MEETING OF THE BOARD OF DIRECTORS
Thursday 29th September 2022
The Boardroom, West Park Hospital, Edward Pease Way, Darlington DL2 2TS
at 1.00 p.m.

AGENDA

Standard Items (1.00 pm – 1.20 pm):

1	Apologies.	**Chair**	**-**
2	Chair's welcome and introduction.	**Chair**	**Verbal**
3	To approve the minutes of the last ordinary meeting held on 28th July 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 (1.20 pm – 2.10 pm):

8	Chief Executive's Report.	**CEO**	**Report**
9	To consider the report of the Chair of the Audit and Risk Committee.	**Committee Chair (JM)**	**Committee Key Issues Report**
10	Board Assurance Framework summary report.	**Co Sec**	**Report**
11	Corporate Risk Register summary report.	**DoN&G**	**Report**
12	To consider the Integrated Performance Dashboard Report.	**Asst CEO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (2.10 pm – 2.40 pm):

13	To consider the report of the Chair of the Quality Assurance Committee.	**Committee Chair (BR)**	**Committee Key Issues Report**
14	To consider the six monthly 'hard truths' nurse staffing report.	**DoN&G**	**Report**
15	To consider the report of the Chair of the Mental Health Legislation Committee.	**Committee Chair (PH)**	**Committee Key Issues Report**
16	To receive and note a progress report on the delivery of the CQC action plan.	**DoN&G**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (2.40 pm – 3.10 pm):

17	To consider the establishment review report.	**DoN&G**	**Report**
18	To approve the publication of the Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard submissions and associated action plans.	**DoP&C**	**Report**
19	To receive the Annual Report of the Responsible Officer on Medical Revalidation and to approve the signing off of the Statement of Compliance.	**MD**	**Report**
20	To review the position on RIDDOR incidents.	**DoFI&E/F**	**Report**

Governance (3.20 pm – 3.35 pm):

21	To approve the submission of the Trust's self-assessment, action plan and statement of compliance with the Core Standards for Emergency Preparedness Resilience and Response.	**MD (NYY&S)**	**Report**
22	To appoint: (a) The Chairs and Non-Executive Director Members of the Board's Committees (b) The Non-Executive Director Champions	**Chair**	**Report**
23	To appoint the Trust's Senior Independent Director.	**Chair**	**Verbal**

Exclusion of the Public (3.35 pm):

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

David Jennings
Chair
23rd September 2022

Contact: Karen Christon, Deputy Company Secretary, Tel: 01325 552312/Email: karen.christon@nhs.net

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 28TH JULY 2022 IN THE REDWORTH HALL HOTEL, SURTEES ROAD, NEWTON AYCLIFFE COMMENCING AT 3.00 PM

Present:
Mr P Murphy, Chair
Mr B Kilmurray, Chief Executive
Dr C Carpenter, Non-Executive Director
Ms J Haley, Non-Executive Director
Prof P Hungin, Non-Executive Director
Mr J Maddison, Non-Executive Director
Mrs B Reilly, Non-Executive Director
Mrs S Richardson, Senior Independent Director and Deputy Chair
Mrs R Barker, Associate Non-Executive Director (Non-Voting)
Mr J Preston, Associate Non-Executive Director (Non-voting)
Mrs Z Campbell, Managing Director, North Yorkshire, York and Selby Care Group
Dr K Kale, Medical Director
Mrs E Moody, Director of Nursing and Governance and Deputy Chief Executive
Mrs L Romaniak, Director of Finance, Information and Estates/Facilities
Mr M Brierley, Assistant Chief Executive (Non-voting)

In Attendance:
Mr P Bellas, Company Secretary
Mrs L Taylor, Care Group Director, Health and Justice Services (representing Mr Scott)
Mrs H Warburton, Acting Head of Communications (representing Mrs Bridges)
Mrs K North, Deputy Director of People and Culture (representing Dr Dexter-Smith)
Mr D Williams, Freedom to Speak Up Guardian
Dr J Boylan, Guardian of Safe Working

Observers/Members of the Public
Mrs K Christon, Deputy Company Secretary (Designate)
Mrs M Booth, Public Governor for Middlesbrough
Mr R Tuckett, Public Governor for Hambleton and Richmondshire

22/101 WELCOME AND INTRODUCTIONS

The Chair welcomed all present including Mr Brierley, who was attending his first Board meeting; those deputising for Executive Directors; the two Public Governors; and Mrs Christon who was due to take up her role as the Deputy Company Secretary in September 2022.

Mr Murphy reported that this would be his and Mrs Richardson's last meeting of the Board before their retirement.

The Board noted that this was the first formal meeting of the Board held in person since February 2020.

Mr Murphy advised that the intention was to move to hybrid meetings once the technology allowed. He also suggested that it might be appropriate to return to holding quarterly meetings peripatetically.

Board Members were reminded of the agreement to provide succinct introductions to their reports to allow sufficient time for questions and discussions.

22/102 APOLOGIES

Apologies for absence were received from Mrs A Bridges, Director of Corporate Affairs and Involvement, Mrs H Crawford, Director of Therapies, Dr S Dexter-Smith, Director of People and Culture, and Mr P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group.

22/103 MINUTES

***Agreed** – that the minutes of the special meeting held on 15th June 2022 and the last ordinary meeting held on 30th June 2022 be approved as correct records and signed by the Chair.*

22/104 DECLARATIONS OF INTEREST

There were no declarations of interest.

22/105 PUBLIC BOARD ACTION LOG

The Board reviewed and noted the Board Action Log.

22/106 CHAIR'S REPORT

The Chair reported that:

(1) He had represented the Trust at the recent graduation ceremony of Teesside University.

During the event he had met Prof Tim Thompson, the Dean of the School of Health and Life Sciences, who had asked for a conversation on increasing the number of student placements provided by the Trust. This would be followed up by Mr Kilmurray.

Mr Murphy observed that it would be beneficial for the Board to have a discussion on the Trust's strategic relationship with higher education and to invite representatives of local universities to participate.

(2) There had been two recent successful visits to Foss Park.

The Board noted that:

(a) Rachael Maskell MP, Member of Parliament for York Central and the Co-Chair of the All-Party Group on Mental Health, had spent over two hours visiting the Hospital. She was keen to understand the issues facing the Trust and to have a separate discussion on mental health legislation. This would be arranged by Mr Kilmurray.

(b) From the discussions during her visit, Sue Symington, the Chair of the Humber and North Yorkshire Integrated Care System (ICS), was now sighted on, and had taken on board, the issues facing the Trust in regard to the funding and commissioning of CAMHS and autism and other pressures e.g. beds.

Mr. Murphy commended Martin Dale, Strategic Project Manager, and Mike Waldie, Modern Matron, for the support they had provided to the visits and the staff at Orca House for the progress they were making.

22/107 MATTERS RAISED BY GOVERNORS

The Chair drew attention to a recent email from Mr Tuckett, Public Governor for Hambleton and Richmondshire (circulated to Board Members) about the Trust's approach to the co-creation of future autism services in the light of national policy discussions and recommendations.

Mr Kilmurray considered that Mr Tuckett had raised some good points in his email which had been reflected in discussions at the recent meeting of the Council of Governors.

He also advised the Board that:

(1) He would welcome discussions with the Chair, Cllr Ann McCoy (the Lead Governor) and Dr Kale on how to engage with Governors on this matter.

(2) Discussions were being held on the autism project and he recognised that co-creation had to be part of the approach.

(3) It was proposed to hold a meeting involving Dr Kale, representatives of the Integrated Care Boards (ICBs) and Mr. Tucket as soon as practicable.

The Chair advised that, previously, the Council of Governors had established task and finish groups, led by a Non-Executive Director, to hold in-depth reviews of important issues. He considered that the establishment of a group would provide an appropriate approach to engaging Governors on this matter.

Mr Murphy thanked Mr Tuckett for his email. He hoped to be able to provide him with information on the establishment of the task and finish group and the meeting with Dr Kale and the ICB representatives before his retirement.

The Chair also noted that there were a number of outstanding matters on the action log of the Council of Governors and asked the Company Secretary to progress these with the relevant Executive Directors before its next meeting.

Action: Mr Bellas

22/108 CHIEF EXECUTIVE'S REPORT

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

In his presentation of the report Mr Kilmurray:

(1) Drew attention to the continuing positive partnership with York St John University, noting the recent launch of its nursing degree with supervised placements being facilitated by the Trust.

Prof Hungin observed that, following conversations with academic colleagues, the Trust's close links with local universities provided opportunities to enhance recruitment and retention through joint appointments; supporting career progression; and increasing the standing of the Trust.

Mr Kilmurray welcomed Prof Hungin's offer to lead conversations with the universities on these matters. He advised that the Trust had a clear and productive relationship with York St John University which had great potential. The relationships built with the other universities were more tactical, at present, and it would be helpful to have a more focussed approach.

Dr Kale fully supported Prof Hungin's approach to improving recruitment and retention; however, he recognised the need to have staff in place to support placements and to grow the Trust's workforce.

(2) Reported in regard to the CQC that:

(a) The inspection of the Trust's Adult Learning Disability Inpatient Services had been completed and the report was expected to be received in early September 2022 in accordance with the regulator's timescales.

The Board noted that, through positive work undertaken with Mersey Care NHS Foundation Trust, a plan had been produced to improve the experiences of patients receiving the services.

Mr Kilmurray considered that the approach could be the start of a longer-term relationship between the Trusts.

(b) Advised that high level feedback had been received from the CQC following the re-inspections of Secure Inpatient Services and CAMHS which was being considered.

It was noted that further discussions on this matter would be held later in the meeting.

(3) Drew attention to the information provided on the national pay awards and the links to agency costs.

The Board noted its relationship to the key risks included in the Board Assurance Framework and the Corporate Risk Register and the mitigations in place to address them including recent successes in recruiting staff.

Clarity was sought on the following matters:

(a) The funding gap arising from the pay award, the Trust's ability to respond to it and the reasons why the funding system was unfair to mental health trusts.

Mrs Romaniak described the approach to the calculation of the tariff uplift which was being used to fund the pay award.

The Board noted that the tariff uplift, which covered both pay and non-pay expenditure, was applied to contracts in response to inflation; however, as it was based on averages and acute providers had higher non-pay costs, the mechanism assumed a lower pay cost base for mental health trusts.

In regard to Agenda for Change, due to the previous three-year pay award and cost of living awards, the Trust was carrying approximately £7m of unfunded pay inflation since 2018. The additional costs of the pay award were expected to be reflected in contracts with the Trust in line with a 1.7% uplift to the tariff. This equated to additional underfunding of approximately £0.5m for the current year. This position was better than had been expected.

It was also noted that the differential approach to the pay award also impacted on the gaps between pay bands and this was likely to create tensions.

(b) The pressure on the agency gap going forward as, although there had been a net increase in staffing, the pressures from demand had also grown.

Mrs Romaniak reported that:

- Initial feedback from the Chief Financial Officer at NHSE/I suggested that there would be a return to pre-covid levels of scrutiny on agency costs particularly those off framework; however, during a briefing on the pay award, there had been reference to reviewing the approach.
- For 2022/23 the cost cap was based on the submitted plans (£9.3m forecast for the Trust) but there would also be other rate limiting factors.
- The position at present was uncertain. The Trust had recently received its cost cap and work was required to understand its implications particularly in the context of the increase in the run rate since 2021/22.

Mr Kilmurray advised that, whilst action was being taken to improve rostering and increase recruitment, significant service pressures remained and further work was required.

The Board noted that a review of the financial plan and pressures had shown a significant use of agency staffing particularly on the learning disability packages of care. The review of recruitment in Secure Inpatient Services had also highlighted staffing requirements. Additional staff were, therefore, required to reduce demand for agency staffing.

The Chair recognised that, whilst the headcount had increased, the pressure on agency staffing required regular monitoring.

(c) The risks that funding might be reduced if the Trust exceeded its agency cap.

Mrs Romaniak explained that the Trust would not lose funding but would be subject to additional scrutiny if it breached the cap.

The Chair reiterated the Board's stance that the Trust would always prioritise safety and quality over money.

(d) Reported that Covid continued to be present in services and was being managed. There was one outbreak at present and PPE and restrictions had had to be to reintroduced in some areas.

It was noted that staff sickness absence rates had reduced to below 7% but continued to fluctuate.

(e) Highlighted a recent publication (appended to the report) by the Northern Health Sciences Alliance, with contributions from the Trust's research and development team, on the impact of the pandemic on the mental health of those living in the North of England.

The Board noted that the issues raised in the report chimed with the work undertaken by the Trust on forecasting.

22/109 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

The Board Assurance Framework (BAF) Summary Report, which provided information on the alignment between the strategic risks and the matters due for consideration during the meeting, was received and noted.

22/110 INTEGRATED PERFORMANCE DASHBOARD REPORT

The Board received and noted the Integrated Performance Dashboard Report.

In his presentation of the report, Mr Brierley:

(1) Advised that this was the second report in the new integrated format. Whilst it remained in development, enhancements had been made including the introduction of benchmarking information. Where issues had been identified the focus of the report was on questions relating to "so what" and "what now" to reflect the richer conversations being held at various stages of the governance structure and to avoid complacency, for example in the context of variation between the Care Groups.

(2) Drew attention to the following matters:

(a) Outcomes (metrics 5, 6 and 7).

It was noted that the Trustwide Outcomes Steering Group, chaired by Dr Kale, would be examining and seeking to understand the issues relating to performance on these metrics.

Dr Kale reported that the outcomes data had been provided to clinicians at a meeting held on 27th July 2022 and had been recognised as being invaluable in enabling the impact of Our Clinical Journey to be measured.

(b) Bed pressures (metrics 8 and 9).

Mr Brierley advised that the need for a significant and urgent response to bed pressures was recognised.

It was noted that a Trustwide Bed Management Group had been established to oversee the management of current levels of occupancy and the longer-term requirement for beds. Extensive discussions had also been held in the Care Groups in regard to current arrangements and pressures, flow, and commissioning arrangements.

(c) Mandatory training (metrics 20 and 21).

The agreement to set a trajectory to support compliance across the organisation was noted.

(d) The progress against the ambitions in the Long-Term Plan.

In regard to the risks highlighted in the report, Mr Brierley advised that recovery plans were in place and the Trust was also working collectively with partners, as a system, to address them.

The Non-Executive Directors raised the following matters:

(1) Noting the availability of benchmarking information on bed numbers and length of stay, whether information was available on the approaches being taken by other trusts and the learning that could be taken from them.

Mr Kilmurray advised that:

(a) The Trust had access to information from the benchmarking clubs which showed that the Trust was in the midspread for the bed ratio.

(b) Data available on lengths of stay and the use of mental health legislation also provided the opportunity for greater understanding of the Trust's position.

(c) The data would be revisited both generally and in the context of patterns of demand.

(2) Whether the Trust had made the Centre aware of the challenges it faced and was being heard.

Mr Kilmurray advised that the challenges facing the Trust were being discussed and considered by the ICBs with regular meetings being held with, and challenges made to, the regional team.

The Board noted that the mental health investment standard was not universally applicable to the Trust's services, for example it covered perinatal services and IAPT but not inpatient services. With the Long-Term Plan being refreshed it was expected that acute inpatient services would be brought within the scope of the investment standard and deliver funding flows.

(3) The importance of the benchmarking information and the "so what" approach in changing perceptions on how the Trust was performing and enabling it to focus on the "art of the possible" e.g. it might be expected that the staff leaver rate (metric 18) would be high given the organisational changes but the Trust was performing well compared to others.

(4) The position on IAPT services which had been recognised by the Board as an area of focus for some time.

Mr Brierley responded that, from his previous role, it had been evident that significant improvements had been made to the services in County Durham and they had been performing well.

He considered that a commissioning decision was required as, at present, the funding levels for access were not aligned to demand.

It was noted that in North York and York there had been significant engagement with GPs in order to increase referrals. Some additional funding had also been agreed to drive improvements.

(5) The need for the data on the staffing metrics to be provided by service area, as soon as practicable, so that trends and hotspots could be identified and to enable services to be better informed to be able to take action.

In particular, and further to the discussions under minute 22/89 (30/6/22), Ms Haley, who raised this matter:

(a) Emphasised the importance of making progress on improving the processes and learning from staff exit interviews in the context of metrics 18 (staff leaver rate) and 19 (percentage sickness absence rate) and the use of agency staff.

(b) Provided clarity that the exit interviews would be provided in-house and not external to the Trust as potentially indicated in the above minute.

The Board noted that discussions were being held between the Director of People and Culture and the Associate Director of Performance on the provision of staffing data by service area.

Mrs Romaniak explained that the majority of agency requirements tended to be rostered.

(6) The difficulties in interpreting the data, for example on patients feeling safe (metric 3), as benchmarking information was not available.

Mrs Moody explained that trusts did not routinely ask the same question in regard to patients feeling safe. It had, therefore, been agreed with Cumbria Northumberland Tyne and Wear NHS Foundation Trust to undertake the same exercise in each trust to seek comparative data.

The Board noted that the position on the metric was not considered to be a cause for concern; however, the Trust wanted to make improvements. Although a national metric, there were difficulties in accessing benchmarking information and it was considered that the Trust would need to contact other providers directly.

Mr Kilmurray observed that, for some metrics, performance should be absolute e.g. all patients should feel safe. There was, therefore, a need to review the data in order to provide visibility on the various elements which contributed to the overall position.

Board Members considered that the introduction of the integrated approach to reporting had improved their ability to ask questions and that additional time should be allocated on agendas for discussions.

The Chair concurred with this view. He also commended Mr Brierley and his staff for distilling the significant amount of data into a very readable report.

In response to the comments made at the meeting Mr Brierley undertook to review the report with a view to highlighting “hot spots” in the future.

22/111 DIRECTORS’ VISITS

The Board received and noted a report on the Directors’ visits held on 13th June 2022 to the following Early Intervention in Psychosis (EIP) and Perinatal Services:

- Redcar EIP – Foxrush
- SWR EIP – Scarborough
- Perinatal Team - Lancaster House, Stockton
- YS EIP - Huntington House
- North EIP – Chester le Street
- PNMH – SWR York Cell, Huntington House

The Chair drew attention to the themes included in the report and asked Board Members to highlight any key issues and risks arising from their visits.

Overall Board Members reported that the teams were well managed and highly functioning.

Arising from the visits:

(1) Mr Murphy reported that the SWR team was one the best he had seen and commended its manager, Martine Revell. He observed that consideration should be given to how its attributes could be replicated across the Trust.

(2) Dr Kale advised that EIP services tended to be comparatively well resourced in regard to their caseloads and considered that similar levels of resourcing were required for community teams generally.

(3) Mrs Moody highlighted that the perinatal team in Stockton was well managed and high functioning; however, it was not fully funded to meet the needs of the population and there was a specific issue relating to its skill mix.

Mrs. Reilly advised that the Team Manager of the Hartlepool CAMHS Team had contacted her as she had not received any feedback from the visit undertaken in April 2022.

The Chair asked Mrs. Warburton to make a note of this issue for inclusion in the discussions on the future arrangements for Directors' visits.

A suggestion that the Non-Executive Directors should be included in the review was supported by the Chair. He also asked for the review to be progressed urgently in recognition of the importance of Directors' visits in providing assurance to Board Members on the quality of services.

Action: Mrs Bridges

22/112 QUALITY ASSURANCE COMMITTEE

The Board received and noted the key issues report on the business transacted and matters arising from the meeting of the Quality Assurance Committee (QuAC) held on 7th July 2022.

It was noted that there were no risks for escalation to the Board.

Mrs. Reilly, the Chair of the Committee, drew attention to the following matters discussed at the meeting:

(1) The review of the relevant risks included in the Board Assurance Framework.

The Committee considered that very good progress had been made on the BAF; however, the Executive Directors had been asked to update the profiles and progress a number of mitigations which remained outstanding.

(2) The review of the risks to quality and safety included in the Corporate Risk Register.

Again, good progress had been noted; however, as mentioned in the report, there had been a deterioration on the delivery of mitigations by their due dates.

The Committee expected further progress to be made on risk management with the embedding of the new structure and governance arrangements, including the risk management groups; the imminent arrival of the new Head of Risk Management; and the refresh of the policy which was due for approval at the meeting (see minute 22/118).

Discussions with the Chair of the Audit and Risk Committee had also highlighted continuing concerns with capacity, capability and the resources available for managing risk.

(3) The updates provided by the Care Groups.

The Board noted that the issues reported by Care Groups, in regard to staffing pressures, bed pressures, demand and staff health and wellbeing, remained consistent and were reflected in the BAF and CRR.

(4) The update provided on the Durham and Darlington Crisis Team.

The discussions at the meeting had focussed on the ongoing work to review the model of care, recruit to established vacancies, enhance skill sets and continue to build a positive culture.

Mrs Reilly advised that the Committee had asked for further updates on progress with the next scheduled for its meeting in September 2022.

(5) The update on suicide and self-harm.

The Committee had received an update from Mrs Moody on the work undertaken and planned and was looking forward to receiving further updates.

Mrs Moody advised that:

(a) Work continued to be undertaken on self-harm due to the high number of incidents particularly in female inpatient services. This included "deep dives" in York and Secure Inpatient Services.
(b) There had been an increase in the number of incidents linked to the new policy on seclusion as flexible segregation was now included within its definition. A long-term segregation panel had now been established to review relevant cases.
(c) A similar approach was being taken to responding to self-harm and segregation with support being provided to the clinical teams, including on the management of risks and evidence-based practice. Arrangements were being made to engage external expertise to support the approach.

Mrs Reilly also reported that the Committee was planning to hold a development session to review reporting arrangements with the aim of supporting a greater focus on strategic issues.

The Board's discussions focussed on risk management.

Mr. Kilmurray considered that care needed to be taken in describing the position on risk management (as per the report) as providing "limited" assurance as this, in terms of application, might be regarded as there being no assurance on the effectiveness of current controls.

He advised the Board that:

(1) The new Head of Risk Management was due to come into post on 1st August 2022 and would provide expert advice and guidance to the Trust and support the embedding of processes.
(2) Work had been undertaken with Deloitte LLP and the capacity and training provided would need to be built upon.
(3) The risk groups were making a difference. The Executive Risk Group was providing a greater understanding of the key risks and focusing on the delivery of outstanding mitigations.
(4) The agendas of the Board's committees were also becoming more focussed.

He considered that there was a greater understanding of the Trust's key risks, the actions required to mitigate them; and the work required to strengthen processes. He asked the Board to be patient whilst the further developments were progressed.

The Executive Directors, supporting Mr Kilmurray's appraisal of the present position, noted that:

(1) The arrival of the new Head of Risk Management, in terms of providing additional capacity and expertise and a fresh perspective, should enable a number of issues to be addressed including workflow and completing the alignment of processes with the new structure.

(2) The richness of conversations and the provision of assurance on controls would improve through the work of the Executive Risk Group.

(3) The Risk Groups of the Care Groups had also been established and were seeking information to support the management of risks. The Care Groups were also taking a joint approach to mitigation.

Mr Maddison, the Chair of the Audit and Risk Committee, reported that its members, including Mrs Reilly, were aware of the issues in regard to risk management. Whilst significant progress had been made the Committee would continue to maintain oversight.

The Executive Directors were asked to review the dates for the delivery of mitigations in the CRR as, in some cases, they had not been set or had elapsed.

Mrs Reilly advised that the Committee recognised that the Trust was on a journey in terms of risk management but had sought to articulate where it considered the position to be at present.

In addition, Prof Hungin, noting the increase in the score of the BAF risk on CITO, considered that it might be worthwhile for the Committee to seek assurance on the delivery of the system.

The Board noted that further discussions were due to be held on this matter later in the meeting as, following user testing, risks had been identified and there was a need to reprofile the plan. This would be clinically led.

The Chair hoped that the members of the Quality Assurance Committee would see sufficient progress being made to increase the level of assurance they would be able to provide to the Board on risk management.

22/113 REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN

The Board received and noted the report of the Freedom to Speak Up Guardian (FTSUG).

In presenting his report Mr Williams drew attention to the following matters:

(1) The information provided on training.

Mr Williams advised that the 'Follow up' e-learning, which had been recently released by the National Guardian's Office (NGO), was available on the ESR system. This training, which was designed for existing and aspiring senior leaders, was not mandatory but he hoped Board Members would find time to complete the module.

Mr Kilmurray undertook to ensure that Non-Executive Directors had access to the training.

Action: Mr Kilmurray

It was also noted that one of the outcomes of the improvement event held earlier in the year was the provision of training for people undertaking reviews. These sessions had now been introduced and had proved to be useful.

(2) The update provided on the event to re-launch the 'dignity at work champion' role.

It was noted that interest in the role, which had been retitled "speaking up ambassador", was growing.

(3) The case study on the rapid support provided to staff based within Adult Learning Disability Inpatient Services at Lanchester Road Hospital in response to specific concerns raised about culture on the ward.

The Board's discussions focussed on the following matters:

(1) The importance of communications in ensuring that staff recognised that it was worth speaking up and that improvements would be made as a result.

Mr Kilmurray advised that:

(a) As there had been instances of staff being disciplined in response to concerns being raised through the FTSU process, it was important to consider how to frame the narrative so as not to create a negative response.
(b) The Trust needed to ensure, through its communications, that staff were aware that concerns were being heard and acted upon.
(c) The Director of Corporate Affairs and Involvement and the Acting Head of Communications were leading an audit of internal communications which should provide an understanding of how this could be best achieved.
(d) Visits to services, such as those undertaken by the Managing Director and Care Group Director to Adult Learning Disability Inpatient Services, were also important and had a positive impact.

Board Members recognised that many concerns were anonymous which hampered the Trust's ability to communicate.

(2) The events in Adult Learning Disability Inpatient Services, where staff had raised their concerns directly with the CQC rather than internally within the Trust, which reflected leadership issues.

It was considered that discussions with the CQC and the MDT suggested that there had been a disconnect between the staff and clinical leadership within the services.

(3) The actions which could be taken to improve feedback on the experience of staff accessing the FTSU service as only six responses had been received in regard to the 39 cases which had been closed since January 2022.

Mr Williams explained that:

(a) Feedback was sought on two questions specified by the NGO: whether the individual had encountered any demeaning treatment because they had spoken up; and whether they would speak up again in the future.
(b) The six responses had been elicited after the staff had been contacted by the FTSU service through follow-up processes. Feedback had only been rarely received prior to the introduction of this approach.

(4) Whether feedback was received on those cases which were not resolved.

Mr Williams considered that this was a constant issue and where feedback was provided it tended to be very bland. This was one of the reasons for the emphasis being placed on the leadership of reviews and the training of reviewers.

Board Members recognised the importance of the reviews being of good quality.

(5) How feedback from reviews was woven into Our Journey to Change.

Mr Williams advised that he was working with the People, Culture and Diversity Committee and others to generate soft intelligence so that a more proactive approach could be taken. This had enabled patterns to be identified and support to be provided to individuals.

Mr Brierley considered that there could be a stronger emphasis on raising concerns in Our People Journey.

In conclusion the Chair:
(1) Observed that concerns being raised should be regarded as being positive as it reflected the willingness of staff to speak up.
(2) Reiterated that the Board wanted to be an organisation where speaking up was encouraged; where action was taken in response; and where there were no recriminations.
(3) Advised that during his visits to services he had been encouraged by the number of posters he had seen promoting awareness of the FTSUG.

22/114 LEARNING FROM DEATHS REPORT

The Board received and noted the Learning from Deaths Report for Quarter 1, 2022/23.

Mrs Moody reported that:
(1) The aim was to reach a point where the focus was on key themes rather than on individual action plans. Significant work had been undertaken by the patient safety team to identify areas of learning from the thematic review of historical serious incidents and to determine whether the actions being taken by the Trust were making a difference to patient safety and the standard of care provided. Seven key themes had been identified (listed in the report) which had been mapped against the Quality Assurance Framework.

The Board noted the progress made on the themes since April 2021 as set out in Appendix 3 to the report.
(2) There had been one inpatient death during the period, in regard to physical health, which was being reviewed under the mortality review process.
(3) A presentation had been provided to Commissioners on 22nd July 2022 from which they had taken assurance and agreed to progress the closure of historic serious incidents.

Board Members sought clarity on the following matters:

(1) How services rated communications on learning from deaths and future plans.

Mrs Moody considered there was good engagement with services. Strong relationships had been built between the reviewers of serious incidents and services and engagement though the SI panels had created greater support and participation. The establishment of the Care Groups had also improved line of sight on learning lessons.

It was noted that assurance on learning lessons was also provided through the Directors' visits.

(2) Whether the Trust received feedback on the deaths of people with learning disabilities and whether there was specific reporting to the Board on them.

Mrs Moody advised that:

(a) Feedback was now received on LD deaths. The Trust attended a regional LeDer group and an annual report had been published which would be considered by the Trust.

(b) For any unexpected LD death an internal investigation was undertaken for rapid learning.

(c) Information on LD deaths was provided in the Learning from Deaths Report which was reviewed by the QuAC prior to presentation to the Board.

Mrs Reilly asked for arrangements to be made for the consideration of the LeDer Annual Report by the Quality Assurance Committee.

Action: Mrs Moody

(3) How the contents of the report influenced the Trust's Integrated Performance Report as the latter did not provide details of serious incidents.

It was noted that:

(a) Information on serious incidents was included in the Integrated Performance Dashboard but only limited narrative was provided.

(b) The QuAC and the Care Group Boards received additional details of incidents.

(c) Discussions had been held on whether the Board needed to be sighted on all incidents.

Board Members considered that it was appropriate for the QuAC to receive detailed information on serious incidents and were content that a process was in place.

(4) The identification of record keeping and records management as separate themes arising from the historic review of serious incidents and whether they should be brought together.

Mrs Moody advised that the latter theme should have read "medicines management" and apologised for the error in the report.

Mr Kilmurray advised that that some services, for example physical health and suicide prevention, were mentioned in the report but their work was not visible to the Board. He suggested that it would be helpful to arrange Directors' visits to the services as these might support discussions on the topic in the future.

The Chair supported this approach and asked for visits to the services to be included in the programme.

Action: Mrs Bridges

22/115 REPORT OF THE GUARDIAN OF SAFE WORKING

The Board received and noted the report of the Guardian of Safe Working (GoSW) for Quarter 1, 2022/23.

Dr Boylan welcomed Dr Kale to the Trust and stated that he looked forward to working with him in the future.

He advised that:

(1) There were no substantial developments or additional concerns to bring to the Board's attention since the last report (minute 22/47 – 26/5/22 refers).
(2) Issues remained about the out of hours support for higher trainees in the Durham area and the difficulties relating to the availability of crisis team support to undertake out of hours assessments. He highlighted the management of an incident by the Senior Clinical Manager in County Durham as a good case example.
(3) The standards and processes to support Junior Doctors were being well maintained and they had opportunities to raise concerns.
(4) In addition to being the GOSW he held two other roles, in regard to providing support for senior registrars and the medical exit initiative, both of which were important for the Board to be aware of in the context of recruitment and retention.
(5) The next quarterly report would reflect the significant annual turnover in medical trainees on 1st August 2022.
(6) At present he was satisfied with the arrangements in place to support junior doctors and considered that they were working well.

The Chair thanked Dr Boylan for his report and considered that it was important for the Board to be aware of his new responsibilities.

Mr Kilmurray informed the Board that the Trust had recently held a quarterly review meeting with the Northern Deanery during which positive feedback had been received.

Clarity was sought on how the Trust was rated in terms of its attractiveness for junior doctors.

Dr Boylan responded that:

(1) The Trust was highly regarded for the quality of training it provided, as evidenced by the national survey, and this was being maintained.
(2) There were some issues concerning the conditions of senior medical colleagues, which impacted on junior doctors, and the Trust needed to address them as part of seeking to improve its overall attractiveness.
(3) Communications were in place; however, there needed to be a greater focus on the Trust's response when issues were raised.
(4) There were a number of emerging themes in regard to how the Trust compared to others and further data was required.

The Chair thanked Dr Boylan for his work and the assurances he provided to the Board.

22/116 NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE GOVERNANCE

Consideration was given to the North East and North Cumbria (NENC) Provider Collaborative governance arrangements including the formal Collaboration Agreement.

An update for Foundation Trust Boards was appended to the covering report. This provided a summary of the proposed formal structure and governance of the NENC Provider Collaborative with the creation of a Provider Leadership Board and which were underpinned by the following key documents:

(1) The "Collaboration Agreement" - a formal memorandum of agreement between the Trusts setting out how the Provider Collaborative would work.

(2) "Our Ambition" – a document setting out the aspiration and ambition that trusts had together, as a form of prospectus, which was particularly designed for partners and stakeholders.
(3) The "Operating Model" - a work programme, which would evolve over time, setting out priorities and the mechanisms for operational delivery such as capacity, workstreams and meeting structures.
(4) The "Responsibility Agreement" - a documented agreement between the Provider Collaborative and the ICB, setting out a shared view on priorities; work areas for the Provider Collaborative to take forward on behalf of the ICB; and accountabilities and resourcing.

The Non-Executive Directors:

(1) Commented that the proposed arrangements were very focussed on acute providers.

Whilst Mr Kilmurray recognised this point, he considered that there were other initiatives being progressed, for example the development of the North East North Cumbria (NENC) Mental Health and Learning Disability Collaborative, which would provide a broader focus.

He also considered that the clinical networks could be more proactive in their engagement with the Trust.

(2) Sought clarity on whether the Board would remain the ultimate decision-making body under the arrangements.

Mr Kilmurray confirmed this but reminded Board Members that the Trust had a duty to collaborate under the Health and Care Act 2022 and the Provider Licence. He considered that the Board should devote more time to this matter over the coming months.

Mr Murphy advised that he had been informed by Mr Jennings (the Chair Designate) that the document had also been considered by South Tees NHS Foundation Trust and he would be seeking wider discussions on the policy issues arising from it.

Agreed –

(1) that the progress made on the development of the NENC Provider Collaborative be noted; and

(2) that the documents setting out the Collaboration Agreement, Operating Model and Our Ambition be approved.

22/117 BOARD COMMITTEE MEMBERSHIP

Mr. Murphy reported that he was undertaking a review of the Non-Executive Director membership of the Board's Committees with a view to making recommendations to the new Chair.

It was noted that the review had not yet been completed and the changes might need to be approved under emergency powers.

22/118 ORGANISATIONAL RISK MANAGEMENT POLICY

Consideration was given to the draft Organisational Risk Management Policy.

Mrs Moody thanked Mrs Lowery, the Director of Quality Governance, for her work on developing the revised policy.

The Chair asked for explicit reference to be made in the document that risks should be managed at the appropriate level in the organisation for mitigating actions to be taken and for assurance to be given.

Mrs Moody took this on board.

Action: Mrs Moody

Clarity was sought on the definition of risk in the policy in that it could have a beneficial effect on the Trust's ability to achieve its objective.

In response it was noted that this reflected the risk appetite; the amount and type of risks that the organisation was willing to take in order to meet its objectives.

> ***Agreed*** *– that the revised Organisational Risk Management Policy, as amended, be approved.*

22/119 REGISTER OF SEALINGS

The Board received and noted the report on the use of the Trust's seal in accordance with Standing Order 15.6.

22/120 CONFIDENTIAL MOTION

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

Following the transaction of the confidential business the meeting concluded at 6.07 pm.

Board of Directors

Item 5

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.	Subject	Action	Owner(s)	Timescale	Status	Comments
31/03/2022	22/03/14/226/14.2	Outcome of the Establishment Reviews	Further updates on the Establishment Reviews to be presented to the People, Culture and Diversity Committee and the Strategy and Resource Committee	DoN&G	Nov-22		Update provided to the SRC on 17/8/22 (see conf item 7)
28/04/2022	22/15	Ockenden Report	Arrangements to be made for further assurance to be provided to the Board on the Trust's approach and the impact of changes following the Organisational Learning Group's review of the Ockenden Report	DoN&G/Co Sec	Oct-22		
26/05/2022	22/46	People Culture and Diversity Committee	Joint report to be provided to the Audit and Risk and People Culture and Diversity Committees on the outcome of counter fraud cases relating to staff working whilst on sick leave	DoP&C	Dec-22		
28/7/2022	22/107	Matters raised by Governors	Outstanding matters on the CoG action log to be progressed with the relevant Executive Directors before its next meeting.	Co Sec	Sep-22		
28/7/2022	22/111	Directors' visits	Non-Executive Directors to be included in the review of Directors' visits	DoN&G (DoQG)	Oct-22		Board report to be presented to the October Board Meeting
28/7/2022	22/113	Report of the Freedom to Speak Up Guardian	Non-Executive Directors to be provided with access to the 'follow up' e-learning module released by the National Guardian's Office	CEO	Oct-22		
28/7/2022	22/114	Learning From Deaths	Arrangements to be made for the consideration of the LeDer Annual Report by the Quality Assurance Committee	DoN&G	-		Report provided to the QuAC meeting held on 1/9/22 (see agenda item 13)

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
28/7/2022	22/114	Learning From Deaths	Teams supporting the Trust's approach to learning from deaths (physical health, suicide prevention, etc) to be included in the programme of Directors' visits	DoN&G (DoQG)	Oct-22		Board report to be presented to the October Board Meeting
28/7/2022	22/118	Risk Management Policy	Explicit reference to be made in the Organisational Risk Management Policy that risks should be managed at the appropriate level in the organisation for mitigating actions to be taken and for assurance to be given	DoN&G	-		

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO 8

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Thursday, 29 September 2022**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Information**

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

Executive Summary:

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

Recommendations:

To receive and note the contents of this report.

Care Quality Commission

The Care Quality Commission published the inspection report for the Children's and Adolescent Mental Health service. They inspected services following their earlier Section 29A notice requiring significant improvement in the safety domain.

Significant work has been undertaken regarding waiting list management, keeping in touch, caseloads and staffing since last year. It is clear that this has made a positive impact and that the CQC has been able to re-rate CAMHS as Requires Improvement in the Safety domain. Clearly, this means there is still a good deal more work to do, however I would like to put on record my thanks to staff and the leadership team within CAMHS for all that they have done to help deliver this improvement. We fully expect that the improvement will continue and further improvement will result.

Inspectors also visited Secure Inpatients Services in July. Again, this was a revisit following the Section 29A. As yet we have not yet received their report, although it is anticipated we will get the draft report for factual accuracy checking any time now.

I have previously reported that the CQC visited Adult Learning Disability services. We have now had the opportunity to complete factual accuracy checks. We expect the report to be published within the next few weeks or so. We are making good progress with the improvement plan for these services. We have made good strides in working with Merseycare following their peer review and we continue to work through our action plan to reduce restrictive interventions. We have also made progress in supporting some successful discharges of long term patients to community placements. Staffing still remains challenging. As the board knows, we have informed the CQC and commissioners that we will remain closed to admissions until the staffing situation improves and we have made more progress with our improvement plans.

We are also aware that it is likely that the CQC will begin a Well Led inspection of the Trust in the near future. It is over a year since our last inspection, so we can expect it any time.

Cost of Living Crisis

The economic situation is incredibly challenging and it is clearly very difficult for the more vulnerable members of our communities.

The role of the NHS in addressing health inequalities is gaining more attention recently and, as the cost of living crisis deepens, this has never been more important for us as an organisation. We know that poverty underpins all kinds of inequality and, though there are areas of action on poverty and financial insecurity that fall beyond the scope of our organisation and indeed the wider NHS, there is much that we can do address both the causes and consequence of poverty both directly and in partnership.

One way we can make a different is through “Poverty Proofing” our services. The mission of poverty proofing is to ensure that ‘no activity or planned activity should identify, exclude, treat differently or make assumptions about those whose household income or resources are lower than others’. Poverty proofing began with Children North East’s (CNE) Poverty Proofing the School Day programme 10 years ago. It has been developed by CNE through the voice of children and young people, to identify barriers to learning and engagement within the school day as a result of poverty (more info here https://children-ne.org.uk/how-we-can-help/poverty-proofing-services/).

This work is now being built up on within health care settings and we are partnering with CNE to pilot this approach in our CAMHS Single Point of Contact and South Tees Getting Help Teams. The process of Poverty Proofing Health Settings will offer us insight and awareness of the challenges that individuals face in accessing, attending, or engaging with us so we can make (often simple) changes and adjustments in respond to these barriers and inequities. The process involves training staff on poverty awareness and having a poverty proofing coordinator engaging individually with all member of the team to gain their insights on how poverty impacts of people access, experience and outcomes within our services.

The most crucial part of the process which is the gathering of lived experience insights is currently underway. This will culminate in a set of recommendations from Children's North East to the Trust. We are looking forward to receiving their report in the Autumn and looking at what might be rolled our more widely.

There are also concerns about the impact of how the current situation is impacting on our staff. We have asked the Pay and Workforce sub-group of our Joint Consultative Committee to take a lead on co-ordinating our response to this. There are a number of ideas that are being worked up including connecting staff to expert financial advice and guidance, signposting to community resources, school supplies banks, giving all staff an NHS discount card, working with chaplaincy services to offer a Helping Hands service, which provides practical support to colleagues in financial crisis.

We will keep the board up to date with this work.

University of York – Institute of Mental Health

The University will launch a brand new Institute of Mental Health on 10th October (World Mental Health Day). Kedar Kale and I are looking forward to meeting the inaugural Director of the Institute before the launch. Prof Lina Gega, the Director works clinically as a Senior Nurse Consultant with TEWV and is enthusiastic about the partnership between us and the new Institute, the ability to further our research work and work across the 35 university departments whose work is relevant and applicable to mental health. We look forward to having further discussions with Lina and her team. There will be a number of large, externally focussed events linked to the York Fesitval of Idea next June anchored around the Institute that we would hope to play a big part in.

Our Journey to Change Conference

As a mark of respect for the national period of mourning following the sad death of HM Queen Elizabeth II we took the decision to stand down our two day conference on 13th and 14th September. Whilst this was clearly the right decision it was disappointing as the Chris Lanigan and Sarah Smith and colleagues had worked extremely hard to put together a really interesting programme to stretch and challenge our thinking.

It is going to be difficult to reschedule the whole event again, so we are currently looking at options at how we can re-schedule as much of the content as possible. We are currently working with speakers to record contributions that we can use in other events over the coming few months. We hope to use these recordings to stimulate discussions with our invited audiences.

We will advise the board as soon as possible on our proposed plans for this.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report

Report Date: 29th September 2022	**Report of: The Audit and Risk Committee (ARC)**
Date of last meeting: 8th September 2022	**Membership Numbers: 4** Quoracy met -100%

Agenda: The Committee considered the following matters:

A Position Statement on the Operation of the Risk Groups.
An update from the Executive Risk Group.
The Corporate Risk Register.
The Board Assurance Framework.
An assurance report on the NHS England Core Standards for Emergency Preparedness, Resilience and Response
An assurance Report that the long-standing issues in regard to patient property, money and valuables; safety alerts and training needs analysis are being given sufficient attention by the Executive Team.
Improving NHS Financial Sustainability – Are you getting the basics right?
The Counter Fraud Progress Report.
The Internal Audit Progress Report.
The Auditors' Annual Report for 2021/22.
A Report on the Performance of the External Auditors during 2021/22, prior to submission to the Council of Governors.
The External Audit Progress Report.
The Committee's Assurance Tracker

2a	**Alert**	The Committee wishes to alert the Board to the following issues: The Committee were appraised of the need to complete the self-assessment tool on Improving NHS Financial Sustainability, which is intended to help finance teams and Boards review the core elements that should be in place to support board assurance over the organisation's financial position and to identify where improvements are needed to drive financial sustainability. The report was for information at this stage and once complete will be reviewed by AuditOne and will be reviewed by the Audit & Risk Committee in December 2022 and subsequently any recommendations will be reported to the Board. The Counter Fraud Progress Report 2021/22 work plan highlighted that there are three tasks outstanding relating to local proactive exercises (LPE's) within the areas of 'Anti-Bribery Management Systems (AMBS)', Contract Management and ERostering/Timesheets. As at the 31st of August 2022 there were six historic overdue recommendations requiring follow up action and due to staff resource issues, one task in the 2022/23 counter fraud workplan has exceeded its deadline. This will be included for the December 2022 ARC meeting.
2b	**Assurance:**	The Committee wishes to draw the following positive assurances to the attention of the Board: **NHS England Core Standards for Emergency Preparedness, Resilience and Response** The self-assessment on the position against the NHS Core Standards, Emergency Preparedness, Resilience and Response (EPRR), which demonstrated that the Trust can effectively respond to emergency

		planning and business continuity incidents whilst maintaining services to patients. A report was presented to the Committee providing assurance that the long-standing issues regarding patient property, money and valuables; safety alerts and training needs analysis are being given sufficient attention by the Executive Team. In relation to Safety Alerts the Quality Assurance Committee has asked for a report outlining progress.
2c	**Advise:**	The Committee wishes to advise Members of the Board that: All Risk Groups are now established (Executive Risk Group and Care Group Risk Groups). Further work to embed the arrangements is required. There will be a review of the new structures during quarter 3 2022/23 and a report is scheduled for ARC to discuss the findings. The Committee drew on assurances from the increasing focus of identifying and mitigating risk shown in the feedback provided by the Executive Sub-Groups and Risk Sub-Groups to the Care Group Boards. Development of a future work plan for the Group will include checks on the impact of mitigating actions for sustainability and a programme of deep dive work will form part of the next steps. The Committee took assurance from the current management of the 15+ risks and the plans to operationalise the new Organisational Risk Management Policy, including clear processes and responsibilities, short term training needs and system development, as well as longer term planning of the overall framework. The Committee was satisfied with the progress being made on the development of the BAF. The CQC action plan has highlighted that 7 of the 8 actions relating to the BAF are considered to be completed and the remaining action to align the BAF to the business cycles of the Board's Committees is outstanding. Further work is ongoing to strengthen the interface between the BAF and Corporate Risk Register and to look at triggers for reducing scores with forward trajectories to be set. Plans are in place for the Sub-Committees' business cycles to be refreshed and aligned to the BAF. The Committee received assurance from the Internal Audit Progress Report on the completion of nine audits and two draft audit reports with three audits to be completed during September 2022. Two final reports have been issued which include reasonable assurance on Risk Management and Training Needs Analysis – Mandatory Training. A change was approved by the Committee to the Internal Audit Plan, linked to HFMA Financial Sustainability Checklist/Q2 Continuous Testing, which means that there will be continuous testing of key finance and payroll controls for Q2 transactions combined with Q3 with a scheduled date for completion in January 2023. The Performance of the External Auditors during 2022/23 was satisfactory. The Auditor's Annual Report was received and noted. The Assurance Tracker has been reset for the 2022/23 audit year. This now reflects the findings of the benchmarking exercise undertaken by the Internal Auditors on audit committee agendas. The receipt of the benchmarking report from Audit One on Audit Committee agendas will help inform the review of the Audit & Risk Committee's terms of reference.

2d	**Review of Risks** The Committee was satisfied with the progress being made in relation to risk management and the implementation of the Risk Management Policy.	
3	**Actions to be considered by the Board:** Following the receipt of satisfactory assurances, there are no specific actions to be considered by the Board. **Recommendation:** that the report of the Audit & Risk Committee, from its meeting held on 8th September 2022 be noted.	
4	**Report compiled by**	*John Maddison, Chair of Committee, Donna Keeping, Corporate Governance Manager*

ITEM NO. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th September 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.

Please note that the risk gradings have been amended in accordance with the new Organisational Risk Policy.

Recommendations:

The Board is asked to receive and note this report.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade *(Score Change since last BoD Meeting)*	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**	**High**	**Good** ↑	Level of exposure not acceptable Strengthening of controls required at pace	▪ Public Item 8 – Chief Executives Report ▪ Public Agenda Item 12 – Board Integrated Performance Dashboard ▪ Public Agenda Item 13 – Quality Assurance Committee Key Issues Report ▪ Public Item 14 – 'Hard Truths' Nurse Staffing Report ▪ Public Item 17 – Establishment Review ▪ Public Item 18 – Equality Standards ▪ Public Item 19 – Medical Revalidation ▪ Public Item 20 – RIDDOR 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	**MD (DTV&F)**	**High**	**Reasonable**	Opportunities to improve controls; however, new controls (if available) are required to reduce exposure	▪ Public Agenda Item 12 – Board Integrated Performance Dashboard ▪ Public Agenda Item 13 – Quality Assurance Committee Key Issues Report
3	✓			**Involvement and Engagement** A fragmented approach to service user and carer engagement and involvement might prevent us from co-creating a great experience	**DoC&I**	**Moderate** ↓	**Good**	Present controls are operating effectively 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**	An acceptable level of exposure can be achieved Strengthening of controls is required, at pace	▪ Public Agenda Item 12 – Board Integrated Performance Dashboard ▪ Public Agenda Item 13 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 15 – Mental Health Legislation Committee Key Issues Report ▪ Public Agenda Item 16 – CQC Action Plan Progress Report ▪ Confidential Agenda Item 3 – Reportable Issues Log

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**	**Good** ↑	Controls are, generally, operating effectively Further strengthening, through the delivery of mitigations, is required at pace to reduce exposure.	▪ Public Agenda Item 12 – Board Integrated Performance Dashboard ▪ Public Item 14 – 'Hard Truths' Nurse Staffing Report ▪ Public Agenda Item 16 – CQC Action Plan Progress Report ▪ Public Item 17 – Establishment Review ▪ Public Item 18 – Equality Standards ▪ Public Item 19 – Medical Revalidation ▪ Public Item 20 – RIDDOR Report
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	**DoN&G**	**High**	**Good**	Controls are, generally, operating effectively. Further strengthening, through the delivery of mitigations, is required at pace to reduce exposure.	▪ Public Agenda Item 12 – Board Integrated Performance Dashboard ▪ Public Agenda Item 13 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 15 – Mental Health Legislation Committee Key Issues Report ▪ Public Agenda Item 16 – CQC Action Plan Progress Report ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 6 – Independent Review Report
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**	**Moderate** ↑	**Good**	The risk is being managed within acceptable limits and controls are. Generally. operating effectively. Continued delivery of mitigations is required to achieve target score.	▪ Public Agenda Item 12 – Board Integrated Performance Dashboard
8	✓	✓	✓	**Cyber Security** A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage	**DoF&I**	**High**	**Reasonable**	Ongoing strengthening of controls required due to the constantly evolving nature of the risk.	
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	**CEO**	**High**	**Good**	Controls considered to be operating effectively and scope for improvement is limited High degree of exposure	▪ Public Agenda Item 8 – Chief Executive's Report ▪ Public Agenda Item 13 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 16 – CQC Action Plan Progress Report

				ref. 11 – Governance and Assurance)				will need to be accepted Regular monitoring of the risk advisable.	▪ Public Agenda Item 16 – CQC Action Plan Progress Report ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report
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**	**Moderate** ↓	**Substantial** ↑	The risk is within acceptable limits. Controls are operating effectively	▪ Public Agenda Item 8 – Chief Executive's Report ▪ Confidential Agenda Item 4 – Chief Executive's Report ▪ Confidential Agenda Item 9 – Commissioning Committee Update
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 exposure will remain higher than acceptable Regular monitoring of the risk advisable	▪ Public Agenda Item 13 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 15 – Mental Health Legislation Committee Report ▪ Public Agenda Item 16 – CQC Action Plan Progress Report ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – 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**	**High**	**Good** ↑	The level of exposure is not acceptable Urgent action is required	
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**	**High**	**Good**	Opportunities to strengthen controls but this will have a limited impact due to third party decision-making. Exposure above acceptable levels will need to be accepted.	
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale	**DoFI**	**High** ↑	**Good**	Whilst controls are, generally, considered to be operating effectively	▪ Confidential Agenda Item 4 – Chief Executive's Report ▪ Confidential Agenda Item 7 – Strategy and

				will delay its benefits for patients and staff				further strengthening is required at pace, through the delivery of identified mitigations, to reduce exposure	Resources Key Issues Report ▪ Confidential Agenda Item 8 – CiTO Update
15	✓	✓	✓	**Financial Sustainability** Failure to gain a fair share of resources for the Trust and mental health could impact on the delivery of Our Journey to Change and the sustainability of services	**DoFI**	**High**	**Reasonable**	Urgent action is required to strengthen controls, where practicable due to national/regional constraints, to reduce exposure	▪ Public Agenda Item 12 – Board Integrated Performance Dashboard ▪ Confidential Agenda Item 7 – Strategy and Resources Key Issues Report

ITEM No.11

Trust Board

DATE:	29th September 2022
TITLE:	Corporate Risk Register
REPORT OF:	Kendra Marley, Head of Risk Management
REPORT FOR:	Assurance

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

Executive Summary:

Purpose

To ensure the Board has been clearly sighted on those high risks that have an organisational wide impact reflected in the Corporate Risk Register.

Key Highlights

The Corporate Risk Register is reviewed and approved by the Executive Risk Group.

This paper presents to the Board the 15+ risks on the Corporate Risk Register as of 1st September 2022.

The work undertaken last month to update 15+ risks has resulted in significant downward movement in risks from the corporate risk register with 14 removed, although these will be quickly replaced by new and increased risks of 15+ once reviewed and approved by the Executive Risk Group.

This work undertaken across the Care Groups and Directorates has also resulted in good risk review compliance with the majority of actions now also being up to date.

There are 23 risks currently on the Corporate Risk Register, this is a decrease of 14. The 14 risks removed include 4 closed and 10 reduced risks.

This does not yet include new or increased risks of 15+ which have been added in the intervening period and were reviewed and challenged or agreed by the Executive Risk Group on the 20th September. These will be reflected in future papers.

Recommendations:

The Trust Board are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Take assurance over the ongoing management of risk.

MEETING OF:	**Trust Board**
DATE:	**29th September 2022**
TITLE:	**Corporate Risk Register**

1. Introduction and Purpose

To ensure the Board has been clearly sighted on those high risks that have an organisational wide impact reflected in the Corporate Risk Register.

The Corporate Risk Register is reviewed and approved by the Executive Risk Group. This paper presents to the Board the 15+ risks on the Corporate Risk Register as of 1st September 2022.

This does not yet include new or increased risks of 15+ which have been added in the intervening period and were reviewed and challenged or agreed by the Executive Risk Group on the 20th September. These will be reflected in future papers.

2. Background Information and Context

The Trusts Organisational Risk Management Policy was approved by the Board in July 2022, and clearly sets out the responsibilities of the Trust Board;

- Responsible for ensuring the Trust has effective systems for managing risk.
- Receipt of the Corporate Risk Register.

3. Purpose of the Corporate Risk Register

The Corporate Risk Register should be reflective of the highest risks affecting the organisation in the delivery of its objectives. It should also enable the Board to easily understand the highest risks that they need to be aware of. Currently the Trust include all risks at a score of 15 or more on the Corporate Risk Register.

At the meeting of the Executive Risk Group on 20th September it was agreed to change the composition of the Corporate Risk Register, moving away from the automatic inclusion of 15+ risks, to a Corporate Risk Register that is drawn from the 15+ registers but contains only high level organisational risks or risks that although specific to a team or service have a direct impact on an organisational objective or would have an organisational impact if the risk materialised (for example where reputational).

This will ensure that the Board and its Committees have clear sight of those risks impacting on strategic goals, while removing duplicative team and service level risks that link to higher level risks already reflected. Risks will be aligned to the Board Assurance Framework.

The Executive Risk Group will continue to review all risks on the Corporate Risk Register as well as those at 15+ that are not included.

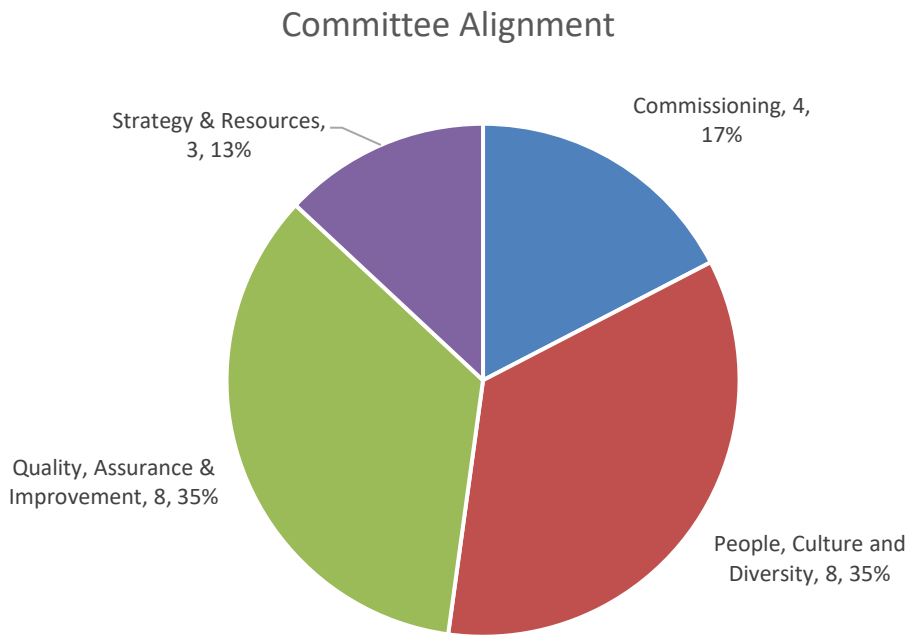
4. Current Corporate Risk Register

As of 1st September 2022, there were a total of 23 risks on the Corporate Risk Register, a decrease of 14. These form the main register that is reported to the Board and Committees. This does not include new or increased risks of 15+ which have been added in the intervening period until they have been reviewed and agreed for inclusion by the Executive Risk Group.

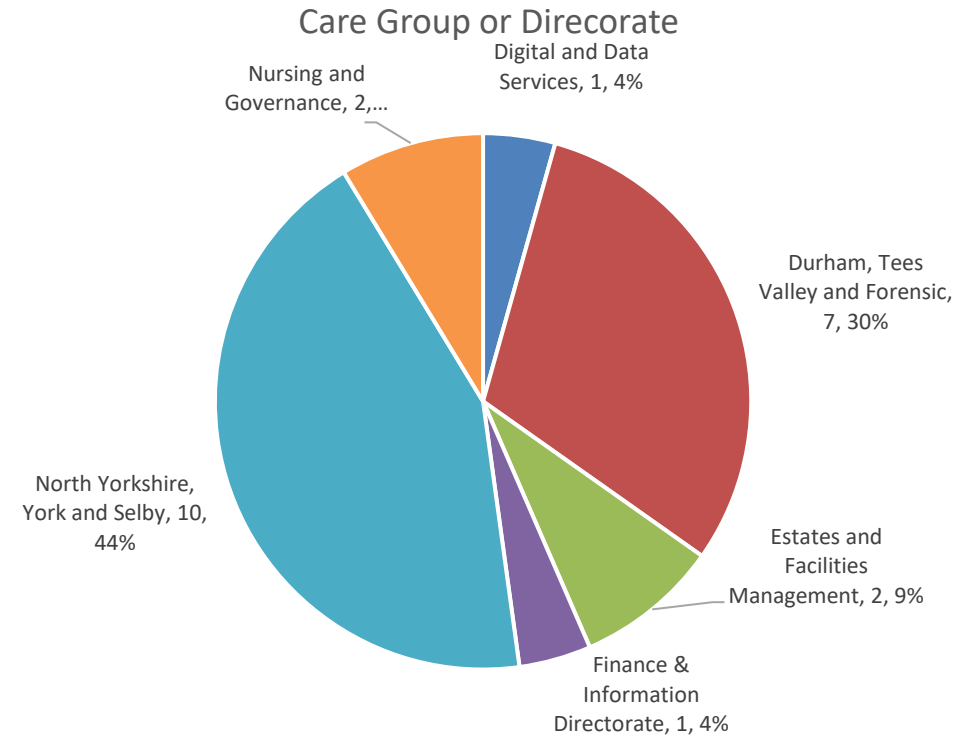
Existing15+ risks were reviewed as part of initial rapid review, with a focus on descriptions, scoring and ensuring both risks and actions were updated. Further detailed work on 15+ risks

will be undertaken going forward to ensure they accurately reflect the risk, controls in place and appropriate mitigations identified.

The current risks on the register align to the main Board Committees as shown in the following chart. This shows that there is an even split between Quality Assurance Committee and People, Culture and Diversity Committee both with 35% of the risks, with Commissioning Committee at 17% and Strategy and Resources Committee at 13%

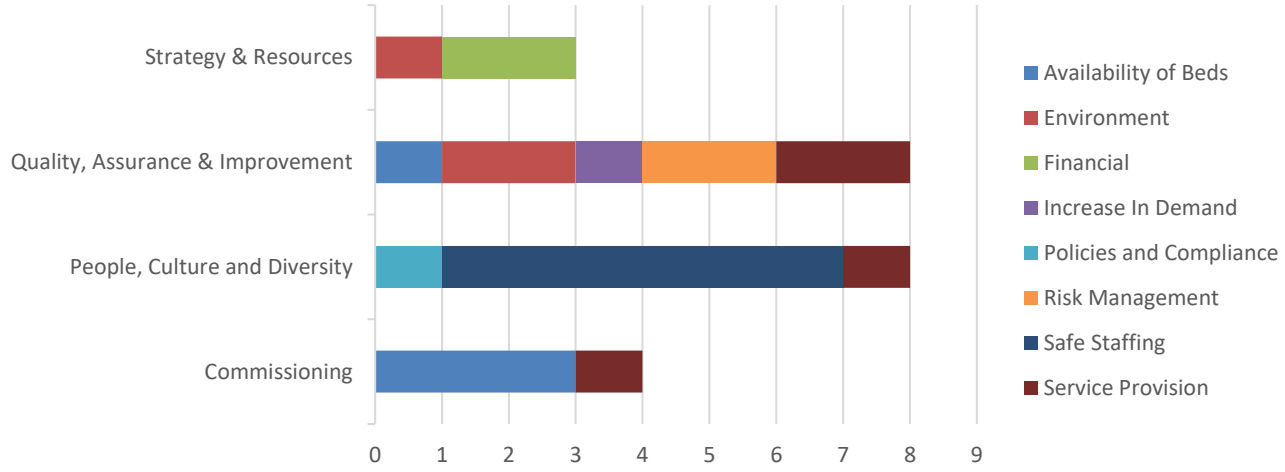


Focussing on the Care Group and Directorate breakdown shows us that 44% of the current corporate risk register is made up of risks from North Yorkshire York & Selby Care Group and 30% from Durham Tess Valley and Forensics Care Group.



4.1 Risk Themes

The 23 risks fall under the following themes within the Committee Alignment.



The below table shows the changes in the period.

Themes	Commissioning	People, Culture and Diversity	Quality, Assurance & Improvement	Strategy & Resources	Total	Change/ previously	
Availability of Beds	3		1		4	↓	6
Environment			2	1	3	↔	3
Financial				2	2	↔	2
Increase In Demand			1		1	↓	2
IT Systems					0	↓	2
Policies and Compliance		1			1	↓	7
Risk Management			2		2	↓	3
Safe Staffing		6			6	↓	7
Service Provision	1	1	2		4	↓	7
Total	4	8	8	3	23		37

With the removals of risks there has been downward movement in most categories, some quite significantly, however new additions coming through may counteract this.

4.2 Risks Downgraded or Removed from the CRR

There were 14 risks either closed or reduced following the targeted review. These are shown in the following table for information. Following detailed review by the Executive Risk Group on 20th September, additional information is being sought for some of these to support the changes.

Closed Risks (4)

Committee	Risk	Date Identified	Locality & Service	Risk	Change
Quality Assurance	705	14/03/2019	Chief Operating Officer	T-CA4-705 There is a risk that there is ongoing negative impact on the reputation of the organisation due to the CQC's decision to remove registration for inpatient services at West Lane Hospital. This may result in lack of confidence from stakeholders, negative press coverage and financial penalties, all which will impact on staff welfare/increase staff sickness and difficulties in recruitment.	Closed – CTNW now provide
People, Culture & Diversity	1028	06/01/2021	DTV&F – D&D AMH	There is a risk that we may be unable to safely deliver crisis services across D&D due to current service model and increased demand resulting in poor response times and potential harm to patients, staff wellbeing and increased sickness.	Closed – linked to risk 1244
People, Culture & Diversity	1057	03/03/2021	DTV&F – DD AMH	There is a risk that if we are unable to recruit to existing and new posts that we will be unable to deliver services to the contractual agreements, maintain quality and safety and that this will impact negatively on staff wellbeing and retention. The service has experienced difficulties in recruiting into Registered Nursing, Psychology, OT and Medical posts which has created gaps in the workforce.	Closed – replaced by new staffing/ recruitment risk across CG
Strategy & Resource	1117	01/04/2021	Finance and Information Directorate - Information	Cause: There are environmental concerns regarding Oak Rise's ability to meet required compliance standards as an LD Assessment and Treatment Unit. Similarly there are concerns about relational risks associated with the site, giving it's remote location in comparison to other sites and the impact this has on the ability to access additional support, particularly out of hours. Oak Rise also has a diminishing core staff team due to people leaving combined with difficulties recruiting to vacancies. Combined there are significant concerns about the ability of Oak Rise as a unit to provide safe care to service users in the setting.	Closed – formal decision not to open Oak Rise

Downgraded Risks (10)

Committee	Risk	Date Identified	Locality & Service	Risk	Change
Quality Assurance	612	11/07/2018	DTV&F – D&D AMH	There is a risk if the D&D locality do not manage the bed flow that D&D patients will be admitted out of locality, possibly impacting on patients' recovery and patient experience. There is also a risk that the additional work linked to the high level of OOA patients admitted into D&D beds, creates additional pressure on ward staff and the wider MDT which impacts staff wellbeing, retention and recruitment of staff.	Reduced from 16 to 12.
Quality Assurance	646	19/07/2018	Nursing & Governance Directorate	There is a risk that 'repeat' patient safety events may occur due to delays in/ lack of identifying, actioning and embedding learning from patient safety events and deaths resulting in the	Reduced from 20 to 12 – assessment of controls in place and

Committee	Risk	Date Identified	Locality & Service	Risk	Change
				occurrence of harm to patients that could potentially have been prevented.	assurances in terms of improvements
Strategy & Resource	787	06/09/2019	Digital & Data Services	The number of no finds for records when requested from Restore has increased from 5 in 2016 to 71 in the year to date (2019). This means that there are 71 requests for information that have not been fully actioned because the records are not where we thought they were. CAUSE: Records are not accurately registered which makes locating them very difficult. EVENT: Records are requested for Subject Access Requests and we are increasingly having to inform patient and staff that we cannot find their records. This could lead to a breach of the DPA and increased complaints. Impact: This is a breach of DPA in several areas and could ultimately result in Litigation claims and an ICO fine.	Reduced from 15 to 9 – actions implemented and reduction in 'no find' incidents
People, Culture & Diversity	806	07/10/2019	Corporate Affairs and Involvement	There is a risk that inappropriate information relating to staff posted on social media may not be removed/ removed timely due to challenges in getting these removed by the media sites involved resulting in a negative impact on the staff members health and wellbeing and organisational reputation.	Reduced from 15 to 9 – controls effective
Strategy & Resource	937	10/06/2020	Finance and Information Directorate - Information	There is a risk that sensitive or confidential data is accessed by those without relevant or legitimate (legal) access due to storage of data on spreadsheets or other local systems with no appropriate governance resulting in the potential for; data breaches, non-compliance with Caldicott principles, malicious use of data against patients, staff or the organisation, compromising safety, reputational damage and financial penalties.	Reduced from 16 to 12 – following review of the controls in place.
Strategy & Resource	1007	26/11/2020	DTV&F – H&J	There is a risk to patient care and staff access to TEWV systems in the prisons. TEWV staff are unable to access Datix and IIC meaning incidents cannot be entered in a timely manner Impact – No access to trust applications including datix, IIC etc meaning incident reports and performance cannot be effectively managed. Impact on staff time contacting IT to attempt to resolve issues • Delays in eliciting team performance updates from IIC ensuring all staff are up to date and complying with Mand/Stat & role based training plus appraisals, and/or undertaking the required online training • Delays in updating the Prison Teams Performance Reports Staff are unable to access DATIX on site HMP Haverigg are unable to access the prison S drive (managed by Spectrum).	Risk reduced from 20 to 9 – access to datix now in place

Committee	Risk	Date Identified	Locality & Service	Risk	Change
				There are issues in Westgate relating to Office 365 licences (cannot create and save care plans)	
Quality Assurance	1088	22/04/2021	Nursing & Governance – Quality Governance	Following a responsive visit by the CQC to AMH inpatient services it was identified that Trust clinical risk assessment and management processes were complex leading to a lack of consistent application and understanding which could pose a risk to patient safety.	Reduced from 15 to 12 – QA assurance tools indicate good progress
People, Culture & Diversity	1140	07/06/2021	DTV&F - Tees AMH	Due to a number of nurse staffing vacancies and reduced clinical experience in the Psychosis Team the ability to complete patient pathways and statutory requirements in a timely manner e.g. completion of timely Tribunal reports and the clinical decision to undertake MHA Assessments may be compromised this could pose a risk that patient care and service delivery.	Reduced from 15 to 12 following review of roles, caseload and management reviews
Quality Assurance	1239	19/05/2022	NYYS - MHSOP	There is a risk that NYY AMH patients may be admitted to MHSOP wards due to challenges accessing AMH beds resulting in a reduced experience for AMH patients not being clinically managed by an AMH in-patient team, impact on MHSOP patients and staff, potential increased length of stay and difficulty managing two specialties within the ward environment.	Reduced from 16 to 9 as daily sitrep and bed escalation process now in place
People, Culture & Diversity	1149	13/09/2021	DTV&F – Tees AMH	Due to staffing pressures created by vacancies, maternity leave, long term sick and caseload increases there is a risk that patients will not be allocated to a care coordinator or lead professional this could compromise patient safety and quality of care.	Reduced from 20 to 9 - wing based patients can now be seen by 1 clinician. Issue remains in healthcare outpatients

4.3 Risk and Action Review Compliance

The new policy includes appendices that outline the process in more detail, including the timing of risk review. This is shown below:

Risk Level	Review Frequency
15 or above	Monthly
12	Bi-Monthly
8 to 10	Quarterly

Of the risks on the corporate risk register, the work undertaken in August to update all 15+ risks resulted in all being up to date at 1 September 2022, and only 4 of the 52 open actions are past their due date (and only just as due end August), although a number were extended when reviewed August 2022 as part of the rapid review work.

Monitoring and reporting of review compliance, including action delivery compliance will be built into reporting processes going forward.

5. Risk Management Systems

Following review of the current system and its configuration, this does not meet the basic requirements that we need, and modifications will need to be made to change this and implement workarounds until it can be replaced.

While a replacement is planned, with the main driver being the national requirement to have a LFPSE (Learning from Patient Safety Events) compliant system, from a risk management perspective this needs to provide a robust system to support the management of risk registers and associated reporting, but also as a wider functionality enabling the triangulation of risk and assurance data from Ward to Board.

6. Implications

6.1 Compliance with the CQC Fundamental Standards

There is the potential of compliance implications with regulation 12- Safe Care and Treatment and regulation 17- Good Governance if risks are not managed effectively.

6.2 Financial/Value for Money

There is the potential of financial implications if risks are not managed effectively.

6.3 Legal and Constitutional (including the NHS Constitution)

There is the potential for non-compliance with legislation if risks are not managed effectively.

6.4 Equality and Diversity

Ensuring that patients have equal access to services means all risks impacting on the quality of these services should be effectively managed and mitigated.

6.5 Other implications

Risks may impact on all areas of the Trusts business, including contractual obligations, safety and quality, staff safety and wellbeing, and delivery of objectives.

7. Risks

This paper includes organisation risks of 15+ and these are detailed in the Corporate Risk Register.

8. Conclusions

The work undertaken last month to update 15+ risks has resulted in significant downward movement in risks from the corporate risk register with 14 removed, although these may quickly be replaced by new and escalated risks in the interim period which are being reviewed by the Executive Risk Group. This has also resulted in good risk review compliance and the majority of actions being up to date.

The current system and its configuration is not suitable for our needs and work will needed to address this and implement workaround until it can be replaced.

9. Recommendations

The Trust Board are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Take assurance over the ongoing management of risk.

Kendra Marley - Head of Risk Management

September 2022

Committee	ID Date Identified Date reviewed	Location/ owner	Type/ sub/ theme	Description	IRR	What mitigating controls already in place	Details of gaps in controls	Assurances to monitor effectiveness of controls	CRR	Description	Due date	Action Owner	TRR
CC	**276** Date ID - 15/06/2016 - Date last reviewed - 10/08/2022	Durham, Tees Valley and Forensic - DTV&F Adults - Dominic Gardner	Operational - Service Delivery - Availability of Beds	There is a risk that we may be unable to admit DTV patients due to bed unavailability as a result of (over) occupancy levels, resulting in patients being admitted out of area potentially affecting treatment pathway, patient experience.	**15**	Trust performance framework Daily bed management teleconference Occupancy and acuity to be monitored through daily SITREP	Demand is 24/7 and limited beds Trust-wide to meet demand Trust-wide lack of visual live bed state to support admission processes lack of knowledge as to increased length of stay and impact of PIPA process.	17/2 - quag update Occupancy has remained above 100% since April last year. The additional pressure of opening Holgate and closure of other units in the Trust continues to put pressure on Tees. Use of private beds is also at full capacity. Feb-22 - 105.52% Mar-22 - 104.15% 17/3/ - Quag update Overdale occupancy rate 140% (High levels of Leave and use of swing beds). No change to risk rating. Esk ward due to open in May 2022 Apr-22 RPH AMH Acute Bed Occupancy 111% May-22 RPH AMH Acute Bed Occupancy 109% Jun-22 RPH AMH Acute Bed Occupancy 111% July - This is now a risk managed across DTV rather than just Roseberry Park Hospital, so will now include 8 acute wards (as PICU now included). Occupancy is at 106% for the month of July	**15**	Provide education and training to new clinical leaders on PIPA processes	09/09/2022	Hayley Stewart	**3**
										Continue development of central bed management team in line with planned phase 2 of project plan	23/09/2022	Simon Lancashire	
										Processes to monitor and progress to discharge inpatient stays of more than 90 days and delayed discharges to be evaluated for impacts	09/09/2022	Hayley Stewart	
										Develop an electronic live visual bed state in conjunction with IT and our digital journey to change	31/10/2022	Simon Lancashire	

Committee	ID Date Identified Date reviewed	Location/ owner	Type/ sub/ theme	Description	IRR	What mitigating controls already in place	Details of gaps in controls	Assurances to monitor effectiveness of controls	CRR	Description	Due date	Action Owner	TRR
SRC	**295** Date ID - 08/09/2016 - Date last reviewed - 11/08/2022	Estates and Facilities Management - Estates - Liz Romaniak	Corporate - Safety/Security - Environment	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	**15**	MIST system now installed into roof voids of all in patient areas to safeguard and reduce fire load and spread of flame until rectification works complete. Block 16 (decant) construction now complete. Phase 1 practical completion achieved, commissioning underway (blocks 5 & 10). Week. Phase 2 programming and procurement options are in train.	Agreed programme of works which resolve all the defects in the design and construction of Roseberry Park Hospital. Unknown quantum and type of defects in individual occupied blocks.	Weekly huddles take place to oversee progress of rectification works. RPH sub-group of the board convened as needed to oversee progress with regular CEO briefings to the board.	**15**	Achieve contract resolution to the satisfaction of the Trust	30/11/2022	Simon Adamson	**10**
										Determine most appropriate route to defect rectification (complete phase 1 and identify phase 2 programme)	31/01/2023	Simon Adamson	
CC	**532** Date ID - 27/02/2018 - Date last reviewed - 05/08/2022	Durham, Tees Valley and Forensic - Secure Inpatient Service (SIS) - Naomi Lonergan	Operational - Service Delivery - Service Provision	There is a risk that patients in the secure service may continue to have extended lengths of stay and/or delayed discharges due to the lack of CCG and Local Authority provided single occupancy/bespoke accommodation for individuals with complex challenging presentations including Autism/LD/PD, resulting in delayed transfers of care, the number of patients waiting for a bed, and a negative impact on patient experience.	**20**	Weekly internal bed management meetings Weekly Provider Collaborative bed management meetings Weekly DTOC reporting Bi-weekly Provider Collaborative senior operational group meetings	MM ruling still impacting and there is no regional/national resolution Appropriate community placements is limited	The Bed Management process and the Care Navigators continue to review and monitor discharge plans for all inpatients. This will be reported through bed management and local governance processes. Weekly performance meetings will ensure DTOCs are monitored and formal escalation takes place appropriately.	**16**	To take to DTOC paper to QAIG	08/09/2022	Richard Hand	**12**
										Participate in the Regional project through North East North Cumbria (NENC)	13/09/2022	Naomi Lonergan	
										Delayed Transfers of Care (DTOCs) to be reviewed across the service.	07/10/2022	Richard Hand	
										For bed management kaizen to be completed	13/09/2022	Richard Hand	

Committee	ID Date Identified Date reviewed	Location/ owner	Type/ sub/ theme	Description	IRR	What mitigating controls already in place	Details of gaps in controls	Assurances to monitor effectiveness of controls	CRR	Description	Due date	Action Owner	TRR
QAC	**785** Date ID - 06/09/2019 - Date last reviewed - 15/08/2022	North Yorkshire, York and Selby - NYY&S MHSOP - Bridget Lentell	Operational - Service Delivery - Increase In Demand	There is a risk due to waiting times for memory services. Demand has outstripped capacity within finite resources, resulting in potential patient deterioration, strain on carers, impact on patient, families and staff and breach of RTT (Referral to Treatment) targets.	**15**	People waiting are prioritised according to changing need and not length of wait.Dementia coordinators placed in some GP practices ensuring more appropriate referrals sent from GPs and early advice and signposting provided to patients/carers before they enter services/assessment.Harrogate memory: York memory; b7 staff sharing diagnosis in MDT without consultantIncreased MDT approach. Pilot - working with GPs to assist them to make/share diagnosis. Clinics being provided to improve access in Wetherby and Ripon. Wetherby commenced. Ripon shortly. Exploring the use of briefing assessment process (DIADEM) for a cohort of patients. Recruited with CCG spending review monies - b6 nurse + team manager for 2 memory teams. Teams routinely make contact with patients by telephone during wait time in order to triage, check patient	Even with Extra hours the capacity is not meeting demand. Needs a system wide approach to understand capacity and demand plus options to improve current situation	Memory Service Dev group now established to monitor risk and review internal management/ mitigations of long waits, such as greater MDT diagnosis.Number of people waiting for initial assessment to be reported to QUAGAverage time waiting for initial appointment to be reported to QUAG if over 4 weeks.Dementia diagnosis ratesComplaints	**15**	Senior Leadership Team time out to discuss what can be stepped back in order to rescope our current model of provision	30/11/2022	Bridget Lentell	**3**

Committee	ID Date Identified Date reviewed	Location/ owner	Type/ sub/ theme	Description	IRR	What mitigating controls already in place	Details of gaps in controls	Assurances to monitor effectiveness of controls	CRR	Description	Due date	Action Owner	TRR
						safety and prevent unnecessary deteriorationCriteria for triage has been reviewed in order to accurately assign patients to appropriate team without delay.							
QAC	**903** Date ID - 01/06/2020 - Date last reviewed - 11/08/2022	Estates and Facilities Management - Estates - Simon Adamson	Corporate - Safety/Security - Environment	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, resulting in severe harm/death to	**15**	Suicide Prevention and Environmental Risk Assessment Procedure Supportive Engagement and Observation Policy Harm Minimisation Policy (Risk Assessment and Management)	Known risks within clinical services have been assessed and mitigating actions are in place. However, there remains the possibility that patients may create ligatures without an anchor point which could cause severe	1.Harm minimisation training show high levels of competency. 2.Suicide prevention survey and risk assessment procedure log demonstrates that the majority of individual teams have been reviewing their	**15**	Implement phase 2 of the ligature reduction programme	30/09/2022	Simon Adamson	**10**

Committee	ID Date Identified Date reviewed	Location/ owner	Type/ sub/ theme	Description	IRR	What mitigating controls already in place	Details of gaps in controls	Assurances to monitor effectiveness of controls	CRR	Description	Due date	Action Owner	TRR
				patients and significant distress to families and staff, and impact on organisational reputation.		Environmental Risk Group Care Rounds Body Camera pilot Oxehealth (extension of installation on further wards agreed) Significant investment in staffing MDT Report Out Individual Safety Summaries Team Risk Logs Estates Work Log System Capital Work Programme Capital Investments Group Capital Planning Group Harm Minimisation Training Programme RPIW risk documentation and guides for staff Monthly reporting to the Quality Assurance and Improvement Group Contractual meetings with contractors to monitor the programme of estates work.	harm and or unexpected death. Limitations have been identified in relation to detailed knowledge of all ligature points amongst some staff. CQC inspections of Acute AMH and PICU wards undertaken in January 2021 highlighted gaps in relation to risk assessment documentation and management.	surveys and they include risk mitigation. 3.Responded and compliance with NPSA ligature alert released in March 2020 and the ESA low lying ligature alert released in 2019. 4.Remedial action taken within 24hr by PFI providers following near miss incidents being identified. 5.Ligature Programme of works is reviewed at the Environmental Risk Group. 6.Phase one of the ligature works programme completed 2021/22 at a cost of £2.8m. 7.Phase 2 programme of ligature reduction works have been agreed and finances allocated in 2022/23 capital plan.		Roll out of Oxehealth technology to be extended for additional Inpatient Wards across the trust.	31/03/2023	Elizabeth Moody	
PCDC	**1001** Date ID - 20/10/2020 - Date last	North Yorkshire, York and Selby - NYY&S	Operational - Workforce - Safe Staffing	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce	**20**	Mitigation is all via locums and mind the gaps though there are increasing pressures with the mind the gap	At the time the risk was identified, there were 12.5 WTE vacant Consultant posts (out of 63 total across AMH, MHSOP, CAMHS and LD	Expressions of interest in posts through promotion of TEWV and engagement with trainees through teaching.Reduction of costs for agency through	**16**	Putting in place a middle grade oncall rota to support medical staff retention	29/12/2022	Dr Tolulope Olusoga	**9**

Committee	ID Date Identified Date reviewed	Location/ owner	Type/ sub/ theme	Description	IRR	What mitigating controls already in place	Details of gaps in controls	Assurances to monitor effectiveness of controls	CRR	Description	Due date	Action Owner	TRR
	reviewed - 10/08/2022	Management - Dr Tolulope Olusoga		across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.		arrangements.Promoting the Trust at Royal College of Psychiatrists events, Trust recruitment event in London and York in January 2022 and Feb 2022. Trust-organised Leadership Programme for Aspiring New Consultants in 2022. Actively reaching out to colleagues and existing networks promoting TEWV. Redesigning job descriptions to be more flexible to support LTFT colleagues.Participate in teaching sessions to higher trainees in Yorkshire Deanery promoting benefits of working in TEWV.Regular touch points to engage with existing medical workforce to support retention (bimonthly visits to bases/local meetings – impacted by Covid but alternative arrangements via MS Teams) and ensure leadership visibility.Ensuring our consultant trainers maintain capacity to train core trainees and higher trainees (to ensure supply route into consultant posts).Addressing place based service issues to improve attractiveness of locations/teams as a good	services), covered by 10 agency locum medical staff in addition to our local staff mind the gap arrangements. It results in an annual agency spend in excess of 1.4 million pounds. Failure to recruit to these vacancies will pose further significant risks to Trust reputation from impact on safe care delivery and will make it more difficult to attract and recruit new staff.We need to identify and implement recruitment options to attract medical staff to NYY eg use of recruitment premium, recruitment of doctors from overseas, review sessional job plans to support working across the locality, implement a middle grade on call rota, propose additional SpR posts. Develop skills across other professions such as non-medical ACs and Physician Associates	monthly budget reportsMonitoring staff wellbeing through sickness levels of medical staff. We have recruited 4 new substantive consultants in the last 12months.Monitor long-term sickness absence		Develop non-medic colleague skills to ensure consistent service delivery	09/02/2023	Dr Tolulope Olusoga	
										Explore and encourage group job planning to increase flexibility of the workforce supporting interests of the consultant workforce	09/02/2023	Dr Tolulope Olusoga	
										proposal to get approval for 8 additional funded Higher Trainee posts (SpRs) in NYY to increase number of front line clinicians and improve pipeline for consultant posts	09/02/2023	Dr Tolulope Olusoga	

Committee	ID Date Identified Date reviewed	Location/ owner	Type/ sub/ theme	Description	IRR	What mitigating controls already in place	Details of gaps in controls	Assurances to monitor effectiveness of controls	CRR	Description	Due date	Action Owner	TRR
						place to work. Engaging with local high schools via careers events promoting psychiatry and TEWV.Developing well being programmes to support retention of medical staff including flexible working and remote working.							

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PCDC	**1063** Date ID - 08/03/2021 - Date last reviewed - 09/08/2022	North Yorkshire, York and Selby - NYY&S Child and YP - Melanie Woodcock	Operational - Workforce - Safe Staffing	There is a risk that patients may not be able to access timely psychiatric care including medication initiation following ADHD diagnosis, and reviews across NYY CAMHS due to high vacancy levels and gaps in cover arrangements resulting in potential for patient harm and poor experience, negative impact on staff wellbeing and staff retention.	**20**	Mind the gap and locum arrangements are providing a degree of cover across the locality. Gaps in Scarborough and resulting gap in Harrogate covered with MTG and cross cover . Consultants have used small amounts of annual leave to provide locum days into Selby CAMHS prior to a locum being appointed Substantive posts will continue to be readvertisedLocums being actively sought for vacant posts.NMP roles being developed using short term finding from medical budgets, with a plan to move to nurse led ADHD services in the longer term.	no locum identified for Northallerton no interest in advertised jobs to date and no likely future candidatesincreasing delays in accessing psychiatry case discussions in NorthallertonReduction in hours requested by psychiatrists will impact on provision of psychiatry in Harrogate and NorthallertonAs at March-21, the service was operating with 65% vacancies resulting in Psychiatry caseloads being very high. Recruitment, Mind the Gap and locum/agency are mitigating to an extent but a more robust option is needed to attract contracted staff.This will address the significant impact on capacity and impact on the wellbeing of the existing workforce, such as referrals to Occupational Health, requests for reduction in hours, and some are leaving the service. Mitigating actions for gaps :Psychiatry	Medical staffing risks reviewed monthly at QUAG.Risk also monitored monthly by specialty senior leadership group.Standing agenda item on monthly Consultant meeting.	**15**	BCP planning	23/09/2022	Siobhan Smart	**9**

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							appointments targeted/prioritised for emergencies / RED rated cases. All cases in teams with psychiatry gaps to have lead professional/ care coordinator and requests for psychiatry input triaged by team leadership cellExisting consultants have offered locum work into Selby using their annual leave to provide very limited cover until a locum is found . MTG arrangements in place to cover 0.5 WTE gap in York and emergency cover for SelbySelby Locum in place - experienced in ADHD work, which will improve assessment and treatment throughputNYY CAMHS senior managers to review options for releasing medical time elsewhere in service - specifically consider move to nurse-led ADHD services across locality Specialty is increasing the number of NMP posts within the locality - this has been funded through additional funding						

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QAC	**1067** Date ID - 17/03/2021 - Date last reviewed - 10/08/2022	Durham, Tees Valley and Forensic - DTV&F Learning Disabilities	Operational - Safety/Security - Risk Management	There is a risk that staff will be injured in ALD inpatient services. This results from high levels of acuity in the units and the need for a minimum number of staff in core teams, especially males. This is in addition to	**20**	agreed minimum staffing according to inpatient with agreed use of agency over staffing on a weekend to provide clinical leadership and response agreed number of PAT level 2 trained staff on shift support from community		daily sitrep daily staff roster meetings across all ALD team managers when needed Review of acuity and incidences - RIDDOR reports 3 times per week formal BC meetings with 7 day per week	**16**	Embed the process of putting new recruits through the necessary training whilst going through the checks and prior to starting.	30/11/2022	Jemma Hill	**9**

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		Services - Sarah Gill		needing staff who are familiar with the patient and appropriately trained to PAT L2. Where these requirements cannot be met, this can lead to high levels of staff assault and injuries through physical intervention.		services staff working into the unit. additional PAT training for community staff increased support to monitor staff wellbeing staffing to be considered as part of the inpatient review project given the sustained level of increased staff to respond to the heightened acuity across the site. 28th June 2021 - unit invoked formal business continuity to manage the potential impact of insufficient staff on site. review of recruitment strategy, increased support from temporary staffing, consideration given to stopping planned services to support inpatient acute services. Additional recruitment in August, October and further recruitment planned in November. this includes fast track training for those appointed as part of their inductions whilst waiting for checks to be completed.		safe staffing reporting.		Advertise for male only staff	30/09/2022	Tracy Whitelock	

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CC	**1069** Date ID - 18/03/2021 - Date last reviewed - 09/08/2022	North Yorkshire, York and Selby - NYY&S Learning Disabilities Services - Melanie Woodcock	Operational - Service Delivery - Availability of Beds	There is a risk due to NYYS LD being unable to provide appropriate accommodation based on clinical need or having the staffing to be able to support increased level of service demand. This is due to increased acuity and demand with a number of service users requiring 5:1 or above staffing leading to reduction in multiple occupancy inpatient provision elsewhere in the Trust, resulting in patient needs not met in a timely way, reduced availability of LD beds trust-wide, and impact on the wider staffing resource.	**20**	Enhanced community support, engagement and consultation on in-patient bed options for NY&Y with commissioners with Humber, Coast and Vale ICS lead and Trust-wide LD bed management processes in place.	Enhanced community support, engagement and consultation on in-patient bed options for NY&Y: discussions ongoing with commissioners Humber, Coast and Vale ICS lead. Associated mitigating actions to be added following review of risk on 09/08/22 Trust-wide LD bed management processes are in place.	Trustwide programme board supports with ongoing review	**15**				**9**
Strat SRC	**1072** Date ID - 18/03/2021 - Date last reviewed - 08/08/2022	North Yorkshire, York and Selby - NYY&S Management - Zoe Campbell	Operational - Financial - Financial	There is a risk that we exceed our allocated budget due to overspending linked to over-establishment against core budget, high use of agency staffing and a lack of funding for key operational services (crisis line, IAPT trainees etc) non-	**20**	NYYS staffing group in place with HR & project lead staffing escalation process -community & inpatient E-rostering maintenance & rollout Contract management & annual planning Making sure that team managers have the necessary financial	Available funding via partnerships in NYY to address shortfall in funding to key services including IAPT and the Crisis Line. Gaps in rota to support SafeCare requirements	NYYS financial dashboard and forecast reviewed monthly at EBD and acre group board CMHF & MHIS investment proposals against LTP targets. Partnership review of finance monthly at commissioning groups and NYY MHLD Partnership Board.	**16**	Workforce Recruitment and Retention	30/11/2022	Irene Steer-Richards	**9**
										e-Roster roll out for coimmunity teams	30/12/2022	Nicky Scott	

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				recurring funding streams and reduced partnership investment via MHIS against 3 year plans from 19/20, resulting in not delivering cash releasing efficiency savings and achieving the wider achieving financial position of NY&Y and the Trust.		awareness knowledge and skills - budget review meetings Workstream in place re agency spend with finance support and operational leads. HNY ICS engagement re future opportunities for transformational funding via CMHTF/ other funding streams. Exit strategy for non recurrent funded roles discussed and agreed cross specialty				IAPT over establishment - trainee impact	31/10/2022	Liz Herring	
										0800 - all age funding	31/10/2022	Liz Herring	

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PCDC	**1076** Date ID - 29/03/2021 - Date last reviewed - 10/08/2022	North Yorkshire, York and Selby - NYY&S Child and YP - Melanie Woodcock	Operational - Patient Safety/Quality - Safe Staffing	There is a risk in Northallerton CAMHS due to delays in assessment and treatment for patients, with staff carrying high caseloads as a result of reduced staff levels. This is resulting in reduced quality and safety for patients as well as impact on staff wellbeing and absence/leaving the service.	**20**	Appointed .45 WTE receptionist. Further hours to be re advertised Appointed band 6 appointed to Recruited 2 x band 5 CAMHS clinicians recruited a band 4 Assistant Psychologist permanently and a fixed term band 4 Volunteer recruited to - focus on waiting room environment and participation with families to improve this FFT feedback will also factor in to her role. Medic case discussions are now June 2022 – this is impacting on throughput , team wellbeing and caseload sizes. Increased complaints due to wating for case discussions. There are 28 cases waiting for	Effective recruitment plan that results in additional clinicians providing capacity within the team. An example of what this will address is current high caseloads (eg Adv Practitioners who have more demand for assessments than slots available) and increased capacity for CNS to plan and implement transitions. Robust plan needed to cover CAMHS medical input to EIP caseload.	Monitor it through daily team manager's report out, weekly performance reporting and discussions at QUAG	**20**	Ongoing recruitment	########	Keri Breary	**9**

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						school observations which would then require a case discussion for a diagnosis of ADHD, this will not happen before June 22. 60% of case discussions are around ADHD. Due to staffing levels we can give sufficient resources to man an efficient duty rota. letters to GPs planned to update on waiting list position letters to families planned to update in waiting list position trial of agency worker to do initial assessments - 6 months; TM monitoring escalated to BCP						

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CC	**1087** Date ID - 21/04/2021 - Date last reviewed - 11/08/2022	Durham, Tees Valley and Forensic - DTV&F Learning Disabilities Services - Jennifer Illingworth	Operational - Service Delivery - Availability of Beds	There is risk that there will not be sufficient specialist ALD beds to meet the demand. This results from a national reduction in bed availability post Transforming Care, a high level of inpatient acuity (many of whom currently require single-occupancy care), and a lack of community providers to facilitate discharge. This leads to the service being unable to accept admissions. Also includes risks relating to CQC S31 activity in June 2022	**20**	CTRsdevelopment of the pathway and interface with case management Enhanced community model and 7 day working flexible transition plans and pathways to discharge through working alongside providers. daily huddles ALD trust wide bed management process - HoS/CDs/Matrons and LM collectively review admission requests where there are local pressures and inability to safely admit.Cross site working and support. DToC monitoring through the above meetings initiated trust wide inpatient review project - program support manager appointed and commencing June 2021. Whilst we are in the position of having a small amount of capacity (2 beds) moved to formal business continuity and closed to admissions due to the inability to safely staff further complex admissions. inpatient design event with short and long term plans developed to address some of the estates and capital issues over the coming few months. external support in relation to current models		Sitreps - minimum twice weekly and increased to daily when required weekly case management DDTP sitrep Governance groups - reporting into new processesDToC report Project group formed mandated inpatient reports and audits BC meetings 3 times per week.	**20**	post design event, participate in project group and progres with the implementation of the estate reccomendations.	31/10/2022	Sarah Gill	**9**

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						of care that is informing current development plan							
PCDC	**1090** Date ID - 26/04/2021 - Date last reviewed - 09/08/2022	Durham, Tees Valley and Forensic - Health and Justice (HJ) - A&C Lisa Taylor	Operational - Workforce - Safe Staffing	There is a risk that we may have to run services with less than minimum staffing levels at HMP Northumberland due to reduced staff availability as a result of being unable to recruit to clinical lead and psychology vacancies resulting in the potential for patient and staff safety issues, reduced quality, poor experience, and impact on staff wellbeing.	**20**	-RAG review of caseloads to ensure patients are managed on clinical risk presentations -Using social media to adverts to target candidates. -Additional and uplifted banding for posts advertised. -Advertisement review -Support from wider regional prison teams (where available) -Use of agency staff - Use of regular phone support for patients - Request to CNTW for secondment - an incentive payment has been put in place (golden hello) for all staff.	The service continue to work with recruitment to attract applicants to posts and continue to use agency staff.	Waiting times monitored through MHTMM and QUAG. Weekly action plan meeting in place.	**16**	Recruit x 5.6 wte B6 Nurses	19/09/2022	Kate Muter	**9**

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PCDC	**1102** Date ID - 01/04/2021 - Date last reviewed - 01/09/2022	Finance & Information Directorate - IT& Systems - Chris Reynolds	Operational - Workforce - Policies and Compliance	There is a risk that we may be unable to disclose staff emails (in cases of bullying and harassment) due to lack of search ability and current self disclosure process resulting in staff distress and and potential compensation claims.	**20**	If the matter is one of bullying and harassment DPA Manager will also ask for email accounts to be copied so that any complaints of dishonesty can be investigated. Staff are aware that emails are records and should not be deleted and this is stated within corporate record keeping policy and promoted via the SIRO network.	NHS Digital control the NHS Mail system so harvesting of emails has to be on an individual email account basis. DPA staff cannot be sure that emails requested wont have been destroyed. Staff already delete emails just to manage inboxs so deletion is not always sinister	Responses to SAR requests and evidence of any complaints made.	**16**				**8**
QAC	**1131** Date ID - 26/07/2021 - Date last reviewed - 08/08/2022	North Yorkshire, York and Selby - NYY&S Adults - Liz Herring	Operational - Patient Safety/Quality - Service Provision	There is a risk associated with patients having long waits for response to NYY&S 0800 all age mental health crisis & support line due to capacity challenge and level of associated funding which is resulting in increased complaints and incidents.	**20**	Trust wide crisis & urgent response policy Crisis operating standard for a 4hours response for face to face assessment call handling information to reflect % call answered; Number of call handlers required per team	Level of service funding & Workforce capacity to meet demands access to temporary staff or agency to support the scale of vacancies in the service.	PALS & complaints had issues relating to the 0800 provision continue Crisis team absence & vacancy rates - 17.33wte registered vacant posts across NYY daily staffing of the rota tracked across the service - unable to sustain minimum standard due to vacancies 4 hours standard in AMH at 94% reporting increase in calls a month with decreased in calls answered (44%)	**16**	requirement for creating safety summary (SS) & safety plan (SP) for non-crisis calls	31/08/2022	Andrew Knox	**6**
										responded to Trust-wide improvement group	30/09/2022	Liz Herring	
										to work with CCG regarding additional funding for alternative model & capacity	30/09/2022	Liz Herring	

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PCDC	**1143** Date ID - 23/08/2021 - Date last reviewed - 10/08/2022	North Yorkshire, York and Selby - NYY&S Child and YP - Melanie Woodcock	Operational - Patient Safety/Quality - Service Provision	There is a risk that TEWV CAMHS and FIRST Service patient care will be compromised due to the FIRST service not having the staff in place to deliver services. Support being provided by CAMHS team and this diluting levels of services for all patients, resulting in potential patient safety and quality issues.	**20**	Meeting in place with CYC and CCG commissioner to review current offer to families and agree multi-agency plan for all children on caseload.First Staff to develop care plans for reduced offer to guide generic team clinicians on on-going offer to families remaining in service. N.b. the children are generally known and have on-going involvement with the psychiatry team for medication reviews which will continue.Vacant post to be advertised asap. CAMHS will set up a peer support group for staff members providing support to young people currently in receipt of support from FIRST.Ensure new band 5 LD nurse is closely integrated with CAMHS team and has strong links with Children's LA services to ensure they are involved in care packages for children typically in receipt of FIRST. FIRST will not accept any new referrals until the staffing situation is improved.	All children on existing caseload to have a forward plan in place prior to the psychologist's maternity leave commencing. All partner agencies to be involved in this care planning to ensure effective communication with families to help contain any anxieties re. this change.Psychologist job to be advertised asap.Without appropriately qualified staff, the children and families will no longer receive this specialist service. These children and families have high levels of need i.e. Learning disability and/or ASC and are at risk of either their home or school placement breaking down. FIRST offers an enhanced service, above and beyond the offer of the generic team.TEWV CAMHS will need to continue to provide support to these children and families from the generic CAMHS Team, which will be an increased offer ordinarily offered by the generic team. This will potentially impact on the care of other children in the generic team not accessing FIRST as resources are utilised differently.	Monthly review at QUAGTask and Finish group to be established with TEWV, CYC LA and VoY Commissioners to review future FIRST offer in both the short and longer term given high levels of demandYoung people with complex needs continue to have multi-agency oversight via the Dynamic Risk Support register on a monthly basis.	**16**	Task and Finish group established. First meeting 28/04/2022. Service to provide impact report	23/09/2022	David LovedaySims	**12**

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PCDC	**1208** Date ID - 14/12/2021 - Date last reviewed - 08/08/2022	Durham, Tees Valley and Forensic - Secure Inpatient Service (SIS) - Naomi Lonergan	Operational - Workforce - Safe Staffing	There is a risk that we may be unable to provide safe and consistent staffing levels for registered and non-registered staff in Secure Inpatient Services due to overall absence levels resulting in potential patient safety and quality issues and impact on staff health and wellbeing and embedding wider culture work.	**25**	Daily operational and safety meeting SafeCare and red flag system to re-allocate resources required Supervisory DNC Group hubs Safe staffing escalation process Daily sitrep Implementation of BCP	Establishment data varies according to source (HR, Workforce Information).	Establishments are being monitored - actual versus planned via established governance routes. Sickness absence is monitored and managed. Staff experience is measured. A recruitment and retention plan is being developed for the service. A review of budgets has been undertaken with Health Roster and Finance and all re-aligned. A service specific induction programme has been successfully developed. A Forensic specific staff side meeting has been implemented.	**20**	To work with Workforce team to on board the 40 HCAs safely and secure training. Plan needs to come to service for review.	16/09/2022	Fiona Robinson	**9**
										Retention Programme	30/09/2022	John Savage	
										Submit SIS ward staff retentia premia	30/09/2022	Steven Tait	
										Cultural and OD work is underway within the service including the Ward Manager Development Programme	31/10/2022	Richard Hand	
										Agreed workforce workstream to look at joint recruitment initiative and international recruitment	31/03/2023	Naomi Lonergan	

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PCDC	**1218** Date ID - 01/02/2022 - Date last reviewed - 10/08/2022	North Yorkshire, York and Selby - NYY&S Child and	Operational - Workforce - Safe Staffing	There is a risk that services are unsustainable across the two York CAMHS teams due to staffing currently below	**20**	STL meeting agreed: Mitigating actions in place – Case load management tool, case load refresh, QIS event for SPA will benefit flow into generic team.	iThrive model to be progressed and implemented across the system. It is anticipated this will result in reduced referrals to the CAMHS team	Staffing/ recruitment reviewed on weekly basis Use of IIC weekly to review performance e.g. waiting times; referral rates Follow-u STL will track progress	**20**	review STL process with monthly meetings	########	Nicola Everett	**9**

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		YP - Melanie Woodcock		commissioned levels resulting in high caseloads, interface issues with SPA team due to high number of referrals and demands, and excessive duty calls to clinicians, impacting on patient safety and quality, and staff morale and wellbeing.		Huddles, drop in surgery daily for staff, reflective practice. SPA have offer of support from team and psychology. OD team have recently conducted Staff listening/discovery event to facilitate staff concerns/feedback to improve services in future as part of ongoing OD work and service improvement. Use of participation/ recovery lead to help manage feedback to families. Standard letter to go to GPs re position of waiting list discuss with adult teams early transfer of nearly 18s WiMT to offer short term interventions into York CAMHS. Additional mitigations added WIMT helping with lower risk cases Transitions to adult service expedited as appropriate	although capacity and planning to progress, internal and external to TEWV, is an issue. Associated mitigating action to be added at next review in 08/22	and escalate as required. Weekly monitoring of Staff sickness. 27/6/22 weekly meetings with care group directors					
QAC	**1223** Date ID - 16/02/2022 - Date last	Nursing and Governance -	Operational - Patient Safety/Quality -	There is a risk that medical devices may not be available/ or safe to use due to the	**16**	Medical device policy clearly states the roles and responsibilities of the wards in relation to	Medical devices safety officer not in situ.Format and content of existing asset register	The number of SI's that have a root cause or contributory finding in relation to medical devices. The number of	**16**	Appointment of a Medical Devices Safety Officer	31/10/2022	Nurse Carole Rutter	**3**

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	reviewed - 12/08/2022	Nursing - Nurse Carole Rutter	Environment	potential for devices being obsolete, out of date, poor working condition etc. when needed most i.e. emergency situation, resulting in patient harm.		medical devices. Central asset register held in the Estates DepartmentNational Safety Alerts actionedMedical devices group		incidents citing medical devicesMonitoring of works to be undertaken around medical devices via the medical devices group		Undertake a baseline assessment of medical devices stored within operational services to ascertain working condition of device	31/10/2022	Nurse Carole Rutter	
										Carry out a review of the current Medical Devices Policy	31/10/2022	Nurse Carole Rutter	
QAC	**1226** Date ID - 07/03/2022 - Date last reviewed - 12/08/2022	Nursing and Governance - Nursing - Elizabeth Moody	Operational - Patient Safety/Quality - Service Provision	There is a risk that LD patients may not be placed in the best environment to support their care due to a local and national shortage of LD beds, resulting in complex patients cared for within temporary ward environments supported by agency nursing staff and potential adverse pateint safety and quality outcomes.	**20**	Daily safe staffing oversight Daily SitRep call occurring Enhanced MDT and Matron oversight (Monday to Friday) Additional senior nurse oversight at night Safety checks being completed Support from the Positive and Safe Team Support with discharge pathways from NHSE Mersey Care review and input from HOPEs team Additional medication management training has been undertaken Locality Manager managing the wrap around timetable Work has been undertaken	Temporary nature of staffing Suitable alternative provision Bed management across the trust	Monitor and report on restrictive intervention usage Monitor and report on patient safety incidents Weekly monitoring of safe staffing (roster work being undertaken)) Monthly Matron report is compiled monthly and forms part of the QA2 and QA3 Ongoing monitoring through Care Group and EDG Bed management is being monitored within NYY Locality Manager and Commissioner Daily report out and weekly MDT review meetings Safety and Wellbeing review has been completed Long Term Segregation reviews Delivery of improvement plan	**16**	Assess and Monitor the temporary staffing usage	30/12/2022	Sarah Gill	**9**
										Investigate suitable alternative provisions	31/08/2022	Rob Berry	
										Monitor the bed management position within the Trust	30/12/2022	Tracy Whitelock	
										Support for discussions with commissioners (esp. Yorkshire) to identify and fund appropriate non-hospital placement	31/08/2022	Janet Telford	

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						with the temporary staffing service to ensure regular agency staff to ensure consistency Escalated through the trusts governance process with weekly report through EDG (ward to board) Psychology support obtained to review debriefs (daily Monday to Friday) Safeguarding oversight				New matron supporting staff training, resilience and formulation	31/08/2022	Jemma Hill	
										Architects floor plans signed off for reconfiguration of Ramsey into 3 single occupancy flats	30/12/2022	Janet Telford	
QAC	**1238** Date ID - 19/05/2022 - Date last reviewed - 18/08/2022	North Yorkshire, York and Selby - NYY&S MHSOP - Bridget Lentell	Operational - Patient Safety/Quality - Availability of Beds	There is a risk to being able to provide quality of care and patient experience for North Yorkshire & York patients need admission due to admission of out of locality and out of specialty patients into NYY MHSOP beds. There is high demand from out of locality and out of specialty, variable control process across the trust, resulting in increased work and pressure on teams, communication difficulties with community teams, increased LOS, impact on patients and families for visiting.	**15**	Matrons screening and gatekeeping during the day to ensure admissions are safe, and asking for assurance that risk assessments have been complete. 1045 sitrep - identify current situation and flow with bed managers.	No local process to monitor our out of locality patents.	Risk assessment for each inpatient admission.	**15**	Review daily in sitrep and bed capacity call feeding into bed oversight meeting	25/08/2022	Bridget Lentell	**9**

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QAC	**1257** Date ID - 25/04/2022 - Date last reviewed - 08/08/2022	Durham, Tees Valley and Forensic - Secure Inpatient Service (SIS) - Naomi Lonergan	Operational - Patient Safety/Quality - Risk Management	There is a risk that patient care documents do not accurately reflect risks, risk management plans, risk of incidents and risk of harm due to lack of training or understanding, and workload pressure, resulting in potential for patient or staff harm.	**20**	Quality assurance schedule is in place	Need to identify the roles of the SDM and PDPs in this process	- 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 - Audits and risk management plans - Quality assurance schedule	**16**	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	30/09/2022	John Savage	**4**

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SRC	**1260** Date ID - 17/06/2022 - Date last reviewed - 11/08/2022	Finance & Information Directorate - Finance - Liz Romaniak	Corporate - Financial - Financial	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality of services.	**20**	2022/23 financial plan.Existing contracts and MHIS/SDF prioritisation processes via MH Partnership Boards and/or CMB.Alignment of Business Planning and budget setting processes.Financial monitoring/reporting processes including new governance arrangements (Care Group, Executive Directors and FSB).Internally reported monthly to Care Group Resource and Business Development Groups and Care Group Boards, the former reports into Exec Strategy and Resources Group (all monthly) - supports identification of variance from plan and actions required to mitigate.Workforce plans, controls and monitoring in place.	Trust 2022/23 financial plan £1.16m surplus (including residual 43% of 21/22 Covid funding – non recurrent) approved by Board June 22.ICS 2022/23 financial plans reflect breakeven position. Pay award, outcome of PRBs communicated. National tariff funding generates non acute funding gap.Qtr 1 deficit £1.3m (on, but not ahead of plan, which requires run rate improvements including via CRES). Since March 22 run rates for staffing and Independent Sector Beds have increased.At point of plan submission, underlying recurrent financial position estimated to be IRO £24m deficit. Above run rates if unmitigated would exacerbate. The below are circumstances that could lead to the risk being realised:Under-achievement of recurrent efficiency targets;Significant financial pressures relating to a very small number of complex Learning Disability packages of care;Inpatient run rate pressures, including: potential roster inefficiencies, acuity, increasing lengths of stay and out of area placements workforce challenges	Financial monitoring reports submitted monthly to NHSE/I and ICB. Trust dashboard includes relevant metrics to support monitoring and delivery.Budget meetings are held with managers to support the delivery of financial plan, identification and mitigation of variances.	**20**	Manage delivery of 22/23 financial plan including run rate pressures and £13.8m CRES requirements	28/04/2023	Liz Romaniak	**12**
										Validate run rate pressures monthly and potential additional actions required	28/04/2023	Wendy Griffiths	

Committee	ID Date Identified Date reviewed	Location/ owner	Type/ sub/ theme	Description	IRR	What mitigating controls already in place	Details of gaps in controls	Assurances to monitor effectiveness of controls	CRR	Description	Due date	Action Owner	TRR
							exacerbated by staffing absence leading to pressures from unfunded temporary staffing (inc premium agency) spend;Demand and acuity for some community-based services;Accumulated national tariff under-funding of AFC pay awards due to MH provider pay cost differential;Underfunding (evidenced by low reference costs);Potential under-funding of contractual commitments and / or unmitigated stranded costs – costing transformation programme to validate pinch points;Inflationary pressures;Unclear recurrent funding mechanism for NHS pensions 6.3% currently funding via NHSE;Changes in NHS architecture (CCG disestablishment, ICB establishment) and revised allocations / pace of change now determined at ICB level means potential dilution of annual growth.			Scope Smart working cost pressures (home working policy implications) and/or forward efficiency opportunities (travel/premises)	30/12/2022	John Chapman	
										Review non recurrent mitigations, including discretionary expenditure controls/approval routes (hospitality, conferences, non clinical agency/overtime)	28/04/2023	Wendy Griffiths	

Item 12

BOARD OF DIRECTORS

DATE:	**29th September 2022**
TITLE:	**Board Integrated Performance Report as at 31st July 2022**
REPORT OF:	**Mike Brierley, Assistant Chief Executive**
REPORT FOR:	**Assurance**

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

Report:

1 Purpose:

1.1 The purpose of this report is to provide oversight of the quality of services being delivered for the period ending **31st July 2022** and to provide assurance to the Board on the actions being taken to improve performance in the required areas.

2 Background:

2.1 As part of the continuous improvement of the Trust's Performance Management Framework, we have developed a more integrated approach to quality and performance assurance and improvement. This approach will enable us to have oversight, monitor and report key measures that demonstrate the delivery of the quality of services we provide and provide assurance to the Board through our new governance structure.

2.2 On a monthly basis the Integrated Performance Report (IPR) will provide oversight and assurance against the agreed key measures in the Integrated Performance Dashboard (IPD). The measures for the IPD were identified by the relevant Board Sub Committees and agreed by the Board of Directors. All the measures have been aligned to one of our three strategic goal(s) and where appropriate, support the monitoring of the Board Assurance Framework risks. The monthly IPR will also include, by exception, the key ambitions agreed with Commissioners in the Long-Term Plan (LTP) that have not been delivered.

2.3 On a quarterly basis the IPR will incorporate reports from the relevant Board Sub Committees (Quality Assurance, Mental Health Legislation, People, Culture & Diversity and Strategy & Resources) and will include other key information issues and risks (not already included in the IPD) but which the sub committees wish to escalate to the Board. The IPR will also provide progress against the System Oversight Framework (the regulatory framework).

3 Key Issues:

This is the IPR for the period ending July 2022 – See Appendix A

3.1 Alert (by exception) the following key areas of concern

3.1.1 Integrated Performance Dashboard

a) IIC Reporting - On 4th August 2022, Advanced Computer Software Group (Advanced), who supply software and applications (including to various NHS organisations) suffered a cyber incident. As a result of the incident, there have been unplanned outages of applications hosted by Advanced, requiring that organisations disconnect from their infrastructure. This included our disconnecting the Integrated Information Centre (IIC), used for reporting by the Trust. National teams have worked with Advanced to seek assurance about a safe return of access to systems, with NHS England also recently sharing assurance ratings for different applications so each organisation could assess the appropriateness of commencing reconnection. Whilst the Trust is now working on a risk-based and phased approach to re-establish connections to the IIC (with daily oversight via the Executive) the need to disconnect has directly impacted the availability of the IIC and related reporting. It has not consequently been possible to produce the routine monthly IIC Integrated Performance Dashboard. However, we have continued with the information and assurance flow from Care Group Board Sub-Groups through to Executive Directors. We have had limited quantitative data for the month of July; however, where we have had this through other means (i.e. manual data) this has been included in the Integrated Performance Report (IPR). This includes some incident data, staff experience data, intelligence on use of independent sector beds and finance data.

b) **Bed Occupancy and Out of Area Placements (measures 8 and 9)** we now have Care Group representation at the Trust-wide Bed Management group; Durham, Tees Valley & Forensic Care Group will be represented by the Care Group Director of Operations & Transformation – Adult Mental Health/Mental Health Services for Older People and the Care Group Medical Director; North Yorkshire York & Selby Care Group will be represented by the Care Group Director of Nursing and Quality and Care Group Director of Operations & Transformation. A number of processes have been established within the Care Groups to reduce admissions and lengths of stay and these are progressing. Work has been led by the Medical Director, with the Care Boards and Trust-wide Bed Management Group, to identify a number of possible future initiatives and these were shared with Executive Directors in August. There has been a reduction in the number of overall block and independent sector beds from 21 as at 27th July to 13 as at the 14th September.

Action: It was agreed at Executives on 24th August to cease new admissions to block beds from 1st September (except where anticipated admission is for weekend only or for max 72 hours) and to repatriate patients into Crisis Home Based Treatment/Community or alternative accommodation/alternative Trust beds by the 30th September 2022. It was also agreed to:

- Prioritise block booked beds with Adult Mental Health consultant with oversight from Crisis/Inpatient service to enable appropriate discharges to Crisis Home Based Treatment/Community
- To circulate a daily Independent Sector bed usage report to Care Group Directors for information and action
- To apply good practice from one care group to the other where this is relevant (e.g. focus on overnight leave/extension of leave; weekly DTOC meetings; weekly service oversight of 30,60,90 to track progress & remove

blockages).

c) **Restrictive Interventions (measure 12)** training continues for Learning Disabilities staff Trust-wide and we are on plan to deliver against the agreed trajectory. In addition, 16 Adult Learning Disability practitioners have attended training with the Hopes National Team. Visits have been arranged to Merseycare in October and plans are underway for similar visits to Herefordshire and Surrey. Dates are now planned for the Positive & Safe Groups starting in September 22. "Leadership" is appearing as a theme in episodes of physical restraint, which is to be addressed through training. In the absence of data from the IIC, we are unable to identify if the actions are having the desired impact.

Action: For those service users with the highest level of restrictive interventions, close attention is being maintained with oversight and support from the Nurse Consultant, Positive and Safe. Early implementation and testing of Reducing Restrictive Intervention panels have commenced and dates planned for October 2022. A paper has been drafted setting out additional resources that may be required to support further embedding of reducing restrictive interventions across the Trust.

D) Mandatory and Statutory Training and Staff Appraisal (measures 20 and 21) we have completed individual 1-1 meetings with all Corporate Executive Directors/Deputies to share their data and to explain how they can access this. All Executive Directors have now provided a trajectory of when they will achieve 85% compliance. For Mandatory Training this is planned to be achieved by the 30th November and for Appraisal this will be 1st December.

Executive People Culture & Diversity Group considered the factors which impact on compliance with appraisal and mandatory and statutory training standards that are out with the training team's control to establish what a realistic standard would be. Considering absence rates (sickness, maternity etc) and turnover, the group proposed that a standard of 85% for appraisal and all courses was appropriate. This was approved by Executive Directors Group for the next 6 months at which point we will formally review with a view to increasing the standard if feasible. Executive People Culture & Diversity Group will monitor this monthly and alert the Executive Directors Group if anything changes significantly in the interim. The only exception to this is Information Governance training which is nationally set at 95% - we will continue to communicate with the national team that this is not realistic given rates of absence and turnover in the NHS (we are not unusual in either of those figures).

Action: We will now track progress for all teams to achieve the 85% standard for both measures by December 2022 and report back to Executive People Culture & Diversity Group by exception

e) **Unique Caseload (measure 23)** whilst further analysis has been delayed due to the IIC outage following the cyber security incident, there continues to be no improvement actions in respect of caseload.

Action: Associate Director of Performance to facilitate a discussion with Finance, People Culture & Diversity and Business Intelligence colleagues to identify possible next steps; this will be completed in September 2022.

f) **Financial plan (measure 24)** delivery continues to be of concern, with elevated run rates having been experienced throughout quarter one for inpatient and

agency expenditures and following continued high numbers of admissions to adult assessment and treatment independent sector beds. Underlying performance and agency costs in particular are also impacted by a small number of very high cost, complex packages of care for adults with a learning disability. Numerous actions are in train across the Trust and being overseen by Care Group leadership to tackle these key drivers of underlying financial performance. These need to be delivered and sustained on an ongoing basis to critically target agency rate and volume reductions, eliminate our use of independent sector beds (but noting rising numbers of delays in discharges from adult inpatient wards) and, working with partners, to expedite the managed discharge to appropriate community-based packages of individuals being supported with complex learning disabilities.

Significantly, an increase in delays in the discharge of adults and older adults from inpatient wards are contributing to increased bed occupancy and are highlighted as contributory system factors in driving both additional safer staffing (both adult and older adult inpatient wards) and independent sector bed pressures (adult beds only to date).

The Trust had planned to deliver stepped agency and independent sector bed cost reductions from month 4, however in-month costs (throughout the first four months) have not reduced, with run rates exceeding 2021/22 levels and rising again in July, most notably for agency costs.

For the reported period, at month 4, the in-month adverse variance to plan was £1.2m. Most recently, in month 5, run rates have reduced significantly, driving an adverse plan variance of £0.6m. Whilst this is a positive one-off movement, actions are now needed to mitigate year to date under performance (£1.8m) and to return (reduce) future month expenditures to planned levels, including through mitigating discretionary actions. Some positive early signs have been seen linked to reduced independent sector bed utilisation in recent weeks. The Executive Directors will consider a financial deep dive, informed by Care Group and Trust improvement trajectories on 5th October to inform financial forecasts and the requirement for additional mitigating actions and expenditure controls.

The Board is asked to consider whether additional complementary financial narrative and reporting (to the current Board IPR) would be appropriate given the current financial context of i) year to date and underlying financial pressures, ii) assurances taken by external audit from standalone financial board reporting when considering value for money arrangements and iii) the current nationally mandated financial sustainability audits which emphasise the need for both bottom up and top down financial scrutiny and controls.

3.1.2 Other Alerts

a) **Levels of agency expenditure** continue to be of concern, both from a volume and a rate perspective. The July Executive Strategy and Resources Group received a deep dive into agency utilisation during quarter 1 and discussed elevated utilisation as compared to 2021/22 levels, including levels of 'non-compliant' off-framework agency assignments (significantly, a number of these relate to a small number of complex very high cost packages of care for adults and the top ten Medical agency assignments by premium level), observations, and backfill for sickness and vacancies, most notably in inpatient rosters. The Board is aware that pre-Covid arrangements to scrutinise and reduce agency

costs are being reintroduced and are intended to achieve challenging regional ICS cost caps set by NHS England.

High inpatient bed occupancy (at above 100%) varies from 'commissioned' permanent staffing (generally accepted to be around 85% occupancy), including due to longer lengths of stay, exacerbating impacts on safe staffing and therefore elevating temporary staffing requirements.

Since month 4, intelligence suggests some early positive impacts, including one successful discharge of a patient with complex learning disabilities to a more appropriate community-based package (reducing the need for off-framework agency staffing) and arrangements to effect a move away from one (the most expensive) off-framework supplier being developed.

b) **Financial Performance** did not improve throughout quarter 1, but remained broadly on plan. The Board is aware that financial plans had assumed the delivery of additional 'stepped' cost reductions from month 4, equivalent to around £0.5m per month and linked to agency and independent sector bed reductions. However July saw a deterioration, rather than the planned improvement, of in-month performance, most notably linked to CRES non delivery and higher agency expenditures.

Monthly costs for independent sector beds, agency/pay run rates and prescribing costs (all of which had increased* during quarter 1) present a significant delivery challenge and are an ongoing focus for Trust-wide attention. The Executive Strategy and Resources Group considered deep dives into all 3 * areas in July 2022 to inform related action planning. A Beds Oversight Group chaired by the Medical Director is coordinating a series of actions to review, understand and then mitigate bed pressures. Initial findings have confirmed that lengths of stay, as opposed to numbers of admissions, are driving elevated bed occupancy, including some impacts from 'system' pressures as a result of delays in discharge of adults and older adults. The impacts of bed pressures on independent sector bed utilisation (adults) and on safer staffing requirements (adults and older adults) have been referenced above.

Since month 4 some (early) positive impacts have been seen recently following concerted actions to mitigate bed occupancy and independent sector bed pressures and giving a 38% reduction to 13 overall (5 block and 8 spot purchased IS beds) as at 14th September, compared to 21 on 27th July and eliminating PICU utilisation. These will need to not only be sustained but improved to eliminate utilisation to deliver the end of year forecast. Given reported delays in discharges it is unclear to what extent additional improvements will be possible / sustained.

c) **Ongoing Regulatory oversight and concerns**. Inspection reports are awaited for factual accuracy checking for Secure Inpatient Services. The Learning Disability Service report is currently undergoing Factual accuracy checks. The CAMHs Community report was published on 15/09/22 demonstrating significant improvements regarding the regulatory breaches noted in the initial inspection findings although staffing remains an issue of concern. A more detailed update is provided within the Board CQC assurance report

d) **Crisis Line** – Positive work in Durham and Tees Valley to manage call volumes and pick up rates, work continues the service improvement plan. There has been a deterioration in North Yorkshire and York in terms of call pick up rates.

Executive Directors group have now escalated and asked for improvement plans to be produced. A trust wide crisis improvement plan is underway which reports into the Urgent Care Steering Group.

3.2 Assuring the Board on the following areas:

3.2.1 Integrated Performance Dashboard

We have now incorporated within the dashboard the contextual data to support the **Outcomes (measures 4-7)** for Adults and Older People; work is progressing to provide the same for Children & Young People's Services, but that has been impacted by the unavailability of the IIC. This data will help to support the improvement work within outcomes. The Care Group Medical Directors have now been confirmed to represent the Care Groups on the Trust-wide Outcomes Group.

3.2.2 Long Term Plan

As a result of the IIC outage following the cyber security incident, we have only been able to complete the Improving Access to Psychological Therapies (IAPT) measures. The two areas for improvement are:

- Total access to IAPT services -Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy: all Sub-ICB location areas
- Percentage of people who have waited more than 90 days between first and second appointments (IAPT) - County Durham Sub-ICB location; Tees Valley Sub-ICB location and Vale of York Sub-ICB location

All our services have been impacted by capacity and recruitment challenges. Mitigating actions are now being implemented by utilising the skills of trainee cohorts in some areas and agency staff in others. Plans to increase the numbers of patients accessing our services by creating an additional online workshop within Durham & Darlington are progressing and North Yorkshire & York services have developed a long-term marketing strategy in conjunction with our Sub-ICB Location colleagues; work is now underway to all actions identified are completed by the end of December 2022.

3.2.3 Other Assurances

Quality Assurance Programme - The Executive Quality Assurance and Improvement Group received the annual report detailing the Quality Assurance programme results from April 21 to June 2022. This demonstrated consistent practice standards achieved across the organisation for some of the key safety themes identified from incidents such as safety summary and plans (risk assessment and management), observation and engagement plans and leave documentation. The Practice Development Practitioners continue to monitor compliance and to facilitate areas where focussed improvement work is needed in collaboration with clinical teams. Further developments on the approach to the future Quality assurance programme are being taken forward.

3.3 **Advising the Board on the following areas:**

3.3.1 Integrated Performance Dashboard

a) Due to the Cyber Security Incident/IIC Outage, we will not be able to make a

patient Friends & Family Test submission this month; this impacts the **Patient Experience (measure 01)**. This has been communicated to NHS England and we plan to make a submission in September that covers both July and August.

b) A number of actions have been identified in our Quality Account in respect of our patients **Feeling Safe (measure 03)**; the first progress update will be presented to the Executive Quality Assurance & Improvement Group in August and a detailed plan is under development to address areas for improvement including staff having a presence in communal areas. Evaluation of body worn cameras and Oxevision are underway as part of this work.

c) Following the release of the 2022/23 Oversight Framework we are proposing that the **Run-rate movement (measure 25)** be replaced with the Framework's Agency Spending metric. This has been approved by the Executive Resources & Strategy Group and Strategy & Resources Sub-Committee to enable to the proposal to be taken to the September Board meeting for approval.

d) Work is underway to provide the underlying **staff survey (measures 16 and 17)** data to provide improved understanding of these measures. This month we have included overall responses given these are key measures in monitoring Our Journey to Change.

3.3.2 Other advise

a) **Agenda for Change (AFC)** – The Trust has an accumulated funding shortfall relating to impacts of recent (prior year) Agenda for Change pay deals (including the nationally negotiated 3-year pay deal). This is because funding is allocated nationally via national determined 'tariff' or inflationary uplifts which are more representative of acute pay cost weights and have left an increasing quantum of recurrent pay cost unfunded. The impact of the recently communicated outcome of the Pay Review Bodies is being quantified. National uplifts to support the 1.66% uplift of all related contracts has been provided to each ICS in September. If allocated to providers as a flat rate percentage uplift, this would generate an additional in-year pressure for the Trust because a higher percentage of our cost base is pay. Concerns relating to this risk were communicated by the Trust to partners and the ICS when submitting final plans in June 2022. NENC ICS was responsive and proposed reviewing the funding methodology to explore alternate mechanisms that might better reflect actual provider costs. Providers have submitted actual cost estimates to the ICS to better inform cost to tariff income differentials by organisation.

b) Levels of **self-harm** continue to be a cause for concern. The July Quality Assurance Committee (QuaC) received a verbal update on the scope of deep dive work being undertaken that will report to QuAC in October 2022. To understand and mitigate current risks, Care Groups have been reviewing their own data for trends and mitigation of risks with reviews taking place at Foss Park and within Secure Inpatient Services. Updates will be received through Executive Quality Assurance and Improvement Group. Additionally, a task and finish group has been established to oversee the review and improvement actions taken. Work is well underway to analyse data and identify key themes. The executive medical and nurse director have reviewed levels of self-harm at individual patient level and are establishing a harm minimisation panel to provide external support and oversight of these complex cases. The highest levels of reported self-harm have occurred SIS and LD services and it is anticipated that the Hopes model will also provide some input and support to approaches for these individuals.

c) Regular reporting on bank and agency use is now being stepped up again by NHS England and NHS Improvement (NHSE) via the monthly Temporary Staffing Data Collection. This information is used by the NHSE National Temporary Staffing Team to monitor the demand for and usage of bank and agency workers across the NHS, and to prioritise the team's support offer to Trusts. We are reviewing our process of sign off of off framework/ above cap agency use across professions and will also sign up to the regional data sharing agreement on us of these staff groups.

3.4 Summary of Key Risks

3.4.1 The Integrated Performance Report is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks.

- **(BAF Risk 15) Financial Sustainability & (CRR risk 1260)** There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality
    a. Failure to reduce inpatient staffing costs and Trustwide agency utilisation (volume and rate reductions to reduce related premium costs)
    b. Failure to reduce lengths of stay, including through work with system partners, to reduce adult A&T and PICU bed occupancy and eliminate unfunded Independent Sector bed placements and reduce safer staffing requirements for inpatient wards
    c. Failure to negotiate equitable recurrent funding mechanism for in-year and accumulated prior year AFC pay deal (tariff-based) pressures
    d. Failure to agree funded alternative clinical models as an alternative to unsustainable high-cost complex packages of care
    e. Failure to retain permanent staffing, including as a consequence of acute cost of living pressures

- **Safe staffing** remains a concern and is being negatively impacted on through multiple factors including vacancies, sickness above target, high levels of bed occupancy and acuity in inpatient wards, demand in community services. Hotspots include Secure Inpatient Services and Learning Disability services due to increased numbers of leavers however there is an improving position with new recruits commencing. Registered nurses across Roseberry Park (Dalesway) have also been flagged as a new risk due to vacancies. Areas of concern affecting the delivery of high-quality care and skill mix include Registered Nurse fill rates on days below 90% (36/54 wards). Establishment reviews are underway using evidence based staffing tools and professional judgement with Learning Disability and MHSOP interim proposed staffing models coming to the Trust Board for approval this month. International recruitment and over recruitment of Health Care Assistants are also key mitigating actions and enablers to maintain safe staffing.

Recommendations:

The Board of Directors is asked to:

1.1 Confirm whether the level of oversight in this report is sufficient and if it is assured on the actions being taken to improve performance in the required areas.

1.2 Agree the proposed standard of 85% for Appraisal and Mandatory Training.

1.3 Consider whether additional complementary financial narrative and reporting (to the current Board IPR) would be appropriate given the current financial context.

1.4 Approve the revised Finance measure on Agency Spending for inclusion in the Board Integrated Performance Dashboard.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Appendix A

Board Integrated Performance Report (IPR) As 31st July 2022

journey to change

CONTENTS

Please Note:
Following the cyber security-related incident on the 4th August 2022 and the impact on the Integrated Information Centre (IIC), data is not available for July 2022. Therefore, the majority of **data and charts** presented within this report are as at June 2022 unless otherwise stated. However, all **narrative and updates on actions** reflect current progress.

Chapter 1

Integrated Performance Dashboard (IPD)

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Within our Board Integrated 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 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

Please note assurance on whether the standard is achievable is currently not in this report as this is pending the work around standards that is referenced in the Executive Oversight.

Our Approach to Data Quality and Action

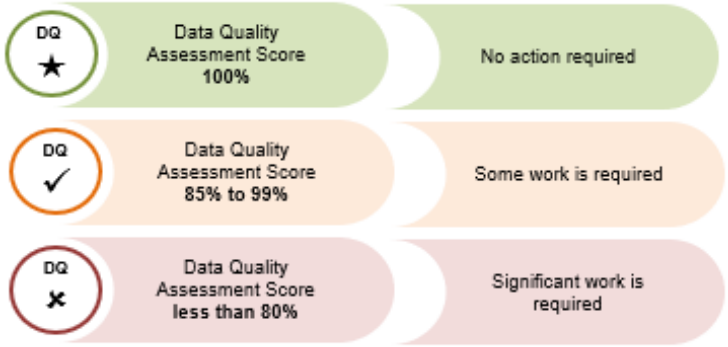
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Data Quality
We regularly undertake a data quality assessment on Board level measures. Our current 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.

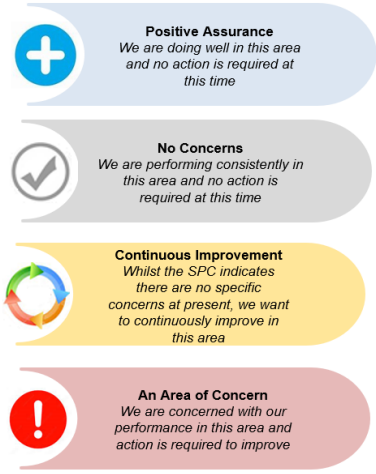
A development is underway to review our current assessment tool and work will be undertaken to complete the assessment for all measures using the new tool, by the 30th September 2022.

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



Action status



Please note the Data Quality Assessment status has only been included for those measures that we reported in the 21/22 Trust Performance Dashboard. Work will be undertaken to complete this assessment for all measures by the 30th September 2022.

Please note in the absence of agreed standards, the action status has been determined upon the current variation depicted within the Statistical Process Chart or other relevant information.

Board Integrated Performance Dashboard Summary as at 30th June 2022

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Please Note:
As a result of the cyber security-related incident experienced this month, the dashboard presented below is the position as at the 30th June 2022.

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC				91.77%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC				70.08%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC				59.06%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC				25.56%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L			46.86%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC				44.94%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L			21.19%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H			99.96%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			1,081	
10)	The number of Serious Incidents reported on STEIS	QAC				35	
11)	The number of Service Reviews relating to incidents of moderate harm and near misses	QAC	L			175	
12)	The number of Restrictive Intervention Incidents	QAC				1,785	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				0	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	
15)	The number of uses of the Mental Health Act	MHLC				1,064	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D				55.01%	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				58.76%	
18)	Staff Leaver Rate	PC&D	H			13.87%	
19)	Percentage Sickness Absence Rate (month behind)	PC&D	H			6.48%	
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L			86.53%	
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	L			79.67%	

Rep Ref	Our Financial and activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				24,916	
23)	Unique Caseload (snapshot)	S&RC	H			61,089	

The following data is as at 31st July 2022

Rep Ref	Out Financial and activity measures	Committee responsible for assurance	Plan (FYTD)	Actual (FYTD)
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit	S&RC	£925,000	£2,111,962
26	Use of Resources Rating - overall score	S&RC	3	3
27	CRES Performance - Recurrent	S&RC	£2,763,100	£2,146,935
28	CRES Performance – Non-Recurrent	S&RC	£463,900	£481,564
29	Capital Expenditure (Capital Allocation)	S&RC	£3,118,000	£2,729,000
30	Cash balances (actual compared to plan)	S&RC	£77,802,000	£80,344,694

Please Note:
Outstanding measure *25) Underlying Performance - run rate movement* – please see slide 56 for update

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

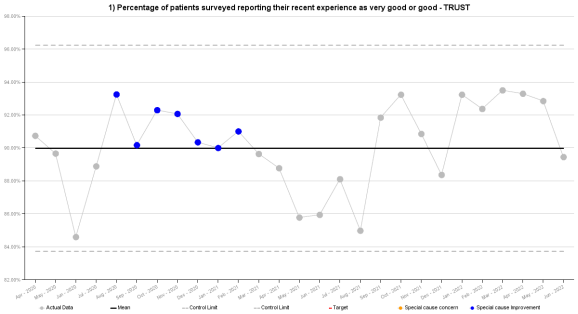
We are all committed to co creating a great experience for patients, and carers and families by ensuring we are providing outstanding and compassionate care and that people tell us this is the case from their experience.

During June, **834** 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, **746 (89.45%)** scored "very good" or "good"

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

DQ ✓ **85%**

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area



Care Group/Directorate	Variation
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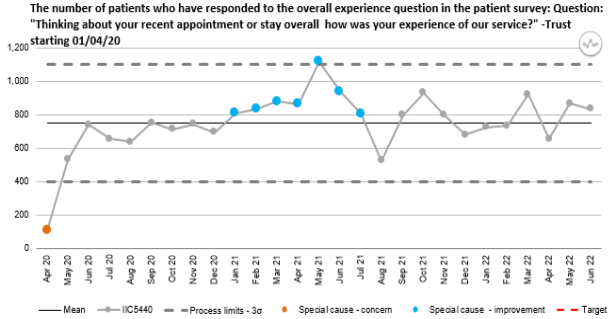
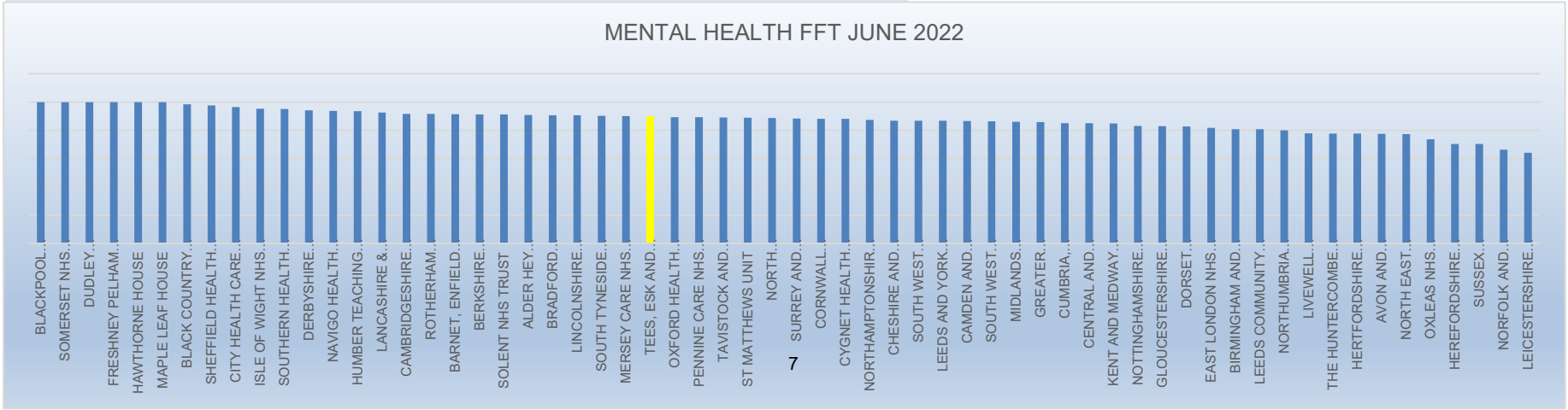
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	



National Benchmarking - Mental Health Friends and Family Test (FFT) data - June 2022. The Mental Health FFT dataset includes FFT responses for the latest month from providers of NHS funded mental health services. The England average (including Independent Sector Providers) percentage positive responses about their overall experience was **86%**, our Trust is identified by the yellow bar in the chart below. We are ranked 26 in the list of providers shown.

Please note due to the Cyber Security Incident/IIC Outage, we will not be able to make a submission this month; however this has been communicated to NHSEI and we plan to make a submission in September that covers both July and August.



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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	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.	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. This work will commence in May 2022.	**Ongoing.** The Directors of Nursing, Directors of Lived Experience and Patient Experience Team met on the 5th August. The aim was to agree the annual work plan; however it was agreed each Care Group would do a stock take to better understand the current position. A paper has been drafted for Management Group seeking approval for 2 Care Board task and finish groups to review the previous action plan, review current data and agree a Service Improvement Plan. It is proposed that progress be monitored within existing forums. The Patient Experience colleagues have commenced quality visits and spoken to staff and patients to remind about the importance of patient and carer experience.	
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, during April 2022 to investigate and identify appropriate actions to correct the measure.	**Ongoing**. The IIC Team are working with Meridian and the Patient Experience Team but this is taking longer than anticipated as a number of additional issues have been identified, including the misalignment of cost centres when setting up teams on the Meridian system and the provision of monthly snapshots from Meridian that do not include late survey submissions. Work will continue through August and September 2022 to resolve.	
As above	The IIC Manager to progress the development of a system alert that will inform the team of any missing meridian reports, with a view to preventing future recurrence of this issue. A timescale for completion will be confirmed prior to the Executive Directors meeting in July 2022.	**Completed.** The new process was implemented on the 18th July 2022.	Not Applicable

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
New The number of responses received will be impacted by the Cyber Security Incident as the devices (tablets) need to be replaced. This has impacted the period commencing 4th August 2022.	The Patient Experience Team have identified a number of mitigating actions (e.g. reverting to paper surveys, requested support from Digital Services to support updates to devices etc.) with immediate effect.	**Ongoing.** Communications have been sent to the wards affected to utilise paper surveys. A number of devices (37) have now been updated and are configured for use by the wards, 21 wards are still without devices. Weekly monitoring will continue in relation to the outstanding devices.	

02) Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for

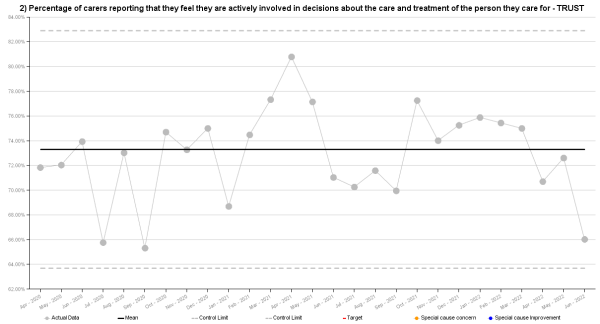
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

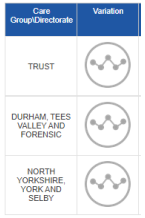
We are all committed to co creating a great experience for patients, carers and families by including carers in any decisions about the person they care for and working with them to provide quality care, and that carers will tell us this is the case from their experience.

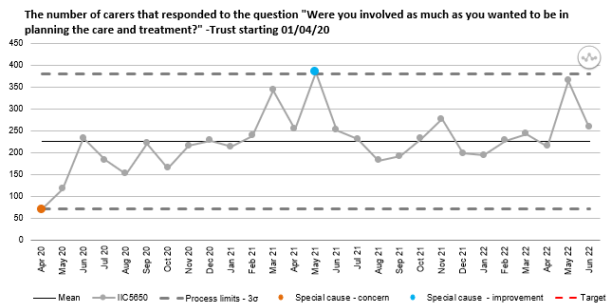
During June, **259** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **171 (66.02%)** scored "yes, always".

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

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area







Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that carers of patients within our North Yorkshire, York & Selby Mental Health Services for Older People do not feel they are actively involved in decisions regarding those they care for.	Head of Performance/Senior Performance Manager to engage with the Head of Patient Experience to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group.	**Completed.** The Associate Director of Performance met with the Head of Patient Experience on 10th June 2022 and this was discussed at the Care Group Quality Assurance & Improvement Sub Groups early June 2022. Within North Yorkshire, York & Selby Care Group there is a bi– monthly participation group with a number of supporting groups at speciality level.	Based on the latest data, Mental Health Services for Older People are no longer indicating a cause for concern and are now within expected levels.

Triangulation

In terms of the improvement work we have undertaken in relation to patient/carer/relative involvement with our **inpatients**, the latest results from the Modern Matron Quality Reviews show that 93% of patient and carer views were included in the safety summary (from 58%) and there was small improvement in terms of evidence that the current prescription of leave/time off the ward was discussed, risks identified and mitigations proposed with carer/relatives (72% to 73%). In terms of **community teams** further improvements are required with only 62% of patient and carer views included in the safety summary from 47%. This is based on the latest peer reviews. ***Source: Thematic Review: Evidence/Assurance of Service Improvements – Presentation to Commissioners 21.07.22***

03) Percentage of inpatients reporting that they feel safe whilst in our care

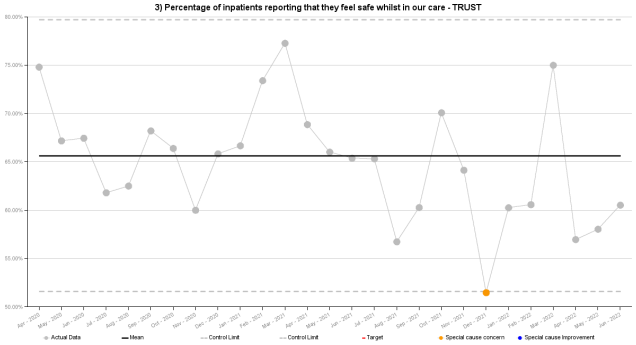
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

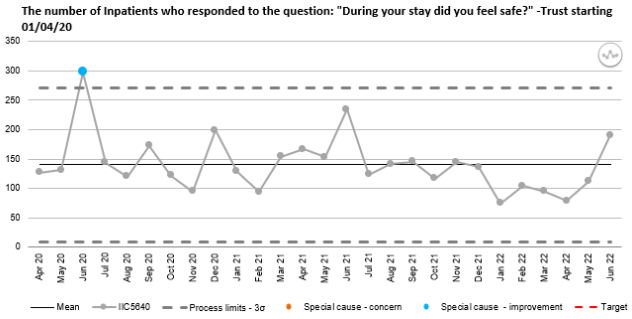
We are all committed to co-creating safe and personalised care, preventing people from receiving unsafe care and treatment and preventing avoidable harm or risk of harm to inpatients within our services, and that patients will tell us this is the case from their experience.

During June, **190** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **115 (60.53%)** scored “yes, always"

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve





Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that inpatients within our Durham and Tees Valley Adult Mental Heath Services do not feel safe during their stay with us.	Senior Performance Manager to engage with the Head of Patient Experience to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group.	**Completed.** This was discussed at the Care Group Quality Assurance & Improvement Sub Group early June 2022. Focused work is being undertaken within Secure Inpatient Services (see action overleaf) and findings will be shared across the Care Group. Patients have reported that having activities to do increases their feeling of safety on the wards therefore activity co-ordinators are being recruited for all wards with some commencing in post from April 2022. This work is being incorporated into the wider service improvement plan for patient and carer experience.	Based on the latest data, Adult Mental Health Services are no longer indicating a statistical cause for concern; however we are concerned and actions are detailed overleaf.

03) Percentage of inpatients reporting that they feel safe whilst in our care

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We previously identified a concern that inpatients within our Secure Inpatient Services did not feel safe during their stay with us. Work was undertaken with Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust on the 'Feeling Safe' theme late 2021, which identified similarities in feedback from inpatients in relation to feeling safe, witnessing violence and aggression and the number of activities available	Head of Patient Experience to hold focus groups initially within secure services during April 2022 to explore these themes further and identify areas of improvement.	**Ongoing.** Secure Inpatient Services (SIS) focus groups were held between April and June 2022. Good data was received on reasons why patients do not feel safe and this was presented to the quality assurance forum in August 2022. It has informed a number of actions to be taken around the need for a staff presence in communal areas-zonal observations, the presence of agency staff, the importance of regular ward-based activities and embedding a positive practice culture based on Trust values. This will be shared with the Executive Quality Assurance & Improvement Group late August 22. A Service Improvement Plan will be developed by the Associate Director of Nursing & Quality by mid September. There is also a proposal to expand this work to Adult services which will be discussed at the Executive Quality Assurance & Improvement Group late August 22.	
We are concerned that inpatients within all our Services do not feel as safe as we would like during their stay with us.	A number of actions have been identified in our Quality Account around "Feeling Safe". We should see an improvement in this measure as a result of the work being progressed. We will review progress within the Quality Account on a quarterly basis and assess whether these actions are having the desired impact.	**Ongoing.** The first progress update will be presented to the Executive Quality Assurance & Improvement Group at the end of August 2022. There are no issues or significant concern to escalate at this point.	
New During Q1 of 22/23 we did not have any responses in relation to feeling safe from 27 wards	The Patient Experience Team have provided the relevant Heads of Service with a list of wards that have not had any responses. This is provided monthly.	**Ongoing**. The list of wards has been provided to Heads of Service to review and establish action plans (where appropriate). This is being raised in the September Quality Assurance & Improvement Groups for action.	

04) Percentage of CYP showing measurable improvement following treatment - patient reported

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

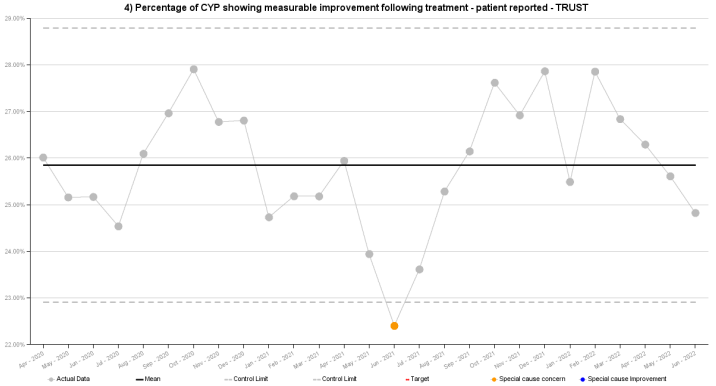
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a patient perspective, is one way we will know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

For the 3 month rolling period ending June, **709** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 176 (24.82%)** made a measurable improvement.

The accepted Patient Rated Outcome Measures are CORS / ORS / GBO (goal based outcomes) / RCADS / SDQ / SCORE-15 / PHQ-9 / GAD-7 / CORE-10.

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

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

06) Percentage of CYP showing measurable improvement following treatment - clinician reported

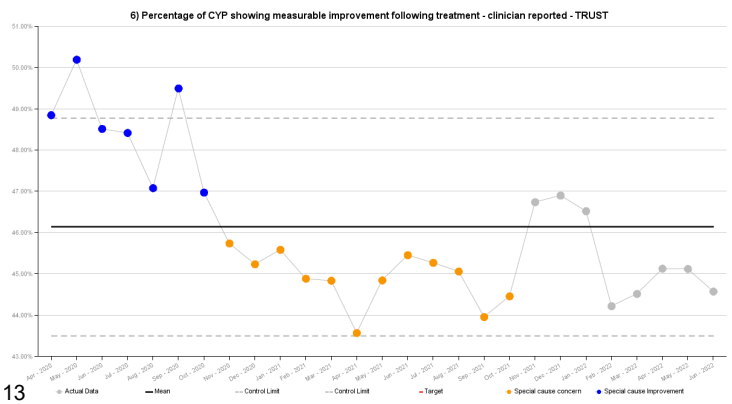
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a clinical perspective, is one way we will know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

For the 3 month rolling period ending June, **774** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 345 (44.57%)** made a measurable improvement.

(The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve



Care Group\Directorate	Variation
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DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	L

Outcomes: 04) Percentage of CYP showing measurable improvement following treatment - patient reported and 06) Percentage of CYP showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, Children & Young People Services are showing an improvement in their clinician-rated outcome measures than we would like.	Care Group Director of Nursing & Quality to facilitate a discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group to identify the actions that are required to address this. Contact will be made with all General Managers before the meeting to ensure that the discussion will be meaningful.	**Complete.** Actions have been identified by the speciality and reported to the June Quality, Assurance & Improvement Sub Group (see new actions included overleaf).	Not Applicable
As above	Head of Performance to engage the Service Development Manager in undertaking a team-level deep dive into the data to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Complete.** Analysis of data at team level is now complete and initial findings have identified a low number of patients discharged with a paired score within the Attention Deficit Hyperactivity Disorder and Autism teams, which are assessment teams and do not deliver treatment. At the July Outcomes Steering Group the following new action was agreed.	Not Applicable
As above	**New** CYP Service Development Manager to engage with the Service Manager for the Durham and Easington Getting Help teams, who are the higher performing teams in respect of outcomes, to identify any lessons learned that can been shared Trust-wide. This will be completed in September and findings reported to the Clinical Network.	**Not started.**	
As above	A working group to be set up to progress the Routine Outcome Monitoring (ROMs) agenda in the clinical workforce through huddles, clinical supervision and caseload management supervision. Service Development Manager to table this at the next Clinical Network meeting in July to agree representatives on this group.	**Complete:** A working group has been set up and work is underway to operationalise the ROMs agenda, which includes delivery of the Commissioning for Quality & Innovation for Routine outcome monitoring in CYP and perinatal mental health services.	We would expect to see an improving position once actions are identified and completed.

Outcomes: 04) Percentage of CYP showing measurable improvement following treatment - patient reported and 06) Percentage of CYP showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned we are aiming to have high performance and we have no significant change in our performance which remains below the mean (average)	The Section Head of Research & Statistics will undertake a piece of analysis to triangulate and correlate the completion rates and timeliness data in order to better understand the variation shown in the SPC chart (previous slide). This work will be completed by the end of July 2022.	**Complete.** Detailed analysis over a 2-year period has been completed. Analysis has identified, that pre-pandemic there was a higher rate of "timely" outcome measurement (at referral and discharge) than post pandemic. This means that we cannot capture the full extent of the impact of care. Improvements are required to facilitate timely recording of outcome measures at the correct stages in patient journeys and further steps will be discussed with the Outcomes Group (see action below).	Not Applicable
As above	Associate Director of Performance and Section Head of Research & Statistics to explore the inclusion of contextual measures (e.g. timely outcomes) within the Integrated Performance Dashboards. Discussion to take place during August 2022.	**Ongoing.** The Associate Director of Performance and Section Head of Research & Statistics met early August to discuss the inclusion of contextual measures (e.g. timely outcomes) within the Integrated Performance Dashboards. This work has been impacted by the IIC outage as the system is required to enable further coverage of the timescales being analysed. This work will be resumed as soon as the IIC becomes operational.	
As above	Care Group Managing Directors to ensure appropriate Care Group representation at the Trust-wide Outcomes Group by August 2022, to maintain oversight and assurance of patient outcomes between the two forums.	**Complete.** Both Care Groups will be represented by the Care Group Medical Directors.	Not Applicable

05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

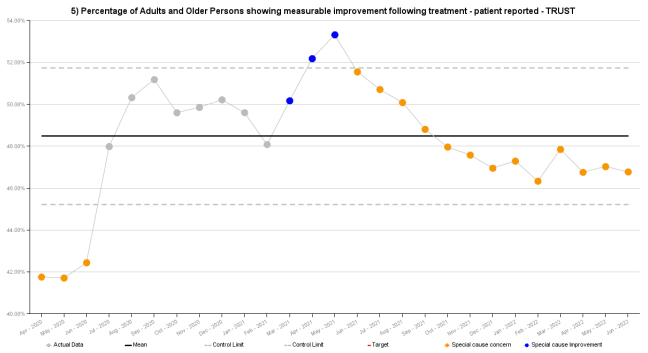
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a patient perspective, is one way we will know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

For the 3 month rolling period ending June, **1939** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 907 (46.78%)** made a measurable improvement.

The accepted Patient Rated Outcome Measure is Short Warwick Edinburgh Mental Well-Being Scale (SWEMWBS).

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve



Care Group\Directorate	Variation
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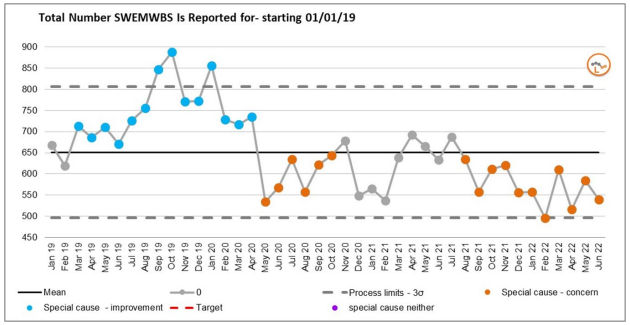
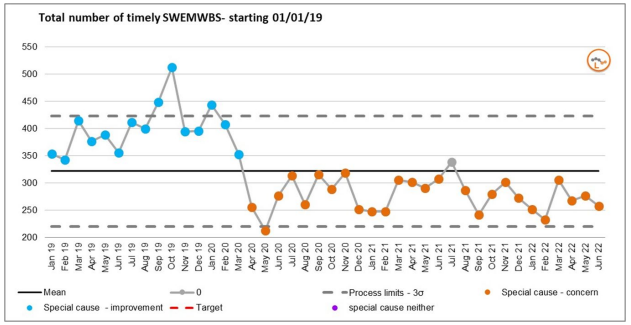
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Supporting Measures

The number of patients that have a paired measure recorded over-time. The SPC chart indicates a significant shift, demonstrating a reduction in the rate of paired measures recorded over-time. The impact of COVID is clear, with a significant reduction denoting the start of the pandemic that is sustained to present day. Impact: If less paired measures are recorded, the patient population captured by the IPD is significantly reduced. This means that a significant proportion of patients are being discharged that we can't evaluate the impact of care for.

The number of patients who are discharged with 2 SWEMWBS recorded that are considered representative of their presentation at the start of care and at the end of care. The SPC chart indicates a significant reduction in the number of measures that are capturing the whole course of treatment. This means that a significant proportion of paired measures are capturing 2 random time points in the patient journey, limiting our ability to evaluate true and meaningful change. Impact: A high rate of untimely measures inhibits our ability to show meaningful change, even when it has happened. We are unable to evaluate the full impact of care if the measures don't capture patient presentation at the beginning and end of their journey.





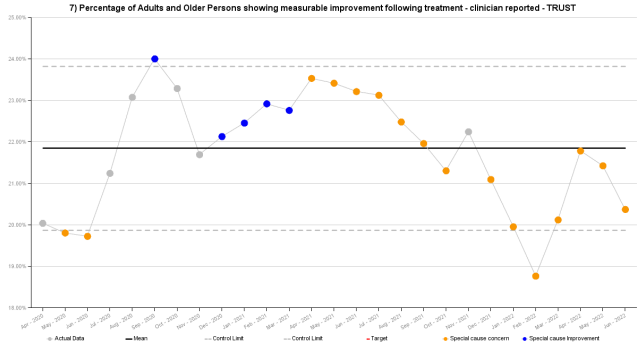
07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

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

For the 3 month rolling period ending June, **3225** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 657 (20.37%)** made a measurable improvement.

The accepted Patient Rated Outcome Measure is Health of the Nation Outcome Scales (HoNOS).



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

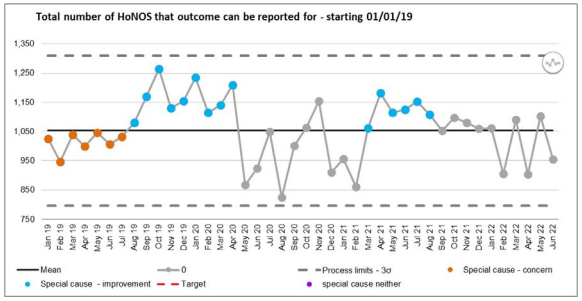
We're aiming to have high performance and we're moving in the wrong direction.

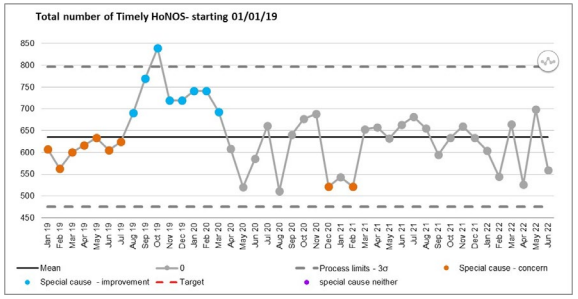
An Area of Concern
We are concerned with our performance in this area and action is required to improve

Supporting Measures

The number of patients that have a paired measure recorded over-time. The total number of HoNOS measures recorded over-time does not show any major fluctuations but there does appear to be a slight impact of COVID that is slowly recovering. Impact: The data indicates that the completion rates for HoNOS are not a significant concern and can provide some assurance that the cohort captured is reflective of the cohort discharged.

The number of patients who are discharged with 2 HoNOS measures recorded that are considered representative of their presentation at the start of care and at the end of care. The SPC chart does indicate a change in the rate of timeliness of measures recorded. Pre-covid the data peaked at 850 timely measures recorded and is indicative of a sustained improvement up to March 20. After that point, the timeliness levels indicate a reduction in the number of timely measures recorded. Impact: A high rate of untimely measures inhibits our ability to show meaningful change, even when it has happened. We are unable to evaluate the full impact of care if the measures don't capture patient presentation at the beginning and end of their journey.





Outcomes: 05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported and 07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, York & Selby Adult and Older People Services are showing an improvement in their patient- and clinician-rated outcome measures than we would like.	Care Group Director of Nursing & Quality to facilitate a discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group to identify the actions that are required to address this. Contact will be made with all General Managers before the meeting to ensure that the discussion will be meaningful.	**Complete.** Actions have been identified by both specialities and reported to the June Quality, Assurance & Improvement Sub Group (see actions included below and overleaf).	Based on the latest data, MHSOP are no longer indicating a cause for concern for both sets of outcome measures.
As above	Head of Performance to engage the Adult Mental Health and Mental Health Services for Older People Service Development Managers in undertaking a team-level deep dive into the data to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Complete.** Analysis of data at team level is now complete and initial findings have been shared with General Managers and Service Development Managers. The findings were discussed within speciality level performance meetings during July and actions agreed are detailed overleaf.	Not Applicable
As above	The Mental Health Services for Older People Service Development Manager to develop a clinical network work plan, which will include actions on training and the support required to improve outcomes from a network point of view. This will be completed in July 2022.	**Complete.** The MHSOP plans were agreed in July. A task and finish group has been set up for each clinical pathway which incorporates clinical outcome work and reports into the Clinical Network for assurance on a monthly basis.	MHSOP are now performing within the levels that we would expect to see and we would expect this to continue as the plans are embedded
As above	The Adult Mental Health Service Development Manager to develop a clinical network work plan, which will include actions on training and the support required to improve outcomes from a network point of view. This will be completed in July 2022.	**Ongoing.** The Clinical Network Group met in July but the plan did not get developed due to time constraints. There is a further meeting on the 1st September to develop the plan.	

Outcomes: 05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported and 07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, York & Selby Adult and Older People Services are showing an improvement in their patient- and clinician-rated outcome measures than we would like.	Adult Mental Health General Manager to introduce team level compliance to the weekly report out during July 2022 to support a targeted approach to understand the gaps in knowledge and process and thus improve outcome for our patients.	**Complete.** Team level compliance has been introduced by the General Manager as part of the weekly performance huddle during July.	We would expect to see an improving position as the process becomes embedded.
As above	Service Development Managers to engage with Digital & Data Services to facilitate the addition of a 'outcomes' prompt within the clinical supervision dashboard. This will be undertaken before the pilot phase of the new dashboard starts on the 15th August 2022.	**Ongoing**. This has been impacted by the IIC outage but it has been agreed that the Clinical Outcomes Group should be involved as the content will need to be clinically developed. This is now to be picked up in phase 2 of the dashboard development.	
As above	MHSOP General Manager to review the current outcome measures (including the Commissioning for Quality & Innovation ambitions) and agree a lead measure that will be given focus within the weekly performance meetings, with a view to supporting a focused approach to continuous improvement for outcomes. This will be agreed by the 31st August 2022.	**Complete.** At the June MHSOP Quality, Assurance and Improvement Group (QAIG) meeting it was agreed that the primary focus will be ensuring that paired scores are recorded for all patients at the start and end of treatment, which will provide accurate data to assess whether our patients are showing improvements in their outcomes.	Based on the latest data, MHSOP are no longer indicating a cause for concern for both sets of outcome measures.
As above	MHSOP General Manager and Service Development Manager to implement Outcomes training within the Care Group by June 2022, to support improved recording of outcomes.	**Complete.** Outcomes training sessions have been undertaken and specific/bespoke training is now monitored through the MHSOP Clinical Network.	Performance is now at a level we would expect to see and we would expect this to improve as the training continues.

Outcomes: 05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported and 07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned we are aiming to have high performance and we are moving in the wrong direction	The Section Head of Research & Statistics will undertake a piece of analysis to triangulate and correlate the completion rates and timeliness data in order to better understand the variation shown in the SPC chart (previous slide). This work will be completed by the end of July 2022.	**Complete.** Detailed analysis over a 2-year period has been completed. Analysis has identified, that pre-pandemic there was a significantly higher rate of "timely" outcome measurement (at referral and discharge) than post pandemic. For SWEMWBS, timely outcome measurement has declined by approximately 35%; for HoNOS, around 20%. This means that we cannot capture the full extent of the impact of care. Improvements are required to facilitate timely recording of outcome measures at the correct stages in patient journeys and further steps will be discussed with the Outcomes Group (see action below).	Not Applicable
As above	Associate Director of Performance and Section Head of Research & Statistics to explore the inclusion of contextual measures (e.g. timely outcomes) within the Integrated Performance Dashboards. Discussion to take place during August 2022.	**Complete.** The Associate Director of Performance and Section Head of Research & Statistics met early August to discuss the inclusion of contextual measures (e.g. timely outcomes) within the Integrated Performance Dashboards.	Not Applicable
As above	Care Group Managing Directors to ensure appropriate Care Group representation at the Trust-wide Outcomes Group by August 2022, to maintain oversight and assurance of patient outcomes between the two forums.	**Complete.** Both Care Groups will be represented by the Care Group Medical Directors.	Not Applicable

08) Bed Occupancy (AMH & MHSOP A & T Wards)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

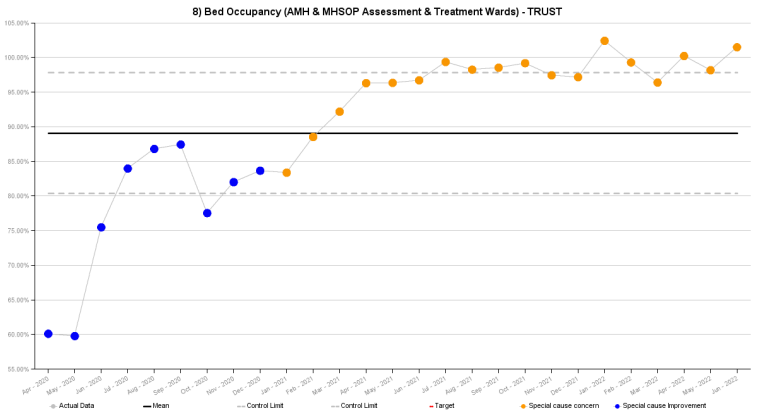
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important 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 June, **10,740** daily beds were available for patients; of those, **10,902 (101.51%)** were occupied.

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve

DQ ★ **100%**



Care Group\Directorate	Variation
TRUST	H
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	H

09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

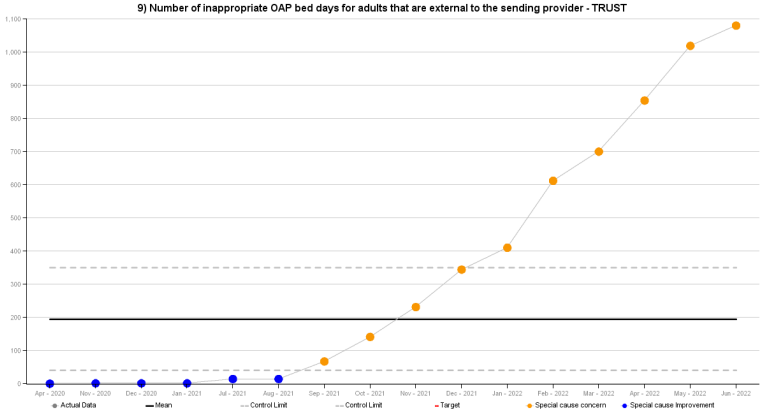
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending June, **1081** days were spent by patients in beds away from their closest hospital.

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve

DQ ★ **100%**



Care Group\Directorate	Variation
TRUST	H
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	H

Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Please note the key issues for bed occupancy and inappropriate Out of Area bed days have been consolidated and some actions revised following the Executive Meeting on the 22nd Jun 22			
Bed occupancy remains high as a result of bed reductions in the North Yorkshire, York and Selby Care Group which is impacting on the number of out of area placements	General Manager for Mental Health Services for Older Persons to open 2 beds on Rowan Lea on 4th April 22 which would create an additional 52 available bed days in April then proportionate amount thereafter	**Completed.** 2 beds were opened on Rowan Lea on the 4th April 2022.	Whilst this created additional bed capacity it did not impact on the overall performance.
As above	General Manager for Adult Mental Health to open 13 beds on Esk Ward by the end of June 22 which would create an additional 403 available bed days in July then proportionate amount thereafter	**Completed.** 13 beds were opened on Esk Ward on 26th April 2022 (earlier than planned); however there was a reduction of beds on Danby Ward (from 13 to 4) on 26th April 2022 to support safe staffing (see below action).	Whilst this created additional bed capacity it did not impact on the overall performance.
As above	General Manager for Adult Mental Health Service to support the increase of beds on Danby Ward to full capacity (13 beds) by September 22.	**Complete.** Danby Ward increased to full capacity (13 beds) on the 17th August 2022.	As the IIC has been unavailable, it is not possible at this stage to confirm how this has impacted overall performance.
As above	Director of Partnerships and Case Management to review the contract for the Priory for 5 beds which are due to cease at the end of June 22, during May 2022.	**Completed.** Gold Command agreed an extension to the end of September 2022, on the 20th May 2022.	Whilst this creates additional bed capacity it is not yet possible to know if this will impact on overall performance.

Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
There are a range of issues impacting on bed occupancy (e.g. increased length of stay, delayed transfers of care) which is impacting on the number of out of area placements	The Associate Director of Strategic Planning & Programmes to form a trust-wide working group, with executive oversight of inpatient bed pressures. This group will be led by the new Medical Director from July 22.	**Complete.** Two meetings of the Trust-wide Bed Management Group have taken place during July. The first (4th) focused on understanding the work undertaken to date and the second (20th) on analysis of data to understand our current position. Key findings will be shared with Clinical Leaders and the Clinical Programme Board on the 29th July. A number of actions were identified and are detailed on this and the following pages.	We would expect to see an improving position as actions are identified and completed.
As above	Care Group Managing Directors to ensure appropriate Care Group representation at the Trust-wide Bed Management Group by August 2022, to maintain oversight and assurance between the two forums.	**Complete.** Durham, Tees Valley & Forensic Care Group will be represented by the Care Group Director of Operations & Transformation - AMH/MHSOP and Care Group Medical Director; North Yorkshire York & Selby Care Group will be represented by the Care Group Director of Nursing and Quality and Care Group Director of Operations & Transformation.	Not Applicable
As above	Associate Director of Strategic Planning and Programmes to engage with the Trust wide Bed Management Group, Care Groups and Clinical Programme Manager to develop a presentation to share with the Medical Director on past, present and potential future initiatives that could be considered to reduce admissions or length of stay. This will be presented to the Trust-wide Bed Management Group on 10th August.	**Ongoing**. The Trust wide Bed Management Group met on the 10th August. Whilst discussions took place around initiatives and ideas and some best practice was shared. It was agreed that the Care Groups would document their proposals around past, present, and potential future initiatives and share these with the Medical Director for discussion with Executive Directors on the 24th August 22.	
We need to determine the longer term requirement for beds which is linked to our Clinical Journey	The Associate Director of Strategic Planning and Programmes to lead a procurement for external support to help us to identify the appropriate number of beds required in the longer-term	**Ongoing.** This procurement will be informed by the work of the new Trust-wide working group *(see previous actions)*	

Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Bed pressures are continuing to impact on our services; however this measure only includes our own Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards therefore is not providing a comprehensive picture of overall occupancy	Senior Performance Manager to facilitate wider analysis of bed pressures which incorporates the available and occupied beds days purchased from the Priory and the occupied bed days for the external out of area placements by the end of June 22.	**Completed.** Overall occupancy data including Trust and Priory beds is now provided within this Bed Pressure section.	Not Applicable
There is concern that a high number of beds within the Care Groups are being occupied by patients outside of their respective Care Group; however still within the Trust.	Head of Performance and Senior Performance Manager to investigate whether we can identify the current patient base (e.g. the use of total bed capacity by the different populations and how long their LOS is) to support discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Groups. Work will start the week commencing 23rd May 2022.	**Complete.** Bed base analysis focusing on the different populations has been completed, including analysis on length of stay. Data was shared at the Trust-wide Bed Management Group on 20th July. See action below.	Not Applicable
Bed Pressures within our Durham and Tees Valley beds, including increased length of stay and out of area placements, are impacting on our service; however further work is required to understand any additional underlying issues and consolidate actions	Senior Performance Manager to engage the Bed Services Manager in undertaking a ward-level deep dive to support the General Managers in a discussion on this measure and the key areas of concern at the June 2022 Care Group Quality & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Completed.** Ward level analysis completed and discussed with Bed Services Manager. The areas of concern identified included some patients with long lengths of stay and high level of occupancy across all inpatient wards. Further analysis will be now picked up by the Trust-wide Bed Management Group.	Not Applicable

Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue: Bed pressures are continuing to impact on our services; however this measure only includes our own Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards therefore is not providing a comprehensive picture of overall occupancy

Action: Senior Performance Manager to facilitate wider analysis of bed pressures which incorporates the available and occupied beds days purchased from the Priory and the occupied bed days for the external out of area placements by the end of June 22.

Outcome: The following table incorporates available and occupied bed days within our Trust beds, the beds we have purchased from the Priory at Middleton St George and actual out of area placements. This shows our level of occupancy over the past three months exceeding 100%.

		2022 - 2023			
		Apr	May	Jun	FYTD
Trust Beds (Measure 8)	Number of occupied bed days	10,453	10,908	10,902	**32,263**
	Number of available bed days	10,428	11,098	10,740	**32,266**
	Percentage Bed Occupancy	**100.24%**	**98.29%**	**101.51%**	**99.99%**
Block Booked Beds - Priory, Middleton St George	Number of occupied bed days	149	154	149	**452**
	Number of available bed days	150	155	150	**455**
	Percentage Bed Occupancy	99.33%	99.35%	99.33%	99.34%
True Out of Area Placements (measure 9 but monthly)	Number of occupied bed days	309	472	300	1,081
	Number of available bed days				
	Percentage Bed Occupancy				
Overall Occupancy	Number of occupied bed days	10,911	11,534	11,351	**33,796**
	Number of available bed days	10,578	11,253	10,890	**32,721**
	Percentage Bed Occupancy	**103.15%**	**102.50%**	**104.23%**	**103.29%**

10) The number of Serious Incidents reported on STEIS

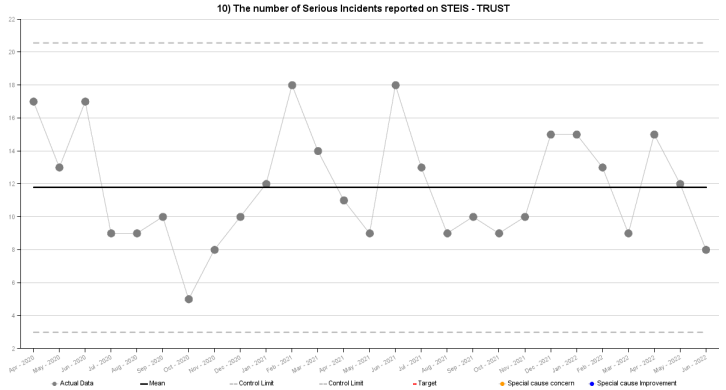
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

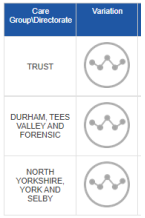
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

16 serious incidents were reported on the Strategic Executive Information System (STEIS) during **July**.

- 14 were within the Community (12 unexpected deaths/ 2 serious harm – no themes)
- 2 Inpatients (both severe harm). One was related to a jump from a Trust Property Roof – discussed in Environmental risk group to formulate robust action plan due to similar incidents where patients have gained access to roofs

(Data provided by the Patient Safety Team)





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

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area

NOTE The narrative reflects July data but the data represented in the chart is as at June

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of Serious Incidents reported on STEIS, we review every Serious Incident and optimise the opportunities for learning and improvement to prevent similar incidents occurring.	Associate Director of Performance to engage with the Director of Quality Governance to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussions at the Quality Assurance & Improvement Groups.	**Complete.** Meeting held 10th June 2022. Where new or consistent themes are identified from the review of Serious Incidents these will be discussed through the appropriate governance route and highlighted to the Board including the actions we are taking to make improvements.	We would expect to see a reduction in number/themes once actions are completed and reported via the Organisational Learning Group.
As above	A monthly huddle to be arranged involving the Director of Quality Governance, Associate Director of Performance and other professional leads to discuss and triangulate relevant information in order to provide assurance to the Executive Meeting. Dates to be arranged by the end of June 2022.	**Complete.** Monthly huddles in the diary from July 22 for the remainder of the financial year.	We would expect to see an improving position as the huddles become embedded.

11) The number of Service Reviews relating to incidents of moderate harm and near misses

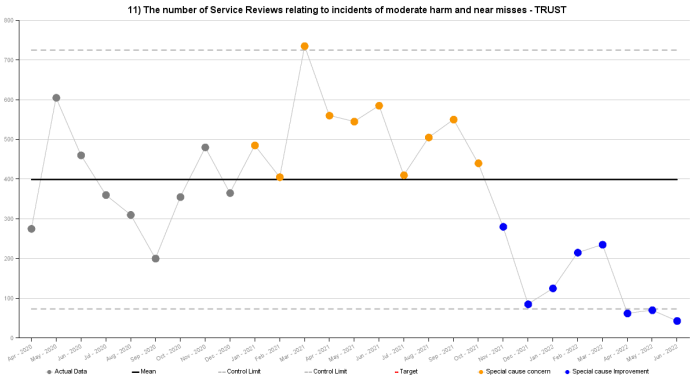
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 and distress to their families and carers.

43 number of service reviews were undertaken in relation to incidents of moderate harm or 'near misses' during June.

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

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area



Care Group\Directorate	Variation
TRUST	L
DURHAM, TEES VALLEY AND FORENSIC	L
NORTH YORKSHIRE, YORK AND SELBY	L

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst we are now indicating positive assurance in the number of Service Reviews relating to incidents of moderate harm and near misses, we review every Incident and optimise the opportunities for learning and improvement to prevent similar incidents occurring.	Associate Director of Performance to engage with the Director of Quality Governance to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussion at the Quality Assurance & Improvement Groups.	**Complete.** Meeting held 10th June 2022. Where new or consistent themes are identified from the review of Incidents these will be discussed through the appropriate governance route and highlighted to the Board including the actions we are taking to make improvements.	We would expect to see a reduction in number/themes once actions are completed and reported via the Organisational Learning Group.
As above	A monthly huddle to be arranged involving the Director of Quality Governance, Associate Director of Performance and other professional leads to discuss and triangulate relevant information in order to provide assurance to the Executive Meeting. Dates to be arranged by the end of June 2022.	**Complete.** Monthly huddles in the diary from July 22 for the remainder of the financial year.	Not Applicable

11) The number of Service Reviews relating to incidents of moderate harm and near misses

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst we are now indicating positive assurance in the number of Service Reviews relating to incidents of moderate harm and near misses, we need to review this measure to ensure it is fit for purpose	**New** Associate Director of Performance and the Director of Quality Governance to review this existing measure to identify whether it is fit for purpose and to identify possible alternatives if necessary. This work will be concluded by mid August 2022.	**Complete.** A revised measure, "The number of Incidents of moderate harm and near misses" has been identified as a more meaningful measure and approved by the Quality Assurance Committee in early August 2022. **Pending Board approval at next meeting**	Not Applicable
As above	**New** Associate Director of Performance and the Director of Quality Governance to develop and agree the technical specification for the revised measure.	**Complete.** Technical specification drafted. This will be submitted to Data and Digital Services for review/development by the end of August 2022. Timescales for implementation will then be sought.	Not Applicable

12) The number of Restrictive Intervention Incidents

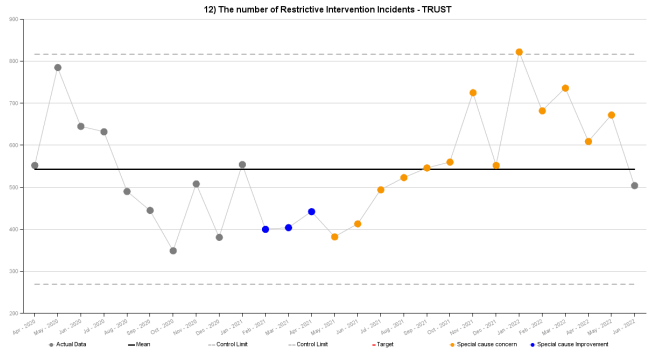
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When restrictive intervention 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 and distress to their families and carers.

504 number of Restrictive Intervention Incidents took place during June.

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	L

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that there have been a higher number of restrictive intervention incidents within our Learning Disability Services in Durham, Tees Valley & Forensics Care Group than we would like.	Associate Director of Performance to engage with the Director of Quality Governance to understand and share the learning on the work undertaken, in order to support the discussions around the measure and the key areas of concern at the Quality Assurance & Improvement Groups.	**Completed.** Meeting held 10th June 2022. This issue has already been identified in the Quality & Learning Report and there are a number of actions underway which are closely monitored by the Positive & Safe Group. We know this relates to a small number of highly complex patients and significant support continues to be provided to Learning Disabilities Services at this time.	We would expect to see a reduction in the number of restrictive intervention incidents once improvements are embedded.

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that there have been a higher number of restrictive intervention incidents within our Learning Disability Services in Durham, Tees Valley & Forensics Care Group than we would like.	A number of actions have been identified within our Learning Disability Services which include: • To progress the transfer of care of some specific patients with complex needs to more appropriate provision • Delivery of bespoke training for staff within Adult Learning Disabilities services and refresher training trust-wide • Working with external partners including Merseycare to review our interim model of care and identify best practice • The development of an assurance panel to review episodes of restraint with the aim of reviewing and developing plans of care to support a reduction in restraint.	**Ongoing.** • One patient with complex needs on S117 leave and due to be discharged by the end of August 22. We have support from Merseycare in undertaking an independent review of 3 complex patients and the Hopes National Team have now commenced work with a complex patient at Bankfields Court. • Training continues for Learning Disabilities staff trust-wide and we are on plan against the agreed trajectory. In addition 16 ALD practitioners have attended training with the Hopes National Team. • Merseycare's report on our interim model of care has been provided and a paper will be going to Quality Assurance Committee early September. Visits have been arranged to Merseycare in October and plans are underway for similar visits to Herefordshire and Surrey (exemplar sites). There has been a meeting with the national PBS leads in July to explore the potential review of the PBS model in Inpatient Services and a further meeting will be arranged in September to agree actions. • An improvement plan has been developed by the Service and clarity is now being obtained as to the appropriate governance route for this to be taken through.	
As above	A Positive & Safe Group will be established within each Care Group which will meet monthly to review key information in relation to positive and safe care with the aim of reducing restrictions across inpatient areas.	**Ongoing.** The proposal to establish Positive & Safe Groups within each Care Group was agreed by the Executive Quality Assurance & Improvement Group on the 28th June 2022. Dates are now planned for these Groups starting in September 22 where the Terms of Reference will be finalised.	
As above	The Executive Director for Nursing & Governance is going to review the resources required to ensure that we can progress our ambition to reduce the use of restrictive practices and become an Exemplar in this area. This will be completed by the end of August 22.	**Ongoing.** Review is now underway and contact has been made with Merseycare and CNTW to help inform this work. This is on track to be completed by the of August 22.	

13) The number of Medication Errors with a severity of moderate harm and above

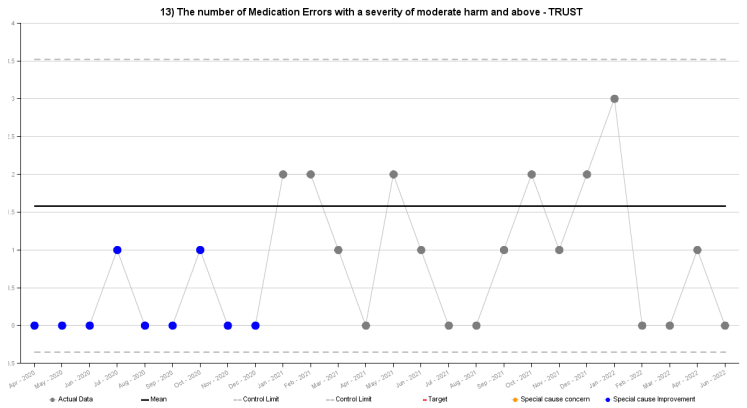
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When medication errors 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 and distress to their families and carers.

0 medication errors have been recorded with a severity of moderate harm, severe or death during June.

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

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of Medication Errors with a severity of moderate harm and above, we review every medication error of moderate harm and above and optimise the opportunities for learning and improvement to prevent similar errors occurring.	Associate Director of Performance to engage with the Director of Quality Governance and Chief Pharmacist during June 2022 to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussions at the Quality Assurance & Improvement Groups.	**Complete.** Meeting held 21st June 2022. Chief Pharmacist outlined the current governance arrangements regarding medicines management at Care Group level and the Drug & Therapeutic Committee which reports into the Quality and Assurance Board Sub Committee.	Not Applicable
As above	A monthly huddle to be arranged involving the Director of Quality Governance, Associate Director of Performance and other professional leads, including the Chief Pharmacist, to discuss and triangulate relevant information in order to provide assurance to the Executive Meeting. Dates to be arranged by the end of June 2022.	**Complete.** Monthly huddles in the diary from July 22 for the remainder of the financial year.	Not Applicable

14) The number of unexpected Inpatient unnatural deaths reported on STEIS

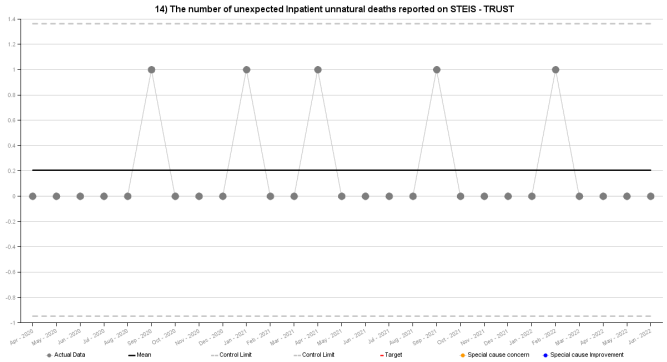
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, 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 and distress to their carers and families.

0 unexpected Inpatient unnatural deaths reported on the Strategic Executive Information System (STEIS) during **July** (confirmed by Head of Patient Safety)

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

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	L
NORTH YORKSHIRE, YORK AND SELBY	L

NOTE The narrative reflects July data but the data represented in the chart is as at June

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of unexpected inpatient unnatural deaths reported on STEIS, every unexpected Inpatient unnatural death is a concern to us We review these through a Rapid Patient Safety Review to identify any immediate learning which is then followed by full Serious Incident Review.	Associate Director of Performance to engage with the Director of Quality Governance to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussions at the Quality Assurance & Improvement Groups.	**Complete.** Meeting held 10th June 2022. We adhere to the Learning from Deaths policy which is based on the National Guidance on Learning from Deaths which includes a report to the Board. Where new or consistent themes are identified from the review these will be discussed through the appropriate governance route as per the Learning from Deaths policy.	We would expect to see a reduction in number/themes once actions are completed and reported via the Organisational Learning Group.
As above	A monthly huddle to be arranged involving the Director of Quality Governance, Associate Director of Performance and other professional leads to discuss and triangulate relevant information in order to provide assurance to the Executive Meeting. Dates to be arranged by the end of June 2022.	**Complete.** Monthly huddles in the diary from July 22 for the remainder of the financial year.	Not Applicable

14) The number of unexpected Inpatient unnatural deaths reported on STEIS

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Learning Lessons

There was evidence from the review of the 1 in-patient death that learning and actions from improvement work in in-patient areas is becoming embedded. There was a robust risk assessment/safety summary safety plan in place which had been created and agreed with both the MDT, the patient and family members.

Source: Learning from Deaths Report

15) The number of uses of the Mental Health Act

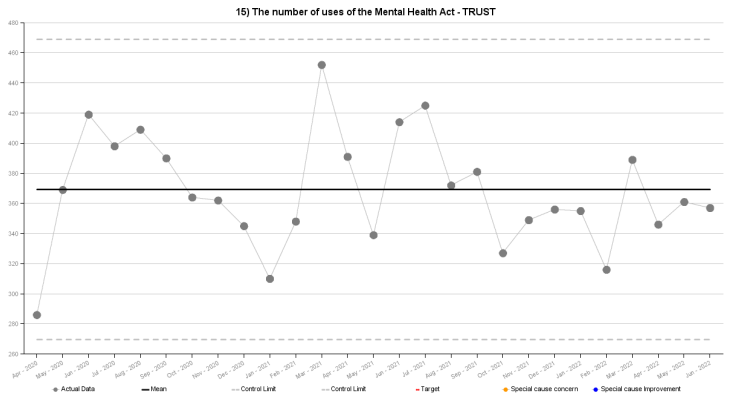
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers, friends and their community.

There were **357** uses of the Mental Health Act during June.

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

No Concerns
We are performing consistently in this area and no action is required at this time



Care Group/Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

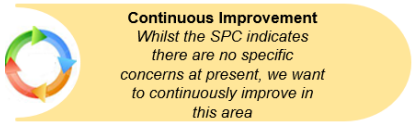
Key Issue(s)	Action(s)	Progress Update	Impact
There are currently no specific trends or areas of concern identified in the number of uses of the Mental Act; however we want to understand whether we treat our patients equally when we deploy the act	The Associate Director of Performance has requested a breakdown of the uses of the Mental Health Act by ethnicity initially, with a view to widening this to the full protected characteristics in the future. This data will be analysed and discussed at the Mental Health Legislation Committee. Timescales for the provision of data to be confirmed with colleagues from Digital and Data Services by the end of July 2022.	**Ongoing.** Digital and Data Services have commenced the work to provide a breakdown of the uses of the Mental Health Act by ethnicity ; however this has been impacted by the Cyber Security Incident/IIC Outage. Once the IIC becomes available we will confirm the new timescales. The Associate Director of Performance will then discuss and confirm next steps/timescales with the Medical Director on receipt of the data.	

16) Percentage of staff recommending the Trust as a place to work

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise staff recommending the Trust as a place to work is an indication of a high level of job satisfaction within our workforce which will support the provision of high quality care.

2056 staff responded to the **July 2022** National Quarterly Pulse Survey question "I would recommend my organisation as a place to work" Of those, **1102 (53.60%)** responded either "Strongly Agree" or "Agree"



	Jul-21	Jan-22	Apr-22	Jul-22
TRUST	54.23%	52.54%	55.01%	53.60%
ASSISTANT CHIEF EXECUTIVE	69.23%	51.61%	61.29%	47.83%
DIGITAL AND DATA SERVICES	68.09%	70.13%	68.00%	57.65%
DURHAM, TEES VALLEY AND FORENSIC	51.50%	50.72%	54.63%	54.64%
ESTATES AND FACILITIES MANAGEMENT	57.14%	46.92%	50.38%	50.76%
FINANCE	61.54%	62.22%	57.58%	61.54%
MEDICAL	67.44%	68.42%	64.10%	65.71%
NORTH YORKSHIRE, YORK AND SELBY	50.19%	50.48%	52.85%	49.89%
NURSING AND GOVERNANCE	61.90%	53.42%	51.95%	35.14%
PEOPLE AND CULTURE	69.86%	57.69%	56.99%	61.05%
THERAPIES	82.35%	62.96%	54.17%	53.85%

NOTE The data represented is for July 2022

National Benchmarking – NHS Staff Survey 2021

- **59.4% of all NHS staff** would recommend their organisation as a place to work.
- The **Picker average*** was **63%** of staff would recommend their organisation as a place to work.
- **52%** of staff from **our Trust** would recommend their organisation as a place to work compared to **66%** in the 2020 NHS Staff Survey

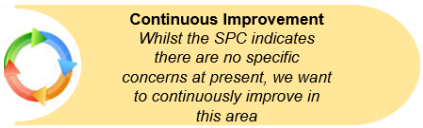
NB. *Picker carried out the NHS Staff Survey for 2021 on behalf of 24 Mental Health and Mental Health Community Trusts.

17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise that having the ability to suggest improvements and a high level of job satisfaction within our workforce which will support the provision of high quality care.

2079 staff responded to the **July 2022** National Quarterly Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **1229 (59.11%)** responded either "Strongly Agree" or "Agree"



	Jul-21	Jan-22	Apr-22	Jul-22
TRUST	57.10%	57.50%	58.76%	59.11%
ASSISTANT CHIEF EXECUTIVE	76.92%	67.74%	74.19%	65.22%
DIGITAL AND DATA SERVICES	65.96%	74.03%	72.00%	65.88%
DURHAM, TEES VALLEY AND FORENSIC	56.23%	57.00%	57.98%	58.94%
ESTATES AND FACILITIES MANAGEMENT	55.24%	53.08%	52.67%	51.52%
FINANCE	65.38%	64.44%	69.70%	71.79%
MEDICAL	67.44%	81.58%	79.49%	68.57%
NORTH YORKSHIRE, YORK AND SELBY	54.44%	54.35%	56.45%	55.77%
NURSING AND GOVERNANCE	61.90%	65.75%	63.64%	59.46%
PEOPLE AND CULTURE	78.08%	73.08%	73.12%	69.47%
THERAPIES	94.12%	81.48%	70.83%	69.23%

NOTE The data represented is for July 2022

National Benchmarking – NHS Staff Survey 2021

- **53.1% of all NHS staff** feel able to make improvements happen in their area of work
- The **Picker average*** was **76%** of staff feel able to make improvements happen in their area of work
- **73%** of staff from **our Trust** feel able to make improvements happen in their area of work compared to **78%** in the 2020 NHS Staff Survey

NB. *Picker carried out the NHS Staff Survey for 2021 on behalf of 24 Mental Health and Mental Health Community Trusts.

Staff Experience: 16) Percentage of staff recommending the Trust as a place to work and 17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We currently have limited data on the percentage of staff recommending the Trust as a place to work and for staff feeling they are able to make improvements happen in their area of work.	Associate Director of Performance to engage with the Director of People & Culture and Head of Business Intelligence to explore options to routinely collect staff experience during May 2022.	**Complete.** Meeting held on 11th May. It was agreed that we would explore technical solutions for the routine collection of staff experience and trial this in a small number of areas.	Not Applicable
As above	The Head of Business Intelligence to discuss technical solutions within Digital and Data Services by 30th June 22.	**Complete.** The initial scoping conversations have taken place within Digital and Data Services and a proposed way forward is now agreed.	Not Applicable
As above	The Head of Business Intelligence to pilot a routine survey, via Microsoft Forms in 4 areas (2 operational/2 corporate) from July 22 for a period of 3 months.	**Not yet started.** This has been delayed due to capacity issues following the cyber security incident and subsequent Integrated Information centre outage in August 2022.	
We currently have some issues in the alignment of services/teams following the organisational change on 1st April 2022. These include a small number of operational teams and the Assistant Chief Executive Portfolio. *Please note this also impacts on the other people measures within this dashboard.*	Colleagues within the Finance, Performance and Information Teams are working with services/teams to identify what changes are required.	**Completed.** A number of services/teams have now been aligned to the correct organisational structure. These changes will be reflected in the next dashboard for the period ending June 22.	Not Applicable

Staff Experience: 16) Percentage of staff recommending the Trust as a place to work and 17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
New We are concerned that the response rate to the National Quarterly Pulse Surveys is low. For the July 2022 survey, 8479 invites were sent, of which 2097 (24.73%) were received.	The Organisational Development Facilitator – Staff Experience to implement an incentive scheme for the quarter 3 2022/23 Staff Survey, with a view to improving staff participation.	**Not yet started**.	
As above	The Organisational Development Facilitator – Staff Experience to review the success of the incentive scheme during quarter 4 22/23, to assess a similar approach would improve participation in the Pulse Surveys.	**Not yet started**.	

18) Staff Leaver Rate

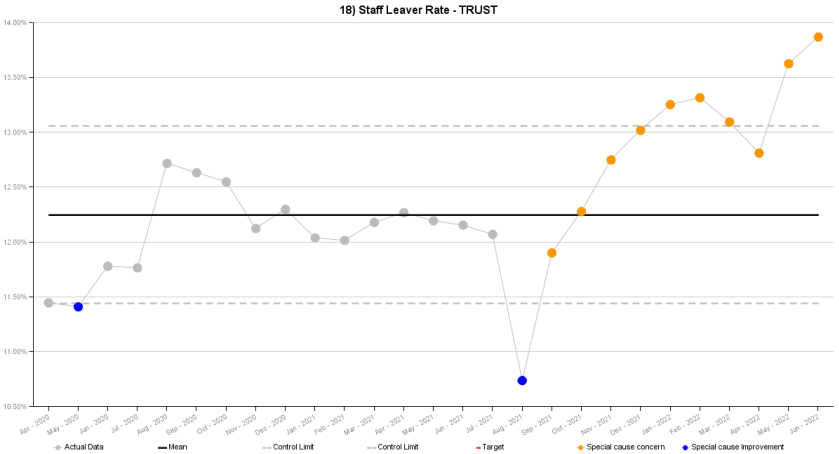
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity of care and the provision of high quality services.

From a total of **6659.94** staff in post, **923.64 (13.87%)** had left the Trust in the 12 month period ending June

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

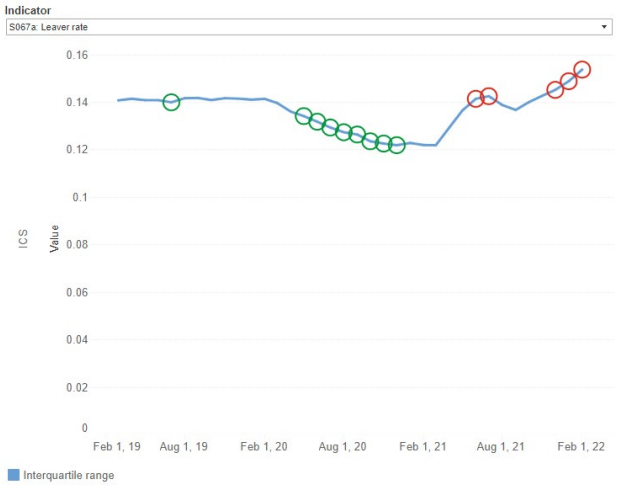
An Area of Concern
We are concerned with our performance in this area and action is required to improve



Care Group/Directorate	Variation	Care Group/Directorate	Variation
TRUST	H	MEDICAL	
ASSISTANT CHIEF EXEC	L	NORTH YORKSHIRE, YORK AND SELBY	L
COMPANY SECRETARY	H	NURSING AND GOVERNANCE	H
CORPORATE AFFAIRS AND INVOLVEMENT		PEOPLE AND CULTURE	L
DIGITAL AND DATA SERVICES	H	THERAPIES	
DURHAM, TEES VALLEY AND FORENSIC	H		
ESTATES AND FACILITIES MANAGEMENT	H		
FINANCE	H		

NHS Staff Leaver Rate - England Mental Health and Learning Disability – February 2022

NHS Staff Leaver Rate published on the Future Collaboration Platform (latest published data is as at February 22) for Mental Health Providers show a similar trend (see right) to that shown for our Trust. The national mean (average) for the period shown is 15.4% compared to the Trust mean of 16%. We are ranked 19 of 72 Trusts (1 being the best with the lowest leaver rate) and are placed in the inter-quartile range.



18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We currently have limited data on Staff Leaver Rate within this report so we are unable to identify if there are any specific trends or areas of concern	Head of Business Intelligence to engage with the Workforce Information Manager by the 31st May 22, to progress a plan of work for the inclusion of historic data for this measure.	**Complete.** Data from April 2020 is now included.	Not Applicable
We are concerned that more members of staff have left the Trust than we would like.	Associate Director of Performance to engage with the Deputy Director of People & Culture to understand the key work undertaken to date and ongoing actions to support the discussions at the People, Culture & Diversity Groups.	**Complete**. Meeting held 6th July 2022. Discussions are underway to identify how we better understand why people are leaving. See new action below	Not Applicable
As above	The Associate Director of Operational Delivery and Resourcing will facilitate a discussion at the Executive People Culture & Diversity Sub Group in July 2022 on how we better understand why people are leaving and what methods we might use to capture this with the intention of retaining staff where appropriate.	**Complete.** Leaver data continues to be reviewed on a monthly basis, including an analysis of reasons for leaving; this is reported to the Executive People, Culture & Diversity Group. In addition each of the care groups discuss the information gathered from the previous month through the leavers process to determine any themes. Retirement continues to be the highest reason for leaving (with a number of people returning), no further themes have been identified as yet.	Not Applicable
As above	**New** Director of People, Culture & Diversity to lead a review of the leavers process to develop a clear, streamlined approach with one central point for the leaver information to be held, that will support how we review the data in a timely way and identify any issues. This work will be completed by the end of October 2022.	**Ongoing.** The review is now underway.	

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

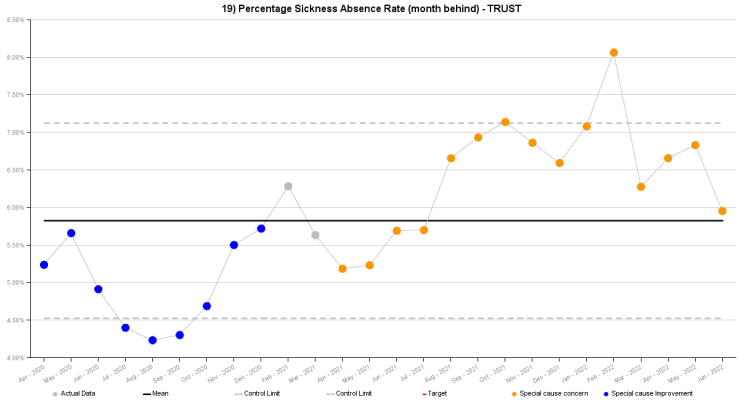
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

There were **217,113.87** working days available for all staff during May (reported month behind); of those, **12,929 (5.95%)** days were lost due to sickness.

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve

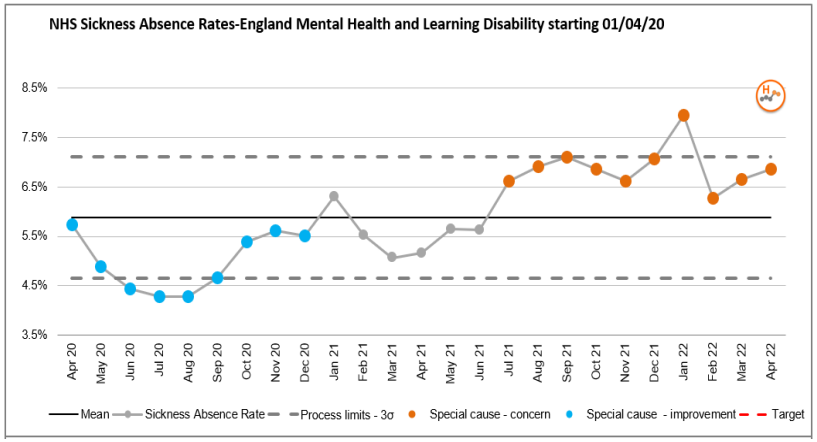
DQ ★ **100%**



Care Group/Directorate	Variation	Care Group/Directorate	Variation
TRUST	H	MEDICAL	
ASSISTANT CHIEF EXEC		NORTH YORKSHIRE, YORK AND SELBY	H
COMPANY SECRETARY	L	NURSING AND GOVERNANCE	L
CORPORATE AFFAIRS AND INVOLVEMENT	L	PEOPLE AND CULTURE	
DIGITAL AND DATA SERVICES		THERAPIES	
DURHAM, TEES VALLEY AND FORENSIC	H		
ESTATES AND FACILITIES MANAGEMENT	H		
FINANCE			

NHS Sickness Absence Rates - England Mental Health and Learning Disability – April 2022.

NHS Sickness Absence Rates published 25th August 22 (data ending April 22) for Mental Health and Learning Disability organisations show a similar trend to that shown for our Trust. The national mean (average) for the period shown is 5.97% compared to the Trust mean of 6.86%.



19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff within our North Yorkshire, York & Selby services are under increasing pressures due to current recruitment challenges.	Care Group Director of Therapies to facilitate a discussion at the June 2022 Care Group People, Culture & Diversity Sub Group to identify the key areas of concern.	**Complete.** Discussion within the People, Culture & Diversity Sub Group in June identified two specific areas of concern: • Within MHSOP work related stress as a common theme linked to sickness. This is related to reduced staffing capacity as a result of recruitment challenges. • Within, Learning Disability an increase in the number of staff on short term sick leave due to covid. See new action below	Not Applicable
As above	People Partner Lead to complete a deep dive into sickness absence rates during June to facilitate a discussion at the July 2022 Care Group People, Culture & Diversity Sub Group in order to identify actions.	**Complete.** The deep dive has been completed and concerns were highlighted in CYP and LD. The data is being shared at the July subgroup; however, in line with the new meeting approach in the Care Group, a separate meeting is to be arranged with the general manager during July. Further actions will be identified following that meeting and included the July report.	We would expect to see an improving position as actions are identified and progressed.
We are concerned that more members of staff within our Durham and Tees Valley services have been absent from work due to sickness than we would like.	Senior Performance Manager to engage the relevant People Partner in undertaking a team level deep dive and discussion with General Managers across CYPS, Learning Disabilities and Mental health services for older people to understand the areas of concern and document key actions in place. These will be shared for discussion in the June 2022 Care Group People, & Culture & Diversity Sub Group. Work will start the week commencing 23rd May 2022.	**Complete.** The report with full analysis will be shared at the People, & Culture & Diversity Sub Group in July 22.	We would expect to see an improving position as actions are identified and progressed.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that more members of staff within our Durham and Tees Valley services have been absent from work due to sickness than we would like.	The Principal People Partner to engage with the People and Culture Operational Managers to consolidate existing actions across CYPS, Learning Disabilities and Mental health services for older people and these will be shared for discussion at the relevant Quality Assurance and Delivery Improvement meetings in July 22. Work will start week commencing 20th June 22.	**Complete.** Principal People Partner has met with the Operational Managers and confirmed that other than ongoing support, there are no specific actions ongoing for CYP, LD and MHSOP. Following discussion at the July Quality & Improvement Subgroup the following concerns and actions were agreed.	Not Applicable
We are concerned that more members of staff within our Secure Inpatient Services have been absent from work due to sickness than we would like.	SIS General Manager and relevant People Partner to ensure completion of the current action plan by end of June 22.	**Complete**. All 17 actions have been completed. The action plan remains a working document and all ongoing actions identified within the plan are continuing. To date no new actions have been identified.	Sickness remains a concern with SIS.
We are concerned that more members of staff within our Durham & Tees Valley Learning Disability Services have been absent from work due to sickness than we would like.	The Principle People Partner to work with the Operational Human Resources Team to develop a Sickness Absence action plan by 25th July 2022 to support the improvement of sickness absence levels.	**Complete**. Action plans have been developed.	We would expect to see an improving position as actions are progressed.
As above	The Principle People Partner to liaise with the Operational Human Resources Team to identify the top three teams of concern by 31st August 2022 for focussed Human Resource support.	**Ongoing**. Work is underway to identify those teams requiring enhanced support.	

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that more members of staff within our Durham & Tees Valley Mental Health Services for Older People have been absent from work due to sickness than we would like.	The Principle People Partner to work with the Operational Human Resources Team to develop a Sickness Absence action plan by 25th July 2022 to support the improvement of sickness absence levels.	**Complete**. Action plans have been developed.	We would expect to see an improving position as actions are progressed.
As above	The Principle People Partner to liaise with the Operational Human Resources Team to identify the top three teams of concern by 31st August 2022 for focussed Human Resource support.	**Ongoing**. Work is underway to identify those teams requiring enhanced support.	
We have a high number of staff absent from work due to sickness within the Oakwood Locked Rehabilitation centre.	By March 2022, relevant People Partner to meet with the team managers to obtain a background and intelligence on any staff concerns.	**Ongoing.** The People and Culture Operational Manager has met with the current team manager but further discussion with the previous manager was delayed due to significant work being required in other services. The Principle People Partner is to link in with the People Partners within Secure Inpatient Services by the end of August to discuss.	
We are concerned that more members of staff within our Corporate services have been absent from work due to sickness than we would like.	Head of Performance and Senior Performance Manager to escalate with Heads of Service during May 2022, to identify areas of concern.	**Complete.** Data shared with all Corporate Directors 30th May 2022. See action below	Not Applicable
We are concerned that more members of staff within our Corporate services have been absent from work due to sickness than we would like.	The Associate Director of Performance/Head of Performance will meet with all Corporate Executive Directors/Senior Colleagues during July 2022, to take them through their individual dashboards which cover all of the people and finance measures within this Integrated Performance Dashboard. This is with a view to agreeing the approach for the provision of assurance and identification of best practice.	**Complete.** Meetings with Directors and Heads of Service started the week commencing the 18th July 2022 and have now been completed.	Not applicable

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

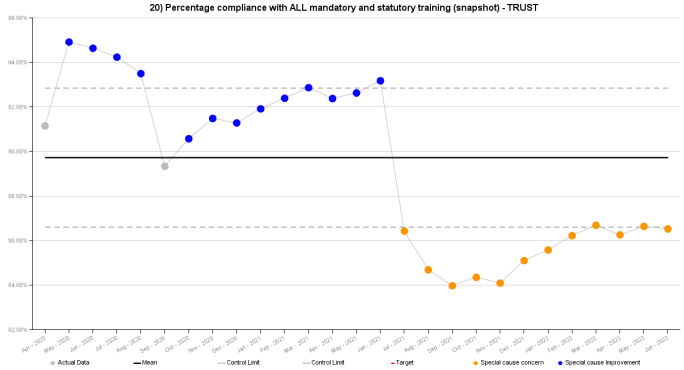
We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our staff having the appropriate levels of training to maintain their skills, which is vital if we are to provide high quality and safe services.

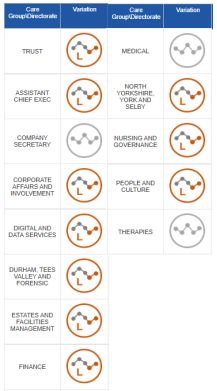
112,922 training courses were due to be completed for all staff in post by the end of June. Of those, **97,709** (**86.53%**) courses were actually completed

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve

DQ ★ **100%**





Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned a significant number of staff Trust-wide, corporate and clinical, do not have up to date training	Care Group Managing Directors and Corporate Directors to develop trajectories by August 2022, by which to achieve 85% compliance.	**Complete.** Trajectories have been agreed; 7 our of 12 Directorates are currently achieving 85%. The remaining Directorates will be compliant by the 30th November 2022.	
We are concerned that staff capacity and demand for our services are impacting on the ability of staff within our North Yorkshire, York & Selby services to undertake their training by the 30th June 2022 as planned.	Care Group Director of Therapies and Quality Improvement Manager to meet with the North Yorkshire, York & Selby Business Manager by the end of June 2022 to discuss potential actions that can be taken forward.	**Complete** Meeting took place on 21st June and action options were shared with general managers. Following further discussions, an action plan was approved at the August People Culture and Diversity Subgroup Meeting. *See new action below.*	We would expect to see an improving position as actions are progressed.
As above	**New** Care Group Director of Therapies and North Yorkshire, York & Selby Business Manager to monitor the delivery of the action plan, to ensure completion by the 10th October 2022 and to provide assurance that it is having the desired impact to improve compliance & address issues challenging staff in completing training.	**Ongoing** Actions are underway and progressing to plan.	

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff capacity and demand for our services are impacting on the ability of staff within our Durham ,Tees Valley & Forensic services to undertake their training by the 30th June 2022 as planned.	Senior Performance Manager to engage the relevant People Partner in undertaking a team level deep dive and to meet with the General Managers to understand the areas of concern and document key actions in place. These will be shared for discussion in the June 2022 Care Group People, Culture & Diversity Sub Group. Work will start the week commencing 23rd May 2022.	**Complete.** Full mandatory and statutory reports were shared with People Culture & Diversity Subgroup in July 2022 with initial analysis and identified areas of support from the People & Culture training team.	Not Applicable
As above	The Principal People Partner to engage with the People and Culture Operational Managers to consolidate existing actions across CYPS, Learning Disabilities and Mental health services for older people and these will be shared for discussion at the relevant Quality Assurance and Delivery Improvement meetings in July 22. Work will start week commencing 20th June 22.	**Not started.** The Principal People Partner to engage with the People and Culture Leadership and Development Team to identify any ongoing actions and agree a lead to take forward this action by the end of August 2022.	
As above	General Managers across all specialities within the Care Group to review how they create time within the working day to enable staff to complete their outstanding training. This will be a topic for discussion at the relevant Quality Assurance and Delivery Improvement meetings in July 22 and key actions shared at the Care Group People, Culture & Diversity Sub Group. in July 22.	**Complete.** General Managers have reviewed ways in which time can be created to allow staff to access training, including facilitating on site training in some locations; however staffing pressures continue to impact the availability for training across all specialities. (*See below new action*)	We would expect to see an improving position as actions are progressed; however, this is dependent on capacity and demand within the services.
As above	**NEW** General Managers to monitor the success of the actions they have established and to report updates and key areas for discussion to the Care Group People, Culture & Diversity Sub Group in September 22.	**Ongoing**. General Managers are monitoring staff attendance and availability, in light of the current staff pressures and business continuity arrangements.	

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff within a number of our corporate teams do not have up to date mandatory and statutory training.	Head of Performance and Senior Performance Manager to escalate with Heads of Service during May 2022, to identify areas of concern.	**Complete.** Data shared with all corporate Directors 30th May 2022. See new action below	Not Applicable
As above	The Associate Director of Performance/Head of Performance will meet with all Corporate Executive Directors/Senior Colleagues during July 2022, to take them through their individual dashboards which cover all of the people and finance measures within this Integrated Performance Dashboard. This is with a view to agreeing the approach for the provision of assurance and identification of best practice.	**Complete.** Meetings with Directors and Heads of Service started the week commencing the 18th July 2022 and have now been completed.	Not applicable

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

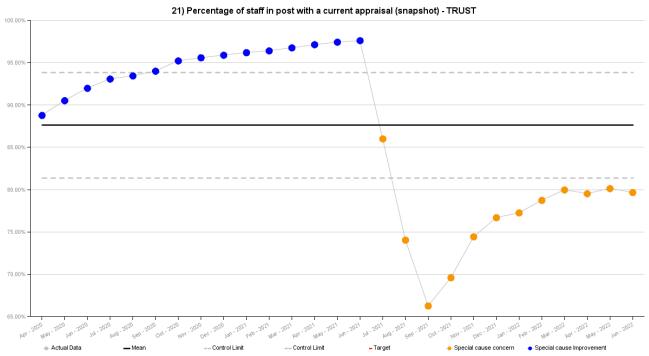
We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our staff having the appropriate levels of training to maintain their skills, which is vital if we are to provide high quality and safe services.

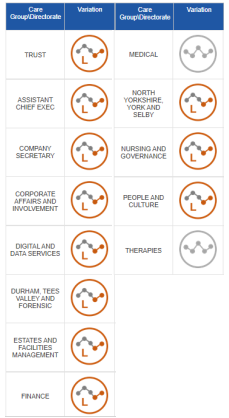
Of the **6236** eligible staff in post at the end of June; **4968** (**79.67%**) had an up to date appraisal

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve

DQ ★ **100%**





Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that a high number of staff within our Care Groups have not received a timely appraisal and that the services are not on track to deliver the trajectories agreed during 2021/22.	Head of Performance/Senior Performance Manager to engage the Care Groups' People Partners in undertaking a deep dive into the service data to support a detailed discussion at the June 2022 Care Group People, Culture & Diversity Sub Group. Work will start the week commencing 23rd May 2022.	**Complete.** The Senior Performance Manager met with the Durham, Tees Valley & Forensics People Partner to discuss the process. The People Partners for both Care Groups are leading a piece of analysis work supported by the People and Culture Operational leads for each speciality and linking with the General Mangers. Findings will be shared for discussion in the June 2022 Care Group People, & Culture & Diversity Sub Groups. *See separate updates for each Care Group below*	Not Applicable
We are concerned a significant number of staff Trust-wide, corporate and clinical, have not received a timely appraisal.	Care Group Managing Directors and Corporate Directors to develop trajectories by August 2022, by which to achieve 85% compliance.	**Complete.** Trajectories have been agreed; no Directorates are currently achieving 85%. All will be compliant by the 1st December 2022.	

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that a high number of staff within the Durham, Tees Valley & Forensics Care Group have not received a timely appraisal and that the services are not on track to deliver the trajectories agreed during 2021/22.	Senior Performance Manager to engage the relevant People Partner in undertaking a team level deep dive and to meet with the Durham, Tees Valley & Forensic General Managers to understand the areas of concern and document key actions in place. These will be shared for discussion in the June 2022 Care Group People & Culture & Diversity Sub Group.	**Ongoing.** This has been delayed as the Human Resources operational structure has not been fully implemented. The Senior Performance Manager has shared all data with the Principal People Partner who will engage with the People and Culture Leadership and Development Team to identify any ongoing actions and agree a lead to take forward this action by the end of August 2022.	
We are concerned that a high number of staff within the Durham, Tees Valley & Forensics Care Group have not received a timely appraisal and that the services are not on track to deliver the trajectories agreed during 2021/22.	The Principal People Partner to engage with the People and Culture Operational Managers to consolidate existing specific concerns and actions in relation to the completion of Appraisals and these will be shared for discussion at the relevant Quality Assurance and Delivery Improvement meetings in July 22. Work will start week commencing 20th June 22.	**Not yet started.** This has been delayed as the Human Resources operational structure has not been fully implemented. The Principal People Partner to engage with the People and Culture Leadership and Development Team to identify any ongoing actions and agree a lead to take forward this action by the end of August 2022.	
We are concerned that a high number of staff within the North Yorkshire, York & Selby Care Group have not received a timely appraisal and that the services are not on track to deliver the trajectories agreed during 2021/22.	The North Yorkshire, York and Selby People, Culture & Diversity Sub Group have identified and agreed the following actions: • For Adult Mental Health Services all outstanding appraisals will be booked by mid-July (except for staff on maternity leave or long-term sick)	**Ongoing.** Outstanding appraisals have been booked; however, some have been rearranged to support operational pressures. Work is underway to rebook these appraisals and further outstanding appraisals. This work will continue during August and September.	
As above	• Within Mental Health Services for Older People Appraiser and Appraisees are planning and diarising protected time to complete appraisals; these will be booked by end of July.	**Ongoing** This work is underway within the community services. However, due to workforce issues and high acuity on inpatient wards an approach has been adopted to stagger appraisals over quarters 2 and 3 2022/23.	

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that a high number of staff within the North Yorkshire, York & Selby Care Group have not received a timely appraisal and that the services are not on track to deliver the trajectories agreed during 2021/22.	Within Learning Disabilities Team Managers are reviewing outstanding appraisals and appraisals due to expire in the 12 weeks and book these by the end of July.	**Complete.** Team managers have reviewed outstanding appraisals and those due to expire have been booked. Appraisals are now being booked as part of an ongoing process.	We would expect to see an improving position as actions are progressed.
As above	Within Children & Young People's Services, the Associate Medical Director will liaise with medical staffing regarding data quality issues during June and the Service Manager will review Scarborough data quality issues during the same period	**Complete.** All data quality issues are now resolved.	Performance is now at a level we would expect
We are concerned that staff within a number of our corporate teams have not received a timely appraisal.	Head of Performance and Senior Performance Manager to escalate with Heads of Service during May 2022, to identify areas of concern.	**Completed.** Data shared with all corporate Directors 30th May 2022. See new action below	Not Applicable
As above	The Associate Director of Performance/Head of Performance will meet with all Corporate Executive Directors/Senior Colleagues during July 2022, to take them through their individual dashboards which cover all of the people and finance measures within this Integrated Performance Dashboard. This is with a view to agreeing the approach for the provision of assurance and identification of best practice.	**Complete.** Meetings with Directors and Heads of Service started the week commencing the 18th July 2022 and have now been completed.	We would expect to see an improving position as improved monitoring is established within the services.

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

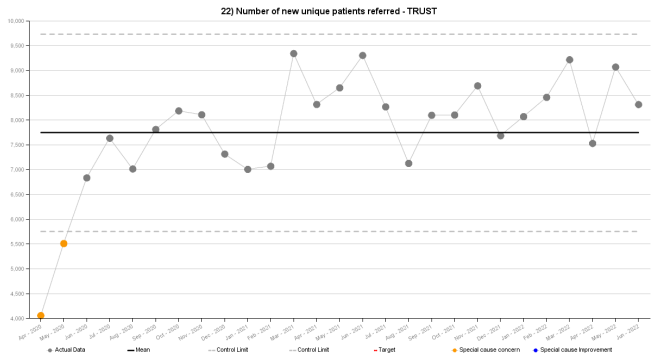
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment 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.

8314 patients referred in June that are not currently open to an existing Trust service

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

DQ ★ 100%

No Concerns
We are performing consistently in this area and no action is required at this time



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Key Issue(s)	Action(s)	Progress Update	Impact
There are currently no specific trends or areas of concern identified in the number of new unique patients referred.	Not Applicable		

23) Unique Caseload (snapshot)

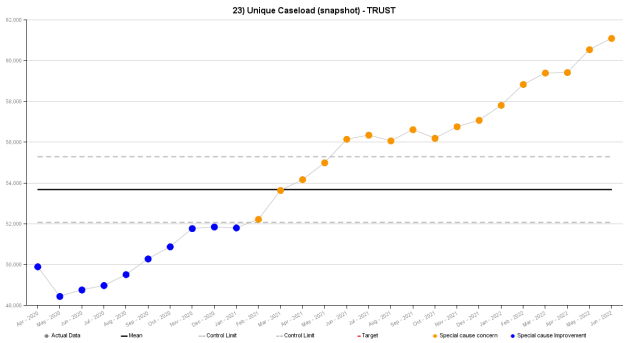
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

61,089 cases were open, including those waiting to be seen, as at the end of June 2022.

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

An Area of Concern
We are concerned with our performance in this area and action is required to improve



Care Group\Directorate	Variation
TRUST	H
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	H

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that we have an extremely high caseloads within our services and that we need to build on the understanding we currently have, to identify key actions that we need to progress.	Head of Performance and Senior Performance Manager to engage the Planning Team in undertaking a deep dive into the service data to support a detailed discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Complete.** Analysis has been completed and the following actions agreed.	Not Applicable
As above	Senior Performance Manager to support the Durham Tees Valley and Forensics general managers to undertake further analysis to understand the variances and deliver focused actions. This will be completed for the August Care Group Board.	**Ongoing**. This work has been impacted by the cyber security incident and subsequent Integrated Information Centre outage. Team-level analysis has been completed by the Senior Performance Manager and shared with the General Managers. Work is now underway to analyse caseloads across the various job roles within the service. An update on progress will be taken to the September Resources & Business Development Subgroup.	

23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that we have extremely high caseloads within our services and that we need to build on the understanding we currently have, to identify key actions that we need to progress.	North Yorkshire, York & Selby General Managers to facilitate further discussions within performance huddles to feed back recommendations to the August Resource and Business Development & People, Culture & Diversity Sub Group.	**Not yet started** Due to capacity issues this work was not progressed in July. It will now be undertaken in August and an update provided in September.	
As above	**New** Associate Director of Performance to review the unique caseload measure and explore the potential correlation with clinical staffing, working in collaboration with Finance, People and Business Intelligence colleagues during August 2022, to identify possible next steps.	**Not yet started.**	

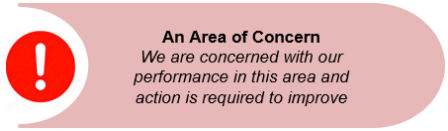
24) Financial Plan: SOCI - Final Accounts - Surplus/Deficit

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 delivered a **(£2.1m)** deficit to 31st July against a planned year to date deficit of **(£0.9m).**

(£1.2m) variance to plan.



Summary

The Trust's final 2022/23 plans were submitted on 20th June 2022, targeting a **£1.2m** planned surplus and supporting a balance ICS financial plan submission. Due to later than normal final plan submissions, final detailed budget sign-off will complete by **31st August**.

The year to date position is an operational deficit of **£2.1m**, representing **higher than planned expenditure.** Key plan assumptions for July were:

- Nil use of independent sector beds from July - the Trust required 577 bed days during July at a cost of £0.4m, contributing to year to date expenditure of £1.7m and representing a year to date plan pressure of £1.4m. This includes £0.1m unachieved in-month CRES – plans assumed no use of spot purchase beds during 2022/23 and no block contracted bed use from July. 5 block contracted beds are in place until the end of September due to operational pressures, largely driven by longer lengths of stay. In addition to contracted beds, use of spot purchased bed capacity has continued.
- £0.4m CRES for agency rate and usage reduction – actual run rates for 22/23 have increased with CRES requirements not being achieved. Compared to plan the Trust is £0.9 above plan, of which £0.4m represents unachieved CRES and £0.5m relates to run rate deterioration.

To deliver expected annual plan requirements the Trust needs to tackle run rate pressures in addition to planned CRES.

Key Issue(s)	Action(s)	Progress Update	Impact
Agency expenditure is high which is impacting on our financial plan and will impact on our Use of Resources Rating when it is reintroduced	• Processes to report and monitor E-roster efficiency information is being stood back-up. • Pre-covid agency controls are being re-established. • Medical Director liaising with other MH Medical Directors to explore price ceiling on agency rates paid and joint overseas recruitment. • LD complex package review to support onward discharge and reduce off framework agency use. • SIS net 60 WTE new starters. • Corporate Teams reviewing actions to reduce agency (August ESRG). CRES plans to mitigate initial targets and mitigate in-year run rate deterioration (reduce volume and off framework / premium rate use) to be completed by September 2022	**Ongoing:** Work continues with the development of CRES Schemes. The first cut of data was discussed at the Executive Strategy & Resources Group and Finance Sustainability Board in July 22 and the following agreed. • To review framework, price cap compliance and highest hourly rates and confirm recovery actions where appropriate by end of September 22. • Information relating to longest agency assignments to be shared with People & Culture to clarify any contractual issues by end of August 22.	

24) Financial Plan: SOCI - Final Accounts - Surplus/Deficit

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Independent Sector Bed utilisation is high which is also impacting on our financial plan delivery	As above and further exploration of issues pertaining to bed pressures - *Please see action relating to the trust-wide working group within Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider*	*Please see progress update relevant to this action*	
Agency expenditure and Independent Sector Bed utilisation is high which is impacting on our financial plan delivery	Plans to re-open Scarborough beds to mitigate Locality pressures - *Please see action relating to the increase of beds on Danby Ward within Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider*	*Please see progress update relevant to this action*	
NEW - Net expenditure run rates are consistently higher than planned, which is impacting on the financial plan delivery.	Review of non recurrent mitigations including recommended discretionary expenditure controls / approval routes by 31st August.	*Work in progress*	

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

25) Underlying Performance - run rate movement

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.

Key Issue(s)	Action(s)	Progress Update	Impact
New The inclusion of this measure was to support the 2021/22 System Oversight Framework and development was pending the release of the technical construction. The 2022/23 Oversight Framework has now been released and this measure is not included.	Associate Director of Performance and Deputy Director of Finance to propose the Agency Spending metric within the 2022/23 Oversight Framework as an alternative measure to the September Exec Resources & Strategy Group to seek approval in August and then for Board approval in September 2022.	**Ongoing.** An initial meeting has been held between the Associate Director of Performance and Deputy Director of Finance to progress the technical specification pending formal approval and this has been supported by the Executive Resources & Strategy Group. It will now be circulated to the Strategy & Resources Committee for approval prior to submission to Board.	

26) Use of Resources Rating - overall score

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 would be capped as a **3** for the period ending 31st July 2022 against a planned rating of **3**.

0 variance to plan.

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area

Summary

The **Use of Resources Rating** (UoRR) was impacted by Covid-19 with national monitoring suspended. However, the Trust has continued to assess the UoRR based on plan submissions and actual performance.

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 0.68x (can cover debt payments due 0.68 times), which is 0.42x (£0.9m) behind plan and is rated as a 4.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 40.0 days; this is ahead of plan and is rated as a 1.
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust has an I&E margin of minus 1.5%, this is worse than plan (£1.2m) and is rated as 4.

Agency expenditure of £6.7m is £2.9m (74%) higher than planned, and rated as a 4. Whilst the agency expenditure metric within UoRR is currently suspended the Trust has continued to assess agency expenditure against planned levels. Expenditure limits have been set for each ICB derived from 22/23 provider financial plans, but with a minimum reduction of 10% from 2021/22 and maximum of 30%. The Trust's plans assumed agency costs of £9.3m or £3.8m YTD. It is unclear as yet what the Trust's share of the ICB system-level agency cap will be, however costs are significantly above plan.

Recent regional reporting of sickness levels suggests peer mental health providers have experienced similar challenges. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence but equally to net new recruitment and securing alternative whole system models of care for specialist adult learning disability packages of care and high cost medical assignments. The agency expenditure metric would be rated 4 in this scenario.

The Trusts financial performance results in an **overall UORR** as a **3** for the period ending 31st July 2022 and is **in line with plan**.

Key Issue(s)	Action(s)	Progress Update	Impact
Agency expenditure is high which is impacting on our financial plan and will impact on our Use of Resources Rating and/or agency cost caps.	2022/23 CRES plans to mitigate initial CRES and mitigate in-year run rate deterioration (reduce overall utilisation and off framework / premium rate contracts) to be completed by September 2022	*Please see progress update relevant in measure 24*	

27) CRES Performance - Recurrent

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 **£2.7m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£2.1m**.

£0.6m variance to plan.

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area

Summary

The Trust continues to identify and consider schemes to deliver future recurrent requirements. Activities continue to disaggregate high level plan assumptions relating to CRES with key focus on:

- Individual scheme baseline assessment by Care Group, including identification and validation of targets.
- Quality impact assessments (QIA) to be completed for all schemes and signed off locally by relevant clinical and management leads, with final approval of schemes by Medical Director, Director of Nursing and Management Directors and Executive Director Group oversight.

CRES delivery is £0.6m behind plan. Key plan assumptions at the end of July assumed:

- £0.1m CRES for OAPs contracted bed elimination and is behind plan
- £0.4m CRES for agency rate and usage reduction and is behind plan
- £0.1m CRES for Crisis Line support from Vale of York CCG and is behind plan

Key Issue(s)	Action(s)	Progress Update	Impact
The delay in the commencement of CRES plans that were phased to commence July 2022 is impacting on the delivery of our financial plan	Actions highlighted in 24) Financial Plan: SOCI will mitigate in-part the under delivery on CRES and provide a sustainable footing and reduced run rate expenditure	**Ongoing:** 2022/23 CRES plans to mitigate initial CRES and mitigate in-year run rate deterioration (reduce overall utilisation and off framework / premium rate contracts) to be completed by September 2022	

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

28) CRES Performance – Non-Recurrent

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 **£0.5m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£0.5m**.

(£0.0m) variance to plan.

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area

Summary

The Trust continues to identify and consider schemes to deliver future requirements. Activities continue to disaggregate high level plan assumptions relating to CRES with key focus on:

- Individual scheme baseline assessment by Care Group, including identification and validation of targets.
- Quality impact assessments (QIA) to be completed for all schemes and signed off locally by relevant clinical and management leads, with final approval of schemes by Medical Director, Director of Nursing and Management Directors and Executive Director Group oversight.

Key Issue(s)	Action(s)	Progress Update	Impact
There are no key issues currently identified in relation to non-recurrent CRES	N/A		

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

29) Capital Expenditure (Capital Allocation)

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.

Capital expenditure at the end of July was **£2.7m** against planned expenditure of **£3.1m**.

(£0.4m) variance to plan.

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area

Summary

Capital expenditure at the end of July was **£2.7m**, and is **£0.4m** below plan **(£3.1m)**. This includes some slippage on lifecycle and health and safety works, which are offset by an overspend on Teesside patient safety works. A detailed report is being shared with Strategy & Resources Committee.

The Trust has received confirmation of £3.4m additional capital funding to develop Crisis and Liaison team bases. Plans are in place to ensure this will complete within the 2022/23 financial year.

The Trust is forecasting to outturn in line with allocation, though variances exist between planned schemes.

Key Issue(s)	Action(s)	Progress Update	Impact
Delays to Health and Safety works may pose a risk to clinical safety and quality	Review of Health and Safety works programme to be progressed via Environmental Risk Group and re-programming as necessary. Capital team escalation to Environmental Risk Group to identify any potential timeline risk.	The majority of schemes have now commenced – re-programming to be overseen by Environmental Risk Group and associated sub group.	

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

30) Cash balances (actual compared to plan)

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 have an actual cash balance of **(£80.3m)** against a planned year to date cash balance of **(£77.8m).**

(£2.5m) Favourable variance from plan

Continuous Improvement
Whilst the SPC indicates there are no specific concerns at present, we want to continuously improve in this area

Summary

Cash balances were **£80.3m** at 31st July 2022, which is **£2.5m** higher than plan **(£77.8m)**. This is mainly linked to the slippage on the capital programme (£0.4m) and accrued pay award (£2.1m) due for cash payment in September 2022.

The Trust achieved the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of both NHS and non-NHS suppliers during July, achieving 95.44%. We continue to support the use of Cardea to make processes as efficient as possible, and ensure suppliers are paid promptly.

Aged debt has reduced £1.1m in month, and 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, and requests for additional back up information.

Key Issue(s)	Action(s)	Progress Update	Impact
There are no key issues currently identified in relation to our cash balances.	N/A		

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

Which strategic goal(s) within Our Journey to Change does this measure support?

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Measures		Goal 1 - To co-create a great experience for our patients,	Goal 2 - To co-create a great experience for our colleagues	Goal 3 - To be a great partner
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	√	√	
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care	√	√	
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported	√		
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√		
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√	
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√	
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√	√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√		
BIPD_10	The number of Serious Incidents reported on STEIS	√	√	
BIPD_11	The number of Service Reviews relating to incidents of moderate harm and near misses	√		
BIPD_12	The number of Restrictive Intervention Incidents	√	√	
BIPD_13	The number of Medication Errors with a severity of moderate harm and above	√		
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		
BIPD_15	The number of uses of the Mental Health Act	√		√

Which strategic goal(s) within Our Journey to Change does this measure support?

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Measures	Goal 1 - To co-create a great experience for our patients, carers and families	Goal 2 - To co-create a great experience for our colleagues	Goal 3 - To be a great partner
BIPD_16	Percentage of staff recommending the Trust as a place to work	√	√	√
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√
BIPD_18	Staff Leaver Rate	√	√	√
BIPD_19	Percentage Sickness Absence Rate	√	√	√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√	√	√
BIPD_21	Percentage of staff in post with a current appraisal	√	√	√
BIPD_22	Number of new unique patients referred	√	√	√
BIPD_23	Unique Caseload (snapshot)	√	√	
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit			
BIPD_25	Underlying Performance - run rate movement			
BIPD_26	Use of Resources Rating - overall score			
BIPD_27	CRES Performance - Recurrent			
BIPD_28	CRES Performance - Non-Recurrent			
BIPD_29	Capital Expenditure (CDEL)			
BIPD_30	Cash balances (actual compared to plan)			

Which risk(s) within our Board Assurance Framework does this measure support/provide assurance towards?

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Measures	1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Culture & Wellbeing	6. Safety	7. Infrastructure	8. Cyber Security	9. Regulatory Action	10. Influence	11. Governance & Assurance	12. Roseberry Park	13. West Lane	14. CITO	15. Financial Sustainability
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good			√	√	√	√			√						
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for			√	√	√	√									
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care			√	√	√	√			√						
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported			√	√		√					√				
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported			√	√		√					√				
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√		√	√	√					√				√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider		√		√							√				√
BIPD_10	The number of Serious Incidents reported on STEIS			√	√		√			√						
BIPD_11	The number of Service Reviews relating to incidents of moderate harm and near misses			√	√		√			√		√				
BIPD_12	The number of Restrictive Intervention Incidents			√	√	√	√			√						
BIPD_13	The number of Medication Errors with a severity of moderate harm and above				√		√			√						
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS			√	√	√	√									
BIPD_15	The number of uses of the Mental Health Act		√	√	√	√	√			√		√				

Which risk(s) within our Board Assurance Framework does this measure support/provide assurance towards?

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Measures	1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Culture & Wellbeing	6. Safety	7. Infrastructure	8. Cyber Security	9. Regulatory Action	10. Influence	11. Governance & Assurance	12. Roseberry Park	13. West Lane	14. CITO	15. Financial Sustainability
BIPD_16	Percentage of staff recommending the Trust as a place to work	√		√	√	√	√			√	√	√				
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√	√	√	√			√	√	√				
BIPD_18	Staff Leaver Rate	√				√	√					√				√
BIPD_19	Percentage Sickness Absence Rate	√	√			√	√			√						√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√		√	√	√	√		√	√		√				√
BIPD_21	Percentage of staff in post with a current appraisal	√			√	√	√			√		√				
BIPD_22	Number of new unique patients referred		√				√					√				√
BIPD_23	Unique Caseload (snapshot)		√			√	√					√				√
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit									√		√				√
BIPD_25	Underlying Performance - run rate movement															
BIPD_26	Use of Resources Rating - overall score									√		√				√
BIPD_27	CRES Performance - Recurrent									√		√				√
BIPD_28	CRES Performance - Non-Recurrent									√		√				√
BIPD_29	Capital Expenditure (CDEL)							√		√		√	√			√
BIPD_30	Cash balances (actual compared to plan)									√		√	√			√

Chapter 2

Long Term Plan Ambitions

Long Term Plan Ambitions

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We monitor progress against the Long Term Plan ambitions, that have been agreed in partnership with our Commissioners, on a monthly basis through the Care Group Boards and report this to our Commissioners; however we are assessed on a quarterly basis against the agreed trajectories.

For the period ending July 2022, following the impact of the cyber security incident we can only provide an assessment on the IAPT measures within our services. We have not delivered the individually agreed ambitions for July 2022 in the following areas:

IAPT Services

1) Total access to IAPT services -Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy: all Sub-ICB location areas.
2) Percentage of people who have waited more than 90 days between first and second appointments (IAPT) - County Durham Sub-ICB location; Tees Valley Sub-ICB location and Vale of York Sub-ICB location

Process for key issues and actions:

- For measures 1-7, key issues and actions have been identified by each of the Care Groups and are being monitored by the Executive Directors Meeting.
- For measure 8, please see 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider within the Integrated Performance Dashboard for further details.

Item No 13

Committee Key Issues Report		
Report Date to Board of Directors – 29th September 2022		
Date of last meeting: 1st September 2022		**Report of: The Quality Assurance Committee**
		Quoracy was met. Observers attending the meeting included Hazel Griffiths, Public Governor for NYYS and Andy Mattin, from the specialist intensive support team commissioned by NHSE and NENC ICB
1	**Agenda**	The Committee considered the following matters: ▪ Risks to Quality and Safety ▪ Management of relevant risks included in the BAF ▪ Progress on delivery of the CQC Action Plan ▪ Trust Level Quality & Learning Report ▪ Executive Quality, Assurance & Improvement Group (QAIG) Report ▪ Safe Staffing ▪ Deep Dive Diagnostic into Self-harm ▪ For information: Safeguarding & Public Protection Sub-Group, PALS/Complaints Annual Report 2021/22, Patient & Carer Experience Annual Report 2021/22, the LeDer Annual Report and Equality Data.
2a	**Alert**	The Committee wishes to alert the following matters to the attention of the Board: 1. CQC Well-Led Action Plan QuAC agreed that the deadline dates for delivery of some of the actions be extended. Moving forward, more realistic dates should be agreed from the outset to avoid extensions and manage expectations. 2. Risks Relating to Quality & Safety Having previously provided the Board with limited assurance on our approach to risk management, QuAC received an update paper which clearly demonstrates positive progress since August. This, combined with the implementation and embedding of new governance and risk management arrangements is a much-improved position. 3. Executive Quality, Assurance & Improvement Group (EQAIG) – main risks include: • Care Group staffing, bed occupancy and high levels of patient acuity. • High levels of self-harm which continue to be a concern and a trust wide task and finish group has been established to oversee the ligature work programme. • Outstanding actions from the Clinical Audit programme and NICE baseline to be actioned at Care Group level. QuAC Chair to advise Audit and Risk Committee. • Capacity issues within the Complaints Team. • Safeguarding. There has been a reduction in staff allegations in SIS, although the numbers of allegations relating to physical interventions are of concern and will continue to be monitored through safeguarding and HR processes 5. Safe Staffing The position is relatively unchanged from last month. Staffing levels continue to be monitored daily for inpatient services and staff are working additional unplanned hours, either as extra shifts or longer working days, cross covering wards and utilising bank and agency staff. There has been a small improvement to the number of teams achieving greater than 90% fill rates, however, fill rates for RN's remains above 60%, failing to achieve this threshold on average over the month. The two reports presented (July and August using June and July's data) reflected shifts over 12 hours and therefore a

		significant increase was noted (+69 in June and +161 in August). Following discussion with the safer staffing lead it has been requested to go back to reporting shifts worked over 13 hours as the increased figures may reflect a number of staff who were late finishing shift. Whilst this is not ideal, we do not want to lose the focus on those shifts worked where shift times have been clearly breached. The Workforce Standards Sub-group provide monitoring and oversight of the above issues. DTVF has very high levels of missed breaks 843 (110 in NYYS). Some designated break areas are going to be provided for staff in secure inpatient services as missed breaks currently reflect those where staff are unable to go off site. Assurance was received that where staff are unable to leave the ward that food, drinks and a rest break are supported within the ward environment. <u>QuAC Confidential Meeting</u> QuAC went into a confidential session following the public meeting in September 2022 to discuss the recommendations from the: "Review of Inpatient Learning Disability Services at Tees, Esk and Wear Valleys NHS FT, June 2022 by Mersey Care NHS FT. (See private Board agenda item 5).
2b	**Assurance**	The Committee wishes to draw the following positive assurances to the attention of the Board: 1. BAF Progress has been made to bring the BAF up to date with the Company Secretary meeting with Executive owners. QuAC continue to seek further assurance on risks relating to CiTo and embedding learning from serious incidents. 2. Risk Management Demonstrable progress has been made in relation to the risk management agenda; with the review of the Corporate Risk Register, alignment of risks – with other Committees and the clear plans for implementation of the Corporate Risk Management Policy. Next steps include review of risk scoring, triggers and the impact and sustainability of actions, together with the links between the BAF and Corporate Risk Register. There is good assurance from the rapid work taken so far. Whilst the Committee omitted the standard Quality and Learning reports at Care Group level and received the Trust Quality and Learning report, there was clear triangulation of the main risks and pressures facing the quality and safety agenda from the reports presented across the services.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: Following requests for further assurances in relation to Health and Justice, Sexual Safety and a deep dive into Self-harm, the Committee will receive formal reports in October 2022. Items that were received for information include Safeguarding & Public Protection Sub-Group, PALS/Complaints Annual Report 2021/22, Patient & Carer Experience Annual Report 2021/22, the LeDer Annual Report and Equality Data.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that there were no material changes to be made to the strategic risks of the Trust.
3	**Actions to be considered by the Board**	The Committee has recommended to the Board: i. That the approval of extending deadline dates for completion of CQC Well-led actions be noted. ii. That good assurance is to be noted in relation to updates of the BAF, CRR and implementation of the Trust Risk Management Policy. iii. That key the areas of concern continue to be monitored closely by QuAC, linked

			to staffing, acuity, demand, bed occupancy and staff well-being and morale. iv. That the requested deep dive on Self-harm will report to the October QuAC meeting, together with an insight into Health and Justice services. v. That the items for information be noted. vi. That the improved effectiveness of the Committee meeting by reducing service reports to focus on the Trust Wide Quality and Safety information be noted.
4		**Report compiled by**	Bev Reilly, Chair of Quality Assurance Committee, Elizabeth Moody, Director of Nursing & Governance, Donna Keeping, Corporate Governance Manager

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**Thursday 29th September 2022**
TITLE:	**To consider the "Hard Truths" 6-Monthly Nurse Staffing Exception Report**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance / Information**

This report supports the achievement of the following Strategic Goals:	
To 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 NQB guidance requires an organisations Board to ensure there is sufficient and sustainable staffing capacity and capability to always provide safe and effective care to patients across all care settings.

In addition Boards should ensure there is an Annual Strategic staffing review with evidence of a triangulated approach and that it takes account of all healthcare groups and is in line with financial plans. To support this there is also a need for a 6-month review.

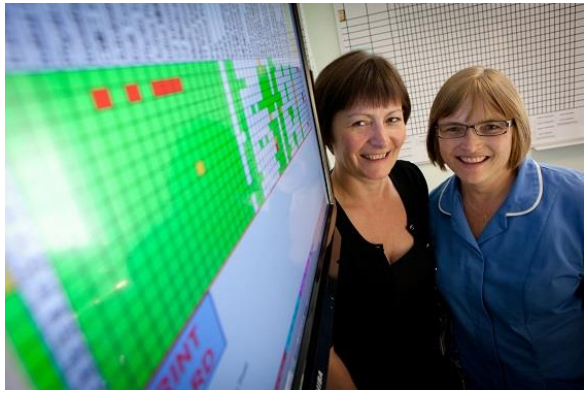
The format of the report follows the NQB guidance (2016) in that it outlines: the right staff, the right skills, in the right place at the right time.

This paper focuses on our approach to ensuring that levels of nurse staffing which includes registered and unregistered nursing staff match the dependency needs of patients during the period 1st December2021 to 31st August 2022. The paper identifies causes and actions taken to address issues relating to safe staffing for our bed-based services. The report provides assurance through a description of the processes implemented with regards to understanding staffing levels through an analysis of staffing, patient safety, patient experience and temporary staffing use for the period of the review.

Recommendations:

That the Board of Directors receive the report as assurance that the Trust has robust and reliable processes in place for reviewing and reporting on Safer Staffing in line with National NQB Safer Staffing requirements and that where we have gaps in compliance we are taking steps to address these.

Trust Level Report



Purpose

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

Staffing across professional groups in the organisation continues to be one of the highest areas of risk affecting quality and safety of care (BAF1 Recruitment and retention)

Monthly Safe Staffing reports are provided to QuAC each month detailing key metrics at service and ward level. This report aims to provide the Board with a summative oversight of the key areas related to Safe Staffing areas of at a trust level. Triangulation with quality metrics has been used where appropriate to alert the Board to situations and areas where that are of concern, improving or deteriorating.

The data contained within this Safe Staffing Report is correct as of the 13th September 2022, and considers the 9 month period of **1st December 2021 to 31st August 2022**. A 9-month period is provided instead of the usual 6-month overview to support moving towards improving the alignment of this report with the establishment review report. Please note that the data and issues highlighted may change due to additional information being made available following investigation.

Please note that due to the IIC outage that certain elements have been removed at this time due to inability to retrieve the up-to-date information. These areas include, Care Hours Per Patient Day (CHPPD), incidents and related triangulation, patient compliments, and statutory and mandatory training and fill rate data.

Summary and analysis of issues:

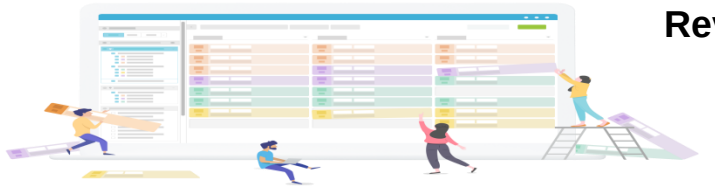
- The ratio of registered practitioners to health care support workers in services across the Trust shows to be a concern. Significant funding has been invested into services over the recent years to support the achievement of benchmark skill mix values, however this is not consistently being realised on the wards. Contributing factors for this include registered nurse vacancies and sickness absence, and the increased reliance upon temporary staffing to support service demand. When requesting additional staffing from the bank (or agency) to either back fill vacancies and sickness, or to support high patient acuity, it is most often filled by an unregistered nurse. The ratio of RN shifts to HCA shifts filled by the temporary staffing service (bank or agency) is on average 12% across the Trust for the 9 month period reviewed, notably for LD, this average is 7%. Increased numbers of HCAs from utilising temporary staffing will therefore dilute the budgeted establishment skill mix ratios, and significantly in the case of SIS this will have an increased impact as their budgeted establishment is already

markedly below the national RN benchmark requirements. Skill mix is a critical factor in determining the quality of care and the nature of patient outcomes and therefore a diluted skill mix presents risks to quality and safety that we are working hard to address.

- Registered nurse shortages are a national issue, and to support the Trust requirements, we continue to consider various recruitment initiatives to meet registered practitioners' requirements within the Trust, for example, the international recruitment programme. The Trusts plan is to continue to recruit increasing numbers of international nurses, therefore consideration needs to be given towards a review and investment of the infrastructure around the support mechanisms for these staff members to support their pastoral care and the cultural embedding into the country and trust including accommodation and living costs. The Director of Nursing and Governance and Director of People, Culture and Diversity are working together to develop a proposal to support this approach as part of the wider workforce plan.
- The Deputy Director and Nursing, the Associate Directors of Nursing, alongside recruitment have begun reaffirming some of the standards regarding staff nurse recruitment to ensure a centralised and coordinated approach is maintained. Despite this however, the Trust had initially expected to recruit over 90 newly qualified nurses from higher education institutions (HEIs), however this number has now reduced to 64, where one of the contributing factors for the withdrawal rate is reported to be due to the length of time to process and provide a confirmed offer.
- There have been a number of successful HCA recruitment events however conversion to posts and retention will need to be closely monitored and reported on to assess impact.
- Further work is to be considered about the effective use of other staff groups to support the skill mix and staffing requirements, together with actions regarding staff retention. The Trust is currently engaged in the fulfilling the national nurse retention tool and related action planning to support this position for nursing staff specifically.
- We have changed the approach to how we report fill rates to be more granular and which removes the averaging effect that may balance out deficits over the reporting period. Data for this new approach at the time of publishing this report is still being validated for accuracy and so not available at this time. Going forward it will be published within the monthly safe staffing reports, the subsequent 6 monthly safe staffing summary report, and the staffing establishment report.
- Data for statutory and mandatory training is not currently available at the time of writing this report but is noted that the achievement of compliance with statutory and mandatory training continues to be a risk for 22/23.
- Staffing requirements identified within the recent staffing establishment review in March 2002 regarding LD and MHSOP services, was reviewed at the Strategy and Resource Committee in August 2022 and following update from their feedback is to be further considered alongside this paper at Trust Board September 2022.
- A review of the Trust's 'headroom' (which accounts for the time in relation to unavailability's such as training and annual leave) was presented to the Finance Sustainability Board in July 2022 which approved the additional expenditure to support registered nurse Continuing Professional Development requirements with the allocation of 3 days over the required 3 year revalidation period.

- Temporary staffing performance shows to be at a reasonably consistent level across the 9 month and highlights an increased level of agency usage for NYY&S care group over DTV&F care group. The fulfilment of shifts by contract type shows that only 64% of shifts are filled by substantive staff, although this average is slightly higher in NYY&S care group. Therefore, a significant proportion of all inpatient shifts are being covered by bank or agency staff which also correlates with the high number of “additional shifts” being applied to the roster where we see a Trustwide average of 32% of all shifts worked being in addition to that of the budgeted establishment. It is acknowledged that the use of temporary and agency staffing impacts negatively on continuity and quality of patient care, therefore part of the agency reduction plan will be to improve staff fill-rates and ‘swap out’ temporary staffing expenditure for substantive posts where possible.
- The average expenditure for agency has increased and shows that nursing agency has the highest spend followed by consultant medical agency staff. The number of requests for temporary staffing has slowly increased month over month. An agency reduction programme of work is underway to support improvements to quality of care and efficient use of resources. Further understanding will need to be sought regarding the driving demand for additional temporary staffing across the trust which will include backfill for vacancies and sickness absence, as well as a more granular view of clinical pathways and risk management on the wards.
- There are a proportion of shifts left unfilled by temporary staffing resources, which may represent a risk. A level of mitigation can be seen where a proportion of these are being addressed by the use of overtime, additional standard hours, and service line managers and coordinators supporting as required.
- The number of Datix incidents citing staffing has seen a general upward trend over the reporting period. This may be due to either an actual increase in the number of incidents, or that there is an improvement in staff compliance with reporting issues as required. Further oversight and monitoring of this area is being undertaken to understand this more fully across services. The Trust is also to contemplate whether the Datix method of reporting is to be replaced by SafeCare red flags – however this will need to be carefully considered.
- TEWV is engaged in several initiatives which are aimed at building a safe and sustainable workforce through the development of new roles including international recruitment, over-recruitment of Health Care Support Workers and nursing apprenticeship schemes.
- Future reports will include the provision of vacancy data alongside the missing detail due to the IIC outage.

Triangulated Approach to Staffing Decisions:
Review of Staffing Establishments



Mental Health Optimal Staffing Tool

Actions we are taking:

- The 2021 staffing establishment review and report was presented to the Finance Sustainability Board and Senior Leadership Group in February and March 2022. Following the funding in to the AMH and SIS services the preceding year, further focus was provided regarding the initial priorities identified with MHSOP and LD inpatient services regarding staffing establishment numbers, skill sets and the skill mix (registered practitioners to support worker ratio).
- The staffing requirements identified within the recent staffing establishment review in March 2002 regarding LD and MHSOP services, was reviewed at the Strategy and Resources Committee in August 2022 and the proposal is to be further considered alongside this paper at Trust Board in September 2022.
- Mental Health Optimum Staffing Tool (MHOST) and Learning Disability Optimum Staffing Tool (LDOST) assessment scores are currently being collected for consideration in the 2022 annual establishment setting review and will be triangulated with available workforce data, patient outcomes measures and professional judgement.
- SafeCare is the acuity-based roster software product used by the Trust. It is fully implemented across the Trust, however it remains to be consistently embedded across all inpatient areas. Along with effective roster management, this will continue to receive support from the safe staffing team going forward to ensure we are using our resources in the most effective way.
- Recent work regarding the community caseload management process has introduced the requirement to assess the acuity and dependency of service users of community teams. Further work is planned into developing an intelligent system to enable an automated assessment of complexity, and the consideration of adopting the Management and Supervision Tool (MaST), which allows for predictive analysis to provide insights to support preventative focussed care. This will also provide the foundation for any evidence-based community version of the MHOST

Right Skills

Percentage compliance with ALL mandatory and statutory training (snapshot)

No Data Available Due to IIC Outage

Analysis (so what)

- Due to the current IIC outage up to date information is not available
- Key points identified in the last report remain ongoing at the time of this report which further stated below.

Key Learning and how we are using this

- Attendance at face to face training sessions continues to be an area of concern requiring to be monitored.
- Capacity to complete online learning is also limited due to ongoing staffing demand because of patient acuity and increased demand and workload pressures. Sickness absence is a contributing factor to the training compliance metric

Actions we are taking (now what)

- Monitoring compliance through Executive Directors Group and Executive People, Culture and Diversity Group, in addition to consideration and review of the areas of double booking and DNAs by the Associate Directors of Nursing and Quality.
- Working with individual services to increase their compliance with essential face to face training with an emphasis on resuscitation training and Positive and Safe training
- To support the programme for the over-recruitment of HCSWs, a two-week block programme of induction and training is now delivered so new staff can provide quality care to patients at the earliest opportunity. This is reported to be working well and it being planned on how to adopt this approach in other areas of the trust.
- Additional headroom has been built into services for Registered Nurses to support Continuing Professional Development

Nurse Development and Initiatives

Registered nurse shortages are a national issue, and to support the Trust requirements, we continue to consider various recruitment initiatives to meet registered practitioners' requirements within the Trust, for example, the international recruitment programme.

This work continues to progress and to date we have one RN who has successfully completed their OSCE and now working as an RN in Scarborough, a further 2 will have their first attempt at OSCEs on 19th October 2022, with a further three due to arrive in the UK on the 30th September 2022. A further 13 posts have been offered within SIS and are we awaiting dates to commence. The Trust has ambitions to recruit an additional 40 RN's alongside other professions as part of an overseas initiative being coordinated by North Yorkshire and Humber ICB to India in November 2022.

If the Trust is to continue to recruit increasing numbers of international nurses consideration will need to be given towards a review of the infrastructure around the support mechanisms for these staff members to support their pastoral care and the cultural embedding in to the country and trust including accommodation and living costs.

The Deputy Director and Nursing, the Associate Directors of Nursing, alongside recruitment have begun reaffirming some of the standards regarding staff nurse recruitment to ensure a centralised and coordinated approach is maintained. Despite this however, the Trust had initially expected to recruit over 90 newly qualified nurses from higher education institutions (HEIs), however this number has now reduced to 64, where one of the contributing factors for the withdrawal rate is reported to be due to the length of time to process and provide a confirmed offer.

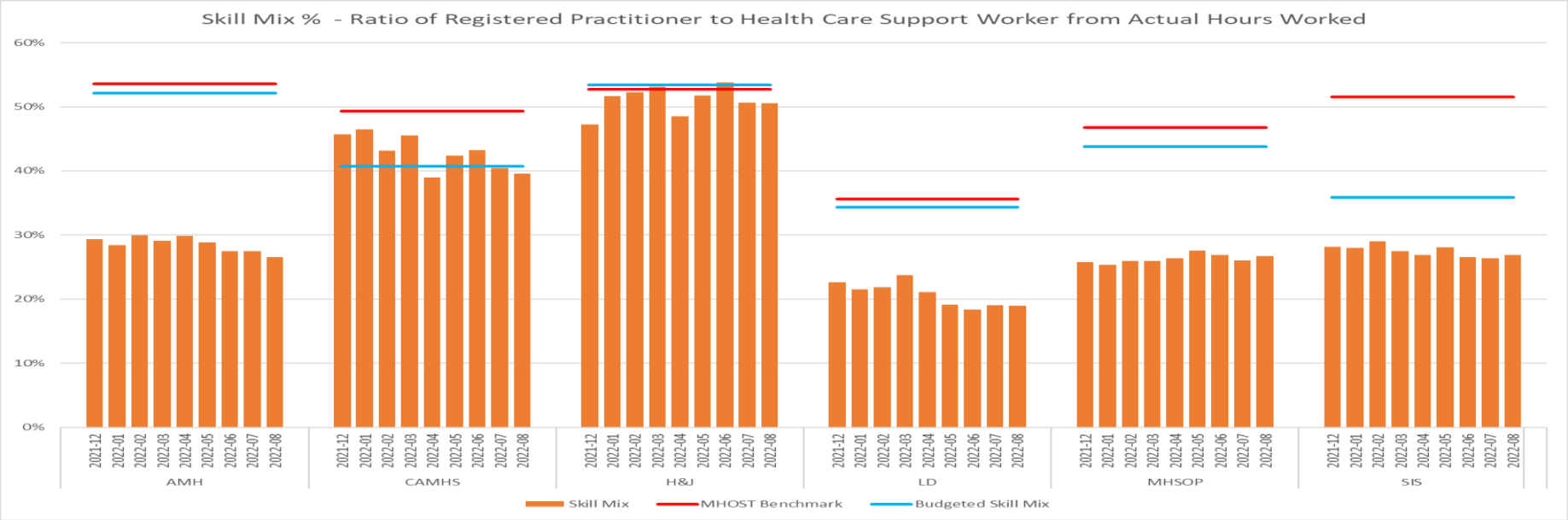
HCSWs recruitment is still ongoing supported by recent recruitment events however conversion rates into posts need to be closely monitored. A number of new HCA's are commencing the Trust as apprentices and will be encouraged to continue on the apprenticeship pathway to Trainee Nursing Associate and through to RN registration in line with our 'growing our own startegy'.

Induction, preceptorship and ongoing support for new HCA's and RN's have ben reviewed and strengthened to improve retention rates and staff well-being.

Body cameras are currently piloting across 10 wards/services within TEWV, feedback is generally positive however technical issues and limited capacity to review footage, has seen TEWV report lesser impact than other trusts reporting nationally. Work is ongoing to refine processes in utilising cameras and developing skills of clinicians who are reviewing footage. Pilot currently remains ongoing.

The Trust has now recruited 12 Professional Nurse Advocates with an ambition to expand this across teams.

Right Place and Right Time - Skill Mix



Analysis (so what)

- Budgeted establishments, SIS aside and to a lesser extent CAMHS (Holly Unit and Baysdale), are approaching in the MHOST benchmark values for registered practitioner to health care support worker ratios. However, the skill mix based upon the actual hours see several of the services fall somewhat short of both the budgeted establishment skill mix and the benchmark values. This shows to be a relatively consistent view for each inpatient service area across the reporting period.

Key Learning and how we are using this

- The ratio of registered practitioners to health care support workers in services across the Trust shows to be a concern. Significant funding has been invested into services over the recent years to support the achievement of benchmark skill mix values, however this is not consistently being realised on the wards. Investments from the Trust into staffing establishments has improved the budgeted skill mix against the

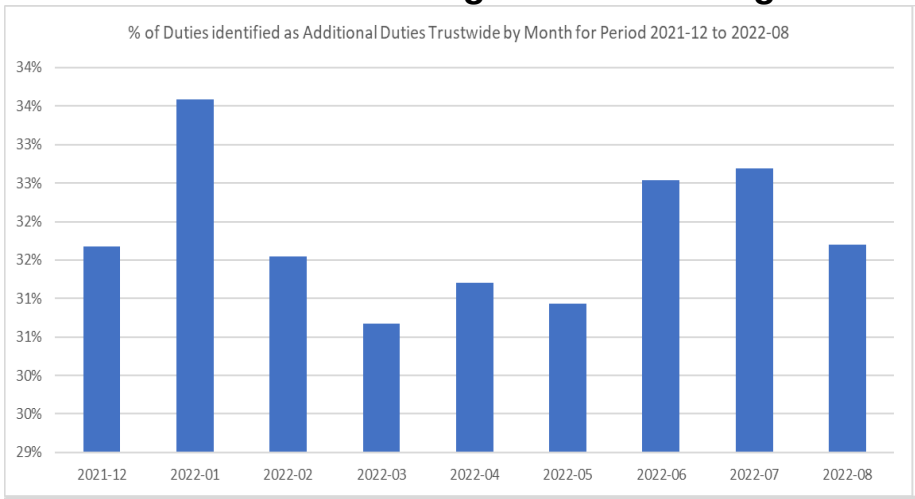
benchmark values, however we need to ensure this is reflected in the daily staffing on the wards. Contributing factors for this will include registered nurse vacancies and sickness absence, and the increased reliance upon temporary staffing to support service demand.

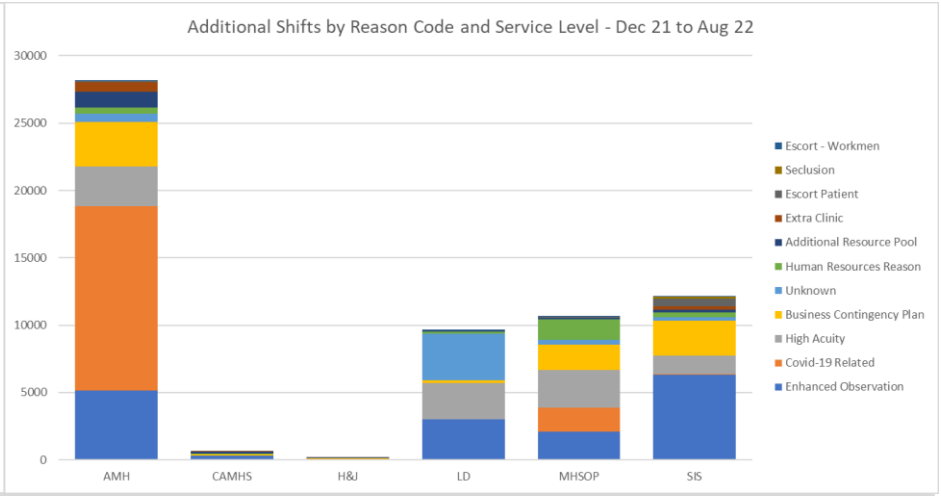
- When requesting additional staffing from the bank (or agency) to either back fill vacancies and sickness, or to support high patient acuity, it is most often filled by an unregistered nurse. The ratio of RN shifts to HCA shifts filled by the temporary staffing service (bank or agency) is on average 12% across the Trust for the 9-month period reviewed, notably for LD, this average is 7%.
- Increased numbers of HCAs from utilising temporary staffing will therefore dilute the budgeted establishment skill mix ratios, and significantly in the case of SIS this will have an increased impact as their budgeted establishment is already markedly below the benchmark requirements.

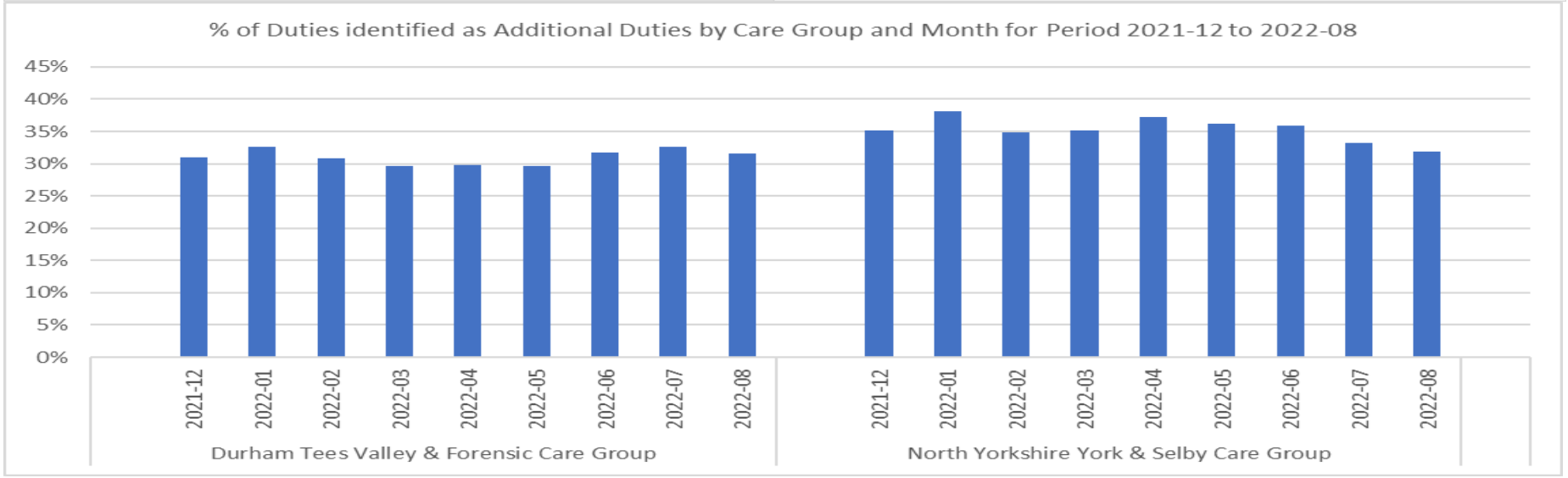
Actions we are taking (now what)

- Recruitment campaigns for registered nursing, international recruitment of registered nurses are amongst some of the initiatives being employed to boost RN numbers.
- Work around self-assessment and action planning using the national tool in support of nurse retention strategies is currently in progress and to be completed by the end of September 2022.
- Establishment setting work, as part of the 6 monthly review cycle, continues for all clinical teams and services, which also considers skill mix ratios alongside required budgeted establishment figures.
- Work continues regarding how we capture the essential contribution of the centralised MDT team staff to better understand the skill mix figures from the roster. Following a successful demonstration, we are looking at the potential of a software solution to support this.

Right Place and Right Time Continued - Additional Duties







Analysis (so what)

- This measure is looking at the number of additional duties that have been created over and above the budgeted establishment.
- The Trust position shows a consistent percentage of all the duties worked, where additional to the budgeted demand (rostered establishment) accounts for 32% of all duties on average over the preceding 9 months. NYY&S show to have 5% more additional duties against the total number of shifts worked than DTV&F
- "COVID 19" figures significantly as a reason code for AMH services and continues to do so into August 2022. This is a similar pattern for LD services and a large number of "Unknown" reason codes for additional shifts. This requires further exploration as wards are no longer cohorting and it is unclear why 'Covid 19' is still accounting for such a high number of shifts.
- There is also a noticeable difference between reason codes provided for the additional duties across the care groups which merits further investigation.
- The average number of additional duties for NYY&S (35%) show to be higher than DTV&F (31%)
- The number of trust wide additional duties against the budgeted establishment held on the roster over the reporting period continues to remain significantly high across the Trust.
- Over the previous 9 months the highest creators of additional duties were Bankfields Court (LD), Bedale (PICU), Ramsey Talbot (LD), Kestrel Kite (SIS), Cedar Ward (PICU), Tunstall Ward (AMH), Overdale Ward (AMH), Minster Ward (AMH), Wold View (MHSOP), Springwood Unit (MHSOP)

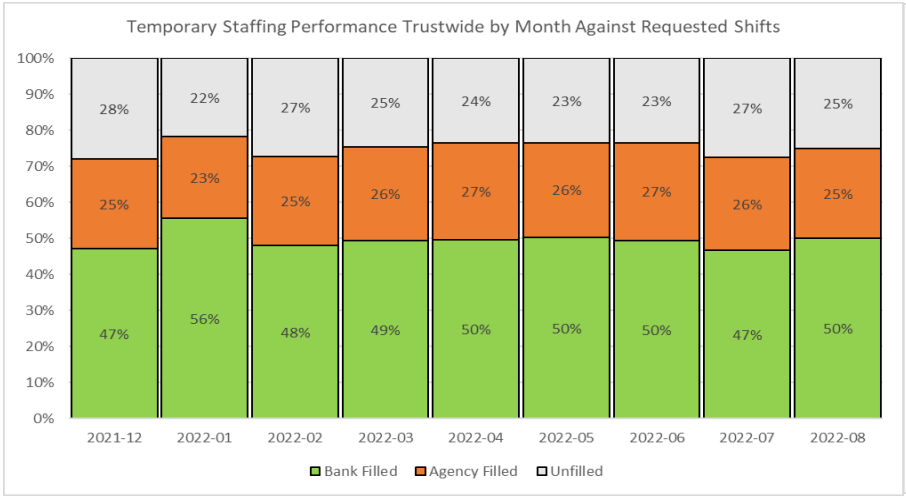
Key Learning and how we are using this

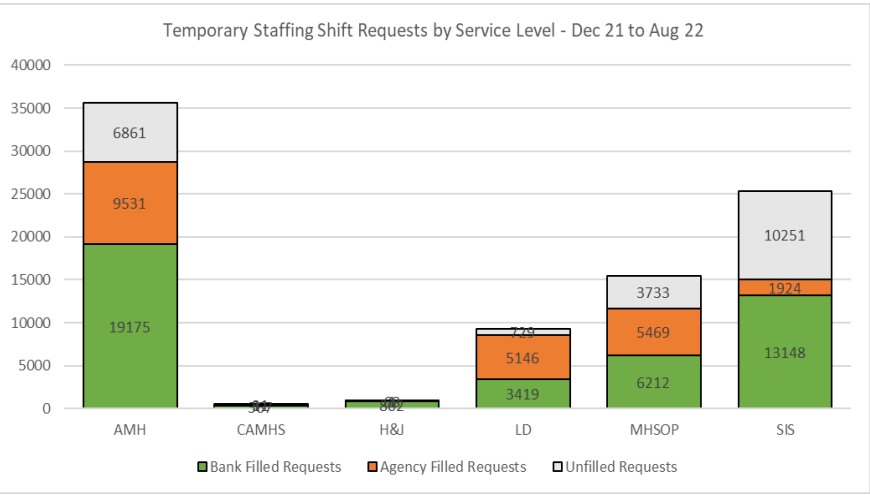
- There is a difference between reason codes provided by each care groups. It remains unclear at this time whether this is a coding/data entry issue or not. This will require further investigation to acquire an understanding of these differences to identify if it is either correct or education, and delivery of standard operating procedure is required to ensure a uniform approach to coding is maintained and therefore achieve a clearer picture of the rationale of the requirements for additional duties.
- The use of additional duties provides further insight into those areas that require staffing above their planned and budgeted establishment, which is triangulated with other workforce data to highlight increased staffing requirements and is to be considered in the establishment review process.

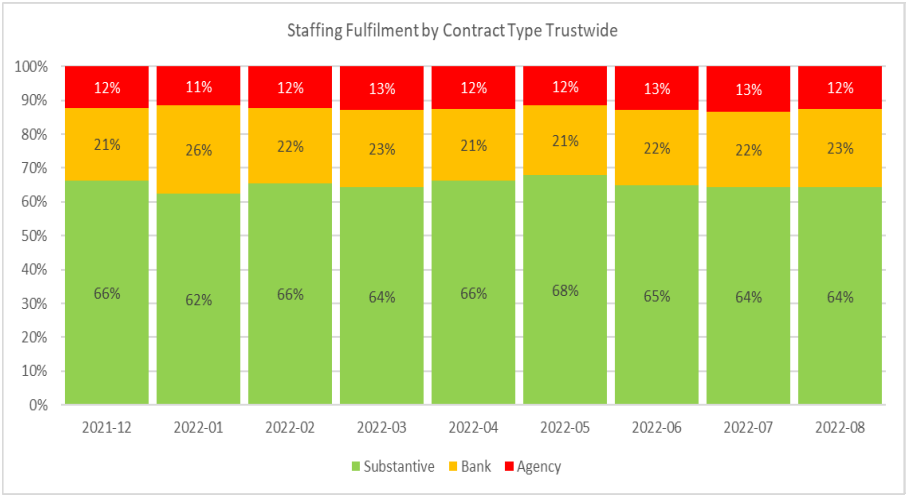
Actions we are taking (now what)

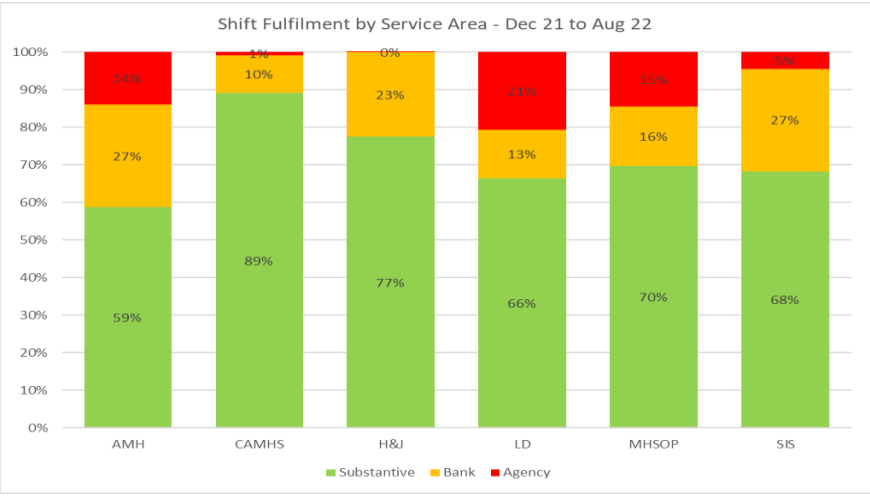
- Review of the reason codes available to staff to reduce any potential ambiguity
- Development of a standard operating procedure and update into the Roster Procedure detailing when the specific reason codes need to be selected and the context and impacts of recording this correctly
- Ongoing roster awareness training continues to be supported regarding best practice and ensure effective rostering
- Establishment reviews

Right Place and Right Time Continued – Temporary Staffing Performance and Fulfilment









Analysis (so what)

- Temporary staffing performance shows that the bank staff fill rates show an average of 49.7% and an average Agency fill rate of 25.6% - giving an overall of 75.3%; therefore approximately 25% of all bank staff requests remain unfilled. The data shows a relatively steady state for fulfilment across the Trust through the reporting period, minor fluctuations aside.
- Fulfilment indicates the contracted position when on duty against the total actual hours worked. The percentages of bank and agency are therefore reflected in the overall fulfilment of staffing against the actual hours worked. We can see from the data that there is a higher percentage of agency hours in NYY&S in comparison to DTV&F. However, it can also be seen that there is a higher level of substantive staff in NYY&S than DTV&F. This is reflected in DTV&F showing a 9% higher ratio of bank fulfilment.
- AMH have had the highest amount of temporary staffing requests, which is reflective in the staffing fulfilment by contract type where we AMH as had only 59% of their shifts covered by substantive staff on average.
- SIS, despite having a similar number of wards to AMH, show to have had the highest number of unfilled requests.
- LD wards see large number of agency staff in the fulfilment of their shifts, which will be influenced by the packages of care across this reporting period which were supported predominately by agency staff with wrap around oversight from TEWV staff only.

Key Learning and how we are using this

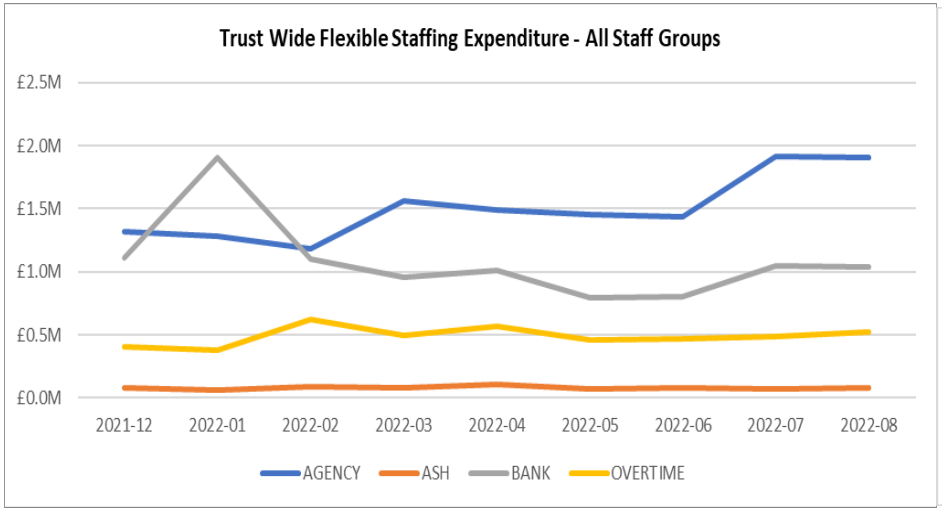
- Contributing factors to increased usage of temporary and flexible staffing include back filling for sickness absence and vacancy in addition to increased levels of staffing required to support patient acuity and need in maintaining patient safety.
- The current demand upon staffing shows to be consistently high with a slightly increasing trend. Further analysis and understanding are required to inform strategic work force planning regarding the drivers for the consistent demand and how best to meet it.
- AMH despite recent investments continue to require significant numbers of staff above their budgeted establishment.
- The noticeable higher use of agency in the NYY&S care group is impacted on by the ability to recruit generally in that area, as well as the reduced bank staff capability within the area.
- There are well documented risks around high use of temporary staffing. The Trust, wherever possible, attempts to mitigate these risks utilising regular bank and agency staff who are familiar and know the clinical areas they are working in.

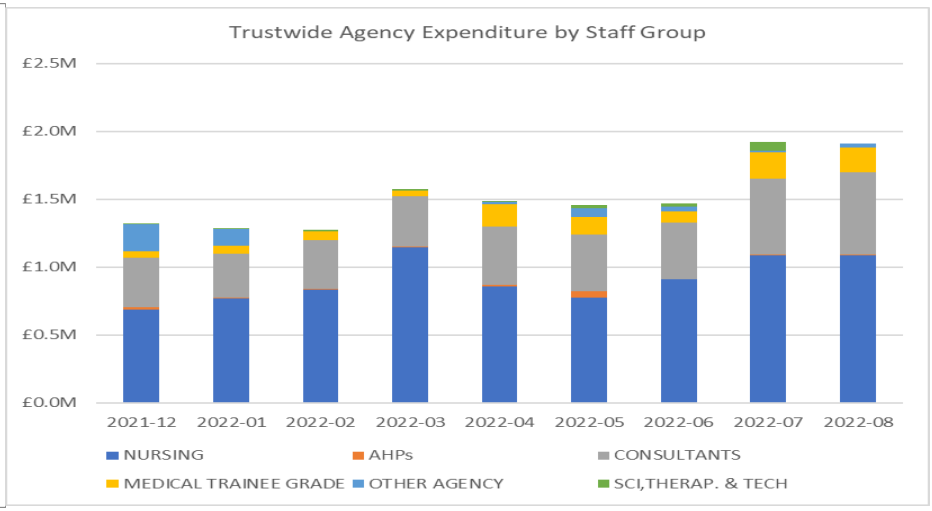
Actions we are taking (now what)

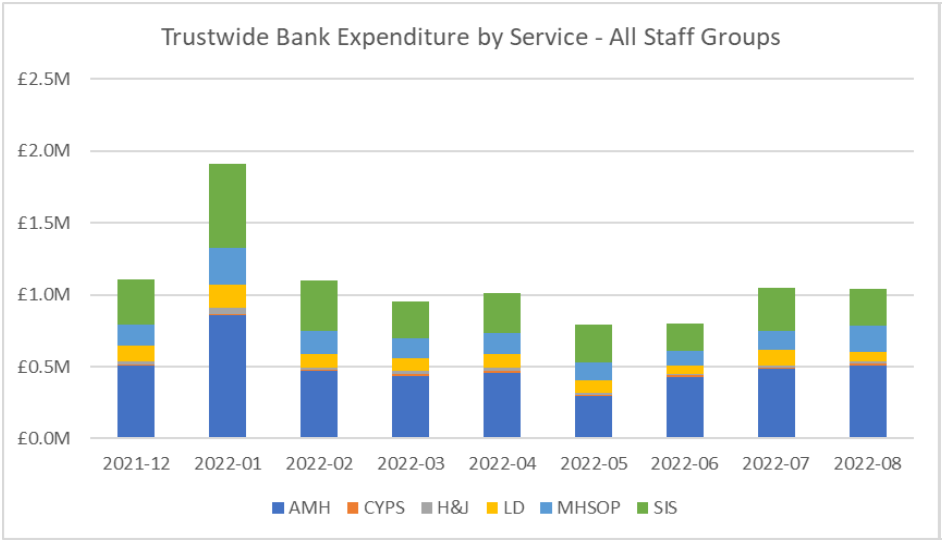
- Care Groups continually review the use of bank and agency usage as part of their ongoing roster management and any concerns are escalated through to their daily huddles and to their governance groups. Ongoing discussions with bank staff to understand their availability to support staffing requirements, and the Trust is requesting all annual leave to be booked until the end of March 2023.
- The TSS are revisiting all bank staff to consider the potential to move to substantive contracts. SIS are undergoing a recruitment episode for nurses and utilising financial incentives recruitment
- A bid is underway with HEE for additional funding to consider various clinical support worker roles across services within the DTV&F care group.
- Staffing establishment reviews will analyse planned and budgeted staffing levels to meet patient need to support the reduction the demand on temporary staffing services, and recommendations are made to the Trust Board regarding staffing establishments.

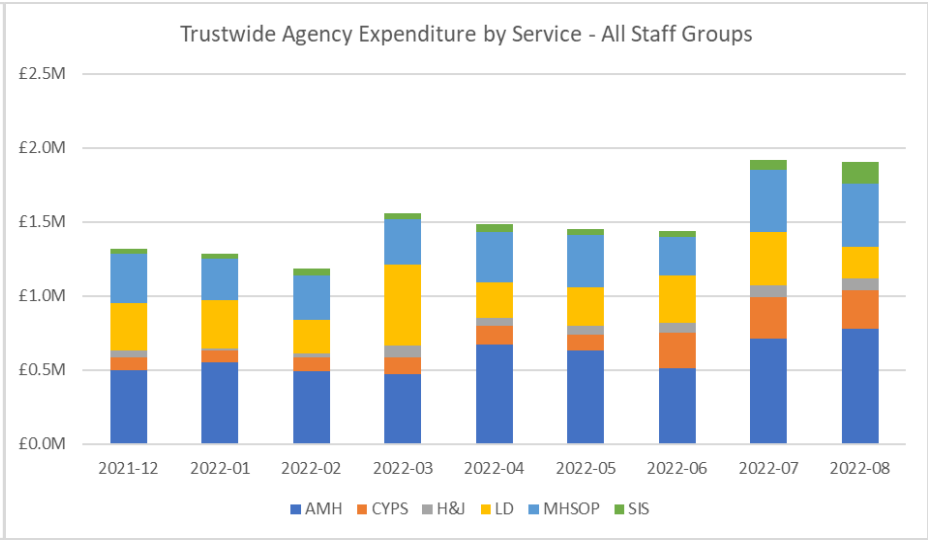
- Supporting staff to use best practice and efficient rostering to ensure that the budgeted establishments effectively utilised.
- The aim to reduce the number of substantive vacancies and reduce the requirement upon temporary staffing. In order to support substantive recruitment, for the interim, member of the temporary staffing team have been redirected from bank staff recruitment to support processing of substantive vacancies. This situation remains under regular review.
- Admin bank, previously put on hold due to the COVID is now being reconsidered with a view to fully implementing from the from the pilot.

Right Place and Right Time Continued – Flexible Staffing Expenditure









Analysis (so what)

- Trustwide agency expenditure for all staff groups shows an increasing trend over the reporting period. Overtime and Additional Standard Hours remains a relatively stable cost, with nursing showing to be the major cost followed by medical consultants.
- From a service level, AMH is the area spending the most on bank and agency across all staff groups. This is reported to be linked to high acuity of patients, vacancies and sickness.

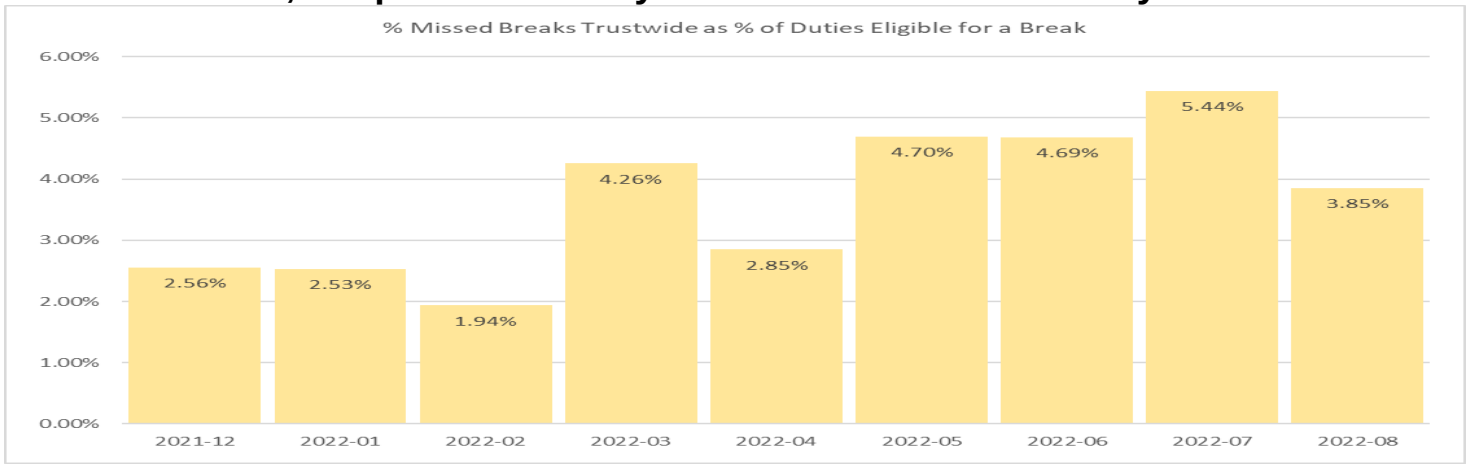
Key Learning and how we are using this

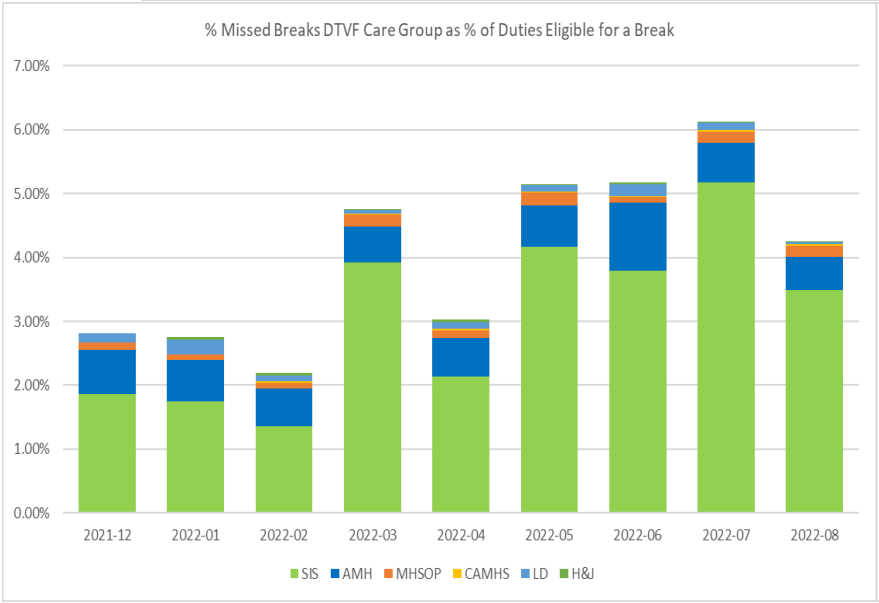
- As highlighted in the previous section, there is a noticeable higher use of agency in the NYY&S care group is impacted on by the ability to recruit generally in that area, as well as the reduced bank staff capability within the area.

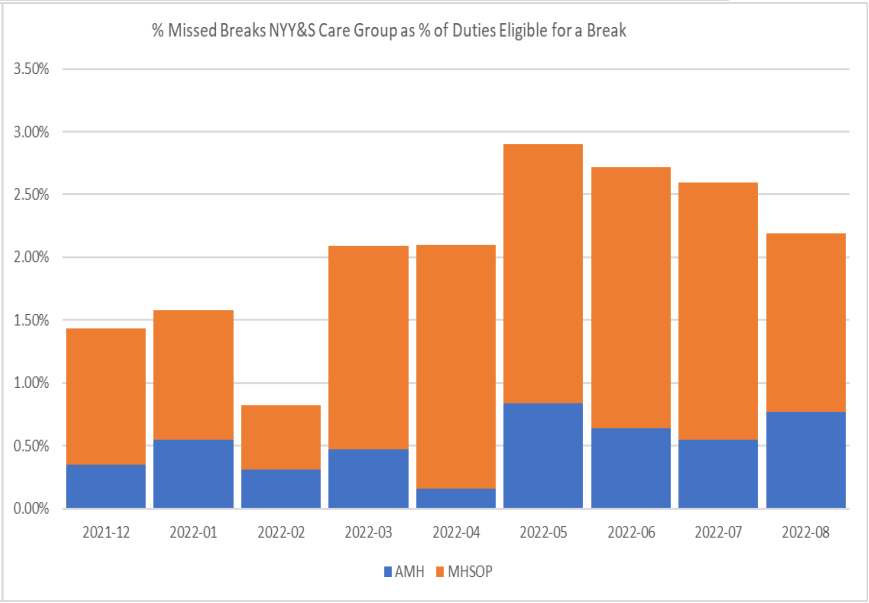
Actions we are taking (now what)

- The Trust is looking at the development of an agency reduction plan to support improved quality of care with efficient and best value for money staffing solutions to meet patient need.
- Discussions with NHSE/I are in place to support this programme of work.
- There is a review of the current process and escalation pathway for the approval of agency staff where the rates of pay are above the national cap rate (ceiling pay limit) and/or if they are provided by an off-framework agency.
- TSS have a recently recruited a coordinator who will assist the TSS agency lead in overseeing agency usage across inpatient and community services.
- As stated, staffing establishment reviews will continue to analyse planned and budgeted staffing levels to meet patient need to support the reduction the demand on temporary staffing services, and recommendations are made to the Trust Board regarding staffing establishments.
- Supporting staff to use best practice and efficient rostering to ensure that the budgeted establishments effectively utilised. The provision of community rosters will further support the process of efficient deployment of staff and monitoring of usage of agency staff in this sector.

Patient Outcomes, People Productivity and Financial Sustainability - Breaks not Taken







Analysis (so what)

- The Trust average for the number of missed breaks recorded on the Health Roster for inpatient wards over the previous 9 months, against the number of shifts eligible for a break, is 3.65 %. An increasing trend is seen from February 2022.
- The service areas showing the highest number of missed breaks for each care group are SIS and MHSOP for DTV&F and NYY&S respectively, followed by AMH across both areas.
- Missed breaks across day and night shifts show a relatively even split, 52% and 48% respectively which is also reflected into the care groups. Feedback indicates that shifts where breaks were not taken as mostly being due to periods of high clinical activity or staffing shortfalls to meet demand.

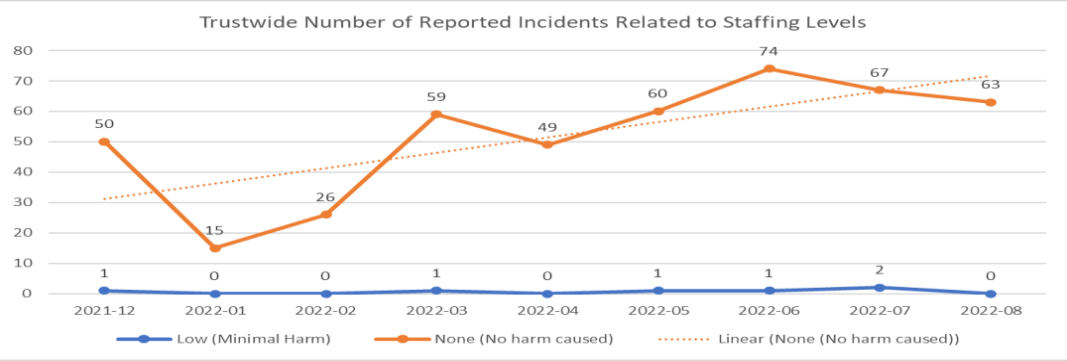
Key Learning and how we are using this

- Breaks are essential to maintain well-being at work and all efforts should be made to support staff to take breaks.
- A greater understanding is needed to understand the reason for the increased numbers of missed breaks being reported, for example, is this an increase in the number of actual missed breaks, or is it that are we getting better at reporting them

Actions we are taking (now what)

- The absence of breaks is monitored by directorates to reinforce locally and responsively the importance of ensuring breaks are taken during the shift. Also ensuring there is appropriate escalation in place and using additional staffing and MDT to support breaks to be taken
- Continued education regarding ensuring the staff Health Roster is properly maintained and updated to record all occurrences of missed breaks and the reasons why breaks are not being taken.
- Further understanding is required as to whether this education and promoted awareness is providing an increase in the number of missed breaks currently being reported to support any further required actions to address any concerns in this area.

Reporting, Investigating and Acting on Incidents Citing Staffing Levels



Analysis (so what)

- There were 469 incidents raised citing issues with staffing levels within the last 9 months. This is an increase of 5 per month over the monthly average when compared to the previous 6-month report.
- 56% (263) of the 469 incidents were inpatient related, the remaining 44% (206) were related to community and urgent care services. 30% (139) of all staffing incidents reported involved the Forensic Services, these also account for 53% of the 263 inpatient reports recorded.
- Themes include, staff vacancies, skill mix, long term and short-term sickness, continuity of staff, high acuity, temporary staffing, capacity to meet demand, enhanced observations, provide cover to inpatient areas, patient leave, activities cancelled, and breaks not taken.

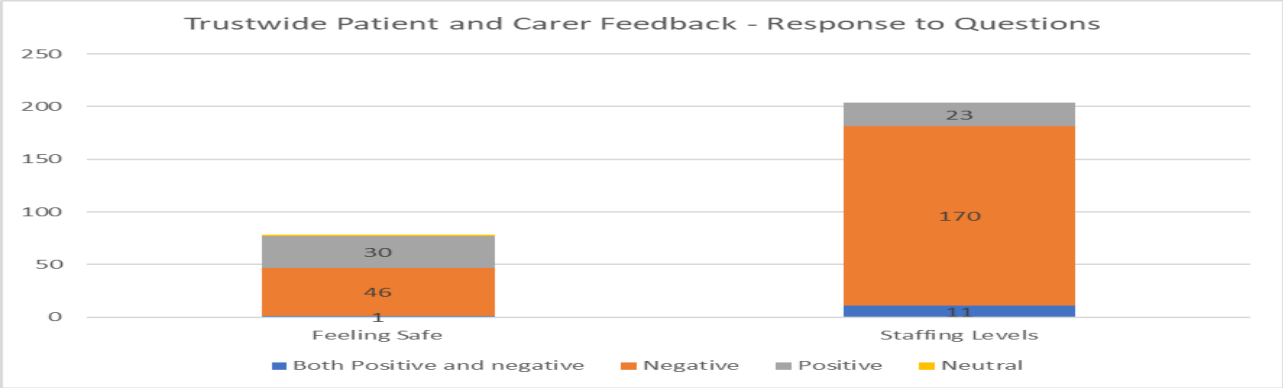
Key Learning and how we are using this

- The increase in the number of incidents reported relating to staffing levels may be due to the uptake of the education and message to report staffing issues via the escalation pathways, or it may be due to an actual increase staffing level issues. Further work is required to gain a better understanding of this in order to provide assurance of the current reported situation.

Actions we are taking (now what)

- The message to encourage staff to report staffing issues using Datix continues through the education of the staffing escalation protocol by local services and through the appropriate forums.
- The escalation procedure has been reviewed and approved and is due to be republished this month. It incorporates alignment with the SafeCare Red Flag process and will be used to support escalation reporting. Future revisions will include consideration of the Trust position on Datix reports for this type of incident as proposed by the QuAC, and how more sustained chronic reporting of staffing levels will be reported upon.

Patient and Carer Feedback



Analysis (so what)

- For the latest 9-month period there have been 204 comments made by patients and carers in relation to "number of Staff available" of which 88% were identified as negative. Of these responses, for inpatient wards and community teams, and from both patients and carers, the feedback provided a set of consistent themes from negative comments which include, more staff numbers are required, staff are always busy, more regular staff and less agency. Less frequently mentioned are, further training required, and improved access to medics
- The total number of compliments is not currently available due to the ongoing IIC outage.
- In relation to feeling safe, the feedback comments identified 60% comments that were identified as negative, broadly identifying concerns over the presentation and behaviours of fellow patients which caused them to feel unsafe. The remaining positive comments and spoke of the caring professional nature of the staff.

Key Learning and how we are using this

- Feedback outcomes into Special Interest Groups, such as "A Great Place to Work", and the Executive People, Culture and Diversity Group to support future strategic planning regarding staffing and workforce.
- Triangulation in workforce planning and establishment reviews.

Actions we are taking (now what)

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

Conclusions:

We continue to work in unprecedented times following the staffing related issues and challenges the pandemic presented. There remains a risk that safe staffing will not be achieved due to deficits in skill mix, sickness, high levels of patient demand and acuity and vacancies.

Recruitment and staff retention is at the fore of the workforce related approaches together with agency staffing reduction to increase quality of care that is financially sustainable. There are several initiatives in place or in train to improve staffing levels however the need to develop this into a coherent workforce plan in order that effective delivery and impact can be monitored is acknowledged.

Following a clinical staffing establishment review, the areas prioritised for investment by the Trust Board are MHSOP and LD services. The establishment review paper should be read and considered in conjunction with this paper to mitigate identified risks.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item No 15

Mental Health Legislation Committee (MHLC): Key Issues Report	
Report Date: September 2022	**Report of: Mental Health Legislation Committee (MHLC)**
Date of last meeting: 9th August 2022	The meeting was informal due to the summer recess. (There was no requirement for formal quoracy, however all members were present).

1	**Agenda: The Committee considered the following agenda items during the meeting:** • Minutes of the last meeting held on 17th May 2022 - approved • Integrated Performance Dashboard • CQC Mental Health Act Inspections • Discharges from Detention • Section 136 • Section 132b • MHA/DoLs Update • Consent to Treatment Policy • Trust response to Liberty Protection Safeguarding under the Mental Capacity Act
2a	**Alert:** The Committee considered that there were no matters of alert that should be referred to the Board of Directors.
2b	**Assurance: The Committee assures members of the Board on the following:** **Integrated Performance Report (IPR)** The IPR for the MHL Committee contains one measure: "The number of uses of the Mental Health Act". There have been 1,064 uses of the MH Act year to date with 357 uses during June 2022. There are currently no specific trends or areas of concern identified in the number of uses of the MH Act, however there is a need to understand whether we treat our patients equally when the Act is deployed. Moving forward, the measures for the MHL Committee will include the Mental Health Act broken down by ethnicity. **Risks** The MHL team are going to undertake a review of any risks on the corporate risk register that might be relative to the Committee. This will then allow the MHL Committee to have oversight and focus on any assurances required to make improvements. **CQC Mental Health Act Inspections** The Committee welcomed the significant improvement in the number of common themes raised in Mental Health inspections. There were seven inspections in total during Q1. Assurances can be provided that the themes raised by the CQC, including Wi-fi connectivity are being progressed. Advocacy provider response times are impacting on IMHA contact with patients and this will be fed back to the Local Authority via the Care Groups. **Discharge from Detention** There are no exceptions from the data during Quarter 1. There were 115 Hospital Managers' reviews, a slight increase from the previous quarter of 109, which is within normal range. **Section 136** From interrogation of the data over a three-year period, assurance can be given that there are no trends or themes in the use of Section 136.

	There were 166 uses in the last quarter, which is the same as the previous quarter. There was one exception to the data where one patient was held for a full 24 hours as a bed could not be located. The Medical Director will share lessons learned via the Medical Director's bulletin. The patient was found a bed in the same hospital as the S 136 suite and moved from the suite to the ward. **Section 132 – Information to Detained Patients** The MHL team have been undertaking some 'deep dive' work into the processes that support Section 132, patients being given their rights. Due to the focus and extra checks that have been made at ward level during Q1 the escalation process was used 60 times compared to 28 in Q4. The escalation process was used in 8% of new detentions (719) with 0.7% of newly detained patients not being given their rights. The longest a patient waited for their rights was 14 days. The work will continue with Modern Matrons and ward staff to ensure that the process is followed, and patients are given their rights. **Meeting evaluation** – Some positive feedback was received from the Service User Representative on the Committee that the information and focus of the reporting to the Committee was more focused on the patient perspective. There is going to be a second developmental session held by the MHL Committee during the Autumn 2022, to re-visit its terms of reference, reporting and levels of assurance. One of the main changes to the terms of reference agreed by the Committee is to include representation from the two Care Group Boards. This will provide the operational conduit for any feedback or actions to the service areas.
2c	**Advise: The Committee advises the Board on the following:** **Mental Capacity Act & DoLs Update** The government has published its much-anticipated draft Mental Health Bill to amend the Mental Health Act 1983 (MHA) in June 2022. According to the government, the draft bill includes "a range of changes to shift the balance of power from the system to the patient, putting service users at the centre of decisions about their own care". The MHL team are busy working with Beachcroft solicitors to prepare for the potential impact on the Trust. A briefing will be circulated for Board members for information, on plans to date. There are no issues currently with DoLS with 59 current cases. **Trust response to Liberty Protection Safeguarding under the Mental Capacity Act** The Committee received and noted, as part of the consultation process, a copy of the Trust's response to the Liberty Protection Safeguarding under the Mental Capacity Act.
2d	**Review of Risks** | There were no risks to be escalated to the Board of Directors

Recommendation: The Committee proposes that the Board:
i) Note that the Integrated Performance Report has been considered and that there will be a refresh of the measures relative to the MHL Committee, to include the breakdown of application of the Mental Health Act by ethnicity. Links will be made between the data considered by the MHL team and the information reported through the IPR.
(ii) Note that there will be a change to the terms of reference for the MHL Committee, to include representation from the Care Group Boards.
(iii) Note that the Board will be provided with a briefing paper on changes to the Mental Health Act 1983.
(iv) Note that there are no exceptions or concerns from the information considered at the meeting.

3	**Actions to be considered by the Board:** There are no actions for the Board to consider.
4	Report prepared by: Donna Keeping**, Corporate Governance Manager,** Pali Hungin, **Chair of the Committee/*Non-Executive Director****, Kedar Kale*, Medical Director***

Item No. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29 September 2022**
TITLE:	**Assurance Report on the Delivery of the CQC Action Plan and CQC Inspection 2022**
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 a detailed update of the current status of all CQC actions. This was presented to the Quality Assurance Committee (QuAC) 01.09.22 and approval provided for extension of the delivery timescales for 15 actions. A summary of the status of Must Do actions as at 01.09.22 is as follows:

- 54 (68%) actions are complete
- 25 (31%) are on track with little risk to delivery
- 1 (1%) have some risk to delivery

A full status update for all must do actions is presented as Appendix 1 of this report.
In terms of Should Do actions, there were no exceptions to report to the Board.

There is currently one must do action related to recruitment in CAMHs and one should do action for which 'some risk to delivery' has been identified. Staffing remains a 'must do' in the recently published CAMH's report and therefore actions and timescale's will be reviewed and revised to reflect any additional actions required. There are no new risks resulting from these actions.

As at 01.09.22, there were 0 actions that were showing as red which were recorded as 'not delivered/ significant risk to delivery'.

Progress regarding CQC inspections of Child & Adolescent Mental Health Services (CAMHS), Secure Inpatient Services, Adult Learning Disability Services (ALD) and Prison Mental Health Services are noted within the report. The CAMH's report has recently being published with the domain of 'Safe' being re-rated to Requires Improvement demonstrating improvement in the areas identified although further work is needed to embed and improve staffing levels. The Factual Accuracy report for ALD was submitted on the 22/09/22.

Governance arrangements are in place to support the Trust's inspection activity and ensure appropriate monitoring and delivery of the Trust's CQC action plans.

Recommendations:

The Board is requested to receive the report with good assurance regarding oversight and delivery of the CQC action plan.

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**29 September 2022**
TITLE:	**Assurance Report on the Delivery of the CQC Action Plan and CQC Inspection 2022**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to present to the Board the current status of the actions arising from the CQC Trust core service and well-led inspection.

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.

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.

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.

From April 2022 all action owners commenced reporting progress against individual actions monthly directly to the Quality Governance Team via the T Drive share point folder. This has supported action owners by providing live access to the plan and it has been successful in ensuring routine progress updates regarding delivery of individual actions.

Implementation of ward Provider Action Statements following MHA inspections supports ongoing compliance with the CQC Fundamental Standards. A

corporate evidence repository for all CQC MHA inspection actions continues to be maintained by the Quality Governance Team and discussed within the Care Group Fundamental Standards Group.

3.2 CQC Fundamental Standards Reporting Arrangements

The Care Groups Fundamental Standards Groups have continued to meet and support progression and embedding of relevant CQC actions. The Strategic Fundamental Standards group scheduled to be held 16 September 2022 was cancelled due to the number of apologies received. The next meeting is scheduled for 07 October 2022 during which there will be a further review of all must do actions, a focus on the should do actions and update reports from both Care Group Fundamental Standards Groups in preparation for any upcoming 'Well Led' inspection.

3.3 Current Must Do Action Plan Status

The Trust CQC Must Do action plan update is presented as Appendix 1 of this report. All CQC actions were presented to the Quality Assurance Committee 01/09/22.

The chart below provides the current status (as at 01/09/22) against all Must Do actions within the Trust CQC action plan and progress against previous reporting positions. Overall, there is good progress noted. Where actions are complete, the focus remains on embedding the changes in practice and sustaining compliance with the Regulations.

- 54 (68%) actions are complete
- 25 (31%) are on track with little risk to delivery
- 1 (1%) have some risk to delivery

The detail against each action is documented within the CQC Must Do action plan, an update of which is provided as Appendix 1 of this report.

A full review of must do actions and associated timescales was presented to the QuAC, 01.09.22. The Committee approved the extension of the delivery timescales for 15 actions in order to support robust implementation.

There was one action where 'some risk to delivery' was reported for CAMHS action:
23a) 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.

Whilst recent recruitment campaigns have been extremely successful e.g. with 11 staff due to commence post in the North Durham Team and skill mixing within teams, the introduction of trainee support workers etc. have also been successful, there remain challenges (in line with national workforce issues). These particularly relate to recruitment of medical and psychology staff. The service has adopted strategies such as the weekly 'Workforce Wednesday' meeting and are working to maintain improvements whilst reducing 'blockages' in recruitment processes.

Ongoing issues with staffing are reflected in the recent CAMH's re-inspection report and previous actions will be reviewed in line with this.

There were no other new risks to bring to the attention of the Board.

3.3 Current Should Do Action Plan Status

In addition to the identification of Must Do actions, the inspection report published included 21 Should Do recommendations. Many of these actions were aligned to must do actions. During August a full review of the should do actions has been undertaken with 20 of the 21 actions now fully reviewed. There remains 1 action which is still undergoing review and is likely to require amendment following the organisational restructure in April 2022.
Of the 21 should do actions the reporting status as at 21.09.22 was as follows:

- 13 (62%) actions are complete
- 6 (28%) are on track with little risk to delivery
- 1 (5%) action has some risk to delivery

The action which currently has some risk to delivery is:

Action 8a) Scope functionality of CITO to deliver a patient status report for patients' mental state examination.

It is likely that due to the delay in the CITO system delivery timescales that this associated action will also be delayed. There is limited risk in respect of this enhanced functioning not being present until being established following CITO delivery.

3.4 SIS CQC Inspection

A number of additional information requests for information were received in respect of the SIS CQC inspection. In follow up to information submitted to the CQC, at their request, a meeting took place with service representatives to

clarify a number of queries and to enhance understanding of the assurance evidence provided. There was positive verbal feedback received following the meeting, although staffing and service oversight of incidents remained an area noted for further assurance. The Trust expect to receive the report for factual accuracy checking imminently. Weekly assurance reporting remains in place to the Executive Directors Group with regard to safeguarding, safe staffing, incident reporting and restrictive interventions. With regard to oversight of incidents 13 out of 15 wards have now moved to the 2nd stage Datix approval process bringing positive assurances. The service are still short of registered nursing establishments but expect 10 newly qualified nurses to commence this month with 47 Health Care Assistants including 6 Activity workers recruited and due to start. Weekly dip samples of safeguarding incident reporting (10 a week) continue bringing greater oversight and opportunities for improvement.

3.5 CAMHS Inspection 6-7 July 2022 Report Published – Must Do Action Plan

The CAMHS CQC inspection report was published 15 September 2022. The report detailed 3 must do actions and 3 should do actions. Must do actions are detailed below:

- The trust must ensure that there are enough staff in each team to meet the demands of the service. Regulation 18(1)(2)(a).
- The trust must ensure that all staff are appropriately trained in the mandatory skills required to fulfil their roles. Regulation 18(1)(2)(a).
- The trust must continue to review waiting times and ensure that children and young people receive treatment in a timely manner. Regulation 91).

The Trust action plan in response to the must do actions was submitted to the CQC on 22.09.22. It should be noted that actions are already being progressed in relation to the first two of the above must do actions as a component of the Core Service Inspection action plan agreed in January 2022.

3.6 ALD Inspection and Factual Accuracy Process

The ALD Service was inspected 29-30 May, 7-8 June and 22-23 June 2022. The ALD Factual Accuracy Report was received by the Trust 07 September 2022. The Trust are required to review the report and to challenge any factual inaccuracies with the CQC by 22.09.22. The content of the report remains embargoed until formal publication by the CQC has taken place, however quality and safety issues are noted within the draft report. The ALD service is progressing areas of concern raised during the recent inspection and is providing weekly assurance reports to the Executive Directors Group. Seclusions episodes continue to decrease with significant improvement in Ramsey and the Lodge. Physical interventions have decreased in all areas with the exception of one patient for whom, the Nurse Consultant, Positive and Safe is working closely with the MDT. There are only two patients who remain at Lanchester Road Hospital as two patients have been discharged supporting a move for another patient to Bankfields Court.

3.7 HMIP/CQC Inspections

Recent joint HMIP/CQC inspections of prisons undertaken have received positive informal feedback to date. Inspections undertaken have included:

- HMP Northumberland: Week Commencing 05.09.22 – 09.09.22
  Inspectors noted that the team responded to patient need, ran a safe service, and offered good support to patients. Assessments were noted to be timely, patients were reviewed appropriately, formulated and care plans were being developed with patients. Inspectors were also particularly impressed by the full-time Speech and Language Therapist with regard to records, communication and support with neurodiverse needs.
  Significant concerns were raised regarding current staffing across Healthcare within the prison, however, there was recognition of the ongoing recruitment and new staff due to commence in post within the Mental Health Team.
  Waiting times for counselling and MHA transfers to secure beds were also noted as too long.

- Immigration Removal Centre: Week Commencing 22/08/22:

  Initial informal feedback received following the inspection was extremely positive. It was noted that staff understand and respect detainee's needs (culture, trauma and social). There was seamless partnership working with Rethink and a good range of skills. Great effort had been made in translating information/ care plans. Pre-release work and support was also commended.

- HMP Lancaster Farms: Week Commencing 15/08/22:

  Inspection feedback was generally positive regarding the mental health team. The service model was noted to work well and the investment in capacity and skill mix will also make a positive difference for the team. Mental Health records were excellent, with a clear plan to follow a patients journey from assessment to discharge.
  However, waiting times were noted to be high for primary care services and access to patients difficult at times due to the impact of roll call on clinics. There was noted to be no robust model for the Personality Disorder pathway currently. Incident reporting also needs to be made more accessible to staff.

  It is anticipated that there may be some Regulatory actions for the Health & Justice Services following publication of theses inspection reports.

3.7 CQC Engagement Meetings

The last CQC Engagement Meeting was held on 20/09/22. Full updates were provided by the Trust in relation to key quality and safety parameters. The CQC did not raise any new quality or safety risks to the attention of the Trust.

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. Risks remian

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. It is widely acknowledged and accepted that safe staffing is fundamental to the delivery of high quality patient care. There remains a risk to compliance with Regulation 18 (staffing) due to our ability to recruit and retain staff (BAF risk 1 Recruitment and Retention).

6. CONCLUSION:

There is nothing to escalate to the Board in relation to current progress being made against the CQC improvement plan. It is envisaged that the focus on accelerating our Journey to Clinical, Quality and Safety programme will support the embedding of high impact actions to address key quality, safety and regulatory concerns.

7. RECOMMENDATIONS:

The Board is requested to receive the report with good assurance regarding oversight and delivery of the CQC 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	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	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	30/06/2022	Complete	Good	Deloittes are undertaking a Board Effectiveness survey at the moment and the results will be discussed at the Board Workshop on 3 May 2022 which will form the basis of the ongoing Board Development Programme. Board Workshop with Deloittes took place on 03/05/22 and analysis of the Board effectiveness survey was presented with some clear actions resulting which will inform a plan for further development. Discussed and considered with Board of Directors 26/05/22.
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	31/03/2023	Complete	Good	Evaluation being undertaken by Deloitte LLP. This has provided a template and baseline for future years.
Trust wide	**1d**		d) Commission a further external governance review.	Company Secretary	Board and Committee Minutes	30/03/2024	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	01/11/2022 ~~31/07/2022~~	On track/Little risk to delivery		Progress has been made with the Operational Agreement. We have made good progress on the development of an accountability framework and a draft has been submitted to the Executive Directors for initial comments. A meeting is planned with the Managing Directors to undertake further consultation on the current draft. It is anticipated that further work will be required. We therefore request an extension to the timescales for delivery to the 1st November 2022. ➢ **Request to extend the target date of completion to the 1st November 2022 approved by the QuAC 01.09.22.**
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]	Group Director of Therapies (KD) and Director of Quality Governance	Review of director visits	30/06/2022	01/10/2022 ~~30/06/2022~~	On track/Little risk to delivery		A review of the quality and safety questions will be undertaken in August 2022 and revised to align with current quality and safety risks. This will be live in October 2022 Director visits. However, a more fundamental revision of the approach is still to be completed. The delay has been due to competing priorities and available capacity. ➢ **Request to extend the target date of completion to the 1st October 2022 approved by the QuAC 01.09. 22.**

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	01/11/2022 ~~30/06/2022~~	On track/Little risk to delivery		Changes to the structure went live from 01 April 2022 and the first full governance cycle of Care Group reporting was June 2022. The focus is now on embedding this to ensure effective delivery. Care Group Development Events (2 days) took place 23.06.22 - 24.06.22. Governance was a key focus at these events. Governance workshops have been developed for delivery at Care Board, General Manager, and Service Manager levels. Unfortunately, the two sessions planned in August 2022 did not go ahead. The next scheduled session is 2nd September 2022. Through an improved collective understanding of good governance including risk management, these workshops will enable the Care Groups to strengthen their governance arrangements. ➢ **Request to extend the target date of completion to the 1st November 2022 approved by the QuAC 01.09.22.**
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	30/06/2022	Complete	Reasonable	Amendments need to be made to the handbook as the governance arrangements evolve - particularly in the early months of operation.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	30/06/2022	Complete	Reasonable	Executive Directors to determine when the reporting templates, linked to the BAF, will come into effect. Governance Master Classes have been developed. These training sessions will be delivered to Trust staff, initially focusing on the Care Groups. Dates have now been agreed to deliver governance workshops to all tiers within the Governance Care Groups. Standard reporting templates using the triple A model have been agreed and implemented. The Quality Improvement System has been reviewed and this revised approach approved in Mar/ April SLG. Care Group Development Events (2 days) took place 23.06.22 - 24.06.22. Governance was a key focus at these events.
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	30/06/2022	Complete	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 training and ongoing evaluation Transition programme for existing certified leaders underway
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	30/09/2022 ~~31/08/2022~~	On track/Little 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 are part of the process. More time is required to conclude this piece of work. ➢ **Request to extend the target date of completion to the end of September 2022 approved by the QuAC 01.09.22.**
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	30/06/2022	Complete	Good	This information is already available within the existing safeguarding adult's procedure; however, it will now be explicit within Trust policy. Policy went to the Safeguarding and Public Protection Team. Consultation was given for a period of 6 weeks and the new policy ratified and published for staff is now available on the Trust Intranet. Training continues to improve staff knowledge and skills which supports policy implementation.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	31/03/2023	On track/Little risk to delivery		New Business Plan document structured around the 3 goals; Workplan investment agreed which will assist alignment of PDPs with OJTC. OD leadership programme continues. Strategy Deployment group has now moved to a 6 weekly cycle.
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	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	31/03/2022	Complete	Substantial	SLG agreed the new framework on 2nd 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	31/03/2022	Complete	Substantial	New framework approved by Executive Directors Group on 13th April 2022.
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	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	31/03/2022	30/09/2022	On track/Little risk to delivery		Draft leading and lagging indicators have been identified for 2 of the 3 goals but some further work to do before Executive team can approve these, particularly the partnership related measures. Work to find available proxies for partnership related measures has not succeeded as at end June 2022, and it will take time to put survey-based methods of data collection in place.
Trust wide	**6a**	The trust must ensure that it responds appropriately to allegations of bullying, discrimination, racial abuse or	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	01/04/2022	Complete	Good	F2SU guardian and officer attended BAME network, ongoing sign posting to relevant support when concerns are raised, weekly bulletin continues to include how to raise a concern, refresh of D@WC underway, B&H and managing concerns procedures followed for formal cases. Ongoing communication of ways in which to raise a concern has resulted in an increase of F2SU concerns.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
Trust wide	**6b**	hate crimes. (Regulation 17)	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	30/09/2022	Complete	Good	Staff networks day held in May 2022 along with screensaver promoting staff networks. Lunch & Learn sessions on hate crime have commenced and will continue to be undertaken. Awareness raising will continue to be ongoing and staff stories to the People Committee are continuing, in addition to promotion via CEO blog and the blog being used for staff experience stories. Executive team have endorsed any staff member in attending 4 networks per year.
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	30/09/2022	On track/Little risk to delivery		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	01/10/2022 ~~31/05/2022~~	On track/Little risk to delivery		Feedback from staff networks show our incidents of B&H for protected groups are reducing, this is also demonstrated through grievance data. 50% of all conduct concerns are being dealt with informally which includes for example learning, training, counselling. Work is ongoing in the Care Groups reviewing the dashboard data and triangulating with information within P&C to identify trends/patterns. ➢ **Request extension to delivery date to 1st October 2022 approved by the QuAC 01.09.22.**
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	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	30/09/2022	Complete	Good	Implemented in line with B&H and managing concerns procedure
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	01/04/2022	Complete	Good	Delivery of all actions from the event continues to be implemented.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	01/04/2022	Complete	Good	From May 2022 the Freedom to Speak Up forum continues to meet monthly and this is formally reported and shared with Care Boards via the People and Culture Committee.
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	01/04/2022	Complete	Reasonable	The first refresher training event for champions/ ambassadors took place in June 2022. We have established a support network and programme of ongoing support.
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	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 a one data Management log, streamlined coordination between the FTSU team, The 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	31/08/2022	Complete	Good	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 across the organisation. The governance workshops are one of the mechanisms we are using to promote the importance of sharing learning and to gain assurance of how this is being operationalised within the Care Groups. A review of the risk has been undertaken and reduced from 16 to 12 within the risk register.
Trust wide	**9a**	The trust must ensure that its corporate risk register is current, has clear actions and timescales. (Regulation 17)	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	30/06/2022	Complete	Substantial	Revised Risk Management Policy approved by the Board on 28/07/22.
Trust wide	**9b**		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	01/04/2022	Complete	Substantial	

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	31/08/2022	Complete	Good	Head of Risk Management has undertaken an initial Training Needs Analysis and the outcome is detailed within the Risk Management Policy. In addition to this formal training programme, it has been agreed with the two managing directors that we will introduce bite size coaching sessions within the current meeting structures to strengthen staff understanding of risk management pending staff completing the revised training programmes.
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	30/09/2022	On track/Little risk to delivery		This will be undertaken by the Head of Risk Management now in post. Target date for delivery was initially amended to allow the post holder to undertake the programme of work following the Training Needs Analysis.
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	01/04/2022	Complete	Reasonable	The review of the CRR identified improvement however there are still outstanding risk that require a 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 took place 15/06/22.
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	01/04/2022	Complete	Good	Terms of reference in place however first meetings are scheduled to take place in April / May. Executive and Care Group Risk meetings have now commenced.
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	31/01/2022	31/07/2022	Complete	Substantial	
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	01/04/2022	Complete	Good	This was approved by Board Oct/Nov-21. Request to be made to extend the target date of completion to the end of Jun-22 in line with policy approval schedule.
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	31/03/2022	Complete	Reasonable	Head of Risk Management commenced in post 1st August 2022. Further review of capacity requirements to take place as part of 2023/24 business planning.
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	01/04/2022	Complete	Good	Risk Groups established as part of the governance structure on 01/04/22.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	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	31/10/2022 ~~31/03/2022~~	On track/Little risk to delivery		Further consultation to take place with Committee chairs in September 2022 with agreement of business cycles. ➢ **Request to extend the target date of completion to the end of October 2022 approved by the QuAC 01.09.22.**
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	01/04/2022	Complete	Limited	The templates are in place and agreed now rolling out and to be embedded. Continual review and evaluation will take place to gain assurance on the effectiveness of the tools.
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	31/07/2022	Complete	Substantial	Revised Risk Management Policy approved by the Board on 28/07/22.
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	31/07/2022	Complete	Good	
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	31/10/2022 ~~30/06/2022~~	On track/Little 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. The exercise to identify any local policies or procedures containing local standards or KPIs via the Service Managers has not identified any in place. A review of all local procedures within the Trust level register identified one procedure with local metrics however this related to a historical CQUIN that is no longer applicable. As a final check, the Service Development Managers for each service line will be asked to confirm if there are any further targets or quality standards locally held. In order to allow this additional assessment to be undertaken, an extension is requested for delivery of this action. ➢ **Request to extend the target date of completion to the 31st October 2022 approved by the QuAC 01.09.22.**
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	31/10/2022 ~~30/06/2022~~	On track/Little risk to delivery		This action may be revised pending the outcome of the final SDM review. ➢ **Request to extend the target date of completion to the 31st October 2022 approved by the QuAC 01.09.22.**

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	31/10/2022 ~~01/06/2022~~	On track/Little risk to delivery		This action may be revised pending the outcome of the final SDM review. ➢ **Request to extend the target date of completion to the 31st October 2022 approved by the QuAC 01.09.22.**
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	30/06/2022	Complete	Substantial	Safeguarding Level 2 training is >92% compliant and Safeguarding Level 3 > 94%. Training compliance is reviewed within the service weekly and there is detailed oversight.
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	30/06/2022	Complete	Good	Education and Training programmes have been developed and are currently being delivered. The Service have a dedicated senior nurse from Safeguarding Team present 1-2 days per week to provide direct support and advice in relation to Safeguarding processes. There has been a significant increase in local authority referrals from Q4 2021 to Q4 2022 and data is positive re general patient experience. Positive feedback from regular meetings with Trust Safeguarding leads and Middlesbrough Local Authority Safeguarding Team (June 2022) in relation to timeliness and quality of referrals, improved relationships and patient involvement. Positive uptake in boundaries training with two additional dates being provided in September and October 2022. Themes and trends are identified via review of Paris documentation and dip samples. Dip sampling of safeguarding incidents during Q1 2022 included 20 incidents, 5 required safeguarding – all 5 safeguarding incidents were appropriately managed. From Aug-22, the dip sampling methodology has been enhanced to 10 per week which is reported to the management team and service Quality Assurance and Improvement Group. The service has developed a schedule to deliver a safeguarding package to staff across the service and support staff in understanding their responsibilities to safeguard those in their care and to keep themselves and their colleagues safe. This includes additional Boundaries training and rollout schedule.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	30/04/2022	Complete	Good	All future prone restraint will be proactively reviewed by CCTV. Learning from LDU. Requested alert to be set up on Datix when prone restraint occurs for immediate review. Appointed Associate Nurse Consultant for Positive and Safe in SIS on 14/07/2022 (Linking to PBS approach).
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	01/10/2022 ~~30/04/2022~~	On track/Little risk to delivery		Recommendation to move target completion date to enable analysis and programme development. ➢ **Request to extend the target date of completion to the 1st October 2022 approved by the QuAC 01.09.22.**
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	01/10/2022 ~~30/04/2022~~	On track/Little risk to delivery		NHSE Benchmarking review complete with positive summary of progress. All services across SIS have demonstrated some level of improvement, collectively wards across RPH reporting specific areas as red on the audit tool have reduced by 50% compared to the results from October 2021 - awaiting full report to review exceptions. Recommendation to extend target date of completion to enable full analysis. ➢ **Request to extend the target date of completion to the 1st October 2022 approved by the QuAC 01.09.22.**
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	~~30/06/2022~~ 01/10/2022	On track/Little risk to delivery		SIS Service Improvement Group agreed action to provide supplementary evidence and learning to be captured via rapid reflections following incidents and feed into the ward improvement groups. Appointed Associate Nurse Consultant for positive and safe - start date to be confirmed. SIS will be part of the newly developed Care Group-wide restrictive practice group. Recommendation to move target completion date to enable full analysis. ➢ **Request to extend the target date of completion to the 1st October 2022 approved by the QuAC 01.09.22.**

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	01/03/2022	Complete	Reasonable	Reports demonstrate increased activity in psychological interventions, activities. % of cancelled leave remains low and 12 WTE staff now appointed to leave team with full complement online in September 2022. Recruitment event on 28.6.22 included activity coordinator posts.
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	30/06/2022	Complete	Reasonable	The service uses Safe Care on a daily basis. This is monitored and reported to the Care Group Board via the SIS People and Culture Group where themes are identified and reviewed.
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 patients within the service. (Regulation 18)	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	01/03/2022	Complete	Reasonable	Continued improvement in BLS and PAT compliance though this remains under Trust standards. Training compliance in clinical supervision module at 97%.
Secure Inpatient Services	**15b**		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	01/10/2022 ~~30/06/2022~~	On track/Little risk to delivery		Additional training capacity for BLS and SRD on site to increase compliance is now in place and the service continues to monitor compliance on a weekly basis. Further review of sustainability of this increased capacity will be undertaken to consider the impact of new staff. ➢ **Request to extend the target date of completion to the 1st October 2022 approved by the QuAC 01.09.22.**

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	01/10/2022 ~~30/06/2022~~	On track/Little risk to delivery		Review and collation of clinical supervision data across all wards as part of CQC data request indicates 86% compliance April to June 2022. The Trust has recently (17/08/22) implemented a new supervision recording template which will facilitate improved recording of supervision sessions. The service is supporting protected time for supervision. To allow further embedding of this new system and review of this, it is recommended to request an extension to the target date of delivery. ➢ **Request to extend the target date of completion to the 1st October 2022 approved by the QuAC 01.09.22.**
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	01/03/2022	Complete	Reasonable	QA2 Summary results for June highlight areas for further improvement re safety summary safety plan - PDP's supporting. Notable links to wards with high acuity.
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	01/03/2022	Complete	Reasonable	Quality Assurance schedule providing evidence of general compliance however identified 3 wards by exception re incident reporting. Action focused in each group to address.

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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	01/03/2022	Complete	Reasonable	A new governance system has been implemented in SIS to replicate the Care Group governance framework. Groups have recently started weekly meetings, the standard agenda and a template set up in each Group shared drive has staff meeting/WIG dates. The attendance is captured in meeting minutes stored on wards individual drives. All dates for meetings are captured within a CQC action spreadsheet and attendance will be captured via meeting minutes. Agreed at SIS Service Improvement Group for the Business Manager to review records, attendance and meetings to identify exceptions and provide any additional support. Daily group operational meetings are in place to facilitate review of incidents and discuss operational issues, and ensure appropriate escalation.
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	30/09/2022	On track/Little risk to delivery		Operational policy ready for formal 6 week consultation, reflecting community requirement to use the designated approach, frequency requirement & compliance against this standard (80%). Designated approach in place within IIC that links to Paris - piloting of approach will start in August 2022. Training tools are being developed to support the policy introduction & use of the designated dashboard.
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	30/09/2022	On track/Little risk to delivery		Meeting arranged with General Managers, Associate Medical Directors and Clinical Network Leads in May 2022 to develop workplan and link to CMHF developments. NYY AMH - IIC dashboard in place at team level to track waiters and weekly performance report out monitors against 90% standard. Improvement plans in place where required and staffing escalation in place to support team capacity - reported into LMGB and linked to risks.

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	30/09/2022	On track/Little risk to delivery		Audit report completed - being submitted to the urgent care network and governance forums within both care groups. Direct support has been provided by Lead Medicines Management Nurse to each crisis team re: storage and other medicines issues. Monthly bespoke crisis medicines management assessments currently being completed.
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	30/09/2022	Some risk to delivery		Recent recruitment campaigns have been extremely successful e.g. with 11 staff due to commence post in the North Durham Team. Skill mixing within teams, the introduction of trainee support workers etc. has also been successful however, there remain challenges (in line with national workforce issues), particularly in relation to recruitment of medical and psychology staff. Weekly 'Workforce Wednesday' meeting established including HR, recruitment and CAMHS leadership team; using a PDSA model. Reducing 'blockages' in recruitment processes.
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	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. Plan was in place for March target date, work anticipated to be completed by December 2022.
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	28/02/2022	Complete	Good	IThrive is now the framework which has been adopted across the CAMHS service. ASD outsourcing has been agreed to close down due concerns over quality and potential for loss of workforce.
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	31/10/2022 ~~01/07/2022~~	On track/Little risk to delivery		This has been reviewed in detail and a paper presented to consider future options. Summits planned by March target date, summits set to conclude by July 2022. More transformation work will fall out of these summits. Multi-agency working groups set up in Durham and Stockton to start piloting new ways of system working. ➢ **Request to extend the target date of completion to the 31st October 2022 approved by the QuAC 01.09.22.**

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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	30/09/2022	On track/Little risk to delivery		Good compliance rates (significant improvements noted) - 89% for trust wide CAMHS 19/07/22.
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	30/09/2022	On track/Little risk to delivery		Good compliance rates (significant improvements noted). Improvements maintained. 89% compliance at 19/07/22.
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	28/02/2022	Complete	Good	Actions were complete (with substantial assurance) on time but we are dealing with data quality issues with the waiters dashboard in IIC and unintended consequences from PARIS changes impacting reliability of system. These issues have been investigated and system has been more reliable.
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	31/03/2022	Complete	Good	Actions were complete (with substantial assurance) on time but we are dealing with data quality issues with the waiters dashboard in IIC and unintended consequences from PARIS changes impacting reliability of system. These issues have been investigated and system has been more reliable.
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	31/03/2022	Complete	Good	Work completed as per action and monitored by senior leadership team on a weekly basis

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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	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	30/04/2023	Complete	Good	Complete as per related action 27d
Complete	Good	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	31/03/2022	Complete	Good	Process working well with daily validation in place
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	31/03/2022	Complete	Good	Outsourcing is not being taken forward as an option at this time
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	31/07/2022	Complete	Good	There are weekly huddles to track process and address issues. Regular problem solving with team managers to look at alternative roles when recruitment unsuccessful (e.g., support workers to run groups)
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	31/07/2022	Complete	Good	

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update – 25/08/22
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	31/07/2022	Complete	Good	Extra administrative support is in place.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 17

TRUST BOARD

DATE:	**29th September 2022**
TITLE:	**Annual Staffing Establishment Review**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information and Decision**

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

Executive Summary:

The purpose of this paper is to update on the review of clinical team staffing establishments undertaken from June 2021 – November 2021. The report is for discussion and agreement.

In March 2022 the Trust Board received a paper outlining the potential additional staffing requirements for Adult Learning Disability and Mental Health Services for Older People (MHSOP) but noting that this included responding to current staffing requirements relating to a small number of complex packages for Adults with Learning Disabilities. That Board paper also highlighted that in comparison to the 2019 establishment review, based upon the same criteria, there has been an increase in the number of teams reporting their RAG rating as Red and Red/Amber. More recently, it has become evident that, in addition to needing a longer-term 'systems' resolution to the clinical model for Learning Disability services, MHSOP occupancy, and therefore related staffing requirements, are also adversely impacted by delays in transfer of care. The underlying recurrent requirements therefore require further consideration. Notwithstanding this, the Trust needs to respond to the current safer staffing requirements to ensure we remain 'safe today' and additionally have more cost effective (than premium rate agency and off framework) agency dependency due to a mismatch of commissioner funded staffing establishments and present need.

Further work has been undertaken with the clinical teams in the care groups to identify what additional staffing and skills are required to keep patients safe and this paper is an update on the reviewed staffing requirements based upon the evolving model of clinical care delivery.

The financial aspects presented within this report represent a **request for temporary uplift to rostered staffing levels / skill mix (but permanent staffing recruitment to fill)** of:

- **MHSOP - equivalent to 57.59 WTE with costings outlined to total £2,487k.** This compares to current projected over spending of £3961k but assumes recruitment to substantive staffing. It should be noted that this reflects an adjustment to 5 (from 7) day working for Practice Development Practitioners compared to proposals discussed at Committee.

  LD - equivalent to 52.88 WTE with costings outlined to total £1,978k. It should be noted that this excludes non-rostered Programme staffing costs of approximately £408k that would support future service transformation and be subject to business planning.

The paper was discussed at the 17th August 2022 Strategy and Resources Committee and members were asked to support an temporary amendment (increase) to rostered staffing elements of the proposals – this was supported in principle. This would equate to a temporary increase to *rostered staffing levels of £4,465k, and target full year best case (full recruitment) agency premium cost reductions of £2,176k and a reduction compared to current projected costs of £3,313k (full recruitment)*Due to turnover and vacancy rates, agreeing to the permanent recruitment of staffing to test an alternative model to target improved quality, safety and value for money recruitment is not felt to be a high risk proposition (with redeployment as a worst case contingency).

Recommendations:

For the Trust Board to approve a temporary increase to rostered staffing levels of £4,465k and 110.47 WTE and permanent staffing recruitment to mitigate the key quality and safety and issues raised and to aim to reduce agency usage and related premium costs.

1. PURPOSE:

1.1. The purpose of this paper is to review the position of LD and MHSOP services, updating from the staffing establishment report presented to the Trust Board earlier this year which considered each service's immediate staffing resource priorities across the locality directorates and approve roster changes to mitigate the key quality and safety issues raised.

2. KEY FINDINGS:

2.1. Service's Professional Judgement Reports

2.1.1. Ward managers were required, as part of the establishment review in June to November 2021, to complete a professional judgement report against a standard format alongside team specific workforce and patient related data. They were requested to provide a RAG rating based upon the criteria shown in Table 1 alongside a review from their respective Heads of Service.

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

Table 1: Professional Judgement RAG rating criteria

2.1.2. Table 2 highlights the LD and MHSOP inpatient wards reporting as Red and Red-Amber for the final team RAG ratings, where 7 out of 10 MHSOP wards, and 2 out of 4 LD wards reviewed are shown.

Area	Loc	Spec	Team Name	RAG
IP	NYY	MHSOP	MHSOP IP MALTON SPRINGWOOD	Red
IP	NYY	MHSOP	MHSOP IP SCARBOROUGH ROWAN LEA	Red
IP	NYY	MHSOP	MHSOP WOLD VIEW IP - FPH	Red
IP	Tees	LD	ALD BANKFIELDS COURT	Red Amber
IP	Tees	LD	ALD BANKFIELDS COURT THE LODGE	Red Amber
IP	D&D	MHSOP	MHSOP AP CEDDESFELD CB	Red Amber
IP	D&D	MHSOP	MHSOP AP HAMSTERLEY CB	Red Amber
IP	D&D	MHSOP	MHSOP BOWES LYON ROSEBERRY WD	Red Amber
IP	Tees	MHSOP	MHSOP RP WESTERDALE SOUTH	Red Amber

Table 2: RAG ratings for LD and MHSOP Inpatient Wards

2.1.3. When compared with the 2019 census, Rowan Lea (MHSOP NYY&S) has deteriorated from Red-Amber to Red, and Westerdale South (MHSOP DTV&F) remains at Red/Amber. This represents an overall worsening picture for these two services with 5 MHSOP and 2 LD wards moving into this level of RAG rating.

2.1.4. The previous establishment setting review carried out Q4 2021/22 saw significant investment towards staffing levels for AMH admissions, PICU, and SIS. Key service priorities were identified with the aim to support clinical leadership, improve skill mix and to increase availability for nursing and service user care time.

2.1.5. Since March 2022, a similar approach to identify immediate priorities was agreed and undertaken in conjunction with operational and clinical service managers for MSHOP and LD services whose outcomes are shown below.

2.2. Mental health services for older people (MHSOP)

2.2.1. The service identified three key elements:

- Immediate requirements for additional investment
- Zonal engagement and associated workforce requirement
- A review of the clinical model to inform future workforce requirements.

In considering what immediate additional investment would be most beneficial the service identified these areas:

- Physical health resource in the role of physician associate posts 5 days per week
- Additional clinical lead time to provide increased clinical leadership 7 days per week
- Clinical team administrator initially to 5 days per week plus leave cover to release nursing time to care
- Activity coordinators would provide opportunity for increased levels of engagement and activity across 7 days per week.

Some of these roles are similar to those identified in AMH and SIS but with the addition of physician associate roles.

Additional investment in Practice Development Practitioners (PDP) as per the current approach within AMH and SIS had been added to the original proposal, as this approach supports best practice and oversight, increasing clinical leadership and quality of care within services by modelling good support, providing feedback to staff and monitoring quality at ward level. Whilst this was not originally identified as a priority from services, the benefits of the roles from AMH and SIS have demonstrated that this is a requirement to ensure quality and safety and achieve regulatory compliance.

2.2.2. Investment would have benefits for leadership and culture, support workforce development and enhance quality focus, skill-mix and patient experience. The skill mix would increase positively for registered staff and care hours per patient day (CHPPD) would increase. Similarly, the other priorities identified to explore a standard for the composition of the multidisciplinary team and the clinical model will offer further opportunities to improve value for money from current expenditure.

2.2.3. Planned additional cost is expected to replace unplanned cost (temporary staffing), provide better value for money and reduce reliance on premium rate agency staffing (and including for some of the highest premium rate off-framework assignments in Learning Disability services). However, as the proposal seeks roster changes to support the quality of care delivered, Temporary Staffing usage will require careful monitoring and management to achieve safe care and value for money.

2.2.4. The proposals for MHSOP are set out below and include Activity Coordinator (Westerdale South) and Physician Associates (Springwood, Rowan Lea, Moorcroft and Wold View) based on a professional judgment approach. The proposed final temporary roster changes equate to 57.59 WTE with costings outlined to total £2,487,383. There needs to be consideration of the management and approach regarding potential unintended consequences of recruiting to the Practice Development Practitioner posts, i.e. the back fill for internal candidates such as Clinical Leads and their subsequent Band 5 uplifts into post and therefore leaving gaps on the wards. For this reason, the coverage has been reduced in this Board paper from 7 days to 5 days as an interim measure.

	Physician Associate B7		Additional Band 6 Clinical lead day shift		Rostered Qualified Nursing		Total Rostered Nursing Excluding B7		Practice Development Practitioners B7		Temporary Roster amendment	
	5 days 7.5 hours exc cover		7 days 7.5 hours inc cover		5 days 7.5 hours inc cover		7 days 7.5 hours		5 days 7.5 hours			
	WTE	£	WTE	£	WTE	£	WTE	£	WTE	£	WTE	£
Roseberry	0.50	£26,386	1.79	£87,228	0.61	£16,433	1.79	£53,078	1.00	£52,771	5.69	£235,896
Oak	0.50	£26,386	1.79	£87,228	0.38	£14,848	1.79	£53,078	1.00	£52,771	5.46	£234,311
Ceddesfeld	0.50	£26,386	1.79	£87,228	0.78	£22,892	1.48	£43,886	1.00	£52,771	5.55	£233,163
Hamsterley	0.50	£26,386	1.79	£87,228	0.78	£22,892	1.48	£43,886	1.00	£52,771	5.55	£233,163
Durham & Darlington	**2.00**	**£105,544**	**7.16**	**£348,912**	**2.55**	**£77,065**	**6.54**	**£193,928**	**4.00**	**£211,084**	**22.25**	**£936,533**
Westerdale North	1.00	£52,771	1.79	£87,228	0.28	£9,886	1.79	£53,078	1.00	£52,771	5.86	£255,734
Westerdale South	1.00	£52,771	1.79	£87,228	0.28	£9,886	1.79	£53,078	1.00	£52,771	5.86	£255,734
Teesside	**2.00**	**£105,542**	**3.58**	**£174,456**	**0.56**	**£19,772**	**3.58**	**£106,156**	**2.00**	**£105,542**	**11.72**	**£511,468**
Moor Croft	1.00	£55,979	1.79	£87,228	0.28	£11,838	1.79	£53,078	1.00	£52,771	5.86	£260,894
Wold View	1.00	£55,979	1.79	£87,228	0.28	£8,895	1.79	£53,078	1.00	£52,771	5.86	£257,951
Springwood	1.00	£52,771	1.79	£87,228	0.48	£15,267	1.79	£53,078	1.00	£52,771	6.06	£261,115
Rowan Lea	1.00	£52,771	1.79	£87,228	0.28	£13,575	1.79	£53,078	1.00	£52,771	5.86	£259,423
North Yorkshire & York	**4.00**	**£217,499**	**7.16**	**£348,912**	**1.32**	**£49,575**	**7.15**	**£212,312**	**4.00**	**£211,084**	**23.63**	**£1,039,382**
TOTAL	**8.00**	**£428,585**	**17.90**	**£872,280**	**4.43**	**£146,412**	**17.26**	**£512,396**	**10.00**	**£527,710**	**57.59**	**£2,487,383**

Table 4 Final Proposal MHSOP

2.2.5. The proposals outlined in the above table support the initial request to ensure that MHSOP is 'safe today'.

2.2.6. A further deep dive analysis of key metrics is required, triangulating data that will include for example Model Hospital benchmarks, MHOST, the impacts of "Length of Stay", unavailability, and temporary staffing usage, working with services to better understand the drivers behind the data reported and any system level issues present, so that the appropriate actions can be taken. A review of Zonal engagement and associated workforce requirement will be considered in line with the Clinical journey following the implementation of the exemplar wards to standardise models of care across Trust. This may result in additional resource being required. This work will commence in September 2022 and these workstreams will synergise in the future.

2.3. Learning Disability Services (LD)

2.3.1. Learning Disability Services developed a prioritised request for additional workforce to meet requirements for the learning disabilities assessment and treatment units. The prioritised requests were considered as high, medium, low, and cross locality and are shown in detail in Table 5.

Learning disabilities inpatient settings - prioritised additional requests								
Service Type	**A&T**		**A&T**		**A&T**		**A&T**	
Directorate	**DURHAM AND DARLINGTON**		**TEESSIDE**		**NORTH YORKSHIRE & YORK**		**TOTALS**	
Cost centre	**RAMSEY TALBOT**		**BANKFIELDS COURT**		**OAKRISE**			
Priority	**WTE Budget**	**Sum of Annual Budget**	**WTE Budget**	**Sum of Annual Budget**	**WTE Budget**	**Sum of Annual Budget**	**WTE Budget**	**Sum of Annual Budget**
High	5.65	£208,782	63.56	£2,177,394	0.00	£34,406	69.21	£2,420,582
Medium	2.86	£99,767	3.00	£81,071	3.43	£119,579	9.29	£300,417
Low	1.86	£90,717	0.00	£0	1.00	£42,582	2.86	£133,299
ALL	**10.37**	**£399,266**	**66.56**	**£2,258,465**	**4.43**	**£196,567**	**81.36**	**£2,854,298**
Priority	**WTE Budget**	**Sum of Annual Budget**	**WTE Budget**	**Sum of Annual Budget**	**WTE Budget**	**Sum of Annual Budget**	**WTE Budget**	**Sum of Annual Budget**
Trustwide	1.67	£90,091	1.67	£90,091	1.67	£90,091	5.00	£270,270
ALL	**12.04**	**£489,357**	**68.23**	**£2,348,556**	**6.10**	**£286,658**	**86.36**	**£3,124,568**

Table 5 For information only - Full Learning Disability Services Proposal Summary

A more detailed analysis of those requirements is appended at Appendix C.

2.3.2. The high priority requests, outlined in Table 5 and at Appendix C, reflected the immediate level of need and acuity often linked to complex autism that is presenting to services, these changes would provide a positive impact to Care Hours Per Patient Day (CHPPD) but would reflect a reduction in the current Registered Practitioner skill mix ratios as the current approach will result in increased Healthcare Support Worker Roles to deliver patient care.

2.3.3. The service model within LD inpatient services has changed from a traditional Assessment and Treatment service to the delivery of a number of individualised complex packages of care. These have been largely unfunded and supported through Temporary Staffing Services as bank and with a significant increase in high-cost agency staffing (including off framework) with a premia for flexible staffing.

2.3.4. An initial 63.56 WTE was required to meet immediate need for staffing at Bankfields Court. Following an agreement after the Staffing Establishment review and Trust Board paper in March 2022, work has progressed to over-recruit HCSWs and RNs to provide consistent staffing for this patient group and make better use of resources (reduction in agency premium cost).

2.3.5. Learning Disability Services Trustwide have undergone a period of change and regulatory scrutiny during the period since the above proposals were agreed with concerns raised about the ability of the service to deliver safe staffing. A further review of the staffing establishment has been undertaken and the service have developed a revised interim proposal to reflect the current position. This work has been informed by the recent CQC inspection, and the report provided by Merseycare in reviewing the model of care and identifying additional roles needed to maintain safe and effective care. In addition, the service will be undertaking a Trustwide inpatient model of care review in the coming months and this will further refine the workforce proposal to meet patient and service need.

2.3.6. ***Revised Proposal Durham Tees Valley and Forensic Care Group***

2.3.7. The period of transition for Learning Disability Services has seen a recent reduction in ‘single occupancy care packages’. As a result, the final revised proposal takes account of this and reflects the Trust response to a change in service alignment and the currently envisioned requirement for Durham Tees Valley and Forensic Care Group. The revised proposal outlines the requirement for a workforce that would operate across both sites based on patient need and acuity. The revised proposal outlined in Appendix 2 outlined the additional staffing in a priority order for recruitment, all roles are essential to support the delivery of safe care. Requirements identified by the service for programme management roles are not progressed at this time pending further discussion and agreement on the future model. Additionally, dependent upon this future model, further consideration will need to be given regarding the identified “Green Light” role to support the management and review of persons admitted into adult or older people wards. This included non-rostered staffing elements equivalent to £409k which are excluded from the proposal for temporary roster change.

DTV Proposal

2.3.8. Unqualified Nurses

The previous proposal for 52.08 WTE Unqualified Nurses has been reduced to 32.88 WTE. Whilst this is a reduction, it is to be acknowledged that this remains

above the current budgeted establishment. The request for 32.88 WTE is required to meet the immediate and long term need of the service. The successful over-recruitment (in reference to current budgeted establishment) has seen **23 WTE already appointed as part of previous senior leadership/executive approval to over-recruit to the service to address the agency quality issues and financial premium pressure.** Approval is now being sought to change the rostered elements on a temporary basis to reflect the remaining Unqualified Nurse proposal of 9.88 as these staff will need to be recruited. The total costing for Unqualified Nursing 32.88 WTE is £1,123,406 per annum. It is anticipated that increasing this substantive workforce would see a reduction in the Agency Expenditure across DTVF by swopping out expensive agency staff for substantive recruitment to HCA posts (April 2022 to July 2022 agency expenditure for DTVF is £1,177,009) as well as improving quality.

In considering what immediate additional investment would be most beneficial to the delivery of safe and effective care the service identified the following areas in order of priority:

- B4 Healthy Living Advisor who will work alongside the physiotherapy and dietician team
- Band 4 Level 3 Trained fitness instructor to support the physical health and well-being of the patient's working alongside the physiotherapy
- Band 4 Physical Health Assistant to support the physical health doctors in supporting the physical health of patients
- Administration support would release nursing time to care initially to 5 days per week plus cover
- Associate Nurse Consultant /Trainee Responsible Clinician and will provide support and oversight for patient care
- Therapy Assistant to support the AHP workforce
- Advanced Clinical Pharmacist for Learning Disability services working predominantly into inpatient areas whilst also providing support to community services
- Increased banding from a B6 to B7 Positive Behaviour Support Practitioner

Acknowledging the shortage in the availability of Band 5 and 6 nursing staff, the above proposals seek to maximise the existing nursing resource by freeing up 'time to care' whilst enriching skill mix in accordance with patient need as well as improving clinical leadership. It is anticipated that these developments will positively impact on length of stay, reducing restrictive interventions in response to recommendations within the Mersey Care report.

The service has identified that a team to support the Reducing Restrictive practice, Positive Behaviour Support and Positive and Safe agenda would be beneficial and support recommendations within the Mersey Care report in relation to reducing restrictive interventions and this would include the following roles:

- Behaviour Specialist Consultant - a role which will provide oversight and expertise in reducing restrictive interventions

- Behaviour Practitioners / Positive and Safe Leads / Autism Specialist- will support the psychological well-being and specific care needs of those patients with a diagnosis of Autism

- Assistant Behaviour Practitioner -will support the psychological well-being and specific care needs of those patients with a diagnosis of Autism

- Family Ambassador Role / Lived Experience Champion This role will provide a different perspective within the MDT with their focus on the experience of care for family and patients, promoting the ethos of co-creation and collaborative accountability.

- Practice Development Practitioners (PDP) as per the current approach within AMH and SIS had been added to the original proposal as this approach supports best practice and oversight increasing clinical leadership and quality of care within services.

Whilst these roles may have limited impact on reducing temporary staffing costs, it is envisaged that they will be a quality investment, positively impacting on quality of care, length of stay, patient experience, patient safety and opportunity costs related to a reduction in restrictive interventions, improved morale and staff well-being resulting in a reduction in staff injuries and sickness. The temporary adjustment of rosters will allow the impacts to be assessed, including financially linked to agency reductions, with turnover and vacancies being a key risk mitigation.

Proposal to support transformation of services

The service has identified **4 WTE posts at a cost of £409k**, as set out in the original proposal at Appendix B that will be required to support service transformation, however it is suggested that as this proposal is based on ensuring the service is 'safe today' and **approval is being sought to change rosters rather than to identify new proposals at this stage that these are excluded from the approval and further considered within the business planning process.**

- Programme Manager Inpatient Service. This post is currently in place fixed term until March 2024 although long term requirement will be needed to support Community Transformation.
- Programme Manager Community Service. This post will be a longer-term requirement and will support the Community Transformation.

- Programme Admin support. This post is currently in place fixed term until March 2024 although long term requirement will be needed to support both the Inpatient and Community Transformation.
- Greenlight Liaison / Autism Practitioner this role will in-reach into MHSOP and AMH wards to support the implementation of reasonable adjustments for patients with Autism and Learning Disability who are receiving care in a mainstream Mental Health Ward.

The updated view of the revised LD model taking into account the above discussion is shown in Table 6 below.

			A&T	
			DTV	
			Bankfields Court & Ramsey Talbot	
			15 & 6	
			11,5 + 6, 4	
Priority	**Band**	**Prioritised workforce investment**	**WTE Budget**	**Sum of Annual Budget**
High	B3	HCA Day (6 on shift)	16.44	£494,679
High	B3	HCA Night Shift (6 on shift)	16.44	£628,727
High	B4	B4 Healthy living advisor	1.00	£27,683
High	B4	Level 3 trained fitness instructor	1.00	£27,683
High	B4	Physical Health Assistant	1.00	£27,683
High	B4	Administration support	1.00	£27,683
High	B3	Administration support	1.00	£26,694
High	B8c	Associate Nurse Consultant post	1.00	£82,948
High	B4	Therapy Assistant (OT/SLT)	2.00	£55,366
High	B7	Top up the current B6 PBS practitioner to a B7 Behaviour Practioner	1.00	£58,178
High	B6	PBS lead on duty at all times	(1.00)	(£47,068)
High	**Totals**	**High**	**40.88**	**1,410,258**
Medium	8c	Behaviour consultant	1.00	£82,948
Medium	B7	1 Behavour practitioner on 7 days	3.00	£172,606
Medium	B4	1 Assitant behaviour practitioner - 7 days	3.00	£92,021
Medium	B4	Family ambassador role / lived experience champion	2.00	£55,366
Medium	B8a	Pharmacist	1.00	£59,186
Medium		**Medium**	**10.00**	**£462,127**
Low	B7	Practice development practitioners	2.00	£105,542
Low	**Totals**	**Low**	**2.00**	**£105,542**
ALL	**Totals**		**52.88**	**£1,977,927**

Table 6 DTVF Care Group Proposal

3. Revised Proposal North Yorkshire York and Selby Care Group

3.1.1. Since the original outlined proposal in Table 5 and Table 6 Oak Rise is now temporarily closed at present and discussions regarding the future configuration of this service remains ongoing with commissioner. As a result, the original proposal is not aligned to current service need. However, following discussion with services there will remain a requirement in the future care model for the provision of the

workforce roles outlined and therefore this will require a further review in the future. Therefore, this paper does not outline any revised proposal at this point. **It is emphasised that proposed changes are only effected as temporary roster changes (but supported by agreement for permanent recruitment)** with any recurrent recruitment risk managed as a result of high vacancy rates and from staffing turnover.

3.2. **Patient Experience**

3.2.1. Comments from patient experience surveys continue to indicate improved staffing is required within our wards, due to patients suggesting that staff have excessive workloads and are not able to support further activities and leave, and continuity of care if regular staff are not available, although patients are generally very complimentary about nursing staff.

Patient feedback regarding feeling safe is currently about 58% and consistently fails to achieve its target of 88%, with reasons given by patients as; “having witnessed incidents, other patients, unfamiliar surroundings, understaffed, unpredictability of the ward, not feeling listened to, and due to own Mental Health”. Comments relating to the number of staff available in community and inpatient settings were 94% negative and related to “more staff, volunteers, funding, one to ones, communication, listening skills, and consistency between staff”.

3.2.2. Patient experience regarding feeling safe has been identified as a priority within the Trust’s Quality Account.

3.2.3. Recent CQC inspections have raised regulatory concerns relating to safe staffing and patient experience across a number of the Trusts core inpatient services (Adult Mental Health - 20-22 January 21 and 25-27 May 2021, Secure Inpatient Services - 14-22 June 2021 and 04-07 July 2022, Learning Disability Services - 29-30 May 2022, 07-08 June 2022 and 22-23 June 2022).

3.3. **Key Issues and Further Discussion**

3.4. The proposals outlined above may have limited impact on Temporary Staffing Services (TSS) expenditure due to the ongoing challenges faced by the organisation regarding staffing recruitment and retention and roster efficiency. High level modelling for Learning Disability services would see a potential reduction in reliance on TSS and premium agency rates as this resource will be replaced by substantive posts. High level modelling Agency Reduction Plan in place within the organisation which links to the Trust’s financial plan.

3.5. Early discussions around workforce modelling to gain an improved understanding of staffing requirements and service provision have commenced regarding how the Trust can develop an approach to identifying the required staffing establishments based upon the clinical pathway that a ward offers to its patients. A standardised model approach, whilst providing flexibility for local needs and available services, would be expected to be applied on a pro rata basis according to bed numbers.

Fundamental to this is the Trust and services setting clear expectations and defining what its deliverables are regarding the care and treatment on offer to patients.

4. PRIOR CONSIDERATION AND FEEDBACK

The financial aspects presented within this report regarding staffing investments for MHSOP and LD have been discussed at the Strategy and Resources Committee in August 2022 who agreed to support a recommendation to temporarily uplift rostered staffing proposals in principle. Further discussion between the Director of Finance and Director of Nursing and Governance have shaped the proposal to approve roster changes whilst closely monitoring the impact of the staffing establishment against the agency reduction plan, reduction in temporary staffing and quality and safety benefits, acknowledging there is further work to do on models of future care and the commissioning model.

5. IMPLICATIONS

5.1. Compliance with the CQC Fundamental Standards:

5.1.1. Adhering to NHSE/I Safe Staffing requirements will provide compliance with CQC regulatory standards. Professional judgment discussions within the team reports are based upon achievement of the CQC fundamental standards. Insufficient staffing and skill mix have negatively impacted on core service ratings for the CQC 'safe' and 'well led' domains following Trust inspections over the past 4 years within CAMHS inpatient and community, Adult and PICU, Secure Inpatient Services and Learning Disability Services. This report aims to highlight areas where staffing shortfalls may need to be addressed and further mitigated to address safe and effective care delivery.

5.2. Financial/Value for Money:

5.2.1. From a financial perspective, the tables below illustrate the current budgeted establishments and projected cost and adverse variance (over spending) based on year to date costs, extrapolated to 31 March 2023 for both MHSOP and Adult LD Wards.

Older Adult Wards for Mental Health are projected to overspend by £3.96m, including the cost of 81.1 (net) WTE actual utilisation over establishment and **an estimated agency premium cost of £805k**. In aggregate the contracted compared to budgeted WTE is marginally over established based on the month 5 ledger position (2.72 WTE). By targeting additional permanent WTE staffing the Trust would aim to reduce premia costs.

In contrast to current projected over-spending of £3,961k the revised proposed staffing skill mix impact on the roster would cost £2,487k if staffed using permanent staffing, representing a reduction of £1,474k.

Straight line projected agency staffing costs represent £1,906k in aggregate, based on costs to 31 August 2022, or 11.05% of overall staffing costs.

If recruitment leaves a similar proportion of posts requiring agency backfill, this would attract an estimated (average of current rostered) 78% premium to 11.05% of staffing cost, or £214k reducing savings to £1,260k. The break even point would be at around 75% agency staffing (above which costs would exceed current projections, assuming similar spread across rostered days/hours/agencies).

Savings scenarios – estimated:

Agency FOT	1906	11.05%
Staff FOT	17244	
Additional Staffing	2487	
Over Spending	3961	
CRES if perm staffed	1474	

Agency % scenarios		**Residual cost reduction**	**Est agency premium**
Current proportion	11.05%	1260	214
Secario 2	25%	989	485
Secario 3	40%	698	776
Secario 4	50%	504	970
Secario 5	75%	19	1455

Month 5 WTE and straight line forecast costs:

MHSOP Inpatient	
WTE Budget	329.15
WTE Contracted	331.87
WTE Actual	410.25
Annual Budget £000	13,283
Forecast Outturn £000	17,244
Forecast Deficit / (Surplus) to Budget £000	3,961
Agency Premium %	78%
Agency Premium Forecast £000	805

Adult Learning Disability Wards are projected to overspend by £3.82m, including the costs of 16.4 (net) WTE actual utilisation over establishment and an **estimated agency premium cost of £1,371k**. This higher proportion of premium reflects the increased agency staff reliance of 26.45%. In aggregate the contracted compared to budgeted WTE is markedly under established (46.57 WTE) based on the month 5 ledger position.

In contrast to current projected over-spending of £3,817k the revised proposed staffing skill mix impact on the roster would cost £1,978k if staffed using permanent staffing, a cost reduction of £1,839k

Straight line projected agency staffing costs represent £3,306k in aggregate, based on costs to 31 August 2022, or 26.45% of overall staffing costs.

If recruitment leaves a similar proportion of posts requiring agency backfill, this would attract an estimated (average of current rostered) 70% premium to 26.45% of staffing cost, or £513k and reducing savings to £1,326k. The break even point would be at around 94% agency staffing (above which costs would exceed current projections, assuming similar spread across rostered days/hours/agencies).

Savings scenarios - estimated

Agency FOT		3306	26.45%
Staff FOT		12499	
Additional Staffing		1978	
Over Spending		3817	
CRES if perm staffed		1839	
Agency % scenarios		**Residual cost reduction**	**Est agency premium**
Current proportion	26.45%	1326	513
Secario 2	40%	1063	776
Secario 3	50%	869	970
Secario 4	75%	384	1455
Secario 5	94%	16	1823

Month 5 WTE and straight line forecast costs:

Adult LD Inpatient	
WTE Budget	248.72
WTE Contracted	202.15
WTE Actual	265.10
Annual Budget £000	8,682
Forecast Outturn £000	12,499
Forecast Deficit / (Surplus) to Budget £000	3,817
Agency Premium %	70%
Agency Premium Forecast £000	1,371

Historically, inpatient ward overspending has been offset by community team underspending due to staffing turnover and vacancies, including from stepped investment via the Mental Health investment standard. This cannot (and is not) be relied upon as anything other than a 'fortuitous' financial mitigation due to the impacts of community vacancies on the workloads of individuals within those teams. As the Trust moves to consider implementing temporary staffing arrangements in community-based services the vacancy levels are expected to reduce.

Partnership discussions will be needed to consider the recurrent ongoing service models for both services and associated recurrent staffing costs. Neither specialty has received additional inpatient staffing investment, in part due to the national requirements to allocate the MHIS funding to community-based Long Term plan priorities, meaning staffing / capacity has not kept pace with acuity / demand. This has been exacerbated more recently by pressures from delayed transfers (MHSOP) and complex packages of care (LD).

5.2.2. The ability to demonstrate effective investment to commissioners and to free up resources for better more effective use will be supported by being able to better manage unavailability and premium cost of workforce cover.

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

None identified

5.4. **Equality and Diversity:**

None identified

5.5. **Risks**

- The Board Assurance Framework recognises that 'Inability to recruit and retain sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services'.
- A significant number of teams are RAG rated as Red and Red/Amber which indicates a presenting risk to patient safety, patient outcomes and patient experience in addition to a risk to staff wellbeing due to increasing work related pressures. It is of note that a large number of teams are currently RAG rated as Amber with the concern that if the issues currently expressed by these teams are not addressed or sufficiently supported this situation may worsen across the forthcoming period.
- The sustained impact of COVID on staff and patient well-being.
- Quality and safety of patient care may be adversely impacted If we are unable to continue to mitigate concerns and key issues raised in this paper.
- National shortages of registered nurses and that of the local picture impact on recruitment, and so there may be long lead times to recruit to any required registered practitioner posts.
- Ability to be clinical effective without service capacity and investment required to meet the ambitions of the long-term plan.
- The chronic shortage of suitable and available doctors provides a significant challenge to the medical directorate which has led to a reliance on temporary staffing measures to fulfil vacant posts which has led to increased costs from using agency as cover.

- Insufficient numbers of substantive staffing will require continued use and reliance upon temporary staffing and overtime again leading to a negative impact upon the quality and continuity of care for the patient, the longer term the safety of patients upon the wards, staff experience and morale, and the Trust's SOF rating.
- Inability to effectively mitigate inpatient wards that are below the benchmark values for RP to SW skill mix ratios will have a negative impact on the clinical care delivered, effective clinical leadership, and the culture of the Trust and ultimately the potential to impact upon the safety and quality of patient care.

6. Further actions from Key Findings

6.1.1. The Trust needs to consider and ensure the correct baseline establishments are in place to provide high quality patient care. This will also prevent a reliance on temporary bank and agency staff, reduced compliance with statutory and mandated training, staff burnout. Recruitment and retention difficulties further compound issues regarding the lack of availability of staff from the registered MDT pool and is also influenced by the reduced levels of experience of new staff entering the Trust. These areas will challenge quality of care and patient safety and experience. As such the overall expectation of the Trust is to provide a positive impact upon the following areas:

- Time to care – releasing nursing staff time to care
- Leadership and culture
- Enhance quality focus and skill mix
- Enhance patient experience and reduce incidents
- Support workforce development and retention
- Reduce the use of bank staff and reliance on overtime

7. RECOMMENDATIONS

For the Trust Board to approve the temporary changes to the rostered (only) components highlighted above ££ LD and ££ MHSOP to mitigate the key quality and safety and issues raised by reducing reliance on agency staffing and additionally securing improved value for money from substantive staff recruitment to reduce premium agency staffing costs.

Appendix 1

Original MHSOP proposal

	Physician Associate B7		Additional Band 6 Clinical lead day shift		B3 Clinical team administrator		Activity Coordinators		Agreed Investmentment Priority 1	
	5 days 7.5 hours exc cover		7 days 7.5 hours inc cover		5 days 7.5 hours inc cover		7 days 7.5 hours		SUB TOTALS	
Immediate ask	**WTE required**	**£**	**WTE required**	**£**	**WTE required**	**£**	**WTE required**	**£**	**WTE required**	**£**
Roseberry	0.50	£26,386	1.79	£87,228	0.61	£16,433	1.79	£53,078	4.69	£183,125
Oak	0.50	£26,386	1.79	£87,228	0.38	£14,848	1.79	£53,078	4.46	£181,540
Ceddesfeld	0.50	£26,386	1.79	£87,228	0.78	£22,892	1.48	£43,886	4.55	£180,392
Hamsterley	0.50	£26,386	1.79	£87,228	0.78	£22,892	1.48	£43,886	4.55	£180,392
Durham & Darlington	**2.00**	**£105,544**	**7.16**	**£348,912**	**2.55**	**£77,065**	**6.54**	**£193,928**	**18.25**	**£725,449**
Westerdale North	1.00	£52,771	1.79	£87,228	0.28	£9,886	1.79	£53,078	4.86	£202,963
Westerdale South	1.00	£52,771	1.79	£87,228	0.28	£9,886	0.00	£0	3.07	£149,885
Teesside	**2.00**	**£105,542**	**3.58**	**£174,456**	**0.56**	**£19,772**	**1.79**	**£53,078**	**7.93**	**£352,848**
Moor Croft	0.00	£3,208	1.79	£87,228	0.28	£11,838	1.79	£53,078	3.86	£155,352
Wold View	0.00	£3,208	1.79	£87,228	0.28	£8,895	1.79	£53,078	3.86	£152,409
Springwood	0.00	£0	1.79	£87,228	0.48	£15,267	1.79	£53,078	4.06	£155,573
Rowan Lea	0.00	£0	1.79	£87,228	0.28	£13,575	1.79	£53,078	3.86	£153,881
North Yorkshire & York	**0.00**	**£6,415**	**7.16**	**£348,912**	**1.32**	**£49,575**	**7.15**	**£212,312**	**15.63**	**£617,214**
TOTAL	**4.00**	**£217,501**	**17.90**	**£872,280**	**4.43**	**£146,412**	**15.47**	**£459,318**	**41.80**	**£1,695,511**

Note : The above figures have not been adjusted for any pending pay awards.

Appendix 2

Initial revision of original LD proposal

		A&T	
		DTV	
		Bankfields Court & Ramsey Talbot	
		15 & 6	
		11,5 + 6, 4	
Band	**Prioritised workforce investment**	**WTE Budget**	**Sum of Annual Budget**
B3	HCA Day (6 on shift)	16.44	£494,679
B3	HCA Night Shift (6 on shift)	16.44	£628,727
B4	B4 Healthy living advisor	1.00	£27,683
B4	Level 3 trained fitness instructor	1.00	£27,683
B4	Physical Health Assistant	1.00	£27,683
B4	Administration support	1.00	£27,683
B3	Administration support	1.00	£26,694
B8c	Associate Nurse Consultant post	1.00	£82,948
B4	Therapy Assistant (OT/SLT)	2.00	£55,366
B7	Top up the current B6 PBS practitioner to a B7 Behaviour Practioner	1.00	£58,178
B6	PBS lead on duty at all times	-1.00	-£47,068
Totals		**40.88**	**1,410,258**
8c	Behaviour consultant	1.00	£82,948
B7	1 Behavour practitioner on 7 days	3.00	£172,606
B4	1 Assitant behaviour practitioner - 7 days	3.00	£92,021
B4	Family ambassador role / lived expereince champior	2.00	£55,366
B8a	Pharmacist	1.00	£59,186
		10.00	**£462,127**
B7	Practice development practitioners	2.00	£105,542
Totals		**2.00**	**£105,542**
Totals		**52.88**	**£1,977,927**

Band	**Prioritised workforce investment**	**WTE Budget**	**Sum of Annual Budget**
B8a	Programme manager (inpatients)	1.00	£59,186
B8a	Programme manager (community)	1.00	£270,270
B3	Programme admin support (trust wide)	1.00	£26,694
B7	Greenlight liaison / autism prac	1.00	£52,771
Total		**4.00**	**£408,921**
Total		**56.88**	**£2,386,847**

Appendix 3

Learning disabilities inpatient settings - prioritised additional requests																
Service Type			A&T				A&T				A&T		A&T	
Directorate			DURHAM AND DARLINGTON				TEESSIDE				NORTH YORKSHIRE & YORK		TOTALS	
Cost Centre And Desc			RAMSEY TALBOT				BANKFIELDS COURT				OAKRISE			
Beds			6				15				8			
Budgeted Shift Pattern			6,4				11,5				6,4			
Priority	Band	Prioritised workforce investment	WTE Budget	Sum of Annual Budget	Band	Prioritised workforce investment	WTE Budget	Sum of Annual Budget	Band	Prioritised workforce investment	WTE Budget	Sum of Annual Budget	WTE Budget	Sum of Annual Budget
High	B5	RN cover CPD & supervisio	1.79	£70,504	B5	Additional RN each day shift	2.74	£72,895	B3	Positive and safe practitione	-2.74	-£95,271	1.79	£48,129
High					B5	Additional RN each night shift	2.74	£129,027					2.74	£129,027
High	B3	HCA	2.86	£89,430	B3	Additional 2 HCA on day shift	27.41	£824,854	B5	Positive and safe practitione	2.74	£118,566	33.013	£1,032,850
High					B3	Additional 2 HCA on night shift	24.67	£943,536					24.672	£943,536
High					B4	Physical Health Assistant	1.00	£27,683					1.00	£27,683
High					B4	Administration support	1.00	£27,683					1.00	£27,683
High					B3	Administration support	2.00	£53,388					2.00	£53,388
High					B8c	Associate Nurse Consultant post	1.00	£59,186					1.00	£59,186
High					B4	Therapy Assistant (OT/SLT)	1.00	£27,683					1.00	£27,683
High					B7	Top up the current B6 PBS	1.00	£52,771	B5	PBS lead on duty at all time	-1.00	-£47,068	0.00	£5,703
High	B6	Nurse Clinical lead specialis	1.00	£48,848	B6	practitioner to a B7 Behaviour	-1.00	-£41,312	B6	PBS lead on duty at all times	1.00	£58,178	1.00	£65,714
High	**Totals**	**High**	**5.65**	**£208,782**	**Totals**	**High**	**63.56**	**£2,177,394**	**Totals**	**High**	**0.00**	**£34,406**	**69.21**	**£2,420,582**
Medium	B4	Assistant practitioner	2.86	£99,767	B4	Ast Behaviour practitoner	1.00	£27,683	B4	Therapy assistant	2.00	£72,006	5.86	£199,456
Medium					B3	Discharge transition support wor	2.00	£53,388	B3	Change shift patterns 2 days	0.95	£24,763	2.95	£78,151
Medium									B5	Change shift patterns 2 days	0.24	£10,191	0.24	£10,191
Medium									B6	Change shift patterns 2 days	0.24	£12,619	0.24	£12,619
Medium	**Totals**	**Medium**	**2.86**	**£99,767**	**Totals**	**Medium**	**3.00**	**£81,071**	**Totals**	**Medium**	**3.43**	**£119,579**	**9.29**	**£300,417**
Low	B6	Nurse clinical lead (trauma)	1.86	£90,717					B6	Transition lead	1.00	42,582	2.86	£133,299
Low	**Totals**		**1.86**	**£90,717**	**Totals**		**0.00**	**£0**	**Totals**		**1.00**	**£42,582**	**2.86**	**£133,299**
ALL	**Totals**		**10.37**	**£399,266**	**Totals**		**66.56**	**£2,258,465**	**Totals**		**4.43**	**£196,567**	**81.36**	**£2,854,298**
Priority	Band	Prioritised workforce investment	WTE Budget	Sum of Annual Budget	Band	Prioritised workforce investment	WTE Budget	Sum of Annual Budget	Band	Prioritised workforce investment	WTE Budget	Sum of Annual Budget	WTE Budget	Sum of Annual Budget
Trustwide	B7	Practice Development Post	0.67	£35,181	B7	Practice Development Post	0.67	£35,181	B7	Practice Development Post	0.67	£35,181	2.00	£105,542
Trustwide	B7	Greenlight Liaison / Autism	0.67	£35,181	B7	Greenlight Liaison / Autism pract	0.67	£35,181	B7	Greenlight Liaison / Autism p	0.67	£35,181	2.00	£105,542
Trustwide	8a	Programme Support Manag	0.33	£19,729	8a	Programme Support Manager	0.33	£19,729	8a	Programme Support Manag	0.33	£19,729	1.00	£59,186
Trustwide	**Total**		**1.67**	**£90,091**	**Total**		**1.67**	**£90,091**	**Total**		**1.67**	**£90,091**	**5.00**	**£270,270**
ALL	**Total**		**12.04**	**£489,357**	**Total**		**68.23**	**£2,348,556**	**Total**		**6.10**	**£286,658**	**86.36**	**£3,124,568**

ITEM NO. 18

FOR GENERAL RELEASE

Board of Directors

DATE:	**29th September 2022**
TITLE:	**2022 Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard submissions and associated action plans and The Publication of Information.**
REPORT OF:	**Sarah Dexter-Smith**
REPORT FOR:	**Board of Directors**

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

Executive Summary:

This report provides the key themes from the WRES, WDES, SOWES, the Publication of Staff Information and the Model Employer trajectory update.

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

Recommendations:

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

MEETING OF:	**Board of Directors**
DATE:	**29th September 2022**
TITLE:	**2022 WRES, WDES, SOWES & Publication of Staff Information**

1. INTRODUCTION & PURPOSE

The purpose of this report is to ask the committee to review the documents below before going to the Board to ratify and agree. The documents are:

- 2022 WRES (Workforce Race Equality Standard) action plan
- 2022 WDES (Workforce Disability Equality Standard) action plan
- 2022 SOWES (Sexual Orientation Workforce Equality Standard) action plan
- The 2022 Publication of Information (staff)
- The Model Employer trajectory update

2. BACKGROUND INFORMATION AND CONTEXT

2.1. The WRES and the WDES are both mandated in the NHS standard contract. The Trust is required to publish its latest WRES and WDES action plans by 31st October 2022 following ratification by the Board of Directors.

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

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

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

3. KEY ISSUES

3.1 Areas of immediate concern

3.1.1 Indicator 2 on the WRES show that White people are 1.38 times more likely to be appointed from shortlisting compared to BAME people; this is lower than in previous years. However, the data shows there is still a difference, and this has been the case for the previous 6 years of reporting.

Actions:

- Deliver a staff mid-career leadership programme for staff from protected characteristics.

- Pilot a virtual interview platform, aimed to help remove bias from the recruitment process.

3.1.2 The Model Employer Trajectory rates show that we are meeting our trajectory targets for all bands 8a and above except for band 8c. The target is two BAME staff members and currently in the trust we only have one BAME band 8c.

Actions:

- Develop a BAME nursing mentorship programme.
- Deliver a staff mid-career leadership programme for staff from protected characteristics.

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

Action:

- Relaunch the hate campaign and include harassment, bullying and abuse from staff towards other staff.

3.1.4 The percentage of staff with a disability saying that their employer has made adequate adjustment(s) to enable them to carry out their work was 72%, this has decreased from last year's 81%. This shows that 28% of people who require workplace adjustments do not have these in place.

Action:

- Request a centralised reasonable adjustment team.

3.1.5 Staff with disabilities are reporting the are less likely than non-disabled staff to believe they have equal opportunities for career progression or promotion, they are less satisfied with the extent that the organisation values their work, and they are less engaged than non-disabled staff.

Actions:

- Deliver a reverse mentoring programme for staff with long term health conditions
- Develop training for staff to raise awareness on issues faced by staff with LTHC's and disabilities.

3.1.6 LGB staff, male staff and staff aged 16-20 are more likely to enter disciplinary processes than other staff.

Actions:

- Undertake an analysis of the disciplinary cases.

3.2 Areas of concern

3.2.1 16.5% of staff have not declared if they have a disability or not and 10% of staff have not declared their sexual orientation, this has improved since last year however this still means the Trust does not have reliable data to fully understand the experiences of staff. There is also incomplete data on ESR for the Trust Board which means it is difficult to fully measure the diversity of the board compared to the workforce.

Action:

- Relaunch the campaign for all staff to update their ESR this includes the importance of why demographic data is collected.

3.3 Areas of progress

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

3.3.2 The percentage of staff from a BAME background, those declaring having a disability and LGB staff has increased this year. BAME staff 5.1% compared to 4.7% last year, staff with disabilities 6.6% compared to 5.9% last year, LGB staff 3.9% compared to 3.3% last year.

3.3.3 The second reverse mentoring programme was delivered and evaluated, this has continued to be a successful way to increase senior leaders understanding of issues and experiences relating to race and to provide mentoring to the BAME staff involved. Due to the success of this the third programme will involve staff with long term health conditions.

3.3.4 The Compassion, Respect, Responsibility and Race training is being delivered to staff and has received feedback that this is encouraging all staff to address discrimination.

3.3.5 The staff networks continue to grow and members report feeling that these are a positive way to engage with the organisation. An Armed Forces network has been established, which means we have 5 active staff networks.

4 IMPLICATIONS:

4.1 Compliance with the CQC fundamental Standards:

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

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

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

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

4.4 Equality and Diversity:

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

4.5 Other implications:

4.5.1 None have been identified.

5 RISKS:

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

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

6 CONCLUSIONS:

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

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

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

7 RECOMMENDATIONS:

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

7.2 To approve the publication of the 2021 WRES, WDES, SOWES, the publication of staff information.

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

Background Papers: WRES, WDES, SOWES, Publication of Staff Information

APPENDIX ONE

Summary Report

1. INTRODUCTION

This summary report outlines the key themes and actions from the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), the Sexual Orientation Equality Standard (SOWES), the Publication of Staff Information that is required to meet the public sector equality duties and the Model Employer trajectory update.

2. WORKFORCE AND TRUST BOARD

2.2 RACE

- There is an increase in the percentage of BAME staff within the trust from 4.7% (359 staff members) in 2021 to 5.1% (387 staff members) in 2022.
- The Model Employer trajectories set aspirational goals for each organisation to increase BAME representation at leadership levels. The trust is above or on track with the 2022 trajectories except for band 8c where we are below our trajectory. The trust needs to retain its existing BAME staff along with recruiting a further 2 BAME senior staff members by 2028.
- BAME staff have a higher voting membership on the board relative to the workforce population, however, there are no executive members on the board from a BAME ethnicity.

2.3 DISABILITY

- There has been an increase in staff recording if they have a disability this year, 16.5% not declare compared to 20% not declared in 2021.
- From the staff survey results 31.8% of people who completed the survey said they had a long-term health condition (LTHC). Therefore, it is likely that the 6.6% of staff with disabilities recorded on ESR is not an accurate reflection.
- 31.25% of the Trust Board has not declared if they have a disability or not therefore we cannot accurately measure if the Board is representative, in terms of disability, to the overall workforce.

2.4 SEXUAL ORIENTATION

- 10% of staff have not declared their sexual orientation, in order to fully understand the experiences of LGB staff the organisation must continue to focus on increasing the demographic data for sexual orientation.
- There is no one who has identified as LGB on the Trust Board.

2.5 GENDER

- 37.5% of the Trust Board is male compared to 21% of the workforce being male.

2.6 KEY ACTIONS

- Run a campaign to encourage staff to complete their demographic information on ESR.

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

3. RECRUITMENT SELECTION AND PROMOTION

3.1 RACE

- White people are 1.38 times more likely to be appointed from shortlisting compared to BAME people, this is lower than in the previous year.

3.2 DISABILITY

- Staff with disabilities are less likely to believe the Trust provides equal opportunities for career progression or promotion - Disabled 55% Non-disabled 64%

3.3 SEXUAL ORIENTATION

- Bisexual staff are less likely than gay men, gay women and heterosexual staff to believe that the Trust provides equal opportunities for career progression or promotion: Gay Man or Gay Woman (Lesbian) 66.4%, Bisexual 49.1%, Heterosexual (straight) 62.3%.

3.4 AGE

- Those in the age group 16-20 were consistently most likely to be appointed to a job from shortlisting when compared to the other groups. Those who were in the age category of 66+ were least likely to be appointed from a shortlisting when compared to the other age categories.

3.5 KEY ACTIONS:

- Deliver a staff mid-career leadership programme for staff from protected characteristics.
- Pilot a virtual interview platform (AYMMI), removing bias from the recruitment process.
- Run a pilot project exploring age bias in recruitment, identify learning for bias for other protected characteristic groups such as race.
- Compare recruitment data to the 2021 Census data to identify if the organisation is recruiting a diverse workforce that reflects the local communities.

4. DISCIPLINARY AND CAPABILITY PROCESSES

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

4.1 RACE

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

4.2 DISABILITY

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

4.3 SEXUAL ORIENTATION

- LGB staff are 1.68 times more likely to enter disciplinary than heterosexual, this has increased from the previous two years of reporting.

4.4 GENDER

- Men are 2.4 times more likely to enter disciplinary processes

4.5 KEY ACTION:

- Analyse the disciplinary data to identify patterns or trends.

5. BULLYING, HARRASSMENT, ABUSE AND DISCRIMINATION

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

5.1 RACE

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

- From patients, relatives or public - White staff: 24% BAME staff: 32%
- From staff – White staff: 18% BAME staff: 21%
- From manager/team leader or colleague – White staff: 6% BAME staff: 10%

5.2 DISABILITY

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

- From patients, relatives or public - disabled staff: 28% non-disabled staff: 23%
- From staff – disabled staff: 20% non-disabled staff: 11%
- From manager/team leader or colleague – disabled staff: 13% non-disabled staff: 6%

5.3 SEXUAL ORIENTATION

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

- From patients, relatives or public – Gay Man or Gay Woman (Lesbian), 33% Bisexual 33%, Heterosexual (straight) 23%

- From staff – Gay Man or Gay Woman (Lesbian) 16%, Bisexual 21%, Heterosexual (straight) 14%
- From manager/team leader or colleague – Gay Man or Gay Woman (Lesbian), 7% bisexual 13%, Heterosexual (straight) 6%

5.4 KEY ACTIONS:

- Relaunch hate campaign
- Launch and promote the hate crime checklist to help with reporting
- Develop training for staff to raise awareness on issues faced by staff with LTHC's and disabilities, continue to deliver LGBTQ+ and race awareness training to staff.

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

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

- Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties: Disabled staff 22% non-disabled staff 15%
- Percentage of staff saying that they are satisfied with the extent to which their organisation values their work: Disabled staff 36%, non-disabled staff 47%
- Percentage of staff with a disability saying that their employer has made adequate adjustment(s) to enable them to carry out their work: 72% (28% do not have these in place)

KEY ACTIONS:

- Request a centralised reasonable adjustment team
- Run the reverse mentoring programme for staff with long term health conditions.

Tees, Esk and Wear Valleys
NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD

2021/2022

	1. Background narrative a. Any issues of completeness of data	
	The Pulse survey does not include a question about CPD and non-mandatory training as the staff FFT did therefore information from the staff survey has been used for indicator 4.	
	b. Any matters relating to reliability of comparisons with previous years	
	2. Total numbers of staff a. Employed within this organisation at the date of the report	
	7633 (data from 31st March 2022)	
	b. Proportion of BME staff employed within this organisation at the date of the report	
	5.1%	
	3. Self-reporting a. The proportion of total staff who have self-reported their ethnicity	
	99%	
	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity	
	No	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity	
	The level of self-reporting is very high.	
	4. Workforce data a. What period does the organisation's workforce data refer to	
	Data as of 31st March 2022	
	5. Are there any other factors or data which should be taken into consideration in assessing progress?	
	6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.	

KEY:

Green = Improvement from the previous year
Amber = Remains the same or similar to previous year
Red = Decline from previous year

WORKFORCE RACE EQUALITY STANDARD

	Indicator	Data for reporting year 2022	Data for previous year 2021	Data for 2020, 2019, 2018, 2017	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Target date and person responsible
	For each of these four workforce indicators, compare the data for White and BME staff.						
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately	Please see appendix 1 for 2021/22 data.	Please see appendix 1 for 2020/21 data.		There is an increase in the % of BAME staff within the trust from 4.7% (359 staff members) in 2021 to 5.1% (387 staff members) in 2022. The percentage of BAME staff in the trust is still affected by the large numbers of medical staff who are from BAME backgrounds. 2021 data shows that there were 14 BAME staff in bands 8a to VSM compared to 18 in 2022.	Deliver a staff mid-career leadership programme for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Develop a BAME nursing mentorship programme.	Q3 22/23 MB SD Q4 22/23 SD LC

	for non-clinical and for clinical staff.				In order to meet the Model Employer Trajectory rates, we need an addition BAME staff member in band 8c. We are meeting or exceeding the trajectories in the other bands	Analyse leavers information to identify any patterns or trends.	Q4 22/23 LC
2	Relative likelihood of staff being appointed from shortlisting across all posts.	White people are **1.38 times more likely** to be appointed from shortlisting compared to BAME people.	White people are 1.71 times more likely to be appointed from shortlisting compared to BAME people.	White people are: 2020 = 1.56 2019 = 1.7 2018 = 1.6 2017 = 1.3 2016 = 1.4 more likely to be appointed from shortlisting compared to BAME people.	There has been a decrease in the likelihood of white people being appointed for shortlisting compared to BAME people. The data still shows that white people are more likely to be appointed than BAME people.	Pilot a virtual interview platform (AYMMI), removing bias from the recruitment process. Run a pilot project exploring age bias in recruitment, identify learning for bias for other protected characteristic groups such as race. Compare recruitment data to the 2021 Census data to identify if the organisation is recruiting a diverse workforce that reflects the local communities.	Q4 22/23 LH SD Q4 22/23 LH SD Q3 22/23 LC
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from last two	BAME staff are **0.78 times more likely** to enter the formal disciplinary process than white staff (this means they are less likely to	BAME staff are 0.76 times more likely to enter the formal disciplinary process than white staff. (this means they are	BAME staff are 2020 = 0.81 2019 = 1.62 2018 = 2.59 2017 = 2.08 2016 = 2.03 more likely to enter the formal	There has been good progress with this indicator. BAME staff continue to be less likely to enter disciplinary processes compared to white staff.		

	year rolling average of the current year and the previous year.	enter disciplinary processes.)	less likely to enter disciplinary processes.)	disciplinary process than white staff.			
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	White staff are **less likely** (0.9) to report that they have access to the right learning and development opportunities when they need to.	White staff are 1.1 more likely to access non-mandatory training and CPD compared to BAME staff.	White staff are 2020 = 1.1 2019 = 1.3 2018 = 1.2 2017 = 1.15 2016 = 0.86 more likely to access non-mandatory training and CPD compared to BAME staff.	This indicator has been taken from a response to the staff survey Q20e due to the new Pulse survey not including a relevant question.	Explore developing a more robust way to gather this data including exploring the information available on Workpal.	Q4 22/23 LC KA
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, <u>compare the outcomes of the responses for White and BAME staff</u>.						
5.	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	**White: 24%** **BAME: 32%**	White: 24% BAME: 29%	2020 = White: 29% BAME: 32% 2019 = White: 27% BAME: 32% 2018 = White: 28% BAME: 34% 2017 =	There has been an increase in the % of BAME staff reporting that they have experienced harassment, bullying, bullying or abuse from patients, relatives or the public. The gap between white staff and BAME has increased this year to 8%.	Relaunch the hate campaign. Launch and promote the hate crime checklist to improve prosecution rates.	Q3 22/23 AH Q2 22/23 SD

				White: 28% BAME: 37% 2016 = White: 21% BAME: 27%			
6.	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**White: 18%** **BAME: 21%**	White: 20% BAME: 25%	2020 = White: 21% BAME: 25% 2019 = White: 20% BAME: 24% 2018= White: 19% BAME: 29% 2017 = White: 17% BAME: 19% 2016 = White: 14% BAME: 36%	There has been a decrease in this indicator for both BAME and white staff. There continues to be a gap between BAME and white staff's experience of bullying, harassment and abuse from staff, with BAME staff being more likely to experience this.	Run 4 Compassion, Respect, Responsibility and Race training sessions for staff. Include harassment, bullying and abuse from staff towards staff in the relaunch of the hate campaign.	Q4 22/23 LC SD Q3 22/23 AH
7.	Percentage believing that Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?	**White: 61%** **BAME: 60%**	2020 results White: 64% BAME: 53.9%	2019 = White: 59% BAME: 59% 2018 = White: 69% BAME: 53% 2017 = White: 68% BAME: 60% 2016 = no data	The gap has decreased with a 1% difference between white staff and BAME staff, with white staff more likely to believe the trust provides equal opportunities for career progression or promotion.		

8	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**White: 6%** **BAME: 10%**	White: 6% BAME: 15%	2020 = White: 5% BAME: 14% 2019 = White: 5% BAME: 7% 2018 = White: 6% BAME: 18% 2017 = White: 5% BAME: 3% 2016 = no data	The % of BAME staff reporting discrimination at work from managers/team leaders or other colleagues has decreased. However there is still between BAME staff and white staff's experiences, with BAME staff more likely to report this.	Facilitate Schwartz round focussing on the experiences of BAME staff. Promote and run this during black history month. Include current WRES data & information in leadership and development training.	Q3 22/23 LC Q3 22/23 LC
	Board representation indicator: <u>For this indicator, compare the difference for White and BME staff.</u>						

9.	Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce	Percentage difference between organisations boards voting membership and its overall workforce is **+ 4%** Percentage difference between organisations board executive membership and its overall workforce is **-5.1%**	Percentage difference between organisations boards voting membership and its overall workforce is + 12% Percentage difference between organisations board executive membership and its overall workforce is + 9%	Percentage difference between organisations boards voting membership and its overall workforce is 2020 = + 11% (voting) + 10% (exec) 2019 = + 4% 2018 = +8.5% 2017 = not available 2016 = not available Percentage difference between organisations board executive membership and its overall workforce is 2019 = + 8.5% 2018 = not available 2017 = not available 2016 = not available	This data shows that the trust board has some BAME representation.		

APPENDIX 1

DETAILED STAFF BREAKDOWN RACE 31st March 2022

	Clinical Staff %		
Band	**White**	**BAME**	**Not Declared**
1-4	96% (1708)	4% (80)	(15)
5-7	96% (3080)	4% (132)	(30)
8ab	96% (306)	4% (13)	(0)
8cd	99% (110)	1% (1)	(0)
9	100% (1)	0% (0)	(0)
VSM	100% (20)	0% (0)	(0)
Medics	53% (141)	41% (107)	6% (15)
	Non-clinical staff %		
Band	**White**	**BAME**	**Not Declared**
1-4	98% (1333)	2% (33)	(12)
5-7	95% (350)	5% (17)	(2)
8ab	97% (87)	3% (3)	(1)
8cd	96% (22)	4% (1)	(1)
9	0	0	0
VSM	0	0	0

DETAILED STAFF BREAKDOWN RACE 31st March 2021

	Clinical Staff %		
Band	**White**	**BAME**	**Not Declared**
1-4	95% (1770)	4% (67)	1% (14)
5-7	95% (3086)	4% (125)	1% (29)
8ab	97% (306)	3% (9)	0% (0)
8cd	99% (106)	1% (1)	0% (0)
9	100% (1)	0% (0)	0% (0)
VSM	100% (2)	0% (0)	0% (0)
Medics	55% (169)	40% (124)	5% (14)
	Non-clinical staff %		
Band	**White**	**BAME**	**Not Declared**
1-4	99% (1360)	1% (19)	1% (12)
5-7	96% (323)	3% (10)	1% (1)
8ab	96% (73)	3% (2)	1% (1)
8cd	95% (20)	5% (1)	0% (0)
9	0	0	0
VSM	95% (18)	5% (1)	0% (0)

APPENDIX 2

Model Employer 2022

The Model Employer trajectories set aspirational goals for each organisation to increase BAME representation at leadership levels.

	Proportion of BAME workforce (as 31st March 2018)	Proportion of BAME workforce (as 31st March 2019)	Proportion of BAME workforce (as 30th November 2020)	Proportion of BAME workforce (as 31st March 2021)	Proportion of BAME workforce (as 31st March 2022)	Trajectory for 2022	Additional recruitment over next 6 years	Total BAME staff by 2028 to reach equity
Band 8a	6	9	9	9	14	8	0	10
Band 8b	0	2	2	2	2	2	2	4
Band 8c	1	1	2	1	1	2	3	4
Band 8d	0	0	0	1	1	0	0	1
Band 9	0	0	0	0	0	0	0	0
VSM	0	0	1	1	0	0	1	1

Orange no change since 2021	Orange same as 2022 trajectory
Green increase since 2021	Green above 2022 trajectory
Red decrease since 2021	Red below 2022 trajectory

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WORKFORCE DISABILITY EQUALITY STANDARD

2021/2022

	1. Background narrative a. Any issues of completeness of data	
	b. Any matters relating to reliability of comparisons with previous years	
	2. Total numbers of staff a. Employed within this organisation at the date of the report	
	7663 (data from 31st March 2022)	
	b. Proportion of disabled staff employed within this organisation at the date of the report	
	6.6 %	
	3. Self-reporting a. The proportion of total staff who have self-reported their disability status	
	83.5%	
	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by disability	
	We ran a campaign encouraging staff to complete their demographics on ESR during 2021.	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by disability	
	Yes	
	4. Workforce data a. What period does the organisation's workforce data refer to	
	Data as of 31st March 2022	
	5. Are there any other factors or data which should be taken into consideration in assessing progress?	
	6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.	

KEY:

Green = Improvement from the previous year
Amber = Remains the same or similar to previous year
Red = Decline from previous year

WORKFORCE DISABILITY EQUALITY STANDARD

	Indicator	Data for reporting year 2022	Data for previous year 2021	Data for 2020, 2019, 2018, 2017	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Target date and person responsible
	For each of these four workforce indicators, compare the data for disabled and non-disabled staff.						
1	% of staff in each of the AfC pay bands or medical and dental subgroups and VSM (excluding executive board members) compared with the % of staff in the overall workforce.	Please see appendix 1 for 2021/22 data.	Please see appendix 1 for 2020/21 data.		There has been an increase in staff recording if they have a disability this year, 16.5% not declare compared to 20% not declared in 2021 and 24% in 2020. From the staff survey results 31.8% of people who completed the survey said they had a long-term health condition. Therefore, it is likely that the 6.6% of staff with disabilities recorded on ESR is not an accurate reflection.	Deliver a staff mid-career leadership programme for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Run a campaign to encourage staff to complete their demographic information on ESR.	Q3 22/23 MB SD Q4 22/23 AH

						Analyse leavers information to identify any patterns or trends.	Q4 22/23 LC
2	Relative likelihood of staff being appointed from shortlisting across all posts.	Non-disabled staff are **1.14 times more likely** to be appointed from shortlisting compared to disabled staff.	Non-disabled staff are 1.29 times more likely to be appointed from shortlisting compared to disabled staff.	Non disabled people are: 2020 = 1.36 2019 = 1.27 more likely to be appointed from shortlisting compared to disabled people.	There has been a decrease in the likelihood of a non-disabled staff member being appointed compared to a disabled staff member.	Pilot a virtual interview platform (AYMMI), removing bias from the recruitment process. Run a pilot project exploring age bias in recruitment, identify learning for bias for other protected characteristic groups such as disability. Compare recruitment data to the 2021 Census data to identify if the organisation is recruiting a diverse workforce that reflects the local communities.	Q4 22/23 LH SD Q4 22/23 LH SD Q3 22/23 LC
3.	Relative likelihood of staff entering the formal capability process, as measured by entry into a formal process. This indicator will be based on data from a two year rolling average of the	Disabled staff are 0.64 times more likely to enter capability than non-disabled staff (they are less likely)	Relative likelihood of staff entering the formal capability process, as measured by entry into a formal process. This indicator	Disabled staff are 0.78 times more likely to enter capability than non-disabled staff (they are less likely)	Relative likelihood of staff entering the formal capability process, as measured by entry into a formal process. This indicator will be based on data from a two year rolling average of the current year and the previous year.		

	current year and the previous year.		will be based on data from a two year rolling average of the current year and the previous year.				
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare the outcomes of the responses for disabled and non-disabled staff.						
4.	Percentage of staff experiencing harassment/bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers Other colleagues	2021 Disabled 28% Non-disabled 23% Disabled 13% Non-disabled 6% Disabled 20% Non-disabled 11%	2020 Disabled 29% Non-disabled 22% Disabled 15% Non-disabled 8% Disabled 23% Non-disabled 13%	2019 Disabled 34% Non-disabled 28% Disabled 14% Non-disabled 9% Disabled 22% Non-disabled 13%	The results are similar to the previous years with disabled staff being more likely to experience harassment/bullying or abuse from patients/service users, their relatives or members of the public, managers and other colleagues. The results for harassment/bullying or abuse from managers and other colleagues show that disabled staff report that they are almost twice more likely to experience harassment and bullying than non-disabled staff.	Relaunch the hate campaign. Launch and promote the hate crime checklist to improve prosecution rates. Develop training for staff to raise awareness on issues faced by staff with LTHC's and disabilities.	Q3 22/23 AH Q2 22/23 SD Q4 22/23 HC
5.	Percentage believing that Trust provides equal opportunities for career progression or promotion.	2021 Disabled 55% Non-disabled 64%	2020 Disabled 56% Non-disabled 66%	2019 Disabled 58% Non-disabled 64% 2018	The results show that disabled staff are less likely than non-disabled staff to believe the Trust provides equal	Run the reverse mentoring programme for staff with LTHCs	Q4 22/23 HC

				Disabled 63% Non-disabled 70%	opportunities for career progression or promotion.		
6.	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	2021 Disabled 22% Non-disabled 15%	2020 Disabled 26% Non-disabled 19%	2019 Disabled 26% Non-disabled 17% 2018 Disabled 22.5% Non-disabled 17%	The percentage of disabled staff and non-disabled staff who have felt pressure to come to work despite not feeling well enough has reduced. There is a 7% difference between disabled staff and non-disabled staff.	Include current WDES data & information in leadership and development training.	Q3 22/23 LC
7.	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	2021 Disabled 36% Non-disabled 47%	2020 Disabled 45% Non-disabled 57%	2019 Disabled 44% Non-disabled 55% 2018 Disabled 46% Non-disabled 57%	There has been a decrease for both disabled and non-disabled staff. There continues to be a large difference of 11% with disabled staff reporting feeling less satisfied with the extent the organisation values their work.	Develop training for staff to raise awareness on issues faced by staff with LTHC's and disabilities. Explore the feasibility of a psychology student supporting further analysis in respect of factors contributing to staff not feeling valued.	Q4 22/23 HC Q4 22/23 HC
8.	Percentage of staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	2021 72%	2020 81%	2019 76% 2018 89%	There has been a decrease of 9% of disabled staff saying their employer has made adequate adjustments. Meaning, 28% of staff advise that adjustments have not been adequately put in place.	Request a centralised reasonable adjustment. Following the decision actions to be developed. Run a reasonable adjustment	Q2 22/23 HC SD

						awareness lunch and learn session.	Q4 22/23 HC
9.	a) The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. (out of 10) b) Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? Yes or No	Disabled 6.5 Non-disabled 6.9 Yes Via Staff networks	Disabled 6.8 Non-disabled 7.3	2019 Disabled 6.8 Non-disabled 7.2 2018 Disabled 6.9 Non-disabled 7.4	The engagement scores have reduced for disabled and non-disabled staff. Disabled staff have a lower engagement score. The Trust has a disability/long term health conditions staff network and a neurodivergent network which engages with disabled staff / those with LTHC.		
10.	Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce	Percentage difference between organisations boards voting membership and its overall workforce = + 2.5% Percentage difference between organisations board executive membership and its overall workforce =	Percentage difference between organisations boards voting membership and its overall workforce = -6% Percentage difference between organisations board executive membership	Percentage difference between organisations boards voting membership and its overall workforce = -5% Percentage difference between organisations board executive membership and its overall workforce = -5%	31.25% of the board has not declared if they have a disability, this is an improvement to last year when 67% of the board had not declared. The data shows that there is some representation on the board.	Request all board members update their demographic data on ESR.	Q3 22/23 SDS

		- 6.6%	and its overall workforce = -6%				

APPENDIX 1

DETAILED STAFF BREAKDOWN DISABILITY 31st March 2022

	Clinical Staff %		
Band	**Disabled**	**Not Disabled**	**Not Declared**
1-4	7% (122)	71% (1275)	23% (406)
5-7	8% (247)	81% (2620)	12% (375)
8ab	5% (18)	83% (275)	11% (38)
8cd	4% (4)	73% (81)	23% (26)
9	0%	100% (1)	0%
VSM	5% (1)	75% (15)	20% (4)
Medics	3% (9)	81% (212)	16% (42)
	Non-clinical staff %		
Band	**Disabled**	**Not Disabled**	**Not Declared**
1-4	5% (75)	73% (1009)	21% (294)
5-7	7% (24)	81% (298)	13% (47)
8ab	7% (6)	71% (65)	22% (12)
8cd	4% (1)	50% (12)	46% (11)
9	0%	0%	0%
VSM	0%	0%	0%

DETAILED STAFF DISABILITY 31st March 2021

	Clinical Staff %		
Band	**Disabled**	**Not Disabled**	**Not Declared**
1-4	6%	69%	25%
5-7	7%	78%	15%
8ab	5%	78%	17%
8cd	5%	68%	27%
9	0%	100%	0%
VSM	0%	100%	0%
Medics	3%	77%	20%
	Non-clinical staff %		
Band	**Disabled**	**Not Disabled**	**Not Declared**
1-4	5%	70%	25%
5-7	6%	78%	16%
8ab	5%	70%	25%
8cd	5%	41%	54%
9	0	0	0
VSM	0%	37%	63%

Tees, Esk and Wear Valleys
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SEXUAL ORIENTATION WORKFORCE EQUALITY STANDARD

2021/2022

	1. Background narrative a. Any issues of completeness of data	
	The Pulse survey does not include a question about CPD and non-mandatory training as the staff FFT did therefore information from the staff survey has been used for indicator 4.	
	b. Any matters relating to reliability of comparisons with previous years	
	2. Total numbers of staff a. Employed within this organisation at the date of the report	
	7633 (data from 31st March 2022)	
	b. Proportion of LGB staff employed within this organisation at the date of the report	
	4 %	
	3. Self-reporting a. The proportion of total staff who have self-reported their sexual orientation	
	90%	
	b. Have any steps been taken in the last reporting period to improve the level of self-reporting	
	Yes	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting	
	Yes	
	4. Workforce data a. What period does the organisation's workforce data refer to	
	Data as of 31st March 2022	
	5. Are there any other factors or data which should be taken into consideration in assessing progress?	

KEY:

Green = Improvement from the previous year
Amber = Remains the same or similar to previous year
Red = Decline from previous year

SEXUAL ORIENTATION WORKFORCE EQUALITY STANDARD

	Indicator	Data for reporting year 2022	Data for previous year 2021	Data for 2020, 2019, 2018, 2017	Narrative – the implications of the data and any additional background explanatory narrative	Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective	Target date and person responsible
	For each of these four workforce indicators, compare the data for LGB staff and heterosexual staff.						
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-	Please see appendix 1 at the end of the document for 2021/22 data.	Please see appendix 1 at the end of the document for 2020/21 data.		10% of staff have not declared their sexual orientation compared to 13% in 2021. In order to fully understand the experiences of LGB staff the organisation must continue to focus on increasing the demographic data for sexual orientation. The percentage of staff in non-clinical roles identifying as LGB is lower than in clinical roles.	Deliver a staff mid-career leadership programme for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Run a campaign to encourage staff to complete their demographic information on ESR. Analyse leavers information to identify any patterns or trends.	Q3 22/23 MB SD Q4 22/23 AH Q4 22/23 LC

	clinical and for clinical staff.						
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	Heterosexual people are 1.09 times more likely to be appointed compared to LGB people.	Heterosexual people and LGB people are equally likely to be appointed compared to LGB people.	2020 Heterosexual people and LGB people are equally likely to be appointed compared to LGB people. 2019 Heterosexual staff are 1.05 times more likely to be appointed from shortlisted posts than LGB staff.	The data shows a similar picture of the previous years. There is little difference in the likelihood of heterosexual people being appointed from shortlisting compared to LBG people.	Pilot a virtual interview platform (AYMMI), removing bias from the recruitment process. Run a pilot project exploring age bias in recruitment, identify learning for bias for other protected characteristic groups such as race. Compare recruitment data to the 2021 Census data to identify if the organisation is recruiting a diverse workforce that reflects the local communities.	Q4 22/23 LH SD Q4 22/23 LH SD Q3 22/23 LC
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from last two year rolling average of the	LGB staff are **1.68** times more likely to enter disciplinary than heterosexual.	LGB staff are 1.11 times more likely to enter disciplinary than heterosexual.	2020 LGB staff are 1.49 times more likely to enter disciplinary than heterosexual 2019 LGB staff are 2.5 times more likely to enter the formal disciplinary	This indicator has worsened from last year, with LGB staff being 1.68 times more likely to enter disciplinary processes.	Work with the rainbow network to try and understand this data further. Analyse the disciplinary data.	Q3 22/23 AH LC Q3 22/23 LC

	current year and the previous year.			process than heterosexual staff.			
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	LGB staff and heterosexual people are equally likely to report that they have access to the right learning and development opportunities when they need to.	LGB staff and heterosexual people are equally likely to respond positively on the staff FFT question on the question: I am able to access job relevant non-mandatory training and/or Continuing Professional Development opportunities	2020 LGB staff and heterosexual people are equally likely to respond positively on the staff FFT question on the question: I am able to access job relevant non-mandatory training and/or Continuing Professional Development opportunities 2019 Heterosexual staff and LGB staff are equally likely to access non-mandatory training and CPD.	This indicator has been taken from a response to the staff survey Q20e due to the new Pulse survey not including a relevant question.	Explore developing a more robust way to gather this data including exploring the information available on Workpal.	Q4 22/23 LC KA
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, compare						

	the outcomes of the responses for LGB and heterosexual staff.						
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	2021 Gay Man or Gay Woman (Lesbian) **33%** Bisexual **33.3%** Heterosexual (straight) **23.4%**	2020 Gay Man or Gay Woman (Lesbian) **32.4%** Bisexual **33.3%** Heterosexual (straight) **23.7%**	2019 Gay Man 38.2% Gay Woman (Lesbian) 33.3% Bisexual 26.7% Heterosexual (straight) 28.9% 2018 Gay Man 36% Gay Woman (Lesbian) 26% Bisexual 40% Heterosexual (straight) 26%	LGB staff continue to report higher levels of harassment and bullying from patients, relatives or the public compared to heterosexual staff.	Relaunch the hate campaign. Having a specific focus on homophobia. Launch and promote the hate crime checklist to improve prosecution rates. Analyse Datix information related to SO to understand the experiences of staff and trends.	Q3 22/23 AH Q2 22/23 SD Q3 22/23 AH LC
6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	2021 Gay Man or Gay Woman (Lesbian) **16.2%** Bisexual **20.8%** Heterosexual (straight) **13.6%**	2020 Gay Man or Gay Woman (Lesbian) **17.6%** Bisexual **30%** Heterosexual (straight) **15.2%**	2019 Gay Man 23.5% Gay Woman (Lesbian) 20.9% Bisexual 20% Heterosexual (straight) 14.8% 2018 Gay Man 18%	LGB staff report higher levels of harassment, bullying or abuse from staff than heterosexual staff. Bisexual staff report the highest levels. The percentages for LGB and Heterosexual staff have reduced this year.	Run 4 LGBTQ+ training sessions for staff. Work with the Rainbow network to understand the experiences of LGB staff also to include the experiences of trans and non-binary staff.	Q4 22/23 AH LC Q3 22/23 AH LC

				Gay Woman (Lesbian) 16% Bisexual 17% Heterosexual (straight) 15%			
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion.	Gay Man or Gay Woman (Lesbian) **66.4%** Bisexual **49.1%** Heterosexual (straight**)** **62.3%**	2020 Gay Man or Gay Woman (Lesbian) **62.2%** Bisexual **56.7%** Heterosexual (straight**)** **64.9%**	2019 Gay Man or Gay Woman (Lesbian) 67.5% Bisexual 56.7% Heterosexual (straight) 63.8% 2018 Gay Man or Gay Woman (Lesbian) 80.9% Bisexual 66.7% Heterosexual (straight) 69.3%	Bisexual staff are less likely than gay men, gay women and heterosexual staff to believe that the Trust provides equal opportunities for career progression or promotion. The percentage of gay men and gay women has improved whist bisexual staff worsened.	Analyse the LGBTQ+ leadership programme pilot feedback to understand staff's experiences. Explore the demand for a second LGBTQ+ leadership programme	Q2 22/23 AH Q3 22/23 AH
8.	Q17. In the last 12 months have you personally experienced discrimination at	2021 Gay Man or Gay Woman (Lesbian) **6.8%** Bisexual **12.7%**	2020 Gay Man or Gay Woman (Lesbian) **5.4%** Bisexual **23.3%**	2019 Gay Man 8.8% Gay Woman (Lesbian) 11.6%	Bisexual staff continue to be more likely to report experiencing discrimination at work. This has decreased to	Explore with the psychology department running a survey to understand experiences of bisexual staff. This information	Q3 22/23 AH

	work from any of the following? b) Manager/team leader or other colleagues.	Heterosexual (straight) **5.8%**	Heterosexual (straight) **6%**	Bisexual 6.9% Heterosexual (straight) 5.1% 2018 Gay Man 4% Gay Woman (Lesbian) 0% Bisexual 17% Heterosexual (straight) 5%	12.7% from 23.3% last year.	would be included in relevant training.	
	Board representation indicator: <u>For this indicator, compare the difference for LGB staff and heterosexual staff</u>						
9.	Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce	2022 Percentage difference between organisations boards voting membership and its overall workforce = **-3.9%** Percentage difference between organisations board executive membership and its overall workforce = **-3.9%**	2021 Percentage difference between organisations boards voting membership and its overall workforce = +5% Percentage difference between organisations board executive membership and its overall workforce = +11%	2020 Percentage difference between organisations boards voting membership and its overall workforce = +5% Percentage difference between organisations board executive membership and its overall workforce = +11%	There is no one on the board who has identified as LGB. 7 board members have not declared their sexual orientation (asked but declined to provide a response or blank)	Request all board members update their demographic data on ESR.	Q3 22/23 SDS

				2019 Percentage difference between organisations boards voting membership and its overall workforce = +8% Percentage difference between organisations board executive membership and its overall workforce = +12.5%			
10.	The staff engagement score on the National Staff Survey for LGB staff, compared to heterosexual staff and the overall engagement score for the organisation. (out of 10)	2021 Gay Man or Gay Woman (Lesbian) **6.5** Bisexual **6.4** Heterosexual (straight) **6.9**	2020 Gay Man or Gay Woman (Lesbian) **7** Bisexual **6.7** Heterosexual (straight) **7.2**	2019 Gay Man 7 Gay Woman (Lesbian) 7.2 Bisexual 7.5 Heterosexual (straight) 7.1 2018 Gay Man 7.3 Gay Woman (Lesbian) 7.7 Bisexual 7 Heterosexual (straight) 7.3	LGB staff have lower engagement scores than heterosexual staff, engagement scores have decreased for LGB and heterosexual staff.	Undertake consultation on what staff want from the Rainbow network.	Q3 22/23 AH

APPENDIX 1

STAFF BREAKDOWN SEXUAL ORIENTATION 31st March 2022

	Clinical Staff %		
Band	**Heterosexual**	**LGB**	**Not Declared**
1-4	84% (1516)	5% (86)	11% (193)
5-7	88% (2844)	4% (144)	8% (294)
8ab	85% (283)	5% (17)	9% (30)
8cd	86% (96)	5% (5)	9% (10)
9	100% (1)	0%	0%
VSM	75% (15)	0%	25% (5)
Medics	61% (161)	4% (10)	35% (91)
	Non-clinical staff %		
Band	**Heterosexual**	**LGB**	**Not Declared**
1-4	86% (1182)	2% (22)	12% (169)
5-7	91% (336)	2% (9)	7% (24)
8ab	90% (82)	1% (1)	8% (7)
8cd	75% (18)	0%	25% (6)
9	0	0	0
VSM	0	0	0

STAFF BREAKDOWN SEXUAL ORIENTATION 31st March 2021

	Clinical Staff %		
Band	**Heterosexual**	**LGB**	**Not Declared**
1-4	83%	4%	13%
5-7	86%	4%	12%
8ab	84%	5%	11%
8cd	87%	3%	10%
9	100%	0%	0%
VSM	100%	0%	0%
Medics	63%	2%	35%
	Non-clinical staff %		
Band	**Heterosexual**	**LGB**	**Not Declared**
1-4	85%	1%	14%
5-7	89%	2%	9%
8ab	92%	1%	7%
8cd	82%	0%	18%
9	0	0	0
VSM	42%	0	58%

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

PUBLICATION OF STAFF EQUALITY DATA

Data up to 31st March 2022

Published September 2022

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

Polish:

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

Arabic:

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

Bengali:

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

Farsi:

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

Hindi:

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

Kurdish (Kurmanji):

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

Punjabi:

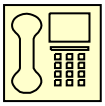
ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈੱਟ ਜਿਵੇਂ ਬ੍ਰੇਲ, ਟਾਕਿੰਗ ਟੇਪ ਜਾਂ DVD ਵਿੱਚ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:

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

Urdu:

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

 Telephone 0191 3336267

Introduction

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

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

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

The Trust has published information to meet its public sector duties for the last eight years.

The information in this report as far as possible replicates the indicators of the Workforce Race Equality standard (WRES). The information in the disability section mirrors the indicators for the Workforce Disability Equality Standard (WDES) and the Sexual Orientation Workforce Equality Standard (SOWES).

Analysis of Trust data has been performed to identify any differences within protected characteristic groups across a number of measures deemed to be important. These measures included: distribution of staff within the Agenda for Change Pay Band structure, recruitment metrics (including shortlisting and subsequent recruitment patterns), capability and disciplinary data, Trust Board membership and staff survey details. Due to the nature of the data properties, the majority of reporting was limited to descriptive analytics. However, where possible, additional analyses were undertaken, and likelihood ratios were calculated. This report aims to track key elements of Trust process, with regard to staff, through a protected characteristic lens.

Recruitment

Relative likelihood of staff from one of the protected characteristic groups compared to the non-protected characteristic groups being appointed from shortlisting across all posts.

Data: Data was extracted from the trac website (the recruitment management system) and supplied by a HR colleague. The data looks at a 12-month period (April 2021 – March 2022), and analysis tracks protected characteristics amongst successful shortlisting and recruitment practices. Information was recorded for all staff in relation to the following protected characteristics: Disability, Ethnicity, Age, Gender and Sexual Orientation. For the purpose of this report, those who did not have a protected characteristic listed have been removed from the analysis (i.e. not stated, not disclosed etc).

Analysis: Descriptive statistics were utilised in order to assess the breakdown of the protected groups entering the process. Further to this, likelihood ratios were calculated to evaluate any disparity between protected groups. The ratios were broken down to show comparisons of the following reference groups:

- Disabled compared to non-disabled.
- BAME compared to White.
- Age categories compared to one another.
- Male compared to Female.
- Heterosexual compared to LGB

Understanding the likelihood calculation.

Likelihood ratios are calculated for both recruitment and disciplinary/capability metrics within this report.

For illustrative purposes, a worked example of fictitious data is provided below to aid understanding of likelihood ratio methodology and interpretation:

Disability Status	Shortlisted N	Appointed N	Ratio	Relative Likelihood
Non-Disabled	780	170	(170/780)= 0.22	(0.22/0.14) = 1.57
Disabled	210	30	(30/210) = 0.14	

If the relative likelihood figure is above 1, it indicates they are more likely to be appointed, if it is below 1 then it indicates that they are less likely to be appointed. Interpretation of the example provided above would be: non-disabled applicants are 1.57 times more likely to be appointed than applicants with a disability.

Results

Disability

	Disability	Non-Disability
Disability		0.88
Non-Disability	1.14	

The above table demonstrates that applicants without a disability were 1.14 times more likely to be appointed from shortlisting than applicants with a disability.

BAME

	BAME	NON-BAME
BAME		0.72
NON-BAME	1.38	

White applicants are 1.38 times more likely to be appointed from shortlisting than BAME applicants.

Gender

	Female	Male
Female		1.08
Male	0.92	

It can be seen from the above table that Females are 1.08 more times more likely to be appointed from shortlisting than Males.

Sexual Orientation

	Heterosexual or Straight	Gay/Lesbian/Bi
Heterosexual or Straight		1.09
Gay/Lesbian/Bi	0.92	

Heterosexual applicants were 1.09 more likely to be appointed from shortlisting than Gay, Lesbian or Bi-sexual applicants.

Age categories

	16-20 yrs.	21-30 yrs.	31-40 yrs.	41-50 yrs.	51 – 65 yrs.	66+
16-20 yrs.		1.38	1.30	1.40	1.52	1.72
21-30 yrs.	0.72		0.94	1.02	1.10	1.25
31-40 yrs.	0.77	1.07		1.08	1.17	1.33
41-50 yrs.	0.71	0.98	0.92		1.08	1.23
51 – 65 yrs.	0.66	0.91	0.85	0.92		1.13
66+	0.58	0.80	0.75	0.81	0.88	

The above categories show the different age groups and the likelihood of someone from that age category being appointed from shortlisting compared to the other age groupings. It can be seen from the above table that those in the age group 16-20 were consistently most likely to be appointed to a job from shortlisting when compared to the other groups. Those who were in the age category of 66+ were least likely to be appointed from a shortlisting when compared to the other age categories.

Summary.

In summary, there are still some small inequalities when comparing the protected characteristic groups against one another, however the likelihood figures have improved since last year. The likelihood of non-disabled applicants being appointed compared to disabled applicants has slightly improved, with last year's figure being 1.29 times more likely, this is now reduced to 1.14 times more likely. Similarly, the likelihood of BAME applicants being appointed compared to white applicants has also improved, last year white applicants were 1.79 times more likely to be appointed from shortlisting, this is now 1.38 times more likely.

Disciplinary and Capability

Relative likelihood of staff from one of the protected characteristic groups compared to the non-protected characteristic groups entering the disciplinary or the capability process.

Data: Data was provided by the Workforce Information department. The data covered a 24 month period from April 2020 to March 2022 and contained a list of all staff members who had entered the disciplinary or capability process within that time frame. Information was recorded for all staff in relation to the following protected characteristics: Disability, Ethnicity, Age, Gender and Sexual Orientation. For the purpose of this report, those who did not have a protected characteristic listed have been removed from the analysis (i.e. not stated, not disclosed etc).

Analysis: Descriptive statistics were utilised in order to assess the breakdown of the protected groups entering the process. Further to this, likelihood ratios were calculated to evaluate any disparity between protected characteristics. The ratios were broken down to show comparisons of the following groups:

- Disabled compared to non-disabled.
- BAME compared to white.
- Age categories compared to one another.
- Male compared to Female.
- Heterosexual compared to LGB

Results:

Disability

Disciplinary

							Overall	
	Disciplinary cases 21/22	Medical 20/21 (non recorder 21/22)	Disciplinary cases 20/21	Total Disciplinary	Total disciplinary minus medical reasons	Total workforce	% likelihood for each grouping	Relative Likelihood
Disability	8		5	13	13	507	0.02564103	0.67849224
Non disability	56	2	44	102	100	5863	0.01739724	

The above table demonstrates that applicants without a disability were less likely to go through the disciplinary process then those with a disability (0.678). Those with a disability were 1.47 times more likely to go through the disciplinary process.

Capability

	Capability Cases 21/22	Medical (non recorded 21/22)	Capability Cases 20/21	Total Capability	Total capability minus medical	Total workforce	Overall % likelihood for each grouping	Overall Relative Likelihood
Disability	1		0	1	1	507	0.00197239	1.55654102
Non disability	7	2	9	18	16	5863	0.0030701	

In this table which looks at capability between disabled and non-disabled staff members, we can see that those without a disability are more likely than those with a disability to enter the capability process. Throughout the previous 2 years, only 1 person with a disability entered the capability procedure compared to 18 for non-disabled staff.

BAME

Disciplinary

	Disciplinary cases 21/22	Medical 20/21 (non recorder 21/22)	Disciplinary cases 20/21	Total Disciplinary	Total disciplinary minus medical reasons	Total workforce figures	Overall % likelihood for each grouping	Overall Relative Likelihood
White	81		61	142	142	7170	0.01980474	0.78283655
BAME	2	2	2	6	4	387	0.01550388	

BAME members of staff are less likely to go through the disciplinary process than white members of staff (0.78), White members of staff are 1.28 times more likely, with only 4 members of the BAME community having gone through the disciplinary process for the 2 years that this report is focusing on.

Capability

	Capability Cases 21/22	Medical (non recorded 21/22)	Capability Cases 20/21	Total Capability	Total capability minus medical	Total workforce figures	Overall % likelihood for each grouping	Overall Relative Likelihood
White	9	0	14	23	23	7170	0.00320781	1.61105494
BAME	0	2	0	2	0	387	0.00516796	

White members of staff are less likely to enter capability proceedings than BAME staff. BAME staff are 1.61 times more likely to enter capability proceedings. However, it should be noted that the

number of people entering the capability procedure are relatively small, with only 2 BAME staff going through this in the 2 years' worth of data considered.

Gender

Disciplinary

	Disciplinary cases 21/22	Medical 20/21 (non recorder 21/22)	Disciplinary cases 20/21	Total Disciplinary	Total disciplinary minus medical reasons	Total workforce figures	Overall % likelihood for each grouping	Overall Relative Likelihood
Male	29	1	26	56	55	1588	0.03526448	2.24393477
Female	55	1	39	95	94	6045	0.01571547	

It can be seen from the above table that males are more likely to enter the disciplinary process than females (2.24 times more likely)

Capability

	Capability Cases 21/22	Medical (non recorded 21/22)	Capability Cases 20/21	Total Capability	Total capability minus medical	Total workforce figures	Overall % likelihood for each grouping	Overall Relative Likelihood
Male	3	2	3	8	6	1588	0.00503778	1.7913765
Female	6	0	11	17	17	6045	0.00281224	

Male staff are 1.79 times more likely than female staff to enter the capability process.

Sexual Orientation

Disciplinary

	Disciplinary cases 21/22	Medical 20/21 (non recorder 21/22)	Disciplinary cases 20/21	Total Disciplinary	Total disciplinary minus medical reasons	Total workforce figures	Overall % likelihood for each grouping	Overall Relative Likelihood
Heterosexual	66	1	52	119	118	6534	0.01821243	1.68084377
LGB	5	0	4	9	9	294	0.03061224	

LGB staff are 1.68 times more likely to enter the disciplinary process.

Capability

							Overall	
	Capability Cases 21/22	Medical (non recorded 21/22)	Capability Cases 20/21	Total Capability	Total capability minus medical	Total workforce figures	% likelihood for each grouping	Relative Likelihood
Heterosexual	7	1	11	19	18	6534	0.00290787	1.16970999
LGB	0	0	1	1	1	294	0.00340136	

It can be seen in the above table that Lesbian, Gay and Bi-sexual members of staff are 1.17 times more likely to enter the capability procedure than Heterosexual members of staff. Although LGB staff are more likely, it is worth noting that this figure is only slightly above 1 (which would indicate there is an equal chance).

Age categories

Disciplinary

Age category	Total workforce figures	Disciplinary cases 21/22	Medical 20/21 (non recorder 21/22)	Disciplinary cases 20/21	Total Disciplinary	Overall: Total disciplinary minus medical reasons	Overall: % likelihood for each grouping	Overall: Relative Likelihood: AGE 16-20	AGE 21-30	AGE 31-40	AGE 41-50	AGE 51-65	AGE 66+
AGE 16-20	21	0		1	1	1	0.0476		2.1317	3.4621	2.2999	2.0536	
AGE 21-30	1343	16	1	13	30	29	0.0223	0.4691		1.6241	1.0789	0.9633	
AGE 31-40	1963	17		10	27	27	0.0138	0.2888	0.6157		0.6643	0.5932	
AGE 41-50	1787	21	1	15	37	36	0.0207	0.4348	0.9269	1.5053		0.8929	
AGE 51-65	2415	30		26	56	56	0.0232	0.4870	1.0381	1.6859	1.1199		
AGE 66+	104	0		0	0	0	0.0000						

We can see from the above table, that overall, staff members who fall in the age category 16-20 are more likely than any other age category to enter the disciplinary process. However, it is worth acknowledging that there was only one person in that age category who had a disciplinary, and that age 16-20 has the lowest total workforce figures out of all the age groupings.

Staff survey results 2021

Data: The national staff survey was sent to all TEWV staff, and they were asked to freely declare their long-term health condition status, gender, age, ethnicity and sexual orientation. The data is measured by those that agree with a series of questions and offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling NHS England and NHS Improvement to explore staff experience across different parts of the NHS and work to bring about the necessary improvements. The data was published on 30th March 2022.

Analysis: The statistics from the staff survey were utilised in order to assess the breakdown of the protected groups completing the staff survey. These were then compared with the scores provided for the previous year. This enabled a comparison to be made for the trust performance compared to the year before. The scores were broken down to show comparisons of the following groups:

- Disabled compared to non-disabled (with a LTHC compared to without a LTHC)
- BAME compared to white
- Age categories compared to one another
- Gender compared to one another
- Sexual orientation compared to one another

Question guide

Question Number	Question
Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
Q14c	Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months.
Q15	Percentage believing that Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?
Q16b	In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues.
Q11c	Percentage feeling unwell due to work related stress in the last 12 months.
Q11e	Percentage pressure from their manager to attending work in the last 3 months despite not feeling well enough to perform their duties
Q4b	Percentage of staff satisfied with the extent to which their organisation values their work
Q28b	Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry out their work
Q14d	Percentage of staff saying that the last time they experienced harassment, bullying, or abuse at work, they or a colleague reported it
Q20e	I am able to access the right learning and development opportunities when I need to
SE	Staff Engagement

When looking at the tables of scores a comparison has been made for the % Agree, with the scores in last year's staff survey. A colour and a directional arrow rating have been used i.e., where an improvement has been made, the box is green and the arrow next to the percentage is pointing up (h), and if the score is worse the box is red, and the arrow is pointing down (i). If the score this year is the same as last year, then an amber colour and a horizontal arrow is used (1). Any percentage box that has no arrow has no comparable category/score in last year's survey. The logic of the question can sometimes be that a higher percentage is a worse score e.g., Q14a, Q14c, Q16b, Q11c and Q11e, and the direction of the arrow reflects this.

Disability Breakdown for Trust Staff and question responses

	Staff with a LTHC		Staff without a LTHC		LTHC Not Declared
Workforce	507		5863		1263
	Responses	% Agree	Responses	% Agree	
Q14a	1091	28.2% ↑	2348	22.5%↓	
Q14c	1079	19.7% ↑	2322	11.3% ↑	
Q15	1120	54.9%↓	2413	63.9%↓	
Q16b	1130	10.5% ↑	2422	4.2%↑	
Q11c	2432	40.8% ↑	1129	58.9%↓	
Q11e	763	21.8% ↑	1197	15.4% ↑	
Q4b	1128	36.4%↓	2429	46.6%↓	
Q28b	No Data	72.2%*↓	N/A	-	
Q14d	414	59.2%	660	58.6%	
Q20e	1133	50.9%	2433	62.8%	
SE	1137	6.5%↓	2442	6.9%↓	

*This question was only for those staff who had a LTHC and only the percentage was supplied and not the number of responses.

Note: Within workforce information it is classed as Disability/Non-Disability and staff with a declared disability total 507. For the survey, Long Term Health Condition (LTHC) was used, and staff completing the survey were asked to self-declare their response to having a LTHC or not. This may offer an explanation into the disparity between the numbers.

Summary

- Staff with a LTHC experience a higher level of harassment, bullying and abuse from patients, relatives, or the public, and from colleagues than those without a LTHC. (Q14a & Q14c)
- Staff with a LTHC experienced more discrimination from managers/team leaders or other colleagues. (Q16b)

- Staff with a LTHC are more likely to have received pressure from their manager to attend work in the last 3 months despite not feeling well enough to perform their duties. (Q11e)
- Staff without a LTCH are more likely to have felt unwell due to work related stress in the last 12 months. (Q11c)
- Staff with a LTCH are less satisfied with the extent to which the organisation values their work. (Q4b)
- Staff with a LTHC are less convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)
- 72% of staff reported that reasonable adjustments had been made to enable them to carry out their work. (Q28b)
- Staff with a LTHC are less engaged than staff without a LTHC. (SE)

Age breakdown for Trust staff and question responses

	21-30		31-40		41-50		51-65		66+	
Workforce	1343		1963		1787		2415		104	
	Responses	% Agree	Responses	% Agree	Responses	% Agree	Responses	% Agree	Responses	% Agree
Q14a	464	28.7%↓	782	23.7%↑	892	23.4%↓	1252	24.2%↓	43	7.0%↓
Q14c	459	11.3%↓	777	14.8%↑	884	16.0%↑	1231	13.3%↑	43	9.3%↑
Q15	470	69.4%↓	787	61.2%↓	916	59.0%↓	1306	59.7%↓	49	51.0%↓
Q16b	470	5.1%↓	792	5.1%↑	920	8.0%↔	1314	6.0%↔	50	8.0%↓
Q11c	472	50.2%↓	793	51.6%↓	926	47.6%↓	1314	42.5%↓	50	26.0%↓
Q11e	261	19.9%↑	464	18.8%↑	540	17.8%↑	667	16.6%↑	No Data	-
Q4b	472	45.6%	790	43.8%	925	43.6%	1315	41.7%	50	54.0%
Q28b	No Data	-	No Data	-	No Data	-	No Data	-	No Data	-
Q14d	145	75.9%	237	59.1%	295	55.3%	387	55.8%	No Data	-
Q20e	472	64.8%	795	58.6%	926	57.5%	1318	57.8%	50	64.0%
SE	No Data*	6.8%↓	796	6.7%↓	930	6.8%↓	1321	6.8%↓	51	7.2%↑

*No response numbers supplied, only proportion.

Summary

- Staff aged 66+ experience a lower level of harassment, bullying and abuse from patients, relatives, or the public, and from colleagues than all other age groups. (Q14a & Q14c)
- Staff aged 66+ are less likely to have felt unwell due to work related stress in the last 12 months. (Q11c)
- Staff in age group 51-65 are less satisfied with the extent to which the organisation values their work. (Q4b)
- Staff aged 66+ are the least convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)

- Staff aged 66+ are more engaged than other staff age groups. (SE)

Gender breakdown for Trust staff and question responses

	Female		Male		Prefer not to say	
Workforce	6045		1588		-	
	Responses	% Agree	Responses	% Agree	Responses	% Agree
Q14a	2612	23.2%↓	736	28.1%↑	81	24.7%
Q14c	2583	14.3%↑	726	11.8%↑	81	25.9%
Q15	2702	63.3%↓	742	55.9%↓	80	35.0%↓
Q16b	2713	5.8%↑	748	6.7%↑	81	17.3%
Q11c	2720	47.0%↓	750	43.1%↓	81	65.4%
Q11e	1493	17.7%↑	401	17.7%↑	55	25.5%
Q4b	2717	44.5%	750	41.3%	81	18.5%
Q28b	No Data	-	No Data	-	No Data	-
Q14d	799	60.1%	239	53.6%	35	57.1%
Q20e	2724	60.4%	752	56.3%	81	33.3%
SE	2735	6.9%↓	754	6.6%↓	81	5.6%

Note: For the prefer not to say group, only Q15 scores provided.

Summary

- Male Staff experience a higher level of harassment, bullying and abuse from patients, relatives, or the public. (Q14a)
- Staff that prefer not to say what their gender is experience a higher level of harassment, bullying and abuse from colleagues. (Q14c)
- Staff that prefer not to say what their gender is experienced more discrimination from managers/team leaders or other colleagues. (Q16b)
- Staff that prefer not to say what their gender is are more likely to have received pressure from their manager to attend work in the last 3 months despite not feeling well enough to perform their duties. (Q11e)
- Staff that prefer not to say what their gender is are more likely to have felt unwell due to work related stress in the last 12 months. (Q11c)
- Staff that prefer not to say what their gender is are less satisfied with the extent to which the organisation values their work. (Q4b)
- Staff that prefer not to say what their gender is are the least convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)
- Staff that prefer not to say what their gender is are less engaged than other staff. (SE)

Ethnicity breakdown for Trust staff and question responses

	White		BAME		Ethnicity Unknown / Null
Workforce	7170		387		76
	Responses	**% Agree**	**Responses**	**% Agree**	
Q14a	3278	24.1%↓	134	32.1%↓	
Q14c	3242	13.8%↑	131	16.8%↑	
Q15	3371	61.2%↓	135	60.0%↑	
Q16b	3388	6.0%↔	136	10.3%↑	
Q11c	3395	46.9%↓	137	38.0%↓	
Q11e	1871	18.0%↑	69	14.5%↑	
Q4b	3391	42.9%	138	54.3%	
Q28b	No Data	-	No Data	-	
Q14d	1016	58.6%	48*	60.4%	
Q20e	3400	58.8%	138	65.9%	
SE	3409	6.8%↓	75	7.4%↓	

*Only Black/Black British: African responded

Summary

- More BAME staff experience a higher level of harassment, bullying and abuse from patients, relatives, or the public and Colleagues. (Q14a & Q14c)
- More BAME staff than white have experienced discrimination from managers/team leaders or other colleagues. (Q16b)
- More BAME staff have attended work in the last 3 months despite not feeling well enough to perform their duties. (Q11e)
- More White staff have felt unwell due to work related stress in the last 12 months. (Q11c)
- More BAME staff are satisfied with the extent to which the organisation values their work. (Q4b)
- White Staff are more convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)
- White staff are less engaged than other staff. (SE)

Sexual Orientation breakdown for Trust staff and question responses

	Bisexual		Gay / Lesbian		Heterosexual		Other		Prefer not to say	
Workforce	294				6534		805			
	Responses	% Agree	Responses	% Agree	Responses	% Agree	Responses	% Agree	Responses	% Agree
Q14a	54	33.3%↓	112	33.0%↓	3096	23.4%↑	23	34.8%	150	34.0%
Q14c	53	20.8%↑	No Data	-	3061	13.6%↑	23	21.7%	150	21.3%
Q15	55	49.1%↓	114	66.4%↓	3179	62.3%↓	25	44.0%	156	38.5%
Q16b	55	12.7%↑	117	6.8%↓	3197	5.8%↑	No Data	-	156	12.2%
Q11c	55	67.3%↓	117	56.4%↓	3205	45.0%↓	25	60.0%	156	62.2%
Q11e	No Data*	22.9%↑	67	19.4%↑	1752	17.2%↑	11	18.2%	95	28.4%
Q4b	55	36.4%	117	38.5%	3203	44.3%	24	37.5%	156	28.8%
Q28b	No Data	-	No Data	-	No Data	-	No Data	-	No Data	-
Q14d	20	60.0%	53	62.3%	932	59.1%	No Data	-	63	47.6%
Q20e	55	50.9%	117	61.5%	3211	59.9%	25	60.0%	156	37.2%
SE	56	6.4%↓	No Data	-	3223	6.9%↓	25	6.5%	156	5.8%

*No response numbers supplied but percentage was.

Workforce data has 4 categories; Hetro, LGB, Undecided and Not Declared which do not immediately align with the choices available when completing the staff survey. The ‘other’ and ‘prefer not to say’ choices have been aligned with ‘Undecided’ and ‘Not Declared’ purely to allow comparison of the data.

Summary

- Heterosexual staff are less likely to experience harassment, bullying and abuse from colleagues or from patients, relatives, or the public than their colleagues. (Q14c & Q14a)
- Bisexual staff experienced more discrimination from managers/team leaders or other colleagues. (Q16b)
- Staff that prefer not to say what their sexuality is are more likely to have received pressure from their manager to attend work in the last 3 months despite not feeling well enough to perform their duties. (Q11e)
- Bisexual staff are more likely to have felt unwell due to work related stress in the last 12 months. (Q11c)
- Heterosexual staff are more satisfied with the extent to which the organisation values their work. (Q4b)
- Staff that prefer not to say what their sexuality is are less convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)
- Staff that prefer not to say what their sexuality is are less engaged than other staff. (SE)

Analysis of individual questions compared with last years results

Q14a. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

In general, a worse score this year than last. Only 4 characteristics improved: Male, Age group 31-40, Staff with a disability and Heterosexuals.

The largest change was the BAME category last year 29% this year 32.1%. All other scores had seen a +/- of <=1.5%

Q14c. Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months.

In general, a better score this year than last. Only 1 characteristic was worse: Age group 21-30. All others had improved.

The largest changes were seen in: Age 51-65 which was 24% last year and 13.3% this year (10.7% improvement), Age 41-50, 23% last year and 16% this year (7% improvement), Bisexual scored 30% last year and 20.8% this year (9.2% improvement).

All other scores had seen a +/- of <=4.2%

Q15. Percentage believing that Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?

Of all the staff surveyed, only BAME and Gay/Lesbian rated this as better this year than last.

The largest changes were seen in: Age 66+ which was 62.9% last year and 51% this year (11.9% worse), Bisexual, 56.7% last year and 49.1% this year (7.6% worse), Male scored 61% last year and 55.9% this year (5.1% worse).

Q16b. In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues.

In general, a better score this year than last. 8 characteristics saw improvement (Female, Male, Age 31-40, BAME, Staff with and without a LTHC, Bisexual and Heterosexual) and 4 were worse (Age 21-30, Age 66+ and Gay/Lesbian)

The largest improvement was seen in: Bisexual which scored 23% last year and 12.7% this year (10.3% improvement).

Age 66+ saw the greatest worsening of score, last year 3% and 8% this year.

Q11c. Percentage feeling unwell due to work related stress in the last 12 months.

All staff, except Staff with LTCH rated this as worse this year than last.

The largest changes were seen in: Staff without LTHC was 38% last year and 58.9% this year (20.9% worse), Gay / Lesbian, 47% last year and 56.4% this year (9.4% worse). Staff with LTHC score improved by 16.2% (57% against 40.8% this year)

Q11e. Percentage pressure from their manager to attending work in the last 3 months despite not feeling well enough to perform their duties

All staff surveyed said that this had improved since last year.

The largest changes were seen in: BAME which was 31% last year and 14.5% this year (16.5% improvement), Gay / Lesbian, 30% last year and 19.4% this year (10.6% improvement)

All other scores had seen a - of <=16.5% with BAME the largest change of 16.5%.

There were Data quality issues with 66+ as there were no figures or no data for this year.

Q4b. Percentage of staff satisfied with the extent to which their organisation values their work

Only the Disability characteristic was surveyed this year and last. Both staff with a LTHC and those without a LTHC scored this worse than last year.

Staff without a LTHC was 57% last year and 46.6 & this year, that is a 10.4% decrease.

Q28b. Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry out their work

The percentage in agreement with the question this year was 72.2%, last year 81% agreed.

Staff Engagement

For all staff (other than the age group 66+ and White ethnicity) the engagement score was worse than last year. However, all scores were within +/- of <0.4% change.

The age group 66+ was the only one to show improvement (0.1%).

Board Representation

Percentage difference between the organisations' Board membership and its overall workforce disaggregated.

Data: Data was provided from Workforce information. The data and analysis was carried out on the 16 board figures, in relation to the total workforce. Information was recorded for all staff in relation to the following protected characteristics: Disability, Ethnicity, Age, Gender and Sexual Orientation.

Analysis: Descriptive statistics were utilised in order to assess the breakdown of the protected groups in respect of Board membership. Further to this, differences between board numbers relative to the workforce were calculated to evaluate any disparity between protected characteristics. The following characteristics were explored.

- Disabled compared to non-disabled.
- BAME compared to white.
- Age categories compared to one another.
- Male compared to Female.
- Heterosexual compared to LGB

Percentage difference between the organisations' Board membership and its overall workforce calculation example :

Voting board members broken down by ethnicity: BAME =1(9.09%)

Total workforce broken down by ethnicity: BAME = 387(5.07%)

Percentage difference between organisations boards voting membership and its overall workforce for BAME members = +4.02%

Results:

There are a total of 16 board figures.

	Total board figures = 16
Voting members	11
Non voting members	5
Executive members	8
Non Executive member	8
Total	16

BAME

	Ethnicity					
	BAME		WHITE		NOT DECLARED	
	%	% difference betweenboard members and workforce	%	% difference betweenboard members and workforce	%	% difference between board members and workforce
Total Workforce	5.07%		93.93%		1.00%	
Voting members	9.09%	4.02%	90.9%	-3.03%	0.0%	-1.00%
Non voting members	0.00%	-5.07%	100.0%	6.07%	0.0%	-1.0%
Executive members	0.00%	-5.07%	100.0%	6.07%	0.0%	-1.0%
Non Executive member	12.50%	7.43%	87.5%	-6.43%	0.0%	-1.0%
Total Board	6.25%	1.18%	93.8%	-0.18%	0.0%	-1.0%

Percentage difference between organisations boards voting membership and its overall workforce for BAME members = +4.02%

Percentage difference between organisations board executive membership and its overall workforce for BAME members = -5.07%. this is due to there being no BAME executive members.

Gender

	Gender			
	MALE		FEMALE	
	%	% difference between board members and workforce	%	% difference between board members and workforce
Total Workforce	21.01%		79.20%	
Voting members	45.5%	24.44%	54.5%	-24.65%
Non voting members	20.0%	-1.01%	80.0%	0.80%
Executive members	37.5%	16.49%	62.5%	-16.70%
Non Executive member	37.5%	16.49%	62.5%	-16.70%
Total Board	37.5%	16.49%	62.5%	-16.70%

Percentage difference between organisations boards voting membership and its overall workforce for Female members = -24.65%

Percentage difference between organisations board executive membership and its overall workforce for Female members = -16.07%.

Disability

	Disability					
	DISABLED		NON-DISABLED		NOT DECLARED	
	%	% difference between board members and workforce	%	% difference between board members and workforce	%	% difference between board members and workforce
Total Workforce	6.64%		76.81%		16.55%	
Voting members	9.09%	2.45%	63.64%	-13.17%	27.27%	10.73%
Non voting members	0.00%	-6.64%	0.00%	-76.81%	100.00%	83.45%
Executive members	0.00%	-6.64%	75.00%	-1.81%	25.00%	8.45%
Non Executive member	12.50%	5.86%	50.00%	-26.81%	37.50%	20.95%
Total Board	6.25%	-0.39%	62.50%	-14.31%	31.25%	14.70%

Percentage difference between organisations boards voting membership and its overall workforce for Disabled members = +2.45%

Percentage difference between organisations board executive membership and its overall workforce for disabled members = -6.64%.

Age

	Age groupings					
	41-50		51-65		66+	
	%	% difference between board members and workforce	%	% difference betweenboard members and workforce	%	% difference between board members and workforce
Total Workforce	23.41%		31.64%		1.36%	
Voting members	18.18%	-5.23%	63.64%	32.00%	18.18%	16.82%
Non voting members	20.00%	-3.41%	60.00%	28.36%	20.00%	18.64%
Executive members	25.00%	1.59%	75.00%	43.36%	0.00%	-1.36%
Non Executive member	12.50%	-10.91%	50.00%	18.36%	37.50%	36.14%
Total Board	18.75%	-4.66%	62.50%	30.86%	18.75%	17.39%

Age group 41-50 are underrepresented on the Board in relation to the prevalence of the age-group in the workforce. The age groups 51-65 and 66+ are generally over-represented on the Board.

Sexual Orientation

	Sexual Orientation							
	Heterosexual		LGB		NOT STATED		BLANK	
	%	% difference between board members and workforce	%	% difference between board members and workforce	%	% difference between board members and workforce	%	% difference between board members and workforce
Total Workforce	85.60%		3.85%		0.28%		10.27%	
Voting members	45.45%	-40.15%	0.00%	-3.85%	45.45%	45.18%	9.09%	-1.18%
Non voting members	80.00%	-5.60%	0.00%	-3.85%	20.00%	19.72%	0.00%	-10.27%
Executive members	87.50%	1.90%	0.00%	-3.85%	12.50%	12.22%	0.00%	-10.27%
Non Executive member	25.00%	-60.60%	0.00%	-3.85%	62.50%	62.22%	12.50%	2.23%
Total Board	56.25%	-29.35%	0.00%	-3.85%	37.50%	37.22%	6.25%	-4.02%

There is currently no member of the trust board who is Lesbian, Gay or Bi-sexual .

Summary:

- BAME Staff have a higher voting membership on the board relative to the workforce population, however, there are no executive members on the board from a BAME ethnicity.
- Females are underrepresented on the board relative to the workforce populations for both voting membership and executive membership.
- Staff with a disability have a higher voting member compared to the workforce population of disables staff but a lower representation of executive membership on the board.
- Board membership is underrepresented in age ranges from 41-50 but over-represented in age brackets 51-65 and 66+.
- There are currently no board members represented by persons identifying as Lesbian, Gay or Bi-sexual.

Agenda for Change Banding Distribution

Data: The data was provided by workforce information and maps the protected characteristics against the agenda for change pay bandings. The information is provided for both the Non-Clinical and Clinical workforce as well as Medical & Dental.

Analysis: The data provided is very high-level count data, for this reason, only descriptive analytics were utilised in order to summarise the variation and patterns within the data. The data was examined for variation in leadership roles (band 7 and above) across the protected groups.

Results

BAME

Indicator		Data Item			WHITE		BME		ETHINICITY UNKNOWN/ NULL	
					Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1						
			2	Band 1	22	100%	0	0%	0	0%
			3	Band 2	468	97%	11	2%	5	1%
			4	Band 3	470	97%	12	2%	3	1%
			5	Band 4	373	96%	10	3%	4	1%
			6	Band 5	144	96%	5	3%	1	1%
			7	Band 6	112	94%	7	6%	0	0%
			8	Band 7	94	94%	5	5%	1	1%
			9	Band 8a	53	96%	2	4%	0	0%
			10	Band 8b	34	94%	1	3%	1	3%
			11	Band 8c	14	93%	0	0%	1	7%
			12	Band 8d	8	89%	1	11%	0	0%
			13	Band 9	0		0		0	
			14	VSM	0		0		0	
		1b) Clinical workforce of which Non Medical	15	Under Band 1						
			16	Band 1	0		0		0	
			17	Band 2	34	87%	5	13%	0	0%
			18	Band 3	1338	95%	59	4%	8	1%
			19	Band 4	336	94%	16	4%	7	2%
			20	Band 5	761	93%	51	6%	10	1%
			21	Band 6	1517	95%	59	4%	13	1%
			22	Band 7	802	97%	22	3%	7	1%
			23	Band 8a	243	95%	12	5%	0	0%
			24	Band 8b	75	99%	1	1%	0	0%
			25	Band 8c	99	99%	1	1%	0	0%
			26	Band 8d	11	100%	0	0%	0	0%
			27	Band 9	1	100%	0	0%	0	0%
			28	VSM	20	100%	0	0%	0	0%
		OR which Medical & Dental	29	Consultants	118	55%	87	41%	8	4%
			30	of which Senior medical manager	1	100%	0	0%	0	0%
			31	Non-consultant career grade	16	64%	9	36%	0	0%
			32	Trainee grades	6	25%	11	46%	7	29%
			33	Other	0		0		0	
					7170	93.9%	**387**	5.1%	**76**	1.0%

The distribution of BAME staff compared to White staff across the banding structures indicated that significantly high proportions of BAME staff make-up the higher banding structures within the Medical and Dental professional roles.

Disability

Indicator		Data Item			DISABILITY		NON DISABLED		DISABILITY NOT DECLARED	
					Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1						
			2	Band 1	0	0%	9	41%	13	59%
			3	Band 2	22	5%	333	69%	129	27%
			4	Band 3	32	7%	386	80%	67	14%
			5	Band 4	21	5%	281	73%	85	22%
			6	Band 5	5	3%	126	84%	19	13%
			7	Band 6	9	8%	99	83%	11	9%
			8	Band 7	10	10%	73	73%	17	17%
			9	Band 8a	4	7%	38	69%	13	24%
			10	Band 8b	2	6%	27	75%	7	19%
			11	Band 8c	1	7%	6	40%	8	53%
			12	Band 8d	0	0%	6	67%	3	33%
			13	Band 9	0		0		0	
			14	VSM	0		0		0	
		1b) Clinical workforce of which Non Medical	15	Under Band 1						
			16	Band 1	0		0		0	
			17	Band 2	2	5%	21	54%	16	41%
			18	Band 3	88	6%	982	70%	335	24%
			19	Band 4	32	9%	272	76%	55	15%
			20	Band 5	70	9%	651	79%	101	12%
			21	Band 6	118	7%	1296	82%	175	11%
			22	Band 7	59	7%	673	81%	99	12%
			23	Band 8a	15	6%	213	84%	27	11%
			24	Band 8b	3	4%	62	82%	11	14%
			25	Band 8c	3	3%	74	74%	23	23%
			26	Band 8d	1	9%	7	64%	3	27%
			27	Band 9	0	0%	1	100%	0	0%
			28	VSM	1	5%	15	75%	4	20%
		OR which Medical & Dental	29	Consultants	4	2%	175	82%	34	16%
			30	of which Senior medical manager	0	0%	0	0%	1	100%
			31	Non-consultant career grade	5	20%	15	60%	5	20%
			32	Trainee grades	0	0%	22	92%	2	8%
			33	Other	0		0		0	
					507	6.6%	**5863**	76.8%	**1263**	16.5%

Within non-clinical roles, leadership posts (band 7 and above) are attained by 3% of the workforce with a disability. This compares to 3% of staff in non-clinical leadership roles without a disability. Very little difference is noted for clinical roles also. The leadership roles between staff with a disability and those without were 16% and 18% respectively. The figures considered for the medical and dental roles are relatively small, however 2% of staff with a disability are employed within these roles, compared to 4% of staff without a disability.

Age

Indicator		Data Item			AGE 16-20		AGE 21-30		AGE 31-40		AGE 41-50		AGE 51-65		AGE 66+	
					Figure	%	Figure	%	Figure	%	Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1												
			2	Band 1	1	5%	3	14%	0	0%	4	18%	12	55%	2	9%
			3	Band 2	4	1%	38	8%	73	15%	98	20%	247	51%	24	5%
			4	Band 3	3	1%	61	13%	106	22%	89	18%	211	44%	15	3%
			5	Band 4	0	0%	47	12%	65	17%	90	23%	170	44%	15	4%
			6	Band 5	1	1%	19	13%	38	25%	35	23%	54	36%	3	2%
			7	Band 6	0	0%	12	10%	31	26%	37	31%	38	32%	1	1%
			8	Band 7	0	0%	3	3%	28	28%	31	31%	38	38%	0	0%
			9	Band 8a	0	0%	2	4%	18	33%	19	35%	16	29%	0	0%
			10	Band 8b	0	0%	0	0%	7	19%	14	39%	15	42%	0	0%
			11	Band 8c	0	0%	0	0%	0	0%	7	47%	8	53%	0	0%
			12	Band 8d	0	0%	0	0%	1	11%	4	44%	4	44%	0	0%
			13	Band 9	0		0		0		0		0		0	
			14	VSM	0		0		0		0		0		0	
		1b) Clinical workforce of which Non Medical	15	Under Band 1												
			16	Band 1	0		0		0		0		0		0	
			17	Band 2	0	0%	1	3%	10	26%	7	18%	18	46%	3	8%
			18	Band 3	12	1%	277	20%	300	21%	288	20%	515	37%	13	1%
			19	Band 4	0	0%	147	41%	65	18%	70	19%	76	21%	1	0%
			20	Band 5	0	0%	310	38%	228	28%	136	17%	143	17%	5	1%
			21	Band 6	0	0%	302	19%	509	32%	347	22%	421	26%	10	1%
			22	Band 7	0	0%	83	10%	287	35%	243	29%	213	26%	5	1%
			23	Band 8a	0	0%	12	5%	94	37%	93	36%	55	22%	1	0%
			24	Band 8b	0	0%	2	3%	15	20%	31	41%	28	37%	0	0%
			25	Band 8c	0	0%	0	0%	21	21%	46	46%	32	32%	1	1%
			26	Band 8d	0	0%	0	0%	1	9%	4	36%	6	55%	0	0%
			27	Band 9	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%
			28	VSM	0	0%	0	0%	0	0%	4	20%	14	70%	2	10%
		OR which Medical & Dental	29	Consultants	0	0%	17	8%	52	24%	77	36%	65	31%	2	1%
			30	of which Senior medical manager	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%
			31	Non-consultant career grade	0	0%	0	0%	1	4%	10	40%	13	52%	1	4%
			32	Trainee grades	0	0%	7	29%	13	54%	3	13%	1	4%	0	0%
			33	Other	0		0		0		0		0		0	
					21	0.3%	**1343**	17.6%	**1963**	25.7%	**1787**	23.4%	**2415**	31.6%	**104**	1.4%

No staff in the age group 16-20 are employed within leadership roles within the organisation. There are also no staff aged 66+ within non-clinical leadership roles. The age groups 31-65 occupy the most non-clinical leadership roles at approximately 34% of the workforce within those age categories. Within clinical leadership roles, the age range of 31-40 and 41-50 occupy the highest number of leadership posts (21% and 24% respectively). This compares to only 7% within the age bracket 21-30 and 9% within 66+). The figures across the medical and dental posts are relatively equal across age groups.

Gender

Indicator		Data Item			FEMALE		MALE	
					Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1				
			2	Band 1	15	68%	7	32%
			3	Band 2	388	80%	96	20%
			4	Band 3	441	91%	44	9%
			5	Band 4	324	84%	63	16%
			6	Band 5	86	57%	64	43%
			7	Band 6	75	63%	44	37%
			8	Band 7	70	70%	30	30%
			9	Band 8a	40	73%	15	27%
			10	Band 8b	23	64%	13	36%
			11	Band 8c	11	73%	4	27%
			12	Band 8d	6	67%	3	33%
			13	Band 9	0		0	
			14	VSM	0		0	
		1b) Clinical workforce of which Non Medical	15	Under Band 1				
			16	Band 1	0		0	
			17	Band 2	25	64%	14	36%
			18	Band 3	1041	74%	364	26%
			19	Band 4	301	84%	58	16%
			20	Band 5	710	86%	112	14%
			21	Band 6	1313	83%	276	17%
			22	Band 7	678	82%	153	18%
			23	Band 8a	209	82%	46	18%
			24	Band 8b	55	72%	21	28%
			25	Band 8c	66	66%	34	34%
			26	Band 8d	7	64%	4	36%
			27	Band 9	1	100%	0	0%
			28	VSM	16	80%	4	20%
		OR which Medical & Dental	29	Consultants	107	50%	106	50%
			30	of which Senior medical manager	1	100%	0	0%
			31	Non-consultant career grade	22	88%	3	12%
			32	Trainee grades	14	58%	10	42%
			33	Other	0		0	

There are double the amount of male staff in non-clinical leadership roles compared to females (4% of male workforce compared to 2% female). There are also significant differences with medical and dental. Approximately 7% of the male workforce are appointed into medical/dental roles compared to 2% of the female workforce. No difference was found in relation to clinical leadership roles between genders.

Sexual Orientation

Indicator		Data Item			SEXUAL ORIENTATION HETRO		SEXUAL ORIENTATION LGB		SEXUAL ORIENTATION UNDECIDED		SEXUAL ORIENTATION NOT DECLARED	
					Figure	%	Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1								
			2	Band 1	13	59%	1	5%	0	0%	8	36%
			3	Band 2	394	81%	5	1%	1	0%	84	17%
			4	Band 3	442	91%	10	2%	3	1%	30	6%
			5	Band 4	333	86%	6	2%	1	0%	47	12%
			6	Band 5	136	91%	2	1%	0	0%	12	8%
			7	Band 6	111	93%	4	3%	0	0%	4	3%
			8	Band 7	89	89%	3	3%	0	0%	8	8%
			9	Band 8a	49	89%	1	2%	0	0%	5	9%
			10	Band 8b	33	92%	0	0%	1	3%	2	6%
			11	Band 8c	11	73%	0	0%	0	0%	4	27%
			12	Band 8d	7	78%	0	0%	0	0%	2	22%
			13	Band 9	0		0		0		0	
			14	VSM	0		0		0		0	
		1b) Clinical workforce of which Non Medical	15	Under Band 1								
			16	Band 1	0		0		0		0	
			17	Band 2	31	79%	0	0%	1	3%	7	18%
			18	Band 3	1184	84%	61	4%	3	0%	157	11%
			19	Band 4	301	84%	25	7%	4	1%	29	8%
			20	Band 5	707	86%	41	5%	2	0%	72	9%
			21	Band 6	1409	89%	72	5%	2	0%	106	7%
			22	Band 7	728	88%	31	4%	1	0%	71	9%
			23	Band 8a	219	86%	14	5%	0	0%	22	9%
			24	Band 8b	64	84%	3	4%	1	1%	8	11%
			25	Band 8c	86	86%	5	5%	0	0%	9	9%
			26	Band 8d	10	91%	0	0%	0	0%	1	9%
			27	Band 9	1	100%	0	0%	0	0%	0	0%
			28	VSM	15	75%	0	0%	0	0%	5	25%
		OR which Medical & Dental	29	Consultants	128	60%	8	4%	1	0%	76	36%
			30	of which Senior medical manager	0	0%	0	0%	0	0%	1	100%
			31	Non-consultant career grade	15	60%	0	0%	0	0%	10	40%
			32	Trainee grades	18	75%	2	8%	0	0%	4	17%
			33	Other	0		0		0		0	
					6534	85.6%	**294**	3.9%	**21**	0.3%	**784**	10.3%

Within non-clinical leadership roles, heterosexual staff make up 3% of appointments, compared to 1% within LGB staff. No other differences were noted in relation to distribution across leadership roles within clinical posts or medical/dental posts.

Summary

- BAME staff are recruited into medical and dental posts at a significantly higher rate than White staff.
- Staff with a disability are appointed to leadership roles within clinical and non-clinical posts at a similar rate to staff without a disability. However, double the amount of staff without a disability are appointed to medical/dental roles compared to staff with a disability (4% vs 2%).
- No leadership roles are appointed to staff in the age range 16-20. No staff within the 66+ bracket are appointed to non-clinical leadership roles. Within clinical leadership roles, significantly more staff are appointed in the age brackets 31-40 and 41-50 compared to the other age categories.

- Significantly more male staff are employed into non-clinical leadership roles and medical/dental roles compared to females, relative to the total workforce numbers for these groups.
- A greater proportion of heterosexual staff are employed into non-clinical leadership roles than LGB staff.

Summary

Recruitment

Some inequalities were apparent when comparing protected characteristic groups across the shortlisting and recruitment process. These differences were as follows:

- Applicants without a disability were 1.14 times more likely to be appointed than applicants with a disability.
- White applicants were 1.38 times more likely to be appointed than BAME applicants.
- Females were 1.08 times more likely to appointed than males.
- Heterosexual applicants were 1.09 times more likely to be appointed than Gay, Lesbian or Bi-sexual applicants.
- Age category 16-20 appeared to be the most successful in being appointed, whilst age group 66+ appeared the least likely to be appointed.

It is important to note that, although differences were found in the likelihood of being appointed, the ratios calculated for disability and BAME applicants have improved since last years report.

Disciplinary and Capability

Inequalities were noted in relation to disciplinary and capability practises across protected characteristics. The inequalities identified were as follows:

- Staff with a disability were 1.47 times more likely to enter the disciplinary process than staff without a disability. However, staff without a disability are more likely to enter the capability process at a ratio of 1.55 times.
- White members of staff are 1.28 times more likely than BAME staff to enter the disciplinary process. However, BAME staff ate 1.61 times more likely to enter the capability process.
- Males are significantly more likely than females to enter the disciplinary process (2.24 likelihood ratio) and 1.79 times more likely to enter the capability process.
- Gay, Lesbian and Bisexual staff members are 1.68 times more likely to enter the disciplinary process than what heterosexual staff members and 1.17 times more likely to enter the capability process.
- Staff aged 16-20 were most likely to enter the disciplinary process (however consideration must be given to the small number of staff employed within this age bracket).

Staff Survey

Inequalities across protected characteristics were found in relation to the staff survey results. These are summarised below:

Long-Term Health Conditions

- Staff with a long-term health condition (LTHC) experienced a higher level of:
    - harassment, bullying and abuse from patients, relatives, the public and colleagues
    - Discrimination from managers, team leaders and colleagues
    - Pressure to attend work despite not feeling well enough
    - Work related stress
    - Not feeling valued at work
    - Equal opportunities for career progression
    - Feeling unengaged with work

However, a high proportion felt that reasonable adjustments had been made to enable them to work effectively.

Age

Within the different age groups, the 66+ group generally experienced lower levels of harassment, bullying and abuse, feeling unwell due to work related stress and felt more engaged with work than other age groups. However, they did feel they had less opportunities for promotion.

Gender

The survey results indicated that male staff experience higher levels of harassment, bullying and abuse. However, all other differences were noted only within the group of staff who preferred not to record their gender.

Ethnicity

In comparison to white staff, BAME staff reported experiencing higher levels of:

- Harassment, bullying and abuse
- Discrimination from managers and team leaders
- Presenteeism (attending work when not well enough)
- Unequal opportunities for career progression
- Feeling engaged
- Feeling valued

Sexual Orientation

In relation to sexual orientation, inequalities included:

- Higher levels of bullying and harassment in non-heterosexual staff
- Bisexual staff experienced higher levels of discrimination by managers and team leaders.
- Bisexual staff are more likely to feel unwell due to work related stress
- Heterosexual staff feel more valued by the organisation

Board Membership

- BAME Staff have a higher voting membership on the board relative to the workforce population, however, there are no executive members on the board from a BAME ethnicity.
- Females are underrepresented on the board relative to the workforce populations for both voting membership and executive membership.
- Staff with a disability have a higher voting member compared to the workforce population of disables staff but a lower representation of executive membership on the board.
- Board membership is underrepresented in age ranges from 41-50 but over-represented in age brackets 51-65 and 66+.
- There are currently no board members represented by persons identifying as Lesbian, Gay or Bi-sexual

Age

- BAME staff are recruited into medical and dental posts at a significantly higher rate than White staff.
- Staff with a disability are appointed to leadership roles within clinical and non-clinical posts at a similar rate to staff without a disability. However, double the amount of staff without a disability are appointed to medical/dental roles compared to staff with a disability (4% vs 2%).
- No leadership roles are appointed to staff in the age range 16-20. No staff within the 66+ bracket are appointed to non-clinical leadership roles. Within clinical leadership roles, significantly more staff are appointed in the age brackets 31-40 and 41-50 compared to the other age categories.
- Significantly more male staff are employed into non-clinical leadership roles and medical/dental roles compared to females, relative to the total workforce numbers for these groups.
- A greater proportion of heterosexual staff are employed into non-clinical leadership roles than LGB staff.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

REVALIDATION / APPRAISAL ANNUAL REPORT
1st April 2021 – 31st March 2022

Management of Appraisal and Revalidation

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

Activity Levels

Number of doctors that TEWV are responsible body	Consultant		SAS		Trust Doctors/MTI	
	2020–21	2021–22	2020-21	2021–22	2020-21	2021–22
Adult Mental Health	64	64	27	26	9	11
Mental Health Services for Older People	30	31	13	17	2	1
Child and Young Person's Services	40	35	7	7	1	0
Learning Disabilities	11	11	2	2	0	0
Forensic Services	16	16	3	2	1	3
Total:	**161**	**157**	**52**	**54**	**13**	**15**

Comments: We had 226 doctors in total with a prescribed connection to TEWV as at 31st March 2022.

Number of doctors who were due for an appraisal	Consultant		SAS		Trust Doctors/MTI	
	2020-21	2021–22	2020-21	2021–22	2020-21	2021–22
Adult Mental Health	60 (36)	61	22 (19)	22	9	8
Mental Health Services for Older People	27 (18)	28	13 (10)	13	2	0
Child and Young Person's Services	39 (28)	34	6 (6)	7	1	0
Learning Disabilities	10 (6)	11	2 (2)	2	0	0
Forensic Services	15 (10)	15	3 (3)	2	1	2
Total	**151 (98)**	**149**	**46 (40)**	**46**	**13**	**10**

Comments:
The above table shows the number of doctors that were due an appraisal with us in the last appraisal year 2021-22.

For 2020-21 as explained in last year's report, the figures in black show the number of doctors who would have been due an appraisal, had a number of appraisals not been cancelled following guidance from NHS England in response to the Covid 19 pandemic. The figures in red show the number of doctors that were due for an appraisal between October 2020-March 2021 only, as we excluded those appraisals that were due between April-September 2020 as these were cancelled due to the pandemic. A total of 59 consultant and SAS doctor appraisals were cancelled between this period.

The reasons why people might not be due an appraisal are that they have already had one in this appraisal year with a previous organisation before joining TEWV, or they might not have worked with us for the minimum time period required to have an appraisal. These account for the difference of 8 in the consultant figure, as we had 8 new consultants join throughout the year who were not due an appraisal with us yet as well as 8 new SAS doctors and 5 new Trust doctors that were not due a 'priming appraisal' at 31st March 2022 as they joined the Trust in February and have their priming appraisal 2 months after joining.

Number of doctors who have been appraised in the appraisal year	Consultant		SAS		Trust Doctors/MTI	
	2020-21	2021–22	2020-21	2021–22	2019-20	2021–22
Adult Mental Health	36	59	18	19	8	7
Mental Health Services for Older People	18	28	9	13	2	0
Child and Young Person's Services	27	33	6	6	0	0
Learning Disabilities	6	11	2	2	0	0
Forensic Services	10	14	3	2	1	2
Total	**97 (99%)**	**145 (97%)**	**38 (95%)**	**42 (91%)**	**12 (92%)**	**9 (90%)**

Comments:
The figures in the table above show the number of doctors that have had an appraisal between 1st April 2021-31st March 2022.

The reasons for doctors missing their annual appraisal are detailed in the next section under exceptions.

Exceptions

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

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

Number of 'approved missed or incomplete appraisals'	Consultant	SAS	Trust Doctors/MTI
Adult Mental Health	2	3	1
Mental Health Services for Older People	0	0	0
Child and Young Person's Services	1	1	0
Learning Disabilities	0	0	0
Forensic Services	1	0	0
Total	**4**	**4**	**1**

Comment:
Overall exceptions consist of four doctors on sick leave, one doctor on maternity leave and one doctor being granted an extension after 31st March 2022.

We also had one doctor who had to delay her appraisal as her appraiser went on sick leave and another doctor was due to retire on 31st March so we agreed she didn't have to do her appraisal as it was due to take place around the time she was leaving. The trust doctor exception is due to this doctor not being able to complete a 'priming appraisal' prior to 31st March 2022 as their appraiser was on sick leave.

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

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

Revalidation

Number of doctors completing revalidation cycle	Consultant		SAS		Trust Doctors	
	2020-21	2021–22	2020-21	2021–22	2020-21	2021–22
Adult Mental Health	8	10	2	9	0	1
Mental Health Services for Older People	5	6	0	3	0	0
Child and Young Person's Services	6	6	0	2	0	0
Learning Disabilities	0	3	0	0	0	0
Forensic Services	3	3	0	0	0	0
Other	1	0	0	0	0	0
Total	**23**	**28**	**2**	**14**	**0**	**1**
Number of doctors receiving revalidation recommendations	Consultant		SAS		Trust Doctors	
	2020-21	2021–22	2020-21	2021–22	2020-21	2021–22
Adult Mental Health	8	9	2	7	0	0
Mental Health Services for Older People	5	6	0	3	0	0
Child and Young Person's Services	6	5	0	2	0	0
Learning Disabilities	0	3	0	0	0	0
Forensic Services	3	3	0	0	0	0
Other	1	0	0	0	0	0
Total	**23**	**26**	**2**	**12**	**0**	**0**

Comments: Of the 43 doctors that were due for revalidation between 1st April 2021-31st March 2022, we revalidated 38. The 5 that had their recommendation deferred were due to one doctor being on sick leave, one doctor on maternity leave and three with missing evidence that needed longer to obtain this, so we deferred their recommendation date.

Performance Review, Support and Development of Appraisers

Training of Appraisers

	Consultant		SAS	
	2020-21	2021-22	2020-21	2021-22
Number of enhanced appraisers	52	54	5	6
Number of enhanced appraisers carrying out appraisals in appraisal year	50	54	5	6
We trained 5 new appraisers in March 2021, ready to start in the role from April 2021.				

Support and Development of Appraisers

Update/Support Sessions	Update/Support Sessions
19th May 2021	17th November 2021
15th September 2021	28th February 2022
Comment: We run 4 training sessions each year, with May and September being repeats of each other and November and February also being repeats of each other. Since the pandemic we have ran these virtually on MS Teams rather than face to face. We've given appraisers the opportunity to share any thoughts or issues at these meetings that they may have faced in recent times especially during the pandemic.	

Performance Review of Appraisers

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

Quality Assurance of Appraisals

We had 24 appraisal summaries from doctors who were revalidated in the previous year 2020/21 (this was a smaller number than normal due to the pandemic and revalidation dates being pushed back a year). These summaries were anonymised and then 8 volunteer appraisers were selected to rate 6 summaries each as part of a quality improvement exercise. We asked for volunteers from our appraisers as well as our medical management structure and those who were not picked this year will be used next year. Each summary was rated by two different appraisers. Feedback was provided to the appraisers at our appraiser update sessions in November and February. We plan to repeat this exercise in summer 2022 for the doctors who were revalidated throughout 2021/22.

Responding to Concerns about doctors in TEWV

Total Number of All doctors who were managed under 'Responding to Concerns' (includes 'Low Level' and 'Investigations')	Consultant				SAS				Trust Doctors/MTI			
	2020/21		2021/22		2020/21		2021/22		2019/20		2021/22	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	1	0	1	1	0	0	0	0
Durham & Darlington	1	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	1	0	3	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	1	0	0	1	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	2	1	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	1	0	0	0	1	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**4**	**1**	**4**	**0**	**1**	**0**	**3**	**1**	**0**	**1**	**0**	**0**

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

Code	Ethnicity	No. of Doctors 2021/22Only
SE	Other Specified	
C	White – Any other white background	2
CQ	CQ White ex USSR	
N	Black or Black British – African	
L	Asian or Asian British – Any other Asian background	
H	Asian or Asian British - Indian	5

Age Range of All Doctors – 2021/22				
	Aged 30-40	Aged 41-50	Aged 51-60	Aged 61-70
Male Consultants	1	1	1	
Female Consultants				
Male SAS Doctor		1	1	1
Female SAS Doctor		1		
Male Trust Doctor				
Female Trust Doctor				

Total Number of doctors spoken to under 'Low Level Concerns'	Consultant				SAS				Trust Doctors/MTI			
	2020/21		2021/22		2020/21		2021/22		2020/21		2021/22	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	1	0	1	1	0	0	0	0
Durham & Darlington	1	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	1	0	1	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	1	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	2	1	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	1	0	0	0	1	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**4**	**1**	**2**	**0**	**1**	**0**	**3**	**1**	**0**	**0**	**0**	**0**

Comments:

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

The purpose of the low level concern forms is to allow concerns to be documented and monitored so that should there be future concerns raised there are records to show that actions had already been taken before making the matter more formal.An example of concerns raised may be comments made by colleagues in relation to a doctor's behaviour or how they communicate with others etc.

2021/22 has seen the same number of low level concerns being brought forward, however, there has been an increase in the number of SAS doctors with a low level concern form this year with a total of four compared to one in the previous year. The reasons behind the low level concerns are related to record keeping issues and concerns in five out of the six cases. The other case was in relation to a complaint that had been received and where it was felt necessary that a reflection needed to be taken by the doctor in question and therefore the manager documented that conversation.

Total Number of doctors where investigation was necessary 'More Serious Concerns'	Consultant				SAS				Trust Doctors/MTI			
	2020/21		2021/22		2020/21		2021/22		2020/21		2021/22	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	2	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	1	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**0**	**0**	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**

Comments:

During 2021/22 we undertook two fact finding investigations, which were not a full investigation, but an opportunity to explore the information that had been presented and to explore whether there was some evidence to substantiate the claims made in order to hold a full investigation. Both cases were in relation to one doctor and on both occasions, no evidence was found to warrant a full investigation taking place.

A meeting was held with the doctor in question and a number of issues were discussed and the doctor was asked to reflect on these in their annual appraisal.

Ongoing Actions

Responding to Concerns – Remediation/Disciplinary

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

The Medical Remediation/ Disciplinary policy has been reviewed and whilst no significant changes to content were required, there has been an opportunity to look at further developing local processes for responding to concerns and how these are classified / escalated and dealt with. The new updated policy is now called 'Dealing with concerns affecting medical staff policy'.

Electronic IT System

SARD JV continues to be used as the electronic system for appraisals and revalidation. Our Associate Responsible Officer continues delivering training sessions on how to use SARD for the purpose of appraisal and job planning for all new Consultant and SAS doctors that join TEWV. Training sessions are run on a quarterly basis.

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

We are also now established in using the 360 MSF module on SARD JV for the production of patient and colleague feedback. The format of the feedback forms mirrors the structure of questionnaires in use by the GMC. Last year we gathered feedback from our appraisers to ensure all questions reflect practices in psychiatry and can accommodate responses from a range of service users, to include those with learning disabilities. We have since reached a decision that medics in AMH and MHSOP services are to use the SARD MSF, whilst medics in CYPS, LD and Forensic services may use the ACP 360 as this has a slightly different patient questionnaire which is more 'user friendly'.

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

The contract with SARD JV was therefore renewed in October 2019 on a contractual model of 3+1+1 years.

Learning from Revalidation

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

The third cycle of revalidation is now underway for a number of our doctors, despite revalidation being postponed by the GMC during most of the 2020/21 year.

Other Information:

Appraisal policy and procedure was updated in 2018/19 and is currently being updated for 2022.

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

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

Contents

Introduction:

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

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

Annual Organisational Audit (AOA):

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

Board Report template:

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

A link to the letter is below:

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

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

Section 2a – Effective Appraisal

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

Section 2b – Appraisal Data

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

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

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

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

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

c) act as evidence for CQC inspections.

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

Statement of Compliance:

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

Designated Body Annual Board Report

Section 1 – General:

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

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

   Action from last year: N/A

   Comments: Yes. Dr Kedar Kale, Executive Medical Director, was appointed Responsible Officer on 27th June 2022. Before this time Dr Steve Wright was the interim Responsible Officer after Dr Ahmad Khouja left the Trust in April 2022.

   Action for next year: No change expected.

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

   Yes. TEWV as the designated body is supported by the medical development department with dedicated members of admin and an Associate Responsible Officer, to support the Responsible Officer.

   Action from last year: N/A

   Comments: The Trust ensures we have the funds and staffing to support the role of RO.

   Action for next year: No change expected.

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

   Action from last year: N/A

   Comments: Yes, this is done by the Medical Development team under the management of Dr Kedar Kale. Names are recorded via GMC Connect.

   Action for next year: This process is ongoing as described above.

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

Action from last year: N/A

Comments: Yes, these are reviewed every 3 years. They were last updated August 2022.

Action for next year: N/A

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

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

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

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

Section 2a – Effective Appraisal

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

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

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

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

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

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

Action from last year: Comments: Yes. The appraisal policy and procedure which has just been updated in August 2022 were approved at the Medical Directorate management meeting. The policy and procedure follows national guidance. Action for next year: None – next due to be reviewed 2025

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

Action from last year: Comments: Yes. There were 60 appraisers for 226 doctors in 2021/22. Action for next year: To continue to monitor the number of appraisers to ensure we always have enough to cover the appraisal cycle.

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

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

Action from last year:
Comments: Yes, there are normally four training sessions a year, of which appraisers must attend at least two. These were ran in May, September, November 2021 and February 2022.
Action for next year: Continue to run four training sessions per year.

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

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

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

Section 2b – Appraisal Data

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

Name of organisation: Tees Esk and Wear Valleys NHS Foundation Trust	
Total number of doctors with a prescribed connection as at 31 March 2022	**226**
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	**217**
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	**9**
Total number of agreed exceptions	**9**

Section 3 – Recommendations to the GMC

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

Action from last year:

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

Action for next year:

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

Action from last year:

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

Action for next year:

Section 4 – Medical governance

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

Action from last year:

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

Action for next year:

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

Action from last year:

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

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

Action for next year:

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

Action from last year:

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

Action for next year:

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

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

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

Action for next year:

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

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

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

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

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

Section 5 – Employment Checks

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

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

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

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

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

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

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

We also had the action to update our appraisal policy and procedure in 2022, which has just been done.

- **Actions still outstanding** None

- **Current Issues** None

- **New Actions:**

We will be reviewing the recommendations by the Academy of Royal Medical Colleges in the next 6 months to consider changes for 2023-24 appraisal year.

Overall conclusion:

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

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

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

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

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

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

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

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This publication can be made available in a number of other formats on request.

Publication approval reference: PAR614

ITEM NO. 20

Meeting of: Board of Directors

DATE:	**September 2022**
TITLE:	Update on reportable incidents to HSE under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. (2013).
REPORT OF:	**Lee Dodds: Head of Health, Safety & Security**
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 paper is to provide an update to the Board on incidents being reported to the HSE under the requirements of RIDDOR (2013).

Identify work place/related incidents which must be reported to the HSE.

This paper sets out the number and types of incidents reported to the HSE over a five-year period. The most prevalent being:

- Violence and aggression (106).
- Slips trips & fall (26).

The paper also sets out what impact, financially and in a broader sense failing to report an incident which falls under RIDDOR, or having high levels of reported incidents, could have on the organisation.

This paper also identifies the interaction between the HSE and CQC and the sanctions which can be imposed by these enforcement bodies.

Recommendations:

The board is asked to accept this paper identifying levels and types of incidents reported under RIDDOR to the HSE (passed onto CQC for patient incidents).

Ongoing commitment is required from the organisation to ensure incidents (including staff) are reported on Datix in a timely manner. Reoccurring delays in reporting under RIDDOR would result in interest from the HSE leading to possible investigation.

MEETING OF:	**TEWV Trust Board**
DATE:	**September 2022**
TITLE:	**Update on reportable incidents to HSE under Reporting of Injury, Disease, Dangerous Occurrence Regulation (RIDDOR).**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this paper is to update the Board on types and numbers of incidents being reported to the HSE under the requirements of the RIDDOR regulations (2013).

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This paper has been produced from information identified by incidents reported and logged onto the trust's incident reporting system and additional information gathered by the HS team (due to inaccuracy in coding and unclear evidence provided in some Datix incident forms).

Providing accurate detail regarding incidents ensures that:

- Enable the Trust to identify trends across its services regarding injury, disease, or dangerous occurrences, should they occur, and in order to take preventative action to ensure any learning from those incidents is extracted and systems ~~of~~ processes adapted as needed to ensure safer environments and working practice.
- The trust complies with its statutory requirements for reporting incidents which fall under RIDDOR.
- Provide evidence to external agencies (CQC/HSE) that incidents involving both patients and staff are identified and escalated appropriately, and actions taken in order to minimise any such future events.

RIDDOR incidents and any lessons learnt form part of the information presented to the Health, Safety & Fire group. Areas of concern can (if needed) be forwarded to the Organisations Risk Committee for assurance or escalation.
Significant learning can also be shared across the organisation by the issuing of SBARDS, these provide clear information on learning or additional actions to be undertaken following an incident

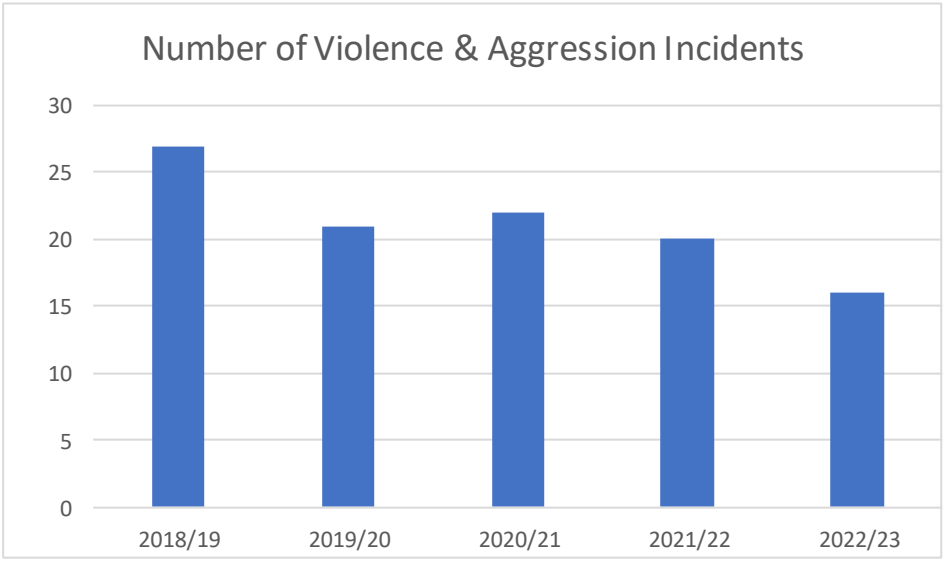
It should be noted that although reportable to the HSE, incidents involving patients are passed to the CQC for investigation.

3. KEY ISSUES:

Types of incidents reported to the HSE under RIDDOR fall into 6 main categories shown below, 2 of which result in higher numbers of injuries: slips trips & falls and violence and aggression.

Comparisons for the past 5 years are listed below, noting data for 2022/23 is only complete to 31st July 2022.

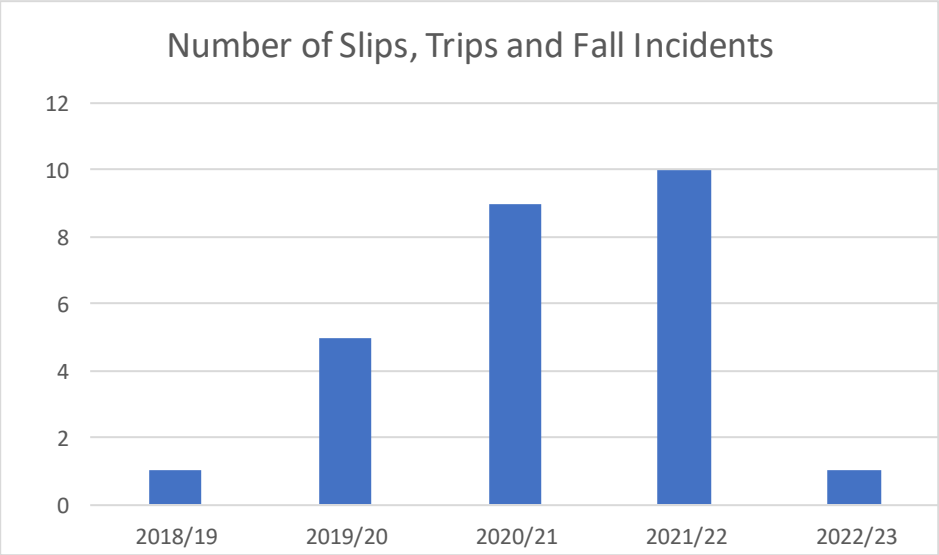
Violence and Aggression



Violence and aggression incidents occur predominantly in adult mental health, secure in-patient, and LD services. The unpredictability of the patient groups frequently calls for some form of physical intervention or restraint to be performed. This combined with the number and frequency of attacks on staff results in significant numbers of incidents reported to the HSE under RIDDOR.

Evidence exists that because of staff shortages, agency and bank staff are on occasion unaware of how to interact with individual patients.

Slips trips and fall

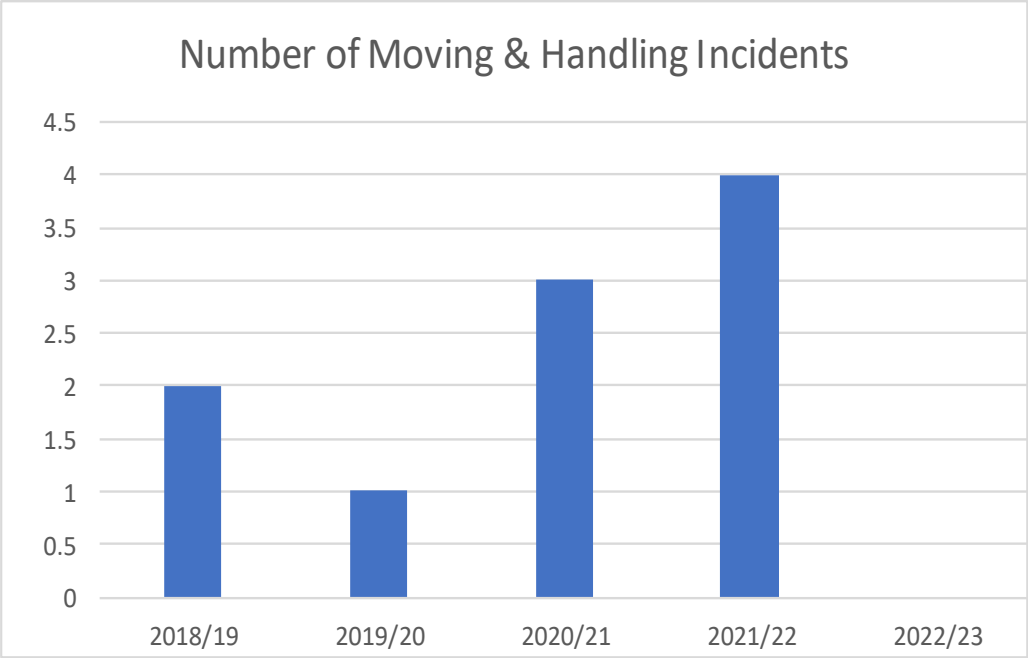


Within the 5-year period, 24 incidents were passed to the HSE.
Examples of Incidents include

- Acklam Road Hospital -Staff slipped when going upstairs carrying a laptop.
- Roseberry Park Hospital- Staff tripped outside entrance injuring left ribs whilst on portering duties.
- Clover Ward Roseberry Park Hospital -Staff fell whist responding to an incident- floor was wet and had signage.
- Tees CAMHS LD -Staff slipped on water which had leaked from shower under the door into the bedroom.
- Tees ALD Kilton View- Staff fell from community bus whilst opening the door from inside as the door was sticking.
- Staff member slipped on ice.

Although showing a steady rise prior to the current financial year, there is no evidence to identify the cause of more frequent slips trips and falls, however the number of staff responding to each patient incident will raise the potential for a fall to occur (greater frequency = greater opportunity for an incident).

Moving & Handling



A number of incidents occurred due to handling/moving objects. These include domestic cleaning equipment such as vacuum cleaners, floor scrubbers, waste bins and furniture. Fluctuation over the 5 years for this type of equipment may have been influenced by the high level of cleaning being undertaken during the covid 19 pandemic.

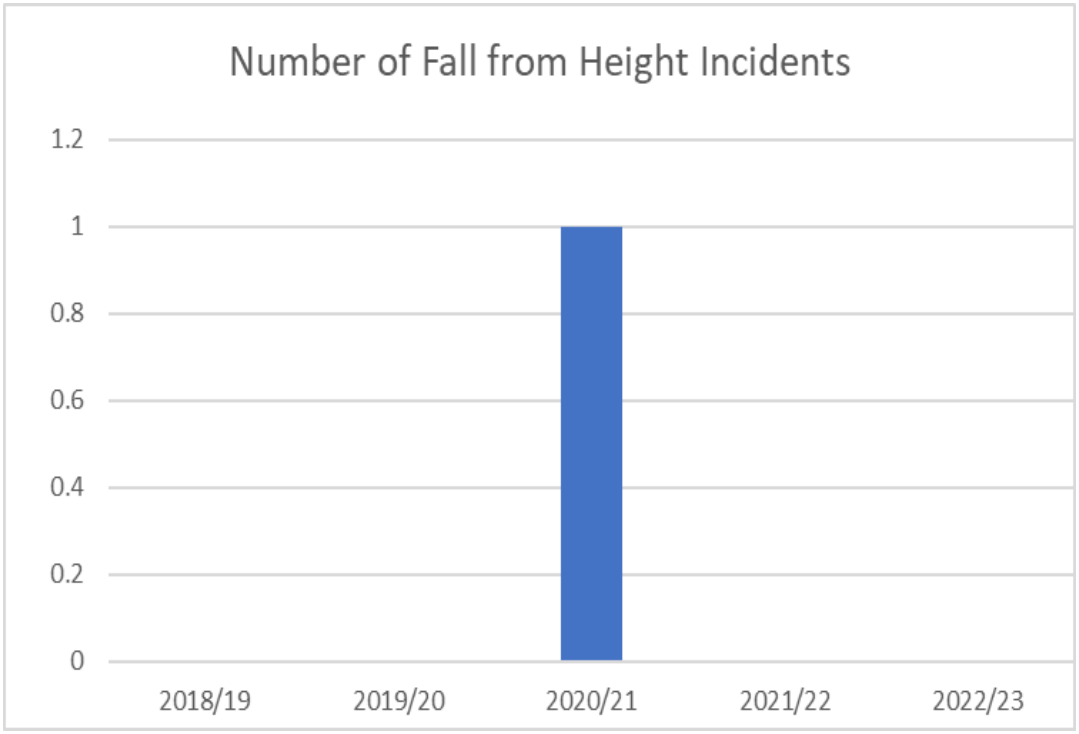
Work is being undertaken across the trust to review the implementation of the H&S toolkit which includes manual handling risk assessments. This is supported by the H&S team providing a Manual handling workshop around manual handling risk assessment)

It should be noted that whilst manual handling of objects risk assessment training is available for all staff, “physical” manual handling training is not currently delivered non-clinical staff across the organisation.

The trust may also benefit by utilising a competent ergonomic specialist, who can provide advice regarding working practice and reduction of workplace injuries.

Other NHS trusts in the region have been contacted to establish what training packages are being utilised to deliver manual handling training. Responses are pending.

Fall From Height



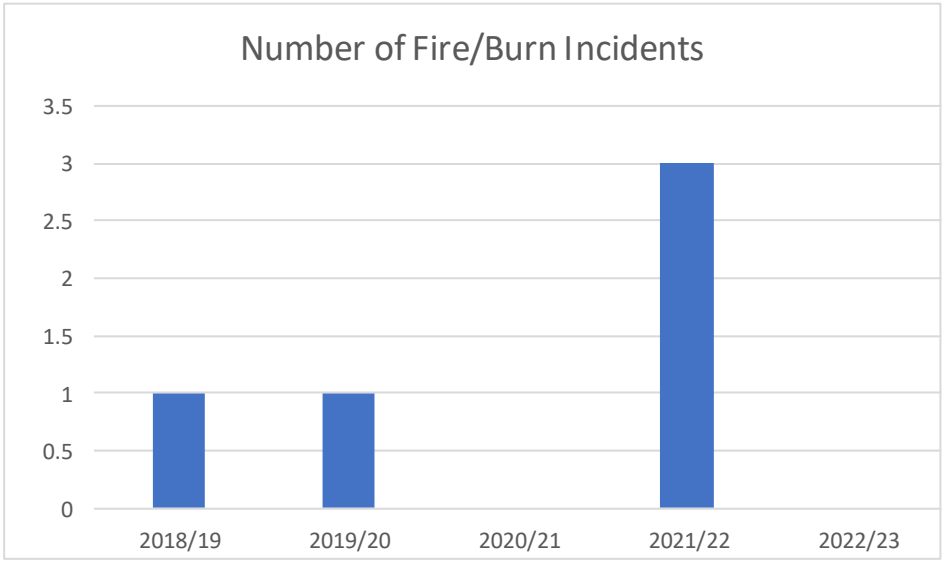
One incident was reported following a patient climbing onto, and subsequently falling from a fence.

Investigation into the is incident identified that the patient was trying to gain access to a roof and abscond form an internal courtyard. Trust staff went into the courtyard, but the patient had already gained access to the top of the fence.

A major review of access to hight/roof is being undertaken across the Trust with the intention of identifying any opportunity for individuals to climb and introduce control /protective measures to reduce this risk.

For information, Incidents involving those who “Jump” rather than fall (slip) would not come under the criteria for reporting as a RIDDOR.

Fire /burns/scalds Related Incidents



Fire related incidents reported include scalds and smoke inhalation resulting in >7-day absence from work.

Incidents include

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- Contactor disconnected hot water feed and scalded both hands
- Burn to wrists with hot curry sauce when taking a large dish from oven.
- Two nurses suffered smoke inhalation after a patient set fire to mattress at Cross Lane Hospital.

Incidents involving scalds have been reviewed and the use of PPE had been identified to prevent reoccurrence of injury in the future

It should be noted that fires started by patients were by utilising forbidden source of ignition.

The nicotine management policy is currently under review. Development of this policy may provide opportunity to reduce the presence of smoking products such as lighters across the trust. Whilst the Trust's policy is for no-smoking sites, there is clear evidence that the policy is not being reinforced.

A refreshed approach is being planned as regards (patient) smoking cessation and will form part of the reviewed policy.

Other incidents reported

In 19/20 an incident occurred where a magnetic lock box fell striking a member of staff on the head resulting in a >7 day absence.

Incorrect fixing screws were identified as the cause and replaced with those of the correct specification.

No other incidents of this type have been reported.

Policy and training Development

Over the past 12 month the H, S&S team have developed new or revised existing policy and training packages to ensure the information and instruction available supports the need of the organisation. These include

- Revised H&S Policy
- New Trust wide H&S (non-clinical) risk assessment policy
- New PPE policy
- New Lone worker policy
- New lone worker training workshop
- New RIDDOR training workshop
- New PPE training workshop
- New Risk assessment training workshop
- New Manual handling training workshop

All designed to support staff in completing documentation set out in the H&S tool kit.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The existing reporting system can clearly demonstrate that the trust identifies and escalates incidents which fall under RIDDOR. This also provides evidence of compliance with the CQC's standards around safety, good governance, and transparency in duty of candour.

There appears to be a large variation in the way DATIX entries are recorded. Incorrect completion results in the potential for incidents to be missed.

The HSE do not publish list of individual organisation and numbers of RIDDOR reportable incident completed.

Regionally, H&S leads from NHS trusts meet on a quarterly basis to discuss issues such as trends and types of incidents which have occurred, for example clarifying the reporting of patient safety incidents which fall under the requirements of RIDDOR.

4.2 Financial/Value for Money:

Failure to report incidents under RIDDOR could result in sanctions being imposed, including fines/enforcement notices from the HSE. An enforcement notice, if served could impact on any future business opportunities for the trust as any ongoing involvement with the HSE forms part of many external business pre-tender questionnaires.

4.3 Legal and Constitutional (including the NHS Constitution):

It is a requirement under RIDDOR that incidents are reported within a prescribed time. Failure to do so could result in enforcement action being taken against the trust.

4.4 Equality and Diversity:

Under H&S law, the Trust has an obligation to ensure the health, safety and wellbeing of staff, service users and other who interact with trust services.

5. RISKS:

Failure to comply with reporting under RIDDOR would result in enforcement action from the HSE. In addition, the lack of RIDDOR documentation would also be detrimental when dealing with litigation claims making a civil defence difficult to uphold.

Poor reporting of staff injuries/incidents increases the risk of failing to comply with the requirement and time scales set out in RIDDOR.

6. CONCLUSIONS:

Although there is evidence to demonstrate TEWV is reporting under the requirements of RIDDOR, the trust must ensure that incidents involving not only patients, but also staff are reported. Again, it should be noted that the memorandum of understanding between the HSE and CQC means information and concerns can be passed between these enforcement agencies for ongoing investigation and action.

Agreed to review CG membership at H&S Group – opportunities for CG and speciality-based learning / policy amendment depending on analysis of incidents

7. RECOMMENDATIONS:

The board are asked to acknowledge this paper identifying the numbers and types of incidents being reported Under RIDDOR to the HSE (and subsequently passed on to CQC for patient incidents).

Ongoing commitment is required from the organisation to ensure incidents (including those involving staff) are reported on Datix in a timely manner. Reoccurring delays in reporting under RIDDOR would result in interest from the HSE potentially leading to investigation.

Lee Dodds
Head of Health, Safety and Security

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 21

TRUST BOARD

DATE:	**Thursday 29th September 2022**
TITLE:	**NHS England Core Standards for Emergency Preparedness Resilience and Response**
REPORT OF:	**Zoe Campbell – Managing Director North Yorkshire, York & Selby Care Group**
REPORT FOR:	**Assurance/Decision**

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

Executive Summary:

It is a requirement for all health organisations to undertake an annual Emergency Preparedness Resilience and Response (EPRR) self assessment which is led by NHS England and NHS Improvement via Local Health Resilience Partnerships (LHRP).

The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards. Compliance with the standard gives assurance that NHS organisations in England can respond to emergencies and business continuity incidents and are resilient in relation to continuing to provide safe patient care.

Recommendations:

Based on the assurances provided by the Audit and Risk Committee The Board is requested to approve the Core Standard Statement of Compliance and to the submission of the completed self assessment document.

Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF:	**Trust Board**
DATE:	**Thursday 29th September 2022**
TITLE:	**NHS England Core Standards for Emergency Preparedness Resilience and Response**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this reort is to provide the Board with assurance that the Trust is complying with NHS England's Core Standards for Emergency Preparedness, Resilience and Response and, based on the assurances provided by the Audit and Risk Committee, approve the associated compliance statement and the onward submission of the completed assessment tool.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The NHS needs to be able to plan for and respond to a wide range of emergencies and business continuity incidents that could affect health and patient safety.

2.2 The Core Standards for EPRR aim to clearly set out the minimum standards which NHS organisations must meet to ensure that they can effectively respond to emergency and business continuity incidents whilst maintaining services to patients.

2.3 In addition they enable agencies to co-ordinate Emergency Preparedness, Resilience and Response acitvities and provide a framework for self- assessments and assurance processes.

3. KEY ISSUES:

3.1 The self-assessment, attached as Appendix 1, shows the Trust to be fully compliant on 58 standards, partially compliant on 11 and not compliant with 1. The evidence which was gathered in carrying out the self-assessment is summarised within the table.

3.2 The actions developed inorder to work towards full compliance (including maintaining compliance) are summarised within the table and will form part of the annual EPRR workplan. Progress against this plan will be monitored at the Emergency & Business Continuity Planning Working Group meetings.

3.3 The self-assessment, action plan and statement of compliance will undergo a peer moderation exercise hosted by the LRF

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The EPRR Core Standards are not part of the CQC inspection framework, but they help us to plan and manage Trust arrangements to effectively deal with any internal or external incident and ensure continuity of our services.

4.2 **Financial/Value for Money:** None identified.

4.3 **Legal and Constitutional (including the NHS Constitution):** None identified.

4.4 **Equality and Diversity:** None identified.

4.5 **Other implications:** None identified.

5. RISKS:

There are no notable risks associated with this report. Actions are in place for all standards assessed as not fully compliant. The standard assessed as not compliant relates to newly published national occupational standards and it is expected and accepted that all trusts will have assessed as non compliant at this stage.

6. CONCLUSIONS:

The self-assessment gives assurance to the Board that the Trust can demonstrate it can effectively respond to emergency planning and business continuity incidents whilst still maintaining provision to service users.

7. RECOMMENDATIONS:

The Board is requested to accept the report and, based on the assurances provided by the Audit and Risk Committee, to approve the Core Standard Statement of Compliance and to the submission of the completed self assessment document.

Zoe Campbell
Managing Director North Yorkshire, York & Selby Car Group
Attachments:

Appendix 1 : EPRR Core Standards Assessment including:
Core Standards Evidence
Core Standards Actions
Appendix 2 : EPRR Core Standards Assurance Statement

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	• Name and role of appointed individual	Managing Director (NY&Y&S) is the Board Level Director nominated as AEO. Trust decision not to have a non-executive board member in support.	Fully compliant			
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Appropriate EPRR Policy has been developed ratified and in place	Fully compliant			
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	The Core Standards Assessment presented to the Board of Directors in October. Future reports to include the debrief of the Microsoft printing incident response to demonstrate the ability to deliver services whilst responding to a number of concurrent disruptive events.	Fully compliant			

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes.	• Process explicitly described within the EPRR policy statement • Annual work plan	The Trust has an annual workplan that is informed by: • lessons identified from incidents and exercises • identified risks • outcomes of assurance processes in place	Fully compliant	Review EPRR Policy to include changes to the Trust structure and new roles and governance arrangements. Review to include the on call arrangements and to include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Within 3 - 6 months
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	EPRR Policy defines roles of staff with key responsibilities. The Trust has improved EPRR resilience through the creation of an additional post to support the EPRR lead.	Fully compliant	Review EPRR Policy to include changes to the Trust structure and new roles and governance arrangements. Review to include the on call arrangements and to include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Within 3 - 6 months
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	• Process explicitly described within the EPRR po	EPRR Policy describes how Integrated Emergency Management (IEM) is used, together with capturing and sharing learning from incidents, exercises and regional meetings. Action plans from exercises are monitored by E&BCP Working Group.	Fully compliant	Review EPRR Policy to include changes to the Trust structure and new roles and governance arrangements. Review to include the on call arrangements and to include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Within 3 - 6 months
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	Risk Assessment template reviewed by E&BCP Working Group. Cross referenced to Datix. Individual NSRA Risk Assessment 2020 templates used as basis for shared risk working across all 4 LRFs. Outcomes are shared with the trust.	Fully compliant			
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	There is a BC sub category on Datix to allow reporting of local risks. High level risks are escalated to locality and trust risk registers. Risk assessment as part of the Integrated Emergency Management cycle is described in the EPRR Policy.	Fully compliant			
9	Duty to maintain plans	Collaborative planning	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Partners consulted with as part of the planning process are demonstrable in planning arrangements	Winter surge planning demonstrate collaboration. Procurement processes include resilience. The Trust participates in regional EPRR planning through the LRFs	Fully compliant			
11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Internal Emergency Plan v 4.5, Business Continuity Command and Control Plan version 6, IT Incident Response Plan and Service Business Continuity plans.	Fully compliant			
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	External Major Incident Plan V9.8. The Therapies Staff Groups Business Continuity Plan outlines the process for providing a therapeutic intervention during a major incident.	Fully compliant			

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	TEWV Summer and Winter Preparedness Plan 2021 - 2022 v2.1	Fully compliant	TEWV Summer and Winter Preparedness Plan 2021 - 2022 to be reviewed	EPRR Lead	Within 3 - 6 months
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	TEWV Summer and Winter Preparedness Plan 2021 - 2022 v2.1	Fully compliant	TEWV Summer and Winter Preparedness Plan 2021 - 2022 to be reviewed	EPRR Lead	Within 3 - 6 months
15	Duty to maintain plans	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Pandemic Influenza Plan	Fully compliant	Pandemic Influenza Plan to be reviewed	Director of Nursing and Governance	Within 3 - 6 months
16	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases such as Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3 and PPE trained individuals commensurate with the organisational risk.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Infection prevention and control policy and the Infectious disease procedure (June 22)	Fully compliant			

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
17	Duty to maintain plans	Mass countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Infection prevention and control policy and the Infectious disease procedure (June 22)	Partially compliant	Consider the Trust position in relation to the distribution of mass counter measures and develop a proportionate response	Director of Nursing and Governance	Within 3 - 6 months
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The trust will use the Business Continuity Command and Control Plan, v6 and the Therapies Staff Groups BCP (providing a therapeutic response) in conjunction with the relevant regional NHS England and Improvement mass casualty framework: Yorkshire & the Humber Mass Casualty Framework for Health or Mass Casualty Framework for Cumbria and the North East of England	Fully compliant			
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Decant facility at Roseberry Park for ward restoration and use of Activity Centre for evacuation. Evacuation facilities within Tees. Decant ward at Auckland Park being repurposed. Lack of formal decant locations within NYY. Decant was successfully deployed following a fire on Esk ward Cross Lane Hospital (facilitated by the temporary closure of Danby ward at the time)	Partially compliant	Managing Directors in conjunction with Director of Estates to identify suitable facilities internally and develop appropriate plans. Where none can be sourced agree mutual aid with local MH trust(s).	Managing Directors & Director of Estates	6 - 12 months
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Appendix 2 of the Security Policy v8 - "Generic Building Emergency Lockdown" can be adapted for individual sites. Forensic BCP and all locality BCPs include lockdown action cards.	Fully compliant			
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	For Royal Visits Police will take the lead and NEAS or YAS will confirm ambulance and emergency attendance with acute trusts. For high profile patients coming from detained settings the Prison Service will liaise directly with service. High Profile Visitor and High Profile Patient on Leave action cards in Forensic BCP and locality BCPs.	Fully compliant			

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
23	Duty to maintain plans	Excess death planning	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust participated in a regional mass fatality exercise. No significant role required	Fully compliant			
24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	NHSE/I and CCGs have the 24/7 out of hours phone number to enable notification of incidents. Rotas in place and circulated for locality first on calls, trust wide second on call and Director on Call. Arrangements from October transfer to 2 tier on call arrangements in line with EPRR roles.	Fully compliant	Review EPRR Policy to include changes to the Trust structure and new roles and governance arrangements. Review to include the on call arrangements and to include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Within 3 - 6 months
25	Command and control	Trained on-call staff	On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	• Process explicitly described within the EPRR policy statement	On call staff have demonstrated they have the skills to respond appropriately to incidents (from incident debriefs) On call roles will be (from 30 September) aligned to EPRR PHC roles and plans are being developed to ensure they receive the EPRR PHC role specific training and demonstrate the Minimum occupational standards	Partially compliant	Review EPRR Policy to include changes to the Trust structure and new roles and governance arrangements. Review to include the on call arrangements and to include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Within 3 - 6 months
26	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	On call staff have demonstrated they have the skills to respond appropriately to incidents (from incident debriefs) On call roles will be (from 30 September) aligned to EPRR PHC roles and plans are being developed to ensure they receive the EPRR PHC role specific training and demonstrate the Minimum occupational standards	Partially compliant	Review EPRR Policy to include changes to the Trust structure and new roles and governance arrangements. Review to include the on call arrangements and to include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Within 3 - 6 months

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
27	Training and exercising	EPRR exercising and testing programme	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Internal exercising has been stood down for some time during the pandemic however there is now a plan in place to run a schedule of exercises prioritised against risk. Additionally the trust has run debrief exercises following live incidents and has drawn out the appropriate learning. The Trust has also participated in regional exercises.	Partially compliant	Further develop the outline exercise schedule, prioritised against risk. Develop meaningful exercises and debrief opportunities.	EPRR Lead	Within 3 Months
28	Training and exercising	Strategic and tactical responder training	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	• Training records • Evidence of personal training and exercising portfolios for key staff	On call staff have demonstrated they have the skills to respond appropriately to incidents (from incident debriefs) On call roles will be (from 30 September) aligned to EPRR PHC roles and plans are being developed to ensure they receive the EPRR PHC role specific training and demonstrate the Minimum occupational standards	Not Compliant	Implement requirements within the Principles of Health Command Training and the Minimum Occupational Standards with on call staff	EPRR Lead	Within 3 - 6 months
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a preidentified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards	Main ICC at West Park with back ups at Roseberry Park, Foss Park and Cross Lane. ICC most recently operationalised in September 21	Fully compliant	ICC will move to the Boardroom at WPH and will need to be tested - incorporate within the testing schedule	EPRR Lead	Within 3 Months
31	Response	Access to planning arrangements	Version controlled, hard copies of all response arrangements are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and hard copies	Business Continuity Plans and associated action cards developed and held local (hard copies available)	Fully compliant			
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans	Business Continuity Command and Control Plan and service business continuity plans	Fully compliant			
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards.	• Documented processes for accessing and utilising loggists • Training records	Trained loggists in place. There is a process for allocating a loggist however due to restructure and leavers the number is reduced. Loggists not currently accessible out of hours.	Partially compliant	Check that loggist duties is within the job descriptions of relevant admin staff. Undertake refresher training for existing loggists and train new/untrained loggist. Consider options for out of hours logging provision	EPRR Lead	Within 3 - 6 months
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (Streps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	• Documented processes for completing, signing off and submitting Streps • Evidence of testing and exercising	All BCPs have system failure sitrep for notification. Standard sitreps for ongoing incidents are held in Appendix 3 of BC Command and Control plan.	Fully compliant			

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Communications Team Member is part of response team. Communications staff have a process to monitor and log information requests and inform via website and social media.	Fully compliant			
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	For internal incidents the Communications Team send emails, update InTouch and reach out via social media. For major incident NHSE Comms Team would take the lead. Trust team would retweet and share consistent messages.	Fully compliant			
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'	Support to nominated directors with statements and preparing for media interviews.	Fully compliant			
40	Cooperation	LRHP attendance	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75% annually) Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings	The Trust participates in both planned and unplanned LHRP meetings and is a member of LRF sub groups. The ICS EPRR lead holds weekly EPRR informal sessions where health providers can share knowledge understand and experiences from the various LRF's	Partially compliant	Map attendance of LHRP's across the Trust footprint and consider the role of the AEO in the arrangements	Business Managers	Within 3 - 6 months
41	Cooperation	LRF / BRF attendance	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • Governance agreement if the organisation is represented	The Trust participates in both planned and unplanned LHRP meetings and is a member of LRF sub groups. The ICS EPRR lead holds weekly EPRR informal sessions where health providers can share knowledge understand and experiences from the various LRF's	Fully compliant	Map attendance of LHRP's across the Trust footprint and consider the role of the AEO in the arrangements	Business Managers	Within 3 - 6 months

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Mutual aid through MOU in Forensic Services. There is a working partnership with Local authorities and LHRP. The trust could access voluntary services support during emergencies via the LRF. MACA can be requested through the relevant LRF but the trust must make the request via NHSE/I and show that all other alternatives have been exhausted. The request must be for a definite need and tasks explicit. Other options including mutual aid must have been discounted with the trust either lacks capability, or too expensive, not available or can't meet the scale and / or urgency. Recharge for this support.	Fully compliant			
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	Protocol outlined in section 4 in External Major Incident plan. Signatory to Durham and Darlington LRF Information Sharing Protocol	Fully compliant			
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) in alignment to the ISO standard 22301.	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Business Continuity Policy	Fully compliant			
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	Business Continuity Policy	Fully compliant			
49	Business Continuity	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.	Business Continuity Policy	Partially compliant	Review EPRR Policy to include changes to the Trust structure and new roles and governance arrangements. Review to include the on call arrangements and to include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Within 3 - 6 months
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance	Comply with toolkit on an annual basis. Working towards Toolkit 2022/23	Fully compliant			
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be reviewed regularly (at a minimum annually), or following organisational change, or incidents and exercises.	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Business Continuity Plans and associated action cards developed and held locally (hard copies available) Existing BCPs need to be updated and additional plans developed.	Partially compliant	Need to align BCPs with the new Care Group structure and review BCPs to ensure they remain relevant - Agree the programme and milestones which services will meet to deliver fit for purpose business continuity plans.	Managing Directors	Within 3 - 6 months

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
52	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• EPRR policy document or stand alone Business continuity policy • Board papers	EPRR working group with annual update on EPRR performance to the Audit and Risk Committee with an annual report to the board	Partially compliant	Review EPRR Policy to include changes to the Trust structure and new roles and governance arrangements. Review to include the on call arrangements and to include requirements within the Principles of Health Command Training and the Minimum Occupational Standards	EPRR Lead	Within 3 - 6 months
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	EPRR is in the audit plan. Audit being undertaken by Audit One in Sept / Oct. Report will be presented to Board.	Fully compliant			
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	BC Policy has been revised. Learning from Covid, inclusion of staffing escalation levels in plans shared. Plans tested and action plans implemented to ensure continual improvement - Exercise Gruber.	Fully compliant			
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Procedures need to be strengthened where appropriate	Partially compliant	Review of contract arrangements as they are awarded or renewed to ascertain if a business continuity plan is required for the provision of the service. If required providers are requested to share, reviewed by the Trust for completeness.	Director of Finance, Information and Estates/Facilities	Within 3 - 6 months
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	The trust does not have decontamination facilities. Patients will need to be taken to acute hospital by ambulance trust. Action cards	Fully compliant			
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Action card in Hotel Services BCP on HAZMAT / CBRN for reception staff to follow in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread.	Fully compliant			
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	• Impact assessment of CBRN decontamination on other key facilities	Risk assessments have taken place to determine likely location, type of contaminant and associated treatment. Staff trained in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread.	Fully compliant			

Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Completed equipment inventories; including comp	Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. Tees card B8	Fully compliant			
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	Main receptions (including Forensic Control Room) maintain supplies of paper towels, plastic bags and disposable paper suits for re-robing, per Initial operating Response "Remove, Remove, Remove" advice. Tees card B9 Action card in Hotel Services BCP on HAZMAT / CBRN for reception staff to follow in recognising the signs of potential contamination, escalation to manager, notification to emergency services and minimising spread.	Fully compliant			
68	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	Action cards for reception staff to use are in Forensic, locality and Hotel Service BCP plans. Based on initial Operating Response and "Remove, Remove, Remove" guidance it emphasises getting patient outside or if not possible restricting contact with others until ambulance paramedics arrive to treat.	Fully compliant			
69	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.		Resus Team members have been provided with fit testing, either in-house by IPC team or by acute hospital trainers. Masks are held in blue resus rucksacks.	Fully compliant			

Ref	Domain	Standard	Detail	Mental Health Providers	Evidence - examples listed below	Organisational Evidence	Rating	Action to be taken	Lead	Timescale
Deep Dive - Severe Weather										
Domain: Severe Weather Response										
1	**Severe Weather response**	**Overheating**	The organisation's heatwave plan allows for the identification and monitoring of inpatient and staff areas that overheat (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	The monitoring processes is explicitly identified in the organisational heatwave plan. This includes staff areas as well as inpatient areas. This process clearly identifies relevant temperature triggers and subsequent actions.	TEWV Summer and Winter Preparedness Plan specifically includes the installation of thermomitors and for the monitoring of the environment at periods of hot weather. Log sheets completed.	Fully compliant	TEWV Summer and Winter Preparedness Plan 2021 - 2022 to be reviewed and to include specific details of sharing and responding to National Severe Weather Warnings and alerts	EPRR Lead	Within 3 - 6 months
2	**Severe Weather response**	**Overheating**	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Y	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	HEATWAVE - Trust Responsibilities Action Plan Appendix 1 of the trust's Summer and Winter Preparedness Plan identifies 5 levels of alertness, the action, the method of address and who is responsible.	Fully Compliant	TEWV Summer and Winter Preparedness Plan 2021 - 2022 to be reviewed and to include specific details of sharing and responding to National Severe Weather Warnings and alerts	EPRR Lead	Within 3 - 6 months
3	**Severe Weather response**	**Staffing**	The organisation has plans to ensure staff can attend work during a period of severe weather (snow, flooding or heatwave), and has suitable arrangements should transport fail and staff need to remain on sites. (Includes provision of 4x4 where needed)	Y	The organisations arrangements outline: - What staff should do if they cannot attend work - Arrangements to maintain services, including how staff may be brought to site during disruption - Arrangements for placing staff into accommodation should they be unable to return home	Local business continuity plans include the provision of accessing local accommodation. An agreement is in place with a 4x4 travel provider for the provision of movement of staff	Fully Compliant			
4	**Severe Weather response**	**Service provision**	Organisations providing services in the community have arrangements to allow for caseloads to be clinically prioritised and alterative support delivered during periods of severe weather disruption. (This includes midwifery in the community, mental health services, district nursing etc)	Y	The organisations arrangements identify how staff will prioritise patients during periods of severe weather, and alternative delivery methods to ensure continued patient care.	TEWV Summer and Winter Preparedness Plan specifically includes provision for community staff to prioritise case loads	Fully Compliant	TEWV Summer and Winter Preparedness Plan 2021 - 2022 to be reviewed and to include specific details of sharing and responding to National Severe Weather Warnings and alerts	EPRR Lead	Within 3 - 6 months
5	**Severe Weather response**	**Discharge**	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Y	The organisations arrangements include how to deal with discharges or transfers of care into non health settings. Organisation can demonstrate information sharing regarding vulnerability to cold or heat with other supporting agencies at discharge	TEWV Summer and Winter Preparedness Plan specifically includes provision for community staff to prioritise case loads. The Admission, Transfer and Discharge Policy requires planned discharge in collaboration with the care co-ordinator and the MDT and relevant others. 72hour follow up is required	Fully Compliant			
6	**Severe Weather response**	**Access**	The organisation has arrangements in place to ensure site access is maintained during periods of snow or cold weather, including gritting and clearance plans activated by predefined triggers	Y	The organisation arrangements have a clear trigger for the pre-emptive placement of grit on key roadways and pavements within the organisations boundaries. When snow / ice occurs there are clear triggers and actions to clear priority roadways and pavements. Arrangements may include the use of a third party gritting or snow clearance service.	The Trust has a 3rd party contract in place for winter maintenance of Trust sites. The contract includes predefined triggers from National Severe Weather Warnings and alerts	Fully compliant			
7	**Severe Weather response**	**Assessment**	The organisation has arrangements to assess the impact of National Severe Weather Warnings (including Met Office Cold and Heatwave Alerts, Daily Air Quality Index and Flood Forecasting Centre alerts) and takes predefined action to mitigate the impact of these where necessary	Y	The organisations arrangements are clear in how it will assesses all weather warnings. These arrangements should identify the role(s) responsible for undertaking these assessments and the predefined triggers and action as a result.	National Severe Weather Warnings and alerts come into the Trust to a number of different individuals (both centrally and locally) these trigger appropriate responses e.g. the Trust has a 3rd party contract in place for winter maintenance of Trust sites. The contract includes predefined triggers from National Severe Weather Warnings and alerts	Fully compliant			
8	**Severe Weather response**	**Flood prevention**	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Y	The organisation has clearly demonstratable Planned Preventative Maintenance programmes for its assets. Where third party owns the drainage system there is a clear mechanism to alert the responsible owner to ensure drainage is cleared and managed in a timely manner	There are PPMs operating to ensure drains are clear of debris, particularly in the autumn months	Fully Compliant			
9	**Severe Weather response**	**Flood response**	The organisation is aware of, and where applicable contributed to, the Local Resilience Forum Multi Agency Flood Plan. The organisation understands its role in this plan.	Y	The organisation has reference to its role and responsibilities in the Multi Agency Flood Plan in its arrangements. Key on-call/response staff are clear how to obtain a copy of the Multi Agency Flood Plan	The Trust participates in both planned and unplanned LHRP meetings and is a member of LRF sub groups. The trust has been involved in the follow plan development work and has a mechanism for identifying and protecting vulnerable patients geographically	Fully Compliant			
10	**Severe Weather response**	**Warning and informir**	The organisation's communications arrangements include working with the LRF and multiagency partners to warn and inform, before and during, periods of Severe Weather, including the use of any national messaging for Heat and Cold.	Y	The organisation has within is arrangements documented roles for its communications teams in the event of Severe Weather alerts and or response. This includes the ability for the organisation to issue appropriate messaging 24/7. Communications plans are clear in what the organisations will issue in terms of severe weather and when.	The Trust participates in both planned and unplanned LHRP meetings and is a member of LRF sub groups. The ICS EPRR lead holds weekly EPRR informal sessions where health providers can share knowledge understand and experiences from the various LRF's. The trust recently participated in an LRF driven incident planning exercise ahead of the recent hot weather	Fully Compliant			

11	**Severe Weather response**	**Flood response**	The organisation has plans in place for any preidentified areas of their site(s) at risk of flooding. These plans include response to flooding and evacuation as required.	Y	The organisation has evidence that it regularly risk assesses its sites against flood risk (pluvial, fluvial and coastal flooding). It has clear site specific arrangements for flood response, for known key high risk areas. On-site flood plans are in place for at risk areas of the organisations site(s).	Evidenced by the Operational Manuals for each property and the site specific BCP's	Fully Compliant	Reviewed as part of Business Continuity Plans and Risk Assessments		
12	**Severe Weather response**	**Risk assess**	The organisation has identified which severe weather events are likely to impact on its patients, services and staff, and takes account of these in emergency plans and business continuity arrangements.	Y	The organisation has documented the severe weather risks on its risk register, and has appropriate plans to address these.	Business Continuity Plans and associated action cards developed and held locally include for the provision of severe weather related incidents. Existing BCPs need to be updated and additional plans developed.	Fully Compliant	Need to align BCPs with the new Care Group structure and review BCPs to ensure they remain relevant - Agree the programme and milestones which services will meet to deliver fit for purpose business continuity plans.		
13	**Severe Weather response**	**Supply chain**	The organisation is assured that its suppliers can maintain services during periods of severe weather, and periods of disruption caused by these.	Y	The organisation has a documented process of seeking risk based assurance from suppliers that services can be maintained during extreme weather events. Where these services can't be maintain the organisation has alternative documented mitigating arrangements in place.	Procedures need to be strengthened where appropriate	Partially compliant	Review of contract arrangements as they are awarded or renewed to ascertain if a business continuity plan is required for the provision of the service. If required providers are requested to share, reviewed by the Trust for completeness.	Director of Finance, Information and Estates/Facilities	Within 3 - 6 months
14	**Severe Weather response**	**Exercising**	The organisation has exercised its arrangements (against a reasonable worst case scenario), or used them in an actual severe weather incident response, and they were effective in managing the risks they were exposed to. From these event lessons were identified and have been incorporated into revised arrangements.	Y	The organisation can demonstrate that its arrangements have been tested in the past 12 months and learning has resulted in changes to its response arrangements.	Internal exercising had been stood down for some time during the pandemic however there is now a plan in place to run a schedule of exercises prioritised against risk this plan includes loss of water. Actual severe weather response has recently been implemented in relation to hot weather and response reviewed locally	Partially compliant	Further develop the outline exercise schedule, prioritised against risk. Develop meaningful exercises and debrief opportunities.	EPRR Lead	Within 3 Months
15	**Severe Weather response**	**ICT BC**	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Y	The organisations arrangements includes the robust testing of access services and remote services to ensure the total number of concurrent users meets the number that may work remotely to maintain identified critical services	Remote access has been stress tested as part of the covid response. Data centre environmental controls are in place to ensure uninterrupted functionality and resilience is in place	Fully Compliant			
Domain: long term adaptation planning										
16	**Long term adaptation planning**	**Risk assess**	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Y	Evidence that the there is an entry in the organisations risk register detailing climate change risk and any mitigating actions	There is a Risk Assessment within the Climate change adaption plan, the entry within the Estates Risk Register relates to the GREEN Plan.	Fully Compliant			
17	**Long term adaptation planning**	**Overheating risk**	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	Y	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	We don't monitor and record on a regular basis building temperatures that exceed 27 celsius and then subsequently input this information onto a risk register. However, our portfolio of buildings do have mitigation strategies to assist with reducing the potential for buildings over heating, such as good installation, lagging of hot water pipework, roof void ventilation etc.	Fully Compliant			
18	**Long term adaptation planning**	**Building adaptations**	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	Y	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	This is picked up as part of the Estates strategy and any new Business Case submissions.	Fully Compliant			
19	**Long term adaptation planning**	**Flooding**	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	y	Areas are identified in the organisations adaptation plans that might benefit drainage surfaces, or evidence that new hard standing areas considered for SUDS	An example would be Block 16 RPH on the existing site completed in 2021 which has substantial SUDS drainage built in under the car park. No overall adaptation trust wide plan has been developed as yet.	Partially compliant	Adaptation requirements for long term climate change and impact on surrounding areas to be considered as part of all planning applications for new builds	Director of Estates, Facilities & Capital	Within 3 - 6 months
20	**Long term adaptation planning**	**New build**	The organisation considers for all its new facilities relevant adaptation requirements for long term climate change	Y	The organisation has relevant documentation that it is including adaptation plans for all new builds	An example of sustainability energy report for our new build at North Moor House (recent new build) attached. No overall trust wide adaptation plan has been developed as yet.	Partially compliant	Adaptation requirements for long term climate change and impact on surrounding areas to be considered as part of all planning applications for new builds	Director of Estates, Facilities & Capital	Within 3 - 6 months

Tees, Esk and Wear Valleys
NHS Foundation Trust

Appendix 2

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)

Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

Tees, Esk and Wear Valleys NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment

Where areas require further action, Tees, Esk and Wear Valleys NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Organisational ratin	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

I confirm that the above level of compliance with the core standards and the associated actions have been agreed by the organisation's board

_____ Date signed _____

Signed by the organisation's Accountable Emergency Officer

Date of Board Meeting Agreed	Date presented at Public Board meeting	Date published in organisations Annual Report

ITEM NO. 22

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**29th September 2022**
TITLE:	**Board Appointments**
REPORT OF:	**David Jennings, Chair of the Trust**
REPORT FOR:	**Decision**

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

Report:

1 Introduction and Purpose

1.1 The purpose of this report is to enable the Board to make appointments to the following roles:

(a) The Chairs and Members of the Board's Committees
(b) The Non-Executive (NED) Champion roles

2 Background

2.1 The appointment of the Chairs and Members of the Board's Committees is a reserved matter under the Constitution. The membership of each Committee is set out in its terms of reference (TOR).

2.2 A range of national reports have required the Board to designate NED Champions. In 2020 these roles were reviewed by NHS England/Improvement (NHS E/I) as it was recognised that trusts were having difficulty discharging them effectively due to the number of them which had been created. NHS E/I considered that three roles (relevant to the Trust) should be retained with the remainder being discharged through committees rather than individuals. The retained roles are as follows:

Role	Background
Wellbeing Guardian	"We are the NHS: People Plan for 2020/21 – action for us all" (2020)
FTSU NED Champion	"Freedom to Speak Up: An independent review into creating an open and honest reporting culture in the NHS" – Sir Robert Francis (2005)
Doctors Disciplinary NED Champion/Independent Member	"Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS" (2003) "Directions on Disciplinary Procedures" (2005)

2.3 It should be noted that the approach recommended by NHS E/I is not mandatory. It is for the Trust to consider whether further NED champion roles should be retained/created where required to provide assurance to the Board on specific issues.

3 Key Issues

3.1 The former Chair, Paul Murphy, discussed the appointments with the Non-Executive Directors during their appraisals.

3.2 The proposed Non-Executive Director appointments to the Board's Committees are set out in Annex 1 attached to this report.

(Note: The Executive Directors, as ex officio Members of the Committees, are included in the schedule for completeness).

3.3 The schedule includes Mrs Shirley Richardson as the Chair of the West Lane Project Committee. Although Mrs Richardson has retired as a Non-Executive Director it is considered to be in the best interests of the Trust, in view of her skills and experience and for continuity, for her to be retained in the role. It is, therefore, proposed to amend paragraph 5.1 of the TOR of the West Lane Project Committee as follows:

"5.1 The Committee shall comprise:
- *An independent Chairman*
- *A Non-Executive Director / Associate Non-Executive Director*
- *The Medical Director*
- *The Director of Nursing and Governance*
- *Managing Directors (Joint Members)"*

3.4 In regard to the NED Champion roles it is proposed that:

(a) The following Non-Executive Directors should be appointed to those recommended for retention by NHS E/I:
- Wellbeing Guardian – Jill Haley
- FTSU NED Champion (including complaints) – Roberta Barker
- Doctors Disciplinary NED Champion/Independent Member – Prof Pali Hungin

(b) The Digital/Cyber NED Champion role should also be retained and John Maddison should be appointed to it.

Recommendations:

(1) That paragraph 5.1 of the terms of reference of the West Lane Project Committee be amended as follows:

"5.1 The Committee shall comprise:
- *An independent Chairman*
- *A Non-Executive Director / Associate Non-Executive Director*
- *The Medical Director*
- *The Director of Nursing and Governance*
- *Managing Directors (Joint Members)"*

(2) That the Chairs and Members of the Board Committees, as set out in Annex 1 to this report, be approved.

(3) That the following Non-Executive Directors be appointed to the Champion roles indicated below:

(a) Jill Haley – Wellbeing Guardian

(b) Roberta Barker - FTSU NED Champion (including complaints)
(c) Prof Pali Hungin - Doctors Disciplinary NED Champion/Independent Member
(d) John Maddison - Digital/Cyber NED Champion

Annex 1

Board Committee Membership

	Audit & Risk Committee	Commissioning Committee	Mental Health Legislation Committee	Nomination & Remuneration Committee	People Culture & Diversity Committee	Quality Assurance Committee	Strategy & Resources Committee	West Lane Project Committee
David Jennings				**Chair**				
Roberta Barker				✓	✓		✓	
Dr. Charlotte Carpenter	✓			✓			**Chair**	
Jill Haley		✓		✓	**Chair**			
Prof. Pali Hungin			**Chair**	✓		✓		
John Maddison	**Chair**	**Chair**		✓			✓	✓
Jules Preston	✓		✓	✓				
Bev Reilly	✓			✓		**Chair**		
Shirley Richardson								**Independent Chair**
Brent Kilmurray				✓ **(for specified matters)**				
Ann Bridges					✓		✓	
Mike Brierley		✓					✓	

Zoe Campbell					✓	✓		✓
Hannah Crawford								
Dr. Sarah Dexter-Smith					✓			
Dr. Kedar Kale			✓			✓		✓
Elizabeth Moody		✓	✓			✓		✓
Liz Romaniak							✓	
Patrick Scott					✓	✓		✓