MEETING OF THE BOARD OF DIRECTORS
Thursday 28th April 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.

AGENDA

Standard Items (1.00 pm – 1.15 pm):

1	Apologies.	**Chair**	**-**
2	Chair's welcome and introduction.	**Chair**	**Verbal**
3	To approve the minutes of the last meeting held on 31st March 2022.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	Board Action Log.	**-**	**Report**
6	Chair's Report.	**Chair**	**Verbal**
7	To note any matters raised by Governors.	**Board**	**Verbal**

Strategic Items (1.15 pm – 1.45 pm):

8	Chief Executive's Report.	**CEO**	**Report**

9	Board Assurance Framework summary report.	**Co Sec**	**Report**
10	To consider the Finance Report as at 31st March 2022.	**DoF&I**	**Report**
11	To consider the Performance Dashboard Report as at 31st March 2022.	**ACEO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (1.45 pm – 3.00 pm):

12	To consider key issues and risks arising from recent Directors' Visits.	**Board Members**	**Verbal**
13	To consider the report of the Chair of the Quality Assurance Committee.	**Committee Chair (BR)**	**Committee Key Issues Report**
14	To consider an assurance report on the delivery of the CQC Action Plan.	**DoN&G**	**Report**
15	To consider the findings of the Ockenden report and the actions to be taken by the Trust.	**DoN&G**	**Report**
16	To consider the Learning from Deaths Report	**DoN&G**	**Report**

Goal 3: To be a Great Partner (3.00 pm – 3.05 pm):

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

Governance (3.05 pm – 3.10 pm):

18	To receive and note the Register of Interests of the Board of Directors	**Co Sec**	**Report**

Matters for Information (3.10 pm – 3.15 pm):

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

Exclusion of the Public (3.15 pm):

20	**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.* *Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.* *Information which, if published would, or be likely to, inhibit -* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.* *Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.* *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.*	**Chair**	**Verbal**

aul Murphy
Chair
22nd April 2022

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 31 MARCH 2022 COMMENCING AT 1.00 PM via MS Teams

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

In Attendance:
Mr P Bellas, Company Secretary
Ms L Hughes, Interim Corporate Governance Advisor

Observers/Members of the Public
Ms S Baxter, Public Governor (Redcar and Cleveland)
Mrs. J. Kirkbride, Public Governor (Darlington)
Ms. A. Eagle, Deloitte LLP
Mr. S. Double, Alder
One Member of the Public

22/03/1/213 APOLOGIES

1.1 Apologies were received from Dr C Carpenter, Non-executive Director and Prof P Hungin, Non-executive Director

22/03/2/214 CHAIRMAN'S INTRODUCTION

2.1 The Interim Chair welcomed everyone to the meeting.

22/03/3/215 MINUTES OF PREVIOUS MEETING

3.1 **Resolved:** the minutes of the previous meeting held on 24 February 2022 were approved as a correct record and agreed to be signed by the Chairman.

22/03/4/216 DECLARATIONS OF INTEREST

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

22/03/5/217 PUBLIC BOARD ACTION LOG

5.1 *Matters Arising* from previous minutes **22/02/15/210 (Guardian of Safe Working Quarterly Report)** – Liz Romaniak explained that the report presented to the last meeting did not clearly reflect the active engagement that is ongoing with the Estates department. The Board was pleased to note the work that is taking place.

5.2 It was noted that the open action (222/01/09/185/9.1.6.1); the ICO Audit report was planned to be discussed at the May 2022 Audit and Risk Sub-Committee meeting. It was agreed to leave this action on the log until completed.

22/03/6/218 CHAIRMAN'S REPORT

6.1 The Interim Chair reported on activities since the last meeting, drawing reference to the following of note:

6.1.1 Secure Inpatient Services wards at Roseberry Park – Since the last meeting he had spent a further full day visiting the Secure Inpatient Services. He found the time spent with patients and staff most valuable, with plans in place to visit all Secure Inpatient Service wards in future.

6.1.2 Stockton Social Care and Select Committee - Stockton Councillors had resolved to write to the Secretary of State to request a public inquiry. The Board noted this was disappointing and arrangements had been made to ensure colleagues within the system including the Trust's regulators are briefed and fully appraised on this and any progress the Trust has made to date.

6.1.3 ICS System Meetings – with the support of Shirley Richardson, Acting Deputy Chair, it had been possible to attend a number of ICS meetings within both systems.

6.1.4 Reflective Practice Conference – the Interim Chair and Chief Executive had attended the Reflective Practice Conference.

6.1.5 Lunch and Learn Session – he had the privilege of chairing the Trust's internal Lunch and Learn Session, which focussed on Ramadan. The session was well attended with over 100 attendees.

6.1.6 Signing of the Armed Forces Covenant Ceremony – the Covenant was signed by the Interim Chair and Dr Jagannath Sharma, who holds a Major rank in the Royal Army Medical Corps Reserve Unit. The Ceremony was also attended by the Trust's Chief Executive, Lt Col Jim Turner, Commander at Catterick Garrison and soldier Mikey Pope, who had painted a mural dedicated to the armed forces, which is displayed on the walls of Maple ward. The Covenant is a pledge that together we understand that service personnel, veterans, their families, and service leaders should be treated with fairness and respect in the communities, economy, and society they serve with their lives, and it is very important to the Trust that people with lived experience of the armed forces and their family members are involved in the development of the Trust's services.

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

22/03/07/219 MATTERS RAISED BY GOVERNORS

7.1 There were no matters raised by Governors reported.

22/03/08/220 CHIEF EXECUTIVE'S REPORT

8.1 The Chief Executive's Report was received and noted with reference drawn to the following:

8.1.1 The Trust continued to make progress on the delivery of improvement plans across Secure Inpatient Services and Community CAHMS to address the Care Quality Commission's (CQC) concerns including the Section 29A Warning Notice. The Trust's meeting with the CQC on 9 March 2022 enabled detailed discussions on the programme of work including deep dives and thematic reviews. Progress on improvement plans will

be presented to the Quality Assurance and Improvement Committee in future with further updates possibly provided to the Board on a quarterly basis.

8.1.2 Well Led and Core Services Action Plan – the Trust's new governance structure is on target to go live from 1 April 2022. The roll-out will be supported by a personal and collective leadership team development programme. The Chief Executive thanked staff and colleagues for their work to progress with the structural changes. He was pleased to report that Patrick Scott was commencing in post as Managing Director of Durham, Tees Valley and Specialist Secure Inpatient services in April 2022 and an appointment has been made to the Managing Director position for North Yorkshire, York and Selby with final recruitment checks taking place before the appointment is formally announced.

8.2 The Interim Chair referred to the progress made in CAHMS with the 37% caseload reduction that had been made since September 2021, commending the Stockton team for the progress they had made to address backlogs.

8.3 Durham CAHMS visit – Shirley Richardson reported on her visit to the Durham CAHMS service and was pleased to note the whole system working approach with schools, the local authority, and the Trust.

8.4 Shirley Richardson queried what work was taking place in preparation of a future CQC inspection. In response the Chief Executive explained that the work is pressing forward to complete the action plan and compliance with the fundamental standards. Evidence to support progress on actions will be provided to the CQC in any future visits/inspections.

8.5 Liz Romaniak reported on the meeting held earlier that week to discuss the national mental health backlogs and the invitation to participate in the long-term plan refresh.

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

22/03/9/221 AUDIT AND RISK COMMITTEE KEY ISSUES CHAIR'S REPORT

9.1 John Maddison, Non-executive Director and Chair of the Audit and Risk Committee reported on the meeting held on 17 March 2022, which mainly focussed on the year end business. The Committee had a detailed discussion on the Head of Internal Audit Opinion with assurances provided that the Trust is a going concern subject to the satisfactory outcome of some final audits.

9.2 The Committee discussed the Corporate Risk Register and Board Assurance Framework and it was agreed that a meeting would be arranged outside of the Committee with the Company Secretary and Director of Quality Governance to discuss risk management plans and progress made to date. The Interim Chair was pleased to note the Committee's focus on risk.

9.2.1 Elizabeth Moody referred to the appointment of the Head of Risk position, which is a new role and will focus on embedding the risk management arrangements to support the governance structure across the organisation. She emphasised the strengthening of risk oversight with the new meetings that have been established within the Care Groups, which will have oversight and scrutiny on risk management and the establishment of an Executive Risk Management meeting, which will have oversight and scrutiny on risk management across the entire Trust, providing assurance to the Audit and Risk Committee in the future.

9.3 **Resolved:** the Audit and Risk Committee Key Issues Chair's Report from the meeting held on 17 March 2022 was received and noted.

22/03/10/222 FINANCE REPORT

10.1 Liz Romaniak spoke to the Finance Report as of 28 February 2022, which reflects financial performance within the national financial arrangements supporting the NHS to sustain the Covid pandemic response. She drew reference to the following of note:

10.1.1 The Trust predicts a 2021/22 probable case surplus of £5.9m, or £800,000 ahead of plan. This reflects receipt of unplanned income, including national funding for prior year Final Pay Control costs.

10.1.2 Cash Balances reported at £93.5m, or £13.7m ahead of plan.

10.1.3 Monitoring of the UoRR nationally is currently suspended due to the Covid pandemic. Agency usage was sustained in 2021/22 with a notable increase since October 2021. The Trust continues to monitor internally against the UoRR criteria and due to the increased use of agency spend this has changed its internal scoring to UoRR capped at 3. Excluding this cap, the Trust would be assessed as a 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 results in the Trust's plans to reduce agency expenditure with business plans and operational focus to decrease agency usage. John Maddison, Non-executive Director noted that Liz Romaniak had continued to report on the Trust's financial position and plans with the Strategy and Resource Committee receiving up to date reports, which had enabled open discussions to take place.

10.1.4 Planning work continues for 2022/23 for organisations and at Place level as part of the Integrated Care System (ICS) with a draft Plan (March) and final (April) level financial plans. National arrangements are targeted to support the NHS to navigate a phased return, or 'glidepath', towards capitation-based revenue allocations.

10.2 Discussion took place around the Capital programme and Jill Haley, Non-executive Director queried if the Trust had back-up plans that excluded staffing. In response Liz Romaniak explained that there are opportunities to look at travel arrangement efficiencies and the use of robotics through programme automation with work taking place to engage with partners in relation to this across the Trust's footprint.

10.3 **Resolved:** the Finance Report as of 28 February 2022 was received and noted.

22/03/11/223 PERFORMANCE DASHBOARD

11.1 Sharon Pickering spoke to the Performance Dashboard as at 28 February 2022, which highlighted out of the 21 key performance measures, 11 areas were of concern, all of which had plans and close monitoring in place.

11.1.1 The key concerns remained within quality, activity and workforce with challenges continuing in relation to staff sickness absences. Increased acuity and demand added to the bed pressures and need to consider Out of Area placements. A ward in Scarborough is still closed and the Trust continues to mitigate risks to manage pressures safely.

11.2 John Maddison, Non-executive Director queried the KPI treatment target used and in response Sharon Pickering explained that it was an internal target and work was ongoing to develop national targets for mental health to work in parallel with the acute national targets.

11.3 Bev Reilly, Non-executive Director queried the longest waiting time known for a patient in the Trust. In response, Sharon Pickering agreed that arrangements would be made to retrieve information from the system to share with members of the Board.

ACTION (S Pickering)

11.3.1 The Chief Executive added that work is taking place to identify the waiting list position for first and second appointments.

11.4 **Resolved:** the Performance Report as of 28 February 2022 was received and noted.

22/03/11/224 REPORT OF THE QUALITY AND ASSURANCE COMMITTEE CHAIR

12.1 Shirley Richardson, Interim Deputy Chair, chaired the last meeting of the Quality and Assurance Committee held on 3 March 2022 and drew reference to the following:

12.1.1 An update on the plans in place to deliver the CQC Action Plan was provided together with an update on the Trust's preparations in advance of the meeting with the CQC on 9 March 2022.

12.1.2 Assurances were received on immediate actions that had been taken to ensure patients were safe and safeguarded following the whistleblowing concerns raised in relation to secure inpatient services.

12.1.3 Following discussion on the Trust Level Quality Learning Report, the Committee requested an update is provided to the next meeting that details the programme of work underway in relation to suicide and self-harm.

12.1.4 An additional agenda item was received on NHS England's report on *Enhancing Board Oversight; a New Approach to the Non-executive Director Champion Roles*, which the Committee was informed would have implications for the Quality Assurance and Improvement, and the Strategy and Resource Committees. It was noted that Executive Leads planned to integrate the changes into future reports.

12.1.5 An update was provided on the Corporate Risk Register and Board Assurance Framework and how risks on the CRR would be assigned to Executive Director leads with scrutiny planned to take place at the Executive Risk Management Group and at the Risk Group within the Care Groups within the new governance structure.

12.1.6 Recruitment and retention of staff, and concerns about staff health and wellbeing, were raised. It was noted that these areas of concern would continue to be overseen by the People, Culture and Diversity Committee.

12.2 Elizabeth Moody reported on the outcome of the annual Clinical Audit of Emergency Response Bags, which found that there is generally high compliance with the practice standards but that there is further work required to achieve 100% compliance. Elizabeth confirmed that any non-compliant areas had mitigating actions in place with immediate follow-up taking place and assurances provided to the Clinical Audit and Effectiveness Team. A new emergency response bag had recently been put in place with a snap-tag closure, which means that the equipment will no longer need to be checked daily unless it has been used. It is anticipated that this will significantly improve assurance going forward.

12.3 **Resolved:** the Report of the Quality and Assurance Committee Chair from the meeting held on 3 March 2022 was received and noted.

22/03/13/225 PEOPLE, CULTURE AND DIVERSITY COMMITTEE

13.1 Shirley Richardson, Interim Deputy Chair and Chair of the People, Culture and Diversity Committee provided an update on the meeting held on 15 March 2022 and drew reference to the following:

13.1.1 Recruitment and retention remains one of the Committee's main areas of focus, with an update provided on staff retention and learning from exit interviews.

13.1.2 A Colleague story was received from a volunteer/service user with the Committee hearing how their role had provided them with a sense of belonging during a difficult time of their life when experiencing mental health challenges.

13.1.3 The Committee received an update on the EDS2 and Staff Networks with a piece of work under way with the University of Surrey to identify ways of reducing bias in the recruitment and interview process.

13.1.4 The Chief Executive drew reference to the results of the NHS Staff Survey with more Trust staff contributing this year. The Trust's position in response to the national results did not show favourably but it was noted that work was under way to address concerns raised and a quarterly Pulse Survey will be monitored closely by the Committee, which will also be reported to the Board.

13.1.4 It was noted that there had been no further changes to the Board Assurance Framework risks assigned to the Committee since the previous meeting. The Corporate Risk Register risks assigned to the Committee enabled discussions on the difficulties recruiting to vacancies and it was agreed that this required to be clearly reflected within the Corporate Risk Register and the Board Assurance Framework.

13.1.5 The Freedom to Speak Up Guardian Report was received, which included an update on the role over the last six months as well as local, regional and national developments. It was agreed further updates would be received bi-annually in the future.

13.2 **Resolved:** the Report of the People, Culture and Diversity Committee Chair from the meeting held on 15 March 2022 was received and noted.

22/03/14/226 OUTCOME OF THE ESTABLISHMENT REVIEWS

14.1 Elizabeth Moody provided an update on the outcome of the Clinical Team Staffing Establishment Reviews for the period covering June to November 2021. She explained that the reviews are undertaken to ensure the Trust has the correct baseline establishments in place to provide high quality, safe patient care. Prior to the Board meeting there had been in depth discussions at Senior Leadership Team and Financial Sustainability Board; and a further review was planned to take place within the People, Diversity and Culture Committee to obtain independent assurance.

14.2 Following discussion it was agreed that due to the potential of a resource implication, further discussion and consideration would be required by the Strategy and Resource Committee. **ACTION (E Moody)**

14.3 **Resolved:** i) the Outcome of the Clinical Team Staffing Establishment Reviews for the period covering June to November 2021 were received and noted; and

ii) Further updates would be provided to the People, Culture and Diversity Committee and the Strategy and Resource Committee.

22/03/15/227 RECOMMENDATIONS OF THE COUNCIL OF GOVERNORS TO CONSIDER CHANGES TO THE TRUST'S CONSTITUTION

15.1 It was noted that a proposal was approved by the Council of Governors at its meeting on 8 March 2022 with regards to the classes of the Staff Constituency and the composition of the Council of Governors to reflect the changes to the governance structure and the formation of the Care Groups.

15.2 **Resolved:** i) the Board ratified the decision of the Council of Governors to have a total number of Governors of 54; and
ii) ratified the decision for the Staff Constituency to include three classes: Corporate Directors 1 Governor, Durham Tees Valley and Forensic Care Group 3 Governors; and North Yorkshire, York and Selby 1 Governor.

22/03/16/228 RECOMMENDATION OF THE AUDIT AND RISK COMMITTEE TO APPROVE THE STANDING FINANCIAL INSTRUCTIONS

16.1 The Trust's Standing Financial Instructions require periodic review to ensure they reflect current practice and remain relevant to the changing environment and working practices. It was noted that a review had taken place with the outcome reported to the Audit and Risk Committee at its 17 March 2022 meeting. The Audit and Risk Committee were assured that the amendments remain appropriate for the changing needs of the organisation, including impacts arising from the recent operational restructure and legal and regulatory requirements and approved the proposed changes for ratification by the Board.

16.2 **Resolved:** amendments to the Trust's Standing Financial Instructions as recommended by the Audit and Risk Committee were ratified.

22/03/17/229 USE OF THE TRUST'S SEAL

17.1 **Resolved:** in accordance with Standing Order 15.6 the Board noted the use of the Trust seal on one occasion since the last Board meeting.

22/03/18/230 CONFIDENTIAL MOTION

18.1 **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 2.45pm.

Paul Murphy
Chair
28 April 2022

Board of Directors

Public Action Log

RAG Ratings:

	Action completed/Approval of documentation
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Date for completion of action not yet reached

Date	Ref No.	Action	Owner(s)	Timescale	Comments	Status
27/01/22	**22/01/09/185/9.1.6.1**	Agreed that the outcome of the ICO Audit would be presented to the next Strategy and Resource Committee; and the next Audit and Risk Committee. Agreed at the February Board meeting to leave this action open until completed.	Co Sec/DoF	April/May 22	Noted for inclusion on agendas	Open
31/03/22	**22/03/11/223/11.3**	**PERFORMANCE DASHBOARD** Bev Reilly, Non-executive Director queried the longest waiting time known for a patient in the Trust.Sharon Pickering agreed that arrangements would be made to retrieve information from the system to share with members of the Board	S Pickering	30-Apr-22	Update to be provided at the meeting	Open
31/03/22	**22/03/14/226/14.2**	**OUTCOME OF THE ESTABLISHMENT REVIEWS** - Further updates to be presented to the People, Culture and Diversity Committee; and the Strategy and Resource Committee	E Moody	May-22	Update to be provided at the meeting	Open

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 28 April 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.

Integrated Care Systems (ICS)

The ICSs across North East and North Cumbria (NENC) and Humber Coast and Vale (HCV) continue to develop their operating arrangements as we move towards 1 July 2022 when they will become statutory organisations (subject to the passage of legislation). Key developments this month include:

- The consultation with staff employed in the CCGs in terms of the organisational change that will take place on 1 July has commenced. Clearly this is a time of uncertainty for these staff in terms of the future so we need to be mindful of that in our interactions over the next few months.

- HCV has rebranded itself as Humber and North Yorkshire (H&NY).

- The H&NY Integrated Care Board includes a place for a Mental Health & Learning Disability member and Steven Eames has written to the three Chief

Executives of the NHS Providers asking them to confirm who will take on this role.

- Together with James Duncan, CEO, CNTW, I met with Sam Allen CEO NENC ICS. It was a very positive first meeting and we are both looking forward to supporting Sam and the ICS in the future.

Covid

Patient activity in relation to covid infection rates has remained low over the past month with only one inpatient outbreak at Rowan Lea, older persons ward in Scarborough and 4 other positive inpatients at the time of writing this report. Revised National guidance has been received setting out a stepping down of IPC measures. The following Trust guidance is now being put in place:

- **Stepping down inpatient COVID-19 isolation precautions:** COVID +VE patients in all settings can reduce isolation from 10 days to 7 following 2 negative LFD tests (currently doing this).

- **Stepping down COVID-19 precautions for exposed patient contacts:** patients are no longer required to isolate as a contact of a positive case (currently doing LFD testing of patients only if symptomatic).

- **Returning to pre-pandemic physical distancing in all areas:** this includes **all** clinical areas**,** ED departments, inpatient settings, primary care, ambulances. (Agreed at Gold Command 22/04/2022) This will allow services to increase capacity in areas such as training numbers in the provision of mandatory training, facilitate the coffee shops to provide a pre pandemic service, inpatients services to return to normal routine in relation to patient dining and the return of activities for the well- being of patients. This will also facilitate the booking of rooms for meetings both internal and external.

- **Returning to pre-pandemic cleaning protocols outside of COVID-19 areas.** As of 1 May, facilities will move to routine detergent cleaning, touch point cleaning will cease in those areas serviced by TEWV staff. The Chlor cleaning product will be used in outbreak management only.

The IPC team will continue to monitor the effect of the reduction in social distancing and its impact through outbreak reporting and raise any areas of concern .

Organisational Restructure

Update on Board appointments and recruitment:

- Zoe Campbell will be taking up the role of Managing Director for North Yorkshire, York and Selby and joins us from the Alzheimer's Society where she is currently Executive Director of Operations. Zoe has extensive experience of leading across operations balancing delivery, governance, EDI

and culture and a passionate commitment to ensuring genuine engagement with colleagues, communities and other partners. As well as the charity sector, Zoe has also held leadership roles in the private health and care sector and in adults' and children's services in local government.

- The Medical Director post was successfully recruited to following an extensive recruitment process. We will be announcing details of this appointment as soon as possible.

- We are in the process of recruiting to the Assistant Chief Executive post following Sharon Pickering's decision to retire. The interviews for the post are scheduled for 17 and 19 May with external, internal and involvement member participation.

In terms of the overall organisation restructure this went live as planned on 1 April 2022. Prior to this I held 4 briefing sessions with staff that were transferring into new roles within the structure. This gave me the opportunity, along with Executive Director colleagues to reiterate the purpose of the restructure. We also described in some detail the new governance structures and the importance of our values. Overall feedback on the sessions was positive.

In terms of the new governance structure positive progress has been made to ensure implementation during April. We have held the first two Executive Directors meetings (which replaces Senior Leadership Group). The Executive Directors sub groups have also started to meet. In some cases to ensure an effective and smooth transition we have agreed that some of the existing groups will remain during April to ensure we manage any risks during the transition but I expect that in May the new governance structure will be fully operational.

Dalesway Entrance Incident at Roseberry Park Hospital

A patient self-presented at Roseberry Park Hospital on Sunday 3 April 2022 to be seen by Crisis however the patient parked his car immediately outside of the main Dalesway entrance restricting access to the hospital. The patient was asked to remove his car from the entrance of Dalesway reception by security on a number of occasions. The patient then left the reception area and got into his car before driving it directly through the front doors at force causing damage to the front of the hospital building, luckily no-one was hurt during the incident. Police were already on-site and in reception at the time of the incident and supported in removing the patient from the vehicle before restraining him, placing him under arrest and taking him into custody.

The 1st Senior Manager on-call was contacted and notified of the incident. This was then escalated to 2nd on-call and Director on-call. Both 1st and 2nd on-call managers attended the site to offer support to staff. Contact was made with Senior Estates personnel who immediately arranged for a team to assemble to secure the front of the building.

All staff who witnessed the incident or who were in close vicinity were spoken to and offered support by Senior Managers on call, who also contacted Supervisors of all staff at the scene to make them aware of the support offered. The names of all staff at the scene have been shared with the Trust's Employee Support Service so additional contact can be made and Employee Support staff have also attended the stie in order to be accessible to staff. A de-brief within the service is ongoing.

CCTV footage was reviewed by Senior Managers on-call and a copy provided to police.

All Inpatient ward safety reviews have been updated to reflect access arrangements and a security proposal is being produced by the Head of Security.

Immediate action was taken to clear glass and debris from the scene and the entrance boarded up safely and securely. Alternative access for patients and families is in place.

On 5 April the patient was released on bail and has been referred to the North Home Intensive Treatment Team for follow up support.

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th April 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 12 – Directors' Visits Feedback ▪ Public Agenda Item 13 – Quality & Assurance Committee Key Issues Report (Locality Reports/Corporate Risk Register/Monthly Safe Staffing Report)
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 (CEO)**	**High** ↔	**Reasonable**	Opportunities to improve controls; however, new controls (if available) are required to reduce exposure to tolerable levels	▪ Public Agenda Item 11 – Performance Dashboard Report ▪ Public Agenda Item 12 – Directors' Visits Feedback
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.	

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 11 – Performance Dashboard Report ▪ Public Agenda Item 12 – Directors' Visits Feedback ▪ Public Agenda Item 13 – Quality & Assurance Committee Key Issues Report (Quality and Learning Report) ▪ Public Agenda Item 15 - Ockenden report
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 11 – Performance Dashboard Report ▪ Public Agenda Item 12 – Directors' Visits Feedback ▪ Public Agenda Item 15 - Ockenden report
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 11 – Performance Dashboard Report ▪ Public Agenda Item 12 – Directors' Visits Feedback ▪ Public Agenda Item 13 – Quality & Assurance Committee Key Issues Report (Quality and Learning Report) ▪ Public Agenda Item 15 - Ockenden report ▪ Public Agenda Item 16 – Learning from Deaths Report ▪ Private Agenda Item 3 – Reportable Issues Log
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 10 – Finance Report ▪ Private Agenda Item 8 – Financial Plan 2022/23

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 6 – 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 13 – Quality & Assurance Committee Key Issues Report (CQC Update) ▪ Public Agenda 14 – CQC Action Plan ▪ Public Agenda Item 17 – System Oversight Framework ▪ Private Agenda Item 3 – Reportable Issues Log ▪ Private Agenda Item 5 – Chief Executive's Report ▪ Private Agenda Item 6 – Strategy and Resources Committee Key Issues Report (ICO Action Plan)
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.	▪ Private Agenda Item 5 – Chief Executive's Report
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 3 – Reportable Issues Log ▪ Private Agenda Item 5 – Chief Executive's Report

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 – Chief Executive's Report
13	✓	✓	✓	**West Lane** The outcome of the independent enquiry, coroners' investigations, and civil legal actions could affect our reputational and regulatory standing if the Trust is not able to demonstrate the necessary improvements and approach	**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 5 – Chief Executive's 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 6 – 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**	**Very High** ↑	**Reasonable** ↓	Urgent action is required to strengthen controls, where practicable due to national/regional constraints, to reduce the risk score to target (within tolerance) through the delivery of mitigations	▪ Public Agenda Item 10 – Finance Report ▪ Public Agenda Item 11 – Performance Dashboard Report ▪ Private Agenda Item 6 – Strategy and Resources Committee Key Issues Report (Finance Updates) ▪ Private Agenda Item 8 – Financial Plan 2022/23

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 10

PUBLIC
BOARD OF DIRECTORS

DATE:	**28th April 2022**
TITLE:	**Month 12 Finance Report - 1 April 2021 to 31 March 2022**
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 draft end of year position reflects performance within the context of national financial arrangements supporting the NHS Coronavirus Pandemic response.

The Trust submitted a plan to deliver a £47k surplus for the second half of 2021/22 (H2), and a composite annual surplus of £5.1m when added to confirmed performance for the first 6 months of the year. The Trust projected delivery of a surplus of £5.9m, or £0.8m ahead of plan. Whilst draft accounts for 2021/22 are not due to be submitted until 26th April, our forecast remains broadly unchanged at £5.948m.

- **Statement of Comprehensive Income:** The year to date position is an operational surplus of £5.948m, which is £0.8m ahead of the required £5.1m surplus. This is before £0.5m additional unplanned profit from the disposal of fixed assets, and fixed asset impairments of (£10.6m), both of which are excluded when assessing NHS provider financial performance.

- **Capital Programme:** 2021/22 capital requirements 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. The Trust's current interim end of year outturn position is £12.9m, or £0.7m below the Trust's £13.6m plan. This reflects receipt of IT infrastructure supplies as planned and accounts for the upside of full recovery of VAT (as advised in narrative reporting last month), giving a favourable variance to plan.

- **Cash Balances** are £81.7m, or £5.2m ahead of plan, with details in section 3.7.

Final plans for 2022/23 are due for submission at the end of April 2022. A financial plan update is being discussed in the private session of the Trust Board on 28th April. The Trust's plan submission will form part of a wider North East and North Cumbria Integrated Care System (ICS) submission. Feedback on the composite ICS plan submission is not therefore expected until May 2022. The Trust Board will approve an interim operating budget pending receipt of any regional or national feedback.

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 12 of 2021/22; 1st April 2021 to 31st March 2022 against a planned surplus for the period of £5.1m.

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 to deliver 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 gave a composite (H1 plus H2) planned surplus of £5.068m for the financial year. Included within this plan is a national 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.

Ongoing iterative run rate, balance sheet and forecast reviews suggested a current Trust probable case forecast that is £0.8m ahead of our planned surplus of £5.1m, i.e., a full year £5.9m surplus. Whilst this deteriorated at Month 10 due to increased rostered staffing costs and independent sector bed utilisation, our assessment is that with an outturn position of £5.948m operational surplus currently, we remain on track to deliver this forecast.

The 2021/22 surplus arises due to:

- Unplanned income and anomalies in planned nationally block income arrangements (based on higher 2019/20 outturn values);
- Changes in the national approach of charging providers for Final Pay Control via NHS Pensions (generating the reimbursement of prior year liabilities); offset by

- Independent Sector bed costs and incentive payments linked to inpatient staffing and Covid pressures.

2.6 The North 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-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 Operational planning guidance for 2022/23 was issued on 24th December 2021, followed by supporting technical guidance in various tranches after 14th January 2022. Indicative contract envelopes (ICE) and agreement on income allocations continued to be pursued during February and into March, with some challenges due to cross-ICS funding flows and varying system timetables. The impact was that, at draft submission stage, there was residual uncertainty around levels of service development and new investment funding available in 2022/23. Commissioner income assumptions in aggregate were finalised in mid-March, leaving financial planning activities compressed around a reduced planning window before final plan submission in April.

2.8 Detailed draft organisation plans, reflected in 'place' and ICS level plans, were submitted on 17th March 2022. The focus now is finalising detailed financial plans to support a final ICS plan submission on 28th April.

3.1 Key Performance Indicators (KPIs)

Appendix 1 provides a summary of KPIs for the year to date.

3.2 Statement of Comprehensive Income – Year to date

The year to date position is a surplus of £5.9m, which is £0.8m ahead of plan (£4.8m plus £0.3m H1 variance required to be maintained in H2). This excludes £0.5m unplanned profit from fixed asset disposals, and (£10.6m) fixed asset impairments, both of which are excluded when assessing NHS provider financial performance, and are therefore included as a 'below the line' adjustment at Table 1. Performance is summarised in table 1:

Income from patient care activities was £28.1m higher than plan due to additional income, including for Mental Health spending review allocations, to support investment by the Trust in adult acute inpatient ward staffing, and from National pay award funding (£4.2m) and NHS Pensions accounting arrangements (£13.3m), where allocations or adjustments were clarified after plan submission.

Other operating income was £3.5m above plan due to training and development, salary recharges, research and development and non-patient care income not anticipated at plan.

Table 1

	Year ended 2021/22			Last Month Variance
	Plan	**Actual**	**Variance**	
	£000	**£000**	**£000**	**£000**
Income From Activities	392,609	420,708	-28,099	-10,406
Other Operating Income	19,381	22,921	-3,540	-1,781
Total Income	**411,990**	**443,629**	**-31,639**	**-12,187**
Employee Operating Expenses	-329,671	-351,167	21,496	6,934
Operating Expenses Excluding Employee Expenses	-69,898	-79,179	9,281	4,708
Non Operating Expenses	-7,654	-7,335	-319	257
Surplus / (Deficit)	**4,767**	**5,948**	**-1,181**	**-288**
Profit on sale of Assets		509	-509	-509
FA Impairment		-10,698	10,698	
Surplus / (Deficit) incl adjustments	**4,767**	**-4,241**	**9,008**	**-797**

Pay expenditure was higher than planned by £21.5m due to:

- £4.2m nationally determined pay award not confirmed at plan;
- £13.3m NHS Pensions accounting arrangements;
- higher than planned temporary staffing expenditure, including costs relating to the Gold Command decision to offer incentives to support acute and forensic inpatient staffing through the peaks of the Omicron variant, but also reflecting elevated observations and sickness and vacancy cover;
- higher than planned trainee grade expenditure due to successful recruitment within the last medical rotation; and
- net vacancies across the Trust which offset the above pressures and vacancy cover.

Non pay expenditure was £9.3m higher than planned, due to:

- 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 fully utilised) five independent sector adult Mental Health assessment and treatment beds which have been contracted to the end of June 2022, however non-contracted capacity is also being used, with a focus currently on reviewing lengths of stay as a contributory driver of adult occupancy pressures;
- higher than planned expenditure to support ICS projects, reviews and investigations;
- unplanned drugs costs due to changed prescribing practice; and,
- computer hardware to support and improve smarter working.

3.4 Cash Releasing Efficiency Savings (CRES)

The Trust has offset its CRES requirements in full, using non-recurrent under spending linked to reduced non-pay costs and remote working arrangements supplemented by other non-recurrent savings. The offsets arising due to pandemic ways of working are reported as non-recurrent and have therefore not been subject to quality impact assessment. Recurrent related smart working schemes are 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. Activities have been delayed because of operational pressures and will need to continue as a key focus into quarter one 2022/23.

3.5 Capital

The Trust's current assessment is that a draft end of year net expenditure of £12.9m will be delivered against the ICS capital allocation of £13.6m. This reflects full VAT recovery via HMRC (to be passported via the Trust's construction partner) and the receipt of IT infrastructure supplies as planned by 31st March.

Indicative capital allocations have been used to develop draft 2022/23 Provider and ICS capital plans. Final plans will be submitted on 28th April, alongside revenue plans.

3.6 Workforce

Outside of Pandemic financial arrangements, tolerances for flexible staffing expenditure were set at 1% of pay budgets for overtime, 2.4% for agency (based on NHSI agency cost cap metric) and were 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 £8.4m for 2021/22 (unindexed). Agency expenditure to date is currently estimated at £13.7m (subject to final accounting adjustments); which is £5.3m above the indicative cap for the period ending 31st March 2022. 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 since 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. A key driver of additional utilisation and expenditure breaches has been additional temporary staffing to

support a small number of very complex packages of care for patients in Learning Disability services.

Actions to target reduced agency staffing expenditure are required to deliver the Trust's 2022/23 financial plans. As pre-pandemic ways of working are re-established the Trust will also review arrangements to ensure optimal roster efficiency and planning. Reducing agency reliance and costs will need to be a key sustained area of oversight for the Board and Committees.

3.7 Statement of Financial Position

Cash balances were £81.7m at 31st March 2022, which is £5.2m ahead of plan (£76.5m). This reflects the £0.8m higher than planned surplus (inclusive of disposals), £0.7m lower than planned capital expenditure, and other movements in working capital.

The Trust achieved the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of both NHS and non-NHS suppliers.

Conversations are ongoing with organisations to take collection of all debt over 90 days. 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.

4. IMPLICATIONS:

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

5. RISKS:

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

5.2 The Trust, alongside NENC partners, is due to submit financial plans for 2022/23 at the end of April 2022. Key concerns include the real terms financial impacts of Pandemic recovery and the differential impact of Agenda for Change pay award costs for non-acute providers. The recurrent mechanism for funding the 6.3% increase in employers' NHS Pensions contributions (due to be funded through central arrangements during 2022/23) is of similar concern for non-acute providers from 2023/24.

5.3 The Board has discussed the challenge of 'post-pandemic' Mental Health recovery, including relating to ongoing staffing sickness levels, acuity, demand, and 'backlog'. Discussions have continued through local Partnership Boards, to agree joint immediate and future investment priorities.

5.4 CRES targets have been offset by non-recurrent underspending for the current financial year. Nationally, efficiency requirements have been more challenging

since October 2021; and equivalent to 1.1%, or £1.8m for TEWV in H2 and confirmed to continue via a 1.1% national tariff efficiency throughout 2022/23. At draft plan stage, NENC providers agreed the need to target a minimum 2% CRES for 2022/23. Nationally allocated Covid support funding reduced by 5% in H2 of 2021/22 and by 57% in 2022/23 (compared to 2021/22). As the Trust concludes financial planning activities an efficiency, and other non-recurrent actions exceeding 2% are likely to be required.

5.5 It is unclear what metrics will be established nationally linked to revised NHS Oversight Framework requirements (including how previous Use of Resources Rating metrics will feature). 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 will target various actions to decrease agency utilisation and cost reductions despite the absence of explicit agency metrics.

5.6 The Trust draft outturn position at 31st March 2022 is subject to external audit review, and any findings may alter the financial outturn position.

6. CONCLUSIONS:

6.1 The Trust expects to submit a draft accounts position of an operating surplus of £5.9m for 2021/22, which is £0.8m ahead of our required surplus. This excludes £0.5m unplanned profit from the disposal of fixed assets and (£10.6m) fixed asset impairments, which are discounted when assessing NHS provider financial performance.

6.2 Work to finalise the Trust's 2022/23 financial plan, and a composite North East and North Cumbria system plan, is due to conclude at the end of April. Significantly delayed contract offers and allocation uncertainty impacted Trust planning work into mid-March, however subsequent progress has been positive. The Board will consider progress in private on 28th April, pending feedback after the system and individual organisation plan submissions.

6.3 Mitigations to offset efficiency requirements during 2021/22 have been identified, with scope to make some savings recurrent and reflected in draft 2022/23 plans.

6.4 Levels of expenditure on agency workers are higher than planned and are a key risk requiring mitigation 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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Draft position pending adjustments prior to 26th April draft accounts submission

Appendix 1

Key Financial Indicators for the period ending 31 March 2022

Surplus variances are shown as negative	Year to date			RAG	Prior Month Variance	RAG
	Plan	Actual	Variance			
I&E (Surplus) / Deficit £m	-4.7	4.2	8.9	◆	-0.8	●
Profit on sale of Asset (Inc in I&E performance shown above)	0.0	-0.5	-0.5	●	-0.5	●
Impairments of Buildings following MEA valuation	0.0	10.7	10.7	◆	0.0	●
Income £m	-412.0	-443.6	-31.6	●	-12.2	●
Pay Expenditure £m	329.7	351.2	21.5	◆	7.0	◆
Non Pay Expenditure £m	69.9	79.2	9.3	◆	4.7	◆
Non Operating Expenditure £m	7.7	7.3	-0.4	●	0.2	◆
Capital Expenditure (including disposals)	13.6	12.9	-0.7	●	-0.8	●
Capital Service Cover	2.53x	2.89x	-0.36x	●	-0.08x	●
Liquidity Days	36.9	38.1	-1.2	●	-0.9	●
I&E Margin	1.1%	1.5%	-0.4%	●	-0.2%	●
Variance from I&E Margin plan	0.0%	0.4%	-0.4%	●	-0.2%	●
Agency Expenditure £m	8.4	13.7	5.3	◆	4.3	◆
Cash Balances £m	76.5	81.7	-5.2	●	-13.7	●
Total debt over 90 days	5.0%	7.9%	2.9%	◆	10.6%	◆
BPPC NHS invoices paid < 30 days	95.0%	95.8%	-0.8%	●	-0.8%	●
BPPC Non NHS invoices paid < 30 days	95.0%	95.6%	-0.6%	●	-0.6%	●

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Board Performance Dashboard
As at 31st March 2022

journey to change

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CONTENTS

Executive Oversight

Tees, Esk and Wear Valleys NHS
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Out of our 21 key performance measures, there are 12 areas of concern identified within the March 2022 report that we are trying to improve.

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

It is important to note that that this is the last month of the current performance dashboard. In May 2022, the Trust will implement the new Integrated Performance Dashboard (IPD), which will include a new set of key measures designed to demonstrate the quality of services we provide.

Quality

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; however, whilst a number of our actions have been completed, we are not seeing the improvements that we anticipated and a number of new actions have now been identified. Whilst the waiting times measures will not feature in the new IPD, we remain committed to reducing the waits for our patients and will continue to have oversight through our internal governance arrangements. We are continuing to see an increase in the number of patients that we are placing in beds external to our Trust. Whilst this is a national issue due to current demand levels, we remain concerned and are committed to eliminating out of area placements by Quarter 3 2022/23.

Activity

Pressures on our inpatient services are continuing and our bed occupancy remains high; within our adult and older people wards we continue to have a high number of patients remaining in beds for over 90 days within all localities; a key challenge continues to be the availability of beds within local funded care homes. Whilst we do not have a concern currently with the number of patients that we are readmitting within 30 days of discharge, there is an increase in numbers and we are closely monitoring the situation.

Workforce

Our vacancy levels have returned to a level that we would expect to see and we are confident that our measure appropriately reflects the level of vacancies within the Trust, which is positive assurance. Our sickness levels continue to be higher than we aspire to across all Localities and whilst all sickness is managed in line with Trust Policy and is closely monitored within operational services, this is impacting the delivery of our some of our services. We are continuing to see small increases in the number of staff that have up to date appraisals and mandatory & statutory training, but these are significant. Work is ongoing within all localities to improve this key workforce measure.

Finance

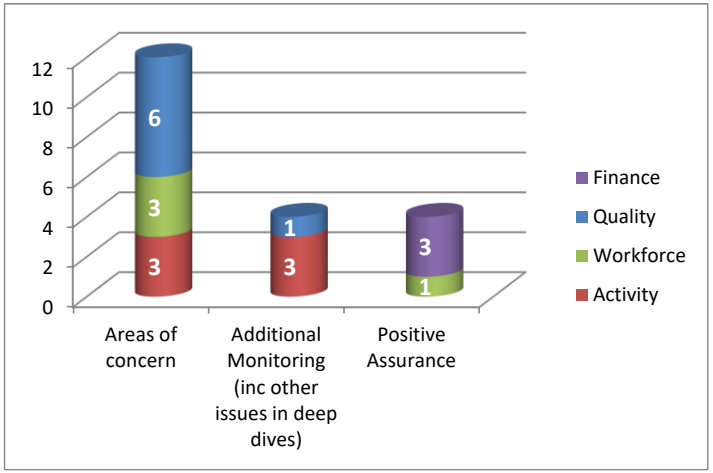
We are continuing to meet our financial targets; however it is important to note that this is not at the expense of our other standards. The key drivers impacting on delivery of the quality, activity and workforce standards are the levels of demand, acuity of patients and availability of staff. The Trust 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 (6613 patients out of 7838 in March which is 84.37% compared to our standard of 90%).
- The number of **patients receiving treatment within 6 weeks** is not as high as we would like (1071 patients out of 1824 in March which is 58.72% compared to our standard of 60%).
- Whilst we are placing fewer of our patients in a bed outside their local hospital, there were 19 patients placed in beds external to the Trust accounting for 701 **inappropriate OAP days** in the 3 months ending March.
- We recognise the potential to improve our learning from **Serious Incidents.** In February, 54.55% (6 from a total of 11) compared to our standard of 32% serious incidents were found to have a significant lapse or lapse in care (equivalent to a root cause or contributory finding).
- Our Adult and Older Persons' teams are not demonstrating the **improvement we would like in patient outcomes (HONOS)** (41 out of 92 in March which is 44.57% compared to our standard of 60%).
- Our Adult and Older Persons' teams are not demonstrating the **improvement we would like in patient outcomes (SWEMWBS**) (57 out of 89 in March which is 64.04% compared to our standard of 65%).
- The number of **patients being referred and taken on for treatment** is fewer than we would expect (1734 patients out of 7544 referred in December which is 22.99%). 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 (10,695 occupied bed days out of 10,317 available bed days which is 96.47% in March compared to our standard of 90%).
- Whilst we achieved standard in March (60 patients compared to our standard of no more than 61), the number of Adult and Older People **staying in beds longer than 90 days** is higher than it has been previously.
- The number of **staff with a current appraisal** is not as high as we would like it to be (5017 members of staff out of 6275 in March which is 79.95% 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 (92,998 training courses out of 107,306 in March which is 86.67% compared to our standard of 92%)
- **Sickness Absence rates** for staff are higher than we would like them to be (12,139 working days out of 195,816 in February which is 6.20% compared to our standard of 4.3%)



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 **patients report their overall experience** is showing an improvement it remains slightly lower than our ambition.
- Whilst the number of **patients referred** is at a level we would expect, concern is visible within 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 than we would expect in Tees and North Yorkshire & York.

All three finance measures are providing assurance that we are delivering in line with our financial plan. Vacancy rate has improved significantly and is now at a rate we would expect.

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 Mar - 2022	Assurance Ending Mar - 2022	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%	86.56%	90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	L	?	60.00%	57.60%	60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	L	?	1,833	701	1,833
4) Percentage of patients surveyed reporting their recent experience as very good or good	H	?	94.00%	89.73%	94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		?	32.00%	60.40%	32.00%
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind	L	?	60.00%	47.06%	60.00%
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind	L	?	65.00%	64.37%	65.00%

Activity

Measure Name	Variation Ending Mar - 2022	Assurance Ending Mar - 2022	Standard (YTD)	Actual (YTD)	Annual Standard
8) Number of new unique patients referred	H			98,147	
9) The percentage of new unique patients referred with an assessment completed (2 months behind)	H			77.37%	
10) The percentage of new unique patients referred and taken on for treatment (3 months behind)	L			30.92%	
11) Number of unique patients discharged (treated only)				34,152	
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	H	?	90.00%	98.13%	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	60	61
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)		?	9.90%	8.36%	9.90%

Workforce

Measure Name	Variation Ending Mar - 2022	Assurance Ending Mar - 2022	Standard (YTD)	Actual (YTD)	Annual Standard
15) Finance Vacancy Rate				-7.83%	
16) Percentage of staff in post with a current appraisal	L	F	95.00%	79.95%	95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	L	?	92.00%	86.67%	92.00%
18) Percentage Sickness Absence Rate (month behind)	H	?	4.30%	6.45%	4.30%

Money

Measure Name	Plan (YTD)	Actual (YTD)
19) Delivery of our financial plan (I and E)	-4,767,000	6,097,560
20) CRES delivery	2,301,000	2,300,996
21) Cash against plan	76,498,000	81,695,554

TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral – *Trust Standard 90%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and treatment is timely as we know this supports patient safety, wellbeing and quality of care. We want to ensure our patients receive an assessment at the earliest opportunity so they are placed on the most appropriate treatment pathway in a timely manner, enhancing their experience and outcomes and reducing the risk of a deterioration in their condition and the potential need for admission.

7838 patients attended a first appointment during March; of those, **6613 (84.37%)** were within 4 weeks of referral

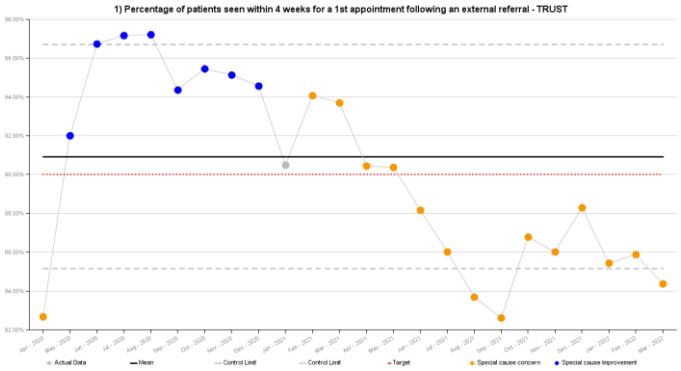
We're aiming to have high performance and we're moving in the wrong direction.

We need to investigate this to understand what's happened and/or take action

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ

100%



Locality	Variation	Assurance
TRUST	L	?
DURHAM AND DARLINGTON		?
FORENSIC SERVICES	L	P
NORTH YORKSHIRE AND YORK	L	?
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we are not seeing as many of our patients in a timely manner as we would like. This was first identified as a potential area of concern in July 2021.	Actions are detailed on the following pages.		A decreasing trend is again visible. Actions remain ongoing.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Tees Locality			
We now have a high number of vacancies within the Middlesbrough Children & Young People's (CYP) Community team which is impacting on the waiting times of patients.	Recruitment is underway to appoint new staff to enable demand to be met.	**Ongoing.** Three posts (2 band 7 and 1 band 6) have been appointed to and are awaiting start dates. A further two psychology posts and one band 6 are currently being advertised.	Whilst currently performance is below standard, an increasing position is visible. Actions remain ongoing.
	Overtime to be offered throughout April and May 2022, pending recruitment to the vacant posts.	**Ongoing.** Overtime is underway and support is being provided by other CYP teams.	
An increase in demand is also impacting on waiting times for our CYP Neurodevelopmental team.	Recruitment is underway to appoint new staff to enable demand to be met.	Ongoing. Four posts are currently vacant; one has been recruited to and is pending a start date, 2 are currently being advertised and 1 is progressing through financial approval.	
	Overtime to be offered throughout April 2022, pending recruitment to the vacant posts.	**Ongoing.** Overtime is being worked by administrative and clinical staff.	
	Neurodevelopmental Team Manager to meet with CCG commissioning leads in April 2022 to discuss streamlining the referral process.	**Not started**.	
Within Learning Disability (LD) services increased sickness and patient acuity are impacting on the lengths of wait being experienced by our patients.	Increased monitoring to be undertaken to confirm whether this is an area of concern.	**Complete**. Improvements have been noted in both teams and we can conclude this is not an area of concern.	An increasing position is visible but whilst the standard is being achieved, performance remains at a lower level that we would expect. Actions remain ongoing.
There are a number of vacancies across the service that are impacting on our waiting times.	Recruitment is ongoing to appoint new staff to enable demand to be met.	**Ongoing**. The recruitment campaign is continuing. There are 16 vacant posts across Tees LD services.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
High levels of sickness and an increase in referrals has impacted capacity within the Adult Mental Health (AMH) Stockton Access Team.	Overtime support is to be provided by the Affective Disorder Team and Perinatal Services. The Associate Nurse Consultant is to work with the team during October 2021 to review processes and identify potential blockages in the system.	**Ongoing.** Overtime slots have continued to be offered throughout March. The Advanced Practitioner continues to have a positive impact on patient flow. One member of staff remains on long term sick leave and is not expected to return to the role.	A decreasing position remains visible; however, actions remain ongoing.
	Team Manager to develop a recruitment plan by the end of May 2022 to improve capacity within the team.	**Ongoing.**	
	Head of Service to lead a review to streamline the referral documentation for Access services, enabling assessments to be undertaken more efficiently and patients to receive timely advice, support and signposting to other services.	**Ongoing.** A drop in session is scheduled in April to aid the Access staff in the use of CITO, our new patient system interface, which will be used to support the assessment process.	
Whilst waiting times within Mental Health Services for Older People have been impacted by support provided into our Forensic Wards to help manage current pressures, the main concerns have been staff sickness, vacancies and increased acuity.	Recruitment is ongoing to appoint new staff to enable demand to be met.	**Ongoing**. February's report indicated this was complete; however the service has confirmed that 10 posts remain vacant and are being advertised.	A decreasing position remains visible; however, actions remain ongoing.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
North Yorkshire & York Locality			
Children and Young People's (CYP) Services are being impacted by staffing resources within the Single Point of Access Team.	Recruitment is underway, which would provide more staff to undertake assessments.	**Complete.** All current posts are recruited and this is supporting timely triage and the assessment of more patients.	An decreasing position is again visible. Further actions are in place.
	Staff from the generic CYP team to provide interim overtime support to reduce the backlog of screening forms.	**Ongoing**. Overtime is continuing.	
	SPA Service Manager to review the referral process during 2022/23 to support the improvement of waiting times.	**Ongoing.** A request for the recruitment of a project manager has been submitted for financial approval. Once appointed to, a project plan will be developed. In the interim, joint huddles have been introduced with service leads and the SPA team to reduce the number of inappropriate referrals being directed to the community teams.	
There are a number of vacancies within the Mental Health Services for Older People (MHSOP) Harrogate, Scarborough and Ryedale community teams and Harrogate Memory team.	Recruitment is underway, which would provide more staff to undertake assessments.	**Complete.** Harrogate, Ryedale and Whitby community teams are fully recruited to. Scarborough Community team have 3 clinical posts vacant; however all recruitment has been put on hold while they are reviewing their services (see below action).	No visible impact; actions remain ongoing.
The teams are concerned they do not have sufficient nursing and medical staff to operate the current model and meet the demand of referrals.	The Scarborough, Whitby and Ryedale Locality Manager for MHSOP, with Quality Improvement and Finance, to review existing vacancies across all teams to better align posts to demand.	**Ongoing.** A review of the waiters and themes is underway by the Service Manager and the Community Matron is to review assessment capacity within the team. The QI team are working with the Scarborough Whitby & Ryedale Memory Services to a process map and drafting a staff questionnaire to support this work. A further meeting is scheduled in May 2022.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
The York Memory Service has been impacted by capacity issues due to an increase in referrals and under-establishment.	A pilot to be undertaken with GPs to support the referral process and minimise inappropriate referrals.	**On hold.** This work has been paused indefinitely to support business continuity. Funding was requested for additional resources for this to continue, but this reduces the availability of staff for assessments and redirected resources from the waiting time work. The service continues to work towards the target of all waiters to be eliminated by April 2022 but this has been impacted by an increase in referrals.	No visible impact; actions remain ongoing.
	A 0.6 whole time equivalent clinical staff member to return from secondment to increase support.	**Complete.** The member of staff has now returned to work in the team.	
Within Adult Mental Health Services, there has been reduced staff capacity due to vacancies and sickness within the Hambleton & Richmondshire East community team, and the team do not have the capacity to meet current demand and acuity of referrals.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing.** The team continues to be impacted by reduced staffing capacity, with 2.6 clinical post vacancies; however, interviews are scheduled for March. A daily staff escalation meeting is in place to mitigate this, looking at patient flow, assessment capacity and any immediate actions that can be taken.	A decreasing position is continuing; further actions are being taken.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
The York North, York South, Scarborough and Whitby & Ryedale community teams have been impacted by vacancies. The Scarborough team has been unsuccessful in sourcing permanent or agency staff.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing**. York North CMHT and York South CMHT are now fully recruited and are achieving standard. The final posts within the Whitby and Ryedale teams are due to commence in March. The Scarborough community team still has 3 Band 6 senior practitioner posts vacant; to mitigate this a Band 4 nurse associate, occupational therapist and a zero contract clinician provide support. It should be noted the Scarborough team is being impacted by long term sickness within the team.	A decreasing position is continuing; further actions are being taken.
	Third sector support as part of winter pressure monies to be explored with commissioners to assist the Scarborough team.	**Complete.** Funding was not approved.	
Capacity within the North Yorkshire & York Perinatal team has been impacted by staff sickness.	Sickness to be managed through the Trust sickness procedure.	**Complete.** All staff have now returned to work	
Capacity within the North Yorkshire and York Perinatal team has been impacted by reduced capacity due to vacancies.	Recruitment is underway which will increase staff's capacity to commence treatment.	**Ongoing.** An Advanced Nurse Practitioner commenced in post during March and the remaining posts are pending start dates.	
	Team Manager to work with the Quality Improvement team during March and April 2022 to support effective diary management and assessment capacity.	**Ongoing**. This work started in March and will continue throughout April, with a view to ensuring the team can provide assessments at maximum capacity.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
The York & Selby Wellbeing Access service has received a significant increase in referrals, which has impacted staff capacity. The team has a number of vacancies and some staff sickness, which has reduced the number of assessments that can be completed and consequently, the number of patients taken on for treatment.	'Stop the line' process to be established to enable current processes to be reviewed.	**Complete.** Staff capacity has improved following the return of staff from short term sickness; therefore support is no longer required from the community teams and the team is no longer in 'Stop the line' process.	A decreasing position is continuing; further actions are being planned.
	All referrals for patients that have been previously discharged within the last year to be allocated directly to the community teams in York and Selby.	**Complete.** Processes are in place to enable patients to be assessed and allocated slots quickly following re-referral; staff have been supported to up-skill to improve the efficiency of assessments. Assessment processes are embedded and most patients are now being assessed within 4 weeks of referral.	
	The service to initiate a triage process to address the backlog of patients waiting for assessment from November 2021.	**Complete**. Triage process is in place and capacity has been created to screen referrals in line with service criteria. This has addressed the backlog; however, referrals continue to be above assessment capacity. Additional capacity has been secured from Crisis and West community mental health teams to review the long waiters, ensuring triage assessments, safety summaries and safety plans are in place for patients.	
	The Head of Service, Locality Manager, Team Manager and Advanced Nurse Practitioner to review staff capacity to enable the maximum number of assessments slots to be offered.	**Complete.** The review has been completed, staffing is now at full capacity and processes are in place to enable efficient management of assessment slots.	
	Recruitment is underway, which would provide more staff to undertake assessments.	**Complete**. The team is fully recruited to and staff are going though pre-employment checks. The service is working at maximum capacity in terms of staff and the number of assessments being offered; however this is not sufficient to meet the increase in demand.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	During April 2022, the Head of Adult Services will lead a conversation with Community Mental Health Framework first contact workers and Improving Access to Psychological Therapies (IAPT) teams to agree joint working to ensure people are considered against the right pathway the first time.	**Not started.**	
Durham & Darlington Locality			
Within Children & Young People's (CYP) Services potential concerns were identified within the Darlington, Easington, North Durham and South Durham Targeted Teams and the specialist Autism and Eating Disorder teams.	A review of waiting list management across all Locality CYP services to be undertaken, with support from the Head of Service, Information team, Performance Team, Quality Improvement and the Service Development Manager. The Corporate Performance lead is to work with the service during March to confirm whether this remains an area of concern.	**Complete**. The standardised procedure for tracking patients waiting for assessment and treatment is in place, including daily huddles and the operation of the visual control board to ensure progress is maintained and any concerns identified immediately and actioned. **Not yet started.** This action will be completed during April 22.	Although an increased position is visible and performance is just below standard, this does not denote an actual improvement.
Within Mental Health Services for Older People, episodes of long term sickness and staff vacancies have impacted the Derwentside community team.	Retire-and-return support to be sourced. Recruitment is underway, which would provide more staff to undertake assessments. Corporate Performance Lead to work with the Team Manager during March to identify the capacity issues that have not been addressed by recruitment.	**Ongoing.** 0.8 wte member of staff is due to start in June; 2 days a week. **Ongoing**. One vacancy remains in the team, which has been ring-fenced for an existing member of staff who is currently undertaking training. No nursing vacancies remain. **Complete**. The Team Manager is assured that once the ongoing actions (detailed above) are completed, there will be sufficient capacity to ensure timely assessments are provided to our patients.	A decreasing position remains visible; however, actions remain ongoing.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
The Darlington-Teesdale community team has been impacted by staff vacancies.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing.** The team has two vacancies for a locum consultant and a Band 5 nurse and is being further impacted by a vacancy within the Darlington-Teesdale Care Home Liaison team (which impacts assessment capacity as it requires backfilling with duty shifts by community team staff). Over-recruitment for 2 Band 6 posts is being pursued.	A decreasing position remains visible; however, actions remain ongoing.
As at March 2022, waiting times within the Darlington-Teesdale community team are being impacted by staff sickness (long and short term).	Sickness to be managed through the Trust sickness procedure.	**Ongoing.** The Trust sickness procedure is being adhered to and Human Resources are supporting the Team Manager.	
Forensic Services			
We are concerned that waiting times for patients within our Health & Justice Service are being impacted by capacity within the Criminal Justice Liaison Service.	Corporate Performance Team with the Service Manager to undertake further analysis during March 2022 to ascertain any areas of concern.	**Complete.** Analysis and actions are provided on the following page.	A decreasing position is visible; actions have been identified.

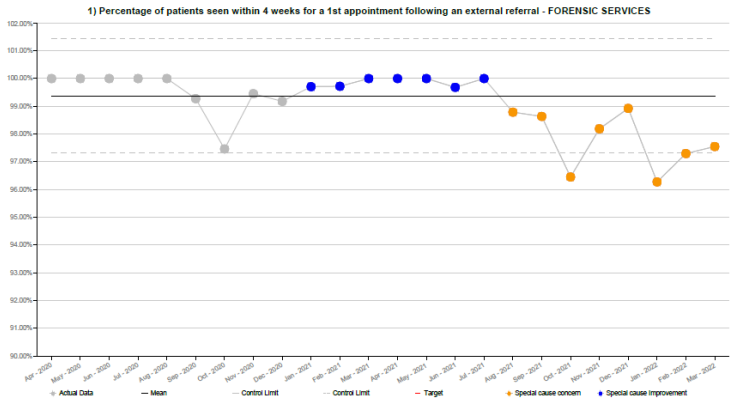
TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral - Forensic Services

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

DETAILED ANALYSIS

We are concerned that we are not seeing patients in a timely manner within Forensic services. Analysis at team level has identified there is a potential concern within the Trust-wide Criminal Justice Liaison Team (CJLT).

Analysis shows there is a high number of patients who do not attend (DNA) their given appointments. Four members of staff (3.4WTE) work within the Service, which covers the main seven Probation hubs (within these hubs there can be up to 3 separate hub locations); if a patient does not attend their appointment they may not be seen until that member of staff returns back to that Probation hub resulting in a longer wait for the patient.



Locality	Variation	Assurance
FORENSIC SERVICES	L	P

Specialty	Variation	Assurance
HEALTH AND JUSTICE	L	P

Due to the small size of the team, there is no staff cover for annual leave or sickness as it is difficult to provide cover geographically across the Hubs. This does result in the delaying of assessments; however mitigating measures to reduce the impact are limited without increased funding.

No concerns have been identified in the other teams.

CONCLUSIONS

Our patients within our Health & Justice Services Trust-wide Criminal Justice Liaison Team are waiting longer than we would like due to the geographical locations of the Probation Hubs into which a limited number of staff work. Patient and staff unavailability is introducing delays when rescheduling appointments.

ACTIONS BEING TAKEN

The Trust-wide CJLS Team Manager to meet with the Probation Service Managers by the end of April 2022 to discuss the issues identified and to agree mitigating actions.

TD02) Percentage of patients starting treatment within 6 weeks of an external referral – *Trust Standard 60%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and treatment is timely as we know this supports patient safety, wellbeing and quality of care. We want our patients to begin their treatment at the earliest opportunity to improve their experience and outcomes and also to reduce the risk of a deterioration of their condition and the potential need for admission.

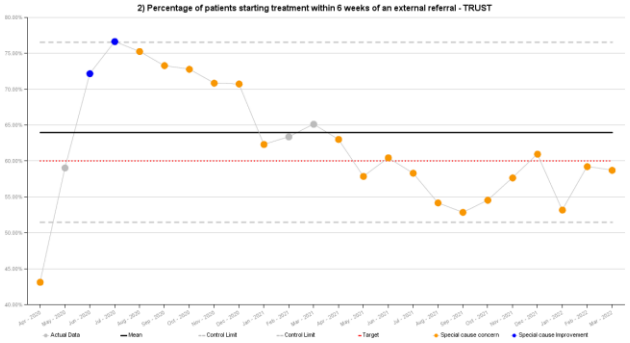
1824 patients started treatment during March; of those, **1071 (58.72%)** started within 6 weeks of being referred

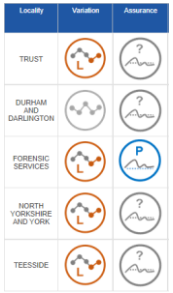
We're aiming to have high performance and we're moving in the wrong direction.

We need to investigate this to understand what's happened and/or take action

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ★ 100%





KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we are not starting treatment for patients in a timely manner. This was first identified in January 2021.	Actions are detailed below and following for each locality.		The decreasing position remains visible; however actions remain ongoing.
Durham & Darlington Locality			
In Children & Young People's Services (CYP) we have been impacted by staff vacancies.	Recruitment is underway, which would provide more staff to offer treatment.	**Ongoing.** There are now 79 vacancies across the CYP service. Recruitment continues and the service are currently receiving support from the Trust recruitment team to market their vacancies. From March pre-employment checks have been managed by the NHS Business Services Authority, releasing capacity in the Recruitment team to provide further support.	An increasing position is visible and performance is above standard; however, this does not yet denote an actual improvement and actions remain ongoing.
Waits for CYP on a neurological pathway to start treatment are longer due to the complexity of assessments.	Service Development Group (SDG) to consider whether these patients should be counted in this measure as they are not waiting for treatment but further assessment.	**Complete.** SDG and Senior Leadership Group have agreed that it is not appropriate for these patients to be included within this measure as they are waiting for specialist assessment not treatment. Work is being undertaken by the Performance and Information Leads to action these changes on the KPIs.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Some data quality issues were identified within the Darlington CYPS Team and Mental Health Services for Older People.	Work to be undertaken to understand and correct data quality issues.	**Ongoing.** All newly identified issues within MHSOP are resolved routinely. Work is continuing to rectify data quality issues in the CYP dashboard; 38 identified issues remain as at March 2022. Timescales are being sought for the completion of this work.	
Within Adult Mental Health Services performance is being impacted by data quality issues within the Access team.	Locality Manager to meet with the Access Team leadership in December 2021 to agree the actions required to improve data quality.	**Ongoing**. The rescheduled meeting took place in February 2022. Recording guidance has been reviewed, including the interventions constituting treatment, and this is being given increased focus during induction to support new staff to record treatment accurately. A sample check of patients is being reviewed by the Locality Manager during April.	No visible impact; actions remain ongoing.
Tees Locality			
There is a delay in the assessment process within the CYP Single Point of Contact (SPOC) team.	The Service is to review SPOC processes to improve efficiency.	**Complete.** Review completed and process streamlined.	Whilst slightly below standard, performance is at a level we would expect. Actions remain ongoing.
	Backlog of referrals to be managed with support from the Getting Help Teams.	**Complete.** The backlog has been cleared and triaged as appropriate.	
	Following clearance of the backlog, patients are to be prioritised for treatment according to clinical need.	**Complete.** Patient flow through the SPOC teams has improved and both teams are now achieving the standard.	
High vacancy levels and sickness has impacted capacity within CYP.	Head of Service to review the current position and identify all required actions.	**Ongoing**. There is currently a 10% vacancy rate, predominantly for nursing posts, which are currently being recruited to. Overtime is being offered to staff and agency staff and support from other teams is in place. (*In addition, please see following action.*)	
	The service manager to review a skill mix across nursing posts to enhance recruitment options by June.	**Ongoing**	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
High levels of sickness and vacancies have impacted capacity within the Mental Health Services for Older People (MHSOP).	Recruitment is underway, which would provide more staff to offer treatment.	**Ongoing.** February's report indicated this was complete; however the service has confirmed that 10 posts remain vacant and are being advertised.	No visible impact in the data; however staff will not be in post until April.
	Overtime to be offered to staff during March and April 2022 to support staff pressures.	**Ongoing**. Overtime has been offered through March 2022.	
North Yorkshire & York Locality			
Waits for CYP on a neurological pathway to start treatment are longer due to the complexity of assessments.	Service Development Group (SDG) to consider whether these patients should be counted in this measure as they are not waiting for treatment but further assessment.	**Complete.** SDG and Senior Leadership Group have agreed that it is not appropriate for these patients to be included within this measure as they are waiting for specialist assessment not treatment. Work is being undertaken by the Performance and Information Leads to action these changes on the KPIs. This action will remain on this paper pending the completion of this work.	Whilst an increasing position is visible and activity is now above standard, this does not denote an actual improvement. Actions remain ongoing.
The Scarborough ADHD team, York & Selby and Harrogate community teams are being impacted by a number of vacancies and the capacity to manage the volume of referrals.	Recruitment is underway, which would provide more staff to commence treatment interventions	**Ongoing.** Vacancies remain in all teams.	
Staffing resources due to sickness and staff turnover is resulting in delays in the Northallerton community team.	Director of Operations to raise staff concerns at Gold command in February to establish whether the team implements business continuity.	**Complete.** The team implemented business continuity processes in February.	
	Recruitment is underway, which would provide more staff and/or release staff's capacity to commence treatment interventions	**Ongoing.** The team currently has 9 clinical vacancies; 2 are pending candidate clearances, 4 are out to advert and 3 are in the process of being advertised.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Within Mental Health Services for Older People (MHSOP) the York Memory Service has been impacted by capacity issues due to an increase in referrals and under-establishment.	The service to establish a trajectory to eliminate waiters.	**Complete.** A trajectory has been established to eliminate all waits by the end of June 2022.	The decreasing position remains visible. Actions remain ongoing.
There are a number of vacancies within Scarborough and Harrogate Memory Service and the community teams within those areas.	Recruitment is underway to provide more staff to undertake assessments.	**Ongoing.** There is only one vacancy now within the Harrogate team. Recruitment within the Scarborough team has been placed on hold pending a capacity/demand exercise being led by the Head of Service. (Please see below action)	
	The Head of Service to work with the Quality Improvement and Finance teams to review the vacancies across all teams to support better alignment of posts to demand, which will support improved waiting times. This will be completed by the end of March 2022.	**Ongoing.** A review of the waiters and themes is underway by the Service Manager and the Community Matron is to review assessment capacity within the team. The QI team are working with the Scarborough Whitby & Ryedale Memory Services to produce a process map and drafting a staff questionnaire to support this work. A further meeting is scheduled in May 2022.	
The Scarborough Memory Team is being impacted by a reduction in medical staff resources due to long term sickness.	Locality Manager to lead on the recruitment to a ring fenced clinical post to take over medication monitoring patients, releasing staffing capacity to the memory service.	**Ongoing.** Discussions are continuing but are dependent and impacted by the Trust restructure. A date for completion is not currently available.	
Scarborough, Whitby Ryedale Memory teams are concerned they do not have sufficient nursing and medical staff to operate the current model and meet the demand of referrals	Scarborough, Whitby & Ryedale MHSOP Locality Manager to lead a review of budgets and current staffing numbers with the Quality Improvement team, which will include consideration of increased medical input. This will be completed by March 2022.	**Ongoing.** A review of the waiters and themes is underway by the Service Manager and the Community Matron is to review assessment capacity within the team. The QI team are working with the Scarborough Whitby & Ryedale Memory Services to produce a process map and drafting a staff questionnaire to support this work. A further meeting is scheduled in May 2022.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

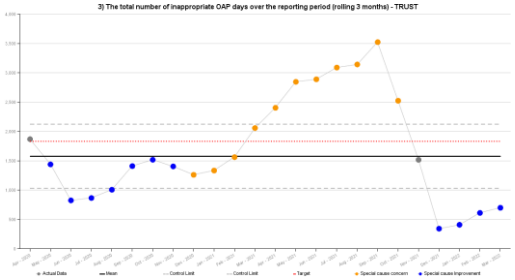
KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
The Hambleton & Richmondshire Memory Team is impacted by reduced staffing capacity due to sickness and reduced medic input	A multi-disciplinary approach to be established within the service to formulate diagnosis without medic input for non-complex patients.	**Complete.** The approach is established but the service has confirmed this will only have a minimal impact as only non-complex patients can be diagnosed without consultant involvement. Corporate Performance Lead to work with the Team Manager during March to identify any further actions that are being undertaken.	

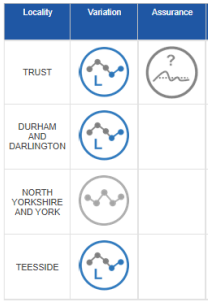
TD03) The total number of inappropriate OAP days over the reporting period – *Trust Standard 1833 days*

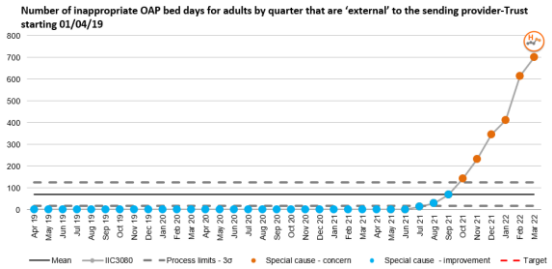
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important that our patients do not stay in hospital longer than they clinically need to and are discharged appropriately, as we know this can affect their recovery.

701 days spent by patients in beds away from their closest hospital during January, February and March 2022.







Note: the improvement in the measure (first chart) is driven by the earlier months, which include internal placements. The second chart shows the increasing position in respect of placements out of the Trust.

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
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.	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.	**Complete.** 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	Whist improvement is visible, reflecting the reduction in internal OAPs and compliance with the Continuity of Care Principles, external OAPs are visibly increasing and are a 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.	**Complete.** 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.	
	The Out of Area Protocol to be reviewed to ensure is up to date and fit for purpose.	**Complete.** The protocol was circulated on the 11th November 2021 with immediate effect.	

TD03) The total number of inappropriate OAP days over the reporting period - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

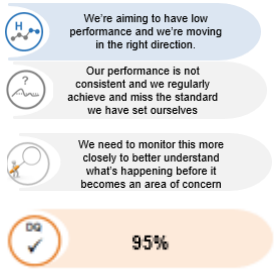
KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Four beds were purchased initially in the independent sector until the 30th September 2021 for AMH and MHSOP patients. This has subsequently been increased to 5 beds and has been extended to the 30th June 2022. Nine patients occupied these beds during February (151 bed days).	External support to help us to understand if there is anything further we can do to manage inpatient pressures and out of area placements to be commissioned.	**Ongoing.** The Trust sought external support to help us to understand anything further we could do to manage inpatient pressures and out of area placements to be commissioned. Unfortunately no suppliers were able to respond during 2021/22. Consequently we are now discussing other options to progress this work as a business planning priority for 2022/23, including with the North of England Commissioning Support Unit.	
	Bed census to be undertaken to help us understand our current patient base.	**Complete.** The bed census has been undertaken and shared with Senior Leadership Group and Service Development Groups. The Service Development Groups are continuing to work on actions and an update on progress will be provided to the Directors of Nursing & Quality by the end of April 22.	
	Increased monitoring of external placements to be undertaken.	**Complete**. External OAPs are now included within this report for oversight.	
	Acting Head of Corporate Performance to contact NHS England to renegotiate the Trust's trajectory for out of area placements.	**Complete.** We are committed to eliminating out of area placements and have agreed a trajectory to have no patients placed in a non-Trust bed by quarter 3 2022/23.	

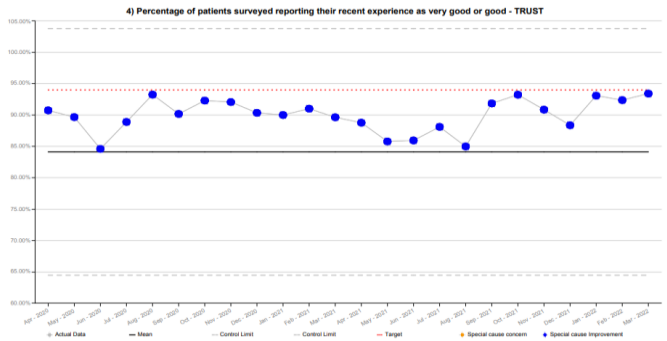
TD04) Percentage of Patients surveyed reporting their recent experience as very good or good – *Trust Standard 94%*

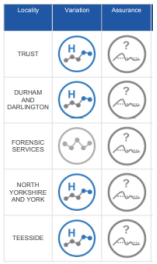
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

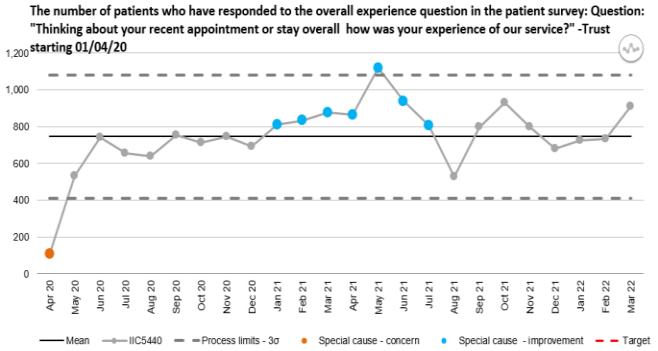
We are all committed to co creating a great experience for patients, and carers and families by ensuring we are providing outstanding and compassionate care and that people tell us this is the case from their experience.

911 patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **851 (93.41%)** scored "very good" or "good"









KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Whilst our patients have continuously rated our care as very good or good, we are concerned that the number of responses we receive to our surveys are not as high as we would like. This has been impacted by operational pressures and a reduction in face to face contact, as remote clinical contacts have increased in response to pandemic pressures.	Monthly monitoring of response rates and progress against the Patient Experience Improvement Plans to be established.	**Ongoing**. 18 out of 27 actions have been completed across all localities**.** The work continues to be impacted by operational pressures, acuity and demand. Localities are currently in the process of considering which actions to take forward under the new organisational structure, with potential to merge the Durham & Darlington and Teesside Patient Experience Groups. There are a number of actions that have been implemented including patient experience projects in Durham & Darlington, introduction of a standard process to reallocate cases following staff absence in Teesside and recruitment of patient experience leads in North Yorkshire & York, as well as providing training on accessing Meridian, the Integrated Information Centre and implementing Quality Assurance Group reporting templates. However, a number of actions across localities have not been completed and are still ongoing.	Whilst performance remains below standard, continuous improvement is visible.

TD04) Percentage of Patients surveyed reporting their recent experience as very good or good continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	Head of Patient Experience to review the outstanding actions in line with the organisational changes, to identify what needs to be taken forward in terms of a new plan for 2022/23.	**Not started.** This work will commence in May 2022 once the Head of Quality Data & Patient Experience is fully in embedded within their new role.	
	A comparison exercise to be undertaken with Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust on the 'Feeling Safe' theme. This is due to be completed December 2021.	**Ongoing.** A joint meeting was held between TEWV and CNTW on the 10th November to undertaken a comparison of themes identified by patients on inpatient wards which found similarities in feedback in relation to feeling safe, witnessing violence and aggression and the number of activities available. To explore further we agreed to hold focus groups initially within secure services during February 2022, which due to capacity issues within the service has been delayed and will now be completed at the end of April.	
A data quality issue has been identified as a number of survey responses have not been aligned to Trust cost centres and are, therefore, incorrectly excluded from the measure.	The IIC team Manager and Corporate Systems Manager to work with Meridian, the survey provider to investigate and identify appropriate actions to correct the measure. Actions will be developed and shared in April 2022.	**Ongoing**. Rectifying actions are being undertaken as part of the Trust restructure project plan and will be completed during April.	

TD05) Percentage of Serious Incidents which are found to have a root cause (significant lapse) or contributory finding (lapse) (month behind) – *Trust Standard 32%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety of our patients and to minimise the risk of any harm to them.

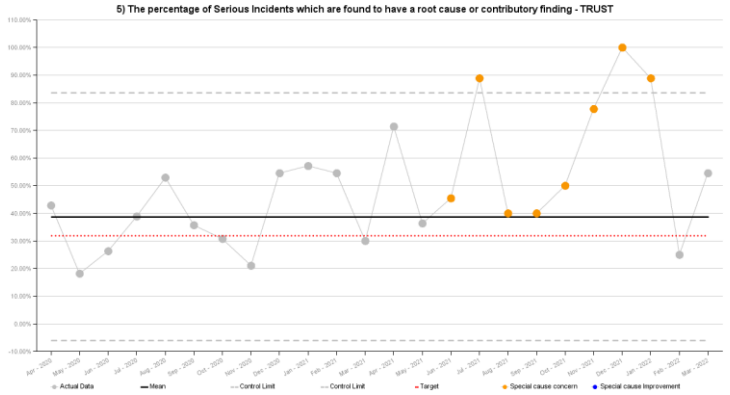
11 serious incidents were reported to the Trust Director Panel during February; of those, **6 (54.55%)** were found to have a root cause or contributory finding

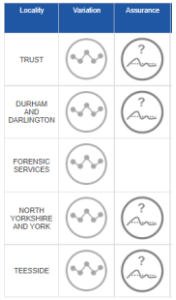
Nothing to note. Our activity is within the expected levels of performance

We need to investigate this to understand what's happened and/or take action

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ✓ **85%**





KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we have not seen a reduction in the number of serious incidents in which lapses and/or serious lapses in patient care and treatment have been identified. First identified in August 2021, this was discussed at the September Organisational Learning Group Meeting. Themes identified included sexual safety, perinatal care and safeguarding.	Work to be undertaken to identify the nature of Serious Incidents and any emerging themes. These will inform any areas of learning and will be used to drive forward any improvements or changes to practice where necessary.	**Ongoing.** All findings are captured on a central database within the Patient Safety Department to enable the identification of themes and key learning (please see following page). This is reviewed monthly and informs any actions or improvement work to be initiated and existing work programmes. Updates are provided to the Organisational Learning Group to provide assurance and learning bulletins are issued following Serious Incident Assurance Panels.	No visible impact; however whilst our improvement work helps us to understand the nature of incidents and prevent recurrence, the wide variance of incidents means that there will not always be a visible impact on the data.

TD05) Percentage of Serious Incidents which are found to have a root cause (significant lapse) or contributory finding (lapse) (month behind) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	External subject matter expert to be identified to enable objective scrutiny of perinatal services, enabling opportunities for sharing mutual learning through external networks.	**Ongoing.** Work between the three localities and the Consultant Perinatal Psychiatrist from Neuro & Specialist services in Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust is continuing to maintain oversight of perinatal patient safety incidents for the purpose of sharing learning between Trusts. Quarterly meetings have been established and learning is being shared in the Trust-wide perinatal forum as well as the Clinical Advisory Group within the Perinatal Mental Health Network.	
	Participation in a national collaborative focusing on sexual safety to assist in testing tools and interventions to reduce sexual safety incidents. The methodology will shared Trust-wide.	**Ongoing.** The sexual safety review continues; findings from two cases have received external oversight and a further two cases are under internal investigation. Findings from the oversight of these four cases will be shared by June 2022 once the review has completed the assurance cycle.	
	A range of safeguarding initiatives to be established.	**Complete.** Best practice guidance has been issued on the completion of the PAMIC tool, a safeguarding tool to support clinicians in considering the likelihood and severity of the impact of an adult's parental mental ill health on a child. This is now available in the Paris safety summary to support easy access and improve the flow of documentation.	

TD06) Percentage of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) (month behind) – *Trust Standard 60%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a clinical perspective, is one way we will know our care is outstanding

92 in scope teams have discharged patients from Trust services in the last three months; of those, **41 (44.57%)** achieved the agreed improvements in their Health of the Nation Outcome Score (clinician rated outcome measure)

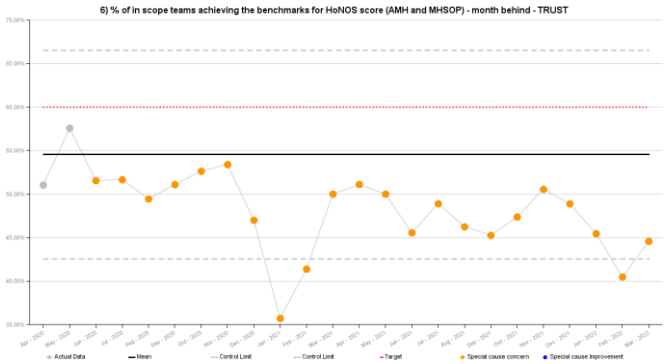
We're aiming to have high performance and we're moving in the wrong direction.

We need to investigate this to understand what's happened and/or take action

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ

95%



Locality	Variation	Assurance
TRUST		
DURHAM AND DARLINGTON		
NORTH YORKSHIRE AND YORK		
TEESSIDE		

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
A number of our teams are discharging patients that have not shown as much improvement as we would like. This was first identified as a concern in October 2020 and work is required to understand the underlying reasons.	Adult Service Development Manager to complete detailed analysis to understand what is impacting on our patients' improvement and why our patients feel that they have experienced an improvement (see TD07 SWEMWBS) but clinically have not shown that. This work will be completed March 2022.	**Not completed.** This work was stood down as the analysis being undertaken shifted its focus to inform baselines for the new CQUIN and dashboard measures.	No visible impact; however some actions remain ongoing and we have identified more clinically meaningful measures which will be included in the new IPD (see key change overleaf)
	Mental Health Services for Older People Service Development Manager to establish training sessions for all staff by March 2022.	**Complete.** Initial and refresher training has been completed. Clinical outcomes now forms part of huddle updates, supervisions sessions and pathway meetings.	
	Adult Mental Health Services Service Development Manager to establish training sessions for all staff by June 2022.	**Ongoing.** Training is being developed and is on track, with delivery commencing in May 2022. Clinical outcomes now forms part of huddle updates, supervisions sessions and pathway meetings.	
	The Chief Clinical Strategy Officer to incorporate outcomes work as part of the Clinical Journey to Change.	**Complete.** Outcomes has been included in the Clinical Strategy and this has a clear link with the new CQUINs and Integrated Performance Dashboard measures which we will have oversight and monitor in our new governance arrangements.	

TD06) Percentage of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) (month behind) – *Trust Standard 60%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	MHSOP Service Development Group to consider an appropriate approach for monitoring outcomes for patients with degenerative illness. This is to be completed by the end of April 2022.	**Ongoing.** This work is progressing to plan and will be completed by the end of April 22.	
	The SDM to review the clinical pathways within MHSOP to ensure they remain in line with Trust policy, sit within the clinical risk management process and the MHSOP specific harm minimisation modules. This is to be completed by the end of April 22.	**Ongoing.** The Delirium Pathway, Dementia Pathway and Behaviours that Challenge Pathway have now all been relaunched incorporating updates around outcomes monitoring and harm minimisation modules. A meeting to review the functional pathway with Adult Mental Health is scheduled during April 2022.	

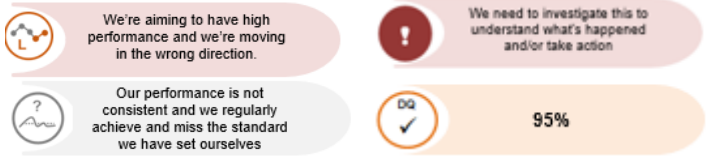
KEY CHANGE
Whilst there are a number of improvement actions as outlined above, we are currently developing a number of key outcome measures that are more clinically meaningful as part of the new Trust Integrated Approach to performance. These new measures will be implemented in 2022/23 as part of the new Integrated Performance Dashboard.

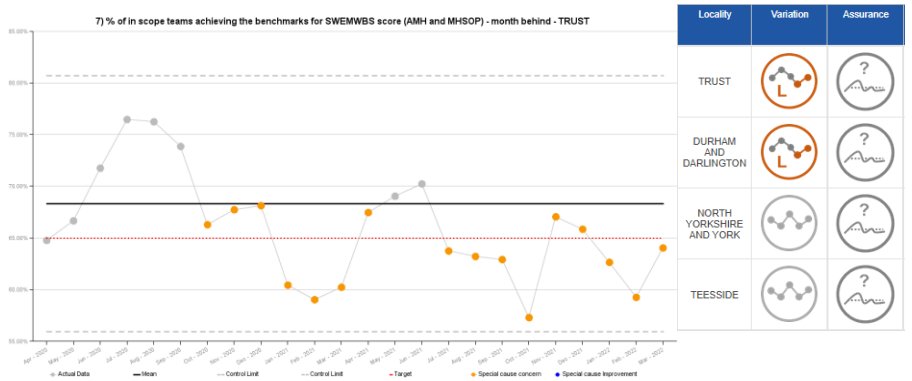
TD07) Percentage of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) (month behind) – *Trust Standard 65%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a patient perspective, is one way we will know our care is outstanding

89 in scope teams have discharged patients from Trust services in the last three months; of those, **57 (64.04%)** achieved the agreed improvements in the short version of the Warwick–Edinburgh Mental Wellbeing Scale (patient rated outcome measure)





KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that a number of our teams are discharging patients that have not reported as much improvement as we would like. This was first identified as a concern in August 2021 within our **Durham & Darlington** Adult Services.	Analysis to be undertaken to identify any areas of concern.	**Completed.** This was included within the August 21 report and highlighted a potential concern within Adult Mental Health Services (AMH).	No visible impact; however actions remain ongoing
A potential concern has been identified within a number of teams: Tunstall/Farnham Inpatient service, Derwentside & Chester le Street Affective team, Durham City Affective team, North Durham & South Durham Psychosis team, Eating Disorders Community team and Durham and Darlington Crisis team.	The Corporate Performance Team is to work with the team and Locality Managers to investigate further to confirm whether these are actual areas of concern. This work will be undertaken during September and findings reported in October 2021.	**Not completed.** This work was stood down as the analysis being undertaken shifted its focus to inform baselines for the new CQUIN and dashboard measures.	

KEY CHANGE

Whilst there are a number of improvement actions as outlined above, we are currently developing a number of key outcome measures that are more clinically meaningful as part of the new Trust Integrated Approach to performance. These new measures will be implemented in 2022/23 as part of the new Integrated Performance Dashboard.

TD08) Number of new unique patients referred – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

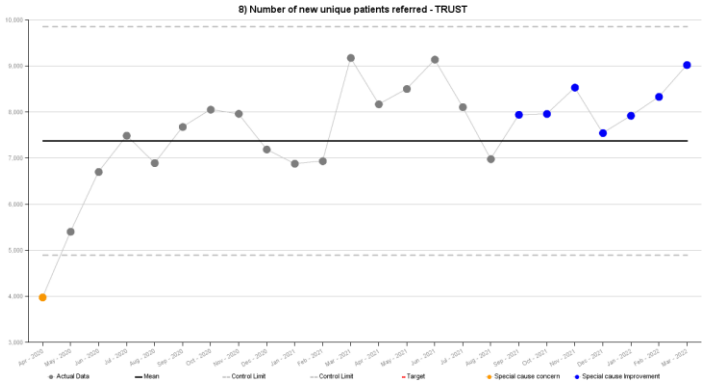
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

9104 patients referred in March that are not currently open to an existing Trust service

H — We're aiming to have low performance and we're moving in the right direction.

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ ★ **100%**



KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We have previously identified a high number of referrals of within our **Forensics** services, linked to an increase in referrals to the Cleveland and Durham Liaison & Diversion teams. One action remains ongoing	Referrals to be reviewed over the next 6 months to understand demand and to inform the discussion and business case with commissioners.	**Ongoing.** It has been agreed with commissioners that data will continue to be collected until April and reviewed in May 2022, to allow more data to be collected to better understand the demand.	A decreasing position is visible; however actions are ongoing.
However, referrals are reducing within the teams and we are now seeing fewer patients in our Health & Justice Liaison & Diversion teams than we would like due to vacancies for Navigators within the Cleveland and North Yorkshire teams.	Recruitment is ongoing to appoint new staff to enable demand to be met.	**Ongoing.** The Cleveland team now has two new navigators in post and recruitment is ongoing for a Partnership Manager. The North Yorkshire service currently has 3 Navigator vacancies; 1 successful candidate is currently going through Police clearance. Once the remaining navigators are appointed the service anticipates an increase in referrals.	

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

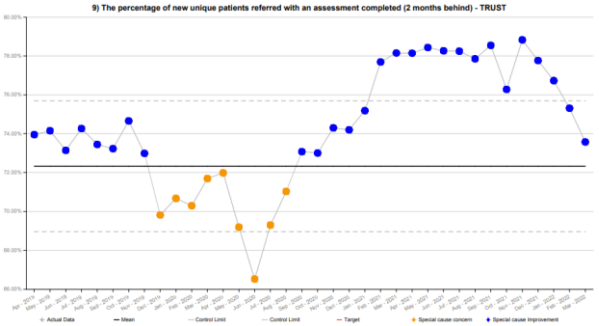
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

7920 patients referred in January; of those **5827 (73.57%)** patients have now had an assessment

H — We're aiming to have low performance and we're moving in the right direction.

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ ★ **100%**



Locality	Variation
TRUST	H
DURHAM AND DARLINGTON	
FORENSIC SERVICES	H
NORTH YORKSHIRE AND YORK	L
TEESSIDE	H

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Whilst as a Trust we are not assessing the numbers of new patients that we would aspire to, potential concerns were first highlighted in September 2020.	Analysis to be undertaken to understand whether there were any areas of concern.	**Completed.** Since September analysis has been undertaken in three localities and a number of issues have been identified. These are detailed on the following pages.	Whilst a decreasing position is visible, improvement has been visible since September 2020.

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
North Yorkshire & York Locality			
Within Adult Mental Health (AMH) the York & Selby Mental Wellbeing Access service has been impacted by a significant increase in referrals.	'Stop the line' process to be initiated.	**Complete.** Staff capacity has improved in the team as staff have returned from short term sickness. Support is no longer required from the community teams and the team is no longer is 'Stop the line' process.	A decreasing position is continuing; further actions have been identified
	The service to initiate a triage process to address the backlog of patients waiting for assessment from November 2021.	**Complete**. Triage process is in place and capacity has been created to screen referrals in line with service criteria. This has addressed the backlog; however, referrals continue to be above assessment capacity. Additional capacity has been secured from Crisis and West community mental health teams to review the long waiters, ensuring triage assessments, safety summaries and safety plans are in place for patients.	
	The Head of Service, Locality Manager, Team Manager and Advanced Nurse Practitioner to review staff capacity to enable the maximum number of assessments slots to be offered.	**Complete**. The review has been completed, staffing is now at full capacity and processes are in place to enable efficient management of the assessment slots.	
	During April 2022, the Head of Adult Services will lead a conversation with Community Mental Health Framework first contact workers and Improving Access to Psychological Therapies (IAPT) teams to agree joint working to ensure people are considered against the right pathway the first time.	**Not started.**	

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Within Mental Health Services for Older People the Hambleton and Richmondshire Memory service has been impacted by reduced consultant capacity.	The Locality Manager to develop a process enabling simpler diagnostic decisions to be made in a multi disciplinary meeting to facilitate quick assessment completion.	**Complete.** The team has developed a process to enable a diagnosis to be made where clinically appropriate, without a consultant. This will enable quicker assessment completions reducing waiting time for patients and will increase consultant availability for complex assessments.	A decreasing position is continuing; further actions have been identified
There are a number of vacancies in Scarborough and Harrogate Memory Services. In addition, there has been a reduction in the number of venues in Ripon and Wetherby at which the Harrogate team can provide assessments.	Recruitment is underway to provide more staff to undertake assessments.	**Complete.** Harrogate, Ryedale and Whitby community teams are fully recruited to. Scarborough Community team have 3 clinical posts vacant however all recruitment has been put on hold while they are reviewing their services.	
	The Harrogate team manager to modify the assessment pathway for less complex referrals using the DIADEM tool, tool used to assess memory patients which are less complex, to increase the number of assessments completed each week	**Complete.** The Diadem tool has been found to not be effective as it is only appropriate for people in the early stages of dementia.	
	The Locality Manager to explore further options for reducing waiting times within the service.	**Not started.**	
	The Harrogate service to agree with primary care services the use of Ripon community building in and a Wetherby GP surgery.	**Complete**. Both locations are now being utilised.	
The teams are concerned they do not have sufficient nursing and medical staff to operate the current model and meet the demand of referrals.	The Scarborough, Whitby and Ryedale Locality Manager for MHSOP, with Quality Improvement and Finance, to review existing vacancies across all teams to better align posts to demand.	**Ongoing.** A review of the waiters and themes is underway by the Service Manager and the Community Matron is to review assessment capacity within the team. The QI team are working with the Scarborough Whitby & Ryedale Memory Services to produce a process map for the Scarborough, Whitby and Ryedale Services and drafting a staff questionnaire to support this work. A further meeting is scheduled in May 2022.	

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Scarborough Memory Team are being impacted by delays in the delivery of computerised tomography scans.	Discussions to be held with the acute Trust.	**Complete**. Whilst discussions have been held it has not been possible to increase the number of scans available.	
Scarborough Memory Team is also being impacted by a reduction in medical staff resources due to long term sickness.	Locality Manager to lead on the recruitment to a ring fenced clinical post to take over medication monitoring patients, releasing staffing capacity to the memory service.	**Ongoing.** Discussions are continuing but are dependent and impacted by the Trust restructure. A date for completion is not currently available.	

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

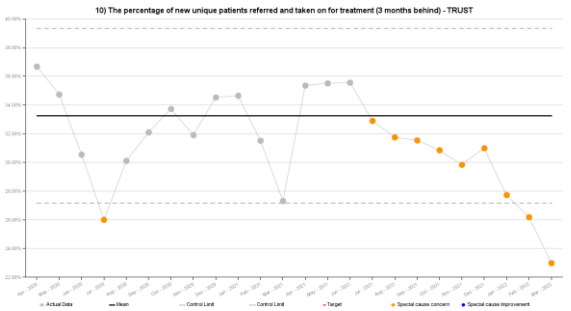
7544 patients were referred in December; of those, **1734 (22.99%)** patients have now been taken on for treatment

We're aiming to have high performance and we're moving in the wrong direction.

We need to investigate this to understand what's happened and/or take action

DQ

100%



KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we are not starting treatment with as many of our patients as we would like. Potential concerns were first highlighted in September 2020.	Analysis to be undertaken to understand whether there were any areas of concern.	**Complete.** Since September analysis has been undertaken in all localities and a number of issues have been identified. These are detailed on this and the following page.	The decreasing position is continuing; however actions remain ongoing.
Forensic Services			
We are treating fewer patients within our Liaison & Diversion Services than we would like. Many referrals are not appropriate for the service and are redirected for appropriate care and a number of clients leave custody prior to receiving assessment and treatment. Many contacts are via telephone, which is currently excluded from this measure.	A list of appropriate treatment codes to be agreed with Team Managers and Paris options to be limited to those relevant to the service. The Head of Health & Justice Services to raise the appropriateness of telephone contacts as a treatment method at the Service Development Group (SDG) in June 2021.	**Complete.** Agreed codes were circulated to staff with effect from December 2020. Paris changes implemented in June 2021. **Complete**. Senior Leadership Group approved the removal of the L&D teams from the scope of this measure on the 24th November 2021. Work will be completed by March 2022 to implement the change within this measure. Providing no further concerns are identified, these issues will be removed from the March report.	Activity is at a level we would expect..

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Tees Locality			
We are treating fewer patients within Mental Health Services for Older People teams than we would like due to waits for a Computed Tomography scan to support a dementia diagnosis.	The Service to review the dementia pathway to minimise the number of patients referred for a scan to support pressures experienced during the pandemic.	**Complete.** The changes made during the pandemic enabled us to offer a memory service to patients without interruption.	A decreasing position remains visible; however one action remains ongoing.
	The Consultant Psychiatrist to lead a wider review of the dementia pathway to strengthen pathway leadership.	**Ongoing.** The Dementia Pathway Group continues to meet monthly. Discussions with GPs to facilitate blood tests and other investigations required as part of the referral process have started. The diagnostic subgroup is reviewing training for staff to support higher standards for assessment and diagnosis. A further meeting is scheduled for April.	
Some treatment codes are not recorded correctly.	Service Development Manager (SDM) to review all data quality issues.	**Complete**. The SDM has developed training, which was rolled out to all staff on the 1st October 2021, and all treatment codes are being recorded correctly.	
Potential concerns have been identified within the MHSOP Middlesbrough and Hartlepool generic community teams. Sickness and vacancies within the teams is impacting the ability to progress as many patients to treatment as would be expected.	Sickness to be managed through the Long Term Sickness Team.	**Complete.** All episodes of long term sickness have ended and staff have returned to work.	
	Recruitment to be undertaken to fill all vacancies.	**Complete.** Recruitment is now complete and staff are going through induction processes.	
Potential concerns have been identified within the MHSOP North Tees Liaison and South Tees Frailty teams.	Analysis to be undertaken by the Service Development Manager and Head of Service to determine whether this is attributable to the service model.	**Complete.** Analysis has confirmed that performance is attributable to the service model, as the teams primarily do not take patients on for treatment but signpost patients to the most appropriate services	

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Children & Young People's Services have a new service model, triaging referrals in a Single Point of Contact (SPOC) team so they can be directed to appropriate services for their needs. A high number of referrals has resulted in delay.	Development of an interim plan to streamline the referral processes Performance Lead to liaise with Service Manager during April 2022 to identify any further areas of concern.	**Complete.** Patient flow has improved in the SPOC team and there continues to be no waiting list. Work is to be undertaken to identify whether there are any further underlying issues impacting on performance. **Not started.**	A decreasing position remains visible indicating we have not identified the main area of concern.
North Yorkshire & York Locality			
We are concerned that within our Mental Health Services for Older People (MHSOP), there is a high number of patients waiting for treatment within the Harrogate Memory Service and this is attributable to capacity within the team.	Recruitment is underway with all staff due in post by the 15th October 2021, with an aim is to complete 20 assessments per week from November.	**Ongoing.** There is now only one vacant post within the team, which has been advertised several times. The MHSOP Locality Manager is currently discussing alternative approaches to filling this post with Recruitment.	A decreasing position is continuing. Actions remain ongoing.
Potential data quality issues have been identified in the Harrogate Vanguard Community Care service.	The Locality Manager to undertake a deep dive during October to understand the underlying reasons; findings will be reported in November 2021.	**Complete**. The deep dive identified that assessment and treatment intervention codes are not recorded consistently on PARIS as this is not the team's primary patient based system.	
	The team manager to work with the team to resolve the current data quality issues and agree a data recording process. This work will be completed in November 2021.	**Ongoing**. As Paris is not the main system for the capture of activity, a standardised process has been established to ensure treatment interventions are recorded and reviewed to resolve any data quality issues. The team's current primary function is the provision of advice and liaison; a large proportion of patients do not receive treatment from the team. However, that function is currently under review, dependant on commissioner funding. That review is expected to be completed by the end of April 2022 and discussions through appropriate governance routes can then be progressed to confirm the appropriateness of the inclusion of this team within this measure.	

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Within Children & Young People Services (CYP) the Northallerton, Selby, Harrogate and York East community teams have reduced staffing capacity due to a number of vacancies. This has been further affected by support they have been providing to the York CYP Crisis service.	Recruitment is underway, which would provide more staff to be able to provide treatment appointments.	**Ongoing.** Recruitment is continuing in all teams; 12 vacancies in Selby (2 pending start dates), 5 in York East (1 pending start), 8 in York West (1 pending start) and 9 in Northallerton (2 pending starts). The Child & Adolescent Mental Health Services community teams continue to provide support to the Crisis team on an ad hoc basis.	A decreasing position is continuing. Actions remain ongoing.
	'Stop the line' process to be established to enable current processes to be reviewed.	**Complete.** The service has held a number of locality-wide events to look at pressures across all of the teams and are working with Organisational Development to understand the impact for staff and to formulate an action plan.	
Staffing resources due to sickness and staff turnover is resulting in delays in the Northallerton community team.	Director of Operations to raise staff concerns at Gold command in February to establish whether the team implements business continuity.	**Complete**. Business continuity has been implemented for the team.	
Potential recording issues have been identified within the Scarborough Community team.	The team manager to review the use of treatment codes within the team during November. An update will be provided in December.	**Complete.** The caseload refresh and safety summary work is now complete and identified recording issues have been resolved.	
Within Adult Mental Health (AMH) the Harrogate Community service has a number of vacancies that they are struggling to appoint to.	Recruitment is underway, which would provide more staff to be able to provide treatment appointments.	**Complete**. All posts have now been recruited to and are pending start dates. Agency staff continue to provide support in the interim.	A decreasing position is continuing. This indicates we have not identified the underlying issues and further analysis needs to be undertaken.

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
The York & Selby Wellbeing Access service has received a significant increase in referrals, which has impacted staff capacity as the team has a number of vacancies and some staff sickness. This has reduced the number of assessments that can be completed and consequently, the number of patients taken on for treatment.	'Stop the line' process to be established to enable current processes to be reviewed.	**Complete.** Staff capacity has improved following the return of staff from short term sickness; therefore support is no longer required from the community teams and the team is no longer in 'Stop the line' process.	
	All referrals for patients that have been discharged within the last year to be allocated directly to the community teams in York and Selby.	**Complete.** Processes are in place to enable patients to be assessed and allocated slots quickly following re-referral; staff have been supported to up-skill to provide more efficient assessments. Assessment processes are embedded and most patients are now being assessed within 4 weeks of referral.	
	The service to initiate a triage process to address the backlog of patients waiting for assessment from November 2021.	**Complete**. Triage process is in place and capacity has been created to screen referrals in line with service criteria. This has addressed the backlog; however, referrals continue to be above assessment capacity. Additional capacity has been secured from Crisis and West community mental health teams to review the long waiters, ensuring triage assessments, safety summaries and safety plans are in place for patients.	
	Recruitment is underway, which would provide more staff to undertake assessments.	**Complete**. The team are fully recruited and staff are progressing through pre-employment checks.	
Durham & Darlington Locality			
In Children & Young People's Services (CYP) we have been impacted by staff vacancies.	Recruitment is underway, which would provide more staff to offer treatment.	**Ongoing.** All actions identified as part of TD02 Percentage of patients starting treatment within 6 weeks of an external referral, are relevant to this measure.	A decreasing position is continuing; however, actions remain ongoing
Within Adult Mental Health Services performance is being impacted by data quality issues within the Access team.	Locality Manager to meet with the Access Team leadership in December to agree the actions required to improve data quality.	**Ongoing.** All actions identified as part of TD02 Percentage of patients starting treatment within 6 weeks of an external referral, are relevant to this measure.	A decreasing position is continuing; however, actions remain ongoing

TD11) Number of unique patients discharged (treated only) – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

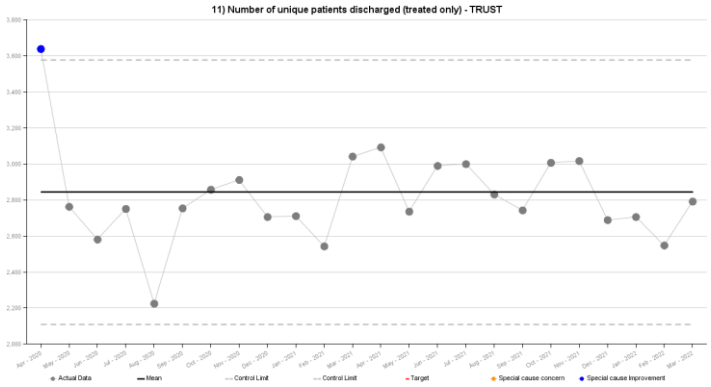
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are discharged from our services is important as it demonstrates that our patients are recovering and allows us to ensure we can maintain sufficient capacity to take on new patients.

2792 have been discharged in March after receiving treatment

There is no significant change in our performance. – it is within the expected levels.

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ ✓ **85%**



KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Whilst there is no concern with regards to the number of patients we are discharging from a Trust perspective, at a locality level there is a visible concern highlighted for **Tees**. First identified in July 2021, this was fully investigated and attributed to changes to service model. However, the decrease within the locality is continuing, indicating there may be further areas of concern.	The Corporate Performance Team to engage with the Service Managers to undertake further analysis during March 2022.	**Complete.** Analysis and actions are provided on the following page.	No visible impact.
A concern is now visible within **North Yorkshire & York.**	The Corporate Performance Team to engage with the Service Managers to undertake further analysis during April 2022.		

TD11) Number of unique patients discharged (treated only) - Tees Locality

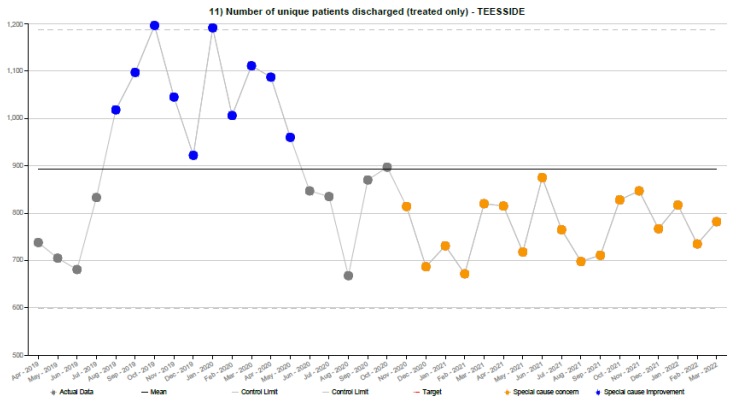
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

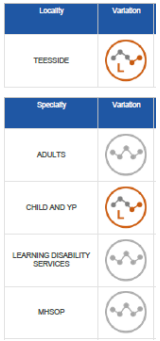
DETAILED ANALYSIS

We are concerned that fewer numbers of our patients are being discharged after receiving treatment from our services than we would like.

Analysis at speciality and team level has identified a potential concern within Children & Young People Services (CYPS).

Their service model facilitates the sign-posting of patients to the more appropriate support service within Trust services but also with external agencies. That means that a large number of our children and young people are signposted to other support services without receiving treatment within the Trust. However, analysis indicates a difference in performance across the four community teams and that there may be a concern within the Hartlepool and Middlesbrough teams.





No concerns have been identified within Adult Mental Health, Mental Health Services for Older People or Learning Disability Services.

CONCLUSIONS	ACTIONS BEING TAKEN
There are potential concerns within the Hartlepool and Middlesbrough generic community teams, that need to be fully investigated.	During April 2022, Performance lead to work with the CYPS service managers to establish any underlying areas of concern and to identify any actions required to mitigate risk.

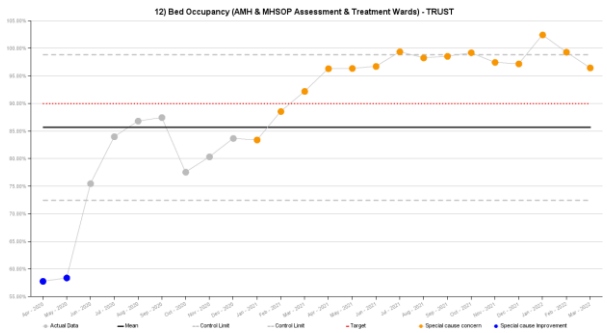
TD12) Bed Occupancy (AMH & MHSOP A & T Wards) – *Trust Standard 90%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important that our patients do not stay in hospital longer than they clinically need to and are discharged appropriately, as we know this can affect their recovery.

During March **10,695** daily beds were available for patients; of those, **10,317 (96.47%)** were occupied.

- We're aiming to have low performance and we're moving in the wrong direction.
- We need to investigate this to understand what's happened and/or take action
- Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves
- DQ ★ **100%**



Locality	Variation	Assurance
TRUST	H	?
DURHAM AND DARLINGTON	H	?
NORTH YORKSHIRE AND YORK	H	?
TEESSIDE	H	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned we have a greater number of patients occupying our inpatient beds than we would expect. Whilst this was first identified as a concern in June 2021, it has been monitored since September 2020 as there are a number of pressures on inpatient services within Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP). Whilst the number of admissions are at a level we would expect, occupancy is above a safe level and we have been unable to identify a safe, sustainable and robust plan to enable us to be flexible with bed capacity when required.	Analysis to be undertaken to understand the impact of community pressures, available resources and other factors, including out of area placements, to identify any areas of concern. Demand forecasting analysis to be undertaken to understand future pressures. Four beds to be purchased in the independent sector for AMH and MHSOP patients. Increased focus to be given to inpatient pressures at Locality Quality Assurance & Improvement Groups.	**Completed.** Following initial analysis, data is monitored monthly. Services have established groups to review patients with longer lengths of stay and Bed Managers are in post to monitor inpatient pressures more closely. **Completed.** Analysis shared with Chief Operating Officer, directors and key representatives of inpatient management. Routine monitoring agreed. **Completed:** Contract commenced 13th August 2021 and has now been extended to the 30th June 2022. An additional fifth bed has been purchased and all 5 beds are occupied. **Ongoing.** The meetings have been stood down over the last three months to support pressures within the clinical services. The Associate Director of Nursing & Quality is reviewing how to progress this and the appropriate forums. Proposals will be developed and agreed with Care Group Directors by the end of April 22.	No visible impact; however, actions are ongoing.

TD12) Bed Occupancy (AMH & MHSOP A & T Wards) - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	External support to help us to understand if there is anything further we can do to manage inpatient pressures and out of area placements to be commissioned.	**Ongoing.** The Trust sought external support to help us to understand anything further we could do to manage inpatient pressures and out of area placements to be commissioned. Unfortunately no suppliers were able to respond during 2021/22. Consequently we are now discussing other options to progress this work as a business planning priority for 2022/23, including with the North of England Commissioning Support Unit.	
	Bed census to be undertaken to help us understand our current patient base.	**Complete.** The bed census has been undertaken and shared with Senior Leadership Group and Service Development Groups. The Service Development Groups are continuing to work on actions and proposals an update on progress will be provided to the Directors of Nursing & Quality by the end of April 22.	

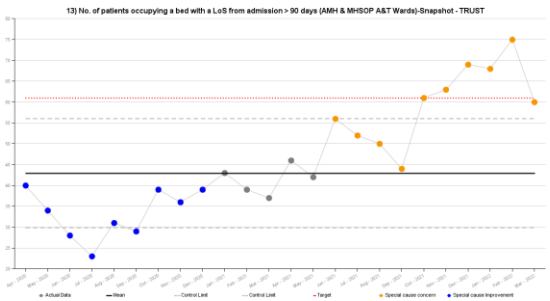
TD13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards – T*rust Standard no more than 61 patients*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important that our patients do not stay in hospital longer than they clinically need to and are discharged appropriately, as we know this can affect their recovery.

As at the 31st March 2022, **60** inpatients had a length of stay longer than 90 days

H – We're aiming to have low performance and we're moving in the wrong direction.	! – We need to investigate this to understand what's happened and/or take action
P – Our system is expected to consistently hit the target/expectation	DQ ★ – **100%**



Locality	Variation	Assurance
TRUST	H	P
DURHAM AND DARLINGTON	H	?
NORTH YORKSHIRE AND YORK	H	P
TEESSIDE	H	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Durham & Darlington Locality			
We are concerned there are a small number of our Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP) patients staying in beds longer than they need to be. This was first identified as a potential area of concern in June 2021 and is due to the needs and level of support required for the patients in their care.	Analysis to be undertaken to understand the impact of community pressures, available resources and other factors, including out of area placements, to identify any areas of concern. Demand forecasting analysis to be undertaken to understand future pressures. AMH service to form a Quality Assurance Group (QuAG) sub group to discuss and agree further actions.	**Complete.** Following initial analysis, data is monitored monthly. Findings continue to show the majority of instances involve patients with complex needs. No further themes were identified. **Complete.** Analysis shared with the Chief Operating Officer, directors and key representatives of inpatient management. Routine monitoring agreed. **Complete.** QuAG met on the 19th November and additional actions have been identified; these are detailed below.	An increasing position remains visible. Actions remain ongoing.

TD13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	The Locality Manager to start weekly locality meetings to review 60+ and 90+ day admissions. The meeting will discuss any concerns and escalate issues from ward level up to locality managers. It will enable the locality to understand any common themes or concerns they need to take to further locality or Trust-wide discussions	**Complete**. From a clinical perspective these meetings are successful for reviewing lengths of stay and progressing discharge for patients with complex needs.	An increasing position remains visible. Actions remain ongoing.
	Service Manager to develop a flowchart detailing funding streams and escalation routes, to make it easier for clinical teams to find suitable placements for patients ready for discharge and address delays.	**Complete.** The flowchart has been developed and is embedded into processes.	
	Consultant Psychologist to develop a template for completion of Independent Funding Requests by the end of December to increase the efficiency of this process.	**Complete.** The template has been developed and embedded into processes.	
	Work is underway within MHSOP with Local Authorities to facilitate discharges into local care following the issue of new legislative guidance.	**Complete.** We have developed partnerships with Local Authority legal teams to seek advice and work through processes where suitable places are available for patients but outside the area their families prefer. This ensures patients and their families are supported by the local authority and ourselves. However, our concern remains that whilst we are working to find patients appropriate care facilities, we are placing more patients in care homes outside of their preferred area.	
	The Associate Medical Director and General Manager for AMH Urgent Care to consider the most effective processes for identifying and monitoring 60 and 90 day lengths of stay within the Care Group. Discussions will commence in May 22.	**Not started.**	

TD13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	The service to meet each week to discuss all patients with a length of stay over 50 days to discuss any issues or concerns and actions in place where possible.	**Complete.** The meetings are continuing and the challenge remains to find care home placements within the locality area and patient/family care home choice. These are issues outside of Trust control.	
Tees Locality			
In October 2021 we identified a potential area of concern in Mental Health Services for Older People (MHSOP). This is attributable to the needs and level of support required for the patients in our care.	Locality Manager, ward managers and community team leads to meet weekly to review patients with a length of stay over 50 days, to discuss any issues or concerns and establish any actions.	**Complete.** The meetings are continuing and the challenge remains to find funded care home placements within the locality area and patient/family care home choice. These are issues outside of Trust control.	A decreasing position is now visible but this does not denote an actual improvement. Actions remain ongoing.
	The Associate Medical Director and General Manager for AMH Urgent Care to consider the most effective processes for identifying and monitoring 60 and 90 day lengths of stay within the Care Group. Discussions will commence in May 22.	**Not started.**	

TD14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days – *Trust Standard 9.90%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important that our patients do not stay in hospital longer than they clinically need to and are discharged appropriately, as we know this can affect their recovery.

238 patients were discharged during March; of those, **25 (10.50%)** were readmitted within 30 days

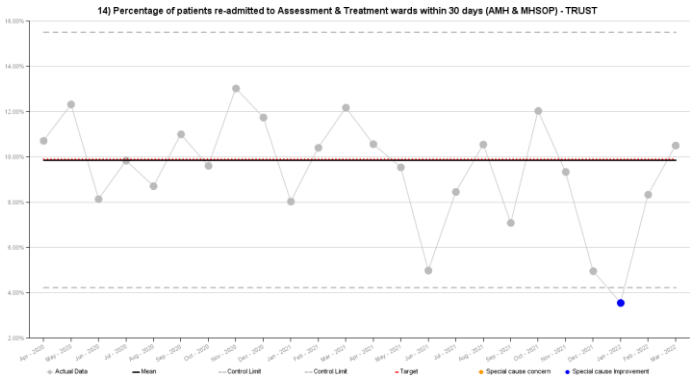
Nothing to note. Our activity is within the expected levels of performance

No further action is needed at this point in time

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ

100%



Locality	Variation	Assurance
TRUST		
DURHAM AND DARLINGTON		
NORTH YORKSHIRE AND YORK		
TEESSIDE		

SUMMARY

Whilst we have achieved the standard we have set ourselves, we remain concerned about the pressures on inpatient services within Adult Mental Health and Mental Health Services for Older People. Our performance against this measure indicates that we are not readmitting a significant number of patients within 30 days of their previous admission.

Therefore, at this stage, this measure is not a cause for concern.

TD15) Finance Vacancy Rate – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

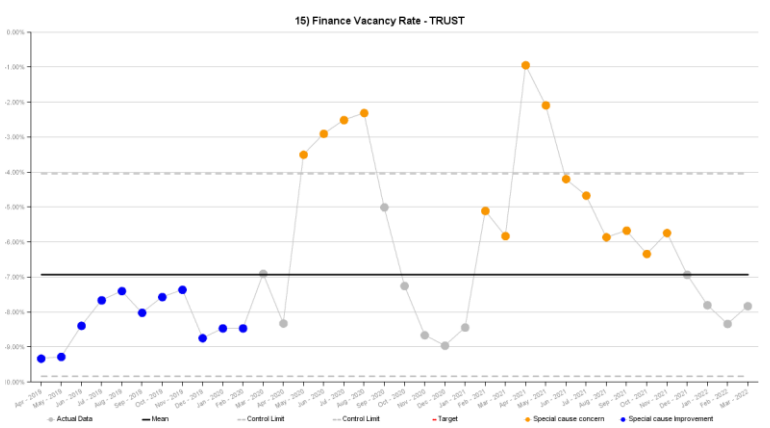
We are all committed to co creating a great experience for patients, and carers and families by ensuring we have staff available in the right place and with the right skills, supporting continuity of care for our patients. As a Trust having a full establishment ensure we can manage our resources and finances effectively.

During March we budgeted for **7736.6** full time posts; however **605.8 (7.83%)** of these were vacant

There is no significant change in our performance. – it is within the expected levels.

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ ✓ **80%**



Locality	Variation
TRUST	
DURHAM AND DARLINGTON	
FORENSIC SERVICES	L
NORTH YORKSHIRE AND YORK	
TEESSIDE	

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we have a high number of vacancies across the Trust. First identified in August 2021, the highest levels were identified within Tees and North Yorkshire & York.	Analysis to be undertaken to understand whether there were any areas of concern.	**Complete.** Analysis has been undertaken and a number of issues have been identified. These are detailed on this and the following page.	A decreasing position is visible and performance is at a level we would expect. Actions remain ongoing.
Tees Locality			
The current position within Children and Young People's (CYP) services is impacted by significant investment into the Child Eating Disorder service earlier in the year. Whilst a number of people are in post, the service model is in the process of being developed and the remaining posts will not be recruited to until the end of this financial year.	Head of CYP and team managers to agree the service model and complete recruitment by the 31st March 2022. An update will be provided in December 2021.	**Complete**. The service model has been agreed and an intensive home treatment team has been established to provide intensive packages of care for families within the home, or support when in acute care. All posts are fully recruited to.	A slightly decreasing trend is now visible but concern remains, indicating there may be concern in other areas.

TD15) Finance Vacancy Rate – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
There is a high number of vacancies within Adult Learning Disability (ALD) Services.	To undertake a recruitment campaign with the external company Indeed, to support the recruitment of up to 18 Health Care Assistants (HCA). This work is being led by the Head of ALD and is part of the work around changing the workforce model for Inpatient services.	**Ongoing.** Vacancies now remain for 16 healthcare assistants as 2 candidates withdrew their applications. Recruitment continues.	A decreasing position is continuing and performance is at a level we would expect. Actions remain ongoing.
	Head of ALD to develop a 12 month recruitment strategy for LD services. The aim is to market the service and nursing roles and includes linking with local schools and colleges to promote the role of ALD nurses.	**Ongoing**. This work is now being undertaken as part of a Trust-wide workforce package within the Adult Learning Disabilities Inpatient Redesign Programme Board. Work including standardising processes and implementing efficiencies, is progressing to plan. A date is still to be arranged for a dedicated recruitment event.	
North Yorkshire & York Locality			
All specialities within the locality are struggling to recruit, with nursing posts, in general, and the Scarborough, Whitby & Ryedale area, in particular, being impacted the most.	Employment of a Project Manager for Recruitment & Retention to support intensive improvement work.	**Complete.**	A decreasing position is continuing and performance is at a level we would expect. Actions remain ongoing.
	Vacancy advertisements to be improved, including communication methods (eg using social media) and international recruitment. An update will be provided in February 2022 once these have been embedded.	**Ongoing**. Improvements have been put in place and wider communication methods are now being used, including digital and social media. 10 nurses have been recruited are pending start dates; the remaining 3 are being advertised on a rolling basis.	

TD15) Finance Vacancy Rate – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
	A 1-year pilot to be undertaken for Scarborough Inpatient services, to enable a premier to be paid to staff recruited to these posts.	**Ongoing**. The service have started recruiting to posts in Scarborough Whitby & Ryedale using premier payment. Whilst uptake of this is not as high as we would have liked, only 2 nurses have been recruited, the initiative is continuing.	A decreasing position is continuing and performance is at a level we would expect. Actions remain ongoing.
	A community bank service to be created within the Trust to reduce the use of agency staff. An update will be provided in January 2022.	**On hold**. A proposed community bank model was discussed at the Workforce Senior Leadership Group in January and the concept approved. This work is being led by the Senior Programme Manager for Safe Staffing and further analysis is required to understand demand within community services. This will be completed early Quarter 1 2022/23.	
	An exercise to be undertaken by the Senior Project Officer Recruitment & Retention to identify the reasons for staff leaving and actions we can take to improve retention. An update will be provided in January 2022.	**Complete.** The exercise has been completed by the Senior Project Officer Recruitment & Retention and findings are being shared with the Locality (please see below action).	
	The Project Manager for Recruitment and Retention to undertake conversations with Locality and Team Managers to discuss any actions to support the work/life balance of staff, including ways jobs could be more flexible.	**Ongoing**. This work remains ongoing; the prioritisation of the international recruitment work has delayed this action and we do not currently have a date for completion. In the interim a 'Don't go' leaflet has been distributed to encourage staff to stay within the Trust.	

TD16) Percentage of staff in post with a current appraisal (snapshot) – *Trust Standard 95%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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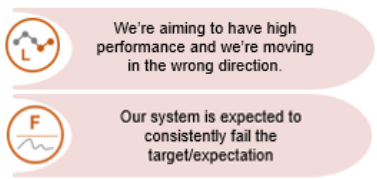
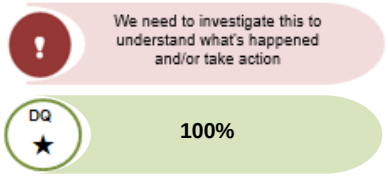
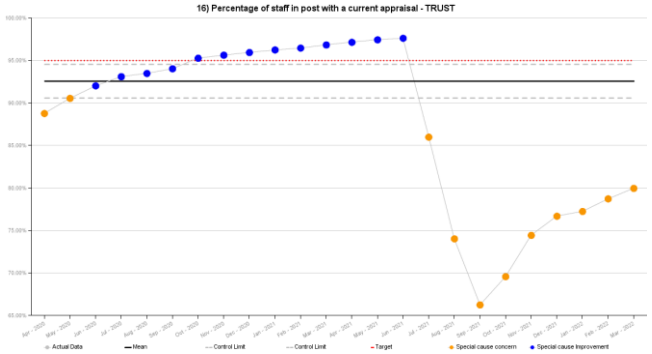
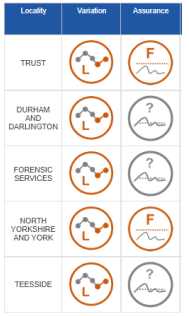
Of the **6275** eligible staff in post at the end of March; **5017 (79.95%)** had an up to date appraisal









KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that staff within our Localities have not received timely appraisals. To support business need during the pandemic, staff were given a series of extensions to ensure clinical care was prioritised. These grace periods started to expire in June and as a result we are starting to see the reduction in compliance.	Services to provide trajectories to be presented to the Locality Quality Assurance & Improvement (QA&I) Groups in October 2021. Progress towards achievement of trajectories to be monitored.	**Complete.** Forensics Services have a trajectory for achieving standard by the 30th April 2022. Durham & Darlington, Tees and North Yorkshire & York have a trajectory for achieving standard by the 30th June 2022. **Ongoing.** Health & Justice are on track to achieve the April 2022 trajectory, SIS have been impacted by staff sickness and trajectories are being revised	An increasing position continuing; however this does not yet denote an improvement. Actions remain ongoing.

TD17) Percentage compliance with ALL mandatory and statutory training (snapshot) – *Trust Standard 92%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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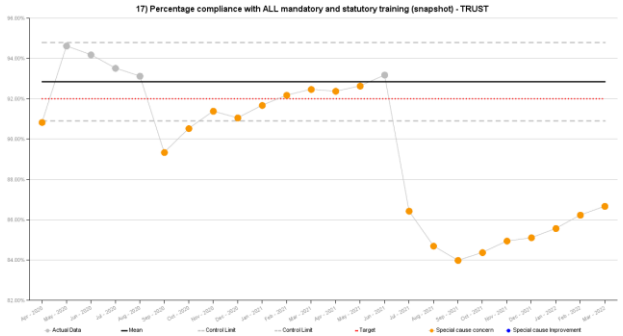
107,306 training courses were due to be completed for all staff in post by the end of March. Of those, **92,998 (86.67%)** courses were actually completed

We're aiming to have high performance and we're moving in the wrong direction.

We need to investigate this to understand what's happened and/or take action

Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ★ **100%**



Locality	Variation	Assurance
TRUST	L	?
DURHAM AND DARLINGTON	L	?
FORENSIC SERVICES	L	P
NORTH YORKSHIRE AND YORK	L	?
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that staff within our Localities have not undertaken training in the required timescales. To support business need during the pandemic, staff were given a series of extensions to ensure clinical care was prioritised. These grace periods started to expire in June and as a result we are starting to see the reduction in compliance.	Services to provide trajectories to be presented to the Locality Quality Assurance & Improvement (QA&I) Groups in October 2021. Progress towards achievement of trajectories to be monitored.	**Complete.** Forensic Services have a trajectory in place to achieve standard by the 31st July 2022; compliance is being impacted by the availability of face to face courses. Durham & Darlington, Tees and North Yorkshire & York have a trajectory in place to achieve standard by the 30th June 2022; however due to ongoing pressures on the ward, Tees inpatients have a trajectory in place to achieve standard by 30th September 2022. **Ongoing**	A slightly increasing position is now visible; however this does not yet denote an improvement. Actions remain ongoing.

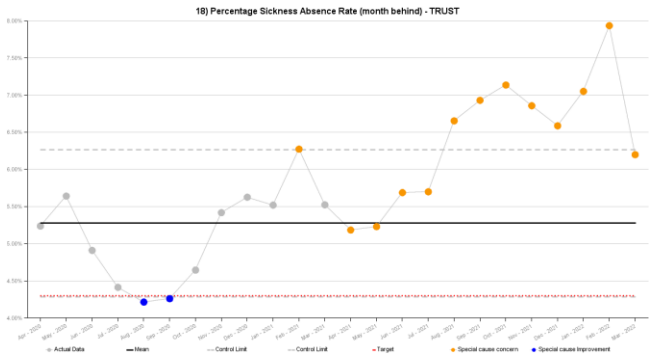
TD18) Sickness Absence – *Trust Standard 4.30%*

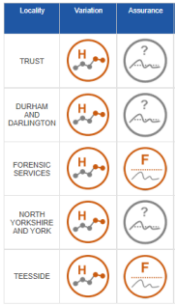
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work.

There were **195,816.23** working days available for all staff during February; of those, **12,139.34 (6.20%)** days were lost due to sickness.

- We're aiming to have low performance and we're moving in the wrong direction.
- We need to investigate this to understand what's happened and/or take action
- Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves
- DQ ★ 100%





KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that more members of our staff have been absent from work due to sickness than we would like.	Actions are detailed overleaf and following for each locality.	**Ongoing.** See individual progress updates.	No visible impact; however actions remain ongoing
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.	**Ongoing.** Regular reviews are in place and a number of members of staff have returned to work; 3 long-term sickness absences are ongoing. The team is currently operating at 55.1% staffing.	A decreasing position is now visible; actions remain ongoing.
	Recruitment is underway to increase capacity within the team.	**Ongoing.** There are currently 18.06 wte vacancies; 6.5 have been recruited to and are pending start dates. The team continues to try to recruit with a rolling advert, reviewing applications as soon as they are received in order to try and speed up the process.	

TD18) Sickness Absence - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
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 Secure Inpatient Services (SIS).	**Ongoing.** The Forensics Sickness action plan has been refreshed to reflect the current situation in the service and focus on Secure Inpatient Services, which has been driving the Directorate position. The new action plan was implemented in January and has 17 actions, of which 13 have been completed. Remaining actions include: • A review of the support packs / leaflets to send to staff absent due to sickness • The provision of sickness administrative resource to support trend analysis of ward sickness. • The uptake of Trust employee support services to be explored to understand why this may be lower in Secure Inpatient Services than other areas of Trust • Quarterly review of cases over 90 days with Head of Service and General Manager.	No visible impact; however actions remain ongoing.
	During March 2022, Human Resources Lead to resend communications out to all Health & Justice (H&J) teams to promote the weekly HR drop I clinics.	**Complete.** Communications were sent our and weekly clinics are now taking place.	
	By April 2022, Human Resources Lead to review the uptake of Trust employee support services by H&J staff, with a view to identifying whether the services are used and if any lessons can be learned and improvements implemented.	**Ongoing.** Data is currently being sourced and analysed.	
We have a high number of staff absent from work due to sickness within the Oakwood Locked Rehabilitation centre.	By March 2022, Human Resources Lead to meet with the team managers to obtain a background and intelligence on any staff concerns.	**Ongoing.** The Human Resources lead has met with the current team manager but further discussion with the previous manager have been delayed and rescheduled for May 2022.	

TD18) Sickness Absence - continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 those staff on long term sickness are being reallocated to ensure that patients are not waiting; however, this is impacting on the wellbeing of the remaining staff.	A decreasing position is visible but this does not denote an actual improvement. Actions remain ongoing.
	The Locality Manager to proactively encourage good wellbeing practice within the Middlesbrough Affective Team.	**Ongoing.** Supervision and caseload management are being prioritised as high caseloads have been identified as impacting on staff wellbeing. Staff feedback also highlighted that communication from Senior Leadership was could be improved to support wellbeing; this has been reviewed and improved, with positive feedback received.	
	Recruitment to be undertaken within the Hartlepool teams.	**Complete.** The remaining vacancies have been filled with start dates pending.	
	Regular contact to be maintained with all staff absent from work. This will be supported by the Workforce team.	**Complete.** Regular contact is maintained and this is supported by the Workforce team.	
Ongoing staff sickness and vacancies are impacting the ADHD team.	Paper to be submitted to the February Quality Assurance Group with a proposal to outsource assessments to a private provider.	**Complete.** At the March Quality Assurance Group it was agreed that further discussions were required with the Care Quality Commission to ensure that any private providers are robustly regulated. This work is being led by the Head of Quality Governance & Compliance.	
North Yorkshire & York Locality			
We are concerned that a number of members of staff within North Yorkshire & York are absent from work due to sickness.	The Corporate Performance Team to undertake further analysis with the Service Managers during March 2022 to identify if this is an area of concern.	**Complete.** Analysis and actions are provided on the following page.	

TD18) Sickness Absence – *Trust Standard 4.30% - North Yorkshire & York*

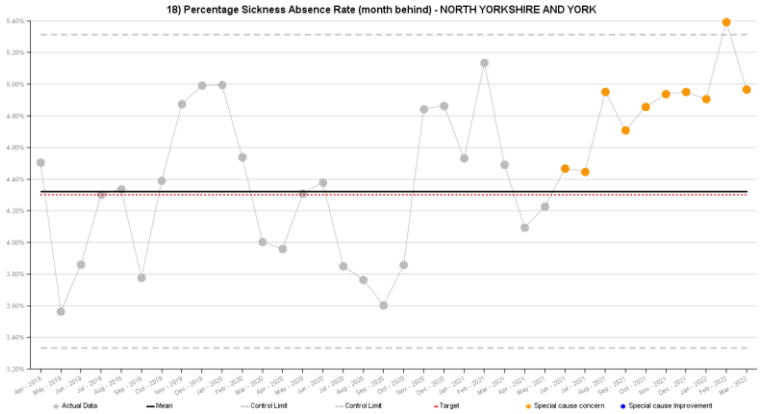
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

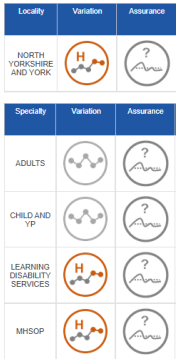
DETAILED ANALYSIS

We are concerned that more members of our staff have been absent from work due to sickness than we would like within North Yorkshire & York. Analysis at speciality and team level has identified the following.

- Within Mental Health Service for Older People's (MHSOP) services, there is a potential concern within Hambleton and Richmondshire Memory and Acute Liaison Service, Scarborough Management and Community teams, York and Selby Medical team, York Acute Liaison team, York and Selby Management team and Wold View Inpatient Service.

- Within Learning Disability (LD) Services there is a potential concern within Harrogate and York & Selby Community team and Oak Rise Inpatient Service.





No concerns have been identified in Adult Mental Health Service and Children and Young People services.

CONCLUSIONS	ACTIONS BEING TAKEN
Within MHSOP there is an impact due to both long term and short term sickness including an impact due to covid. Whilst we are seeing more members of staff, including medics, absent from work within MHSOP services, staff are also returning to work following short episode of sickness.	During April 2022, Performance lead to liaise with MHSOP Locality managers and Medical Development to establish whether the teams identified are an actual area of concern and to identify any actions required to mitigate risk.
Within LD a number of our staff have been impacted by the closure of Oak Rise due to safety reasons. The staff employed within that unit have been redeployed into other teams, introducing a level of instability and insecurity as to their future.	Head of Service and team managers to maintain touchpoints with all staff during the period of closure, providing a shared space for the team and staff members to discuss their concerns. Team managers to continue regular supervisions with staff to ensure any welfare issues are addressed.
Staff within our LD community teams have been impacted by clinical pressures and demand, particularly within the York Team which currently has a number of vacancies.	Head of Service and team managers to provide an increased leadership presence throughout April 2022. Stop the line has been implemented and weekly meetings are taking place with team managers to review the impact of the contingency plans.

Finance Measures

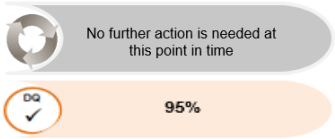
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and partners by ensuring we manage our resources and finances effectively.

TD19) Delivery of our Financial Plan (I&E)

The Trust's 2021/22 operational performance delivered a draft **(£5,948k)** surplus to 31st March against a planned surplus of **(£5,068k).** Composite financial performance is a deficit of £4,241k, but includes £509k unplanned profit on asset disposal and £10,638k impairments which are excluded when measuring performance against plan.

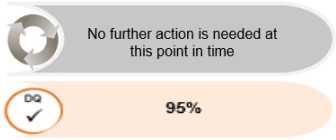
(£1,030k) Favourable variance from plan



TD 21) Cash against Plan

We have an actual cash balance of **(£81,696k)** against a planned year to date cash balance of **(£76,498k).**

(£5,198k) Favourable variance from plan



Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

SUMMARY

The Trust targeted a (£4,720k) surplus for the first 6 months of the financial year (H1), and delivered a £5,021k actual surplus. A second half (H2) surplus of (£47k) was planned, providing a full year planned surplus of (£5,068k). Composite financial performance is deficit of £4,241k, adjusted for impairments of (£10,638k) and disposal profits of £509k - both are excluded when measuring performance). The Trust's operational performance is therefore a surplus of (£5,948k) to 31st March, or (£880k) ahead of the 2021/22 plan.

Work is now in train at Integrated Care System (ICS) levels to deliver detailed plans by 14th April with ICS working to triangulate plans before final national submission on 28th April for both revenue and capital. 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 revenue allocations.

Business Planning activities to assess, coordinate and prioritise resource requirements for the new financial year included assessing options for delivering recurrent cash releasing efficiency savings and the scoping of opportunities identified before the Pandemic. Targets have been set and further scoping during Q1 2022/23 will assign actions and model delivery timeframes, particularly to target agency cost reductions. Other key programmes of work include:

- Risk and Mitigation assessment
- Work on the underlying financial position (using estimated income in the absence of confirmed recurrent funding streams and allocations).

Cash balances are £5,198k higher than plan. This reflects the £1,030k higher than planned surplus, £701k lower than planned capital expenditure, and other movements in working capital including increased accruals linked to capital, IT equipment, where invoices from suppliers have not yet been received, and Thank you payments that were approved at the March Board of Directors meeting and payable at the end of April.

Financial performance and planning is discussed periodically at the Board of Directors, Financial Sustainability Board, Locality Management meetings and Strategy and Resources Committee.

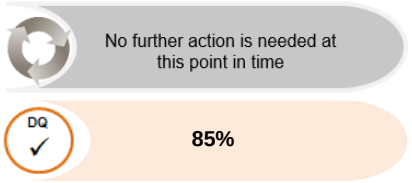
TD20) CRES Delivery

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and Partners by ensuring we can manage our resources and finances effectively.

We planned to deliver **£2,301k** Cash-Releasing Efficiency Savings (CRES) for the year to date and have identified **£2,301k non-recurrent** CRES mitigations.

£0k Variance to plan



Financial values with brackets indicate a (surplus) or (favourable) position, financial values without brackets indicate a deficit or adverse position.

SUMMARY

Cash-Releasing Efficiency Savings (CRES) requirements arise where NHS organisations need to balance expenditure to within overall income, including to deliver national efficiency expectations (set out in national tariff assumptions) and to managed any additional cost pressures arising from organisational and / or system operational plan requirements. Tariff adjustments are usually applied to provider contracts annually and comprise:

- a national % uplift for estimated pay and price inflation, offset by
- a national % 'deflator' for the required annual efficiency requirement

Providers receive the 'net' cash increase of an inflationary % uplift less the efficiency % deflator. This means that CRES are needed to maintain real terms funding levels (to finance inflation). CRES requirements will exceed the national tariff efficiency requirement where other local unfunded cost pressures need to be managed. The NHS seeks to find more cost efficient ways to deliver services and utilise resources. E.g. CRES might include reviewing processes, staffing skills mix, premises utilisation, procurement or digital solutions.

As a result of national financial arrangements operating during the pandemic, the focus on CRES was initially suspended. More recently, the NHS was asked to recommence CRES delivery in 2021/22 with a view to returning to more normal arrangements from 2022/23. Nationally, 0.28% was targeted during H1 (April to September) with a national requirement of 1.1% during H2 (October to March).

Guidance included a national tariff efficiency requirement of 1.1% for 2022/23. The revenue plan has CRES modelled at 2% in recognition of the non-recurrent requirement scheme delivery during 2021/22. In preparation, the Trust is starting to focus on identifying 2022/23 recurrent efficiency or waste reduction schemes through annualised Business Planning arrangements and with Financial Sustainability Board oversight.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item 13

Quality Assurance Committee: Key Issues Report

Report Date to Board: 28th April 2022

Date of last meeting: 7th April 2022. **Membership:** Quoracy was met. Apologies received – Steve Wright

1 **Agenda items considered:**

- Board Assurance Framework and Corporate Risk Register – risks to Quality and Safety
- Trust Level Quality Assurance & Learning Report
- Trust Action Plan in response to Well-led CQC Inspection and updates from NHSE/I and TEWV Quality Improvement Board
- Locality updates (North Yorkshire & York, Teesside, Durham & Darlington, and Forensics)
- Safe Staffing
- Pilot of Body Worn Cameras
- Absent Without Leave
- Research Governance
- Health, Safety Fire & Security

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

Board Assurance Framework (BAF) - risks relating to quality and safety

The Committee welcomed the progress on the BAF, however, concerns are to be noted on the lack of assurance that can be provided to the Board, in terms of the risks in relation to quality and safety. This is in connection with the management of risks and contemporaneous updates.

Members pointed that there is a disparity between the BAF and the Corporate Risk Register. They were advised that the new governance layers, part of the Trust re-structure, such as the Care Group Boards and Executive Risk Group, will provide more controlled oversight and management of risks. The recent appointment of a Head of Risk Management will support driving some of this work forward.

Essentially, members recognise that the BAF should be driving the agendas of the Committee, and it was acknowledged that there is some work to be done to support the Quality Assurance Committee to be able to effectively review and agree any changes to risk scores, whether there are sufficient controls in place to manage risks and if mitigations are having an impact.

There is some good assurance that can be provided in relation to the BAF, from a recent draft internal audit report, which reported improvements compared to the previous year. Recommendations from the report, include tightening up the trajectories and end points for achieving mitigations and greater emphasis to be placed on the management of risks and evidence to support this.

Further discussions have been arranged to discuss the BAF in more depth outside the Committee, with some input from other Non-Executive Directors.

Corporate Risk Register – risks to Quality and Safety

Key developments are that Datix has been aligned with the new operational structures, the Risk Management Policy will be ready for approval by the end of April 2022 and the appointment has been made for a Head of Risk Management.

Two new risks were added during February- staffing levels are below commissioned levels in NY&Y Children and Young People services – impacting on waiting lists and the ability to implement the THRIVE model of care. Staff have high caseloads, issues with interface between teams and are at risk of burn out. The other risk is to patient safety is in relation to ongoing medical device management with potential devices being obsolete, out of date or poor working condition when they might be required in an emergency.

	There were risks described (5) which did not have mitigating actions. NY,Y&S locality confirmed that there were mitigations in place for three of those risks. **Trust Level Quality and Learning Report:** The key messages from this report are the four measures of quality and safety that were causing concern during February 2022. These were self-harm (675 incidents), patients in beds longer than 90 days (75 patients compared to the standard of no more than 61), mandatory training (ongoing concerns for Basic Life Support and Positive Approaches Team training) and appraisals (78.70% compared to standard of 95%). The Board is to note that a deep dive will be undertaken in relation to the high levels of self-harm incidents. Members sought further assurance in relation to the self-harm work and were advised that the Suicide and Self Harm Reduction Group will be giving this some attention. Non-Executive Directors picked up on a recent visit to CAMHS crisis services and the significant increase in the use of ligatures in children and young adults, where it was clear there is a lack of understanding about the dangers of using ligatures as a method of self-harm. Members sought clarity on the reporting of information from the Patient Experience Group, which was stood down during the pandemic. Going forward it is expected that the Care Group Quality Assurance and Improvement sub-group will feed into the Executive Quality Assurance and Improvement Group and report into QuAC through the Trust Quality and Learning Report. **Locality Updates:** The messages from the four localities remained consistent. Staffing challenges with a lack of Registered Nurses for some shifts. Staff resilience, health and morale. High bed occupancy with continued high acuity of patients and increasing levels of self-harm, particularly among female patients in Durham & Darlington and Teesside. Lack of community infrastructure to support discharging people. The continued challenges to meet mandatory training and appraisal compliance. Each locality provided mitigations in relation to the efforts being made to address concerns and despite the real struggles there was some positive feedback through staff experience surveys. **Monthly Safe Staffing Exception Report** From the February 2022 report the Board should be alerted to the following: 36 of rostered wards had a Registered Nurse (RN), on day shifts below the fill rate threshold of 90%. Services are skill mixing and backfilling to mitigate against this. The top three concerning areas were Westerdale South (MHSOP), Fern (SIS) and Wold View (MHSOP). There were 74 shifts worked across the Trust that exceeded 13 hours to provide continuity of care and support patient acuity, this was an improvement from January (89) but still a cause for concern in terms of staff well-being. Esk Ward remains closed. Business Continuity Arrangements in place during February included SIS, Bankfields Court (LD) and D&D Crisis Team. The average use of agency over the 54 wards reviewed had increased to 14.6% from the previous month (upper target 4%) and bank usage decreased from 27.2% in January, to 23.3%. Brambling and Kingfisher wards were the highest users. A subgroup of Workforce SLG has been established to review and address key concerns and priorities relating to workforce requirements and standards, including shift patterns, clinical supervision, missing shift breaks, extended working hours, and impacts upon patient experience and safety due to staffing pressures.
2b	**Assurance: The Committee assures members of the Board on the following matters:** **CQC Well-led Inspection and NHSEI Quality Board Update** Following a presentation to the Committee on the actions in response to the CQC Well-led inspection, it was confirmed by the Forensic locality that most of the actions following the S29A in relation to secure inpatient services have been completed. Those outstanding in relation to safeguarding, staffing and governance are currently being embedded - waiting for evidence of the impact of the changes before they will be marked as complete. The biggest issue – staffing is causing considerable risks and challenges for

all localities and innovative recruitment methods to prevent a disappointing cycle of advertising with little success will be key.

Members were advised that the CQC had fed back that from the recent presentation to the CQC from the services that they could see a real difference in the way staff were talking and focusing on the impacts of changes in response to the Well-led inspection.

Absent without Leave

The Board is to be aware that following discussions at the Mental Health Legislation Committee in January 2022, members agreed to look further into the data that relates to those patients that go absent without leave, to be able to consider whether there is anything further that can be done to prevent this from happening and keep patients safe. A Developmental session is being held by the MHL Committee on 22nd April 2022, where this will be discussed.

Pilot of Body Worn Cameras

The pilot of body worn cameras continues across ten areas in TEWV services. More time will be needed to effectively come to any firm conclusions on whether the cameras are reducing restrictive interventions. In seeking assurances on any impact of a reduction in violence and aggression, members were informed that, whilst feedback from staff and patients in focus groups has been positive, there are no changes to the numbers of incidents. It is acknowledged that in other Trusts who had made positive progress that impact can take several years to embed and sustain. Moving forward, the focus will be on checking data measures, sustainability and embedding practices.

Research Governance

The key messages from Research Governance include that there are 117 open research studies in TEWV, however some projects will not be able to take place, due to the lack of resources. This could have an impact on the Trust, both in terms of reputation and growth.

One of the positive developments is that the Trust has, along with thirteen other Mental Health Trusts, joined 'Akrivia Health Platform', previously knows as CRIS. This will enable information to be found from clinical records that is not structured in coded fields and will aid other methods of undertaking research.

Health, Safety, Fire & Security

Key assurances can be provided to the Board, which include the development of a 'Management of violence and aggression policy' with key measures to be put in place to actively reduce violence and aggression, protecting staff and other service users. A new Risk Assessment Procedure has been established through joint working with Estates, to tackle some gaps that have been found in Workplace and Health and Safety audits, undertaken across the organisation.

Potential areas of risk include the current Lone working system and risk assessment documentation, which does not provide evidence that all lone workers are adequately protected and that available measures are being used. In response, a Lone working group is being set up to review processes and existing lone working control measures are being reviewed.

Whilst there has been a reduction in false alarms relating to fire, there were two serious fires which resulted in two wards being evacuated and the loss of a seclusion room to allow remedial works to be carried out.

Positive Practice Examples

Localities wanted to state that a key success over February was managing to maintain service provision in the challenging internal and external environment.
Staff from the MHSOP Harrogate CMHT team reported their experiences as mixed with some feeling like there is no time to rest before more change comes along to others, who are keen to work collaboratively and use more autonomy to improve patient care.
Staff from Forensics have fed back on their experiences that there is a lot of support at Ward Manager and Clinical Lead level and after some difficult times morale seems a lot better.

2c	**Advise:** The Committee members agreed that the key issues to draw to the Boards attention are: 1. The discussions about the lack of assurance in relation to the BAF and the Corporate Risk Register. 2. The positive assurances received about progress of the Trust action plan in response to the Well-led CQC inspection. 3. Concerns in relation to the increasing numbers of self-harm incidents and the use of ligatures, particularly in Durham & Darlington and Teesside and to note the deep dive that will be undertaken. 4. Concerns over safe staffing levels, particularly SIS and to note the workforce modelling in response to this. 5. 74 breaches of staff working over 13 hours on one shift (an improvement from January with 89). 6. To note the updates on the pilot of body worn cameras, absent without Leave, Health, Safety & Fire and Research Governance with concerns over research studies and projects being cancelled, due to lack of resources. 7. Ongoing concerns about staff resilience and wellbeing.
Recommendation: **The Board is asked to note** the contents of the report.	
3	**Risks to be considered by the Board:** There were no risks that were considered should be escalated to the Board.
	Report compiled by Bev Reilly, Chair of Quality Assurance Committee, Elizabeth Moody, Director of Nursing & Governance/ Donna Keeping, Corporate Governance Manager

Item 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Thursday, 28th April 2022**
TITLE:	**Assurance report on the delivery of the CQC Action Plan**
REPORT OF:	**Avril Lowery, Director of Quality 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:

The purpose of this report is to present to the Board of Directors a detailed update of the current status of all CQC must do actions. A summary of the current status as at 22/04/22 is as follows:

- 37.5% (30/80) of actions are complete
- 37.5% (30/80) are on track with little risk to delivery
- 21% (17/80) have some risk to delivery
- 4% (3/80) are not delivered with significant risk to delivery

A full status update for all must do actions is presented as Appendix 1 of this report.

The CQC action plan is subject to rigorous monitoring in order to ensure effective delivery of actions in line with agreed timescales. A new electronic share point folder has been developed and implemented April 2022 to ensure that all action owners have live access to the plan and are able to provide routine progress updates regarding delivery of individual actions.

An Engagement Meeting took place with the CQC 9th March 2022 to share a detailed progress update regarding the Section 29A plans for Secure Inpatient Services and Community Child and Adolescent Services. The CQC noted progress made and the need to ensure a sustained focus on delivery of must do actions.

There are three actions that are showing as red (11a, 13d and 19) which are currently recorded as not delivered/ significant risk to delivery. The timescales will be reviewed by the Trust Quality Assurance & Improvement Group 26/04/22 to consider amendment to the target date for completion.

Recommendations:
The Board is requested to note the content of this report and agree the level of assurance as reasonable with regard to oversight and delivery of the action plan.

MEETING OF:	**Board of Directors**
DATE:	**Thursday, 28th April 2022**
TITLE:	**Assurance report on the delivery of the CQC Action Plan**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board of Directors, the current status of the 'must do' actions arising from the CQC Trust core service and well-led inspection. In addition, it will describe the refreshed governance arrangements and ongoing activity.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Between 14 June 2021 and 05 August 2021, the Trust received a series of core service inspections from the CQC. This included inspection of Secure Inpatient Services, Adult Mental Health Crisis Services and Health Based Places of Safety, Adult Mental Health Community Services and Community Child and Adolescent Mental Health Services. Core service inspections were also followed by a well-led inspection of the Trust.

Following the inspection, the CQC formally raised several areas of concern with a Section 29A notification received for Secure Inpatient and Community Child and Adolescent Mental Health Services. Immediate action plans were developed in response to these issues and implementation has been well progressed, reporting weekly to QIB and now the new executive directors weekly meeting. The deadline for implementation was 31 March 2022. It is however recognised by the CQC that full implementation and embedding of some of these actions will require longer timescales. Section 29a issues have subsequently been encompassed by the CQC within the 'Must Do' regulatory actions.

The Trust CQC inspection report was issued 10 December 2021 and rated the Trust as 'requires improvement'. A copy of the report may be viewed at:
https://api.cqc.org.uk/public/v1/reports/39d313da-63b8-4a46-a423-11f1958c89b0?20211223164650
The report identified a number of Regulatory breaches from which twenty-seven 'must do' actions and twenty-one 'should do' actions were stipulated.

A collective, collaborative approach was taken to the development of a comprehensive Trust action plan and a facilitated event took place on the 21 December 2021. An action plan in response to each of the findings was co-created by service users and carers, staff from across all specialties inspected, senior managers and the Senior Leadership Team. The action plan was approved by the Trust Quality Improvement Board 19 January 2022 and the Trust submitted the action plan to the CQC 21 January 2022. The action plan

was formally accepted by the Trust Board on 27th January 2022. A further event was also held in March to develop the action plan for delivery of the should do actions.

An engagement meeting was held with the CQC on 9th March when the Trust presented the extensive improvement work, they had undertaken in response to the Section 29a. Feedback was positive and the CQC recognised the significant progress made however, noted there was limited impact evidence at this point. The CQC emphasised the need for the Trust to demonstrate overall improvement against all must do's as well as the wider fundamental standards and advised that this will be a focus of the next follow up inspections.

3. KEY ISSUES:

3.1 Governance Arrangements

All action plans resulting from external inspections, assessment and accreditations are held within the Integrated Oversight and Reporting Database. The database enables the Trust to have oversight of the progress against all actions plans resulting from these reviews. It also enables the identification of emerging and recurring themes across a range of inspections and a co-ordinated approach to addressing these.

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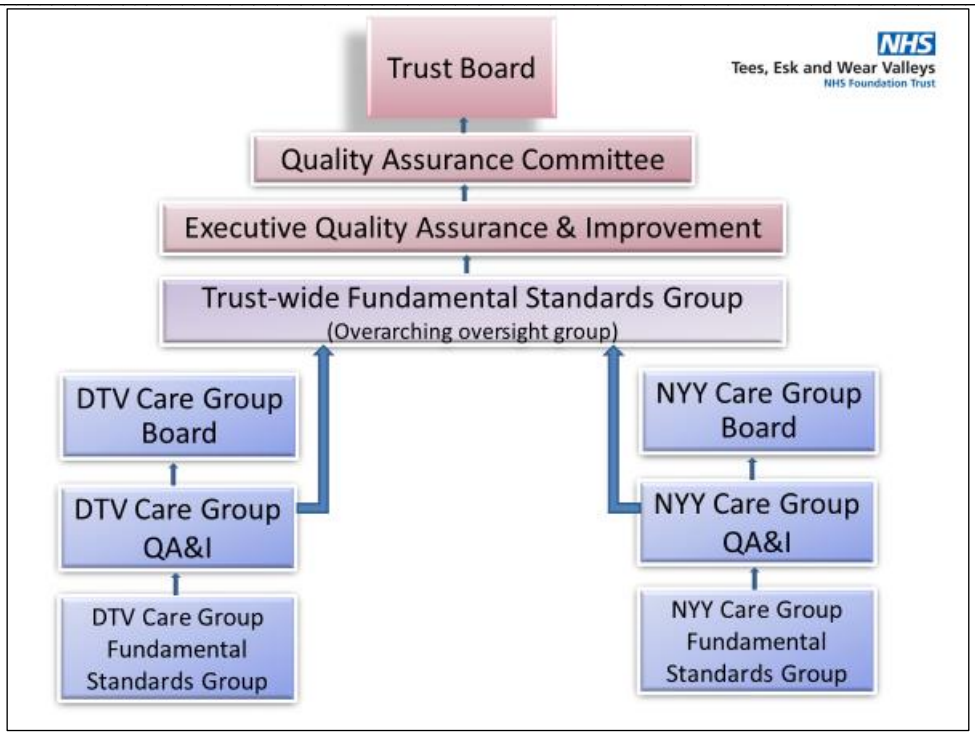
More recently further fields have been added to the database to improve the robustness of the monitoring process. These include:

- A revised status field that now identifies the level of risk to delivery of the actions
- A field to grade the level of assurance regarding the evidence of compliance
- Plans for assessing sustained improvement

From April 2022 all action owners can report progress against individual actions monthly directly to the Quality Governance Team via the T Drive share point folder thereby becoming a live document.

3.2 CQC Fundamental Standards Reporting Arrangements

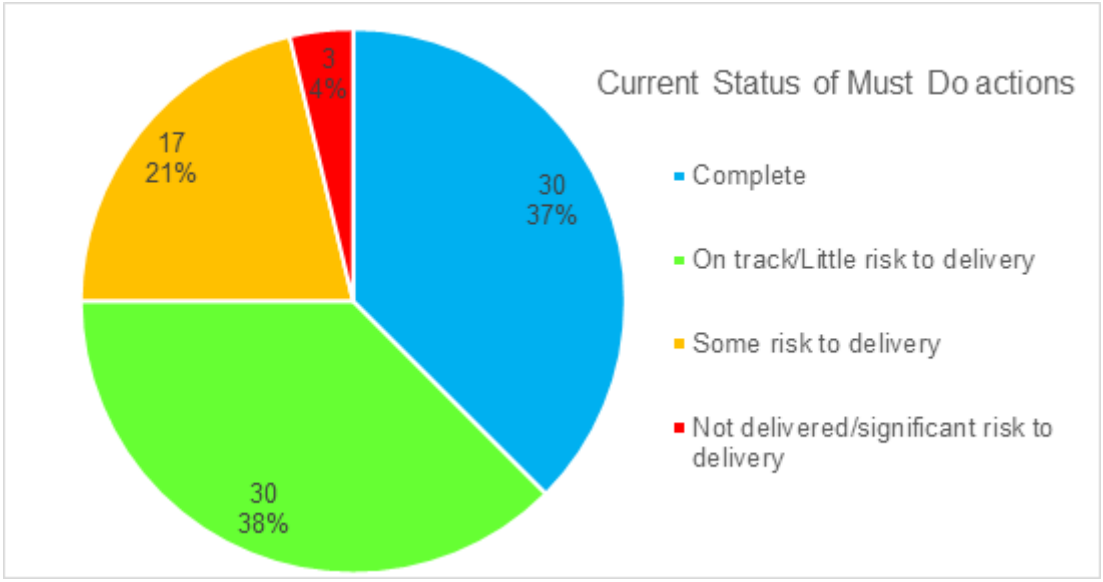
Reporting and monitoring arrangements have been refreshed and are illustrated below. These changes are being communicated as part of the new Trust governance arrangements.



3.3 Current Status

The Trust CQC must do action plan update is presented as Appendix 1 of this report.

The chart below provides the current status against all must do actions within the action plan. Overall, there is good progress noted however, the delivery of some actions has been impacted by capacity restraints and service pressures. Our focus is on embedding the changes in practice and plans to assess the sustained improvement will be key to gaining assurance.



The detail against each action is documented within the CQC must do action plan update in Appendix 1. With regard to the three actions that are not delivered or significant risks to delivery:

Action 11a:
The trust must ensure they collect performance data relating to targets and quality standards so that senior managers can ensure there is appropriate governance and quality assurance. (Regulation 17)

a) Process owners for each operational policy will be requested to review their respective policies to identify any targets or quality standards and clarify what the processes for assurance is. [Improvement measure: Review of operational policies complete and the Trust will have identified those containing any local targets.]

The risks associated with regard to this action relate to delivery in line with the anticipated timescales and underestimation of the scale of the actions required to address this for all operational policies. The timescales will be reviewed by the Trust Quality Assurance & Improvement Group 26/04/22 to consider amendment to the target date for completion.

Action 13d:
The trust must ensure that the use of restraint within the service is proportionate and used only as a last resort and that any restrictions placed on patients are individualised, proportionate, regularly reviewed and removed as soon as possible. (Regulation 13)

d) Based on the outcome of the review implement a continuous improvement plan that ensures current practice reflects Regulatory requirements and best practice in relation to blanket restrictions.

The risks with regard to this action relate to delivery in line with the anticipated timescales. It is clear from the action plan that considerable work has already been undertaken in terms of a review and baseline assessment of current staff awareness, practice and performance with the Trusts subject matter expert however an extension is required to the timescales to allow additional time for completion of a QI Event to improve levels of assurance around practice. The timescales will be reviewed by the Trust Quality Assurance & Improvement Group 26/04/22 to consider amendment to the target date for completion.

Action 19:
The trust must ensure that regular team meetings take place on all the wards within the service to ensure staff receive key information and have the opportunity to provide their own feedback on the service. (Regulation 17)
Refresh secure inpatient service governance - meeting structures to facilitate regular meaningful staff involvement and engagement. [Improvement measures: Regular meetings take place for staff at ward level and attendance is monitored. Improved levels of staff engagement within the annual staff survey.]

Work is ongoing to facilitate delivery of this action however, the required outcomes have not yet been achieved with regard to all wards consistently holding team meetings and improving staff engagement in the staff survey. Attendance has been hampered by staffing challenges however a number of other ways of engaging staff have been improved such as Band 7 away days, MS teams meetings.

3.4 Services are currently undertaking a CQC Fundamental Standards Baseline Self-assessment that involves assessment of evidence, information and data as well as importantly, validating this within the clinical services through peer review visits engaging with service users, carers and staff. Key priority areas are SIS and CAMHs in the first instance.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The focus of this report is to provide assurance regarding compliance with key elements of the CQC Fundamental Standards which were not met during previous CQC core service and well-led inspections. The report provides assurance regarding progress made in relation to actions to address these and thereby ongoing assurance regarding compliance with the CQC fundamental standards.

4.2 Financial/Value for Money:

There are financial risks associated with failure of the organisation to achieve ongoing compliance with the CQC Fundamental Standards. These risks include Regulatory enforcement actions which include financial penalties for the organisations should it fail to make required improvements.

4.3 Legal and Constitutional (including the NHS Constitution):

There are legal and constitutional risks associated with failure of the organisation to consistently comply with the CQC Fundamental Standards. Legal risks may result in CQC enforcement actions, loss of reputation and ultimately loss of CQC Registration.

4.4 Equality and Diversity:

Compliance with the CQC Fundamental Standards is a key enabler in ensuring that services meet relevant equality and diversity obligations.

4.5 Other implications:

There are no other immediate implications resulting from this paper.

5. RISKS:

There are fundamental risks to patient safety, clinical effectiveness and patient experience, as well as the broader financial and reputational risks should the Trust fail to consistently comply with the CQC Fundamental Standards.

6. CONCLUSION:

Overall, positive progress is being made in the delivery of the CQC Must Do action plan with a small number of actions not delivered/ with significant risks to delivery, mainly due to service pressures and capacity challenges. Work continues to progress to address these actions.

7. RECOMMENDATIONS:

The Board is requested to note the content of this report and agree the level of assurance as reasonable with regard to oversight and delivery of the action plan**.**

Background Papers:
Appendix 1 CQC Must Do Action Update

Appendix 1 – CQC Must Do action status and level of assurance update

Current Status Key:	Complete	On track/Little risk to delivery	Some risk to delivery	Not delivered/ significant risk to delivery
Level of Assurance Key:	Substantial	Good	Reasonable	Limited

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Trust wide	1a	The trust must ensure that it continues to deliver its board development programme to strengthen the scrutiny and challenge by boards members. (Regulation 17)	a) Review relevant section of the Good Governance Institute action plan.	Company Secretary	Review of Good governance institute action plan	28/02/2022	Complete	Good	Well-led Implementation Plan presented to Board on 31/03/22 with recommendations approved.
Trust wide	1b		b) Review Deloitte's Board Development Terms of Reference to ensure that all requirements are included.	Chief Executive Officer	Final Board Development Terms of Reference	30/06/2022	On track/Little risk to delivery		Deloitte's are undertaking a Board Effectiveness survey at the moment and the results will be discussed at the Board Workshop on 03 May 2022 which will form the basis of the ongoing Board Development Programme.
Trust wide	1c		c) Identify how we will know that the actions are having an impact - develop evaluation methodology e.g., Board feedback	Company Secretary	Board Performance Evaluation Scheme Feedback	31/03/2023	On track/Little risk to delivery		Evaluation being undertaken by Deloitte LLP. Results are due to be considered by the Board at a workshop on 03/5/22
Trust wide	1d		d) Commission a further external governance review.	Company Secretary	Board and Committee Minutes	30/03/2024	On track/Little risk to delivery		See above.
Trust wide	2a	The trust must ensure that planned changes to the governance structure are implemented to provide assurance that patients receive safe, good quality care and treatment. (Regulation 17)	a) Develop a shared understanding and approach of how we will get assurance (both quantitative and qualitative) at different levels of the organisation (including escalation triggers). [Improvement measures: Structured assurance methodology for using quantitative and qualitative intelligence to draw out key themes and hotspots]	Director of Quality Governance, Associate Director of Performance and Company Secretary	Structured assurance methodology	30/06/2022	On track/Little risk to delivery		Progress being made to develop an accountability framework. An event is planned to take place facilitated by the QI team in May 2022.
Trust wide	2b		b) Review Directors visits to ensure that they support gathering assurance on the delivery of fundamentals of care e.g., service users/carer experience [Improvement measures - Greater and deeper intelligence from the Directors visits and greater triangulation with other intelligence, demonstrable changes in response to intelligence gathered]	Director of Therapies	Review of director visits	30/06/2022	Some risk to delivery		This work is in the initial stages due to urgent unplanned leave as well as capacity challenges of the leads. We have identified a coaching approach and we are working with one of the NEDs to develop this. The delay has been escalated to SLG and a reassessment of the situation is planned for the end of April.
Trust wide	2c		c) Ensure there is a collective understanding at each level within the governance structure, including the clinical networks, of what good governance looks like and individuals' roles within it. [Improvement measures: Clearly defined expectations around risk tolerances including escalation triggers, strategic oversight, and quality methodology at each level i.e., standards]	Director of Quality Governance and Company Secretary	Terms of reference	30/06/2022	On track/Little risk to delivery		
Trust wide	2d		d) Implement the new Governance Structures and assess the impact and effectiveness of these changes. [Improvement measures: Provision of a handbook available that describes different tools and support that is available for use linked to safety quality and governance systems. Increased levels of skills for analysis, escalation, and assurance. Care Group Board development programme will be in place with suite of evaluation measures (as per Board Development Programme)]	Director of Quality Governance and Company Secretary	Agreed new governance structure	30/06/2022	Some risk to delivery		Capacity issues might delay provision of the handbook

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Trust wide	2e		e) Develop a set of resources (e.g., templates, tools, and training) to support the delivery of good governance. [Improvement measures: Relaunch of QIS. Improvement in service led PDSA. Feedback from staff on ability to make changes to improve quality.]	Director of Quality Governance and Company Secretary	Reporting templates	30/06/2022	On track/Little risk to delivery		Executive Directors will determine when the reporting templates will come into effect.
Trust wide	2f		f) Revisit the current work to re position QIS to provide a focus on the individual tools for quality and innovation for individual leaders including coaching support. [Improvement measures: Tools and evaluation]	Director of People and Culture and Head of Quality Improvement	Tools and evaluation	30/06/2022	On track/Little risk to delivery	Good	QI approach refreshed and aligned to Coaching and OD. Blended QI/Coaching OD approach utilised where beneficial. QI expert level includes coaching and mentoring elements as part of the training and ongoing evaluation.
Trust wide	3	The trust must ensure that fit and proper checks have been carried out as required by legislation. (Regulation 19)	Processes for Fit and Proper Persons assessment to be reviewed and revised to ensure that these are carried out as required by legislation. [Improvement measures: Internal Audit review of the personnel files]	Company Secretary and Director of People and Culture	Personnel files of Board and SLG Members, Internal Audit report	31/03/2022	Some risk to delivery		Personal files have been reviewed. Additional evidence is being collected and collated. Level of assurance on certain matters e.g., qualifications and OH assessments, will be reviewed
Trust wide	4	The trust must ensure there is a safeguarding policy which clearly outlines the governance and accountability at each level within the organisation. (Regulation 17)	Safeguarding policy to be developed which clearly outlines the governance and accountability at each level within the organisation. [Improvement measures: Revised Safeguarding Policy ratified and available on the Trust intranet.]	Director of Nursing & Governance and Associate Director of Nursing - Safeguarding	Ratified Policy	30/06/2022	On track/Little risk to delivery		This information is already available within the existing safeguarding adult's procedure; however, it will now be explicit within Trust policy.
Trust wide	5a	The trust must ensure that work continues to develop the "Our Journey to change" strategy to clearly set out how it will achieve its strategic goals. (Regulation 17)	a) Implement the plan developed by the Strategy Deployment Group including how we support more personal responsibility through PDPs, and team development, refresh and reframe how we seek/use feedback in line with OJTC, Refresh business planning approach.	Associate Director of Strategic Planning & Programmes	Plan implemented by the Strategy Deployment Group	31/03/2023	On track/Little risk to delivery	Reasonable	New Business Plan document structured around the 3 goals; Workplan investment agreed which will assist alignment of PDPs with OJTC.
Trust wide	5b		b) Ensure that Our Journey to Change is a key, prominent part of induction	Director of People and Culture	Evidence to support Our Journey to Change part of induction e.g. standard presentation	31/03/2022	Complete	Good	
Trust wide	5c		c) Develop the Trust Business Planning Framework	Associate Director of Strategic Planning & Programmes	Trust business planning framework	31/03/2022	Complete	Substantial	SLG agreed the new framework on 02nd March 2022.
Trust wide	5d		d) Develop the Trust Programme/Project Management Framework	Associate Director of Strategic Planning & Programmes	Trust Programme/Project Management Framework	31/03/2022	Complete	Substantial	New framework approved by Executive Directors Group on 13th April 2022.

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Trust wide	5e		e) Develop a more robust approach to communicating to and engagement of colleagues, service user, carers, and stakeholders with Our Journey to Change including celebrations	Director of Corporate Affairs & Engagement	Communication and engagement approach details	31/03/2022	Complete	Substantial	A communication strategy has been implemented across the Trust, setting out how we'll communicate and engage with all our audiences, and by what means. Two other pieces of work are also underway to (1) review / audit internal communications channels, with (2) a stakeholder mapping and audit exercise to follow.
Trust wide	5f		f) Identify the key metrics that will be used to monitor progress of delivery and establish monitoring mechanism	Associate Director of Strategic Planning & Programmes, Associate Director of Performance	Key metrics	30/04/2022	Some risk to delivery		Draft leading and lagging indicators have been identified for all 3 goals but there is some further work to do before the Executive team can approve these. This is likely to take place in May / June rather than April.
Trust wide	6a	The trust must ensure that it responds appropriately to allegations of bullying, discrimination, racial abuse or hate crimes. (Regulation 17)	a) Develop a clear framework and communication strategy on what support and processes are available to staff to not only raise concerns but challenge behaviour which is not aligned with the Trust values.	Associate Director for People and Culture and Head of HR	Framework and communication strategy	01/04/2022	On track/Little risk to delivery	Good	In progress - F2SU Guardian and Officer attended the BAME network, ongoing sign posting to relevant support when concerns are raised, weekly bulletin continues to include how to raise a concern, refresh of Dignity at Work Champions is underway, B&H and managing concerns procedures followed for formal cases.
Trust wide	6b		b) Further promote awareness of Staff Networks, encourage membership, and ensure that staff stories are part of the People, Culture and Diversity Committee.	Associate Director for People and Culture and Head of HR	Promotion	30/09/2022	On track/Little risk to delivery	Good	Staff networks day planned in May along with screensaver promoting staff networks. Awareness raising is ongoing and staff stories to the People Committee are continuing.
Trust wide	6c		c) Develop a manager's toolkit, ensuring that this is part of the Managers bite size training which is planned.	Associate Director for People and Culture and Head of HR	Manager's toolkit	30/09/2022	On track/Little risk to delivery	Good	Training, HR operations and OD working on bitesize training toolkit for managers is in progress.
Trust wide	6d		d) Undertake a thematic review and analysis of workforce data to highlight any patterns/trends (including in sickness absence, concerns and complaints, turnover, HR casework etc).	Associate Director for People and Culture and Head of HR	Thematic review	31/05/2022	On track/Little risk to delivery	Good	Scoping of review in progress.
Trust wide	6e		e) The new management of potential concerns process ensures that protected characteristics are considered before any formal process starts and ensures that Equality Diversity and Inclusion support is sought.	Associate Director for People and Culture and Head of HR	New management of potential concerns process	31/07/2022	Complete	Good	Implemented.
Trust wide	6f		f) Ensure that appropriate action is taken in those cases where allegations are upheld.	Associate Director for People and Culture and Head of HR	Evidence of appropriate action	30/09/2022	Complete	Good	Implemented in line with B&H and managing concerns procedure

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Trust wide	**7a**	The trust must ensure it reviews its freedom to speak up and whistleblowing policy and processes to ensure they are effective. (Regulation 17)	a) A 3 day Quality Improvement Event planned for January 2022. To include: • reviewing the current process for Freedom to Speak Up and Whistle Blowing and producing standard work to ensure consistency across the trust. • update training for staff and managers • ensure that the policy is up to date and reflects best practice • communication plan to include the options staff have to raise a concern and the changes made following the QI event.	Freedom to Speak up Guardian and Head of Quality improvement	QI Event details and outcome	01/04/2022	Complete	Good	Delivery of all actions is ongoing.
Trust wide	**7b**		b) Monthly data collection on themes from the contacts with the Freedom to Speak up Guardian, alongside other feedback from the raising concerns group to be reported bimonthly to the Workforce Subgroup of the Senior Leadership Group.	Freedom to Speak up Guardian and Head of Quality improvement	Monthly data collection	01/04/2022	Complete	Reasonable	From May our renewed Speaking up forum will meet monthly, and will review numbers of cases, monitor themes and prepare lessons learned, which will be shared with the new care group boards.
Trust wide	**7c**		c) Further develop and promote Trust Dignity Champions	Freedom to Speak up Guardian and Head of Quality improvement	Promotion of Trust Dignity Champions	01/04/2022	Some risk to delivery		A training programme has been developed, and this will be delivered in May-June 22 slightly behind schedule. This will enhance the skills and more effective utilisation of the Dignity Champions within the Trust.
Trust wide	**7d**		d) Review the impact of the additional resource introduced into the Freedom to Speak Up Team.	Freedom to Speak up Guardian and Head of Quality improvement	Review impact of resource introduced	01/04/2022	Complete	Substantial	The six-month secondment of additional full time FTSU officer time has enabled delivery of the improvements identified in our quality improvement event in January. We now have one data Management log, streamlined coordination between the FTSU team, he review commissioning manager, and the reviewers, and greater capacity to support staff who speak up.
Trust wide	**8**	The trust must ensure that learning from incidents and complaints is implemented effectively to improve the safety and quality of care patients receive. (Regulation 17)	Hold a formal QI event to consider how we can improve embedding of learning and know that it is sustained (to include learning from good practice in other organisations).	Care Group Directors	QI event held. Improvement plan. Thematic Reviews and related action plans. Development of the Organisational Learning Database and Library. Analysis of agreed improvement measures.	31/08/2022	On track/Little risk to delivery		We have met with the QI team and agreed an approach that does not involve a specific event but a programme of visits and consultation with staff from across the organisation.
Trust wide	**9a**	The trust must ensure that its corporate risk register is current, has clear actions and	a) Review and refresh the Risk Management Policy that will set out roles and responsibilities aligned to new organisational structures. [Improvement measures: Ratified Risk Management Policy]	Director of Quality Governance, Company Secretary and Care and Group Directors	Reviewed Risk management policy	01/03/2022	On track/Little risk to delivery		Draft complete - now ready to go through approval process leading up to the Board in May 2022.

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Trust wide	**9b**	timescales. (Regulation 17)	b) Reconfigure the Trusts Risk Management organisational hierarchy within the electronic risk management system (Datix) to align to new operational structures and governance structures. [Improvement measures: Reconfigure hierarchy within the risk management system (Datix).]	Director of Quality Governance, Company Secretary and Care and Group Directors	Organisational hierarchy of risk management	01/04/2022	Complete	Substantial	
Trust wide	**9c**		c) Undertake a Training Needs Analysis (TNA) regarding risk management and utilisation of the risk register. [Risk management and risk register Training Needs Analysis]	Director of Quality Governance, Company Secretary and Care and Group Directors	Training Needs Analysis	30/04/2022	Some risk to delivery		This will be undertaken by the Head of Risk Management on appointment. New target date to be agreed via QA&I group.
Trust wide	**9d**		d) Develop and implement a stratified programme of education and risk management training based on the results of the TNA. [Stratified risk management training programme and compliance data]	Director of Quality Governance, Company Secretary and Care and Group Directors	Stratified programme of education and risk in place	30/06/2022	Some risk to delivery		As above re review of target date. This will be undertaken by the Head of Risk Management on appointment
Trust wide	**9e**		e) Undertake a full review and refresh of all risks currently recorded on the risk register starting with corporate risk level (25 and above). [Refreshed risk register for all corporate risks scored as 25 and above.]	Director of Quality Governance, Company Secretary and Care and Group Directors	Refreshed corporate risk register	01/04/2022	Complete	Limited	The review of the CRR identified improvement however there are still outstanding risks that require review. It also identifies a number of data quality issues. Further work is required and his should be through the risk management meeting structures recently implemented. A further evaluation of the status of the CRR will take place June 2022
Trust wide	**9f**		f) Implement and support the new governance structures with regard to dedicated risk management meetings, that will provide greater focus and scrutiny of risk management. [Improvement measures: New governance structures, Terms of Reference, and minutes of the risk management meetings]	Director of Quality Governance, Company Secretary and Care and Group Directors	New governance structures re risk management meetings	01/04/2022	On track/Little risk to delivery		Terms of reference in place however first meetings are scheduled to take place in April / May.
Trust wide	**9g**		g) Advertise and appoint to the recently secured Head of Risk post that will provide the expertise and support required by the Trust in line with the Good Governance Institute recommendations. [Improvement measures: Head of Risk post established and appointed to.]	Director of Quality Governance, Company Secretary and Care and Group Directors	Head of Risk advertised and successfully in post	31/07/2022	Complete	Substantial	Start date to be confirmed.
Trust wide	**10a**	The trust must ensure that the revised board assurance framework is implemented, and its effectiveness reviewed. (Regulation 17)	a) Implement new risk escalation structure as agreed by the Board of Directors (November 2021)	Company Secretary	Risk escalation structure	01/04/2022	Some risk to delivery		Implementation
Trust wide	**10b**		b) Increase capacity and capability for risk management as per Good Governance Institute recommendation.	Company Secretary	Increased capacity and capability	31/03/2022	Some risk to delivery		Decision on investment by Executive Directors is awaited.
Trust wide	**10c**		c) Establish the Risk Groups at Executive and Care Group levels of the new governance structure.	Company Secretary	Reports and minutes of governance groups.	01/04/2022	On track/Little risk to delivery		Risk Groups established as part of the governance structure on 01/04/22; however, yet to meet.
Trust wide	**10d**		d) Undertake a Board Workshop on risk management as part of the Board Development Programme.	Company Secretary	Board workshop details	31/03/2022	Complete	Substantial	Board workshop, facilitated by Deloitte LLP
Trust wide	**10e**		e) Complete the Board and Committee business cycles aligned to the Board Assurance Framework. [Improvement measures: Internal Audit review of the Board Assurance Framework]	Company Secretary	Internal audit reports	31/03/2022	Some risk to delivery		Draft Board Business Cycle, aligned to the BAF, in place. Business Cycles for the Board's committees delayed due to capacity issues and ongoing restructure

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Trust wide	**10f**		f) Implementation of revised Board/Committee reporting template aligned to the Board Assurance Framework.	Company Secretary	BAF risk profiles/ reporting templates	01/04/2022	Some risk to delivery		Awaiting sign off by Executive Directors
Trust wide	**10g**		g) Review and refresh the organisational Risk Management Policy that will set out roles and responsibilities aligned to new organisational structures.	Company Secretary	Reviewed risk management policy	28/02/2022	On track/Little risk to delivery		Draft complete - now ready to go through approval process leading up to the Board in May.
Trust wide	**10h**		h) Responsibility for the management of the Board Assurance Framework risks is to be included in the Job Descriptions of Executive Directors.	Director of People and Culture	Job descriptions of Executive Directors	31/07/2022	On track/Little risk to delivery		
Trust wide	**11a**	The trust must ensure they collect performance data relating to targets and quality standards so that senior managers can ensure there is appropriate governance and quality assurance. (Regulation 17)	a) Process owners for each operational policy will be requested to review their respective policies to identify any targets or quality standards and clarify what the processes for assurance is. [Improvement measure: Review of operational policies complete and the Trust will have identified those containing any local targets.]	Director of Quality Governance and Associate Director of Performance	Operational policies reviewed	01/04/2022	Not delivered/significant risk to delivery		A paper was taken to SLG in March regarding the scope of this action and its potential to be vaster than originally recognised. It was agreed that action a) would proceed and a further review of subsequent actions would be taken once the scale of the issue was known,
Trust wide	**11b**		b) We will agree a Trust process for the identification, approval, monitoring and reporting of compliance with any targets and quality standards. [Improvement measure: Agreed Trust process for the identification, approval, monitoring and reporting of compliance with any targets and quality standards.]	Director of Quality Governance and Associate Director of Performance	Agreed Trust process	01/06/2022	Some risk to delivery		As above
Trust wide	**11c**		c) We will review and refresh the Trust policy guidance to ensure that it reflects the agreed approach regarding targets and quality standards. [Improvement measure: Refreshed Trust policy guidance reflecting the approach regarding targets and quality standards.]	Director of Quality Governance and Associate Director of Performance	Refreshed Trust policy guidance reflecting the approach regarding targets and quality standards	01/06/2022	Some risk to delivery		As above
Secure Inpatient Services	**12a**	The trust must ensure that all patients are safeguarded from abuse; all patients are treated with kindness, respect and dignity and that safeguarding referrals are sent to the local authority when appropriate to do so. (Regulation 13)	a) Ensure compliance with Safeguarding training within the service. [Improvement measures: Target levels of training compliance are reached within specified timescales.]	General Manager / Associate Director of Nursing and Quality	Evidence of training compliance reached within specified timescales	30/06/2022	On track/Little risk to delivery	Good	Achievable within existing resources allocated and supported by corporate support. Safeguarding level 3 training: Compliance increased from 88.21% in October 2021 to 92.2% in February 2022 with 50% of wards at >95% with trajectory for all to be greater than 95% by end of April. There has been positive feedback from staff involved for example being more aware of current concerns and decreasing duration and frequency of incidents.
Secure Inpatient Services	**12b**		b) Supplement the Trust mandatory safeguarding package with additional local education and training programmes targeted responsive to themes and trends e.g., Boundaries and Raising Concerns processes. [Improvement measures: The internal patient experience survey data will evidence improvements in the delivery of care that is compassionate respectful and supports patient's privacy and dignity and their families. A review of safeguarding referrals to demonstrate assurance. Undertake a review of incidents that assesses compliance with the requirements for Local Authority safeguarding referrals.]	Safeguarding Team	Education and Training Programmes developed and implemented Detailed operational delivery plan in progress with evidence of implementation	30/06/2022	On track/Little risk to delivery	Reasonable	There have been Increased opportunities to discuss and reflect on safeguarding issues through a combination of: visual aids, matron quality walkarounds, the re- introduction of ward improvement groups. The presence of the safeguarding nurse on site a number of days per week has proven very advantageous to support staff with safeguarding issues.

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Secure Inpatient Services	13a	The trust must ensure that the use of restraint within the service is proportionate and used only as a last resort and that any restrictions placed on patients are individualised, proportionate, regularly reviewed and removed as soon as possible. (Regulation 13)	a) Undertake a review and assessment of current staff awareness, practice, and performance in relation to restrictive interventions in collaboration with the Trust's subject expert/ Senior Lead - Positive and Safe. [Improvement measures: Positive and safe dashboard data, Debrief used following every episode of restraint to understand service user experience and opportunities for learning. Benchmarking of restrictive interventions. Positive service user feedback. Improved staff awareness. Baseline and follow up results of the NHSE Toolkit.]	Associate Director of Nursing and Quality, Positive and Safe Lead	Review evidence	30/04/2022	Complete	Good	Further review is planned and to be led by Stephen Davison, Positive and Safe Lead and John Savage, Associate Director of Nursing for SIS. Positive and Safe Dashboard provides contemporaneous data including physical restraint, rapid tranquilisation incidents ad long term seclusion.
Secure Inpatient Services	13b		b) Based on the outcome of the review implement a programme of education that ensure current practice reflects Regulatory requirements and best practice.	Associate Director of Nursing and Quality, Positive and Safe Lead	Programme details	30/04/2022	On track/Little risk to delivery	Reasonable	
Secure Inpatient Services	13c		c) Undertake a review and assessment of current staff awareness, practice, and performance in relation to blanket restrictions in collaboration with the Trust's subject expert/ Senior Lead - Positive and Safe.	Associate Director of Nursing and Quality, Positive and Safe Lead	Review evidence	30/04/2022	On track/Little risk to delivery	Reasonable	Further review is planned and to be led by Stephen Davison, Positive and Safe Lead and John Savage, Associate Director of Nursing for SIS.
Secure Inpatient Services	13d		d) Based on the outcome of the review implement a continuous improvement plan that ensures current practice reflects Regulatory requirements and best practice in relation to blanket restrictions.	Associate Director of Nursing and Quality, Positive and Safe Lead	Programme details	30/04/2022	Not delivered/significant risk to delivery		Plan for programme of improvement is 30/6/2022
Secure Inpatient Services	14a	The trust must ensure that the wards within the service are staffed in accordance with its assessed safe staffing numbers so that care and treatment is delivered in a safe way; patients have access to activities, psychological interventions, occupational therapy, escorted Section 17 leave and staff can take their breaks. (Regulation 18)	a) In line with the national quality board safe staffing guidance, undertake a further review of staffing establishments and refresh the current safe staffing processes to ensure the provision of safe staffing levels to meet patient needs (including access to activities, psychological interventions, occupational therapy, escorted Section 17 leave, and staff taking their breaks)	Associate Director of Therapies	Safe Care reports	01/03/2022	Complete	Reasonable	Trust wide establishment review is complete. Received by Board 23/ 3/ 2022. A key outcome is the undertaking of a granular review of establishment and workforce modelling within SIS. This is underway. A dedicated leave management team have been established and this is having positive impact in consistently facilitating patient leave. The challenges of recruiting to the activity co-ordinator post is being resolved through commissioning independent sector providers.
Secure Inpatient Services	14b		b) Monitor compliance with staffing escalation processes. [Improvement measures: Sustained improvements with the key performance indicators within the safe staffing reports. Monitoring of themes and trends using Safe Care, where staffing issues were escalated. Numbers of escorted Section 17 leave untaken, activities cancelled and psychological interventions cancelled. Improvement in patient and staff experience regarding availability of suitably skilled staff. Improvements in vacancy rates and recruitment to new roles.]	General Manager / Associate Director of Nursing and Quality	QuAG reports to LMG	30/06/2022	On track/Little risk to delivery	Reasonable	
Secure Inpatient Services	15a	The trust must ensure that all staff receive and are compliant with a mandatory training programme which meets the needs of all	a) Improve training compliance rates through robust performance management systems which include oversight of staff who do not attend scheduled training. [Improvement measures: Mandatory training reports demonstrating compliance with the Board indicator (including to ward level).]	Care Group Director	Mandatory Training Reports to Team level. (with individual wards/ teams not falling below required targets)	01/03/2022	Complete	Reasonable	Improved compliance noted in mandatory and statutory training completion. However, some challenges remain with delivering face to face Mandatory Training.

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Secure Inpatient Services	**15b**	patients within the service. (Regulation 18)	b) Increase training capacity for mandatory and statutory training courses for the service where this is required and utilise alternative modes of training delivery to support completion of training.	Care Group Director	Increased capacity for training courses	30/06/2022	On track/Little risk to delivery	Reasonable	Good progress has been made in increasing the training capacity e.g. onsite training provision including at weekends and evenings to enable improved attendance.
Secure Inpatient Services	**16**	The trust must ensure that all staff receive regular clinical supervision. (Regulation 18)	Undertake a review of current arrangements for the provision of clinical supervision within Secure Inpatient Services, identify the current barriers to compliance with the current supervision standards and work with staff to co-create an approach that ensures that staff receive regular clinical supervision. [Improvement measures: Clinical supervision compliance reports]	General Manager / Associate Director of Nursing and Quality and Associate Director of Therapies	Supervision compliance reports	30/06/2022	Some risk to delivery		A range of work has been undertaken and supervision compliance reports are in place however further work is required to ensure consistent high quality capture of supervision activity. Current compliance reports indicate some improvement, but further improvement needed.
Secure Inpatient Services	**17**	The trust must ensure that audits of care records identify any errors or omissions in relation to patients' risk management plans in order to ensure all risks are identified and mitigated in order to keep patients and others safe. (Regulation 17)	Taking into account the improvement work already undertaken, ensure that the Trust wide work in relation to safety summaries and plans is embedded and consideration of further quality improvement work. [Improvement measures: Audit demonstrates that safety summaries and plans are in place and that they effectively identify the appropriate risks and mitigations. Increase in clinical leadership to support quality assurance processes. Validation audits to strengthen quality assurance processes.]	Care Group Board	Quality Assurance reports	01/03/2022	Complete	Reasonable	Refreshed and enhanced quality assurance programme now place
Secure Inpatient Services	**18**	The trust must ensure that all incidents within the service have been reported by staff using the trust's incident reporting procedure. (Regulation 17)	Implement a programme that will increase the knowledge and skills of staff in relation to patient safety, improve incident reporting and enable learning from patient safety incidents thereby developing a positive patient safety culture. To understand the level of staff confidence in raising concerns at ward level. [Improvement measures: Sustained high levels of service incident reporting. The service is able to evidence improvements as a result of learning from patient safety incidents. Cultural metrics and staff feedback regarding reporting of incidents.]	General Manager, Associate Medical Director	Incident reports (including to Ward level). Incident debriefs which include shared learning for the service where appropriate.	01/03/2022	Complete	Reasonable	
Secure Inpatient Services	**19**	The trust must ensure that regular team meetings take place on all the wards within the service to ensure staff receive key information and have the opportunity to provide their own feedback on the service. (Regulation 17)	Refresh secure inpatient service governance - meeting structures to facilitate regular meaningful staff involvement and engagement. [Improvement measures: Regular meetings take place for staff at ward level and attendance is monitored. Improved levels of staff engagement within the annual staff survey.]	Care Group Director and Medical Director	Staff survey. Documentary evidence of staff attendance and contributions to team meetings.	01/03/2022	Not delivered/significant risk to delivery		This work is ongoing and there is variability in terms of attendance at ward meetings. Staff survey engagement remains a challenge.

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Community mental health services for working age adults	20	The trust must have effective oversight of caseloads and case management within all community teams. (Regulation 17)	A Trust-wide quality improvement event will be held focusing on agreeing consistent clinical caseload management processes across teams to provide oversight of implementation and development of robust systems for monitoring and oversight. [Improvement measures: Quality improvement event. Compliance reports that will provide oversight of caseload management across the Trust.]	Managing Director and QI Event Sponsor	Caseload Management Process	30/09/2022	Some risk to delivery		Trust wide- Meeting held with QIS & CITO leads & AMH General Managers. We are currently gathering tools & undertaking a scoping exercise to identify different models and approaches. Currently panning the arrangements for the quality improvement event taking place in June 2022. This will focus on the development and agreeing a single caseload management tool, processes for oversight and monitoring as well as a programme of training and implementation.
Community mental health services for working age adults	21	The trust must ensure that they are delivering care and treatment that is appropriate and meeting the needs of all patients across the community teams. Assessments and treatment must be offered in a timely way. (Regulation 9)	A Trust-wide quality improvement event to take place with developed working groups or links to existing groups to support the delivery of appropriate care and treatment of patients across community teams. [Improvement measures: Quality improvement event. Compliance reports that will provide robust oversight of assessment and treatment waiting times across Community Teams.]	General Managers	Assessment and treatment waiting time reports demonstrating improved position.	30/09/2022	Some risk to delivery		Meeting arranged with General Managers, AMD and Clinical Networks leads in May to develop workplan and link to CMHF developments - Shaun Mayo DTV General Manager. NYY AMH - IIC dashboard in place at team level to track waiters & weekly performance report out monitors against 90% standard. Improvement plans in place where required & staffing escalation in place to support team capacity - reported into LMGB & linked to risks
Crisis services and health-based places of safety	22	The trust must ensure the proper and safe management of medicines. (Regulation 12)	The Trust will review the current storage and management of medicines within Crisis Teams and the Pharmacy support available to them. Separate reports will be produced for presentation to Quality Assurance Groups (QuAGs) for presentation and follow up of necessary actions. [Improvement measures: Targeted Community Medicines Management assessments undertaken in Crisis Teams to be undertaken to monitor compliance (existing audit). Locality Medicines Management Group to maintain oversight of any quality issues and mitigate any potential risks regarding safe medicines storage and management.]	Trust Chief Pharmacist and Urgent Care Pathways Lead	Medicines Management Assessments	30/09/2022	On track/Little risk to delivery	Reasonable	In progress
Community child and adolescent mental health services	23a	The trust must ensure that there are enough staff in each team to meet the demands of the service. Staffing level must be reviewed and amended promptly at times of high pressure and demand. (Regulation 18)	a) Implement a robust recruitment and retention programme with additional support to develop bespoke campaigns to specifically attract CAMHS staff. Use of some agency staff in the interim.	General Managers (CAMHS)	Recruitment and retention programme	30/09/2022	Some risk to delivery		Support from colleagues in HR, as well as communications, is required in order to deliver targeted CAMHS recruitment campaigns.
Community child and adolescent mental health services	23b		b) Demand and capacity work (Planning and Finance) to be undertaken to determine baseline demand and then to determine appropriate resource required to meet the demand.	Heads of Services (CAMHS)	Demand and capacity reports	31/03/2022	Complete	Good	Baseline demand work complete. Further work required to undertake team level analysis. There is a detailed delivery plan to achieve this by December 2022.

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Community child and adolescent mental health services	23c		c) Model of Service (iThrive etc.) to be considered in relation to where young people experience waits and how these can be addressed and also how wider services can support young people in the future.	Heads of Services (CAMHS)	Outsourcing of ASD assessments to be considered and either agreed or ruled out	28/02/2022	Complete	Good	IThrive is now the framework which has been adopted across the CAMHS service.
Community child and adolescent mental health services	23d		d) Consider how demand can be addressed as a system (ICS) with Partners to understand how patients' needs are best met (including staffing skill mix and getting it right first time). Consideration of outsourcing specific specialised ASD assessments.	General Managers (CAMHS)	System discussions and agreement of next steps	01/07/2022	Complete	Reasonable	This has been reviewed in detail and a paper presented to consider future options.
Community child and adolescent mental health services	24a	The trust must ensure that all staff are appropriately trained in the mandatory skills required to fulfil their roles. (Regulation 18)	a) Improve training compliance rates through robust performance management systems which include oversight of staff who do not attend scheduled training. [Improvement measure: Weekly review of team compliance data and appropriate actions identified and implemented.]	General Managers (CAMHS)	Weekly progress reports	30/09/2022	On track/Little risk to delivery	Good	Good compliance rates (significant improvements noted)
Community child and adolescent mental health services	24b		b) Increase training capacity for mandatory and statutory training courses for the service where this is required and utilise alternative modes of training delivery to support completion of training.	General Managers (CAMHS)	Increased capacity for training courses	30/09/2022	On track/Little risk to delivery	Good	Good compliance rates (significant improvements noted)
Community child and adolescent mental health services	25	The trust must ensure there is clear oversight of the waiting list management process and that it is robust enough to ensure all children and young people and reviewed and any risk acted upon. (Regulation 12)	To develop and implement an improved waiting list process including an initial risk assessment for every child and a robust Keeping in Touch process. [Improvement measures: Development of a Patient Tracker List and standard processes that are reviewed daily in a CAMHS service wide huddle by Locality Management. Additional development of an automated process for same to reduce resource required and ensure long term sustainability. Reduction in the waiting list and a more "managed" waiting list. This will be achieved by the delivery of standard processes, patient trackers and consistent utilisation of the Keeping in touch process.]	Heads of Services (CAMHS)	Patient Tracker List, Keeping in Touch letters Standard work processes. Daily huddle progress reports Oversight of waiting lists and KIT at appropriate governance groups. Reduced waiting lists for service users, evidence of increased utilisation of Keeping in Touch process. Progress reviews via the patient tracker.	28/02/2022	Complete	Good	
Community child and adolescent mental health services	26a	The trust senior management team must respond promptly to address issues within the service to ensure effective service delivery without delay (Regulation 17)	a) Daily monitoring in place of children waiting for treatment and implementation of the revised Keeping In Touch process.	QuAG/LMGB, CAMHS Heads of Service	Evidence of daily monitoring in place. KIT process.	31/03/2022	Complete	Good	
Community child and adolescent mental health services	26b		b) Set and monitor statutory and mandatory training trajectories. [Improvement measures: Clear line of sight and assurance indicators for board.]	QuAG/LMGB, CAMHS Heads of Service	Mandatory and Statutory Training Compliance reports	31/03/2022	Complete	Good	

Core Service	No.	Recommendation / Finding	Action	Action Owner	Evidence of Completion	Latest target date for completion	Current Status	Level of assurance against evidence	Progress Update – as at 22/04/22
Community child and adolescent mental health services	26c		c) Ensure recruitment to CAMHS posts is prioritised and engage agency market for fixed term staffing - explore the opportunity of using other professional groups in some roles. [Improvement measures: Improvements in vacancy rate, reduction in absence rate and caseload size, KIT monitoring huddles, reduction in average waits for assessment and treatment.]	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Vacancy rates Caseload Monitoring reports Patient Tracker List/ Keeping in Touch Letters	31/07/2022	Complete	Good	
Community child and adolescent mental health services	26d		d) Arrange system-wide (by Locality) summits to explore and problem solve drivers for demand.	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Summits	30/04/2023	On track/Little risk to delivery	Good	
Community child and adolescent mental health services	27a	The trust must ensure that the service can be accessed promptly for all children who are referred (Regulation 9)	a) To develop and implement an improved waiting list process including an initial risk assessment for every child and a robust Keeping in Touch (KIT) process	QuAG/LMGB, CAMHS Heads of Service	Improved waiting list process. Patient Tracker List, Keeping in Touch letters. Standard work processes. Daily huddle progress reports	31/03/2022	Complete	Good	
Community child and adolescent mental health services	27b		b) Consideration of outsourcing specific specialised ASD assessments	QuAG/LMGB, CAMHS Heads of Service	Outsourcing of ASD assessments to be considered and either agreed or ruled out	31/03/2022	Complete	Good	
Community child and adolescent mental health services	27c		c) Ensure recruitment to CAMHS posts is prioritised and engage agency market for fixed term staffing - explore the opportunity of using other professional groups in some roles	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Recruitment to CAMHS posts, and exploration of using other professional groups in some roles	31/07/2022	Complete	Good	
Community child and adolescent mental health services	27d		d) Arrange system-wide (by locality) summits to explore and problem solve drivers for demand and determine in which organisations some needs may be better met	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Summits	31/07/2022	On track/Little risk to delivery	Good	
Community child and adolescent mental health services	27e		e) Provide additional administration capacity to ensure phone calls are responded to in a timely manner - future consideration of electronic /telephony options for the service	Quality Assurance and Improvements Groups DTV&NYY&S, General Managers (CAMHS)	Additional administration capacity	31/07/2022	Complete	Good	

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM. 15

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th April 2022**
TITLE:	**Ockendon – learning from final report**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
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	✓

Executive Summary:

The Ockenden Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022.

All Trust Boards have a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening within their organisation / local system. NHSE/I have written to all Trusts to ask that the Ockenden report should be taken to their next public Board meeting and be shared with all relevant staff.

Trusts are expected to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

This report sets out the key issues and learning from the National report, recognising that this is not unique to Shrewsbury and Telford Hospitals or Trusts delivering maternity services. The paper suggests how learning from this report should be taken forward to mitigate risks to quality and safety.

Recommendations:

- The Board is requested to note the content of this report and agree the detail to be further considered by the Organisational Learning Group who will review the report in detail, agree any additional actions to mitigate any risks identified and develop robust plans where required paying particular attention to the report's four key pillars.

- That further assurance regarding the Trust's approach and impact of changes are reported to the Quality Assurance and Improvement Committee.

Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF:	**Board of Directors**
DATE:	**28th April 2022**
TITLE:	**Ockendon – learning from final report**

1. INTRODUCTION & PURPOSE:

1.1 The Ockenden Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

All Trust Boards have a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening within their organisation / local system. NHSE/I have written to all Trusts to ask that the Ockenden report should be taken to the next public Board meeting and be shared with all relevant staff. Following the terrible failings suffered by families that have been set out in the report, Trusts are expected to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

2. BACKGROUND INFORMATION AND CONTEXT:

The impact of death or serious health complications suffered as a result of maternity care cannot be underestimated. The impact on the lives of families and loved ones is profound and permanent. The independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt MP when he was Secretary of State for Health and Social Care, and commissioned by NHS Improvement, to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the trust in 2009 and 2016 respectively. The independent review examined the maternity care of 1,486 families, the majority of which were patients at the trust between the years 2000 and 2019. The review found that consistently lessons were not learned, mistakes in care were repeated, and the safety of mothers and babies was unnecessarily compromised as a result.
There were a number of external reviews carried out by external bodies, including local clinical commissioning groups and the Care Quality Commission, during the last decade. The review team were concerned that some of the findings from these reviews gave false reassurance about maternity services at the trust, despite repeated concerns being raised by families and therefore opportunities for improvement were lost.

3. KEY ISSUES:

3.1 Patterns of repeated poor care

Through the review of 1,486 family cases, the review team was able to identify:

- Thematic patterns in the quality of care and investigation procedures carried out by the trust.
- Opportunities for learning and improving quality of care had been missed.
- A lack of transparency and dialogue with families.
- 498 cases of stillbirth were reviewed and graded. One in 4 cases were found to have significant or major concerns in maternity care that, if managed appropriately, might or would have resulted in a different outcome.
- Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9%) were identified to have significant or major concerns in the maternity care provided that might or would have resulted in a different outcome.
- An over-confidence to manage highly complex situations and failure to escalate to the wider multi-disciplinary team or specialist services.

3.2 Failure in governance and leadership

Throughout the various stages of care the review identified the following:

- A failure to follow national clinical guidelines.
- Delays in escalation and failure to work collaboratively across disciplines resulting in poor outcomes for mothers and their babies- some of the causes of these delays were due to the culture among the trust's workforce and were witnessed by families adding to their stress and distress.
- A lack of compassion expressed by staff.
- Staffing and training gaps-staff cited suboptimal staffing levels and unsafe inpatient-to-staffing ratios to the review team, and said they often felt fearful and stressed at work due to poor staffing levels.
- The review found the trust leadership team up to board level to be in a constant state of churn and change. Therefore, it failed to foster a positive environment to support and encourage service improvement at all levels. In addition, the trust board did not have oversight or a full understanding of issues and concerns within the maternity service, resulting in neither strategic direction and effective change, nor the development of accountable implementation plans.
- Investigatory processes were not followed to a standard that would have been expected for the particular time the incident occurred and some incidents were down-graded- where investigations took place, there was a lack of oversight by the trust board.

4.0 IMPLICATIONS:

4.1 Local actions for learning, and immediate and essential actions

It is recognised that many of the issues highlighted in this report are not unique to Shrewsbury and Telford Hospitals NHS Trust or indeed only to those Trusts delivering maternity services.

The review team identified 15 areas as Immediate and Essential Actions (IEA's) that should be considered by all trusts in England providing maternity services. Some of these are included below with reference in bold brackets to where this might sit in terms of Trust projects or workstreams to take this learning forward.

- the need for significant investment in the maternity workforce and multi-professional training **(A well trained workforce/safer staffing levels**)
- suspension of the midwifery continuity of carer model until – and unless – safe staffing is shown to be present **(does not apply to the Trust)**
- strengthened accountability for improvements in care among senior maternity staff, with timely implementation of changes in practice and improved investigations involving families **(Learning from incidents/listening to families)**

Other relevant key areas of learning identified in the report that could impact on quality and safety for Trust services and a compassionate, open culture include: workforce planning and sustainability; training including multi-professional training; clear escalation procedures for safe staffing; escalation of concerns; leadership governance-Trust boards to have oversight of the quality and performance of their maternity services, clinical governance-incident investigation and complaints; learning from deaths; the importance of listening to women and their families; mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well-supported staff teams are better able to consistently deliver kind and compassionate care; bereavement care and supporting families.

Further action also needs to be taken to ensure all service users and their carers/families have the necessary information and support to make informed, personalised and safe decisions about their care. This is a theme that is frequently highlighted through Trust investigation of incidents and is currently being addressed through work on care-planning but is also very relevant to the delivery of Our Journey to Change, particularly our Quality and Safety Journey and Our clinical Journey.

The report illustrates the importance of creating a culture where staff feel safe to speak up. There is an expectation that every Trust Board has robust Freedom to Speak up training for all managers and leaders and regular listening events.

4.2 Compliance with the CQC Fundamental Standard

Improvements in the learning from deaths processes outlined will support the Trust to demonstrate the delivery of high quality, safe patient care in line with CQC Fundamental standards.

4.3 Financial/Value for Money:

There are financial and reputational implications associated with poor standards of care. A focus on learning helps the Trust to improve the quality and safety of our care services.

4.4 Legal and Constitutional (including the NHS Constitution):

CQC's Fundamental Standards in respect of Regulation 17 - Good Governance.

4.5 Equality and Diversity:

The Trusts learning will consider any issues relating to equality and diversity to ensure that any issues of discrimination are addressed.

5. RISKS:

There is a risk that if we fail to recognise and embed key learning from the Ockendon report that patient safety and quality will be compromised.

There is a risk that that if lessons are not learned and implemented in a timely way then further tragedies will not be prevented.

The risks highlighted in this paper primarily relate to the following BAF strategic risks:
BAF 6 **Failure to effectively undertake and embed learning could result in repeated serious incidents.**

BAF 4 **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.**

BAF 5 **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**

6. CONCLUSION:

This paper outlines the failings and key learning in the final Ockendon report. It should be recognised that there are wider implications for learning and improvement across the Trust in relation to the four key pillars despite us not delivering maternity services. Work is in progress in relation to safer staffing, learning from incidents and changes to the Trusts investigation processes especially regarding the involvement and experience of families, however it is timely to review the report in detail and identify any further opportunities for improvement.

7. RECOMMENDATIONS:

- The Board is requested to note the content of this report and agree the detail to be further considered by the Organisational Learning Group who will review the report in detail, agree any additional actions to mitigate any risks identified and develop robust plans where required paying particular attention to the report's four key pillars.

- That further assurance regarding the Trusts approach and impact of changes are reported to the Quality and Improvement Committee.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th April 2022**
TITLE:	**Learning from Deaths Dashboard Report Q4 2021/22**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

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

Executive Summary:

The Learning from Deaths Dashboard Report sets out the approach the Trust is taking towards the identification, categorisation, and investigation of deaths in line with national guidance. The mortality dashboard for Q4 of the 2021/2022 financial year is included at Appendix 1 and includes 2020/2021 data for comparison.

During Q4, there were 483 deaths and 19 learning disability deaths. 31 deaths were reported on the Strategic Executive Information System (StEIS). 29 deaths were community deaths and 2 were unexpected in-patient deaths. Both inpatient deaths unexpectedly occurred during a period of leave. There were 4 expected inpatient deaths related to physical health. 118, met the criteria for a mortality review. 24 of those cases were selected for a more detailed Part 2 Structured Judgement Review (SJR).

21 serious incident reviews were completed and discussed at Directors panel. 8 cases were found to have lapses in the care and/or treatment provided. Recurring lapses relate to the Care Programme Approach (CPA), risk assessments/safety summaries and relative/carer involvement. These are recurring themes and ongoing improvement work is in place but not yet fully embedded. The paper sets out in detail the key learning from Serious Incidents and the Trust approach to taking this learning forward.

Key to learning from incidents is the quality of the review and the experience of families within this. A project manager has been appointed to lead on the implementation of the new Patient Safety Incident Response Framework (PSIRF) and is now in post. Completion of actions are progressing in line with the project plan following a quality improvement event entitled 'Improving the Experience of Patients, Families, and Staff during Serious Untoward Incident Reviews' (SIR). The project manager will also ensure that preparations are in place for implementation of the new framework which will gradually be introduced in line with national requirements during 2022.

The Incident Reporting and Serious Incident Review policy is currently being reviewed to incorporate improvement work which has been co-produced with clinical services and bereaved families/carers. A further event is planned for 20th May 2022entitled 'Co-creating for Patient Safety'.

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

MEETING OF:	**Board of Directors**
DATE:	**28th April 2022**
TITLE:	**Learning from deaths - Dashboard Report Q4 2021/2022**

1. INTRODUCTION & PURPOSE:

1.1 The national guidance on learning from deaths requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period from January to March 2022. The Board is receiving the report for information and assurance of the Trust's approach.

2. BACKGROUND INFORMATION AND CONTEXT:

It is expected when people die in our care, that the Trust reviews practice and works with families and others to understand what happened and what can be learned from the death to prevent reoccurrence where possible. All NHS Trusts are required to publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy, and which have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all the deaths categorised as in scope for the Learning from Deaths policy are subject to an initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) can be found in Appendix 2.

The Learning from Deaths policy has been reviewed. The Incident Reporting and Serious Incident Review policy is currently being reviewed to reflect improvement work as well as incorporating the National Standards for Patient Safety Investigation. Both are aligned to our Journey to Change in that we will ensure that carers and families receive compassionate care following the loss of a loved one. We will work more closely with families and carers of patients who have died to ensure meaningful support and engagement with them at all stages, from the notification of death through to actions taken following an investigation/review.

Our staff are trained to undertake thorough reviews of deaths to ensure that learning is identified and embedded into practice to improve the services we provide.

We also work collaboratively with other Trusts, as part of the Better Tomorrow Programme to facilitate shared learning/good practice and valid comparisons.

3. KEY ISSUES:

3.1 Mortality Reviews and Learning

There is a full-time mortality review lead in place to develop and take new processes forward as part of the Better Tomorrow Programme. Other serious incident reviewers undertake SJRs where required.

The Learning from Deaths policy has been reviewed to reflect improvement work and changes to the National Learning Disability Mortality Review Programme (LeDeR) reporting system. The LeDeR programme is now entitled 'Learning from Life and Death Reviews'. Deaths of people with a diagnosis of autism are now being reported by the Trust in line with national requirements.

A monthly meeting is held with the regional mortality reviewer and the Trusts mortality review lead, to identify themes and to ensure that any learning is shared Trust wide.

The mortality lead also attends the Mortality Leads Network. The aim of the network is to provide a supportive forum to share practical ideas for developing and delivering a high-quality service and as an interested group to identify best practice and solutions to any areas of concern. It is facilitated by the Better Tomorrow Programme, who provide national updates and take forward any issues that may require a national solution.

Mortality Review 2021/2022

In Q4 2021/2022, 118 cases had a part 1 mortality review. 24 of those cases were selected for a more detailed Part 2 Structured Judgement Review (SJR). Further details and the locally agreed criteria for Mortality reviews and SJRs can be found in Appendix 2.

Month	Total Number of Deaths which has been reviewed under locally agreed criteria.	Total Number identified as requiring a Structured Judgement Review
January	63	10
February	43	19
March	12	45
Total	**118**	**24**

** NB not all data for March 2022 has been reviewed which reflects the lower numbers currently recorded. These figures will be amended when the dashboard is updated for Q1 2022/23*

Mortality Reviews

The following table highlights learning and good practice from the SJRs returned in Q4.

Points of learning
• Lack of safeguarding considerations

• Lack of care planning • Lack of assertive engagement with difficult to engage patients • Poor record keeping
Points of Good Practice • Patient-centred care • Evidence of multi-agency working for example substance misuse services and social care services • Good communication with GPs following reviews • Good monitoring of physical health • Evidence of regular CPA reviews

3.2 **Learning from deaths and serious incidents**

During Q4, 31 deaths were reported on StEIS. 29 deaths were community deaths and 2 were unexpected in-patient deaths. Both inpatient deaths occurred unexpectedly during a period of leave. There were 4 expected inpatient deaths related to physical health which were reviewed under the mortality review process.

21 StEIS reportable serious incidents resulting in death were reviewed in this period. 8 cases were found to have lapses in the care and/or treatment provided. Recurring themes related to risk assessments/safety summaries, the Care Programme Approach (CPA), and lack of relative/carer involvement. These themes reflect the same most common themes in Q3 which is an area of concern that is being addressed as detailed below.

When analysing themes and the impact of learning from deaths during Q3 and Q4, the following information must be taken into consideration. The improvement work relating to risk assessment, risk mitigation, safety plans, commenced in January 2021 in inpatient areas. Most reviewed cases in Q3 and Q4 were community deaths. The improvement work is now focusing on people using community services; all cases reviewed in Q4 pre-date the improvement work in community settings.

Community Caseload Management Reviews should be carried out during supervision sessions for a sample of patients on a clinician's caseload. These reviews seek assurance around the presence and quality of safety summaries, safety plans, care plans as well as evidence of patient and carer involvement. There has been a notable decline in the numbers of community teams using this tool during Q4. This has been addressed through the Practice Development Group (PDG) and will be reported through to the Care Groups for assurance purposes going forward. A community Modern Matron Quality Review tool has been developed and is currently being piloted. A date for roll out to community services trust wide and an agreed format for the tool, will be determined on completion of the pilot. This quality review tool will seek assurance around the presence and quality of safety summaries, safety plans, care plans as well as evidence of patient and carer involvement. The appointment of community matrons is seen as pivotal in improving care and service delivery in relation to the issues identified above.

A Quality Improvement event, sponsored by the Director of Nursing and Governance and the Trusts Clinical Strategy Lead, was held in March 2022 to focus on the clinical model of care planning across the Trust. The event was well attended by service users, carer representatives, professionals from across all localities, corporate services, and the quality improvement team. A statement from a relative bereaved by suicide was read out at the

beginning, it described the impact of not being involved in care planning from a patient and relative's perspective. Consensus from the event was that care planning must be owned by the patient and contributed to by the care network involved in the person's care.

Actions from the event include additional training sessions throughout April and May that will be developed to ensure staff have the appropriate skills to co-create meaningful, goal orientated care plans. Awareness sessions will be arranged for service users, carers, and our partners to facilitate a shared understanding of the changes. The launch of CITO in September will enhance the care planning process with the use of Dialogue as a goal focussed tool however there is an expectation that staff start to work towards the agreed model straightaway. Part of the event also looked at how part of the care plan review could be stopped to reduce duplication and free up staff time to care.

The work around care planning continues to be a priority and will be overseen by the Quality and Safety programme Board as well as the Clinical Strategy Board.

In January 2022 the Trust Board heard the story of a relative bereaved by suicide. The Board found the relative's account, about the impact of loss, very powerful and informative. Patient /relative stories will be a regular feature at each Board meeting.

The Trust has appointed to two Lived Experience Care Group Director posts. These appointments will bring the lens of lived experience to strategic leadership and support co-creation throughout the care groups. There are also 3 lived experience members on the Quality and Safety programme Board. The Quality and safety programme Board have identified 5 key areas for focussed improvement work that align with themes from Serious Incidents and Our Journey to Safer Care. A series of workshops from May to August are taking place to agree key performance indicators and how to measure improvement across these areas.

3.3 Structures to support and embed learning

3.3.1 Practice Development Group (PDG)

The Practice Development Teams (PDTs) overseen by the PDG are addressing the areas of learning as identified by lapses in both Q3 and Q4, namely safety summaries/safety plans, care planning and carer involvement as detailed above.

Practice Development Practitioners (PDP) continue to develop in their posts across in-patient wards. They are also offering training in relation to risk assessment and safety summaries Trust-wide including community staff

3.3.2 Organisational Learning Group (OLG)

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group. There have been 12 urgent patient safety briefings, circulated Trust wide during this reporting period. Examples of these urgent safety messages relate to new anchor points/ligature risks identified within the Trust and how these risks are to be addressed.
The briefings are specific about any assurance required from services; on receipt of completed actions these are stored in the learning database. 'Learning from Serious Incidents Bulletins' are also regularly distributed across the Trust. The bulletins have shared key learning and

good practice highlighted in serious incident reports presented at the Directors assurance panel. All briefings and bulletins are stored in the learning library on the Trust's intranet.

A quality Improvement event is being held in August 2022 to focus upon how we can further improve the communication and impact of learning in front line services.

3.3.3 Patient Safety Priorities

The Journey to Safer Care as part of the Trust's Journey to Change highlights four key patient safety priorities:

- Suicide Prevention and Self-harm Reduction
- Reducing Physical Restraint and Seclusion
- Harm Free care, Psychological Safety including sexual safety and a Safe Environment
- Promoting Physical Health

The Service Development Managers who are members of the Patient Safety Campaign steering group have been tasked to map out work that is taking place across services in relation to these priorities. This will be used to inform the work plan for the Quality and Safety programme Board.

i) Suicide Prevention and Harm minimisation

A period of engagement has been carried out with staff, service users, carers/relatives, and partners to help shape the Trust's draft Preventing Suicide Strategy. Leadership for suicide prevention is through the Clinical Strategy Lead supported by a multi-disciplinary Preventing Suicide and Self Harm Reduction group which will monitor progress against the strategy's action plan. All actions will be aligned to our Journey to Change.

In support of the above strategy, the preventing suicide project leads continue to work closely with the Patient Safety team and our partners by:

- sharing information from the early alerts system in Teesside for all suspected suicides (not just people open to the Trust) to facilitate shared learning with partners
- attending and working with partners in all localities where there have been multiple suicides in a particular area or site (not just people open to the Trust)
- targeted work with rail network; to work closer together with shared protocols for preventing suicides
- Providing direct support & guidance to teams on completing Rapid Reviews, reflecting on lessons learnt and how the project workers can support clinical services
- Identifying emerging themes within their locality then engaging with those services directly to share the learning and provide guidance and support on best practice.

Examples of good practice include a very prompt response by the suicide prevention leads in relation to a cohort of people who had become involved in a potential suicide pact. A rapid multi-agency response ensured that the safety of all concerned was maintained with appropriate contingency plans put in place.

ii) Harm Free Care - Safe Environment

The Environmental Risk Group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated Trust wide via Patient Safety Briefings or SBards, examples for Q4 are detailed above in para 3.3.2.

As part of the ligature reduction programme, in in-patient areas en-suite doors and main bedrooms doors are currently being replaced. Main bedroom doors are being replaced with sensor doors in designated wards. The roll out of oxe-health continues to support patient safety through enhanced observation. An early learning report has been undertaken and will go through various governance routes over the next month to highlight progress and areas for further development.

Environmental surveys with input from estates, health and safety and clinical services have been recommenced.

iii) Promoting Physical Heath

Work continues in relation to improving the physical health of people with mental health problems in keeping with ICS priorities when learning from deaths. This includes weight management, care of the deteriorating patient, reducing alcohol and drug use, reducing falls.

3.3.4 Safeguarding

Despite improvement work already undertaken to embed the principles of 'think family' and use of the PAMIC tool, it continued to be a finding in serious incidents investigations. It was agreed that the issue is about the qualitative aspect of how parental mental health impacts on children and that this should be considered as part of a comprehensive risk assessment under the category of risk to others. Having this as a narrative in the risk assessment has enable fuller information to be shared/documented about what has been considered from a 'think family' perspective. Outcomes of this improvement work will be triangulated with evidence from the Central Approval team, Patient Safety Team, and the Safeguarding team to determine the impact of changes made on patient safety.

Links between the patient safety team and the safeguarding team continue to be strengthened with joint working on SI cases and in the Patient Safety team huddle.

3.3.5 Serious Incident Investigation Process

A quality improvement event 'Improving the Experience of Patients, Families, and Staff during Serious Untoward Incident Reviews (SIRs)' commissioned by the Director of Quality Governance, built on existing work that had been already been carried out to improve the SI investigation process. A further event was held in February 2022 where 4 additional work streams relating to the SI process and incident reporting were identified. A Project Manager is in place to drive delivery of all this improvement work as well as the wider PSIRF standards. In keeping with the Journey to Change, an event has been planned for the 20th May 2022 to facilitate full engagement with all relevant stakeholders.

Improvement work has continued to identify early learning/themes from rapid reviews ensuring that clinical services embed early actions into practice. This work has been supported by Serious Incident Reviewers and the Preventing Suicide project leads.

A more proactive approach to learning from deaths has been taken by facilitating closer working relationships between clinical services and the patient safety team. In some cases, clinicians, and where required subject matter advisors, are invited into the patient safety team huddle to discuss early learning and immediate actions required.

Reviewers are now working with clinicians in areas such a peri-natal services, suicide prevention, physical health and health and safety to share Trust-wide learning at these groups. This is promoting a more 'wrap around' approach to learning between corporate and organisational services.

All newly appointed serious incident reviewers are attending serious incident investigation training which is being provided by the Healthcare Safety Investigation Branch (HSIB)

3.3.6 Better Tomorrow Programme

The Better Tomorrow Team undertook a desk top review of the Trust's current Mortality Review systems and processes to help identify and support with potential areas of development. This work was put on hold due to the pandemic but has recently recommenced. Outcomes will be reported on in Q1 2022/23.

3.3.7 Thematic reviews

External oversight has been provided in relation to serious incidents occurring in Trust-wide perinatal services and one of the Trust's crisis teams. The aim of this oversight was to facilitate a sharing of expertise and learning and to provide assurance that all learning had been identified and acted upon by the Trust. Four themes were identified in the Crisis Team review these were service model, culture, inter-relationships with other teams and patient/carer experience. A plan has been formulated to include robust actions with clear measurable outcomes. Learning from the perinatal review was around the importance of formulation, supervision, establishing clear lines of responsibility/accountability and recognition of the impact of the 'toxic trio' namely mental health, domestic abuse, and substance misuse. This has been fed into the Trust's Perinatal Mental Health Steering group. External oversight confirmed that the Trust had identified and addressed all areas of actionable learning in its internal serious incident reviews.

3.3.8 Training

189 staff have received 'connecting for people' suicide awareness training during this reporting period. A further 8 Trust staff will be trained as trainers in May 2022.

The Trusts mandatory harm minimisation training continues to include updated headlines from serious incidents in relation to learning from deaths.

As part of the improvement work around the serious incident process and learning from deaths, several training needs for staff trust-wide have been identified. These include incident reporting, holding difficult conversations with bereaved relatives, duty of candour/culture of

candour, report writing and writing smart action plans. These have been fed into the Trust-wide training needs analysis event.

The Trust is currently reviewing the first two levels of patient safety training released as part of the National Patient Safety Strategy to ascertain how it fits in with other essential and mandatory training provided by the trust prior to deciding whether this training should also be made mandatory. A further update will be provided in Q1 2022/23

3.3.9 Clinical strategy
Learning from deaths during Q2 and Q3 highlighted that patients with dual diagnoses were often not followed up proactively by mental health services. This work stream will be picked up in the clinical strategy.

3.3.10 Patient Safety Specialist

The Trust's Patient Safety Specialist continues to attend the Patient Safety Specialist Improvement Programme Webinars, arranged by the National Patient Safety Team. These interactive forums connect over 700 Specialists from around the country. There is also the opportunity to discuss any issues relating to patient safety including learning from deaths on the Patient Safety Specialists' workspace both from a national and regional perspective.

3.5 The Learning from Deaths Dashboard

The learning from deaths dashboard is attached at Appendix 1 and includes 2020/21 data for comparison.

For Q4 the dashboard highlights the following:

- A total of 483 deaths were recorded (not including LD deaths). This is all deaths (including natural expected and unexpected) in relation to people who were currently open to the Trust's caseload as recorded on datix.
- There were 21 StEIS reportable serious incidents resulting in death reviewed and 31 StEIS reportable serious incidents resulting in death reported.
- 118 cases within the combined number of deaths were reviewed under the mortality review criteria
- 19 community learning disability deaths were reported on Datix. All these cases were reviewed via the Trust mortality review process and have been reported to LeDeR.
- 6 in-patient deaths were reported over this period. There were 2 unexpected in-patient deaths. 4 other deaths occurred in MHSOP services; all 4 were related to physical health and will be reviewed via the mortality review process.

4.0 IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
Improvements in the learning from deaths processes outlined will support the Trust to demonstrate the delivery of high quality, safe patient care in line with CQC Fundamental standards.

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

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

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

4.5 **Other implications:**
No other implications identified.

5. RISKS:

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

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

6. CONCLUSION:

This paper outlines how the Trust is strengthening its arrangements for organisational learning and the provision of assurance in the context of learning from deaths and embedding these to improve patient safety in both in-patient and community settings. Significant progress has been made in the project work relating to the serious incident review process and preparations for implementing PSIRF. There is evidence that joint working between corporate and organisational services is positively impacting on the safety of our patients and learning from deaths.

7. RECOMMENDATIONS:

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

Background Papers:

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

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

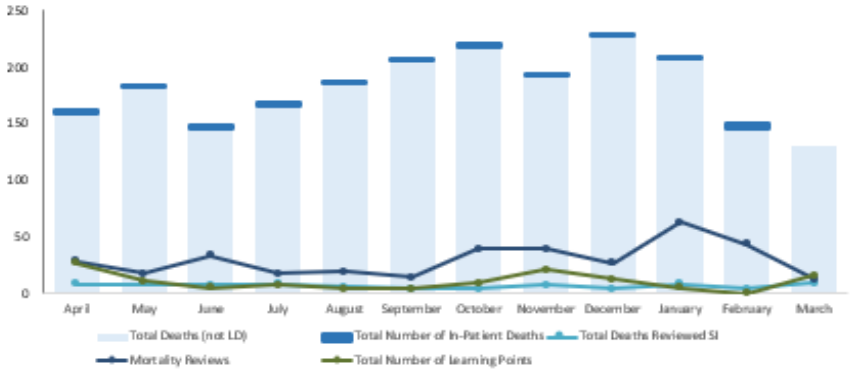
Appendix 1 Learning from Deaths Dashboard

Learning from Deaths Dashboard - Data Taken from Paris and Datix
Reporting Period - Quarter 4 -January - March 2022

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

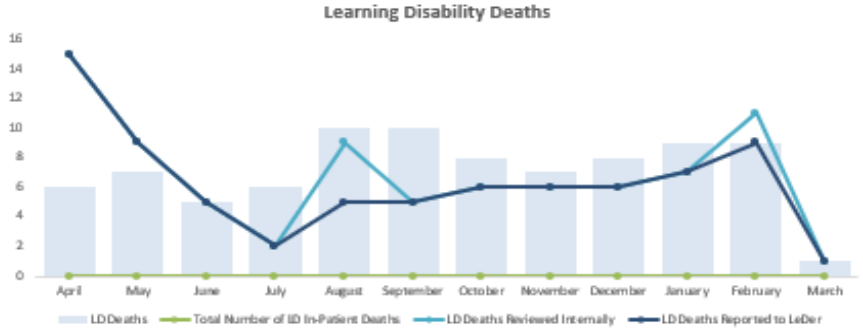
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2021/2	2020/21	2021/2	2020/21	2021/2	2020/21	2021/2	2020/21	2021/2	2020/21
Q1	486	↘ 979	8	↘ 14	23	↘ 29	78	↘ 337	43	↗ 18
Q2	556	↗ 486	7	↗ 6	18	↘ 43	50	↘ 194	15	↘ 30
Q3	638	↘ 731	5	↔ 5	15	↘ 35	105	↘ 126	42	↗ 29
Q4	483	↘ 692	6	↘ 7	21	↘ 26	118	↗ 93	21	↘ 33
YTD	2163	↘ 2888	26	↘ 32	77	↘ 133	351	↘ 750	121	↗ 110



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2021/2	2020/21	2021/2	2020/21	2021/2	2020/21	2021/2	2020/21
Q1	18	↘ 34	0	↔ 0	29	↘ 34	29	↘ 34
Q2	26	↗ 13	0	↔ 0	16	↗ 12	12	↔ 12
Q3	23	↘ 28	0	↘ 1	18	↘ 25	18	↘ 25
Q4	19	↘ 33	0	↘ 2	19	↘ 31	17	↘ 32
YTD	86	↘ 108	0	↘ 3	82	↘ 102	76	↘ 103



Mortality Reviews 2021/2022

Appendix 2

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

The “red-flags” to be considered during the Part 1 review are as follows:

- Family, carers, or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)
- Patient had a Learning Disability. These cases will also be referred to LeDeR
- Prescribed Clozapine or high doses of anti-psychotic medication

This criterion allows for greater learning from a more suitable selection of cases reviewed. To prioritise the most significant cases for learning from unexpected and expected physical health deaths throughout Q4, the following actions have been taken for those deaths reported on datix:

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

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th April 2022**
TITLE:	**NHS System Oversight Framework – Position as at Quarter 4, 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 4, 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 CQC ratings of "Requires Improvement" both overall and in the well-led domain.

3.3 The Trust's position against the SOF metrics, at Quarter 4 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.

  The Trust achieved the national standards for recovery and waiting times for accessing IAPT services for Quarter 4 and for 2021/22 overall; however, the access rates commissioned by the CCGs were not achieved.

  In addition, whilst the national standard for waiting times, between first and second appointments, was achieved for the year, performance for Quarter 4 was below target.

  The dashboard highlights the actions being taken to increase access and reduce IAPT in-treatment pathway waits. These are continuing and although, to date, there has been no visible impact on performance in some cases new staff have yet to come into post.

- Waiting times for children and young people with eating disorders.

  Performance on waiting times for CYP eating disorder services remains below target; however, the actions being taken by the Trust are having a positive impact.

- The number of inappropriate Out of Area Placements (OAP) for adults.

  Further information on this matter is provided in the Performance Dashboard (see agenda item 11).

- The number of women accessing specialist community perinatal mental health services (against the CCG ambition)

  The Trust has not achieved the ambitions set nationally for each individual CCG. Work has been undertaken with them to develop a set of local trajectories for the measures as part of the 2022/23 operational planning round for mental health services and these have been submitted to NHS England & Improvement for approval.

- The Trust's CQC ratings

  An assurance report on the delivery of the CQC Action Plan is provided under agenda item 14.

3.5 The next meeting of the regional Quality Board is due to be held on 25th April 2022. Any issues arising from this meeting will be reported verbally to the Board.

4 **Risks**

4.1 The prospect of further regulatory intervention (BAF risk 4) against the Trust, based on its SOF position at Quarter 4, 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 and actions are in place and are being delivered. 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

System Oversight Framework
As at Quarter 4 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 two reasons:

- The measure has not yet been developed within the Trust and the data could not be sourced externally.
- A number of measures are yet to be defined by NHS England & Improvement.

We are now including national benchmarking positions to enable an accurate assessment of Trust performance against that of other Mental Health providers. This benchmarking identifies whether we are in the upper quartile (positive), lower quartile (negative) or inter-quartile (in the middle) At trust level we are in the upper quartile for 2 of our measures (External Out of Trust Placements and potential under reporting of patient safety incidents).

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. The Trust level IAPT recovery is a positive position with the standard being achieved consistently over the quarter.

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.We are continuing to see an increase in the number of patients that we are placing in beds external to our Trust. Whilst this is a national issue due to current demand levels, we remain concerned and are committed to eliminating out of area placements by Quarter 3 2022/23.

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 demand that is being experienced nationally, this has been greatly impacted by vacancies within our services. Recruitment continues and work has been undertaken to increase the number of appointments.

People

Our sickness levels continue to be higher than we aspire to across all Localities and whilst all sickness is managed in line with Trust Policy and is closely monitored within operational services, this is impacting the delivery of our some of our services.

This report includes data on the staff survey result which were made available at the end of Quarter 4. When comparing results to the same position last year, improvements can be seen in all measures but particularly with regard to the percentage of people who are satisfied with opportunities for flexible working patterns and staff who say they have experienced bullying or abuse.

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	Benchmarking
Total access to IAPT services - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	N/A	CCG Ambition	2096	2188	2664	2419	2424	2263	2183	2531	2273	2307	2192	2755	6948	7106	6987	7254	28295	
Access to IAPT services for adults aged 65+ - Number of people aged 65+ accessing IAPT	N/A	CCG Ambition																		
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%	50.18%	51.57%	51.65%	53.70%	51.35%	54.51%	50.68%	51.46%	52.18%	52.22%	
IAPT: The proportion of BAME people who are moving to recovery	50.00%	Standard																		
3.A1: 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%	99.12%	99.23%	98.13%	99.23%	99.25%	99.00%	98.98%	98.89%	99.04%	
3.A2: 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%	99.87%	100.00%	100.00%	99.68%	100.00%	99.95%	99.93%	99.90%	99.90%	99.92%	
3.B1: 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%	98.58%	99.38%	98.31%	98.91%	98.84%	99.21%	99.04%	99.11%	98.69%	99.01%	
3.B2: 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%	99.92%	99.91%	99.96%	99.77%	99.78%	99.96%	99.90%	99.91%	99.83%	99.90%	
3.C1: 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	1.73	1.57	1.78	1.55	1.79	2.01	1.80	1.70	1.71	1.80	
3.C2: IAPT: Average number of treatment sessions	N/A	Supporting measure	7.76	8.19	7.00	7.49	7.30	7.26	7.76	7.63	8.95	8.92	9.02	8.89	7.57	7.35	8.07	8.94	7.94	
3.C3: 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%	49.11%	51.15%	44.89%	46.55%	40.30%	59.51%	49.89%	47.93%	43.87%	50.49%	
3.C4: 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%	93.45%	91.36%	87.41%	86.28%	86.28%	92.65%	93.54%	92.84%	86.63%	91.52%	
Percentage of people who have waited more than 90 days between first and second appointments	<10%	Standard	7.28%	7.08%	7.64%	7.13%	5.45%	6.69%	6.64%	6.55%	8.64%	12.59%	13.72%	13.72%	7.35%	6.46%	7.16%	13.37%	8.48%	
Implementation of IAPT - Long Term Condition pathways	N/A	CCG Ambition	No	No	No	No	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	Benchmarking
Number of CYP aged under 18 supported through NHS funded mental health with at least one contact	N/A	CCG Ambition	27844	28251	28906	29243	29877	30376	30676	31004	30939	31069	30995	31796	28906	30376	30939	31796	31796	
Percentage of closed referrals, with at least two contacts, with paired outcome scores within reporting period	40% by Q4	CCG Ambition	32%	36%	36%	34%	35%	36%	36%	40%	39%	36%								
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%	54.30%	54.79%	53.82%	69.90%	60.78%	54.30%	53.82%	53.82%	
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%	42.86%	45.76%	46.96%	50.91%	45.00%	38.14%	42.86%	50.91%	50.91%	
Number of people accessing IPS services as a rolling total each quarter	N/A	CCG Ambition	54	103	154	229	269	327	388	458	500	558	616	674	154	327	500	674	674	
Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services for adults and older adults with severe mental illnesses.	N/A	CCG Ambition	22094	22147	22328	22352	22324	22379	22386	22526	22532	22675	22801	22902	66569	67055	67444	68378	269446	
13a: 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	405	589	701	2892	3526	345	701	701	
13b: 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	405	589	701	0	69	345	701	701	Benchmarking data as at December 2021 reports the Trust in the upper quartile (a postive position)
Percentage of people who are admitted to hospital without having had any prior 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%	14.49%	16.51%	12.61%	15.13%	14.16%	15.34%	14.48%	14.79%	
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours.	80%	Standard	90.55%	90.18%	92.45%	91.95%	88.67%	89.49%	90.87%	91.20%	88.33%	86.61%	89.72%	90.94%	91.12%	90.11%	90.17%	89.16%	90.21%	
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																		
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																		
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	1113	1127	1126	1025	1096	1132	1126	1126	
Percentage of women accessing specialist community PMH services in the reporting period (12-month rolling)	N/A	Supporting measure	4.73%	4.90%	5.00%	5.08%	5.28%	5.34%	53.64%	5.46%	5.52%	5.42%	5.40%	5.41%	5.00%	5.34%	5.52%	5.40%	5.41%	
Data Quality Maturity Index	90%	Standard	98.20%	98.10%	98.00%	97.80%	97.90%	98.10%	97.80%	97.80%	97.60%	97.79%	97.72%	97.19%	98.00%	98.10%	97.60%	97.19%	98.10%	

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** service for treatment than the CCG ambition due to difficulties in maintaining patient engagement as a result of the service being unable to provide timely workshops and appointments for Patients. This is impacted by staff capacity in terms of vacancies and staff sickness.	Service to reinstate group workshop sessions by April 21, to support the engagement of patients and improve access to treatment.	**Complete**. The success of the additional one daytime and one evening workshop each day is being monitored. These workshops are usually fully booked, consistently demonstrating recovery over 50%.	No visible impact; performance remains consistent.
	To recruit 3 x 6 months fixed term Therapy support workers to increase capacity.	**Ongoing.** Three 6-month fixed-term Therapy Support Worker posts have been advertised, 2 have start dates in May and the third is in the process of having a start date agreed.	
	To consider adding an additional online workshop to provide additional choice for patients by the end of May 22.	**Ongoing.** Once the fixed term therapy support workers are in post, this will enable the consideration of another online workshop at a time different to the existing ones to be considered. This will be decided by the end of May 22.	
	The new cohort of trainees to be used to increase capacity within the single point of access commencing in November 21 and being fully embedded by the end of March 22.	**Complete.** 32 new trainees commenced in post during November 21. The Trainee High Intensity Trainees began picking up assessments from early February, whilst the Trainee Psychological Wellbeing Practitioners began completing assessments independently at the end of March 22.The impact of this should be seen by the end of April 22	
	Recruitment of 2 High Intensity Therapists and 9.44 Psychological wellbeing practitioner vacancies by May 2022.	**Ongoing.** One High intensity Trainee has been appointed, and is pending a start date The remaining post has been readvertised. A 'rolling' advert is out for the Psychological Wellbeing Practitioner, offering fully remote working as an option, with the hope of attracting greater interest. 1.6WTE agency PWP's are currently being utilised to support service provision.	
	The Service Manager to monitor staff sickness levels and will manage long-term sickness in line with Trust policy.	**Ongoing.** Overall sickness levels have been higher than the Trust standard since August '21. This is managed in line with policy and monitored weekly by the Service Manager and Head of Adult Mental Health. Three members of staff are currently absent and due to return during April 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
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:** We currently have 3.8wte IAPT Psychological Wellbeing Practitioners (PWP); 1 is pending a start date and 2.8 are out to advert. 1 PWP commenced in February 22 . 2 Trainee PWPs were recruited at the end of December, 1 took up post at the end of March 22. The remining PWP post cannot be readvertised as this years training course has now commenced. We have 4.7 wte High intensity workers posts vacant. 1 pending a start date and following unsuccessful recruitment, 1.8 will be readvertised and 1.5 wte will be skill mixed to a Band 8a clinical lead; this is progressing through Trust redeployment. This post would support the team in terms of clinical leadership and allow resources to be released from treatment to provide additional assessments.	No visible impact, Performance remains consistent
	The qualified high intensity workers to complete trainee's supervision sessions in order to free up clinical lead capacity.	**Complete.** This is now being undertaken to minimise the demands on clinical leads.	
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.	**Complete**. 6 additional trainees have been recruited and commenced in post at the end of December.	

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**: A mapping meeting took place in February to discuss current pressures faced by the services as well as appropriateness of referrals. Findings identified some confusion in respect of the referral criteria of some community teams; Team Managers have a meeting arranged during April with community teams to clarify with these services. Team Managers are also meeting GPs during May to ensure they understand the referral criteria.	
The **North Yorkshire IAPT** service has been impacted by short- and long-term sickness absence.	Trust sickness policies and procedures to be followed.	**Complete**. All staff have returned to work	
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**. The team continues to be impacted by episodes of short-term sickness. To mitigate the impact, the team has been offering additional assessment capacity to maintain access standard.	No visible impact; performance remains consistent
	The Service Manager to arrange a Team event to focus on stress which is one of the most common themes if sickness across the team.	A Resilience Hub listening day was arranged by the service manager. Team Managers are reviewing feedback from the day which took place in March. Team actions for PWPs will be agreed in order to improve staff experience at work. These actions will be agreed by the end of April 22	
There has been a lack of capacity within our **Vale of York IAPT** service 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.	**Complete:** The number of training days have now reduced and this is no longer an issue affecting the teams capacity**.**	

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
IAPT: The proportion of people who are moving to recovery			
We are concerned that patients from our **North Yorkshire IAPT** Service are not demonstrating the national recovery standard.	Detailed analysis to be undertaken to ascertain if this is an area of concern.	**Complete.** The analysis identified 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. Please see further action in the previous section on 'Total access to IAPT Services' regarding the service receiving a high number of inappropriate referrals, the administration of which impacts on clinical time.	No visible impact; performance remains consistent.
We are concerned that patients from our **Vale of York IAPT** Service 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. The Clinical Lead to establish quarterly CPD events to focus on recovery data for each modality in order to improve recovery levels in these areas.	**Complete**. The pilot changes have been embedded and a reduction in the drop out rates can be positively seen. **Complete.** A programme of quarterly events are planned across the year. The most recent event focused on Health Anxiety for Step 3. Following this event a 4% increase in recovery for this specific diagnosis has been seen. An update on the next event will be provided at the end of Quarter 1.	No visible impact; performance remains consistent.
There are capacity issues within the **Vale of York** service due to sickness and the Long Term Conditions training noted above.	Please refer to the Total Access to IAPT section		

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
IAPT in-treatment pathway waits			
We are concerned that more of our **Durham and Darlington 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. An update will be provided in March 2022	**Complete.** The analysis identified that there is concern in relation to the number of patients currently awaiting a 2nd treatment appointment and that the increasing volume of patients waiting is impacting on the proportion of those who receive this within 90 days. Actions have been developed and are detailed below	No visible impact, Performance remains consistent
	The new cohort of trainees to be used to increase capacity to deliver treatment, effective from February 22.	**Ongoing**. 16 Trainee High Intensity Therapists are providing additional treatment capacity to the service. This is supporting the management of the Cognitive Behavioural Therapy waiting list. The impact of this is expected to be seen by the end of April 22	
	Recruitment is ongoing to appoint new staff to enable demand to be met.	**Ongoing.** Interviews for four Step 1 counsellors took place during January was successful. The remaining three posts have been readvertised with a 0.6wte being appointed The remaining 2.4wte posts are advertised on a rolling basis.. Please see additional update on previous slide regarding recruitment of 9.44 PWP vacancies by May 2022.	
We are concerned that more of our **North Yorkshire IAPT** patients are waiting over 90 days between first and second treatment appointment (in-treatment pathway waits) than the national standard.	Further analysis is to be completed by the service supported by the Corporate Performance Lead to understand if this is an actual area of concern. This will be completed by the end of April 2022.	**Complete.** Initial analysis demonstrated that the main concern is around patients who are moved from step 2 to step 3 treatment at first appointment and this is as a result of the availability of staff to provide these levels of treatment. actions are in place to address this concern**.** Please see below.	No visible impact, Performance remains consistent
	Recruitment is underway, which will provide more staff to provide assessment and treatment appointments.	Please see recruitment update in 'Total Access to IAPT services' section.	
The **North Yorkshire IAPT** service has also been impacted by short sickness absence which has impacted in this area.	Trust sickness policies and procedures to be followed.	**Ongoing.** Short term sickness continues within the team and Trust Policy is being adhered to. Staff are due to return to work before the end of the month and as a result no further actions are currently in place.	

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 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 as a result of the service being under staffed as a result of being under funded.	Further analysis to understand if this is an actual area of concern. .	**Complete** Analysis identified that the clients primarily waiting over 90 days between first and second appointments are those waiting for CBT. They are waiting as the current staffing resources is unable to meet the demand. Actions have been developed and are detailed below	Performance remains consistent Actions remain ongoing.
	Recruitment is underway, which will provide more staff to provide assessment and treatment appointments. If recruitment is successful, the impact should be seen by the end of July 2022.	**Ongoing** The service have 5.8wte vacancies of which 4 are now filled with one PWP post readvertised with a closing date of and of April 22..	
	The service manager to utilise monies from the CCG (in addition to the contracted budget) to increase staffing levels to ensure the waiting times are reduced.	**Complete:** The current staffing resources have been supported by 1.2wte agency post.	
	A waiters dashboard is to be developed to support improved monitoring of waiters. This will be completed by the end of March 22.	**Complete**. We have now deployed a new IAPT waiters Dashboard and the service are actively using this to monitor waiting times for 1st and 2nd treatment.	

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 and 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 with monies received in June 21. These monies have been used to fund 8 wte staff across the team. These posts have been recruited to and staff are now in those posts.	A positive impact can be seen in urgent cases whilst no visible impact in routine cases; performance remains consistent
	The service will increase the number of assessment slots from 2 to 4, to improve access, by May-21.	**Complete.** The number of assessment slots has increased from 2 to 4 per week, comprising 3 routine and 1 urgent. Routine assessment slots are rescheduled to accommodate additional urgent assessments, where possible and clinically appropriate.	
	The service change their service model to support the scheduling of additional assessment appointments, with a view to addressing the waiting list backlog by the end of Apr-22.	**Ongoing.** The service developed an Early intervention team, a core treatment team and an intensive home treatment team. The Early Intervention Team offer screening to ascertain what package of care or signposting a patient needs, thereby improving assessment capacity. The service is working initially to improve Access and Waiting time Standards (AWTS) for urgent young people as soon as possible. However, it is anticipated the routine assessments will be within the 28 days by end of April. All patients who did not have an appointments booked and were outside of the 28 days now have appointments in April with those inside of 28 days are now booked to be seen within the timescales.	

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			
	The Team Manager to increase the number of venues across the locality where patients can access appointments by the end of April 22.	**Complete.** Having previously offered appointments in Newton Aycliffe and Chester-le-Street, the expansion includes Easington, Durham and Darlington and Stanley.	
	The Service to review the referral process by January 21, to ensure all patients are directed to the Eating Disorder team quickly as possible after referral.	**Complete.** 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. This has been beneficial in reducing the number of inappropriate referrals to the team as well as reducing the waiting times for those who do require a referral.	
	Recruitment is underway for 7 wte vacant posts (which is in addition to the 8wte above) , which will provide more staff to provide treatment appointments.	**Ongoing. 7**.8 WTE have been appointed; 6.8 are in post and 1 nurse is due to commence in May 22. This is recruitment above that originally planned due to flexibility in the posts appointed due to recruitment issues and the option to utilise surplus monies from the bid from CCGs (see action 1)	
A key area of concern within the Durham and Darlington service is the shortage of dieticians within the team and this is a national shortage. Dieticians are crucial member of the multi-disciplinary team who provide initial assessments, therefore the team's capacity to deliver these and start treatment depends significantly on these appointments.	Recruitment is underway for 3 wte dietician posts are to be recruited to in order to increase the number of initial assessments offered.	Two dieticians have been recruited and will start in their roles in August 2022, after obtaining their Health & Care Professions Council registration. Pending that, they will work as Band 4 Dietetic Assistants from June 2022. One dietician post remains vacant; however, advertisement of this post is on hold at present due to a large volume of dietetic posts already going through recruitment. The impact of this recruitment will not be seen until individuals take up their posts, which is to be by the end of Quarter 2.	

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 and York** Eating Disorders service are waiting longer than the national standard for both routine and urgent referrals due to capacity within the teams.	Recruitment to be undertaken to ensure we have the appropriate levels of staff to provide treatment appointments.	**Complete.** The team have no vacancies and we have appointed an Eating Disorders Liaison Nurse, a Healthcare Assistant, a Band 5 Nurse and a Psychologist over and above the current budget.	An improving position is visible for both routine and urgent cases.
	A bid for additional investment to be submitted as part of the Financial planning for 2022/23, which will support the service to increase staffing levels and facilitate more timely treatment for our patients.	**Complete.** The bid had been submitted and we await confirmation	
The **North Yorkshire and York service** works over multiple sites/geographies, impacting on its ability to offer flexible appointments, particularly refilling appointment slots cancelled at short notice.	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.	**Complete**. The kaizen event took place in February 22 and the assessment process has been streamlined. From the 14th February 2022 assessments have increased to 6 per week; 3 in Harrogate/ Northallerton and 3 in York/ Scarborough.	
	A review of the improvements established within the February Kaizen event to be undertaken by April 2022 to assess success and any further improvements that need to be actioned.	**Ongoing**. A Review has taken place and questionnaires have been disseminated to clinicians and service users/families to seek feedback on the success of the initiatives. A feedback review meeting is arranged for the end of April, following which the second part of the Kaizen will be arranged. A date for this will be confirmed in May 22.	

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			
Within the **North Yorkshire and York service** the provision of insufficient information on the referral from GPs is impacting on the service's ability to assess patients within the national standards.	The service to work with commissioners to introduce an Eating Disorders specific referral form by the end of June 22. This will improve the triage process to enable more efficient booking of new initial assessment appointments.	**Ongoing** The service is meeting with GP representatives on 20th May to consider how they can embed an ED specific referral form into the Universal CAMHS referral forms that GPs currently use and would support.	
	A second Kaizen is to be held to review the pathway from referral to the initial assessment, ensuring that all information is available at the point of referral and to enable assessments to be booked timely. This is an extension of the initial Kaizen which focused on the initial assessment only.	**Not started.** A date for this will be confirmed in May 22.	

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Number of people accessing Individual Placement Support services as a rolling total each quarter			
Whilst the Trust has not achieved the ambitions set nationally for each individual CCG, work has been undertaken with Clinical Commissioning Group partners to develop a set of local trajectories for these measures as part of the 2022/23 operational planning round for mental health services. These have been submitted to NHS England & Improvement for approval. Our proposals, whilst achievable, are stretching to support progress towards the national ambitions.			

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Number of women accessing specialist community PMH services			
Whilst the Trust has not achieved the ambitions set nationally for each individual CCG, work has been undertaken with Clinical Commissioning Group partners to develop a set of local trajectories for these measures as part of the 2022/23 operational planning round for mental health services. These have been submitted to NHS England & Improvement for approval. Our proposals, whilst achievable, are stretching to support progress towards the national ambitions.			

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Number of inappropriate OAP bed days for adults (Internal & External) This measure is included in the Trust Board Performance Dashboard please see page 23			

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					
Acting to improve safety (safety culture theme in NHS Staff survey)													6.2						New measure for 2021/22 - no previous comparative data
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%	100.00%	100.00%		100.00%	Benchmarking data as at January 2022 reports the Trust in the upper quartile (positive position)
National Patient Safety Alerts not completed by deadline		0	0	0	0	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 must do 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 submitted by the deadline of the 21st January. These actions have been included on the IOP (Integrated Oversight Plan) which is used for theming actions and for monitoring completion. A meeting takes place on a 3 weekly basis chaired by the Head of Quality Governance and Compliance alongside the CQC locality leads to update progress on these actions.	

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					
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
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 must do 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 submitted by the deadline of the 21st January. These actions have been included on the IOP (Integrated Oversight Plan) which is used for theming actions and for monitoring completion. A meeting takes place on a 3 weekly basis chaired by the Head of Quality Governance and Compliance alongside the CQC locality leads to update progress on these actions.	

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													6.2						New measure for 2021/22 - no previous comparative data
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																			
(a) managers													8.00%						Staff Survey result 20/21 - 10%
(b) other colleagues													14.00%						Staff Survey result 20/21 - 16%
(c) patients/ service users, their relatives or other members of the public													25.00%						Staff survey result 20/21 - 30%
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													55.00%						staff survey result 20/21 - 56%
Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns													59.00%						Staff survey Result 20/21 - 40%. Benchmarking data as at 2020 reports the Trust in the lower quartile (a negative postion)
% of jobs advertised as flexible		5.30%	3.98%	13.85%	8.88%	8.08%	7.06%	7.31%	10.81%	8.85%	16.03%	19.95%	1.31%	7.81%	8.04%	8.97%	11.58%	9.22%	
NHS Staff Leaver Rate		11.47%	10.81%	11.66%	11.45%	11.06%	11.24%	11.49%	11.42%	12.15%	12.85%	12.97%	13.30%	11.66%	11.24%	12.15%	13.30%	13.30%	
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%	7.14%	7.85%	6.20%	5.36%	6.42%	6.83%	7.09%	6.43%	
Proportion of staff who say they have a positive experience of engagement													7.00						Note: This is a score out of 10. Staff survey result 20/21 - 7 out of 10. Benchmarking data as at 2020 reports the Trust in the lower quartile (a negative position)
Number of people working in the NHS who have had a 'flu vaccination								30.26%	46.44%	55.51%	50.39%	62.48%	62.24%			55.51%	62.24%	62.24%	Benchmarking data as at August 2021 reports the Trust in the interquartile range
Nursing vacancy rate		0.40%	-2.33%	-4.75%	-5.39%	-7.21%	-7.70%	-8.34%	-7.61%	-8.54%	-9.63%	-10.01%	-9.59%	-4.75%	-7.70%	-8.54%	-9.59%	-9.59%	Benchmarking data as at August 2021 reports the Trust in the upper performing quartile (a postive postion)
Number of healthcare support workers employed by the NHS		1180.45	1178.40	1191.62	1206.77	1212.36	1213.24	1217.89	1215.56	1200.04	1214.51	1215.97	1222.12	1191.62	1213.24	1200.04	1222.12	1222.12	
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													56.00%						No staff survey 2020/21 comparable data

People

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Sickness Absence (working days lost to sickness)			
This measure is included in the Trust Board Performance Dashboard please see page 55			

Finance

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. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th April 2022**
TITLE:	**Register of Interests of the Board of Directors**
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:

1 **Introduction**

1.1 This report presents the updated Register of Interests of the Board of Directors.

2 **Key Issues**

2.1 The Trust is required to compile a Register of Interests in accordance with paragraph 20 (1) of schedule 7 of the NHS Act 2006 (as amended).

2.2 The format of the Register is aligned to the types of interests included in NHS E/I guidance.

2.3 The Register will be published on the Trust's website and publicised, as required, in the Annual Report.

3 **Recommendation**

3.1 The Board is asked to receive and note this report.

Tees, Esk and Wear Valleys NHS Foundation Trust

Register of Interests of Members of the Board of Directors

Date: April 2022

Note: 1 - This Register has been established in accordance with the National Health Service Act 2006 (as amended) and the Consitution
Note: 2 - Descriptions of the types of interests are provided in NHS England Guidance "Managing Conflicts of Interests in the NHS" (Publications Gateway Number 06419) and the Trust's Conflicts of Interest Policy
Note: 3 - Changes of interest should be recorded as notified
Note: 4 - The Register should be refreshed annually

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Paul Murphy	Chair	**None**	**Yes** Chair of Trustees at the National Centre for Early Music and at the York and North Yorkshire Welfare Benefits Unit, neither of which at present has any connection to TEWV.	**None**	**Yes** Daughter is Head of Healthcare Policy (EMEA) for Amazon Web Services
Shirley Richardson	Deputy Chair and Senior Independent Director	**None**	**Yes** Member of the Royal College of Nursing, Nurses and Midwifes Council	**None**	**None**
Brent Kilmurray	Chief Executive	**None**	**Yes** Director of NETS Ltd (Dormant)	**None**	**Yes** Spouse is clinical member of staff at CNTW NHSFT
Charlotte Carpenter	Non-Executive Director	**None**	**None**	**None**	**None**
Jill Haley	Non-Executive Director	**None**	**None**	**None**	**None**
Prof. Pali Hungin	Non-Executive Director	**Yes** I provide occasional, freelance advisory services to academic (university) institutions and pharmaceutical companies, chiefly in gastroenterology.	**Yes** The Chair of the Changing Face of Medicine Commission of the Academy of Medical Royal Colleges An Advisory Board member of the forthcoming renewal of the GMC's "Good Medical Practice" guideline.A member of Genomics England's Access Review Committee. An Advisory Board member of the Wesleyan Assurance Company.	**None**	**None**
John Maddison	Non-Executive Director	**None**	**None**	**None**	**None**
Bev Reilly	Non-Executive Director	**None**	**None**	**None**	**None**

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Roberta Barker	Associate Non-Executive Director	**None**	**None**	**None**	**None**
Jules Preston	Associate Non-Executive Director	**None**	**None**	**None**	**None**
Ann Bridges	Executive Director of Corporate Affairs and Involvement	**None**	**None**	**None**	**None**
Dr Sarah Dexter-Smith	Director of People and Culture	**None**	**None**	**None**	**None**
Elizabeth Moody	Director of Nursing and Governance & Deputy Chief Executive	**None**	**None**	**None**	**None**
Sharon Pickering	Assistant Chief Executive	**None**	**None**	**None**	**Yes** Husband employed by Tees Valley CCG as Chief Finance Officer
Liz Romaniak	Director of Finance and Information	**None**	**None**	**None**	**None**
Patrick Scott	Managing Director (DTVF)	**None**	**None**	**None**	**None**
Dr Steve Wright	Interim Medical Director	**None**	**None**	**None**	Yes My son has recently been offered a post with Deloitte, who are currently working with the Board (on Board development). His employment was and is unconnected with my role (ie: entirely coincidental and in another region of the country) and will not commence until I have left this post.

ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th April 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
421	31.3.22	Renewal lease relating to land at the Flatts Lane Centre, Normanby	Liz Romaniak, Director of Finance and Information Phil Bellas, Company Secretary

Recommendations:

The Board is asked to receive and note this report.