MEETING OF THE BOARD OF DIRECTORS

Thursday 27 October 2022

The Boardroom, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS at 1.00 p.m.

AGENDA

Standard Items (1.00 pm – 1.10 pm)

1	Apologies for absence	**Chair**	**-**
2	Chair's welcome and introduction	**Chair**	**Verbal**
3	To receive any declarations of interest	**-**	**Verbal**
4	To approve the minutes of the last ordinary meeting held on 29 September 2022	**-**	**Draft Minutes**
5	Board Action Log	**-**	**Report**
6	Chair's Report	**Chair**	**Report**
7	To note any matters raised by Governors	**Board**	**Verbal**

Strategic Items (1.10 pm – 1.40 pm)

8	Chief Executive's Report	**CEO**	**Report**
9	Board Assurance Framework summary report	**Co Sec**	**Report**
10	To consider the Integrated Performance Dashboard Report	**Asst CEO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (1.40 pm – 2.05 pm)

11	Leadership Walkabout Report	**DoCA&I**	**Report**
12	To consider the report of the Chair of the Quality Assurance Committee.	**Committee Chair (BR)**	**Committee Key Issues Report**
13	Learning from Deaths Report	**DoN&G**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (2.05 pm – 3.15 pm)

14	Deep dive into staffing and workforce	**DP&C DoN&G**	**Presentation**
15	Report of the Guardian of Safe Working	**Dr J Boylan**	**Report**

Exclusion of the Public:

16	**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*	**Chair**	**Verbal**

	(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.		

David Jennings
Chair
21 October 2022

Contact: Karen Christon, Deputy Company Secretary
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MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 29 SEPTEMBER 2022 AT WEST PARK HOSPITAL, EDWARD PEASE WAY, DARLINGTON, DL2 2TS, COMMENCING AT 1.00 PM

Present:
Mr D Jennings, 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, Deputy Chair
Mrs R Barker, Associate Non-Executive Director
Mr J Preston, Associate Non-Executive Director
Mrs Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
Dr K Kale, Medical Director
Mrs L Romaniak, Director of Finance, Information and Estates/Facilities
Mr P Scott, Managing Director, Durham, Tees Valley & Forensics Care Group
Mrs A Bridges, Director of Corporate Affairs and Involvement (non-voting)
Mr M Brierley, Assistant Chief Executive (non-voting)
Dr H Crawford, Director of Therapies (non-voting)
Dr S Dexter-Smith, Director of People and Culture (non-voting)

In attendance:
Mr P Bellas, Company Secretary
Mrs K Christon, Deputy Company Secretary
Mrs E Devanney, Director of Nursing and Quality (representing Mrs E Moody)
Mrs A Lowery, Director of Quality Governance (representing Mrs E Moody)

Observers/members of the public:
None

22/130 APOLOGIES

Apologies for absence were received from Mrs E Moody, Director of Nursing and Governance/ Deputy Chief Executive.

22/131 CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, noting that it was his first as Chair of the board. He welcomed the recent appointments of Mrs Barker and Mr Preston as a Non-Executive Directors.

In order to focus the discussion at the meeting, Executive Directors were advised to provide a short summary of the report and the recommendations, the level of assurance provided to the board and the route by which that had been determined. NED committee Chair's would also be asked to comment.

22/132 MINUTES OF THE LAST ORDINARY MEETING ON 28 JULY 2022

Agreed: *that the minutes of the last ordinary meeting held on 28 July 2022 be approved as an accurate record and signed by the Chair.*

22/133 DECLARATIONS OF INTEREST

There were no declarations of interest.

22/134 BOARD ACTION LOG

The board reviewed and noted the board action log.

In respect of action 22/114 [Report of the Freedom to Speak up Guardian], the Chair asked that confirmation be sought from all Non-Executive Directors that they had access to the e-learning module released by the National Guardian's Office.

Action: Dr Dexter-Smith

In respect of action 22/118 [Risk Management Policy], a query was raised on how the board would be assured that risks were managed at the appropriate level in the organisation.

In response, it was noted that implementation of the new governance arrangements would provide clarity. Mr Kilmurray also indicated that the Executive Risk Management Group had looked at risk related roles and responsibilities and the Head of Risk Management would lead on training associated with roll out of the policy and in measuring compliance.

22/135 CHAIR'S REPORT

The Chair provided an overview of work carried out since taking up his appointment, which included attendance at meetings with the Secure Inpatient Services Team, CQC, Tees Valley Scrutiny Panel and the Great North Air Ambulance. He had also been privileged to attend the Queen's memorial service on behalf of the Trust.

Reference was made to a recent meeting of Trust Chairs, facilitated by NHS Providers, which had discussed the benefits of preventive work and the recent BBC Panorama programme.

The Chair went on to note that he had met with most Non-Executive Directors, a Care Group Board and senior teams and he welcomed the recent launch of the Life at Ridgeway video. He had also chaired meetings of the Council of Governors, a Governors development session and a Council of Governors locality meeting, which had been productive.

22/136 MATTERS RAISED BY GOVERNORS

Mr Scott commented on the recent Council of Governors locality meeting in Durham, Tees Valley and Forensics where an overview of services and the pressures, challenges and risks faced by the trust had been provided and questions about the Crisis Service had been responded to.

Providing feedback from meetings with Governors, the Chair indicated that they felt their capability was not used to best effect, both as representatives of place but also as ambassadors of the trust, and the board was invited to consider how to respond to this.

The Chair also reported that in some external meetings he had attended, he had noted a lack of understanding about the structure of a Foundation Trust at board and Council of Governor level and suggested that information on this could be highlighted more publicly.

22/137 CHIEF EXECUTIVE'S REPORT

The board received and noted the Chief Executive's report.

In presentation, Mr Kilmurray drew attention to:

(1) The recent BBC Panorama programme, which had highlighted use of restrictive practices and a poor culture at a mental health service in Greater Manchester.

Recognising there may be an impact on staff, carers and service users, communications had gone to staff in advance of and in follow up to the programme, to offer reassurance and support. The programme provided an opportunity to reflect on the current position in Secure Inpatient Services and ALD units, and senior officers would work with staff to ensure that this area remained a priority.

Assistance had been offered to the Greater Manchester trust and officers were alert to any response from the regulatory system.

Prof Hungin highlighted the lack of comparative data between NHS trusts and suggested that the board would note that TEWV was on an improving journey.

In response, Mr Kilmurray advised that the National Patient Safety Improvement Programme was seeking to provide national data for Psychiatric Intensive Care Units.

In respect of the response to the programme on social media, Mrs Bridges indicated that, as expected, there had been a significant response on Twitter. During the evening the trust had proactively pushed out messages providing advice on where to go for help. Information for staff had also been cascaded prior to and after the programme.

Dr Dexter-Smith suggested that the programme could be used in future years as an example of behaviour that the trust would not tolerate.

The Chair commented on the Ridgeway video, as a reminder that services provided a home and community for patients and the trust would operate services on that basis.

(2) The current position of the CQC reports on the Children's and Adolescent Mental Health Service, Secure Inpatient Services and Adult Learning Disability Services.

Responding to a query on regulatory next steps, Mr Kilmurray advised that the Secure Inpatient Services report had been received and would be factually checked before publication. It was anticipated that the Adult Learning Disability Services report would be published within the next two weeks. He concluded by noting the significant work that had taken place in services and acknowledged that there was more to do.

(3) Action the trust was taking in response to the cost of living crisis.

Mrs Carpenter and Mr Preston raised queries about the impact of providing poverty awareness training to front line staff at this time.

Mr Kilmurray provided assurance that the training was not a significant length and noted that staff would be better equipped to respond to patients and families who may be struggling. The pilot had potential for wider application and learning, reflecting that the trust would develop services to benefit patients and carers and to reflect the wider context and its role as a partner in the health and care system.

Dr Dexter-Smith advised that meetings had been held with trade unions and staff volunteers were helping to share information and provide support, for example school uniform donations.

The chair welcomed the initiative, noting that assurance had been provided to the board that it would not distract from the trust's core work and would support staff to deliver services to patients.

(4) Proposals to re-schedule content and record contributions from speakers who had been due to attend the Journey to Change Conference.

Mr Brierley discussed the opportunity this provided to maintain momentum as work moved into the delivery phase.

Mr Kilmurray indicated that little external feedback had been received on the Journey to Change proposals and information would be circulated to the board within the next two weeks on the proposed next steps and timetable.

Mr Maddison queried the impact of the current unstable economic position on the financial position of the trust for 2022/23, noting that the Secretary of State had asked government departments to make efficiency savings.

In response, Mrs Romaniak indicated that there had been no information through formal NHS routes and it was noted that mental health was not a feature of the ABCD priorities of the new Secretary of State for Health and Care.

22/138 REPORT OF THE CHAIR OF THE AUDIT AND RISK COMMITTEE

The board received and noted the key issues report from the meeting of the Audit and Risk Committee (ARC) held on 8 September 2022.

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

Mr Maddison, Chair of the committee, highlighted the following points:

(1) The Improving NHS Financial Sustainability self-assessment tool that would be completed and reviewed by Audit One before review by ARC in December, prior to a report to the board.

(2) ARC had carried out a review of the NHS England Core Standards for Emergency, Preparedness, Resilience and Response Self-Assessment and the committee was able to give good assurance to the board.

(3) The positive progress that ARC had noted on risk management and improved reporting arrangements.

(4) Continued good progress made in respect of internal audit activity and completion of recommendations.

(5) Positive feedback that had been received from Audit One on the development of ARC agendas which indicated that the committee was well placed to carry out its work.

The Chair raised a query on ARC's role in reviewing how risks were considered by each of the committees and if the committee had all the tools it needed to carry out its role.

In response, Mr Maddison advised that ARC would seek assurance from each committee Chair and discussions were underway on how best to achieve this, including an invitation to each Chair to attend ARC to provide feedback about the assurance they had received on risk management.

Mrs Reilly, Chair of Quality Assurance Committee, suggested there were good examples of joint work on risk management and welcomed the proposal to attend ARC.

22/139 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

The board noted and received the Board Assurance Framework (BAF) Summary Report, which provided information on alignment between the strategic risks and matters due to be considered at the meeting. It was noted that risk gradings had changed since the last meeting to align with the new organisational risk policy.

Clarity was sought on the following matters:

(1) If the board should consider an additional risk related to gender assignment, particularly for male and female wards and the use of appropriate terminology.

In response, Mr Kilmurray suggested the issue was one of patient experience and acknowledged that services needed to respect an individual's self determination, particularly in a secure inpatient setting. Related work was taking place with Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust through revised terms of reference.

Mrs Reilly proposed that the Quality Assurance Committee review the position and report back to the board at a future meeting.

Action: Mrs Moody

(2) If consideration could be given to ensuring trust visibility on Involvement and Engagement [BAF ref. 3].

(3) In respect of Recruitment and Retention [BAF ref. 1] if the related items on the agenda provided the board with assurance that the level of risk and mitigation was appropriate.

In response, Dr Dexter-Smith acknowledged that the agenda may not provide assurance on this occasion and offered to present the Workforce Delivery Plan to a future meeting, to provide clarity. This was agreed by the Chair.

Action: Dr Dexter-Smith/Mrs Christon

Mr Kilmurray discussed use of the BAF to provide clarity on key themes and to assist the board to focus its agenda, taking account of feedback from the Intensive Support Team. Board members were invited to comment on the level of detail and assurance provided.

Mrs Haley queried some of the terminology used and suggested that the BAF incorporate timelines to provide greater assurance.

The Chair noted that the BAF would be discussed as part of the confidential board agenda.

22/140 CORPORATE RISK REGISTER SUMMARY REPORT

The board received and noted the Corporate Risk Register Summary Report, which aimed to ensure the board was clearly sighted on those high risks that would have an organisational wide impact.

In presentation, Mrs Lowery made reference to the significant progress that had been made following the appointment of the Head of Risk Management.

Mr Kilmurray reminded the board that the risk register reflected work carried out in 2021 on the risk appetite and tolerance. He noted that the Executive Risk Management Group had challenged a number of risks proposed for closure and requested that further work be carried out.

Mr Maddison, Chair of the Audit & Risk Committee, suggested that the focused report demonstrated the progress that had been made and that risk scoring was now more accurate. Risk management by the Care Group Boards and the Executive Risk Management Group had also improved.

Clarity was sought on the following matters:

(1) The existence of an asset replacement programme, in relation to the availability of medical devices [risk 1223].

In response, Mrs Romaniak indicated that a replacement programme had not been established, with work underway to develop an asset register in the first instance.

(2) The timeline for identification and presentation of new risks to the board.

Mr Kilmurray indicated that this would usually be one meeting cycle. However, there was the opportunity to escalate risks to the board if necessary. Work would take place during October to review governance arrangements, and this would identify if there was any undue lag in the process.

Mrs Lowery confirmed that new risks would be scrutinised by the Executive Risk Management Group for inclusion and management through the risk register even if not reported to the board at that point.

Mrs Reilly noted that a review of strategic risks on a three monthly basis would provide the opportunity for the board to understand what progress had been made.

Mr Maddison noted that the Commissioning Committee had begun to gain a greater understanding of its role and he indicated that although there were a significant number of risks related to commissioning, the majority were provider based.

It was suggested that the new Head of Risk Management provided an opportunity to ensure there was consistency across the register, with risks well-articulated and up to date, and clear mitigation controls in place and outlined.

Mr Scott advised that the Head of Risk Management was transforming engagement with risk management at a care group and team level. This included helping to build capacity and develop a clearer understanding of how to articulate risk, mitigation and risk ratings.

The Chair advised that Mersey Care had indicated that the risk register would provide an indication of those issues of highest importance, how the organisation managed itself and its approach to risk. He acknowledged that the register had improved, noting it was still work in progress and there was a need to maintain momentum. The board was invited to submit further comments after the meeting.

22/141 INTEGRATED PERFORMANCE DASHBOARD REPORT

The board received and noted the Integrated Performance Dashboard report.

In presentation, Mr Brierley advised that there had been some changes to the report format, reflecting continuous improvement of the Performance Management Framework. This would provide clarity for the board on key measures that demonstrated delivery of quality services and would identify areas for the board's attention and information. Reference was then made to the following areas:

(1) IIC reporting

It was noted that the IIC had been unavailable for some time due to a cyber-attack and a measured risk based approach had been taken to its recovery with production of a contingency method statement detailing how the organisation would be assured through ward data when the IIC was not available. The system was now back online, and Mr Brierley thanked the team for their efforts in this regard.

(2) Bed occupancy (metrics 8 and 9)

A significant amount of work had taken place and five independent sector beds were now in use, a reduction from 13 reported at the last meeting. The position was moving in the right direction and needed to be sustained.

(3) Mandatory training and appraisals (metrics 20 and 21)

Executive Directors had provided a trajectory for 85% compliance by 30 November 2022 for training and 1 December 2022 for appraisals.

(4) Unique caseload (metric 23)

A task and finish group had been proposed to consider caseload management, which was a multilayer issue.

(5) Financial plan (metric 24)

The board was asked to consider if additional financial narrative and reporting would be appropriate in the current financial context.

Attention was also drawn to the elevated run rates in quarter one for inpatient and agency expenditure and the board was invited to approve changes to these metrics.

(6) Crisis line

It was noted that there had been a deterioration in pick up rates in North Yorkshire and York. The Care Group Board was sighted on the issue and an improvement plan would be produced.

(7) Ongoing regulatory oversight and concerns.

It was noted that the inspection report for Secure Inpatient Services had been received and would be checked for factual accuracy.

Mr Maddison, Chair of Audit and Risk Committee, welcomed the development of the report and the inclusion of targeted actions on some measures, which provided some confidence and assurance that progress had been made. He suggested that the report could be further developed to include actions, timescales and what was required for delivery, which would be of benefit to the board.

Clarity was sought on the following matters:

(1) If, in the context of a challenging financial environment, a separate report detailing the financial issues and challenges facing the trust, would be of benefit to the board.

Mrs Romaniak cautioned about team capacity and noted that good assurance had been provided by Internal Audit on reporting to the board. However, she acknowledged that the board may wish to be sighted on some financial aspects and may wish to scrutinise the current financial position. It was noted that the trust's financial position was reported into the Integrated Care Board Finance Committee on a monthly basis.

In response, Mr Maddison suggested there was potential to develop metrics that would highlight the current position, building on existing available information, in order for the board to maintain oversight.

(2) How the AFC pay deal had been funded in previous years and what confidence there was that the position would be addressed.

In response, Mrs Romaniak advised that the trust had received a small in year uplift in the pay award. There remained an issue in respect of the £7-8m gap brought forward.

(3) When the trust might anticipate changes to the financial budgets managed by the Integrated Care System and Integrated Care Board.

Mrs Romaniak advised that changes had been ongoing for some time and there was a collective responsibility to manage the financial position and consider different scenarios, mitigation, the scale of ambition and cost improvements.

(4) The reason for the reduction in the percentage of staff who would recommend the trust as a place to work and the percentage of staff who responded to the survey. Mrs Haley proposed that the People, Culture and Diversity Committee carry out a deep dive to understand the position and what more could be done.

Action: Dr Dexter-Smith

Dr Dexter-Smith advised that the drop in responses was also reflected nationally. The response rate was the second highest in the region and staff would be visiting services to promote the next staff survey.

(5) If there would be benefit in reviewing the outcome of exit interviews to understand why staff had left, what trends there may be and what could be done to prevent them leaving.

Dr Dexter-Smith advised that reported reasons for leaving included retirement, access to training, stepping down from work and employment within the private sector. It was noted that many staff did not provide a reason.

Mrs Haley suggested that exit interviews should not be completed by the line manager.

Noting that staff may feel disengaged with the organisation at the point of an exit interview, Mrs Barker highlighted the potential to carry out stay interviews as part of the appraisal process. Dr Dexter-Smith also indicated that 'thinking about leaving' group discussions may be helpful.

Dr Kale noted that the Guardian of Safe Working would carry out exit interviews for high level trainees and he offered to collate this information and share it with the board.

(6) Following the decision to stop new admissions to block beds, where new patients had gone and if assurance could be provided on those patients who were not able to be discharged after 72 hours.

Mr Kilmurray advised that the additional short term capacity was established in response to bed closures at Scarborough at a cost of £320,000 per quarter. Scarborough had reopened and, whilst additional capacity was welcomed, an exit strategy was now required to address the financial position. Winter and social care pressures would make this a challenge and there may be a requirement to use independent sector beds to release short term pressure.

Mrs Haley commented on the wide geographic area covered by the trust that would result in differing requirements and suggested there was benefit in holding a roundtable strategic discussion with care and housing providers on the long term approach.

Mr Kilmurray noted that discussions had been held with Directors of Adult Social Care and acknowledged that accommodation and housing was a significant barrier, although there appeared to be some appetite in the sector. A multi-agency response was required, and officers were employed within the Integrated Care Board to lead on related transformation and coordination work.

Mrs Campbell indicated that work had taken place in York to consider issues related to delayed transfers and there was potential to revisit a proposed supported housing scheme.

Mrs Carpenter advised that the viability of a supported housing schemes would depend on the level of rent and service charge paid by the local authority.

The Chair noted that the board would wish to maintain oversight of this area and any need to push back to commissioners on funding requirements.

(7) If the CQC action plan expected all staff to complete mandatory training by the end of October.

In response, the board was advised that the CQC required the trust to be consistent with its own policy.

Mrs Carpenter acknowledged that a 100% target would be unrealistic and queried the CQC view on a target of 85%, suggesting that there may be a way of defining the 15% exception or applying a higher target to individuals returning to work or as a requirement to work in a specific area.

Dr Dexter-Smith agreed to reflect on how services would track the impact of the new mandatory target at service level.

Drawing the discussion to a close, the Chair welcomed the progress that had been made on the report. He queried if there was an opportunity to provide summary narrative on the level of assurance to the board in respect of the risks included in the BAF, particularly where the variance

between the present and target risk scores was material. This would assist the board to understand the current position and where it would focus its attention.

Action: Mr Brierley

Agreed *that approval be given to:*

a) *The proposed standard of 85% for appraisal and mandatory training.*
b) *The revised finance measure on agency spending for inclusion in the Board Integrated Performance Dashboard.*

22/142 REPORT OF THE CHAIR OF THE QUALITY ASSURANCE COMMITTEE

The board received and noted the key issues report from the meeting of the Quality Assurance Committee (QuAC) held on 29 September 2022.

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

Mrs Reilly, Chair of the committee, highlighted the following points:

(1) The recommendation to approve an extension to the deadline for completion of the CQC well-led actions.

(2) That good assurance had been noted in respect of updates to the Board Assurance Framework, Corporate Risk Register and implementation of the risk management policy, reflecting a much improved position.

(3) The new reporting schedule from the Executive Quality Assurance Group, which showed there was activity on risks and pressures between levels under the Care Group Boards, with QuAC focussing on strategic issues.

(4) The committee had received little assurance on safe staffing, where a significant level of missed breaks had been reported and there was disparity in how different staff groups were monitored.

(5) There had been a confidential agenda item to discuss the Mersey Care report, where it was considered that there was potential for patients to be identified.

Summing up, Mrs Reilly advised that as Chair of the committee for 18 months she considered that its work had moved on significantly towards that of a strategic focus and she welcomed the attendance of the IST representative at the last meeting.

In respect of missed breaks, Mrs Romaniak advised that Executive Directors had reviewed the position and it was noted that the figure was equivalent to eight people during the month of August. Mr Scott also noted that there had been some inconsistency in what constituted a missed break and advised that space was provided within wards to allow staff to have a break, even if they were unable to leave the ward.

22/143 SIX MONTHLY 'HARD TRUTHS' NURSE STAFFING REPORT

Mrs Devanney introduced the report which aimed to provide assurance on the process for reviewing and reporting safe staffing, in line with NQB guidance. Attention was drawn to the following:

(1) Despite significant investment the trust was not able to consistently achieve the right skill mix between Registered Nurses and Health Care Assistants, with challenges linked to vacancies, long term sickness and recruitment.

(2) In respect of recruitment, 90 Registered Nurses had applied to work at the trust but 26 had been lost through the application process. Work would take place to expedite the process and keep in touch with applicants. International recruitment would take place in India for 40 staff nurses and officers were working hard to keep in touch with student nurses.

(3) There had been an increase in Datix reporting of staffing issues. It was unclear if this had arisen due to an increased focus on reporting and would be closely monitored.

(4) An increase in the trust's headroom had been approved by the Finance Sustainability Board to accommodate for sickness and continued professional development training for nurses, which was a positive position for recruitment and retention.

In discussion, clarity was sought on:

(1) The current position with the Covid and Flu vaccine programmes.

Mrs Devanney confirmed that communications had already gone to staff on how to access the flu vaccine and to re-engage with vaccinators who participated last year.

Dr Dexter-Smith advised that vaccinations would commence the following week, with a new model in place to cover clinics and to provide extra pharmacy time for Covid vaccinations.

(2) If the trust needed a coherent workforce plan and to what extent the establishment review report [agenda item 17] addressed the challenges outlined, and if not, how assurance could be provided to the board and when.

Mrs Devanney advised that the report focused on Secure Inpatient Services and Adult Learning Disability, following agreement by the board in March. It would be expected that increased rostered staffing levels would ensure consistent staffing and higher quality care as a result.

In respect of the workforce plan, Dr Dexter-Smith indicated that every service had a 12 month workforce delivery plan based on safe and fully staffed levels. A number of workshops had been held on workforce planning and Health Education England had provided assistance with focused work in Secure Inpatient Services and Children and Adolescent Mental Health Services.

Mrs Romaniak commented on the complexity created by a patient population with changing needs and occupancy levels and the flexibility that would be required by the workforce plan to accommodate changes in length of stay and delays in discharge.

Mr Maddison commented on the significant gap and challenges outlined in the report, suggesting that a workforce plan would provide some assurance. There was also the potential to provide detailed information to the People, Culture and Diversity Committee and the Strategy and Resources Committee on each staff group by grade, current staff levels and the establishment level, financial impact, related risks and progress that had been made.

Mr Kilmurray suggested that the trust would wish to move toward a model of integrated operational planning over the coming year, to contribute to decision making but it was not in

a position to do that currently. Work was underway to look at responding to operational requirements, which may include the block recruitment of Health Care Assistants.

(3) Medical staffing levels, where there may be greater recruitment challenges and where the trust may wish to consider the level of risk and alternative options.

In response, Dr Kale advised that a Medical Workforce Strategy was in development, where international recruitment was a key feature and he would participate in the recruitment initiative in Kerala where there was an oversupply of doctors and nurses. Work was also taking place in respect of agency gaps and a process had been developed to try to ensure that rates were negotiated directly with doctors and to offer support on 360 feedback and appraisals as part of their revalidation.

(4) If concerns about staffing within individual services was hidden by the trust wide position and if the board was assured that committees were sighted on the issues and could triangulate the information provided.

The Chair suggested it would be helpful for Non-Executive Directors to map common areas, to aid this understanding.

(5) If, as part of the planning process and future scenario modelling, the trust should focus on areas of core business where it was able to consistently provide safe staffing levels.

Mr Kilmurray acknowledged the suggestion and noted that Adult Learning Disability had been closed to new admissions.

(6) What action would be taken to address the high number of job applicants who were lost through the application process.

Dr Dexter-Smith advised that action would take place earlier in the process to identify those without the right to work and there would be clearer information to applicants about the nature of the role applied for.

(7) What assurance the report provided to the board.

Mr Kilmurray indicated that the report fulfilled its statutory purpose but may not provide the level of detail in areas that were of interest to the board.

Mrs Carpenter acknowledged that the discussion had been helpful and suggested that a cover report be included with the next report to provide detail on risk and action underway to meet minimum staffing levels.

22/144 REPORT OF THE CHAIR OF THE MENTAL HEALTH LEGISLATION COMMITTEE

The board received and noted the key issues report from the meeting of the Mental Health Legislation Committee (MHLC) held on 9 August 2022.

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

Prof. Hungin, Chair of the committee, highlighted the following points:

(1) The level of assurance provided to the committee was considered to be moderate heading towards good.

(2) It was unclear if wellbeing information had been collected and updated correctly and therefore, if the information presented an accurate position. Committee needed to have meaningful assurance on the data provided and a programme of training and an outline of performance measures for those supplying the information, would be developed.

Commenting further, Dr Kale acknowledged that it was important for committee to understand the detail behind the numbers provided for example, narrative on why a patient had waited 14 days for their rights.

Mr Kilmurray suggested it would be beneficial for the board to undertake training on the Mental Capacity Act.

Action: Dr Kale

22/145 16 - CQC ACTION PLAN PROGRESS REPORT

The board received and noted the CQC Action Plan Progress Report, which provided a detailed update on the current status of all CQC actions, as reviewed at the last Quality and Assurance Committee meeting.

In presentation, Mrs Lowery advised that it provided a positive picture as actions moved towards implementation and included an assessment of assurance in relation to the delivery of actions and the focus on future sustainability.

The risks in relation to staffing and delivery of Children and Adolescent Mental Health Services were noted, and Mrs Lowery highlighted the imminent well-led inspection which would find the trust in an improved position, though noting there may be new risks in relation to well-led.

Mrs Reilly, Chair of QuAC, confirmed that the committee had given approval to a review of the timescales to ensure they were realistic, and this would be monitored.

The Chair thanked officers for the good work and the analysis of the assurance provided to the board.

22/146 17 - ESTABLISHMENT REVIEW REPORT

The board received and noted the Establishment Review Report, which provided an update to the board on the review of clinical team staffing establishments in Adult Learning Disability (ALD) and Mental Health Services for Older People (MHSOP), undertaken from June 2021 to November 2021.

In presentation, Mrs Devanney highlighted the increase in the number of teams reporting their RAG rating as Red or Red/Amber and the high use of temporary staffing and high cost agency staffing. In response the report proposed a temporary increase in rostered staffing levels to provide a consistent directly employed workforce with an appropriate skill mix and to reduce agency costs. The increase would include different roles and would support practice development in MHSOP and senior roles in ALD.

Mrs Romaniak confirmed that the proposal had been discussed by the Strategy and Resources Committee in August and was expected lead to recruitment on a permanent basis. Work was also underway to identify the desired clinical model, taking account of board feedback in March that there should be a focus on quality and safety.

The report highlighted the point at which agency staffing would exceed current projections and have an adverse financial impact, this was at 75% in MHSOP and 94% for ALD.

Mr Maddison, Chair of Strategy and Resources Committee, advised that the committee had supported the direction of travel on the basis that sufficient permanent staff would lead to quality and safety improvements and would, as a minimum, displace the cost of agency staff and may result in a cost reduction.

Clarity was sought on the following matters:

(1) How the increase in staffing would be achieved.

Dr Dexter-Smith advised that the next phase would be to complete a series of workforce planning workshops with senior staff, then to map both the short term trajectories to fill established vacancies and at the same time develop a medium term workforce plan for each service management group, looking creatively at how services would be reconfigured.

Work was also underway to ensure the trust was clearer with applicants about the nature of the role applied for, to reduce the number of people who dropped out during the application process.

(2) The scope of the establishment reviews.

Mrs Romaniak advised that there had been a focus on immediate safety requirements within inpatient services and it was noted that reviews had been carried out on Adult Mental Health and Secure Inpatient Services. A casework review was underway in respect of Adult Mental Health Community Services in the Vale of York, which the trust was not commissioned to provide. It was suggested that the issue be flagged with commissioners.

Mr Kilmurray confirmed that discussions were held with commissioners on funding requirements, linked to long term plan priorities.

In discussion, Prof Hungin suggested that when the trust was requested by the Integrated Care Board to increase or re-establish services, then appropriate funding and staffing capacity should be requested.

(3) How monitoring and review of the pilot would be completed.

Mrs Devanney confirmed that establishment reviews were standard practice and carried out annually and reviewed every six months. Updates were available for the board if required.

Agreed: *that the board approve the proposed temporary changes to the roster.*

22/147 PUBLICATION OF THE WORKFORCE RACE EQUALITY STANDARD, WORKFORCE DISABILITY EQUALITY STANDARD, SEXUAL ORIENTATION WORKFORCE EQUALITY STANDARD SUBMISSIONS AND ASSOCIATED ACTION PLANS

The board received and noted the report, which set out the key themes from the WRES, WDES, SOWES, the Publication of Staff Information and the Model Employer Trajectory update, which the trust had a duty to publish.

Dr Dexter-Smith presented the report, advising that trust rates compared well with national levels or were slightly below. The People, Culture and Diversity Committee would consider those areas

that would make a difference, including a focus on groups most likely to enter the disciplinary processes. Board attention was drawn to the low self-declaration levels by the board in respect of sexuality and long term health conditions.

Mrs Haley, Chair of the People, Culture and Diversity Committee, suggested that there was a need to understand individual data sets and to map these against Care Groups, in order that any gaps could be considered, but data was not currently available.

Clarity was sought on the following matters:

(1) The definition of bullying and if this was self-reported.

Dr Dexter-Smith advised that there were a number of measures of bullying with some self-reported incidents. It was noted that BAME staff and staff from protected groups were more likely to experience instances of bullying from colleagues.

Prof Hungin suggested that the trust be mindful of cultural and regional sensitivities in relation to reported bullying. Commenting further, Mrs Haley highlighted the potential to benchmark across the organisation on the perception of bullying, particularly across individuals with protected characteristics and in differing geography, which may provide a litmus test on performance.

(2) The underlying theme that staff were unwilling to share information or show their true self at work and how this would be addressed.

(3) The report highlighted the breadth of work underway, but it was not clear if it would be sufficient to drive change and provide assurance to the board that the right workforce strategy was in place to take the trust forward.

It was acknowledged that the workforce strategy was work in progress and the Chair suggested that it could be shared with the board as it developed if that was helpful.

Agreed: *publication of the WRES, WDES SOWES action plans and the Publication of Staff Information.*

22/148 ANNUAL REPORT OF THE RESPONSIBLE OFFICER ON MEDICAL REVALIDATION AND THE STATEMENT OF COMPLIANCE

Dr Kale presented the annual report and Statement of Compliance, commenting on the process in place through the Medical Department and the trust to ensure appraisals were completed and in rare circumstances, to agree exceptions. 60 appraisers were now trained for 126 doctors, which had helped to maintain the appraisal rate and regular training was provided during the year alongside anonymous feedback from appraisees.

The GMC had requested demographic information and as a result Dr Kale had undertaken to investigate the reported difference between the number of BAME colleagues with a low level of concern at five, compared to white colleagues at two.

Summing up Dr Kale noted that there were no overall concerns.

Agreed: *the report be noted and Statement of Compliance be agreed for signature by the Chief Executive or Chairman on behalf of the trust.*

22/149 20 - RIDDOR INCIDENTS

The board received and noted the update on reportable incidents to HSE under the requirements of Riddor.

Mrs Romaniak presented the report, noting that further work had been identified, including the development of an annual report which would provide greater detail on proactive measures such as staff training and support to carry out risk assessments, particularly in relation to management of violence and aggression. However, the team was of limited capacity.

In discussion, clarity was sought on the following matters:

(1) Whether the reported 20 episodes of violence and aggression was an underrepresentation.

In response, Mrs Romaniak confirmed that the report included only Riddor reportable incidents. These were incidents resulting in serious harm.

(2) If there was an audit on the line of reporting from incident to recording.

Mrs Romaniak advised that this depended on the incident and if the right level of information had been provided. There were clear definitions for Riddor reportable incidents, including at what point they should be reported.

Mrs Carpenter suggested that the trust would benefit from reviewing incidents that occurred below those that were reportable to Riddor, in order to understand and learn from the complete picture.

22/150 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

The board received and noted the report on the self-assessment against NHS England Core Standards for Emergency Preparedness, Resilience and Response.

Mrs Campbell presented the report, noting that there were a number of amber ratings which reflected the current position of the trust. A red rating had been included in respect of strategic and tactical responder training, which was a new requirement that the trust would work towards. Progress against the plan would be monitored by the Emergency and Business Continuity Planning Working Group.

Mr Maddison, Chair of Audit and Risk Committee, confirmed that the report had been presented to the last meeting of the Audit & Risk Committee and a good level of assurance had been provided.

Agreed: *that the Core Standard Statement of Compliance be agreed and the completed self-assessment document be submitted.*

22/151 APPOINTMENT OF MEMBERS OF THE BOARD COMMITTEE'S AND NON-EXECUTIVE DIRECTOR CHAMPIONS

The board received and noted the report which enabled the board to make appointments to the Chairs and Members of the board's committees and to the Non-Executive Champion roles.

In discussion, it was noted that the Quality Assurance Committee only had two Non-Executive Director appointments and the Chair and Vice-Chair agreed to consider the matter outside of the board meeting.

Responding to a query about the approval process for the proposed appointments, Mr Bellas confirmed that these were matters reserved for the board and there would be no need for board members to declare an interest.

Agreed: *that*

(1) Paragraph 5.1 of the terms of reference of the West Lane Project Committee be amended as follows:

"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) The Chairs and members of the board committees, as set out in annex 1 to the report, be approved.

(3) That the following Non-Executive Directors be appointed to the champion roles indicated below:
- *Jill Haley – Wellbeing Guardian*
- *Roberta Barker – Freedom to Speak up Champion (including complaints)*
- *Pali Hungin – Doctors Disciplinary Champion/Independent Member*
- *John Maddison – Digital/Cyber Champion*

22/152 APPOINTMENT OF SENIOR INDEPENDENT DIRECTOR

The Chair proposed that Mr Preston be appointed to the position of Senior Independent Director.

Agreed: *that Mr Preston be appointed to the position of Senior Independent Director.*

22/153 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 transaction of the confidential business, the meeting concluded at 5:15pm.

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
31/03/22	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)
28/04/22	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		Report deferred to Nov-22 board meeting
26/05/22	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	22/111	Directors' visits	Non-Executive Directors to be included in the review of Directors' visits	DoN&G (DoQG)	Oct-22		See agenda item 11
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		See agenda items 11&13
29/09/2022	22/134	Freedom to Speak up Guardian	Confirmation to be sought from all Non-Executive Directors that they can access to the e-learning module released by the National Guardian's office	DfP&C	Oct-22		Confirmation was provided at the meeting

Chair's Report : 30th September 2022 – 27th October 2022.

Headlines:

External:

- Meetings with Yorkshire & Humberside and North-East & North Cumbria NHS FT Chairs networks
- Meetings South Tees Chair
- Meetings with CQC
- Weekly MH Chairs' Network
- Positive Practice in Mental Health Awards
- Meetings various MPs relating to CQC ALD Report publication

Governors

- Council of Governors
- Meeting specific Governor

Internal

- Meetings with various Execs and their senior Teams.
- Judging, and giving, Living the Values Awards
- Initial discussion around AGM
- Brent's monthly webinar – DJ as guest.
- Leadership Walkabout North Moor House Northallerton
- Board Seminar on West Lane, Niche Reports, and timeline

Personal:

- Annual Leave week commencing 17/10 – 1 week.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 27 October 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

Adult Learning Disability Report

The Adult Learning Disability Inpatient service report was published on 5 October. The Board has been briefed in full regarding the findings and the Trust's response since the inspection in July. The Council of Governors received a briefing on the Mersey Care report at its seminar in September and a full briefing on the CQC report at its full meeting on 13 October.

The service is progressing well with the "must do" actions. The Executive Directors Group is receiving a weekly update.

The content of the report throws up a number of key system issues and raises questions about the future service model for adults with learning disabilities with complex needs. Both Integrated Care Boards are very supportive and through the

collaboratives committed to working with us to co-design with people who use the service and their carers a new model.

Secure Inpatient Service Draft Report and Factual Accuracy Response

The draft CQC SIS report was received by the Trust for factual accuracy comments and a response submitted 11 October. The full report content remains embargoed until publication. We hope that the final report will recognise the improvements we have made, whilst acknowledging there is still work to do. CQC are expecting the report to be published next week.

Vaccinations

We are now providing both flu and covid vaccines to all our staff. Clinics are running across the trust geography for staff to book into and during November we will be putting on drop in clinics for both vaccines. As the training is different for vaccinators with each vaccine, the coordination of this is more complex than in previous years but we are constantly reviewing the provision and demand. The Quality Improvement team are supporting this work to ensure we provide the clinics as smoothly as possible and also set up standard work for next year given that it is likely we will be providing both vaccines for the foreseeable future.

Business Planning

We have been reviewing our business planning process. Strategy and Resources Committee support a change of approach earlier this year.

We are required to have completed the planning process, including budget setting and CRES planning by March 2023. It is our intention to run a process this year that allows the Board the opportunity to shape and review the business plan at the key junctures. It is also important that the business plan is bottom up – driven by operational and corporate service teams, partnership focussed and is clearly co-created.

The new style business planning process must result in us having a smaller number of clear, actionable priorities that reflect all of the key environmental and contextual drivers, our focus on quality and safety and deliver our efficiency requirements. It will be set firmly within Our Journey to Change.

Care Groups are running planning workshops during October and November. There are also Financial Recovery workshops underway that will support this process. Both Care Groups are looking at the workforce change and recruitment plans and will be undertaking quality impact assessments against all proposals.

The Executives will be reviewing the output from these workshops on 9 November and a summary view will be presented to Board on 24 November.

There will be a “catch ball” process during November between Care Groups and Corporate services, programme boards, with patient, carer and partner involvement throughout.

We are currently planning for there to be a full day Board workshop on 15 December where we will review the latest environmental issues (including any implications of the budget on 31 October). We will revisit our risk appetite and tolerance, consider the key Trustwide delivery priorities for 23/24 and 24/25 and review the high level CRES plan.

It is then intended there will be a broader event on 9 February to involve the board, governors, senior clinical, operational and corporate leaders and service users, carers and partners.

The final draft plan will be presented to Board of Directors, March 2023.

Positive Practice in Mental Health Awards 2022

The Trust was delighted to host the National Positive Practice Awards on 6 October. These awards are the main mental health only awards in the UK. Over 400 people attended the evening at Ramside Hall Hotel.

We were delighted to win four categories and to be highly recommended in two:

Winners

- None clinical team of the year – Voluntary Services Team
- Outstanding leadership awards – Tom Hurst
- Forensic mental health services – ‘A recipe for a healthier lifestyle’ Secure Inpatient Service
- Mental health rehab and /or recovery – Recovery and Outcomes Support Team

Highly Commended

- Complex mental health needs - Primrose Service
- Mental wellbeing workforce – Employee Support Services

Congratulations to all of those nominated and especially our winners and highly commended nominees. And thank you to all of those involved in organising the highly successful event.

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

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

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

Report:

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

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

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

Recommendations:

The Board is asked to receive and note this report.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade *(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 Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 14 – Deep Dive into Staffing and Workforce ▪ Public Agenda Item 15 – Report of the Guardian of Safe Working ▪ Confidential Agenda Item 8 – Quality Assurance Committee Key Issues 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 10 – Board Integrated Performance Dashboard ▪ Public Item 11 – Leadership Walkabout Report ▪ Public Agenda Item 12 – 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 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 14 – Deep Dive into Staffing and Workforce ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 6 – Assurance Statements ▪ Confidential Agenda Item 8 – Quality Assurance Committee Key Issues Report

5	✓	✓		**Culture & Wellbeing** Pockets of poor culture or low staff wellbeing could undermine our ability to provide a safe and sustainable service as well as putting individual staff and patients at risk of harm	**DoP&C**	**High**	**Good** ↑	Controls are, generally, operating effectively Further strengthening, through the delivery of mitigations, is required at pace to reduce exposure.	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Item 11 – Leadership Walkabout Report ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 14 – Deep Dive into Staffing and Workforce ▪ Public Agenda Item 15 – Report of the Guardian of Safe Working ▪ Confidential Agenda Item 8 – Quality Assurance Committee Key Issues 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 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 13 – Learning from Deaths Report ▪ Public Agenda Item 14 – Deep Dive into Staffing and Workforce ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 6 – Assurance Statements ▪ Confidential Agenda Item 8 – Quality Assurance Committee Key Issues 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 10 – Board Integrated Performance Dashboard ▪ Public Item 11 – Leadership Walkabout Report ▪ Confidential Agenda Item 7 – IIC Business Case
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 ref. 11 – Governance and Assurance)	**CEO**	**High**	**Good**	Controls considered to be operating effectively and scope for improvement is limited High degree of exposure will need to be accepted Regular monitoring of the risk advisable.	▪ Public Agenda Item 8 – Chief Executive's Report ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report ▪ Confidential Agenda Item 5 – West Lane Project Committee Key Issues Report ▪ Confidential Agenda Item 6 – Assurance Statements ▪ Confidential Agenda Item 8 – Quality Assurance Committee Key Issues 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 12 – Quality Assurance Committee Key Issues Report ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report ▪ Confidential Agenda Item 5 – West Lane Project Committee Key Issues Report ▪ Confidential Agenda Item 6 – Assurance Statements ▪ Confidential Agenda Item 8 – Quality Assurance Committee Key Issues 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.	▪ Confidential Agenda Item 5 – West Lane Project Committee Key Issues Report ▪ Confidential Agenda Item 6 – Assurance Statements
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	**DoFI**	**High** ↑	**Good**	Whilst controls are, generally, considered to be operating effectively further strengthening is required at pace, through the delivery of identified mitigations, to reduce exposure	
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 8 – Chief Executive's Report ▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Confidential Agenda Item 4 – Chief Executive's Report

BOARD OF DIRECTORS

DATE:	**27th October 2022**
TITLE:	**Board Integrated Performance Report as at 31st August 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 August 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 August 2022 – See Appendix A

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

3.1.1 Integrated Performance Dashboard

a) **Clinical/Patient Reported Outcomes: Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported; Percentage of CYP showing measurable improvement following treatment - clinician reported; Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported (measures 5-7)** – a number of actions have now been identified which includes a briefing for all on the staff on expected standards for the completion of outcomes, training for new and existing staff (CYP specifically) and the testing of the new caseload supervision process which has an outcome component.

Action: More detailed discussions and focus on Outcomes has been requested of both Care Board Quality Assurance & Improvement Subgroups which are being supported by the Clinical Networks and the Trust-wide Outcomes Steering Group.

b) **Bed Occupancy and Out of Area Placements (measures 8 and 9)** Care Groups have implemented a range of processes to share good practice and learning which includes increased focus on patient leave; review of delayed transfers of care and patients with a length of stay over 30 days. This work will continue to be overseen by the Trust-wide Bed Oversight group. There has been a reduction in the number of overall block and independent sector beds from 21 as at 27th July to 4 as at the 4th October.

Action: A range of bed information will continue to be monitored by the Trust-wide Bed Oversight group to ensure the Care Group processes are effective and the bed position will be discussed routinely at the Executive Directors Performance Meeting each month.

c) Restrictive Interventions (measure 12) there are a range of actions underway to reduce the number of restrictive intervention incidents within Adult Learning Disability Inpatient Wards which include ensuring there is a discharge plan in place for each individual patient, bespoke training for staff, independent assurance panels and the development of restraint reduction plans. Service level data for Adult Learning Disabilities shows a decreasing trend with reductions being maintained in seclusions (127 in June to 105 September) and restraints (134 to 75) with the exception of one person.

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 which is currently being reviewed. This will be considered as part of the Clinical, Quality and Safety programme and as part of business planning.

d) **Staff Leaver Rate (measure 18)** remains a concern and we recognise that we

need to encourage staff to participate in leavers interviews, so we understand the reasons why and to identify any themes and issues that need to be addressed.

Action: Several actions have been identified that will be completed by the end of November 22 including a new intranet page for staff to know the different ways to accessing a leavers interview; a central point to return and analyse leavers information and a review of the impact of the "thinking about leaving group". We are also setting up a central form to complete to share reasons for leaving or thinking about leaving and to access an independent 1:1 conversation.

e) **Unique Caseload (measure 23)** the increase in caseload at Trust level appears to be a concern. This new measure was designed to support Trust assessments of capacity and demand. A key first step will be to separate services for which an increase in unique caseload would be expected and linked to increased levels of investment in services, including linked to the Mental Health Investment Standard, from services for which increased caseloads are a cause for concern. Following a more detailed discussion at the Executive Directors Meeting late September, it was agreed to establish a task and finish group to take this forward.

Action: The Executive Strategy & Resources Subgroup will establish and oversee the task and finish group.

f) **Financial plan (measure 24)** delivery has been impacted materially since April 2022 by adverse run rates that have exceeded 2021/22 levels, most notably for inpatient and agency expenditures and following continued reliance on admissions to adult assessment and treatment independent sector beds due to bed pressures. 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 (most notably for medical premium rate assignments) 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, delays in the discharge of adults and older adults from inpatient wards are exacerbating bed pressures 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). Further systems discussion is needed to understand potential mitigations and associated impacts on patient flow and occupancy.

The Trust had planned to deliver stepped agency and independent sector bed cost reductions from quarter 2, however in-month costs have not reduced, with run rates exceeding 2021/22 levels and consequently generating increased CRES requirements. Some early signs of improvement are noted from September into October (date of drafting) with Independent Sector bed utilisation having reduced to between 4 and 7 beds. It is unclear to what extent impacts from delayed transfers and the sensor door capital programme (2 rooms unavailable consecutively) will impact the national requirement to eliminate

Independent Sector bed placements.

Performance in quarter two has been consistently worse than planned, with in-month adverse variances to plan of £1.2m and £0.6m respectively for months 4 and 5. Costs are £0.85m higher than planned in the position just closing for month 6. The Executive Directors are considering a financial deep dive into review actions already in train, additional actions now needed, and key forecast assumptions, to mitigate year to date under performance (£1.8m to month 5) and to 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 agree targeted improvement trajectories on 12th October to inform financial forecasts and discussions with ICS partners

The Board supported a recommendation that it should receive a separate but complementary financial narrative report given the current financial context and challenges to in-year and underlying performance.

3.1.2 Other Alerts

a) **Levels of agency expenditure** are of ongoing concern, both from a volume and a rate perspective. Key drivers since April have been support for complex packages of care for Adults with a Learning Disability, cover for increased medical vacancies, and staffing needed for patient observations, and backfill for sickness and vacancies, most notably for inpatient rosters. High inpatient bed occupancy, including due to longer lengths of stay, is continuing to exacerbate impacts on safe staffing and therefore elevating temporary staffing requirements.

Pre-Covid approval arrangements to ensure the scrutiny of agency bookings and costs have been reintroduced to support ongoing oversight and management.

As reported last month, are some early positive signs of improvement, including a successful discharge of a patient with complex learning disabilities at the end of August to a more appropriate community-based package, that has reduced the need for off-framework agency staffing assignments after the reporting period. Plans are also in train to effect a move away from the most expensive off-framework agency supplier for Learning Disability services (without impacting quality or safety).

b) **Financial Performance** Whilst quarter 1 performance was broadly on plan, financial plans approved at the end of June had assumed the delivery of additional 'stepped' cost reductions from quarter 2 to the end of the year, equivalent to around £0.5m per month. These were linked specifically to agency cost reductions and eliminating reliance on Independent Sector beds and reflected national planning assumptions of a return to summer 2021 levels of covid impacts on services and workforce. By contrast, since July, underlying costs have increased and stepped cost reductions have also not been achieved. Non delivery of cost reductions principally relates to agency and Independent Sector bed placements, where costs in 2022/23 exceed levels incurred in the last financial year.

Monthly costs for Independent Sector beds, agency/pay run rates and prescribing costs are an ongoing focus for Trust-wide attention. The Beds Oversight Group, chaired by the Medical Director, has coordinated a series of actions to review, understand and then mitigate bed pressures. Analysis

confirmed that lengths of stay (rather than numbers of admissions) are driving elevated bed occupancy. This includes some impacts from 'system' pressures because 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 5, further (early, but variable) positive impacts have been seen. This reflects concerted action to mitigate Trust and Independent Sector bed pressures and an 81% reduction to 4 spot purchased Independent Sector beds for females as at 4th October, but rising again to 10 Independent Sector beds (a 52% reduction), and compared to 21 on 27th July. Impacts include fully eliminating Male adult assessment and treatment and PICU admissions to non-Trust beds at the time of writing. Volatility in October requirements indicates the need for close oversight and a key focus to agree potential actions with system partners to tackle delayed transfers. Given current ('pre-Winter') levels of delays in discharges, it is unclear to what extent these improvements will be sustained.

c) **Ongoing Regulatory oversight and concerns**. Inspection reports for factual accuracy checking have been returned to CQC for Secure Inpatient Services. The Learning Disability Service report was published on the 6th October 2022. The CAMHs Community report was published on 15th September 22 demonstrating significant improvements regarding the regulatory breaches noted in the initial inspection findings although staffing and waiting times remains areas where we must demonstrate further improvement.

d) **Crisis Line** – Positive improvements have been seen in Durham and Tees Valley to manage call volumes and increase pick up rates. There has been a deterioration in North Yorkshire and York in terms of call pick up rates. Executive Directors group have now escalated this position 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

Following discussion at the last Board about the introduction of a control's assurance rating for each performance measure, a first draft has been developed and will be discussed with the Executive Team at the end of October 2022.

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

3.3.1 Integrated Performance Dashboard

a) **Key Changes** – We have undertaken some improvement work in this month's Integrated Performance Dashboard to remove completed actions and tried to be clearer on what the current focus and improvement actions are. This will be subject to ongoing continuous improvement and our focus is now on identifying what the current improvement actions are as opposed to more enabling actions.

b) **IIC Reporting** – We have now re-established connections to the IIC following the cyber incident that we reported last month. This has meant we have been able to produce the IIC Integrated Performance Dashboard for this month's report; however due to the timing of the reconnection, we still had limited data for the Care Group meetings which too place earlier in the process. The Care Group

level dashboards have now been provided to the Care Groups for information. We were also not able to make a patient Friends & Family Test submission in September which impacts the **Patient Experience (measure 01)**. However, we plan to make a submission in October that covers the period July-September 22.

c) **Revised Measures** - Following approval by the Board of Directors, work is underway to develop and implement the revised measures for the ***Number of Incidents of moderate harm and near misses (measures 11) and Agency Spend (measure 25)*.**

d) **Standards –** Whilst we have identified and agreed a small number of "standards" within the Integrated Performance Dashboard, we recognise that other measures would benefit from an agreed standard, so we are clear, as an organisation, on what we are trying to achieve. The Associate Director of Performance will discuss this with the relevant Executive Leads during October in order to agree next steps.

E) **Mandatory and Statutory Training and Staff Appraisal (measures 20 and 21)** whilst compliance levels remain a concern, we now feel we have good assurance in terms of agreed trajectories and a range of monitoring mechanisms in place to track compliance at all levels. From the 1st October 22, all services are being monitored against the agreed 85% standards and regular reports will be produced highlighting those areas which require targeted interventions.

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 awards and the disproportionate impacts of the nationally negotiated 3-year pay deal (2018 to 2021). Funding for inflationary pressures is allocated by applying a nationally determined annual 'tariff' or inflationary uplift to provider contract values. National tariff uplifts are more representative of acute pay cost weights (where a lower proportion of costs are typically pay related) and have left an increasing quantum of recurrent pay inflation unfunded. The impact of the recently communicated outcome of the Pay Review Bodies has been estimated by all organisations within the Integrated Care System. Plans submitted at the end of June had included a nationally agreed assumption of a 2% pay award, pending the outcome of pay review body discussions. National average uplifts of 1.66% have been applied to related contracts from allocations 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 has responsively worked with all organisations to estimate the costs for payroll and other contracts impacted by AFC pay review outcomes and is reviewing the funding methodology to explore alternate mechanisms that might better reflect actual provider costs. Current actual cost estimates indicate a cost pressure relative to funding received by the ICS. This is currently being validated. Pending the outcome of this review organisations within the ICS have agreed to assume the funding gap is mitigated during 2022/23 but will report adverse year to date variances at Month 6 (effective payment date).

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 subsequently reported to QuAC in October 2022. As part of this work to better 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, DTV adult inpatient acute wards and within Secure Inpatient Service. Work undertaken to date was also set out in the paper. Key issues highlighted:

- A small number of patients account for a high level of self-harm incidents
- Themes and patterns were similar across care groups
- That the majority of self-harm incidents result in low or no harm to patients. Caution however should be applied to making assumptions about risks to patients however as in line with the draft NICE guidelines for self-harm (September 2022), risk assessment tools and scales or risk stratification into low, medium or high risk to predict future suicide or self-harm repetition should not be used
- The Trusts environmental ligature reduction programme has seen a related reduction in ligatures to fixed fittings however other self-harm methods can be seen to be increasing in numbers of our incidents and is associated with a risk of high lethality.
- Our female wards account for the highest levels of self harm incidents. One male ward was found to be an outlier amongst male wards however further data review suggested this was related to 1 patient who accounted for 61 of the 88 incidents.
- Areas of improvement including staff training and guidance were identified.

Based on the analysis undertaken to date the following key actions have been agreed:

- Individual patient reviews to commence in October 2022 for those patients identified to have the highest number of self-harm incidents to provide assurance that patient care plans including restrictions and proactive actions being taken to support the effective management of self-harm are robust and in line with best practice. These reviews will also provide 'live examples' to inform and shape the development of a standard process and escalation procedure.

- A Task and Finish Group has been established that will oversee the development of the new process, ongoing data collection and analysis and improvement actions identified. The group will report into the Quality and Safety programme (through suicide and self-harm reduction group) and through governance routes (EQAIG/QUAC). Progress updates will be received through Executive Quality Assurance and Improvement Group.

c) Regular reporting on **bank and agency use** has been re-instated 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. Processes for the approval of off framework/above price cap agency use across professions have been refreshed to ensure appropriate scrutiny of lower cost alternatives to improve compliance but without impacting quality or safety. Integrated Care Systems have been set agency cost caps for 2022/23, and the Trust's agency costs are accounted within the North East and North Cumbria ICS cost cap and will be monitored through new ICB governance arrangements.

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 (in particular Medical and LD premium rate) 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, maintain nil older adult 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, high levels of bed occupancy, delayed transfers, and acuity in inpatient wards as well as 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. Proposed roster changes to Learning Disability and MHSOP inpatient wards to include enhanced staffing levels were approved by the Trust Board in September and are now being taken forward. International recruitment, review of skill-mix and over recruitment of Health Care Assistants are also key mitigating actions and enablers to maintain safe staffing as well as daily operational management and escalation.

Recommendations:

The Board of Directors is asked to 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.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Appendix A

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

journey to change

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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	No significant change in the data during the reporting period shown
 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

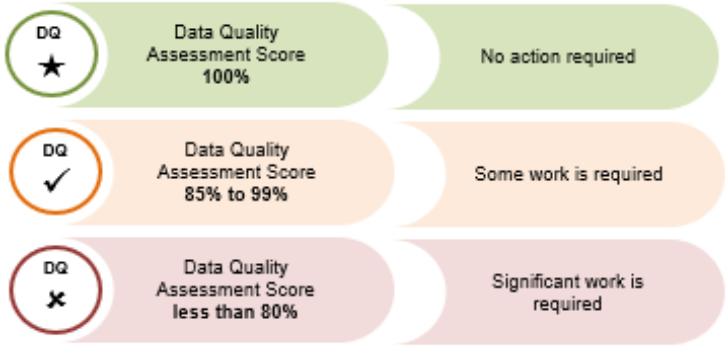
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

Following the development of our new assessment tool, work has commenced on the assessment of our 2022/23 measures; however, this has been delayed as additional work has been identified. An update on this will now be included within the next report.

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.

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 31st August 2022

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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				91.70%	
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				70.99%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC				57.93%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC				25.43%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L			46.97%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	L			43.72%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L			20.44%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H			99.70%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			1,118	
10)	The number of Serious Incidents reported on STEIS	QAC				58	
12)	The number of Restrictive Intervention Incidents	QAC	H			3,088	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				3	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	
15)	The number of uses of the Mental Health Act	MHLC				1,827	

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				54.33%	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				58.93%	
18)	Staff Leaver Rate	PC&D	H			13.49%	
19)	Percentage Sickness Absence Rate (month behind)	PC&D				6.36%	
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L			86.28%	
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	L			78.51%	

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				41,401	
23)	Unique Caseload (snapshot)	S&RC	H			60,958	

Rep Ref	Our Financial and activity measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	601,000	2,199,571
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	3,837,125	2,656,651
28)	CRES Performance - Non-Recurrent	S&RC	579,875	601,955
29)	Capital Expenditure (CDEL)	S&RC	3,939,000	3,513,000
30)	Cash against plan	S&RC	78,438,000	79,751,813

Please Note:

Outstanding measure *11) The number of Incidents of moderate harm and near misses* – please see slide 20 for update
Outstanding measure *25) Agency spend* – please see slide 41 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

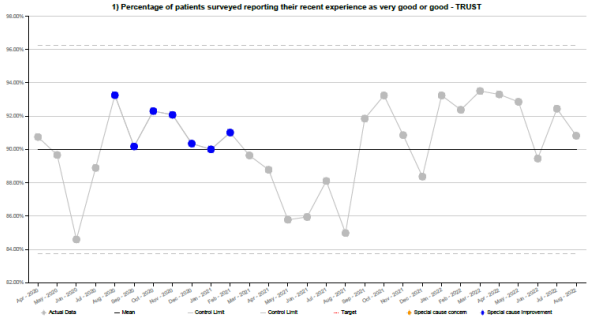
We are all committed to co creating a great experience for patients, and carers and families by ensuring we are providing outstanding and compassionate care and that people tell us this is the case from their experience.

During August, **893** 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, **811 (90.82%)** scored "very good" or "good"

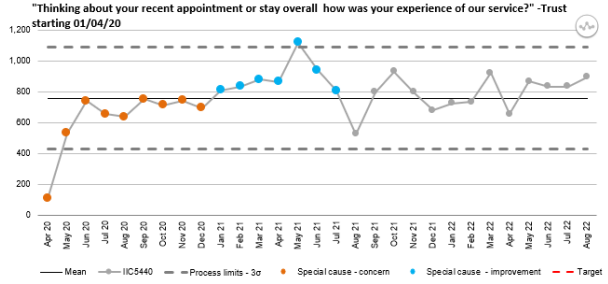
No significant change in the data during the reporting period shown

DQ ✓ **85%**

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

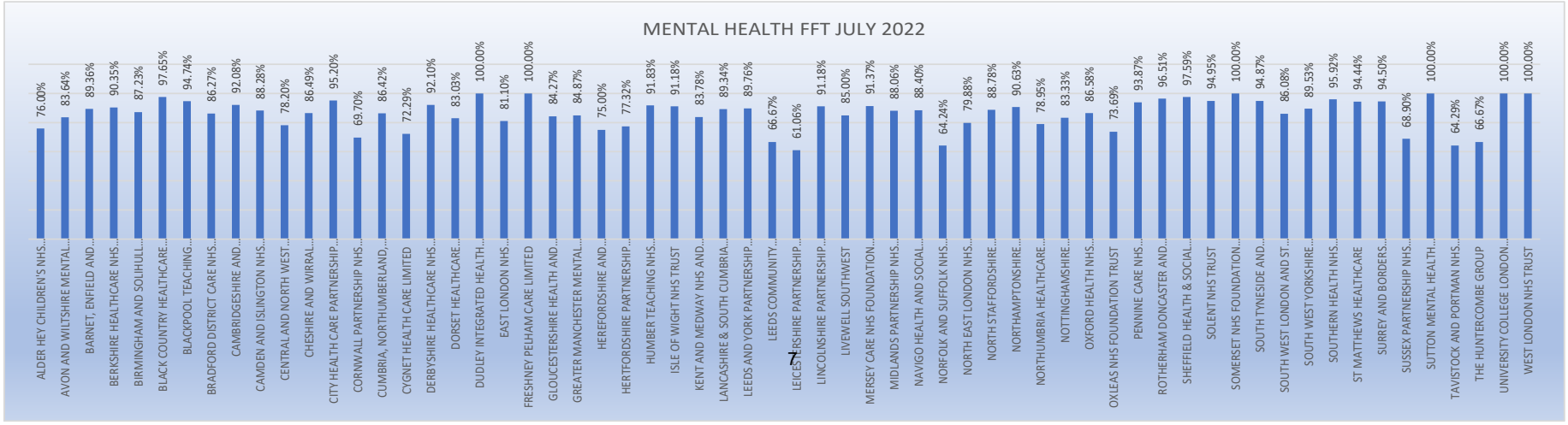


Care Group \Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	



National Benchmarking - Mental Health Friends and Family Test (FFT) data - July 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 was unable to provide a submission in July due to the cyber security incident.

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 October that covers July, August and September.



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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

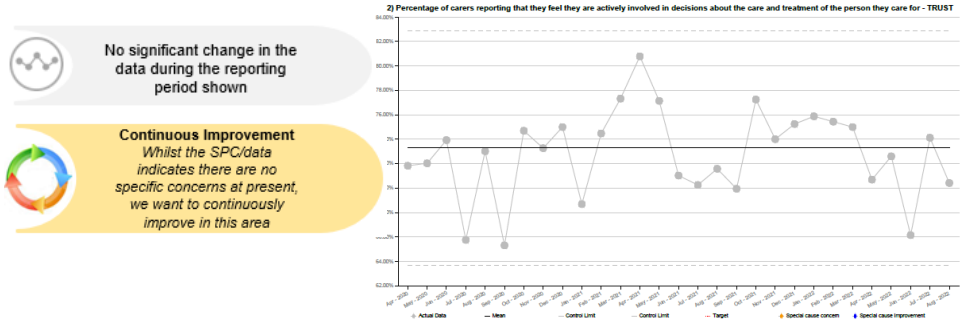
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
A cohesive programme of work is required to improve our understanding of the experience our patients are having, improve survey response rates, identify key themes and hotspot areas, and develop a set of clearly defined improvement actions.	*Enabling action:* Executive Quality Assurance & Improvement Group to establish a task & finish group during October 2022.		

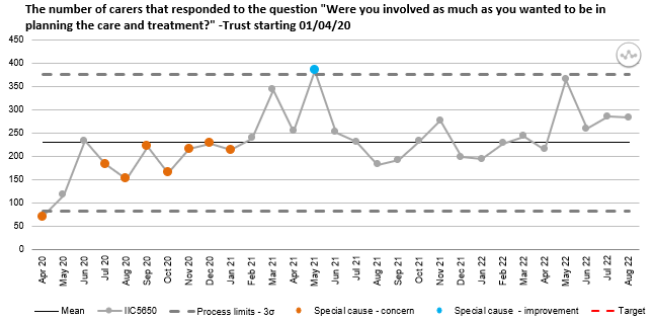
02) Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for

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 August, **284** 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, **200 (70.42%)** scored “yes, always”.





Additional Intelligence in support of continuous improvement

- We have retained Level 2 star rating (the highest possible for Mental Health Trusts) for the Triangle of Care. This has National Accreditation from the Carers Trust and is endorsed by the Care Quality Commission.
- We now have a Carers Charter and are currently undertaking quality visits to raise awareness.
- We have a Carers Hub (web page) on the Internet which is created by carers and is interactive (this is reviewed quarterly).

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

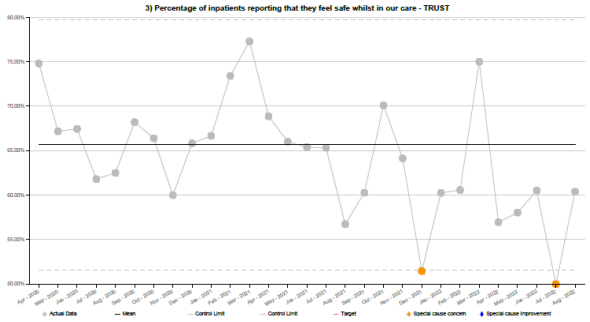
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

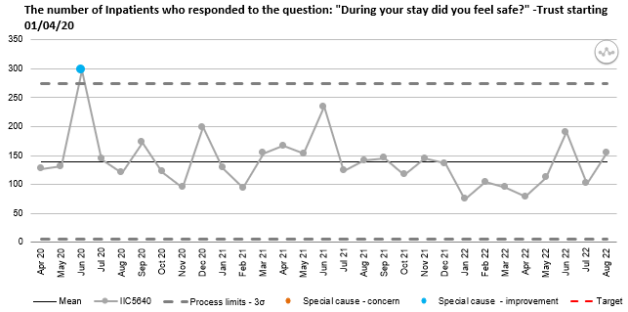
We are all committed to co-creating safe and personalised care, preventing people from receiving unsafe care and treatment and preventing avoidable harm or risk of harm to inpatients within our services, and that patients will tell us this is the case from their experience.

During August, **154** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **93 (60.39%)** scored “yes, always"

No significant change in the data during the reporting period shown

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





Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We are concerned that inpatients in our Secure Inpatient Services (SIS) do not feel as safe as we would like during their stay with us	*Enabling action*: The Associate Director of Nursing & Quality and General Manager for SIS to develop a service improvement plan in October 2022.		
We are concerned that inpatients in our Female Adult Mental Health Wards do not feel as safe as we would like during their stay with us	*Enabling action*: The Patient and Carer Experience Team to undertake focus groups for all Adult Mental Health Wards by the end of October to understand why patients do not feel safe and what would help them.	Focus Groups have started and is on track to be completed by the end of October.	
‘Feeling safe’ has been identified as a priority within our 2022/23 Quality Account.	In order to improve Ward safety, 4 actions have been identified, which are being monitored on a quarterly basis by the Executive Quality Assurance & Improvement Group.	**Ongoing.** Of the 4 actions, 2 are on track for delivery by March 2023 and whilst 2 are not currently on track, risks to delivery are being managed by the teams working on these actions.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
A cohesive programme of work is required to improve our understanding of the experience our patients are having, improve survey response rates, identify key themes and hotspot areas, and develop a set of clearly defined improvement actions.	*Enabling action*: Executive Quality Assurance & Improvement Group to establish a task & finish group during October 2022.	*Please see update in respect of 01) Percentage of Patients surveyed reporting their recent experience as very good or good*	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

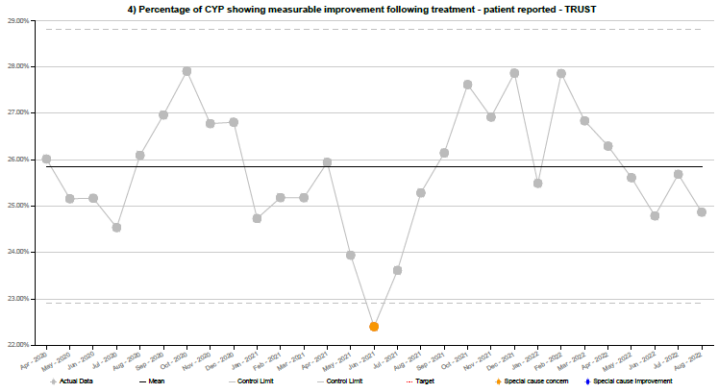
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a patient perspective, is one way we will know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

For the 3 month rolling period ending August, **764** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 190 (24.87%)** 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.

No significant change in the data during the reporting period shown

Continuous Improvement
Whilst the SPC/data 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	

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

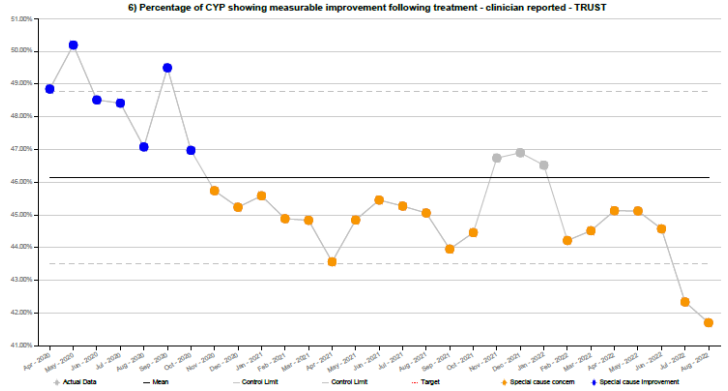
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a clinical perspective, is one way we will know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

For the 3 month rolling period ending August, **856** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 357 (41.71%)** 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)

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



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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

Update

Work is underway to develop supporting measures for Children and Young Peoples Services as we have for Adult and Older Persons Services. We hope to have this additional information in the report next month.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
To support continuous improvement, we need to share learning, experiences and best practice within our services.	*Enabling action:* CYP Service Development Manager to identify any key learning from the highest performing teams within the Trust by the end of September 2022.	**Complete.** The key learning from the highest performing teams (Getting Help Team) was outcomes is embedded in core training for staff and therefore clinical practice which is contributing positively to both completion and meaningful outcomes. See enabling actinons below regarding how this learning will be taken forward.	Given this is enabling action we would not expect to see a specific impact.
We need to ensure outcomes training is provided for both new and existing staff to ensure clinical outcomes is fully embedded into clinical practice	*Enabling action:* The CYP Specialist Practitioner in Clinical Outcomes Development will provide a monthly training session for all new starters	Team Managers are ensuring all new starters attend these sessions.	
	Enabling action: The CYP Specialist Practitioner in Clinical Outcomes Development will provide 3 refresher sessions for all staff by January 2023.	Refresher training offered for all staff with a plan to review how many staff attended, evaluate training itself and then revise and book further sessions for clinicians. Two sessions have been completed with a further one planned for January 2023.	
To support continuous improvement there is a focus on the completion of ROMs to support clinical practice within Caseload Management Supervision	*Enabling Action:* CYP Services will test the new Caseload Supervision process in line with the Caseload Supervision Policy in 3 pilot areas (Easington, Stockton, Harrogate) between October-December 2022.		

Additional information

- To support the embedding of outcomes into clinical practice we have identified ROMs (Routine Outcome Measures) champions in every clinical team to promote outcomes
- Clinical Outcomes is one of the top 3 priorities for the clinical network – further details on this will be provided in the next report

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

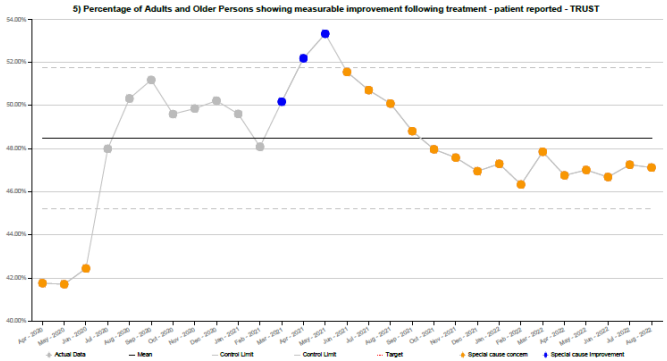
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a patient perspective, is one way we will know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

For the 3 month rolling period ending August, **2048** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 965 (47.12%)** 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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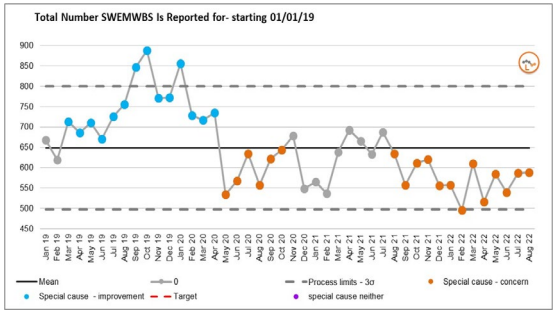
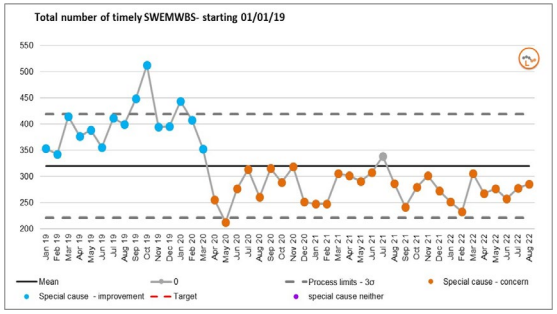
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

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

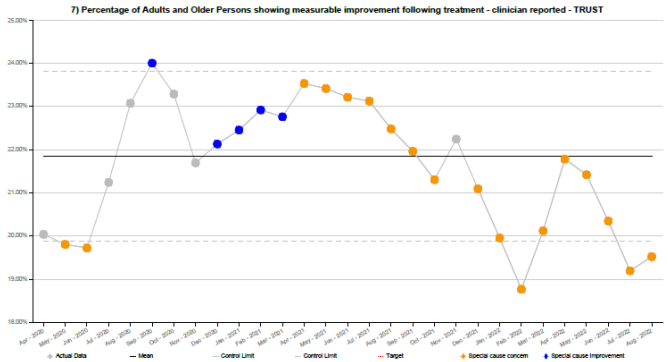
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a clinical perspective, is one way we will know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

For the 3 month rolling period ending August, **3345** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 653 (19.52%)** made a measurable improvement.

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

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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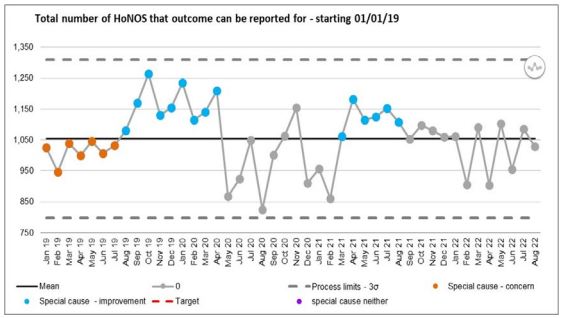
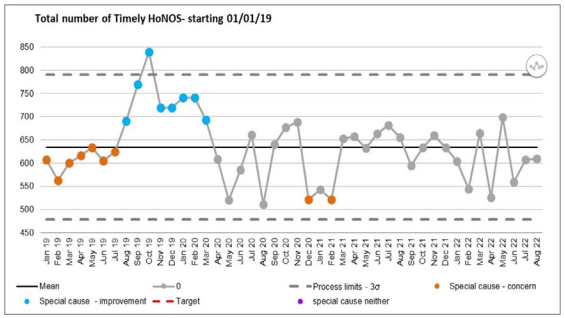
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Supporting Measures

The number of patients that have a paired measure recorded over-time. The 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

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
There needs to be clear communication to all staff stating the current expected standards for completion of outcomes measures.	*Enabling Action:* The Specialty Clinical Directors and Speciality Development Managers for Adult and Older Persons Services' to produce a short briefing for all staff on expected standards for the completion of outcome measures which will be taken to the next Trust Outcomes Steering Group late October 2022 and then disseminated via the Trust E-Bulletin and the Care Board Quality Assurance & Improvement Groups in early November 2022. This will include the links to the promotional material already produced.		
The staff need to have easily accessible displays of real time, patient and service level outcome data in order for outcomes to be used in a clinically meaningful way.	*Enabling Action:* A cross-speciality Task and Finish Group, chaired by the Clinical Lead for Community Transformation to meet on the 18th October 2022 to identify how this work will be taken forward.		
There needs to be appropriate care group and workforce representatives at the Trust Outcomes Steering Group in order to effect change.	*Enabling Actions:* • The Specialty Clinical Directors and Speciality Development Managers for Adult and Older Persons Services' to discuss and agree appropriate care group representation at the Clinical Network Meetings in November. This should ensure that the care groups and the clinical network are joined up in their approach and consistency of message. • The Associate Director of Performance to discuss and agree appropriate workforce representation with People & Culture by the end of October.		
Clinical teams should have regular oversight of their progress regarding outcome measures.	*Enabling Action:* The Service Managers for Adult and Older Persons Services to introduce team level compliance for outcomes at the weekly report out meetings by the end of October 2022. This will enable a targeted approach to understanding the gaps in knowledge and process across the teams.		
	Enabling Action: Adults and Older Persons Services to utilise the outcomes component of the Caseload Supervision Process (including the tool) to support outcome discussions with testing taking place between 17th October and 15th November. This will support the embedding of routine outcome measures in clinical practice and identifying gaps in service delivery.		

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

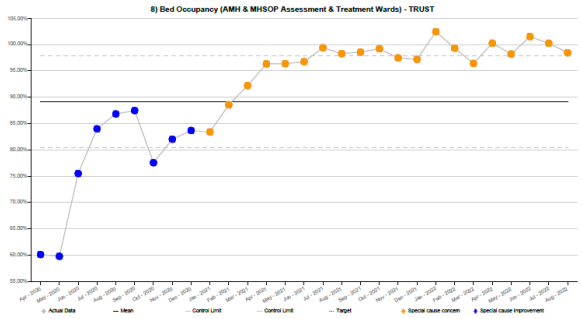
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important 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 August, **11,098** daily beds were available for patients; of those, **10,924 (98.43%)** were occupied.

H — 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
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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

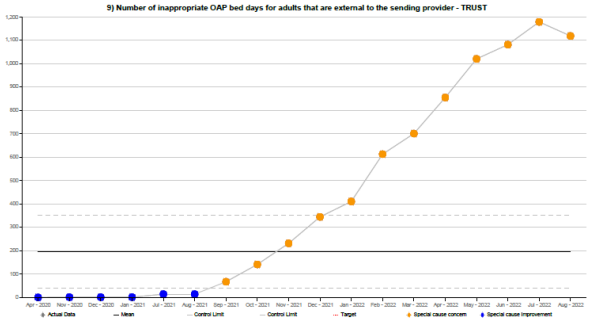
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending August, **1118** days were spent by patients in beds away from their closest hospital.

H — 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%**



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DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	H

Supporting Measure

		2022 - 2023					
		Apr	May	Jun	Jul	Aug	FYTD
Overall Occupancy including Trust, block booked (Priory) and independent sector bed usage	Number of occupied bed days	10,926	11,534	11,351	11,681	11,492	**56,984**
	Number of available bed days	10,578	11,253	10,890	11,253	11,253	**55,227**
	Percentage Bed Occupancy	**103.29%**	**102.50%**	**104.23%**	**103.80%**	**102.12%**	**103.18%**

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

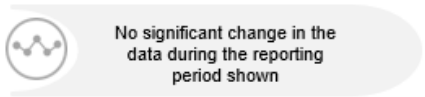
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Trust-wide bed management were tasked with leading a piece of work with the Care Group leads to understand the key pressures within our inpatient services and the actions that need to be established to minimise these.	Care Groups to implement processes during August 2022 to ensure we share good practice and learning between the care group. This includes: • increased focus on overnight leave and the extension of leave for our patients, • the establishment of weekly meetings to review delayed transfers of care and • the establishment of weekly meetings to review patients with a length of stay in excess of 30 days to identify blockages and facilitate safe and effective discharge for patients.	**Complete.** These processes will continue as part of business as usual.	Concern remains visible within both measures however, there has been a significant reduction in the number of patients we have out of area (from 21 in July to 4 as at the 4th October). There has also been a reduction (improvement) in both measures between July and August.
	Senior Consultant Psychiatrists to review all records and attend multi-disciplinary team meetings for patients currently within the Priory block purchased beds to facilitate safe and timely discharge.	**Complete**. These processes will continue as part of business as usual. From the 30th August 2022 no new patients have been admitted into the Priory block purchased bed and we have not extended the contract.	
	Enabling action: Bed Management Team to circulate the daily independent sector bed usage report to Care Group Directors to provide increased oversight of our out of area placements.	**Complete.** These are now circulated as part of business as usual.	
We need to better understand capacity and demand for beds within the Trust, to understand where our pressures are and whether we have the correct number of beds available within our care groups.	*Enabling action:* Assistant Chief Executive and Associate Director of Strategic Planning & Programmes to scope a data modelling exercise by the end of November 2022 with a view to establishing an appropriate team to enable us to understand current pressure and enable future planning of our inpatient resources.		

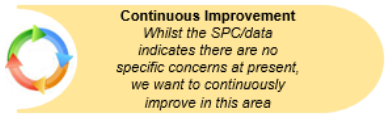
10) The number of Serious Incidents reported on STEIS

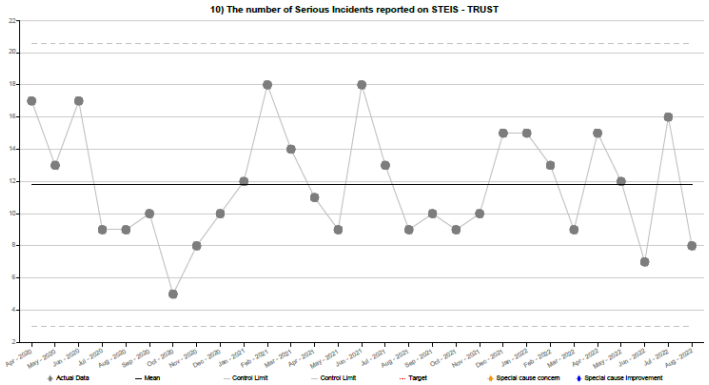
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

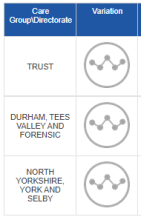
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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









Additional Intelligence in support of continuous improvement

There were no specific themes in the 8 serious incidents reported in August; however we continue to work proactively to reduce the number of Serious Incidents.

- We are working with our partners, such as UK Health Security Agency (previously known as Public Health England) and the Preventing Suicide Leads to undertake Multi Agency Reviews (MARs) of suicides. These meetings identify particular suicide locations with a view to proactively preventing further suicides and also to identify themes from analysis of real time data.
- Work continues to develop a Preventing Suicide and Self Harm Strategy involving staff, carers, people with lived experience and our partners.
- A Trust-wide self-harm review group has been established. The role of the group is to provide assurance to the Trust Board via the Quality Improvement subgroup by reviewing reports and identifying key areas for review of patient care and supporting teams to maintain patient safety and ensure best practice is delivered. The group will also maintain robust oversight of significant self-harm trends and occurrences. This group will work in conjunction with work in relation to self-harm which is being carried out by operational services.
- In the event of any new/environmental risks being identified within our clinical areas, urgent patient safety briefings are disseminated Trust wide to be discussed at ward safety report out meetings/team meetings. The Quality Assurance Programme, which includes MDT walkabouts, provides evidence that staff are aware of the content of these bulletins and can identify new areas of risks in their clinical areas. Any assurance in relation to completion of actions is collated and stored in the learning database. Should any similar incident occur this assurance can be revisited to ascertain whether other actions need to be put in place. Environmental risks are closely monitored at the Environmental Risk Group, an example of this is access to roof spaces by patients. There is evidence that where preventative measures have been taken, such as anti-climb walls/fences and secured garden furniture, and patients continue to gain access to rooves, other actions are considered and acted upon.
- Significant work has been undertaken as part of the thematic SI closure programme to identify the top themes from incidents dating back from 2017 to the current day. The Quality Assurance programme has been mapped to these themes to support ongoing monitoring . Improvement standards and trajectories have also been developed and will be overseen by the Clinical, Quality and Safety Programme Board.

11) The number of 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.

Update

The Business Intelligence and Reporting Team are currently developing this new measure in the Integrated Information Centre (IIC). It is hoped that this will be included within the next report.

12) The number of Restrictive Intervention Incidents

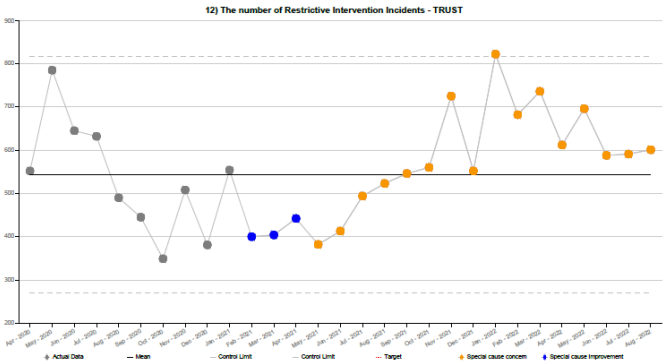
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

601 number of Restrictive Intervention Incidents took place during August.

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



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DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	L

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We have a number of patients within our two Adult Learning Disabilities Inpatient Wards with complex needs that require discharge from hospital.	The General Manager and Associate Clinical Director to ensure there is a discharge plan in place for each individual patient, in order to progress a safe discharge from hospital as outlined in their plan.	There are currently 8 patients that are ready for discharge. The Hopes National Team continues to provide support for one patient and conversations are taking place with the Challenging Behaviour Foundation, with a view to them providing support to our clinical teams for 4 of our complex patients, where we feel we need more support. Of the 3 complex patients that Merseycare recommended for an independent review, one has been discharged, one has transferred from LRH (Harland) to a flat at Bankfields Court and one remains at LRH but is to receive support from the Challenging Behaviour Foundation.	
Following feedback from the Care Quality Commission, we have identified a training need within our Adult Learning Disability services.	The General Manager and Associate Clinical Director to ensure all Adult Learning Disabilities Inpatient staff attend the bespoke training by December 22.	We are on plan against the agreed trajectory.	

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We require greater assurance of the episodes of restraint that occur, to support a reduction in restraint	*Enabling action:* The Nurse Consultant for Positive and Safe Care to support the introduction of enhanced governance for patients exposed to multiple forms of restrictive practices to reduce the number of restrictive interventions	The independent Assurance Panels are now underway and will continue until December 22, when a review will be completed to see if this action has contributed towards a reduction in the number of restrictive interventions.	
We require greater assurance locally from Care Boards on the implementation of the Restraint Reduction Plan	*Enabling action:* Care Boards to ensure delivery of the Restraint Reduction Plan by 31st March 2023.		
We require additional resource to support Care Boards with reduction of restrictive practices	*Enabling action:* The Nurse Consultant for Positive and Safe Care to review current resource and to make recommendations on additional resources	Review completed and the draft proposal is with the Executive Director for Nursing & Governance.	

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

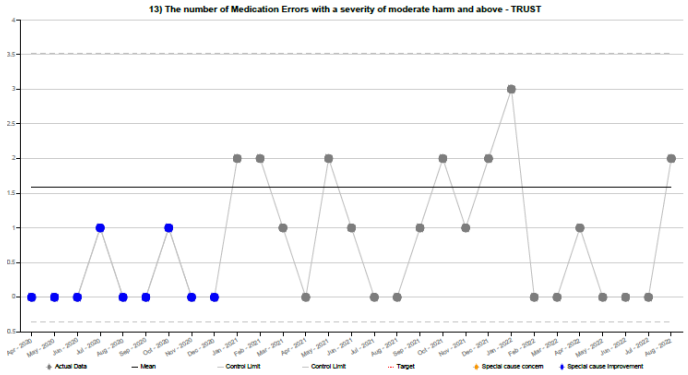
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

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

No significant change in the data during the reporting period shown

Continuous Improvement
Whilst the SPC/data 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	

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Clozapine is a “high-risk” medication and was being taken in 6 of the incidents above. We need to improve staff education and introduce effective resources that enable high quality discussions with patients reducing incidents of the same type.	The Safe Medication Practice Group has co-created a set of clozapine-focused improvement actions, which will include the development of e-learning, provision of patient information and 5 quality standards that will be audited at the end of 2022/23.	Of the 17 agreed actions so far, 9 have been completed. The remaining 8 are on track for delivery.	

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

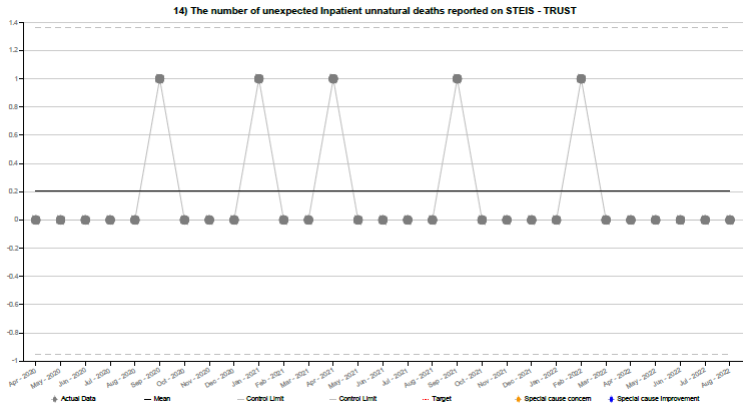
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 August

No significant change in the data during the reporting period shown

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



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Additional Intelligence in support of continuous improvement

The key areas for improvement previously identified were risk assessment/safety planning including observation levels and leave arrangements, as well as the importance of involving patient/carers/families within these multi disciplinary team discussions.

There is evidence to suggest that the learning from previous incidents and subsequent improvement work is now more embedded into clinical practice. This is evidenced by positive results from the Quality Assurance Programme. Unexpected inpatient unnatural deaths are low in numbers so the impact of such improvements on mortality will continue to be monitored.

15) The number of uses of the Mental Health Act

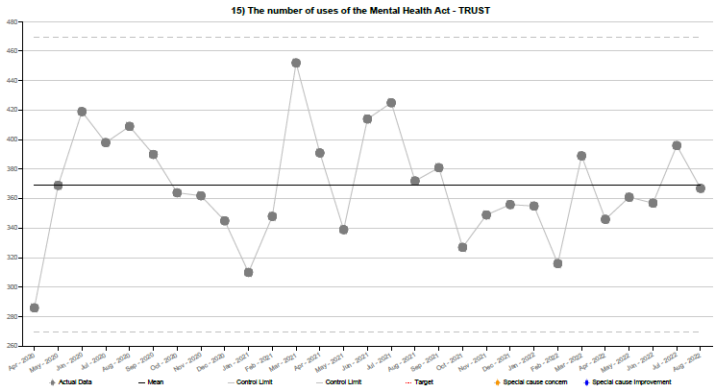
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 **367** uses of the Mental Health Act during August.

No significant change in the data during the reporting period shown

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	

Current Focus	Current Improvement Action(s)	Progress Update	Actual 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 as we understand nationally this is a concern.	*Enabling action:* Digital and Data Services to provide the Mental Health Legislation Committee with uses of the Mental Health Act by ethnicity by early October to help them understand whether we treat our patients equally.	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. The revised timescale has been included in the improvement action.	

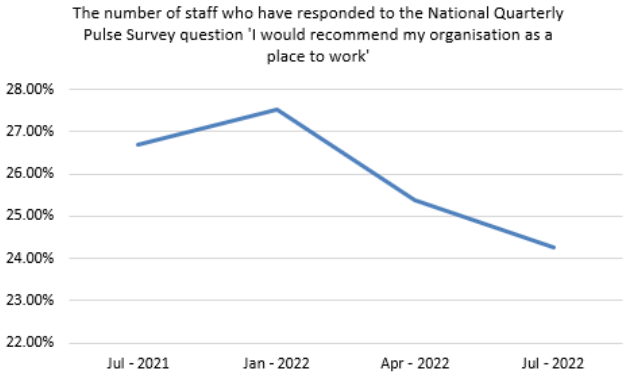
16) Percentage of staff recommending the Trust as a place to work

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". ***Please note this is not "new" data as survey is only undertaken once a quarter***

	Jul - 2021	Jan - 2022	Apr - 2022	Jul - 2022
TRUST	54.23%	52.54%	55.01%	53.60%
ASSISTANT CHIEF EXEC	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%



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

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.

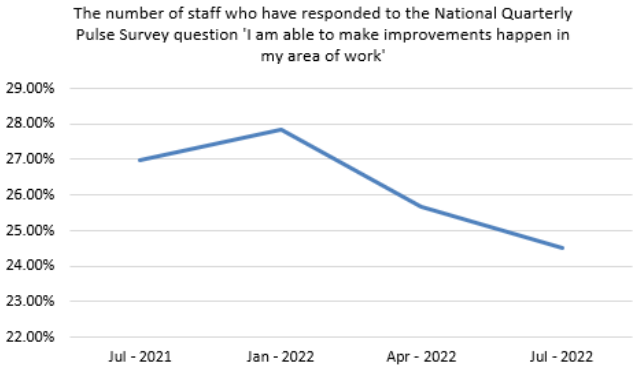
17) Percentage of staff feeling they are able to make improvements happen in their area of work

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". ***Please note this is not "new" data as survey is only undertaken once a quarter***

	Jul - 2021	Jan - 2022	Apr - 2022	Jul - 2022
TRUST	57.10%	57.50%	58.76%	59.12%
ASSISTANT CHIEF EXEC	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%



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

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

Current Focus	Current Improvement Action(s)	Progress Update	Actual 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.	*Enabling action:* 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.	This has been delayed due to capacity issues following the cyber security incident and subsequent Integrated Information centre outage in August 2022.	
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.	*Enabling action:* 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. Upon completion success will be assessed to determine whether a similar approach would improve participation in the Pulse Surveys.	This has commenced.	

18) Staff Leaver Rate

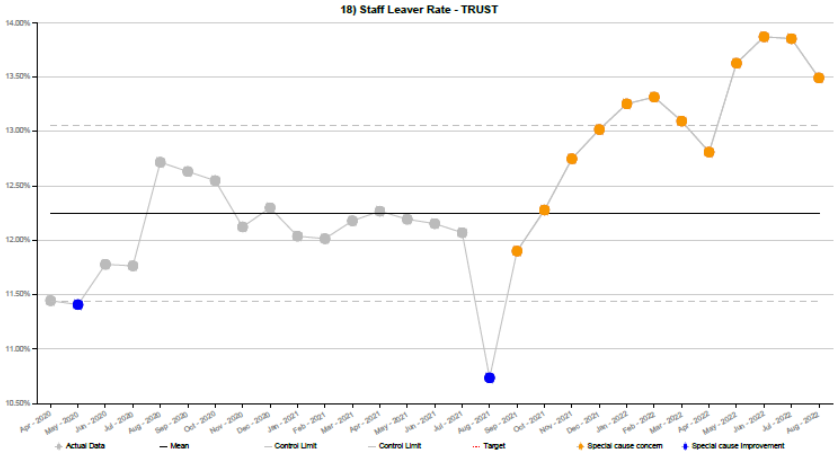
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 **6721.41** staff in post, **906.81 (13.59%)** had left the Trust in the 12 month period ending August

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

National Benchmarking: NHS Staff Leaver Rate - England Mental Health and Learning Disability – February 2022 (latest published data)
The NHS Staff Leaver Rate published on the Future Collaboration Platform for Mental Health Providers shows a similar trend to that shown for our Trust. The national mean (average) was 15.4% compared to the Trust mean of 16%. We were ranked 19 of 72 Trusts (1 being the best with the lowest leaver rate) and are placed in the inter-quartile range.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
To ensure staff have an independent route to participate in leavers interviews so we understand the reasons why and to identify any themes and issues that need to be addressed.	*Enabling Action:* The Communications and People & Culture Teams to develop an intranet page to ensure that all staff know the different ways of accessing a leavers interview by the end of November 22 with the aim to increase uptake of leavers interviews.		
	Enabling Action: The Director of People Culture & Diversity to identify one place for leavers interviews to be returned and analysed by the end of November 22 in order to identify any new actions that need to be undertaken to address the reasons people are leaving the trust.		

18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
To understand whether the “thinking about leaving” group is having an impact on staff who may be considering leaving	*Enabling Action:* The Employee Support Service to gather data by the end of November 22 (and routinely thereafter) on how many people who attended a ‘thinking about leaving’ group actually left the trust in the following 6 months.		

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

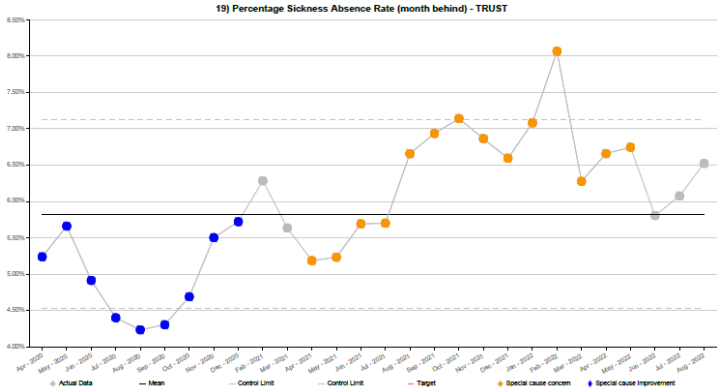
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

There were **218,109.56** working days available for all staff during July (reported month behind); of those, **14,227.56 (6.52%)** days were lost due to sickness.

No significant change in the data during the reporting period shown

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

DQ ★ **100%**

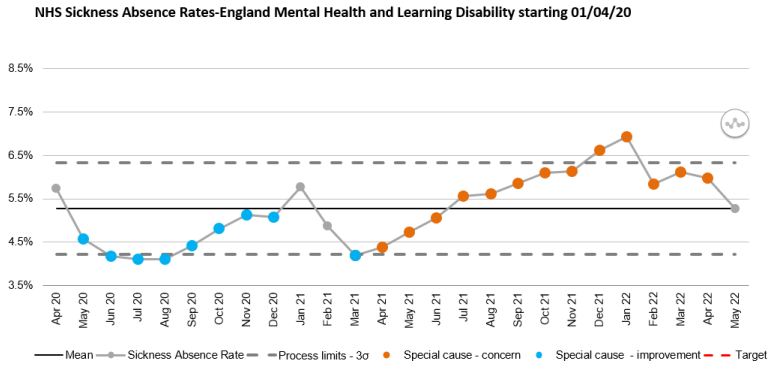


Care Group / Directorate	Variation	Care Group / Directorate	Variation
TRUST		FINANCE	
ASSISTANT CHIEF EXEC	H	MEDICAL	
COMPANY SECRETARY	H	NORTH YORKSHIRE, YORK AND SELBY	H
CORPORATE AFFAIRS AND INVOLVEMENT		NURSING AND GOVERNANCE	
DIGITAL AND DATA SERVICES		PEOPLE AND CULTURE	
DURHAM, TEES VALLEY AND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

National Benchmarking: NHS Sickness Absence Rates - England Mental Health and Learning Disability – May 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 5.28% compared to the Trust mean of 5.88%.

Regional Benchmarking: We continue to see improvement in our sickness absence rates and as at the 28th September 2022, we were positioned 11th (out of 31) for sickness absence within the region's mental health, acute and ambulance trusts.



Update

Whilst our latest sickness absence data is indicating common cause (no significant change); the level of sickness absence remains an area of concern and remains above the 5.83% mean (average) for the period shown, especially given the indications that covid is affecting acute trust sickness rates already.

As at the 5th October 2022, sickness absence for September is 4.78%.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to ensure we have strategic oversight of sickness absence so we can target interventions appropriately as well as share learning across the trust.	*Enabling Action*: The Executive People Culture & Diversity group to review the services with high levels of sickness, the actions being undertaken and identify what interventions may be appropriate starting in October 22.		
We need to better understand the improvements made by North Yorkshire, York & Selby Adult Learning Disability Services, who have reduced sickness from 11.59 to 2.69% since March 22.	*Enabling Action* Director of People, Culture & Diversity to identify and share the learning from North Yorkshire, York & Selby Adult Learning Disability Services by the end of October 22.		

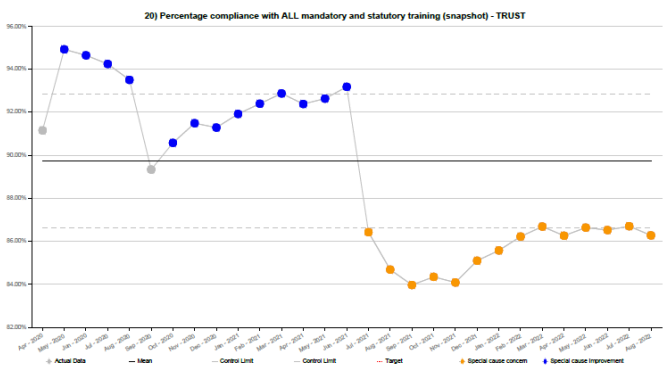
20) Percentage compliance with ALL mandatory and statutory training

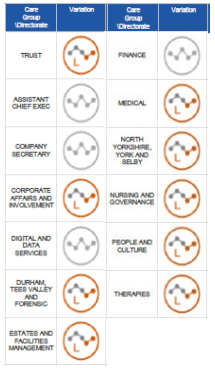
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

111,935 training courses were due to be completed for all staff in post by the end of August. Of those, **96,576** (**86.28%**) courses were actually completed.

Percentage Compliance with Information Governance & Data Security Training. As required by the Information Governance Tool Kit the Trust must achieve 95% staff compliance by December 2022. As at end of August, **6639** were due for completion, **5896 (88.81%)** 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%

Update

At its September 2022 meeting, Trust Board agreed to implement an 85% compliance standard for mandatory & statutory training. This standard will be implemented from the 1st October 2022.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need a focused, coordinated approach to ensure that our services meet their agreed trajectories for 85% compliance.	*Enabling action:* Associate Director of Leadership & Development and Workforce Development Lead to establish regular reports for the People Partners to enable support to be focused on those clinical and corporate services at risk of achieving compliance.	The Training team have now mapped all the missing courses that need completing to reach compliance with the standard, checked who is booked on the relevant courses and calculated the impact on trajectories. This information has now been shared with each Executive about whether their teams are on course to meet their stated trajectory. This assumes no DNAs and that all e-learning is completed.	

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need a focused, coordinated approach to ensure that our services meet their agreed trajectories for 85% compliance.	*Enabling action:* Associate Director of Performance to provide Executive Management Team with regular reports showing performance against the agreed trajectories to ensure oversight and enable targeted discussions on those areas at risk of achieving compliance.	First report provided to the Executive Management Team 28th September. This will now be extended to include Information Governance Compliance and provided twice-monthly.	
We need to ensure we have oversight of services' training compliance in order to ensure they remain safe on a day to day basis	*Enabling action:* The Executive People Culture and Diversity group and People Culture & Diversity Committee will monitor compliance with the key patient safety related modules from late October/early November 22 and work with services to provide assurance to the Board via the People Culture & Diversity Committee on the methods in place for oversight.		
We need to ensure we have comprehensive and accurate training records of staff who transfer from other NHS organisations so staff do not have to repeat their training	*Enabling action:* The Director of People, Culture & Diversity to take a paper to October's Executive People Culture and Diversity group proposing to move to the national content for mandatory and statutory training, to enable more staff to be signed off compliant when they move here from other NHS trusts and enable automatic update by the central team.		

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

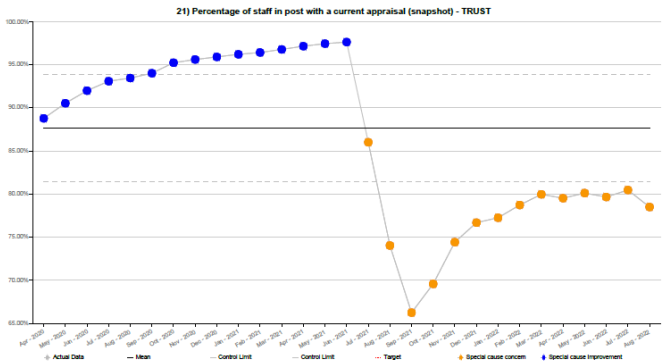
We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our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

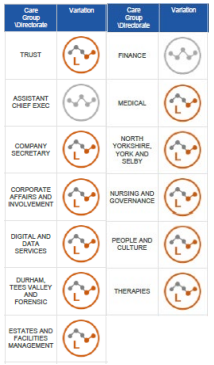
Of the **6248** eligible staff in post at the end of August; **4905** (**78.51%**) had an up to date appraisal

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%**





Update

At its September 2022 meeting, Trust Board agreed to implement an 85% compliance standard for mandatory & statutory training. This standard will be implemented from the 1st October 2022.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need a focused, coordinated approach to ensure that our services meet their agreed trajectories for 85% compliance.	*Enabling action:* Associate Director of Performance to provide Executive Management Team with regular reports showing performance against the agreed trajectories to ensure oversight and enable targeted discussions on those areas at risk of achieving compliance.	First report provided to the Executive Management Team 28th September. This will now be provided twice-monthly.	

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

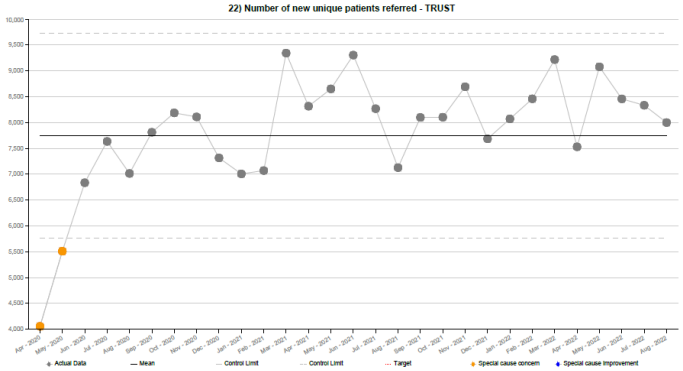
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

8000 patients referred in August that are not currently open to an existing Trust service

No significant change in the data during the reporting period shown

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

DQ ★ **100%**



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

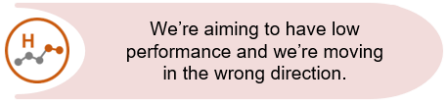
There are currently no specific trends or areas of concern identified within this measure.

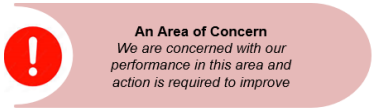
23) Unique Caseload (snapshot)

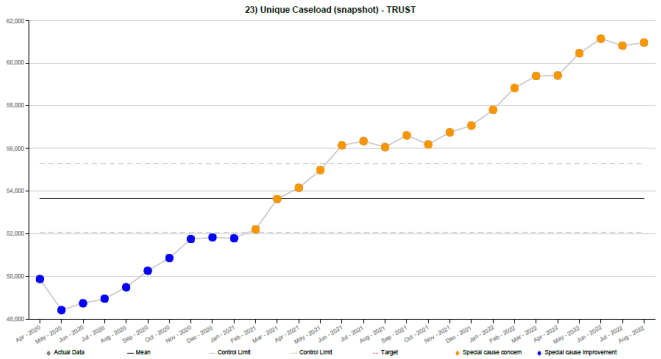
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

60,958 cases were open, including those waiting to be seen, as at the end of August 2022.







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

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
This was a new measure developed to better understand the size of our overall caseload and services' capacity and demand, including connected to annual increases in levels of commissioner investment into services.	Enabling action: Executive Strategy & Resources Subgroup to establish a task & finish group during October 2022.		

To note

Areas of concern in relation to the size and management of caseloads were identified in Children & Young People's Services and Adult Mental Health Community Services CQC Inspections and are current regulatory breaches (Must Do's) for the core services. A programme of team caseload 'deep-dives' is underway in CAMH's and Adult Mental Health Community case load management approaches are under review. This work will be fundamental to aid the understanding and sustainability of this work.

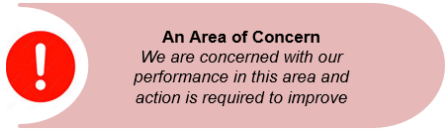
24) Financial Plan: SOCI - Final Accounts - Surplus/Deficit

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 **£2.4m** deficit to 31st August against a planned year to date deficit of **£0.6m,** resulting in a **(£1.8m)** variance to plan.

We have had an exceptional unplanned benefit from the sale of an asset of **£0.3m**, however this is not included when comparing performance against our planned operating surplus / deficit.



Summary

The Trust's final 2022/23 plans were submitted on 20th June 2022, targeting a **£1.2m** planned surplus and supporting a balanced ICS financial plan submission. Due to later than normal final plan submissions, final detailed budget sign-off has been extended to **30th September**.

The year to date position is an operational deficit of **£2.4m** against a planned year to date deficit of **£0.6m,** resulting in a **(£1.8m)** variance to plan., representing **higher than planned expenditure.** Key observations for August were:

- Independent sector beds - the Trust required 580 bed days during August 2022 (577 for July 2022) at a cost of £0.6m, contributing to year to date expenditure of £2.1m and representing a year to date adverse variance compared to plan of £1.8m. The financial plan assumed no use of spot purchase beds during 2022/23 and no block contracted bed use beyond quarter one (£320k costs assumed in quarter one only). 5 block contracted beds are in place until the end of September 2022 due to operational pressures, largely driven by longer lengths of stay, with actions in train to reduce utilisation and expenditure. Whilst additional use of spot purchased bed capacity continued into quarter two, reductions in overall external bed use were seen in August and into September. This remains a key area of clinical and management focus.
- Agency expenditure as at August 2022 is £8.5m, which is £4.0m ahead of plan and includes material costs linked to inpatient rosters, medical cover and complex specialist packages of care.
- Computer hardware, software and maintenance expenditure is ahead of plan by £1.5m, further detailed analysis to review plan phasing and develop and implement a related action plan is in train, including consideration of accounting change for networked assets.
- Planned CRES performance as at August 2022 is behind plan by £1.3m, however unplanned interest receivable (£0.4m) is partially offsetting this resulting in a final CRES performance of £0.9m behind plan. Key variances relate to agency and independent sector bed pressures driving run rates significantly above 2021/22 levels.
- An exceptional £0.3m unplanned benefit from the sale of an asset is excluded when comparing performance against planned operating surplus / deficit.

To deliver expected annual plan requirements the Trust needs to tackle bed pressures and elevated temporary staffing run rate pressures in addition to planned CRES.

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual 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 • 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	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 30th September 2022 • Information relating to longest agency assignments to be shared with People & Culture to clarify any contractual issues by 31st August 2022 *(Update – this information has been shared with People & Culture)* • An establishment review paper for MHSOP and LD went to September Board meeting to consider temporary changes to flexible staffing into substantive recruitment and reduce agency premia, whilst addressing key quality and safety issues. Next steps during October is to establish a working group to operationalise.	One successful discharge of a complex LD package of care reducing agency premium costs Plans in train to switch agency provider for most expensive off framework LD care packages An alternative on framework supplier has been identified and is working with the Trust to reduce the off framework supply, particularly within LD complex packages.
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*	

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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*	
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 2022	Initial discussions have taken place around this action, however focus has been on higher impact agency and bed pressures. Care Groups and corporate functions to propose actions to inform Executive Directors Group deep dive 5th October 2022	
NEW – Significant unplanned expenditure relating to computer hardware, software and maintenance	• Review of expenditure including understanding of expenditure profile and onward impact on remaining expenditure plan for 2022/23 • Discussion with external audit regarding the possible accounting treatment of networked assets.	Initial review undertaken with further detailed analysis and action planning to complete during September. Findings to inform above deep dive	

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

25) Agency Spend

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.

Update

Following approval by the Board of Directors on the 29th September 22, to revise this Finance measure to **Agency Spend**, work is now underway to complete the technical specifications and a development plan for implementation. Timescales for this work will be included in next month's report.

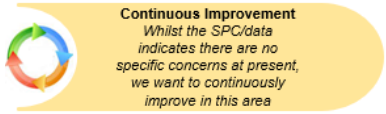
26) Use of Resources Rating - overall score

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 August 2022 against a planned rating of **3**.

0 variance to plan.



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 compared to 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 0.40x (can cover debt payments due 0.40 times), which is 0.79x (£2.3m) 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 28.7 days; this is behind 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 1.3%, this is worse than plan (£1.8m) and is rated as 4.

Agency expenditure of £8.5m is £4.0m (89%) 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 £4.5m 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. Actions are targeting all of those areas for improvement.

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

Current Focus	Current Improvement Action(s)	Progress Update	Actual 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*	

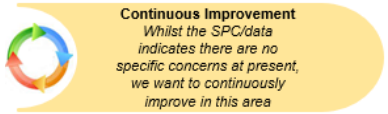
27) CRES Performance - Recurrent

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 **£3.8m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£2.9m**.

£0.9m variance to plan.



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 £0.9m behind plan with specific performance noted as:

- £0.2m CRES for OAPs contracted bed elimination is behind plan
- £0.7m CRES for agency rate compliance and usage reduction is behind plan
- £0.1m CRES for Crisis Line support from Vale of York CCG is behind plan
- £0.3m CRES for reduction in covid measures is behind plan
- £0.4m CRES for interest receivable and is ahead of plan

Current Focus	Current Improvement Action(s)	Progress Update	Actual 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	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.

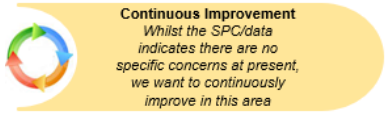
28) CRES Performance – Non-Recurrent

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 **£0.6m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£0.6m**.

(£0.0m) variance to plan.



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.

Current Focus	Current Improvement Action(s)	Progress Update	Actual 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.

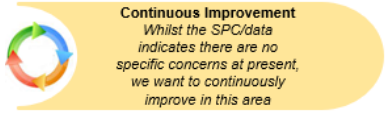
29) Capital Expenditure (Capital Allocation)

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 August was **£3.5m** against planned expenditure of **£3.9m**.

(£0.4m) variance to plan.



Summary

Capital expenditure at the end of August was **£3.5m**, and is **£0.4m** below plan **(£3.9m)**. This includes some slippage on lifecycle and health and safety works, which are offset by an overspend on Teesside patient safety works.

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, with a business case confirming revenue assumptions to be circulated for approval in September.

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

Current Focus	Current Improvement Action(s)	Progress Update	Actual 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 have escalated Health and Safety work programme to Environmental Risk Group to agree and 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.

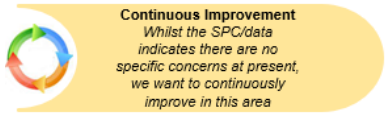
30) Cash balances (actual compared to plan)

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 **(£79.8m)** against a planned year to date cash balance of **(£78.4m).**

(£1.4m) Favourable variance from plan



Summary

Cash balances were **£79.8m** at 31st August 2022, which is **£1.4m** higher than plan **(£78.4m)**. 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 being offset by the current deficit against plan, and working capital movements.

The Trust achieved the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of NHS suppliers, but failed to meet the target for non-NHS suppliers during August, achieving a combined BPPC of 94.20%. We continue to support the use of Cardea to make processes as efficient as possible, and ensure suppliers are paid promptly.

The value of debt outstanding over 90 days is higher than targeted (£1.9m excluding amounts being paid via instalments), but £0.7m of this is from a single supplier. We are working with them to facilitate payment in line with contract terms, but currently they owe the Trust £2.2m in total (for context total debt is £4.2m). 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.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
The delay in debt recovery from a single supplier is contributing to debt outstanding over 90 days being higher than target, which increases PDC expenditure and lower interest receivable.	Accounts Receivable team to escalate debt recovery to contract management meeting for resolution.	Discussion took place during September and an agreement for regular payments in line with contract agreed.	All debt> 90 days outstanding has been cleared during September

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

There are 16 Mental Health Long Term Plan ambitions where we have agreed plans for delivery or national standards. Four of these measures are monitored at Trust level with the remainder (12) monitored at ICB sub location (what was CCG).

Trust Level Long Term Plans

Our performance against the Trust level plans are provided in the table below.

Quality, access and outcomes: Mental Health Trust Standards	Agreed Standard for 22/23	Q1	Q2 (Jul-Aug)		FYTD
13a: Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	Q1 606 Q2 185 Q3 0 Q4 0	1081	1086		1086
13b: Number of inappropriate OAP bed days for adults by quarter that are 'external' to the sending provider	Q1 606 Q2 185 Q3 0 Q4 0	1081	1086		1086
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours.	85%	91.69%	88.05%		90.17%
Data Quality Maturity Index	93.00	97.50	97.40		97.40

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We currently have a risk to deliver our planned reduction in out of area placements. Individual trajectories were agreed in both Integrated Care Systems; both are performing above the agreed ambition.	*Please see actions relating to 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider*	*Please see progress update relevant to this action*	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

The remaining 12 are monitored at Sub-ICB Location level and the following ambitions are currently at risk of delivery:

County Durham Sub-ICB Location

There are currently **4** measures at risk of delivery for both quarter 2 and the financial year

	Measure	Agreed CCG/Sub-ICB location Ambition	Q1	Q2 (Jul-Aug)		FYTD
1. IAPT Roll-Out	**Total access to IAPT services** - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	12448	2828	1437		4265
4. IAPT in-treatment pathway waits	Percentage of people who have waited more than 90 days between first and second appointments	<10%	28.43%	35.35%		31.34%
8. & 9. Waiting times for Urgent and Routine Referrals to Children and Young People Eating Disorder Services	The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Q1 50% Q2 75% Q3 95% Q4 95%	36.71%	50.00%		50.00%
11. Number of people accessing Individual Placement and Support	Number of people accessing IPS services as a rolling total each quarter	169 at Quarter End	140	115		115

Tees Valley Sub-ICB Location

There are currently **5** measures at risk of delivery for both quarter 2 and the financial year

	Measure	Agreed CCG/Sub-ICB location Ambition	Q1	Q2 (Jul-Aug)		FYTD
1. IAPT Roll-Out	**Total access to IAPT services** - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	2260	600	292		892
4. IAPT in-treatment pathway waits	Percentage of people who have waited more than 90 days between first and second appointments	<10%	30.05%	39.15%		33.70%
8. & 9. Waiting times for Urgent and Routine Referrals to Children and Young People Eating Disorder Services	The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Standard	75.82%	80.85%		80.85%
	The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months)	Standard	66.67%	69.57%		69.57%
11. Number of people accessing Individual Placement and Support	Number of people accessing IPS services as a rolling total each quarter	216 at Quarter End	166	157		157

North Yorkshire Sub-ICB Location

There are currently **5** measures at risk of delivery for both quarter 2 and the financial year

	Measure	Agreed Sub-ICB location Ambition	Q1	Q2 (Jul-Aug)		FYTD
1. IAPT Roll-Out	**Total access to IAPT services** - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	8272	1676	1166		2842
2. IAPT recovery rate	IAPT: The proportion of people who are moving to recovery	50.00%	50.05%	48.62%		49.49%
8. & 9. Waiting times for Urgent and Routine Referrals to Children and Young People Eating Disorder Services	The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months)	Q1 50% Q2 60% Q3 70% Q4 80%	55.56%	55.56%		55.56%
11. Number of people accessing Individual Placement and Support	Number of people accessing IPS services as a rolling total each quarter	123 at Quarter End	60	54		54
17. Number of women accessing specialist community perinatal mental health services	Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 71 Q2 142 Q3 213 Q4 284	71	88		88

Vale of York Sub-ICB Location

There are currently **6** measures at risk of delivery for both quarter 2 and the financial year and **1** measure at risk for delivery at year end

Measure	Agreed Sub-ICB location Ambition	Q1	Q2 (Jul-Aug)		FYTD
Total access to IAPT services - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	6282	1441	951		2392
IAPT: The proportion of people who are moving to recovery	50.00%	47.12%	51.37%		48.70%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	17.65%	19.86%		18.50%
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Q1 55% Q2 60% Q3 70% Q4 80%	56.34%	57.97%		57.97%
The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months)	Q1 50% Q2 60% Q3 70% Q4 80%	46.15%	54.55%		54.55%
Number of people accessing IPS services as a rolling total each quarter	92 at Quarter End	68	72		72
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 60 Q2 120 Q3 180 Q4 240	50	67		67

Process for key issues and actions:

- For all IAPT measures, key issues and actions have been identified by each of the Care Groups and are being monitored by the Executive Directors Meeting.

- The remaining measures were impacted by the cyber security incident and became available after the monthly reports had been shared with the Care Boards. That data has been included within this report, but it is important to note that the Care Boards have not had oversight of this through the governance route and whilst ongoing actions have continued, they have not had an opportunity to address any new concerns.

  Going forward, we will look to provide assurance of all key areas of focus and actions being taken, within this report.

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27 October 2022**
TITLE:	**Feedback from Leadership Walkabouts (formerly known as Director's Visits)**
REPORT OF:	**Director of Corporate Affairs & Involvement**
REPORT FOR:	**Information & Assurance**

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

Report:

1 **Purpose**

1.1 The purpose of this report is to enable the Board to consider high-level feedback from recent Leadership Walkabout (formerly known as Directors' visits).

2 **Background**

2.1 The Trust has historically had a programme of regular Director's visits to services, to enable teams to raise any matters of importance directly with Board Members and Governors. These tended to be conversations with team managers and senior leaders in each of the teams visited.

2.2 In October, we piloted a new refreshed approach to these visits to make them more collaborative, taking a whole team approach working alongside teams to really understand the strengths of the service, and consider the more challenging areas and how we can collectively work together to resolve these.

2.3 We called these Leadership Walkabouts to demonstrate this new model.

2.5 As part of this new approach, we encourage the teams to do some reflective thinking beforehand, so that we could really focus on the big tickets issues they were facing and make efficient use of their time.

2.6 We received really positive feedback unilaterally from all the teams visited in October, who welcomed this new collegiate approach, particularly the pre-visit preparation, as well as the opportunity to meet, hear and spend time with the wider team.

2.7 Importantly for the teams was acknowledging the challenges they were facing, and

capturing the areas of support and how these might be actioned to support the teams to address these quickly.

3 Speciality areas visited

3.1 The Leadership Walkabouts took place face-to-face on Monday 10 October 2022 across crisis, urgent care and liaison services including:

- North Tees Intensive Home Treatment Team
- Durham Liaison Team
- Durham and Darlington Crisis Team
- York Acute Hospital Liaison Service
- Hambleton & Richmondshire Crisis Team

Unfortunately, the visit to Scarborough Whitby Rydale Crisis Team didn't go ahead as planned due to unforeseen circumstances, however the team will be visited in November.

4 Key Issues

4.1 Feedback from the visits is summarised below.

Strengths:

- Team dynamics and support across the teams we visited was palpable, particularly in terms of support for each when demand for those in crisis is high.
- Establishing multi-disciplinary teams was seen as a positive move to help with complex case management in a collaborative way – not fully embedded across all teams.
- Strengthened leadership in the teams following the new care group structures being implemented was welcomed, and teams felt supported to work on improvements needed together.
- Solution-focused: the teams felt confident in using their skills, knowledge and experience to tackle issues, and comfortable in escalating issues and developing the solutions collectively.
- Good communication, both formal and informal was cited as good across the teams – with good support from the leadership team.

Challenges:

- Estate issues reported across all teams in terms of space, with a lack of appropriate accommodation for staff as well as patients, carers and families including assessments suites. Some IT and connectivity also mentioned, including dictation software to reduce time recording releasing time to handle the volume of calls.
- Access into service / call rates / staffing levels: call rates increased, staffing crisis lines can be challenging with lengthy assessments and home-based treatment, and staff get pulled into support other areas.
- Working with other services in terms of awaiting allocations / referral decisions / waits for primary services and ward discharges.

4.2 For assurance, lead Directors have followed up on feedback received to escalate issues and areas of concern where relevant and agree next steps.

Recommendations:

The Board is asked to:

1. Receive and note the summary of feedback as outlined.

2. Consider any key issues, risks or matters of concern arising from the visits held on 10 October 2022.

3. Approve the roll-out of new refreshed approach the Leadership Walkabouts based on feedback received.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item No 12

Committee Key Issues Report		
Report Date to Board of Directors – 27th October 2022		
Date of last meeting: 6th October 2022		**Report of: The Quality Assurance Committee**
		Quoracy met.
1	**Agenda**	The Committee considered the following matters: • Progress on delivery of the CQC Action Plan • Risks relating to Quality and Safety • The Management of relevant risks included in the BAF • Executive Quality, Assurance & Improvement Group (EQAIG) • Trust Level Quality & Learning Report • Pilot of body worn cameras • Positive & Safe • Analysis of self-harm in adult acute MH Inpatient Wards • Management of Sexual Safety • Health & Justice Services
2a	**Alert**	The Committee wishes to alert the following matters to the attention of the Board: **1. CQC Action Plan and Activity** Good assurance was provided in relation to oversight and delivery of the CQC action plan with no actions showing as red recorded as not delivered or significant risk to delivery. Due to the delay with implementing CITO there is one must do action at risk of delivery. The Committee received and update on progress relating to CQC inspections of CAMHS, Secure Inpatient Services, and HMP Services. The Chair acknowledged the publication of the CQC report following the inspection of wards for people with a learning disability or autism. The Improvement Plan will be received and monitored by the Committee in November 2022. **2. Pilot of Body Worn Cameras** There has been limited progress made with the recommendations of implementing the pilot of body worn cameras in further ward areas. Data on the use of restrictive interventions for the 10 wards where the cameras are currently worn continues to show no significant reduction. The main issues are related to poor support from our external IT partner and training and staff not remembering to activate the cameras when an incident is occurring, which is also reported as a national concern. QuAC will continue to hear updates on progress and whether any learning from other Trusts can help, although it is apparent from other organisations that any real benefits are seen over a period of years. **3. Risks relating to Quality & Safety** There are currently eight risks 15+ that are aligned to QuAC. Of the risks aligned to the People, Culture & Diversity Committee, seven of the eight are also relevant to QuAC. The Chair of QuAC has raised concerns with the Chair of PCDC and suggested some joint work of with the Executive leads to review the controls in place to manage the associated risks. From the risk categories and themes detailed in the report, with the highest number of risks relating to safe staffing, service provision and availability of beds, it was evident that these were also the key messages triangulated from other reports presented on the agenda.

		The Committee recognises the progress made in reviewing and updating risks and will continue to monitor closely the level of resources available for the management and oversight of risks, considering the significant program of work for the Head of Risk Management. **4. Executive Quality, Assurance & Improvement Group (EQAIG)** The areas of risk discussed by EQAIG, at its meeting on 27th September were related to waiting times for community ASD/ADHD with evaluation requested via the Integrated Care Board, access to beds (Tier 4 CAHMS, ED and LD), concerns from the Environmental Risk Group relating to access to roof spaces and capacity in the Complaints team due to sickness, which is impacting on the ability to provide responses in 60 days. The Committee expressed concern as performance was currently 3%. Actions are underway to provide support to the team and a full review of the policy is planned. The key areas of alert relate to staffing issues: recruitment and retention, high numbers of vacancies, which is impacting on the provision of services leading to increased use of medical agency and bank staff. Pursuing international recruitment is one method being pursued and a Trust wide Crisis Group has been established. There are some positive assurances, demonstrated by the reduction in out of area placements and independent sector beds – down to five in September, compared to 21 in July 2022. Benchmarking data from NHSE/I in June shows 90% would rate TEWV service as very good or good (national average 86%). An Executive Risk Group Steering Group has been established to oversee delivery of the anti-ligature programme, with weekly leadership cell meetings to consider ongoing challenges. **5. Positive & Safe** Data on the use of restrictive intervention for the September period was unavailable due to issues in accessing the IIC therefore the in-depth 6-month analysis report was deferred until November 2022. TEWV has made significant reductions in recent years of the use of all forms of restrictive interventions, however, usage remains high in a small number of areas. The report received by the Committee contained information on current themes and trends which shows that Adult LD inpatient services continue to report as significant outliers reporting 51% of the total Trust incidents. A group of wards including ALD, PICU and female secure services is where 71% of incidents occurred. The top 10 highest recording patients account for 1877 (47.7%) restrictive intervention incidents. With one patient accounting for 534 (13.6%) incidents alone. Bankfields Court has the highest number of incidents with 28% of incidents occurring on one ward. Due to the data continuing to identify that the majority of usage is attributed to a small group of patients with a range of complex needs we have developed a regular assurance panel focused upon reducing restrictive interventions for these individuals. Panels reflect MDT working and are facilitated via associate directors working across clinical areas. We have developed a monthly Trust wide assurance group, chaired by the executive medical director who will review all episodes of long-term segregation and prolonged seclusion. The first of these meetings commenced on 13 September 2022. Further analysis is required to provide a fully informed review of the previous six months however early indication suggests incidents reported within adult learning disability inpatient areas continue to occur at significantly high rates. We continue to implement a range of interventions across services to support this agenda, however, recognise that the complexity of need and level of challenge within services is limiting the impact of this approach. The Committee noted that the Nurse Consultant was also supporting neighbouring acute Trusts with patients who required expert and safe intervention support. The Committee sought assurance on the resources available to continue to support our improvements in reducing restrictive interventions.

2b	**Assurance**	The Committee wishes to draw the following positive assurances to the attention of the Board: **1. Board Assurance Framework (BAF)** The Committee reviewed the updated Board Assurance Framework and were content with the updates, with no concerns over any gaps in control or assurance that needed to be addressed. There were now new or emerging risks considered that will impact on the BAF. The next full review of the BAF would take place during November 2022. **2. Trust Level Quality and Learning Report** A report was presented to QuAC which recognises the national system issues with IIC and data not being available. An ongoing concern is the considerable backlog of serious incident reviews and work continues to improve the move away from centralized management of incidents to services. Shifts worked over 13 hours decreased in August to 90 clinical inpatient shifts, compared to 195 in July. There were 16 Formal Complaints received in August, a decrease when compared to July (26). The year-to-date position is 119 complaints, a decrease of 9 complaints when compared to the same period last year. The top themes identified from those complaints received were: clinical care, care planning and continuity of care, communication, confidentiality, inadequate information received, involvement of carers, discharge arrangements, discharge planning and waiting times. Compliance with the 60-day target for complaints in August is reporting at 3% which is a decrease when compared to July (10%). The non-compliance relates to capacity within the team due to high caseloads and delays in the final approval/sign off process. **3. Management of Sexual Safety** The Committee were assured that the Quality and Safety Programme Board will have oversight of sexual safety, which is part of our quality journey to promote harm free care. The management of sexual safety in PICUs is being partially addressed by proposals to move to one all male PICU and one mixed sex PICU. The national collaborative work has been rolled out to Cedar ward, which reflects an increase in the number of incidents reported. Some further analysis will be undertaken regarding 'no-harm' incidents to consider the impact of psychological harm and complaints relating to sexual safety and patient/carer experience will be cross checked. The Equality and Diversity Lead will help advise on transgender initiatives being explored regionally. **4. Analysis of self-harm in adult acute MH Inpatient Wards** At the request of the Committee, a significant piece of work was undertaken into the themes and patterns of self-harm within adult acute inpatient services. Some assurance was found from the research that the majority of self-harm incidents result in low or no harm to patients with the majority being on female wards. Bilsdale Ward is an outlier amongst the male wards, however on further review of the data there was one patient that accounted for 61 of the 88 incidents. Some further work will look at Tunstall Ward as an outlier in terms of lower numbers of incidents compared to other female wards, which may identify some areas of good practice and/or under reporting.

		Assurance was received regarding the actions that have been taken to reduce self-harm which include environmental improvements, protocols to guide practice and safety briefings from review of themes. The Committee will hear an update in due course on the actions to review individual patients with the highest number of incidents to have 'live examples' to inform and shape process and escalation procedure. A Task & Finish Group has been established to oversee this work, which will report to the Quality & Safety programme, through the suicide and self-harm reduction group and then through to QuAIG and QuAC. The Committee commended the piece of work, which they thought would be beneficial to share with other MH Trusts.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **Health & Justice Services (H&JS)** At the request of the Committee, in seeking some assurances and greater visibility, a report was presented giving an overview of the provision of services within Health and Justice. There have been some key successes for services, staff who have won awards and some positive feedback received from patients. The service is reporting similar concerns in relation to staffing and recruitment and retention A further report including more information on the mitigations to prevent self harm and suicide in prisons, together with a review of the Suicide Prevention Strategy will also be presented to QuAC – this is something that members of the Committee would like some further assurance on and the mitigations in place to support individuals with mental health issues in prisons. The report advised the Committee that there were some concerns following contract mobilization in The Humber which were being addressed. The Committee were also advised that the service was regularly being approached to scope future business opportunities.
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, however the staffing and recruitment and retention theme was constant and consistent throughout the meeting.
3	**Actions to be considered by the Board**	The Committee has recommended to the Board: 1. To note the CQC updates on our action plan and activity 2. To support the QuAC in receiving and monitoring the ALD Improvement Plan 3. To note the update on positive and safe care 4. To note the Committees concerns in relation to staffing and recruitment and retention
4	**Report compiled by**	Bev Reilly, Chair of Quality Assurance Committee/Deputy Chair of Trust, Elizabeth Moody, Director of Nursing & Governance, Donna Keeping, Corporate Governance Manager

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 13

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**27th October 2022**
TITLE:	**Learning from Deaths - Dashboard Report Q2 2022/2023**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Information**

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

Executive Summary:

The Learning from Deaths Dashboard Report sets out the approach the Trust is taking towards the identification, categorisation, and investigation of deaths in line with national guidance. The mortality dashboard for the period of Q2 2022/2023 financial year is included at Appendix 1 and includes 2021/2022 data for comparison.

During Q2, there were 463 deaths including 23 people with a learning disability. 6 of these deaths were in-patient deaths which were related to physical health. 20 deaths were reported on the national Strategic Executive Information System (StEIS). 52 deaths met the criteria for a mortality review. 20 of those cases were selected for a more detailed Part 2 Structured Judgement Review (SJR) which includes the 6 physical health related in-patient deaths.

16 serious incident reviews were completed and discussed at the Directors Assurance panel. All cases had some actionable learning which replaces previous categories of learning including root cause and contributory causes. This language supports the Trust's approach towards a just and learning culture in line with Our Journey to Change.

This paper sets out key themes from incidents and provides current progress and assurance against these as well as the Trust approach to take this learning forward. A greater level of assurance can be seen within in-patient settings as this has been the area of most focus however improved assurance can also be noted from across our community settings.

In the interim period, whilst transitioning to the national Patient Safety Incident Response Framework (PSIRF), the Trust's existing Incident Reporting and Serious Incident Review policy has been strengthened in relation to the National Patient Safety Standards.

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

Recommendations:

The Board is requested to note the content of this report, the dashboard and the learning points as good assurance of reporting and learning in line with national guidance and consider any additional actions to be taken.

MEETING OF:	**Board of Directors**
DATE:	**27th October 2022**
TITLE:	**Learning from deaths - Dashboard Report Q2 2022/2023**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

All NHS Trusts are required to publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy, and which have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all the deaths categorised as in scope for the Learning from Deaths policy are subject to an initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) can be found in Appendix 2.

In the interim period, whilst transitioning to the Patient Safety Incident Response Framework (PSIRF), the Trust's existing Incident Reporting and Serious Incident Review processes has been strengthened in relation to the National Patient Safety Standards. Examples include, adopting a people focused approach, use of subject matter advisors, system-wide learning and promoting a fair and just culture. Due to on-going improvement work, it is envisaged that the Trust will be in a position to draft and agree our new Patient Safety Incident Response Policy and Plan by Q4 22/23 which is well in advance of PSIRF's implementation date of September 2023.

This paper identifies current themes and learning from deaths and provides current progress and assurance against these.

3. KEY ISSUES:

3.1 Mortality Reviews and Learning

Mortality Review 2022/2023

In Q2 2022/2023, 52 patient deaths required a part 1 Mortality review. 20 of those cases were selected for a more detailed Part 2 Structured Judgement Review (SJR). Details on the locally agreed criteria for Mortality reviews and SJRs can be found in Appendix 2.

Month	Total Number of Deaths which have been reviewed under locally agreed criteria.	Total Number identified as requiring a Structured Judgement Review
July	26	9
August	17	4
September	9	7
Total	**52**	**20**

** NB due to capacity issues not all data for Q2 has been reviewed which reflects the lower numbers currently recorded. These figures will be amended when the dashboard is updated for Q2 2022/23*

Mortality Reviews

In the reporting period there were 5 expected in-patient deaths within MHSOP services; all were related to physical health problems. There was 1 unexpected in-patient death in AMH of what appears to be natural causes. These deaths will be reviewed via a structured judgement review under the mortality review process. A joint review will be carried out with the acute trust for the AMH patient death to identify any learning.

Learning and good practice from Q2 mortality review panels is identified in the table below.

Points of learning
• Staff understanding of the Mental Capacity Act • To maintain proactive liaison with external agencies, to ensure people admitted to Trust hospitals don't miss out on physical health care appointments arranged in the community • To use creative ways to ensure a person's care is coordinated when that person has no fixed abode (rough sleepers)
Points of Good Practice • Excellent compassionate care was provided during end-of-life care to both the patient and family.

In relation to the points of learning above, the following actions are being taken:
Training for the Mental Capacity Act is mandatory within the Trust. Learning from deaths in relation to the Mental Capacity Act has been shared with the Head of Mental Health Legislation to determine whether the training package needs reviewing and strengthening to address issues identified within reviews.

Community transformation work will facilitate collaborative pathways across the system it operates within. It aims to create a core mental health service which is aligned with primary care networks and voluntary sector organisations to ensure that services are accessible to the community it serves and inclusive of population need.

Previous learning from Mortality reviews and rapid reviews has suggested that a community frailty pathway to help staff in recognising the deteriorating patient in community settings should be considered. Training has commenced in recognition of the physically deteriorating

patient in community settings. A planning meeting is underway with key stakeholders including the primary care networks to create a pathway / guidance document.

We have been working together with the Better Tomorrow Programme to strengthen our internal mortality review processes. The next meeting is on 25/10/2022. At this meeting we will be evidencing improvement work we have undertaken including revised membership and terms of reference for the Mortality Review Panel, how we are sharing learning and how the Mortality Review Panel links into the Trust's Physical Health and Wellbeing group.

Deaths of people with a dual diagnosis appears to be on the increase. A thematic review into 6 deaths of people with a dual diagnosis will be presented at the Trust's Drug and Alcohol Strategy task and finish group on 7th November to identify common themes and to understand any factors that hinder our ability to adhere to Trust standards, values and behaviours when working with this group of people.

3.2 Learning from deaths and serious incidents

Significant work has been undertaken over the last 3 quarters to identify areas of learning from the thematic review of historical serious incidents and to determine whether the actions we are taking are making a difference to patient safety and the standard of care and services we provide.

The top 7 themes were identified as:

- Risk Assessment and Management (Safety Summary/Plan/contingency planning)
- Care Planning
- Safeguarding (including use of PAMIC tool)
- Family Involvement
- Record Keeping
- Multi-agency working
- Records Management

Through intelligence gathered via the Trust's Quality Assurance Programme it is evident that improvements have been made across all 7 learning themes. Whilst there is good evidence with regard to the co-production of safety plans with patients within the community, there are opportunities for further improvements in ensuring patient and carer views are included as well as clear evidence that the patient has been offered or provided with a copy of their safety plan**.** MDT walkabouts have also identified a need for further training for staff in relation to effective record keeping with regard to the Suicide Prevention Environmental Risk Survey. We continue to review and monitor learning from recent serious incident reviews against the 7 themes detailed above to ensure improvements are being sustained.

In Q2, 16 StEIS reportable serious incidents resulting in unexpected deaths were completed; these related to 15 community patients and 1 in-patient who died whilst on leave. There was some element of actionable learning identified in all 16 cases:

The five most common learning themes from Q2 were as follows:

- Harm minimisation and risk assessments
- CPA/Care Planning/Transitions
- Carer involvement
- Adherence to Polices/Procedures
- Minimum standards for clinical record keeping

15 of the cases reviewed in Q2, were community deaths. Although similar themes have been identified as previous quarters, some of these incidents occurred prior to improvement work in community teams. Learning continues to be embedded in our community services, with improvement in risk assessment and care planning noted through our quality assurance programme. A greater level of assurance regarding embedded learning can also be seen within our in-patient settings.

Rapid reviews (completed within 72 hours of an incident occurring) which capture early learning have provided assurance that learning in relation to the 7 themes identified above is becoming more embedded and reflected in the care people receive.

A new theme emerging from early learning rapid reviews of deaths is around safe discharge with associated issues around the Did Not Attend/Was Not Brought policy. Although some improvement work was carried out in relation to this policy, which is part of an annual audit programme, the findings in Q1 & Q2 indicate further improvement work is required in this area. This early learning theme has been escalated to both Care Groups for further discussion regarding actions and the outcome will be reported on, in this report, in Q3.

3.3 Structures to support and embed learning

3.3.1 Fundamental standards group

Practice Development Practitioners are now integrated into the Care Group Fundamental Standards meetings where wider learning and good practice can be shared to facilitate improvements Trust-wide. Fundamental Standards Briefings provide key messages including the importance of raising concerns to help us keep everyone safe and to ensure we continually improve our services for all patients and for staff working within the Trust. The latest bulletin provided the key message that safety summaries and safety plans must be reviewed regularly in ward settings and following every contact in community settings. Assurance around this is sought through our quality assurance programme.

3.3.2 Organisational Learning Group (OLG)

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group. Analysis of our current learning from deaths will inform how our quality assurance tools may be adapted to capture areas of risk that need further assurance. This will ensure we keep our patients safe, for example audit around safe discharges in both in-patient and community settings.

There have been 9 urgent Patient Safety Briefings circulated Trust wide during this reporting period. Examples include:

- Patient access to roof spaces
- High Dose Anti-Psychotic Therapy and bowel monitoring
- Identification of a new ligature point
- Advice on removal of ligatures

The briefings circulated are specific about the assurance required from services; on receipt of confirmation of completed actions, this is registered in the learning database.

'Learning from Serious Incidents Bulletins' are also regularly distributed across the Trust. The bulletins have shared key learning and good practice highlighted in serious incident reports presented at the Directors review panel. All briefings and bulletins are stored in the learning library on the Trust's intranet and are accessible to all Trust employees. An evaluation of the learning library is currently being undertaken by a member of the Patient Safety Team.

3.3.3 Preventing Suicide and Self harm Group

The Trust continues to work on its Preventing Suicide Plan with input from all stakeholders. Feedback from stakeholders has been collated and shared within the Trust and with our external partners. The Trust has dedicated preventing suicide leads in each care group. This work along with a recently established self-harm task and finish group forms part of the Advancing Quality and Safety programme.

3.3.4 The Environmental Risk Group

This group receives monthly reports of incident data involving ligatures and other risks where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is disseminated Trust-wide via Patient Safety Briefings or SBARD's (Situation, Background, Assessment, Recommendation) communications. Examples for Q2 are detailed above in para 3.3.2.

The annual Environmental survey programme with a multi professional input from estates, health and safety and clinical services continue. A recent focus has been on minimising risks around patient access to roofs and estates have undertaken risk assessments in accordance with this. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures.

3.3.5 Serious Incident Investigation

The Trust has a continued focus on improving the quality of incident reporting, investigation, and identification of key actionable learning. A Strategic Project Manager, with additional support from the NHSE/I's System Improvement Team, has been taking this work forward. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring they are compliant with the requirements of the National NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF). This improvement workstream forms part of the Trust's key quality priorities within its 'Quality Journey', the Trusts quality strategy with formal governance routes in place.

3.3.6 Better Tomorrow Programme

A desk top review of the Trust's current Mortality Review systems and processes was completed by the Better Tomorrow team to help identify and support with potential areas of development. This work has recently been refreshed by the Trust to include improvement work in learning from deaths; oversight is being provided by the multi-disciplinary Mortality Review panel. Trust staff attended a workshop organised by the Better Tomorrow Team which looked at the new 'Structured Judgement Review Plus' template, potential for a 'community mental health dashboard' as well as a proposed national template for Learning from Deaths Board reports. 2 staff attend the 'Better Together' network which provides an opportunity to share best practice issues and learning from deaths nationally. The capacity of the patient safety team to progress this work has been impacted on however the next meeting with the Better

Tomorrow Programme and the Trust is on 25/10/2022. The purpose of this meeting is to discuss the Trust's progression on improving the learning from deaths process.

3.4 The Learning from Deaths Dashboard

The learning from deaths dashboard is attached at Appendix 1 and includes 2021/22 data for comparison.

For Q2 the dashboard highlights the following:

- A total of 463 deaths were recorded (which includes 23 deaths of patients with a Learning Disability in the community). This figure represents all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were currently open to the Trust's caseload (>70,000) as reported on datix. The 23 community deaths of patients with a learning disability have been/will be reviewed internally via the mortality review process. All will be reported to LeDeR in line with national requirements.
- Out of the 463 deaths there were 6 in-patient deaths all related to physical health issues
- There were 16 StEIS reportable serious incidents resulting in death reviewed and 20 StEIS reportable serious incidents resulting in death reported.
- 52 cases within the combined number of deaths were reviewed under the mortality review criteria, 20 of these will progress to a full Structured Judgement Review.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

Improvements in the learning from deaths processes outlined will support the Trust to demonstrate the delivery of high quality, safe patient care in line with CQC Fundamental standards. Fundamental standard briefings are circulated Trust-wide. September's issue highlighted the importance of staff raising concerns to keep everyone safe and to ensure that we continually improve our services for all patients and staff.

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

Adherence to Learning from Deaths provide assurance we meet CQC's Fundamental Standards in respect of Regulation 17 - Good Governance.

4.4 Equality and Diversity:

The Trust's learning from deaths reviews consider any issues relating to equality and diversity to ensure that any issues of discrimination are addressed. Our community transformation will work ensure that everyone receives the right care in the right place at the right time.

4.5 Other implications:

No other implications identified.

5. RISKS:

There is a risk that if we fail to embed key learning from deaths that patient safety and quality will be compromised and the people we serve will lose confidence in the services we provide.

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

6. CONCLUSION:

The Trust's Quality Assurance Programme provides evidence that learning from deaths is being embedded into clinical practice. New themes have been identified and escalated to Care Groups and existing workstreams for further consideration. We are on target to meet the implementation of the new PSIRF.

7. RECOMMENDATIONS:

The Board is requested to note the content of this report, the dashboard and the learning points as good assurance of reporting and learning in line with national guidance and consider any additional actions to be taken.

Background Papers:

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

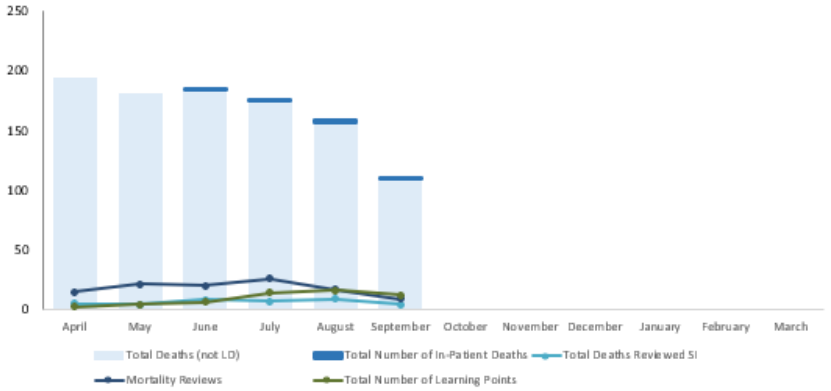
Southern Health Report
https://www.england.nhs.uk/2015/12/mazars/

Appendix 1: Learning from Deaths Dashboard

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

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

	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
Q1	558	↗ 486	1	↘ 8	17	↘ 23	56	↘ 78	12	↘ 43
Q2	440	↘ 557	6	↘ 7	20	↗ 18	52	↗ 50	42	↗ 15
Q3		640		5		15		105		42
Q4		556		6		12		37		5
YTD	998	↘ 2239	7	↘ 26	37	↘ 68	108	↘ 270	54	↘ 105



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

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

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
Q1	19	↗ 18	0	↔ 0	12	↘ 29	12	↘ 34
Q2	23	↘ 26	0	↔ 0	23	↗ 16	23	↗ 12
Q3		23		0		18		25
Q4		28		0		18		25
YTD	42	↘ 95	0	↔ 0	35	↘ 81	35	↘ 96

Mortality Reviews 2022/2023

Appendix 2

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

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

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

This criterion allows for greater learning from a more suitable selection of cases reviewed. To prioritise the most significant cases for learning from unexpected and expected physical health deaths throughout Q1, the following actions have been taken for those deaths reported on datix:

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

ITEM NO. 15

Trust Board of Directors

DATE:	**19th October 2022**
TITLE:	**Guardian of Safe Working Quarterly Report - October 2022**
REPORT OF:	**Dr Jim Boylan - Guardian of Safe Working**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
A great experience for patients, carers and families	
A great experience for staff	✓
A great experience for partners	✓

Executive Summary:

It is the responsibility of the Guardian of Safe Working to provide annual & quarterly reports to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service.

There has been a some continuing impact on working conditions by the CoVID 19 pandemic for all staff, including Junior Doctors, over the past year and the infectivity of new variants has maintained the escalation of positive cases and consequent staff absences due to self isolation or sick leave.

The North and South Junior Doctor Forums were held in September with good representation of Juniors from all localities. A number of notable issues were discussed including reports of continuing difficulties with access to LYPFT clinical information systems for TEWV based trainees in the South sector, changes of service provision at Sandwell park and their implications for Junior Doctors and the familiar topic of work intensity on call across the localities. In addition it was recognised that there needs to be a comprehensive and more in-depth trust-wide review of the status of on-call rotas for Juniors across the trust in terms of the intensity of working, particularly where Non-Residential rotas are in place.

In the recent trust-wide LNC meeting concerns were raised about the impact of plans to provide out of hours cover for Learning Disability services by general adult trainees (and Consultants) which is a source of concern for both grades.

As can be seen in the appendices to this report there continue to be the most notable number of exception reports emanating from the Teesside locality – but also North Yorks, York and Scarborough – again where there are Non-Residential On Call Rotas. Where it has been necessary to levy Guardian fines these continue to be almost exclusively due to the breach of the 5 hours continuous rest rule.

We continue to monitor and review the process for exception reporting to try to ensure timely reporting by Junior Doctors and accurate intelligence of work intensity across all localities. Medical staffing continue excellent work in this regard.

Recommendations:
The Board are asked to read and note this Quarterly report from the Guardian of Safe Working.

MEETING OF:	**Trust Board**
DATE:	**27th October 2022**
TITLE:	**Quarterly Report by Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

The Board receive Annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for Junior Doctors. This report contains both annual and quarterly data in the appendices and includes aggregated data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern. This will provide assurance to the Board and if needed, ask for approval for action to rectify a safety concern.

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours and during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.

The Guardian role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The guardian is required to levy a fine against a department(s) if a Junior Doctor :-

- works on average over 48 hours/week
- works over 72 hours in 7 days
- misses more than 25% of required rest breaks
- on non-residential on call (NROC) does not have a minimum of continuous rest for 5 hours between 22:00 and 07:00
- does not have the minimum 8 hours total rest per 24 hour NROC shift
- has more than the maximum 13 hour residential shift length
- does not have the minimum 11 hours rest between resident shifts

The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

3. KEY ISSUES:

- **Appendices 1 and 2** provide more details for North (Durham & Teesside) and South (York and North Yorks) sectors respectively for the quarter July to September (inclusive) 2022 with a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendices are shared with the corresponding Health Education England body for the different sectors.

- From these appendices we can see that during this quarter there was an increase in exceptions reported in the North sector (47 vs 31 in the previous quarter) with a very striking focus on Teesside (42 out of the total 47). In the South the exceptions fell slightly (27 compared to 34 previous quarter) with the majority being in the Scarborough locality (16 out of 27). Teesside continues to be the locality with highest work intensity. The number of separate breaches requiring fines for this quarter represents an increase over the rate in previous quarters (47 separate fines in this quarter compared to a total of 66 for all 3 of the previous quarters summed). In conversation with my Guardian colleagues in the region it would seem that we have a consistently high rate of fines (and by implication breaches of contract) compared to the other trusts. This is a metric that merits continued monitoring and is clearly related to our NROC rotas.

- There were reports of continuing difficulties with access to LYPFT clinical information systems for TEWV based trainees. This is related to problems in registering for access and in the last forum in September the management representative from LYPFT promised to take the issue back again to senior management there.

- Discussions regarding ongoing issues of work intensity on call and service re-structuring and re-provision on Teesside prompted the decision for a more in-depth analysis of the current status of on-call rotas across the trust – particularly in the most work intensive areas (notably Teesside and Scarborough) and consideration of options to potentially institute residential rotas where appropriate. The importance of trainee involvement in this process from the outset was acknowledged.

- As mentioned in the executive summary, in the recent trust-wide LNC meeting concerns were raised about the impact of plans to provide out of hours cover for Learning Disability services by general adult trainees (and Consultants) which is a source of concern for both grades. It was again emphasised how important it is that trainees from all grades involved are included in ongoing consultation about this issue moving forward.

- There were no significant reports of any major concerns with facilities and on-call accommodation during this quarter in any of the localities. We continue to monitor progress for the further development of facilities on Roseberry Park and Lanchester Road sites.

- There were no reports of concerns for the new dual middle tier NROC rotas in County Durham during this period.

- Over the past quarter we continued to witness the continuing impact of CoVID 19 and, if anything, the new Omicron variant appears to have caused an upsurge in staff absences, particularly upon nursing staff levels. This has obviously had a negative impact on work intensity for all working staff.

- There were no specific reported concerns about the availability of Crisis Team staff out of hours in County Durham or elsewhere to support the Section 136 assessments by Higher Trainees during out of hours assessments during this last quarter. We continue to monitor this situation. We also continue to monitor for reports by Higher Trainees of pressure to discharge patients from section 136 without an AMHP having been in attendance. I have not received any specific reports of this, however, during the last quarter.

- Over this quarter I am satisfied that all exception reports submitted by doctors on the new contract have been actioned within specified and reasonable timeframes. The medical staffing department have supported doctors' supervisors to action these appropriately and maintain a log that enables trends to be spotted and reports submitted to locality forums.

- There have been no evident rota gaps of concern during this quarter and the internal locum system appear to function well with no reported use of Agency locums on Junior Doctors rotas.

- The Trust continues to monitor and provide compensatory rest arrangements that match or exceed requirements set out in the contract.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour. This report evidences maintenance of these standards.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board understands that extra costs will be incurred for additional anti-social hours work and breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to junior doctors is necessary and appropriate.

4.3 Legal and Constitutional (including the NHS Constitution):

The Learning and Development Agreement signed by the Trust with Health Education England clearly sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow junior doctors to fulfil their curriculum needs within a sound learning environment.

4.4 Equality and Diversity:

The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity has therefore been invited to the quarterly trustwide Junior Doctor Forum. An Equality Impact Assessment has been completed and is updated within the forum. The Champion of Less Than Full-time Working is a core member of the Junior Doctor forum and holds an additional forum / network for less than full time doctors.

4.5 **Other implications:**
It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.

5. RISKS:

The ongoing and developing situation with Covid 19 and the recent escalation of cases resulting in staff vacancies and shortages in key areas has compromised safety for Junior Doctors in some localities for urgent out of hours assessments and it is important that monitoring of this situation continues.

Review of on call rotas may lead to a need for increasing the number of funded training and trust grade posts in some localities within the trust which implies a potential increase in expenditure by clinical services.

In terms of promoting recruitment and retention of doctors into more senior positions within the trust it is important for the board to continue active support for the development of resources and facilities for the accommodation and educational provision of trainees. Failure to do so is likely to risk a negative influence on decisions by our high quality trainee workforce to consider a future position within the organisation.

Pressure upon Junior doctors to assess section 136 patients without the support of locality Crisis Team staff or in some instances the presence of an AMHP does not constitute best practice and may compromise the level of assurance for decisions made about these patients and pose a professional risk for Junior Doctors.

Failure to anticipate the impact on Junior Doctors working situations of any major service changes remain a generic risk for a large and dispersed organisation such as the Trust and may lead to a Junior Doctor being placed in an unsafe situation. In addition failure to engage with trainees and invite participation in discussion about the potential impacts of planned service changes on terms of working may have a negative impact on longer term recruitment to the Medical workforce within the trust.

The Trust rightly encourage high levels of necessary exception reporting and with current levels of negative media attention – these may be misunderstood and be reported in the media without adequate understanding of Trust policy and processes – which may lead in turn to reputational risk.

In the context of the current requirements for social distancing our normally robust structures for Junior Doctor Forums and meetings between senior medics are

potentially more challenged, although there is continuing evolution in the availability and use of technology for remote linkage.

6. CONCLUSIONS:

The continuing challenges of the Covid19 Pandemic manifested through staff shortages, increasing demand and work pressure have impacted upon staff morale and inter-professional working relationships in some teams and particular situations (such as being on-call) across the trust. This is an issue of some importance to consider in the longer term for retention of all staff groups including medics.

There is a need for an in depth evaluation / review of the structure and functioning of on call rotas for trainees across all areas of the trust – most especially in the high intensity work load areas. It is important that juniors are directly involved in this process.

There continue to be issues around work intensity in some Non-Residential Rotas around the trust but it is encouraging to see indicators for improvement in these sectors and no evidence in the last quarter of increasing intensification. We will, of course, continue active monitoring.

Active support from the board to re-provision on call accommodation and educational facilities for Junior Doctors on the Roseberry Park site, where there is probably the highest concentration of trainees in the trust, is likely to be viewed positively and in the longer term could help with recruitment and retention.

Junior Doctors are appropriately submitting exception reports but continuing review of how to maintain and improve the efficiency of this process is important. Medical staffing are actioning exception reports in an appropriate and fair way. I am satisfied that reasonable processes continue to be in place to identify and rectify issues of safety despite the stringencies of safe distance working.

Teaching and training is gradually returning to more face to face interaction but appropriate alternative measures continue to be taken to provide ongoing training and support for Junior Doctors through regular webinars and video conferencing.
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7. RECOMMENDATIONS:

The Board are asked to read and note this quarterly report from the Guardian of Safe Working.

Author: Dr Jim Boylan
Title: Guardian of Safe Working for Junior Doctors

Background Papers:
Appendices 1 & 2: detailed information on numbers, exception reports and locum usage- North and South Sectors respectively – Third Quarter 2022.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	76
Number of doctors / dentists in training on 2016 TCS (total):	72
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st July up to 30th September 2022

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	0	3	3	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	10	10	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	26	26	0
CT1-2 –North Durham	0	0	0	0
CT1-2 – South Durham	0	0	0	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	3	3	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	5	5	0
Total	**0**	**47**	**47**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	44	44	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	3	3	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
Total	**0**	**47**	**47**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	10	9	25	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	0	3	0
South Durham Juniors	0	0	0	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
Total	10	9	28	0

Narrative for Exception Reports

There were no senior registrar exception reports in Teesside. A third of the exception reports were from those claiming 4 plain hours for shadowing. DRS is currently unable to download information for closing of exception reports, therefore the above table cannot be completed.

Work schedule reviews

Work schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST4 - 6	0

Work schedule reviews by locality	
Teesside & Forensics	0
North Durham	0
South Durham	0

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	17	5	0	228.5	50
	CT1/2/GP	25	12	0	302	160.5
	CT3	0	12	0	0	173.5
	Trust Doctor	0	11	0	0	156
	SPR/SAS	9	8	0	168	122
North Durham	F2	3	7	0	37.5	62
	CT1/2/GP	18	5	0	178.5	62.5
	CT3	3	11	0	20.5	108
	Trust Doctor	0	0	0	0	0
	SPR/SAS	38	38	0	704	704
South Durham	F2	0	2	0	0	25
	CT1/2/GP	26	23	0	231.5	185.5
	CT3	0	2	0	0	25
	Trust Doctor	0	0	0	0	0
	SPR/SAS	61	61	0	1,096	1,096
Total		200	197	0	2966.5	2930

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Special Leave	1	1	0	16	16
COVID isolation	1	1	0	24	24
Maternity leave	0	0	0	0	0
On call cover	136	135	0	1506.5	1482.5
Vacancy	15	14	0	207.5	183.5
Sickness	42	41	0	524	511.5
Bank Holiday	1	1	0	6	6
Total	196	193	0	2284	2223.5

Vacancies

Vacancies by month						
Locality	**Grade**	**July 2022**	**August 2022**	**September 2022**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	2	2	1.3	0
	GP	0	0	0	0	0

	Trust Doctor	0	0	0	0	0
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	2	2	1.3	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
South Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	1	1	0.6	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	1	0	0	0.3	0
	GP	1	1	1	1	0
	Trust Doctor	0	0	0	0	0
Total		**2**	**6**	**6**	**4.5**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	10	£3,879.23
North Durham	0	£00.00
South Durham	0	£00.00
Total	**0**	**£00.00**

Narrative – there may be more fines to be added in as the NROC period overlaps the end of this report.

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
£528.20	**£3,879.23**	**£1,533.14**	**£2,874.29**

Purchases:

The following purchases have been made:

Date	Item	Location	Cost
22 Jul 2022	Coffee Pods	Jr Doctors Office WPH	£248.86
22 Jul 2022	Coffee Pods	Jr Doctors Office RPH	£248.86
22 Jul 2022	Coffee Pods	Jr Doctors Office LRH	£248.86
2 Sept 2022	Coffee Pods	Jr Doctors Office WPH	£248.86
2 Sept 2022	Coffee Pods	Jr Doctors Office RPH	£248.86
2 Sept 2022	Coffee Pods	Jr Doctors Office LRH	£248.86
16 Sept 2022	DAB Radio	Jr Doctors Office WPH	£39.98
		Total Spent	**£1,533.14**

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	64
Number of doctors / dentists in training on 2016 TCS (total):	64
Amount of time available in job plan for guardian to do the role:	1 PA
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st July 2022 up to 30th September 2022

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	3	3	0
F1 - York	0	0	0	0
F2 - York	0	0	0	0
CT1-2 - Northallerton	0	0	0	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	4	4	0
CT1-2 - York	0	4	4	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	6	6	0
CT3/ST4-6 – York	0	7	7	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	3	3	0
Trust Doctors - York	0	0	0	0
Total	**0**	**27**	**27**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton/ Harrogate/ York	0	11	11	0
Scarborough	0	16	16	0
Total	**0**	**27**	**27**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Northallerton/ Harrogate/ York	5	3	3	0
Scarborough	6	9	1	0
Total	**11**	**12**	**4**	**0**

Narrative around Exception Reports

Northallerton/Harrogate/York rota – majority of exception reports to claim for additional payments following submission of the 8 week NROC monitoring form. There were also some to report late finishes and inadequate rest while on call.

Scarborough rota – majority of exception reports to report inadequate rest while on call. There were also some to report late finishes and to claim additional payment following submission of the 8 week NROC monitoring form.

Middle tier rota – one exception report to claim for additional payment following submission of the 8 week NROC monitoring form and one to report inadequate rest while on call.

Work Schedule reviews

Work schedule reviews by locality	
Northallerton	0
Harrogate	0
Scarborough	0
York	0

Work schedule reviews by grade	
F1	0
F2	0
CT1-3	0
ST4 - 6	0

Locum bookings

Locum bookings by Locality & Grade

Locality	Grade	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Northallerton/ Harrogate/ York	F2	1	1	0	16	16
	CT1/2/GP	32	31	0	380.5	374.5
	CT3	3	3	0	44	44
	Trust Doctor	0	0	0	0	0
	ST4-6/SAS	29	27	0	552	512
Scarborough	F2	1	1	0	16	16
	CT1/2/GP	16	16	0	312	312
	CT3	1	1	0	16	16
	Trust Doctor	0	0	0	0	0
	ST4-6/ SAS	89	86	0	1648	1584
Total		**172**	**166**	**0**	**2984.5**	**2874.5**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	76	74	0	1401.5	1361.5
Sickness	20	20	0	310.5	310.5
Other	76	72	0	1272.5	1202.5
Total	**172**	**166**	**0**	**2984.5**	**2874.5**

Vacancies

Vacancies by month						
Locality	**Grade**	**July 2022**	**August 2022**	**September 2022**	**Total gaps (average)**	**Number of shifts uncovered**
Northallerton/ Harrogate/ York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	3.5	0	0	1.16	0
	CT3	0	0	0	0	0
	ST4 -6	2.2	0	0	0.73	0
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	1.2	0	0	0.4	0
	CT3	0	0	0	0	0
	ST4 -6	8	8	8	8	0
	Trust Doctor	0	0	0	0	0
Total		**14.9**	**8**	**8**	**10.29**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	6	£834.78
North Yorkshire & York	16	£2,121.37
Total	22	£2,956.15

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£2,956.15	**£2,956.15**	**£1,095.41**	**£4,816.89**

Purchases

Date	Item	Location	Cost
22 Jul 2022	Coffee Pods	Jr Doctors Office CLH	£248.86
22 Jul 2022	Coffee Pods	Jr Doctors Office FPH	£248.86
2 Sept 2022	Coffee Pods	Jr Doctors Office CLH	£248.86
2 Sept 2022	Coffee Pods	Jr Doctors Office FPH	£248.86
26 Sept 2022	Aromatherapy Diffuser & Oils	Jr Doctors Office CLH	£99.97
		Total Spent	**£1,095.41**