MEETING OF THE BOARD OF DIRECTORS
Thursday 27th January 2022
at 1.00 p.m.

The meeting will be held via MS Teams

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

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

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

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

The timings provided in the agenda are indicative only.

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

Joining instructions for the event have been circulated separately.

AGENDA

Standard Items (1.00 pm – 1.15 pm):

1	Apologies.	**Chair**	**-**
2	Chair's Introduction.	**Chair**	**Verbal**
3	To approve the minutes of the last meeting held on 25th November 2021.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	Board Action Log. There are no open actions	**-**	**-**
6	Chair's Report.	**Chair**	**Verbal**
7	To note any matters raised by Governors.	**Board**	**Verbal**

Patient Story (1.15 pm – 2.15 pm):

8	To receive a patient story. *(Note: Board Members are asked to note that there will not be a question and answer session. There will an opportunity to reflect on the matters raised in regard to the quality and the business of the meeting)*	**-**	**Verbal**

Strategic Items (2.15 pm – 2.55 pm):

9	Chief Executive's Report.	**CEO**	**Report**
10	BAF summary report.	**Co Sec**	**Report**
11	To consider the report of the Chair of the Audit and Risk Committee.	**Committee Chair (JM)**	**Committee Key Issues Report**
12	To consider the Finance Report to 31st December 2022.	**DoF&I**	**Report**
13	To consider the Performance Dashboard Report as at 31st December 2022. *(Note: An abridged version of the report is provided, as agreed, to enable the redeployment of staff from the Performance Team into services and to reduce pressures on the clinical teams)*	**Asst CEO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (2.55 pm – 3.30 pm):

14	To consider key issues and risks arising from the Directors' Visits to: ▪ Durham Perinatal Team ▪ Tees Community Autism Service ▪ Forensic Outpatient Services for CAMHS ▪ Military Personnel Inpatient Services ▪ FOLS Team, North Yorkshire and York	**Board Members**	**Reports**

15	To consider the report of the Chair of the Quality Assurance Committee *(Note: the Key issues report includes the Trust's position against the NHS Staffing Assurance framework for Winter 2021 preparedness for ratification)*	**Committee Chair (BR)**	**Committee Key Issues Report**
16	To consider the six monthly "Hard Truths" Nurse Staffing Report.	**DoN&G**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (3.30 pm – 3.50 pm):

17	To consider the report of the Chair of the People, Culture and Diversity Committee.	**Committee Chair (SR)**	**Verbal**
18	To approve the self-assessment against the Equality Delivery System (EDS 2).*	**DoP&C**	**Report**
19	To consider and approve the publication of the Gender Pay Gap Report.*	**DoP&C**	**Report**

(Note: the recommendations of the People, Culture and Diversity Committee will be reported verbally at the meeting)

Goal 3: To be a Great Partner (3.50 pm – 4.00 pm):

20	To consider Quarterly System Oversight Framework Report.	**Co Sec/ Asst CEO**	**Report**

Matters for Information (4.00 pm – 4.05 pm):

21	To receive and note a report on the use of the Trust's seal.	**Co Sec**	**Report**

Exclusion of the Public (4.05 pm):

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

Paul Murphy
Chair
21st January 2022

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

MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 25th NOVEMBER 2021 COMMENCING AT 1.00 PM via MS Teams

Present:
Mr P Murphy, Interim Chair
Dr C Carpenter, Non-executive Director
Dr S Wright, Interim Medical Director
Mr J Maddison, Non-executive Director
Mrs B Reilly, Non-executive Director
Mrs S Richardson, Non-executive Director/Senior Independent Director/Interim Deputy Chair
Mrs R Barker, Associate Non-executive Director (Non-voting)
Mr J Preston, Associate Non-executive Director (Non-voting)
Mr B Kilmurray, Chief Executive
Dr S Dexter-Smith, Director of People and Culture (Non-voting) Mr R Patton, Interim Chief Operating Officer
Mrs A Bridges, Director of Corporate Affairs and Involvement (Non-voting)
Mrs E Moody, Director of Nursing and Governance/Deputy Chief Executive
Mrs L Romaniak, Director of Finance, Information and Estates
Mrs S Pickering, Director of Planning, Commissioning, Performance and Communications/Assistant Chief Executive (Non-voting)

In Attendance:
Mr P Bellas, Company Secretary
Ms L Hughes, Interim Corporate Governance Advisor
Mrs W Johnson, Team Secretary
Ms D Oliver, Deputy Trust Secretary (Corporate)

Observers/Members of the Public
Mr S Double
Ms J Wardle
Ms S Baxter

21/11/1/181 APOLOGIES

1.1 Apologies were received from Prof P Hungin, Non-executive Director and Ms J Haley, Non-executive Director.

21/11/2/182 CHAIRMAN'S INTRODUCTION

2.1 The Interim Chair welcomed everyone to the meeting. He formally welcomed Jules Preston and Roberta Barker to their first meeting as Associate Non-executive Directors.

21/11/3/183 MINUTES OF PREVIOUS MEETING

3.1 **Resolved:** the minutes of the previous meeting held on 28 October 2021 were approved as a correct record and agreed to be signed by the Chairman.

3.2 Matters Arising from the minutes – Jules Preston queried the oversight arrangements in place in relation to staff appraisals. In response, Sarah Dexter-Smith explained that there is an action plan in place to improve the appraisal position. This was paused for some time during COVID but work had recommenced with oversight of this to be taken forward by the People, Culture and Diversity Committee.

21/11/4/184 DECLARATIONS OF INTEREST

4.1 There were no new interests declared and no declarations of interest received in relation to open agenda items.

21/11/5/185 PUBLIC BOARD ACTION LOG

5.1 The Board noted the completed action and it was noted that the open action in relation to the feasibility of forming a task and finish group had yet to be discussed between Elizabeth Moody, Pali Hungin and Bev Reilly. It was noted that this was planned to be discussed at the next Quality Assurance Committee and it was agreed to be closed.

21/11/6/186 CHAIRMAN'S REPORT

6.1 Paul Murphy, Interim Chair provided a verbal report and drew reference to:

6.1.1 The meeting held with Chairs of other NHS providers and the ICS. As ambassadors of mental health and learning disabilities they continue to drive forward key discussions nationally to support and improve services.

6.1.2 Work continued to take forward the GGI actions.

6.1.3 The Board session held recently focussed on patient safety and security and the work required to take forward the Trust's Digital agenda.

6.1.4 He had the pleasure of speaking at an event organised by Steve Wright for aspiring doctors and nurses. The event was most uplifting with a diverse group of people from around the world attending who had all shown an interest in working at the Trust.

6.2 **Resolved:** the Interim Chair's verbal report was noted.

21/11/07/187 MATTERS RAISED BY GOVERNORS

7.1 The Interim Chair explained that there was no pre-meeting with Governors prior to the Board meeting that day due to the Council of Governors meeting taking place earlier that week. At the Council of Governors meeting issues around Peer Support Workers were raised and it was agreed that Sarah Dexter-Smith would take an action forward.

7.2 **Resolved:** the matters raised by Governors were noted.

21/11/08/188 CHIEF EXECUTIVE'S REPORT

8.1 The Chief Executive's Report was received and noted. The Chief Executive drew attention to the following:

8.1.1 The Care Quality Commission (CQC) – the Trust had received the confidential reports and had been invited to complete a factual accuracy check. The reports include the CQC's findings following the core services and well led inspections, which were carried out in June and August 2021. It was noted that the Trust was making progress with action planning and had implemented a number of improvements, specifically within Forensics and CAMHS to date.

8.1.2 Organisational Change, Structures Update – Following the business case approval by the Board at its last meeting work was taking place to recruit to the Care Groups. Work had also taken place on the governance structure to support the organisational changes, which was included on the agenda for approval. In addition to the clinical and operational structure the appointment process had commenced to recruit to the Director of Estates, Facilities and Capital role in advance of Paul Foxton's planned retirement in the New Year.

8.1.3 Integrated Care System (ICS) update - Sam Allen is currently the Chief Executive of Sussex Partnership NHS FT, a mental health and learning disability provider and had successfully been appointed as Chief Executive of the North East and North Cumbria ICS. Work continues to appoint to other senior positions.

8.1.3.1 Humber, Coast and Vale ICS had yet to announce the appointment of their Chief Executive.

8.1.4 Veterans Covenant - the Trust had signed the Veterans Aware Covenant, which is a commitment to raise awareness of veterans and seek to better accommodate veterans' needs. The Trust will proactively engage with veterans as part of the Trust's co-creation approach and is interested in promoting the Defence Employer Recognition Scheme, which will require a commitment to employing reservists, veterans and military spouses.

8.1.5 COVID booster vaccinations and the 2021/22 staff flu vaccination programme. Media coverage recently highlighted the government's plans to make COVID vaccinations mandatory for front line workers. Guidance had yet to be released on the requirements of implementation and once received this would be reviewed by the Trust's Ethics Committee.

8.1.6 Charlotte Carpenter queried if the front-line staff would be redeployed if unvaccinated and if the Trust was concerned this would further impact to the current staffing issues. In response, the Chief Executive explained that it was currently unknown if there will be any discretion and the Trust would need to wait to receive the guidance once published.

8.1.7 The Interim Chair was pleased to report that the Council of Governors had complemented the work that had taken place at the Trust on its COVID and staff flu vaccination programme.

8.1.8 Director Visit – the next Director visit would include some military/ex-services members, staff members and Governors.

8.2 **Resolved:** the Chief Executive's Report was noted.

21/11/9/166 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

9.1 The Board Assurance Framework (BAF) summary report was received. It was noted that since the last Board meeting the BAF had been reviewed by Executive Risk owners and updated accordingly.

9.2 **Resolved:** the Board Assurance Framework summary report was received, noted and accepted.

21/11/10/168 FINANCE REPORT

10.1 The Finance Report as at 31 October 2021 was noted. Liz Romaniak drew reference to:

10.1.1 The national planning guidance, which was released for the second six months (H2) on 1 October 2021. The guidance detailed a run rate analysis indicating H2 surplus of (£47,000) is expected, which would provide a full year planned surplus of £5.1m. The Strategy and Resources Committee reviewed the plans following approval by Senior Leadership Group, which are planned to be presented to the Board in private for approval.

10.1.2 Cash balances at £89.4m, which is £7.1m ahead of plan.

10.1.3 Agency staffing metric was highlighted at £4.6m ahead of the target.

10.2 Jules Preston, Associate Non-executive Director drew reference to the financial challenges for 2022/23 and if the Trust was aware of the efficiency savings required in 2022/23. In response, Liz Romaniak explained that the cash releasing efficiency savings target for the second part of 2021/22 is £1.8m. The Trust had yet to be informed on the details of efficiency savings for 2022/23. It was noted that a quality impact assessment will be carried out if the requirements for home working continue into the longer term.

10.3 **Resolved:** the Finance Report for the period ending 31 October 2021 was received and noted.

21/11/11/169 PERFORMANCE DASHBOARD

11.1 The Performance Dashboard as at 31 October 2021 was received and noted. Sharon Pickering explained that there had been discussion around the majority of the report during the meeting. She drew particular attention to:

11.1.1 Patients seen within 4 weeks for a first appointment was below the 90% standard at 86.91% this resulted in 6453 out of 7425 patients seen during October.

11.1.2 Patients that had received treatment within 6 weeks was below the 60% standard at 54.43% resulting in 947 patients seen out of the 1740 target.

11.1.3 Wards continued to be extremely busy with bed occupancy above the 90% target at 99.64% during October. (It was noted that as a result of Esk Ward closure the figures for that ward were included, which resulted in the bed occupancy reflecting a slightly worsened position.)

11.1.4 Compliance against staff mandatory and statutory training was 84.31% against the 92% target in October. Work was under way across localities and corporate divisions to improve on the position.

11.2 The Interim Chair queried staff sickness absence. In response Sarah Dexter-Smith explained that the level of sickness absence remained fairly static at present; it had not shown a noted increase or decrease during October.

11.3 Charlotte Carpenter, Non-executive Director queried if the Trust used local and national benchmarks to compare its performance and if this information could be included in future report. In response Sharon Pickering explained that there were only two benchmark targets included: sickness absence and out of area placements, all others included were internal targets, which initiated discussion. It was noted that acute NHS providers had a range of benchmarks and used comparative data analysis.

11.4 John Maddison, Non-executive Director drew reference to the mandatory training compliance, staff absence and the increased use in agency staff and if this had an impact on the compliance position. In response, the Chief Executive explained that the organisational change being taken forward required investment and formed part of the Trust's strategy to increase its workforce. Sarah Dexter-Smith added that over the last month stronger mitigations had been noted with regards to this area of work, which is now overseen by the Quality Improvement Board and the People, Culture and Diversity Committee.

11.5 **Resolved:** the Performance Report as at 31 October 2021 was discussed and noted.

21/11/12/170 REVISED ORGANISATIONAL GOVERNANCE STRUCTURES

12.1 The Chief Executive presented the revised governance structure that had been developed to strengthen governance arrangements from ward to Board. He explained that this had been reviewed and supported by the Executive Team and staff side, and

shared with staff during the case for change restructure of clinical and operational services prior to submission to the Board.

12.2 It was noted that evidence collected from the Trust's internal learning, feedback obtained through Our Big Conversation, the Good Governance Institute's (GGI) Independent Well-led review' and the CQC's feedback confirmed that there was a need to make changes to deliver services and how they are implemented through the Trust's internal governance structures and processes. The Chief Executive proposed that the revised governance structure was approved to strengthen the governance arrangements from ward to Board and referred to the appendices, which provided detail on the assurance and operational delivery levels of the structure including the two Care Groups up to Executive level, Board Sub-committees, Board and the Council of Governors.

12.3 The interim Chair drew reference to the appendices, which he found to be clearly understood and fully supported the proposals. Bev Reilly, Non-executive Director expressed her support; she felt the revised structures were less complex than the current governance structures and would help to strengthen governance at the Trust. She also drew reference to the risk framework (Appendix C) and queried who had supported the governance review. In response the Chief Executive explained that it was undertaken by Lynn Hughes with the support of Executive colleagues and the Director of Quality.

12.4 John Maddison, Non-executive Director drew reference to the recommendation to strengthen risk management and queried how that would report up to Board. In response the Chief Executive explained that the revised governance structure aimed to strengthen risk management to support quality improvement and good governance. The introduction of Risk Management groups within the governance structure aimed to strengthen the oversight and management of risk throughout the organisation with the escalation of risks from ward to Board whilst retaining the sensitivity to monitor changes at a local level. Assurance on risk management would be reported up to the Audit and Risk Committee and to the Board. Following discussion, the proposal was approved with the aim of implementation from April 2022.

12.5 **Resolved:** i) the revised governance structure was received and approved; and
ii) work to produce Terms of Reference, update Standing Orders, Standing Financial Instructions and the Risk Management Strategy/Policy would now commence to support the revised governance structure coming into place from April 2022.

21/11/13/171 DIRECTOR VISITS

13.1 An update was provided on the Director Visits that had taken place for North Durham MH Liaison Team; Harrogate CMHT; ICLS and Middlesbrough CMHT; Redcar and Cleveland CMHT; D&D Care Home Liaison Hub; and York CHAD. It was noted that the visits are informal to encourage an open discussion, to share good experiences across the organisation, and to support any required improvements with the aim of empowering and supporting staff. It was noted that there was a standard process in place for the Director Visits with at least one Governor invited to attend and work was under way to develop a new one-year programme. Feedback from the Director Visits was planned to be captured in Board papers going forward.

13.2 **Resolved:** the Director Visits update was noted and future arrangements for a one-year programme were supported.

21/11/14/172 QUALITY ASSURANCE COMMITTEE REPORT

14.1 Bev Reilly, Non-executive Director, Chair of Quality Assurance Committee (QAC) spoke to the QAC report from the meeting held on 4 November 2021. She explained that she welcomed the changes to the revised governance structure, which would help to strengthen assurance arrangements for QAC with oversight of operational delivery being overseen by Executive and Care Group level. Bev Reilly drew reference to:

14.1.1 The Quality and Safety risk register, which included 40 risks. There had been five risks removed in September and two risks added. Actions and mitigations against risks were received and an assurance report had been requested to provide an update on how risks are being managed. Bev Reilly felt that the risk escalation framework (Appendix C) included in the revised Governance Structure paper earlier in the meeting would help to strength and embed risk management throughout the organisation with the support of the recruitment of a Risk Manager.

14.1.2 CQC Inspections and updates from NHSE/I and TEWV Quality Improvement Boards were received and noted with no additional escalations reported.

14.2 Elizabeth Moody explained that risk management training will be organised to strengthen and embed the updated risk management arrangements.

14.3 Elizabeth Moody referred to the Positive and Safe six month review report, which highlighted the continued reduction of restraint across the organisation. For the first time, the Trust reported no instances of the use of prone restraint over a one-week period and it is anticipated that the initiatives in place will continue to support further reductions.

14.4 The Chief Executive drew reference to the number of positives highlighted and explained that Shirley Richardson had queried if arrangements could be made for staff to be recognised at a Celebration event in the future, which was being explored.

14.5 **Resolved:** the Quality Assurance Report from the meeting held 4 November 2021 was received and noted.

21/11/15/173 PATIENT STORIES AT BOARD MEETINGS

15.1 The paper on the Patient Stories for future Board meetings was received and noted. Discussion took place around the arrangements to establish Patient Stories at future Board meetings. It was noted that the newly formed People, Culture and Diversity Committee had introduced a Colleague Story at its meetings. There had been one Colleague Story to date, which was very moving and enabled lessons to be learned. Following discussion, it was agreed the Patient Stories process would be established.

15.2 **Resolved:** Patient Stories for future Board meetings was agreed to be taken forward.

21/11/16/174 PEOPLE, CULTURE AND DIVERSITY COMMITTEE REPORT

16.1 Shirley Richardson, Interim Deputy Chair and Chair of the People, Culture and Diversity Committee (PCDC) spoke to the report and explained that the first meeting of the Committee had been most productive. The meeting commenced with a Colleague Story, which was most powerful and emotional and helped to connect with members of staff to triangulate against the information provided in papers and discussions at meetings. The meeting covered a range of items including the adoption of the Terms of Reference, the BAF/Corporate Risk Register; Performance Workforce Dashboard; a Deep Dive into Recruitment/Vacancy Review; Staff Networks update. A Committee Workplan had been developed, which was accepted and agreed would be further developed over time. The

meeting ended with a discussion on risks that had been discussed during the meeting and if any items required escalating to any other Board Sub-Committees or the Board for information or action. It was noted that the next Committee meeting agenda included a Deep Dive item on Health and Wellbeing.

16.2 The Interim Chair explained that he had observed the meeting and found it to be a refreshing couple of hours and he was pleased with the progress made. The Interim Chair reported that Jill Haley, Non-executive Director had queried the content of the summary reports to Board and he had explained that the detail of the meeting is routinely included within the minutes and not the summary report.

16.3 **Resolved:** the People, Culture and Diversity Committee report from the meeting held on 16 November 2021 was received and noted.

21/11/18/175 USE OF THE TRUST SEAL

18.1 **Resolved:** in accordance with Standing Order 15.6, the Board received and noted the update report on the use of the Trust Seal.

21/11/19/176 CONFIDENTIAL MOTION

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

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

Information which, if published would, or be likely to, inhibit:
(a) the free and frank provision of advice, or
(b) the free and frank exchange of views for the purposes of deliberation, or
(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.

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

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

Following the transaction of the confidential business the meeting concluded at 3.15 pm.

Paul Murphy
Interim Chair
27 January 2022

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 9

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 27 January 2022**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

To receive and note the contents of this report.

Care Quality Commission (CQC)

The Board is aware that the CQC published the well led and four core services reports on 10 December. We went through the report and in our Board Seminar. At the Quality Assurance Committee meeting in January there was a further detailed presentation which set out the process being adopted to develop the action plan.

The Trust has until 21 January to submit the actions to address the "must dos" as set out in the reports. The Trust has tried to do this through co-creating responses with staff, patients and carers.

Many aspects of the report are consistent with work the Trust has been doing on the following improvement plans:

- Governance Plan in response to the GGI review.
- The organisational restructure.
- S29A CAMHS and Forensics action plans.
- Community mental health transformation.

We have taken the opportunity to review these plans and a further detailed plan has been developed to pull together these strands and adding some new ones.

The Board will be reviewing the detail later today, we will publish this once the Board has signed off on it.

Covid / Omicron

During December and January the communities we serve have been hit by the latest variant of Covid. During December, York and parts of North Yorkshire were hardest hit, whilst during January the North East has been the hardest hit part of the country.

During this phase the Trust has experienced very high levels of staff absence and extremely high levels of bed occupancy.

We continue to declare Opel 4, our highest level of escalation, short of a critical incident. This means a number of services are into their business continuity plans and that the Trust's level of operational oversight has been heightened.

Sickness absence has peaked out in the first week of January at over 13% and bed occupancy remains very high and often at over 100% occupancy.

We have had 13 Covid outbreaks over the period and this has included up to 90 patients. Each case is individually investigated to identify a cause where possible.

We are seeing some improvement in the situation, although the communities within the North East still have the highest rates.

We have managed the pressures through stepping up our temporary staffing services including introducing incentive payments for staff taking on additional shifts.

A number of corporate colleagues and some community staff have been redeployed to support pressured services.

Staff have stepped up and we have sought to give clear leadership and communication on changing guidelines, how we manage risk and keeping patients, carers and themsevls as safe as possible.

I'd like to put on record my thanks to our staff and for the ongoing support of our pateitns and carers.

Mandatory Vaccinations

The mandatory vaccination legislation, going live on 1 April will mean that Trust's are no longer able to deploy unvaccinated staff into services.

There has been a great deal of work done to date to reconcile national databases with Trust information about the vaccine status of our colleagues. Whilst we are still tracking a large number of staff, we believe that there are currently 286 colleagues that we have no record of their vaccine status.

We have a team of HR, service and clinical leaders who are tracking each remaining employee to have personal conversations with them regarding their vaccine history and where they have not had vaccines, their intentions.

Some staff are claiming exemptions on the basis of medical issues. These are currently being reviewed. Some colleagues are making a case to be re-deployed. However, we have determined that there are likely to be a very limited number of opportunities to be redployed given that most roles require access to clinical buildings, are patient facing or work closely with those who are patient facing.

Unvaccinated colleagues have until 3 February to access their first dose in order ensure they have received both vaccines by 31 March.

For those colleagues who are not vaccinated at this point, have not had an agreed exemption or have not been able to be redeployed then it will be illegal for the Trust to employ them. Therefore, their employment will end at that point.

We are keen to do everything we can to work with colleagues to ensure that the number whose employment is terminated is minimised as much as we possibly can.

Integrated Care System Developments

The Planning guidance issued on 24 December 2021 confirmed that the start of the Integrated Care Boards will now be formally delayed by three months. They will now go live on 1 July 2022. This will allow the legislation to clear the parliamentary process. This means that Clinical Commissioning Groups (CCGs) will continue for another three months until the ICBs come into being.

Locally, our ICS colleagues are continuing to make preparations for their new operating models. There has been some progress with senior appointments, and others will be completed during February and early March. Structures for all other current CCG staff are also being prepared for consultation.

There are very few direct implications for the Trust from this delay.

Organisational Structure

There has been significant progress with the new organisational structure.

At an Executive level the interviews for the Managing Director posts went ahead on 12 and 13 January. One offer has been made and the second post is now being re-advertised. The Executive Medical Director post is also being advertised and interviews are being scheduled for February.

The trustwide Director of Therapies has been shortlisted with four candidates and interviews are planned for 1 February.

There have been offers made following interviews for the Care Group Directors of Nursing and Quality.

All Care Group Directors of Operations and Transformation – except for Specialised Inpatient Services (Forensics) were subject to “slot in” processes. The vacant post has been shortlisted with five candidates invited to interviews on 1 February.

Care Group Medical Directors have been appointed until September 2022, whilst further work is done on job plans and recruitment.

The Lived Experience Director posts in each Care Group have been advertised and the reaction has been very positive on social media and in direct response to the Trust. Twenty people have directly expressed an interest in further conversations. Interviews are scheduled for 9 February.

Care Group Directors of Therapies are also progressing. One post has been subject to slot in procedures. The other post, for Durham, Tees Valley and Forensics has received a positive response and interviews will take place on 10 February.

All General Managers are now in place other than one, which could not be filled in the first round and is now out to advert (NYY&S CAMHS/LD) interviews are on 10 February.

Associate Nurse directors all in post.

Associate Director of Therapies posts are in process and progressing (mix of adverts and matching).

Associate Medical Director posts currently out to advert for interviews at the beginning of February.

Some Service Manager posts have been appointed to where slot in applied. The process to fill the other continues with those involved in the organisational change process now expressing their preferences for roles and offers being worked through this week.

There will be further consultation with Matrons about areas of responsibilities and portfolios, this should be resolved during the first half of February.

Changes to Therapies leads posts regarding on call responsibilities are going to consultation over the next few weeks.

Lead Psychiatry post adverts to be released in the next few weeks.

Business managers – 4 staff not successful and registered in redeployment, the process for remaining staff will be concluded by the end of January

The next phase of the restructure will concern corporate teams. An extra meeting of the Joint Consultative Committee will be held on 27 January to go through the key principles and plans to date. Senior levels of these structures will be in place by April. Detailed work is also underway to ensure that all corporate systems changes required for 1 April are completed and there are plans for those to be carried forward into 2022/23.

A key emphasis will be in the development and organisational development and support aspects of the implementation plan to ensure that the changes we have made make the intended difference and that those in new roles are well supported and set up to succeed.

Information Commissioner's Office - Audit Update

The Information Commissioner's Office (ICO) conducted a consensual audit during the week of the 25 November. After receiving and commenting on a draft report, the Trust has now received the final results.

The audit was split into two parts:

- Governance and Assurance
- Data Sharing

In both areas the ICO has concluded that our compliance levels are 'reasonable' - compliance level RAG ratings run from very limited (red), limited (amber), reasonable (yellow) though to high (green). This means that there is a reasonable level of assurance that processes and procedures are in place and are delivering data protection compliance.

The audit has identified scope for improvement in existing arrangements to reduce the risk of non-compliance with data protection legislation. The recommendations form the basis for an action plan that has been agreed with the ICO (and submitted to them) and which has been reviewed by the Digital Performance and Assurance Group.

The report recommendations are broken down as follows and an action plan is available with timescales for each area:

Governance & Accountability has 11 high, 11 medium and 4 low priority recommendations

Data Sharing has 7 high, 7 medium and 1 low priority recommendations

A final report from the ICO has now been received and an executive summary has been posted on the ICO website. This summary is attached for information – please see Appendix 1.

The Digital Performance and Assurance Group will monitor delivery of the actions and ensure reporting quarterly into the SLG in the short term (and Strategy and Resources Group as structures change subsequently). It is proposed that the Audit and Risk Committee received assurance on progress to implement the agreed actions.

Tees, Esk & Wear Valleys NHS Foundation Trust

Data protection audit report

January 2022

Information Commissioner's Office

Executive summary

Audit Methodology

The Information Commissioner is responsible for enforcing and promoting compliance with the UK General Data Protection Regulation (UK GDPR), the Data Protection Act 2018 (DPA18) and other data protection legislation. Section 146 of the DPA18 provides the Information Commissioner's Office (ICO) with the power to conduct compulsory audits through the issue of assessment notices. Section 129 of the DPA18 allows the ICO to carry out consensual audits.

The ICO is an independent, proportionate regulator and sees auditing as a constructive process with real benefits for controllers and so aims to establish a participative approach. High standards of personal data protection compliance help organisations innovate and deliver great services by building trust with the public. The ICO's expertise and consistent approach to regulation provides certainty enabling organisations to feel confident to use personal data responsibly, innovate and support economic growth.

The audit was conducted consensually as part of our ongoing audit strategy.

The purpose of the audit is to provide the Information Commissioner and Tees, Esk and Wear Valleys NHS Foundation Trust (the Trust) with an independent assurance of the extent to which the Trust, within the scope of this agreed audit, is complying with data protection legislation.

The scope areas covered by this audit were determined following a risk based analysis of the Trust processing of personal data. The scope may take into account any data protection issues or risks which are specific to the Trust, identified from ICO intelligence or the Trust own concerns, and/or any data protection issues or risks which affect their specific sector or organisations more widely. The ICO has further tailored the controls covered in each scope area to take into account the organisational structure of the Trust, the nature and extent of the Trust processing of personal data, and to avoid duplication across scope areas. As such, the scope of this audit is unique to the Trust.

It was agreed that the audit would focus on the following area(s)

Scope area	Description
Governance & Accountability	The extent to which information governance accountability, policies and procedures, performance measurement controls, and reporting mechanisms to monitor data protection compliance to both the UK GDPR and national data protection legislation are in place and in operation throughout the organisation.
Data Sharing	The design and operation of controls to ensure the sharing of personal data complies with the principles of all data protection legislation.

Audits are conducted following the Information Commissioner's data protection audit methodology. The key elements of this are normally a desk-based review of selected policies and procedures, on-site visits including interviews with selected staff, and an inspection of selected records.

However, due to the outbreak of Covid -19, and the resulting restrictions on travel, this methodology was no longer appropriate. Therefore, the Trust agreed to continue with the audit on a remote basis. A desk based review of selected policies and procedures and remote telephone interviews were conducted from 22 November to 26 November. The ICO would like to thank the Trust for its flexibility and commitment to the audit during difficult and challenging circumstances.

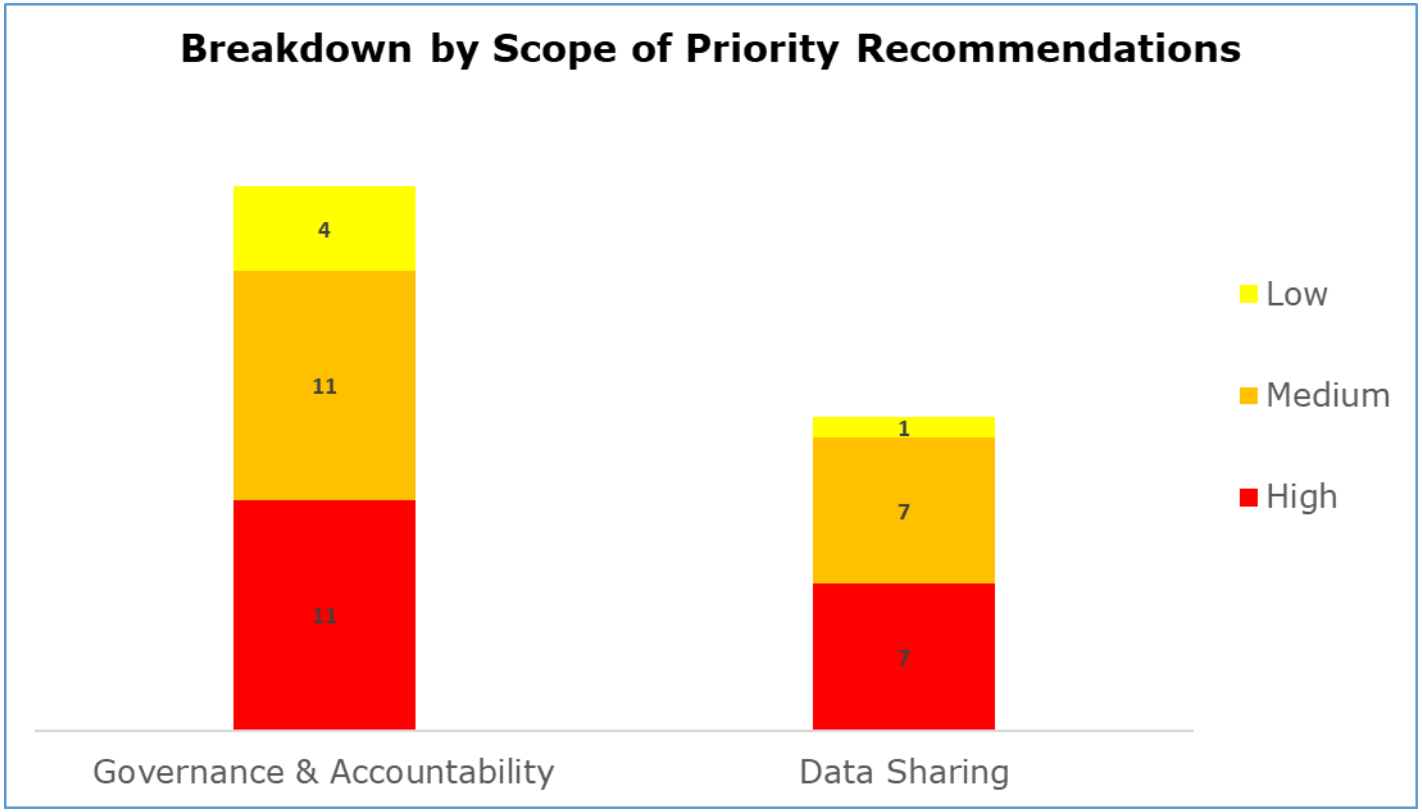
Where weaknesses were identified recommendations have been made, primarily around enhancing existing processes to facilitate compliance with data protection legislation. In order to assist the Trust in implementing the recommendations each has been assigned a priority rating based upon the risks that they are intended to address. The ratings are assigned based upon the ICO's assessment of the risks involved. The Trust priorities and risk appetite may vary and, therefore, they should undertake their own assessments of the risks identified.

Audit Summary

Audit Scope area	Assurance Rating	Overall Opinion
Governance & Accountability	Reasonable	There is a reasonable level of assurance that processes and procedures are in place and are delivering data protection compliance. The audit has identified some scope for improvement in existing arrangements to reduce the risk of non-compliance with data protection legislation.
Data Sharing	Reasonable	There is a reasonable level of assurance that processes and procedures are in place and are delivering data protection compliance. The audit has identified some scope for improvement in existing arrangements to reduce the risk of non-compliance with data protection legislation.

*The assurance ratings above are reflective of the remote audit methodology deployed at this time and the rating may not necessarily represent a comprehensive assessment of compliance.

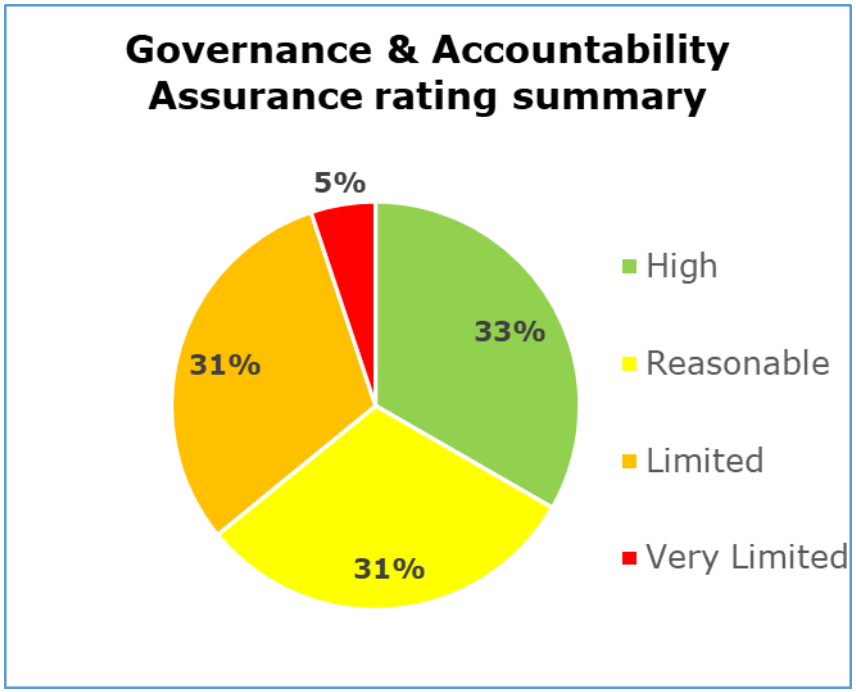
Priority Recommendations



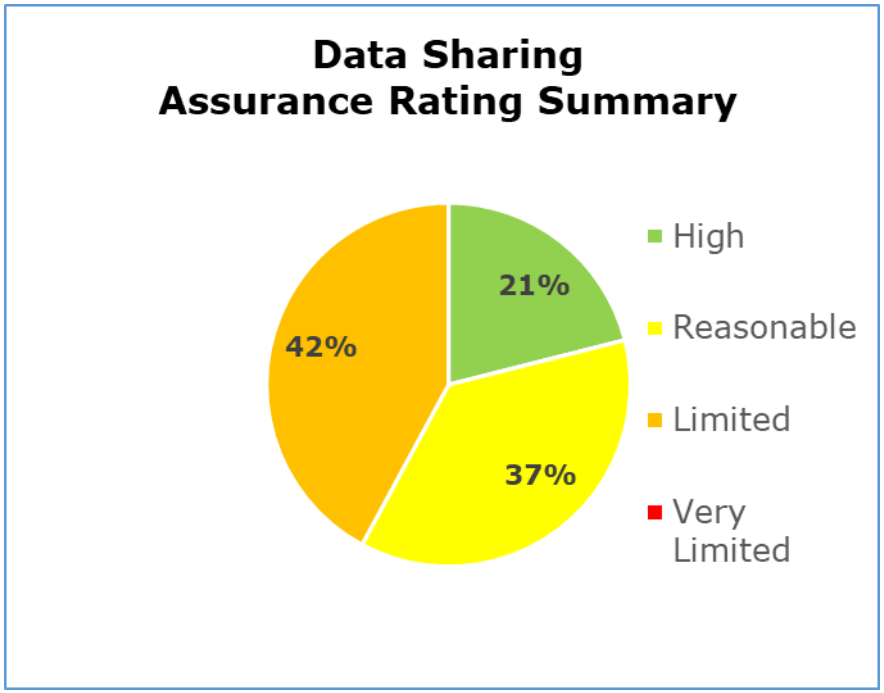
The bar chart above shows a breakdown by scope area of the priorities assigned to our recommendations made:

- Governance & Accountability has 11 high, 11 medium and 4 low priority recommendations
- Data Sharing has 7 high, 7 medium and 1 low priority recommendations

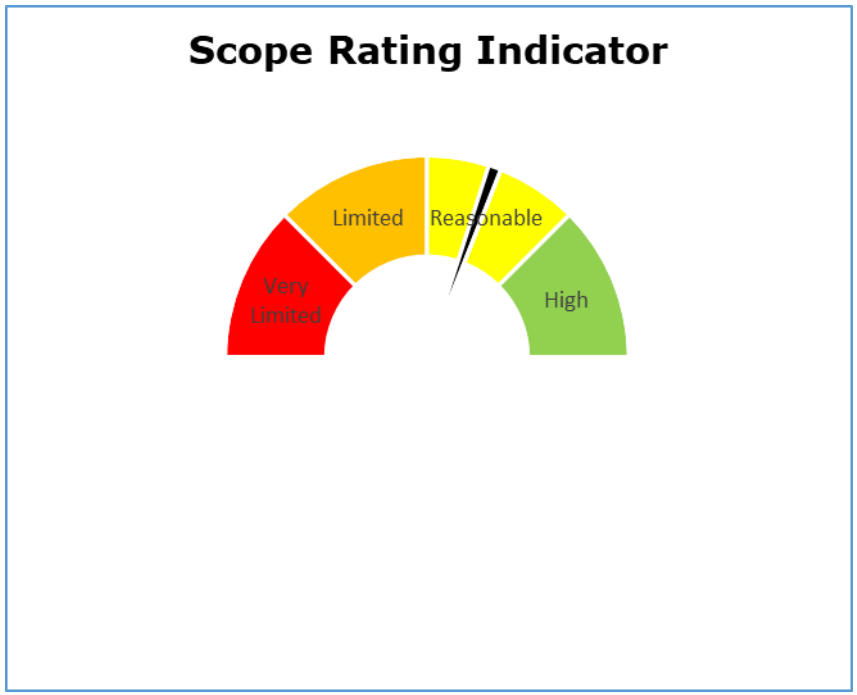
Graphs and Charts



The pie chart above shows a summary of the assurance ratings awarded in the Governance & Accountability scope. 33% high assurance, 31% reasonable assurance, 31% limited assurance, 5% very limited assurance.



The pie chart above shows a summary of the assurance ratings awarded in the Data Sharing scope. 21% high assurance, 37% reasonable assurance, 42% limited assurance, 0% very limited assurance.



The speedometer chart above gives a gauge of where the organisation sits on our assurance rating scale from high assurance to very limited assurance.

Areas for Improvement

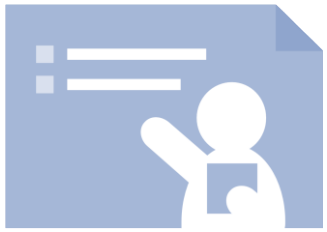
Governance & Accountability:

- The Trust's Records of Processing Activity (ROPA) needs work. What the Trust has in place is more of a data flow map and, whilst this is comprehensive, it does not include all of the requirements of Article 30 of UK GDPR.
- The Trust's DPIA screening questions and template is hard to follow and difficult to complete, this increases the risk of the template being inaccurately completed or not used at all. In addition, the DPIA screening questions do not contain all of the relevant considerations expected, such as the scope, purpose, type, and manner of proposed processing. This makes it difficult to establish the context of the new processing and for the designated reviewer to accurately review it.

Data Sharing:

- Not all staff likely to make decisions about data sharing have been identified and made aware of their responsibilities, and there is a lack of specialised training provided to staff with data sharing responsibilities both at induction as well as through periodic refresher training.
- The Trust's Information Sharing Agreement (ISA) library is not up to date and not all routine data sharing activities are covered by a sufficiently detailed ISA signed by the senior management of all sharing partners.
- Existing ISAs are not reviewed periodically, in all cases, to provide assurance that each agreement continues to operate as intended and in line with legislative requirements. The Data Performance and Assurance Group (DPAG) does not have sufficient oversight of ISA reviews as they do not feature as a standing agenda item at the DPAG's meetings.
- Sufficiently detailed policies, procedures and guidance are not in place to ensure that all staff that handle ad hoc third party disclosure requests can do so in a lawful, effective, and consistent manner.

Credits



ICO Audit Team

ICO Team Manager – Julie Wood
ICO Engagement Lead Auditor – Harry Evans
ICO Lead Auditor – Ben Gnatiuk

Thanks

The ICO would like to thank Louise Eastham, Head of IG and DPO for their help in the audit engagement.

Distribution List

This report is for the attention of Louise Eastham, Head of IG and DPO and Liz Romaniak Director of Finance and SIRO.

Disclaimer

The matters arising in this report are only those that came to our attention during the course of the audit and are not necessarily a comprehensive statement of all the areas requiring improvement.

The responsibility for ensuring that there are adequate risk management, governance, and internal control arrangements in place rest with the management of the Trust.

We take all reasonable care to ensure that our audit report is fair and accurate but cannot accept any liability to any person or organisation, including any third party, for any loss or damage suffered or costs incurred by it arising out of, or in connection with, the use of this report, however such loss or damage is caused. We cannot accept liability for loss occasioned to any person or organisation, including any third party, acting, or refraining from acting as a result of any information contained in this report.

This report is an exception report and is solely for the use of the Trust. The scope areas and controls covered by the audit have been tailored to the Trust and, as a result, the audit report is not intended to be used in comparison with other ICO audit reports.

ITEM NO. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th January 2022**
TITLE:	**Board Assurance Framework – Summary Report**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Information & Assurance**

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

Report:

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

A summary of the BAF, highlighting relevant reports included on the agenda, is provided in Annex 1 to this report.

This summary is intended to act as an aide memoire to support the Board to focus on the strategic risks in its discussions. It also provides assurance on the alignment of the BAF with the matters due for consideration at the meeting.

Recommendations:

The Board is asked to receive and note this report.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade (& Movement)	Indicative Controls Assurance Rating	Risk Management Approach	Related Agenda Items
	1	2	3						
1	✓	✓		**Recruitment and Retention** Inability to recruit and retain sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services	**DoP&C**	**Very High**	**Good** ↑	Risk significantly above tolerance Strengthening of controls required, at pace, to reduce exposure to tolerable levels	▪ Public Agenda Item 14 – Directors' Visits Feedback Reports ▪ Public Agenda Item 15 – Quality & Assurance Committee Key Issues Report (Locality Reports) ▪ Public Agenda Item 16 – Six Monthly 'Hard Truths' Nurse Staffing Report ▪ Public Agenda Item 17 – People, Culture and Diversity Committee (Workforce Report) ▪ Private Agenda Item 8 – Strategy and Resources Committee Key Issues Report (22/23 Board Integrated Performance Dashboard Measures)
2	✓			**Demand** Demand for our services, particularly as a result of the post-Covid surge, might result in us not being able to meet patient/carer expectations or commissioner requirements	**COO**	**High** ↔	**Reasonable**	Opportunities to improve controls; however, new controls (if available) are required to reduce exposure to tolerable levels	▪ Public Agenda Item 13 – Performance Dashboard Report ▪ Public Agenda Item 14 – Directors' Visits Feedback Reports ▪ Public Agenda Item 15 – Quality & Assurance Committee Key Issues Report (Locality Reports) ▪ Public Agenda Item 16 – Six Monthly 'Hard Truths' Nurse Staffing Report
3	✓			**Involvement and Engagement** A fragmented approach to service user and carer engagement and involvement might prevent us from co-creating a great experience	**DoC&I**	**High** ↔	**Good**	Present controls are, generally, considered to be operating effectively; however, achievement of the target risk score is dependent on the implementation of identified new controls.	▪ Private Agenda Item 10 – Nomination and Remuneration Committee Key Issues Report (Update on Organisational Restructure)

4	✓			**Experience** We might not always provide a good enough experience for those who use our services, their carers and their families, in all places and all of the time (see also BAF refs 1 (recruitment and retention) and 6 (Learning))	**DoN&G**	**High** ↔	**Reasonable** ↓	Controls are, generally, considered to be operating effectively; however, further strengthening is required, at pace, to reduce exposure to tolerable levels	▪ Public Agenda Item 13 – Performance Dashboard Report ▪ Public Agenda Item 14 – Directors' Visits Feedback Reports ▪ Public Agenda Item 15 – Quality & Assurance Committee Key Issues Report (Quality and Learning Report/Winter 2021 Preparedness) ▪ Private Agenda Item 8 – Strategy and Resources Committee Key Issues Report (22/23 Board Integrated Performance Dashboard Measures)
5	✓	✓		**Culture & Wellbeing** Pockets of poor culture or low staff wellbeing could undermine our ability to provide a safe and sustainable service as well as putting individual staff and patients at risk of harm	**DoP&C**	**High** ↔	**Reasonable**	Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels.	▪ Public Agenda Item 13 – Performance Dashboard Report ▪ Public Agenda Item 14 – Directors' Visits Feedback Reports ▪ Public Agenda Item 17 – People, Culture and Diversity Committee ▪ Private Agenda Item 6 – CQC Report and Action Plan ▪ Private Agenda Item 8 – Strategy and Resources Committee Key Issues Report (22/23 Board Integrated Performance Dashboard Measures)
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	**DoN&G**	**High** ↔	**Good**	Controls are, generally, considered to be operating effectively; however, further strengthening, through the delivery of mitigations, is required at pace to reduce the risk to tolerable levels.	▪ Public Agenda Item 13 – Performance Dashboard Report ▪ Public Agenda Item 14 – Directors' Visits Feedback Reports ▪ Public Agenda Item 15 – Quality & Assurance Committee Key Issues Report (Quality and Learning Report) ▪ Private Agenda Item 8 – Strategy and Resources Committee Key Issues Report (22/23 Board Integrated Performance Dashboard Measures) ▪ Private Agenda Item 10 – Nomination and Remuneration Committee Key Issues Report (Update on Organisational Restructure)

7	✓	✓	✓	**Infrastructure** Poor quality physical or digital infrastructure could impede our ability to co-create a great experience both for staff and for patients [excludes CITO (see risk 12), Cyber security (see risk 8) and RPH (see risk 14)].	**DoF&I**	**Medium** ↔	**Good**	The risk is within tolerance and controls are operating effectively. Continued delivery of mitigations is required to achieve target score.	▪ Public Agenda Item 12 – Finance Report
8	✓	✓	✓	**Cyber Security** A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage	**DoF&I**	**Very High** ↔	**Reasonable**	Ongoing strengthening of controls required due to the constantly evolving nature of the risk	▪ Private Agenda Item 8 – Strategy and Resources Committee Key Issues Report
9	✓	✓	✓	**Regulatory Action** Further regulatory action could result in loss of confidence and affect our reputation among service users, staff, and other key stakeholders (see also BAF ref. 11 – Governance and Assurance)	**CEO**	**High** ↔	**Good**	Controls considered to be operating effectively and scope for improvements limited. Higher degree of exposure than acceptable will need to be tolerated. Regular monitoring of the risk advisable.	▪ Public Agenda Item 20 – System Oversight Framework ▪ Private Agenda Item 3 – Reportable Issues Log ▪ Private Agenda Item 6 – CQC Report and Action Plans
10			✓	**Influence** Changes in the external environment, and insufficient capacity to respond or to align our objectives with those of partners, might lead to loss of strategic influence and reputation	**Asst CEO**	**High** ↔	**Good**	The risk is within tolerance. Further strengthening of controls required through the delivery of mitigations to achieve target score.	▪ Public Agenda Item 12 – Finance Report ▪ Private Agenda Item 3 – Reportable Issues Log ▪ Private Agenda Item 4 – Chief Executive's Report ▪ Private Agenda Item 8 – Strategy and Resources Committee Key Issues Report (BAF)
11	✓			**Governance & Assurance** The absence of a clear line of sight from ward to Board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risks to patients	**CEO**	**High** ↔	**Good**	Urgent action to be taken to strengthen controls but a higher degree of exposure than acceptable will need to be tolerated. Regular monitoring of the risk advisable.	▪ Private Agenda Item 7 – Well-Led (GGI) Implementation Plan ▪ Private Agenda Item 10 – Nomination and Remuneration Committee Key Issues Report (Update on Organisational Restructure)

12	✓	✓	✓	**Roseberry Park** The necessary Programme of rectification works at Roseberry Park and associated legal case could adversely affect our service quality/safety and financial, reputational and regulatory standing	**DoF&I**	**Very High** ↔	**Good**	The risk is significantly in excess of tolerance. Urgent action is required to reduce exposure.	▪ Private Agenda Item 5 – Update Report on Roseberry Park
13	✓	✓	✓	**West Lane** The outcome of the independent enquiry, coroners' investigations, and civil legal actions could affect our reputational and regulatory standing *(Note: amendment to the risk description proposed)*	**CEO**	**Very High** ↔	**Good**	Opportunities to strengthen controls but this will have a limited impact due to third party decision-making. Exposure above tolerance will need to be accepted.	▪ Private Agenda Item 9 – West Lane Project Committee Key Issues Report
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	**DoFI**	**High** ↔	**Good**	Whilst controls are, generally, considered to be operating effectively further strengthening is required at pace, through the delivery of identified mitigations, to reduce exposure to tolerable levels	▪ Private Agenda Item 8 – Strategy and Resources Committee Key Issues Report (EPR Programme Update)
15	✓	✓	✓	**Financial Sustainability** Failure to gain a fair share of resources for the Trust and mental health could impact on the delivery of Our Journey to Change and the sustainability of services	**DoFI**	**High** ↔	**Good**	Although controls are generally operating effectively, action is required where practicable due to national/regional constraints, to reduce the risk score to target (within tolerance) through the delivery of identified mitigations	▪ Public Agenda Item 12 – Finance Report ▪ Public Agenda Item 13 – Performance Dashboard Report ▪ Private Agenda Item 8 – Strategy and Resources Committee Key Issues Report (22/23 Board Integrated Performance Dashboard Measures/Financial Update)

Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report

Report Date: 27 January 2022		**Report of: The Audit and Risk Committee**
Date of last meeting: 13 January 2022		**Membership Numbers: 4** Quoracy met -100% *(Note: Apart from the Chair, all the Members of the Committee were attending their first meeting. The Membership of the Committee now includes the Chair of the Quality Assurance Committee to strengthen liaison and oversight on clinical and operational governance and risk)*
1	**Agenda**	The Committee considered the following matters: ▪ A briefing on the strengthening of controls in regard to leases and preparations for the implementation of IFRS 16 ▪ The Corporate Risk Register and the BAF ▪ Progress on the delivery of the Clinical Audit Programme ▪ A Counter Fraud Progress Report. ▪ An Internal Audit Progress Report. ▪ An External Audit Progress Report ▪ The timetable for the preparation and submission of the Annual Accounts 2021/22 ▪ The draft Procurement Strategy ▪ The tender waiver report ▪ The retendering of the contract for External Audit Services ▪ The Committee's Assurance Tracker
2a	**Alert**	There are no matters of concern which the Committee wishes to bring to the attention of the Board.
2b	**Assurance**	The Committee wishes to draw the following positive assurances to the attention of the Board: ▪ The progress being made on the development of the Corporate Risk Register and the BAF. ▪ The Internal Auditors have not identified any issues from their work, to date, that might impact significantly on the Head of Internal Audit Annual Opinion (HoIAO) for 2021/22. ▪ The decreasing trend in the number of overdue high and medium priority Internal Audit recommendations is continuing. ▪ The Internal Audit review of clinical supervision which provided 'good' assurance. ▪ The progress being made on the strengthening of controls relating to lease management (which previously received 'limited' assurance from the Internal Auditors). A further review will be undertaken by the Committee at its next meeting. ▪ The arrangements in place to enable the Trust to respond effectively to the implementation of IFRS 16 (leases) from 1st April 2022. ▪ The processes in place to prepare and submit the Annual Accounts for 2021/22. ▪ The reduction in the number of tender waivers by 81% on the same period in the last financial year.
2c	**Advise**	The Committee wishes to advise Members of the Board that: In regard to Counter Fraud: ▪ No update has yet been received on the report on the NHS Counter Fraud Authority (CFA) national post-event assurance exercise in relation to NHS procurement spending during Covid-19. ▪ The difficulties in receiving details of historic referrals relating to the Trust from the CFA were unlikely to be resolved, but the new CEO is reviewing the issue going forward.

		▪ There had been a reduction in referrals across all AuditOne clients due to the impact of Covid-19 on the visibility of the Team. Alternative approaches to raising awareness are being considered. ▪ AuditOne has been asked to consider the use of SPC charts in its reporting. ▪ It was noted that all cases, irrespective of financial impact, are kept under review and internal disciplinary cases are reported back to the ARC. ▪ The report on Manipulation of E-rostering was received. In summary the review found that there were some counter fraud measures within the Trust policies, system and procedures for using Allocate and these could be enhanced further with the implementation of the report's recommendations. No instances of potential fraud had been identified during the review. ▪ Delivery of the Internal Audit Operational Plan for 2021/22 is behind schedule due to levels of unplanned sickness absence and staff turnover within AuditOne. The Internal Auditors' focus over the coming months will be on delivering a robust HoIA annual opinion. The Committee was reassured that the required audits are scheduled but achievement is dependent upon effective engagement from the Trust. ▪ The Internal Audit review of clinical waste has provided only 'limited' assurance. In view of the potential risks, follow up work on the delivery of the recommendations was commencing imminently with a view to having an improved position by the end of the month. ▪ The deferral of three Internal Audit assignments was approved: Emergency Preparedness, Resilience & Response (EPRR) and Business Continuity; corporate governance; and the management of the replacement of the current Integrated Information Centre (IIC). The Committee was satisfied that the reasons for the changes were appropriate and would not impact on the HoIA annual opinion for 2021/22. ▪ The work of the External Auditors is also slightly behind plan due to Covid-19 but is considered to be recoverable. The Committee received an update on the potential key risks and other significant areas of judgement to be considered as part of the audit. These are similar to previous years. ▪ A report will be presented to the meeting of the Council of Governors in March 2022 in relation to the tendering of external audit services during 2022/23. As in previous years it is intended to establish a joint working group comprising Members of the Committee and Governors to oversee the procurement exercise from drafting the specification to award of contract. As part of the process consideration will be given to how, through innovative approaches, market engagement can be increased.		
2d	**Review of Risks**	The role of the Committee is not to scrutinise individual risks but to gain assurance that risk management processes are operating effectively. It was recognised that whilst progress is being made, further work is required linked to the review of the Organisational Risk Management Policy; the implementation of the new governance and reporting arrangements and the enhancement of capacity and capability for managing risks as recommended in the GGI report. The Committee will further review progress on the development of the Corporate Risk Register and BAF in May 2022 following the implementation of the new governance arrangements.		
3	**Actions to be considered by the Board**	There are no actions, arising from the discussions at the meeting, which require consideration by the Board at this time.		
4	**Report compiled by**	*John Maddison, Chair of Committee* *Phil Bellas, Company Secretary*	**Minutes available from**	*Angela Grant* *Senior Administrator*

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 12

PUBLIC
BOARD OF DIRECTORS

DATE:	**27th January 2022**
TITLE:	**Month 9 Finance Report for Period 1 April to 31 December 2021**
REPORT OF:	**Liz Romaniak, Director of Finance, Information and Estates**
REPORT FOR:	**Assurance and Information**

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

Executive Summary:

The Month 9 report reflects performance within the context of national financial arrangements supporting the NHS to sustain the Coronavirus Pandemic response.

The Trust submistted a plan to deliver a surplus of £47k for the second 6 months of 2021/22 (H2), giving a 2021/22 composite planned surplus of £5.1m when added to confirmed performance for the first 6 months of the year. The Trust projects a probable case end of year surplus of £8.1m, which is £3m ahead of our planned surplus of £5.1m for 2021/22. This reflects receipt of unplanned income, including for prior year Final Pay Control provisions.

- **Statement of Comprehensive Income:** The year to date position is a surplus of £5.0m, which is £0.3m ahead of the planned £4.7m surplus. This is before £0.5m additional unplanned profit from disposal of fixed assets, which is excluded when assessing NHS provider financial performance.
- **Capital Programme:** Annual capital requirements for 2021/22 were prioritised to set a programme that was affordable within the Trust's £13.6m capital allocation. Schemes were impact assessed to inform the final plan. Capital expenditure is £1.2m behind plan. Two planned asset sales have also been delayed meaning the Trust is below its Capital Allocation by £0.8m at the end of month 9. The larger of these will not now proceed, the smaller will be subject to auction in February 2022. The Trust expects to fully commit the £13.6m allocation but notes some uncertainty, including due to impacts of the pandemic, rectification work phasing, and in relation to the timing and quantum of VAT recovery.
- **Cash Balances** are £84.5m, or £1.3m ahead of plan, with details in section 3.7.

Work is underway at Integrated Care System (ICS) level to understand the implications, for individual organisations and 'sub ICS' places, of 2022/23 ICS-level draft revenue and capital envelopes. High level details were issued on 24th December, with supporting allocation tools and technical guidance following during January. Planning requirements for 2022/23 to 2024/25 are understood to be targeted to support the NHS to navigate a planned phased national return, or 'glidepath', to more normal capitation-based allocations.

Recommendations:

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

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for month 9 of 2021/22; 1 April to 31 December 2021 against a planned surplus for the period of £4.7m.

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

2.3 National financial arrangements operated throughout 2020/21 and block funding mechanisms have continued throughout 2021/22, supporting the NHS in responding to the Covid-19 pandemic. The Trust supported the submission of high level systems plans that would deliver a H1 surplus of £4.7m for the Trust and a breakeven plan for the Tees Valley 'place' and wider North East and North Cumbria Integrated Care System (NENC ICS). The Trust delivered a surplus of £5,441k for the period April to September 2021 (H1). When adjusted to remove profits from fixed asset disposals of £420k, this gave a £5,021k surplus and surpassed the H1 operational plan by £301k.

2.4 The Trust submitted its financial plan in November with an anticipated surplus position of £47k for H2. This results in a composite (H1 plus H2) planned surplus of £5,068k for the financial year. Included within this plan is an efficiency requirement of £1.8m.

2.5 Month end processes now include system partner consideration of best, probable and worst case forecasts. The level of variability between best and worst case in aggregate means we have informally considered the collective ICS and Place probable case outturn forecasts.

A run rate, balance sheet and forecast review suggests a current Trust probable case forecast that is £3m ahead of our planned surplus of £5.1m, i.e. a fully year £8.1m surplus.

Variability in the forecast is expected to reduce as the Trust's more significant end of year accounting issues relating to annual leave, provisions and central guidance (including on Spending Review /other income) crystallise.

The increased surplus arises due to:

- Unplanned income; and
- Changes in the national approach of charging providers for Final Pay Control via NHS Pensions (generating the reimbursement of prior year liabilities).

Work continues through Quarter 4 to monitor and risk assess other material variables to ensure the delivery of financial plans is supported at a system, place and Trust level.

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

2.7 High level operational planning guidance for 2022/23 was issued on 24th December 2021, followed by supporting draft technical guidance on 14th January 2022, and additional tools and allocation information continuing to be issued during January 2022. National guidance remains draft due to ongoing uncertainty relating to Omicron and impacts on the NHS.

2.8 Guidance confirms that plan submissions have been delayed, with an expectation of submitting draft plans on 17th March 2022 and final plans on 28th April. Implications for related place and ICS-level plan submissions are not yet known.

3.1 Key Performance Indicators (KPIs)

Appendix 1 provides a summary of KPIs for the period ending 31 December 2021.

3.2 Statement of Comprehensive Income – Year to date

The year to date position is a surplus of £5.0m, which is £0.3m ahead of plan. This excludes £0.5m unplanned profit from fixed asset disposal, which is excluded when assessing NHS provider financial performance, and is therefore included as a 'below the line' adjustment at Table 1. Performance is summarised in table 1:

Table 1

	Year to Date			
	Plan	**Actual**	**Variance**	**Last Month Variance**
	£000	**£000**	**£000**	**£000**
Income From Activities	292,528	299,431	-6,903	-6,392
Other Operating Income	14,659	15,159	-500	-431
Total Income	**307,187**	**314,590**	**-7,403**	**-6,823**
Employee Operating Expenses	-244,034	-249,557	5,523	5,051
Operating Expenses Excluding Employee Expenses	-55,482	-57,060	1,578	1,559
Non Operating Expenses	-2,970	-2,969	-1	-175
Surplus / (Deficit)	**4,701**	**5,003**	**-303**	**-388**
Profit on sale of Assets	0	509	-509	-509
Surplus / (Deficit) incl adjustments	**4,701**	**5,512**	**-812**	**-897**

Income from patient care activities was £6.9m higher than plan due to additional income, including for Mental Health spending review allocations, and pay award funding (£4.2m), where allocations were clarified after plan submission. The Trust is discussing additional Mental Health income with Partnership Boards and Commissioners, with a focus on progressing external (including VCS) schemes to alleviate capacity and winter pressures.

Other operating income is £0.5m above plan due to increased research and development, and non-patient care income not anticipated at plan.

Pay expenditure was higher than planned by £5.5m due to:

- £4.2m nationally determined pay award not confirmed at plan;
- £4.5m higher than planned agency and bank expenditure, including costs relating to the Trust Board's decision to bolster acute and forensic inpatient safer staffing, but also reflecting observations and sickness and vacancy cover;
- £0.7m higher than planned trainee grade expenditure due to successful recruitment within the last medical rotation; and
- £3.9m net vacancies across the Trust which offset the above pressures and vacancy cover. Activities to progress recruitment and attract and retain staffing, including to bolster staff bank, are ongoing.

Non pay expenditure is £1.6m higher than planned, due to:

- £0.8m higher than planned purchased healthcare due to the need to provide additional bed capacity, including following the temporary closure of an acute admissions ward in Scarborough due to staffing pressures. The Trust block contracted (and is fully utilising) four independent sector adult Mental Health assessment and treatment beds in the summer and needed to subsequently contract to secure a fifth bed. Independent sector capacity has been contracted to the end of March 2022 based on current utilisation;
- £0.2m higher than planned clinical supplies and services largely relating to voluntary and community sector collaboration associated with Community Mental Health Transformation;
- £0.6m NHS Pensions final pay controls not included in plan;
- £0.3k above planned drugs costs due to changed prescribing practices;
- £0.5m unplanned Research and Development expenditure incurred in H1 and offset by receipt of unplanned other operating income and,
- £0.5m partial mitigation of the above variances as a consequence of lower than planned expenditure on furniture and fittings, including from delays in capital enabling schemes at Baccus and North Moor House.

3.4 Cash Releasing Efficiency Savings (CRES)

The Trust has offset its CRES requirements in full, using non-recurrent under spending linked to a reduction in travel expenditure due to remote working arrangements and other non-recurrent savings. These 'fortuitous' offsets arising due to pandemic ways of working are reported as non-recurrent CRES and

have therefore not been subject to quality impact assessment. Recurrent related smart working schemes are however being worked up for 2022/23.

The Trust continues to identify and consider schemes to deliver future requirements and will include quality impact assessments (QIA) where schemes have been identified and due to commence.

3.5 Capital

Capital expenditure is £1.2m below plan. Two modest planned asset sales have also been delayed meaning the Trust is below its Capital Allocation by £0.7m at the end of month 9. The larger of these is not not proceeding, the smaller will be subject to auction in February 2022.

The Trust is forecasting to outturn in line with its agreed ICS capital allocation of £13.6m, however plans have required re-prioritisation in-year to keep required expenditure within the overall envelope (plus disposals and on the assumption that a £1.1m VAT recovery completes by 31 March 2022).

3.6 Workforce

Tolerances for flexible staffing expenditure are set at 1% of pay budgets for overtime, 2.4% for agency (based on NHSI agency cost cap metric), and are flexed in correlation with staff in post for bank and Additional Standard Hours (ASH).

The NHSI agency cap has not applied during the pandemic but would equate to an equivalent cost cap of £6.3m for the year to date. Agency expenditure to date is £9.4m; which is £3.1m above the indicative cap for the period ending 31 December 2021. Expenditure spans all localities and reflects operational and business continuity staffing pressures experienced due to community infection rates and the impact on staffing levels, and substantive staff recruitment gaps. Levels have been volatile during the pandemic, but elevated use of inpatient 'headroom' has been observed during quarter 3.

Nursing and Medical expenditure headings account for 95% of total agency expenditure; cover is required to maintain essential services and to cover vacancies, sickness, increased test and trace and isolation levels and to support enhanced observations with complex clients.

The Workforec sub group of the Senior Leadership Group is considering actions to target improved substantive recruitment and retention and will consider related resource implications as Business Plans for 2022/23 are developed.

3.7 Statement of Financial Position

Cash balances are £84.5m as at 31 December 2021 and £1.3m ahead of plan (£83.2m). This reflects the £0.8m higher than planned surplus (inclusive of

disposals), £0.8m lower than planned capital, offset by other movements on working capital for the period.

The Trust achieved the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of non-NHS suppliers, and was marginally behind (94.7%) for NHS bodies.

Conversations are ongoing with organisations to take collection of all debt over 90 days. 71% of aged debt relates to 4 organisations, all of which are public bodies. None of the amounts outstanding are currently disputed, the delay in payment is linked to process delays within organisations e.g. purchase orders not raised, invoices mislaid, staff sickness.

Aged debts that are not subject to repayment plans constitute £210k. Of this quantum, no further receipts have been collected at the time the report was circulated. Discussions continue as we support organisations to settle all debts.

3.8 Use of Resources Risk Rating (UoRR) and Indicators

3.8.1 The UoRR is impacted by Covid-19 with national monitoring suspended. However, the Trust continues to assess the UoRR based on planning submissions and actual performance. Detail can be found in table 2 below.

Table 2: Use of Resource Rating at 31 December 2021

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

Actual performance 31 December 2021	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	2.98x	1	2.76x	1	
Liquidity	41.2	1	41.5	1	
I&E margin	1.8%	1	1.5%	1	
I&E margin distance from plan	0.2%	1	0.0%	1	
Agency expenditure (£000)	£9,431k	3	£6,311k	1	
Overall Use of Resource Rating		**1**		**1**	

Operational planning guidance for 2022/23 indicates that a return to more normal agency expenditure levels and controls is required from April 2022. The Trust will need to re-visit and refresh related controls, including actions to closely monitor and address price and wage breaches and to develop sustainable bank alternatives and permanent staff recruitment as infection rates from the Omicron variant subside.

3.8.2 The **capital service capacity** metric assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 2.98x (can cover debt payments due 2.98 times), which is ahead of plan and is rated as a 1.

3.8.3 The **liquidity** metric assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 41.2 days; this is marginally behind plan and is rated as a 1.

3.8.4 The **Income and Expenditure (I&E) margin** metric assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 1.8%, this is ahead of plan and is rated as 1.

3.8.5 The **I&E margin distance from plan ratio** metric assesses the I&E surplus/deficit relative to planned performance. The Trust I&E margin is 0.2% ahead of plan, which is rated as a 1.

3.8.6 The **agency expenditure** metric assesses agency expenditure against a capped target (pre-pandemic) for the Trust. Agency expenditure of £9.4m is £3.1m (49%) higher than planned and is rated as a 3. This will be a renewed area of focus for 2022/23.

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

- Capital service cover - to deteriorate to a 2 rating the Trust's financial position would have to decrease by £4.6m.
- Liquidity - to deteriorate to a 2 rating the Trust's working capital position would have to decrease by £45.6m.
- I&E Margin – to deteriorate to a 2 rating the Trust's financial position would have to decrease by £2.4m.
- Agency Costs – to improve to a 2 rating the Trust's agency expenditure would have to decrease by £1.5m.

4. IMPLICATIONS:

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

5. RISKS:

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

5.2 Despite including an increased efficiency requirement in H2, national financial arrangements provide short term assurance on the 2021/22 financial position. Residual uncertainty in relation to recurrent organisation-level revenue and capital allocations from 2022/23 makes coherent longer-term financial planning challenging. Key concerns include the extent to which real terms mental health investment standard funding is maintained. Risks include the differential impact

of Agenda for Change pay award costs for non acute providers and the recurrent mechanism for funding the 6.3% increase in employers' NHS Pensions contributions (albeit that Pensions remain fully funded through central arrangements during 2022/23). Whilst significant national funding will be targeted to effect Elective Recovery (acute provider) from April 2022, no similar provision has been confirmed for Mental Health. These significant uncertainties have the potential to impede progress to deliver long term plan priorities aand wider service sustainability by diluting real terms growth. Discussions continue, including through local Partnership Boards, to agree immediate and future investment priorities.

5.3 CRES targets have been offset by non-recurrent underspending for the year to date and forecast to continue for the financial year. The Trust's Financial Sustainability Board (FSB) oversees CRES planning and delivery and coordinates overall financial planning activities. Nationally efficiency requirements have been more challenging since October 2021; and equivalent to 1.1%, or £1.8m for TEWV in H2 and expected to continue via a 1.1% national tariff efficiency throughout 2022/23. Non recurrent national allocations of Covid support funding reduced by 5% in H2 of 2021/22 and will reduce by 57% in 2022/23 (compared to 2021/22). Business Planning work will take account of anticipated CRES requirements as allocations are understood at place and oranisation level and as the Trust begins to formulate sustainable recurrent plans for future years.

5.4 The UoRR is impacted by Covid-19 with national monitoring currently suspended. Agency usage has been sustained in 2021/22 and increased moving into quarter 3, meaning that the Trust would score 3 against this individual metric (whilst retaining a UoR overall rating of 1). Planning requirements for 2022/23 are targeted to support the NHS to navigate a planned phased national return, or 'glidepath', to more normal capitation-based allocations. This, alongside an explicit expectation of reduced agency expenditure, means our business plans and operational focus need to increase agency utilisation and cost reduction measures.

6. CONCLUSIONS:

6.1 The Trust achieved a surplus of £5.0m for the period ending 31 December 2021, which is £0.3m ahead of our operational financial plan. This excludes £0.5m unplanned profit from the disposal of fixed assets, which are discounted when assessing NHS provider financial performance.

6.2 The CRES framework is yet to be agreed for 2022/23, however the Trust has commenced activity to identify schemes to deliver requirements on a recurrent basis, including through Business Planning. Mitigations to offset efficiency requirements during 2021/22 have been identified, with scope to make some savings recurrent.

6.3 Whilst the UoRR for the Trust is assessed as 1 for the period ending 31 December 2021, and is in line with plan, levels of expenditure on agency

workers is higher than planned and will require action moving into the new financial year.

7. RECOMMENDATIONS:

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

Liz Romaniak
Director of Finance, Information and Estates

Appendix 1

Key Financial Indicators for the period ending 31 December 2021

Surplus variances are shown as negative	Year to date			RAG	Prior Month	RAG
	Plan	Actual	Variance		Variance	
I&E (Surplus) / Deficit £m	-4.7	-5.5	-0.8	●	-0.9	●
Profit on sale of Asset (Inc in I&E performance shown above)	0.0	-0.5	-0.5	●	-0.5	●
Income £m	-307.2	-314.6	-7.4	●	-6.8	●
Pay Expenditure £m	244.0	249.5	5.5	◆	5.0	◆
Non Pay Expenditure £m	55.5	57.1	1.6	◆	1.6	◆
Non Operating Expenditure £m	3.0	3.0	0.0	●	-0.2	●
Capital Expenditure (including disposals) £m	9.8	9.0	-0.8	●	-0.6	◆
Capital Service Cover	2.76x	2.98x	-0.22x	●	-0.22x	●
Liquidity Days	41.5	41.2	0.3	◆	-0.9	●
I&E Margin	1.5%	1.8%	-0.2%	●	-0.3%	●
Variance from I&E Margin plan	0.0%	0.2%	-0.2%	●	-0.3%	●
Agency Expenditure £m	6.3	9.4	3.1	◆	2.5	◆
Cash Balances £m	83.2	84.5	-1.3	●	2.3	◆
Total debt over 90 days	5.0%	7.6%	2.6%	◆	7.4%	◆
BPPC NHS invoices paid < 30 days	95.0%	95.8%	-0.8%	●	0.3%	◆
BPPC Non NHS invoices paid < 30 days	95.0%	95.8%	-0.8%	●	-0.8%	●

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Board Performance Dashboard
As at 31st December 2021

journey to change

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CONTENTS

Executive Oversight

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Due to the increased pressures on our clinical services at the current time, December's report is an abridged summary of the Dashboard. We have taken this approach to minimise the impact on our clinical teams and to facilitate the release of Corporate Performance Team staff to support operational services, thereby ensuring our focus remains on the care of our patients and the welfare of our staff.

Out of our 21 key performance measures, there are 11 areas of concern identified within the December 2021 report that we are trying to improve. One area that had been a concern in previous months has shown some improvement but we are continuing to monitor it as there is an open action against it.

Our key concerns remain within our Quality, Activity and Workforce domains and we continue to experience challenges in relation to staff sickness and our ability to recruit to staff vacancies. Our waiting times are longer than we would like our patients to experience and the pressures on our inpatient services remain a significant concern.

Quality

Whilst we are assessing and treating more patients within the standards we have set ourselves, performance continues to be impacted by national pressures throughout the NHS and locally within Trust services in respect of high demand and staff capacity, and we remain concerned that we are not assessing or treating our patients in as timely a manner as we would like. Initiatives are continuing in relation to service models and whilst there have been a number of staff commencing post during December, staff vacancies remain a concern.

Our out of area placements have significantly improved as we have ensured that the NHS Continuity of Care Principles are robustly embedded across all of our services; however we are observing an increase in the number of patients that we are placing in beds external to our Trust due to the lack of availability of local beds and where the principles do not apply. Whilst this is a national issue due to current demand levels, it is something that is of concern and we are monitoring closely.

We recognise the potential to improve our learning from any Serious Incidents that occur. During November (this measure is reported a month behind) all five serious incidents were identified to be due to a lapse or serious lapse in patient care or treatment. All incidents are reviewed and our findings used to identify key themes and learning and a number of initiatives/improvements are currently underway, including a joint exercise with our partners at Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust to share learning.

For some months we have been concerned that our Adult and Older Persons' teams are not demonstrating the improvement in patient outcomes that we would aspire to. Whilst we have seen a positive increase within our patient-rate outcome measure, our clinician-rated measure continues to be a concern. Progress on the development of a Trust-wide action plan that will include staff training and an approach for integrating outcome measures within our clinical services is continuing however current pressures have impacted in the progress being made.

Executive Oversight

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Activity

Pressures on capacity and demand continue to impact on the number of patients that are starting treatment within our services. Recruitment is underway in a number of areas and service models are being reviewed to streamline clinical pathways.

Pressures on our inpatient services are continuing and bed occupancy remains at a high level, with a further increase being noted in the number of patients remaining in beds for over 90 days within Durham and Tees localities. Both areas are establishing processes to monitor all inpatients that have been with the Trust for over 50 days.

Workforce

The challenges facing our workforce continue to impact on the delivery of our services and a number of initiatives are being pursued to minimise the impact on patient care. Recruitment continues to be a challenge both locally and nationally, and we continue to have a significant number of vacancies across most Trust services. Improvement work has been undertaken within the Trust to streamline our recruitment processes and recruitment initiatives are continuing, which include international recruitment opportunities, the creation of a community bank service and advertising via social media.

Whilst we are continuing to see some small increases in the number of staff that have up to date appraisals and mandatory & statutory training, this is not as significant as we would like to see. This is an issue across all Trust services, corporate and clinical. A Trust-wide tool has been developed to enable services to identify the resources required to make improvements in this area and work is currently underway in completing that.

Throughout November our sickness levels continued to be higher than we aspire to across all Localities. All sickness is managed in line with Trust Policy and is closely monitored within operational services. Work continues to progress the action plan within our Forensic Services; all actions will be completed by the end of January 2022.

Finance

We are continuing to meet our financial targets; however it is important to note that this is not at the expense of our other standards. The key drivers impacting on delivery of the quality, activity and workforce standards are the levels of demand and availability of staff as a consequences of vacancies and sickness. The Trust is committed to improving the quality of our services and the health and well being of our patients and staff and considerable work is being undertaken to improve our performance in those areas.

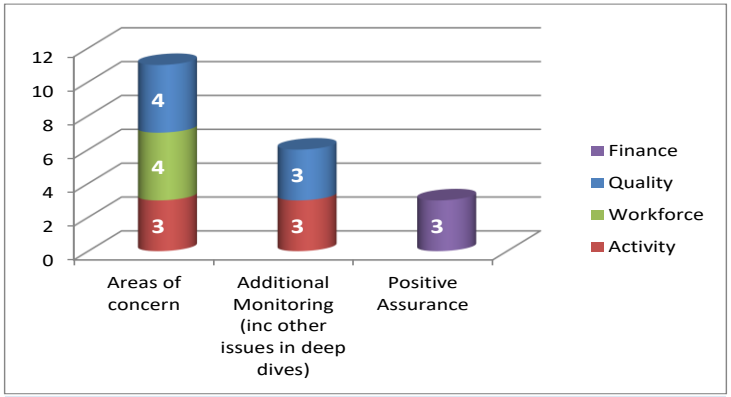
Summary Position

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

These are the areas of concern we are trying to improve:

- We are not seeing as many patients **within 4 weeks for a first appointment** as we would like (6136 patients out of 6931 in December which is 88.53% compared to our standard of 90%).
- The number of **patients receiving treatment within 6 weeks** is not as high as we would like (886 patients out of 1469 in December which is 60.31% compared to our standard of 60%).
- We recognise the potential to improve our learning from **Serious Incidents.** In December, 5 Serious Incidents (from a total of 5) were found to have a significant lapse or lapse in care (equivalent to a root cause or contributory finding). This is 100% compared to our standard of 32%.
- Our Adult and Older Persons' teams are not demonstrating the **improvement we would like in patient outcomes (HONOS)** (44 out of 90 in December which is 48.89% compared to our standard of 60%).
- The number of **patients being referred and taken on for treatment** is fewer than we would expect (2108 patients out of 7945 referred in September which is 26.53%). No standard has been set for this measure.
- Our wards are extremely busy and **bed occupancy** is higher than we would like it to be (10,213 occupied bed days out of 10,912 available bed days which is 93.59% in December compared to our standard of 90%).
- The number of Adult and Older People **staying in beds longer than 90 days** is higher than we would like (69 patients in December compared to our standard of no more than 61).
- The number of **vacancies** is higher that we would like (528.62 out of 7623.53 (6.93%) whole time equivalent staff in December). No standard has been set for this measure.
- The number of **staff with a current appraisal** is not as high as it was previously (4792 members of staff out of 6253 in December which is 76.64% compared to our standard of 95%).
- The number of **staff compliant with their mandatory and statutory training** is not as high as we would like it to be (92,683 training courses out of 108,927 in December which is 85.09% compared to our standard of 92%)
- **Sickness Absence rates** for staff are higher than we would like them to be (13,846 working days out of 209,323 in November which is 6.61% compared to our standard of 4.3%)

All three finance measures are providing assurance that we are delivering in line with our financial plan.



These are the areas that require monitoring to better understand what's happening before we are certain that they are an area of concern or that the actions we have taken are having the desired impact:

- Whilst we are placing significantly fewer of our patients in a bed outside their local hospital, there were 10 patients placed in beds external to the Trust accounting for 345 **inappropriate OAP days** in the 3 months ending December.
- Whilst **patients report their overall experience** as very good it is remains slightly lower than our ambition.
- Whilst the number of **patients referred** is at a level we would expect, actions are ongoing in Forensics.
- The number of **patients with an assessment completed** is lower in North Yorkshire & York than we would expect.
- The number of **patients discharged** is lower in Tees than it was previously.

One measures previously identified as an area of concern is now being monitored:

- Whilst our Adult and Older Persons' teams are demonstrating the **improvement we would like in patient outcomes (SWEMWBS**), this is being monitored as actions remain outstanding.

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Within our Trust Performance Dashboard we use Statistical Process Control Charts to determine whether we have any underlying causes for concern. SPC is an analytical tool that plots data over time; it helps understand variation in data and in doing so guides when and where it is appropriate to take action.

Variation: natural (common cause) or real change (special cause)?

Special Cause Improvement Low is good	We're aiming to have low performance and we're moving in the right direction.
Special Cause Improvement High is good	We're aiming to have high performance and we're moving in the right direction.
Common Cause – no significant change	There is no significant change in our performance. – it is within the expected levels.
Special Cause Concern Low is good	We're aiming to have low performance and we're moving in the wrong direction.
Special Cause Concern High is good	We're aiming to have high performance and we're moving in the wrong direction.

Assurance: is the target/standard achievable?

Target Pass	We will consistently achieve the target/standard
Target Pass / Fail	Our performance is not consistent and we regularly achieve or miss the target/standard
Target Fail	We will consistently fail the target/standard

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Data Quality
We regularly undertake a data quality assessment on the Trust's Performance Dashboard measures. Our assessment focusses on 4 key elements: data source, data reliability, construct/definition of the measures, and when it was last amended/tested. Liaising with Trust leads for each measure, we assess and score against each element to calculate an overall Data Quality Assessment (DQA) status.

Action Status
Our action status is informed by a combination of current performance, performance over time (including trends) and general intelligence. When we interpret an SPC chart we look at how our performance is compared to what we are trying to achieve, whether we have assurance that we will achieve the standard and whether our performance over time is improving.

Data Quality Assessment status

DQ ★	Data Quality Assessment Score **100%**	No action required
DQ ✓	Data Quality Assessment Score **85% to 99%**	Some work is required
DQ ✗	Data Quality Assessment Score **less than 80%**	Significant work is required

Action status

	Positive Assurance	We are doing well in this area and therefore no action is required
	No Concerns	No further action is needed at this point in time
	Additional Monitoring	We need to monitor this more closely to better understand what's happening before it becomes an area of concern
	An Area of Concern	We need to investigate this to understand what's happened and/or take action

Trust Dashboard Summary

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality

Measure Name	Variation Ending Dec - 2021	Assurance Ending Dec - 2021	Standard (YTD)	Actual (YTD)	Annual Standard
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	L	?	90.00%	87.02%	90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	L	?	60.00%	57.74%	60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	L	?	1,833	345	1,833
4) Percentage of patients surveyed reporting their overall experience as excellent or good		?	94.00%	89.62%	94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding	H	?	32.00%	61.64%	32.00%
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind	L	?	60.00%	48.18%	60.00%
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind		?	65.00%	65.14%	65.00%

Activity

Measure Name	Variation Ending Dec - 2021	Assurance Ending Dec - 2021	Standard (YTD)	Actual (YTD)	Annual Standard
8) Number of new unique patients referred				72,855	
9) The percentage of new unique patients referred with an assessment completed (2 months behind)	H			77.03%	
10) The percentage of new unique patients referred and taken on for treatment (3 months behind)	L			30.66%	
11) Number of unique patients discharged (treated only)				26,090	
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	H	?	90.00%	97.09%	90.00%
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	H	P	61	69	61
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)		?	9.90%	8.54%	9.90%

Workforce

Measure Name	Variation Ending Dec - 2021	Assurance Ending Dec - 2021	Standard (YTD)	Actual (YTD)	Annual Standard
15) Finance Vacancy Rate				-6.93%	
16) Percentage of staff in post with a current appraisal	L	F	95.00%	76.64%	95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	L	?	92.00%	85.09%	92.00%
18) Percentage Sickness Absence Rate (month behind)	H	?	4.30%	6.22%	4.30%

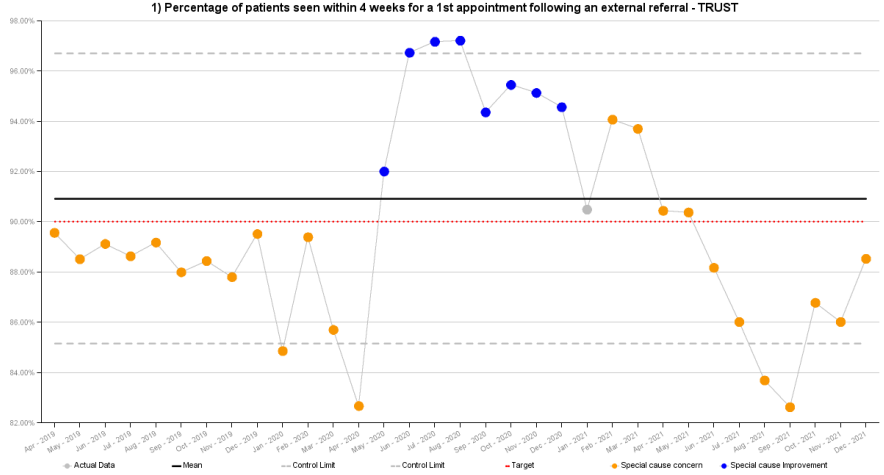
Money

Measure Name	Plan (YTD)	Actual (YTD)
19) Delivery of our financial plan (I and E)	-4,701,000	-5,456,902
20) CRES delivery	0	0
21) Cash against plan	83,192,000	84,453,958

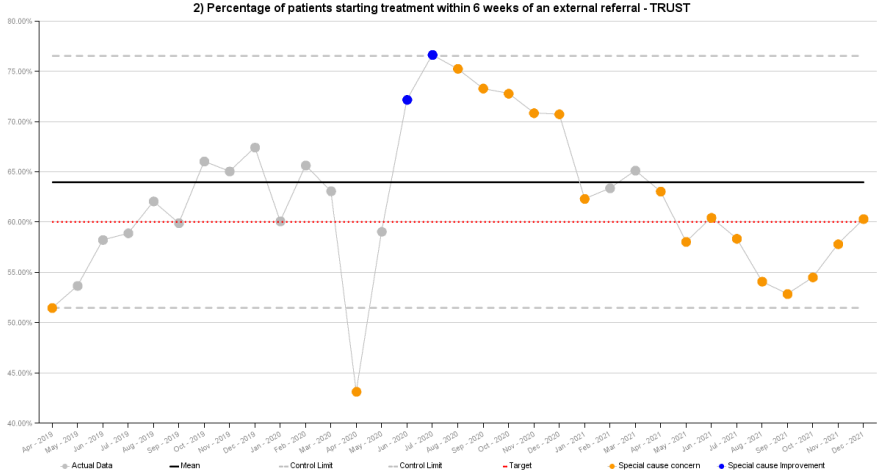
Dashboard Measures

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

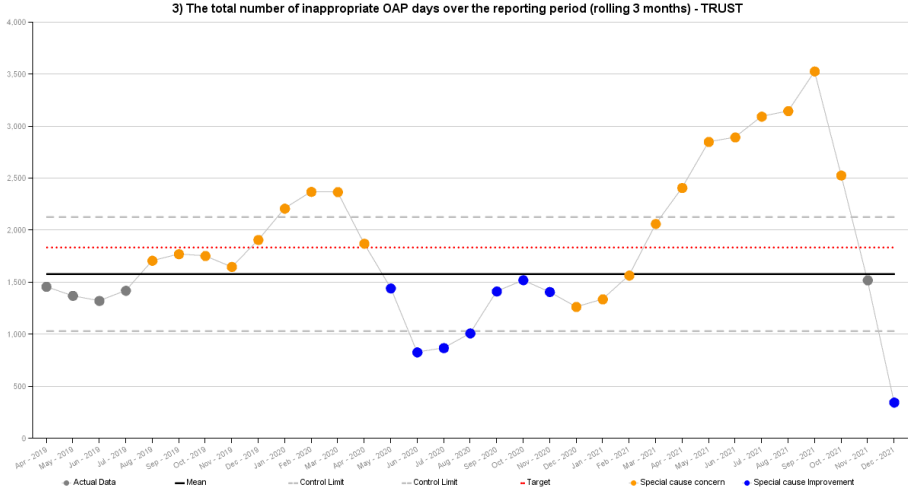
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral - TRUST



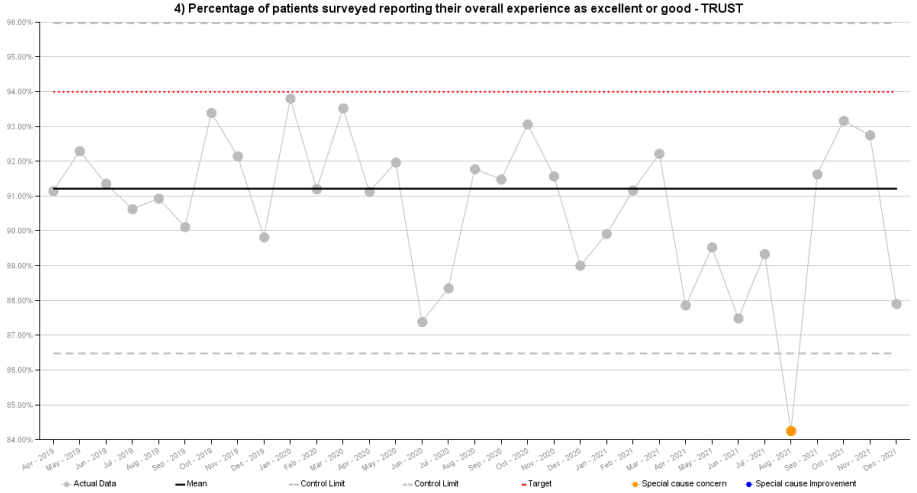
2) Percentage of patients starting treatment within 6 weeks of an external referral - TRUST



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



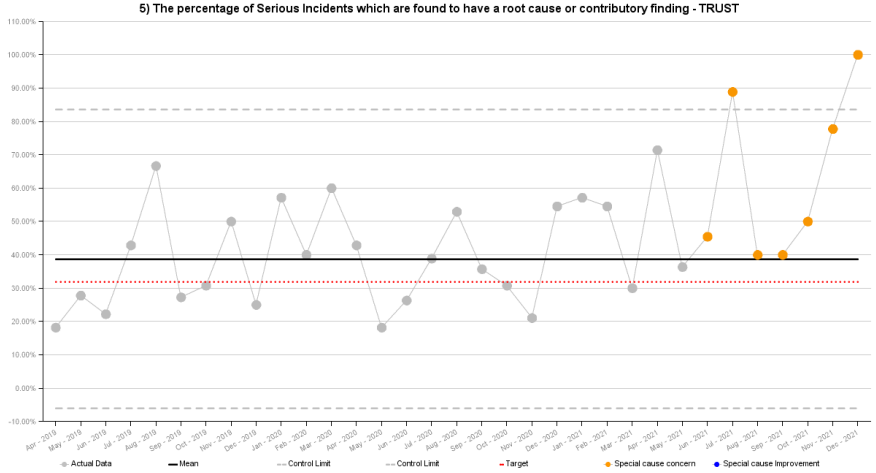
4) Percentage of patients surveyed reporting their overall experience as excellent or good - TRUST



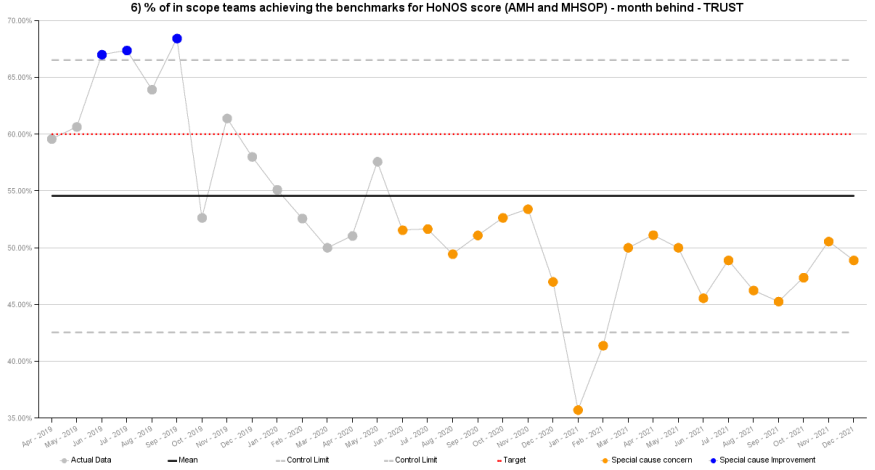
Dashboard Measures cont

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

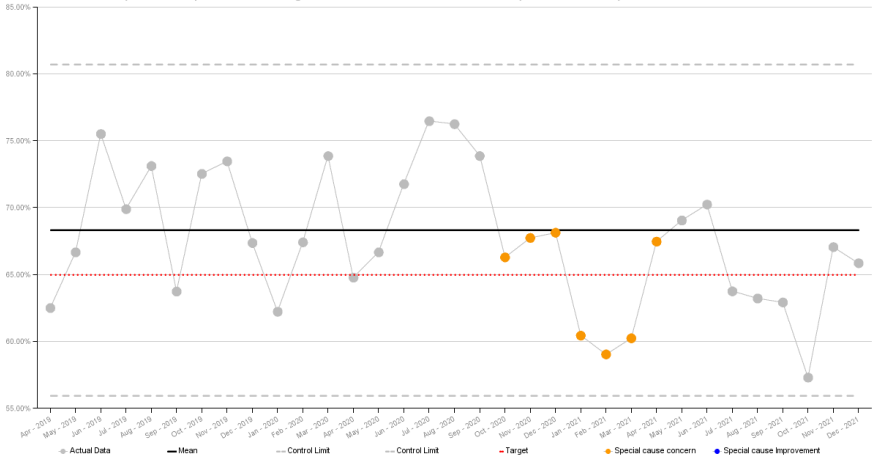
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding - TRUST



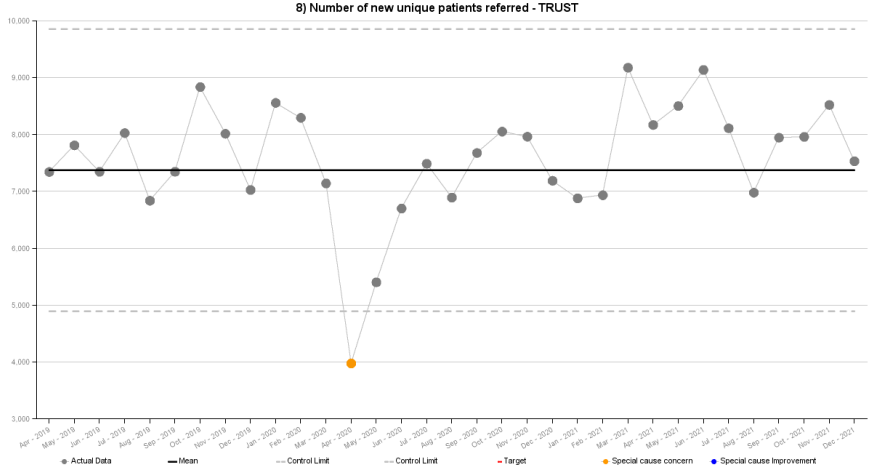
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind - TRUST



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



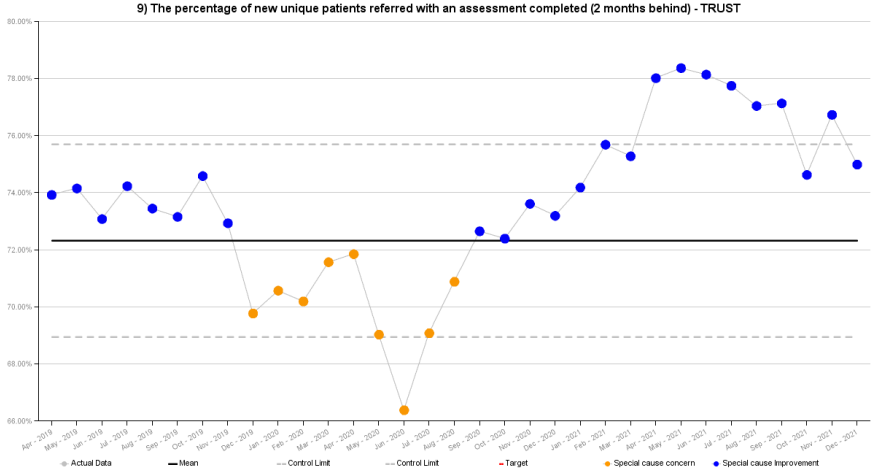
8) Number of new unique patients referred - TRUST



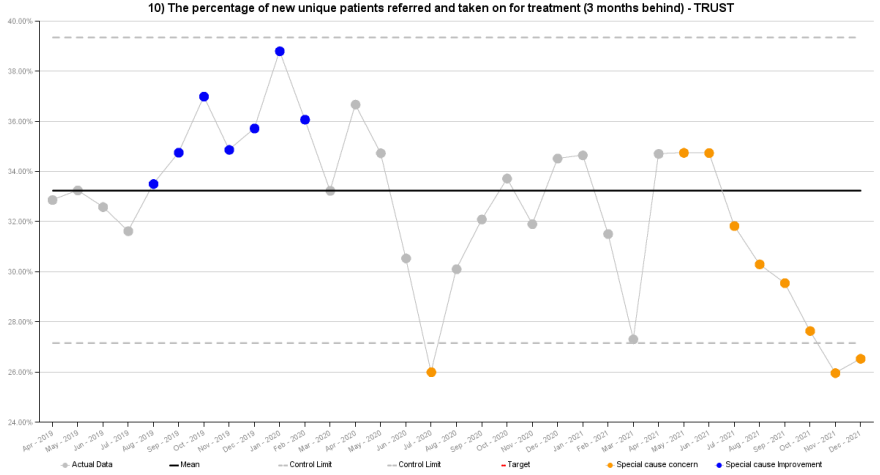
Dashboard Measures cont

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

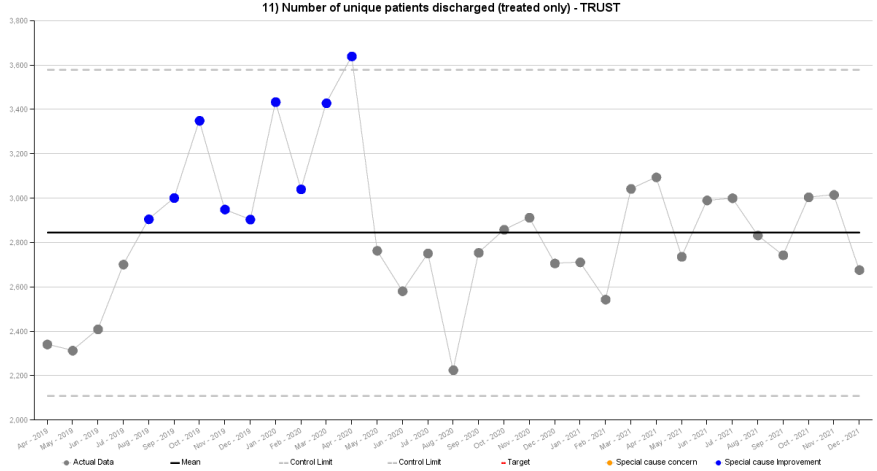
9) The percentage of new unique patients referred with an assessment completed (2 months behind) - TRUST



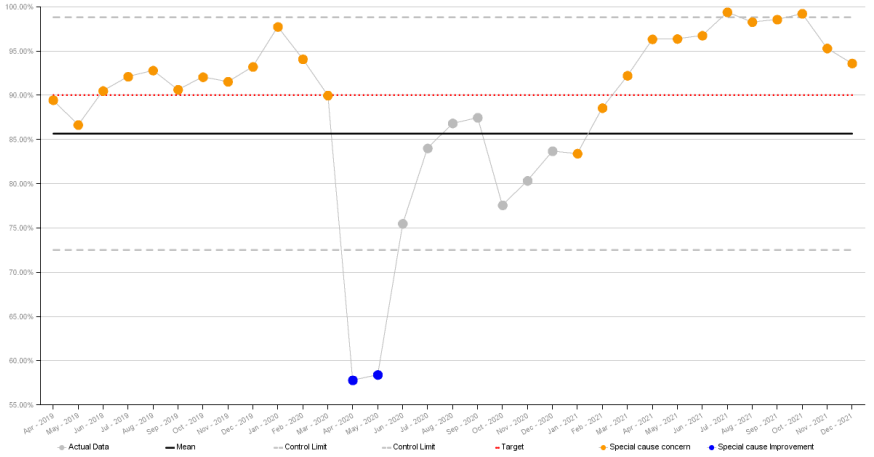
10) The percentage of new unique patients referred and taken on for treatment (3 months behind) - TRUST



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



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



Dashboard Measures cont

Tees, Esk and Wear Valleys NHS
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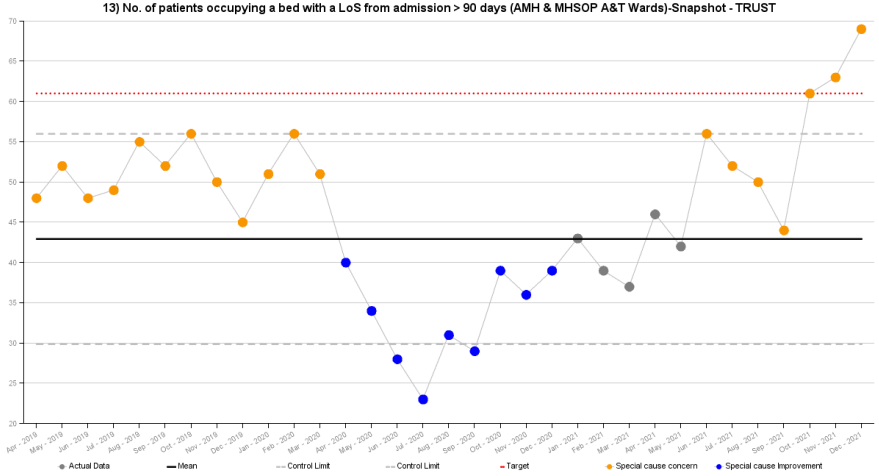
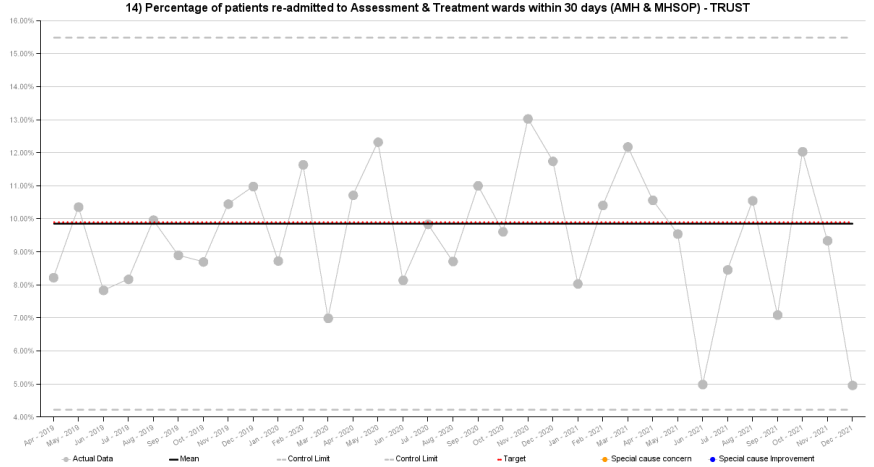
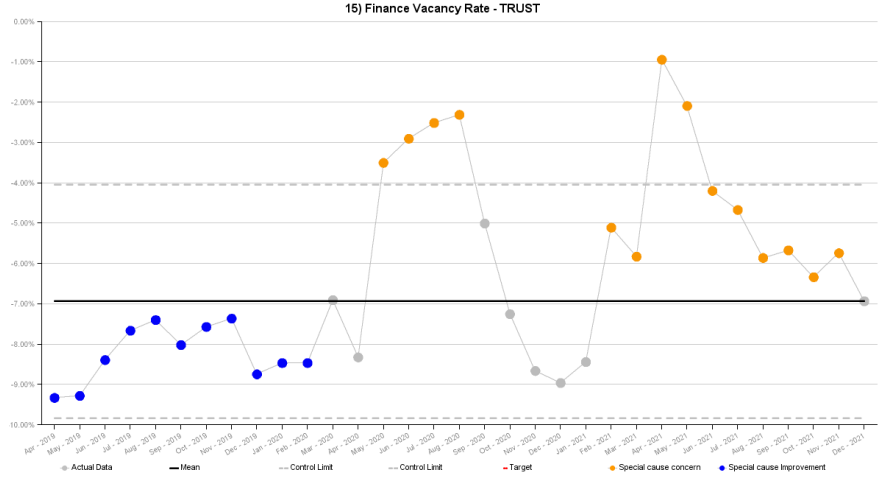
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot - TRUST



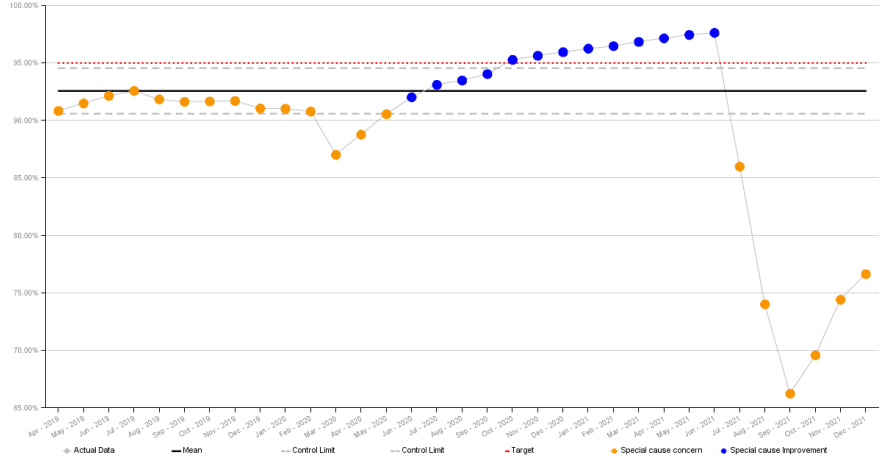
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP) - TRUST



15) Finance Vacancy Rate - TRUST



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



Dashboard Measures cont

Tees, Esk and Wear Valleys NHS
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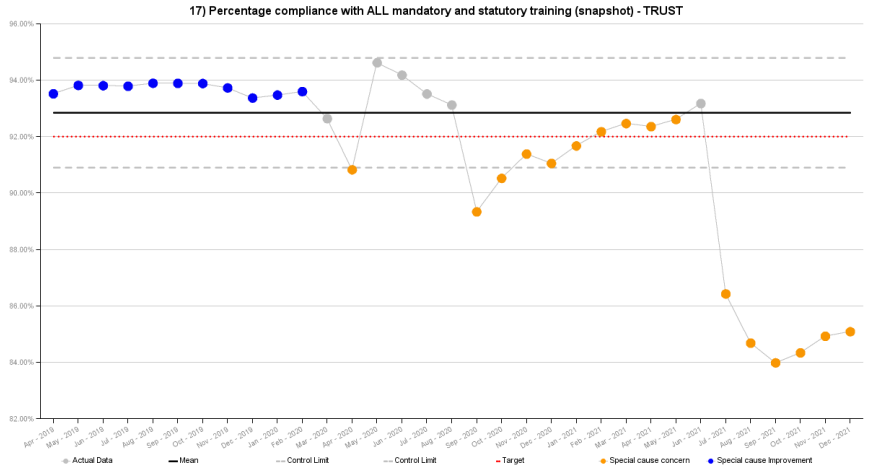
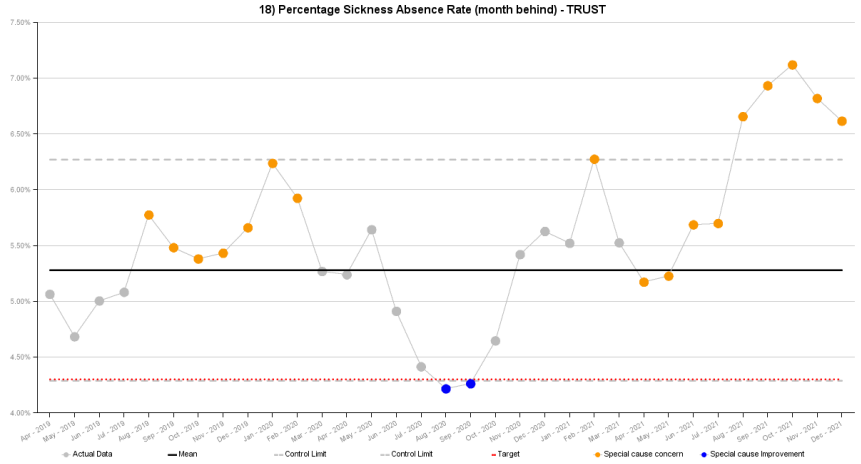




ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th January 2022**
TITLE:	**Feedback from Directors' Visits**
REPORT OF:	**Company Secretary**
REPORT FOR:	**Information & Assurance**

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

Report:

1 **Purpose**

1.1 The purpose of this report is to enable the Board to consider feedback from recent Directors' visits.

2 **Background**

2.1 The Trust has a programme of regular visits to services. These visits are not inspections but enable teams to hold conversations directly with Board Members to raise any matters of importance.

2.2 From the perspective of Board Members, the visits support a fuller understanding of the issues and risks facing services and enable information and assurances, presented in Board reports, to be triangulated.

3 **Key Issues**

3.1 The feedback reports on the visits to the following services, which took place virtually on 13th December 2021, are appended to this report for information and assurance:

- Durham Perinatal Team
- Tees Community Autism Service
- Forensic Outpatient Services for CAMHS
- Military Personnel Inpatient Services
- FOLS Team, North Yorkshire and York

3.2 Board Members are asked to highlight any key issues, risks or matters of concern arising from these visits at the meeting.

Recommendations:

The Board is asked to:

1. Receive and note the feedback reports.

2. Consider any key issues, risks or matters of concern arising from the Directors' Visits held on 13th December 2021.

FEEDBACK FROM DIRECTORS' VISITS

Name of ward or service:	Durham and Darlington Perinatal Team (Sniperley House)
Date of visit:	13/12/2021 (virtual)
Names of visiting Directors:	Donna Sweet – Head of Service Adult D&D Drew Kendall – Associate Director of Finance Jackie Park – Director North England Support

1. Strengths of service / team:

- Positive team culture (teamwork and togetherness) developed since the D&D Perinatal team setup in 2019.
- Fully recruited and **retained** team with good skill mix of professions across team.
- New members have valued induction, training and clinical supervision to settle quickly into role, and enhance team delivery.
- Team Flowchart from Assessment, Formulation, Care Plan and Interventions demonstrating roles and skills of Perinatal teams (working alongside generic MH Community and Crisis Team)
- Meet the team board (welcoming) within Sniperley base.
- Shared learning within Trustwide Perinatal and initiated early system partner meetings (inc Acute, Primary Care and Voluntary sector)

2. Concerns about service / team:

- No concerns about team or issues raised by team.

3. Working / Learning from Covid:

- Proud" of pandemic response supporting our patients face to face.
- Resilience - Can do attititude, supporting team wellbeing.
- Positive team learning from recent SI.

4. Material actions required (if any): N/A	**Action Lead**
• Explore baby changing facility within Sniperley House.	Director of Estates, Capital Planning & Facilities Management
• Patient feedback - Team progressing Outcome reporting and use of data collected.	Locality Manager,. Team Manager, Head of Service
• Communications - Team leadership consider wider	Locality Manager,. Team Manager,

promotion of team success stories within wider Trust and with System partners comms (Local and National)	Head of Service
4. Update on actions:N/A	

FEEDBACK FROM VIRTUAL COVID DIRECTORS' VISITS

Name of ward or service:	Community Autism Team - Tees
Date of visit:	13th December 2021
Names of visiting Directors:	Paul Murphy – Non-Executive Director Russell Patton-Chief Operating Officer Avril Lowery – Director of Quality Governance - On Teams Paul Foxton – Director of Estates, Capital Planning and Facilities

1. What has worked well:

- Small well-established team dealing with 800 referrals a year.
- Has been subject to internal review and is felt to be more streamlined.
- The team have moved from diagnostic only to provide other supportive interventions including clinical in reach and specialist training.
- Introduction of virtual assessments through Attend Anywhere, linked to Covid restrictions.
- Have developed diagnostic training and will provide supervision into other areas on autism speciality.
- Electronic huddle and case management boards all developed.
- Process to address the backlog of referrals, through training CMHT staff to do this, and trajectory agreed circa 57/month.

2. Concerns about service / team:

- The team has a small number of vacancies and recruitment remains a challenge in appointing the appropriate practitioner.
- There is a recognition that wating times remain problematic for this service and it is an area of concern to the whole team.
- The team felt that pathway issues were problematic giving examples of how and where individual patients can be transferred to.
- They are particularly keen on the concept of scaffolding and are keen to broaden their input into mainstream CMHTs rather than having patients referred directly to them.

3. Working learning from COVID:

- Use of Teams/Attend Anywhere has assisted Teams to work remotely and share responsibility and make sure support is in place.
- Team can travel, to use other facilities where they can, e.g., Pioneering Care Centre

4. Wishlist

- The Team recognised that wishing for extra staff was unrealistic. However, they wanted to raise autism awareness across the Trust, and appreciated recognition for their specialist area of work.
- To encourage a greater number of visits from senior colleagues/managers and directors as they feel they have a positive "story" to tell in terms of their role and remit.

5. Material actions required (if any):	**Action Lead**

Update on actions:

FEEDBACK FROM DIRECTORS' VISITS

Name of ward or service:	AFOS /FCAMHS
Date of visit:	09th November 2020
Names of visiting Directors:	Elizabeth Moody Pali Hungin Dominic Gardner

1. Strengths of service / team:

1) Very stable and cohesive team
2) Lots of clinical experience and knowledge within the service
3) Team are very supportive of each other and colleagues around them
4) High value placed on reflective practice / clinical supervision
5) Highly skilled in providing very specialist risk assessments

2. Concerns about service / team:

1) Increasingly stretched in terms of resources. The team has an intervention and consultation function. Increasing pressure to do more and more interventions
2) LA's across the geographical areas covered have differing approaches. There has been a consistent reduction in the availability of LAC services, this coupled with a desire not to admit inappropriately to Tier 4, creates some significant challenges in supporting young people. There is a need for a clearer 'complex trauma' pathway and similarly for LD /Autism. There is a lack of therapeutic placements.
3) The service deals with a lot of the impact of social injustice – would like the Trust to be more active in this sphere
4) Not strictly a concern about the team but there may have been a missed opportunity to include Foetal Alcohol Syndrome within the neuro-pathway

3. The three wishes of the service / team:
(Is there anything that you could fund from your Charitable Funds to improve well-being or the environment?)

1) Clearer / more consistent community pathways and approaches across all partners – explore potential of neuro-pathway to include foetal alcohol syndrome
2) Resource to be able to support increasing numbers of referrals being received
3) The Trust to be more active in the sphere of social injustice

4. Material actions required (if any):	**Action Lead**
1)Links to be made to Provider Collaborative and Whole Pathway Commissioning to ensure this is identified as a priority	HoS – Tees Community CAMHS
2) Capacity and demand to be reviewed as part of the business planning process	HoS – Tees Community CAMHS
3) Health Inequalities to be reflected in the clinical strategy work being undertaken by the Chief Clinical Strategy Officer (CCSO)	CCSO

5. Update on actions
(To be completed when actions have been followed up)

Actions forwarded to Head of Service – Tees Community CAMHS

Health Inequalities a fundamental underpinning element of the developing clinical strategy

FEEDBACK FROM DIRECTORS' VISITS

Name of ward or service:	Maple Ward
Date of visit:	13/12/21
Names of visiting Directors:	Beverley Reilly, Phil Bellas, Steve Wright, Kath Davies, John Manson (governor and veteran)

1. Strengths of service / team:

- Committed, passionate and experienced leadership
- 3 Bed service for serving men & women (all three forces)
- Only has females on the ward a few times a year
- Regular communication with MoD & 100% compliance with the contract.
- The ward can be sectioned off to support the trust in managing beds under pressure or with cohorting during Covid outbreak. This has helped the system and has been done with MoD approval
- Environment much improved (eg: the garden) and activity coordinators able to support residents with meaningful activity.
- Learning shared with other centres

2. Concerns about service / team:

- Some concerns about staffing the unit with qualified staff at times

3. The three wishes of the service / team:

1) Establish peer support and/or lived experience volunteer support
2) Extended hours for gym (benefits the whole site)
3) Access to equipment such as ipads and DVD players

4. Material actions required (if any):	**Action Lead**
Additional gym instructor time or link up with PTI instructors from Leeming Bar, Catterick or other bases. One specifically for MOD garden with PTI's coming in to do exercise programme and the other site wide re increasing staffing for access to gym?	CEO and CO at base
Preserve the art work currently being exhibited	Co Sec
Consider how to highlight work as Veterans Aware including identifying champions working towards	Co Sec and Veterans Lead

5. Update on actions
(To be completed when actions have been followed up)

FEEDBACK FROM DIRECTORS' VISITS

Name of ward or service:	Forensic Outreach Liaison Service – North Yorkshire and York
Date of visit:	13th December 2021
Names of visiting Directors:	Shirley Richardson and Sarah Dexter-Smith

1. Strengths of service / team:

- 7 day 9-5 service, but work 8-6 shifts to cover travel needed. Each nurse covers a set area to reduce travel
- 50-60 on caseload – can be fluctuating and impact of community work (rather than transforming care) is higher than expected (supporting the general community teams with forensic/ risk issues). Have developed acks to help train the generic teams to do some of this work themselves.
- Support people with IMHAs and Advocates where they can if they don't have supportive family.
- Do daily huddles and an in-depth huddle weekly with whole caseload which gives everyone a good overview of caseload/ priorities. Huddle each night to check wellbeing/ enable team to switch off. Also have consultation clinics to discuss referrals / if they're stuck.
- Lot of team DBT trained so are all bought in to the ethos/ reason for the check ins.
- MST has helped team given how disparate they are.

2. Concerns about service / team:

- Hard to recruit into team from the NYY area.
- Work across multiple teams with different styles/ needs. Supporting people with autism is growing in scale.
- COVID has made hot-desking hard in local bases and therefore to see clients easily face to face. Have had to rent rooms to see people in at times.
- Commissioning seems very different to D&TV. Team is valued and asked to provide a lot of support but this creates pressure.
- Risks relating to the model of internally checking on the quality of care being provided by other Trust colleagues have been identified. These have been raised at QuAG. Discussion around whether FTSU could help with the framework of thinking this through if the risks materialised.
- Access to specialist beds for an urgent admission for a person with Learning Disabilities. Number of hospital patients whose transition can be managed well at the same time by the team
- When patients with Autism are admitted to AMH, the staff don't always have the time or skills to carry out an in-depth assessment
- Concern about the potential for the most complex patients who are now being discharged needing to be readmitted if their care package breaks down

3. The three wishes of the service / team: That admin and office space had been considered before the team was set up. Reduction in depth and repetition of oversight from commissioners in different areas. NY and HCV can be repetitive but working to reduce that. Could do with extra SLT, psychology, psychiatry and nursing wte.	
4. Material actions required (if any): SDS to invite team to talk about their wellbeing huddles/ daily and in-depth check ins to a coffee break. Highlight potential for difficult relationships with internal commissioning model	**Action Lead** DoP&C DoP&C with Asst CEO
6. Update on actions **(To be completed when actions have been followed up)**	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item 15

Quality Assurance Committee: Key Issues Report

Report Date to Board: 27th January 2022

Date of last meeting: 13th January 2022. **Membership:** Quoracy was met. Apologies received – Shirley Richardson, Russell Patton, Elizabeth Moody

1 **Agenda items considered:**

- Board Assurance Framework (BAF) (risks relating to QuAC)
- Corporate Risk Register (risks relating to quality and safety)
- Trust Level Quality Assurance & Learning Report
- CQC Inspections and updates from NHSE/I and TEWV Quality Improvement Board
- Sexual Safety
- Infection, Prevention and Control
- Locality updates (North Yorkshire & York, Teesside, Durham & Darlington, and Forensics)
- Safe Staffing and Winter 2021 Preparedness
- Safeguarding
- TEWV Community Transformation Report by Tees Valley Healthwatch Network – deferred to February 2022

2a **Alert (by exception)**
The Committee alerts the Board to the following:

The Chair asked that it was formally recorded that the Committee met whilst the Trust, and indeed the NHS nationally, was operating under extreme pressure. TEWV had declared OPEL level 4. The Chair acknowledged the significant efforts of the authors and presenters of the Committee papers during this period.

Board Assurance Framework (BAF) (risks relating to QuAC)
Members considered the BAF at the beginning of the agenda and then again at the end to reflect on discussions generated from reports. No changes to the BAF were proposed; however, it was recognised that some of the risk profiles did not yet fully reflect the findings of recent CQC reports and actions to be taken in response to them. This will be addressed. Members sought further assurance on the processes for managing and reducing risks. The Committee was advised that The Audit and Risk Committee had gone through this in some detail at its recent meeting, specifically in relation to any strategic impact and the systems and processes to support the BAF. Members were advised that work is underway to align the Corporate Risk Register and the BAF so that one can inform the other. A revised report template will include a clear focus on ensuring risks are explicit will be used for all reports to Committees and will be implemented in due course.

Corporate Risk Register - Risks relating to Quality and Safety: There continues to be a lack of full assurance that can be provided to Board that the corporate risks in relation to quality and safety are being managed appropriately. The Committee were pleased to note the significant work that continues to improve our position, however requested that the reported information be enriched further to include the rationale for any changes to risk scores. The scoring matrix will also be changed to reflect the national scoring system, in line with the Trust Board Assurance Framework.

CQC Update and NHSEI Quality Board: The Trust action plan in response to the CQC inspection was to be considered by the Quality Improvement Board on 19th January 2022. Due to the timescales required, neither the Committee or Board would have sight of the action plan prior to submission. The CQC update report will feature on the Board agenda.

It was noted that the CQC had visited HMP Durham. The Trust had received a letter detailing some concerns which were being addressed. The Committee have requested an update at the next meeting.

Update on Sexual Safety:

The Committee received a verbal update from the Interim Medical Director on progress against the strategy, which is slow due to some external issues in thematic reviews. All wards have been issued with revised guidance and safety alerts. A detailed update will come to the Committee in the coming months.

Trust Level Quality and Learning Report:

Concerns were discussed in relation to the capacity and business continuity within the Central Approvals Team following a backlog of 1030 unapproved incidents in November. Assurance was given within the report and narrative in actions that had been taken.

Concerns were raised in relation to The Patient Safety Team capacity. At the end of November 82 serious incidents were in the system with 41 unallocated. The Committee received a contemporaneous update on an improved position and additional over recruitment to address capacity.

There has been a Trust level increase in self harm which is being reviewed.

There is Trust level concern about compliance with some elements of mandatory training and appraisals. The Trust is implementing a recovery plan based on high-risk areas.

Locality Updates:

Without exception, the clear messages from all 4 localities were consistent. Staffing issues, exacerbated by Covid and other sickness. Vacancies and recruitment and retention. Other providers ability to attract staff by offering financial incentives. Staff health, wellbeing and morale. High bed occupancy accompanied by a continued high acuity of patients. The impact of the closure of some care homes. A continued challenge to meet mandatory training requirements, appraisals and basic life support training. Each locality gave clarity in relation to addressing the concerns, with clear actions and narrative in their written reports.

The Committee were alerted to the admission of an under 18-year-old to an adult ward due to lack of bed provision.

Monthly Safe Staffing Exception Report

The Committee noted the safe staffing reports for October and November 2021. The Committee also received a contemporaneous update from the Deputy Director of Nursing. Staffing continues to be an ongoing significant challenge for the organisation. Assurance was provided that the monitoring of safe staffing levels continues daily and Safecare has been introduced across inpatient services to support decision making and prioritising deployment based on patient acuity and dependency. There was concern raised over a member of staff working a 23hour shift.

Winter 2021 Preparedness: Nursing safer staffing
The Committee received the document which had been reviewed by the Workforce SLG in December 2021. The report provides an initial view of the Trust's position against the actions set out in the guidance, in terms of its focus on planning, governance and assurance, decision making and escalation processes to support safer nursing and midwifery staffing during the Winter period, as well as staff training and well-being.

Trust board members are collectively responsible for workforce planning, practice and safeguards and the aim of the document is to help the Board seek assurance that effective plans are in place to ensure safe nursing staffing. Therefore, there is a need for the Board to know the standards and for QuAC to appraise the Board of potential risks, quality impacts and mitigations in place where standards are not met.

QuAC considered there was significant assurance set out in the Trust analysis against the national standards. Areas for the Trust that were identified as requiring additional review and development were:

	• staff well-being and the impact of strategies to support staff • length of shift patterns and impact on staff well-being • ongoing review of Business Continuity Plans and arrangements • Further work is required to support the Quality Impact Assessment approach to all staffing changes and requirements to both ensure that all risks are considered, documented and signed off as required by National mandate • Further demand and capacity modelling Additionally, the RCN workforce standards gap analysis identified ensuring time for nurse leadership, clinical supervision and development and the need to continually support the reporting of discriminatory behaviour. QuAC noted and accepted that progress in these areas will be monitored through the Workforce Senior Leadership Group. The Board is also required to review their risk appetite and tolerances in relation to quality and workforce risks and to be clear on the tolerances they are willing to accept, understanding that not all risks can be fully mitigated. The current Trust risk tolerance for quality is 9 (medium) and the Committee supported the position. The Board are asked to consider the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and that these risks are adequately documented on the Board Assurance Framework. The Committee agreed to recommend that the Board reflect on the risk tolerance and appetite in relation to quality and workforce risks noting that there are further areas to consider, and work required as set out above (the full report is attached as Appendix 1).
2b	**Assurance: The Committee assures members of the Board on the following matters:** **Infection, Prevention & Control – Six monthly report:** The Committee received and considered the six-monthly report. Despite being our experts on Covid, the team had also continued to deliver other elements of their core business in supporting the Trust. The IPC team provided support seven days a week and was noted by all members to have been a significant factor in ensuring localities could manage outbreaks as effectively and quickly as possible. The report provides positive assurance to the Committee and onwards to the Board. The efforts of the team are commended. **Six monthly Assurance Report of the Safeguarding and Public Protection Sub-Group:** There were a few elements of concern raised by the CQC which are being addressed and are detailed in the CQC Action Plan. QuAC will monitor progress moving forward. There are no other items to note other than to commend the team for their continued work. **Positive Practice Examples:** There has been a very positive outcome for a service user with very complex needs who recently transferred from another Trust. Upon transfer she was having 2 incidents of restraint and rapid tranquilisation per day. Following in-depth assessment and the development of a Positive Behaviour Plan she has now gone over 4 weeks with no restraints and no rapid tranquilisation.
2c	**Advise: The Committee would like to advise the Board of the following matters for information:** The Committee advises the Board that the contents of this report capture an abridged narrative from a complex committee. At the end of each meeting, Committee Members collectively agree on the matters they wish Board to be sighted on. From the meeting held on 13th January 2022, concisely these are: 1. There continues to be a lack of full assurance in relation to the risks for quality and safety on the Corporate Risk Register. But there is positive progress. 2. The Trust has received a letter from the CQC in relation to HMP Durham. The Committee will review this appropriately via the locality.

	3. There is concern about the capacity and business continuity of the Central Approvals Team impacting on our ability to review incidents. Actions are being taken. 4. There is concern about the capacity within the Patient Safety Team which is impacting on the ability to review serious incidents. Actions are being taken. 5. There is an increase in self harm incidents across the Trust, which is being investigated. 6. An under 18-year-old was admitted as an inpatient to an adult ward due to lack of bed provision. This is being investigated. 7. There was an incident involving a member of staff working a 23 hour shift. This has been investigated. 8. There remain concerns about the health, safety and wellbeing of our staff during unprecedented times across the NHS.

Recommendation: **The Board is asked to note:**

i) Note the contents of the report and comments/questions are invited.
ii) Reflect on the risk tolerance and appetite in relation to quality and workforce risks noting that there are further areas to consider, and work required as set out above

3	**Risks to be considered by the Board:** There were no risks that were considered should be escalated to the Board.
4	**Report compiled by, Bev** Reilly, Chair of Quality Assurance Committee/ Donna Keeping, Deputy Trust Secretary

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Appendix A

DATE:	**27th January 2022**
TITLE:	**Winter 2021 preparedness: Nursing safer staffing.**
REPORT OF:	**Elizabeth Moody**
REPORT FOR:	**Board of Directors**

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

Executive Summary

The NHS continues to experience significant levels of pressure. The continued impact of managing COVID-19, plus the recovery of services and relative return to usual activity levels has led to a challenging summer; especially in the context of constrained capacity due to COVID-19 related infection prevention and control (IPC) and workforce issues

Trust board members are collectively responsible for workforce planning, practice and safeguards. The recent Staffing Assurance Framework (NHS, 2021), see Appendix One, details actions focussed upon the preparedness, decision making and escalation processes to support safer nursing staffing as the winter period approaches. It builds on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance.

Using the provided "Assurance Framework" tool (NHS, 2001) this report provides an initial view of the Trust's position in terms of the controls in place, assurance levels, further action needed, and what ongoing monitoring / review is in place (Appendix 2).

The aim of this report is provide an insight into the Trust position and to seek assurance measured against the standards and suggested requirements set down in the NHS (2021) "Winter 2021 preparedness" report and to appraise the Board of the actions and potential mitigations in place where the standards are not met.

Whilst the actuality of winter pressures are more significantly experienced in the acute medical sector, the principles of the NHS (2021) paper (Appendix 1) remain of equal importance regarding the staffing pressures seen in the Trust, and as a result of COVID over these past 18 months. As such the Trust needs to be assured that systems and controls are in

place for managing and supporting services in the delivery of care for patients and identify any gaps which need further attention. Key areas highlighted from the initial review (appendix 2) that require further consideration to address compliance are;

- The Board is required to have reviewed their "risk appetite" in relation to quality and workforce risks and be clear on the tolerances the board are willing to accept, understanding that not all risks can be fully mitigated, and for this to be clearly communicated to the organisation. It is recommended that this task is required to be completed by senior leaders and the Board to inform and support their decision making around risks outside of their "desired appetite". There is a tool provided for a piece of work to discuss, an example taken from the NHS report is shown in Appendix 3.
- Currently the Trusts risk appetite statement is as follows:

Quality and Safety (including innovation)

  - The Trust has a low appetite for quality and safety risk exposure that could result in harm or loss of life to patients, the public, or staff.
  - Quality and safety drive all major decisions in the organisation.
  - All quality and safety risks must be actively mitigated.
  - Innovations which could impact negatively on quality and safety must be subject to an impact assessment and be approved by the Director of Nursing and Governance and the Medical Director
  - The Trust has a risk tolerance of 9 (medium) for quality

- The "risk management approach" in the BAF profiles highlights where the risk score can or cannot be mitigated to tolerable levels.
- Staff wellbeing support structures and processes are in place across the Trust, however it is not clear how well they are directly aligned to inform upon workforce related issues. The key indicators at present regarding staff wellbeing in the clinical areas appear to be related to sickness absence and a subsequent reliance upon temporary staffing measures to support the absence. It is felt that further involvement and development of measures relating to staff wellbeing will provide additional key information to the workforce planning agenda.
- Demand and capacity modelling for community teams is currently in its early stages within the CAMHS community sector. The Safe staffing team are currently underway with the rollout of community e-roster, (as required by national requirements), which will further support demand and capacity work, which will benefit from additional support from senior service managers and directors to ensure a timely and smooth implementation; this rollout is currently scheduled to be completed by Q3 2022.
- The appointment to a permanent substantive Emergency Planning Lead/Officer will support the Trusts position with regard to emergency preparedness.
- Further work is required to support the Quality Impact Assessment approach to all staffing changes and requirements to both ensure that all risks are considered, documented and signed off as required by National mandate. This is currently being introduced across the Trust and will require further work and support to embed this process.
- Business Continuity Plans require a process to continually review and update thresholds. Once a new emergency planning lead is in post they will lead on a review of plans and methods used to manage the emergency response during the pandemic.

  Areas for further consideration include:

  - a review of ownership of the plans was suggested by the Operational Support Managers.
  - the way in which critical incidents or events may impact on staffing requires improved engagement and levels of awareness. These areas are captured in the Risk Register and need to be consistently considered

at a more granular level within the BCPs and it is suggested that they could be more explicit and defined for clarity.

  - plans regarding the established nursing workforce and their roles, skills and responsibilities are not consistent across all areas and need further detail to drill down to skills and responsibilities.
  - contingency plans for situations in which the nursing workforce is compromised, understaffed or redeployed requires plans to be aligned to the safe staffing escalation process. This requires a review of action cards that are aligned to staffing escalation and it is suggested that these continue to be embedded in all areas.

- Processes and structures are in place across the Trust to support governance and assurance of the workforce, however assurance of consistency and a standardised application and the level of monitoring is not consistently available.

Recommendations

- Remaining tasks to be completed on the assurance framework tool are to review the detail provided and provide update for the remaining fields, "Residual Risk Score / Risk register reference" and "Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell"- Joe Bergin, safe staffing lead
- For the Board to review and comment on the report and agree any further actions or potential mitigations needed where the standards are not met.
- For the Board to reflect on their 'risk appetite' in relation to quality and workforce risks to inform and support their decision making around risks outside of their "desired appetite

Appendix 1

BW1068_Staffing%2
0Assurance%20frame

Appendix 2

REF	Detail	Controls	Assurance (Positive and Negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
Staffing Escalation / Surge and Super Surge Plans							
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e. intensive care) or as per the NQB safe staffing guidance	Surge planning completed during the peak of the COVID pandemic to consider the increased surge in demand for staffing for longer term pressures on the organisation. The Trust staffing escalation procedure supports staff in decision making regarding response to staffing shortfalls. The organisation has recently implemented a software solution to support oversight and assurance of staffing levels. Business Continuity Plans (BCP) are in place to support decision making regarding service need. Staffing Establishment reviews are being undertaken to support longer term staffing responsiveness and preparedness.	Positive Assurance: Staff have used the BCP levels to trigger escalation of staffing pressures as required to highlight an increased demand.		Staffing Escalation procedures is currently under review to ensure software solution recently implemented is part of this process. BCP protocols are under review to ensure standardisation across the organisation and communication of process.	Emergency Planning officer is an interim appointment at present. Ongoing recruitment process remains an issue regarding processing of applications and appointment to vacant posts.	Reporting to Gold command via the locality leads. Monthly Safe Staffing report and reporting via the Trust quality structure.
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.	Staffing Escalation procedures have undergone a recent review to ensure software solution recently implemented is part of this process. BCP protocols are under review to ensure standardisation across the organisation and communication of process. OPEL procedure has been reviewed during 2021 to consider increased pressures and reporting structure.	Reporting process is in place although there is a potential risk that due to staffing pressures may conversely under report staffing pressures.		Staffing Escalation procedures is currently under review to ensure software solution recently implemented is part of this process. BCP protocols are under review to ensure standardisation across the organisation and communication of process.		Reporting to Gold command via the locality leads. Monthly Safe Staffing report and reporting via the Trust quality structure.

1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	Prior consultation was undertaken via the Right Staffing Programme Board and agreed, during which staff side representatives were present.	Staffing Escalation procedures are available to all staff via the Trust Intranet. Negative Assurance - The Trust continue to promote the procedure to ensure that all staff are aware of the Staffing Escalation procedure and embed this into day to day practice.		The Trust will continue to monitor the DATIX reporting system. Liaison with Operational Services to promote the completion of DATIX in relation to staffing shortfalls.		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report regarding the DATIX in relation to staffing related pressures. The Trust continue to review the process of reporting via the governance structures.
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	Quality Impact Assessments are in place and the embedding of this process is ongoing.	Quality Impact Assessment are reviewed by CN/MD. Negative Assurance regarding the embedding the process of QIA requirements. Negative Assurance - The Trust continue to promote the procedure to ensure that all staff are aware of the Staffing Escalation procedure and embed this into day to day practice.		Ongoing education and training regarding QIA use and requirements to complete the documentation to support decision making		Safe Staffing team will lead on the review of the documentation and continue to support services in completion of same.

2.1	There are clear processes for review and escalation of an immediate safer staffing shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.	Staffing reviews are undertaken on a shift by shift basis and any staffing pressures are escalated via software solution or local solutions, whereby the software is not currently in use. Staffing Escalation procedure provides a risk assessment template to support decision making at a local level.	Staffing Escalation process in place. The use of acuity and dependency based rostering software is monitored by Safe Staffing team and reports by expectation to Gold Command and Operational Directors in conjunction with local mitigation process. Monitoring of DATIX reports.		Ongoing monitoring and compliance reports to embed the use of the software aligned to staffing escalation procedure		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report regarding the DATIX in relation to staffing related pressures. The Trust continue to review the process of reporting via the governance structures.
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful, and that safe care is sustained.	Staffing calls are carried out on a daily and weekly basis whereby any shortfalls or potential risks to staffing levels are highlighted and mitigation takes place from a Trust wide position via redeployment of staffing.	Local procedures in place which are escalated to Silver command. Local process in place to respond to staffing pressures. As required the Trust will move towards a site management process, whereby senior staff are present to support staffing decisions.		To continually review and update determine thresholds based on patient acuity and need.		
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient can meet their individual care needs	Shift lengths and timings are embedded to allow for a comprehensive patient handover to be completed. This is completed at the start and end of each span of duty between the Nurse In Charge and the staff team.	The Trust have a system in place which outlines the minimum requirements of a patient handover. Daily Safety Huddles are in place Trust wide which supports Patient handover.		No Further Action required		Local procedures in place to ensure that Daily Safety Huddles are completed, and these are stored centrally and supported by the Practice Development Practitioners.

2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.	Staff are supported and encouraged to raise and concerns regarding their own skills and ability to provide adequate patient care, whilst also acting as a lead for the staff team. Staff have access to the incident reporting process to record any concerns regarding staffing levels.	Staff Whistleblowing Procedure in Place and On Call both in an out of hours manager system in place to support staff experiencing concerns, as aligned to the Staffing Escalation Procedure.		No Further Action required		
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	Agency staff are supported by the Temporary Staffing Team during induction and 'onboarding' to ensure minimum standards of competence and compliance training. Local inductions are carried out at a team level to support agency staff.	Records of Induction are retained for registered staff.		No Further Action required		Monitoring is carried out by Temporary Staffing Services.
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice.	Staff are supported and encouraged to raise and concerns regarding their own skills and ability to provide adequate patient care, whilst also acting as a lead for the staff team. Staff have access to the Freedom to Speak Up Guardian and DATIX reporting.	Trust 'You Said We did' process in place. Freedom to Speak up guardian in place and whistleblowing procedure. Negative assurance that staff who have concerns are raising these with the organisation.		No Further Action required		Ward Managers, Matron, Locality Managers and Duty Nurse Coordinators are in place to monitor the safe and effective care delivery
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff, and leaders have taken action to address these risks to minimise the impact on patient care.	Staff on inpatient ward areas use a software tool to raise red flags and in addition staff have access to raising concerns procedure and DATIX	DATIX reporting and lessons learned shared via managers, matron, and locality managers. Duty Nurse coordinators are available to take immediate action to maintain staff and patient safety.		No Further Action required		All incidents are reviewed, and the daily safety huddles highlight any areas of concern or immediate actions required. Local area reviews are undertaken and DATIX reporting and reviews are completed.

2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care	Staff well-being is supported via the Employee support officers and the provision of Staff Retreats and benefit packages. Staff individual risk assessment process is in place.	Staff attendance at events and contact with employee support service is monitored. Staff feedback via Staff Survey is responded to		No Further Action required		Ongoing monitor takes place to assess and respond to the challenges faced by staff regarding well-being.
2.9	The trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care. These mechanisms consider both those staff who are absent from clinical duties due to required self-Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence	Staff reporting is carried out at a local and trust level to provide the SLG with a report on any staffing pressures which includes a breakdown absence and if these are Coved related or not.	Current reporting process in place to review and monitor staffing absence at a granular level and the potential impact on patient care		E-rostering roll out to 90% of the clinical workforce will further support and enhance this process.		
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g. use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence	Staff are supported to report any staffing pressures via Datix and following any incidents staff are encouraged and supported to complete a rapid review debrief. Staff are encouraged to utilise the available support if any incidents have a lasting impact via Employee Support Service.	Staff reporting of pressures are reviewed via the DATIX system. Negative assurance due to a potential under reporting due to staff time required to report a staffing shortfall.		No Further Action required		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report regarding the DATIX in relation to staffing related pressures. The Trust continue to review the process of reporting via the governance structures.
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings	Staff well-being group is in place which considers all aspects of staff well-being and informs strategic long-term initiatives.	Negative Assurance: The staff wellbeing group require alignment to the Workforce group to support integrated approach to Strategic Approach regarding staff well-being		Staff Well-Being requires further embedding to support the daily approach to well-being		Ongoing monitoring and review via Senior Workforce Group and Program Board
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	Immediate staffing challenges are discussed and escalated at a local and site wide level daily and a Trust wide level weekly at Silver and Gold command	Ward Managers, Matron and Locality Managers and Duty Nurse Coordinators escalate staffing pressures as required to Local governance		No Further Action required		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report

			structure and report by exception via Silver and Gold command. Negative Assurance regarding the impact of staffing challenges on patients				
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	The trust has an electronic rostering system in place to support daily staffing reviews at a Trust wide level which can be analysed on at a team by team level. Safe Staffing monthly report which incorporates fill rates. Report via the Trust governance routes and escalation by exception	OPEL system scoring is utilised within the Trust to support alignment to National reporting mechanisms.		Current Emergency Planning Officer is temporary posting and therefore permanent recruitment required.		Ongoing monitoring and review via Senior Workforce Group and Program Board
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	The trust has an electronic rostering system in place to support daily staffing reviews at a Trust wide level which can be analysed on at a team by team level. Safe Staffing monthly report which incorporates fill rates. Report via the Trust governance routes and escalation by exception	Monitoring of the acuity and dependency-based software is completed. Staffing redeployment is in line with identified needs.		The Trust continue to review the impact of staffing shortfalls on patient experiences of service delivery. Demand and Capacity modelling has commenced and will support review of staffing resource.		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report regarding the DATIX in relation to staffing related pressures. The Trust continue to review the process of reporting via the governance structures.
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short- and medium-term solutions to mitigate the risks.	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception	Minutes and papers are available		No Further Action required		
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	Safe Staffing monthly report, 6 monthly staffing report this incorporates the CQI and an addition exception report via the Trust governance routes and escalation by exception. Staffing Establishment Review report is provided from ward to board level/	Minutes and papers are available		No Further Action required		

4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges	Trust Integrated Information Centre has a specific dashboard which supports reporting of COVID related pressures	Reports and Access to the dashboards available to all Trust staff as required. Triangulation and reports are carried out in the Safe Staffing reports.		No Further Action required		
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception. This report also highlights Key areas of Risk, Mitigation in place and unresolved issues	Minutes and papers are available		No Further Action required		
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis.	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception. This report also highlights Key areas of Risk, Mitigation in place and unresolved issues	Minutes and papers are available		No Further Action required		
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception. This report also highlights Key areas of Risk, Mitigation in place and unresolved issues	Minutes and papers are available		No Further Action required		
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception. This report also highlights Key areas of Risk, Mitigation in place and unresolved issues. Staffing risks are identified on the Trust risk registers.	Minutes and papers are available		No Further Action required		
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e. risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	Business Continuity plans are in place and these outline the response of the organisation to highlight issues of risk and mitigation plans.	Discussed and monitored at Gold and the Quality Improvement Board		To continually review and update determine thresholds based on patient acuity and need.		
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework	Phil Bellas	Phil Bellas - Donna (QUAC)				

4.10	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	The Trust has a quality board in place at present to discuss any staffing pressures and the impact this may have on patient care.	OPEL system scoring is utilised within the Trust to support alignment to National reporting mechanisms and the Quality Board.		No Further Action Required		
4.11	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus	Discuss with Phil Bellas	Discuss with Phil Bellas				

Appendix 3

Category (highest impact of the risk)	Proposed Risk appetite statement	Risk appetite	Risk score
Clinical innovation	We have a HIGH risk appetite for clinical innovation that does not compromise quality of care	HIGH	8-12
Commercial	We have a HIGH risk appetite aimed at increasing the impact of services. The high risk appetite allows the Trust to explore opportunities to deliver existing and new services into new markets	HIGH	8-12
Compliance / regulatory	We have a LOW risk appetite for risks which may compromise compliance with statutory duties and regulatory requirements	LOW	1-3
Environment	We are committed to providing patient care in a safe environment; however we have a MEDIUM risk appetite for risks related to the Trust estate and infrastructure except where they adversely impact on patient safety and regulatory compliance.	MEDIUM	4-6
Financial / value for money	We have a HIGH risk appetite for financial / value for money risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards	HIGH	8-12
Systems and Partnerships	We have a HIGH risk appetite for system working and partnerships which will benefit our local population	HIGH	8-12
Reputation	We have a HIGH risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the Trust	HIGH	8-12
Quality – effectiveness	We have a LOW risk appetite for risks that may compromise the delivery of outcomes for our patients	LOW	1-3
Quality - experience	We have a MEDIUM risk appetite for risks to patient experience if this is required to achieve patient safety and quality improvements	MEDIUM	4-6
Quality - safety	Patient safety is paramount to the Trust and as such it we have a LOW appetite for risks which may compromise patient safety	LOW	1-3
Technology	We have a HIGH risk appetite for the adoption and spread of new technologies whilst ensuring quality for our service users	HIGH	8-12
Workforce	We have a MEDIUM appetite for risks to workforce. This medium appetite allows scope to implement initiatives that support transformational change whilst ensuring it remains a safe place to work	MEDIUM	4-6

Classification: Official

Publication approval reference: PAR1068

Key actions

Winter 2021 preparedness: Nursing and midwifery safer staffing

12 November 2021, Version 1

Trust board members are collectively responsible for workforce planning, practice and safeguards. The following actions focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing as the winter period approaches. They build on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance. The document summarises and signposts to existing resources, tools, and templates in support of nursing and midwifery workforce planning, preparation, and board assurance.

Planning

- When planning the nursing and midwifery workforce, boards should ensure that system wide and local learning from previous staffing deployments in Covid-19 pandemic continue to be incorporated into staffing escalation plans.

- Work with providers of temporary workforce to be clear about anticipated requirements during activity peaks and consider steps such as block booking for hard to fill areas.

- Executive directors of nursing should ensure that all forecast staffing plans are reviewed weekly or more frequently as required by the operating context and changing circumstances.

- Changes in estate function or staffing configuration should be subject to a quality impact assessment with final sign-off by the executive director of nursing and countersigned by the medical director as joint quality lead.

- Redeployment should be voluntary where possible and individual risk assessments must be undertaken with staff prior to any redeployment.

Decision making and escalation

- Even during challenging times, executive directors of nursing should be mindful of the fundamental principles set out in the NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.

- When implementing escalation plans, decisions regarding skill mix and nurse ratios should be taken in conjunction with an assessment of patient acuity and dependency, professional judgement and the environment of care.

- In preparation for periods of increased demand, organisations should ensure that staffing plans are reviewed and signed off by the executive director of nursing, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams.

- Staffing risk assessments should be undertaken on a shift by shift basis and concerns and issues escalated in a timely manner via clearly established routes. Unresolved issues should be escalated in line with provider governance processes. A system wide discussion and focus should be taken to reach solutions wherever appropriate.

- Escalation mechanisms and governance processes should be clear to all staff and the board should seek assurance that effective escalation occurs and that issues are addressed and recorded.

- Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. The board must seek assurance that there are clear mechanisms in place for staff to raise concerns and that these are acknowledged and mitigated where possible.

- Clinical leaders should take a multi-professional and skills-based approach to staffing and ensure each clinical area is supervised by a senior clinical leader.

Staff training and wellbeing

- Supporting the workforce is paramount; boards should seek assurance that there are well-publicised and accessible resources in place for staff.

- Staff wellbeing should be embedded at every level. For example, team-based check-ins, wellbeing support hubs and wobble rooms.

- Professional nurse/midwife Advocates (PNA/PMAs) who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice, should be readily available.

- Boards should ensure that local leaders are supporting staff wellbeing, which in turn will support the delivery of high standards of patient care.

Indemnity and regulation

- NHS Resolution has confirmed additional indemnity arrangements that cover healthcare workers who are supporting the COVID-19 response, including those who have been asked to undertake duties outside of their usual role.

- It is recognised that at times staff might need to act outside their normal role or places of work/scope of practice. A risk-based approach should be used to mitigate emerging risks using available resources effectively and responsibly.

- The Nursing and Midwifery Council (NMC) and the four chief nursing officers in the UK have written to all registrants reminding all of the importance of working in partnership with people receiving care and their fellow professionals; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. This remains as important as it ever was. Trust boards must be assured that wherever possible these standards are met.

Governance and assurance

- There must be a clear and effective line of sight from point of care delivery to board, in relation to nursing and midwifery staffing decisions and challenges.

- To help boards understand the quality impact of decisions that have been taken around staffing, boards should be provided with triangulated information linking staffing with wider intelligence, through regular reporting. For example incidents, complaints and NICE red flags.

- Boards should have reviewed their risk appetite in relation to quality and workforce risks and be clear on the tolerances the board is willing to accept, understanding that not all risks can be fully mitigated. This should be clearly communicated to the organisation.

- Boards should seek assurance that plans are in place to ensure safe nursing and midwifery staffing over the winter period and that these plans are connected to the wider system staffing planning, resourcing and mutual aid.

- The Care Quality Commission (CQC) recognises that services are facing tremendous challenges as result of the pandemic – and that the nursing workforce is experiencing these pressures particularly acutely. This includes decisions around nursing, midwifery and care staffing capacity and capability. CQC expects boards to make staffing decisions with a focus on mitigating emerging risks and trends using available resources effectively and responsibly, in line with national guidance – and that where staffing shortages are identified, use of temporary solutions including a multidisciplinary approach to manage immediate risks should be implemented.

- Where necessary, CQC and regional NHS England and NHS Improvement teams should be made aware of any fundamental concerns arising from significant and sustained staffing challenges.

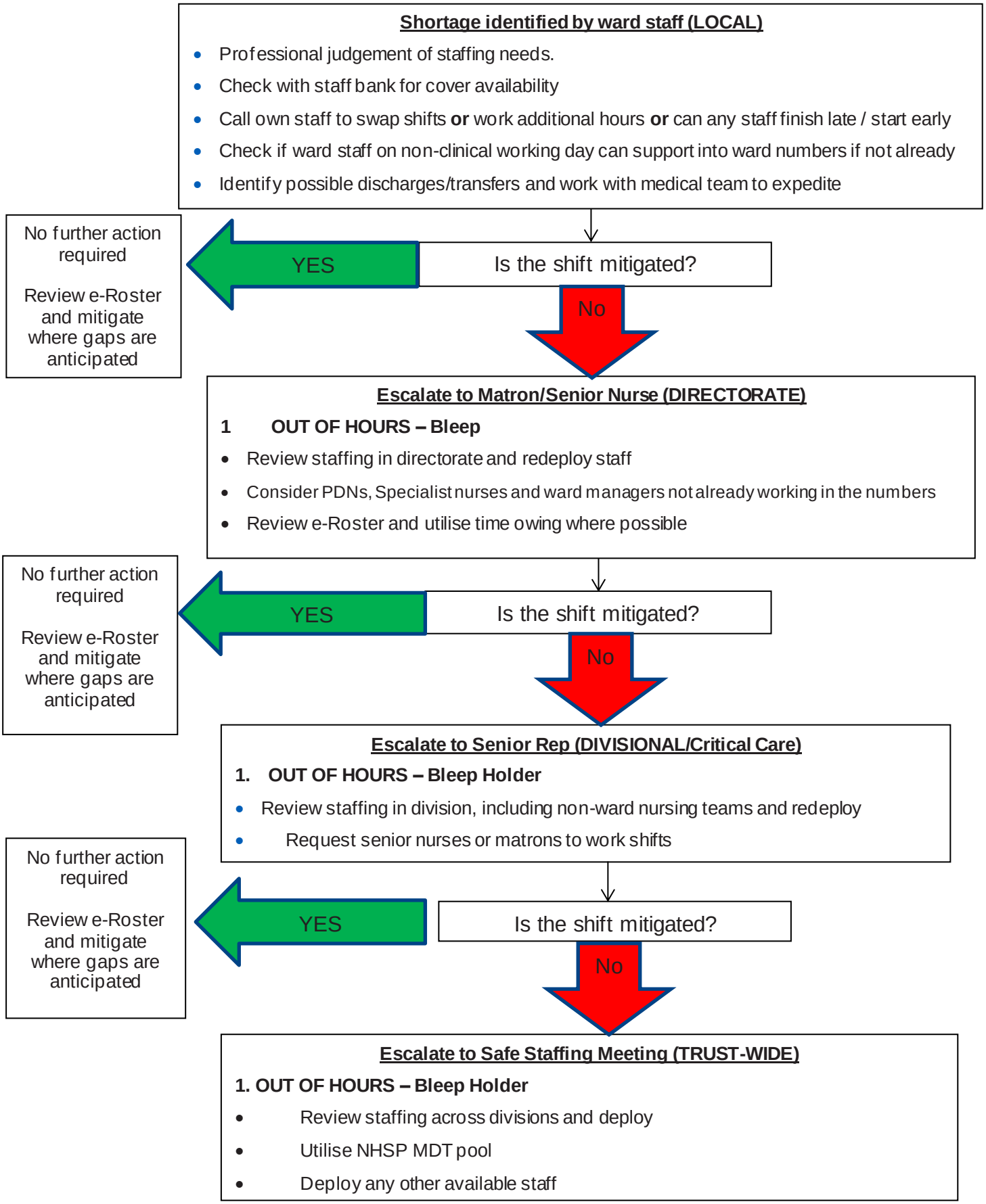
Useful links:

Alongside the formal guidance that has previously been issued in this area, a collection of additional resources has been collated for use by providers. These resources are attached as appendices and/or via the following links:

Planning • NHS England and NHS Improvement: Advice on acute sector workforce models during COVID-19 • NHS England – Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals • NHS England – Nursing and midwifery e-rostering: a good practice guide • Safe midwifery staffing for maternity settings	**Staff training and wellbeing** • NHSX: Digital staff passport • NHS People: Support and wellbeing resources • NHS Horizons: Caring for NHS people • NHS Employers: Risk assessments for staff	**Decision making and escalation** • Appendix 1: Decision and escalation framework tool • Appendix 2: Quality impact assessment • Appendix 3: Staffing escalation (SBAR) • Appendix 7: EPRR escalation and alerting
Governance and assurance • Appendix 4: Risk appetite statement • Appendix 5: Assurance Framework • Appendix 6: Safe staffing Governance framework • NQB Safe Sustainable and Productive staffing guidance • Developing Workforce Safeguards • Care Quality Commission	**Indemnity and regulation** • NHS Resolution Clinical Negligence Scheme for Coronavirus (CNSC)	**Additional resources** • Report template - NHSI website (england.nhs.uk)

Appendix 1: Decision tool and escalation framework

Flow chart for resolution of staff shortages, to support nurse(s) in charge and matrons on a shift-by-shift basis.



Appendix 2: Example quality impact assessment

Follow this link to view (FutureNHS account required):
https://future.nhs.uk/BeneficialChangesCOVID19/view?objectId=93995109

Appendix 3: Example staffing SBAR Tool

Staffing communication tool using situation, background, assessment, recommendation (SBAR) principles to ensure critical staffing issues are received and actioned.

Staffing Escalation SBAR

SITUATION:

Ward:

Date, Shift and Band that require covering:

Number of beds:

Acuity and dependency score:

Describe your concern, include Safety/Quality concern:

BACKGROUND:

Current problem:

Reason for problem on shift:

How long has the shift been out to the Hospital Nurse Bank:

How long has the shift been out to Framework Agency:

ASSESSMENT:

My assessment of the situation is:

Current concern:

Describe actions have been taken to solve the current problem:

RECOMMENDATION:

Based on my assessment I request that you approve:

Things to consider:

Explain what you need:

Appendix 4: Example risk appetite statement

For boards and senior leaders outlining the pressures on the service and any potential changes in the level of accepted risk.

Category (highest impact of the risk)	Proposed Risk appetite statement	Risk appetite	Risk score
Clinical innovation	We have a HIGH risk appetite for clinical innovation that does not compromise quality of care	HIGH	8-12
Commercial	We have a HIGH risk appetite aimed at increasing the impact of services. The high risk appetite allows the Trust to explore opportunities to deliver existing and new services into new markets	HIGH	8-12
Compliance / regulatory	We have a LOW risk appetite for risks which may compromise compliance with statutory duties and regulatory requirements	LOW	1-3
Environment	We are committed to providing patient care in a safe environment; however we have a MEDIUM risk appetite for risks related to the Trust estate and infrastructure except where they adversely impact on patient safety and regulatory compliance.	MEDIUM	4-6
Financial / value for money	We have a HIGH risk appetite for financial / value for money risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards	HIGH	8-12
Systems and Partnerships	We have a HIGH risk appetite for system working and partnerships which will benefit our local population	HIGH	8-12
Reputation	We have a HIGH risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the Trust	HIGH	8-12
Quality – effectiveness	We have a LOW risk appetite for risks that may compromise the delivery of outcomes for our patients	LOW	1-3
Quality - experience	We have a MEDIUM risk appetite for risks to patient experience if this is required to achieve patient safety and quality improvements	MEDIUM	4-6
Quality - safety	Patient safety is paramount to the Trust and as such it we have a LOW appetite for risks which may compromise patient safety	LOW	1-3
Technology	We have a HIGH risk appetite for the adoption and spread of new technologies whilst ensuring quality for our service users	HIGH	8-12
Workforce	We have a MEDIUM appetite for risks to workforce. This medium appetite allows scope to implement initiatives that support transformational change whilst ensuring it remains a safe place to work	MEDIUM	4-6

Appendix 5: Assurance framework – nursing and midwifery staffing

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	**Details**	**Controls**	**Assurance (positive and Negative)**	**Residual Risk Score / Risk register reference**	**Further action needed**	**Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell**	**Ongoing Monitoring / Review**
	Guidance notes	*Outline the current controls (controls are actions that mitigate risk include policies, practice, process and technologies)*	*Detail both the current positive and negative assurance position to give a balanced view of the current position* *Assurance is evidence that the control is effective – or conversely is evidence that a control is ineffective / there are still gaps* *Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight.* *Effective Assurance should be a triangulated picture of the evidence (staff shortages, sickness absence,pt outcomes, complaints, harm reviews)*	*What is the remaining risk score (using the trusts existing risk systems and matrix)* *Are these risks recorded on the risk register?*	*Where there are identified gaps in either control or assurance, outline the additional action to be undertaken to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the LRF/region/ national teams and outlined in the following column*	*Provide oversight to the board what the current significant gaps are* *Outline those risks that are currently not fully mitigated /needing external oversight and support*	*Due to the likely prevailing nature of these risks, outlines through what operational channels and how are these active risk being monitored (e.g daily silver meetings via safe staffing heatmap)*
1.	**Staffing Escalation / Surge and Super Surge Plans**						

1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance						
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.						
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee						
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD						
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate						

	shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.						
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.						
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.						
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.						

2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.						
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individuals scope of practice.						
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care.						
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.						
2.9	The trust has robust mechanisms for understanding the current staffing						

	levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence.						
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.						
3.0 Daily Governance via EPRR route (when/if required)							
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver						

	and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.						
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).						
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.						
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.						
4.0 Board oversight and Assurance (BAU structures)							
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and						

	medium term solutions to mitigate the risks.						
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.						
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.						
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.						
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis.						

4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.						
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.						
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)						
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework						

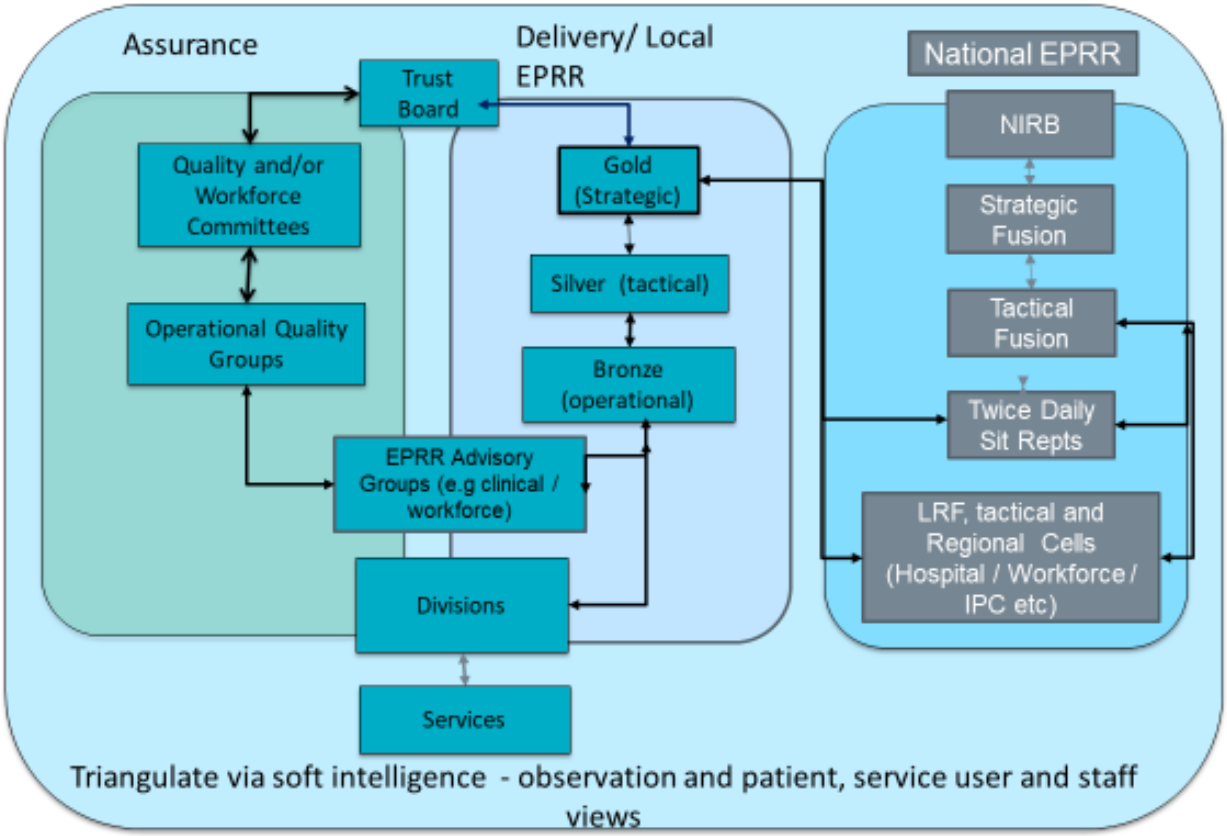
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus						
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges						

Appendix 6: Example safe staffing governance framework

The flowchart below is a general illustrative example. It outlines the two arms of a provider governance framework (assurance and delivery) and further indicates the relationships with the national emergency preparedness, resilience and response (EPRR) structures.

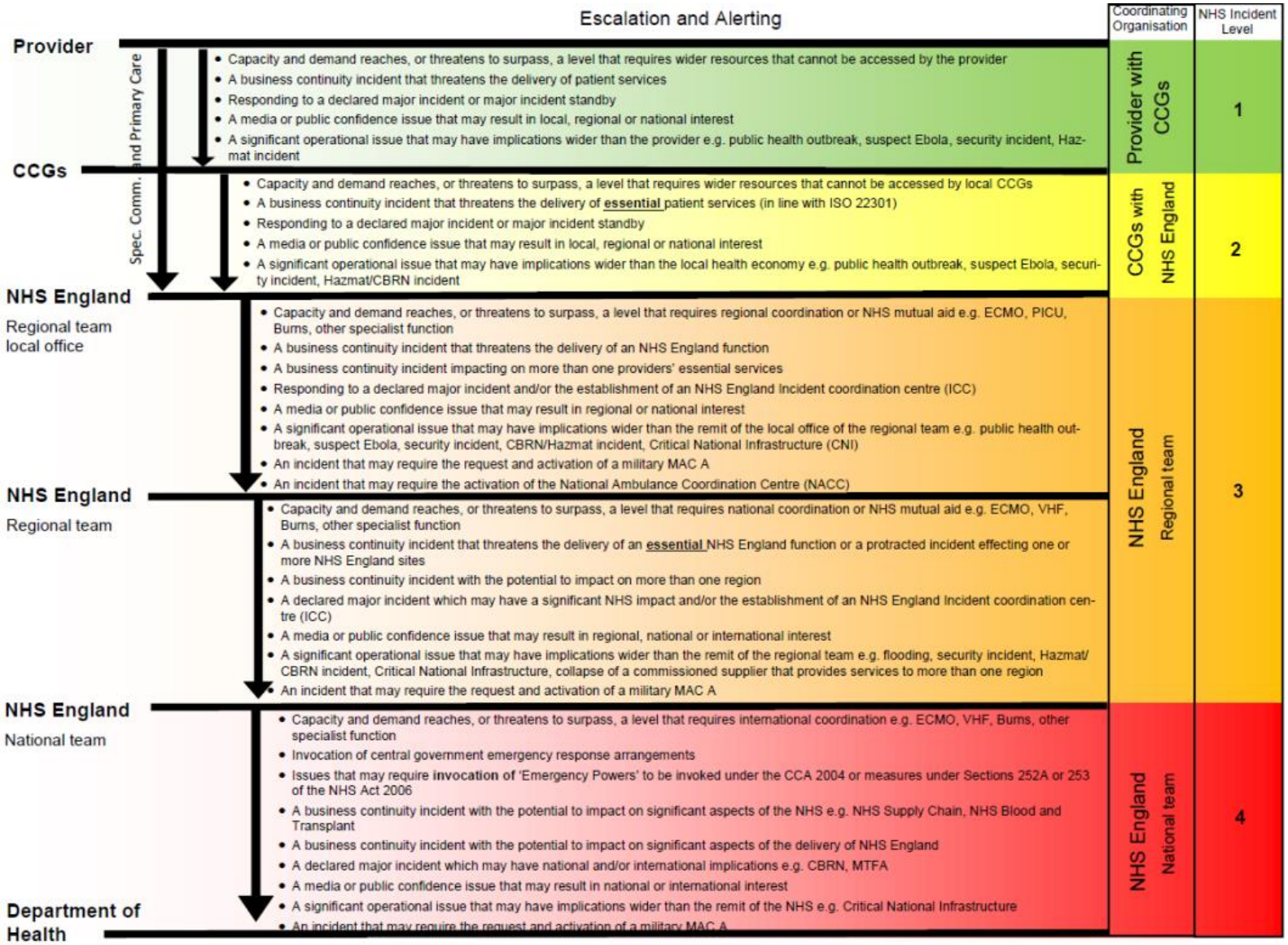
Providers must ensure that non-executive members of the board have clear sight of the significant or sustained operational issues and challenges that are being discussed in the day-to-day delivery of care during these challenging times.

This should be through their existing board assurance routes (ie quality committee, strategic workforce and organisational development committee to the board), to allow the non-executive directors to adequately fulfil their duties of holding the executive director members to account so that quality care is maintained.



Appendix 7: EPRR escalation and alerting

Extracted from NHS England EPRR Framework



Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Thursday, 27th January 2022**
TITLE:	**To consider the "Hard Truths" Six monthly Nurse Staffing 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 co-create a great experience for our patients, carers and families	✓
To co-create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

There are 4 key areas which are recurrent throughout the report

1. High use of bank, agency and overtime to maintain safe staffing levels
2. Challenges to recruitment of registered nurse vacancies
3. Compliance with statutory and mandatory training
4. Embedding best practice in roster management

Key actions to address these

- Over recruitment of HCSW
- On-going recruitment of registered nurses including international recruitment
- Flexible approaches to the delivery of statutory and mandatory training
- Increased emphasis and support of roster competency and usage with ward managers and matrons
- Risk escalation and oversight of safer staffing including Business Continuity Arrangements

NHSE Winter 2021 Preparedness: Nursing Safer Staffing and Royal College of Nursing Workforce Standards Gap Analysis were reviewed, analysed and shared at Workforce Senior Leadership Group.
QUAC considered the Winter 2021 Preparedness Nursing Safer Staffing and felt a comprehensive review of assurances was in place in line with Board tolerances to quality and safety risks.
Areas for development identified for action will be monitored through the workforce senior leadership group.

A neighbouring trust has offered a “golden hello” retention package and some of the independent sectors are offering enhanced salaries, a small number of newly qualified nurses and substantive in-patient staff have potentially moved into these areas. The Trust needs to consider its position and response to ensure we are not adversely affected.

Recommendations:

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

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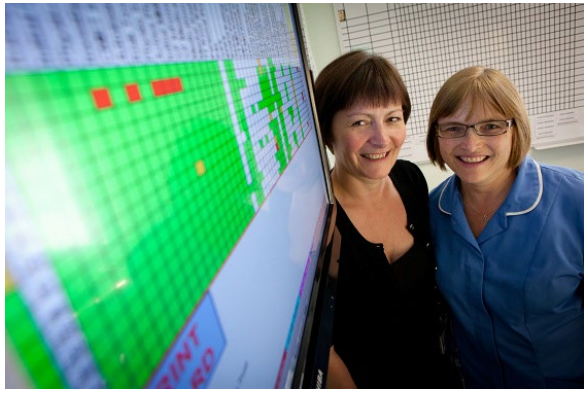
Trust Level Report



Purpose

Appropriate staffing is fundamental to the delivery of safe and effective care. Safe staffing must be matched to patients' needs and is about skill-mix as well as numbers. The purpose of the report is to advise the Board of a 6-monthly review (1st June to 30th of November 2021) in relation to nurse staffing (inpatients) as required to meet the commitments of the 'Hard Truths' response to the Public Inquiry into Mid-Staffordshire Foundation Trust (Francis Review, 2014) and in line with the NQB Guidance (NHS, 2016) and compliance with Developing Workforce Safeguards (NHSI, 2018).

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

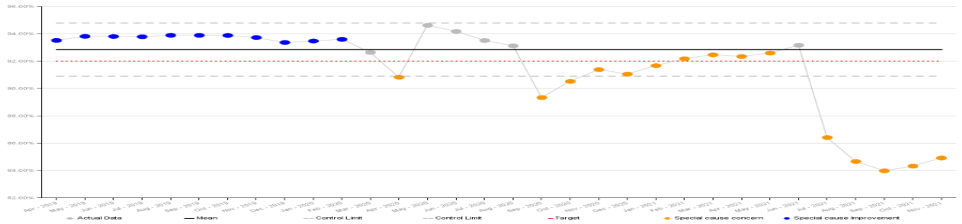
The data contained within the 6 Month Safe Staffing Report is correct as at November 2021. Of the 12 measures identified we have been able to apply Statistical Process Control (SPC) Charts to 14 of these for the period of **1st June to 30th November 2021**. The narrative is reflective to date.

Included in this Report

Right Skills	4	• Mandatory Training Compliance	
Right Place and Right Time	9-13	• Fill Rates RN Days and Nights • Fill Rates HCA Days and Nights • Additional Duties	• Bank Usage • Agency Usage • Overtime Usage
Patient Outcomes, People Productivity and Financial Sustainability	14-20	• Triangulation with Quality Indicators • Triangulation with Safe Indicators • Breaks not Taken	
Reporting, Investigating and Acting on Incidents	20-23	• Incidents Citing Staffing Levels	
Patient, Staff and Carer Feedback	24	• Patient and Carer Feedback • Staff Experience – In our Shoes	
Care Hours per Patient Day	25	• CHPPD	

Right Skills

Percentage compliance with ALL mandatory and statutory training (snapshot)



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

Analysis (so what)

- The SPC Charts are reporting this measure as a cause for concern at trust and locality level, which will pose a significant risk to the trust.
- The COVID extensions for mandatory and statutory training came to an end in September 2021, and it was expected that there would be a significant compliance issue, as can be seen above.

Key Learning and how we are using this

- Attendance at face-to-face training sessions and completion of on-line training continues to be an area of concern requiring monitoring and oversight at all levels in the trust. This is due to availability of staff compounded by patient acuity and staff sickness.

Actions we are taking (now what)

- Monitoring compliance at QIB and Workforce SLG, in addition to consideration and review of the areas of double booking and DNAs by Heads of Nursing.
- Working with individual and targeted services to increase their compliance with an emphasis on resuscitation training and PAT training through covid safe sessions.
- Resuscitation training is now being provided in-house to provide flexibility and responsiveness to service requests for weekend training.
- Additional in-house venues sought to provide the ability to deliver PAT and resuscitation training more locally to service areas
- To support the programme for the over-recruitment of HCSWs, a two-week block programme of induction and training will be held in February 2022 so new staff can deliver and provide quality care to patients at the earliest opportunity.

Nurse Development and Initiatives

We have continued to work in partnership with 5 other Mental health trusts, led by South West Yorkshire Foundation Trust, to begin the journey of international recruitment. The focus is on recruitment of candidates who can quickly be supported to join the NMC register. We have offered 9 posts 7 of which are progressing, hopefully the first cohort will arrive end of February 2022. We are continuing to try and to recruit to 20 staff.

We are progressing in 2022/2023 with international recruitment to recruit an additional 20 MH nurses. We have been asked by NHSI to try to recruit 5 learning disability nurses and 20 general nurses, working collaboratively with NHS I to progress these areas as there will need to be additional support and help provided to successful on-board these staff.

We are working in partnership with Indeed digital recruitment agency and NHSE regional office to be part of the national initiative to have zero HCSW posts by 31.3.2021. This is on-going work due to on-going vacancy rates arising.

We are implementing the over recruitment of HCSW and are testing a 2-week induction for these new starters. Additionally, we are appointing to 2 new roles on a temporary basis to support HCSW nursing careers in the trust.

We have held our first virtual skills clinic session to assist HCSW who are keen to progress to nurse training. Guiding them with their own individual and collective requirements to be best placed to progress to nurse training. We are working towards having HCSW ready to progress as opportunities arise.

We have recruited nearly 50 newly qualified registered nurses into the trust, who will commence in January. A neighbouring trust has offered a “golden hello” retention package and some of the independent sectors are also offering enhanced salaries bringing increased competition for posts. A small number of newly qualified nurses and substantive in-patient staff have potentially moved into these areas. The Trust needs to understand the impact and consider its position and response to ensure we are not adversely affected.

We are working with Princes’ Trust to recruit young people who have no healthcare experience but display values and behaviours we would want to see. To date we have recruited 11 candidates into various roles across the trust.

Two national workforce staffing assurance papers were considered at Workforce SLG in December, ‘NHSE Winter 2021 Preparedness: Nursing Safer Staffing’ and Royal College of Nursing (2021) Nursing workforce standards: supporting a safe and effective nursing workforce. The papers presented an analysis on actions the Trust has taken to focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing during winter pressures.

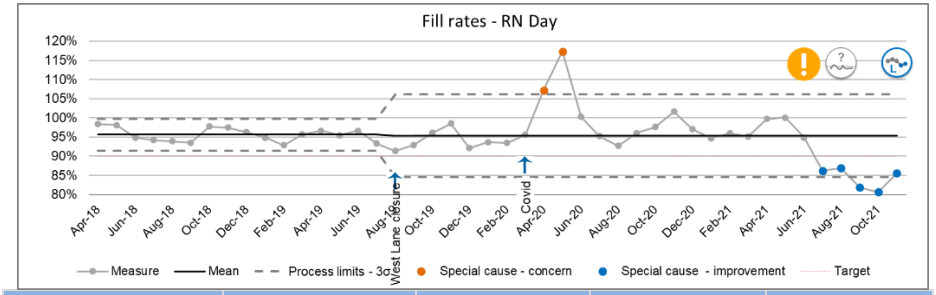
QUAC further considered the Winter Preparedness 2021 Nursing Safer Staffing and felt the work undertaken was comprehensive. Further work is be undertaken to complete the risk scoring.
Areas that have been identified as requiring additional review and development are set out as follows:

- staff well-being and the impact of strategies to support staff
- length of shift patterns and impact on staff well-being
- ongoing review of Business Continuity Plans and arrangements
- Additionally, the RCN workforce standards gap analysis identified ensuring time for nurse leadership, clinical supervision and development and the need to continually support the reporting of discriminatory behaviour.

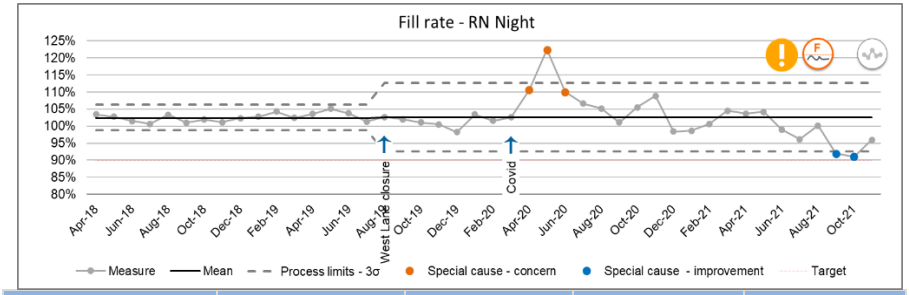
Oversight of these areas will be through the Workforce Senior Leadership Group.

Right Place and Right Time

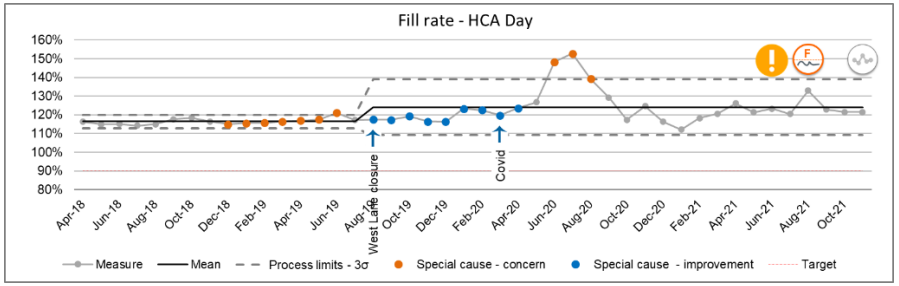
Staffing Fill Rates



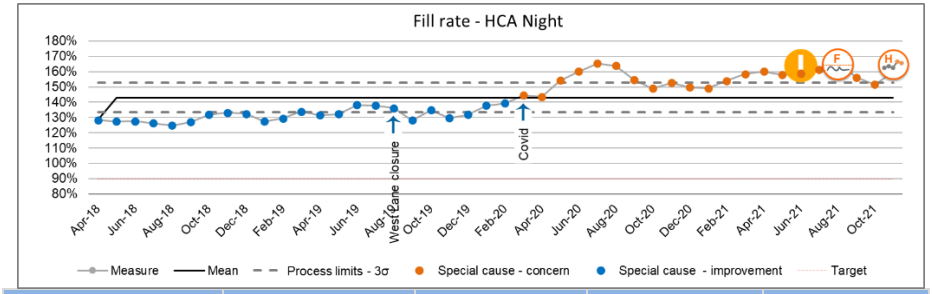
Level	Durham & Darlington	Secure Inpatient Services	North Yorkshire & York	Teesside
Variation	L	L	L	L
Assurance	?	?	?	F



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



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



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

Right Place and Right Time Continued…

Analysis (so what)

- The SPC charts at Trust Level are reporting low levels of RNs on Days and Nights, despite showing a slightly improved picture for November 2021. A registered nurse has always been available to take charge of each ward.
- HCA on Days and Nights indicate high levels of staffing on the ward, for Night shifts in particular. This would support achieving the required safe staffing numbers to meet patient need.
- At locality level, North Yorkshire and York showed low levels of staffing fill rates for day shifts - this was particularly related to Esk Ward.
- There is occasion where there is a reduction in the ratio of the planned skill mix of registered to non-registered nursing staff. This limits the ability to provide high quality interventions to the patient from a registered nursing perspective.
- Across the reporting period, Secure Inpatient Services have the greatest number of occurrences where fill rates for registered nurses were below 90%.
- The wards with the lowest average fill rates were Jay Ward (SIS); Thistle Ward (SIS) and Westerdale South (Organic older persons ward).
- The wards with the highest average fill rates were the two PICUs, Bedale Ward, and Cedar Ward Tunstall Ward (Acute adult mental health).

Key Learning and how we are using this

- This metric supports the understanding of whether the planned (budgeted) staffing levels are being met. It can also provide, alongside other metrics, an indication of where staffing resources are required above the budgeted establishment. The Trust continues to struggle to meet the planned skill mix of RNs to HCAs, contributing factors include: sickness absence, vacancies and national recruitment issues to registered nursing posts.

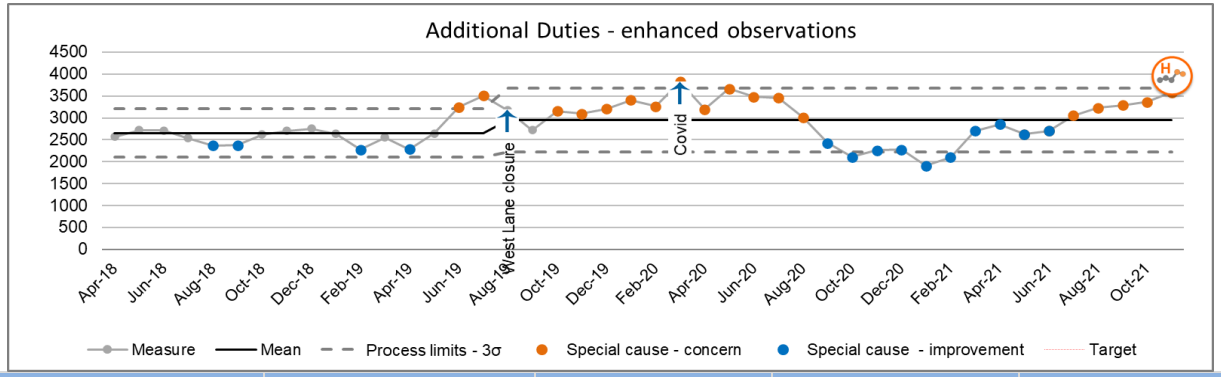
Actions we are taking (now what)

- Business continuity arrangements at the time of the report were in place. In Secure Inpatient Services wards were collapsed (4 in total), Bankfields Court, NYY Perinatal Team, D&D Crisis Team, Baysdale, Teesside Liaison North and Teesside Liaison South. Consequently, additional staffing resources were prioritised to meet the demand, this included ward managers working clinically and AHPs were basing themselves in the clinical areas as necessary. Staffing was monitored in the daily staffing huddles with an oversight of rostering practices and ongoing patient need to ensure safe patient care. NYY have had significant staffing pressures across the community and inpatient services. The staffing of these services and escalation of risks are overseen through gold command on a weekly basis. Esk ward (acute mental health Scarborough) temporarily closed October 2021 as result of extreme staffing pressures. A review will take place February 2022.
- Establishment setting work, as part of the 6 monthly review cycle, continues for all clinical teams and services, which also considers skill mix ratios alongside required budgeted establishment figures, this will report to the board March 2022.
- Funding for staffing posts provided early 2021 to improve skill mix and quality of care in the AMH and SIS service areas have mostly been recruited to. There are 15 clinical lead posts vacant. Due to difficulty in recruiting to clinical lead posts alternative options of clinical leadership are been explored.
- There are 7 activity coordinator posts still not recruited to in SIS we are working with the 3rd sector to support recruitment.

- 5 of the activity coordinator posts in AMH are now vacant due to staff moving on so they are linking in with SIS to recruit.
- Work continues on how we capture the essential contribution of the centralised MDT team staff to better understand the skill mix figures from the roster. Following a successful demonstration, we are looking at the potential of a software solution to support this.
- Approval has been given to over-recruit to HCA posts, with the initial aim to reduce the HCA agency usage to zero. This also aligns with the national initiative for zero vacancies for HCAs. Recruitment is underway, and this is will be a ongoing process.
- The staffing escalation process is under review to align it to Safecare. The heads of nursing continue to have oversight of escalations and associated actions taken.

Right Place and Right Time Continued…

Additional Duties



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

Analysis (so what)

- This measure is looking at the number of additional duties that have been created over and above the budgeted establishment with a "reason for request" code of *'enhanced observations', 'business continuity', 'seclusion', 'high acuity'* and *'escort of a patient'*.
- The number of trust wide additional duties created in line with the increased fill rates for HCA linked to enhanced observations, business continuity, seclusion, high acuity, and escort of a patient a month over the 6-month period continues to remain significantly high across the Trust.
- The highest creators of additional duties over the previous six months were: Bankfields Court (Learning Disability Teesside), Kestrel/Kite (Forensic LD, Secure Inpatient Services) and Birch Ward (Eating Disorder ward Durham & Darlington).
- Secure Inpatient Services requested a large number of additional shifts which were not all filled. Safe staffing team continue to support rostering best practice.

Key Learning and how we are using this

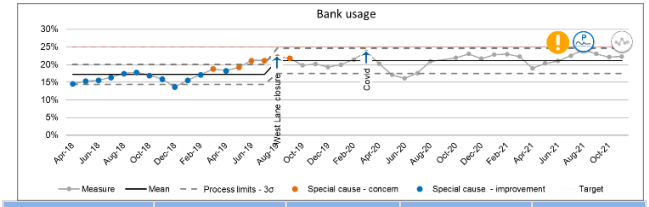
- Additional staffing requirements in SIS is reflective of the known staffing challenges, however there is a misalignment regarding the wards where shifts are actually allocated too. This is being addressed through rostering oversight work by the safe staffing team.
- Bankfields Court have seen a number of complex patients during this period, and it is expected that additional staffing requirements would be needed to support care and to meet patient safety and need.
- Birch ward report additional duties are required to support the well-being of patients at mealtimes.

Actions we are taking (now what)

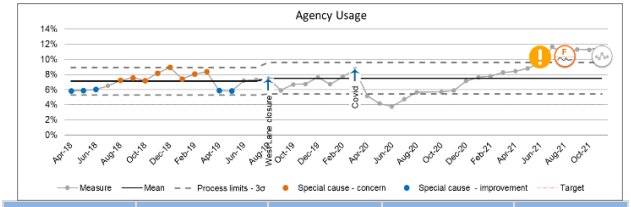
- At the end of the reporting period SIS, Baysdale and Bankfields Court were in BCP arrangements to ensure effective oversight and monitoring of staffing. They have a minimum of a daily review of staffing across the site and re-allocation of staff to meet patient need. This includes ward managers, matrons, and clinical leads been in the staffing numbers the use of senior staff and MDT colleagues to ensure patient safety and support activities and breaks on the wards.
- Non-essential meetings are postponed ensuring the focus of all is on the front-line delivery of clinical care.
- Ongoing roster awareness training continues to be supported regarding best practice and ensure effective rostering.
- Gold command continues to ensure senior leadership is available to support complex decision making and to have an oversight and assurance of patient safety and quality particularly those areas in BCP, monitoring and overseeing staffing at a trust level.
- The use of additional duties provides further insight into those areas that require staffing above their planned and budgeted establishment, which is triangulated with other workforce data to highlight increased staffing requirements.

Right Place and Right Time Continued…

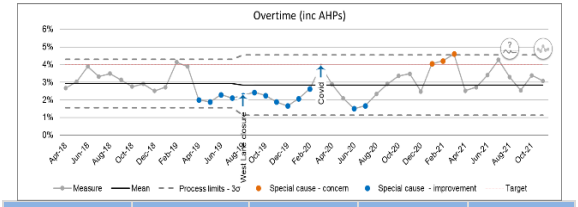
Bank, Agency and Overtime Usage



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



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



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

Analysis (so what)

- The SPC charts for Bank demonstrate a plateauing of its ability to fulfil the number of requests placed. The Banks Staff roster demonstrates a continued increase of temporary staffing requests which are not filled by bank due to its resource being fully utilised, and this is reflected by the increase in agency fulfilment as shown above - there is however a growing number of unfilled temporary staffing requests. Overtime shows to be variable across this period, with no specific trend.
- The highest users of bank as a proportion of the actual hours worked (over 25% usage) were Kingfisher Ward (39.5%), Kestrel/Kite (37.6%) and Jay Ward (37.6%), all of which related to Secure Inpatient Services. Kingfisher ward has a single occupancy placement package in place that utilises bank to deliver this.
- The highest users of agency as a proportion of the actual hours worked (over 4%) were Wold View (37.1%)(organic older person ward); Bransdale (31.8%)(Acute Mental Health) and Ebor Ward (25.1%) (Acute Mental Health). All these wards report vacancies and clinical acuity as the reason for agency use.
- The highest users of Overtime (over 4%) of the actual hours worked related to Harrier/Hawk (13%) (SIS); Bek/Ramsey/Talbot (12.3%) (Adult Learning Disability) and Holly (11.6%) (Individual Care package). Teesside are using the most overtime (13,106 hours) whilst North Yorkshire & York are using the least (8,697 hours).
- There is a noticeable higher use of agency in the North Yorkshire and York locality, it is recognised that this impacted on by the ability to recruit generally in that area as well as the limited availability of bank staff.

Key Learning and how we are using this

- Contributing factors to increased usage of temporary and flexible staffing include back filling for sickness absence and vacancy in addition to increased levels of staffing required to support patient acuity and need in maintaining patient safety.
- Information relating use of bank agency and overtime is used to support and inform the staffing establishment review process in the understanding of staffing levels.
- SIS use a small number of wards to request additional staffing and will redeploy to other areas as required which may impact upon the figures demonstrated in this service area.
- There are well documented risks around high use of temporary staffing. The Trust, wherever possible, attempts to mitigate these risks by the use of regular bank and agency staff who are familiar and know the clinical areas they are working in.

Actions we are taking (now what)

- The localities continually review the use of bank and agency usage as part of their ongoing roster management and any concerns are escalated through to their daily huddles and to their governance groups.
- The model of over recruitment of permanent staff is underway in SIS first, to be followed by PICU and adult learning disability.
- The ability to buy back annual leave remains in place to enable as many staff as possible to consider this as an option to support staffing.
- Nursing and Governance staff are working collaboratively with operational services supporting with substantive staff interviews.
- Ongoing discussions with Bank staff re availability over holiday periods to understand their availability to support staffing
- Staff who were appointed on a fixed term contract were offered a permanent contract.
- Staffing establishment reviews continue to analyse planned and budgeted staffing levels to meet patient need to support the reduction the demand on temporary staffing services, and recommendations are made to the Trust Board regarding staffing establishments.
- Supporting staff to use best practice and efficient rostering to ensure that the budgeted establishments effectively utilised.
- The aim to reduce the number of substantive vacancies and reduce the requirement upon temporary staffing. In order to support substantive recruitment, for the interim, member of the temporary staffing team have been redirected from bank staff recruitment to support processing of substantive vacancies. This situation remains under regular review.

Patient Outcomes, People Productivity and Financial Sustainability
Triangulation with Quality Indicators

Quality Indicator				Ward Name	Bank Usage	Agency Usage	RN Days	RN Nights	HCA Days	HCA Nights
SI's	L4	L3	Complaints							
3	3	0	1	Westerdale North	18.60%	11.5%	105.3%	110.8%	123.6%	154.3%
1	2	3	6	Esk Ward	14.30%	5.0%	54.6%	96.4%	190.4%	133.4%
1	1	1	1	Bransdale Ward	29.7%	30.1%	76.6%	99.5%	205.5%	254.0%
1	0	3	3	Cedar Ward	29.7%	22.8%	86.7%	87.4%	309.9%	255.9%
1	0	0	4	Farnham Ward	29.8%	16.8%	93.1%	103.0%	196.5%	243.8%
1	1	0	2	Mandarin	23.2%	4.6%	92.3%	103.1%	125.6%	135.6%
1	0	0	2	Newtondale Ward	17.3%	3.2%	78.6%	64.8%	84.2%	126.9%
1	0	0	0	Oak Ward	14.9%	9.3%	98.0%	99.1%	127.0%	138.6%
1	1	0	1	Roseberry Wards	19.2%	0.9%	99.7%	97.8%	115.1%	103.7%
1	1	1	1	Stockdale Ward	39.1%	14.3%	96.0%	90.7%	192.7%	205.2%
1	1	0	0	Thistle	25.1%	6.6%	39.2%	63.3%	56.8%	65.4%
1	1	0	0	Westerdale South	15.0%	13.0%	89.2%	58.2%	89.8%	142.5%
1	1	0	1	Wold View	14.9%	37.5%	82.1%	74.4%	121.8%	200.1%
0	1	0	0	Bilsdale Ward	25.2%	12.6%	76.8%	94.0%	173.3%	211.0%
0	0	1	1	Bedale	34.6%	19.1%	72.4%	83.5%	226.9%	340.5%
0	0	1	0	Birch	36.4%	7.9%	98.6%	102.8%	276.2%	221.0%
0	0	1	0	Bransdale Ward	29.7%	30.1%	76.6%	99.5%	205.5%	254.0%
0	0	3	2	Ebor Ward	22.8%	31.5%	96.7%	157.4%	121.1%	222.7%
0	0	1	0	Elm	28.3%	15.5%	96.6%	107.2%	157.9%	194.8%
0	0	1	1	Maple	26.6%	11.0%	88.0%	102.9%	196.1%	195.2%
0	0	1	1	Moor Croft	9.3%	22.7%	99.7%	99.4%	131.1%	218.0%
0	0	6	1	Overdale	28.1%	24.5%	88.2%	95.8%	204.3%	232.6%
0	0	1	0	Primrose Lodge	21.6%	3.3%	93.8%	99.5%	114.3%	108.8%
0	0	1	0	Rowan Lea	24.7%	7.4%	81.8%	99.7%	193.3%	160.2%
0	0	4	1	Swift	28.0%	4.1%	81.5%	102.9%	106.1%	161.6%
0	0	3	2	Tunstall	28.4%	23.6%	95.1%	100.2%	269.4%	332.8%
0	0	0	1	Danby Ward	20.4%	2.7%	78.2%	97.7%	182.3%	156.9%
0	0	0	2	Brambling	37.9%	4.1%	74.6%	100.7%	138.7%	132.3%
0	0	0	1	Harrier/Hawk	18.9%	5.0%	19.7%	23.5%	21.9%	31.8%
0	0	0	1	Kestrel/kite	32.94%	3.3%	95.3%	113.3%	189.5%	258.1%
0	0	0	1	Lustrum Vale	24.0%	1.2%	97.7%	101.7%	94.6%	99.2%
0	0	0	4	Northdale	27.6%	2.1%	79.7%	104.6%	84.5%	106.9%

Analysis (so what)

This section explores all serious incidents, severe harm incidents (L4); self-harm incidents of moderate harm (L3) and all complaints raised within the 6-month reporting period.

The Patient Safety investigation team have been asked to specifically consider staffing levels and skill mix in relation to their investigation of inpatient SI's to support more robust triangulation of staffing data and aid root cause analysis. From an inpatient perspective there were none reported, however following review of those cases examined at Directors Panel during the reporting period, there were 4 cases that identified staffing / skill mix as a potential lapse in care from community based teams reported as being linked to high caseloads, staffing levels/numbers resulting in issues with continuity of care and achieving KPI targets.

- None of the complaints raised cited issues with staffing levels or skill mix.
- Although it is highlighted that the majority of inpatient areas have high use of bank and agency use, it is difficult to identify any direct correlations from the data shown above between incidents and complaints against the fill rates and temporary staffing usage although it is noted that of the 32 wards shown as having a complaint or incident recorded (Level 3 and above) that 56% of these showed to have low RN fill rates on day shifts. It is recognised that lower numbers of registered nurses will impact on a positive patient experience and potentially on the quality of care.

Key Learning

- It is recognised that complaints are not always raised formally within in-patient services, and that this may account for low numbers in complaints, and that the formal categorisation may not capture availability of staff, however anecdotally during senior staff visits to wards areas, e.g. SIS, it was heard directly from patient's that ward leaves could not always be undertaken as planned due to staffing levels which caused distress for patients and staff.
- The FFT scores under 'patients feeling safe' also provides information that especially during times of high acuity on Acute inpatient wards that our service users do not always feel staff are as available as they would wish them to be.

Actions we are taking (now what)

- Wider themes relating to serious incidents and complaint data are analysed further through the monthly Quality Assurance and Improvement Sub Group along with any actions needed for further investigation.
- The staffing skill mix continues to be reviewed in the staffing review analysis.
- Analysis and triangulation take place within the localities to identify themes or areas of learning that need to be actioned key risk and actions to are then reported to QUAC for assurance.
- SIS are reviewing how they facilitate leave and activities by the extension of a peripatetic team so that wards can be supported to ensure these essential activities for patients take place.

Patient Outcomes, People Productivity and Financial Sustainability Continued…

Triangulation - Safe Indicators

Quality Indicator			Ward Name	Bank Usage	Agency Usage	Actual Staff Rostered			
Falls with Harm	Pressure Ulcers	Medication Errors				RN Days	RN Nights	HCA Days	HCA Nights
1	0	16	Westerdale North	18.57%	11.53%	105.3%	110.8%	123.6%	154.3%
1	0	5	Westerdale South	14.99%	13.05%	89.2%	58.2%	89.8%	142.5%
1	3	18	Wold View	14.93%	37.50%	37.5%	74.4%	121.8%	200.1%
0	1	2	Ceddesfeld Ward	16.10%	4.50%	97.0%	101.1%	133.0%	176.6%
0	1	7	Hamsterley Ward	11.20%	4.40%	97.6%	101.1%	140.5%	172.7%
0	1	5	Moor Croft	9.30%	22.70%	99.7%	99.4%	131.1%	218.0%
0	1	4	Oak Ward	14.90%	9.30%	98.0%	99.1%	127.0%	138.6%
0	1	2	Roseberry Wards	19.20%	0.90%	99.7%	97.8%	115.1%	103.7%
0	1	8	Rowan Lea	24.70%	7.40%	81.8%	99.7%	193.3%	160.2%
0	1	13	Stockdale Ward	39.10%	14.30%	96.0%	90.7%	192.7%	205.2%
0	0	12	Bilsdale	25.20%	12.60%	76.8%	94.0%	173.3%	211.0%
0	0	11	Ebor	22.80%	31.50%	96.7%	157.4%	121.1%	222.7%
0	0	22	Elm	28.30%	15.50%	96.6%	107.2%	157.9%	194.8%
0	0	14	Farnham	29.80%	16.80%	93.1%	103.0%	196.5%	243.8%
0	0	14	Mandarin	23.20%	4.60%	92.3%	103.1%	125.6%	135.6%
0	0	12	Northdale	27.60%	2.10%	79.7%	104.6%	84.5%	106.9%
0	0	12	Springwood	19.20%	21.50%	73.7%	105.9%	193.4%	227.7%

Analysis (so what)

- There were 3 incidents, compared to 1 in the last report, recorded as a fall that resulted in significant harm within inpatient services. All of the falls occurred within older people's service.
- There were 10 incidents reported in relation to pressure ulcers. Again, the majority of these occurred within older people's service.
- There were 387 incidents of medication errors reporting within the reporting period across 58 wards. The top 10 wards for medication errors are listed within the data set above.

Key Learning and how we are using this

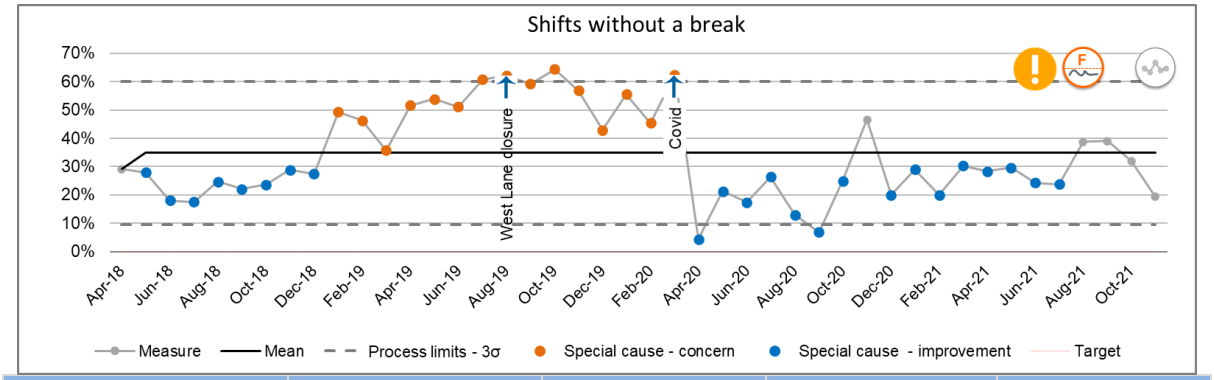
- Following a recent SI for a pressure ulcer the learning from this identified the need to implement training on pressure ulcer prevention and how to complete the Waterlow Pressure Ulcer Risk Assessment. To support this, the trust in-house Tissue Viability Service have produced a pressure ulcer equipment protocol and a wound infection algorithm to help staff to identify when to order pressure relieving equipment and how to manage wound infections/suspected wound infections.
- Analysis of medication incidents indicated areas that needed actions putting in place, which included wrong patient administration errors, and administration of the wrong drug due to similar drug names causing confusion.
- Pharmacy are working with clinical services to implement different ways of working in relation to above areas.

Actions we are taking (now what)

- Commencing the introduction of photographic identification of patients onto prescription and administration records on admission as the first-choice option with wristband identification being the second-choice option has been made. The use of photographs on prescription charts has been made a mandatory process across all MHSOP wards from 17/01/2022 and will also go live in adult services in Feb 2022
- Tallman lettering has been introduced successfully and we are continuing to add to our catalogue of drugs we are using this lettering on. We have shared this work regionally as it is recognised there is no standardised list of agreed lettering. A meeting scheduled for September 2021 was cancelled due to workload pressures, with a new date yet to be set, so there is no list regionally available at this time. It is reported however that has been an improvement regarding the number of DATIX reports for drugs being mixed up.
- The Tissue Viability Service have delivered numerous bespoke pressure ulcer prevention and management training throughout the year and the tissue viability training programme, Wound Resource Education Nurse (WREN), has restarted in January 2022, which has been well attended.
- The Tissue Viability Service is currently undertaken an SI for a pressure ulcer and some of the learning identified has already been shared as above.

Patient Outcomes, People Productivity and Financial Sustainability Continued…

Breaks not Taken



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

Analysis (so what)

- The top 6 wards were Elm Ward (127 shifts) (Adult mental Health); Cedar Ward (119 shifts) (PICU); Kestrel/Kite (108 shifts) (SIS); Swift Ward (106 shifts) (SIS); Springwood (102 shifts) (Organic older people) and Clover/Ivy (102 shifts) (SIS).
- The majority of shifts where breaks were not taken occurred on day shifts and are reported by the services as being due to periods of high clinical activity or staffing shortfalls to meet demand.
- There are a range of potential considerations with regard to the drop in the missed break figures since COVID which will need to be further explored, one such example such as “are staff too busy to accurately record missed breaks”.

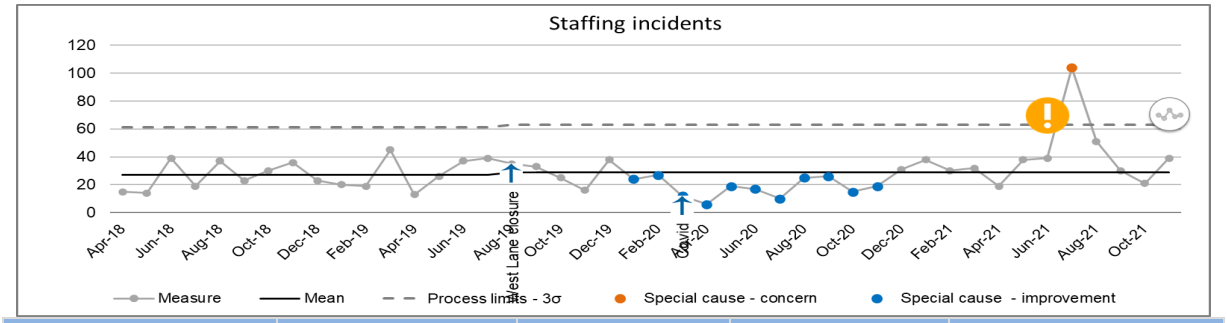
Key Learning and how we are using this

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

Actions we are taking (now what)

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

Reporting, Investigating and Acting on Incidents Citing Staffing Levels



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

Analysis (so what)

- The SPC Charts are reporting this measure within a normal variation at trust level. At locality level Teesside are reporting a cause for concern whilst the other localities are reporting within a normal variation.
- There were 285 incidents raised citing issues with staffing. This is an increase of 1 when compared to the previous 6-month report.
- 28% (80) of all staffing incidents reported involved the Forensic Services followed by 26% (74) involving the wards at Durham & Darlington.
- 204 incidents were reported for inpatient areas whilst there were 76 reported involving community services and 7 from Corporate Services.
- Themes include – staff vacancies, skill mix, long term and short-term sickness, isolation and quarantine, continuity of staff, high acuity, temporary staffing, capacity to meet demand, enhanced observations, need provide cover to inpatient areas, patient leave and activities cancelled, quality of services, and breaks not taken.
- The peak of reporting seen in August correlates to the Trust highlighting the importance of using Datix to escalate risks associated with staffing issues.
- The incidents raised in SIS were reported retrospectively due to staff not always escalating staffing concerns through Datix which was highlighted by the CQC during their inspection in September 2021.

Key Learning and how we are using this

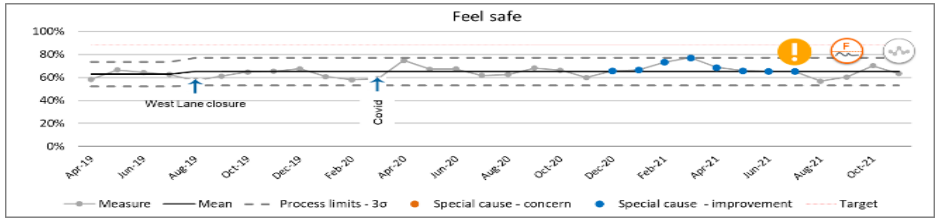
- Following the introduction of Safecare (September 2021) and the red flag system in within it, there may be the potential that for inpatient services we have seen a reduction in the number of Datix reports due to the increased utilisation of the red flag system in Safecare instead which is used to highlight and mitigate risks.

Actions we are taking (now what)

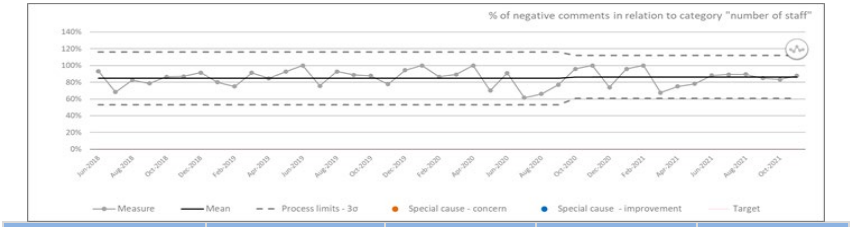
- The establishment review process has seen significant investment in 2021; the identified posts have mostly been recruited to for the identified areas of AMH and PICUs, and SIS, only the skill mix uplift for AMH wards requiring approval of the updated plan/request to use these funds for night shift duties instead of day shift to support having sufficient staff.
- The escalation procedure is under review and will consider how Safecare Red Flags will be used to support escalation reporting and intended mitigation; this will also consider the Trust position on Datix reports for this type of incident as proposed by QUAC.
- Gold command remains in place to have an oversight and provide assurance of safe staffing.
- The message to encourage staff to report staffing issues using Datix continues through the re circulation and education of the staffing escalation protocol by local services and through the appropriate forums.

Patient, Staff and Carer Feedback

Patient and Carer Feedback



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



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

Analysis (so what)

- Comments received from our patient experience surveys that the availability of staffing was a concern. Patients suggested that staff are very busy and are not always able to support activities and leave. Patients commented on continuity of care if regular staff are not available. An example of the comments received by patients included *"more staff, volunteers, funding, one to ones, communication, listening skills, more outside space, TVs in bedrooms so it feels more homely, and continuity of care".*
- Patients were very complimentary of the actual care interactions with nursing staff.
- The SPC chart at trust and locality level in relation to feeling safe is reporting this metric within a normal variation; however, the target of 88% consistently fails to be achieved. The reasons given by the patients were "*having witnessed incidents, other patients, unfamiliar surroundings, understaffed, unpredictability of the ward, not feeling listened to, and due to own Mental Health".*

Key Learning and how we are using this

- Feedback is shared at Special Interest Groups, such as "A Great Place to Work", and the Trust Workforce sub-group of SLG to support future strategic planning regarding staffing and workforce.
- Feedback and comments are fed into the patient experience and quality assurance forums
- Triangulation in workforce planning and establishment reviews.
- Work has been undertaken to improve liaison with the Police, this work is becoming embedded as business as usual.

Actions we are taking (now what)

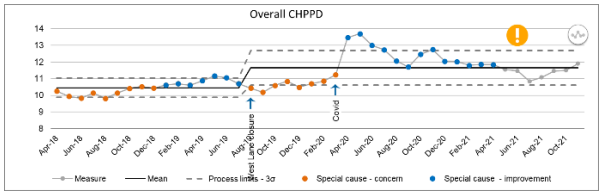
- This feedback informed and informs staffing establishment setting exercises
- Feeling safe has been identified as a priority within the Trust's Quality Account. A range of work is being undertaken to address these concerns where this is possible across localities. During 2021/22 we aim to:
  - Work proactively within the newly formed Regional Patient Experience network maximising opportunities for benchmarking patient experience data.
  - Seek ideas as part of the 'mutual help' meetings that take place on the wards on what we can do to make patients feel safe. Review current 'ward orientation' process for patients being admitted onto our wards and incorporate into personal safety plans.
  - Continue the existing pilot of body cameras to a further 6 wards and an additional 60 cameras with a benefits realisation planned for Spring 2022.
- The Medical Director continues to lead the improvement work with the national network work regarding sexual safety. Consideration is been given to the configuration of the PICU's.

Patient, Staff and Carer Feedback Continued…

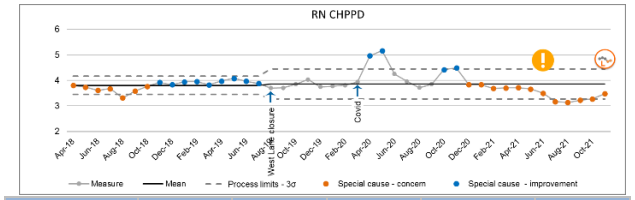
Staff Experience – in our shoes

Staff from Adult Learning Disabilities were asked to share their experience of working in the D&D Locality and how involved they felt:

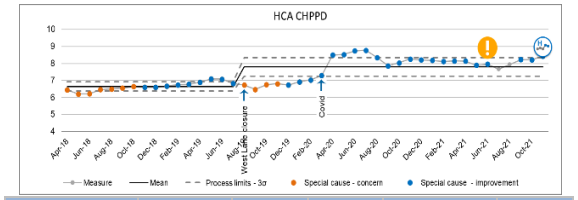
Care Hours per Patient Day (CHPPD)



Level	AMH	CYP	LD	MHSOP	SIS
Variation			H	L	



Level	AMH	CYP	LD	MHSOP	SIS
Variation	L		H	L	



Level	AMH	CYP	LD	MHSOP	SIS
Variation	H		H	L	H

Analysis (so what)

- This metric tracks the total number of direct care hours against the number of patients on the ward at midnight. The Trust average CHPPD across all inpatient areas was 11.63 (11.1 nursing (RN and HCA); 2.6 nursing associates; 0.2 AHP).
- There is no significant change to the care hours from previous reports.
- It is noted that the overall skill mix ratio for RNs to HCA is significantly low for RNs when compared to HCAs.

Key Learning and how we are using this

- Further reports will review at a more granular detail as suggested by NHSE/I in order to highlight any potential specific areas of concern.

Actions we are taking (now what)

- This information is incorporated into establishment review reports for all inpatient services to support triangulation for increasing staffing and skill mix establishments.
- Local TEWV dashboard is available on IIC for CHPPD so teams can understand how best to deliver care within their resource available. The fill rates are monitored locally on a monthly basis and reported to NHSE as per national requirements
- Benchmarking against peer and national Trusts using Model Hospital
- Benchmarking against local wards of same speciality / sub-speciality
- Variation between wards within a speciality needs to be reviewed at a more granular level.
- On -going recruitment of registered nurses.

Appendix 1

SPC symbols

Variation:

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

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

Special cause – improvement
(indicator where high is good)

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

Common cause variation

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

Assurance:

Consistently hit target

Hit and miss target randomly

Consistently miss target

Item No 18

Board of Directors

The following report is due to be considered at the meeting of the People, Culture and Diversity Committee, to be held on 27th January 2022. It is reproduced to enable the Board to consider any matters and related recommendations arising from that meeting.

DATE:	**27 January 2022**
TITLE:	**To consider the Equality Delivery System 2 as required by NHS England**
REPORT OF:	**Sarah Dexter- Smith, Director of People and Culture**
REPORT FOR:	**Review and Approval**

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

Executive Summary:

The Equality Delivery System 2 (EDS2) is a self-assessment tool developed by NHSE which enables NHS trusts to comply with the Public Sector Equality Duty and promote equality for all in service delivery and employment, in line with the requirements of the Equality Act 2010. It is mandated by the NHS contract.

The Trust's EDS2 self-assessment for services is attached at Appendix 1. The self-assessment relating to staff was completed in 2020. QUAC are asked to review, comment, and approve the Trust grades which have been subject to consultation and review. Following approval, the EDS2 will be published on the Trust website

The EDS2 summary report provides self-assessed insight into areas of good practice and areas that require improvement across the 9 outcomes that relate to the Trust as a provider of services. The Trust position across the 9 outcomes has proved varied – meaning that our evidence suggests that service users from some but not all the protected groups fare as well as people overall.

The process has highlighted the need for greater access to complete data collected and broken down by protected characteristics. In some instances, it has not been possible to identify inequalities in experience and outcomes for service users within protected groups compared to those in non-protected groups due to the lack of data available. The assessment has therefore been based on the evidence, consultation feedback and data that was available at this time

The information highlights that some disparities exist for service users within protected groups compared to those in non-protected groups and efforts to address

these differences must continue.

Recommendations:

The People, Culture and Diversity Committee is asked to:

- note the contents of the report and to comment accordingly
- Recommend that the Board: approve and ratify the Trust's EDS2 (2021) report regarding service provision, prior to publication on the Trust's website
- note the differences in outcomes and experiences for service users from protected groups outlined in the attached document.
- recommend that more data on the outcomes and experiences of service users is analysed by protected groups so that corporate and clinical services can better understand and address the differences experienced by some of these groups.

MEETING OF:	**Board of Directors**
DATE:	**27th January 2022**
TITLE:	**To consider the Equality Delivery System 2 as required by NHS England – Service section only to comply with the public sector duty under the Equality Act**

1.0 INTRODUCTION & PURPOSE:

1.1 The Trust has been required to complete the EDS since July 2011 after it was commissioned by the National Equality and Diversity Council in 2010

1.2 The purpose of this report is to provide the committee with the updated EDS2 (2021) information on services for review and ratification prior to publication on the Trust's website. This will also support the Trust's compliance with its Equality Act duties.

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The EDS is a toolkit and framework for NHS organisations to self-assess their performance in regard to equality, diversity, and human rights. It identifies areas of good practice as well as areas for improvement.

2.2 The Trust is required to grade itself against 18 outcomes and to have those gradings agreed through public consultation. This paper relates to outcomes 1 and 2 relate to service delivery. Outcomes 3 and 4 relate to staff experience and were reviewed in 2020.

2.3 The Trust is required to publish the EDS2 (2021) following consultation and ratification by the People Culture and Diversity Committee on the 27.1.22.

2.4 Of the 18 outcomes of the EDS2 only the 9 outcomes that relate to the Trust as a service provider have undergone self-assessment as the staff outcomes were self-assessed previously in 2020. There are four grades used to assess the experiences and outcomes for service users who have a protected characteristic compared to service users overall. The measurements are as follows; 'Undeveloped – No Evidence or 2 or less protected characteristics', 'Developing – 3 to 5 protected characteristics', 'Achieving – 6 to 8 protected characteristics' and 'Excelling – all 9 protected characteristics.

3.0 KEY ISSUES:

3.1 The previous EDS2 was completed in 2018.

3.1.1 The self-assessment carried out in 2021 has resulted in all outcomes being graded lower than the EDS2 carried out in 2018. This is based on the data available, consultation and feedback received

3.1.3 6 Of the 9 outcomes 6 were graded as 'Developing' within the self-assessment and 3 as 'Achieving'.

3.2 Good progress has been made in the following areas:

- Training staff in LGBTQ+ awareness 386 staff have been trained and the training has been positively evaluated.
- Feedback from the majority of BAME service users in the patient Friends and Family survey have a very good or good experience.
- Feedback about the support the dementia hubs offer to older people is very positive

3.3 It has been difficult to find data on all protected characteristics which aligns to the service provision outcomes in EDS2

3.4 Feedback from Tees Valley Healthwatch Network – Darlington, Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton on Tees from a survey co-designed with the Trust into people's experiences of accessing mental health and well-being services. is that:

- Participants let us know that they felt waiting times for appointments was too long including initial GP appointments and referrals. It is crucial for people get the help and support they need when they need it.

- Service users mention accessibility is a major factor, so whatever support is available it should be easy to access and available at different times of the day (not just during work hours). Shorter waiting times were regularly mentioned.

- Of the 39% who felt they had not been helped by the support offered, long waiting times, lack of appointments, unwanted medication solutions, and unhelpful services were quoted as the most likely cause of dissatisfaction

- The LGBT community were concerned about long waiting lists, help was often needed urgently and waiting often exacerbated the issue.

- Throughout the report, one of the common themes, which were cited by members of the public within the Tees Valley region as the most important factors for an enhanced mental health community-based offer included shorter waiting lists.

3.2. This report describes where the outcomes and experience of service users who access services in TEWV from some protected groups are less than service users who do not share those protected characteristics. Actions to address these issues are detailed in the Equality, Diversity and Human Rights Strategy.

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 with regards to EDS2 and its public sector equality duties

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. The EDS2 supports the trust in meeting its duties under the Public Sector Equality Duty.

4.3 **Legal and Constitutional (including the NHS Constitution).**
The Trust is required to publish information demonstrating its compliance with the public sector duties of the Equality Act 2010. The EDS2 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 and contractual equality requirements. Failure to do so may result in legal action and subsequent financial penalties and damage to the Trust's reputation.

4.5 **Other implications:**
None have been identified.

5.0 RISKS:

5.1 There is a risk of reputational damage if TEWV does not work to improve the experience and outcomes of service users with protected characteristics.

6.0 CONCLUSIONS:

6.1 The EDS2 (2021) shows a decrease in grades in all of the 9 outcomes when compared to the EDS2 of (2018). Grading has been based on a wider range of sources than those used in previous years.

6.2 The Trust position across the 9 outcomes has proved to be varied – meaning that our evidence suggests that service users from some but not all the protected groups fare as well as people overall.

6.3 The Trust needs to develop reliable patient data which aligns with the outcomes of the EDS to ensure that the self-assessment that takes place in 2024 is based on reliable data

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

6.5 The Trust needs to understand the differences in experience and outcome for its service users and to act where necessary to lessen the disparities.

7.0 RECOMMENDATIONS:

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

7.2 To recommend to the Board the approval and ratification of the Trust's 2020/2021 EDS2 prior to publication.

7.3 The People Culture and Diversity Committee is asked to note the differences in outcomes and experiences for service users from protected groups outlined in the attached document.

7.4 To recommend that more data on the outcomes and experiences of service users is analysed by protected groups so that corporate and clinical services can better understand and address the differences experienced by some of these groups.

Sarah Dexter - Smith, Director of People and Culture
Abigail Holder, Helen Cooke and Lisa Cole EDHR Officers
Sarah Dallal EDHR lead

APPENDIX 1.

EQUALITY DELIVERY SYSTEM FOR THE NHS
ED2S SUMMARY REPORT

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the 9 steps for EDS2 Implementation as outlined in the 2013 EDS2 guidance document. The document can be found at: http/www.england/nhs.uk/wp-content/uploads/2013/11eds-nov131.pdf.

The EDS2 Summary Report is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS Organisation name:		Tees, Esk and Wear NHS Foundation Trust
Organisation's Board lead for EDS2:		Sarah Dexter-Smith Director of People and Culture
Organisation's EDS2 lead (name/email):		Sarah Dallal, Equality and Diversity Lead. Email: sarahdallal@nhs.net
Level of stakeholder involvement in EDS2 grading and subsequent actions:		The Trust invited members of Health Watch and Patient and Public involvement
Organisation's Equality Objectives (including duration period):		
The Equality Diversity and Human Rights Strategy (2020 - 2023) have set the following objectives in relation to service development and patient care: Ensure we have a suitably trained and skilled workforce to address the needs of Trans patients and staff We will achieve this by: The EDHR team will develop and deliver a range of training for staff to improve the understanding of Trans equality issues, improve		

confidence and improve patient experience by Q4, 19/20.

The Organisational Development team will embed Trans training into leadership and management programmes for staff by Q1, 20/21.

The EDHR team will develop guidance for staff supporting Trans service users including information on recording and the law regarding Trans. This will include frequently asked questions which can be readily available via the intranet with links to relevant policies by Q2, 20/21.

The HR Operations team will review relevant HR policies to ensure that the needs of Trans staff are included by Q2, 20/21

The EDHR team will engage the Diversity Engagement Group to increase awareness and focus on a communication campaign on Trans issues to raise awareness throughout the trust. A campaign will be run in Q4, 20/21 and then reviewed to see if further action is needed.

The Patient Experience team will review the demographics on patient satisfaction surveys (friends and family test) in April 2020 to identify if it is possible to develop a question that will identify Trans patients and their feedback. Outcome of this review to be gained by Q2, 20/21 to enable the capture of feedback and development of a baseline in Q4 20/21.

A review of the demographics on staff Friends and Family test and National Staff survey to identify if it is possible to develop a question that will identify Trans staff and their feedback. The outcome of this review will be available by Q4 20/21.

We will know we are achieving this by reporting and improving the:
Percentage of staff who have passed the competency test following trans awareness.
Percentage of positive responses from trans patients in the Patient Friends and Family Test.
Number of staff that have attended trans awareness training.

To Increase the recording of disability and sexual orientation on Paris (clinical record system) and ESR (Electronic Staff Record system) of patients and staff
We will achieve this by:
The EDHR team will explore with Paris/CITO teams how and where this information is recorded and which areas are mandatory for staff to complete by Q2, 20/21and look to include the recording of disability and sexual orientation as mandatory.

The EDHR team will explore with the IIC team if there are areas within the trust where the recording of patient information on Paris is lower than in other areas of the trust by Q4, 20/21

The EDHR team will consult with a variety of clinical and non-clinical teams to gain a better understanding of why staff do not record disability and sexual orientation on ESR and consult with some of the teams identified by IIC who do not record these details on PARIS. This will be completed by Q4, 20/21.
The EDHR team will look at the national research outcomes carried out by Leeds University which will look at why staff do not complete sexual orientation fields on patient records. This will be carried out during 20/21.
The EDHR team, with the involvement of the Diversity and Engagement Group, will develop a campaign which will include a review process to ensure that staff know the importance of why data is collected on ESR and PARIS. This will take place during 20/21.

We will know we are achieving this by reporting and improving the:

Percentage of patients that have their disability recorded on PARIS. A 100% increase year on year is anticipated.

Percentage of patients that have their sexual orientation recorded on PARIS. A 100% increase year on year is anticipated.

Percentage of staff that have their sexual orientation recorded on ESR. A 5% increase year on year is anticipated.

Percentage of staff that have their disability recorded on ESR. A 10% increase year on year is anticipated.

Increase the number of BAME service users who access services within the trust and report a positive experience.
We will do this by: -
The EDHR team will explore and establish a baseline with IIC of the current number of BAME service users in each locality and compare this to the population census of 2011. This will be carried out by Q4, 19/20.

The EDHR team along with locality services will develop action plans which will outline how work will take place with underrepresented BAME communities in the 4 localities across the trust. The action plans will be completed by Q1, 20/21. It is envisaged that this will include an understanding of why communities are underrepresented in mental health services, mental health promotion and to gain an understanding of what improvement need to be made. This will also lead to making sustainable links with BAME communities.

We will know we are achieving this by reporting and improving the
Percentage of BAME patients assessed by the Trust
Percentage of positive responses from BAME patients in the patient FFT

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

The Equality, Diversity and Human Rights Steering Group
The group meets every quarter to progress the Trusts Equality and Human Rights work. Members of the group include senior clinical representatives from the services, corporate service leads, service users' representatives and a designated Governor. The steering group is chaired by the Director of Human Resources and Organisational Development (HROD). The deputy chairs are the Deputy Director of HROD and the Equality, Diversity and Human Rights Lead.

EDHR Team
The Trust has a designated Equality, Diversity and Human Rights Team. The team focuses on delivering on the legislative requirements of the equality act 2010 by taking these principles and putting them into practice across TEWV services and in employment. The team also works with policy and service leads to conduct equality analyses on all new and reviewed policies - this is to ensure that the Trusts impact on equality is well considered before decisions are made.

Green Lights Initiative
The Trust has invested a considerable amount of resource into the Green Lights initiative. The initiative which comes from The Foundation for People with Learning Disabilities aims to improve mental health care for people with learning disabilities, ensuring that each person has access to appropriate care.

Forensic Services - Support for LGBTQ+ service users
Work began three years ago and looked at how Forensic Services could better engage with service users who identify as LGB&T. This work is set to continue over the next three years and includes engaging with and meeting the needs of service users who identify as trans (transgender) and non-binary looking at how the Trust can best meet the needs of LGBTQ+ people in times of distress and/or mental ill health.

British Institute of Human Rights
Delivering Compassionate Care: Connecting Human Rights to the Front-line is an exciting new initiative that was launched in 2014 by the British Institute of Human Rights, supported by the Department of Health. This project was developed in the wake of recent failures of care and seeks to place human rights at the heart of mental health services, helping to ensure front-line staff are empowered to fulfil the vital role they can play in respecting and protecting the dignity and human rights of patients. Human Rights training continues to be available for staff since the three-year project was completed. This has maintained an increased awareness across the Trust of Human Rights Principles and

Practices and how these impact on the delivery of mental health and learning disability care.

ARCH Recovery College
The Trust has an established recovery college in Durham. In York, the Discovery Hub is a TEWV service which works closely with Converge, a Recovery College hosted by York St. John University. The recovery college provides education and support for service users and their carers who want to learn more about mental health. The college is currently seeking to work in partnership with Mind to establish Recovery Colleges in Teesside and are working with voluntary sector providers in Scarborough to establish a pilot there. The Trust has established a Virtual College and has been available since November 2016.

Trust Experts by experience
The Trust works in collaboration and co-production with service users. The Experts are a group of people who have accessed or are currently accessing Trust services. Their experiences ensure that the Trust considers a wide range of viewpoints and perspectives. Trust Experts also have access to a wide range of developmental opportunities including Leadership Training and volunteering opportunities which can and has helped some Experts to secure paid employment in the Trust.

Equality Diversity and Human Rights Leads
Each locality has a designated EDHR Lead Equality and Diversity Leads who have been appointed to ensure that matters regarding health inequalities are acted on at a local level.

Interpreters and Translation Services
The Trust works closely with Everyday Language Solutions who provide interpreters and translation services to patients whose first language first English to ensure that access to information is assessable and timely.

Accessible Patient Information
All our patient information has Information Standard accreditation www.theinformationstandard.org/members this includes a plain English certification. Information is also available in a number of different formats. The Mental Health Act Team has information available about people's rights in a number of different languages and has published leaflets in easy read. The Information Governance Team has leaflets in the Trusts core languages and other languages are available when a need is identified. Pharmacy services provide information about medication choice and medication which is available in different languages and formats. Information is also available on our website at http://www.tewv.nhs.uk/medication there are different styles of leaflets and an audio facility.

Patient and Carer Involvement

The Patient and Carer Involvement (PCI) Team implements the 'Triangle of Care' Document's six key elements to ensure carers have appropriate support and information that meets their needs. This involves working with external Carer Support Organisations to involve them with our inpatient and community teams. The PCI team support service users and their carers to be involved with the Trust. This includes a service user 'reader's panel' which is managed by the PCI team, further supporting the Trust to produce information that is accessible to all protected groups.

<table>
<tr><th>Goal</th><th>Outcome</th><th colspan="3">Grade and Reason for rating</th><th>Outcome links to an Equality Objective</th></tr>
<tr><td></td><td></td><td colspan="3">Services are commissioned, procured, designed and delivered to meet the health needs of local communities.</td><td></td></tr>
<tr><td rowspan="2">Better health outcomes.</td><td>1.1</td><td>Achieving
 
</td><td>Which characteristics fare well
Age
Disability
Gender reassignment
Marriage and civil partnership</td><td>Pregnancy and maternity
Race
Religion or belief
Sex
Sexual orientation</td><td>☑</td></tr>
<tr><td colspan="5">Examples of improvement or continual actions:
• As a provider of mental health, learning disability and specialist services the Trust works in partnership with our commissioners, local authority, third sector providers and local communities to review and develop current services and to inform the future commissioning of services to meet the health support needs of our diverse communities. TEWV has good partnerships in place with our commissioners and ICSs which makes it easier to plan 2 or 3 years ahead and co-</td></tr>
</table>

ordinate investment and workforce development.

- The 5 Year Forward View, and subsequently the NHS Long Term Plan have clearly set out national priorities for mental health and learning disability services. Expansion / improvement in Individual Placement and Support, Perinatal, mental health support teams in schools and Early Intervention in Psychosis services are all key national priorities. There is also an expectation that mental and physical health care should be better integrated.

- The Trust is working in partnership with other providers to deliver the Community Mental Health Framework transformation. This emphasises the importance of supporting self-care, family and community capacity and primary care level support to encourage early intervention and to reduce unnecessary demand on secondary care services. This requires secondary care providers such as TEWV to reconsider how they can best support early intervention by other agencies, and how their specialist expertise should best be focused and deployed.

- Feedback was received requesting a more welcoming and child-focused environment for children and adolescent mental health services (CAMHS). In response to this the Redcar CAMHS team have recently moved to a new base and the team space was designed with families.

- The Trust has an Engagement and Involvement Framework which details how the development and delivery of our services is being taken forward through a number of strategies, frameworks and activities including our:

  Recovery Strategy including Recovery Colleges

  Carers Strategy and our continued support for the principles of the Triangle of Care

  Integrated Governance Framework

  Communications and Engagement Framework

  Volunteering Strategy

  Education and Training for our workforce

Quality Improvement System

Research and Development projects

- We obtain feedback from service users and local communities via a range of sources such as Patient Surveys, Friends and Family Tests etc. This feedback influences the Trusts corporate strategies, business plans, quality account and associated action plans.

- For example, People said we should have more welcoming and child-focused environments for our children and adolescent mental health services (CAMHS). In response to this the Redcar CAMHS team have recently moved to a new base and the team space was designed with families.

- Equality Impact Assessments are completed on Business Plans to ensure people from protected characteristic groups are not negatively impacted.

- The service conditions that apply to the NHS contract, for all contracts TEWV as a provider reference equality and diversity

- The Trusts Journey to Change identifies how the Trust will co create with patients and service users to develop services that meet the needs of the communities we serve e.g., developing a Lived Experience Advisory Board (LEAB).

- The Equality & Diversity and Human Rights Strategy states the aim of the Trust to be an inclusive service provider in which diversity is welcomed and valued, and where service users are able to access person- centred care which supports them to lead meaningful and satisfying lives.

- Most of TEWV's inpatient and community estate is recently built and of good quality. Consideration is given when designing and refurbishing trust premises to how the buildings and facilities meet the needs of the users, e.g., access for services with disabilities, or specific cultural / religious requirements.

- According to the TEWV Community Transformation Report 2021, Older people reported privacy, confidentiality and transport availability as values very important to them and in some cases, this would alleviate anxiety. This group felt that awareness raising of availability of support via public bus stands and through local free papers would reach more people within the community. Anti-social behaviour and extreme isolation rate highly on their list of concerns.

- The TEWV Community Transformation Report 2021 also suggests that some service users with hearing or sight impairment feel barriers to accessing mental health and wellbeing support is due to requiring equal opportunity to access services. The report also highlights that a barrier to accessing services is related to requiring communication support.

- 45% of respondents who took part in the consultation for the TEWV Community Transformation Report suggested they would prefer services to be available in community venues, 37% GP practices, and 22% online.

Better health outcomes		**Individual people's health needs are assessed and met in appropriate and effective ways**			Outcome links to an objective
	1.2	**Achieving**  	Which characteristics fare well		☑
			Age	Pregnancy and maternity	
			Disability	Race	
			Gender reassignment	Religion or belief	
			Marriage and civil partnership	Sex	
				Sexual orientation	

	Examples of improvement or continual actions: • In relation to patient experience the Trust will start to review service users gender identity demographic information to ensure that any health inequalities can be rectified. • Staff LGBTQ+ training to improve support for people going through Gender reassignment in accessing support from other agencies. • Links with Leeds and Newcastle Gender Reassignment clinics have been established to aid joint working and information sharing. • Work to support Deaf / deaf service users access crisis services directly is being developed. • The Trust continues to develop and identify new ways for service users with a protected characteristic to access information. • The Trust has one interpretation and translation provider that covers all trust localities to ensure people have a continuation of communication support. • The Trust continues to monitor patient satisfaction levels through NHS friends and family test results • The Trust has identified data incompleteness in relation to certain protected characteristic groups and has therefore responded through a publicity campaign, fact sheets and training for staff to reinforce the importance of complete data to review patient experience and health inequalities. • The Trust continues to have a dedicated advanced nurse practitioner for the Deaf / deaf community who is very proactive in identifying community needs.

- We continue our work in the Green Lights project - access to mental health care for people with learning disabilities
- Staff have been involved with the Rainbow initiative which identifies staff who are allies to service users who may wish to discuss matters relating to their sexual orientation or gender identity.
- The Trust continues to involve service users, carers and families in consultation processes to ensure that services are developed to meet the needs of service users with protected characteristics.
- According to the TEWV Community Transformation Report 2021, the Deaf community were unaware of how to access support and cited poor communications to those with sensory impairment. This was also a concern in the Blind and Visually Impaired focus group. Dissemination of accessible information was often seen as a barrier to service usage for those with sensory impairments.
- The report identified that there is a lack of accessible information, such as different languages, large print etc. and people don't know what help is out there, or how to access support. Equity of access is important for those presented with barriers due to physical impairment, including but not limited to the Deaf community and the Blind and visually impaired community.

<table>
<tr><td rowspan="2">Better health outcomes</td><td></td><td colspan="3">Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed</td><td>Outcome links to an objective</td></tr>
<tr><td>1.3</td><td>Developing

 
</td><td>Which characteristics fare well
Age

Disability

Gender reassignment

Marriage and civil partnership</td><td>Pregnancy and maternity

Race

Religion or belief

Sex

Sexual orientation</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Examples of improvement or continual actions:

• We have protocols in place to ensure that transitions between our services are smooth and efficient. e.g., Transfer of Care from Child and Adolescent to Adult Services Protocol, Clinical Pathways, Admission, Transfer and Discharge policy, Transfer guidelines from adult mental health services to older people services, Delayed transfers of care protocol, Transfer protocol for hospital transfers between TEWV and acute hospitals.

• Equality Impact Assessments are completed on all policies, procedures, protocols and guidance including the ones identified above to ensure people from protected characteristic groups are not negatively impacted.

• TEWV has joint working protocols including TEWV and Healthwatch organisation’s and for adults with Learning Disabilities and Mental Health problems (Greenlights). These protocols aim to ensure that service users receive the most</td></tr>
</table>

appropriate support to meet their needs, including accessing multiple services when required.

- We are developing much closer relationships with primary care, including adult mental health staff working into GP practices, offering single points of access for services at locality level, joining multi-agency multidisciplinary teams and delivering training for GPs.

- The 5 Year Forward View, and subsequently the NHS Long Term Plan have clearly set out national priorities for mental health and learning disability services. Expansion / improvement in Individual Placement and Support, Perinatal, mental health support teams in schools and Early Intervention in Psychosis services are all key national priorities. There is also an expectation that mental and physical health care should be better integrated.

- The Trust has one interpretation and translation provider that covers all trust localities to ensure people have a continuation of communication support.

- Trust wide chaplaincy service to ensure continued support in all services.

- Staff LGBTQ+ training to improve support for people going through Gender reassignment in accessing support from other agencies.

- Young people with ongoing or long-term health or social care needs may be required to transition into adult services, other service provision or back to their GP. The preparation and planning around moving on to new services can be an uncertain time for young people with health or social care needs. There is evidence of service gaps where there is a lack of appropriate services for young people to transfer into, and evidence that young people may fail to engage with services without proper support. TEWV initially agreed to put a two-year quality improvement priority in place, focusing on this specific transition, this has been extended as the full extent of the work required has become apparent:

<table>
<tr><td rowspan="2">Better health outcomes</td><td></td><td colspan="3">When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse</td><td rowspan="2"></td></tr>
<tr><td>1.4</td><td>Developing
 
</td><td colspan="2">Which characteristics fare well

Age
Disability
Gender reassignment
Marriage and civil partnership

Pregnancy and maternity
Race
Religion or belief
Sex
Sexual orientation</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Examples of improvement or continual actions:

• A known theme among mental health inpatients is that they do not feel safe whilst on wards; this is identified as a priority for Trusts in the NHS Long-Term Plan (2019).

• Feedback from our stakeholders in 2019/20 indicated awareness of this as an issue and we therefore agreed to include Safer Care as one of our priority areas for improvement within the Quality Account 2020/21 with the aim to increasing the proportion of inpatients who feel safe on our wards. This is an amalgamation of - priorities from the Trust Quality Account – Reducing Preventable Deaths and Increasing the Percentage of Inpatients who feel Safe on our Wards (now known as Safer Care).</td></tr>
</table>

	Actions linked with this include: • Improve multidisciplinary staffing establishments to ensure staff have the right skills, behaviours and leadership culture to make patient safety a priority. • Establish a steering group with identified governance structures to oversee development and implementation of high quality, collaborative care planning that is fit for purpose • In line with our Clinical Assurance Framework the review of data and information relating to our services is undertaken monthly by the relevant Quality Assurance Group (QuAG) for each service. Information reviewed includes that related to patient safety e.g. information on incidents, serious incidents, levels of violence and aggression, infection prevention and control and health and safety • We have idented “Feeling safe actions” within the Business Plan 2020 – 2024 and a Quality Assurance Framework. As a Trust we promote a culture of transparency where raising concerns is encouraged in order to improve patient safety. We have a number of ways in which people may raise concerns, prioritise safety and learn from mistakes as well as good practice, including: • PALS / Complaints policies and processes • Raising Concerns procedures / Freedom to Speak up Guardian • Safeguarding Adult and Children policies • Risk Management and patient safety policies and guidance • A program of training which includes key areas in relation to patient safety such as, reducing restrictive interventions, manual handling, safe and secure medicines, multi-agency safeguarding adults, and children training, PREVENT, Female Genital Mutilation, and domestic abuse. • Policies to provide staff with guidance and promote consistency in relation to the reporting and investigation of serious incidents, and the management of environmental risks in clinical areas • The Trust has an electronic Incident Reporting system (DATIX) – which allows us to generate reports and undertake trend analysis. • Serious Incident reporting • We are rated as “requires improvement” on the safety standard by CQC since 2015 improvement events have taken place and Exec level oversight relating to quality assurance standards are in place

	• Plans to expand the use of body cameras following a pilot that was carried out • The TEWV Community Transformation Report 2021 reports that a third of respondents said they did not seek help because of long waiting lists, poor communication, stigma, lack of awareness of what was on offer, poor previous experiences of mental health services, and being restricted by caring responsibilities.

<table>
<tr><td rowspan="2">Better health outcomes, continued</td><td rowspan="2">1.5</td><td colspan="3">Screening, vaccination and other health promotion services reach and benefit all local communities</td><td>Outcome links to an objective</td></tr>
<tr><td>Developing
 
</td><td colspan="2">Which characteristics fare well
Age
Disability
Gender reassignment
Marriage and civil partnership
Pregnancy and maternity
Race
Religion or belief
Sex
Sexual orientation</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Examples of improvement or continual actions:
• Service users accessing TEWV services are offered physical health screening, intervention and ongoing monitoring and that individuals' physical healthcare needs are not overlooked or disadvantaged because of their mental illness and/or learning disability.
• Ensure that all staff are aware of the agreed physical healthcare standards required to comply with Care Quality Commission (CQC) standards, National Health Service Litigation Authority (NHSLA) standards, National Institute for Health and Care Excellence (NICE) and local guidance.</td></tr>
</table>

	• Ensure that service users receive physical healthcare that is individualised, holistic and evidence based, in accordance with their needs, preferences and wishes. • Ensure that any major physical health issues and/or physical health issues that impact on mental health, are captured in the service user's Safety Summary, and where relevant, also in the Safety Plan. • Ensure that physical healthcare is delivered to individuals with dignity, sensitivity and compassion. • Ensure that fair and equal treatment is offered to all service users across the Trust (who may require physical healthcare). • The Trust recognises the importance of supporting primary care colleagues to ensure ongoing, appropriate physical healthcare is maintained and that physical health examination, assessment, treatment and review are effectively managed within the community setting. • Where required, reasonable adjustments must be provided to support service users to access physical healthcare in the community, and also, to help service users to understand the information, recommendations and/or advice regarding physical health that is given to them. • As part of robust physical healthcare provision, all service users are offered and encouraged to have the necessary investigations required to establish a comprehensive physical health baseline e.g., physiological observations, bloods, electrocardiogram (ECG) and urinalysis (where indicated). Additional investigations and/or physical health risk assessments may also be necessary depending on the individual's mental health diagnoses, prescribed medication, lifestyle factors and physical health comorbidities. • We ascertain whether the service user is registered with a GP and encourage, and where appropriate facilitate registration with a GP if not already registered. • Service users are encouraged to attend their own GP practice for an annual health care review.	

- TEWV encourage and facilitate service users to access relevant health promotion services within the community.
- All ongoing physical healthcare monitoring, treatment, intervention and review is clearly documented on the service user's electronic care record
- Any service user who has been an inpatient for 12 months (or longer) must be offered an annual physical health review inclusive of a comprehensive physical health re-assessment and examination.
- We ensure that all service users have access to Flu vaccinations and COVID – 19 vaccinations and we monitor take up.
- We issue resource packs that are available for staff to use with people with learning disabilities so that all are fully informed about their choices and understand the health screening processes.
- We ensure that all our service users have an understanding of the benefits of exercise and healthy eating. All our inpatient hospitals have gyms and staff that are trained in physical education, some services cook meals with service users (dependent on need) to enable them to continue to eat healthily once they leave hospital
- Service users are advised (age appropriate), signposted, supported and encouraged by TEWV staff to take advantage of NHS screening and if indicated, relevant interventions must be implemented to address any issues identified in order to promote recovery and wellbeing.

<table>
<tr><td rowspan="2">Improved patient access and experience</td><td></td><td colspan="3">People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds</td><td>Outcome links to an objective</td></tr>
<tr><td>2.1</td><td>Achieving

 
</td><td>Which characteristics fare well
Age

Disability

Gender reassignment

Marriage and civil partnership</td><td>
Pregnancy and maternity

Race

Religion or belief

Sex

Sexual orientation</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Examples of improvement or continual actions:

• People can access our services in a number of ways including:

• GP referral
• The Trust has a single point of access for crisis services
• Improving Access to Psychological Therapies referral – people can self-refer into our IAPT services
• A person may be referred by police under Section 136 of the Mental Health Act
• A person could voluntarily attend at one of our sites (not ideal but we do respond)
• The Police may request street triage, we attend, and an admission or referral is made</td></tr>
</table>

	• Our crisis team attend an incident and an admission or referral is made
	• A person may present at A&E and the liaison team see them and recommend admission or a referral
	• Social services may make a referral
	
	• The Trust provides age-appropriate services: Children services, adult services, and older people services.
	
	• Annually the Trust produces the Publication of Service User Equality Data this information enables us to see who is accessing our services and their experiences. There is incomplete demographical information which makes it difficult to assess if our services are being accesses by all groups in the community.
	
	• The Trust is trying different ways for people to engage with services such as the introduction of online consultations and online support courses. This makes support more accessible for some.
	
	• The Trust has an interpretation and translation service to ensure people who do not speak English can access services.
	
	• The Trust follows the Accessible Information Standard:
	  ○ Giving service users the opportunity to be able to contact and be contacted by the service in accessible ways for e.g., via e-mail, text, text relay.
	  ○ Receive information and correspondence in formats they can read and understand for example audio, easy read, large print.
	  ○ Allow the patient to be supported by a communication professional at appointments if this is needed to support the conversation
	• The Trust has a spirituality pathway which embeds spirituality and religion into a person's care plan.
	
	• The Trust is working in partnership with other providers to deliver the Community Mental Health Framework transformation. This emphasises the importance of supporting self-care, family and community capacity and primary care level support to encourage early intervention. This work involves working with communities to improve access to all people who require support.

	• The Trusts Journey to Change identifies how the Trust will co create with patients and service users to develop services that meet the needs of the communities we serve. • We measure and review patient experiences and this can be broken down into demographic information, this helps us to understand patients' experiences and identify ways to improve. • New builds / refurbs are assessed to ensure they are accessible, if there are any barriers identified alternative arrangements are made e.g. home visits. Equality Impact Assessments are completed on all new builds/renovations to ensure accessibility • TEWV's 2021- 2024 Business plan includes how the Trust will meet the 5 Year Forward View, and subsequently the NHS Long Term Plan which have clearly set out national priorities for mental health and learning disability services. Expansion / improvement in Individual Placement and Support, Perinatal, mental health support teams in schools and Early Intervention in Psychosis services are all key national priorities. There is also an expectation that mental and physical health care should be better integrated. • The Equality & Diversity and Human Rights Strategy includes an objective to increase the number of BAME service users who access services within the trust and report a positive experience • A well-being and community hub has been developed in Middlesbrough to increase access to service for older people • Currently our Deaf / deaf service users are unable to access crisis services without the support of a third party however systems are currently under review to ensure that an inclusive service for all is developed. • The TEWV Community Transformation Report 2021 reports a lack of awareness of where to go to access services and the lack of signposting to the 'right service at the right time', leading to some patients not seeking the help they need to support them with their mental health. The report also suggests that patients with more complex mental health conditions (e.g., Post Traumatic Stress Disorder (PTSD) or Bipolar) reported finding it hard to get the right support, understanding and knowledge from mental health services. They reported NHS services are not able to offer prolonged support due to restricted numbers of sessions, and patients feel they are then offered medication 'too readily'.

	• The report also highlights the need for awareness raising in communities to reduce the stigma of mental health as one of its key themes.

<table>
<tr><td rowspan="2">Improved patient access and experience</td><td></td><td colspan="3">People are informed and supported to be as involved as they wish to be in decisions about their care</td><td>Outcome links to an objective</td></tr>
<tr><td>2.2</td><td>Developing
 
</td><td colspan="2">Which characteristics fare well</td><td></td></tr>
<tr><td></td><td></td><td>Age

Disability

Gender reassignment

Marriage and civil partnership</td><td>Pregnancy and maternity

Race

Religion or belief

Sex

Sexual orientation</td><td>☑</td></tr>
<tr><td></td><td colspan="5">Examples of improvement or continual actions:

• Patient Survey data suggests that service users are not as involved as we would want them to be in agreeing and discussing the care they receive.

• Therefore, one of the 3 Quality Improvement priorities identified by the Trust in the Quality Account 2021/22 is to make care planning for patients more personal. This means that care is designed in close collaboration with service users and carers.</td></tr>
</table>

	• To support revised CPA process, we have reviewed how we utilise and implement technology to improve the quality and effectiveness of care planning and reduce the burden of completing care planning documentation with the planned introduction of new developments such as CITO and DIALOG (a clinical tool which allows more personal care planning) • The Trust follows the Accessible Information Standard: ▪ Giving service users the opportunity to be able to contact and be contacted by the service in accessible ways for e.g., via e-mail, text, text relay. ▪ Receive information and correspondence in formats they can read and understand for example audio, easy read, large print. ▪ Allow the patient to be supported by a communication professional at appointments if this is needed to support the conversation • The Trust has a spirituality pathway which embeds spirituality and religion into a person's care plan. • The Trust has an interpretation and translation service to ensure people who do not speak English can access services and can be actively involved in their care planning. • The Trust has CPA policies and procedures which are reviewed and are subject to an equality impact assessment

<table>
<tr><td></td><td></td><td colspan="3">People report positive experiences in the NHS</td><td></td></tr>
<tr><td rowspan="2">Improved patient access and experience</td><td rowspan="2">2.3</td><td rowspan="2">Developing
 
</td><td colspan="2">Which characteristics fare well</td><td rowspan="2">☑</td></tr>
<tr><td>Age

Disability

Gender reassignment

Marriage and civil partnership</td><td>Pregnancy and maternity

Race

Religion or belief

Sex

Sexual orientation</td></tr>
<tr><td></td><td colspan="5">Examples of improvement or continual actions:

• The Patient Friends and Family Test is also analysed by some protected groups.
• All services receive reports that identify difference in the experiences of service users identifying with protected groups. Services are then able to formulate improvement actions
• In relation to patient experience the Trust will start to review service users gender identity demographic information to ensure that any health inequalities can be rectified.
• The new clinical record CITO will be developed in order to ensure demographic data is mandatory to ensure data</td></tr>
</table>

	completeness and the review and monitoring of positive experiences. • The new CITO systems will be designed in a way that can report anonymously on gender identity so that health inequalities can be monitored. • Equality and Diversity Leads have been appointed in each locality to ensure that matters regarding health inequalities are acted on at a local level too. • The Patient Friends and Family test results revied over the past 3 years show there is some differences in the experience off patients from different ethnicity groups however the majority of patients who respond report having a 'very good' or 'good' experience when asked the question 'Overall, how was your experience of our services?' • There is no evidence to show that male or female patients are having a different experience however currently the Patient Friends and Family do not currently record non-binary, so it was not possible to review the experience of patients who identify as non-binary / gender fluid / gender neutral etc. • Bi-sexual patients report lower satisfaction than heterosexual, Lesbian and Gay patients however the majority of bi-sexual patients still report having a 'good' or 'very good' experience. • There are some differences in relation to 'age' from results taken from the patient FFT however the majority of people are still reporting a 'very good' or 'good' experience. • The TEWV Community Transformation Report 2021 reports that a third of respondents said they did not seek help because of long waiting lists, poor communication, stigma, lack of awareness of what was on offer, poor previous experiences of mental health services, and being restricted by caring responsibilities. • The report however also suggests that people with additional communication needs reported finding it difficult to access service, and health professionals that work with individuals to understand additional communication needs were praised highly.

<table>
<tr><td></td><td></td><td colspan="3">People's complaints about services are handled respectfully and efficiently</td><td>Outcome links to an objective</td></tr>
<tr><td rowspan="2">Improved patient access and experience</td><td rowspan="2">2.4</td><td rowspan="2">Developing
 
</td><td colspan="2">Which characteristics fare well</td><td rowspan="2"></td></tr>
<tr><td>Age

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Race

Religion or belief ☑

Sex

Sexual orientation</td></tr>
<tr><td></td><td colspan="5">Examples of improvement or continual actions:

▪ The Trust is committed to providing opportunity for any user of the organisation to seek advice, raise concerns or make a complaint about the services it provides.

▪ The Trust has a Complaints Team who manage all complaints to ensure a consistent approach.

▪ Complaints are handled within agreed timescales, involving the complainant as far as possible. Complainants are regularly updated regarding progress.

▪ Interpretation and translation services are available to support someone who wishes to make a complaint.</td></tr>
</table>

	▪ There is a PALS helpline available with free phone number and facility for mobile/text contacts. All issues raised including those relating to equality are forwarded to operational services and specialist services are informed where necessary. ▪ Complaint information and demographics is on the Equality & Diversity and Human Rights steering group agenda to review and identify issues. ▪ An Equality Impact Assessment has been completed on the Trust's complaints procedure to prevent negative impacts on people from protected characteristic groups. ▪ Service users, families and carers can contact the PALS team in a variety of ways including in writing, on the telephone, text or email to give people choice in how they communicate. ▪ People can also submit a complaint via the tewv.enquiries@nhs.net (trust generic) email address. These are acknowledged on the same working day and passed through to the correct department. The sender is also informed about which the correct department is should they wish to contact them directly. ▪ Complaint's data includes demographic information on age, ethnicity, gender, sexual orientation and marital status. The data shows that people from protected characteristic groups access the complaints procedure. This information also is used to identify if there are any issues related to people from protected characteristic groups. ▪ People are asked if they require any additional support or adjustments to engage in the complaints process. ▪ We produce reports with trends and data on PALS and complaints to the Quality Assurance Groups, Locality Management Governance Boards and Commissioners. ▪ The data suggests that complaints are received from patients who have protected characteristics however the complaints data doesn't report on the patient's experience relating to the handling of complaints.

Consultation Process

- TEWV PPI Team promoted the EDS2 consultation, there were three consultation meetings arranged and ten people were involved in the consultation.

- A consultation was due to take place with at the Spirituality and Recovery course, but the course didn't go ahead.

- Healthwatch leads from Stockton, Durham, Middlesbrough, Darlington, North Yorkshire and York were all contacted regarding promoting and supporting the EDS2 consultation process. Two out of six Healthwatch leads responded to the request and helped to promote the consultation in their areas.

- Links with the TEWV Community Transformation Report 2021 were made in order to access results that could inform the EDS2 self-assessment.

- The report provided insight into what matters most to the people of the Tees Valley in terms of mental health support in the community. The Tees Valley Healthwatch Network engaged over 900 people, including seldom heard groups, who all have a vested interest in an effective mental health offering.

- 16 focus groups were held around the survey questions that were co-produced with TEWV. There were 876 responses to the survey.

- Many of the respondents in the engagement exercise had received help or support in the past from a wide range of practitioners, offering a wide array of support mechanisms, and 61% of respondents told us the support they had been offered did help them.

- The demographics of those sharing their experiences through the survey and attention to those areas of communities which are often 'seldom heard' through the focus groups, created a well-rounded and diverse foundation for the report.

- The survey upon which this report is built, was co-designed with TEWV, and this report was shared and discussed with TEWV to provide an insight into those areas that would benefit from more attention.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item 19

Board of Directors

The following report is due to be considered at the meeting of the People, Culture and Diversity Committee, to be held on 27th January 2022. It is reproduced to enable the Board to consider any matters and related recommendations arising from that meeting.

DATE:	**27 January 2022**
TITLE:	**Gender Pay Gap Report**
REPORT OF:	**Sarah Dexter- Smith, Director of People and Culture**
REPORT FOR:	**Review and Approval to publish**

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

Executive Summary:

The Trust is legally required to produce an annual Gender Pay Gap report which it is required to publish on the Government Gender Pay Gap Service website and the Trust external website. The report is based on a snapshot date of 31st March 2021 and must be published by 30th March 2022. The following report includes the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality. The Trust is committed to understanding any differences identified in the gender pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

Recommendations:

The People, Culture and Diversity Committee is asked to:

- note the contents of the report and to comment accordingly.
- Recommend to the Board: the approval of the publication of the statutory data on to the Government Gender Pay Gap Service and publication of the full report on the Trust's website.
- note the positive progress being made in reducing the differences in pay being experienced by female employees.
- duly consider the information within the report which is provided to better understand factors which may be contributing to pay differences being

experienced eg Salary Sacrifice Schemes, Bonus Schemes in operation (Clinical Excellence Awards).

- Identify any additional analysis or work to be undertaken which may help further reduce pay differentials being experienced by females.

MEETING OF:	**Board of Directors**
DATE:	**27th January 2022**
TITLE:	**The Gender Pay Gap Report**

1.0 INTRODUCTION & PURPOSE:

1.1 The Trust has been required to produce and publish a Gender Pay Gap Report since April 2018. The attached report is based on a snapshot date of 31st March 2021 and is required to be published by 30th March 2022.

1.2 The purpose of the report is to demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality.

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

2.2 The Trust is required to publish the details of the six different measures on the Government Gender Pay Gap Service website. The following report includes the details of the six measures plus narrative to explain what may be contributing to any differences in pay identified.

3.0 KEY ISSUES:

3.1 The report generally is showing a positive trend towards differences in pay between females and males as reducing particularly when compared with the report produced in April 2018.

- The gender profile of the Trust has increased in the last five years from 77% female to 79%.
- The mean gender pay gap has decreased by 34.6% since March 2018. The median pay gap has decreased by 29.0%.
- There has been an increase in staff choosing to contribute to salary sacrifice schemes which is one of the factors which impacts on an employees basic pay.
- Bonus payments include Clinical Excellence Awards made to Consultant Medics and long service awards made to staff on reaching 25 years' service. The narrative included in the report goes some way to explain the significant differences in awards between female and male employees.

4.0 IMPLICATIONS:

Compliance with the CQC fundamental Standards:

It is a requirement of the CQC fundamental standards that the Trust meets its obligations with regards to its public sector equality duties

4.1 **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.

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

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

4.4 **Other implications:**
None have been identified.

5.0 RISKS:

5.1 It may be advisable to undertake a review of the continuation of historical Clinical Excellence Awards in relation to Equal Pay Legislation.

6.0 CONCLUSIONS:

6.1 The Gender Pay Gap Report on the whole is showing a positive trend towards reducing gender pay inequalities being experienced by females.

7.0 RECOMMENDATIONS:

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

7.2 To recommend to the Board approval and ratifications of the Trust's Gender Pay Gap report prior to publication.

Sarah Dexter - Smith, Director of People and Culture
Beverley Vardon-Odonkor, Head of Health and Wellbeing and Workforce Information

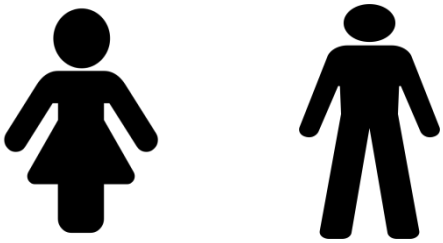
Gender Pay Gap Report – 2021

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures. This is the fifth report and is based upon a snapshot date of **31st March 2021.** We are required to publish data on the Government Equalities Office website and on the Trust website by 30th March 2022 and annually going forward.

The gender pay gap differs from equal pay in the following way. Equal pay deals with the pay differences between men and women who carry out **the same jobs, similar jobs or work of equal value**. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women.

The following report includes the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality. The Trust is committed to understanding any differences identified in the gender pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

The gender profile of the Trust is



79.0% **21.0%**

The gender profile split in the Trust has increased from 78% female and 22% male during the last 12 months. There has been a 2% increase in favour of females since we started to report in March 2017. The gender split at that time was 77% female and 23% male.

Mean and Median Gender Pay Gap

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

Mean Gender Pay Gap **Median Gender Pay Gap**

10.66% less than males -
equating to £1.93 per hour less

7.27% less than males -
equating to £1.11 per hour less

The mean gender pay gap linked to the amount a female is paid per hour has decreased by 12.33% in the last 12 months. The mean gender pay gap has reduced from 12.16% to 10.66%. The median pay gap linked to the amount a female is paid per hour has decreased by 18.40% on the previously reported position. The median gender pay gap has reduced from 8.91% to 7.27%.

The table below highlights the mean and median gender pay gap reported figures between March 2017 and March 2021. It's positive to note the gender pay gap difference has decreased year on year since 2018. The mean gender pay gap has decreased by 34.6% since March 2018. The median pay gap has decreased by 29.0%.

	2017	**2018**	**2019**	**2020**	**2021**
Mean gender pay gap	14.9%	16.3%	14.65%	12.16%	10.66%
Median gender pay gap	9.34%	10.24%	10.14%	8.91%	7.27%

The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car. The table below highlights the number of staff by gender contributing to the schemes. As you would expect, in line with the gender split within the organisation, the majority of staff opting to participate in one or more salary sacrifice schemes are female. The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median gender pay gap and will be one of a number of contributory factors which may be causing the differences being reported.

There has been an increase of **35.4%** in the number of staff contributing to the lease car salary sacrifice scheme compared to March 2020. Based on the average monthly sacrifice of £233 this will reduce the gross pay of a female member of staff by approximately £2,796 per annum. It is also worth noting a proportion of staff contribute to more than one salary sacrifice scheme.

March 2021

Salary Sacrifice Schemes	**Child Care Vouchers**	**Lease Car Scheme**	**Cycle to Work Scheme**	**Electronics**
Female	150 (81.5%) average sacrifice per month £89	369 (72.5%) average sacrifice per month £233	119(76.6%) average sacrifice per month £30	210 (76.9%) average sacrifice per month £43
Male	34 (18.5%) average sacrifice per month £77	140 (27.5%) average sacrifice per month £263	49 (23.4%) average sacrifice per month £45	63 (23.1%) average sacrifice per month £35

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

Mean Gender Pay Gap (AfC & Executive Pay)

Median Gender Pay Gap (AfC & Executive Pay)

2.97% less than males -
equating to £0.48 per hour less

0.85% less than males –
equating to 0.12p per hour less.

The mean gender pay gap has decreased by 42.21% and the median gender pay gap has decreased by 86.33% compared to the previous year.

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

Mean Gender Pay Gap (M&D)

9.05% less than males -
equating to £3.94 per hour less

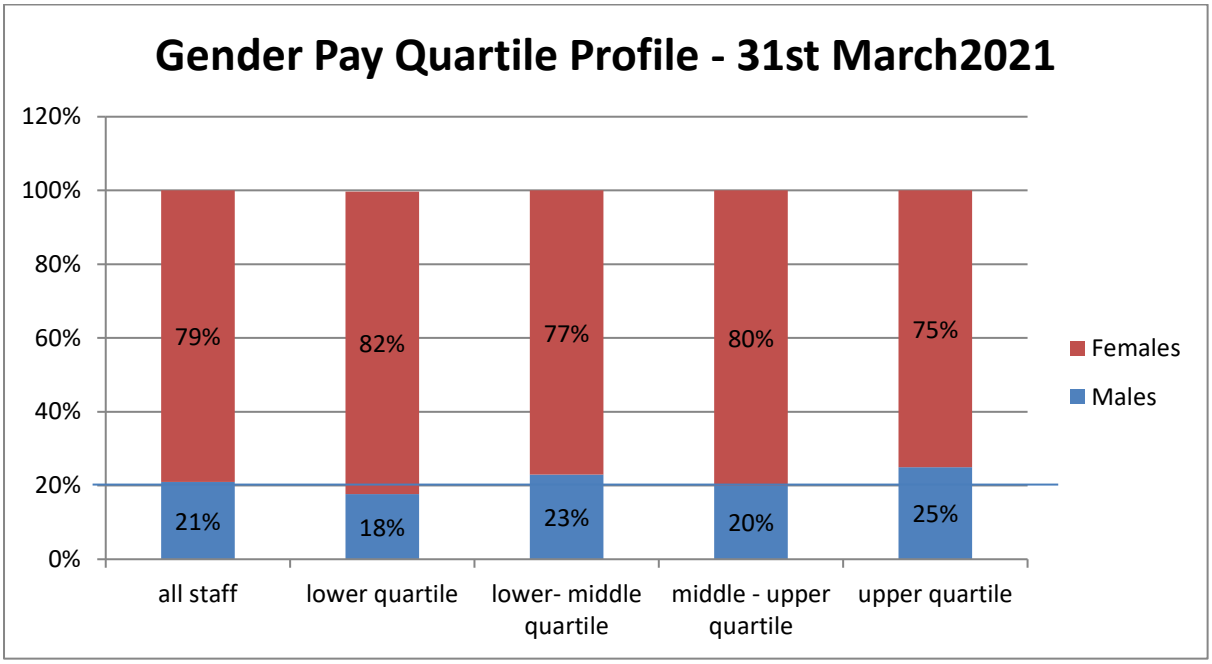
Median Gender Pay Gap (M&D)

3.17% less than males –
equating to £1.45 per hour less

The mean gender pay gap has decreased by 36.26% which has resulted in a smaller difference in hourly pay for females based on the previous report. The median gender pay gap has increased by 8.51%.

Gender Pay Quartile Profile

The following graph shows the proportion of males and females in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile. 82% of employees in the lower quartile are female, compared with 75% in the upper quartile. The gender pay upper quartile has seen the proportion of females increase from 71% to 75% in the last 12 months. The remaining quartiles have remained broadly the same.



Bonus Payments

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

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£9,557	£7,343
Female	£5,264	£1,311
Difference	£4,293	£6,032
Pay Gap %	44.9%	82.1%

At the time of reporting the Trust was operating a local clinical excellence award scheme based on the national terms and conditions. Due to COVID-19, guidance was issued to say that the Trust could stand down the usual formal process of application and review for CEA's in 2020, instead the money could be divided equally between all eligible individuals and they received a non-consolidated and non-pensionable payment for the year. Therefore everyone received the same amount of award for 2020.

There are also however a number of individuals receiving historic awards from 2017 which are recurrently paid each year. Once an award had been made the Consultant continues to receive that level of award going forward. A further submission may be made the following year and as a consequence progression through the varying payment levels occurred. This may account for one of the reasons for the significant difference being reported.

Proportion of eligible Consultants receiving a CEA

100%

100%

All eligible Consultants received a Clinical Excellence Award in the reporting year.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 172 staff received an award. **133 females and 39 males** received an award, equating to 77% of females which is lower than the Trust gender breakdown.

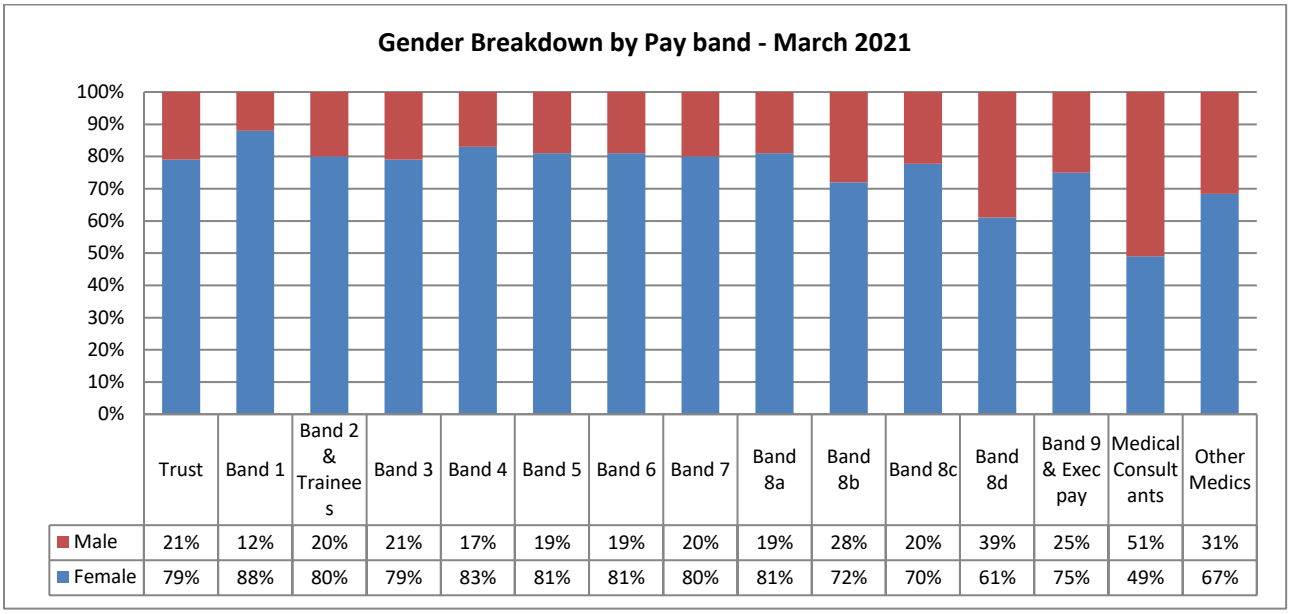
Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above.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

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£6,142	£1,311
Female	£1,830	£100
Difference	£4,312	£1,211
Pay Gap %	70.2%	92.3%

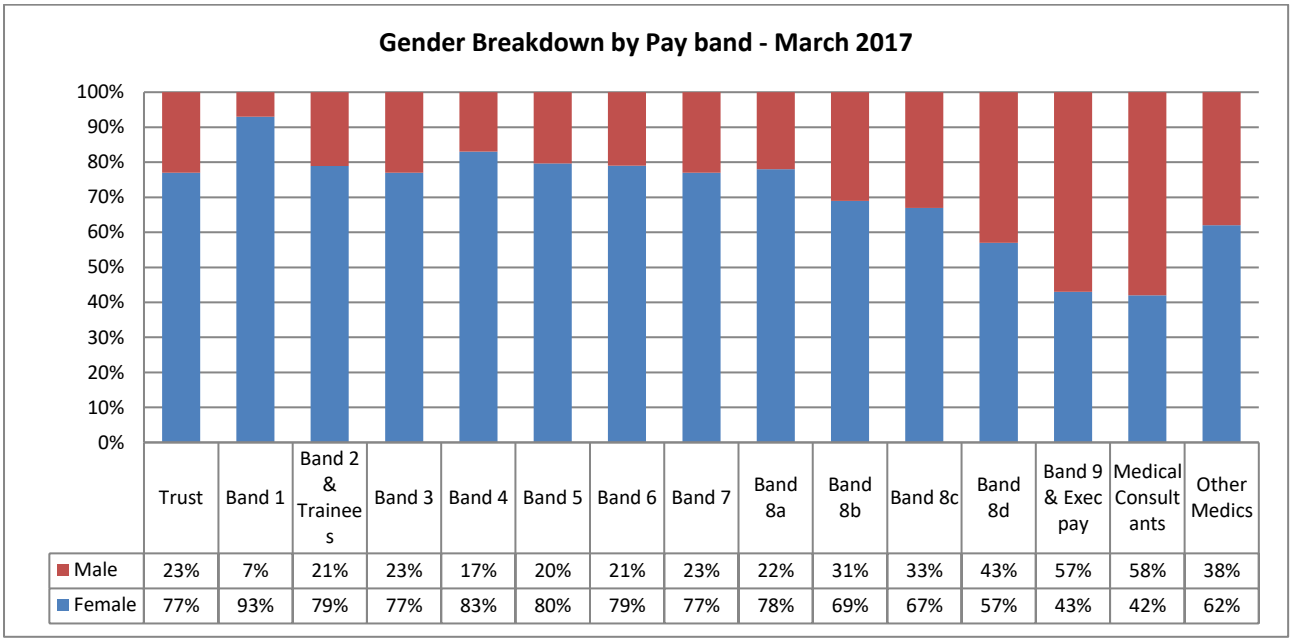
It is important to recognise when combining the bonus awards in this way the data is skewed as long service awards are predominantly paid to women with a higher proportion of males receiving clinical excellence award payments.

Gender Breakdown by Pay Band

The following two graphs provide a gender profile breakdown by pay band as at March 2021 and March 2017. **The graphs highlight there have been changes in the profile in a number of bands, most notably in band 9 and Executive pay and Medical Consultants.**



	Trust	Band 1	Band 2 & Trainees	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultants	Other Medics
Male	21%	12%	20%	21%	17%	19%	19%	20%	19%	28%	20%	39%	25%	51%	31%
Female	79%	88%	80%	79%	83%	81%	81%	80%	81%	72%	70%	61%	75%	49%	67%



	Trust	Band 1	Band 2 & Trainees	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultants	Other Medics
Male	23%	7%	21%	23%	17%	20%	21%	23%	22%	31%	33%	43%	57%	58%	38%
Female	77%	93%	79%	77%	83%	80%	79%	77%	78%	69%	67%	57%	43%	42%	62%

Gender Pay Gap by Banding

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

	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6
Mean pay difference	0.17p per hour 1.78% less	0.09p per hour 0.9% **less**	0.34p per hour 2.9% **less**	0.25p per hour 2.1% **less**	0.44p per hour 2.88% **less**	0.42p per hour 2.26% **less**
Median pay difference	No difference reported	No difference reported	0.59p per hour 5.17% **less**	No difference reported	1.17p per hour 7.47% **less**	£1.48 per hour 7.63% **less**

	Band 7 	Band 8a 	Band 8b 	Band 8c 	Band 8d 	Band 9 and Executive Pay 
Mean pay difference	**No difference reported**	0.56p per hour 2.22% **less**	0.27p per hour 0.91% **less**	0.65p per hour 1.85% **less**	0.42p per hour 1.00% less	£6.47 per hour 10.07% **less**
Median pay difference	0.10p per hour 0.47% less	£2.07 per hour 8.12% **less**	£3.30 per hour 10.40% **less**	£3.26 per hour **9.09% less**	£5.34 per hour **11.89% less**	£1.54 per hour 2.66% **more**

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

	Consultants 	All other Doctors 
Mean pay difference	£2.22 per hour 4.37% less	**No difference reported.**
Median pay difference	£1.28 per hour 2.56% **less**	**£3.26 per hour 12.07% less**

Update on Progress from Gender Pay Report 2020

In previous years following the publication of the Gender Pay Report further work has been undertaken to better understand the reasons for differences in gender pay. Due to the impact of the Covid pandemic following the publication of the report in March 202 further work was not identified to be undertaken.

Clinical Excellence Awards

Local Clinical Excellence Awards (LCEA) were halted this year as a result of the COVID-19 pandemic, with the award money that was due distributed equally among eligible consultants. This meant there was no formal process of application and review and instead all eligible individuals received a non-consolidated and non-pensionable payment for the 2021 year.

ITEM NO. 20

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th January 2022**
TITLE:	**NHS System Oversight Framework – Position as at Quarter 3, 2021/22**
REPORT OF:	**Phil Bellas, Company Secretary and Sharon Pickering, Assistant Chief Executive**
REPORT FOR:	**Information and Assurance**

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

Report:

1 **Purpose**

1.1 The purpose of this report is to examine the Trust's position against the criteria set out in the System Oversight Framework at Quarter 2, 2021/22 and:

- To provide assurance on actions being taken to rectify underperformance against the mandated metrics
- To consider future risks to the Trust

2 **Background**

2.1 The NHS System Oversight Framework (SOF) sets out NHS E/I's:

- Approach to monitoring performance at system, place-based and organisational levels
- Expectations for working together to maintain and improve the quality of care
- Objective basis on when and how it will intervene in cases where there are serious problems or risks to the quality of care.

2.2 The SOF seeks to identify where ICS and NHS organisations may benefit from or require support to meet the standards required of them, in a sustainable way, and deliver the overall objectives of the sector in line with the priorities set out in Operational Planning Guidance, the NHS Long Term Plan and the NHS People Plan.

2.3 As such the position against the SOF contributes to the Trust's understanding of how it is viewed by the regulator and at a system-level.

2.4 The SOF is built around the five national themes of the Long Term Plan (quality of care, access and outcomes, preventing ill health and reducing inequalities, people, finance and use of resources and leadership and capability) together with a sixth

theme, local strategic priorities.

2.5 Under the SOF, NHS organisations are allocated to one of four segments to enable consideration (not determination) of specific support needs. These range from Segment 1 (no specific support needs) to Segment 4 (mandated intensive support). Segment 2 is the default position.

2.6 The criteria for segmentation is based on two components:
- Objective, measurable eligibility criteria based on performance against the six oversight themes using relevant metrics
- Additional considerations focussed on the assessment of leadership and behaviours and improvement capability and capacity

3 Key Issues

3.1 The Trust was placed in Segment 3 in June 2021 when the SOF came into effect. This segment describes organisations as having "Significant support needs against one of more of the five national oversight themes and in actual or suspected breach of the licence."

3.2 This position reflects the Trust's overall CQC rating of "Requires Improvement" and has been further confirmed with the reduction in the "well-led" rating from "good" to "requires improvement" in December 2021.

3.3 The Trust's position against the SOF metrics, at Quarter 3 2021/22, is provided in the Dashboard attached as Annex 1 to this report.

3.4 The Dashboard report highlights that, for those metrics where data is available, the areas of interest at a regulatory/system level are likely to be:
- IAPT services both in terms of access and the proportion of people moving to recovery
- Waiting times for children and young people with eating disorders
- The number of inappropriate Out of Area Placements (OAP) for adults
- The number of women accessing specialist community perinatal mental health services (against the CCG ambition)
- The Trust's CQC ratings
- Sickness absence levels.

3.5 The Board will note that:
- Many of the above areas have been impacted on by the Covid-19 pandemic
- The Dashboard report provides assurance on the action being taken to address the areas of underperformance. Whilst there have been some improvements, for example in waiting times for CYP with eating disorders and internal OAPs, in many cases either work is continuing to understand the position or the actions taken have yet to have a discernible impact on performance.

3.6 Feedback from the last meeting of the regional Quality Board suggests that pressures on the Trust and the System from the pandemic are recognised and that the confidence of partners in the organisation is building; however, risk mitigation through the delivery of agreed plans needs to continue.

4 **Risks**

4.1 The prospect of further regulatory intervention (BAF risk 4) against the Trust, based on its SOF position at quarter 3, appears to be low; however, this might change in the future depending on the outcomes of the Independent Investigations and if the Trust fails to deliver the 'must do' actions set out in the recent CQC report.

4.2 Conversely, it is unlikely that the Trust will be able to achieve the default segmentation (Segment 2) until its CQC ratings have improved.

5 **Conclusions**

5.1 It is likely that the Trust will remain in segment 3 for the next quarter.

5.2 The Trust understands where it needs to make improvements against the SOF metrics. Action is being taken but in many cases needs to gain traction. Recovery from the Covid-19 pandemic should also support the Trust achieve the required standards.

5.3 The Trust's segmentation appears to be stable so long as the CQC action plan is delivered and the findings of the Independent Investigations do not suggest any longstanding or complex issues that will prevent agreed levels of improvement or further concerns over and above those already identified and being addressed.

Recommendations:

The Board is asked to receive and note this report.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

DRAFT
System Oversight Framework
As at Quarter 3 2021/22

journey to change

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CONTENTS

Report Overview

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

A new System Oversight Framework (SOF) was released in June 2021, setting out NHS England and NHS Improvement's (NHSE/I) approach to the oversight of integrated care systems, CCGs and trusts, with a focus on system-led delivery of care.

All measures have been included for completeness and oversight; however, many do not have data available at this stage. This is attributable to one of three reasons:

- The data is yet to be released; for example, many measures within the SOF are based on the Staff Survey, which is due for release in Quarter 4.
- Developments are currently underway to ensure all Long Term Plan measures are available on the Integrated Information Centre; pending that, the data has been obtained from existing sources where possible.
- A number of measures are yet to be defined by NHS England & Improvement.

Future reports will include national benchmarking positions to enable an accurate assessment of Trust performance against national and mental health trust standards; however this has not been possible this month due to technical issues on the national platform.

Long Term Plan

We do not have as many people accessing our IAPT services as is our ambition across all our CCG areas. This continues to be impacted by staff sickness and vacancies within our services, and recruitment is ongoing in all areas.

Our out of area placements have significantly improved as we have ensured that the NHS Continuity of Care Principles are robustly embedded across all of our services; however we are observing an increase in the number of patients that we are placing in beds external to our Trust due to the lack of availability of local beds and where the principles do not apply. Whilst this is a national issue due to current demand levels, it is something that is of concern and we are monitoring closely.

We are concerned that across all of our CCG areas we are not treating our children & young people with an eating disorder in a timely manner. Whilst this is a pressure in terms of capacity and demand that is being experienced nationally, this has been greatly impacted by vacancies within our services. Recruitment continues and reviews are underway to facilitate the availability of an increased number of appointments.

People

Our sickness levels continue to be higher than we aspire to across all Localities and it must be noted that the latest data available is as at the 3th November 2021. All sickness is managed in line with Trust Policy and is closely monitored within operational services. Work continues to progress the action plan within our Forensic Services; all actions will be completed by the end of January 2022.

Long Term Plan: Tees, Esk & Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Oversight	Standard	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	FYTD	Notes
Total access to IAPT services	N/A	CCG Ambition	2096	2188	2664	2419	2424	2263	2183	2530	2271				6948	7106	6984		21038	
Access to IAPT services for adults aged 65+	N/A	CCG Ambition																		Measure is currently under development
IAPT: The proportion of people who are moving to recovery	50.00%	Standard	57.09%	53.08%	53.22%	52.14%	48.94%	50.92%	52.75%	50.04%	51.69%				54.51%	50.68%	51.44%		52.22%	
IAPT: The proportion of BAME people who are moving to recovery	50.00%	Standard																		Measure is currently under development
The proportion of people who wait 6 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period.	75.00%	Standard	98.95%	99.41%	99.42%	99.40%	99.09%	98.55%	98.99%	98.87%	99.10%				99.25%	99.00%	98.98%		99.08%	
The proportion of people who wait 18 weeks or less from referral to accessing IAPT against the number of people who finish a course of treatment in the reporting period.	95.00%	Standard	100.00%	99.93%	99.94%	99.93%	100.00%	99.87%	99.86%	99.93%	100.00%				99.95%	99.93%	99.93%		99.94%	
The proportion of people who wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.	N/A	Supporting measure	99.43%	98.99%	99.21%	99.17%	98.93%	99.03%	99.45%	98.54%	99.34%				99.21%	99.04%	99.08%		99.11%	
The proportion of people who wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.	N/A	Supporting measure	99.90%	99.95%	100.00%	100.00%	99.83%	99.87%	99.91%	99.96%	99.91%				99.96%	99.90%	99.93%		99.93%	
IAPT: Number of ended referrals in the reporting period who received a course of treatment against the number of ended referrals in the reporting period who received a single treatment appointment.	N/A	Supporting measure	2.16	1.96	1.91	1.82	1.84	1.75	1.79	1.74	1.51				2.01	1.80	1.68		1.82	
IAPT: Average number of treatment sessions	N/A	Supporting measure	7.76	8.19	7.00	7.49	7.30	7.26	7.76	7.62	7.77				7.57	7.35	7.71		7.54	
IAPT: The proportion of people who waited less than 28 days from their first treatment appointment to their second treatment appointment	N/A	Supporting measure	58.40%	63.28%	57.29%	55.51%	50.69%	43.34%	43.48%	49.08%	50.54%				59.51%	49.89%	47.74%		52.47%	
IAPT: The proportion of people who waited less than 90 days from their first treatment appointment to their second treatment appointment	N/A	Supporting measure	92.72%	92.92%	92.36%	92.87%	94.55%	93.31%	93.36%	93.46%	91.16%				92.65%	93.54%	92.79%		93.01%	
IAPT in-treatment pathway waits	<10%	Standard	7.28%	7.08%	7.64%	7.13%	5.45%	6.69%	6.64%	6.54%	8.84%				7.35%	6.46%	7.21%		6.99%	
Implementation of IAPT - Long Term Condition pathways	N/A	CCG Ambition	No	No	No	No	No	No	No	No	No				No	No	No		No	

Long Term Plan: Tees, Esk & Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Oversight	Standard	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	FYTD	Notes
CYP access	N/A	CCG Ambition	27844	28251	28906	29243	29877	30376	30676	31004	30937				28906	30376	30937		267114	
CYP outcomes	40% by Q4	CCG Ambition	32%	36%	36%	34%	35%	36%												Measure is currently under development
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Standard	73.85%	71.96%	69.90%	66.45%	62.63%	60.78%	58.77%	56.11%	54.30%				69.90%	60.78%	54.30%		63.60%	
The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Standard	51.43%	48.70%	45.00%	42.98%	42.52%	38.14%	37.61%	38.66%	42.50%				45.00%	38.14%	42.50%		42.94%	
Number of people accessing IPS services as a rolling total each quarter	N/A	CCG Ambition	223	206	203	231	216	221	231	240	243				203	221	243		243	
Access to community mental health services for adults and older adults with severe mental illnesses	N/A	CCG Ambition																		Measure is currently under development
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	0 by Q4	Standard*	2406	2849	2892	3092	3145	3526	2526	1519	345				2892	3526	345		345	Latest published data September 2021: 3825 Benchmarking data as at August 2021 reports the Trust in the lowest performing quartile
Number of inappropriate OAP bed days for adults by quarter that are 'external' to the sending provider	0 by Q4	Standard	0	0	0	15	30	69	143	232	345				0	69	345		345	Benchmarking data as at August 2021 reports the Trust in the highest performing quartile
Inpatient admissions for people who have had no previous contact with community mental health services	N/A	CCG Ambition	14.04%	15.59%	13.71%	12.00%	16.67%	16.94%	15.53%	15.53%	13.60%				15.13%	14.16%	15.34%		14.87%	
Adult mental health inpatients receiving a follow up within 72hrs of discharge	80%	Standard	90.55%	90.18%	92.45%	91.95%	88.67%	89.49%	90.87%	91.20%	88.33%				91.12%	90.11%	90.17%		90.49%	Latest published data September 2021: 89%
Rate per 100,000 population of people in adult acute mental health beds with a length of stay over 60 days	N/A	CCG Ambition																		Measure is currently under development
Rate per 100,000 population of people in older adult acute mental health care with a length of stay over 90 days	N/A	CCG Ambition																		Measure is currently under development
Number of women accessing specialist community PMH services in the reporting period (12-month rolling)	N/A	CCG Ambition	970	1006	1025	1042	1084	1096	11006	1121	1132				317	261	252		830	
Percentage of women accessing specialist community PMH services in the reporting period (12-month rolling)	N/A	Supporting measure	4.73%	4.91%	5.00%	5.08%	5.19%	5.24%	5.29%	5.37%	5.42%				5.00%	5.24%	5.42%		5.14%	
Data Quality Maturity Index	90%	Standard	98.20%	98.10%	98.00%	97.80%	97.90%	98.10%							98.00%	98.10%			98.10%	Latest published data September 2021: 98.20%

* CCG agreed ambition of 1833 for 2021 to reduce to 0 by Q4

Long Term Plan: Tees, Esk & Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Total access to IAPT services			
There have been fewer patients entering our **Durham & Darlington IAPT** services for treatment than the CCG ambitions due to difficulties in maintaining patient engagement.	To establish group workshop sessions to support the engagement of patients and improve access to treatment.	**Ongoing.** One daytime and one evening workshop now operate on a daily basis to support the 1:1 appointments offered to patients. This ensures patients wait no longer than 21 days to start treatment and helps maintain engagement and reduces the risk of patients not attending booked appointments. The success of these is being monitored but the workshops need to be embedded within the service before their success can be appropriately assessed. An update will be provided in March 2022.	No visible impact; performance remains consistent with previous months.
	The new cohort of trainees to be used to increase capacity within the single point of access.	**Ongoing.** 32 new trainees commenced in post during November 21. Following completion of their induction in Spring 2022 they will support the single point of access to ensure patients can enter treatment in a timely way.	
There have been fewer patients entering our **North Yorkshire IAPT** service for treatment than the CCG ambition due to vacancies within the team.	Recruitment is underway, which will provide more staff to provide assessment and treatment appointments.	**Ongoing.** 1 Psychological Wellbeing Practitioner (PWP) has started in post during December and a second is due to start in January. A temporary team manager has been recruited and interviews are scheduled in January for 3.8 wte PWPs and 2.5 wte HIWs.	No visible impact; performance remains consistent with previous months.
There has been a disruption to the **North Yorkshire IAPT** service's trainee programme for the PWPs delivered through Bradford University, which has resulted in trainees spending extra days at University to catch up.	Escalation of issue to NHS England & Improvement and Health Education England and a recovery plan put into place.	**Ongoing**. 6 additional trainees have been recruited and commenced in post at the end of December.	

Long Term Plan: Tees, Esk & Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
The **North Yorkshire IAPT** service is receiving a high number of inappropriate referrals, the administration of which impacts on clinical time.	Dedicated clinical support to be provided for triaging referrals.	**Ongoing**: 3 days clinical support is being provided to ensure those referrals appropriate for IAPT are processed efficiently into the service, whilst maintaining treatment sessions for those patients currently receiving care.	
The **North Yorkshire IAPT** service has been impacted by short- and long-term sickness absence.	Trust sickness policies and procedures to be followed.	**Ongoing.** All staff on short term sick leave have returned to work; however, 3 members of staff remain on long term sick leave.	
There have been fewer patients entering our **Vale of York** IAPT service for treatment than the CCG ambition due short- and long-term sickness absence within the team.	Trust sickness policies and procedures to be followed.	**Ongoing.** Staff on short term sick leave have now returned to work however the team still has 1 member of staff on long-term absence from work	No visible impact; performance remains consistent with previous months.
There has been a lack of capacity within the **Vale of York** team due to a number of staff having to complete Long term physical health conditions top up training.	The service to align staff as effectively as possible to ensure service provision is maintained.	**Ongoing**	

Long Term Plan: Tees, Esk & Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
IAPT: The proportion of people who are moving to recovery			
We are concerned that our **North Yorkshire & York** IAPT patients are not demonstrating the national recovery standard.	Detailed analysis to be undertaken to ascertain if this is an area of concern.	**Ongoing.** A provisional finding is that the service continues to receive a low level of mild and moderate referrals and a very high proportion of patients who are categorised as severe. The data confirms that the more severe the symptoms the less likely it is that recovery (as defined by IAPT) will be achieved. Due to service pressures this work has been delayed. An update will be provided in February 2022 once the work is completed	Performance remains consistent with previous months but has improved on November.
We are concerned that our **Vale of York** IAPT patients are not demonstrating the national recovery standard. Identified in September this is due to a number of patients choosing not to receive treatment through the service, including some that may already have received treatment in IAPT and do not want IAPT offers.	The Service to pilot Computerised Cognitive Behavioural Therapy (cCBT) to provide an additional form of treatment for those patients who would benefit from this.	**Ongoing.** The pilot changes have now been embedded with the first cohort of service users receiving this treatment in December. Continuous Professional Development (CPD) sessions for the CBT workforce to support working with depression have been booked, and a consultation has been held with Step 2 staff to discuss changes to cCBT processes.	No visible impact; performance remains consistent with previous months and below standard.
There are capacity issues within the **Vale of York** service due to sickness and the Long Term Conditions training noted above.	Note actions above.		
IAPT in-treatment pathway waits			
We are concerned that more of our **Vale of York** IAPT patients are waiting over 90 days between first and second treatment appointment (in-treatment pathway waits) than the national standard.	Further analysis to understand if this is an actual area of concern.	**Ongoing.** This has not been completed due to service pressures, etc	No visible impact; performance remains consistent with previous months.

Long Term Plan: Tees, Esk & Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
The proportion of CYP with Eating Disorders that start of NICE-approved treatment within 4 weeks (routine cases) and 1 week (urgent cases) from referral			
We are concerned that the children and young people within our **Durham & Darlington** Eating Disorders service are waiting longer than the national standard for both routine and urgent referrals due to demand for appointments exceeding availability.	A bid to be submitted to the Clinical Commissioning Group to support an increase in staffing numbers to ensure the service can meet demand.	**Complete:** Bid successful. These monies have been used to fund 8 wte staff across the team who previously were unfunded.	No visible impact for the urgent referrals measure; performance remains consistent with previous months.
	Recruitment is underway for 11.8 wte posts, which will provide more staff to provide treatment appointments.	**Ongoing.** During December, 3 nurses and 1 dietician were appointed; however a further band 6 post was made vacant. Recruitment continues and an update will be provided in February 2022.	Visible decrease in performance for routine cases.
	The Service to increase the number of appointment slots and venues across the locality where patients can access appointments.	**Ongoing.** The number of assessment slots has increased from 2 to 4 per week and venues across the locality.	
	The Service to review the referral process to ensure all patients are directed to the Eating Disorder team quickly as possible after referral.	**Ongoing.** The Eating Disorder team now has a representative at the CYPS Single Point of Access team's daily huddle, to take part in discussions on new referrals	
	The Service to use the patient tracking list to enable closer monitoring and action planning around suitable appointments for each patient.	**Ongoing.** The Eating Disorder team use the tracker and reports are circulated weekly by the Corporate Performance Team to Directors and Heads of Service.	

Long Term Plan: Tees, Esk & Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
The proportion of CYP with Eating Disorders that start of NICE-approved treatment within 4 weeks (routine cases) and 1 week (urgent cases) from referral			
We are concerned that the children and young people within our **North Yorkshire & York** Eating Disorders service are waiting longer than the national standard for both routine and urgent referrals due to capacity within the teams.	Recruitment is underway, which will provide more staff to provide treatment appointments.	**Ongoing.** An Eating Disorders Liaison Nurse and a Healthcare Assistant are due to start in January, a Nurse in April and a Psychologist in May.	A decreasing position is visible for both routine and urgent cases.
	The service to use free assessment appointments to ensure timely assessment and commencement of NICE approved treatment.	**Ongoing.** Appointments are being used in conjunction with a keeping in touch process to monitor risk and update patients where appropriate.	
	The service is to work with commissioners to introduce an Eating Disorders specific referral form to improve the triage process to enable more efficient booking of new initial assessment appointments	**Ongoing.** A meeting was scheduled to progress this work in November however this was cancelled; the next meeting is due to take in December was also cancelled and has been arranged for 26th January 2022. An update will be provided in February 22.	
	A kaizen event to be held in February 22 to review the initial assessment process with an aim to be able to increase the number of initial assessments offered by the service.	**Ongoing**. A scoping meeting took place in November to agree initial plans. As a result of the ongoing improvement work the service has been able to increase their offer of initial assessments in Harrogate/Northallerton by 2 per month from December. This is being monitored and an update will be provided in February 2022.	

Long Term Plan: Tees, Esk & Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Number of inappropriate OAP bed days for adults (Internal & External)			
More patients in our Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP) services are spending time in Trust beds away from their closest hospital. This was first identified in March 2021 and is being largely impacted by current pressures on our inpatient services. The Executive Team has agreed that we need some external support to help with this and this is currently being progressed. Four beds were purchased in the independent sector until the 31st January 2022 (extended from September 2021) for AMH and MHSOP patients; an additional bed has now been sourced. 8 patients occupied these beds during December (153 bed days).	Analysis to be undertaken to understand the impact of inpatient and community pressures on our out of area placements, to identify any areas of concern. A Trust-wide review to be undertaken to ensure the Continuity of Care Principles are embedded within all Service processes by the 30th September 2021. The Out of Area Protocol to be reviewed to ensure is up to date and fit for purpose. Increased monitoring of external placements to be undertaken. Acting Deputy Head of Corporate Performance to contact NHS England to renegotiate the Trust's trajectory for out of area placements.	**Completed.** Following initial analysis, data is monitored monthly. Bed managers continue to work together to support repatriation as soon as a local bed becomes available and it is clinically appropriate to do so **Completed.** A paper was presented to the Executive Oversight Team on the 5th October 2021. All recommendations were supported and work is now underway to include the principles within the Modern Matrons Audit from January 2022. **Completed.** The protocol was circulated on the 11th November 2021 with immediate effect. **Ongoing**. An improved understanding of our external placements will be available from January. **Ongoing.** Discussions are ongoing with commissioners in respect of our trajectory to achieve zero out of area placements. An update will be provided in February.	A decreasing position is now visible within the data, reflecting the reduction in internal OAPs from October and compliance to the Continuity of Care Principles.
Number of inappropriate OAP bed days for adults (External)			
More patients in our Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP) services are spending time in beds external to the Trust due to the demand nationally for inpatient care.	Analysis to be undertaken to better understand the position.	**Ongoing.** An update will be provided in February.	An increasing position is visible within the data.

Long Term Plan: Tees, Esk & Wear Valleys NHS Foundation Trust

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Number of women accessing specialist community PMH services			
There have been fewer women accessing our specialist community Perinatal Mental Health services than is the CCG ambition due to pressures that are being experienced nationally including increased acuity/complexity, and covid.	Further analysis to understand if this is an actual area of concern.	**Ongoing.** An update will be provided in February 2022.	

Quality, access and outcomes

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Oversight Standard	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	FYTD	Notes
Overall CQC rating (provision of high-quality care)	N/A	Requires Improvement												Requires Improvement				0.00%	
Acting to improve safety (safety culture theme in NHS Staff survey)																			Staff Survey data will be available in Quarter 4
Potential under-reporting of patient safety incidents		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%						100.00%	100.00%	100.00%		100.00%	
National Patient Safety Alerts not completed by deadline		0	0	0	0	0	0	0	0					0	0	0		0	
Venous thromboembolism (VTE) risk assessment																			Definition and construction guidance has not yet been released. However, all other Healthcare Associated Illness measures are applicable only to acute Trusts. Whilst it is not anticipated that this will be monitored for the Trust we are continuing to maintain oversight on this until that is confirmed.

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Our overall CQC rating is not as high as we would like to achieve.	CQC action plan development event to be held to develop a plan to address the 'must do' actions. Implementation of the required actions will support the Trust to demonstrate that it is consistently achieving the CQC Fundamental Standards enabling required improvements and a higher rating to be achieved following future inspections.	**Completed.** The event took place on the 21st December 2021 to review the actions that the Trust must take as a result of the inspection of core services and well-led inspection, and to develop actions to address these (mitigating any potential quality risks). The plan was co-created at this event with service users and carers and representatives from across Trust services and will be submitted by the deadline of the 21st January.	

Preventing ill health and reducing inequalities

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Oversight Standard	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	FYTD	Notes
Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics																			Definition and construction guidance has not yet been released.
Proportions of patient activities with an ethnicity code																			Definition and construction guidance has not yet been released.

Leadership and capability

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Oversight Standard	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	FYTD	Notes
Quality of leadership		Requires Improvement												Requires Improvement				Requires Improvement	
Aggregate score for NHS Staff Survey questions that measure perception of leadership culture																			Definition and construction guidance has not yet been released.

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Quality of Leadership	CQC action plan development event to be held to develop a plan to address the 'must do' actions. Implementation of the required actions will support the Trust to demonstrate that it is consistently achieving the CQC Fundamental Standards enabling required improvements and a higher rating to be achieved following future inspections.	**Completed.** The event took place on the 21st December 2021 to review the actions that the Trust must take as a result of the inspection of core services and well-led inspection, and to develop actions to address these (mitigating any potential quality risks). The plan was co-created at this event with service users and carers and representatives from across Trust services and will be submitted by the deadline of the 21st January.	

People

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Oversight Standard	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	FYTD	Notes
People promise index																			Definition and construction guidance has not yet been released.
Health and wellbeing index																			Staff Survey data will be available in Quarter 4
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months																			Staff Survey data will be available in Quarter 4
(a) managers																			
(b) other colleagues																			
(c) patients/ service users, their relatives or other members of the public																			
Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties																			Staff Survey data will be available in Quarter 4
Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns																			Staff Survey data will be available in Quarter 4
% of jobs advertised as flexible		5.30%	3.98%	13.85%	8.88%	8.08%	7.06%	7.31%	10.81%	8.85%				7.81%	8.04%	8.97%		8.29%	
NHS Staff Leaver Rate		11.47%	10.81%	11.66%	11.45%	11.06%	11.24%	11.49%	11.42%	12.15%				11.66%	11.24%	12.15%		12.15%	
Sickness absence (working days lost to sickness)		5.17%	5.22%	5.68%	5.69%	6.63%	6.90%	7.08%	6.79%	6.61%				5.36%	6.42%	6.83%		6.21%	Latest data published August 2021: 6.90%
Proportion of staff who say they have a positive experience of engagement																			Staff Survey data will be available in Quarter 4
Number of people working in the NHS who have had a 'flu vaccination								30.26%	46.44%	55.51%						55.51%		55.51%	Latest data published September 2020 - February 2021: 71.52% Benchmarking data as at August 2021 reports the Trust in the interquartile range
Nursing vacancy rate																			Latest data published September 2021: 7.17%Benchmarking data as at August 2021 reports the Trust in the highest performing quartile
Number of healthcare support workers employed by the NHS		1726.48	1722.87	1747.45	1769.80	1780.23	1862.32	1795.35	1818.33	1859.71				1747.45	1862.32	1859.71		1859.71	
Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women																			
Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women																			Definition and construction guidance has not yet been released.
Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women																			
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age																			Staff Survey data will be available in Quarter 4

People

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Durham & Darlington Locality			
Sickness within the Crisis team in Adult Mental Health Services is being impacted by current low staffing levels.	Team Manager to ensure all long term sickness Is managed in line with Trust policy. Recruitment is underway to increase capacity within the team.	**Ongoing.** Regular reviews are in place and a number of members of staff have returned to work. The team is currently operating at 49% staffing. **Ongoing.** Recruitment continues. Whilst these posts are being readvertised, further options are being considered to try to attract more applicants.	No visible impact; however actions remain ongoing.
Forensic Services			
This was first identified as a concern in May 2020 and issues identified included a number of long term sickness episodes and the impact of Covid-19.	An action plan is in place for Forensic Services.	**Ongoing.** There are 6 actions within the plan; 4 completed, including the quarterly reviews for any staff within restrictions. A number of actions were due for delivery in October but have been delayed due to staffing and business continuity pressures. All actions are on track for completion end of January 2022. • Review leaver information to establish if there are factors relating to sickness from staff leaving the teams. There were no returned leavers questionnaire from Secure Inpatient Services (SIS) between April – Sept 21 to enable analysis. The work within Health & Justice (H&J) has been delayed due to capacity within the Workforce team. • Review vacancy/use of bank staff. Completed within SIS; actions are being developed. The work within H&J has been delayed due to capacity within the Workforce team. • Review absences in Apr 20 – Mar 21 relating to anxiety/stress and other psychiatric issues to establish any themes. Both reports were presented to their leadership teams in December 2021 and further actions were identified. An update will be provided in February 22. • Human Resources to carry out audits of staff personal files / sickness data to ensure sickness is being managing in line with the Trust Sickness Absence Management procedure. This work is now underway.	No visible impact; however actions are still ongoing.

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Tees Locality			
Within AMH, long and short term sickness absence is monitored weekly by the Head of Service and Locality Manager. All episodes of sickness are managed according to Trust Policy. Caseloads of those staff on long term sickness are being reallocated to ensure that patients are not waiting; however, this is impacting on the stress levels of remaining staff.	A review of locality sickness pressure to be undertaken to identify any actions required to mitigate risk.	**Complete**: Caseloads of people on long term sick are being reallocated and appointments for those on short term sick are being covered or rescheduled when that is not possible. All patients are provided with crisis contact details.	No impact visible; however actions remain ongoing.
	The Locality Manager is to proactively encourage good wellbeing practice within the Middlesbrough Affective Team.	**Ongoing**	
	Recruitment to be undertaken within the Hartlepool teams.	**Ongoing**	
	Regular contact to be maintained with all staff absent from work. This will be supported by the Workforce team.	**Ongoing**	
Whilst we are seeing more members of staff absent from work within CYP services, staff are returning to work.	Close monitoring will be maintained to confirm whether this is an action area of concern.	**Complete:** CYPS are no longer showing as an area of concern and sickness levels are within normal range. Pending any further change, this will be removed from next month's report.	Performance is at a level we would expect.
Whilst we are seeing more members of staff absent from work within LD services, staff are returning to work.	Close monitoring will be maintained to confirm whether this is an action area of concern.	**Complete:** LD are no longer showing as an area of concern and sickness levels are within normal range. Pending any further change, this will be removed from next month's report.	Performance is at a level we would expect

Finance and use of resources

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Oversight Standard	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Q1	Q2	Q3	Q4	FYTD	Notes
Performance against financial plan																			Definition and construction guidance has not yet been released.
Underlying financial position																			Definition and construction guidance has not yet been released.
Run rate expenditure																			Definition and construction guidance has not yet been released.
Overall trend in reported financial position																			Definition and construction guidance has not yet been released.

ITEM NO. 21

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th January 2022**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Information**

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

Report:

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

Ref.	Date	Document	Sealing Officers
413	30.11.21	Appointment of P+HS Architects Ltd in relation to Block 9, Roseberry Park Hospital, Middlesbrough	Brent Kilmurray, Chief Executive Phil Bellas, Company Secretary
414	30.11.21	Appointment of P+HS Architects Ltd in relation to Sandwell Park, Hartlepool	Brent Kilmurray, Chief Executive Phil Bellas, Company Secretary
415	30.11.21	Licence to underlet and lease relating to part of St Margaret's House, Crossgate, Durham	Brent Kilmurray, Chief Executive Phil Bellas, Company Secretary
416	22.12.21	Appointment of Services Design Partnership Ltd in relation to Sandwell Park, Hartlepool	Brent Kilmurray, Chief Executive Phil Bellas, Company Secretary
417	22.12.21	Appointment of Services Design Partnership Ltd in relation to Block 9, Roseberry Park Hospital, Middlesbrough	Brent Kilmurray, Chief Executive Phil Bellas, Company Secretary

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