month secondment – just about to going into recruitment process.
CMHT	NYY	AMH	Ham & Rich EIP	**Red**	Commitment of £300k funding from CCG for next financial year, however still a shortfall of ~£600k of required amount. Mental Health Investment funding paper has returned to CCG this week to identify where spending is being directed. As a result the service is to be measured against Level 2 of the National Quality Standards as opposed to the current Level 3 requirements. Service remains vulnerable, locally trying to increase support worker capacity.
CMHT	NYY	AMH	SWR EIP	**Red**	
CMHT	NYY	AMH	NY Eating Disorder	**Red**	Needs decision how Eating Decisions will be funded going forward. This is documented as part of the Mental Health Investment funding paper – discussions with commissioners, however no decision regarding a funding or how this will be addressed – requires further discussions at the earliest opportunity
CMHT	NYY	AMH	York Eating Disorders	**Red**	

CMHT	NYY	CYPS	York Community	**Red**	The Trust has agreed to implement an intensive support plan into these CAMHS services following an external review by Meridian, a Productivity Company. The findings from the Meridian report illustrated the need for dedicated KPO, Management and Leadership support to work within a project management framework to address the capacity and demand issues and ensure all resources are utilised to maximum benefit for patient care.
CMHT	NYY	CYPS	Scarborough ADHD	**Red**	
CMHT	NYY	CYPS	York & Selby Community	**Red**	
CMHT	NYY	CYPS	Scarborough CAMHS	**Amber Red**	
CMHT	D&D	CYPS	South Durham Tier 3	**Amber Red**	Tier 2 & Tier 3 teams are functioning as one team/new model of working. Current and persistent escalated issues with PARIS data in aligning the teams continue to remain; this prevents the ability to use data to inform and support the effective and optimal delivery of care. Recruitment remains an issue, high level of internal churn from summer 2019 which is impacting upon sickness levels; high numbers on caseloads, waiting referrals and hidden "waiters. Ongoing mitigating actions include recruitment drives, QIS event June 2020, further escalation of data issues.
CMHT	D&D	CYPS	South Durham Tier 2	**Amber Red**	
InPt	Tees	AMH	Kirkdale	**Amber Red**	Issues now resolved with ward closure. Previous issues related to staff transitions.
InPt	Tees	AMH	Lustrum Vale	**Amber Red**	Issues now improved due to transitioning staff from Kirkdale into ward team, no immediate or significant concerns.
CMHT	Tees	AMH	Middlesbrough Access	**Amber Red**	Increased staffing resource into team alleviating pressures. Indications are that the situation has improved. Identified planned ongoing actions to mitigate risks remain on track.
CMHT	Tees	AMH	Middlesbrough Affective	**Amber Red**	Easing of pressure on Middlesbrough Access team resulting in a positive impact on the pressures experienced in the Affective team as the two teams work closely together. Indications are that the situation has improved. Identified planned ongoing actions to mitigate risks remain on track.
InPt	Tees	MHSOP	Westerdale South	**Amber Red**	Zonal Engagement pilot underway; feedback positive, reduction in falls noted. Full recruitment to required posts expected end of March 2020. Expectations to reflect as green RAG rating once achieved – this is mitigating previous highlighted concerns.
CMHT	Tees	MHSOP	North Tees Liaison Psychiatry	**Amber Red**	Introducing health roster – recent review of shift patterns has enabled increased and better use of current resources; this new roster model to be in place 01/04/20. Bid placed to secure additional funding to increase staffing levels; decision expected Feb/March 2020.
CMHT	Tees	MHSOP	South Tees Liaison Psychiatry	**Amber Red**	Introducing health roster – recent review of shift patterns has enabled increased and better use of current resources; this new roster model to be in place 01/04/20. Bid placed to secure additional funding to increase staffing levels; decision expected Feb/March 2020.
CMHT	Tees	MHSOP	Tees Intensive Community Liaison	**Amber Red**	Initial concerns re staffing levels and caseload size - referral rates and caseloads have reduced dramatically in recent months since establishment review. Hold placed on increasing staffing as current staffing levels now sufficient with new reduced caseload & referral rates - to be monitored across the coming months for changes. All current risks are mitigated by internal plans; longer term plans include ongoing work with RCRP review of overall care support and provision

CMHT	NYY	LD	York Medics	**Amber Red**	Issues and risks reported to still remain with recruiting to substantive consultant post. Recent anticipated appointment of consultant failed, applicant declined 2 days before agreed take up of post. Locum currently providing cover who has stated commitment until the end of year, however risk remains with the potential of short notice nature of locum posts. Post currently out to advert again; also recruiting to a B4 Associate Practitioner post to support with clinic A&C work and follow ups; additionally NMP providing support into the teams where required, local actions mitigating risks at this current time.
InPt	NYY	MHSOP	Rowan Lea	**Amber Red**	Difficulties in recruiting to vacant posts, impacted by difficulties within recruitment process. Reliance upon temporary staffing increasing demand upon substantive staff. Head of Nursing and recruitment team taking lead in support; recruitment fairs being organised. Improving roster efficiencies work underway to maximise utilisation of current resources. Seeking to recruit above budgeted establishment to maintain required establishment for full bed occupancy.
CMHT	NYY	CYPS	Eating Disorders	**Amber Red**	Awaiting the release of the agreed funding from the New Models of Care programme. It is anticipated this will be made available from April 2020. Once recruited to, the service rating will be reviewed.
CMHT	H&J	H&J	HMP Durham	**Amber Red**	High demands from referrals and high prison transfer rates placing extra strain on staffing resources resulting in increased staff turnover and sickness due to work related stress. The current situation is reported to be slowly deteriorating. New approach to triage and ways of working developed, but unable to deploy until sufficient staffing numbers are in post. Issues continue with recruitment and retention; forensic wide task and finish group set up to focus and address recruitment issues, to include working closely with recruitment team. Issues with progressing staff through recruitment highlighted. Issues escalated, within Trust and National H&J; additional funding for staffing resource allocated; just appointed experienced advanced practitioner, exploring development of evidence based tool to asses demand and capacity.

Table 1c: Teams with RAG ratings of Red or Amber/Red

5.4. Locality perspectives/issues as highlighted from Service Reports (Appendix 2)

5.4.1. Durham and Darlington

- Increased use of flexible staffing to manage higher levels of patient acuity
- Waiting times standards and assessment to treatment targets due to capacity within community teams.
- Medical staffing recruitment for both inpatient and community services
- High demand on access and community services resulting in high caseloads; inconsistencies across access teams in relation to caseload numbers.

5.4.2. North Yorkshire and York

- Recruitment and retention and high staff turnover - high use of agency
- Medical staffing - use of locums
- The strength of clinical and managerial leadership,

- The impact of service changes in locality and out of locality, and uncertainty for staff,
- Community teams cover large geographical areas impacting upon their visits
- Access to Psychological Professions or Allied Health Professions.

5.4.3. Teesside

- Increased level of complexity and acuity.
- Recruitment and retention of staff remains a challenge across all services.
- Access and availability of Allied Health and psychological services across services
- Staffing capacity and demand for the community teams.
- Inappropriate referrals into specialist community CAMHS and bottlenecks in the patient journey which has an impact on access to the most appropriate pathway and evidence based interventions.
- Service changes

5.4.4. Forensic Services

- Little room for fluctuation in staff attendance/availability, which then requires the use of bank staff to cover the shortfall. Reliance on additional hours from Bank nurses and to a much lesser degree overtime.
- The national Transforming Care Agenda impact on inpatient services for people with a Learning Disability and or Autism. The continued drive to reduce beds and length of stay
- Maternity leave and adjustments for expectant mothers along with a consistently large group of staff who for physical health reasons, cannot meet the physical requirements of working on a secure unit.
- The Medical Staffing team, Physical Healthcare Team, Psychological professions, and Allied Health Professions not currently aligned to ward based budgets.
- Occupational Therapy and Psychology teams are currently undergoing comprehensive reviews which will determine their future staffing requirements.

5.5. MHOST results were collected from 57 inpatient wards in the data collection period; day units, wards undergoing closure, and a single patient ward were not part of the exercise this time. A further 8 wards were excluded from the MHOST analysis at this time due to small ward issues as detailed in Appendix 1. The resultant acuity profile for each ward, showing the total daily average acuity and dependency scores, is presented in the following linked document (**ward acuity score graphs**) alongside the national benchmark scores taken from the 320 participating wards in the tool development. Also shown is an adjusted benchmark score which has been pro rata'ed to align with the ward's patient numbers for easier comparison.

5.6. The linked document (**speciality acuity scores**) shows ward acuity profiles according to speciality and patient mix on the ward i.e. male, female or mixed sex.

The ward scores have each been scaled upwards on a pro rata basis to align to the national benchmark to allow for relative comparison across the wards.

5.7. Comparing the shape of the curve against the national benchmark provides an indication of scoring against the national benchmark data. A curve skewed left of the national benchmark will provide a lower recommended value of staffing required; conversely a curve skewed to the right of the benchmark score will deliver a higher recommended staffing number. Whilst it is quite legitimate to deviate from the national norm, we would want to explore with the teams why this might be.

5.8. Table 2 provides a summary of the variances from the contracted and actual FTEs from budgeted FTEs.

Locality	Contracted FTE less Budget FTE	Actual FTE less Budget FTE
D&D		
AMH	-1.11	10.41
ED	-4.26	1.33
LD A&T	0.01	4.68
LSU/Rehab	-2.08	0.80
MHSOP	4.04	0.48
PICU	-3.79	1.31
D&D Total	-7.19	19.02
NYY		
AMH	-21.50	6.37
LD A&T	-2.94	3.55
MHSOP	-11.70	25.56
NYY Total	-36.14	35.49
SIS		
LSU/Rehab	-19.07	-5.49
MSU	-24.34	-0.82
SIS Total	-43.41	-6.30
Tees		
AMH	-5.35	0.42
CAMHS	-0.13	0.46
LD A&T	-6.35	-0.62
LSU/Rehab	-11.52	2.57
MHSOP	-1.81	15.72
PICU	-3.37	6.14
Tees Total	-28.53	24.69
Grand Total	-115.27	72.89

Table 2 – Inpatient FTEs for All specialities across all localities (for 49 wards included in MHOST analysis)

5.9. The actual FTE worked in excess of the current budgeted establishment at September 2019 was ~73 FTEs; factors may include, but are not limited to additional cover requirements for patient needs, and inefficient rostering. The difference between actual staffing used and staff in post was ~155 FTEs; therefore it can be stated that temporary staffing and overtime used to meet the shortfall of staff in post to that actually used, has amounted to the equivalent 188 FTEs (i.e. the amount of staff to cover the shortfall of staff due to vacancies plus the staff required to cover additional requirements). Effective roster practice will have a positive influence in this area to make the best use of available staffing resources.

5.10. The 115 FTEs figure is the aggregated value of actual vacancies against the number of staff that have been employed above the current ward budget, i.e. a staffing over-establishment. This is detailed further in Table 3 which shows the vacancy and over-

established position split by Registered Practitioner (RP) and Support Worker (SW); RP describes; registered nurses (including Ward Managers), registered Allied Health Professionals, Psychology Professionals and other patient facing registered professionals such as pharmacy and social work staff. SW is the non-registered counterpart of the RP staff group.

Inpatient Vacancies	RP FTE Vacancies.	SW FTE Vacancies.	RP FTE Overestab'd	SW FTE Overestab'd
⊟D&D				
⊞AMH	-3.48	-0.8	0.43	2.74
⊞ED	-1.48	-2.78	0	0
⊞LD A&T	0	-0.61	0.62	0
⊞LSU/Rehab	-2.2	-0.44	0	0.56
⊞MHSOP	-1.46	-2	0.46	7.04
⊞PICU	-2.29	-1.5	0	0
D&D Total	-10.91	-8.13	1.51	10.34
⊟NYY				
⊞AMH	-15.87	-7.57	0	1.94
⊞LD A&T	0	-3.39	0.45	0
⊞MHSOP	-8.21	-5.95	0.6	1.86
NYY Total	-24.08	-16.91	1.05	3.8
⊟SIS				
⊞LSU/Rehab	-6.12	-12.95	0	0
⊞MSU	-7.56	-20.41	3.63	0
SIS Total	-13.68	-33.36	3.63	0
⊟Tees				
⊞AMH	-0.95	-6.8	2.4	0
⊞CAMHS	0	-1.49	1.36	0
⊞LD A&T	0	-10.76	4.41	0
⊞LSU/Rehab	-3.75	-8.05	0.28	0
⊞MHSOP	-1.7	-3.88	3.77	0
⊞PICU	-1.59	-1.78	0	0
Tees Total	-7.99	-32.76	12.22	0
Grand Total	-56.66	-91.16	18.41	14.14

Table 3 – Inpatient FTEs for All specialities across all localities (for 49 wards included in MHOST analysis)

5.11. It can be seen that for September 2019 there were ~148 FTE inpatient vacancies across the teams, with North Yorkshire (RPs in particular), SIS and Tees being the most notable areas; there was also an over-establishment of 14 SW FTEs, with 50% of these in D&D MHSOP. Similarly it is noted that 66% of over-established RPs are within Tees. A negative value indicates a vacancy; the effective Trust wide inpatient staff shortfall position was therefore 115 FTE, however if dynamic staff allocation across services is not in place then the 33 over-established staff are only effective in addressing shortfalls on their own wards. The issues regarding the RP vacancy rate is further discussed further in the paper in context of skill mix requirements.

5.12. To provide context it is worth noting that the total budgeted establishment for the 57 MHOST wards for the month of September 2019 was 1192 FTEs; when considering the 49 wards included in the MHOST analysis this equated to 1071 FTEs. Therefore the number of inpatient vacancies (148 FTEs) is 13.8% of the inpatient budgeted establishment (1071 FTEs) for September 2019.

5.13. Appendix 4 (Table 11) provides a table (columns A-D) of the FTE variances from the MHOST results. Columns A and B show the variances from the ward MHOST recommended FTE compared to budgeted and actual FTEs for September 2019. Actual FTE refers to staff that were actually deployed to the wards. These figures relate to total FTE numbers and do not address skill mix, which will be discussed further at a later point in the report.

5.14. If the acuity scoring from each ward had the same distribution of acuity scores as seen in the national benchmark, the results would be as seen in Columns C and D. To achieve this, the national benchmark figures have been aligned pro rata to the average daily patient numbers of the wards. The adjusted benchmark figures are seen in the acuity profiles (graphs in linked document in paragraph 5.8), and are the same as the "aligned" benchmark scores.

5.15. Positive values in Column A and Column B shows the additional staff required to meet the MHOST recommended results, i.e. shows a staffing shortfall when compared to the current budget establishment and the actual number of staff used on the wards at September 2019; conversely a negative value can be considered as an over establishment where the budget and actual figures exceed the MHOST recommended values. Note, all 'actual' figures refer to staff deployed to the wards as opposed to actual contracted (staff in post). It can be seen where the MHOST recommended staffing based on ward scores shows an overall staffing shortfall of 99 FTEs when compared to the current budgeted establishment; and a staffing shortfall of 26 FTEs in comparison to our actual staffing for this month. AMH, for example shows that:

- The ward MHOST scores recommended 112.23 FTEs are required in excess of the current budgeted FTE establishment for the month of September 2019
- The ward MHOST scores recommended 95.03 FTEs are required in excess of the actual staffing used for the month of September 2019.
- The aligned benchmark MHOST scores recommended 39.91 FTEs are required in excess of the current budgeted FTE establishment for the month of September 2019
- The aligned benchmark MHOST scores recommended 22.71 FTEs are required in excess of the actual staffing used for the month of September 2019.

5.16. Regarding the average fill rate (1st June to 30th November 2019) for both days and nights for both registered and non-registered staff, the 6 monthly position shows that there were 19 wards (29%) with a fill rate of less than 89.9% for registered nurses on daytime shifts. In terms of unregistered nurses this equated to 2 wards (3%) where the fill rates were below 89.9%. This shows that although the trust usually meets its planned staffing numbers there is often a deficit of the planned skill mix from

registered to non-registered. This presents risks in terms of CQC compliance and limits the quality and safety of interventions that can be offered from a registered nursing perspective and is required to be considered as part of the establishment review process.

5.17. Review of the ward and community team manager's reports highlighted a number of issues and concerns; a summary of the top 10 key themes is given in Table 4 and Table 5 respectively; full detail is provided in Appendix 5. These concerns and issues will be followed up at the Right Staffing Establishment Work Stream Group and Programme Board to discuss priorities and actions.

Graph key	Areas of concern / issue	% Wards
Stress / Morale	Staff have expressed concern regarding the levels of stress / burn out /low morale	61%
Temp Staffing (TSS)	Pre-planned or regular reliance on temporary staffing or concerns regarding the skills provided by temporary staff are a concern	58%
Engagement / Leave Cancellation	Low staffing numbers lead to reduced engagement / activity or leave being cancelled	54%
Recruitment	Difficulties in recruitment/ retention / achieving current establishment	48%
Sickness Levels	Increased sickness levels/Maternity/ Staff Restrictions	41%
High Acuity	High acuity / Observations	32%
Environment	Mixed sex population / Environment poses a challenge	32%
Other Wards	Supporting other wards impacts on own ward staffing	22%
Over Establishment	Current over-establishment agreed	20%
Physical Health	Physical health care needs of patients increasing	14%

Table 4: Top 10 ward issues reported

Graph key	Area of concern / issue	% CMHTs
Capacity	Capacity vs demand is a challenge in terms of meeting targets / Referral Rates are high or increasing / High caseloads	43%
Stress	Staff feeling Pressure due to workload / Increased levels of Stress / Frustration / Low Morale / Burnout	38%
Sickness	Sickness has impact on ability to achieve targets	28%
Recruit	Recruitment and Retention issues	24%
Training	Difficulty Accessing Mand and Stat / ESR / Training completed on Non-Working Days	18%
Environment	Environment poses a challenge to care delivery / Room Availability / IT Infrastructure poor connectivity etc.	17%
Well Being	Staff Well Being poses a concern	16%
Geography	Geography poses a challenge	13%
Leadership	Leadership Team not in post or require development	9%
Triage	Triage Process in Place during staff shortfall	8%

Table 5: Top 10 CMHT issues reported

6. KEY ISSUES

6.1. Centrally held data on IIC and Paris systems do not accurately represent or reflect the situation of some community teams, which prevents using data informatics to support effective practice, examples include caseload size, cost centre issues, teams on Paris not showing a true picture of team composition.

6.2. Feedback from services so far has indicated that a further review of community data requirements would be welcomed to support staff teams with their reviews and allow for increased monitoring of key issues; this will support the development of a community dashboard in the IIC. Discussions regarding creating dashboards with the new IIC product are in progress to make data more accessible to teams to extract and review. The Right Staffing programme is currently liaising with the KPO team to arrange a QIS event for May 2020 in readiness for the next establishment setting review in August/September 2020 to consider data requirements and the progression of the community evidence based tool (EBT) solution.

6.3. The level of input from clinical staff/teams working from central locations i.e. staff/teams working in a “hub” model, are not factored into the actual FTE figures presented in the paper. An algorithm will need to be derived to determine the equivalent FTE level of input across the required period for the hub teams; this will be crucial in obtaining an accurate calculation of the actual FTE and how this may be incorporated in to the budgeted FTE figures for comparison with the recommended FTEs from MHOST and the future CMHT EBT. An event is planned with AHP professional leads, psychology, pharmacy, social work and chaplaincy to explore and develop how this can be most accurately captured, and the data requirements needed to achieve this.

6.4. Acuity dependency scores that align with the benchmark figures provide an indicative level of assurance of a picture seen nationally across similar wards. It is important that the Trust MHOST assessment scoring is as robust as possible for there to be confidence in the results obtained that could influence decisions about staffing and workforce requirements; it would be therefore be prudent to achieve at least 2 consistent sets of consistent data as a minimum to be fully assured of this. The current dataset collected will be the first ward based reference point. However, we can consider the ward collected scores in conjunction with benchmarked data that is aligned to the ward patient numbers as a reference point that will support the validation and “sense checking” of the ward scores.

6.5. Seeing an increase staffing requirement from both sets of scores would provide a reasonable indication of a staffing shortfall in this area; it would not be unreasonable to suggest that benchmarked data results for the interim are seen a minimum threshold for staffing levels until such a time that he Trust’s own data collection and

scores provide its own benchmark criteria based upon the local socio-economic and geographical environment of the Trust.

6.6. It can be seen from the acuity profiles (paragraphs 5.8 and 5.9) there are varying results in respect to the national benchmark which requires follow up with the teams on an individual (small group) basis to understand if there are any themes arising or not, providing support where needed. Professional judgement has been correctly applied in all cases by the clinical teams in respect to these early results. Further work is underway with SIS and to be furthered with other specialities regarding additional training, support and monitoring to ensure acuity scoring is robust.

6.7. If all wards had scored as the national benchmark data, i.e. an acuity profile matching the adjusted benchmark, the Trust's overall budgeted establishment (numbers of staff) would exceed the recommended value by ~63 FTEs (RP+SW). However, this aggregated figure conceals the impacts of the MHOST scores at a more granular level for particular services where there are significant variances seen for example SIS services, which require further exploration as previously discussed. More specifically we can see from Table 11 (Appendix 4):

- AMH shows a staffing shortfall from both the wards acuity scores and the national benchmark data, most significantly D&D and Teesside; this would suggest that there is indeed a staffing shortfall in these areas.
- Eating Disorders (Birch Ward) shows a result set that is also consistent with the benchmark data stating a staffing deficit - it is also worth noting here that Birch Ward was a participant in the national MHOST programme.
- LD shows a staffing shortfall from both the wards scores and the benchmark data, with Bankfields Court as having a shortfall of staffing.
- SIS-MSU as a service has MHOST national benchmark figures close to their current budgeted establishment. However, looking at a more granular level, staffing for Northdale and Merlin Wards have the significant negative impact on the aggregated figures hiding that there is an apparent staffing shortfall on Linnet, Mandarin and Nightingale wards when viewing the benchmark figures. These 3 wards appear to have underscored on MHOST in relation to benchmark data. Further understanding on staffing deployment within SIS services is required to better understand these figures.
- MHSOP results would indicate that the ward results show an over establishment of staffing; however benchmark data shows functional MHSOP wards Cherry Tree and Westerdale North have a staffing shortfall – ward data would appear to be under scored in these. Further work is required to understand the results suggesting over-establishment across MHSOP services.

- Further work is required to understand the results suggesting significant over-establishment in the areas SIS-LSU in particular, as already discussed this work has commenced with Right Staffing and SIS modern matrons; further training and knowledge transfer sessions are scheduled for February 2020 ahead of next MHOST collection, with further support during data collection.

6.8. The inpatient vacancy rate for the wards included in the MHOST analysis was 12.4% of the inpatient budgeted establishment (1192 FTEs) for September 2019. Table 6 shows a summary locality view for all 57 MHOST wards (including those excluded for small ward issues); the updated inpatient vacancy percentage (13.6%) remains in the same region as that previously outlined in the speciality view on paragraph 5.12.

Inpatient Vacancies	RP FTE Vacancies.	SW FTE Vacancies.	RP FTE Overestab'd	SW FTE Overestab'd	% Vacancy
⊞D&D	-10.91	-8.33	1.59	10.34	12%
⊞NYY	-24.08	-16.91	2.15	4.1	25%
⊞SIS	-17.3	-42.16	3.63	0.07	37%
⊞Tees	-9.14	-32.76	12.22	0.36	26%
Grand Total	-61.43	-100.16	19.59	14.87	100%

Table 6 – Inpatient FTEs for All specialities by RP SW split (for ALL 57 wards)

6.9. Recruitment and retention is a key issue in all areas, however we can see this particularly significant in SIS, also reporting a high turnover of staff at this current time. A SIS wide task and finish group is being set up to address recruitment and retention issues.

6.10. SIS utilise a flexible resource pool, currently provided and managed by the temporary staffing service. For the calendar year 2019 (Figure 1);

- 535 individual bank staff had undertaken shifts for SIS;
- Of the 24586 shifts they had all worked, 75% of these were for SIS.
- 47% of the 535 staff had worked shifts solely for SIS – this was 26% of the 24586 shifts worked
- 392 (73%) of the 535 bank staff had worked 75% of their shifts in SIS – this was 66% of the total 24586 shifts on Forensics.

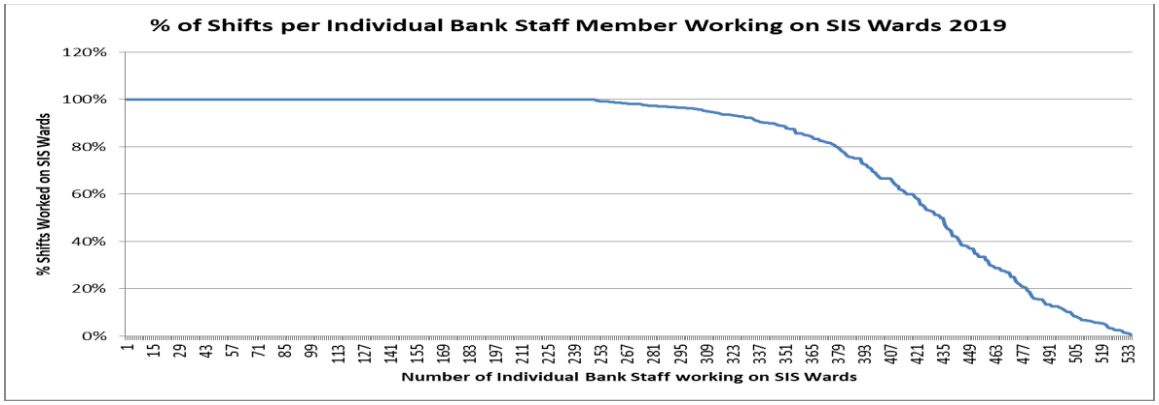


Figure 1: Current RP ratios compared to the Preferred RP ratio

6.11. The Trust reports on high use of temporary staffing on SIS wards; this gives a negative perspective of the staffing of the wards, in regard to the risks of using temporary staffing such as unfamiliarity of environment, lack of continuity of care for example. However it can be seen that the bank staff used by SIS is predominantly a flexible SIS workforce rather than temporary staffing workforce. Further work is therefore recommended to explore and consider options with regard to how this part of the workforce is managed, utilised and reported upon, which may include the potential to utilise annualised hours for this flexible SIS staffing resource.

6.12. **INPATIENT SKILL MIX**

MHOST provides benchmark data for preferred Registered Practitioner (RP) to Support Worker (SW) ratios. Figure 1 shows the budgeted, contracted staff and actual RP percentages against this benchmark. Only 12% of the 57 MHOST wards met the benchmark with actual RP staffing. It is noted that Nursing Associates (NAs) and Trainee Nursing Associates (TNAs) are included as SWs in these figures; at this current time the numbers of NAs and TNAs do not significantly influence these figures.

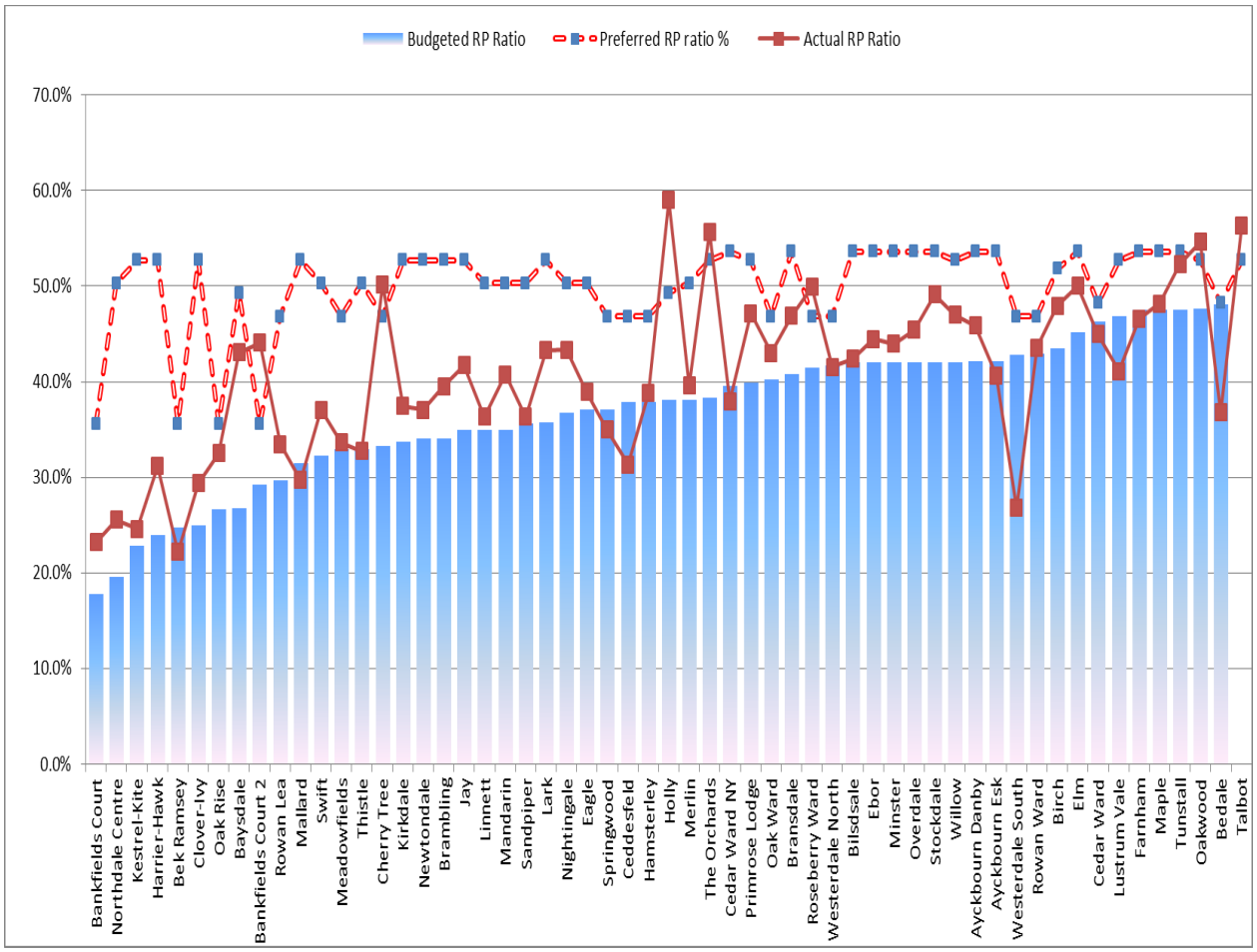


Figure 1: Current RP ratios compared to the Preferred RP ratio

6.13. Table 7 shows required increase in RP FTEs and the respective costing required to align the Trust RP ratio to the national RP ratio benchmark, whilst retaining the current budgeted staffing levels, i.e. by increasing RPs and decreasing SWs. The costs are based on an £11.5k increase to fund the uplift from SW (AfC Band 3) to RP (AfC Band 5). These figures do not consider the MHOST staffing FTE recommendations; they are based on addressing the skill mix ratios based upon the current budgeted staffing establishments. Any uplift to staffing numbers would need to consider skill mix ratios to maintain the recommended or preferred RP to SW ratio.

Speciality	RP Increase FTEs	Additional Cost £'s
AMH		
D&D	5.40	£ 62,085
NYY	11.85	£ 136,239
Tees	8.24	£ 94,799
AMH Total	**25.49**	**£ 293,123**
CAMHS		
D&D	0.99	£ 11,422
Tees	3.92	£ 45,059
CAMHS Total	**4.91**	**£ 56,481**
ED		
D&D	1.83	£ 21,003
ED Total	**1.83**	**£ 21,003**
LD A&T		
D&D	2.89	£ 33,230
NYY	2.29	£ 26,335
Tees	8.47	£ 97,385
LD A&T Total	**13.65**	**£ 156,951**
LSU/Rehab		
D&D	4.36	£ 50,141
NYY	0.86	£ 9,913
SIS	38.94	£ 447,834
Tees	10.33	£ 118,848
LSU/Rehab Total	**54.50**	**£ 626,736**
MHSOP		
D&D	6.54	£ 75,250
NYY	14.57	£ 167,509
Tees	2.12	£ 24,429
MHSOP Total	**23.23**	**£ 267,188**
MSU		
SIS	33.68	£ 387,294
MSU Total	**33.68**	**£ 387,294**
PICU		
D&D	0.52	£ 5,994
Tees	0.02	£ 281
PICU Total	**0.55**	**£ 6,275**
Grand Total	**157.83**	**£ 1,815,051**

Table 7: RP FTE increase to meet recommended %'s

6.14. Further consideration will need to be given regarding how best to approach the issue of the skill mix of RP to SW given the national and local issues surrounding recruitment and availability of registered practitioners; whilst not appropriate to use a Nursing Associate (NA) to replace an RP, further consideration is required on how the Trust uses NA's and the potential of how NAs can be best utilised towards supporting a stepped approach to achieving the recommended RP staffing ratio. Similarly, other registered professions could be factored into ward based establishments dependant on the assessed patient need.

6.15. It is important to note that the accurate determination of RP direct care from the centrally placed teams, as outlined in paragraph 6.3, will potentially reduce the costings for skill mix requirements seen in Table 8.

6.16. Griffiths et al (2019) acknowledges the importance role health care assistants (SWs) play in maintaining safety of hospital wards, however states emphatically that they cannot act as substitutes for registered staff, highlighting the potential consequences and negative impacts on patient safety. He further concludes that "the adverse consequences of RN shortages are unlikely to be remedied by increasing the numbers of lesser trained nursing staff in the workforce".

6.17. Clinical leadership is identified as a critical factor for improving the performance of health care organisations, and essential to delivering the NHS Plan (Kings Fund, 2019). Schein (2010) states "leadership and culture are fundamentally intertwined, and leaders play a crucial role in successfully applying the principles of culture to achieve their organisational goals". Ward leaders are central to creating a culture of high quality, compassionate care that strives to continuously improve (NHSI, 2018); enriching the RP to SW skill mix on the wards will support in improving the clinical leadership and subsequently the culture in teams.

6.18. This aspect may be further influenced by ongoing work regarding workforce roles to better enable and support current MDT staffing to achieve the level of safe and effective care required. Increasing the availability and awareness of how to use roles such as Peer Support Workers, Physician Associates, Advanced Clinical Practitioners, Nursing Associates, Clinical Team Administrators (aka Ward Clerks) will also support in providing a multi-skilled, sustainable and cost effective workforce.

7. NEXT STEPS

Action	Completion Date
Develop plan with services and implement MHOST level 3 analyses on AMH wards. This will include activity follows and audits to provide detail regarding RP roles and function.	Q2 20/21
CMHT Caseload analysis - getting the data right	Q2 20/21
Analysis of regional benchmarking data and national work from MH & LD forum	Q4 19/20
Follow up and feedback sessions with Heads of Service and staff to continue to make improvements to the process and timelines.	Q4 19/20
Themed concerns identified from ward and team managers reports to be taken to the Right Staffing Establishment Workstream Group and Programme Board and Programme Office for consideration of required actions.	March-20
Improve data collection mechanism - pilot to collect acuity dependency data on Paris at WPH. Currently being piloted, planned roll out March 2020	March-20

Further training sessions on a more local basis has been actioned and are currently being scheduled, along with local support during the assessment period; the priority will be on those areas where there appears to be a significant deviation to the national benchmark.	Q4 19/20
Community – review of CAST pilot and decision of an EBT to be used for community teams and data requirements. QIS event being planned for May 2020	Q1 20/21
Roll out EBT solution to CMHTs	Q2 20/21
Development of a tool for prison service(s). Discussions underway with H&J.	Q2/Q3 20/21
Develop standardised format of MHOST report and EMT/Board report	Q4 19/20
Review and refine process for collection and centrally provided data	Q2 20/21
Better use of data – how do we achieve this and feedback to teams in good time	Q2 20/21
Trust to consider the potential resource implication as highlighted in Tables, 3, 7 and 11	Q4 19/20
Skill Mix analysis - how we incorporate psychological and Allied Health Professions and Pharmacy into the reckoning for FTE equivalents – and how will this impact the FTE requirement and the skill mix	Q4 19/20

Table 8: Action plan

8. IMPLICATIONS

8.1. **Compliance with the CQC Fundamental Standards**:

Adhering to NHSI requirements will provide compliance with CQC standards. Professional judgment discussions within the team reports are based upon the CQC fundamental standards. Insufficient staffing and skill mix can negatively impact on the safe domain ratings during CQC inspection, this exercise aims to highlight areas where staffing shortfalls may need to be addressed and mitigated.

8.2. **Financial/Value for Money**:

From a financial perspective the in-patient wards and community teams actual staffing spend is broadly in balance, although under and overspends are present against budget lines. This reflects the fact that in-patient wards overspend against budgets set but community teams underspend due to vacancy factors. The budget for 20/21 has been developed with no additional funding provided for the impact of the establishment review process as there is more work to be undertaken to finalise this position. It is anticipated that there will be a part year impact in 20/21 once this work is completed and that this will be managed as an in-year pressure. By 21/22 a clear position on the scale of any cost pressure will be quantified and from a practical perspective the Trust will consider the following options or mix of options:

1. Seek additional funding from commissioners – this approach has been pursued by other Trusts with some success around securing funding for in-patient wards reflecting increased acuity
2. Reduce the funding provided to non-core functions e.g. Strategic Change Fund and non-recurrent Reserves

3. Increase the level of cost reduction (CRES)

At this stage the EMT view is that this approach is a sensible and balanced approach to adopt.

8.3. **Legal and Constitutional (including the NHS Constitution)**:

None identified

8.4. **Equality and Diversity**:

None identified

9. RISKS

There is a risk that:

- If we are unable to mitigate concerns and key issues raised in this paper that there will be a negative impact on the quality and safety of patient care.
- National shortages of registered nurses and the local picture particularly in North Yorkshire and York impact on recruitment.
- The impacts of the establishment reviews do not positively influence 2019/20 agency expenditure (anticipated impact for 2020/21).

10. CONCLUSIONS:

10.1 The support and engagement from all services in the delivery of the establishment review process from its development and the speed of implementation has been exemplary. It has been shown from the service reports and the RAG ratings that services have identified and own their individual and group actions to address and mitigate issues and risks identified for making the best use of their staffing resources; where it is anticipated that these actions will be evaluated and reviewed at the next mid-term establishment review in April 2020.

10.2 The Trust has used the inpatient MHOST to provide an evidence base with which to triangulate workforce data and professional judgement discussion. The initial ward results are viewed alongside aligned benchmarked results to support validation and verification. The Trust may consider using acuity scores aligned to the benchmarking values as a minimum standard or reference point until there is sufficient assurance that the ward's data on its own is sufficiently robust.

10.3 Whilst it is useful to remember it is a tool that supports professional judgement of staffing requirements, the analysis from the MHOST results has highlighted key areas for the Trust to consider, which include:

- Registered Practitioner to Support Worker ratios are significantly below national benchmark figures
- Areas that show results from MHOST indicating that the ward is overstaffed require further exploration before making decisions based upon these results; particularly so for SIS LSU, Rehab and MHSOP wards.
- AMH Durham and Darlington and Teesside ward and benchmark results show a staffing short fall when comparing recommend staffing against budgeted staffing
- Eating Disorders (Birch Ward) shows a staffing short fall when comparing recommend staffing against budgeted staffing, with consistent results in ward and benchmark data.
- SIS MSU ward and benchmark results show a staffing short fall on Linnet, Mandarin and Nightingale wards when comparing recommend staffing against budgeted staffing.
- MHSOP ward and benchmark results show a staffing short fall on functional wards Cherry Tree and Westerdale North when comparing recommend staffing against budgeted staffing.

10.4 Almost all of the red RAG ratings from localities highlighted risks across community teams. Mitigation for this includes new funding from commissioners, new models of care delivery and productivity work being undertaken by Meridian. The development of an evidence based tool is required for community teams to further support analysis. The current pilot will be evaluated and consideration will be given to roll out to all community teams. The aim is to achieve the same level of detail regarding staffing in the community as that of the inpatient wards.

10.5 Registered Practitioner to Support Worker budgeted ratios are significantly lower than the national benchmark ratios in some areas. Despite the fact that actual staffing RP increases this ratio to a point, it nevertheless remains substantially below the national benchmark value in most cases. The Trust will need to consider its approach to addressing this particular area of concern. Where additional investment has previously been provided by the Trust i.e. PICU it is evident that they are similar to the national benchmark.

10.6 The areas of concern and issues taken from the ward and team manager reports will require to be communicated and discussed with the relevant programmes, workstreams and services to consider how these issues may be progressed

11 RECOMMENDATIONS: -

- For EMT to consider the report and agree further actions required in relation to staffing resources and mitigation of key issues raised.

Joe Bergin - Right Staffing Senior Programme Manager

References

Griffiths et al. (2019) Nurse staffing, nursing assistants and hospital mortality: retrospective longitudinal cohort study. BMJ Quality & Safety 2019; 28 603-605. Available from: https://qualitysafety.bmj.com/content/28/8/609

Kingsfund (2019) NHS Leadership and Culture: our position. Available from: https://www.kingsfund.org.uk/projects/positions/NHS-leadership-culture

NHSI (2018) The Ward Leaders Handbook. Available from https://improvement.nhs.uk/documents/3359/Ward_leaders_handbook.pdf

Schein E H (2010). Organizational culture and leadership. The Jossey-Bass Business & Management Series. 4th edition. Vol. 2. San Francisco, Ca : Jossey-Bass: John Wiley & Sons.

APPENDIX 1

12. METHODOLGY AND APPROACH

12.1. A previous review of inpatient services using the Hurst evidence based staffing tool (EBT) revealed key issues with the method of approach and data collection. Whilst there were some deficiencies in the EBT the exercise was valuable and meant that significant investment could be targeted to key areas. Learning has been taken forward from this previous exercise to pilot sites, together with improvements in the EBT (MHOST).

12.2. For the purpose of this review, a Trust wide series of quality improvement systems (QIS) events were carried out for each speciality for the full MDT and for community and inpatient teams comprising:

- Heads of Service (Process Owners)
- Service Managers
- Clinical staff (inpatient and community)
- Nursing (ward/team managers, clinical leads, modern matrons, heads of nursing)
- Allied Health and Psychological professionals (NB social work, chaplaincy and pharmacy were not included)
- Medical staff
- Finance
- Human Resources

12.3. Each event was to successively build upon the previous Kaizen event's outputs to deliver a final set of outcomes and deliverables that were compatible to all specialities for final agreement on achieving the overarching aims of:

- Improving upon the timeline of the previous inpatient staffing review of 13 months to deliver a timeline that allows for an annual establishment setting review and a mid-year review.
- The review to take account of:
    - patient acuity and dependency using an EBT (where available)
    - staff activity levels
    - seasonal variation in demand
    - service developments; contract commissioning; service changes
    - staff supply and experience issues

- where temporary staff have been required above the set planned establishment
- patient and staff outcome measures

- Reporting through current governance arrangements
- Ensuring there is a suitable feedback process to all staff
- Identifying each areas data requirements and its collection
- Producing a standard reporting format that is visible from “ward (team) to board”
- Delivering the MHOST training and data collection to all required staff

12.4. All aims were met and subsequently implemented. Follow up meetings within localities are in the process of being arranged to take feedback and discuss any lessons learned from this first pass through the process.

13. MENTAL HEALTH OPTIMAL STAFFING TOOL (MHOST)

13.1. MHOST is multi-disciplinary, evidence based system that enables ward based clinicians to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that ward establishments reflect patient needs in acuity and dependency terms across a range of specialities.

13.2. Development of the staffing tool was a large scale project involving:

- 35 mental health organisations across England (including TEWV)
- 320 best practice wards (including TEWV)
- 303,350 clinical interventions
- 161,200 patients

13.3. Acuity and dependency scores are updated into the tool which provides recommended staffing levels based on these scores. Usually, the higher the acuity and dependency score the higher the multiplier, therefore providing a larger staffing requirement.

13.4. The length of the collection period should be sufficient to provide a view of the ward that is reflective of an average period on the ward. For the Trust review processes, a full calendar month was used, which extends upon the minimum time of 21 day stated in the guidance. MHOST is designed to support professional judgement discussions and triangulated with other workforce and patient data; it should not be a measure used in isolation.

13.5. A characteristic of the tool that caused issues seen in the last exercise regarding small wards (<=8 beds) remains. The potential for gaming is aimed to be reduced by steps described in the following paragraph.

13.6. One of the issues from the previous Trust exercise in 2017 highlighted the inconsistency in the scoring due to many staff of different grades and experience with no (or very little) training doing the assessment and scoring; and no external validation being performed. This review sought to improve upon these issues of inter-rater reliability and lack of oversight by ensuring that:

- Wards would undergo the assessment scoring during MDT report out to ensure consistency where possible.
- Where this was not achievable, i.e. Secure Inpatient Services, that three senior staff were identified per ward to complete the scoring daily for the full period of the data collection
- Matrons were to validate and sense check the scores on a minimum of a weekly basis across the data collection period

13.7. MHOST training was delivered on 2 full day sessions with 69% of the 200 invited staff attending. This was further supplemented by ad hoc ‘mop up’ sessions where possible, and ongoing support throughout the collection period. MHOST data collection was initially undertaken for the calendar month of September 2019, and is then planned for every 6 months from this point.

13.8. A pilot was run on 2 AMH wards in North Yorkshire and York; feedback from the use of the tool was very good, and the ward managers supported the delivery of the training sessions.

13.9. The Kaizen events also developed a Community Acuity Staffing Tool (CAST) for pilot in NYY AMH CMHTs which extends upon the community evidence based tool built by Professor Keith Hurst, whilst ensuring the key functionality of the original tool remains in place as designed to guarantee its validity against the software database. The pilot will determine its suitability and whether this also provides value to the Trust community teams going forward; evaluation and review of the pilot and discussion of a community tool will begin in February 2020.

13.10. Fourteen of the Trust wards participating in the MHOST assessment had a daily average of < 8 patients on the wards across the collection period; note that this is not the physical number of beds on the wards but the average daily occupancy during the MHOST data collection period. The small ward issue with MHOST is such that wards with less than 8 patients are likely to show inconsistent and very low results; however this issue can be mitigated if high acuity scores are recorded for the ward. To prevent skewing of results the significant outliers have been removed for this

results data set, Table 9 shows the wards that have been included and excluded and the respective rationale.

Ward	Status	Reason
Bankfields Court 2	Included	High Acuity Scored
Baysdale	Included	High Acuity Scored
Bek Ramsey	Included	High Acuity Scored
Cedar Ward	Included	High Acuity Scored
Clover-Ivy	Excluded	Low Acuity Scored
Eagle	Included	High Acuity Scored
Holly	Excluded	Significant Outlier
Jay	Excluded	Low Acuity Scored
Oak Rise	Included	High Acuity Scored
Oakwood	Excluded	Normal Acuity Scored
Sandpiper	Excluded	Normal Acuity Scored
Talbot	Excluded	Normal Acuity Scored
The Orchards	Excluded	Low Acuity Scored
Thistle	Excluded	Normal Acuity Scored

Table 9 – Wards with less than 8 patients Sept 2019

APPENDIX 2

Locality Establishment Review Reports

Durham and Darlington

201909 Staffing Establishment Review Report D&D ALD

201909 Staffing Establishment Review Report D&D AMH

201909 Staffing Establishment Review Report D&D CAMHS

201909 Staffing Establishment Review Report D&D MHSOP

Forensic Services

201909 Staffing Establishment Review Report Health & Justice Services

201909 Staffing Establishment Review Report Secure Inpatient Services

North Yorkshire and York

201909 Staffing Establishment Review Report NYY ALD

201909 Staffing Establishment Review Report NYY AMH

201909 Staffing Establishment Review Report NYY CAMHS

201909 Staffing Establishment Review Report NYY MHSOP

Teesside

201909 Staffing Establishment Review Report Tees ALD

201909 Staffing Establishment Review Report Tees AMH

201909 Staffing Establishment Review Report Tees CAMHS

201909 Staffing Establishment Review Report Tees MHSOP

APPENDIX 3

	Community					Inpatient				
Speciality	Red	Amber Red	Amber	Amber Green	Green	Red	Amber Red	Amber	Amber Green	Green
AMH										
NYY	5	0	7	7	3	0	0	3	2	1
Tees	0	2	1	5	8	0	2	1	4	0
D&D	2	0	5	3	21	1	0	2	5	1
AMH Total	7	2	13	15	32	1	2	6	11	2
CYPS										
NYY	3	2	2	3	0					
Tees	0	0	8	0	3	0	0	0	1	0
D&D	0	2	5	0	7					
CYPS Total	3	4	15	3	10	0	0	0	1	0
LD										
NYY	0	1	3	3	2	0	0	1	0	0
Tees	0	0	3	5	5	0	0	0	1	2
D&D	0	0	0	0	6	0	0	1	0	0
LD Total	0	1	6	8	13	0	0	2	1	2
MHSOP										
NYY	0	0	9	7	9	0	1	2	2	0
Tees	0	3	0	3	1	0	1	0	1	0
D&D	0	0	5	9	6	0	0	3	0	1
MHSOP Total	0	3	14	19	16	0	2	5	3	1
SIS						0	0	0	10	9
H&J	0	1	0	0	16	0	0	0	1	1
Grand Total	10	11	48	45	87	1	4	13	27	15

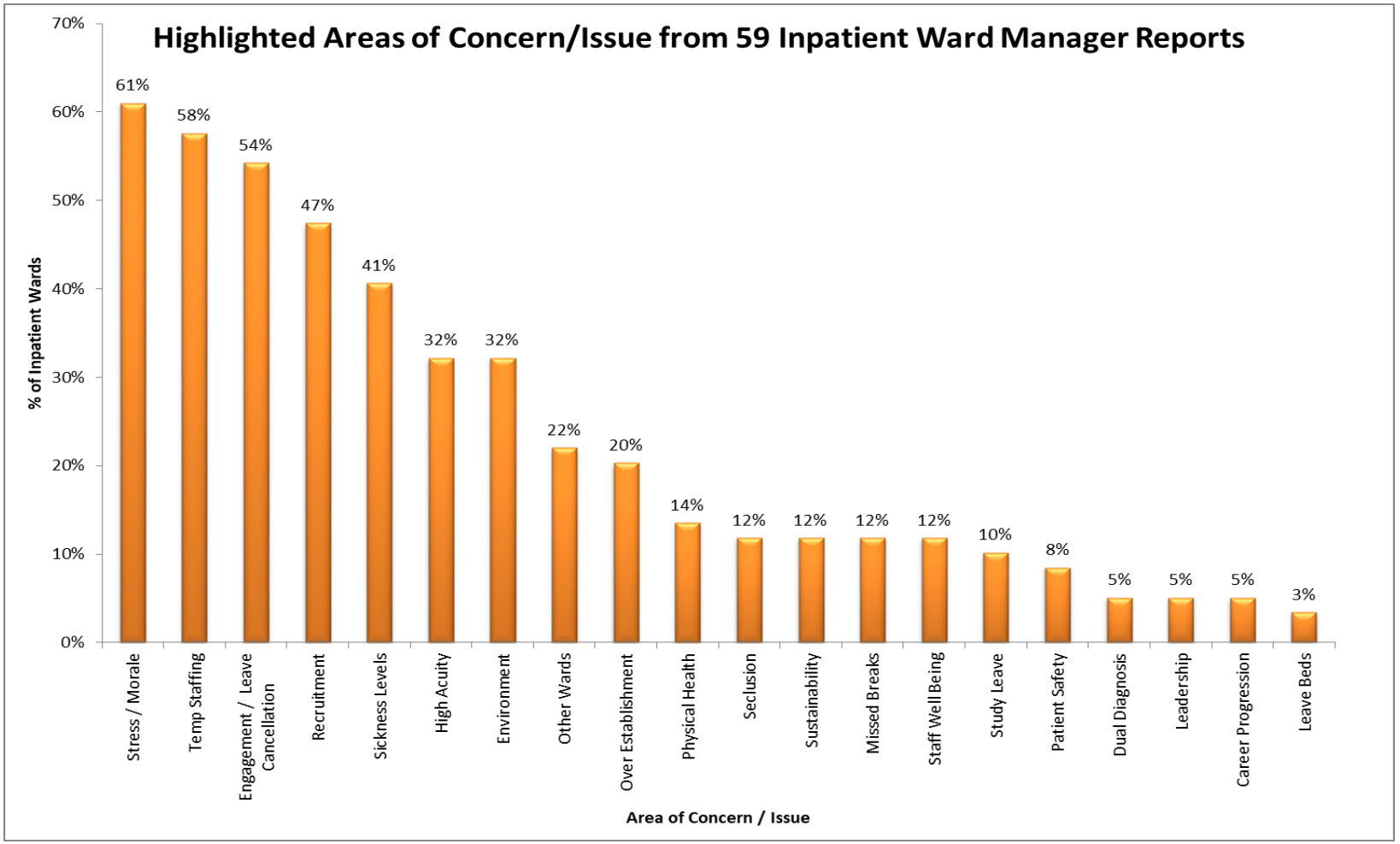
Table 10: Ward and Community Team's RAG Ratings

APPENDIX 4

	Column A	Column B	Column C	Column D
All Wards Total FTEs: 1071	MHOST Recmd'd FTE less Budget FTE	MHOST Recmd'd FTE less Actual FTE	MHOST Aligned NB Recmd'd FTE less	MHOST Aligned NB Recmd'd FTE less
AMH				
Ayckbourn Danby	4.84	4.70	-0.71	-0.84
Ayckbourn Esk	6.79	9.01	-0.60	1.63
Bilsdsale	7.30	7.01	4.57	4.28
Bransdale	7.99	8.10	1.43	1.54
Cedar Ward NY	6.87	6.62	-2.68	-2.93
Ebor	2.89	-1.36	1.39	-2.87
Elm	14.25	13.01	7.00	5.76
Farnham	10.28	7.70	5.18	2.61
Maple	14.27	12.07	9.04	6.84
Minster	3.46	-0.49	-0.59	-4.55
Overdale	9.40	9.13	3.05	2.79
Stockdale	11.40	11.43	4.90	4.93
Tunstall	12.50	8.10	7.93	3.53
AMH Total	**112.23**	**95.03**	**39.91**	**22.71**
CAMHS				
Baysdale	-1.32	-1.79	-4.26	-4.72
CAMHS Total	**-1.32**	**-1.79**	**-4.26**	**-4.72**
ED				
Birch	4.76	3.44	5.28	3.96
ED Total	**4.76**	**3.44**	**5.28**	**3.96**
LD A&T				
Bankfields Court	31.67	31.03	10.61	9.96
Bankfields Court 2	7.28	8.54	1.28	2.54
Bek Ramsey	3.42	-1.25	-3.64	-8.32
Oak Rise	5.77	2.22	-0.13	-3.69
LD A&T Total	**48.15**	**40.53**	**8.11**	**0.49**
LSU/Rehab				
Brambling	-9.77	-9.07	-6.67	-5.97
Harrier-Hawk	-16.40	-13.61	-14.04	-11.25
Kestrel-Kite	-5.44	-7.64	-9.69	-11.89
Kirkdale	-4.27	-4.08	-8.13	-7.93
Lark	-3.20	-0.30	1.92	4.83
Lustrum Vale	-3.07	-6.53	-3.38	-6.83
Mallard	0.33	-2.08	-7.07	-9.48
Newtondale	-7.97	-3.57	-5.72	-1.32
Primrose Lodge	-5.97	-5.09	-5.70	-4.82
Willow	-2.19	-3.87	-3.52	-5.20
LSU/Rehab Total	**-57.95**	**-55.83**	**-62.00**	**-59.88**
MHSOP				
Ceddesfeld	-1.60	-5.23	0.24	-3.39
Cherry Tree	-8.79	-11.65	2.60	-0.26
Hamsterley	7.04	5.25	-1.65	-3.45
Meadowfields	1.52	-2.17	-7.53	-11.23
Oak Ward	-10.34	-9.18	-4.19	-3.02
Roseberry Ward	-2.39	1.39	-2.41	1.38
Rowan Lea	-2.67	-8.78	-8.51	-14.62
Rowan Ward	-1.97	-9.92	-5.03	-12.98
Springwood	3.16	-1.78	-8.54	-13.49
Westerdale North	2.59	-3.31	7.21	1.32
Westerdale South	0.43	-9.40	-8.29	-18.11
MHSOP Total	**-13.01**	**-54.78**	**-36.09**	**-77.86**
MSU				
Eagle	11.75	3.03	1.05	-7.68
Linnett	7.70	6.17	11.33	9.81
Mandarin	-3.18	0.08	5.28	8.54
Merlin	-8.77	-6.90	-8.69	-6.82
Nightingale	-0.10	2.31	7.07	9.48
Northdale Centre	-14.95	-12.38	-13.28	-10.71
Swift	-9.29	-8.33	-4.34	-3.39
MSU Total	**-16.84**	**-16.03**	**-1.58**	**-0.76**
PICU				
Bedale	17.59	11.45	-4.61	-10.75
Cedar Ward	5.55	4.24	-7.48	-8.79
PICU Total	**23.15**	**15.69**	**-12.09**	**-19.55**
Grand Total	**99.16**	**26.27**	**-62.71**	**-135.60**

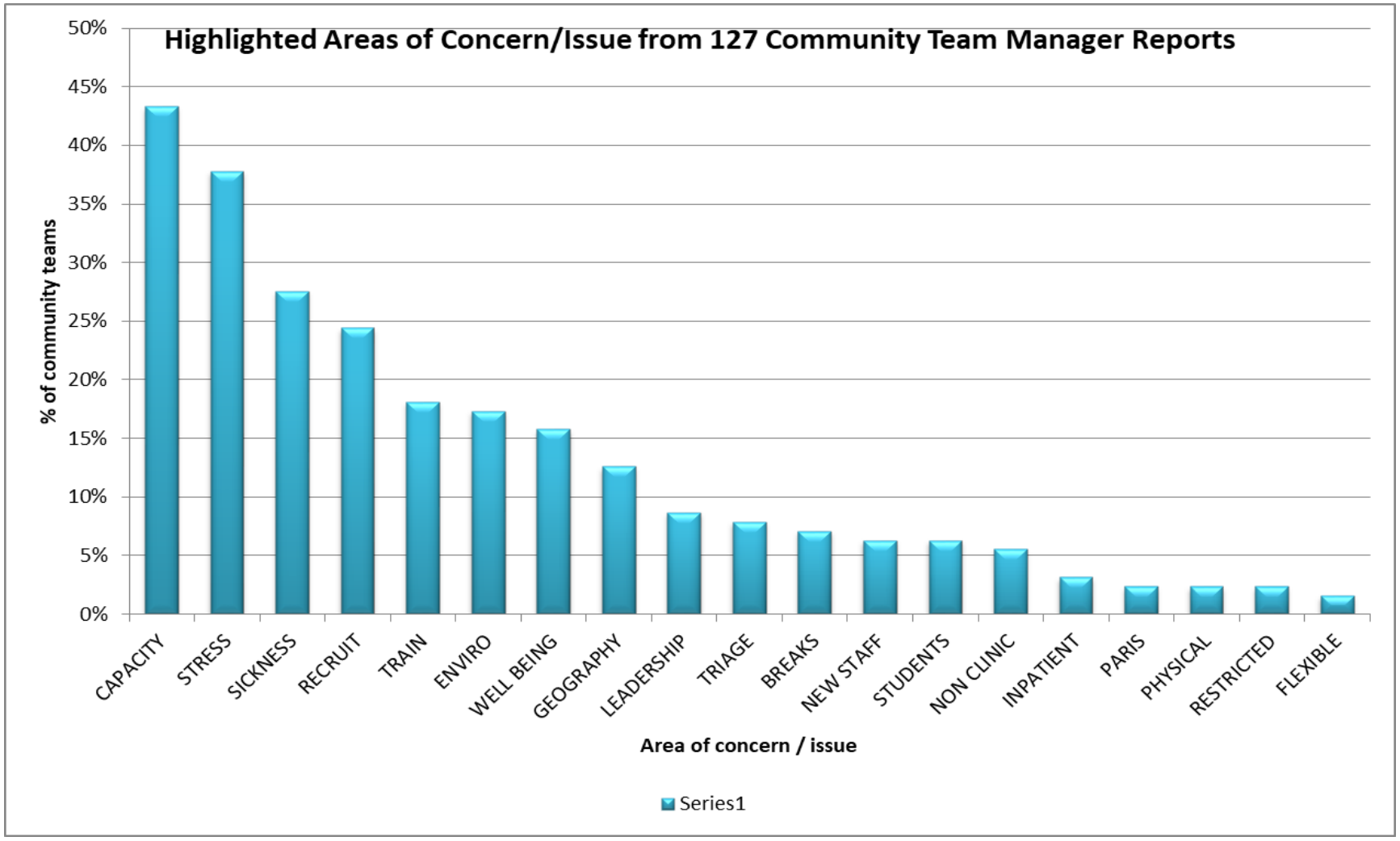
Table 11: - MHOST Results for 49 Wards (exclusions apply)

APPENDIX 5


Highlighted Areas of Concern/Issue from 59 Inpatient Ward Manager Reports
% of Inpatient Wards
70%
60%
50%
40%
30%
20%
10%
0%
61%
58%
54%
47%
41%
32%
32%
22%
20%
14%
12%
12%
12%
12%
10%
8%
5%
5%
5%
3%
Stress / Morale
Temp Staffing
Engagement / Leave Cancellation
Recruitment
Sickness Levels
High Acuity
Environment
Other Wards
Over Establishment
Physical Health
Seclusion
Sustainability
Missed Breaks
Staff Well Being
Study Leave
Patient Safety
Dual Diagnosis
Leadership
Career Progression
Leave Beds
Area of Concern / Issue

Graph key	Areas on concern/issue
Stress / Morale	Staff have expressed concern regarding the levels of stress / burn out / low morale
Temp Staffing	Pre-planned or regular reliance on temporary staffing or concerns regarding the skills provided by temporary staff are a concern
Engagement / Leave Cancellation	Low staffing numbers lead to reduced engagement / activity or leave being cancelled
Recruitment	Difficulties in recruitment/ retention / achieving current establishment
Sickness Levels	Increased sickness levels/Maternity/ Staff Restrictions
High Acuity	High acuity / Observations
Environment	Mixed sex population / Environment poses a challenge
Other Wards	Supporting other wards impacts on own ward staffing
Over Establishment	Current over-establishment agreed
Physical Health	Physical health care needs of patients increasing
Seclusion	Seclusion reviews impact on staffing levels
Sustainability	Concerns for sustainability of current service model
Missed Breaks	Staff experience missed breaks OR disrupted breaks OR staff feel pressure to miss breaks due to workload
Staff Well Being	Staff well-being is a concern
Study Leave	Study leave impacts staffing levels
Patient Safety	Patient report not feeling safe/ frustrated or concerned about unfamiliar staff
Dual Diagnosis	Increased dual diagnosis patient group which poses problems during inpatient stays
Leadership	Concerns regarding "Leadership Team"
Career Progression	Perceived lack of career progression opportunities
Leave Beds	High use of leave beds is a concern for staff workload

Table 12: Key for inpatient manager reports


Highlighted Areas of Concern/Issue from 127 Community Team Manager Reports
% of community teams
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
CAPACITY
STRESS
SICKNESS
RECRUIT
TRAIN
ENVIRO
WELL BEING
GEOGRAPHY
LEADERSHIP
TRIAGE
BREAKS
NEW STAFF
STUDENTS
NON CLINIC
INPATIENT
PARIS
PHYSICAL
RESTRICTED
FLEXIBLE
Area of concern / issue
Series1

Graph key	Areas on concern/issue
Capacity	Capacity vs demand is a challenge in terms of meeting targets / Referral Rates are high or increasing / High caseloads
Stress	Staff feeling Pressure due to workload / Increased levels of Stress / Frustration / Low Morale / Burnout
Sickness	Sickness has impact on ability to achieve targets
Recruit	Recruitment and Retention issues
Training	Difficulty Accessing Mand and Stat / ESR / Training completed on Non-Working Days
Environment	Environment poses a challenge to care delivery / Room Availability / IT Infrastructure poor connectivity etc.
Well Being	Staff Well Being poses a concern
Geography	Geography poses a challenge
Leadership	Leadership Team not in post or require development
Triage	Triage Process in Place during staff shortfall
Breaks	Missed breaks or longer hours to maintain workload compliance
New Staff	Preceptorship Nurses / Newly qualified / Students Placements
Students	Students Placements / Multiple Students poses a challenge
Non Clinical	The amount of non-clinical work required
Inpatients	Supporting Inpatient units / 136 suite (including consultants)
Paris	Multiple Patient records System pose a challenge
Physical	Physical Healthcare of patients requires increased attention
Restricted	Staff on restricted duties
Flexible	Staff Flexible working patterns in place impact ability to meet targets

Table 13: Key for community manager reports

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM No. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25 February 2020**
TITLE:	**Learning from deaths – Dashboard Report Q3 2019/20**
REPORT OF:	**Elizabeth Moody, Director of Nursing**
REPORT FOR:	**Information**

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

Executive Summary:

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 the Q3 2019/20 financial year is included at Appendix 1 and includes 2018/19 data for comparison.

Work continues to ensure the numbers of deaths reported (both in and out of scope) are as accurate as possible to allow us to gain maximum learning from this process. The mortality review process has also continued to be refined and there is further detail included within the body of the paper.

Recommendations:

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

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**25 February 2020**
TITLE:	**Learning from deaths - Dashboard Report Q1&Q2 2019/20**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Following the publication of the Southern Health report in 2015 there has been continued enhanced national scrutiny on how all NHS organisations respond to the deaths of service users in their care.

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 also the proportion of those deaths which were 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 clinical review before determining if they require further investigation.

The Learning from Deaths policy is currently being reviewed, in conjunction with the other Trusts in the region and this work is anticipated to be completed by the end of the financial year.

3. KEY ISSUES:

3.1 Mortality Review and Learning

In Q3 2019/20 there were 41 mortality reviews undertaken. Of those 41 cases 8 were selected for a more detailed structured judgement review however due to absences and pressures within the patient safety team, none of these are currently complete. A new mortality reviewer has recently been appointed and these will all be picked up in the next quarter.

Our previous approach to mortality review was to identify those service users on the Care Programme Approach who had died but did not fall into the category of a Serious Incident. Following guidance from the Royal College of Psychiatrists and in line with peer organisations across the region in 2019/20 this process has been amended to look at service users who have died and fall into a 'red flag' category:

- Family, carers or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric inpatient at the time of death, or discharged from care within the last month
- Under Crisis Resolution and Home Treatment Team at the time of death
- Patient had Learning Disability diagnosis

A random selection of cases is also considered each month. It is felt that this revised criteria will allow for greater learning from a more suitable selection of cases reviewed.

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

3.2 Appendix 1: Dashboard

The learning from deaths dashboard is attached at Appendix 1 which also includes 2018/19 data for comparison. For Q3 2019/20 the dashboard highlights the following:

- 605 deaths were recorded in total (735 in 2018/19). These are all deaths (mostly natural expected and unexpected) in relation to people who are currently open to the Trusts caseload including older peoples community and memory services.
- 26 serious incident reviews relating to deaths were completed in the period (34 completed in Q3 of 2018/19).
- 21 learning points* were identified from the 26 serious incidents reviewed (24 learning points were identified in Q3 of 2018/19)
- 41 deaths have been reviewed as part of the mortality review process
- 19 learning disability deaths (all community) were reviewed and also reported to LeDeR
- 7 deaths of in-patients were reported in Q3 (3 are being investigated as serious incidents, 4 were natural deaths that are being reviewed as part of the mortality review process). None of the deaths involved a person with a Learning Disability.

The numbers of deaths on the dashboard are broadly similar to the comparison from the previous year which suggests reporting processes are more stable and consistent.

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

3.3 Serious Incidents

For the Serious Incidents completed in Q3, the most common finding overall was related to multi-disciplinary/agency working, specifically that when multiple services/teams are involved with a patients care there is a lack of clarity regarding responsibilities and no one person or team has a full overview of the patients care. Discussions are ongoing to improve the interface between agencies such as GP's, Police and acute care settings as a result of the learning points identified and in the areas where this has been a particular issue this has been raised at the Urgent Care Interface Meeting. The second most common theme related to risk assessment including insufficient/incomplete risk assessments and a lack of consideration for

historical risk factors. The findings relating to risk assessment have been shared with the lead for Harm Minimisation and incorporated into the Trusts training package. There is also work ongoing to improve the Trusts electronic recording system to improve how we record, retrieve and consider patient risk information.

Serious Incident reports and findings are shared with services via Quality Assurance Groups and Patient Safety Sub-groups. Key messages are also shared Trust wide via the patient safety bulletin and where appropriate the SBARD process. Themes and trends are discussed at the Trust Patient Safety Group who monitor trust wide issues, provide support and guidance to clinical services and seek additional assurances that key issues are understood and learning is being implemented. Detailed analysis of all themes for both serious incidents and mortality reviews for 2019/20 and comparison with previous years will be provided in the annual patient safety report in May 2020.

Formal action plans are in place for all incidents where a root cause or contributory finding is identified which are closely monitored by the Patient Safety team and our commissioners.

3.4 In line with the National Quality Board (NQB) guidance for NHS Trusts working with bereaved families, we continue to support and engage families in review processes following the death of a family member. The Trusts Family Liaison Officer role is now well established within the serious incident investigation process and we are reviewing how we can better engage and support families through the mortality review process. This role has received extremely positive feedback from both families and staff.

3.5 Information up to the end of quarter 3 shows an increase in the number of in-patient deaths reported as serious incidents compared with previous years and a range of work is ongoing to better understand this. This has included a recent presentation to the Quality Assurance Committee based upon independent thematic analysis and a Safety Summit being held on the 18th February to further consider actions that can be taken to learn from these deaths.

4.0 IMPLICATIONS:

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

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

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

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

4.5 **Other implications:**

No other implications identified.

5. RISKS:

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

6. CONCLUSION:

The Trust continues to refine its approach to identification, categorisation and investigation of deaths in line with national guidance. Work is ongoing to ensure the numbers of deaths reported (both in and out of scope) are as accurate as possible and we continue to undertake work to improve the mortality and serious incident review processes to allow us to gain maximum learning. Unexpected deaths continue to be reviewed in a way that is proportionate to the circumstances of the incident with the primary aim being to learn lessons and improve the safety of the service we provide. Work is ongoing to ensure that learning identified during the review process is implemented and embedded into everyday practice.

7. RECOMMENDATIONS:

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

Elizabeth Moody
Director of Nursing
February 2020

Background Papers:

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

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

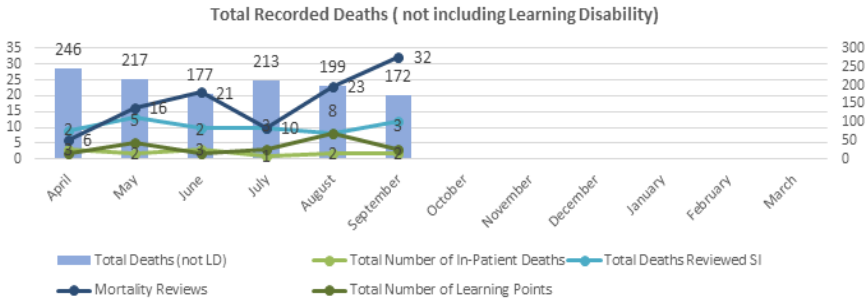
Appendix 1 Dashboard

Learning from Deaths Dashboard - Data Taken from Paris and Datix
Reporting Period - Quarter 2 - July - Septemebr 2019

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	
	2019/20	2018/19	**2019/20**	2018/19	**2019/20**	2018/19	**2019/20**	2018/19	**2019/20**	2018/19
Q1	**640**	↘ 661	**8**	↗ 4	**32**	↘ 34	**43**	↘ 53	**9**	↘ 13
Q2	**584**	↘ 598	**6**	↗ 2	**30**	↘ 31	**65**	↘ 66	**14**	↘ 18
Q3	**605**	↘ 735	**7**	↘ 10	**26**	↘ 34	**41**	↗ 0	**21**	↘ 24
Q4										
YTD	**1224**	↘ 1259	**13**	↗ 6	**62**	↘ 65	**108**	↘ 119	**23**	↘ 31



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	
	2019/20	2018/19	**2019/20**	2018/19	**2019/20**	2018/19	**2019/20**	2018/19
Q1	**16**	↘ 21	**0**	↔ 0	**10**	↗ 7	**10**	↗ 7
Q2	**13**	↗ 11	**1**	↗ 0	**7**	↗ 6	**7**	↗ 6
Q3								
Q4								
YTD	**29**	↘ 32	**1**	↗ 0	**17**	↗ 13	**17**	↗ 13

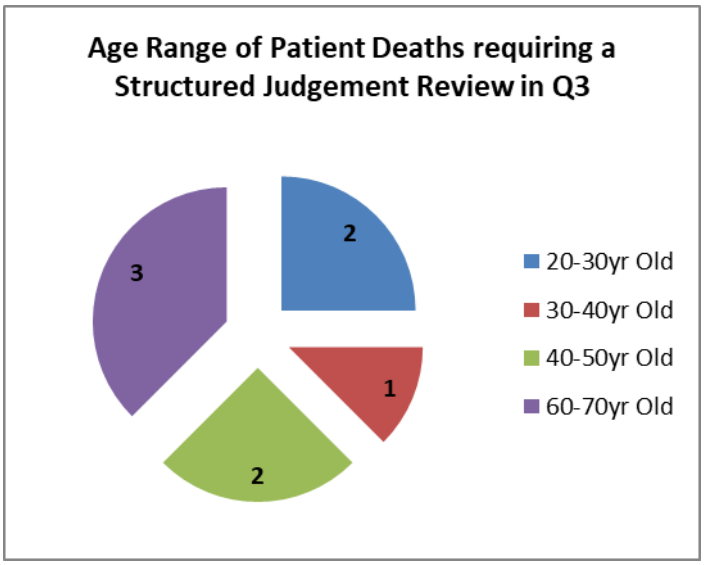
Appendix 2

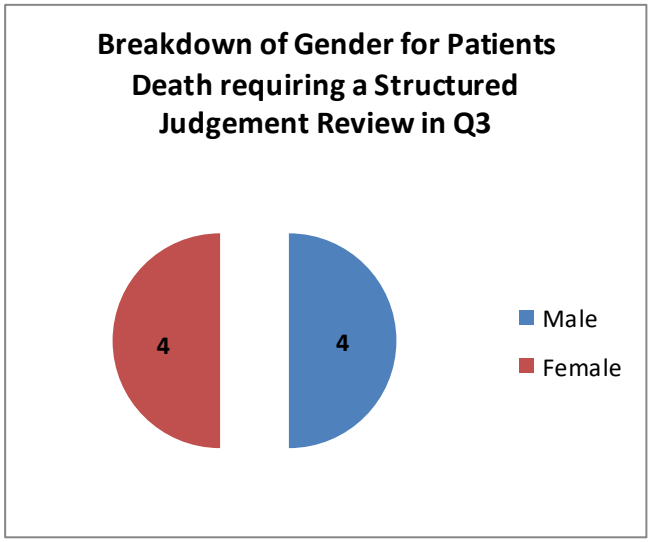
Mortality Review April 2019 – 31st December 2019

Overall Figures

Month	Total Number of Deaths which met criteria for a review	Total Number identified as requiring a Structured Judgement Review
April	6	1
May	16	5
June	21	3
July	10	0
August	23	3
September	32	8
October	12	4
November	4	2
December	24	2
Total	149	28
From the 149 there were a total of 28 were Learning Disability Deaths reviewed and sent to LeDer		

Demographics of Patients

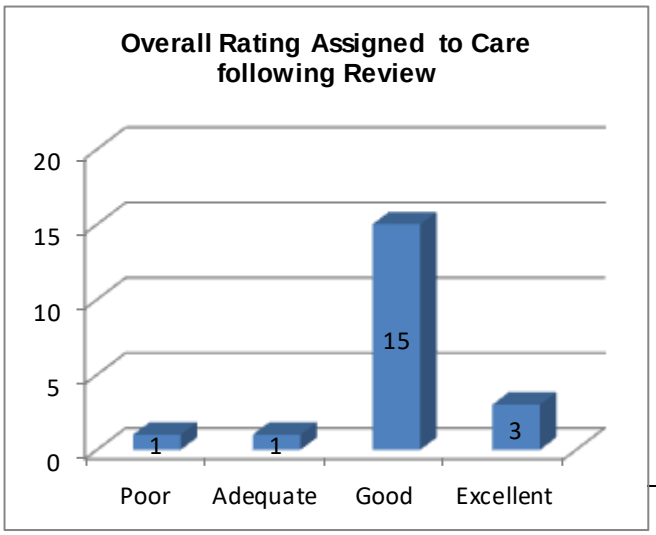


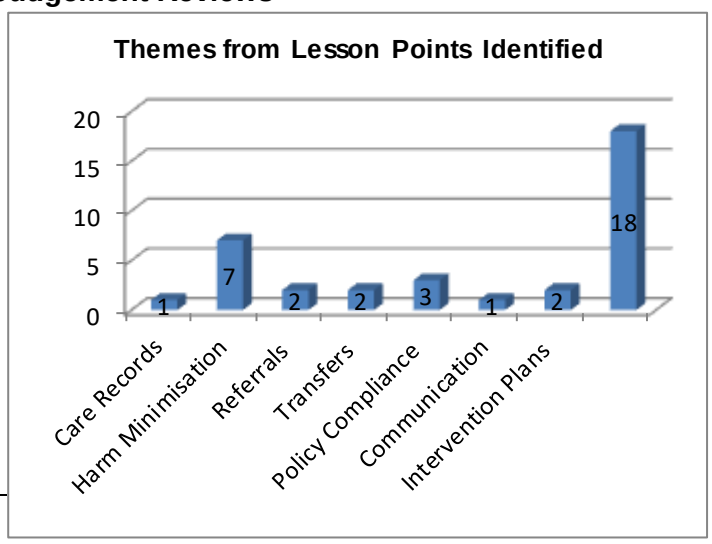


Rating of Care

Themes of Lessons Learned

Details of Learning Points from Structured Judgement Reviews





Details of Learning Points from Structured Judgement Reviews

Care Records 1. Care Records – records refers to patient's diagnosis of alcohol related dementia, no results or information from third party to confirm this diagnosis.
Communication 1. Communication between MH and Acute regarding patients best interests, pt. was admitted into MH ward when his main needs were clearly physical health, learning for TEWV/acute trust as to whether appropriate
Intervention Plan 1. No new interventions identified in response to increase in the patients risk level 2. Not fully completed, not clear what interventions were being provided to patient to meet individual needs
Harm Minimisation 1. No evidence of ongoing risk assessing, only at points of crisis. 2. Safety Summary completed by Access not updated by receiving team 3. Safety Summary not updated in relation to risks from lifestyle i.e. when drunk pose risk to others 4. Safety summary not updated following self-harm episodes to reflect risk posed and to clarify management plan. 5. Safety Summary was not accurate in relation to patient's risks, in particular in relation to harm from others. 6. There was evidence of stock piling physical health medication – no evidence of intervention or risk assessed. 7. Safety summary not updated at point of being transitioned between teams to identify risks at point in patients journey
Policy Compliance 1. Safety summary documents not updated or closed by different teams 2. Staff did not following the standards set out in the Falls Policy following the patient having a fall on the ward. 3. Reference to capacity assessment within patients records however, no evidence this took place.
Referral 1. Seen by access numerous occasions within 2yr period, may have benefited from referral to primary or secondary services for further assessment/treatment. 2. Patient should have been referred to the end of life care team earlier
Transfers 1. It took a lengthy time for the patient to be transferred from Crisis to Affective Disorders 2. The patient missed critical medication when transferred to Acute Trust - more robust process required to ensure all patients needs continue to be met when on leave from the ward or transferred to another healthcare provider.

Areas of Good Practice Noted

1. Effective collaborative working and formulation of care 2. Robust risk assessments and discharge plans in place for Mental Health. 3. All care documents regularly completed and open lines of communication with all other Healthcare Professionals involved 4. Evidence of robust care planning to mitigate risks posed and to promote recovery. 5. Open lines of communicating maintained with GP in form of letter regards outcome of primary care assessment and future plan. 6. Good Partnership working 7. Multi-agency working between MH & Acute Trust, actively including family in decision making. 8. Good review of needs when deterioration noted in physical health needs.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

FOR GENERAL RELEASE **Item12**

BOARD OF DIRECTORS

DATE:	**25th February 2020**
TITLE:	**To consider the publication of information on compliance with the public sector duty under the Equality Act**
REPORT OF:	**Director of Human Resources and Organisational Development**
REPORT FOR:	**Decision**

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

Executive Summary:

The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The attached paper contains the necessary information in relation to service users.
The information highlights that considerable disparities exist for service users within protected groups compared to those in non-protected groups and efforts to address these differences must continue.
The Trust needs to ensure compliance with the Mental Health Act Code of Practice by undertaking an annual review of its Human Rights, Equality and Diversity Policy at Trust Board level or equivalent

Recommendations:

- The Board is asked to ratify the publication of equality data documents and approve their publication on the trust website as required by the Equality Act.
- The Board is asked to agree that the paper is considered in more detail by the Resources Committee.
- The Board is asked to review and ratify the attached Human Rights, Equality and Diversity Policy.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

MEETING OF:	**Board of Directors**
DATE:	**25th February 2020**

1.0 INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to seek ratification of the information to be published under the Trust's Equality Act duties

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

2.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users and staff who share a relevant protected characteristic who are affected by its policies and practices

2.3 At its meeting on 15th July 2020 the Resources Committee agreed that in future the publication of information would be split with patient information published in February and staff information published in May.

2.4 The Trust needs to ensure compliance with the Mental Health Act Code of Practice by undertaking an annual review of its Human Rights, Equality and Diversity Policy at Trust Board level or equivalent

3.0 KEY ISSUES:

3.1 The Trust needs to ensure compliance with the Equality Act 2010, by publishing information to demonstrate its compliance with the general equality duty.

3.2 There is increasingly a national focus upon improving outcomes and experiences for people from protected groups.

- The NHS The Long Term Plan states that the NHS will set out specific, measurable goals for narrowing inequalities, including those relating to protected groups. All local health systems will be expected to set out during 2019 how they will reduce health inequalities by 2023/24 and by 2028/29.
- The Commission for Equality in Mental Health have recently published a briefing on the unequal determinants of mental health which seeks to explore the complex interaction between identity, geography, gender, ethnicity, social class, sexual orientation and many other factors including poverty, homelessness, exclusion and discrimination or oppression, for instance on grounds of disability or gender identity. The impact of some of these factors include:
- Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%
- Men and women from African-Caribbean communities in the UK have higher rates of post-traumatic stress disorder and suicide risk and are more likely to be diagnosed with schizophrenia

- Deaf people are twice as likely to experience mental health difficulties
- Women are ten times as likely as men to have experienced extensive physical and sexual abuse during their lives: of those who have, 36% have attempted suicide, 22% have self-harmed and 21% have been homeless
- People who identify as LGBT+ have higher rates of common mental health problems and lower wellbeing than heterosexual people, and the gap is greater for older adults (over 55 years) and those under 35 than during middle age

3.3 This report describes where the outcomes and experience of TEWV and service users from particular protected groups are less than service users who do not share those protected characteristics.

4.0 IMPLICATIONS:

4.1 Compliance with the CQC fundamental Standards:
It is a requirement of the CQC fundamental standards that the Trust meets its obligations under the Equality Act 2010.

4.2 **Financial/Value for Money:**
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.

4.3 **Legal and Constitutional (including the NHS Constitution).**
The Trust is required to publish information demonstrating its compliance with the general public sector duties of the Equality Act 2010. This document will meet that legal requirement and as Equality Act compliance is a pre-requisite of Care Quality Commission registration will maintain Trust registration.

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

Other implications:
None have been identified.

5.0 RISKS:

5.1 The quality of information submitted for publication continues to be subject to improvement and there may be risks related to the data quality.

6.0 CONCLUSIONS:

6.1 The Trust needs to publish information demonstrating it is compliant with the general public sector duties of the Equality Act 2010 and the information in the attached document will meet that requirement.

6.2 The Trust needs to understand whether and why particular groups in the community are under or over represented in its service user population and to take action as appropriate. The Trust also needs to ensure that any differences in experience between protected groups and the service user population in general are understood and appropriate action taken to ensure high quality care is delivered for all.

6.3 The trust needs to understand the differences in experience and outcome for its staff and to take action where necessary to lessen the disparities.

6.4 Whilst actions have been undertaken for some time to address the issues described above it must be noted that considerable disparities still exist for both staff and service users from protected groups and that serious consideration is needed of both the actions required and the resources available to lessen the differentials in experience and outcomes for these groups.

6.5 The Trust needs to ensure compliance with the Mental Health Act Code of Practice by undertaking an annual review of its Human Rights, Equality and Diversity Policy at Trust Board level or equivalent

7.0 RECOMMENDATIONS:

7.1 The Board is asked to ratify the publication of equality data documents.

7.2 The Board is asked to agree that the equality data documents are considered in more detail by the Resources Committee

7.3 The Board is asked to review and ratify the attached Human Rights, Equality and Diversity Policy

David Levy, Director of Human Resources and Organisational Development
Sarah Jay, Equality, Diversity and Human Rights Lead
Jools Smithies, Equality, Diversity and Human Rights Officer

Background Papers:

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

PUBLICATION OF SERVICE USER EQUALITY DATA

1st JANUARY 2019– 31st DECEMBER 2019

Published February 2020

making a difference together

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

If you need this information summarised in another language or format such as Braille, talking tape or DVD please call the number below.

Polish:
Jeżeli potrzebujesz streszczenia tych informacji w innym języku lub formacie, np. w Braille'u lub w formie nagrania dźwiękowego, zadzwoń na poniższy numer.

Arabic:
إذا أردت منا تلخيص هذه المعلومات بلغة أخرى أو بصيغة مختلفة مثل لغة بريل أو شريط صوتي أو قرص DVD
يرجى الاتصال برقم الهاتف التالي.

Bengali:
যদি আপনি অন্য একটি ভাষায় এই তথ্যের সংক্ষিপ্তসার চান অথবা ব্রেইল, কথা বলা টেপ অথবা ডি.ভি.ডি. ফরম্যাট-এ এই তথ্য চান, তাহলে অনুগ্রহ করে নিচের নম্বরে টেলিফোন করুন।

Farsi:
در صورتی که مایلید خلاصه این اطلاعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره زیر تماس بگیرید.

Hindi:
यदि आप इस सूचना का सारांश किसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टाकिंग टेप या DVD में चाहते हों, तो कृपया नीचे दिए गए नंबर पर फोन करें।

Kurdish (Kurmanji):
Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਸਿ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈੱਟ ਜਵਿੇਂ ਬ੍ਰੇਲ, □□□□□□ ਟੇਪ ਜਾਂ DVD ਵਚਿ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਰਿਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਤਿ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:
如果您需要该条信息用其他语言或格式概述，例如盲文，录音磁带或 DVD。请联系以下号码：

Urdu:
اگر آپ کو ان معلومات کے خلاصہ کی کسی دیگر زبان یا شکل مثلاً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو برائے مہربانی درج ذیل نمبر پر کال کریں۔

Telephone 0191 3336267

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

PUBLICATION OF EQUALITY DATA

1. INTRODUCTION

1.1 The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

1.2 The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are sex, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

1.3 The Trust has published information to meet its public sector duties for the last seven years. During this time the quality of the data has steadily improved however the Trust recognises that there are still qualifications around the quality and validity of the data; particularly as in some areas the numbers are relatively low. The Trust wants to be transparent in demonstrating its compliance with its Equality Act duties and has decided to publish raw data. The information published must therefore be viewed as descriptive and any interpretations of it must be conservative.

1.4 The information in this report includes:

- An analysis of service users who were referred to Trust services between 1st January 2019 and 31st December 2019 by race and ethnicity, sex, disability, religion, sexual orientation, age, marriage and civil partnership. The data is taken from information given by service users who at times refuse to provide information requested, giving incomplete data. In the data a blank is recorded as null, refuse to disclose means that the service user preferred not to give the trust that information and not known means that the clinician has recorded that they do not know that information.
- An analysis of the length of waiting time from referral to first contact by ethnicity and an analysis of length of hospital stay by ethnicity.
- Where possible the Trust's data has been compared to that of the 2011 Census produced by the Office of National Statistics. Copyright is acknowledged as adapted from data from the Office for National Statistics licensed under the Open Government License v.1.0.

2. ACCESS TO SERVICES

2.1 The following data is for the year 1st January 2019 and 31st December 2019 and is the information contained on the Trust's electronic clinical record system. Some of the fields are incomplete for some service users and some service users have preferred not to give the Trust certain information. The level of missing values and non-disclosure is indicated in each section.

2.2 Where it is available the makeup of the Trust's service user population has been compared to the information on the general population that was gathered in the 2011 census.

2.3 Summary of Service Users by Ethnic Group Compared to the ONS 2011 Census

Ethnic Group	Ethnic breakdown of service users in the Trust (number)	Ethnic Breakdown of service users in the Trust (%)	Ethnic Breakdown 2011 Census (number)	Ethnic Breakdown 2011 Census (%)
White; British	181032	87.14	1857153	93.7
White; Irish	498	0.24	7592	0.38
White; Other White includes Eastern European	2376	1.14	38067	1.92
Mixed; White and Black Caribbean	338	0.16	5229	0.27
Mixed; White and Black African	226	0.11	2544	0.14
Mixed; white and Asian	407	0.20	6934	0.35
Mixed; Other Mixed	671	0.32	4443	0.23
Asian or Asian British; Indian	328	0.16	9517	0.48
Asian or Asian British; Pakistani	677	0.33	12739	0.64
Asian or Asian British; Bangladeshi	132	0.06	2338	0.12
Asian or Asian British; Other Asian	494	0.24	10009	0.5
Black or Black British; Caribbean	132	0.06	1200	0.06
Black or Black British; African	332	0.16	5792	0.29
Black or Black British; Other Black	181	0.09	1178	0.07
Asian or Asian British Chinese	172	0.08	8735	0.45
Other Ethnic Group includes Iranians and Arabs	1079	0.52	5688	0.29
Travellers including Gypsy, Roma Traveller/Irish Traveller	146	0.07	2183	0.11
Not stated and declined to disclose	7229	3.48		
NULL	11305	5.44		
Total	207755.00	100%	1,981,391	100%

2.3.1 11305, 5.44% of service users' race/ ethnicity is not available as the data field on PARIS has not been completed. This compares to 4.19% last year. There has been an increase of Mixed White and Black Caribbean service users of 0.12 % and a decrease of Black or Black British Caribbean service users which the trust will further explore. There are variations from the census norms which the Trust will use to explore access issues.

2.3.2 Length of waiting time from referral to first contact by ethnicity

The Trust has produced its own figures on the length of waiting time from first referral to first contact analysed by ethnicity. There are some differentials in these which will be explored and appropriate action taken. A degree of caution must be applied in interpreting these figures because of the number of service users whose ethnicity is not known or not stated.

Ethnic Group	No. of patients	Average length of time (days)
White; British	55766	12.45
White; Irish	140	13.99
White; Other White includes Eastern European	606	11.08
Mixed; White and Black Caribbean	78	11.51
Mixed; White and Black African	70	7.52
Mixed; white and Asian	123	14.42
Mixed - Other Mixed	203	13.51
Asian or Asian British; Indian	93	10.18
Asian or Asian British; Pakistani	209	11.47
Asian or Asian British; Bangladeshi	45	10.17
Asian or Asian British; Other	138	9.15
Black or Black British; Caribbean	32	6.16
Black or Black British; African	85	6.27
Black or Black British; Other Black	52	9.87
Asian/Asian British - Chinese	60	11.91
Travellers including Gypsy, Roma, Irish	52	7.26
Other Ethnic Group including Iranian/Arabs	362	17.08

Null	3945	9.55
Decline to disclose	2456	19.35
TOTAL	64515.00	

The trust will seek to explore the reasons for the waiting time being 19.35 days if the service user declines to disclose ethnicity. The trust will seek to explore the differences between waiting times comparing urgent referrals and routine referrals to capture the route into services for those of different ethnicities.

2.3.3 Length of hospital stay by ethnicity

Following feedback figures have been produced for long stay wards, acute wards and short stay respite to provide a more accurate understanding of differences between ethnic groups These figures are for the period 1st January 2019 to 31st December 2019

Length of hospital stay by Ethnicity 01/01/2019 - 31/12/2019
ACUTE WARDS:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	2707	39.19	0	365
White; Irish	8	59.63	4	158
White; Other White	35	57.83	1	343
Mixed; White and Black African	3	44	9	85
Mixed White/Black Caribbean	9	64.44	3	324
Mixed; white and Asian	4	14	9	19
Mixed; Other Mixed	12	20.83	1	57
Asian/Asian British Bangladesh	5	25.20	11	46
Asian or Asian British; Indian	10	71.20	1	175
Asian or Asian British; Pakistani	19	53	1	184
Asian or Asian British; Other Asian	11	22.64	1	55
Black or Black British; Caribbean	4	13.25	1	47
Black or Black British; African	16	43.69	12	201

Black or Black British; Other Black	1	30	30	30
Asian / Asian British - Chinese	2	50	26	74
Other Ethnic group includes Iranians/Arabs	37	27.04	2	182
Travellers including gypsy, Roma, Irish	3	39.50	15	51
Null	126	22.19	0	151
Not stated, declined to disclose	17	26.23	2	141
Total	3029.00			

Long Stay wards:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	354	86.49	0	365
White; Irish	2	56.50	26	87
White; Other White	7	13.83	3	70
Mixed; White and Black Caribbean	0	5	5	5
Mixed white, Asian	2	6	6	6
Traveller including Gypsy, Roma and Irish	0	0	0	0
Mixed White/Black African	1	70	70	70
Mixed; Other Mixed	0	0	0	0
Other Ethnic group – any other	0	0	0	0
Asian/Asian British Indian	1	5	5	5
Asian or Asian British; Pakistani	4	14.50	5	25
Asian or Asian British; Other Asian	3	109	2	245
Black or Black British; African	2	8	5	11
Black British, other black	0	0	0	0
Black, Black British Caribbean	1	5	5	5
Asian / Asian British - Chinese	1	65	65	65
Other ethnic group , Iranians and Arab	9	67.69	3	336
Not stated, declined to disclose	2	9.50	1	18
Null	12	7.75	0	24
Total	401.00			

Short stay/respite stay:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	137	31.96	1	123
White Irish	1	5	5	5
White; Other White includes Eastern European	1	1	1	1
Mixed; Other Mixed	1	10	10	10
Asian, Asian British Indian	1	2	2	2
Asian or Asian British; Pakistani	7	12.86	0	26
Asian or Asian British; Other Asian	0	0	0	0
Asian/Asian British Chinese	0	0	0	0
Black or Black British; African	1	33	33	33
Black or Black British; Other	0	0	0	0
Gypsy	0	0	0	0
Other ethnic group, includes Irian and Arab	1	18	18	18
Null	1	2	2	2
Not stated, declined to disclose	1	51	51	51
Total	152.00			

Other:

Ethnic Group	No. of patients	Average length of stay in hospital	Shortest length of stay in hospital	Longest length of stay in hospital
White British	709	126.96	0	365
White Irish	4	94	1	365
White; Other White includes Eastern European	18	45.44	0	195
Mixed; Other Mixed	7	68.86	7	365
Asian, Asian British Indian	1	18	18	18
Asian or Asian British; Pakistani	2	28	8	48
Asian or Asian British; Other Asian	6	129.83	7	365
Asian/Asian British Chinese	2	156.50	13	300
Black or Black British; African	11	2390	2	365
Black or Black British; Caribbean	1	79	79	79
Black Black British Other Black	1	1	218	218
Mixed white and Asian	1	7	7	7
Mixed white Black Caribbean	2	184.50	4	365
Mixed white Black African	2	290.50	216	365
Other ethnic group, includes Irian and Arab	8	111.50	2	316
Null	39	39.07	1	328
Not stated, declined to disclose	19	59.25	1	239
Traveller including Gypsy, Roma, Irish	2	130	15	245
Total	835.00			

2.4 Summary of Service Users by age compared to the ONS 2011 Census

Age	Breakdown of Service Users in the Trust by age (Number)	Breakdown of Service Users in the Trust by age (%)	ONS Census 2011 Breakdown by age (number)	ONS Census 2011 Breakdown by age (%)
0-18	42152	20.29	414839	18.6
18-29	44012	21.18	342007	15.3
30-44	41708	20.08	422893	18.9
45-64	37740	18.17	629030	28.3
Over 65	42125	20.28	423194	18.9
Null	18	0.01		
Total	**207755.00**	**100%**	**2231963**	

2.4.1 Comparing the age categories of the Trust to those of the ONS 2011 Census the number of service users in the 45 - 64 categories are less than the Census figures. The number of service users in the over 65 age group is expected due to the increased prevalence of age related mental health problems in this group. 0.01% of the trust's data on the age of service users was incomplete.

2.5 Summary of Service Users by Sexual Orientation

Sexual Orientation	Breakdown of service users by sexual orientation (number)	Breakdown of service users by sexual orientation (%)
Person does not know	673	0.32
Null	38530	18.55
Persons of the opposite sex	12546	6.04
Persons of the Same or opposite sex	242	0.12
Persons of the Same Sex	245	0.12
Prefer not to say, Not stated/declined	16,449	7.92
Other	56	0.03
Not age appropriate	17,833	8.58
Not developmentally appropriate	4,791	2.31
Not known	2,885	1.39
Total	207,755	

2.5.1 The Office for National Statistics, Sexual orientation 2017, Experimental statistics on sexual orientation in the UK in 2017 state that 2.0% of the UK population identified as Lesbian, gay or bisexual (LGB) and estimated that 1.1 million of the population aged

16 years and over identified as LGB out of a total UK population of those aged 16 years and over of 52.8 million.

Comparing these estimated figures with the Trusts' service users the Trust has an under- representation of those who have declared that they are lesbian, gay or bisexual. This is a particularly sensitive area for many service users and this is possibly reflected in the fact that for 38530 or 18.55% of service user's information about their sexual orientation is not recorded on PARIS. The completion rates of sexual orientation has greatly increased for the reported period and this is because in previous years the reports from IIC only picked up sexual orientation from the care documents and not from the Master Patient Index (MPI) and this issue has now been corrected in IIC.

2.6 Summary of Marital and Civil Partnership Status of Service Users within the Trust compared to the ONS 2011 Census.

Status	Breakdown of service users in the Trust by Marriage Civil Partnership (number)	Breakdown of service users in the Trust by Marriage Civil Partnership (%)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (number)	ONS Census 2011 Breakdown by Marriage/ Civil Partnership (%)
Divorced/ Civil Partnership Dissolved	8248	3.78	177476	9.38
Married / Civil Partnership	36233	16.58	923446	48.78
In a relationship	7299	3.34		
Living with a partner	6126	2.80		
Not Disclosed	14826	6.79		
Separated	5114	2.34	45932	2.44
Single	112158	51.34	598958	31.64
Surviving Partner/ Widowed	14120	6.46	147062	7.76
Null	14107	6.46		
Not known	238	0.11		
Total	**218469.00**	**100%**	**1892874**	

2.6.1 For 14107 or 6.46 % of service users' marital and civil partnership status information is not recorded on PARIS. This is a 0.83% decrease in the data completeness compared to last year. 'In a relationship' and 'living with a partner' were added as additional fields in PARIS in 2016 to better reflect the range of relationships amongst our service users. There are no categories in the 2011 census with which to compare these options.
There is a variation between the Trust's data for marriage and civil partnership and that of the ONS 2011 in the categories of those who are divorced or whose civil partnership has been dissolved, those married or in civil partnerships and those who are single.

2.7 Summary of sex of service users within the Trust compared to the ONS 2011 Census

Status	Breakdown of service users in the Trust by sex (number)	Breakdown of service users in the Trust by sex (%)	ONS Census 2011 breakdown by sex (number)	ONS Census 2011 breakdown by sex (%)
Male	100316	48.29	1,119,471	49
Female	105654	50.86	1,169,017	51
Null	1357	0.65		
Birth sex female gender neutral	290	0.14		
Birth sex male gender neutral	93	0.04		
Indeterminate	32	0.02		
Not known/not specified	13	0.01		
Total	**207755.00**	**100%**	**2,288,488**	

2.7.1 The sex breakdown of the Trust's service users is very similar to that of the ONS data. For 1357 or 0.65 % of service users the data on sex is incomplete. This is a decrease of 0.06% compared to last year. Additional fields were added to PARIS in 2018 to allow service users' sex to be recorded in ways that better reflect their gender identity.

2.8 Summary of Service Users by religion compared to the ONS 2011 Census service user Population by religion

Religion	Breakdown of Service Users in the Trust by religion (number)	Breakdown of Service Users in the Trust by religion (%)	ONS 2011 Census Breakdown by religion (number)	ONS 2011 Census Breakdown by religion (%)
Any other	3912	1.15	6619	0.29
Buddhist	313	0.15	8008	0.35
Christian	78605	37.84	1568297	68.46
Hindu	132	0.06	4921	0.21
Jewish	77	0.04	1368	0.06
Muslim	1411	0.68	23328	1.01
Sikh	119	0.06	3118	0.15
None	59776	28.77	525253	22.93
Baha'i	26	0.01		
Pagan	196	0.09		
Zoroastrian	4	0		
Patient religion unknown	30514	14.69		

Declined to disclose/not stated	18418	8.87	149976	6.54
NULL	14252	6.86		
TOTAL	207755.00		2,290,888	

2.8.1 Data on religion is not available for 14252 or 6.86% 14.29% % of the Trust's service users the data is incomplete. This is an improvement of 7.43 % compared to the level of data completeness last year.
There are differences between the data on the religion of the Trust's service users and the data in the 2011 Census in the categories of any other religion, Christian, Muslim, Hindu, Sikh and none.

2.9 Summary of Servicer Users by Disability

Disability	Breakdown of Service Users in Trust (number)	Breakdown of Service Users in Trust (%)
Hearing Impairment	3301	1.59
Mobility impairment	3305	1.59
Multi-sensory impairment	430	0.21
Other Disability	933	0.45
Physical disability	1875	0.90
Visual Impairment	5721	2.75
Speech Impairment	482	0.23
Mental Health	7022	3.38
Learning Disability	3552	1.71
Null	181134	87.19
Total number of unique referrals	207755.00	100%

2.9.1 The Trust has been able to report on the numbers of service users with hearing impairment, mobility impairment, multi- sensory impairment, other disability, physical disability, visual impairment and speech impairment. Some service users have more than one disability so may appear in more than one category. Figures from the Royal National institute for the blind in 2013 estimated that almost two million people in the UK are living with sight loss that has a significant impact on their daily lives and figures from Action on Hearing loss 2015 state that 1 in 6 people or 16.66 % have some kind of hearing loss.. Information from the 2011 census states that 38% of the population of the North East and 33% of the population of Yorkshire and Humber report a long standing illness or disability with 20% of the population of the North East and 19% of the population of Yorkshire and Humber reporting a limiting long standing illness or disability

3. Equality Objectives

3.1 Service user and carer involvement is essential to help the Trust deliver and develop services which are service user centred and feedback on services is essential in order to continually improve our services in response to what we are told. The Trust has well-established mechanisms for engaging with its service users and carers in a variety of ways.

3.2 In March 2016 each locality was asked to develop an equality objective for 2016 – 2020. There has been evidence of good consultation and activities in localities which led to the development of the equality objectives.

3.2.1 Durham and Darlington Equality Objective 2017 - 2020
To continue to ensure that the principles of Green Light are embedded in services

Progress:
Due to multiple changes in the locality the green light innovation event has had to be delayed and Staff from Durham and Darlington are attending the Greenlight 'review' Kaizen event in Tees locality in January 2020 and considering what can be utilised via a share and spread event in the Durham and Darlington locality in Q4 19/20 Durham and Darlington Adult Mental Health & Adult Learning Disabilities services continue to work closely together around a small number of patients with complex needs who require input from both services and consideration of the Greenlight principles of reasonable adjustments to support people with learning disabilities and autism within services are considered within these joint pieces of work.

3.2.2 York and Selby overall objective 2016 - 2020: Working with partners to improve access and experience of mental health services for students and young people (16 – 25) in York and Selby.
Progress:
The York and Selby objective has been completed within the agreed timescale at the end of 18/19

3.2.3 Forensic Services Equality Objectives 2017/2020
Objective 1 To improve the support for staff that is on extended forms of planned maternity / paternity / adoption leave.

Progress:
The service has re audited compliance with the Maternity, Adoption and Paternity Procedure using a sample provided by Human Resources of the people currently on maternity leave. The results are currently being analysed to identify further work that may be needed and a report will be presented to LMGB in q4 19/20

3.2.4 Teesside objective 1 2016-2020. To continue implementation of the Greenlight audit in adult services, building on the work carried out last year and completing the self-assessment.

Progress: Teesside objective 1 was completed within the agreed timescale

Teesside Objective 2. Under/ Over - Represented Communities 2017 – 2020. Based upon the information identified from analysis of our data, the locality has begun to explore the reasons for the under/over representation of particular BAME communities within services.

Progress:
The locality has continued to use a community development approach to review the experience of services for its BAME communities and to identify remedial actions that need to be taken to support access for those communities to achieve successful outcomes. MHSOP are continuing to build on the introduction to the NHS course

training provided to South Asian communities, and following on from the latest course a further 7 volunteers have been recruited into paid roles as bank staff. A further introduction to the NHS course started in January 2020. The introduction to the NHS course is a five week health and social care course, which is run by the Trust, a third sector partner and Middlesbrough community learning services. The aim is for women who have taken the course to become volunteers and eventually work for the Trust through the temporary staffing team. This opportunity is allowing the trust to begin changing the staffing demographic within older people's services, to ensure it is more reflective of the communities that it serves as well as breaking barriers around mental health. The women attending the course now feel confident about their understanding of mental health and the treatment options open to them. Work this year in MHSOP has also included continuing to improve access to dementia services for the South Asian community by running locally based.

3.2.5 **North Yorkshire objective 2016 - 2020:** To better understand the mental health needs of the farming communities in North Yorkshire and where appropriate take action to improve and increase access to services.

3.2.6 **Progress:**
The locality have developed a project group with community stakeholders, including local farming support groups. This group is leading the work with the farming community. The group have engaged in further out reach sessions with positive feedback at the Great Yorkshire show. An awareness raising package on mental health issues was developed for use at the Great Yorkshire show... The group has been working with the communications team to use social media as a tool to raise awareness of mental health issues within the farming community and filmed a series of talking heads which have received positive feedback. A training package on working with the farming community has been developed and rolled out to staff. The group are planning to engage with local agricultural colleges to reach a younger audience and to include mental health is included in Nation Farmers Union newsletters

3.2.7 **Equality, Diversity and Human Rights Strategy** A revised Equality, Diversity and Human Rights Strategy for 2020 – 2023 was approved by the Board of Directors in January 2020 in order to more fully realise the vision, mission and strategic goals of the Trust. As part of the development of this strategy a consultation was held with service users, carers, and staff and partner organisations during 2019. There was an encouraging level of engagement in the consultation exercise. A number of very clear themes emerged from this consultation and these themes have helped to shape the strategy:

Disability
Work needs to be done to ensure managers understand disability fully and are aware of how to support staff with disabilities.

Trans
Staff overwhelmingly asked for Tran's awareness training

Race and ethnicity
Staff requested more training on managing verbal aggression from patients, carers and relatives towards staff (this applies more widely than race and ethnicity).

Data completeness
There was strong agreement that demographic data on both ESR and PARIS needed to be improved.

Community Engagement

More work needs to be undertaken with hard to reach service user and carer groups to improve their access to and experienced of services

3.2.7.1 As a result of the consultation the following objectives with associated metrics have been agreed:

- Ensure that where agreed, staff that require a reasonable adjustment have this/these in place.
- Ensure we support and respond to staff that experience verbal aggression and to proactively reduce the number of incidents of verbal aggression towards staff.
- Ensure we have a suitable trained and skilled workforce to address the needs of Trans patients and staff
- To increase the recording of disability and sexual orientation on PARIS and ESR of patients and staff
- To increase the number of BAME service users who access services within the trust and report a positive experience.

4. Analysis of the effects of the Trust's policies and practices

4.1 Equality analyses are carried out on all Trust policies and procedures and these are available on the Trust website.

4.2 Equality analysis is also carried out on service developments and improvements and is an integral part of the Trust's project management processes through which all major service changes are progressed.

5. Equality in Practice

The Trust is committed to ensuring that all people have equal access to its services. Some of the initiatives the Trust has taken to realising this vision are described in the information relating to the Trust's equality objectives in section 3. Others are described below.

5.1 Disability Access Audits

Trust recognises the importance of ensuring that people with disabilities can access its premises. The Health and Safety team have carried out audits on all inpatient sites previously and. these audits are planned to continue as part of the health and safety workbook audit. In 18/19 audits were carried out on outpatient areas. It must be acknowledged that the audit only covers limited areas and do not include clinic rooms, ward and other areas in which patients are seen or areas which are solely used by staff. Progress on these is monitored by the EDHR steering group and reported bi- annually to QAC.

5.2 Interpreting Services

In order to deliver an equitable service to those whose first language is not English the Trust has a contract with an interpreting agency, ensuring quick access to appropriately qualified interpreters. The quality and usage of the service is regularly monitored. Following a tender in 2019 the new provider for the interpretation service is Everyday Language Solutions (ELS)

5.3 Data Completeness

Measurement is key to understanding whether there are differences in experience or outcomes for those in protected groups and then acting on these. Crucial to this is achieving a high level of data completeness and accuracy in the demographic data on PARIS. Work

will be undertaken as part of the new Equality, Diversity and Human Rights strategy to improve data completeness for disability and sexual orientation.

5.4 Human Rights

The trust were successful in a bid to the Health Foundation to pilot an approach to embedding a human rights based approach to decision making within clinical services. This work has been undertaken in partnership with the British Institute of Human Rights. The MHSOP team in Hartlepool and the Psychosis team in Stockton were identified as the pilot sites for this work. The project has involved training these times in Human Rights and working with them to develop tools and resources to support the further roll out of a Human Rights based approach to clinical decision making. Work is ongoing to develop options for the longer term adoption and embedding of a rights based approach to service delivery within TEWV.

5.5 Patient Friends and Family Test (FFT)

The trust analyses its patient FFT by sexual orientation, gender, disability, ethnicity and age. This information is included at appendix 1.

Currently the Trust is unable to collect information about the experiences of the Trans community and a request has been made to the Patient Experience team for a further question to be added to the FFT when the survey is refreshed in April 2020.

Responses during 2019 showed:

- Those who identify as lesbian or bisexual did not rate the care they received as highly as those identifying as gay or heterosexual
- Service users under 18 and aged 18 to 29 did not rate the care they received as highly as those of other age groups
- Service users identifying as Black, Asian, mixed race or other did not rate the care they received as highly as those identifying as other ethnicities.

Work will be undertaken to better understand these differences.

6 Conclusions

6.1 The levels of data completeness available to the Trust to measure its performance in its public sector duties have either remained static or deteriorated. Further work is needed to improve rates of completeness in certain categories this will be addressed for sexual orientation and disability in the revised Equality Strategy 2020. Higher levels of data completeness would allow the Trust to have greater confidence in its understanding of the makeup of its service users and their needs.

6.2 Progress has been made on the Trust's equality objectives and localities have taken ownership of these and are committed to achieving them and a revised Equality, Diversity and Human Rights strategy has been developed which sets out clear Trust wide objectives.

7. Recommendations

7.1 It is proposed that the information contained in this report is published on the Trust's website as evidence that the Trust is meeting its public sector equality duties.

7.2 It is recommended that further work be undertaken to support staff to improve the level of data completeness so that we can better understand any differences in outcomes and experiences for our patients. There are actions to support this in the 2020- 2023 Equality, Diversity and Human Rights strategy.

SEXUAL ORIENTATION

Sexual Orientation and Year	*2013-14*	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*Jan 19 - Dec 19*	*Total*	*Overall % Apr 2013 to Dec 2019*
Heterosexual - Total % of Excellent and Good Responses	92.3%	91.2%	88.3%	90.9%	90.8%	90.7%	91.8%	14784 (out of 16261)	90.9%
	3319	4327	2420	2185	658	594	1281		
Gay - Total % of Excellent and Good Responses	84.5%	80.2%	73.4%	85.0%	71.4%	93.3%	92.0%	274 (out of 335)	81.8%
	60	69	47	51	10	14	23		
Lesbian - Total % of Excellent and Good Responses	74.4%	84.3%	75.0%	81.3%	77.3%	81.8%	80.0%	205 (out of 258)	79.5%
	29	59	36	39	17	9	16		
Bisexual - Total % of Excellent and Good Responses	88.3%	79.5%	80.9%	81.4%	78.7%	76.6%	78.8%	520 (out of 640)	81.3%
	91	105	127	83	37	36	41		
Prefer not to say - Total % of Excellent and Good Responses	86.8%	81.2%	86.1%	82.3%	84.5%	83.7%	84.8%	4070 (out of 4831)	84.2%
	511	474	346	311	1772	477	179		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	2494	1130	1540	45592 (out of 48363)	

Key:
90% and over
85%-89.9%
Below 85%

GENDER

Gender and Year	*2013-14*	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*Jan 19 - Dec 19*	*Total*	*Overall % Apr 2013 to Dec 2019*
Male - Total % of Excellent and Good Responses	91.9%	84.6%	92.4%	92.2%	92.3%	92.3%	92.5%	21444 (out of 23251)	92.2%
	237	307	1163	1636	5456	6218	6427		
Female - Total % of Excellent and Good Responses	94.1%	95.2%	96.4%	94.4%	93.5%	93.1%	92.7%	24804 (out of 26558)	93.4%
	269	295	1373	1687	6812	7352	7016		
Other - Total % of Excellent and Good Responses	100.0%	66.7%	66.7%	0	40.0%	77.8%	66.7%	32 (out of 50)	64.0%
	3	4	4	0	4	7	10		
Prefer not to say - Total % of Excellent and Good Responses	83.3%	71.4%	80.0%	50.0%	85.8%	86.5%	81.3%	4786 (out of 5585)	85.7%
	5	5	4	2	3455	1119	196		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	15727	14696	13649	84500 (out of 77335)	

Key:
90% and over
85%-89.9%
Below 85%

DISABILITY

Disability Answer and Year	*2013-14*	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*Jan 19 - Dec 19*	*Total*	*Overall % Apr 2013 to Dec 2019*
Yes - Total % of Excellent and Good Responses	-	93.7%	94.9%	93.6%	92.8%	92.2%	91.8%	19467 (out of 21035)	92.5%
	0	193	1263	1795	5075	5530	5611		
No - Total % of Excellent and Good Responses	-	92.6%	93.6%	92.5%	94.1%	94.3%	94.1%	20884 (out of 22208)	94.0%
	0	87	991	1282	5686	6348	6490		
Prefer not to say - Total % of Excellent and Good Responses	-	-	59.1%	72.7%	86.5%	87.9%	87.1%	6552 (out of 7548)	86.8%
	0	0	13	8	4105	1652	774		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	14866	13530	12875	81699 (out of 75024)	

Key:
90% and over
85%-89.9%
Below 85%

AGE BAND

Age Band and Year	*2013-14*	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*Jan 19 - Dec 19*	*Total*	*Overall % Apr 2013 to Dec 2019*
Under 18 - Total % of Excellent and Good Responses (0-18 in 2017-18)	100.0%	100.0%	79.7%	70.9%	88.9%	90.4%	88.2%	8623 (out of 9705)	88.9%
	1	9	59	122	2233	3188	3011		
18-29 - Total % of Excellent and Good Responses (19-29 in 2017-18)	74.4%	76.0%	87.4%	89.5%	91.5%	90.7%	89.7%	7347 (out of 8153)	90.1%
	58	76	167	468	2075	2197	2306		
30-44 - Total % of Excellent and Good Responses	96.4%	79.1%	84.6%	91.4%	92.6%	91.9%	91.4%	8213 (out of 8970)	91.6%
	53	87	226	466	2340	2411	2630		
45-64 - Total % of Excellent and Good Responses	97.0%	91.2%	95.6%	93.8%	93.5%	93.6%	94.7%	10135 (out of 10780)	94.0%
	98	104	390	576	2929	2910	3128		
65 and over - Total % of Excellent and Good Responses	96.1%	98.5%	97.3%	97.2%	95.9%	96.3%	96.7%	11902 (out of 12321)	96.6%
	219	258	1741	1712	2578	2808	2586		
Prefer not to say - Total % of Excellent and Good Responses	100.0%	75.0%	63.6%	25.0%	86.6%	87.3%	89.1%	4936 (out of 5689)	86.8%
	12	6	7	1	3544	1153	213		
Total for all Responses where Excellent or Good	4111	7176	14064	15077	15699	14667	13874	84668 (out of 77298)	

Key:
90% and over
85%-89.9%
Below 85%

ETHNICITY

Ethnicity and Year	*2013-14*	*2014-15*	*2015-16*	*2016-17*	*2017-18*	*2018-19*	*Jan 19 - Dec 19*	*Total*	*Overall % Apr 2013 to Dec 2019*
White British - Total % of Excellent and Good Responses	91.7%	91.0%	92.2%	93.1%	93.7%	93.6%	93.8%	66991 (out of 72073)	92.9%
	3740	5981	12130	12960	10208	11339	10633		
White Other - Total % of Excellent and Good Responses	83.7%	97.3%	100.0%	-	89.8%	89.4%	90.8%	3041 (out of 3371)	90.2%
	36	36	2	0	794	728	1445		
Black or Black British - Total % of Excellent and Good Responses	83.3%	68.1%	74.4%	77.4%	87.1%	93.7%	81.8%	453 (out of 568)	79.8%
	20	32	90	137	61	59	54		
Asian or Asian British - Total % of Excellent and Good Responses	87.9%	76.0%	84.7%	86.8%	89.7%	91.6%	88.2%	1019 (out of 1173)	86.9%
	58	76	211	211	157	164	142		
Mixed Race - Total % of Excellent and Good Responses	89.4%	87.3%	84.6%	89.9%	90.7%	89.4%	89.4%	1115 (out of 1252)	89.1%
	42	69	121	143	225	261	254		
Other - Total % of Excellent and Good Responses	87.5%	80.4%	80.5%	88.5%	90.7%	85.4%	81.7%	508 (out of 596)	85.2%
	21	37	91	116	97	70	76		
Prefer not to say - Total % of Excellent and Good Responses	-	-	-	-	85.9%	85.6%	77.7%	4458 (out of 5207)	85.6%
	0	0	0	0	3370	1001	87		
Any Other Ethnic Group - Total % of Excellent and Good Responses	-	-	-	-	-	-	63.6%	7 (out of 11)	63.6%
	0	0	0	0	0	0	7		
Total for all Responses where Excellent or Good	3917	6231	12645	13567	14912	13622	12698	77592 (out of 13652)	

Key:
90% and over
85%-89.9%
Below 85%

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Human Rights, Equality and Diversity Policy
Ref: HR-0013-v8

Status: Ratified

Contents

1 Introduction

The NHS Constitution states that **'The NHS belongs to us all'**, it is with this principle in mind that this policy has been written.
The Trust is under increasing pressure to deliver high quality services, with limited resources to an increasingly diverse population whose needs and expectations are growing year on year. At the heart of the Trust is a commitment to provide comprehensive and flexible services that meet people's needs and are available and accessible to all. In order for the Trust to be equipped to deliver its services in a respectful, fair and inclusive way, the Trust must become more innovative in how it can meet the different needs of service users and make best use of the resources it has, most notably its people.

In employment matters the Trust recognises that harassment, discrimination, bullying and victimisation are destructive behaviours that can happen within any team, in any organisation. Wherever they exist they contribute and exacerbate poor mental health and wellbeing, add to workplace stress and lower team morale. This in turn can result in increased sickness absence levels, high staff turnover and can ultimately result in mental ill health.

If bullying is allowed to thrive within an organisation it becomes a destructive force that can prohibit open challenge, whistleblowing or raising concerns. Staff may become fearful of reprisal (victimisation) from both managerial and non-managerial colleagues. Left unchecked this can have a direct impact on the safety and quality of patient care as was highlighted in the Francis Report into Mid Staffordshire Hospital. The Trust considers all of the above mentioned abusive behaviours as 'avoidable and unjustifiable harm'.

"Patients must be the first priority in all of what the NHS does… protected from avoidable harm and any deprivation of their basic human rights" **The Francis Inquiry Report.**

"The culture at the Trust was not conducive to providing good care for patients or providing a supportive working environment for staff; there was an atmosphere of fear, of adverse repercussions" **The Francis Inquiry Report.**

Trust staff have a duty of care towards their colleagues, service users, their relatives and carers or anyone else they come into contact with whilst engaged in Trust business.

1.1 Who this policy applies to

This policy applies to the following groups of people. Expected standards of behaviour can be found in section 4.0 Roles and Responsibilities

- The Chief Executive and The Trust Board of Directors including Non-Executive Directors
- All Trust Managers, regardless of role, grade or position
- All Trust staff regardless of role, grade or position
- Bank Workers and Agency Workers
- Service users, their carers, relatives and friends
- Trust Governors
- Trust experts by experience
- Trust Volunteers
- Hospital Managers
- Contractors

2 Purpose – why we need this policy

This policy sets out how the organisation complies with applicable human rights and equality legislation (MHA CoP 2015, para.3.15)

2.1 Services

Human Rights belong to everyone. They are the basic rights that we all have simply because we are human, regardless of who we are, where we live or what we do. Human Rights represent all the things that are important to us as human beings, such as being able to choose how to live our lives whilst being treated with dignity and respect. We have Human Rights from the moment we are born until the moment we die.
Health inequalities can be wide ranging in both nature and impact. Health inequalities can be seen in many arenas of healthcare and can range from limiting patient choice and independence to misdiagnoses of health conditions and/or poor treatment or a lack of health education which can result in some protected groups not accessing services in the same way as other groups of people. The most serious breaches can reduce the opportunity of early diagnosis, impacting on the overall likelihood of recovery taking place.
Putting Human Rights at the heart of the way Trust services are designed and delivered ensures better services for everyone, with patient and staff experiences reflecting the core values of Fairness, Respect, Equality, Dignity and Autonomy.

2.2 Employment

The purpose of this policy is to provide a set of minimum standards that everyone who has dealings with the Trust must adhere to. We must also ensure that all aspects of Trust business are non-discriminatory and are carried out in a fair and consistent manner. The Trust is committed to providing services and employment environments that promote Equality, Diversity and Human Rights and will make every effort not to discriminate against service users, relatives, carers, Trust staff, potential Trust staff, bank workers, agency workers, volunteers, students, contractors or anyone that deals with the Trust in any way.

Bullying, harassment and discrimination in the workplace can be described as '***any unwanted behaviour that makes someone feel intimidated, degraded, humiliated or offended'***. It is not necessarily always obvious or apparent to others. It can be insidious and can happen in the workplace without an employer's awareness. Bullying, harassment,

discrimination or victimisation can be between two individuals or it may involve groups of people or teams.
It is sometimes obvious and witnessed by other people or it can be insidious and hidden from others. It can be persistent (over days, months or years) or an isolated incident. It can occur in written communications, by phone, text or email and not just face-to-face. It is physical, psychological and emotional abuse, it damages mental health and wellbeing and will not be tolerated by the Trust. Further information about the impact of a negative culture in an organisation can be found in section 5.2.

3 Legislation - The Human Rights Act 1998

The Human Rights Act is a foundation law, meaning that all other laws must be compatible with it. When there are abuses of Human Rights people have the right to challenge, speak up or to request an investigation. The Act has three duties which all staff and those acting on behalf of the Trust must abide by at all times. The three duties are;

- **Respect**; this means to **not** violate rights
- **Protect**; to take action to prevent a violation (by whistleblowing, raising concerns etc.)
- **Fulfil**; to provide investigation and review when violations occur (procedural duty)

The Human Rights Act is an enabling foundation law that aims to promote the rights of human beings, whatever their circumstances. It is not possible for a person not to have rights; a person always has human rights.

In particular circumstances Human Rights can be limited or restricted, but rights can never be taken away completely. Human Rights provide a set of minimum standards and are a vital safety net for the treatment we can all expect from our services, including;

- **Better services and outcomes**: can help drive up quality and improve outcomes
- **Not reinventing the wheel**: Not about completely changing what you do, human rights are a practical framework to help you improve how you do it
- **Familiar shared values**: dignity, respect, fairness, autonomy, equality and choice – upholding these values under challenging circumstances
- **Power not pity**: human rights provides a powerful language
- **About the day-to-day practice**: not theory

3.1 Key Human Rights for mental health and learning disability services

There are five key Human Rights for mental health and learning disability services, these are:

Article 2 - The right to life includes a duty not to take away anyone's life, a positive duty to take reasonable steps to protect life and a procedural duty to investigate deaths where public officials may be implicated / involved.

Article 3 - The right to be free from torture, inhuman and degrading treatment. This is an absolute right. It covers three types of treatment: Torture, Inhuman treatment, degrading treatment

It imposes three types of obligations on public officials:

- A negative duty **not** to torture or treat someone in an inhuman and degrading way
- A positive duty to take reasonable steps to protect people known to be at risk of such treatment
- A procedural duty to investigate where torture, inhuman or degrading treatment has occurred

Article 5 - The right to liberty is a non-absolute right. In specific circumstances liberty can be limited, e.g. detention under Mental Health Act or prison. The right to liberty is not a right to be free to do whatever you want. It is a right not have extreme restrictions placed on a person's movement. It includes procedural safeguards such as review mechanisms and time limits etc.

Article 8 – **The right to respect for private and family life, home and correspondence**. This right protects four interests: private life, family life, home and correspondence

This right is non-absolute and can be restricted. It has to be balanced against the rights of others and the needs of society. This right involves three types of obligations on public officials:

- A negative duty **not** to interfere with people's family life, private life, home and correspondence
- A positive duty to take reasonable steps to protect people known to be at risk of having their rights violated, especially in relation to mental and physical well-being
- A procedural duty to ensure fair decision-making processes

Article 14 – **The right to non-discrimination**. This right can only be used in conjunction with another right or rights. The definition of discrimination is broader than that of the Equality Act and a person can bring a case of discrimination for any reason.

4 Legislation - The Equality Act 2010

The Trust focuses on Equality, Diversity and Human Rights from two perspectives that are intertwined with each other.

- **Service Delivery** – Equality, Diversity and Human Rights in healthcare for service users and their carers
- **Employment** – Equality, Diversity and Human Rights for our staff

The Equality Act 2010 makes it unlawful to discriminate against someone because of one or more protected characteristics. The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Section 149(1) of the Equality Act 2010 states – A public authority must, in the exercise of its functions, have due regard (take seriously) to the need to –

- **Eliminate** unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act

- **Advance** equality of opportunity between people who share a protected characteristic and those who do not
- **Foster** good relations between people who share a protected characteristic and those who do not

These are more commonly known as the three aims of the Act.

The Act requires that the Trust demonstrates 'due regard' this means the Trust **MUST** demonstrate that it has reasonably considered its impact on equality. This is an ongoing requirement (continuous duty) and it is essential that this is done in a proactive and anticipatory way, rather than in a reactive way which is ineffective and does not evidence or demonstrate 'due regard' (reasonable consideration) of the requirements of the Act.

Section 149(2) of the Equality Act 2010 states
A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).
Section 149(2) relates to Trust staff and anyone else who provides or delivers services to the public such as council workers, the police, teachers etc. All NHS staff and anyone else who carries out a function or functions on, or on behalf of the Trust must take their responsibility seriously and in accordance with the Act, acting in compliance with section 149(1) of the Act at all times. Further information on how to access the Equality Act 2010 can be found on page 15.

5 Policy

This policy lays down the Trusts expected standards in relation to Equality, Diversity and Human Rights in employment and service delivery. This policy applies to anyone who has dealings with the Trust. It is hoped that by taking a unified approach the Trust can promote a message that is clear and well understood by all parties.

1. The Trust will respect and protect the Human Rights of all service users, staff and anyone else who has a relationship to the Trust.
2. Any restriction/s placed on the rights of service users, for example a decision to detain a person under the Mental Health Act will be lawful, justifiable and proportionate, will have a legitimate aim and will be the least restrictive option in the circumstance
3. The Trust takes breaches of policy very seriously, particularly those that when breached have a harmful effect on other people. Victimisation, harassment, discrimination (or an attempt to do so) and bullying will not be tolerated and will, where substantiated lead to disciplinary action
4. Staff who identify with protected groups have the right to be treated in a fairly and with dignity and respect and without the fear of unlawful discrimination, harassment, victimisation or bullying
5. Service users who identify with protected groups, their relatives and their carers have the right to be treated in a fair, reasonable and consistent way with dignity, respect and

	compassion and without the fear of unlawful discrimination, harassment, victimisation or bullying
6.	The Trust will work to reduce health inequalities for all service users
7.	The Trust is committed to the ongoing development of staff awareness and knowledge of Equality, Diversity and Human Rights. Staff development begins on employment and continues throughout an individual's career until they leave the Trust
8.	The Trust is committed to monitoring, evaluating and reporting on issues of Equality, Diversity and Human Rights in employment and service provision
9.	The Trust will work towards best practice standards of Equality, Diversity and Human Rights and not merely comply with legislation
10.	The Trust will promote equality, foster good relations and take an anti-discriminatory approach in all areas of employment and service delivery
11.	The Trust will ensure that barriers to accessing services and employment are identified and removed so that no person is treated less favourably because they identify with a protected group/s
12.	The Trust recognises the importance of this policy in the employment relationship it has with its staff and in provision of services for service users, and will reflect this commitment in all Trust policies, procedures and practices etc.
13.	Anyone that deals with the Trust will receive equitable treatment whether they are receiving a service, providing a service, tendering for a contract or in any other relationship with the Trust
14.	This policy extends outside the workplace and Trust staff should be aware that work place behaviour includes time when they are not physically at work but are participating in activities where work is a factor, i.e. team nights out, shopping trips with colleagues etc.
15.	Abusive, discriminatory and / or unethical behaviour outside of work could still affect the relationship between the Trust and its employees, particularly if it is deemed to be so serious that it would warrant disciplinary action or allegations of gross misconduct, as would be the case if the individual or group concerned were at work
16.	Staff with a professional registration may also find that discriminatory and or unethical practices outside work may lead to complaints to their professional body and possible action by them
17.	This policy is a key policy and as such should be read by all staff regardless of role, grade or position.

5.1 Associated Benefits

The Trust recognises the benefits which will arise from implementation of the Human Rights, Equality and Diversity Policy including:

1. Right respecting clinical practice provides the very best opportunity for recovery. Services take a positive and inclusive approach to minimising distress and harm
2. The provision of accessible, flexible and adaptable services that are delivered by highly capable staff that meet the needs of service users', resulting in equitable levels of patient satisfaction regardless of which protected group/s they identify with
3. Equality, Diversity and Human Rights enhance opportunity, inclusivity, creativity and innovation leading to better working and patient care environments
4. Employing staff from different protected groups and cultural backgrounds enables a better understanding of the needs of all service users, and results in a workforce with increased levels of empathy and compassion
5. A diverse workforce and inclusive working environments increase the reputation of the Trust in different communities. In turn this encourages people from these communities such as BAME and LGB&T people, and people with disabilities to apply for positions within the Trusts as its reputation grows as an employer of choice
6. A diverse organisation has higher levels of emotional intelligence and empathy than less diverse organisations. Diversity also drives innovation and creativity which is a key element in developing inclusive working practices and service provision. Staff that share similar values on issues such as respect, compassion, equality and fairness are more likely to get on and more likely to be part of an effective and successful team

5.2 Associated Risks

There are a number of risks associated with not implementing this policy. Including:

- Low staff morale
- Reduced team performance due to bullying
- Higher than average sickness levels in teams where there are issues
- High turnover of staff
- Nepotism
- Litigation and associated financial costs and penalties
- Investigation of individual, team, service, Trust etc.
- CQC and EHRC warnings and fines
- Unwanted (negative) media attention
- Loss of public confidence
- Loss of future business
- Poor patient reported outcome measures
- Reduction in Staff Survey outcome measures

The associated risks stated in 3.2 are more likely to occur when the following takes place.

1. **Discrimination arising from disability:** Discrimination for any reason connected to the person's disability that is not covered by other forms of discrimination. For example, people with disabilities having to walk on the road because the pavements at a hospital are not suitable for people who use wheelchairs or people who are registered blind

2. **Failure to make reasonable adjustments in relation to disability:** Where a physical feature, provision, criterion or practice puts a disabled person at a substantial disadvantage, the service provider has a duty to take reasonable steps to alter, remove or avoid that disadvantage. E.g. providing aids and equipment, changes to working arrangements and ensuring services are accessible and inclusive to people who have a range of disabilities
3. **Harassment:** unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual
4. **Bullying:** Unwanted conduct, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual
5. **Equality, Diversity and Human Rights Breaches:** Human Rights breaches, failure to provide and deliver services or provide employment that is appropriate and meet the needs of the individual service user or member of staff
6. **Direct discrimination:** when someone is treated less favourably than another person because of a protected characteristic they have. Includes, age, disability, gender reassignment, race, religion or belief, sex (gender) and sexual orientation. Note – the protected characteristics of marriage and civil partnership and pregnancy and maternity are not covered by perceptive discrimination or associative discrimination
7. **Perceptive discrimination:** Discrimination by perception happens when a person is discriminated against because they are thought to have a particular protected characteristic. People are protected even if they do not have the protected characteristic, and they are protected if they do. E.g. Tim finds homophobic abuse written on his locker. He reports it to his manager. Tim is protected whatever his sexual orientation because even if Tim is heterosexual he is still receiving homophobic abuse
8. **Associative Discrimination:** Discrimination by association occurs when a person is treated less favourably because of their association with a person who has a protected characteristic. It could be that they are being treated less favourably than others because of the protected characteristic of spouse, partner, parent or another person with whom they are associated
9. **Indirect discrimination:** a rule, policy or practice which is applied to all but has a disproportionately adverse effect on particular groups of people and it cannot be objectively justified
10. **Victimisation:** treating a person worse because they have made, or people think they have made, a complaint about discrimination, harassment, bullying or have given or about to give evidence in an investigation or discrimination case – victimisation is unlawful

6 Equality Analysis

The Trust will use Equality Analysis (EA) to ensure that the Trust reasonably considers its impact on equality. Equality Analysis Policy and Guidance, defines the requirements of the Trust and its staff in more detail. The Trust has identified some additional priorities and these are identified in sections 5 to 6.8.

Valuing staff and ensuring that they feel they have been treated fairly results in staff feeling engaged, improves morale, motivation, loyalty and job satisfaction. It also reduces staff turnover meaning that the Trust is more likely to retain staff with the right values, attitudes and skills

7 Interpreting and Translation

Trust staff will refer to the Interpreting and Translation Policy and Guidance when providing care for people who speak using a language other than English or who communicate using British Sign Language. Patient care cannot take place if the service user is unable to understand the clinician or any member of staff involved in their care and treatment.

8 How this policy will be embedded

Equality, Diversity and Human Rights will be embedded into every aspect of Trust business. This section highlights some of the key areas and themes that have been identified within the Trust.

8.1 Recruitment, Selection and Employment

- All recruitment processes, conditions of service, job requirements and learning and development opportunities, must fit with the needs of the service and those who work in it. The trust will comply with the legal requirements of the Equality Act 2010 and the Human Rights Act 1998
- The Trust will strive to provide a positive working environment in which people want to work and be a leader in good employment practices and effective communication
- Under representation, where it exists, will be identified and addressed by removing barriers. People will have equal access to career advancement and other opportunities within the organisation
- Taking positive action, where appropriate, to ensure applicants and employees can participate in, and have opportunity work for the Trust, further ensuring that Trust services meet the needs of its communities
- The Trust is also committed to enabling every member of staff to achieve their full potential in an environment characterised by opportunity, dignity and mutual respect

8.2 Learning and Development

- All staff must undertake Equality and Diversity training as they start working for the Trust. Additionally staff are required to undertake regular refresher training in accordance with the mandatory training needs analysis which is part of the staff development policy
- All employees should have an annual individual appraisal including a personal development plan. This should completed in accordance with the staff development policy On an annual basis the Trust will produce a Training Needs Analysis to outline how the Trust priorities for development will be achieved
- Information on training and development opportunities is widely publicised and all employees will be encouraged to undertake appropriate training and development, which will enable them to meet the requirements of their role in meeting service needs

8.3 Performance Management

- Performance assessments should be based on employee's performance against their actual objectives and the Knowledge and Skills Framework profile linked to their job description
- All managers with responsibility for appraisal should be able to show evidence of competence in Appraisal and Equality and Diversity Awareness
- Concerns over discriminatory or inappropriate behaviour picked up through supervision, whether clinical, professional or managerial, should be dealt with promptly by the manager
- In relation to disability, the Trust will make every effort to make reasonable adjustments for Trust staff that have or develop a disability whilst employed by the Trust. This could include people who can continue to work but the reasonable adjustments can't be accommodated in that particular role. Under the Trusts capability or sickness procedures there would be opportunity for staff to enter redeployment to explore whether adjustments could be accommodated in another job in a different area
- If an individual is so unwell or the condition is so severe/life-threatening that they cannot continue working then Occupational Health advice would be sought and the Trust would follow the Sickness Absence Management Procedure (Stage 4)
- Reasonable adjustments and other support procedures will be put in place to support and enable staff with disabilities to meet the requirements of their role, but on very rare occasions it will be not be possible to make reasonable adjustments or redeploy staff. This may be because the nature of the person's disability will be such that it inhibits the person's ability to work at all. When this happens the Trust will follow the End of Employment Procedure.
- If you believe that you have been subjected to bullying, harassment, discrimination or victimisation, you can raise a grievance using the Trust's Grievance Procedure. The Trust will not tolerate harassment, discrimination, victimisation or bullying of staff because of a protected characteristic(s) or for any other reason. Any member of staff

committing such actions will be subject to the Trusts Disciplinary Procedure and it could result in dismissal

- **If you witness someone being subjected to bullying, harassment, discrimination or victimisation and don't feel you can raise it with your line manager then you should use the Trust's Whistleblowing Procedure and Raising Serious Concerns Procedure to raise the issue.**

8.4 Partnership Agreement

The Trust has an agreement with staff side representatives which reinforces the importance of partnership working with all parties sharing a commitment to the business and service needs of the Trust.
The agreement encourages managers to spread the benefits of partnership working by ensuring that staff and staff side representatives are systematically and routinely involved in shaping the service and involved in the decision making process. This reinforces an environment where the right balance is reached between the needs of the service and the needs of its employees, ultimately improving the working environment for staff which has a positive knock on effect which can be seen in the quality of patient care. Further information on Joint Staff Side work can be found here.

8.5 Trust Services – Planning Services

- The Trust will ensure that its priorities are informed by the health needs of the communities it serves. When health inequalities are recognised steps will be taken to remove them by engaging and seeking the views of the communities, including those represented by protected groups and by working with commissioners
- Equality, Diversity and Human Rights will be considered throughout the planning stages of all Trust services

8.6 Trust Services – Service Design

- Equality analysis and/or demographic equality data will be used to consider Equality, Diversity and Human Rights and the needs of service users and carers at every stage of the service design process
- Trust staff will take a positive and proactive approach to Equality, Diversity and Human Rights by raising their own awareness and knowledge levels to accomplish this aim. The Trust (the equality and diversity team) will support staff to do this

8.7 Trust Services – Access to Services

- All Trust services will proactively endeavour to anticipate and meet the needs of people that identify with protected groups. When a protected group is underrepresented in a service the Trust will investigate the reasons for this and where necessary will take action to remove barriers that impact on services being accessed in an equitable way

- The Trust will ensure that its services are accessible to people with disabilities

8.8 Trust Services – Service Delivery

- Trust services will be delivered in a respectful, dignified, compassionate and professional way with the needs of the service user taking priority
- Trust services and the staff involved in the delivery of services will maintain a flexible and adaptable approach to delivering care, if concerns or issues arise around working with protected groups or in how to meet the human rights of service users, staff will seek advice from the Equality and Diversity Team in the first instance
- Trust services will ensure that patients are involved in discussions about their care and treatment and that their culture and ethnicity are respected and supported. The Care Programme Approach and Standard Care
- The Trust will gather feedback on patients' experiences at appropriate times. Quality Strategy 2017- 2020

The Trust expects that staff will actively challenge and report abusive behaviour of any kind. The Trust expects managers to take steps to support staff who experience challenging or abusive behaviour of any kind. If you are unsure what this is, you can seek further advice and guidance from the Equality, Diversity and Human Rights Team

	Responsibility
Chief Executive and the Trust Board of Directors	• The Chief Executive is responsible for providing leadership to the Trust in the promotion of Equality, Diversity and Human Rights in both service delivery and employment matters • Members of the Trust Board collectively and individually are responsible for supporting the Chief Executive in this objective • The Trust must conform to current legislative requirements of the Human Rights Act 1998 and the Equality Act 2010. • The Trust seeks to ensure equitability of access in the provision of its services, which meets the needs of service users • As a provider of mental health, learning disability and substance misuse services, the Trust is committed to meaningful engagement with all parts of its communities and commissioners • The Trust seeks to dismantle barriers that prevent equality of access to employment, promotion, training and development opportunities for all protected groups
Director of HR&OD	• The Director of HR&OD has operational responsibility for Equality, Diversity and Human Rights throughout the Trust in both Employment and Service Delivery

The Equality and Diversity Lead - Services	• The Equality, Diversity and Human Rights Lead role is to support the Director of HR&OD to be able to make informed decisions in all matters relating to Equality, Diversity and Human Rights. The EDHR Lead reports to the Director of HR&OD monthly and to the Quality and Assurance Committee (QUAC) three times a year, submitting an annual report of progress made as part of the reporting cycle. Further to this the EDHR Lead reports to the Executive Management Team (EMT) and Workforce Development Group as and when necessary and in accordance with Trust requirements
Equality, Diversity and Human Rights Officer	• The Equality, Diversity and Human Rights Officer reports to the Equality and Diversity Lead and has an active role in supporting the Equality, Diversity and Human Rights Lead, supporting Trust staff to embed Equality, Diversity and Human Rights within employment and services
Managers	• Managers understand that unlawful discrimination, harassment, bullying and victimisation are unacceptable practices and have no place in Trust services, departments or teams. • Managers are expected to foster positive working environments where mutual respect for Equality, Diversity and Human Rights are central to their role as manager, leading by example, and actively challenging abusive behaviour of any kind to maintain good staff morale, wellbeing and good patient care • Making staff aware of the Trust policy on Equality, Diversity and Human Rights and the supporting policies in relation to employment and service delivery • Promoting Equality, Diversity and Human Rights by their behaviour and actions • Ensuring that complaints are dealt with in a fair and consistent manner • Ensuring that contractors working within the Trust adhere to the principles of the Equality, Diversity and Human Rights Policy
Staff, including agency workers, bank workers and students	• Are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision • Must not discriminate e.g. This includes any person who is responsible for selection decisions in recruitment, promotion, transfer, training etc. or those responsible for the provision and delivery of services • Not acting, persuading, attempting to persuade or instructing other employees, unions or Management to practice unlawful discrimination, harassment, bullying, victimisation or any act that would result in a breach of the Human Rights Act 1998 • Not harassing, bullying or intimidating other employees, including their peers, subordinates or seniors. This includes

	amongst others: sexual, racial and homophobic harassment • Not victimising or attempting to victimise individuals on the grounds that they have made complaints or provided information on discriminatory practice. • Informing management if they suspect or are aware that an act or acts of discrimination or inhumane treatment of any kind is or have taken place
Contractors	• All contractors must comply with the requirements of the Equality Act 2010 and the Human Rights Act 1998 whilst providing or delivering goods, services and facilities to Trust staff, service users, their relatives, carers and anyone else who has links with the Trust. • Not complying with the above means that the contractor is in direct breach of the 'Terms and Conditions of its contract with the Trust and the contract will be terminated.
Service users, their relatives and carers	• Service users, their relatives, friends and carers can expect to be treated with respect and courtesy whilst accessing or engaging with Trust services. We encourage service users, their carers and relatives to contact the Trust using the PALS service if they experience unfair or unequal treatment or feel that Trust services do not meet their needs. • Service users, their relatives, friends and carers are expected to treat Trust staff with respect and courtesy whilst receiving Trust services. The Trust will not tolerate racist, sexist or homophobic abuse etc., towards its staff, other service users, their relatives or carers. The Trust will provide support and/or signposting to staff or anyone else who feels that they have been harassed, discriminated against or victimised whilst they have been delivering services or receiving care.
Trust Governors and Volunteers	• Trust Governors and Volunteers are expected to treat each other and anyone else they come into contact with whilst carrying out their duties with respect and courtesy • Trust Governors and Volunteers can expect to be treated with respect and courtesy whilst performing duties, with or on behalf of the Trust
Hospital Managers	• Hospital Managers have a statutory role under the Mental Health Act 1983 which requires them to attend review meetings to ensure the lawful criteria for detention under the Act is met. This role is also pivotal in that it addresses the Human Rights of service users. It is expected that they will be non-biased and that their decisions will be made without prejudice. It is expected that individuals who are selected to act on behalf of the Trust as Hospital Managers will uphold the principles of this policy, in that the Trust expects high standards in relation to Equality, Diversity and Human Rights from Hospital Managers. The Trust will take action to remove Hospital Managers who do not meet the Trusts expected standards.

10 Glossary

Term	Definition
CQC	Care Quality Commission
Diversity (difference)	The Trust recognises that everyone has a unique contribution to make and that a person's personal attributes contribute significantly in achieving the Trusts goals. Diversity is a strength and it should be visible at all levels of the organisation. Valuing Diversity is integral to valuing people. When we value Diversity we promote a positive, supportive and innovative working environment. When we value the Diversity of our service users we are more likely to meet their needs and support them on their journey to recovery.
EHRC	Equality and Human Rights Commission
Equality	Equality in the UK is about fostering and promoting the right to be different, to be free from discrimination, and to have equal choices, opportunities being valued as an individual.
HR&OD	Human Resources and Organisational Development
Human Rights	The rights that we all have and share, simply because we are human
BAME	Black, Asian and Minority Ethnic
LGB&T	Lesbian, Gay, Bisexual and Transgender

11 Related documents

To provide context the Trust has a number of closely associated policies, procedures, guidance and other documents that support the aims of this central policy, they include:

- Disciplinary Policy and Procedure, Whistle Blowing and Raising Serious Concerns, Incident Reporting and Investigating Policy, Security Procedure, Equality Analysis Policy and Guidance, Interpreting and Translation Policy and Guidance, Staff Development Policy, Dress Code Policy, Special Leave and Flexible Working Policy, Health and Wellbeing Strategy, Recruitment & Selection Policy, End of Employment Policy and Procedure, Grievance Policy and Procedure (including bullying and harassment), Job Evaluation Policy and Procedure, Organisational Change Policy, Retirement and Long Service Policy, Information Governance and Information Security and Risk Policy, End of Employment Procedure and Capability Procedure

12 How this policy will be promoted

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.
- Where additional training needs for staff are identified they will be taken forward using existing Trust processes by the Equality and Diversity Lead and the Workforce Lead

13 How this policy will be monitored

The Director of Human Resources and Organisational Development will ensure this policy is reviewed with respect to changes in legislation and/or at any time where it can be shown the needs staff, service users or any other group are not being met

1. Publish equality information as required by the Equality Act 2010 and by the Mental Health Act Code of Practice 2015 (para.3.15)
2. Publish 'Equality Objectives' every four years which will be supported by an annual work plan which will be reviewed annually. The work plan is aimed at meeting the requirements of the 'Public Sector Equality. Regular progress reports will be made to the Trust Board via the Equality, Diversity and Human Rights Steering Group, the Equality and Diversity Lead and Work Force Lead.

The Equality, Diversity and Human Rights Steering Group will monitor and evaluate progress made on delivering the Trusts equality objectives including:

3. Develop and performance manage the systems to monitor and improve Equality, Diversity and Human Rights within the Trust with particular reference to ensuring the Trust meets its responsibilities under the Equality Act 2010 and the Human Rights Act 1998

4. Develop an annual work plan to progress the delivery of Equality, Diversity and Human Rights and to ensure the Trust meets its legal responsibilities under the Acts

5. Ensure that systems are in place to provide assurance that demonstrates compliance with all legislative and quality requirements

6. Monitor incidents and breaches of Equality, Diversity and Human Rights legislation and monitor and audit the dissemination of learning lessons and feedback from actions

7. Oversee any relevant procedural and policy development and review

8. Ensure that systems are in place to provide evidence of the Trust's compliance with the expectations of any external regulatory bodies and their standards

The Trust will monitor and where appropriate:

9. Report incidents towards service users, carers and staff. If incidents such as racial, sexist, and homophobic or any other abuse occurs while on Trust premises or whilst staff are representing the Trust, these will be challenged and dealt with in line with the Trust security policy and/or disciplinary policy and procedure and the grievance policy and procedure (including bullying and harassment).

The Trust:

10. Recognises an individual's right to privacy, under European Human Rights Regulations and the provisions laid out in the Data Protection Act 1998. Information will therefore be stored in accordance with the Information Governance and

Information Security and Risk Policy

In order to assess the effectiveness of its Human Rights, Equality and Diversity policy in employment matters the Trust will review and maintain the following information in relation to staff identifying with protected groups, including:

11. Statistical information about the composition of the workforce. This will be used for measuring the achievement of the Trust's annual work plan in relation to employment, including:

    - Job applicants
    - Short-listed candidates
    - Existing and new employees deployment and managerial/leadership level within the Trust and the protected characteristics identified.
    - Details of selections decisions for recruitment, redeployment, promotion, transfer and training and reasons for these decisions
    - Exit interviews
    - Grievances
    - Disciplinary decisions

Where information is collated in line with the Human Rights, Equality and Diversity Policy, it will be published using established communication mechanisms and in line with the NHS confidentiality code of practice.

14 Contact Details and Further Information

The Equality and Diversity Team can be contacted on 0191 3336267/6542 if you have concerns or would like advice about any issue relating to services and employment.
Sarah Jay – Equality, Diversity and Human Rights Lead
Email: sarahjay@nhs.net

The Equality and Human Rights Commission
The Equality Advisory and Support Service (EASS) provide bespoke advice and in-depth support to individuals with discrimination problems and can be contacted on the following number: 0808 800 0082 (or textphone 0808 800 0084).
The Equality and Human Rights Commission have advice on their website regarding all forms of discrimination as well as a useful glossary of terms which can be found here

Press ctrl +click on these links in order to access further information.
The Human Rights Act 1998
The Equality Act 2010
The Health and Social Care Act 2008 (regulated activities) Regulations 2009
The Health and Safety at Work Act 1974
The Care Quality Commissions – Essential Standards of Quality and Safety and Equality and Human Rights in Outcomes
FREDA and Human Rights in Health Care - Mersey Care NHS Trust
Mental Health Act 1983: Code of Practice

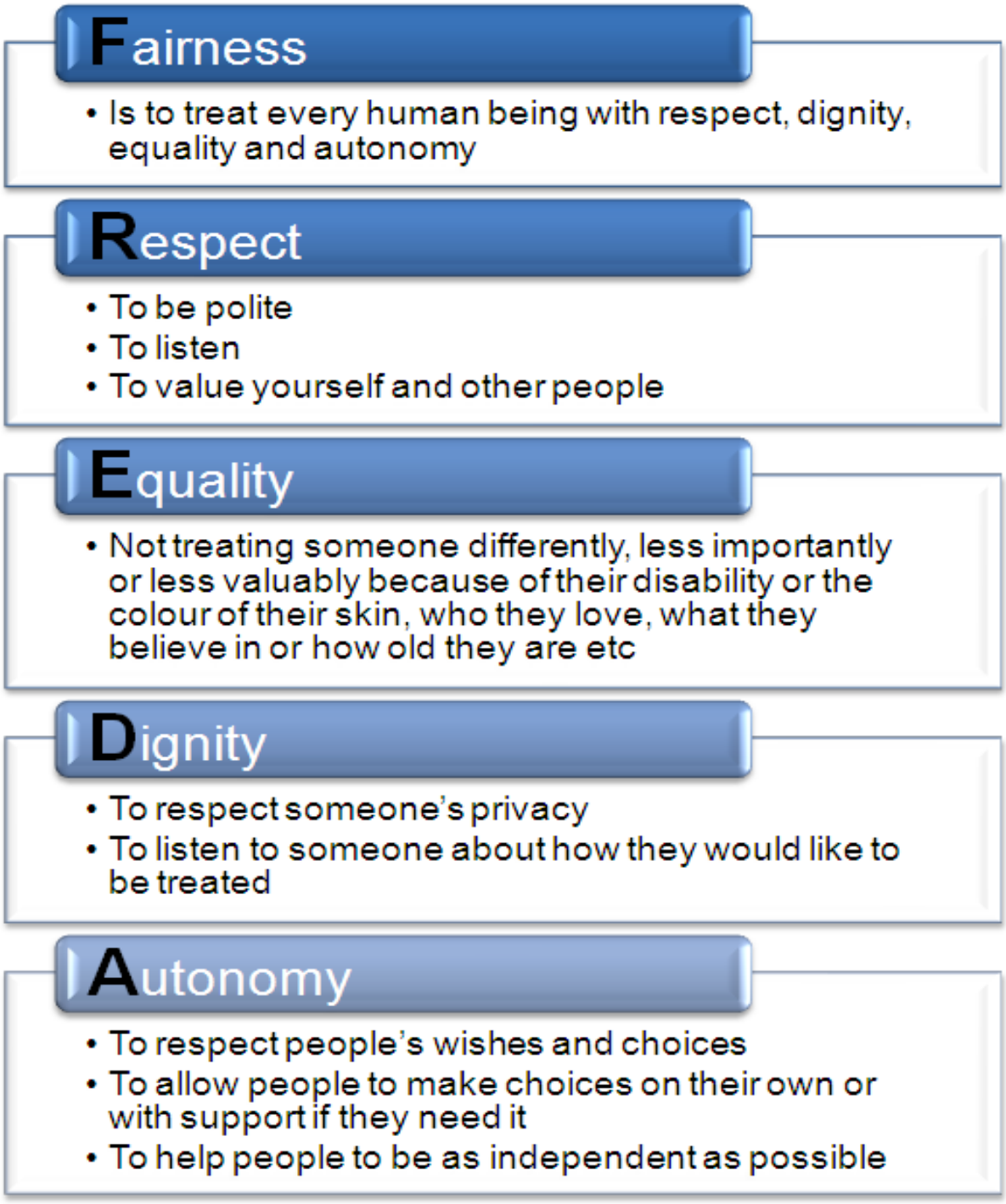
15 Document control

Date of approval:	**22 January 2020 (12 December 2018)**	
Next review date:	**22 January 2023 (Annual review required by MHA CoP para.3.15)**	
This document replaces:	**HR-0013-v7**	
Lead:	**Name**	**Title**
	Sarah Jay	**Human Rights Equality and Diversity Lead**
Members of working party:	**Name**	**Title**
	Policy Working Group	
This document has been agreed and accepted by: (Director)	**Name**	**Title**
	David Levy	**Director of Human Resources and OD**
This document was ratified by:	**Name of committee/group**	**Date**
	EMT **Board of Directors** **Board of Directors**	**22 January 2020** **23 January 2018** **February 2020**
An equality analysis was completed on this document on:	**22 January 2020**	

Change record

Version	Date	Amendment details	Status
8	12 Dec 2018		Published
8	09 Oct 2019	Review dated extended from 12 Dec 2019 to 28 Feb 2019	Published
8	22 Jan 2020	Policy reviewed with no changes. Review date extended for 3 years	Published

16 Appendix 1 – F.R.E.D.A Human Rights in Health Care



FREDA courtesy of
Mersey Care NHS Trust

17 Appendix 2 – The Human Rights Act 1998

The UK Human Rights Act 1998 contains sixteen basic rights. They fall into two categories

1. Absolute – Rights that are absolute cannot be taken away.

- (N A) Non Absolute Rights can be restricted or limited in certain circumstances, e.g. to protect a person or when a person's actions are likely to impact on the person or to protect the wider community from harm

  - (A2)Right to life (A)
  - (A3)Right not to be tortured or treated in an inhuman or degrading way (A)
  - (A4)Right to be free from slavery or forced labour (A)
  - (A5)Right to liberty (N A)
  - (A6)Right to a fair trial (N A)
  - (A7)Right to no punishment without law (A)
  - (A8)Right to respect for private, family life, home and correspondence (N A)
  - (A9)Right to freedom of thought, conscience and religion (N A)
  - (A10)Right to freedom of expression (N A)
  - (A11)Right to freedom of assembly and association (N A)
  - (A12)Right to marry and found a family (N A)
  - (A14)Right not to be discriminated against in relation to the enjoyment of any of the rights contained in the European Convention (is used in conjunction with other article or protocol)
  - (A1 P1)Right to peaceful enjoyment of possessions (N A)
  - (A2 P1)Right to education (N A)
  - (A3 P1)Right to free elections (N A)
  - (A1 P13) Abolition of death penalty (A)

For further information on The Human Rights Act 1998 press ctrl + click on this link

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Equality Analysis Screening Form

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc	Human Resources and Organisational Development					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	EDHR team					
Title	Human Rights, Equality and Diversity Policy					
Is the area being assessed a	**Policy/Strategy**	**X**	**Service/Business plan**		**Project**	
	Procedure/Guidance				**Code of practice**	
	Other – Please state					
Geographical area	Trustwide					
Aims and objectives	This policy sets out how the organisation complies with applicable human rights and equality legislation					
Start date of Equality Analysis Screening	1.2.20					
End date of Equality Analysis Screening	2.2.20					

Please read the Equality Analysis Procedure for further information

You must contact the E&D team if you identify a negative impact. If you require further advice and support please ring Sarah Jay on 0191 3336267/3542

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?
All trust staff, carers, service users

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	**Disability** (includes physical and mental impairment)	No	**Sex**(Men and women)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and some other non religious beliefs)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite sex and same sex couples who are either married or civil partners)	No
Yes – Please describe the anticipated negative impact **No – Please describe any positive outcomes** This policy describes how the trust will comply with its legal obligations under the Equality and Human Rights Acts. It seeks to ensure that those coming into contact with the trust are treated in a way that respects their rights and ensures equality of outcomes and experiences.					

3. Have you considered any codes of practice, guidance, project or business plan benefit? **If 'No', why not?**	**Yes**			

Sources of Information may include:

- Feedback from equality bodies, e.g. Care Quality Commission, Disability Rights Commission, etc
- Investigation findings
- Trust Strategic Direction
- Data collection/Analysis
- Staff grievances
- Media
- Community Consultation/Consultation Groups
- Internal Consultation
- Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Please describe the engagement and involvement that has taken place

This policy is reviewed annually in accordance with the MHA Code of Practice. The trust has ongoing engagement with its staff and service users from protected groups and any relevant information is fed into this policy.

No – Please describe future plans that you may have to engage and involve people from different groups

5. As part of this equality analysis have any training needs/service needs been identified?

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

No	Please describe the identified training needs/service needs below				
A training need has been identified for					
Trust staff	No	Service users	Yes/No	Contractors or other outside agencies	Yes/No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					
The completed EA has been signed off by: You the Policy owner/manager: Type name: Sarah Jay					Date: 2.2.20
Your reporting manager: David Levy					Date: 3.2.20
Please forward this form by email to: tewv.policies@nhs.net **Please Telephone: 0191 3336267/6542 for further advice and information on equality analysis**					

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Tuesday 25 February 2020**
TITLE:	**Report of the Mental Health Legislation Committee**
REPORT OF:	**Paul Murphy, Non-Executive Director**
REPORT FOR:	**Assurance/Information**

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

Executive Summary:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for quarter 2, 2019/20.

Key areas for consideration:

- Reports on Discharges from Detention, Section 23 (2), Notification of discharge by relative; Section 132 (information to detained patients), Section 136 Exception Report.
- Seclusion Report
- Section 15 MHA Medical and Administrative Scrutiny
- Report on MCA and DoLS
- CQC Quarterly Update
- Case study

Recommendations:

The Board of Directors is asked to:

Receive and note the assurance report, following the MHLC meeting held on 22 January 2020 and to note the approved minutes of the MHLC meeting held on 23 October 2019. (Annex 1)

MEETING OF:	**Board of Directors**
DATE:	**Tuesday 25 February 2020**
TITLE:	**Report of the Mental Health Legislation Committee**

1. INTRODUCTION & PURPOSE:

To assure the Board of Directors of the compliance with Care Quality Commission (CQC) regulatory requirements with respect to Mental Health legislative activity for Quarter 3, 2019-20; through consideration of the work of the Mental Health Legislation Committee at its meeting held on 22 January 2020.

2. BACKGROUND INFORMATION AND CONTEXT:

The Mental Health Legislation Committee has been established as a formal Committee of the Board of Directors under the Constitution.

The Terms of Reference of the MHLC require the minutes of its meetings to be formally presented to the Board of Directors.

3. KEY ISSUES:

The confirmed minutes of the Mental Health Legislation Committee held on 23 October 2019 are attached as Annex 1.
The MHLC also met on 22 January 2020. The key issues considered at this meeting were as follows:

COMPLIANCE WITH MHA PROCESSES

3.1 Discharges from Detention

The Committee considered the Discharges from Detention.

The key points for the Board to note are:

- In Quarter 3 there were 155 Hospital Managers' review meetings held resulting in two patients being discharged from section 3.
- There were 108 First-tier Tribunals, which resulted in three patients being discharged from their section. One remained as an informal patient on the ward, one patient went home the same day as the discharge and the other on Section 37/41 was conditionally discharged.
- Members considered that the information and data collected around the Mental Health Act, once the IIC electronic system was up and running would be more effective for data process control methods.

3.2 Section 23 (2) Assurance Report – Notification of discharge by nearest relative

The Committee considered the data on Section 23 (2) – notification of discharge by nearest relative.

The key matters to note are:

- During 2019 Hospital Managers received two notifications of discharge by a nearest relative. This figure is low compared to the previous year of five. Both discharges were barred by the responsible Clinician. Hospital Managers Review hearings were arranged in both cases.
- One relative did not exercise their right to apply to the Tribunal following the Hospital Manager Review meeting for a patient detained under section 3 where the Hospital Managers decision at the barring hearing was "not discharged".
- For the second patient, a Hospital Managers barring hearing was arranged but then cancelled as the notification to discharge was invalid as the nearest relative had already exercised their power of discharge in the previous six months.

3.3 **Section 132 Information to Detained Patients**

The Committee discussed the Section 132 report – Information to detained patients.

The key matters for the Board to note are:

- During Quarter 3 the escalation process was used 12 times (19 in Quarter 2) including three times requiring escalation to the Mental Health Legislation team Manager.
- There was one occasion where form 132b had not been received for one patient before they were discharged.
- It will be helpful when prompts added to CITO will provide alert notifications on a daily basis, which should hopefully eliminate this problem.

3.4 **Section 136**

The Committee considered data and trends around S136.

The key matters for the Board to note are:

- TEWV place of safety continues to be the optimum choice for Section 136 with a police station only being used once in Quarter 3. This was an appropriate use due to the level of violence and aggression displayed. There were seven uses of Section 136 that occurred at the police station where people were in custody for criminal matters and then brought to a TEWV PoS on Section 136. All were in the North Yorkshire police area.
- There were 156 uses of S136 across the Trust, compared to 174 in the previous quarter. Of the 155 uses of Section 136, 14 lasted more than 12 hours and six lasted longer than 18 hours.
- For those lasting more than 18 hours reasons included unavailability of a CAMHS bed, delays in attendance of an AMHP and delays in the availability of a first doctor to attend.
  The availability of AMHPs in the North Yorkshire area is impacted by the fact that North Yorkshire is a large rural geographic area and there is generally only one AMHP covering the whole of York and North Yorkshire.

COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS

3.5 **Seclusion**

The Committee considered the seclusion data.

The Board is to note:

- In Q3 there had been 67 episodes of seclusion, (89 in previous quarter) with multiple episodes for 13 patients and 62 episodes lasting more than 12 hours, of which 50 were over 24 hours.
- One episode of seclusion lasted for 578 hours, which was well above the 350 hours in the previous Quarter. This individual had been waiting for a higher level of security.
- Members queried the periods of time for patients in seclusion compared with other MH Trusts. Efforts had been made in the past to undertake some benchmarking, which had proven difficult, due to the variances across MH Trusts, as well as an unwillingness to share information.

3.6 **Section 15 MHA Medical and Administrative Scrutiny**

The Committee considered the Section 15 report.

The key matters highlighted from the period 1 January 2019 to 31 December 2019 around detentions that were invalid due to fundamental flaws or medical insufficiency were:

- There had been 17 occasions when Section 15 could not be used to rectify flaws or insufficiencies.
- Since July 2018 a new step had been introduced into the process whereby medical recommendations deemed insufficient could be re-scrutinised by the ACD or above.
- From that process one section that would have been invalid had been passed as sufficient by the second scrutineer.
- Learning around these matters will be publicised through the Doctors bulletin.

EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS

4.0 Mental Capacity Act and DoLS

The Committee discussed the quarterly update report on MCA and DoLS.

The key point to note is there will be key legislative changes anticipated from October 2020 at the earliest when the Liberty Protection Safeguards (LPS) will replace the Deprivation of Liberty Safeguards (DoLS). We are awaiting the Code of Practice to accompany LPS and also the associated Regulations. The Mental Health Legislation team are making preparations for these changes but cannot progress until the Code and Regulations are available.

KEY GOVERNANCE INFORMATION

5.0 CQC Report

The Committee received a quarterly CQC compliance report.

The key issues for the Board to note are members of the Committee considered the continued emerging themes from the five CQC MHA inspections to various wards including care plans, leave, patient rights and restrictive practice.

It was noted that around the issue of patients being given their rights there had been some conflicting advice from the CQC to staff about this matter; however the Medical Director provided assurance that staff on wards already do over and above what the Code of Practice requires.

HOW THE EXPERIENCES AND VIEWS OF DETAINED PATIENTS FORM PART OF THE COMMITTEE'S CONSIDERATIONS

6.0 Case Study

The Committee received a case study of a patient on PICU Bedale Unit, Roseberry Park Hospital, including the presenting risks and rationale for seclusion.

6.1 Issues that could impact on the Trust's Strategic or key operational risks

There are no concerns to raise that might impact on the Trust's strategic or key risks.

7.0 IMPLICATIONS:

7.1 **Compliance with the CQC Fundamental Standards:**

CQC MHA visit reports do not indicate any significant issues with regard to compliance with the Fundamental Standards in terms of the MHA and MCA however themes from MHA inspections continue to reoccur and it is important that actions and progress against these are closely monitored.

7.2 **Financial/Value for Money:**
There are no implications.

7.3 **Legal and Constitutional (including the NHS Constitution):**
Non-compliance with the CQC regulatory framework for the Mental Health Act and Mental Capacity Act and DoLS and/or non-compliance with the MHA or MCA itself would have serious consequences for the organisation and place the organisation at risk of breach of the conditions of the Independent Regulators or potential litigation.

7.4 **Equality and Diversity:**
There are no implications.

8 CONCLUSIONS:

The MHL Committee receives reports and evidence for assurance on all elements of the Mental Health Act administration and implementation, demonstrating compliance with CQC regulatory requirements. This assurance is externally supported by the feedback from the CQC Mental Health Act inspections.

9 RECOMMENDATIONS:

The Board of Directors is asked to:

(i) Receive and note this report including the confirmed minutes of the meeting of the MHLC held on 23 October 2019.

Mr Paul Murphy
Chairman of the Committee/Non-Executive Director
25 February 2020

Background Papers:
Annex 1 – Confirmed minutes of the 23 October 2019 MHL Committee Meeting

Annex 1

MINUTES OF THE MEETING OF THE MENTAL HEALTH LEGISLATION COMMITTEE HELD ON 23 OCTOBER 2019 IN SEMINAR ROOM 4, WEST PARK HOSPITAL, DARLINGTON AT 2.00PM

Present:
Mr P Murphy, Chairman of the Committee and Non-Executive Director
Mrs E Moody, Director of Nursing & Governance
Mrs R Hill, Chief Operating Officer
Mrs B Reilly, Non-Executive Director
Dr A Khouja, Medical Director
Mrs J Illingworth, Director of Quality and Governance

In Attendance:
Miss M Wilkinson, Head of Mental Health Legislation
Mrs J Ramsey, Mental Health Team Manager (for minutes 19/58-63)
Mrs R Down, MHL Advisor (for minute 19/64)
Mrs J Harrison, Expert by Experience Representative
Mr C Allison, Public Governor, Durham
Mrs A Marshall, Deputy Director of Nursing
Ms D Oliver, Deputy Trust Secretary, (Corporate)

Apologies: Apologies for absence were received from Dr P Hungin, Non-Executive Director and Mr J Creer, Public Governor, Durham.

19/56 MINUTES OF LAST MEETING

Agreed – *That the minutes of the last meeting held on 24 July 2019 be approved as a correct record and signed by the Chairman, subject to the amendment of the date on page 4: 19/48: (6) An update would be brought back to the* ***22 January 2020*** *MHLC meeting.*

19/57 ACTION LOG

The Committee noted the actions and following updates:

17/33 Benchmarking – talk to NTW about seclusions.
Members considered that this action, which had been on the log since October 2017, should now be removed and closed in light of the publication of some pending national information around seclusion. Whilst information had been requested from NTW Trust, this had not been received and members recognised that it would have been difficult to benchmark since their seclusion arrangements for inpatient areas were different to TEWV. Members were satisfied that due to the significant variation in the arrangements across MH Trusts in the UK, at the present time benchmarking would not provide anything further for TEWV.

Following a question from a Governor, it was noted that those patients secluded and waiting to transfer to another hospital would be more likely to include forensic patients waiting to move to a high secure unit.

Assurance was provided by the Director of Nursing that the care for these individuals was at its least restrictive level possible.

18/42a Section 62 information to be reported to MHLC in October 2018 and then annually. This report had been deferred since it had been placed on to the action log, due to the information not being readily available on the long waits for Second Opinion Appointed Doctors (SOADs).
The head of the MH Legislation team advised that the data could be obtained either through request to the CQC or by asking the responsible clinician (RC) directly.

The Chairman sought clarification on the original issue to be explored, which had been to look into instances where section 62 had been used when a SOAD was delayed.

The Director of Nursing advised that going forward the RCs should be advised to communicate any issues with the MH team; however it was recognised that this was really an operational issue.

(It was noted post-meeting that this had been an action on the Trust Board of Directors from April 2019, 9/103, which stated: "The shortage of SOADs and its impact on operational services to be included in the corporate risk register" – marked as completed in September 2019).

The Medical Director suggested that a one-off exercise/census could be undertaken on the problem with long waits for obtaining a second on call doctor and would bring back the results to the 22 January MHLC meeting.

Action: Dr A Khouja

19/45 Section 136 Report: table 6, under 18's brought to a TEWV place of safety to show comparisons with the previous quarter.
This matter was covered under agenda item number 4b (minute 19/59 refers).

Completed

19/49 Look at those episodes of seclusion where the MHL team are notified within 24 hours at Roseberry Park.
This matter was covered under agenda item number 5 (minute 19/63 refers).

Completed

HOW DOES THE TRUST DEMONSTRATE COMPLIANCE WITH MHA PROCESSES?

19/58 DISCHARGES REPORT

The Committee considered and noted the MHA Discharges Report.

The following was highlighted:

- In Quarter 2 there had been 155 Hospital Managers' review meetings with no patients discharged.
- There had been 117 First-tier Tribunals, which had resulted in 3 patients being discharged.

Following discussion, it was noted that:

(a) There were no trends or concerns from Q2. There had been no patients discharged over the last two quarters, which was thought to be attributable to the fact that the individuals within inpatient settings were the most unwell from the community, so it

would be expected that the Hospital Managers' review meetings would find that patients continued to meet the criteria for detention.

(b) It would be useful for members to be able to contextualise the figures in the report by showing the previous quarter's results in future reports and Mrs Ramsey undertook to include further narrative next time.

Action: Mrs J Ramsey

19/59 SECTION 136 REPORT

The Committee considered and noted the Section 136 report.

The following was highlighted from the report:

- There had been 174 uses of S136 across the Trust, compared to 165 in the previous quarter.
- There had been 19 episodes that had lasted 12 hours or more and some examples of the reasons behind these longer time periods were provided in the report.
  It was noted that a couple of these episodes had lasted over 18 hours and members considered how well the escalation processes had been working since the change in law from 72 hours to 24 hours.

  Miss Wilkinson undertook to provide the information around the two individuals held for more than 18 hours and the doctors on call at the time and this would be fed back to the 22 January 2020 MHL meeting.

  Action: Miss M Wilkinson/Mrs E Moody

- Dr Khouja reported that there had potentially been a breach of the 24 hour escalation period and he undertook to look into this further to check if this had in fact occurred and feed back to the next meeting.

  Action: Dr A Khouja

- There had been five individuals aged between 14 and 17 held under section 136 in Q2, which was a decrease from nine in Q1.

Following discussion members:

(a) Recognised that the numbers for Scarborough of individuals held under section 136 in a Trust place of safety was high (up to 31 in Q2 from 17 in Q1) and this was thought to be due to the increase in the population at the seaside over the summer season.

The Chairman requested that this be contextualised and explained in future reports.

Action: Mrs J Ramsey

(b) Raised the 17-year-old from the Scarborough locality that had been taken to a TEWV place of safety and was returned to the community without follow up.
It was considered by a Non-Executive Director that the language around this suggested that the individual had not been followed up, however it was explained that this person could have been assessed and identified that there was no requirement for follow up.

(c) Questioned whether there could be any lower level interventions in place at community level to prevent young individuals being placed under Section 136.

The director of Nursing agreed that from a clinical perspective this was an important point, and something that the MHL Committee had discussed in the past (including

whether there was a need for a sub-group with more clinical representation to discuss such matters). However, within the terms of reference of the Committee as it stood, it was the legislation that was the focus.

(d) Queried on page 7 of the report that Tees appeared to be an outlier in terms of the outcome of section 136 for Q2, with 20 individuals not open to services and returned to the community with no follow up.
This was explained as potentially being due to the easy access to the crisis assessment suite and facilities in the Tees area, which were available 24 hours a day and the possibility that people were brought for assessment who had needs other than those related to mental health.

19/60 SECTION 132 - INFORMATION TO DETAINED PATIENTS REPORT

The Committee considered and noted the Section 132 report.

The key issues highlighted from the report were:

- In Q2 the escalation process had been used 19 times, an increase from 13 in Q1.
- Assurance was provided that following implementation of the escalation processes all 132b forms had been received.
- The report provided additional information around patients being given their rights and when this had been escalated to a ward manager, modern matron and the MHL team manager.
Members acknowledged that this matter of patients being given their rights was something that had been repeatedly picked up in MHA inspections and was a recurring problem across ward areas that the Trust had been trying to improve.

Following discussion, it was noted that:

(a) There had been instances of individuals not receiving their rights in over seven days.

Members requested that this be picked up operationally and the Director of Nursing agreed to take this to the appropriate operational groups, including Ward Managers and OMT.

Action: Mrs E Moody

(b) The recording of the information around patients receiving their rights was limited to the time of admission for individuals, so it did not give a true picture of the patient pathway, however it was anticipated that with the introduction of CITO this could be captured in a more robust way.

(c) Any patient who wanted to take any action if they did not receive their rights could raise an individual concern or make a complaint.

19/61 SECTION 5 - HOLDING POWERS SIX MONTHLY REPORT

The Committee considered and noted the Section 5 MHA Holding Powers Report.

The following was highlighted:

(1) This bi-annual report set out exceptions in the use of section 5(4) nursing holding power and section 5(2) doctors or AC holding power and the occasions where these had been allowed to lapse or where the outcome was not usual or lawful.

(2) There had been 177 uses of section 5(2) and 38 uses of section 5(4) in Quarters 1 and 2.

(3) Of these, there had been one lapse of each due to different reasons, one 5(4) lapsed as staff had waited until report out to discuss a patient with the consultant and the 6 hours had been exceeded, and the other due to Section 5(2) being used incorrectly to monitor a patient, rather than for its purpose as a holding power to allow time for assessment.

Following discussion members were assured that two out of 200 uses of Section 5 had been positive; however, they requested that for the two lapses that had occurred that this should be fed back to the appropriate staff.

Action: Miss M Wilkinson

19/62 SECTION 18 – ABSENT WITHOUT LEAVE REPORT

The Committee considered and noted the Section 18 – absent without leave report.

The main issues highlighted were:

(1) In Q1 and 2 there had been 179 AWOL episodes across the Trust and one patient had sadly died whilst AWOL.
(2) Of those patients that were AWOL there were a number of multiple absences, with one patient absent on 13 occasions.
(3) All of those that went AWOL from medium level of security were notified to the CQC.

Following discussion members acknowledged that patients go absent without leave for a number of different reasons including to see family and friends, to drink or use illicit substances.

In response to the discussion, the Director of Nursing noted that there was a piece of work, perhaps a Task and Finish Group, required across the localities to look further into this matter, which wards have the higher numbers of AWOL patients and the reasons behind it.

Mrs Moody undertook to take forward this piece of work, with no deadline set for completion to the Committee at this initial stage, but with a verbal update to the 22January 2020 meeting.

Action: Mrs E Moody

The Chairman of the Committee requested that future reports include the previous quarter's information for comparisons to be made.

Action: Mrs J Ramsey

HOW DOES THE TRUST DEMONSTRATE COMPLIANCE WITH KEY CODE OF PRACTICE REQUIREMENTS?

19/63 SECLUSION QUARTERLY REPORT

The Committee received and noted the Seclusion report.

The key points highlighted from the report were:

- In Q2 there had been 89 episodes of seclusion, (99 in previous quarter). Of the 89 episodes 77 had been over 12 hours, of which 64 had been over 24 hours.
- The longest completed seclusion for those in excess of 24 hours was 350 hours, compared to 328 in Q1.
- There had been 23 patients that had multiple seclusion episodes.

The Medical Director advised:

(a) That following the audit of a sample of 10 patients where it had been found that formulation audits and medical reviews for seclusion at Roseberry Park were not always carried out in a timely manner (Board of Directors, 24.09.19, minute: 19/231 refers) a further piece of work would be undertaken to look at 20 episodes of seclusion both prospectively and retrospectively.
(b) The results would be brought back to the January 2020 MHLC meeting and Non-Executive Directors could in the meantime be informed of the timescale for this work.

Action: Dr A Khouja

Members considered the use of segregation:

(i) Miss Wilkinson provided a definition, which had changed since the CQC had published the interim findings with a range of recommendations on prolonged seclusion and segregation.
On this matter it was noted that the Trust, in response to the publication, would be reviewing clinical procedures concerning the use of seclusion and segregation and this would commence some time in December 2019.

HOW DOES THE TRUST DEMONSTRATE EFFECTIVE IMPLEMENTATION OF THE MCA AND DOLS?

19/64 MENTAL CAPACITY ACT AND DOLS REPORT

The Committee received and noted the quarterly update report on the Mental Capacity Act and the use of DoLS.

In introducing the report Mrs Down drew attention to:

(1) Updates around the Trust-wide audit on the quality of MCA assessments, DoLS module and the accuracy of the data and the Liberty Protection Safeguards (LPS), which would replace the Deprivation of Liberty Safeguards (DoLS).
(2) The Act to replace DoLS would be supplemented by a new Code of Practice and also Regulations.
(3) It was expected that the new Code of Practice would be introduced in April 2020. The changes to legislation had been raised at a previous Board of Directors meeting where it had been flagged to list this as a topic for a future Board Seminar.

Non-Executive Directors queried the level of confidence in the new Code of Practice being finalised and Miss Wilkinson responded that there was a firm commitment from DHSC for the April 2020 completion.

Following discussion, it was noted that the implications around the Liberty Protection Safeguards would impact on individuals aged between 16-18 years, as LPS included this age range where DoLS currently did not. This was important given the recent (September 2019) piece of case law that made it clear that parental consent cannot be relied upon to authorise a deprivation of liberty for 16 and 17 year olds. The impact for the Trust would mean that it would particularly affect wards such as Holly and Baysdale.

Miss Wilkinson explained that guidance had been provided to Holly and Baysdale prior to the case law being handed down and this guidance would be revised in light of the Supreme Court decision.

Action: Miss M Wilkinson

Mrs A Marshall left the meeting

The Committee was assured that the Trust was compliant with the Mental Health Act and DoLS legislation.

WHAT KEY GOVERNANCE INFOMRATION DOES THE MHLC NEED TO BE AWARE OF/AGREE?

19/65 CQC REPORT

The Committee received and noted the CQC report.

The following key matters were highlighted from the report:

(1) The Trust continued to maintain full registration with the CQC however some conditions of registration had been imposed following the unannounced inspection to the children and young people's inpatient services.

(2) The top themes and trends for recent MHA reviews which included the recurring themes around care plans and section 17 leave forms.

The Director of Quality Governance suggested that the report should include some comparisons with the previous year.

Action: Mrs J Illingworth

(3) The well led inspection by the CQC would commence in November 2019, with the draft reports expected over Christmas in order to check for accuracy.

Following a query from the Chairman of the Committee it was noted that the Trust had adequate systems in place for patients presenting with a different language to English, this included leaflets and access to interpretation services; however there had been a few occasions when it hadn't been as effective as it could be.

A Non-Executive Director queried how often wards were inspected, which was annually and whether the CQC would find the same issues and concerns a year on.

Members considered that it would be useful for Directors to have information on previous MHA inspections in a pack for Directors visits. It was important that there was sharing of issues across the wards for continued improvements to be made. Some assurance could be provided however from recent inspections as there had been an improvement around locking doors where 65 wards had none reported as locked.

The matter of packs for Directors visits would need to be discussed with the Chief Executive.

Action: Mrs M Moody

HOW IS THE COMMITTEE ASSURED THAT IT IS REFLECTING THE VIEWS AND LIVED EXPERIENCES OF SERVICE USERS?

19/66 CASE STUDY

The Committee received a case study of a patient requiring seclusion on Cedar Ward, Psychiatric Intensive Care Unit at West Park Hospital.
Members commented how the case study brought home the complexity and acuity of some individuals, the specialist support they required and how the narrative provided the reality and human element to the data and statistics that the Committee considered.

The Chairman of the Committee requested that the staff member that had prepared the case study be thanked.

19/67 TRUST'S STRATEGIC RISKS

There were no issues raised that might impact on the Trust's strategic risks.

19/68 ANY OTHER BUSINESS

The Medical Director raised the issues of discharges from non-section 2 detentions within 48 hours of a scheduled tribunal, as the Trust had been contacted by the Tribunals Service highlighting the cost of this.
It was agreed that a small piece of work by the MHL team would be presented to the next meeting of the MHL Committee in 22 January 2020.

Action: Miss M Wilkinson

The meeting concluded at 3.55pm

Item. 14

FOR GENERAL RELEASE
BOARD OF DIRECTORS

DATE:	**25 February 2019**
TITLE:	**Finance Report for Period 1 April 2019 to 31 January 2020**
REPORT OF:	**Patrick McGahon, Director of Finance and Information**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The comprehensive income outturn for the period ending 31 January 2020 is a surplus of £5,921k, representing 2.1% of the Trust's turnover and is £77k ahead of the NHSI plan.

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

The Trust is currently £77k ahead of its year to date financial plan.	**Variance £000**	**Monthly Movement £000**	
	-77	-35	↑

Cash Releasing Efficiency Savings (CRES) (3.3)

Identified CRES schemes for the financial year are forecast to be £2,121k ahead of financial plan.	**CRES Type**	**Annual Variance £000**	**Movement**
	Recurrent	505	→
	Non recurrent	-2,625	↑
	Target	0	
	Variance	-2,121	↑

Identified CRES schemes for the rolling 3 year period were £5,460k **behind** the £21,810k CRES target.	**CRES Type**	**Annual Variance £000**	
	Recurrent	5,460	↑

A Waste Reduction Programme has been established to assist the Trust in delivering the current year CRES requirements in full, and a rolling 3 year recurrent CRES plan.

Capital (3.4)

The Trust is £7,164k **behind of** its capital plan.	**Variance £000**	**Monthly Movement £000**	
	-7,164	-2,185	↑

Expenditure against the capital programme to 31 January 2020 is £ 30,216k and is behind plan by £7,164k. The variance arises largely due to delays in:

- commencing the rectification scheme at Roseberry Park Hospital (£4,805k);
- the purchase of land for the North Yorkshire and York community mental health team base (Kings park) (£635k), and;
- the purchase of land for Worsley Court replacement (£663k);
- the purchase of the Limetrees replacement building (Bacchus House) (£960k).

Purchase of land and building are now anticipated to be purchased in February and March respectively.

The forecast for the capital programme is now planned to be £4,114k behind plan at the year end, subject to confirmation of land and building purchases going to planned timelines.

Workforce (3.5)

The Trust is £1,615k **in excess** of its agency cap (29%)	**Variance £000**	**Monthly Movement £000**	
	1,615	137	↑

Agency expenditure is 29% in excess of cap for the period ending 31 January 2020 (25% in month), with expenditure across all localities. Agency expenditure has reduced during the year, reflecting the impact of the Trust's agency reduction plan.

Use of Resources Risk Rating (UoRR) (3.7)

	Plan	**Actual**	**Movement**
The Trusts UoRR is behind plan which is rated 1 to 4 with 1 being good.	1	2	→

The UoRR for the Trust is assessed as 2 for the period ending 31 January 2020 and is behind plan (Table 4). The actual rating of 2 arises due to agency expenditure continuing to exceed the NHSI cap by 29%, although month on month reductions in spend are continuing, and is rated as a 3. Recruitment options are being explored and monthly agency expenditure has reduced since April 2019. Progress continues to be monitored and inform conversations with NHSI.

Despite the improving agency expenditure position it is unlikely that expenditure will reduce to be within cap and therefore the UoRR is forecast to be a 2 rating at the year end which is behind the plan.

Recommendations:

The Board of Directors is requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

MEETING OF:	**Board of Directors**
DATE:	**25 February 2020**
TITLE:	**Finance Report for Period 1 April 2018 to 31 January 2020**

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for 1 April 2019 to 31 January 2020.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

3. KEY ISSUES:

3.1 Key Performance Indicators

The Trust is ahead of plan against the control total set by NHSI.

The UoRR for the Trust is assessed as 2 for the period ending 31 January 2020 and is behind plan. The actual rating of 2 arises due to agency expenditure continuing to exceed the NHSI cap by 29% and is rated as a 3.

Despite the improving agency expenditure position it is unlikely that expenditure will reduce to be within cap and therefore the UoRR is forecast to be a 2 rating at the year end which is behind the plan.

3.2 Statement of Comprehensive Income

The comprehensive income outturn for the period ending 31 January 2020 is a surplus of £5,921k, representing 2.1% of the Trust's turnover and is £77k ahead of the NHSI plan. This is summarised in table 1 below:

Table 1

	Annual Plan	Year to Date Plan	Year to Date Actual	YTD Variance	Prior Month Variance
	£000	£000	£000	£000	£000
Income From Activities	(352,595)	(286,811)	(286,362)	449	390
Other Operating Income	(16,009)	(13,605)	(13,385)	220	269
Total Income	**(368,604)**	**(300,416)**	**(299,747)**	**669**	**659**
Pay Expenditure	282,378	235,947	231,222	(3,613)	(2,361)
Non Pay Expenditure	71,696	51,194	54,814	2,308	1,898
Depreciation and Financing	8,920	7,432	7,058	(374)	(339)
Variance from plan	**(5,610)**	**(5,843)**	**(6,653)**	**(809)**	**(42)**
Fixed Asset Impairments	0	0	732	732	0
Variance from plan	**(5,610)**	**(5,843)**	**(5,921)**	**(77)**	**(42)**

The improvement within pay expenditure is largely due to the establishment of new posts following an increase in contracted income within clinical services. Recruitment is on-going.

Non-pay expenditure is higher than the original plan and is largely due to additional investment in IT infrastructure in preparation for the improvements to the patient information system, and purchase of replacement furniture and fittings in clinical services.

Fixed asset impairments arise in month for work and fees incurred on schemes reflected in the latest capital plan.

3.3 Cash Releasing Efficiency Savings (CRES)

The Trust's performance against the 2019/20 CRES target is shown in Table 2 below. The Trust is anticipating being ahead of plan (£2,121k) at the financial year end and continues to identify schemes for future years.

Table 2: Cash Releasing Efficiency Scheme Performance 2019/20	**2019/20 Target**	**2019/20 Identified Schemes**	**Variance from Target**
Locality	**£000**	**£000**	**£000**
Chief Operating Officer	4,319	5,895	-1,576
Corporate and EFM	1,014	1,405	-391
Trustwide recurrent schemes	4,566	4,720	-154
Total identified and approved recurrent CRES	**9,899**	**12,020**	**-2,121**

3.4 Capital

Expenditure against the capital programme to 31 January 2020 is £ 30,216k and is behind plan by £7,164k. The variance arises largely due to delays in:

- commencing the rectification scheme at Roseberry Park Hospital (£4,805k);
- the purchase of land for the North Yorkshire and York community mental health team base (Kings park) (£635k), and;
- the purchase of land for Worsley Court replacement (£663k);
- the purchase of the Limetrees replacement building (Bacchus House) (£960k).

Purchase of land and building are now anticipated to be purchased in February and March respectively.

3.5 Workforce

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

Table 3	**Pay Expenditure as a % of Pay Budgets**						
Tolerance	Tolerance January-20	August	September	October	November	December	January
Establishment (a) (90%-95%)	91.53%	92.26%	92.01%	92.45%	92.44%	91.25%	91.53%
Agency (b)	2.40%	3.20%	3.13%	3.11%	3.08%	3.05%	3.02%
Overtime (c)	1.00%	0.87%	0.88%	0.90%	0.92%	0.92%	0.90%
Bank & ASH (flexed against establishment) (100%-a-b-c)	5.07%	3.59%	3.55%	3.50%	3.45%	3.52%	3.46%
Total	**100.00%**	**99.92%**	**99.57%**	**99.96%**	**99.89%**	**98.74%**	**98.92%**

The tolerances for flexible staffing expenditure are set at 1% of pay budgets for overtime and 2.4% for agency, and flexed in correlation to staff in post for bank and additional standard hours (ASH). For January 2020 the tolerance for Bank and ASH is 5.07% of pay budgets.

NHS Improvement monitors agency expenditure against a capped target. Agency expenditure at 31 January 2020 is £7,130k which is £1,615k (29%) in excess of the agreed year to date capped target of £5,516k. Nursing and Medical agency expenditure accounts for 87% of total agency expenditure, and is used to support vacancies and enhanced observations with complex clients.

Agency expenditure has reduced during the year, reflecting the impact of the Trust's agency reduction plan.

Recruitment options are being explored to reduce dependency on agency further, and progress continues to inform conversations with NHSI.

3.6 Cash

Total cash at 31 January 2020 is £84,929k; this is £8,752k ahead of plan and is largely due to higher than anticipated creditor accruals where invoices have not been received by the Trust and delays within the capital expenditure plan.

3.7 Use of Resources Risk Rating (UoRR) and Indicators

3.7.1 The UoRR for the Trust is assessed as 2 for the period ending 31 January 2020 and is behind plan (Table 4). The actual rating of 2 arises due to agency expenditure continuing to exceed the NHSI cap by 29% and is rated as a 3. Should agency expenditure reduce to be within cap the UoRR would improve at the year end to a rating of 1.

The Trust is ahead of its income and expenditure target (£77k) despite the agency expenditure position.

Table 4: Use of Resource Rating at 31 January 2020

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

TEWV Performance	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	1.76x	2	1.65x	3	
Liquidity	53.9 days	1	47.5 days	1	
I&E margin	1.9%	1	1.9%	1	
I&E margin distance from plan	0.0%	1	0.0%	1	
Agency expenditure	£7,130k	3	£5,516k	1	
Overall Use of Resource Rating		**2**		**1**	

3.7.2 The capital service capacity rating assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 1.76x (can cover debt payments due 1.76 times), which is ahead of plan and is rated as a 1.

3.7.3 The liquidity metric assesses the number of days operating expenditure held in working capital (current assets less current liabilities). The Trust liquidity metric is 53.9 days; this is ahead of plan and is rated as a 1.

3.7.4 The income and expenditure (I&E) margin assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 1.9%, which is on plan and is rated as 1.

3.7.5 The I&E margin distance from plan ratio assesses the I&E Margin against plan, excluding PSF income. The Trust I&E margin distance from plan is 0% which is on plan and rated as a 1.

The agency rating assesses agency expenditure against a capped target for the Trust. Agency expenditure is 29% higher than the capped target and is rated as a 3.

The margins on UoRR are as follows:

- Capital service cover - to improve to a 1 a surplus increase of £5,533k is required.
- Liquidity - to reduce to a 2 a working capital decrease of £56,474k is required.
- I&E Margin – to reduce to a 2 an operating surplus decrease of £78k is required.
- Agency Cap rating – to improve to a 2 a reduction in agency expenditure of £236k is required.

4. IMPLICATIONS:

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

5. RISKS:

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

6. CONCLUSIONS:

6.1 For the period ending 31 January 2020 the Trust is £77k ahead of its planned control total surplus (£5,921k) submitted to NHSI.

6.2 The amount of CRES identified for the financial year is ahead of plan and the Trust continues to identify schemes to ensure full delivery of recurrent CRES requirements for the 3 year rolling programme.

6.3 The UoRR for the Trust is assessed as 2 for the period ending 31 January 2020 and is behind plan (Table 4).

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to receive the report, to note the conclusions in section 6 and to raise any issues of concern, clarification or interest.

Patrick McGahon
Director of Finance

ITEM 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th February 2020**
TITLE:	**Board Dashboard as at 31st January 2020**
REPORT OF:	**Sharon Pickering, Director of Planning, Performance & Communication**
REPORT FOR:	**Assurance**

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

Executive Summary:

As at the end of January 2020, 6 (35%) of the indicators reported are not achieving the expected levels and are red across three of the four domains (three in the Quality domain, one in the Activity domain and two in the Workforce domain). This is two more than the position as at the end of December 2019. In addition there are 5 KPIs (29%) that whilst not achieving the expected standard are within the 'amber' tolerance levels, with 6 achieving the standards and being rated as green (35%), which is three less than in December 2019.

The Year to Date position shows 9 (53%) of the KPIs are rated as green (1 less than in December) with 4 rated as red which is also one more than in December.

In terms of the Oversight Framework (OF) the Trust did not achieve two of the standards:

- IAPT- proportion of people completing treatment who move to recovery standard. The main area of concern continues to be within Durham and Darlington where the standard has not been achieved in two of the three CCG. A detailed action plan has been developed and agreed with commissioners to improve the position and there has been some small improvements seen in January
- Out of Area Placements – the agreed standard was not achieved for the first time in the year to date. This is linked to significantly high bed occupancy across the Trust but particularly in Teesside. The is a detailed 'bed management' action plan which ash been developed by the Right Care Right Place Programme and the Teesside locality are considering what further action they could take to try to address this issue.

In addition to the above there were also variances in achievement of the OF standards at CCG levels and further detail is provided within the report.

There has been no change to the Data Quality Assessment Scores since the last report

Recommendations:
It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

MEETING OF:	**Board of Directors**
DATE:	**25th February 2020**
TITLE:	**Board Dashboard as at 31st January 2020**

1. INTRODUCTION & PURPOSE:

1.1 To present to the Board the Trust Dashboard as at 31st January 2020 (Appendix A) in order to identify any significant risks to the organisation in terms of operational delivery. Definitions of the KPIs within the dashboard are provided in Appendix B.

2. KEY ISSUES:

2.1 Performance Issues

The key issues in terms of the performance reported are as follows:

- As at the end of January 2020, 6 (35%) of the indicators reported are not achieving the expected levels and are red across three of the four domains (three in the Quality domain, one in the Activity domain and two in the Workforce domain). This is two more than the position as at the end of December 2019. In addition there are 5 KPIs (29%) that whilst not achieving the expected standard are within the 'amber' tolerance levels, with 6 achieving the standards and being rated as green (35%), which is three less than in December 2019. Of the 11 indicators that are either red or amber 3 are showing an improving trend over the previous 3 months.

  The Year to Date position shows 9 (53%) of the KPIs are rated as green (1 less than in December) with 4 rated as red which is also one more than in December.

- In terms of the Oversight Framework (OF) there were two areas in January that are of concern as follows:

  - IAPT- proportion of people completing treatment who move to recovery. The Trust continues to not achieve the standard in January achieving 47.64%. Whilst not achieving the 50% standard this position is higher than the 45.19% achieved in December (and the 45.95% achieved for Quarter 3 as a whole). The main area of concern is within Durham where the standard has not been achieved for a number of months. A detailed action plan has been agreed with commissioners focussed on improving recovery by reducing the numbers of people that are waiting, and the time that they are waiting, increasing productivity and ensuring appropriate referrals into the service. The action plan is being monitored with commissioners, in addition to internally, and there has been some reduction in the numbers of people waiting recently. It should be noted that the standard was achieved in Darlington CCG for the first

time since July 2019. The standard was also not achieved in January 2020 in the Scarborough and Ryedale CCG.

- Inappropriate Out of Areas Placements (Adult and Older People Services) – the Trust did not achieve the agreed standard in January for the first time in the year to date. There has been significant pressure on beds during the month of January. The key issue appear to be in Durham and Darlington however there are a number of people in beds within Durham and Darlington from other localities which is impacting on bed availability when an admission is required from the population of Durham and Darlington. The standard was also not met in Scarborough and Ryedale CCG and the Vale of York CCG. The Right Care Right Place Programme has developed a specific 'bed management' action plan to address the bed pressures which have been experienced over recent months. Other potential actions are also currently being considered by the Teesside locality which has the highest level of bed occupancy. All out of area placements were internal to the Trust.

In addition to the above there were also variances in achievement of the Oversight Framework (OF) standards at CCG level as described below:

- Access to Early Intervention in Psychosis Services – Whilst the Trust overachieved against the standard in January we did not deliver the required standard in Darlington CCG, Hambleton and Richmondshire CCG and Scarborough and Ryedale CCG.

3.2 Key Risks

- Waiting times for first appointment (KPI 1) – As a Trust delivery of the 4 week waiting time standard continues to be a challenge and dropped to below 80% for the first time in the past three years. From a quality perspective this can impact on patient safety and experience. There continues to be concern in terms of delivering against the standard in North Yorkshire and York. Vacancies and sickness in AMH services are key factors contributing to this position although there has been additional staff recruited who are now in post. Within Older Peoples Services work is ongoing to review the pathway for the memory service in order to identify any changes that would help address the gap between demand and the capacity available to meet that demand. An improvement event is planned for later in the year to try to improve processes thereby increasing capacity. In addition concerns remain in Durham and Darlington AMH services linked to staff sickness and vacancies.
- Bed Pressures (KPI 3 & 12) – For the first time since August 2018 the agreed standard for inappropriate Out of Areas Placement days (KPI 3) has not been met which is clearly linked to the extremely high levels of occupancy reported in KPI 12 (97.7%). Significant work is being done via the action plan on bed management led by the Right care Right Place Programme Board. However the levels of bed occupancy, particularly in Teesside is a cause for concern and the locality are considering what other action could be taken to address the issue. The number of people

occupying a bed with a length of stay over 90 days (KPI 13) and the %age of patients readmitted within 30 days (KPI 14) do not appear to be significant areas of concern.

- Percentage of Serious Incidents which are found to have a root or contributory cause (KPI 5) – The Trust position is worse than the standard set and the position has fluctuated considerably over the year. The position in January related to 4 incidents which had a root or contributory finding of which 3 were in Durham and Darlington Adult Mental Health community teams. At this time no themes from the 3 have been identified.
- %age of teams achieving the benchmarks for Outcomes score (KPI 6 and 7) – Whilst there has been a further decline in the position for January the Year to Date figure is above the agreed standard. There has been discussion between the Medical Director, Chief Operating Officer and staff from the Performance and Information Teams and a further discussion with the Chief Executive is to take place in February 2020.
- Vacancy Rate (KPI 15) – The level of vacancies being actively recruited to continues to be higher than we planned, although there was a further reduction in January. **It should be noted that a number of these vacancies will still have staff in post working their notice.** The vacancy census reports which have been discussed by EMT will continue to be produced quarterly so that issues can be identified and discussed.
- Sickness Absence Rate (KPI 19) – The Trust continues to have a greater amount of sickness than it would wish with the figure reported in January (relating to sickness in December) at the highest level in the past three years. All localities are reporting worse than the standard with North Yorkshire and York being the best performing locality at 4.92% and Forensic being the most challenged at 8.66%. Within the Forensic locality there is considerable long term sickness and the service is working with Human Resources to ensure that all sickness is being managed appropriately.

2.4 Data Quality Assessment.

The Data Quality Assessment for the dashboard indicators is attached in Appendix C. There has been no change to that reported in last month report.

3. RECOMMENDATIONS:

It is recommended that the Board consider the content of this paper and raise any areas of concern/query.

Sharon Pickering
Director of Planning, Performance and Communications

Background Papers:

Trust Dashboard Summary for TRUST

Quality

	January 2020				April 2019 To January 2020			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	90.00%	79.75%			90.00%	83.48%		90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.00%	60.44%			60.00%	60.77%		60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,075.00	2,208.00			2,075.00	2,208.00		2,075.00
4) Percentage of patients surveyed reporting their overall experience as excellent or good	94.00%	93.52%			94.00%	91.57%		94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	32.00%	57.14%			32.00%	35.58%		32.00%
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	60.00%	55.10%			60.00%	61.40%		60.00%
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	65.00%	62.22%			65.00%	68.82%		65.00%

Activity

	January 2020				April 2019 To January 2020			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
8) Number of new unique patients referred		8,121.00				72,985.00		
9) The number of new unique patients referred with an assessment completed		4,457.00				41,870.00		
10) Number of new unique patients referred and taken on for treatment		2,016.00				17,158.00		
11) Number unique patients referred who received treatment and were discharged		3,379.00				27,909.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	90.00%	97.72%			90.00%	91.68%		90.00%

Trust Dashboard Summary for TRUST

	January 2020				April 2019 To January 2020			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	61.00	51.00			61.00	51.00		61.00
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.00%	23.58%			23.00%	25.36%		23.00%

Workforce

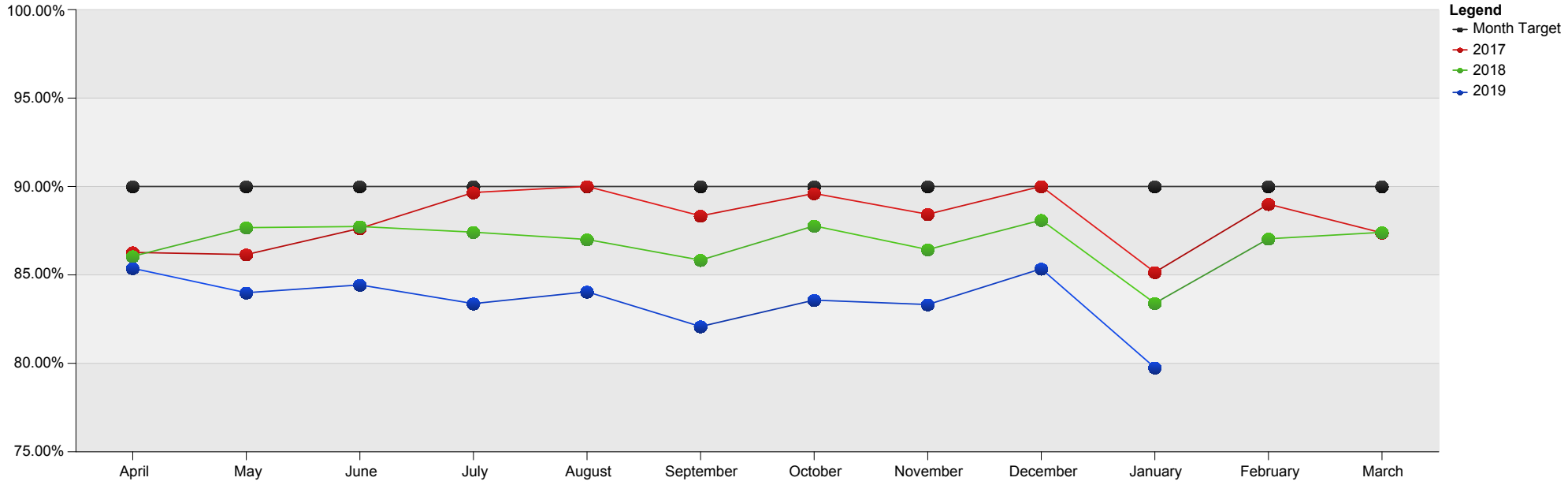
	January 2020				April 2019 To January 2020			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
15) Vacancy Rate (Healthcare Professionals only)	6.50%	14.72%			6.50%	12.10%		6.50%
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	95.00%	91.04%			95.00%	91.04%		95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	92.00%	93.54%			92.00%	93.54%		92.00%
18) Percentage Sickness Absence Rate (month behind)	4.40%	6.22%			4.40%	5.38%		4.40%

Money

	January 2020				April 2019 To January 2020			Annual
	Target	Month	Status	Trend Arrow (3 Months)	Target	YTD	Status	Target
19) Delivery of our financial plan (I and E)	-614,000.00	-648,999.00			-5,844,000.00	-5,920,934.00		-5,610,000.00
20) CRES delivery	824,916.00	1,036,858.00			8,249,160.00	10,016,673.00		9,898,992.00
21) Cash against plan	65,429,000.00	84,929,055.00			65,429,000.00	84,929,055.00		54,409,000.00

Trust Dashboard Graphs for TRUST

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



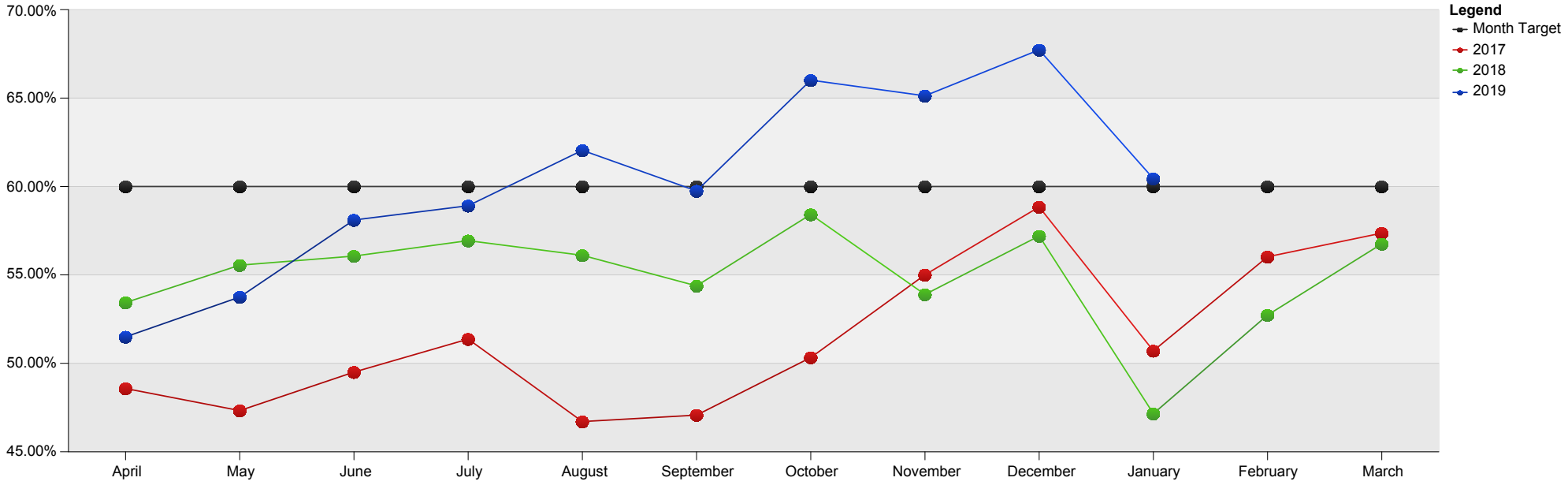
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	79.75%	83.48%	78.69%	82.02%	86.90%	89.86%	68.15%	74.54%	99.04%	99.19%		

Narrative

The position for January 20 is 85.44%, which is not meeting the standard of 90%. This follows a similar trend to previous years where we have seen a dip in Performance. Durham and Darlington and North Yorkshire and York localities continue to report furthest from the standard at 78.69% and 68.15% respectively. Key areas of concern are:• Durham and Darlington AMH at 59.25% (317 out of 535 patients). This is worse than the position reported in December 19. The service continue to be impacted by staff sickness and vacancies particularly in Durham City and Darlington • North Yorkshire and York AMH at 62.77% (408 of 650 patients). This is worse than the position reported in December 19. Since September a 20% increase in referrals has been seen, as a result additional clinics are being offered. However sickness levels continue to impact on performance, particularly in Harrogate and York. • North Yorkshire and York MHSOP at 70.63% (546 of 773 patients). This is worse than the position reported in December 19. Issues in the memory service across all areas continue to be due to capacity not meeting demand. An event is planned within this service for June 20 to standardise and improve processes. The event is supported by the KPO team and is planned around other commitments including the opening of Foss Park Hospital. An action plan is in place to address issues prior to the event.

Trust Dashboard Graphs for TRUST

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



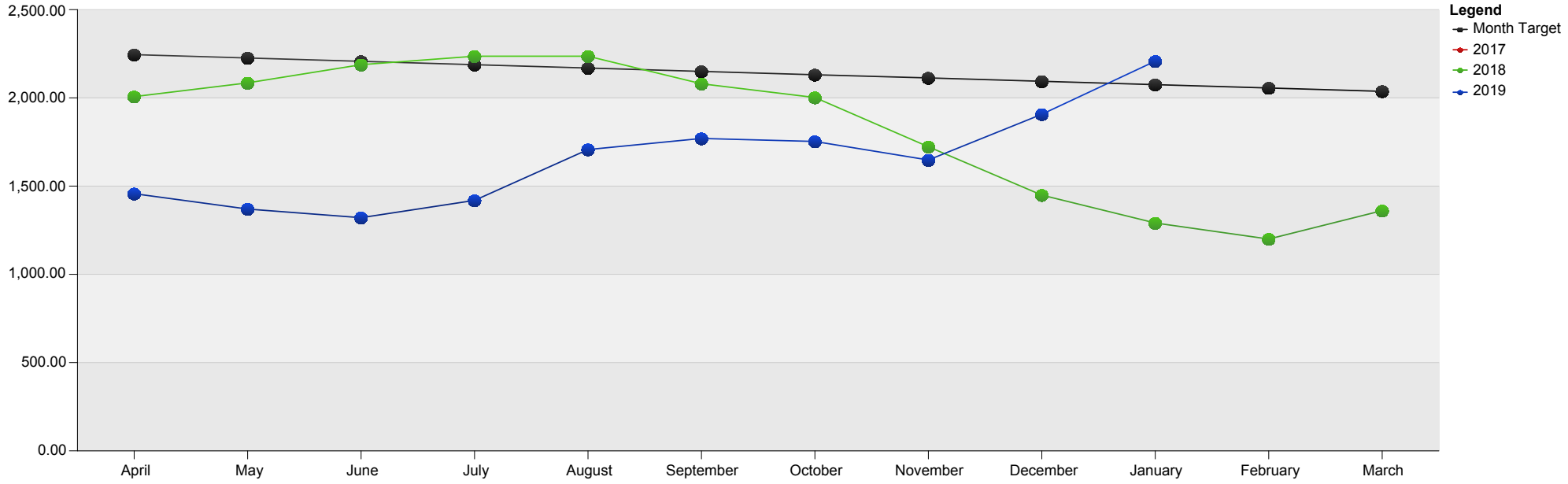
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
2) Percentage of patients starting treatment within 6 weeks of an external referral	60.44%	60.77%	65.87%	65.32%	58.24%	58.15%	57.21%	57.37%	94.64%	97.16%		

Narrative

The position for January 2020 is 60.44% which is continuing to meet the standard of 60.00%, but is worse than the position reported in December 2019. Durham and Darlington and Forensic Services are meeting the standard with Teeside and North Yorkshire and York performing within 10% of the standard. An action plan which was developed by the Performance Improvement Group (PIG) in October to ensure consistent recording of intervention codes is continuing to be monitored by the Corporate Performance Team and progress reported to the Chief Operating Officer each month.

Trust Dashboard Graphs for TRUST

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

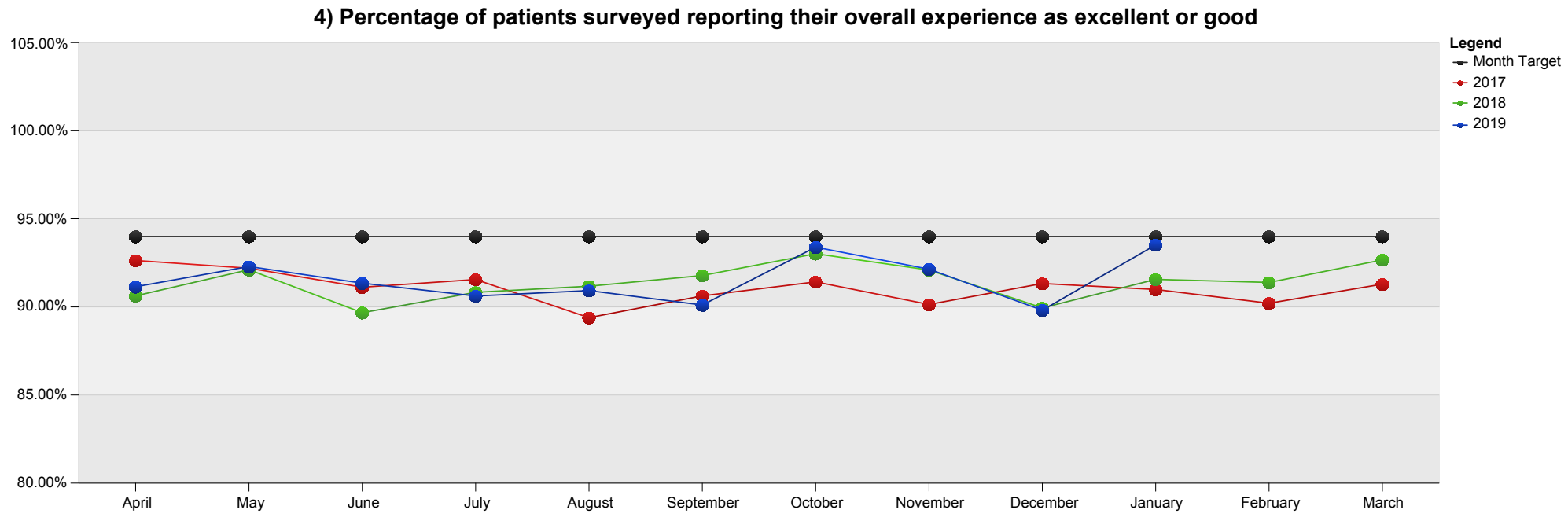


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	2,208.00	2,208.00	374.00	374.00	457.00	457.00	1,329.00	1,329.00				

Narrative

The Trust position for January 2020 is 2,208 which is worse than the standard of 2,075. This is the first time we've failed to achieve the standard since August 2018. Durham and Darlington is the only locality not meeting the standard for this indicator and MHSOP continues to be a key area of concern. Bed pressures are due to the admission of patients from localities elsewhere in the Trust. Specific work is being taken forward with regards to bed management as part of the Right Care Right Place Programme and an action plan has been developed.

Trust Dashboard Graphs for TRUST

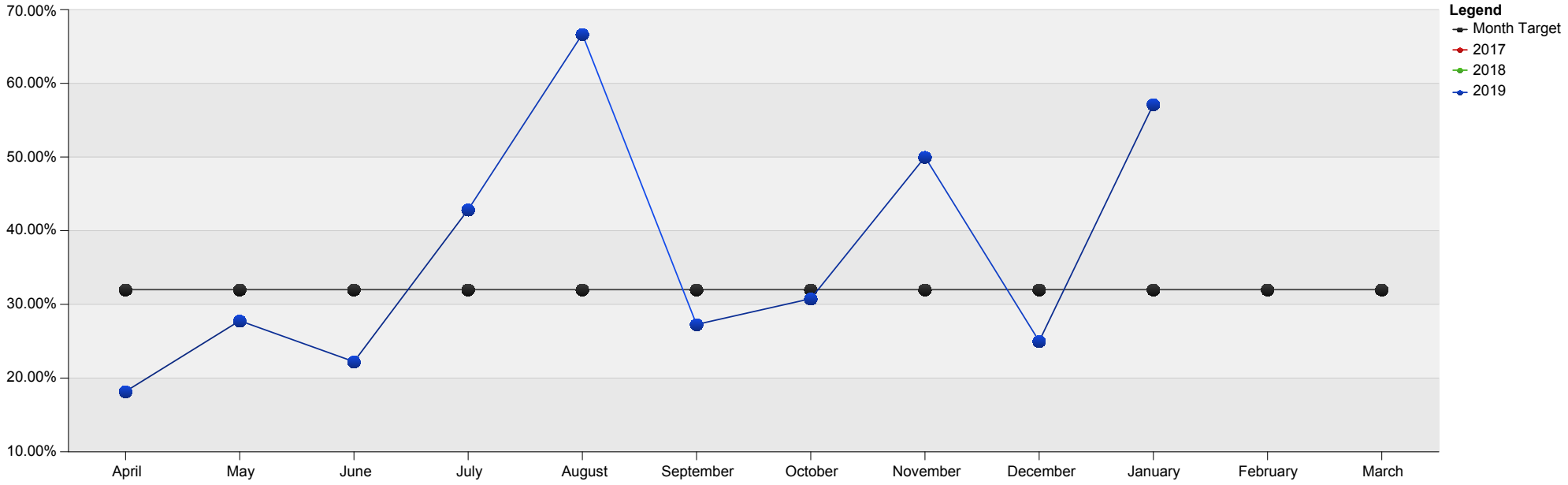


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
4) Percentage of patients surveyed reporting their overall experience as excellent or good	93.52%	91.57%	92.78%	92.16%	94.67%	92.39%	92.52%	91.64%	98.00%	86.62%		

Narrative
The Trust position for January 2020 is 93.52% which is just below the standard of 94.00% and the second highest position reported since 2017/2018.Teeside and Forensic Services are achieving the target with Durham and Darlington and North Yorkshire and York performing within 10% of the target. All localities monitor and review this at QUAG meetings and investigations on how to use the data more effectively are ongoing.

Trust Dashboard Graphs for TRUST

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

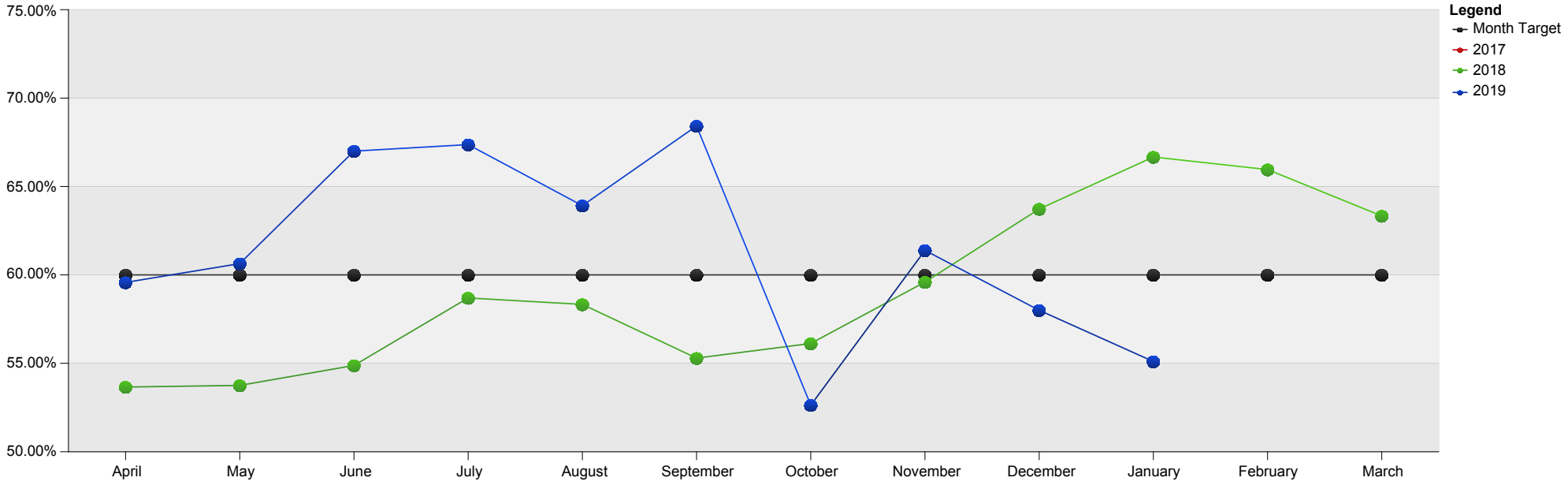


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	57.14%	35.58%	75.00%	50.00%	33.33%	20.93%						

Narrative
The Trust position for January 2020 is 57.14% which is not achieving the standard of 32%. This relates to 4 serious incidents out of 7 which were found to have a root cause or contributory finding in January 2020. The 4 incidents occurred in the following localities:• 3 x Durham and Darlington• 1 x TeessideThe 3 incidents within Durham and Darlington all occurred in communities teams within Adult mental health, no themes have been identified or actions put in place at this stage. This will continue to be monitored closely within the locality. Any themes identified are shared Trust wide through the Patient Safety Group.

Trust Dashboard Graphs for TRUST

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



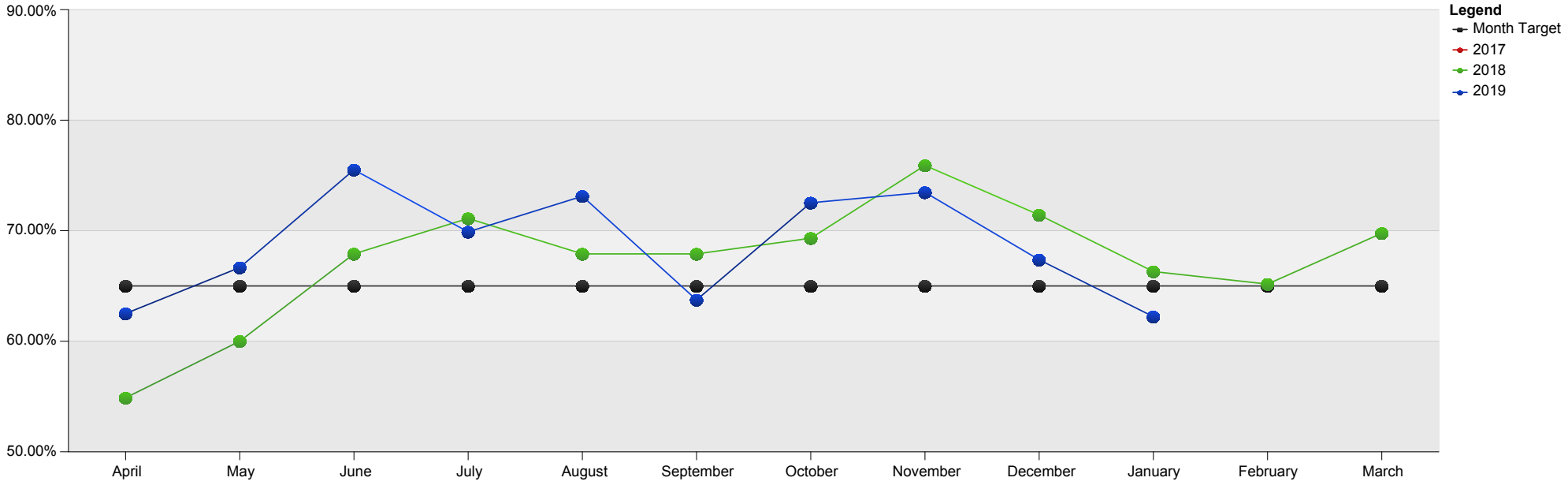
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind	55.10%	61.40%	51.72%	61.08%	48.28%	59.52%	61.54%	62.82%				

Narrative

The Trust position for January 2020 is 55.10%, which is not meeting the standard of 60%. Teesside are failing to meet the target for this indicator. This has been impacted by a high number of short care spells during the month, this leads to higher numbers of patients disengaging and as a result we are unable to offer and complete the final HoNOS. This will be monitored carefully going forward. Within each locality, this is discussed on a weekly basis in their huddles with the Clinical Outcomes Lead to agree actions to address this performance. Trust wide, discussions have taken place at Executive Management Team (EMT) and a meeting has taken place which included the Chief Operating Officer and Medical Director to agree ways to move forward in this area. Further discussions and agreement on actions are to take place with the Chief Executive during February 2020. Within this KPI an improvement in HONOS is shown by a decrease in the patient's actual HONOS score on PARIS. The change is identified by comparing the first HONOS score calculated on admission to TEWV, and the score on discharge.

Trust Dashboard Graphs for TRUST

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

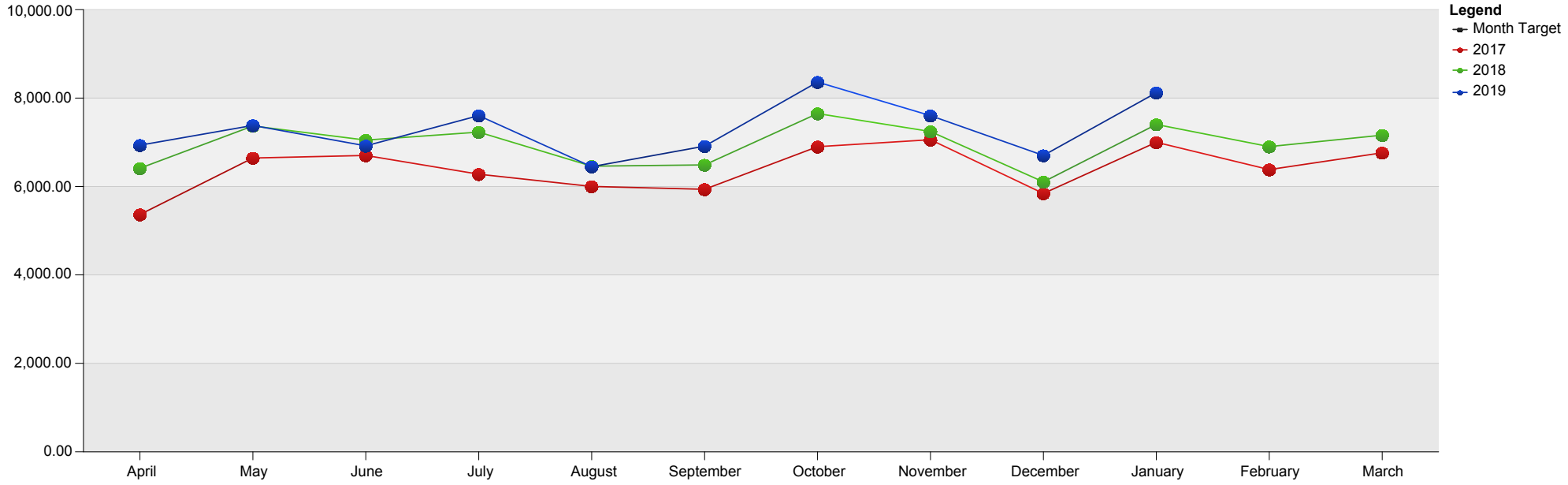


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind	62.22%	68.82%	62.96%	71.47%	62.96%	67.37%	60.00%	67.28%				

Narrative
The Trust position for January 2020 is 62.77%, which is not meeting the standard of 65%. All localities are performing within 10% of the target. Within each locality, this is discussed on a weekly basis in their huddles with the Clinical Outcomes Lead to agree actions to address this performance.Within this KPI, an improvement in SWEMWBS (which is a patient experience measure) is shown by an increase in the patient's actual SWEMWBS score. The change is identified by comparing the first SWEMWBS score calculated on admission, and the score on discharge.

Trust Dashboard Graphs for TRUST

8) Number of new unique patients referred

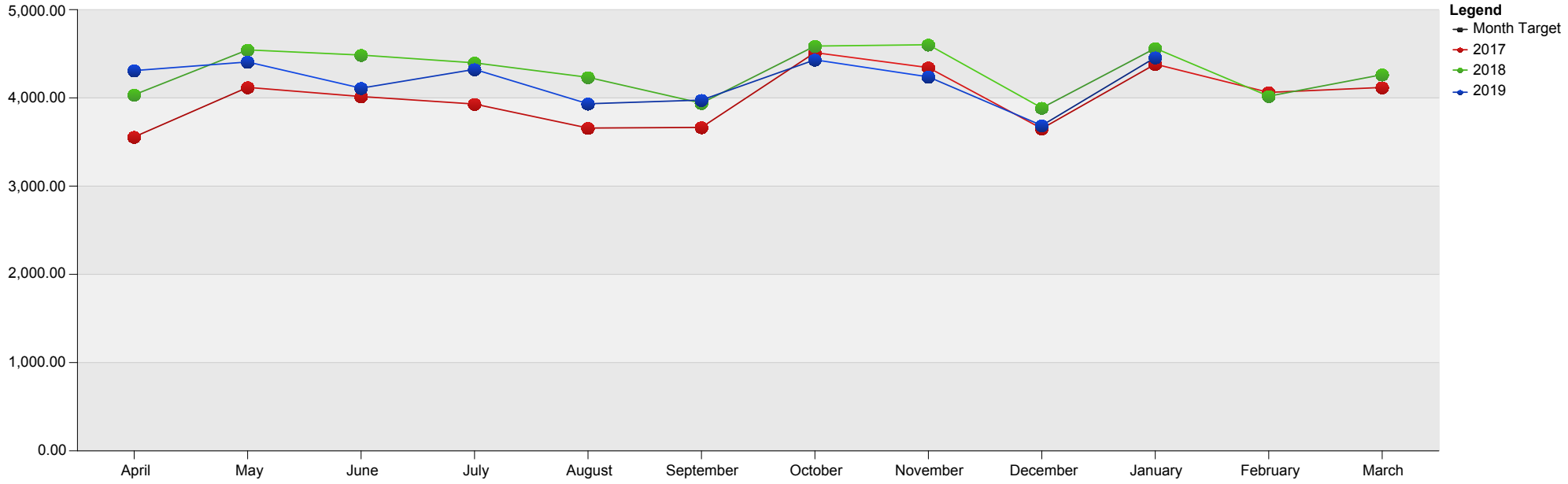


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
8) Number of new unique patients referred	8,121.00	72,985.00	2,451.00	22,075.00	2,514.00	23,979.00	2,326.00	21,012.00	830.00	5,917.00		

Narrative
The Trust position for January 2020 is 8,121. This follows similar trends to previous years although is higher than previous years Trust level Statistical Process Control (SPC) charts have been developed and are discussed by EMT on a quarterly basis at ‘speciality’ level in addition to the data and charts being reviewed by localities.

Trust Dashboard Graphs for TRUST

9) The number of new unique patients referred with an assessment completed

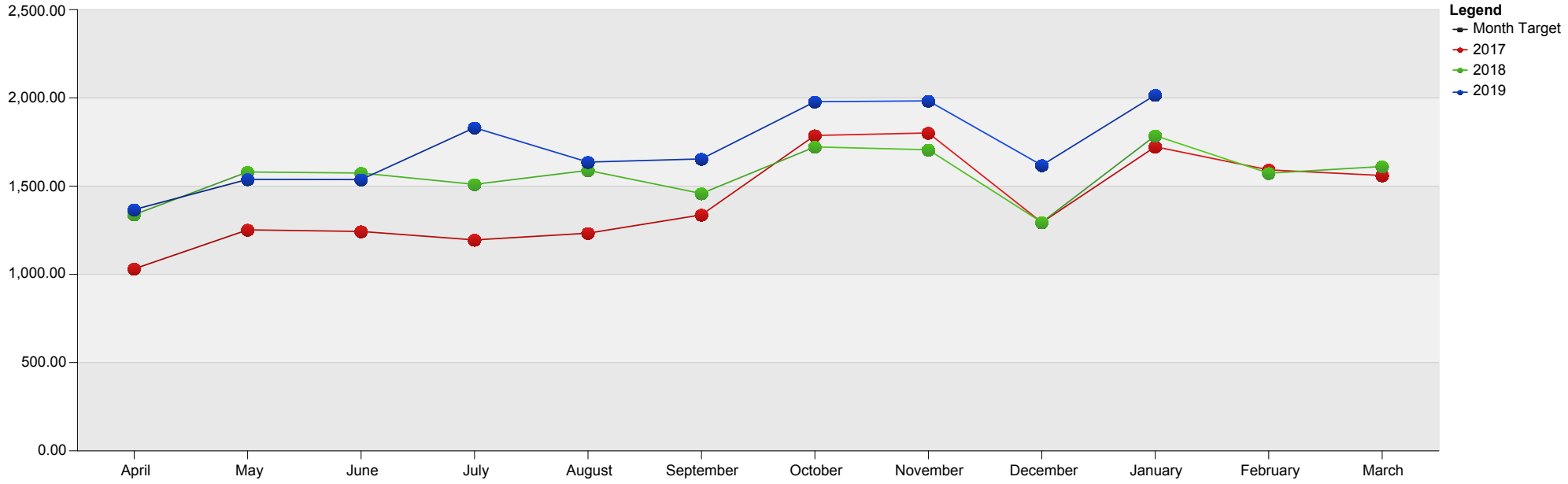


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
9) The number of new unique patients referred with an assessment completed	4,457.00	41,870.00	1,214.00	12,050.00	1,461.00	14,315.00	1,430.00	12,844.00	352.00	2,660.00		

Narrative
The Trust position for January 2020 is 4,457. This follows similar trends to previous years which is a very positive position given the increase in referrals that have been seen. Trust level Statistical Process Control (SPC) charts have been developed and are discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

Trust Dashboard Graphs for TRUST

10) Number of new unique patients referred and taken on for treatment

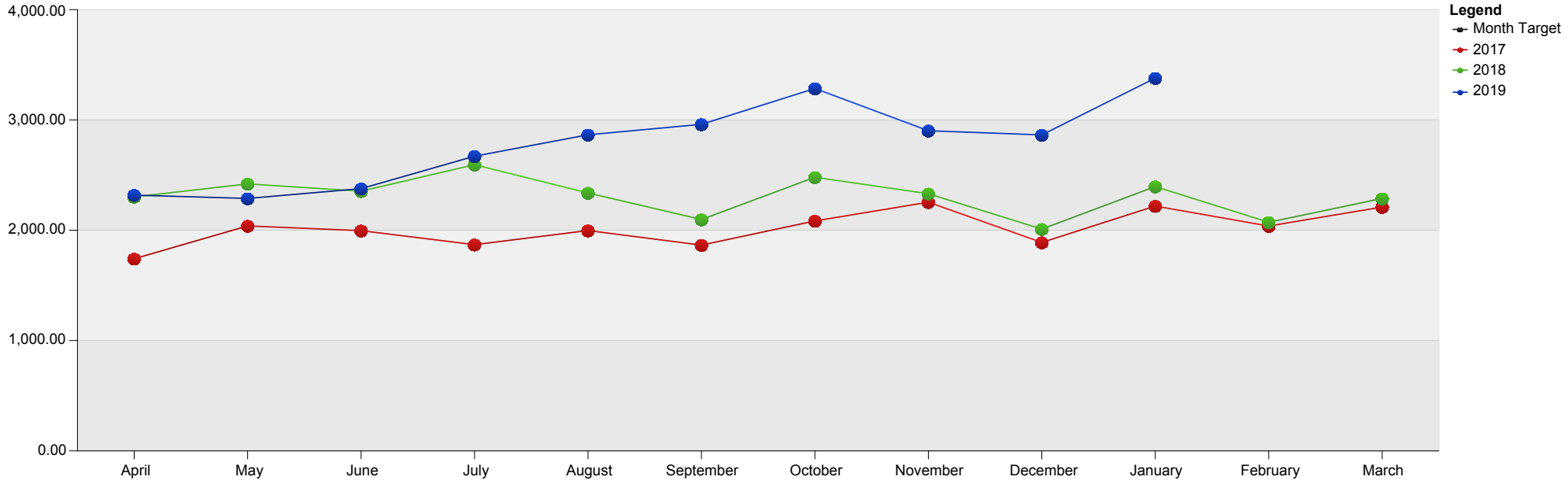


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
10) Number of new unique patients referred and taken on for treatment	2,016.00	17,158.00	587.00	5,236.00	607.00	5,240.00	785.00	6,337.00	27.00	241.00		

Narrative
The Trust position for January 2020 is 2,016. Trust level Statistical Process Control (SPC) charts have been developed and are discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

Trust Dashboard Graphs for TRUST

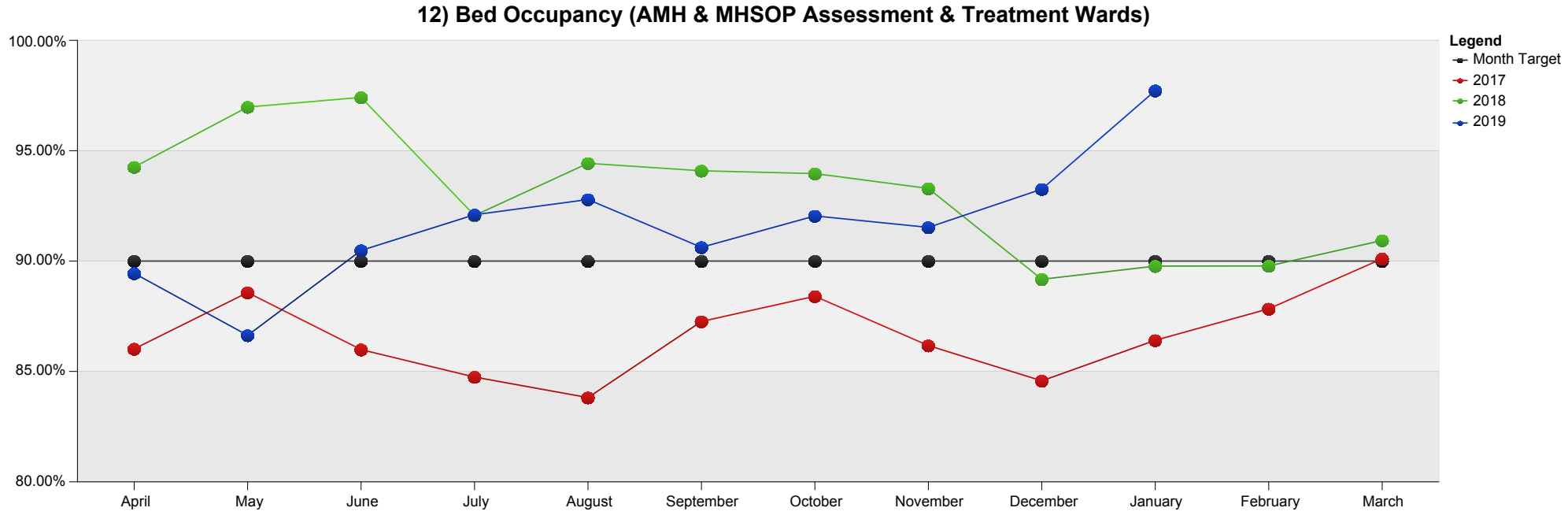
11) Number unique patients referred who received treatment and were discharged



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
11) Number unique patients referred who received treatment and were discharged	3,379.00	27,909.00	1,072.00	8,865.00	1,166.00	9,327.00	1,053.00	9,080.00	87.00	623.00		

Narrative
The Trust position for January 2020 is 3,379. This is a positive position in terms of caseloads for teams as we are discharging more patients than are being referred and taken into services. Trust level Statistical Process Control (SPC) charts have been developed and are discussed by EMT on a quarterly basis at 'speciality' level in addition to the data and charts being reviewed by localities.

Trust Dashboard Graphs for TRUST

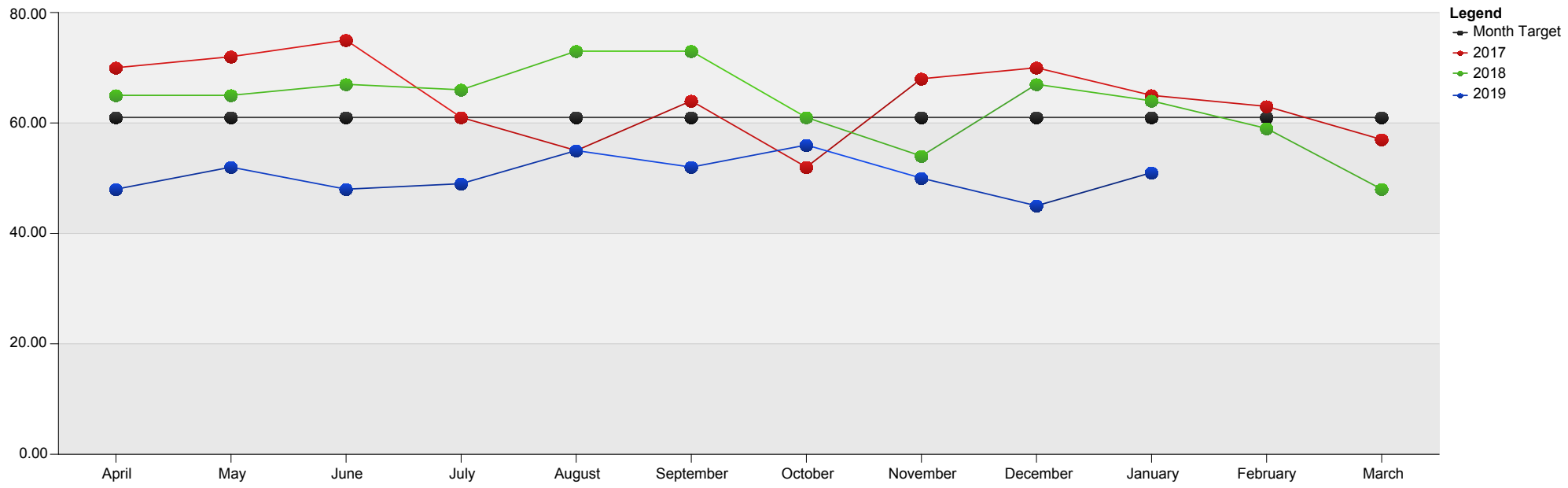


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	97.72%	91.68%	98.62%	93.77%	103.82%	98.10%	92.46%	84.95%	NA	NA		

Narrative
The Trust position for January 2020 is 97.72% which is not within the agreed tolerance of the standard and is a further increase to the highest level of occupancy in 2019/20 to date. This reflects the messages begin received from services during December in terms of pressure on beds.Teesside continue to report the poorest position at 103.81%, which continues to be due to increased demand on beds within both AMH and MHSOP. The locality are reviewing processes to ensure that discussions around individual patients take place between the right people at the earliest opportunity focusing on involvement with the crisis and rehabilitation teams to ensure a safe, timely and effective discharge. This is monitored by all localities on a continual basis and appropriate actions are discussed and agreed in daily huddles.

Trust Dashboard Graphs for TRUST

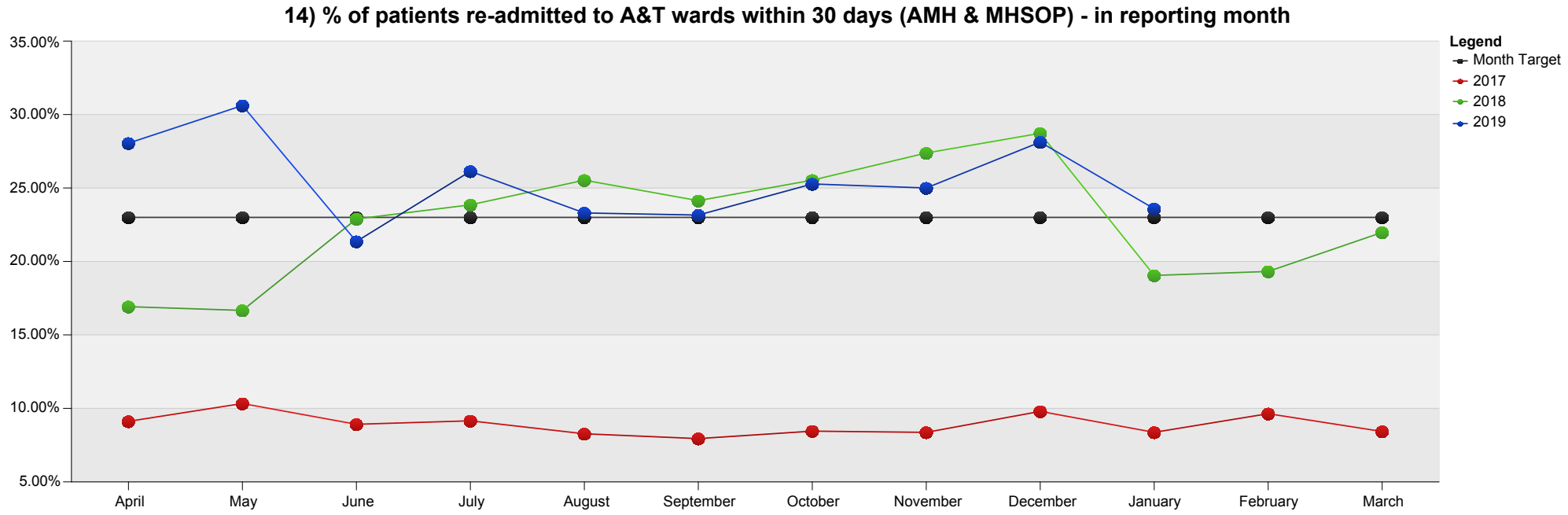
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	51.00	51.00	10.00	10.00	11.00	11.00	29.00	29.00				

Narrative
The Trust position for January 2020 is 51 which is better than the standard of 61.Teesside locality is not meeting the standard for this indicator. They continue to report issues relating to complex patients and finding suitable placements prior to discharge as impacting on performance in this area. A number of these patients have now secured accommodation and have been discharged so improvements should be seen in February. All localities are monitoring this on a continual basis and actions are discussed and agreed in daily huddles. This is also now monitored at a Trust level within the Chief Operating Officers report out.

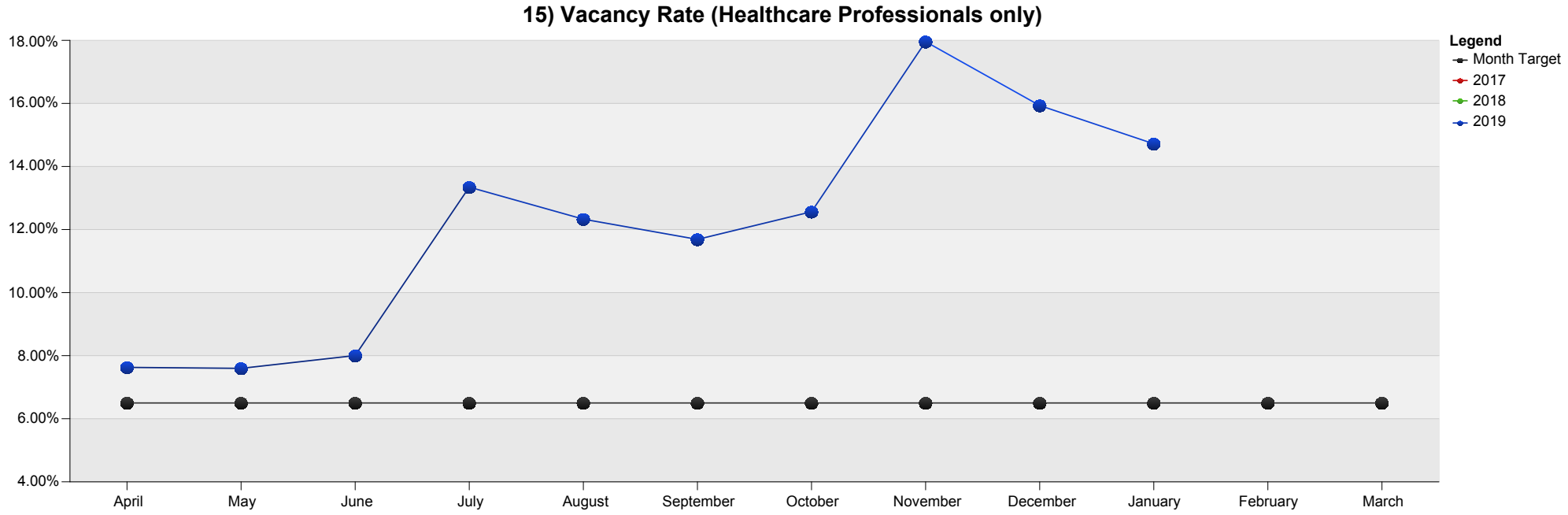
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month	23.58%	25.36%	32.43%	25.88%	13.51%	23.64%	23.33%	26.04%				

Narrative
The Trust position for January 2020 is 23.58% which is not meeting the standard of 23%. This relates to 25 readmissions out of 106 readmissions that were within 30 days. Durham and Darlington report the worst position at 32.43%. This is monitored routinely in locality report outs and all patients were clinically appropriate for admission.

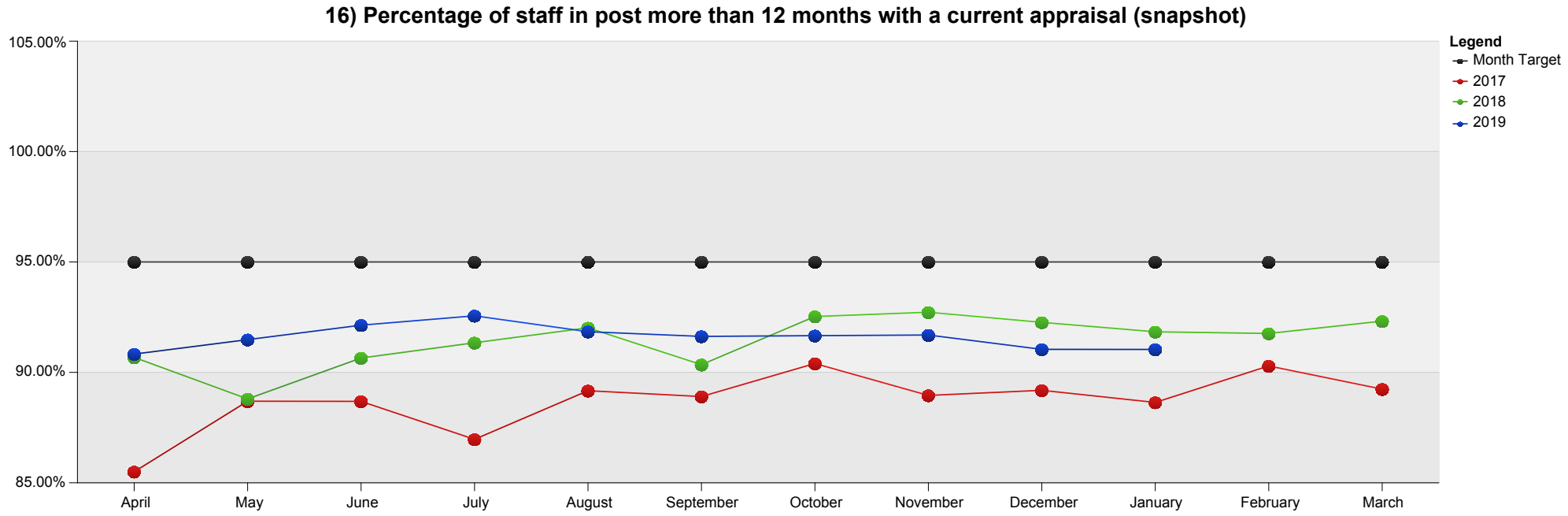
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
15) Vacancy Rate (Healthcare Professionals only)	14.72%	12.10%	18.86%	15.85%	8.13%	7.57%	17.02%	14.44%	14.24%	8.96%		

Narrative
The position for January 2020 is 14.72% which represents a continuing improvement on the position reported in November. The reported position is worse than the standard. This equates to 487.24 wte vacancies currently being actively recruited to, which represents a reduction on the number of vacancies reported in December. Durham and Darlington are reporting the highest volume of recruitment. A Right Staffing Agency dashboard is now in place to monitor the usage of agency staff; this will allow operational services to monitor vacancies more effectively. Vacancy census reports were produced and presented to EMT on 18th December, it's envisaged the reports will be produced quarterly. This is a new indicator for 2019/20 therefore data relating to previous year's performance is not available.The vacancy rate calculation is been reviewed ahead of 2020/21 as it was felt that the primary source of establishment control information was the finance system which reflects true vacancies, not only those actively in recruitment via Trac. Vacancy rate percentage will be derived by dividing trust wide contracted wte by budgeted wte for all staff groups. The current rate is 91.53% with recruitment being supported by the initiatives described above.

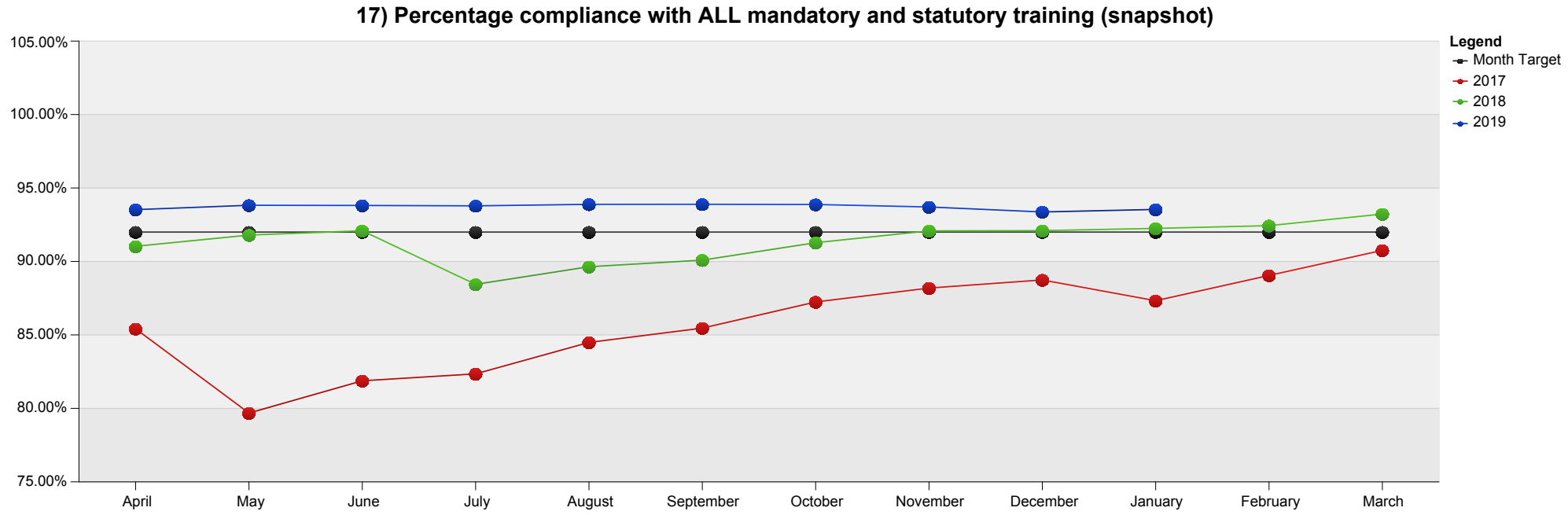
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)	91.04%	91.04%	90.58%	90.58%	92.60%	92.60%	89.30%	89.30%	95.91%	95.91%		

Narrative
The Trust position for January 2020 is 91.04% which is below the agreed standard. This relates to 519 members of staff out of 5791 that do not have a current appraisal. This is comparable to the figure reported over the few last months but represents a deterioration to the position reported in July 2019. The use of operational management huddles is now embedded across the Trust which includes discussions on appraisal compliance levels. However issues such as vacancies and sickness, referred to within this report, impact on the ability to deliver appraisals.

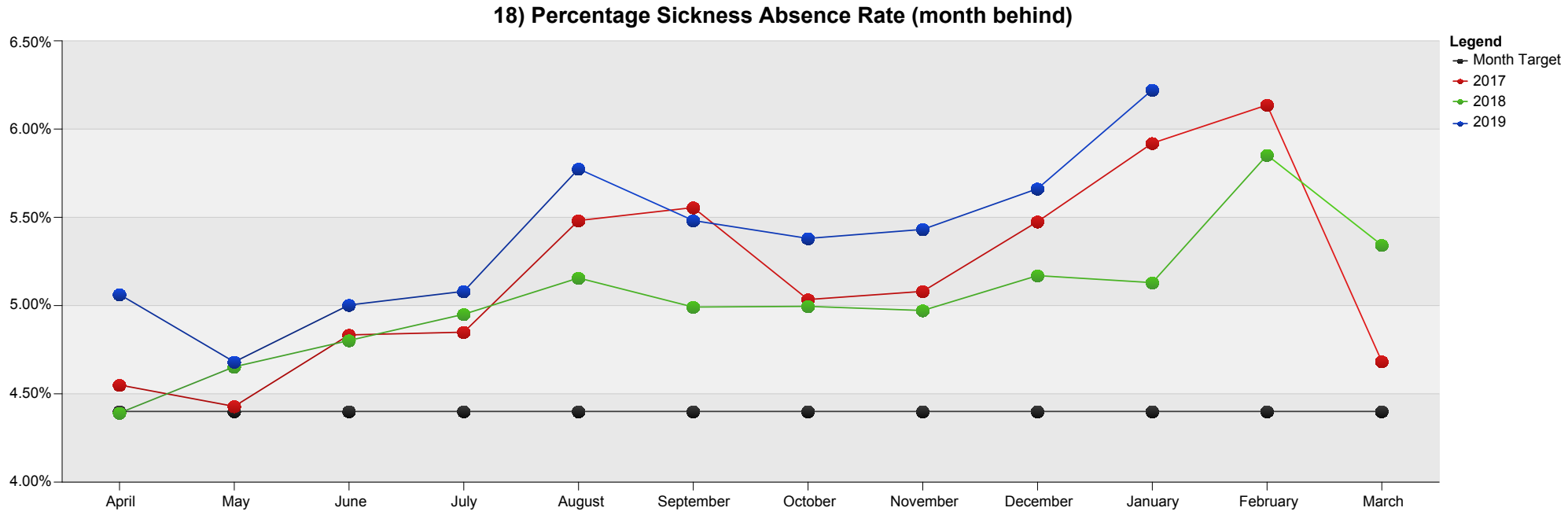
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	93.54%	93.54%	93.86%	93.86%	94.35%	94.35%	90.65%	90.65%	96.14%	96.14%		

Narrative
The position for January 2020 is 93.54% which is comparable to the position reported in December 2019 and is achieving the standard. This is the best position reported since 2017/18. All localities are achieving the standard.The operational management huddles continue to drive improvements in performance. The improved frequency of the IIC refresh also allows a timelier update of accurate performance information to managers, enabling proactive action to take place.

Trust Dashboard Graphs for TRUST

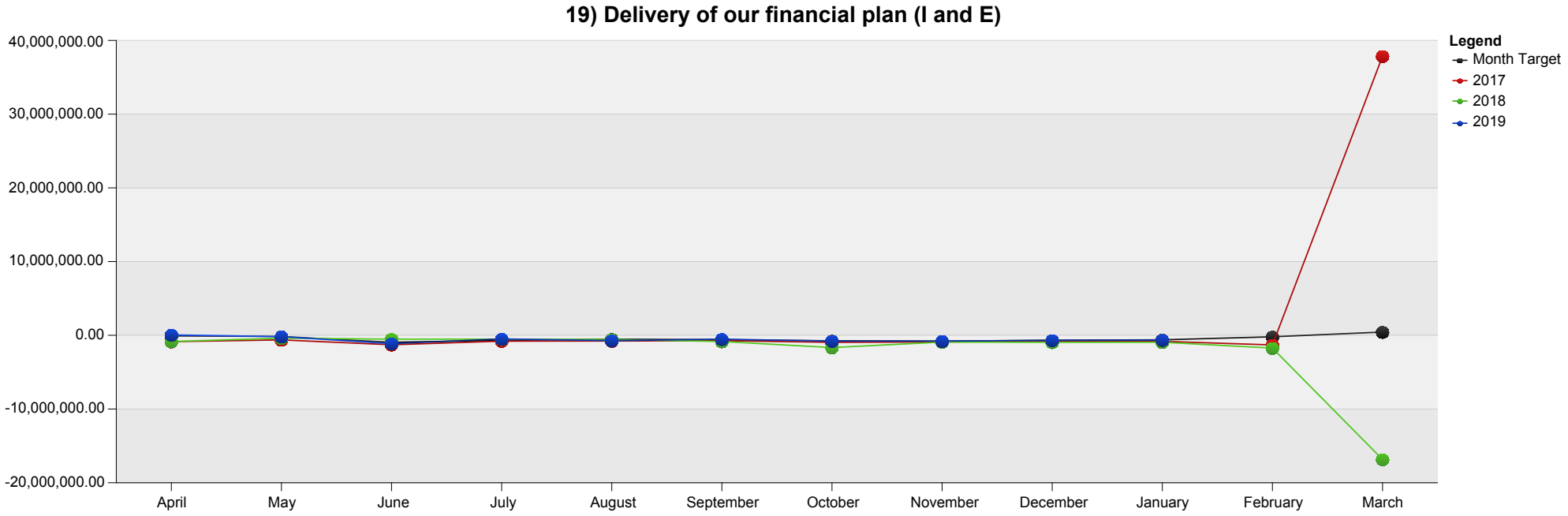


	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
18) Percentage Sickness Absence Rate (month behind)	6.22%	5.38%	5.59%	5.10%	7.89%	6.50%	4.92%	4.37%	8.66%	6.83%		

Narrative

The Trust position reported in January relates to the December sickness level. The Trust position reported in January 2020 at 6.22% is higher than the previous 2 years and is not meeting the standard of 4.50%. The following Directorates are reporting high levels of absence Durham and Darlington – 5.59%, EFM – 6.82%, Forensic – 8.66% and Teesside – 7.89%. North Yorkshire and York are reporting a rate of 4.92%.Sickness is both long and short term and is being monitored closely by each locality. Across Forensics, within inpatients this is long term sickness. Within the Health and Justice Service the liaison and diversion team have 3 members of staff on long term sick, one who returned at the end of January. Durham prison has a high level of sickness due to seasonal sickness but also stress related issues. All services are working with HR to resolve issues and concerns. The Sickness Absence Management Procedure is currently being reviewed and a revised procedure is currently being considered by the Policy Working Group.

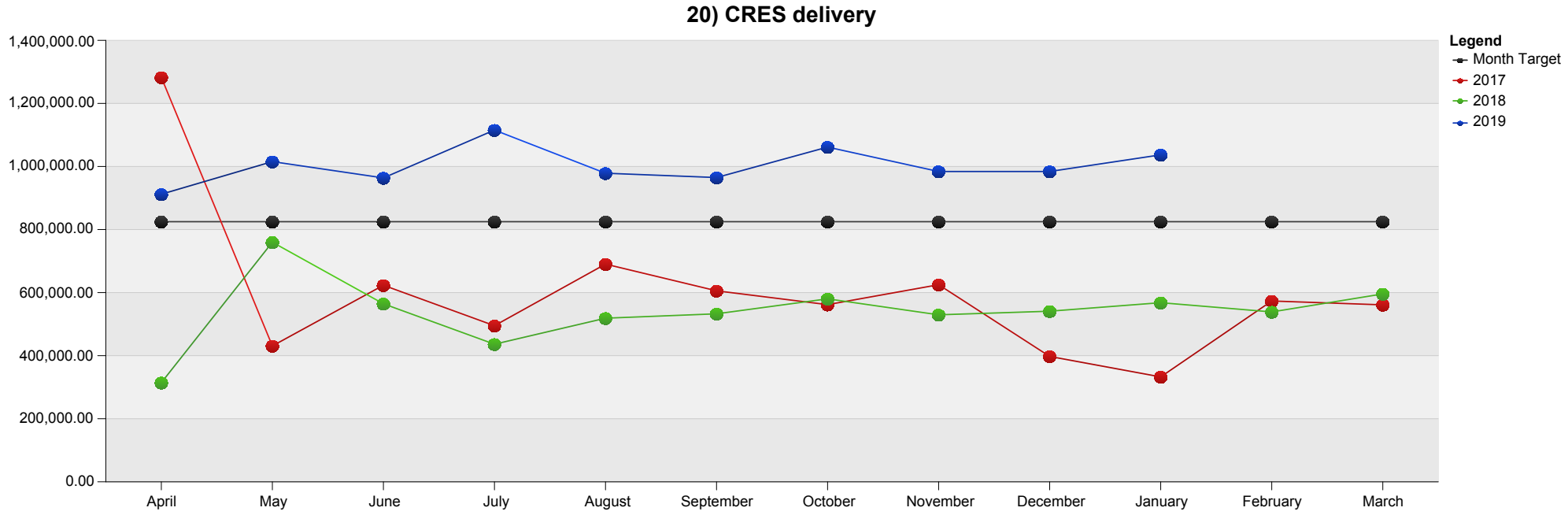
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
19) Delivery of our financial plan (I and E)	-648,999.00	-5,920,934.00	-80,133.00	-608,410.00	-106,742.00	2,688,946.00	-116,356.00	440,768.00	-204,566.00	-545,462.00		

Narrative
The comprehensive income outturn for the period ending 31 January 2020 is a surplus of £5,921k, representing 2.1% of the Trust's turnover and is £77k ahead of the NHSI plan.

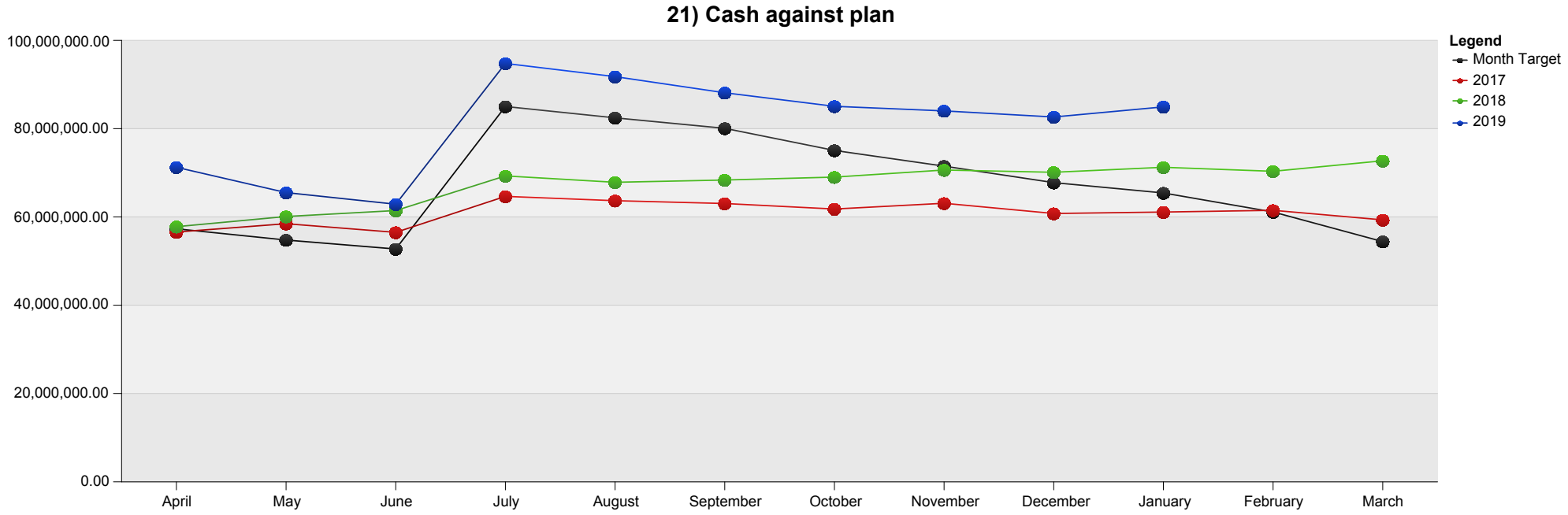
Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
20) CRES delivery	1,036,858.00	10,016,673.00	127,061.00	1,084,186.00	106,803.00	922,530.00	226,684.00	2,250,267.00	51,466.00	507,553.00		

Narrative
Identified Cash Releasing Efficiency Savings at 31 January 2020 is £8,429k and is £1,767k ahead of plan for the year to date. The Trust is anticipating being ahead of plan (£2,121k) at the financial year end and continues to identify schemes for future years.

Trust Dashboard Graphs for TRUST



	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD	Current Month	YTD
21) Cash against plan	84,929,055.00	84,929,055.00	NA	NA	NA	NA			NA	NA		

Narrative
Total cash at 31 January 2020 is £84,929k; this is £8,752k ahead of plan and is largely due to higher than anticipated creditor accruals where invoices have not been received by the Trust and delays within the capital expenditure plan

Trust Dashboard - Locality Breakdown for TRUST

1 - Quality

	January 2020												April 2019 To January 2020											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral		79.75%		78.69%		86.90%		68.15%		99.04%				83.48%		82.02%		89.86%		74.54%		99.19%		
2) Percentage of patients starting treatment within 6 weeks of an external referral		60.44%		65.87%		58.24%		57.21%		94.64%				60.77%		65.32%		58.15%		57.37%		97.16%		
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)		2,208.00		374.00		457.00		1,329.00						2,208.00		374.00		457.00		1,329.00				
4) Percentage of patients surveyed reporting their overall experience as excellent or good		93.52%		92.78%		94.67%		92.52%		98.00%				91.57%		92.16%		92.39%		91.64%		86.62%		
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		57.14%		75.00%		33.33%								35.58%		50.00%		20.93%						
6) The percentage of in scope teams achieving the agreed improvement benchmarks for HoNOS total score (AMH and MHSOP) - month behind		55.10%		51.72%		48.28%		61.54%						61.40%		61.08%		59.52%		62.82%				
7) The percentage of in scope teams achieving the agreed improvement benchmarks for SWEMWBS total score (AMH and MHSOP) - month behind		62.22%		62.96%		62.96%		60.00%						68.82%		71.47%		67.37%		67.28%				

Trust Dashboard - Locality Breakdown for TRUST

2 - Activity

	January 2020												April 2019 To January 2020											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
8) Number of new unique patients referred		8,121.00		2,451.00		2,514.00		2,326.00		830.00				72,985.00		22,075.00		23,979.00		21,012.00		5,917.00		
9) The number of new unique patients referred with an assessment completed		4,457.00		1,214.00		1,461.00		1,430.00		352.00				41,870.00		12,050.00		14,315.00		12,844.00		2,660.00		
10) Number of new unique patients referred and taken on for treatment		2,016.00		587.00		607.00		785.00		27.00				17,158.00		5,236.00		5,240.00		6,337.00		241.00		
11) Number unique patients referred who received treatment and were discharged		3,379.00		1,072.00		1,166.00		1,053.00		87.00				27,909.00		8,865.00		9,327.00		9,080.00		623.00		
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)		97.72%		98.62%		103.82%		92.46%	NA	NA				91.68%		93.77%		98.10%		84.95%	NA	NA		
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot		51.00		10.00		11.00		29.00						51.00		10.00		11.00		29.00				
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - in reporting month		23.58%		32.43%		13.51%		23.33%						25.36%		25.88%		23.64%		26.04%				

Trust Dashboard - Locality Breakdown for TRUST

3 - Workforce

	January 2020												April 2019 To January 2020											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
15) Vacancy Rate (Healthcare Professionals only)		14.72%		18.86%		8.13%		17.02%		14.24%				12.10%		15.85%		7.57%		14.44%		8.96%		
16) Percentage of staff in post more than 12 months with a current appraisal (snapshot)		91.04%		90.58%		92.60%		89.30%		95.91%				91.04%		90.58%		92.60%		89.30%		95.91%		
17) Percentage compliance with ALL mandatory and statutory training (snapshot)		93.54%		93.86%		94.35%		90.65%		96.14%				93.54%		93.86%		94.35%		90.65%		96.14%		
18) Percentage Sickness Absence Rate (month behind)		6.22%		5.59%		7.89%		4.92%		8.66%				5.38%		5.10%		6.50%		4.37%		6.83%		

Trust Dashboard - Locality Breakdown for TRUST

4 - Money

	January 2020												April 2019 To January 2020											
	TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN		TRUST		DURHAM AND DARLINGTON		TEESSIDE		NORTH YORKSHIRE AND YORK		FORENSIC SERVICES		UNKNOWN	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
19) Delivery of our financial plan (I and E)		-648,999.00	NA	-80,133.00	NA	-106,742.00		-116,356.00	NA	-204,566.00				-5,920,934.00	NA	-608,410.00	NA	2,688,946.00		440,768.00	NA	-545,462.00		
20) CRES delivery		1,036,858.00		127,061.00		106,803.00		226,684.00		51,466.00				10,016,673.00		1,084,186.00		922,530.00		2,250,267.00		507,553.00		
21) Cash against plan		84,929,055.00	NA	NA	NA	NA			NA	NA				84,929,055.00	NA	NA	NA	NA			NA	NA		

Appendix B

Trust Dashboard 2019/20 KPI Guide

No.	KPI	Target	Definition
1	Percentage of patients who were seen within 4 weeks for a first appointment following an external referral	90%	This measures, the number of patients who attend their first appointment in 4 weeks of their referral date out of the total number of people who attend their first appointment following their referral. This KPI has been amended for 2018/19 and the clock will now NOT restart if the patient DNAs or the patient cancels an appointment. This looks at patients with an external referral only. This excludes IAPT patients.
2	Percentage of patients starting “treatment” within 6 weeks of external referral	60%	This measures, the number of people starting treatment within 6 weeks of an external referral against number of people starting treatment. This looks at patients with an external referral only.
3	The total number of inappropriate OAP days over the reporting period (Rolling 3 months)	2,245	This measures, the total number of days patients have spent in an out of area bed inappropriately. In line with national reporting this measures a rolling 3 months’ time frame
4	Percentage of patients surveyed reporting their overall experience as excellent or good	94%	Within all inpatient and community services, this measures: Of the number of people in the Patient Survey who answered the question: -"Overall how would you rate the care you have received?,” the number of patients who have scored "excellent" or "good"
5	The percentage of Serious Incidents which are found to have a root cause or contributory finding	32%	This measure looks at the percentage of serious incidents that are investigated and found to have a root cause or contributory finding
6	The % teams achieving the agreed improvement benchmarks for HoNOS total score	60%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total HoNOS scores are compared from first rating against the last. A reduction in total HoNOS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 40% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are

Appendix B

Trust Dashboard 2019/20 KPI Guide

No.	KPI	Target	Definition
			transferred to a different In Scope team.
7	The % teams achieving the agreed improvement benchmarks for SWEMWBS	65%	This measure relates to patients discharged from TEWV In Scope services (Spells ended with a Adult or MHSOP subject to Currency & Tariff National requirements). Patients total SWEMWBS scores are compared from the first rating against the last. An increase in SWEMWBS score is classified as improvement. 80% of patients in the Non Psychotic and Psychotic superclass and 50% in the organic superclass are expected to achieve this reduction. Teams are subject to the measure if they discharge more than 5 patients in any of the superclasses. The measure will report against the team the patient was with at the point they are discharged entirely from TEWV not if they are transferred to a different In Scope team.
8	Number of new unique patients referred	N/A	This measure relates to the number of new individual patients referred (so a patient is only counted once and not open to any other team in the Trust). This excludes IAPT patients.
9	The number of new unique patients referred with an assessment completed	N/A	This measure relates to the number of new unique patients with an assessment completed (and is a subset of measure 8).
10	Number of new unique patients referred and taken on for treatment	N/A	This measure relates to the number of new unique patients referred, assessed and then taken on for treatment (and is a subset of measure 9).
11	Number unique patients referred who received treatment and were discharged	N/A	This measure relates to the number of new unique patients referred who were taken on for treatment and then discharged.
12	Bed Occupancy (AMH & MHSOP A & T Wards)	90%	This measures the number of days beds that are occupied out of the number of possible bed days available. (The calculation is on the number of beds available and the days in the month). This looks at AMH and MHSOP Assessment and Treatment wards only
13	Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards (Snapshot)	61	This measures the number of patients occupying a bed with a length of stay longer than 90 days from the day they were admitted. This looks at AMH and MHSOP Assessment and Treatment wards only

No.	KPI	Target	Definition
14	Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)	23%	This measures the number of patients who are readmitted onto a ward within 30 days of their last discharge. This looks at AMH and MHSOP Assessment and Treatment wards only
15	Vacancy Rate (Healthcare Professionals only)	6.50%	This measures the total number of advertised vacancies against the total number of budgeted staff
16	Percentage of staff in post more than 12 months with a current appraisal	95%	This measures the number of staff in post more than 12 months and of those how many have a current appraisal. For medical staff this is monitored against 13 months.
17	Percentage compliance with ALL mandatory and statutory training	92%	This measures the total number of courses completed by each member of staff for ALL mandatory and statutory training out of the number of courses due to be completed for each member of staff
18	Percentage Sickness Absence Rate	4.50%	This measures the number of days lost to sickness out of the number of days within the month
19	Delivery of our financial plan (I&E)	132,000	This shows the Trusts surplus or deficit position (£). The target is the planned surplus position.
20	CRES delivery	824,916	This shows the CRES Identified against the planned amount
21	Cash against plan	52,027	This shows the actual cash held by the Trust against the amount of cash forecasted to be held

Appendix C

		Data Source					Data Reliability					KPI Construct/Definition					KPI Amended / Tested							
		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 %	Notes
		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	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			
1	Pergentage of patients who were seen within 4 weeks for a first appointment following an external referral	5						4					4						3			16	80%	There are issues concerning telephone assessments and when this type of assessment should stop the clock. The logic for this metric currently only acknowldeges a clock stop for CAMHS. The KPI pro forma specifies this should be applied to AMH, however this is not reflected with in the data and this inconsistentcy was not picked up in previous testing. Also 'was not brought' is counting as a successful contact, this should be treat the same as DNA and should no stop the clock. A deep dive took place at Performance Improvement Group in October 2019 and an action plan has been developed and implemented.
2	Percentage of patients starting treament within 6 weeks of external referral	5						4					4						3			16	80%	Some data quality issues have been reported in relation to the use of appropriate intervention/treatment codes. Guidance has been circulated to improve understanding however there is still a lack of understanding and clarity. A deep dive took place at Performance Improvement Group in October 2019 and an action plan has been developed and implemented.
3	Total number of inappropriate OAP days over the reporting period (rolling 3 months)		4				5					5							3			19	95%	Data is extracted electronically, validated manually and reuploaded into the system. Work is underway to amend PARIS to enable this to be recorded completely on the system, timescale to be confirmed. 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. Conversarions are ongoing
4	Percentage of patients surveyed reporting their overall experience as excellent or good.				2		5					5							3			15	75%	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 now where clinicians can send the survey to patients and carers phones via email or SMS. The Quality Data Team access the system to generate reports.
5	The percentage of Serious Incidents which are found to have a root cause or contributory finding				2		5					5					5					17	85%	Data is collated onto excel for manual process after retrieval from the Dataix system
6	The percentage of teams achieving the agreed improvement benchmarks for HoNOS total score		4				5					5					5					19	95%	
7	The percentage of teams achieving the agreed improvement benchmarks for SWEMWBS total score		4				5					5					5					19	95%	
8	Number of new unique patients referred	5					5					5					3					18	90%	
9	The number of new unique patients referred with an assessment completed	5					5					5					3					18	90%	
10	Number of new unique patients referred and taken on for treatment	5					5					5					3					18	90%	
11	Number unique patients referred who received treatment and were discharged	5					5					5					3					18	90%	

Appendix C

		Data Source					Data Reliability					KPI Construct/Definition					KPI Amended / Tested							
		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 %	Notes
		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 constructio n 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	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			
12	Bed Occupancy (AMH & MHSOP A&T wards)	5					5					5					3					18	90%	
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							3			18	90%	
14	Percentage of patients readmitted to Assesement and treatment wards within 30 days	5					5					5							3			18	90%	
15	Vacancy rate (score from old KPI)				2			4				5					5					16	80%	Data extracted elecronically but processed manually
16	Percentage of staff in post more than 12 months with a current appraisal	5						4				5							3			17	85%	Issues with appraisal dates being entered to ESR have been reported. Compliance levels are effectively being monitored via monthly Huddle meetings and support is being provided where necessary to address ESR issues. A refresh of ESR guidance is being scheduled to improve accurate recording on the source system. Issues around the inclusion of medical staff within this data is being investigated
17	Percentage compliance with ALL mandatory and statutory training	5						4				5							3			17	85%	Issues with training compliance figures being reported have lessened - there appears to be greater confidence in the data being reported and this has been supported by scrutiny of issues in report out processes. Inclusion of PREVENT training within this data is being resolved
18	Percentage Sickness Absence Rate (month behind)	5						4				5							3			17	85%	Sickness absence data for inpatient services is now being taken directly from the rostering system which should help to eliminate inaccuracies the remainder of the Trust continue to input directly into ESR. There are some data quality issues concerned with failing to end sickness in a timely manner– this is picked up and monitored through sickness absence audits that the Operational HR team undertake.
19	Delivery of our financial plan (I and E)		4				5					5					5					19	95%	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 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 is collected on Excel with input co-ordinated and controlled by the Financial Controller and version control in operation.
21	Cash against plan		4				5					5					5					19	95%	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 other priorities identified by the Managing the Business group no date has been agreed for the finance development

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25 February 2020**
TITLE:	**Strategic Direction Performance Report – Quarter 3 2019/20**
REPORT OF:	**Sharon Pickering, Director of Planning and Performance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 3 (31st December 2019).

This report reflects the new performance indicators that were agreed to monitor and report progress against the Trust's 5 year strategic direction in conjunction with the Trust Business Plan and other forms of intelligence.

Quarter 3 has reported an overall improvement with 64% (9 out of 14) of the metrics reporting green compared to 56% (9 out of 16) in quarter 2. Of the remaining 36% (5) metrics are reported as red and one has reported an improvement compared to quarter 2.

Progress against the Business Plan is mixed, in particular in relation to Strategic Goal 5, which has only delivered three actions in quarter 3.

Recommendations:

Board of Directors is asked to:

- Note the changes to the Trust Business Plan that require Board approval in Appendix 1.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**25 February 2020**
TITLE:	**Strategic Direction Performance Report – Quarter 3 2019/20**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to Board of Directors the Strategic Direction Performance Report as at Quarter 3 (31st December 2019).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report demonstrates progress against the Strategic Direction via progress against the agreed KPI Scorecard, the Trust Business Plan and other forms of qualitative intelligence.

2.2 The current KPIs for the Trust Strategic Direction Scorecard were agreed by the Board on the 19th July 2018, with the majority of targets being agreed at the October 2018 Board meeting.

2.3 The Strategic Direction Scorecard is shown under each strategic goal with proposed changes to the Business Plan requiring approval, by exception, detailed in Appendix 1.

3. KEY ISSUES:

3.1 Trust Strategic Direction Scorecard

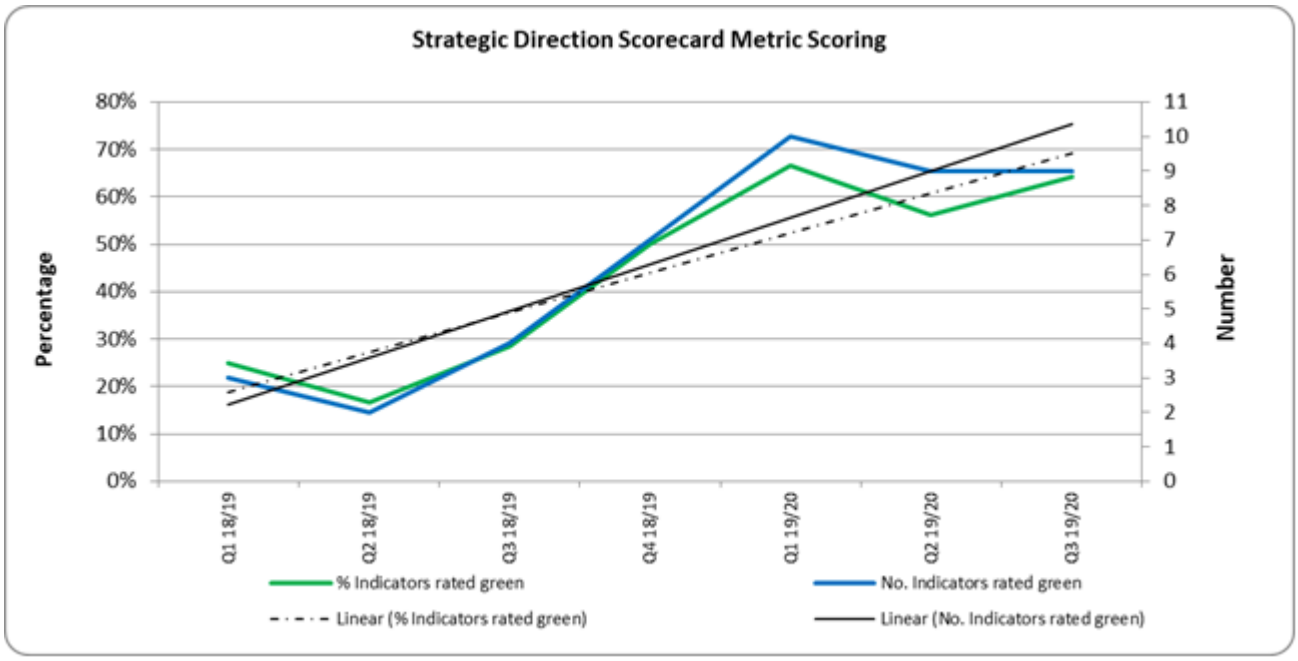
The following table provides a summary of the RAG ratings at quarter 3 compared to the position in the previous quarters.

Quarter 3 has reported an overall improvement with 64% (9 out of 14) of the metrics reporting green compared to 56% (9 out of 16) in quarter 2. Of the 36% (5) metrics reporting red, one has reported an improvement compared to quarter 2 - percentage of patients who report their overall experience as excellent or good.

There remains a number (9) that are not being rated as they are either not required to be reported in this quarter or are still under development.

SDS	Q4 2018/19		Q1 2019/20		Q2 2019/20		Q3 2019/20	
	No	%*	No.	%*	No.	%*	No	%*
Indicators rated green	7	50%	10	67%	9	56%	9	64%
Indicators rated red	7	50%	5	33%	7	44%	5	36%
Indicators rated	**14**		**15**		**16**		**14**	
Indicators with no target agreed								
Indicators currently under development/being finalised	7		7		6		7	
Indicators where data is not yet available or not applicable in qtr	1		1		1		2	
Metric will not be possible to report and we are identifying a further indicator	1							

The graph below shows an overall improving trend in the percentage of greens since the metrics were introduced in 2018/19. Quarter 3 has reported an improvement on quarter 2 2019/20.



3.2 **Strategic Goal *1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)***

3.2.1 Trust Strategic Direction Scorecard

This strategic goal is showing 1 metric rated red. That is consistent with the quarter 2 position; however the indicator showing red is different from that in quarter 2. Of the metrics that can be reported, two are reporting an improvement on the quarter 2 position.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20											
	Indicator	Q2 Target 2019/20	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 1 (To provide excellent services, working with the individual users of our services and their carers to promote recovery and well-being)											
1	Percentage of teams achieving the agreed improvement benchmarks for HoNOS total score	60.00%	62.50%	66.55%	57.43%	⇩	60.00%	64.52%	59.41%	44.00%	60.00%
2	Percentage of teams achieving the agreed improvement benchmarks for SWEMWBS	65.00%	68.48%	68.95%	71.13%	⇧	65.00%	68.72%	67.38%	50.00%	65.00%
3	Number of patients who said we helped them achieve the goals they set	TBC	Metric currently under development			N/A	N/A	Metric currently under development	N/A	N/A	TBC
4	Percentage of carers that report feeling listened to and heard	76.20%	77.13%	74.84%	77.17%	⇧	76.20%	75.98%	76.45%	76.08%	76.20%

Indicators of concern are:

- **KPI 1 - Percentage of teams achieving the agreed improvement benchmarks for HONOS total score –** The Trust position reported in quarter 3 is 57.43% which relates to 126 patients out of 296 patients who have not achieved the improvement benchmarks for HONOS total score. This is 2.57% worse than the standard of 60% and is deterioration on the quarter 2 position.

  Two localities are reporting below target:

  - Durham & Darlington report 56.12%, a deterioration from quarter 2 which was consistent with quarter 1 (67.37%)
  - Teesside report 55.91% which is worse than quarter 2 (64.04%).

3.2.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 3 were rated green 87% (67 out of 77) compared to 88% (53 out of 60) in quarter 2 2019/20. 82% of the priorities under Strategic Goal 1 are reporting that there is no significant risk to the completion on time of the priority. There are 9% of priorities that have a moderate risk of failure to deliver the final milestone or benefits on time.

However, there are 4 (9%) priorities / service developments in the Business Plan at high risk of failure to deliver on-time or within budget:

- 1 priority (1.13.53) **D&D New community team model** -The model will not be in place by Q4 19/20. An improvement event is currently being arranged to help with this work. The priority is identified to implement in 2020/21 Business plan. The Board are asked to note and approve this.
- 1 priority (1.13.26) **Individual Placement & Support** (IPS) - The implementation plan Trust wide is based on requirements of all 3 ICS bids, and this business plan action has been interpreted as relating to implementation of all elements of that plan within the timescales given. The RAG is red as although much of the implementation plan is now achieved and attaining timescale targets there are a few outliers. EMT approved the extension to Q4 19/20 and for additional actions to be included in the 2020/21 Business Plan.

- 1 priority (1.13.70) **Rehabilitation** - Following a comprehensive review of the project and a completed Change Implementation Workbook, it has been agreed that patients will be moved from Kirkdale to Lustrum Vale by 31st January 2020. Discharge plans are in place and beds are being held on Lustrum Vale to ensure this happens as planned. EMT approved the extension to Q4 19/20.
- 1 Priority (1.7.7 – 1-4) **Implement the transforming care agenda -** A review of LD bed space is currently underway with a view to enabling bed reductions. Trust Board are asked to approve the request to extend the timescale to Q1 2020/21.

There is one priority reporting Grey on the basis that it has not been completed on time and/or benefits realised due to external factors:

- **CORE 24 Tees** - Following clarification from NHSE the service have revised the bid for submission at the end January 2020. If the service is successful the funding will be available from April 2020. Non-recurring funding of £191k has been secured through winter pressures money via the Durham Darlington and Teesside MH & LD partnership.

There are 2 metrics for (Durham Community model and LD Transforming care) that require Board approval to extend the timescales noted in the table attached in appendix 1.

3.2.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- The Trust's internal **pharmacy service** launched on Monday 4 November. This provides "A person centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines".

- **Cleveland liaison and diversion team** won the 'Nursing in Mental Health' category at the Nursing Times Awards. The team, based at Middlehaven Police Station in Middlesbrough, offer assessment and advice to people in contact with the criminal justice system who have mental ill health, learning disabilities.

- **The North Tees adult learning disability team** from Wessex House in Stockton won the Team of the Year for Intellectual Disability at the prestigious Royal College of Psychiatrists Awards.

- The **talking therapies service in County Durham** were highly commended in the improving access to psychological therapies category of the Positive Practice in Mental Health Awards.

- A bid to NHSE Health & Justice Commissioners to enhance the Mental Health Care Navigator role across the **North East Prisons** has been

successful and will enable more intensive support upon release, targeting specialist patient groups and prioritising those most at risk of mental health relapse and reoffending.

- **North learning disabilities team,** Chester-le-Street Health Centre, Chester-le-Street, Durham were finalists in the Health and Wellbeing in the Workplace category of the Inspiring People Awards 2019 from Durham County Council.

- **Talking Changes**, a joint venture between Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV), County Durham and Darlington NHS Foundation Trust, Mental Health Matters and Sunderland Counselling Services, were highly commended in the improving access to psychological therapies (IAPT) category of the recent "Positive Practice in Mental Health Awards".

3.2.4 Other points to note:

- **KPI 3 - Number of patients who said we helped them achieve the goals they set** – The additional question did not go live until 1st September and has only been implemented for adult mental health teams. Changes for the other teams are anticipated go live from the 1st April 2020. This has been delayed due to the National FFT Changes which have had to take precedence. The changes to the other teams will be made as soon as possible after the go live of the FFT. Processes have now been agreed for the initial reporting of the metric in February 2020 and this development is currently being tested and will be made live soon for those who are currently capturing this information.

3.2.5 In conclusion, a positive position is presented in terms of this strategic goal and the services we provide to patients and carers, with two of the three reportable metrics green (both reporting an improvement on quarter 2) and a good amount of positive qualitative intelligence. In terms of the business plan, although there are four priorities/service developments at high risk of failure to deliver on time or within budget, this is an improvement on the quarter 2 position of 6.

3.3 Strategic Goal 2 - *To continuously improve the quality and value of what we do*

3.3.1 Trust Strategic Direction Scorecard

This strategic goal is showing two indicators rated red, which is consistent with the quarter 2 position. Of the two metrics reporting red, one has reported an improvement.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20											
	Indicator	Q2 Target 2019/20	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 2 (To continuously improve the quality and value of what we do)											
5	Percentage of staff reporting that they can contribute towards improvement at work (reported a quarter behind)	87.00%	82.30%	81.87%	79.00%	⇩	87.00%	82.13%	81.50%	81.59%	87.00%
6	Percentage of patients who report feeling supported by staff to feel safe	65.20%	65.57%	70.83%	70.06%	⇩	65.20%	66.90%	61.53%	65.63%	65.20%
7	Percentage of patients who report their overall experience as excellent or good	94.00%	92.06%	90.85%	91.93%	⇧	94.00%	91.48%	91.41%	90.68%	94.00%

Indicators of concern are:

- **KPI 5 - Percentage of staff reporting that they can contribute towards improvement at work –** this metric is reported a quarter behind; the quarter 3 data therefore relates to the quarter 2 survey. The Trust position for quarter 2 is 79% which relates to 402 members of staff out of 1914 who stated they did not feel they could contribute towards improvements at work. This is 8% worse than the standard of 87% and is deterioration on the quarter 2 position.

  All areas are reporting below target:
  - Durham & Darlington report 75.92% which is worse than quarter 1 (79.90%)
  - Forensics report 77.12% which is worse than quarter 1 (83.04%).
  - North Yorkshire report 81.61% which is worse than quarter 1 (82.52%).
  - Teesside report 80.97% which is worse than quarter 1 (82.07%).

  Feedback indicates that staff are committed to making suggestions but do not always feel they are in a position to follow them through; either due to time, resources or staffing issues. In addition, the time it can take to implement changes can mean that it is not immediately apparent to staff that their suggestions are being implemented, which may result in some staff believing that they have limited influence.

- **KPI 7 - Percentage of patients who report their overall experience as excellent or good** – The Trust position for quarter 3 is 91.93% which relates to 256 patients out of 3172 patient survey responses that report their overall experience other than excellent or good. This is 2.07% worse than the standard of 94% but is an improvement on the quarter 2 position.

All localities, with the exception of Teesside are reporting below target:

- Durham & Darlington report 93.14% which is better than quarter 2 (90.35%)
- Forensics report 87.20% which is slightly worse than quarter 2 (88.43%).
- North Yorkshire & York report 89.31% which is worse than quarter 2 (91.32%).

Patient experience is monitored at weekly directorate report outs, but there is some concern that the data on its own does not always indicate themes or specific improvements that are required in the services.

In Durham and Darlington locality there is challenge in obtaining sufficient volumes of responses so as to capture a more accurate cross-section of service users, as often the less satisfied service users are more inclined to provide feedback. This is being monitored and scrutinised at QUAG meetings by challenging return rates and any exceptions. Completion of surveys has also been placed on the ward discharge checklist and investigations as to how use better use of the data are ongoing. There has been an increase in January return rates as a result. The Forensics Directorate have commenced a deep dive on this topic.

It should be noted that due to a change in the FREEPOST address for the return of surveys some surveys had been held at the post office awaiting release, which will have an impact on the December response rates. The data will be refreshed when all surveys are received.

3.3.2 Trust Business Plan

The majority of business plan actions due to be completed by the end of quarter 3 were rated green 81% (26 out of 32) compared to 63% in quarter 2 2019/20. 67% of the priorities under Strategic Goal 2 are reporting that there is no significant risk to the completion on time of the priority. There are 17% of priorities that have a moderate risk of failure to deliver the final milestone or benefits on time.

However, there is 1 (17%) priority / service development in the Business Plan at high risk of failure to deliver on-time or within budget

- **Make Care Plans more personal** (2.12.4-6) - to date there has been 213 sessions held for training on the CPA process. However it has been noted that any future CPA related training must focus on practical examples of how to identify ‘needs, goals and actions’ at the most basic level. This will also better support the transition to the new ways of working that are being developed as part of the CITO development, including DIALOG. There is now a consensus that DIALOG needs to be used where possible, adopting a DIALOG ‘style’ approach to ensure consistency to make the product accessible and meaningful. There are requests to extend the timescales to

ensure the work is in line with the first pilot of CITO in a live environment to commence the testing of DIALOG.

There are 2 metrics for (Trust wide Dual Diagnosis, Care plans) that requested an extension to time which has been approved by EMT and a further 2 requests for Care plans that require Board approval to extend the timescales noted in the table attached in appendix 1.

3.3.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) were one of ten NHS trusts in the UK to be highlighted in a new report monitoring speaking up culture in the NHS for our work to support staff to speak up about issues affecting patient care. The report, known as the Freedom to Speak Up Index, has been compiled by the National Guardians Office (NGO), an independent, non-statutory body sponsored by the Care Quality Commission (CQC), NHS England and NHS Improvement.
- **Dr Ahmad Khouja**, Medical Director, has started a piece of work to improve the experience of sexual safety in in-patient settings following a CQC themed report on sexual safety on mental health in-patient units.
- The Trust has implemented a new learning disability bed management function from 2 December 2019 which will enable us to have a central process for all learning disability (LD) speciality admissions across the Trust.

3.3.5 In conclusion, performance against this strategic goal is mixed with the majority of business plan actions due to be completed by the end of quarter 3 rated green 81% (26 out of 32), an improvement on the quarter 2 positions. However, two KPIs continue to perform below target, one reporting deterioration and the other an improvement, compared to quarter 2.

3.4 **Strategic Goal 3** - ***To recruit, develop and retain a skilled, compassionate and motivated workforce***

3.4.1 Trust Strategic Direction Scorecard

This strategic goal is showing all indicators rated red as at quarter 3 out of a possible 2 that could be rated, which is consistent with quarter 2. Neither have reported an improvement on quarter 2.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20											
	Indicator	Q2 Target 2019/20	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 3 - To recruit, develop and retain a skilled, compassionate and motivated workforce											
8	Percentage rolling 12 month TEWV labour turnover rate	9.00%	10.35%	10.46%	10.54%	⇩	9.00%	10.41%	10.44%	N/A	10.00%
9	Percentage rolling sickness absence rate	<4.40%	5.03%	5.06%	5.36%	⇩	<4.40%	5.06%	5.17%	N/A	<4.40%
10	Percentage staff recommending TEWV as a place to work	76.00%	70.72%	67.78%	No FFT During quarter 3	N/A	76.00%	69.26%	74.04%	70.95%	76.00%
11	Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified.	TBC				N/A	N/A		N/A	N/A	TBC

Indicators of concern are:

- **KPI 8 - Percentage rolling 12 month TEWV labour turnover rate** - The Trust position for quarter 3 is 10.54% which relates to 724 leavers out of 6867 total staff. This is 1.54% worse than the standard of 9% and is comparable with the quarter 2 position.

  Only Forensics and Teesside are reporting better than target. However both have reported deterioration on quarter 2.

  Trust-wide 30% (230) of leavers highlight retirement as their reason for leaving. North Yorkshire and York continues to report the highest labour turnover rate at 14.01%, the figure is an increase on quarter 2 (13.28%). The figures reported exclude doctors in training.

- **KPI 9 - Percentage rolling sickness absence rate -** The Trust position for quarter 3 is 5.36% which relates to 119492 days lost to sickness out of 2229452 available working days for the Trust. This is 0.96% worse than the standard of 4.40% and is consistent with the previous quarters.

  Only North Yorkshire is reporting better than target but all localities are reporting deterioration on quarter 2.

  Mental health/stress and anxiety related absences continues to account for the greatest amount of time lost for absence. (40%) There were 47,818 fte days lost to mental health related absence which equates to an average of 34 days per episode. Gastrointestinal related absences amount to the highest number of episodes of absence at 2,116.

3.4.2 Trust Business Plan

The majority of the business plan actions due to be completed by the end of quarter 3 were rated green 92% (12 out of 13) compared to 73% in quarter 2. There are 2 business plan priorities assigned to Strategic Goal 3 (Right Staffing and Making a Difference together) which are currently reporting amber green due to there been a moderate risk of failure to deliver the final milestone or benefits on time.

There is 1 metric for Right Staffing that requested an extension to time which has been approved by EMT. This related to the Roster and Safe staffing dashboards to be added to IIC and this action has been extended to Q4 19/20.

3.4.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Charlie Darby-Villis**, B3 occupational therapy assistant with the Durham and Darlington occupational therapy hub based at Lanchester Road Hospital, Durham has contributed a series of practical examples of the problems and the rewards of setting up and sustaining a reading group in a women's prison in Durham to a recently published book 'Reading and Mental Health'

- Junior doctors have placed the Trust among the top five organisations in the UK for medical education for the third consecutive year. The annual General Medical Council (GMC) trainee survey, which collects feedback from junior doctors across Great Britain, ranked TEWV as the fourth best NHS Trust in the UK.

- The new NHS England Chief Nursing Officer Awards were announced at the Chief Nurse Summit earlier this year. A silver badge aims to recognise individuals who have excelled, celebrating performance of those who have gone above and beyond the expectations of the role. Margaret Kitching, regional Chief Nurse awarded the prestigious Silver Chief Nursing Officer Award to John Savage, Head of Nursing Durham and Darlington at the Trusts Annual Nursing Conference on the 3rd October 2019.

- **Jim Boylan**, consultant psychiatrist, has won the Psychiatric Educator of the Year award at the prestigious Royal College of Psychiatrists Awards.

- **John Venable** was the winner of the Service User / Patient Contributor of the Year category at the prestigious Royal College of Psychiatrists Awards.

- **Arran Scott**, senior accountancy assistant, Flatts Lane Centre, Middlesbrough won the Student of the Year category in the Healthcare Financial Management Association (HFMA) Awards.

- **Louise Ferguson**, assistant locality accountant, Flatts Lane Centre, Middlesbrough was shortlisted in the Technician of the Year category of the Healthcare Financial Management Association (HFMA) Awards and won the Chairman's Award.

- **Jamie Roberts,** financial accountant shortlisted in the Accountant of the Year category of the Healthcare Financial Management Association (HFMA) Awards.

- New funding for the continuous professional development (CPD) of nurses and AHP's has recently been announced by Health Education England (HEE). Funding has been allocated across the region which will enable the Trust to

provide a £1,000 training budget over the next three years for each registered nurse and AHP across the Trust.

- **Jacqueline Lynas**, staff nurse, adult mental health services (PICU), Cedar ward, West Park Hospital, Darlington has been awarded a Cavell Star Award for shining bright and showing exceptional care

3.4.4 Other points to note:

- **KPI 11 - Report and increase the % frontline multi-professional leadership and management teams that have trained in the core skills identified** - There was a delay to the Supercell Leadership development programme (in relation to Teesside cohort not being able to start the programme until September rather than June as originally intended) which mean that the evaluation work will not be completed until February 2020, meaning the metrics will not be available until quarter 4 2019/20. Further discussions are to take place to confirm the processes for monitoring the leadership strategy

- **KPI 10** - **Percentage staff recommending TEWV as a place to work - the Friends & Family Test** is not undertaken during quarter 3

3.4.5 In conclusion, performance against this Strategic Goal is good, although both metrics are reporting red out of those that were possible to be rated; with both deteriorating compared to last quarter. Progress against the Business Plan and the significant amount of qualitative intelligence is more positive for the recruitment, development and retention of our workforce.

3.5 Strategic Goal 4 - *To have effective partnerships with local, national and international organisations for the benefit of the communities we serve*

3.5.1 Trust Strategic Direction Scorecard

This strategic goal is showing all metrics are rated green out of a possible 3 metrics that can be rated, which is consistent with the quarter 2 position. No metrics reported an improvement on that quarter but one remained consistent with quarter 2.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20

	Indicator	Q2 Target 2019/20	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 4 - To have effective partnerships with local, national and international organisations for the benefit of the communities we serve											
12	Percentage joint bids with CCGs that are successful	80%	**80.56%**	N/A	N/A	N/A	80%	**80.56%**	70.83%	N/A	80%
13	Percentage of mental health and learning disability budget covered by a ring-fenced budget	85%	**91.90%**	**90.14%**	**89.95%**	⇩	85%	**90.14%**	77.17%	N/A	85%
14	Percentage delayed transfers of care due to non Trust issues	3.5%	**2.52%**	**2.28%**	**2.77%**	⇩	3.5%	**2.40%**	3.01%	N/A	3.50%
15	Percentage of e-letters developed against the total number of GP letters required	100%	**100.00%**	**100.00%**	**100.00%**	⇔	N/A	**100.00%**	N/A	N/A	100%

There are no concerns for the indicators reported above.

3.5.2 Trust Business Plan

There are no business plan priorities assigned to Strategic Goal 4.

3.5.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- **Research & Development** have been successful in a bid to co-host a Clinical Academic NMAHP Leadership post across TEWV and Teesside University. As part of MaDT/ coaching and leadership, we were awarded £18,500 from NELA to evaluate the leadership training programme that started in September.

- Working together as an 'Integrated Care System', all NHS organisations in the North East and North Cumbria along with Local Authorities and other voluntary and third sector organisations, have committed to work together on six shared priorities to help build a health and care system which is fit for the future. Staff, patients and members of the public have been invited to join a series of NHS 'Join of Journey' roadshows to find out more; these commenced in October.

- Local NHS Trusts and clinical commissioning groups have partnered with Coventry University Scarborough to introduce two new mental health nursing courses. The Trust has worked with CU Scarborough – part of the Coventry University Group, York Teaching Hospital NHS Foundation Trust and NHS Scarborough and Ryedale CCG to introduce a Registered Mental Health Nursing course and Nursing Associate course. The first students on the Nursing Associate course will start in January 2020, while the Mental Health Nursing course began in September 2019.

- The fourth annual EPIC mental health update conference was held by TEWV in November, seeing more than 150 GPs, members of practice nursing teams and mental health trust staff, supported by carers and experts by experience, come together to share best practice for the benefit of patients.

3.5.4 Other Points to Note

In addition to the reported position the following points should be noted:

- **KPI 12 - Percentage joint bids with CCGs that are successful** – No joint bids with CCGs were submitted during quarter 3.

- **KPI 15 - Percentage of e-letters developed against the total number of GP letters required** – All letters are developed in PARIS; however PARIS

is unable to email them/send them electronically at this current time. A way forward has been identified but this relies on CITO being implemented.

3.5.5 In conclusion performance against this strategic goal indicates work with our partners is strong. All three of the reportable metrics are green and these are supported by a significant amount of qualitative intelligence.

3.6 Strategic Goal 5 - *To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve*

3.6.1 Trust Strategic Direction Scorecard

This strategic goal shows that all three metrics of those that can be reported are rated green, which is an improvement on quarter 2, when one action was rated red.

TRUST STRATEGIC DIRECTION SCORECARD 2019/20

	Indicator	Q2 Target 2019/20	Quarter 1 Actual	Quarter 2 Actual	Quarter 3 Actual	Change on previous quarter	YTD Target 2019/20	FYTD 19/20	2018/19 Actual	2017/18 Actual	Annual Target 2019/20
Strategic Goal 5 - To be recognised as an excellent and well governed foundation trust that makes best use of its resources for the benefit of the communities we serve											
16	Delivery of control total in full as per NHSI financial plan	-£2,223,000.00	-1,267,392	-1,750,573	-2,253,970	⇧	-£1,201,000	-£3,017,965	-£26,766,868	n/a	
17	Achieve an NHSI SOF rating of 1 *(reported one quarter behind)*	1	1	1	1	⇔	1	1	1	N/A	1
18	All clinical teams to be able to access pathology results via PARIS and order test by PARIS	75.00%	68.82%	98.39%	98.39%	⇔	25.00%	98.39%	24.30%	N/A	100.00%
19	All service users being able to access care plan online or digitally	TBC		Not Available for Quarter 2	Not Available for Quarter 3	N/A	N/A	Not Available for the FYTD	N/A	N/A	TBC
20	100% clinical pathways developed and in use within PARIS	100%		Not Available for Quarter 2	Not Available for Quarter 3	N/A	100%	Not Available for the FYTD	N/A	N/A	100%
21	All clinicians to have access to Datix Incidents, Datix Risks, Datix Complaints, Clinical Caseload, Clinical Huddle Dashboard, Bed Management View in near to real-time	100%		Not Available for Quarter 2	Not Available for Quarter 3	N/A	N/A	Not Available for the FYTD	N/A	N/A	TBC
22	Placeholder: E &D Strategy			Not Available for Quarter 2	Not Available for Quarter 3	N/A	N/A	Not Available for the FYTD	N/A	N/A	TBC
23	Placeholder: E &D Strategy			Not Available for Quarter 2	Not Available for Quarter 3	N/A	N/A	Not Available for the FYTD	N/A	N/A	TBC

Indicators of concern are:

- **KPI 21 - All clinicians to have access to Datix Incidents, Datix Risks, Datix Complaints, Clinical Caseload, Clinical Huddle Dashboard, Bed Management View in near to real-time**.

  This metric has been included following approval by Board in quarter 2.

  Initial work with the Trust's third party suppliers was delayed but this has been now been resolved and timescales for implementation are as follows:

Area	Timescale	Comments
Datix Incidents	Quarter 4 2019/20	
Datix Risks	Quarter 1 2020/21	
Datix Complaints	Quarter 1 2020/21	
Clinical Caseload	Quarter 2 2020/21	This will be delivered via Cito

Clinical Huddle Dashboard	Quarter 2 2020/201	This will be delivered via Cito.
Bed Management View	Awaiting go live date	This will be delivered via PARIS and is built -

3.6.2 Trust Business Plan

Only 3 of the 11 (27%) business plan actions due to be completed by the end of quarter 3 has been delivered on time.

There are two business plan priorities assigned to Strategic Goal 5; one to Identify and Reduce Waste and the other to deliver our Digital Transformation Strategy which are both currently reporting Red.

- **Identify and reduce waste** – Due to issues with IT firewalls and invoicing it has not been possible to start the pilot relating to Reducing Travel and Venue Hire costs in December. Following a system demonstration and credit check the commencement date in January 2020 will be confirmed. The plan has been changed to a soft launch approach, commencing mid-January 2020 through to 31st March 2020 across the proposed pilot areas (Finance, Performance and Planning, Therapies and North Yorkshire & York) to "proof" the system. The go live for the wider Trust is still planned for 1st April 2020. This work will then move from a CRES project approach to a business as usual approach and will coordinated by the Finance Team to ensure a central and consistent approach. A dedicated lead will be identified prior to the April roll out. EMT has approved the extension of time.

- **Deliver our Digital Transformation Strategy -** The Digital mail room pilot is currently active, the work to introduce Datix real time is ongoing and the new Intranet Go-live are due to be delivered in Q4 19/20. These 3 actions requested an extension to timescales which were approved by EMT.

  There are 3 metrics for centralised asset management, CITO design and patient portal which require Board approval to extend the timescales noted in the table attached in appendix 1.

3.6.3 Other Qualitative Intelligence

In addition to the reported position the following points should be noted:

- Over 270 staff from clinical services, members of the Trust Board and Experts by Experience attended a digital showcase event earlier this month, which included an update on Cito which is the new electronic patient record (EPR).

3.6.4 Other points to note:

- **KPI 19 - All service users being able to access care plan online or digitally** – data is not available as yet. The plan is that care planning will be built in CITO and then patients will receive an electronic copy alongside being able to access a Patient Portal where a patient can access their plan. CITO rollout is being managed but the plan is now that MHSOP will be aiming to go live during Spring 2020; a delay from the original plan of Autumn 2019.

- **KPI 20 - 100% clinical pathways developed and in use within PARIS** - data is not available as yet. Version 2.4 of CITO includes workflow functionality to allow development of pathways. The plan is that the pilot teams for CITO will include this high level pathways/workflow functionality. CITO rollout is being managed but the plan is now that MHSOP will be aiming to go live during Spring 2020; a delay from the original plan of Autumn 2019.

- **KPI 22/23 - E&D Strategy metrics** – these metrics are not yet finalised. The Resources meeting in November 2019 agreed the revised equality and Diversity Strategy and it was presented to the Board of Directors in January 2020. The metrics will now be finalised.

3.6.5 In conclusion performance against this Strategic Goal is mixed. Whilst all three reportable KPIs are green, only three out of Business Plan actions has been delivered this quarter and there is little qualitative intelligence.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
There are no issues of compliance with the CQC fundamental standards.

4.2 **Financial/Value for Money:**
The report highlights that none of the Sustainability metrics are below target.

4.3 **Legal and Constitutional (including the NHS Constitution):**
There are no direct legal or constitutional implications from this paper.

4.4 **Equality and Diversity:**
Following the approval of the new E&D Strategy metrics will be identified for future inclusion.

4.5 **Other implications:**
There are no other implications associated with this paper.

5. RISKS:

The paper identifies that there are various risks attached to the overall delivery of our Strategic Direction.

6. CONCLUSIONS:

Quarter 3 has reported an overall improvement with 64% (9 out of 14) of the metrics reporting green compared to 56% (9 out of 16) in quarter 2. Of the 36% (5) metrics reporting red, one has reported an improvement compared to quarter 2 - percentage of patients who report their overall experience as excellent or good.

Progress against the Business Plan is mixed, in particular in relation to Strategic Goal 5, which has only delivered three actions in quarter 3.

7. RECOMMENDATIONS:

Board of Directors is asked to:

- Note the changes to the Trust Business Plan that require Board approval in Appendix 1.

Sharon Pickering
Director of Planning, Performance & Communications

Background Papers:

Appendix 1– Requests to the Board of Directors for a Change to the Business Plan

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
1.13.53	New community team model	D&D	AMH	Implementation of new model (in line with recommendations from paper submitted and supported by EMT Q4 18/19)	New community team model in place	Q4 19/20	Donna Sweet		The new community team model will not be in place by Q4. An improvement event is being arranged and the priority is identified to implement in 2020/21 Business plan. Trust Board are asked to note this update
1.13.25	Core 24	Tees	MHSOP	Should application for Wave 2 National funding be successful, implement model	Model implemented	Q4 19/20	Shaun Mayo		Following clarification from NHSE the service have revised their bid, however if successful the funding will not be available until April 2020
1.7.1	Implement the Transforming Care agenda	COO	FLD	Achievement of bed reductions in line with trajectories - Forensic LD	Kestrel/Kite reduce to 12 beds (Each reduce from 8 to 6)	19/20 Q3	Paul Cartmel	R	Current review of LD bed spaces is being undertaken with a view to enabling reduction. Trust Board are requested to extend the timescale to Q1 20/21
1.7.2	Implement the Transforming Care agenda	COO	FLD	Achievement of bed reductions in line with trajectories - Forensic LD	Harrier/Hawk reduce by 4 beds (from 10 to 6)	19/20 Q3	Paul Cartmel	R	Current review of LD bed spaces is being undertaken with a view to enabling reduction. Trust Board are requested to extend the timescale to Q1 20/21
1.7.3	Implement the Transforming Care agenda	COO	FLD	Achievement of bed reductions in line with trajectories - Forensic LD	Northdale - contracted beds reduced from 12 to 6. Non contracted beds remain for spot purchase	19/20 Q3	Paul Cartmel	R	Current review of LD bed spaces is being undertaken with a view to enabling reduction. Trust Board are requested to extend the timescale to Q1 20/21

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
1.7.4	Implement the Transforming Care agenda	COO	FLD	Achievement of bed reductions in line with trajectories - Forensic LD	Kestrel reduce by 1 bed (from 6 to 5) Kite reduce by 2 beds (from 6 to 4)	19/20 Q4	Paul Cartmel		Current review of LD bed spaces is being undertaken with a view to enabling reduction. Trust Board are requested to extend the timescale to Q1 20/21
2.15.4	Make Care Plans more personal	Medical Directorate		To continue training on the CPA process so that 500 staff have been trained	500 members of staff to have completed training by end Q2 19/20	Q3 19/20	Michael Cowan	R	The figures remain the same as last time (231), as there have been no more sessions of the original co-produced package in Q3. It is evident that this is liked by staff but does not improve the personalisation of care planning. Timing is the key barrier, as staff are frustrated with current systems and processes and this is intensified when new ways are not been delivered. It has also become increasingly clear via direct contact with services throughout 2019 that any future CPA related training must focus on practical examples of how to identify 'needs, goals and actions' at the most basic level. This will also better support the transition to the new ways of working that are being developed as part of the CITO development, including DIALOG. Trust Board are asked to approve the require to extend this action to Q2 20/21

Bus Plan Ref	Priority Title & overall status RAG	Locality/ Corporate Service	Clinical Speciality	Action	Key Metric	Time-scale	Service Lead	Q3 Metric Status	Comment and requests for decisions
	Make Care Plans more personal	Medical Directorate		To test DIALOG in a live environment (in line with roll-out of CITO)	Testing of DIALOG in a live environment commenced (in line with CITO rollout)	19/20 Q3	Michael Cowan/ Brian Cole Richard Yaldren/	R	The first pilot of CITO in a live environment is currently set at Q1 20/21, with non-live User Acceptance Testing (UAT) just prior to this in Q4 19/20. Trust Board are requested to agree an extension to Q1 20/21
5.6.2	Identify and Reduce Waste	COO	All	Introduce centralised asset management of Information Technology hardware	Centralised asset management of IT hardware introduced	19/20 Q3	Bob Craig	R	Waste Reduction Board have asked for an update at its February meeting which will agree proposed new timescales. These will be included in the Business Plan for 2020/21. and presented to Trust Board for approval
5.5.1	Deliver our Digital Transformation Strategy	Information	MHSOP	Test MHSOP pathway CITO design	CITO being tested "live" by MHSOP teams	Q3 19/20	Richard Yaldren	R	There has been a change in scolpe and the Cito group has now combined with Adults and MHSOP. As such go-live is now expected to be Q1 2020 Trust Board are requested to agree an extension to Q1 20/21
5.5.22		Information	All	pilot the new patient portal	patient portal pilot commenced	19/20 Q3	Richard Yaldren		The Trust is going to be part of the regional patient portal development which is likely to start in Q3 20/21 Trust Board are requested to agree an Extension to Q3 20/21

Please note that if approved, future monitoring will be against the amended timescale

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th February 2020**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Trust Secretary**
REPORT FOR:	**Information**

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

Executive Summary:

This report provides information on the use of the Trust Seal as required under Standing Order 15.6.

Recommendations:

The Board is asked to receive and note this report.

MEETING OF:	**The Board of Directors**
DATE:	**25th February 2020**
TITLE:	**Report on the Register of Sealing**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board of Directors of the use of the Trust's Seal in accordance with Standing Orders.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 An entry of every sealing is made and numbered consecutively in a Register specifically provided for the purpose. It is signed by the persons who have approved and authorised the document and those who attested the seal.

3. KEY ISSUES:

3.1 The Trust Seal has been used as follows:

Number	Date	Document	Sealing Officers
361	12/02/2020	Deed of Indemnity between Wates Construction Ltd and TEWV	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary
362	14/02/2020	Deed of Guarantee between Interserve and TEWV	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary
363	14/02/2020	Sub-Contractor Agreement – James Paul Services to Industry Ltd	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary
364	14/02/2020	Sub-Contractor Agreement – Levin UK Lightning Protection and Earthing Ltd	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary

365	14/02/2020	Sub-Contractor Agreement – CAD 21 Ltd	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary
366	14/02/2020	Sub-Contractor Agreement – Robinson Structures Ltd	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary
367	14/02/2020	Sub-Contractor Agreement – Catalyst Engineering Ltd	Patrick McGahon, Director of Finance and Information Phil Bellas, Trust Secretary

4. IMPLICATIONS:

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

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

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

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

5.1 There are no risks associated with this report.

6. CONCLUSIONS:

6.1 This report supports compliance with Standing Orders.

7. RECOMMENDATIONS:

7.1 The Board is asked to receive and note this report.

Phil Bellas, Trust Secretary

Background Papers:
The Trust's Constitution
Seals Register

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO.18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25 February 2020**
TITLE:	**Policies Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

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

Executive Summary:

The policy paper contains the following information:

- 2 policies that have undergone full review with no amendments and required ratification:
  - CORP-0052-v3.1 Equality Analysis Policy
  - HR-0013-v8 Human Rights and Equality & Diversity Policy

- 2 policies and 1 procedure that had minor amendment:
  - HS-0008-v4 Fire Safety Policy
  - PHARM-0001-v9.1 Non-Medical Prescriber (NMP) Policy to Practice
  - CLIN-0017-001-v3.1 Supportive Observations and Engagement Procedure

- 4 policies that required an extension to the review date:
  - CLIN-0012-v7.5 Admission, Transfer and Discharge Policy
  - IT-0007-v6 Internet Policy
  - PLAN-0004 IT Major Incident Plan
  - CLIN-0004 Controlling Access to and exit from Inpatient Areas

Recommendations:

The Board are asked to ratify the decisions made by EMT at the meeting held on 22 January 2020.

DATE:	**25 February 2020**
TITLE:	**Policies and Procedures Ratified by the Executive Management Team**
REPORT OF:	**Colin Martin**
REPORT FOR:	**Information**

1. INTRODUCTION & PURPOSE:

The purpose of this report is to advise the Board of Directors on the policies and procedures that have been ratified by the Executive Management Team.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 It is important that the Trust policy portfolio is updated and revised in a timely way to ensure best practice, current legislation and regulation is reflected in policy content. Policies no longer required to control and assure practice should be terminated and withdrawn from the portfolio.

2.2 Following the last revision of the Trust's Integrated Governance arrangements, it was agreed that the Executive Management Team ratify all new and revised Trust policies.

2.3 Each policy ratified by the Executive Management Team will have gone through the Trust's consultation process.

2.4 Currently all corporate Trust policies are ratified by the EMT on behalf of the Board of Directors, following approval by the appropriate specialist committees and groups. All decisions regarding the management of the policy framework must be ratified by the EMT.

3. KEY ISSUES:

3.1 The following policies have undergone full review and required approval

Ref and Title	CORP-0052-v3.1 Equality Analysis Policy
Review date	22 January 2023
Reviewed by	Not required – no change
Approved by	No appropriate approval body
Description of change	This policy has been fully reviewed with no changes required except an updated Equality Assessment

Ref and Title	HR-0013-v8 Human Rights and Equality & Diversity Policy
Review date	28 February 2021

Reviewed by	Not required – no change
Approved by	No appropriate approval body
Description of change	This policy undergoes annual review as a requirement of the Code of Practice: Mental Health Act 1983. The policy has been reviewed but does not require change, so is to be re-ratified for a further 12 months.

3.2 The following has undergone minor amendment.

Ref and Title	HS-0008-v4 Fire Safety Policy
Review date	27 November 2022
Reviewed by	Sharon Pickering
Approved by	Health Safety Security and Fire (HSSF) Group 30 October 2019
Description of change	Clarification of responsibilities, staff and groups throughout document. Note these minor amendments and clarifications are from independent director review that was submitted after EMT meeting 27 November 2019.

Ref and Title	PHARM-0001-v9.1 NMP Policy to Practice
Review date	27 November 2019
Reviewed by	Not required – minor amendment
Approved by	Drugs and Therapeutic Committee - pending 23 Jan 2020 meeting
Description of change	Minor amendment - role of supervisor and assessor corrected.

Ref and Title	CLIN-0017-001-v3.1 Supportive Observations and Engagement Procedure
Review date	06 November 2022
Reviewed by	Not required – minor amendment
Approved by	No appropriate approval body
Description of change	Minor amendment to wording

3.3 The following required extension to the review date.

Ref and Title	CLIN-0012-V7.5 Admission, Transfer and Discharge Policy
Review date	30 April 2020
Comments	This policy has had the review date extended to allow review.

Ref and Title	IT-0007-v6 Internet Policy
Review date	31 March 2020
Comments	This policy has had the review date extended to allow review.

Ref and Title	PLAN-0004 IT Major Incident Plan
Review date	31 March2020
Comments	This policy has had the review date extended to allow review.

Ref and Title	CLIN-0004 Controlling Access to and exit from Inpatient Areas
Review date	06 April 2020
Comments	The policy has undergone full revision and major change. Local consultation is underway prior to full Trust-wide consultation. A 3 month extension has therefore been requested to enable this work to be completed.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Sound policy development improves patient experience and enhances patient safety and clinical effectiveness.

4.2 Financial/Value for Money:

Any financial implications from the proposals arising from operational and/or practice changes will be managed by the Directorates responsible for policy implementation.

4.3 Legal and Constitutional (including the NHS Constitution):

The Trust requires a contemporary policy portfolio to ensure practice is compliant with legislation, regulation and best practice. The policy ratifications, review extensions and withdrawals will ensure the portfolio is managed to provide the necessary evidence based operational and practice frameworks.

4.4 Equality and Diversity:

The current policy portfolio ensures the Trust meets the required legislative and regulatory frameworks and all policies are impact assessed for any equality and diversity implications. Policy revision and /or specific implementation plans would result from any adverse impact assessments.

4.5 Other implications:

None identified

5. RISKS:

None identified

6. CONCLUSIONS:

The decisions detailed above made at the EMT meeting on 27 November 2019 have been presented for ratification.

7. RECOMMENDATIONS:

The Board is required to ratify the decisions of the Executive Management Team and is requested to accept this report.

Author: Colin Martin
Title: Chief Executive