MEETING OF THE BOARD OF DIRECTORS

Thursday 24 November 2022

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

AGENDA

Standard Items (1.00 pm – 1.15 pm)

1	Apologies for absence	**Chair**	**-**
2	Chair's welcome and introduction	**Chair**	**Verbal**
3	Declarations of interest	**-**	**Verbal**
4	To approve the minutes of the last ordinary meeting held on 27 October 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 (1:15 pm – 2:30 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**
11	To consider the Corporate Risk Register	**DoN&G**	**Report**
12	To consider the six month review of progress against the 2022/23 business plan	**Asst CEO**	**Report**
13	To consider the report on Accelerating our Clinical, Quality and Safety Journey to Change	**CEO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (2:30 pm – 3:10 pm)

14	To consider the Leadership Walkabout Report	**DoCA&I**	**Report**
15	To consider the report of the Acting Chair of the Quality Assurance Committee *(See agenda item 10 chapter 4 for the Committee Key Issues Report)*	**Committee Chair (PH)**	**Verbal**
16	To consider the report of the Mental Health Legislation Committee *(See agenda item 10 chapter 4 for the Committee Key Issues Report)*	**Committee Chair (PH)**	**Verbal**
17	To consider the assurance report on the delivery of recommendations in the Ockenden Report	**DoN&G**	**Report**
18	To consider the response to the National Mental Health Director, NHS England	**DoN&G**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (3:10 pm – 3:15 pm)

19	To consider the report of the Chair of the People, Culture & Diversity Committee *(See agenda item 10 chapter 4 for the Committee Key Issues Report)*	**Committee Chair (JH)**	**Verbal**

Exclusion of the Public:

20	**The Chair to move:** *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office holder or applicant to become an office-holder under, the Trust.*	**Chair**	**Verbal**

	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.*		

David Jennings
Chair
18 November 2022

Contact: Karen Christon, Deputy Company Secretary
Tel: 01325 552307
Email: karen.christon@nhs.net

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 27 OCTOBER 2022 AT WEST PARK HOSPITAL, EDWARD PEASE WAY, DARLINGTON, DL2 2TS AND VIRTUALLY VIA MS TEAMS, COMMENCING AT 1.00 PM

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
C Carpenter, Non-Executive Director
J Haley, Non-Executive Director
P Hungin, Non-Executive Director
J Maddison, Non-Executive Director
B Reilly, Deputy Chair
J Preston, Non-Executive Director & Senior Independent Director
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
K Kale, Medical Director
L Romaniak, Director of Finance, Information and Estates
A Bridges, Director of Corporate Affairs and Involvement (non-voting)
M Brierley, Assistant Chief Executive (non-voting)
S Dexter-Smith, Director of People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
J Boylan, Guardian of Safe Working
K Christon, Deputy Company Secretary
L Howey, Head of Psychological Professions (attending for H Crawford)
L Taylor, Care Group Director of Operations and Transformation (attending for P Scott)

Observers/members of the public:
J Venables (Governor)
R Tuckett (Governor)
H Griffiths (Governor)
J Kirkbride (Governor)
J Wardle (Governor)

22/166 APOLOGIES FOR ABSENCE

Apologies for absence were received from R Barker, Non-Executive Director, H Crawford, Director of Therapies and P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group.

22/167 CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and acknowledged the officer support that had been provided to allow it to be held as a hybrid meeting, in response to requests from governors.

22/168 DECLARATIONS OF INTEREST

None.

22/169 MINUTES OF THE LAST ORDINARY MEETING ON 29 SEPTEMBER 2022

Agreed: *that the minutes of the last ordinary meeting held on 29 September 2022 be approved as an accurate record and signed by the Chair, subject to the following amendments:*

- *Para 22/148 – to be amended to 226 doctors*
- *Para 22/146 – to be amended to remove reference to J Maddison as Chair of the Strategy and Resources Committee.*
- *Reference to Mrs Carpenter be amended to Dr Carpenter*

22/170 BOARD ACTION LOG

The board reviewed and noted the Board Action Log.

Reference was made to ensuring that the action log captured actions from previous meetings and the board noted the need to be clear on aspects of discussion that resulted in a formal action of the board.

Action: K Christon

Responding to a query, E Moody indicated that the Oakenden Report had been deferred to the November board meeting due to staff capacity. This change had been approved by the Deputy Chair, in the Chair's absence. It was proposed and agreed that narrative be included in the action log where there had been a delay to reports.

22/171 CHAIR'S REPORT

The Chair introduced the report, which provided a summary of work carried out since the last meeting. He noted his involvement in the Chairs network and his intention to maintain a relationship with the joint Chair of North Tees and Hartlepool Foundation Trust and South Tees Hospitals Foundation Trust due to overlapping geography, common challenges and the need for a close working relationship.

22/171 MATTERS RAISED BY GOVERNORS

None.

22/172 CHIEF EXECUTIVE'S REPORT

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

In presentation B Kilmurray drew attention to:

(1) Publication of the CQC report on Secure Inpatient Services the following day, which was expected to report an improved position.

B Reilly queried communications with governors and staff in advance of the publication and stressed the importance of service user and carer involvement in the co-design of services.

Responding, A Bridges confirmed that communications would be circulated to governors and staff prior to publication of the report.

(2) The board seminar on 13 December 2022, which would provide an opportunity for the board to drive the next business planning process, with a focus on co-creation and the development of a manageable number of priorities.

M Brierley referred to a review of the current business plan as part of this process to ensure that nothing was missed.

The Chair welcomed the focus on a smaller number of priorities and the involvement of the board, with support from the Council of Governors, to develop a collective view of what these would be.

J Maddison supported the focus on key priorities and suggested that implications linked to the change in the Secretary of State for Health and Social Care would also need to be considered as part of the process.

M Brierley indicated that there would be a focus on safety and quality, and the enabling functions that supported service delivery and ensured the trust was a good place to work. Following the December board session, events would be held with governors and stakeholders prior to a board discussion in February, before further engagement and involvement.

The Chair requested that proposed board meeting dates for the coming year be circulated as soon as possible, and options be given for dates for board seminars.

Action: K Christon/P Bellas

J Preston referred to the potential for overlap between the recently agreed Autism Task and Finish Group, work carried out by Mersey Care and related work that governors were personally involved in.

B Kilmurray acknowledged the potential for this and proposed that P Scott maintained contact with the group.

The Chair acknowledged the valuable input from governors who had volunteered to take part and suggested the terms of reference recognise links they had and any overlap or potential for duplication.

In response to a query raised by B Reilly, the board discussed its response to the publication of the CQC Adult Learning Disability Inpatient Service Report. It was agreed that the board would formally record its apology for the position and those actions for which it was responsible and would note the action that had been taken place in response to ensure improvements were made. The board also noted that there were areas where change would only be delivered with support from local authorities and partners within the wider system.

22/173 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

The board noted and received the Board Assurance Framework Summary Report (BAF), which provided information on alignment between the strategic risks and matters due to be considered at the meeting.

A suggestion was made that summary narrative be included in the BAF to outline what had changed since the previous meeting.

Responding, P Bellas noted that little information had changed from the previous month and there were no significant issues to draw to the attention of the board. The quarter two review due

to be reported to the board in November would include substantial changes, with assurances aligned to the three lines of defence model, to support the reporting process.

The Chair welcomed use of the model, which he suggested would lead to insightful conversations on first line assurance by senior management. He also noted that the relevant aspects of the BAF and related risks were delegated to and discussed by each of the board's sub-committees.

22/174 10 - INTEGRATED PERFORMANCE DASHBOARD REPORT

The board received and noted the Integrated Performance Dashboard Report.

In presentation, M Brierley highlighted that, as part of the ongoing cycle of improvement, a number of old actions had been removed. The board's attention was then drawn to:

(1) Bed occupancy and out of area placements (measures 8 and 9), which remained volatile. It was noted that there had been a recent increase to seven beds from the four reported, but this remained a significant improvement on the reported 21 beds in July 2022.

(2) Restrictive Interventions (measure 12) where there was an overall decreasing trend, except for one individual where a move to a new ward had taken place.

B Reilly, Chair of the Quality Assurance Committee (QuAC), highlighted that despite an overall decreasing trend, there had been limited reductions in some areas and she noted that QuAC would explore the position further.

In response, E Moody acknowledged that the position was complex and a six month report would be provided to QuAC at the next meeting. She suggested that progress had been made but for a small number of patients in Learning Disability and Psychiatric Intensive Care Unit, but this was also moving in the right direction, albeit for one individual patient.

The Chair discussed the need for appropriateness of use, noting the trust's aspiration was to use the right intervention at the right time to protect the patient, other patients and staff.

(3) The staff leaver rate (measure 18), where the board was asked to note the reported actions that had taken place.

(4) Development of a framework to accompany the report, which would be provided to the board in November. The framework would include narrative on the level of assurance against all measures, providing an opportunity to identify and focus on areas where specific action or greater assurance was needed.

J Preston raised a concern about the lack of information provided on time frames and in response, M Brierley indicated that the framework would provide a timeline where this could be defined.

(5) The revised measures outlined in the report, which would be reported to the next Quality Assurance Committee for approval.

Clarification was then sought on the following matters:

(1) Whether additional resources were required to support the Nurse Consultant role, who was also providing expert positive and safe intervention support to neighbouring acute trusts.

E Moody advised that the post holder, whilst working in other trusts, was supporting TEWV patients. A business case for additional capacity would be developed and presented to the programme board in November, taking account of feedback from the Mersey Care review.

(2) The reported £2.2m deficit position at month 5 and proposals to address this without an impact on quality and safety.

In response, L Romaniak advised that a trust wide stocktake had taken place during month six to understand the position, including the revised forecast and required recovery action. The aim would be to reach the end of the year as close to target as possible, whilst also considering future sustainability. It was reported that the deficit position was expected to worsen in month six due to the additional pay award, which if funded solely through the tariff, would result in an annual deficit of £3.3m. Other costs that had impacted on the financial position included digital expenditure, packages of high cost care, occupancy levels and extended lengths of stay due to delayed transfers in the system.

It was noted that the ICB had provided support to understand the financial pressures and if TEWV was unique compared to other areas and to influence NHS allocations, to ensure a more equitable distribution of resources.

B Kilmurray advised that regular financial reporting to the board would start in November. This was welcomed by the Chair as a means of giving the board visibility of key issues and consequences and would support decisions the board would take on priorities.

(3) Caution was expressed at the reported 70% of carers who had responded to the carer survey to indicate that they had been involved in decisions about care and treatment, as this represented a small number of the carers that the trust engaged with.

(4) Why an improvement plan was needed to respond to the reported deterioration in crisis line call pick up rates in North Yorkshire and York.

B Kilmurray indicated that the improvement plan provided a mechanism for Executive Directors to be assured that action had been taken and to understand if measures had worked.

Z Campbell confirmed that action had also taken place immediately. The underlying issue related to capacity and changes were underway to develop job descriptions and new roles to ensure calls would be answered and resolved in a timely manner.

(5) The level of reported outcomes following treatment and if this was comparable to that reported across the mental health sector.

In response, K Kale indicated that the Outcomes Steering Group had considered the issue and it was noted there had been an impact on outcomes where progress was not measured across the whole course of treatment. A number of actions had been identified including staff briefings on standards for completion of outcomes, staff training and testing of the caseload supervision process.

The Chair proposed a further discussion be held on this as part of a board development session.

Action: K Kale

With agreement of the board, the Chair varied the agenda to bring forward item 15, the report of the Guardian of Safe Working

22/175 REPORT OF THE GUARDIAN OF SAFE WORKING

The board received and noted the quarterly report, which provided assurance that Junior Doctors were safely rostered and working hours were safe and in compliance with Terms and Conditions of Service.

In presentation, J Boylan indicated that he was satisfied to provide assurance that the trust had continued to support doctors' wellbeing. He then drew the board's attention to two areas:

(1) Work intensity, which continued to be a consistent issue in Teesside, Scarborough and North Yorkshire. The issue related to breach of the continuous rest rule within non-residential on call rotas and resulted in a higher rate of fining compared to neighbouring trusts, although the differing geography was noted. In response, an in depth review of on call rotas was proposed with junior doctors involved from the outset.

In response, K Kale advised that the points raised had been discussed at the Medical Director huddle and raised with the Local Medical Committee, and it had been agreed that a review of all rotas, including junior doctor rotas and consultants, would be completed in January 2023.

(2) The realignment of on call cover for Adult Learning Disability (ALD) Services and concern at the proposal that general adult on call clinicians would provide out of hours cover.

In response, K Kale noted that locums from adult services had been required to fill rota gaps created by insufficient supply of ALD doctors. National documents suggested that generic rather than specialist doctors should be deployed to support specialist ALD consultants. He undertook to review the position and to meet with junior doctors to find a solution.

B Kilmurray acknowledged that ALD cover, including the level of specialism required, was a long standing issue, and may benefit from an options appraisal.

J Boylan recognised the issues raised were not straight forward to resolve and stressed the importance of junior doctor involvement at an early stage for a variety of reasons, including morale.

Clarification was then sought on the following matters:

(1) How the fine system worked.

J Boylan advised that a fine may be levied where working conditions fell outside the parameters of the national contract for junior doctors. The fine would be pre-determined by the nature of the exception reported. For example, if a junior doctor had less than five hours continuous rest during a shift it would result in a breach and the doctor would submit an exception report. Not all exceptions would result in a fine. A percentage of the fine would be paid to the doctor and the remainder would be held by the Guardian of Safe Working to support doctor wellbeing.

(2) The impact of vacancies and sickness.

J Boylan advised that the trust did not employ external locums but operated a system of internal cover and this provided sufficient cover 99% of the time. Exception reports arose from shifts worked by doctors employed by the trust.

P Hungin noted the importance of addressing the concerns raised, which would influence junior doctors' perception of the trust and impact on recruitment and retention.

22/176 LEADERSHIP WALKABOUT REPORT

The board received and noted the report, which provided high-level feedback from recent leadership walkabouts to crisis, urgent care and liaison services.

Presenting the report, A Bridges discussed the refreshed format, as part of the board's assurance process and noted that it provided an opportunity to be more collaborative, with the discussion focused on issues that teams had identified in advance. It was proposed that this new format be continued.

It was also noted that as part of quality and improvement work, the patient experience teams would carry out focus groups with service users and carers and the trust was to re-introduce the 15 step challenge, that was in place pre-Covid.

The board's attention was drawn to the feedback summarised in the report on strengths and challenges and Executive Directors were encouraged to follow-up after a walkabout to ensure that issues had been responded to and to provide feedback.

The Chair queried why it had been necessary to escalate some of the issues to the Chief Executive. In response, B Kilmurray and L Romaniak advised that many of the issues raised related to concerns about the estate and were outside of TEWV's control. They had already been noted and escalated, including with the relevant acute trust Chief Executive, for response.

Responding to a query, B Kilmurray indicated that a hybrid approach to the discussion with staff was not the preferred option. It was noted that walkabouts had been scheduled for the year and the Chair requested that a reminder of dates be circulated.

Action: A Bridges

22/177 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 6 October 2022.

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

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

(1) Committee would monitor implementation of the Adult Learning Disability Improvement Plan.

(2) QuAC and the People, Culture and Diversity Committee had oversight of a number of risks related to quality and safety, where staffing, recruitment and retention was noted as a consistent issue. This may lead to a piece of joint work.

(3) A correction was made to the report in respect of reference to oversight of delivery of the anti-ligature programme, which would be by the existing Executive Quality Assurance and Improvement Group.

(4) Concerns had been raised by the committee about complaints performance, where 3% of complaints were responded to within 60 days.

A Bridges acknowledged that performance needed to improve. The significant volume and complexity of complaints had impacted on performance and a review of the service would be completed in January 2023.

(5) Committee had received a detailed paper on themes and patterns of self-harm within acute inpatient services and had suggested it be shared with other mental health trusts for their information.

(6) Committee had received an update from Health and Justice Services, where concerns had been raised about implementation of the contract in the Hull and Humber area.

22/178 LEARNING FROM DEATHS REPORT

The board received and noted the report, which set out the approach the trust had taken towards the identification, categorisation and investigation of deaths, in line with national guidance.

E Moody presented the report, highlighting the following:

(1) Work carried out on areas of learning from the thematic review of historical serious incidents, which had highlighted seven themes. These would be reported to the NHS Quality Board for additional assurance.

Two new themes – safe discharge and did not attend – had been identified and further improvement work would be carried out and reported in the following quarterly report.

(2) Trust involvement, as early implementors in the pilot Better Tomorrow Programme, which had included a desk top assessment of the deaths review progress. This had indicated that the redesign of processes had led to a more robust system. They had also welcomed inclusion of reviewers and public health at mortality panels and had recognised the focus on positive and negative aspects of learning as an area of good practice that they intended to share with other trusts.

Clarification was sought on the following matters:

(1) Whether the sector had standardised mortality rates, against which the trust could be compared.

E Moody advised that CQC and NHSE/I had previously indicated that the trust was not an outlier, but there were no benchmarking or standardised rates available for the sector. A piece of regional work had been carried out, but this had been limited to themes and the impact of learning.

(2) The relationship between the differing groups in the structure.

E Moody indicated that there was communication between the groups, who all reported into the Executive Quality Assurance and Improvement Group and the Quality and Safety Programme.

Drawing the discussion to a close, the Chair noted the level of assurance provided to the board on the robust process for investigating deaths and identifying and implementing areas of learning. He noted that challenges linked to transition from children and adolescent services to adult services had been recognised across sectors for some time.

22/179 DEEP DIVE INTO STAFFING AND WORKFORCE

E Moody presented an overview of: the national guidance in relation to staffing; what good board governance looked like; the definition of safe staffing; CQC regulation 18; and the safe staffing model. She also discussed the importance of culture in relation to safe staffing.

E Devanney provided a summary of operational oversight and escalation arrangements, which allowed for daily management of staffing levels and supported timely intervention, and the community process around staffing challenges. As an example, an overview was provided of the Secure Inpatient Services daily operational assurance model.

Responding to a query, the board was advised that by quarter four 50% of teams would be using the system.

E Moody then went onto discuss good governance around staffing establishments, and the three components that were used in the safe staffing process being professional judgement, evidence based tools and data, and outcomes. National guidance outlined how often reports would be presented to the board and the trust had operated the model for the previous two years.

S Dexter-Smith provided an overview of trust wide actions that were underway including: collection and analysis of reasons for leaving; weekly tracking and monthly reporting of mandatory and statutory training and staff appraisal levels; analysis of sickness against national data; and bi-weekly reporting to the Executive People, Culture and Diversity sub-group on recruitment.

It was agreed that a copy of the presentation would be circulated to the board following the meeting.

Action: S Dexter-Smith

Clarification was then sought on the following matters:

(1) If the daily position was able to be aggregated to provide a trust wide picture of actual staffing levels against establishment, or if there was clarity on the number of vacant posts, or when that level of detail would be available to the board.

B Kilmurray acknowledged that the IST had challenged the trust to provide more detail at a service or locality level, but this would not be achieved immediately. S Dexter-Smith went onto highlight that work was underway to align the differing trust staff systems and noted that a regional return was submitted, which identified the level of growth needed, in which professions and by when.

(2) The mismatch between the staffing concerns reported by the CQC and the operational management of staffing, as outlined in presentation.

S Dexter-Smith advised that the operational model supported safe staffing on a day to day basis and reported on Nurse and Health Care Assistant levels. In contrast, the CQC would consider how safe staffing was provided on a sustainable basis.

The Chair expressed concern that there was an opportunity for the trust to be criticised on issues that it was not fully in control of and queried when the board would have a clear understanding of the overall staffing position.

B Kilmurray acknowledged a comment raised by the board previously, that where there was a deficit in staffing and skills, the trust had the opportunity to consider if it was able to achieve the CQC standard or if it should no longer provide the service.

(3) The level of assurance that could be provided that processes were followed and working, noting that the process in place or the completion of it appeared not to be to the satisfaction of the CQC.

E Moody suggested that staff followed procedures and noted that the CQC had previously been satisfied about the operational processes in place to ensure safe staffing on a daily basis. As an example, she advised that earlier in the week the trust had one registered nurse on every ward across the trust. Services were safe but would not have met CQC requirements. The CQC regulation was acute focused and provided for services to temporarily, partially or fully close. This was not always an option for TEWV, where closing part of a service would have an impact elsewhere in the system.

Commenting further, she noted that the trust was commissioned to deliver services at 85% occupancy, but demand had since changed, and services would now run at 100% and over. Significant investment had been made in response.

In response, B Reilly queried whether the trust had been fortunate to achieve staffing levels on all occasions and why a service was delivered at 100% when it was commissioned at 85%.

J Maddison noted that the board could not take assurance that staffing levels would be at a desired level every day. Processes identified where issues existed and what action was needed on a daily basis, but it would be challenging for the trust to determine that a service should not be provided and therefore it may need to be satisfied that it would not achieve the CQC definition of safe staffing, all the time.

In response, B Kilmurray advised that the system provided an improved level of information and assurance on daily staffing but acknowledged that there was not a consistent level of staffing every day. Where a significant concern was raised about the level of staffing within a service a flash alert would be issued to the board and a decision taken about ongoing service delivery.

Commenting further, E Moody suggested that the trust had good controls and mitigation for minimum daily staffing levels, but there were challenges in relation to the skill mix between Registered Nurses and Health Care Assistants which would impact on the quality of care provided.

(4) The opportunity for a board deep dive or discussion at the People, Culture and Diversity Committee (PCDC) on the challenges linked to recruitment and retention, in order that the board could be assured that action had been taken that would make a difference.

S Dexter-Smith indicated that the Workforce Delivery Plan would be presented to the board following discussion at PCDC. The plan would detail what action would take place in the following six month period. Reference was also made to significant work underway on recruitment and apprenticeships.

(5) Responsibility for staffing, including delivery of training for each staff group.

S Dexter-Smith indicated that as Director for People, Culture and Diversity she had overall responsibility, but there were shared areas of responsibility with the care groups including

around the commissioning and delivery of training. Vacancies, sickness and recruitment were monitored centrally, and action would be taken where data suggested staff groups were not achieving the agreed trajectory.

(6) It was suggested that there were examples of staff who had moved to other areas outside of their expertise and had felt vulnerable and demoralised as a result.

The Chair brought the discussion to a close, noting that assurance had been provided on processes, controls and escalation in respect of daily staffing levels. In relation to work in progress on sustainable staffing levels and skills, a summary report to be provided detailing work underway, what would be delivered and when, noting links to the business planning process. Once information was available, the board would wish to create space for a further discussion on staffing levels and service delivery.

Action: S Dexter-Smith

The Chair noted the board's understanding of the challenges discussed and their importance to improving the quality of care

22/180 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 5.08 pm.

David Jennings
Chair
24 November 2022

Board of Directors

ITEM NO. 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		See agenda item 17
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		Report to PCDC and ARC in Nov-22
29/09/2022	22/139	Patient experience	Quality Assurance Committee to review that services, particularly secure inpatient services, are provided in a way that is respectful of a individual's affirmed gender.	DoN&G	tbc		
29/09/2022	22/139	Workforce Delivery Plan	Workforce Delivery Plan to be presented to a future board meeting.	DfP&C	Jan-23		Draft plan presented to PCDC in Nov-22
29/09/2022	22/139	Staff survey	People, Culture & Diversity Committee to carry out a deep dive into the reductions 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.	DfP&C	tbc		
29/09/2022	22/139	Integrated Performance Dashboard	Future reports to include summary narrative to be provided on the level of assurance to the board in resepct of risks included in the BAF, particularly where the variance between the present and target risk scores was material.	ACEO	Nov-22		See item 10
29/09/2022	22/144	Mental Health Legislation	Training to be provided to the board on the Mental Capacity Act	MD	tbc		Brieifng circulated to the board on 8-Nov

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
22/10/2022	22/170	Board Action Log	To be reviewed to ensure all previous actions were included or completed	Deputy Co-Sec	Nov-22		Completed. PH/KK to discuss how the Trust's close links with local universities could be used to to enhance recruitment and retention (see July-22 Board minutes)
22/10/2022	22/172	Board meetings	Dates be circulated for board meetings for 2023/24	Deputy Co-Sec	Jan-22		Dates for May23-Apr24 are pending the outcome of the governance review
22/10/2022	22/172	Board Seminars	Options be given for dates for future board seminars	Co Sec	Ongoing		
22/10/2022	22/174	Integrated Performance Dashboard	Disucssion to be held at future board development session on the level of reported outcomes following treatment	MD	tbc		
22/10/2022	22/176	Leadership Walkabout visits	Future dates to be circulated to the board	DoCA&I	Nov-22		Circulated on 18-Nov
22/10/2022	22/179	Deep dive into staffing and workforce	A copy of the presentation from the meeting to be circulated to the board.	DfP&C	Oct-22		circulated via email on 8-Nov
22/10/2022	22/179	Deep dive into staffing and workforce	Summary report to be provided on work in progress on sustainable staffing levels and skills.	DfP&C	tbc		linked to action 22/139 (workforce delivery plan)

Chair's Report : 28th October 2022 – 24th November 2022.

Headlines:

External:

- Meetings Good Governance Institute
- Weekly MH Chairs' Network
- Remembrance Sunday Wreath Laying Darlington
- Meetings MPs

Governors

- Council of Governors
- Discussions with specific Governor

Internal

- NICHE Reports, and visits to WPH, RPH, LRH
- Staff Webinar following NICHE publication
- New Consultants Programme : Headlam Hall
- Meetings with various Execs / Teams.
- Strategy & Resources Committee attendee
- Judging, and giving, Living the Values Awards
- Leadership Walkabout HMP Holme House
- Visits Foss Park, Orca House, Huntington House
- Resilience Hub Humber & North Yorks (slides circulated)
- Ridgeway Patient Recovery Awards

- To ensure the last Quality and Assurance Committee meeting was quorate, we used the emergency powers of the Chair and Chief Executive to appoint Jules Preston to the committee, in lieu of an available Board meeting to ratify such a decision.

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 24 November 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.

Niche Reports

On 2nd November the three reports relating to the deaths of Christie, Nadia and Emily were published. They were three young women who had been associated with our CAMHS inpatient service. Chisitie and Nadia died following incidents at West Lane Hospital. Emily died after an incident at Lanchester Road Hospital.

We fully accept the findings of these reports and the recommendations provided.

We offer an unreserved apology for the failings that led to these sad and untimely deaths.

At the same time as the publication of the reports the Trust issued statements setting out what has happened with regard to addressing the failings within the reports.

We are committed to making ongoing improvements and working with patients, families and colleagues to ensure that we can embed changes that prevent similar incidents from happening in the future.

Flu and Covid Vaccination update

We have made a good start with the Trust's covid and flu vaccination programmes. Despite supplies only being available from October we have achieved a 29% take up of covid vaccinations and a 34% take up on flu.

We are keen to maintain momentum with this and a communication plan has been developed to encourage and incentivise participation. Clinics are being offered across the Trust that can be booked and a number of drop in sites are also available. Most of these clinics are now offering both vaccines in one appointment or visit.

Colleagues can also access vaccinations at their local GPs and Pharmacies. Whilst this increases flexibility we do have some timelag in the receipt of data, therefore as yet this activity is not reflected in our numbers.

Leaders are being encouraged to promote vaccinations, highlighting that this is a key preventative measure that protects them, patients and their families and friends.

GP Conference in York

Our annual GP education conference took place in York on 10th November. This year the conference was organised by colleagues from planning, the medical directorate and the therapies team.

The event was well attended and provided opportunities for GPs to hear from Trust colleagues, who shared their expertise on: veterans health, CAMHS transformation, managing distress, perinatal services, eating disorders, psychosis, autism, ADHD, body dysmorphia, dementia medically unexplained physical symptoms, dual diagnosis and community mental health transformation.

Early review of the evaluation indicates that the event was well received by GPs. It was a good opportunity to network with primary care colleagues and staff from the Trust.

International Recruitment

The Trust has joined with NHS colleagues from the Humber and North Yorkshire ICB in partnering with the State of Kerala in India. The purpose of the partnership is to support the recruitment of health professionals to roles in the UK. This is an approach that has been endorsed by the Department of Health and Social Care as an ethical approach. This means that in recruiting from Kerala we are tapping into a deliberate over supply of workers, as their state system is training more health care professionals than they need there.

With this in mind, on 18th November representatives from across the ICB, including from TEWV will be going to Kerala to attend a careers fair. Interviews have been arranged with hundreds of potential recruits covering medical staff, nurses, allied health professionals, social workers and pharmacists.

It is anticipated that we will be successful in recruiting from this talent pool and will bring back a number of new colleagues to the Trust.

We fully acknowledge that in order to make this successful we need to make significant preparations in advance of these new colleagues arriving into the UK and we are putting in place pastoral support to identify accommodation and the key practicalities required.

This is not the first time the Trust has benefited from international recruitment, however it is hoped that we will achieve more significant numbers of high quality recruits through this new partnership.

IAPT Renaming

The Improving Access to Psychological Therapies programme has been in existence since 2008. It is widely known by its acronym IAPT. IAPT offers a stepped programme of talking therapies for a range of people to help them overcome depression and anxiety and better manage their mental health. The service provides an evidenced based approach based on pathways of care. There is an associated workforce model that supports the delivery of stretching access and outcome targets.

NHS England has announced that they are currently engaging on renaming the service. The aim being to make it easier to identify and support improvement in access. The engagement will run until 16th December.

The Trust provides IAPT services in Durham, North Yorkshire, York and Selby.

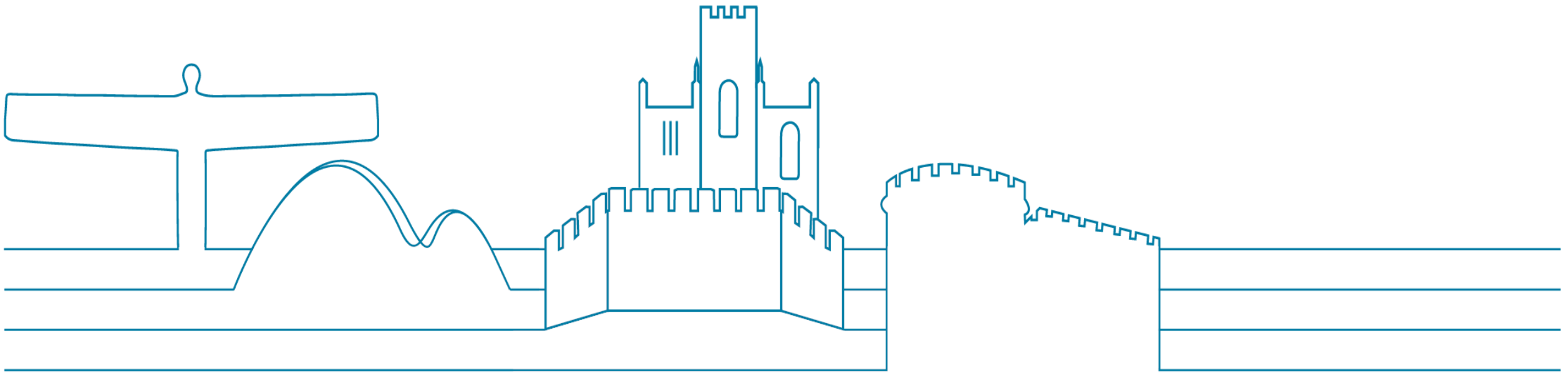
Draft North East North Cumbria Integrated Care Strategy

NENC Integrated Care Partnership has issued its draft Integrated Care Strategy for consultation and comment. Comments can be made up to 25th November. The ICP is required to publish the final strategy by December.

Attached at appendix 1 is a presentation that sets out the main aspects and key features of the strategy. There is a full document available should Board members wish to see it.

A Trust response is being drafted and will be shared with the board in advance of the meeting.

North East and North Cumbria Draft Integrated Care Strategy



North East and North Cumbria Integrated Care Partnership (ICP) Strategy

- The ICP is a statutory committee, established by the NHS and local government as equal partners, and involving partner organisations and stakeholders. It forms part of the arrangements for the Integrated Care System (ICS).

- Each Integrated Care Partnership is required to develop an integrated care strategy covering the whole ICP population by December 2022

- ICBs and local authorities must 'have regard to' the strategy when making decisions, and commissioning or delivering services

- The strategy must use the best evidence, building from local assessments of needs (JSNAs), and enable integration and innovation.

Structure of the Draft Strategy

- Vision, Goals and Enablers
- Building on our Assets and the Case for Change
- Longer, Healthier Life Expectancy and Fairer Outcomes
- Health and Care Services and Enablers
- Involvement and Delivering the Strategy

Vision, Goals and Enablers

Assets and Case for Change

- We have strong communities, an amazing Voluntary, Community and Social Enterprise sector, World Class natural assets and vibrant industries
- We have a strong foundation of partnership working, an outstanding health and care workforce, and some of the best research and development programmes of any system
- Our health outcomes are some of the worst in England, with deep and protracted inequalities, which correlate with socio-economic deprivation
- Life expectancy at birth is 81 (women) and 76.9 (men), compared to 82.6 and 78.7 for England
- Healthy life expectancy is 60.2 (women) and 59.4 (men), compared to 63.9 and 63.1 for England.

Draft Key Commitments

- We will reduce the gap in healthy life expectancy between our ICP and the England average by at least 25% by 2030, and aim to raise the average healthy life expectancy to a minimum of 60 years in every Local Authority by 2030

- We will reduce smoking prevalence from 13% of people aged over 18 in 2020 to 5% or below by 2030.

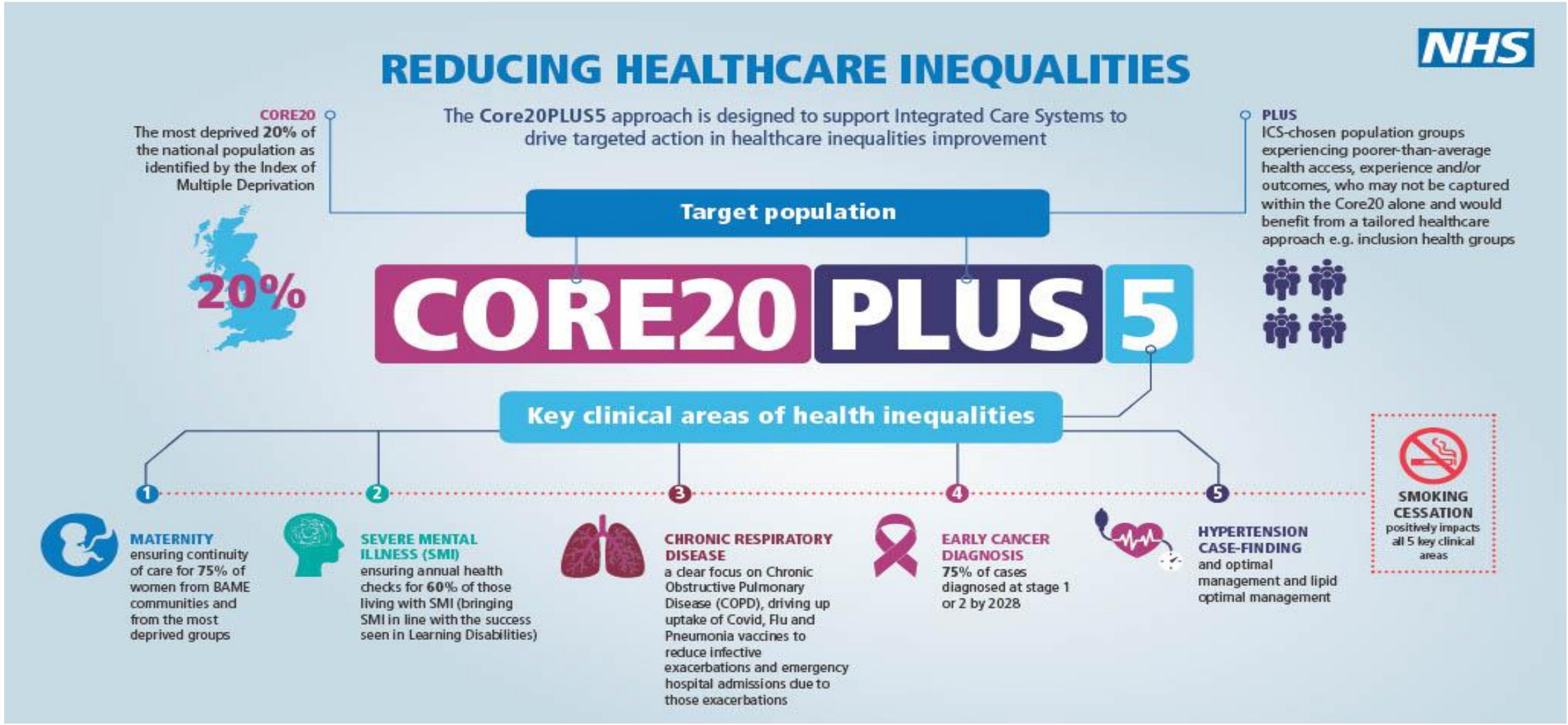
- We will reduce the inequality in life expectancy between the most deprived and least deprived deciles within our ICP by 25% by 2030

- We will reduce the suicide rate from 13 per 100, 000 population in 2019/2021 to below the England average of 10.4 per 100, 000 population in 2019/2021 by 2030.

Longer, Healthier Life Expectancy

- We will raise overall levels of health and improve at pace where the need is higher
- We will act as Anchor Institutions supporting social and economic development
- We will ensure Community Centred and Asset Based approaches building on the knowledge, skills, experience, resilience, and expertise in communities.
- We will implement evidence-based prevention programmes including smoking cessation, alcohol reduction, and healthy weight programmes, and support wider systems enabling good education, employment, fair pay, and better homes and neighbourhoods
- We will maximise routine adult and childhood vaccination programmes, covid and seasonal flu vaccination programmes, and reduce iatrogenic harms.

Fairer Outcomes – Delivering Core20plus5



Excellent Health and Care Services

- We will improve quality, more organisations will achieve a 'Good' or 'Outstanding' CQC rating and improve the sustainability of the most challenged parts of our system
- We will enable personalised care, organised around the holistic needs of people and improve the support offered to unpaid carers
- We will support the development of provider collaboration and value the voluntary, community and social enterprise sector as equal partners
- We will ensure parity of esteem between mental health, learning disability and autism services and physical health
- We will improve integration between physical and mental health, primary and secondary care, and health and social care, and value services equally across sectors.

Enablers

- A skilled, sufficient, compassionate and empowered workforce: we will improve recruitment and retention, and enable people to work in positive cultural environments

- Working together to strengthen our places and neighbourhoods: we will support social and economic wellbeing, and enabling services to work together

- Innovating with improved technology, equipment, estates and facilities: we will maximise the opportunities to utilise existing, and embrace new technologies, and invest wisely in maintaining and improving contemporary estates, facilities and equipment

- Making best and equitable use of our resources and protecting our environment: we will develop sustainable financial plans, and protect the environment.

Engagement

- Strategy Steering Group jointly chaired between the NHS and Local Government
- Call for evidence – over 300 documents received
- Stakeholder engagement and survey in November
- Local ICPs and Health and Wellbeing Boards discussions where possible
- Working with Health Watch and the Voluntary, Community and Social Enterprise sector to engage experts by experience
- Publicly available draft document and survey for feedback

Delivering the Strategy

- Detailed delivery plans and the NHS Joint Forward Plan by end of March 2023
- Refresh of Place plans in light of the big, systemwide commitments we agree in the strategy, with room for local definition and flexibility for local context
- Working together as partners to align system drivers to deliver of the strategic priorities
- Clear accountability and regular, transparent reporting of progress.

Questions, discussion and feedback

Communications Dashboard

October 2022

Tees, Esk and Wear Valleys
NHS Foundation Trust

This month we...

- Promoted the NHS staff survey and the prizes on offer for completing it
- Posted the video of the most recent EDHR Lunch & Learn with ex-footballer Gary Bennett
- Celebrated AHPs Day and spotlighted some of our wonderful AHP colleagues
- Promoted a unique project that supports both military personnel and civilians in their roles as unpaid carers for people with mental ill health, that was launched in Catterick
- Marked Worrld Mental Health Day

Highlights

Ridgeway held a 5k charity walk to raise money for Teesside charity Red Balloons

Therapy pets visited Willow Ward for World Mental Health Day

The gardening team at Lanchester Road wins the prestigious Northumbria in Bloom Gold Award

Our South Tees CAMHS team raised over £1000 for charity on their beach walk from Redcar to Saltburn

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

31
Media enquiries handled by the team

5
Media releases issued

94
Total pieces of coverage across online news, TV, and radio

News stories

- **Whitby man overcomes mental health struggles to become professional photographer and YouTuber –** *The Scarborough News*
- **Supernurse, 72, back at work caring for children after spending six weeks in a coma –** *Hull Daily Mail*
- **Grants on offer to improve access to support for Scarborough residents living with serious mental illness and their carers –** *The Scarborough*
- **Health trust slammed for use of restraints which left 3 disabled patients injured –** *Teesside Live*

Our website

43,659
Unique page views

Top three visited pages

1. Jobs
2. Services
3. Crisis

Staff intranet

236,312
Number of visits - sessions

Top three news stories

1. Positive Practice in Mental Health Awards
2. CQC report publication
3. NHS Staff Survey

We've told our staff about...

1. Allied Health Professional day
2. ADHD awareness month
3. Cito launch date update

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

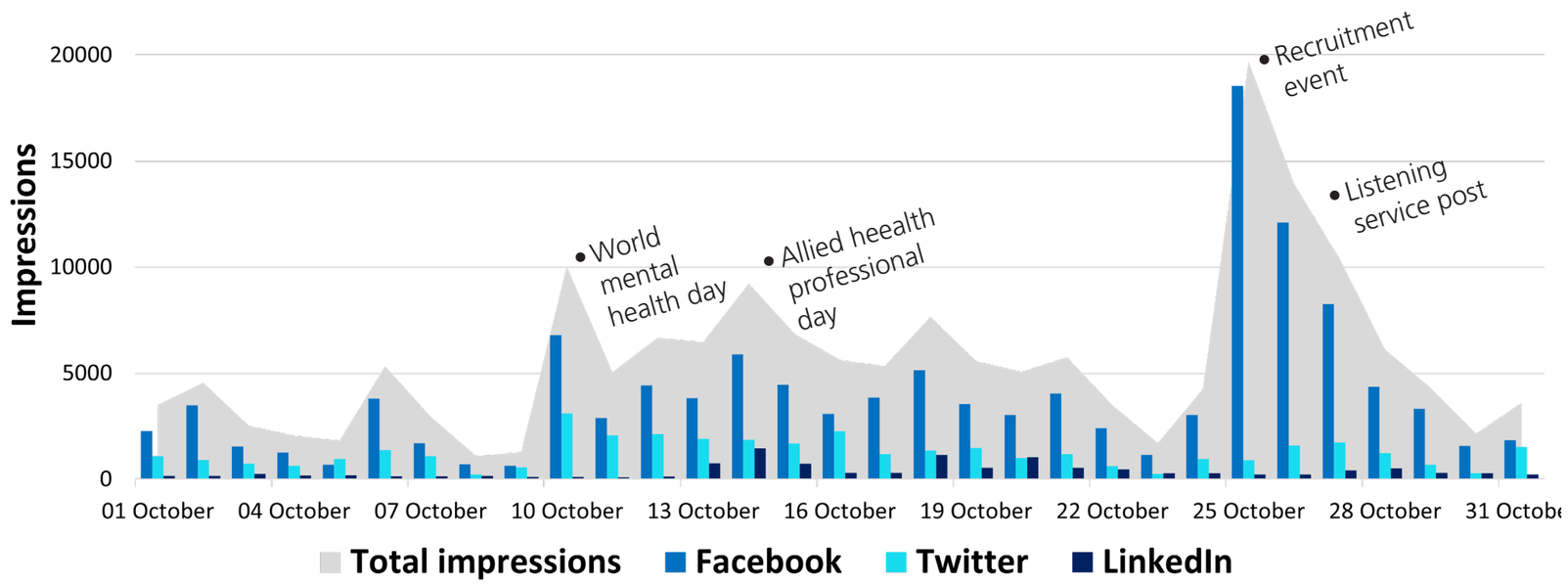
23,169
Total followers

165
New followers

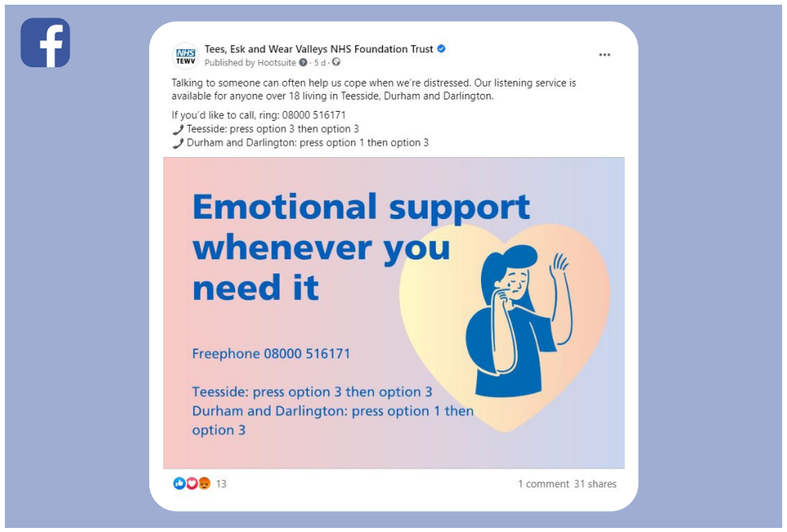
179,778
People who saw our content - impressions

2,244
Engagements

Daily impressions

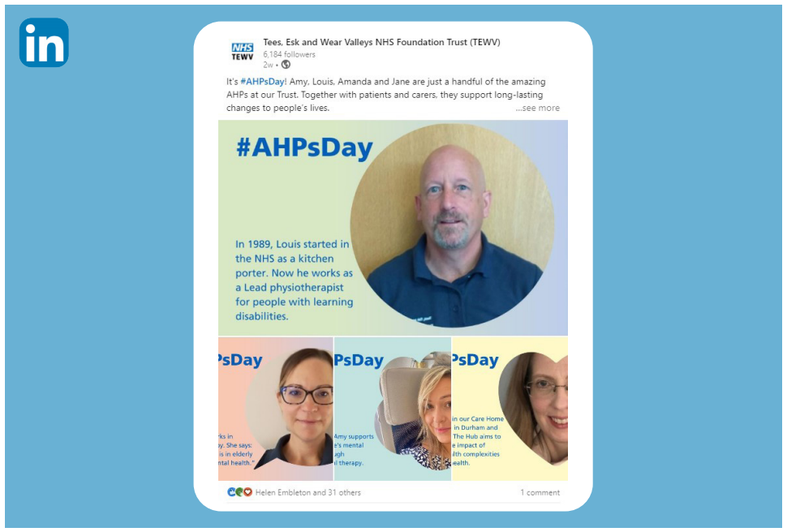


Top posts



Impressions 7,174 - Engagement 92

Impressions 1,318 - Engagement 55



Impressions 1,953 - Engagement 338

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24th November 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	Indicative Controls Assurance Rating	Risk Management Approach	Related Agenda Items
	1	2	3						
1	✓	✓		**Recruitment** Inability to recruit sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services	**DoP&C**	**High**	**Good**	Level of exposure not acceptable Strengthening of controls required at pace	▪ Public Item 8 – Chief Executives Report ▪ Public Agenda Item 10 – Board Integrated Performance Report ▪ Public Item 14 – Leadership Walkaround Report ▪ Public Item 17 – Ockenden Report Update
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 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.	▪ Public Agenda Item 13 – OJTC Report
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 Report ▪ Public Item 14 – Leadership Walkaround Report ▪ Public Item 17 – Ockenden Report Update ▪ Public Item 18 – Closed Cultures Report ▪ Public Agenda Item 13 – OJTC Report

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade	Indicative Controls Assurance Rating	Risk Management Approach	Related Agenda Items
5	✓	✓		**Staff Retention** Multiple factors could contribute to staff not choosing to stay with the Trust once we have recruited them. This will undermine the provision of safe and sustainable services 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 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 Report ▪ Public Item 17 – Ockenden Report Update ▪ Public Item 18 – Closed Cultures Report ▪ Confidential Item 3 – Reportable Issues log
7	✓	✓	✓	**Infrastructure** Poor quality physical or digital infrastructure could impede our ability to co-create a great experience both for staff and for patients [excludes CITO (see risk 12), Cyber security (see risk 8) and RPH (see risk 14)].	DoF&I	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 Report ▪ Public Item 14 – Leadership Walkaround Report ▪ Confidential Item 5 – Financial Forecast Assessment
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.	▪ Public Agenda Item 10 – Board Integrated Performance Report
9	✓	✓	✓	**Regulatory Action** Further regulatory action could result in loss of confidence and affect our reputation among service users, staff, and other key stakeholders (see also BAF ref. 11 – Governance and Assurance)	CEO	High	Good	Controls considered to be operating effectively and scope for improvement is limited High degree of exposure will need to be accepted Regular monitoring of the risk advisable.	▪ Public Agenda Item 10 – Board Integrated Performance Report ▪ Confidential Item 3 – Reportable Issues log

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade	Indicative Controls Assurance Rating	Risk Management Approach	Related Agenda Items
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 Item 8 – Chief Executives Report ▪ Public Agenda Item 13 – OJTC Report ▪ Confidential Item 3 – Reportable Issues log
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	
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	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade	Indicative Controls Assurance Rating	Risk Management Approach	Related Agenda Items
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.	▪ Public Item 8 – Chief Executives Report ▪ Confidential Item 3 – Reportable Issues log ▪ Confidential Item 4 – Chief Executives Report
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	DoFI	High	Good	Whilst controls are, generally, considered to be operating effectively further strengthening is required at pace, through the delivery of identified mitigations, to reduce exposure	
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 10 – Board Integrated Performance Report ▪ Public Agenda Item 13 – OJTC Report ▪ Confidential Item 3 – Reportable Issues log ▪ Confidential Item 5 – Financial Forecast Assessment

BOARD OF DIRECTORS

DATE:	**24th November 2022**
TITLE:	**Board Integrated Performance Report as at 30th September 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 **30th September 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 monthly IPR will also include, by exception, the key ambitions agreed with Commissioners in the Long-Term Plan (LTP) that have not been delivered. 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). The IPR will also provide progress against the System Oversight Framework (the regulatory framework).

3 Key Issues:

This is the second quarterly IPR for the period ending September 2022 (Q2 2022/23) – See Appendix A.

As part of the continuous improvement of the Integrated Approach to Performance, we have developed a **Performance & Controls Assurance Framework** which we have implemented this month. We have rated each measure using a statistical evidence-based tool/methodology starting with the Statistical Process Control (SPC)

charts or where this is not appropriate, we have utilised our forecast position or National benchmarking data. This is known as our Controls Assurance Rating to link this to the Board Assurance Framework approach. We have then given each measure a Performance Assurance Rating; where we have taken into consideration the Controls Assurance Rating, the level of additional intelligence we have; whether we have clear actions or where we have an agreed way forward. This is then combined with a more detailed examination of the SPC charts (where appropriate) to determine an overall performance assurance rating. This assessment is initially completed by the Associate Director of Performance and then considered at Executive Directors Group (EDG) to collaboratively agree the level of assurance being provided to the Board of Directors. A summary of the overall assessment agreed by EDG is included at the back of this summary paper.

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

3.1.1 Integrated Performance Dashboard

a) **Unique Caseload (measure 23)** We have an increasing position at both Trust and Care Group level. The Executive Strategy & Resources Subgroup have now established a task and finish group and the first phase is to undertake analysis at team level to identify which specific teams are indicating a concern and triangulate this with a range of staffing information. Timescales to complete the first phase will be confirmed once the initial scoping has been completed by Digital and Data Services, and a programme for subsequent actions will be agreed. There is **limited assurance** given there are no improvement actions identified.

b) **Financial plan (measure 24)** The Trust is not in line with its financial plan and without further mitigating actions delivery of the £1.16m planned surplus may prove challenging. There are 3 key drivers of financial performance: elevated bed occupancy, independent sector bed utilisation and elevated agency staffing pressures. In addition, organisations have needed to account in September for April to September implications of the nationally negotiated pay review body outcomes on NHS staff pay. Associated funding has not yet been confirmed and is subject to ongoing ICS discussion (see 3.3.2 Agenda for Change below). Trust plans were submitted on the understanding that pay award costs would be fully funded. If remitted on the nationally allocated basis of a 1.66% contract uplift the Trust has a £1.93m year to date pressure (included in position at month 6 and £3.3m full year).

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. Performance in quarter two has been consistently worse than planned, with in-month adverse variances to plan of £1.2m, £0.6m and £0.85m respectively for months 4 to 6.

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 last month concerted actions to mitigate Trust and Independent Sector bed pressures have sustained a significant reduction in dependency on external beds. Impacts include sustaining the elimination of dependency on Male adult assessment and treatment and PICU admissions to non-Trust beds at the time of writing. However ongoing volatility indicates the need for close oversight, caution in relation to the forecast 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.

The Executive Directors Group considered a series of financial deep dives to review actions already in train, additional actions now needed, and key forecast assumptions, to mitigate year to date under performance and to reduce future month expenditures to planned levels, including through mitigating discretionary actions.

Strategy & Resources Committee considered progress to develop risk-based forecasts on 8th November, taking into account mitigating actions identified to date. Recovery of the position by 31st March in the context of ongoing operational and workforce pressures and moving towards winter feels significantly challenging, hence there is **limited assurance** in relation to this measure. The Board is due to consider a more detailed consideration of the position and outlook for 2022/23 in private session.

c) **Financial plan: Agency Expenditure (measure 25a ****New***)** The Trust is overspending compared to planned agency costs for 2022/23. Monthly run rates for agency staff costs considerably exceed 2021/22 levels, meaning that the financial plan including associated CRES are not being delivered. There is **limited assurance** with elevated levels of agency expenditure being a cause 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, 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.

The Board is aware of modest 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, reducing 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), with financial implications from rate reductions being worked through. However, despite wider discussions, including through regional Quality Board, there are limited agreed system plans for the discharge of a small number of individuals supported through complex Care Packages.

d) **Financial plan: Agency price cap compliance (measure 25b ****New***)** Agency usage includes shifts fulfilled on hourly rates above the price cap. There is

limited assurance due to the pressures highlighted at 24 and 25a) above driving staffing pressures.

e) **Use of Resources Rating – overall score (measure 26)** The Trust is not achieving its planned Use of Resources Rating (UoRR). The issues highlighted in measures 24, 25a and 25 b above have impacted metrics across the UoRR measure (with the exception of liquidity), therefore there is **limited assurance.**

f) **CRES Performance Recurrent (measure 27)** The Trust is not achieving its recurrent CRES savings target. This is being compensated by good assurance on measure 28 (non-recurrent); however, in addition this is impacted by the assurance we have for agency and OAPs, therefore there is **limited assurance.**

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.

3.1.2 Other Alerts

a) **Crisis Lines** – In Durham and Tees Valley alongside a focus on transforming our crisis offer, work is underway in the short term to increase capacity to improve our call pick up rates further. The Governance around our Crisis services has been amended to create a single crisis line work program with PMO support. This work will now report in directly to the Clinical Quality and Safety Program Board. In North Yorkshire and York actions are being taken to improve the current call answering rate by reducing the record keeping time following each call; working with commissioners to identify additional support services that may be able to answer calls and provide a level of support increasing our capacity to support those people that need the level of support provided by mental health clinicians. An update of actions and expected impact will be provided to the Executive Directors Group on the 23rd of November.

b) **Long Term Plan Ambitions -** there are several measures not on plan for delivery for 2022/23.

- We currently have a risk to deliver our planned reduction in the number of out of area placements; however as outlined in 3.3.1 (f), improvements are now visible.
- We are not currently delivering our plans for IAPT Access, IAPT Waits and IAPT Recovery in several sub-ICB areas. Improvement actions are contained in the report for each area and are being closely monitored by the Care Boards.
- We are not currently delivering our plans for Children and Young People's Eating Disorder Waits (routine/urgent) in several sub-ICB areas; however, there is an improvement from Q1 to Q2 in most areas.
- We are not delivering our plans for people accessing IPS services across all sub-ICB areas. The calculation for this measure is new for 22/23 and work is underway to identify the level of staff commissioned to deliver this service and how this equates to the actual measure. This work is being prioritised to better understand this.
- We are not delivering our plans for the number of women accessing specialist perinatal services in several sub-ICB areas. An improvement action has been identified and is being closely monitored by the North Yorkshire, York & Selby Care Board.

c) **NHS Oversight Framework** we are currently placed in **Segment 3** which is *bespoke mandated support, potential through a regional improvement hub, drawing on system and national expertise as required.* There are several measures where we are placed in the lowest performing quartile which indicates a position of concern or where we are not achieving the Oversight Standard. Several of these measures are included within the IPD and the Long-Term Plan.

Our focus is quality improvement and to embed all our quality improvement actions. In line with our NHSE improvement plan, a key focus area is achieving CQC fundamental standards across all domains with a particular focus on the delivery of safe patient care. Our Advancing our Journey to Clinical, Quality and Safety to prioritise the relevant projects and programmes of work that will ensure effective delivery of our CQC action plan. Another key priority is addressing the backlog of Serious Incidents.

Financial pressures on safer staffing are increasingly presenting as tensions between different regulatory requirements, including as the Trust Board agreed to prioritise quality and safety through rostered inpatient staffing levels.

3.2 Assuring the Board on the following areas:

3.2.1 Integrated Performance Dashboard

The number of unexpected inpatient deaths reported on STEIS (measure 14). We have **substantial assurance** evidenced by the additional intelligence contained in the report and supported by the special cause improvement indicated in the SPC chart.

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

3.3.1 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 enabling actions are agreed by the Trust-wide Outcomes Group in collaboration with the Care Groups; however there is a decreasing position visible at Trust level with some specific areas of concern at Care Group level therefore we only have **reasonable assurance.** We will be monitoring the actions outlined in the report to see if they have the desired impact.

b) **Bed Occupancy (measure 8)** a range of actions have been completed, however there are no new actions identified, except for the existing wider work planned on bed modelling. It is possibly too early to see the impact on the completed actions; however overall occupancy is still over 100% and there is an increasing position visible at Trust level and both Care Groups are showing concern therefore we only have **reasonable assurance**. We will continue to monitor the bed position and if there is no improvement, we will be asking the Trust-wide Bed Oversight Group to identify new actions. In the context that bed pressures remain significant (especially in relation to female adult beds, and exacerbated for adult and older adult beds by delayed transfers of care) and as we move into the traditional winter pressures period, we will need to continue to

monitor the bed position dynamically through the Trust-wide Bed Oversight Group to consider scope for additional actions. Central to management will be our ability to secure movement on delayed transfers.

c) **Staff recommending the Trust as a place to work (measure 16)** several enabling actions are agreed and we have consistent performance at Trust level. However, The Trust is in the lowest performing quartile (a position of concern); ranked 48 out of 51 Mental Health & Learning Disability Trusts therefore we only have **reasonable assurance**. We will be monitoring the actions outlined in the report and if there is no improvement, we will be asking the People Groups to identify improvement actions.

d) **Staff Leaver Rate (measure 18)** several enabling actions are agreed and whilst there is a decreasing position visible at Trust level, there are several areas showing a concern and an increasing position, hence we only have **reasonable assurance**. We will be monitoring the actions outlined in the report to see if they have the desired impact.

e) **Mandatory and Statutory Training and Staff Appraisal (measures 20 and 21)** whilst compliance levels are consistent at Trust level, most areas (Care Group and Corporate) are showing a concern. Enabling actions are identified however we still have a low level of compliance hence **reasonable assurance.**

f) **Inappropriate OAP bed days (measure 9)** Whilst statistically this is still an area of concern, a range of actions have been completed and the latest 2 months data is indicating a reduction at Trust level therefore we have **good assurance.**

g) **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. There is a decreasing position visible at trust level and the overall trend in Adult Learning Disability Services is one of a decreasing nature therefore we have **good assurance.**

h) **New Measures** - Following approval by the Board of Directors, the revised measures for the ***Number of Incidents of moderate harm and near misses (measure 11) and Agency Spend (measures 25 a and b)*** are now included in this report**.** We have **limited assurance** on measure 11 purely on the basis this is new for this month and not something previously reported on.

i) **Data Quality Assessment** – as part of our assurance to the Board we undertaken a bi-annual data quality assessment on each measure being reported in the IPD. The first assessment has been completed and the results incorporated within the IPD this month.

j) **Standards –** We have identified several "standards" in relation to the quality measures that we want to propose to the Board for approval this month. The following proposals were discussed and agreed by the Executive Quality Assurance & Improvement Group, measures TD04-TD07 were informed by the Trust Clinical Outcomes Group/Clinical services. These were then discussed and supported by the Quality Assurance Committee in November. The Board are asked to support these proposals and for these standards to be implemented from the 1st December 2022.

- TD01) Percentage of Patients surveyed reporting their recent experience as very good or good - *proposal 92%*

- TD02) Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for - *proposal 75%*
- TD03) Percentage of inpatients reporting that they feel safe whilst in our care – *proposal 75%*
- TD04) Percentage of CYP showing measurable improvement following treatment - patient reported – *proposal 35%*
- TD05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported - *proposal 55%*
- TD06) Percentage of CYP showing measurable improvement following treatment - clinician reported – *proposal 50%*
- TD07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported – *proposal 30%*

3.3.2 Other advise

a) **Agenda for Change (AFC) and Other Pay Awards** – The Trust has an accumulated funding shortfall relating to impacts of recent (prior year) Agenda for Change pay awards and disproportionate impacts from funding via nationally determined annual 'tariff' uplifts to provider contract values. The impact of the recently communicated outcome of the Pay Review Bodies has been estimated by all organisations within the Integrated Care System and suggests a shortfall of £20m when compared to the national average uplift of 1.66% (applied to related contracts with each ICS provider 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. As previously alerted, NENC ICS has worked responsively with all organisations to estimate the financial implications, to review the funding methodology and explore alternate mechanisms that might better reflect actual provider costs, and to highlight potential funding shortfall regionally and nationally. Pending the outcome of this review, partners within the (NENC) ICS agreed to assume the funding gap will be mitigated by March 2023 (fully funded) but to report adverse in-year variances at Month 6 (the initial effective payment date).

b) **Financial Forecast 2022/23** - due to escalating financial pressures and risks to delivery of the planned surplus, the Board is due to consider a paper in private session on the most probable forecast outturn positions and to consider next steps to mitigate and/or manage, including working closely with NENC ICB system partners

c) **Levels of self-harm** continue to be a cause for concern but following the discharge of a small number of individual patients some wards have seen an improvement and levelling out. The Task and Finish Group continues to meet, and a key priority has been to establish the complex harm minimisation panels and progress identified actions from last month's QuAC paper. Progress updates will be received through Executive Quality Assurance and Improvement Group

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.

a) **(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 adult 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 and nationally negotiated 2022/23 pay deals (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

b) **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. Registered Nurse fill rates continue to remain low across a significant number of wards for day shifts, with a small but slightly worsening picture for RNs across the previous month. It is remarked that both PICUs are reporting low RN fill rates alongside SIS wards. There are a number of wards with high fill rates for HCAs, which alongside patient acuity will include a skill mix backfill for the low RN numbers. There is a known risk that this can negatively impact on the quality of care received by our patients and therefore we continue to try to mitigate this risk through daily operational processes and a relentless focus on recruitment and retention. Inpatient agency expenditure across all professional staff groups remains high and increasing. Agency fulfilment (14.4%) however continues to be significantly higher than the Trust threshold of 4% despite a small reduction this month. There are 38 teams (>70% of all teams considered) that are using greater than 4% agency staff – this number of teams remains the same as last month. Registered nurse shortages are a national issue, and to support the Trust requirements we continue to engage with the international recruitment programme.

The Trusts plan is to continue to recruit increasing numbers of international nurses and the Director of Nursing and Governance and Director of People, Culture and Diversity are working together to develop a proposal to support this approach as part of the wider workforce plan, and will see the Trust furthering this agenda by attending a recruitment event in India in November 2022, aiming to recruit an additional 40 registered nurses.

We see the number of missed breaks (3% of all shifts eligible for a break) has decreased this month, alongside a reduction in shifts worked greater than 13 hours, a reduction in the number of temporary staffing shifts requested and a reduction in Datix reports for staffing levels. Whilst this can be seen as a positive indicator, we still see a fill rate statistic that shows to be a slightly worsened position and need to be mindful of the risks to staff well-being and compassion fatigue due to long shifts worked. The Board had a session on safe staffing at the last Board meeting and recognises the risks associated with safe staffing currently.

Recommendations:

The Board of Directors is asked to:

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

1.2 Agree to the future inclusion of the new Performance and Controls Assurance Framework.

1.3 Agree the proposed standards included of 85% for Appraisal and Mandatory Training.

- TD01) Percentage of Patients surveyed reporting their recent experience as very good or good - *proposal 92%*
- TD02) Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for - *proposal 75%*
- TD03) Percentage of inpatients reporting that they feel safe whilst in our care – *proposal 75%*
- TD04) Percentage of CYP showing measurable improvement following treatment - patient reported – *proposal 35%*
- TD05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported - *proposal 55%*
- TD06) Percentage of CYP showing measurable improvement following treatment - clinician reported – *proposal 50%*
- TD07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported – *proposal 30%*

Performance and Controls Assurance Framework Assessment

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive	*Unexpected Inpatient unnatural deaths reported on STEIS	*CRES Performance – Non-Recurrent		
Neutral		*Serious Incidents reported on STEIS *Medication Errors with a severity of moderate harm and above *Capital Expenditure (Capital Allocation) *Cash balances (actual compared to plan)	*Patients surveyed reporting their recent experience as very good or good *Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for *Inpatients reporting that they feel safe whilst in our care *CYP showing measurable improvement following treatment - patient reported *Uses of the Mental Health Act *Staff feeling they are able to make improvements happen in their area of work *Percentage Sickness Absence Rate *New unique patients referred	*Incidents of moderate harm and near misses
Negative		*Inappropriate OAP bed days for adults that are 'external' to the sending provider *Restrictive Intervention Incidents	*Adults and Older Persons showing measurable improvement following treatment - patient reported *CYP showing measurable improvement following treatment - clinician reported *Adults and Older Persons showing measurable improvement following treatment - clinician reported *Bed Occupancy (AMH & MHSOP A & T Wards) *Staff recommending the Trust as a place to work *Staff Leaver Rate *Compliance with ALL mandatory and statutory training *Staff in post with a current appraisal	*Unique Caseload (snapshot) *Financial Plan: SOCI - Final Accounts - Surplus/Deficit *Financial Plan: Agency expenditure compared to agency target *Agency price cap compliance *Use of Resources Rating - overall score *CRES Performance - Recurrent

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Appendix A

Board Integrated Performance Report (IPR)
As 30th September 2022

journey to change

CONTENTS

Chapter	Summary	Page no.
Chapter 1	Integrated Performance Dashboard (IPD): • Our Guide To Our Statistical Process Control Charts • Our Approach to Data Quality and Action • Board Integrated Performance Dashboard Summary • Integrated Performance Dashboard Measures individually detailed • Strategic Context: Our Journey to Change and Board Assurance Framework	3 4 5 6 7 50
Chapter 2	Long Term Plan Ambitions	54
Chapter 3	NHS Oversight Framework	62
Chapter 4	Reports from Board Sub Committees • Quality Assurance • Mental Health Legislation • People, Culture & Diversity • Strategy & Resources	68 69 73 76 80

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 included for two measures only. Work is continuing to develop the standards for the remaining measures.

Our Approach to Data Quality and Action

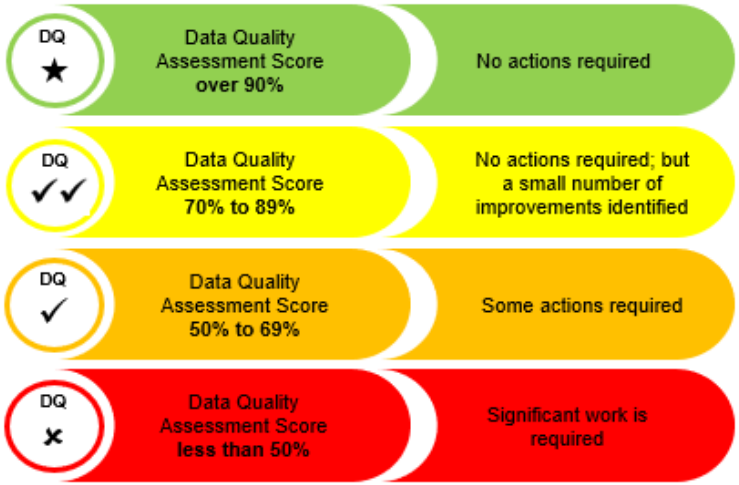
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. We have recently improved our data quality assessment which now focusses on 4 key elements: robustness of the measure, data source, data reliability and audit. Please note we are currently in the process of establishing a local audit framework; therefore, the audit element has been omitted from the initial assessment however, it will be included in the next assessment (March 2023). The first assessment has been completed and the results incorporated within this report. Please note an assessment has not been undertaken on the following measures as these are new. Assessments will be undertaken and reported in March 2023.

11) The number of Incidents of moderate harm and near misses
25a) Financial Plan: Agency expenditure compared to agency target
25b) Agency price cap compliance

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.

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



Board Integrated Performance Dashboard Summary as at 30th September 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				91.80%	
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				71.22%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC				58.78%	
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC				25.11%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L			47.06%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	L			43.70%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L			20.35%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H			99.55%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			1,031	
10)	The number of Serious Incidents reported on STEIS	QAC				66	
11)	The number of Incidents of moderate harm and near misses	QAC				810	
12)	The number of Restrictive Intervention Incidents	QAC	H			3,729	
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	L			0	
15)	The number of uses of the Mental Health Act	MHLC				2,183	

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			13.39%	
19)	Percentage Sickness Absence Rate (month behind)	PC&D				6.23%	
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L			86.15%	
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	L			77.37%	

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				49,557	
23)	Unique Caseload (snapshot)	S&RC	H			61,434	

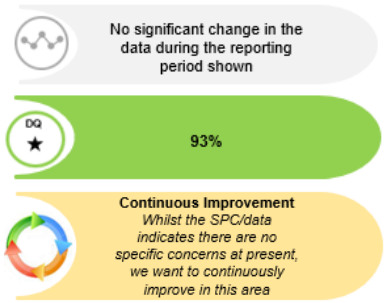
Rep Ref	Our Financial measures	Committee Responsible for Assurance	Plan/Standard (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	283,000	4,290,781
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	£5,197,961	£10,823,626
25b)	Agency price cap compliance	S&RC	100%	64%
26)	Use of Resources Rating - overall score	S&RC	2	3
27)	CRES Performance - Recurrent	S&RC	4,938,150	3,871,945
28)	CRES Performance - Non-Recurrent	S&RC	695,850	722,346
29)	Capital Expenditure (CDEL)	S&RC	4,747,000	3,796,970
30)	Cash balances (actual compared to plan)	S&RC	75,791,000	76,218,890

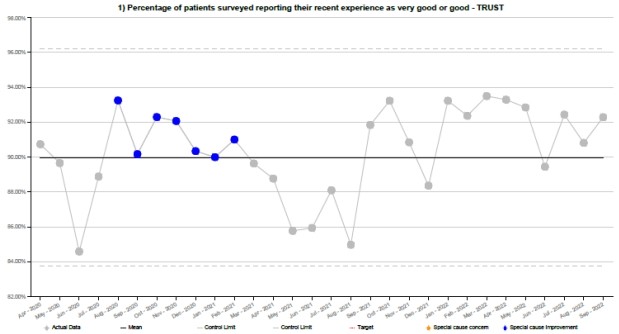
01) Percentage of Patients surveyed reporting their recent experience as very good or good

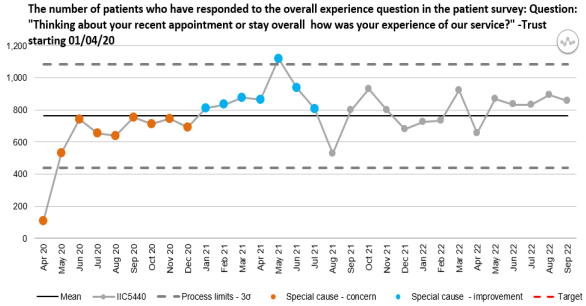
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

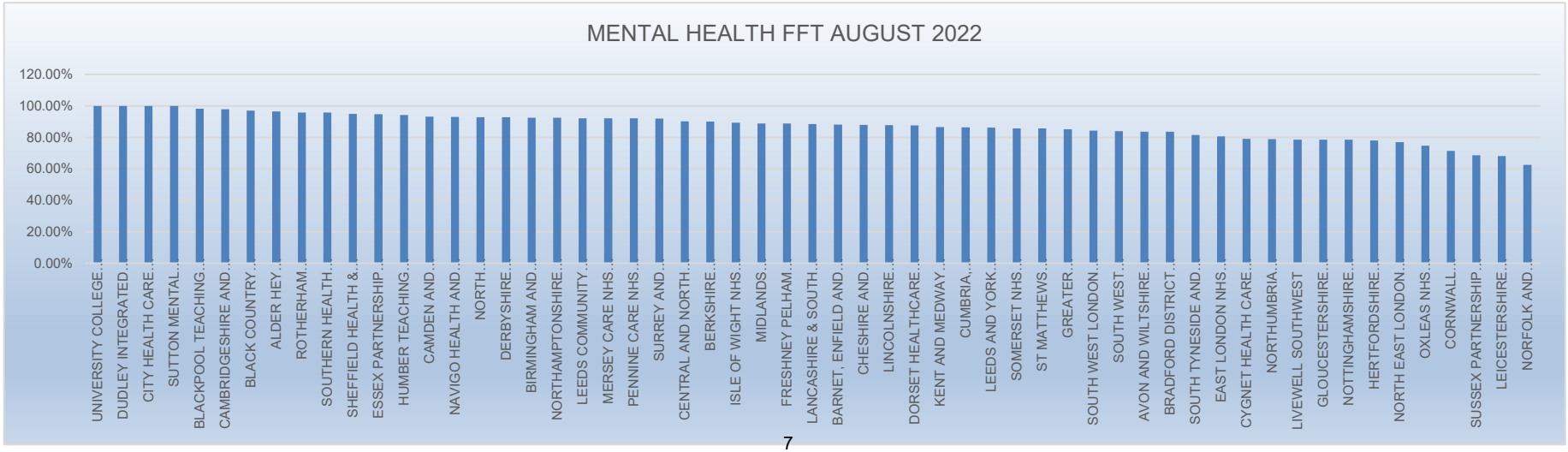
During September, **856** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **790 (92.29%)** scored "very good" or "good"







National Benchmarking - Mental Health Friends and Family Test (FFT) data - August 2022 (latest data available)**.** 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 August due to the cyber security incident. We have now made a successful submission covering the period July to September 2022 following the cyber security incident.



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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

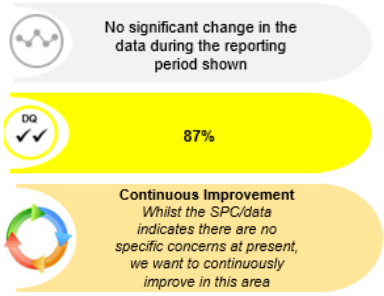
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
A cohesive programme of work is required to improve our understanding of the experience our patients are having, improve survey response rates, identify key themes and hotspot areas, and develop a set of clearly defined improvement actions.	*Enabling action:* Executive Quality Assurance & Improvement Group to establish a task & finish group during October 2022.	A task and finish group has been established to develop the Patient Experience Service Improvement Action Plans. Chaired by the Head of Patient Experience, the first meeting will be held on the 26th October 2022 with representation from both Care Group Boards and the Lived Experience Directors.	

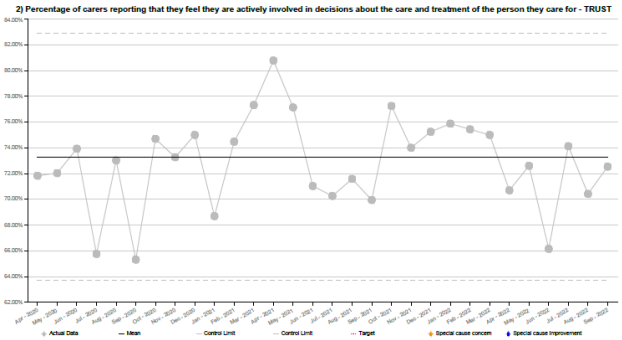
02) Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for

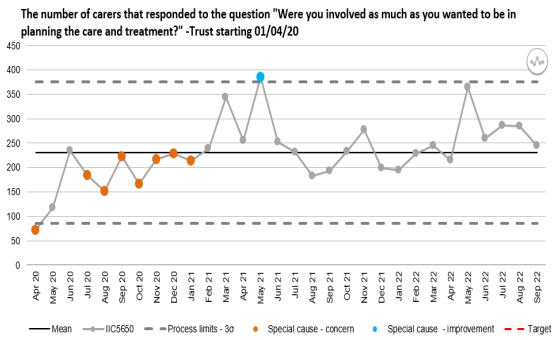
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 September, **244** 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, **177 (72.54%)** 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 the quality visits that have been initially focused on inpatient services are now being rolled out to community teams. Past experience indicates that response rates do improve as a result of these visits and any feedback is used to inform the service improvement plans within each of the care groups.
- We have an interactive Carers Hub (web page) on the Internet which is created by carers and reviewed quarterly; the latest review was completed at the end of September 2022.
- Support meetings are currently in place between the Patient Experience Team Manager and the North Yorkshire, York & Selby General Manager for Children's Services.
- We want all families and carers to be considered and valued in the care planning process and our cocreation strategy has identified a number of workstreams to ensure this, including:
    - Patients and families having information about advanced directives and the option to have them included in their care.
    - Patients and families having a safety plan written in their own words and have it shared with them.
    - All new care planning tools are co-created with people and families

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

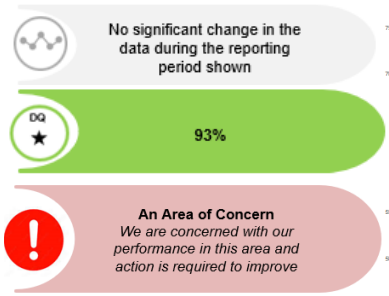
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We are aware that the percentage of carers reporting that they feel actively involved in decisions about the care and treatment of the person they care for is indicating a concern within the North Yorkshire, York & Selby Care Group; however all specialities are indicating common cause variation therefore we need to better understand what is driving the concern.	*Enabling action*: The Performance Lead for this Care Group will undertake some high level analysis to identify which services/teams are driving this cause for concern and link in with the Patient Experience Team in terms of any additional intelligence. This will be completed by the end of October 2022.		

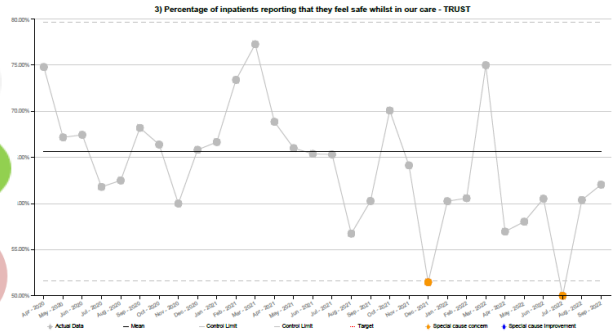
03) Percentage of inpatients reporting that they feel safe whilst in our care

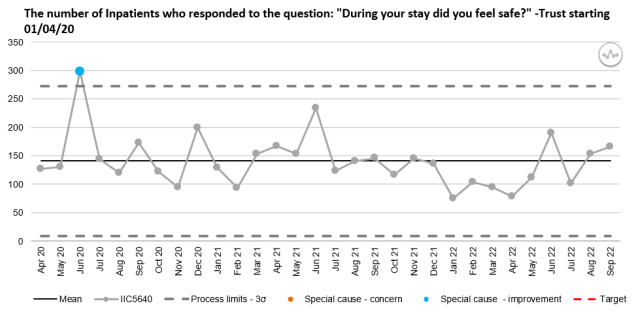
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 September, **166** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **103 (62.05%)** scored “yes, always"







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*: Care Group Director 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 are 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.	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*	

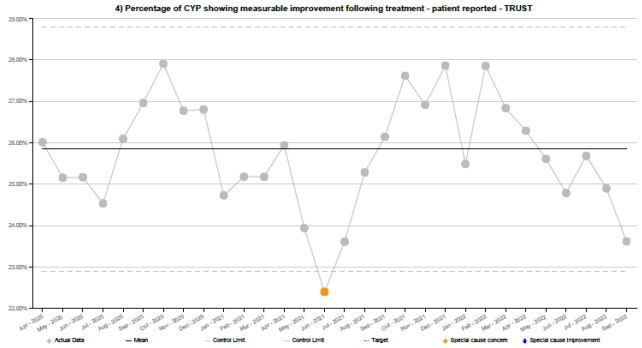
04) Percentage of CYP showing measurable improvement following treatment - patient reported

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 September, **779** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 184 (23.62%)** 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.



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

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

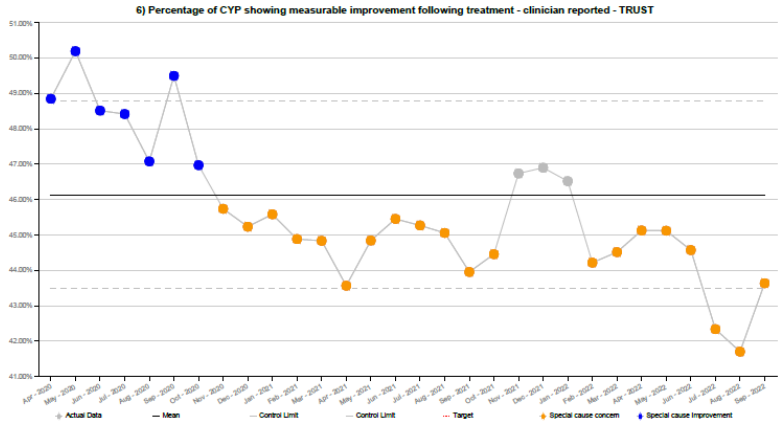
DQ 93%

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 September, **896** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 391 (43.64%)** 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)



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

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

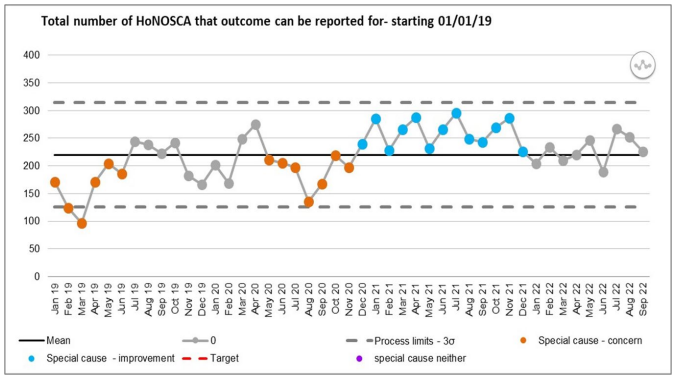
DQ 93%

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

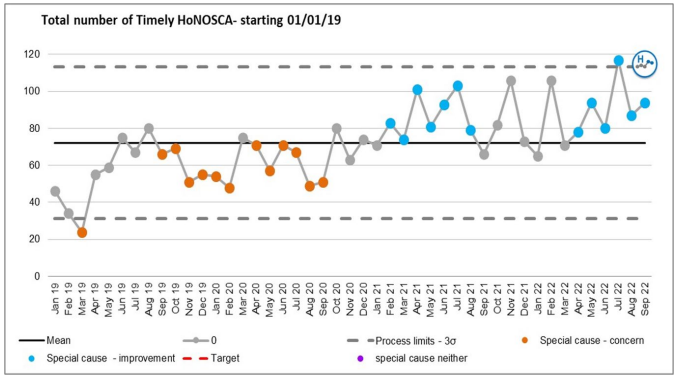
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Supporting Measures

The number of patients that have a paired measure recorded over-time. The impact of COVID is clear, with a reduction denoting the start of the pandemic; however, there is evidence of recovery from September 2020 and performance is now at a level consistent with pre-covid activity. 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 HoNOSCA recorded that are considered representative of their presentation at the start of care and at the end of care. The SPC chart indicates an improvement 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 appropriate time points in the patient journey, supporting our ability to evaluate true and meaningful change.



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

Current Focus	Current Improvement Action(s)	Progress Update	Actual 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
- The Clinical Network have agreed a work plan for Children & Adolescent Meant Health Services, focusing on Patient Experience, Workforce and Service Delivery. Improvements for our patient outcomes is prioritised within the Patient Experience workstream.

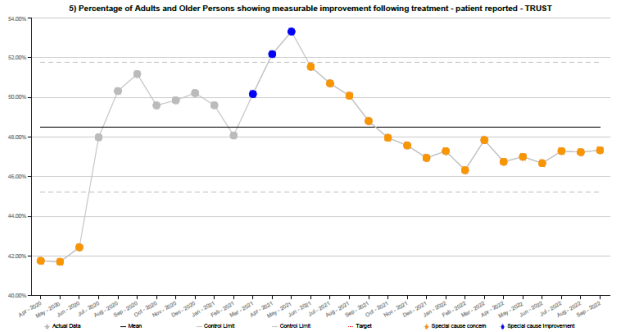
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

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 September, **2009** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 951 (47.34%)** made a measurable improvement.

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



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

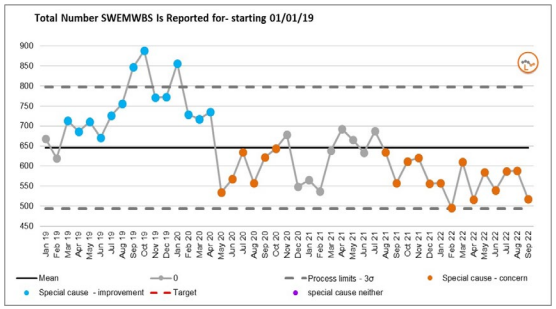
We're aiming to have high performance and we're moving in the wrong direction.

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

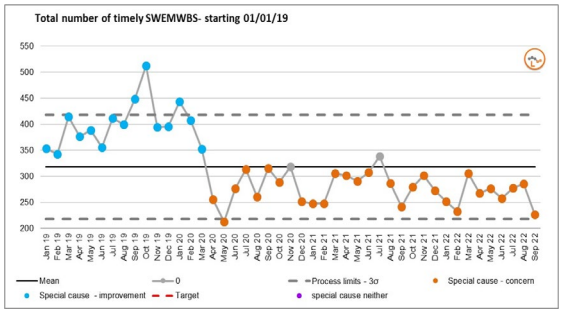
DQ ★ 93%

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.



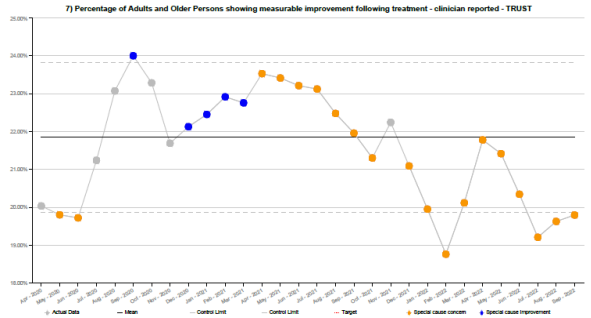
07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

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 September, **3278** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 649 (19.80%)** made a measurable improvement.

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



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

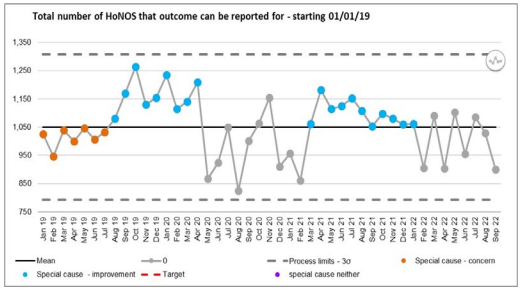
We're aiming to have high performance and we're moving in the wrong direction.

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

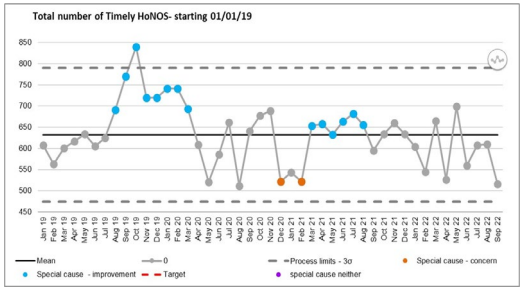
DQ
93%

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.	The task & finish group have met for an initial discussion to assess the current position and work that needs to be undertaken. The priorities and action plan will be agreed at the November meeting.	
There needs to be appropriate care group and workforce representatives at the Trust Outcomes Steering Group in order to effect change.	*Enabling Action:* 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.		
	Enabling Action: The Associate Director of Performance to discuss and agree appropriate workforce representation with People & Culture by the end of October.	**Completed** It has been agreed the Associate Director of Improvement and Redesign will represent People & Culture on the Trust Outcomes Steering Group.	

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
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

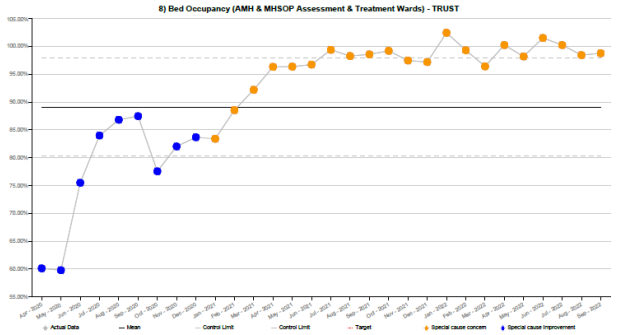
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important 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 September, **10,740** daily beds were available for patients; of those, **10,607 (98.76%)** were occupied.

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

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

DQ ★ 93%



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

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

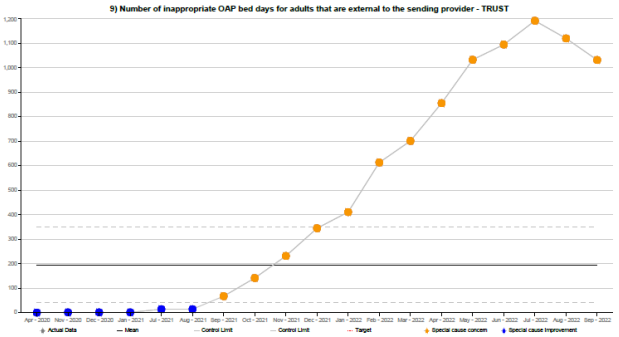
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending September, **1031** days were spent by patients in beds away from their closest hospital.

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

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

DQ ✓✓ 73%



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

Supporting Measure

		2022 - 2023						
		Apr	May	Jun	Jul	Aug	Sep	FYTD
Overall Occupancy including Trust, block booked (Priory) and independent sector bed usage	Number of occupied bed days	10,926	11,535	11,352	11,681	11,492	10,908	**67,894**
	Number of available bed days	10,578	11,253	10,890	11,253	11,253	10,890	**66,117**
	Percentage Bed Occupancy	**103.29%**	**102.51%**	**104.24%**	**103.80%**	**102.12%**	**100.17%**	**102.69%**

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
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.	The Associate Director of Strategic Planning & Programmes has circulated an initial draft of a project scope for this work, and is collating comments for discussion at the Beds Oversight Group on 14th November. The project will then take place when internal resources allow.	

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

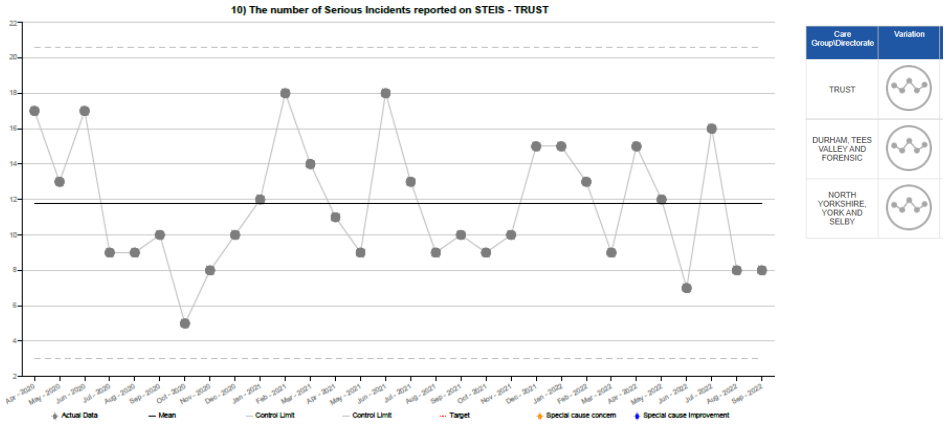
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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

DQ
87%



Additional Intelligence in support of continuous improvement

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

- Whilst all self-harm incidents do not lead to serious incidents, a key objective of our journey to safer care is to reduce suicide and self-harm. Having a greater understanding of our patterns and themes from self-harm will support us to reduce more serious harm from occurring. A review was commissioned by the Quality Assurance Committee following an increase in incidents of self-harm across adult inpatient wards, with the female inpatient wards showing the highest incidence. The review was undertaken at ward and individual patient level. Key findings showed that themes and patterns were similar across the care groups, a small number of patients accounted for a high level of self- harm and the majority result in low or no harm. An increase in incidents using non-anchored ligatures was noted. Further actions have been agreed and are being progressed.

- Significant work has been undertaken as part of the thematic Serious Incident closure programme to identify the top themes from incidents dating back from 2017 to the current day. The current Quality Assurance programme is being reviewed and a half day event is taking place on the 6th November to develop the final programme for the coming 6 months to a year, based on recognised areas of risk where assurance is required, as well as ensuring we continue to monitor the sustainable improvements from previous areas for improvement.

11) The number of Incidents of moderate harm and near misses

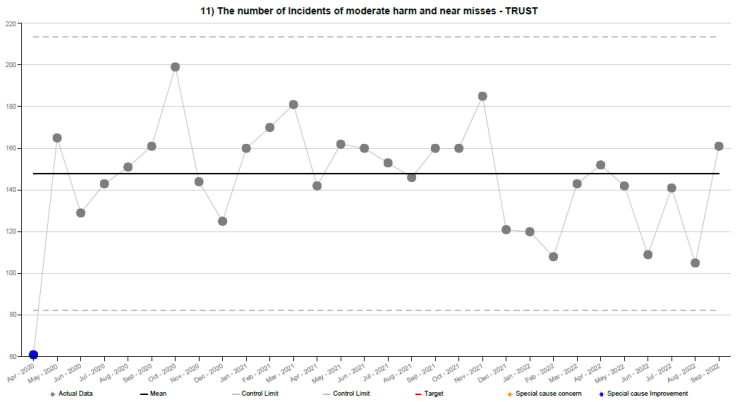
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

161 incidents of moderate harm or near misses were reported during September.

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

Update

This is the first month this measure has been presented within the report. Work is now underway to understand the data and to identify any themes and areas for improvement; these will be included in reports from next month.

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

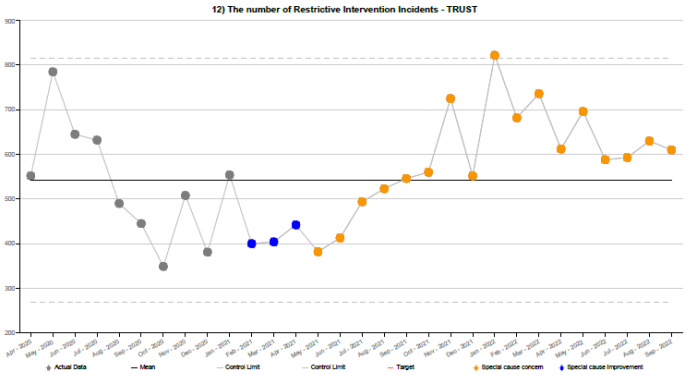
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When restrictive intervention incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented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

610 number of Restrictive Intervention Incidents took place during September.

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 ★ 93%



Care Group \Directorate	Variation
TRUST	H
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 ready for discharge: • 1 patient from Bankfields is on track for discharge in December and funding has been agreed for another Bankfields patient • it is anticipated that 1 patient at Lanchester Road Hospital will be discharged in December, provided a support team can be recruited by the identified provider • 3 patients have dates for discharge in 2023 and funding is to be agreed for remaining 2 patients.	
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. Feedback from Clinical Services has been positive.	
We must be assured that we have a robust Restrictive Intervention Reduction Programme that meet national standards and reflects best practice	*Enabling action:* The Nurse Consultant for Positive and Safe Care to complete a gap analysis on the currently agreed Restrictive Intervention Reduction workstreams to ensure compliance with the Use of Forces Act. This work will be completed by December 2022.	An initial draft has been completed and feedback is currently being sourced from local and Trust wide positive and safe groups.	
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.	Positive & Restraint Groups at Care Board level are established and Terms of Reference are being drafted. These groups will have responsibility for delivering the Restraint Reduction Plan.	
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	The draft proposal is to be presented to the Advancing Our Clinical, Quality and Safety Journey to Change for further discussion. If it is agreed to progress the proposal, a business case will be developed.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

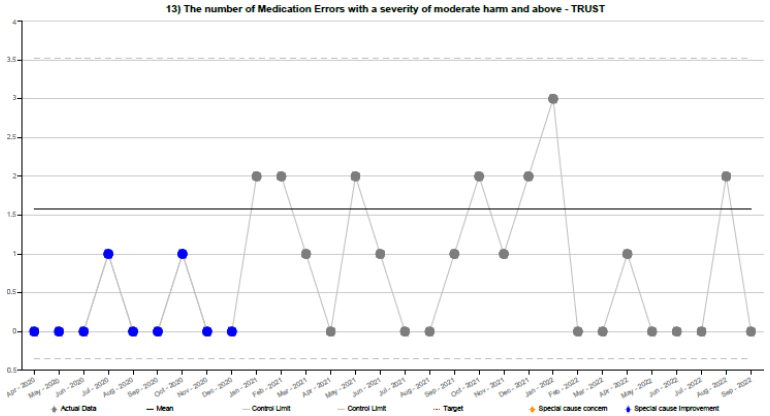
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When medication errors occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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

No significant change in the data during the reporting period shown

DQ ★ 93%

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	

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.	There are 25 actions improvement actions identified. Of these, 15 have been completed and the remaining 10, include some new actions and all 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

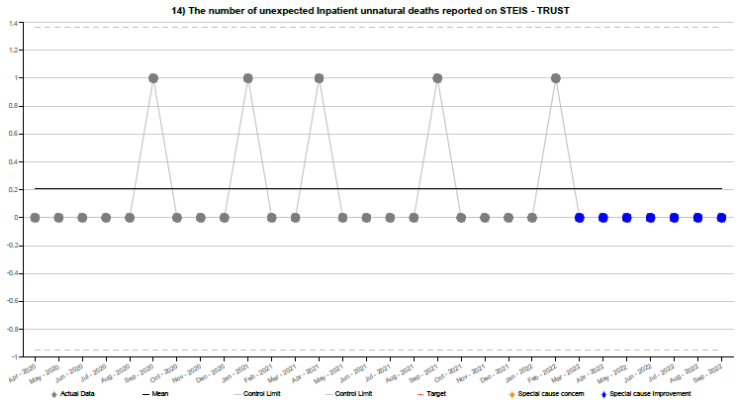
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements 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 September

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

DQ
93%

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	

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

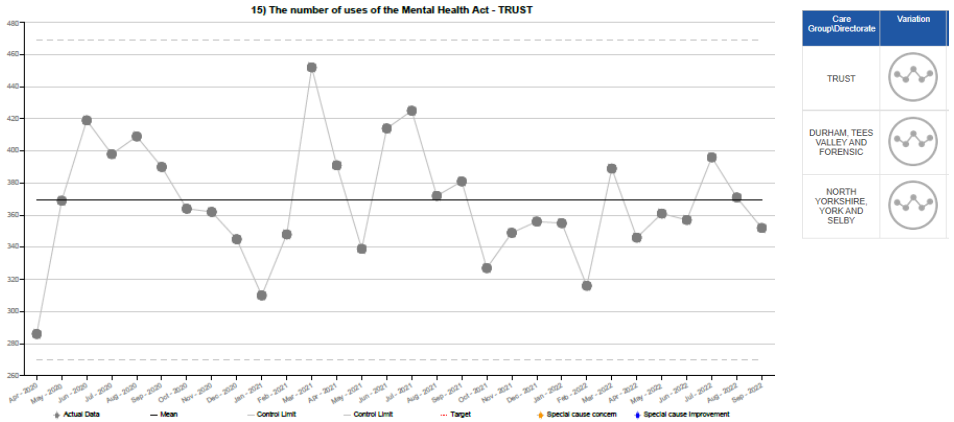
We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers,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

There were **352** 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

DQ
60%



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.	**Completed.** Data provided and will be shared with the Mental Health Legislation Committee in November 2022.	

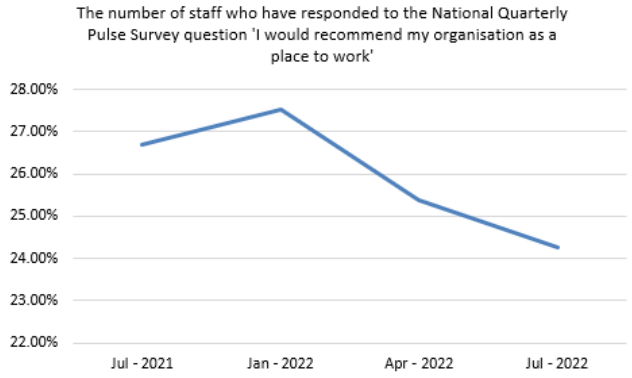
16) Percentage of staff recommending the Trust as a place to work

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%



DQ ✓✓ 87%

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.

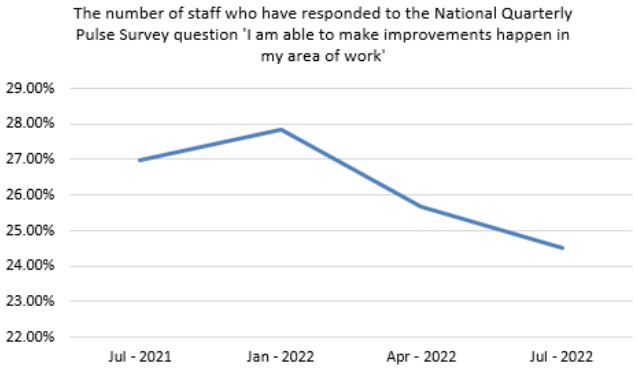
17) Percentage of staff feeling they are able to make improvements happen in their area of work

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%



DQ 87%

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 work was delayed due to capacity issues following the cyber security incident and subsequent Integrated Information centre outage in August 2022 but has now resumed and is on track for completion by the end of December 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.	The staff survey is underway is due to complete 25th November 2022. A number of incentives have been offered to staff and current participation is 25.23%	

18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

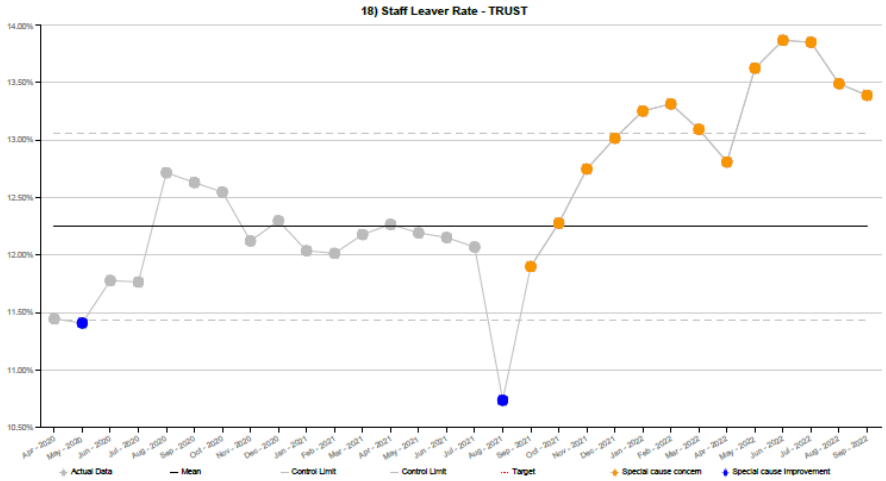
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

From a total of **6789.71** staff in post, **909.17 (13.39%)** had left the Trust in the 12 month period ending September

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

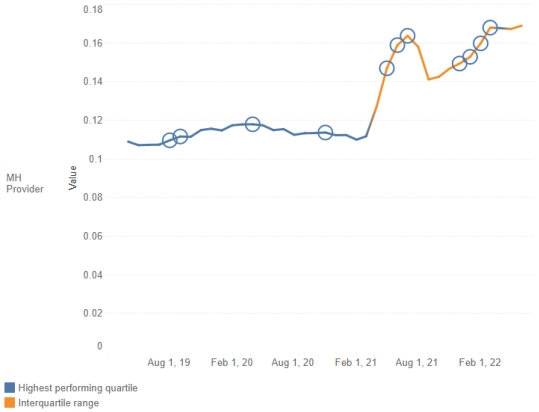
DQ 80%

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	
ESTATES AND FACILITIES MANAGEMENT	H		

National Benchmarking: NHS Staff Leaver Rate - England Mental Health and Learning Disability – June 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 16.78% compared to the Trust mean of 16.88%. We were ranked 21 of 69 Trusts (1 being the best with the lowest leaver rate) and are placed in the inter-quartile range.



18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.	An exit interview has been drafted and will be completed the week commencing the 24th October 2022; once available, that will be posted on the intranet page for staff use.	
	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.		
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

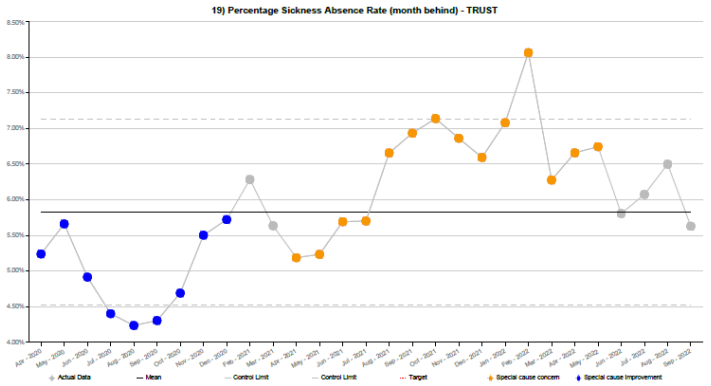
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

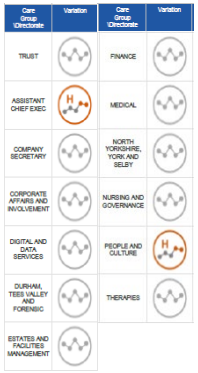
There were **218,849.92** working days available for all staff during July (reported month behind); of those, **12,317.4 (5.63%)** days were lost due to sickness.

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 87%

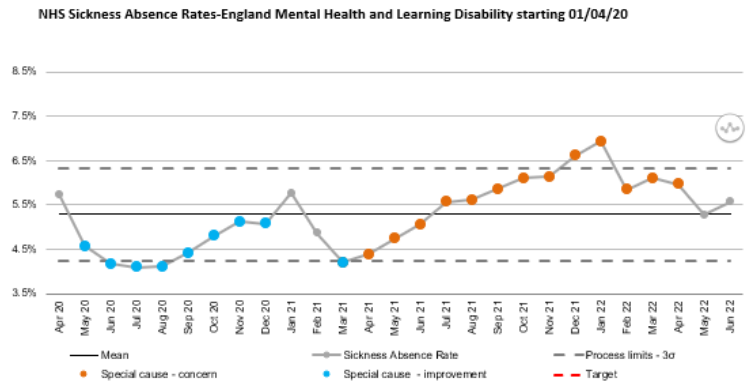




National Benchmarking: NHS Sickness Absence Rates - England Mental Health and Learning Disability – June 2022.

NHS Sickness Absence Rates published 27th October 22 (data ending June 22) for Mental Health and Learning Disability organisations shows a similar trend to that shown for our Trust. The national mean (average) for the period shown is 5.29% compared to the Trust mean of 5.89%.

Regional Benchmarking: We continue to see improvement in our sickness absence rates and as at the 18th October 2022, we were positioned 10th (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) and is now below the 5.83% mean (average) for the period shown, the level of sickness absence remains an area of concern especially given the indications that covid is affecting acute trust sickness rates already.

As at the 23rd October 2022, sickness absence is 5.55% for October 2022.

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.	Learning has been gathered and will be shared at the next People, Culture & Diversity Sub-Group meeting on the 25th October 2022	

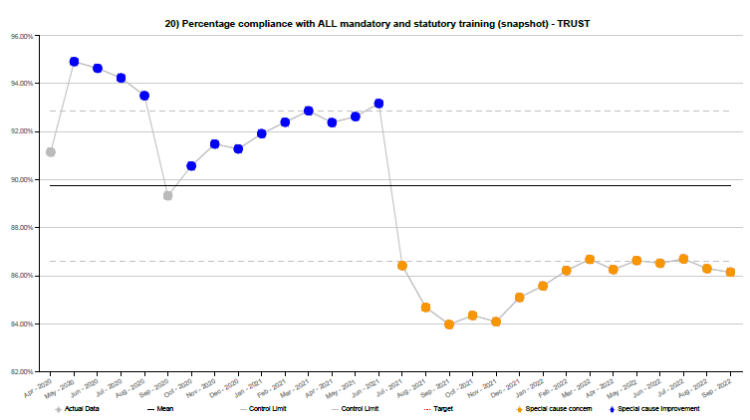
20) Percentage compliance with ALL mandatory and statutory training

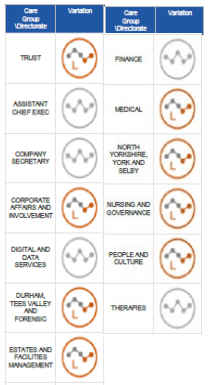
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

111,013 training courses were due to be completed for all staff in post by the end of September. Of those, **95,642** (**86.15%**) 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 September, **6576** were due for completion, **5856 (89.05%)** 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 ★ 93%

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.	Regular reports have been established and will continue until we achieve our standard.	

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.	**Complete.** The reports with Information Governance included were sent on the 12th October and will be sent bi-monthly going forward.	
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

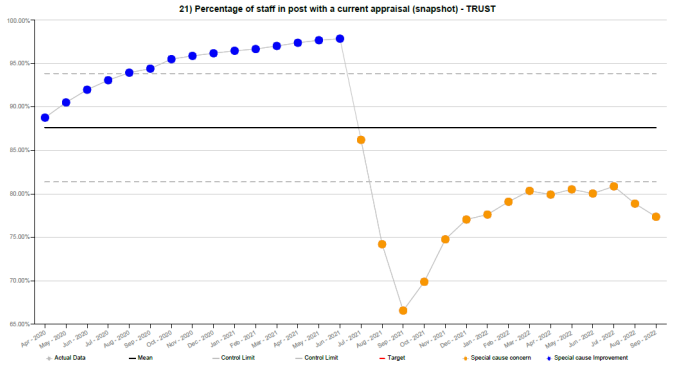
We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our 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 **6283** eligible staff in post at the end of September; **4861** (**77.37%**) 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
93%



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.	**Complete.** The reports were sent on the 12th October and will be sent bi-monthly going forward.	

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

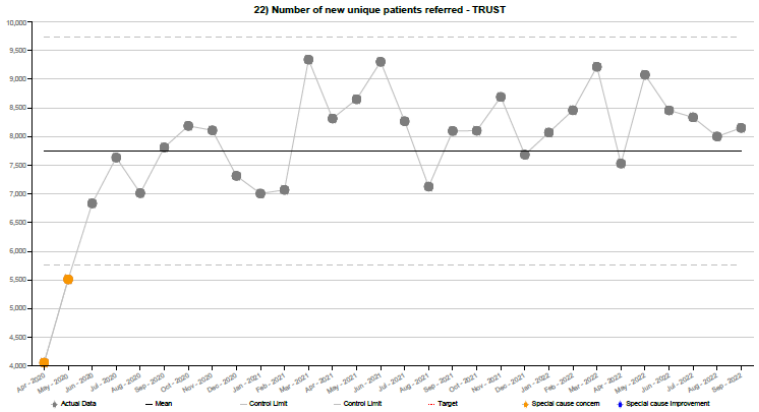
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

8152 patients referred in September 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 ★ 93%



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

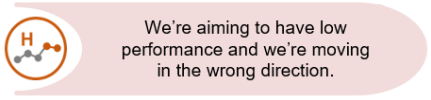
There are currently no specific trends or areas of concern identified within this measure.

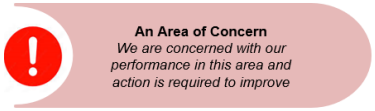
23) Unique Caseload (snapshot)

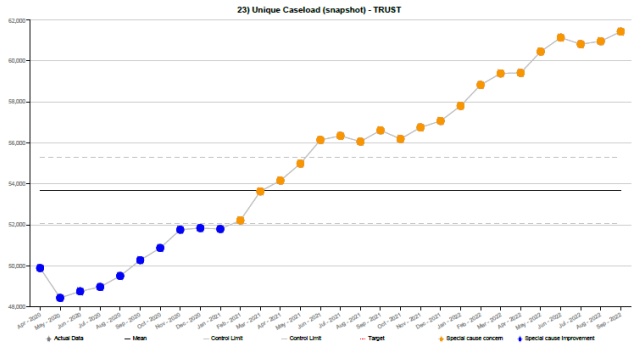
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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.

61,434 cases were open, including those waiting to be seen, as at the end of September 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.	A group has been established and work is in train to scope the agreed first action and to subsequently establish a timescale for a proposed two-phase work plan. The first phase is to aim to scope IIC reporting using Statistical Process Control charts at individual team level. Subsequent work will aim to align workforce metrics to better understand key pinch points, e.g. commissioning, staffing absence, staffing vacancies etc. It is noted that caseload as a measure does not capture wider consequences from differential acuity.	

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 **£4.6m** deficit (to break even) to 30th September 2022 against a planned year to date deficit of **£0.3m,** resulting in a **£4.3m** 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 year to date position is an operational deficit of **£4.6m** against a planned year to date deficit of **£0.3m,** resulting in a **£4.3m** variance to plan., representing **higher than planned expenditure.** Key observations for September were:

- **Pay Award** – September costs include accounting for the backdated costs of pay award, of £5.0m for the first 6 months. This is partly offset by assumed pay award income of £3.3m, resulting in a net pay award pressure of £1.7m. The Integrated Care Board is considering alternative methodologies for distributing funding and has escalated system level funding pressures to NHS England for their consideration. Forecasts (consistently across the ICB) assume that pay award costs are fully funded.
- **Independent sector beds** - the Trust required 331 bed days during September 2022 (580 for August 2022) at a cost of £0.5m. This is a reduction in 249 bed days, however costs incurred in September include £0.2m relating to prior periods, including observation costs. Year to date expenditure is £2.7m which is £2.4m ahead of plan. The financial plan assumed no use of spot purchase beds during 2022/23 and no block contracted bed use beyond quarter one (£0.3m costs assumed in quarter one only). 5 block contracted beds were 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. This remains a key area of clinical and management focus.
- **Agency expenditure** as at September 2022 is £10.8m, which is £5.6m ahead of plan and includes material costs linked to inpatient rosters, medical cover and complex specialist packages of care.
- **Computer hardware, software and maintenance** Computer Hardware is £1.7m ahead of plan. This is partly offset by a surplus to plan on computer software and maintenance of £0.6m, resulting in a net deficit to plan of £1.1m
- **Planned CRES performance** as at September 2022 is behind plan by £1.6m, however unplanned schemes to the value of £0.6m is partially offsetting this resulting in a final CRES performance of £1.0m behind plan. Key variances relate to agency and independent sector bed pressures driving run rates significantly above 2021/22 levels. Further risks and mitigations are being identified to offset under performance of CRES.
- **Sale of Asset** - 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 significantly impacting our financial plan and will impact on our Use of Resources Rating when reintroduced; therefore, we need focused work to reduce.	*Enabling Action:* The Financial Management Team have established recovery meetings to monitor the ongoing impact of increased agency expenditure, to identify and establish appropriate mitigating actions. In addition pre-covid agency controls are being stood up.	Financial recovery meetings progressed substantially during October, informing iterative financial forecasts presented to Executive Directors during October and to Strategy & Resources Committee 8th November.	Unmitigated straight line forecast of £11.2m variance from plan reduced, some ongoing key lines of enquiry including in relation to Adult LD budgets
We need to reduce Trust use of independent sector beds.	*Please refer to progress for measures - 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*		
The costs of Computer Hardware is high and we need to mitigate overspend in this area.	The Finance Team to discuss a change in the application of the Trust's policy for accounting for grouped IT assets with External Auditors by November 2022 and include assumed benefits from capitalising in the 2022/23 financial forecast This would lead to an improved revenue position and once agreed may be backdated to the 1st April 2022. The Digital and Data Team to continue to progress arrangements for Centralised Asset Management, including agreeing annualised capital and revenue budget requirements for 2023/24 Business Planning with the organisation.	Discussions are underway with External Audit with Trust intending to effect changes in applications during quarter 4.	Impacts reflected in forecasts shared with Strategy & Resources Committee 8th November 22
Pressures relating to Independent Sector Bed and agency staffing costs have driven adverse performance compared to CRES plans phased to commence from July 2022 and impacting on the delivery of our financial plan	*Please refer to progress for measure - 27) CRES Performance – Recurrent and 25a) Agency*		

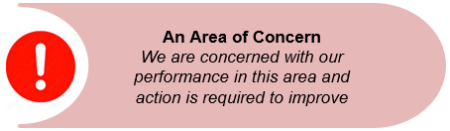
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

25a) Financial Plan: Agency expenditure compared to agency target

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.

Agency expenditure of £10.8m is £5.6m **(108%)** higher than target.



Summary

Agency expenditure of £10.8m is £5.6m (108%) higher than target. 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 and share of the ICB system-level agency cap is £9.3m for 22/23 or £5.2m YTD resulting in a breach of this cap by £5.6m.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Agency expenditure is significantly impacting our financial plan and will impact on our Use of Resources Rating when reintroduced; therefore, we need focused work to reduce.	*Please refer to progress for measure – 24)* Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit		

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

25b) Agency price cap compliance

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.

During September 2022 there were 4,357 agency shifts worked, with 2,778 shifts compliant **(64%).**

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

Summary

During September 2022 there were 4,357 agency shifts worked, with 2,778 shifts compliant (64%). There were 1,222 shifts (28%) of on framework price cap breaches and 357 shifts (8%) of off framework price cap breaches.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Agency expenditure is significantly impacting our financial plan and will impact on our Use of Resources Rating when reintroduced; therefore, we need focused work to reduce.	*Please refer to progress for measure – 24)* Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit		

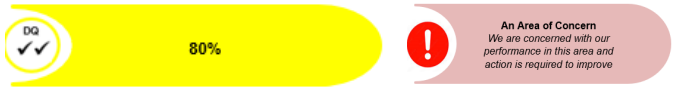
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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 30th September 2022 against a planned rating of **2**.
1 behind 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. As a consequence of adverse revenue performance, the Trust has a capital service capacity of minus 0.34x, which is 1.65x or £5.6m 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 30.1 days; this is behind plan by 1.8 days 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 2.1%, this is worse than plan by £4.3m and is rated as 4.
- Agency expenditure of £10.8m is £5.6m (108%) 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 and share of the ICB system-level agency cap is £9.3m or £5.2m YTD resulting in a breach of this cap by £5.6m. During September 2022 there were 4,357 agency shifts worked, with 2,778 shifts compliant (64%). There were 1,222 shifts (28%) of on framework price cap breaches and 357 shifts (8%) of off framework price cap breaches. 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. Actions are targeting all of those areas for improvement.

The Trust's financial performance results in an **overall UORR** as a **3** for the period ending 30th September 2022 and is **behind plan by 1**.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Agency expenditure is significantly impacting our financial plan and will impact on our Use of Resources Rating when reintroduced; therefore, we need focused work to reduce.	*Please refer to progress for measure – 24)* Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit		

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

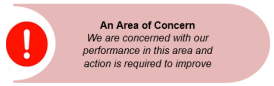
27) CRES Performance - Recurrent

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 **£4.9m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£3.9m**.

£1.0m variance to plan.



Summary

The Trust continues to identify and consider schemes to deliver future recurrent requirements. . Activities continue to aim to mitigate adverse in year performance on CRES with key focus on:

- Individual scheme baseline assessment by Care Group, including actions to support delivery.
- 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 £1.0m behind plan with specific performance noted as:

- £0.4m CRES for OAPs contracted bed elimination is behind plan
- £1.1m 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
- £0.6m CRES for interest receivable and is ahead of plan
- £0.2m CRES for PDC
- £0.1m CRES for other schemes including contract overhead contribution and salary sacrifice benefit,

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	*Please refer to progress for measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit as this will mitigate in-part the under delivery on CRES and provide a sustainable footing and reduced run rate expenditure*		

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

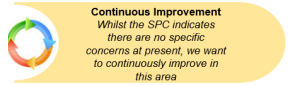
28) CRES Performance – Non-Recurrent

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 **£0.7m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£0.7m**.

(£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.

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

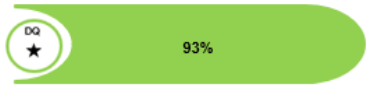
29) Capital Expenditure (Capital Allocation)

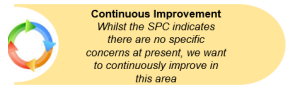
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 September was **£3.8m** against planned expenditure of **£4.8m**

(£1.0m) variance to plan.





Summary

Capital expenditure at the end of September was **£3.8m**, and is **£4.8m** below plan **(£1.0m)**. This includes slippage on lifecycle and health and safety works, which are offset by an overspend on Teesside patient safety works. All slipped works programmes have been re-programmed and are overseen at Environmental Risk Group.

The Trust is forecasting to **underspend against its capital allocation**, but is analysing future planned schemes to see if any can be brought forward, and is exploring the possibility of capitalising IT assets linked to the network. This is forecast to result in Trust capital expenditure being in line with plan.

All delays to health and safety schemes are escalated to Environmental Risk Group as soon as they are known to manage / mitigate any risks to clinical safety and quality. The majority of schemes have now commenced.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Not spending the full capital allocation in year could lead to pressure in future years as annual plans are managed at ICS level.	The Capital Development Team are reviewing future year schemes to see if any can be brought forward to use the forecast underspend this financial year and to accommodate accounting for grouped IT assets. Considerations will be discussed in November's capital planning meeting.	Review is in train with initial feedback provided to ICB partners to inform collective risk management. Key residual actions include re-programming to support capitalisation of IT grouped assets.	

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

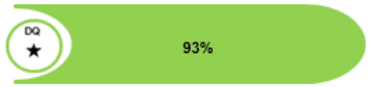
30) Cash balances (actual compared to plan)

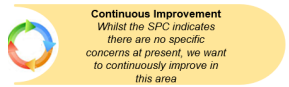
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 **(£76.2m)** against a planned year to date cash balance of **(£75.8m).**

(£0.4m) Favourable variance from plan





Summary

Cash balances were **£76.2m** at 30th September 2022, which is **£0.4m** higher than plan **(£75.8m)**. This is mainly linked to the slippage on the capital programme (£1.0m) and movements in working capital, being offset by the deficit against plan. This metric is close to plan as the pay award has been paid to colleagues in September (was previously accrued).

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 September, achieving a combined BPPC of 94.32%. 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 (£1.1m excluding amounts being paid via instalments), but has reduced by £0.8m from last month as we resolve queries. £0.5m of the over 90 days debt is linked to a debt that has a collection pause, so is not actively being chased.

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.	**Completed** Payment collected	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, carers and families	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 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_25a	Financial Plan: Agency expenditure compared to agency target			
BIPD_25b	Agency price cap compliance			
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 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_25a	Financial Plan: Agency expenditure compared to agency target									√		√				√
BIPD_25b	Agency price cap compliance									√		√				√
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 local plans for delivery or delivery of 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		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	1094	994		994
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	994		994
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours.	85%	91.69%	88.48%		90.01%
Data Quality Maturity Index	93.00	97.50	96.90		96.90

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*	

The remaining 12 measures are monitored at Sub-ICB Location level. The Trust agreed LTP trajectories with the former CCGs in Spring 2022. We only agreed to improved trajectories where there was either 2021/22 investment that had not fully worked through into improved performance; where additional 2022/23 investment was agreed, or where quality improvement work held out the prospect of increased performance. It was acknowledged by both CCGs and TEWV that there was insufficient financial resources to deliver on all LTP trajectories therefore a number of "recovery plans" were developed. The following pages detail the ambitions currently at risk of delivery.

Long Term Plan Ambitions - County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

There are **4** measures that have not been delivered at quarter 2.

Measure	Agreed CCG/Sub-ICB location Ambition	Q1	Q2		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	12448	2828	2208		5036
Percentage of people who have waited more than 90 days between first and second appointments	<10%	28.43%	30.93%		29.72%
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%	52.05%		52.05%
Number of people accessing IPS services as a rolling total each quarter	169 at Quarter End	140	118		118

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Ongoing recruitment challenges within our IAPT service, are impacting on the number of appointments and level of choice available to people considering access to our services.	The IAPT Service Manager to continue recruitment for 12.44 Psychological wellbeing practitioner vacancies.	Following recruitment challenges 1.4 wte agency PWP is in contract until the end of June 2023, and the Talking Changes Board agreed in May to utilise the next cohorts of trainees to fill these posts. The first cohort started in September 2022.	
We need to ensure we are offering sufficient choice for people that may be considering access to our IAPT service.	The Service Manager to continue recruitment for 3 fixed term Therapy Support Workers to enable the addition of a further online workshop that would enable more people to access our service.	This has been impacted by recruitment challenges; however, 1 applicant is now progressing through recruitment and interviews will be held for the remaining 2 posts in late October. In the interim, the additional workshop will be introduced and will be supported by the current Trainee PWP cohort.	

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
To improve access to our IAPT services, there is a need to increase awareness of what is offered and generate additional referrals.	The Durham & Darlington IAPT Service Manager to contact all GP surgeries by the end of October 2022 to introduce local Team Managers and Senior Therapists and offer visits to surgeries to provide further information.	**Complete.** All GP surgeries have been contacted by letter, with the support of NECS. Currently no responses have been received but this is being monitored as part of the Service Delivery Improvement Plan.	
Dieticians are crucial members of our Children's Eating Disorder Service and a shortage of dieticians within the team and nationally is impacting the team's capacity to deliver assessments and start patient treatment.	The CED Team Manager to continue recruitment for 3 WTE dietician posts to increase the number of initial assessments available to be offered.	Two dieticians are now in post; the service is readvertising the final vacancy.	
The CED service is currently providing dietetic support into County Durham and Darlington Foundation Trust (CDDTF) paediatric wards to support patients presenting with an eating disorder, which is further impacting staff capacity.	Care Group Director to progress a temporary Service Level agreement with CDDFT.	The Trust has engaged with solicitors to progress this.	
We need to better understand our data for Individual Placement & Support (IPS) service, to identify the underlying reasons for not meeting our locally agreed trajectories with commissioners.	Head of Performance to work with the Service Manager and Finance and Business Intelligence colleagues to develop an evidenced-based paper by the end of November 2022, to inform next steps.		

Long Term Plan Ambitions – Tees Valley Sub-ICB Location

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

There are **5** measures that have not been delivered at quarter 2.

Measure	Agreed CCG/Sub-ICB location Ambition	Q1	Q2		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	2260	600	437		1037
Percentage of people who have waited more than 90 days between first and second appointments	<10%	30.05%	33.51%		31.78%
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%	82.29%		82.29%
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%	73.68%		73.68%
Number of people accessing IPS services as a rolling total each quarter	216 at Quarter End	166	151		151

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
For all IAPT commentary, please see the Long Term Plan section for County Durham Sub-ICB Location			
For all Children's Eating Disorders commentary, please see the Long Term Plan section for County Durham Sub-ICB Location			
For all IPS commentary, please see the Long Term Plan section for County Durham Sub-ICB Location			

Long Term Plan Ambitions – North Yorkshire Sub-ICB Location

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

There are **7** measures that have not been delivered at quarter 2.

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	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	11623	8272	1676	1815	3491
IAPT: The proportion of people who are moving to recovery	50.00%	50.00%	50.05%	49.09%	49.58%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	<10%	8.59%	14.27%	11.24%
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Q1 55% Q2 60% Q3 70% Q4 80%	57.81%	58.18%	58.18%
The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Q1 50% Q2 60% Q3 70% Q4 80%	55.56%	55.56%	55.56%
Number of people accessing IPS services as a rolling total each quarter	559 ICS Ambition	123 at Quarter End	60	71	71
Number of women accessing specialist community PMH services in the reporting period (cumulative)	398	Q1 71 Q2 142 Q3 213 Q4 284	71	97	97

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
To improve access to our North Yorkshire & York IAPT services, there is a need to increase awareness of what is offered and generate additional referrals.	Service Managers have established a marketing plan to improve awareness within local GP practices; all actions to be completed by the end of December 2022.	The marketing plan is progressing as planned. IAPT Marketing material has been refreshed and a tool kit has been created including posters, social media posts and IAPT banner added GP practice websites.	
Within our IAPT service there is a need for a coordinated approach to offer appointments to our long waiters within locally available clinics.	Team managers to establish a process to review long waiters within weekly huddles during October 2022.	**Complete.** A process is now in place, a review of Step 3 long waiters by clinicians is under way and clinic are being made available on an ongoing basis to offer appointments to patients that have been waiting long lengths of time.	

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Our North Yorkshire IAPT service has a number of vacancies, which has impacted their ability to respond to an increase in the number of people placed directly onto step 2 Guided Self Help and Step 3.	IAPT Service Manager to continue recruitment for 9.97wte Psychological Wellbeing Practitioners (PWP) and 1.2 wte High Intensity Worker (HIW).	5 PWP and 2 HIW posts remain vacant and are to be readvertised.	
Within our North Yorkshire, York & Children's Eating Disorder Services there is a need to review the pathway from referral to the initial assessment, to ensure all information required to assess patients is available at the point of referral and to enable assessments to be booked timely	*Enabling Action:* Team Manager to arrange a second Kaizen event to review the pathway from referral to the initial assessment. This is an extension of the initial Kaizen which focused on the initial assessment only.	**On hold.** This remains a priority, but has temporarily been placed on hold to enable the Team Manager to focus capacity and resources and to support the staff through the number of changes that are currently in progress, including the establishment of the Eating Disorders Home Treatment Service, implementing the Medical Emergencies in Eating Disorders (MEED) requirements and embedding the changes from the first Kaizen event.	
Within our North Yorkshire, York & Children's Eating Disorder Services there is a need to ensure sufficient information is provided on referral from GPs, to enable the service to assess patients within the national standards.	Service Managers to work with commissioners to introduce an Eating Disorders specific referral form by the end of June 22. This will improve the triage process to enable more efficient booking of new initial assessment appointments.	**On hold.** Service Managers presented proposed referrals forms to the North Yorkshire & York Local Medical Committee Officers and TEWV Liaison on 15th September; these were not supported by the wider primary care network to progress roll out due to not being able to incorporate the referral form in their electronic system.	
	Enabling action: The team manager to draft a business case to adopt a CED specific referral form. This will be presented to the November North Yorkshire, York & Selby Quality Assurance & Improvement Subgroup.		
Access to our North Yorkshire, York & Selby perinatal services is being impacted by team capacity as a result of staff on long term sickness, maternity leave and vacancies.	The service manager to progress a recruitment exercise for 5.6 wte vacancies by the end of November 2022.	Only one member of staff were recruited in the first recruitment round. Support is being given to the York and Scarborough team, which has been most impacted, and patients are being seen by clinical priority.	

For all IPS commentary, please see the Long Term Plan section for County Durham Sub-ICB Location

Long Term Plan Ambitions – Vale of York Sub-ICB Location

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

There are **6** measures that have not been delivered at quarter 2.

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	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	9661	6282	1441	1407	2848
Percentage of people who have waited more than 90 days between first and second appointments	<10%	<10%	17.65%	15.55%	16.62%
The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Q1 50% Q2 60% Q3 70% Q4 80%	46.15%	58.33%	58.33%
Number of people accessing IPS services as a rolling total each quarter	559 ICS Ambition	92 at Quarter End	68	89	89
Number of women accessing specialist community PMH services in the reporting period (cumulative)	336	Q1 60 Q2 120 Q3 180 Q4 240	50	72	72

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
To improve access to our IAPT services, there is a need to increase awareness of what is offered and generate additional referrals.	*Please see the Long Term Plan section for North Yorkshire Sub-ICB Location*		
There has been an increase in the number of people placed directly onto step 2 Guided Self Help and Step 3 as the first treatment option due to increased acuity seen in patients, impacting staff capacity	Service Manager to continue recruitment for 1.8 Psychological Wellbeing Practitioners (PWP) and 2.6 wte High Intensity Therapists (HIT).	The PWP posts have been recruited; however, following unsuccessful recruitment, the HIT posts are to be readvertised.	
For all Children's Eating Disorders commentary, please see the Long Term Plan section for North Yorkshire Sub-ICB Location			
For all Perinatal Services commentary, please see the Long Term Plan section for North Yorkshire Sub-ICB Location			
For all IPS commentary, please see the Long Term Plan section for County Durham Sub-ICB Location			

Chapter 3

NHS Oversight Framework

NHS Oversight Framework

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Introduction:

The NHS Oversight Framework is built around five national themes:

1) Quality of care, access and outcomes
2) Leadership and capability
3) People
4) Preventing ill health and reducing inequalities
5) Finance and use of resources, and a sixth theme focusses on local strategic priorities.

The 5 themes are underpinned by 23 key performance measures and sub-measures and Trust/ICB performance is monitored via an allocation to a top, inter- or bottom quartile. Those typically within the top quartile indicate the higher performing Trusts.

To provide an overview of the level and nature of support and the oversight arrangements required across systems, Integrated Care Boards and Trusts are allocated to one of four 'segments', determined by the scale and nature of their support needs, ranging from no specific support needs (Segment 1) to intensive support needs (Segment 4).

Summary:

The Trust is currently placed within **Segment 3** which is "*Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required*"

There are a number of measures where we are placed in the lowest performing quartile which indicates a position of concern or where we are not achieving the Oversight Standard These are:

- Inappropriate OAP bed days for adults that are either internal or external to the sending provider*
- Access rate for IAPT services*
- Overall CQC rating
- NHS Staff Survey compassionate culture people promise element sub score
- NHS Staff Survey compassionate leadership people promise element sub score
- CQC well led rating
- Staff survey engagement theme score
- Sickness absence rate*
- Proportion of staff in a senior leadership role who are from a BME background
- Agency spending

**Please see the relevant sections within the Integrated Performance Dashboard and Long Term Plan*

Further details on our performance is included in the pages overleaf.

1) Quality, Access & Outcomes: Mental Health

There are 4 Mental Health measures monitored as part of the 2022/23 Framework; 1 is monitored at Trust level and 3 are monitored at ICB level. Our achievement against these has been provided in the tables below.

Tees, Esk & Wear Valleys NHS Trust	Oversight Standard	Q1	Q2	Latest National Position
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	0	1094	994	Interquartile range as at June 2022 (1190) 38 out of 57 Trusts

Please see the Bed Pressures section within the Integrated Performance Dashboard from slide 20.

North East & North Cumbria ICB	Oversight Standard	Q1	Q2	Latest National Position
Access rate for IAPT services	100.00%	93.23%	71.93%	Lowest performing quartile (a position of concern) as at Quarter 1 2022/23 33 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100.00%	120.03%	119.96%	Interquartile range as at June 2022 21 out of 42 ICBs
Access rates to community mental health services for adult and older adults with severe mental illness	100.00%	225.41%	228.48%	Interquartile range as at June 2022 14 out of 42 ICBs

Humber & North Yorkshire ICB	Oversight Standard	Q1	Q2	Latest National Position
Access rate for IAPT services	100.00%	85.67%	88.55%	Interquartile range as at June 2022 26 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100.00%	152.24%	156.62%	Interquartile range as at June 2022 24 out of 42 ICBs
Access rates to community mental health services for adult and older adults with severe mental illness	100.00%	258.94%	250.05%	Interquartile range as at June 2022 24 out of 42 ICBs

Please see the relevant measures within the Long Term Plan section from slide 54.

Quality of care, access and outcomes; Safe, high-quality care

Quality of care, access and outcomes; Safe, high-quality care	Oversight Standard	Q1	Q2	Latest National Position
National Patient Safety Alerts not completed by deadline	0	0	0	
Consistency of reporting patient safety incidents	100.00%	100.00%	100.00%	Highest performing quartile (a positive position) as at July 2022 (100%) 1 out of 72 Trusts
Overall CQC rating	N/A	Requires Improvement		Lowest performing quartile (a position of concern) as at August 2022 54 out of 69 Trusts
NHS Staff Survey compassionate culture people promise element sub-score		6.9	6.9	Lowest performing quartile (a position of concern) as at 2021 survey 63 out of 70 Trusts
NHS Staff Survey raising concerns people promise element sub-score		6.7	6.7	Interquartile range as at 2021 survey 49 out of 70 Trusts

Leadership and Capability; Leadership

Leadership and Capability; Leadership	Oversight Standard	Q1	Q2	Latest National Position
NHS Staff Survey compassionate leadership people promise element sub-score	As per staff survey benchmarking	7.17	7.17	Lowest performing quartile (a position of concern) as at 2021 survey 65 out of 70 Trusts
CQC well-led rating	N/A	Requires Improvement		Lowest performing quartile (a position of concern) as at August 2022 56 out of 69 Trusts

People; Looking after our people

People; Looking after our people	Oversight Standard	Q1	Q2	Latest National Position
Staff survey engagement theme score	As per staff survey benchmarking	7.00	7.00	Lowest performing quartile (a position of concern) as at 2021 survey (6.79) 64 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking	8.00%	8.00%	Interquartile range as at 2021 survey (8.33%) 32 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	As per staff survey benchmarking	14.00%	14.00%	Interquartile range as at 2021 survey (13.80%) 28 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	As per staff survey benchmarking	25.00%	25.00%	Interquartile range as at 2021 survey (24%) 20 out of 70 Trusts
NHS Staff Leaver rate	None	13.87%	13.39%	Interquartile range as at June 2022 (16%) 21 out of 69 Trusts
Sickness absence rate (working days lost to sickness)	None	6.40%	6.07%	Lowest performing quartile (a position of concern) as at April 2022 (6.74%) 55 out of 71 Trusts

People; Belonging in the NHS

People; Belonging in the NHS	Oversight Standard	Q1	Q2	Latest National Position
Proportion of staff in senior leadership roles who a) are from a BME background b) are women c) disabled staff				
BME background	12%	1%	1%	
Women	62%	66%	67%	Interquartile range as at June 2022 (66.88%) 42 out of 69 Trusts
Disabled staff	3.20%	4%	4%	
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	As per staff survey benchmarking	56.00%	56.00%	Interquartile range as at 2021 calendar year (60.50%) 28 out of 70 Trusts

Finance and use of resources

There are 4 measures and sub measures monitored as part of finance and use of resources; of these, a Trust assessment has not been possible at this stage. Work is currently underway to develop the Agency measures.

Finance and use of resources	Oversight Standard	Q1	Q2	Latest National Position
Financial efficiency - variance from efficiency plan - Recurrent	N/A	£1,208,577	£3,871,945	Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.
Financial efficiency - variance from efficiency plan - Non-Recurrent	N/A	£361,173	£722,346	
Financial stability - variance from break-even	N/A	£1,296,930	£4,290,781	
Agency spending: Agency spend compared to the agency ceiling	100%	Not currently available	208.23%	
Agency spending: Price cap compliance	100%	Not currently available	63.76%	

Chapter 4

Reports from Board Sub Committees

Committee Key Issues Report		
Report Date to Board of Directors – 24th November 2022		
Date of last meeting: 3rd November 2022		**Report of: The Quality Assurance Committee**
		Apologies from B Reilly, Chair of Committee/Deputy Chair of the Trust Quoracy met with Substitute Non-Executive Director, J Maddison and Acting Chair/non-Executive Director, P Hungin
1	**Agenda**	The Committee considered the following matters: • Integrated Performance Dashboard • Risks relating to Quality and Safety • The Management of relevant risks included in the BAF • Progress on delivery of the CQC Action Plan • Adult Learning Disability Services (ALD) Improvement Plan • Trust Level Quality & Learning Report • Executive Quality, Assurance & Improvement Group (EQAIG) • Safe Staffing • Positive & Safe Mid-Point review • Improvement Plan related to learning from a patient death – Vicktor's story • Quality Assurance Programme Annual Report
2a	**Alert**	The Committee wishes to alert the following matters to the attention of the Board: **1. Integrated Performance Dashboard (IPD)** The IPD had been discussed in detail at the Equality Quality, Assurance & Improvement Group, (EQAIG), where standards were agreed, informed by the Trust Clinical Outcomes Group and relate to patient experience and carer involvement. The priority to improve carers' involvement in decisions about care and treatment has been set at a standard of 75%. **2. Risks relating to Quality & Safety** The position remains unchanged from last month with eight risks scored 15+ aligned to QuAC. Of the risks aligned to the People, Culture & Diversity Committee, seven of the eight are also relevant to QuAC. On assessing whether there are effective controls to manage corporate risks, the Committee received evidence and assurance relating to the top themes across the reports: bed availability, environment, demand, risk management and the provision of services. It is recognised that there is some way to go to embed risk management across the organisation and to deliver the associated training with priority given to train those who are responsible for risk management, particularly at Care Group level. Training sessions will commence in November 2022. It was felt that risk management and oversight is moving steadily towards a stronger, improved position. **3. Executive Quality, Assurance & Improvement Group (EQAIG)** The key matters that were discussed by EQAIG, on 25th October relate to: • Patient experience surveys were not undertaken by 123 teams in August 2022. • Capacity within the complaints team. • Availability of beds. • Increased use of seclusion in SIS by adults. A task and finish group is going to be established. • Community clinical risk management indicate concerns in relation to quality, MDT involvement and co-production.

- Recruitment and retention across all specialties.
- CAMHS staffing with a risk of regulatory breach.
- 30 - 45% of calls to the NYYS Crisis line answered first time.
- Senior clinical capacity impacting on delivery of fundamental standards and associated work.

Alerts relating to:

- Issues with completion of the annual audit of emergency resuscitation bags.
- High numbers of restrictive intervention, self-harm and seclusion incidents.
- Risks of achieving CQUIN targets for flu, cirrhosis, routine outcome measures for CYP and perinatal (predominantly in CYP). A recovery plan is being developed for cirrhosis and fibrosis.

Positive assurances, demonstrated by:

- High compliance achieved in the Quality Assurance schedule QA4 for observation and Section 17 leave.
- Friends and Family Test reveals that 92% patients would recommend the Trust, a slight increase compared with August (90.93%). The national average is 86%.
- The Trust wide Assurance Panel for reducing restrictive interventions is now in place.
- Improvements in safeguarding training compliance.

The Committee welcomes this report, which consolidates the four previous locality reports and supplements other reports. It is for information, as it is discussed with Executive Directors, but it does provide a rich overview of the current issues relating to safety and quality. The biggest theme to note, coming through EQAIG, and an ongoing concern for the Committee is the lack of staff capacity. This was escalated by EQAIG to Executive Directors for further discussion.

4. Safe Staffing

Pressures relating to safe staffing continue, with low registered nurse (RN) fill rates across a number of wards for day shifts, which has worsened from the previous month. Both PICUs and SIS wards are reporting low RN fill rates. High backfill of HCAs is a risk that can negatively impact on quality of care for patients. Additional local actions support the wards and services, with a relentless focus on recruitment and retention. The position is causing a further rise in the use of agency staff across all professional groups. Bank expenditure is unchanged from last month.

5. Positive & Safe – Mid-Point Review

There is positive assurance in the reductions of the use of “prone” across the Trust, with 49 incidents in the last six months and 11 uses of mechanical restraint in Secure Inpatient Services. This compares favorably to neighboring MH Trusts.
Various initiatives include a deep dive work into self-harm, good interventions, taking advice from CQC and Mersey Care and the introduction of a new assurance panel, however there is still more work to do to ensure that all wards and services are adhering to the Restrictive Interventions policy. The real challenge is supporting the small areas that are facing the extremely complex needs of individuals and high acuity.

The Committee sought further information on the reported 315 restrictive intervention incidents categorized as “other”. This may be a data recording issue and the Positive and Safe lead is going to define these further.
A Positive & Safe Conference, jointly hosted with CNTW was very well attended with complimentary feedback.

6. Trust Level Quality and Learning Report

This report is under development with the Committee to receive its own quality assurance dashboard measures.
From the range of quality and safety measures, there was improvement from last month in the number of shifts worked over 13 hours which have decreased to 71, compared to 90 in August 2022. This had reached 195 in July.
The Committee focused discussions on the capacity within the Patient Safety Team to deal with serious incident reviews. The current backlog of SI reviews waiting to be allocated has gone down from 34 to 26 and there are plans for an enhanced team capacity with interviews planned in early November. Some staff have left due to career progression and

		it has to be recognised that SIs are a difficult area due to the heavy emotional impact relating to the reviews and associated support work. Assurance was provided that any environmental risks around group ligatures are fed into the capital porgramme and work is underway to identify standards for each specialty based on a continuous safety programme.
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 assured that: • The assigned risks are being managed appropriately and there are no further assurances required on the operation of the controls. • The risk and assurance ratings remain appropriate and there are no new gaps in control or assurance with mitigations being delivered to plan. • The inclusion of expected trajectory charts for each of the risk scores is a significant improvement to the monitoring of risks. • Work has begun on describing sources of assurance using the "3 lines model" (formerly the "3 lines of defence model"). Once completed this will support the identification of gaps in assurance and will form the basis of the Board and Committee's business cycles. The only material change to the BAF is the increase in the indicative assurance rating for BAF ref. 6 (safety) from 56% to 62.5% due to the process of embedding learning and the escalation of concerns within the Trust's new governance arrangements. There were no new or emerging risks considered that will impact on the BAF. **2. Delivery of the CQC Action Plan and CQC Inspection 2022** Good assurance was provided in relation to oversight and delivery of the CQC action plan from the inspection of core service and Well-led in 2021, with 80% of the actions now complete, 16% on track for delivery and 4% not delivered or at significant risk to delivery. The Committee agreed that the deadlines for the three Must Do actions could be moved to more realistic dates between December to March 2023. Relating to one of the Must Do actions - to establish key metrics that will be used to monitor progress on delivery of the Well-led (5f), the Committee requested an interim action report before the deadline of March 2023 mapping out against the Trust goals what has been done to date. The last CQC Engagement meeting regarding progress with the Secure Inpatient Services action plan did not raise any new quality or safety risks with the next meeting due to take place on 10th November 2022. **3. Improvement Plan related to learning from a patient death – Vicktor's Care** By continuing to have oversight on the progress made with actions and the impact of learning related to Vicktor's care, this six-month update provides assurance on any improvements that have been made. The key areas for learning include medications and potential side effects, case load management, the Freedom to Speak up process and duty of candor. The Committee will continue to receive six monthly updates.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **1. Quality Assurance Programme Annual Report** This report, which has been reported to the Executive Quality Assurance & Improvement Group was seen by QuAC for information and assurance. One of the key areas of focus moving forward will be to build in greater peer review to ensure the tools used in the Programme are more robust. The report demonstrates good assurance on key learning from serious incidents by showing where progress has been made and has been shared with key stake holders.

2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considered that there were no material changes to be made to the strategic risks of the Trust, however, staffing remains a constant theme.
3	**Actions to be considered by the Board**	The Committee has recommended to the Board: That the update be considered reflecting on the current themes that remain of ongoing concern, such as staffing and meeting the demand and complex needs of the individuals and to note that there is evidence and assurance of progress made in the provision of care.
4	**Report compiled by**	Pali Hungin, Acting Chair, Non-Executive Director, Elizabeth Moody, Director of Nursing & Governance, Donna Keeping, Corporate Governance Manager

Mental Health Legislation Committee (MHLC): Key Issues Report		
Report Date: 24th November 2022	**Report of: Mental Health Legislation Committee (MHLC)**	
Date of last meeting: 8 November 2022	Full quoracy was met	
1	**Agenda: The Committee considered the following agenda items during the meeting:** • Reflections from the MHLC Developmental Session, held on 31st October 2022 • Risk identified relating to Mental Health Legislation • Integrated Performance Dashboard • CQC Mental Health Act Inspections • Discharges from Detention • Section 136 • Section 132b • Section 5(2) and 4(4) – "holding powers" • MHA Update • Human Rights, Equality & Diversity Information • Scheme of Delegation • Revised Associate Hospital Manager Policy and Hospital Manager Procedure	
2a	**Alert: The Committee alerts members of the Board on the following:** **Moderate Risks relating to MH Legislation** Three moderate risks have been identified relating to legislation and include: risk of failing to comply with the Mental Capacity Act (Ref. 1300), unlawful deprivation of a patient's liberty (Ref. 1299) and unlawfully depriving a patient of their liberty when Liberty Protection Safeguards come into place (Ref. 1298). Mitigations are in place to control these three risks and they will be taken to the Risk Subgroups of the Care Group Boards for discussion and shared ownership.	
2b	**Assurance: The Committee assures members of the Board on the following:** **Committee Development** Following a second development meeting on 31 October 2022 to consider the role of the Mental Health Legislation Committee, improvements are being pursued to narrow the gap between the data presented on agendas, evaluation, measurement, and the impact at the point of care for patients. Membership now reflects an operational link with representation from the two Care Group Boards, and this will enable any exceptions or areas of concern to be picked up and addressed in services. One example is Section 132 – information to detained patients and giving them their rights. Further consideration is being given to extend the membership to include the Lived Experience Directors. This will facilitate, for example, being able to hear from patients about their experiences of being detained. The Committee's terms of reference will need to be amended in line with anomalies picked up during the Development Day, relating to Committee Functions. **Integrated Performance Report (IPR)** The IPR for the MHL Committee contains one measure: "The number of uses of the Mental Health Act". There have been 2,183 uses of the MH Act year to date with 352 during September, which is static compared to 357 uses during June 2022. From the SPC data there is "cause for concern" relating to Adult Mental Health for NYYS in the number of the uses of the Mental Health Act by	

	ethnic group from April to September 2022. This is being investigated further by the Performance Lead for the NYYS Care Group Board. **Scheme of Delegation** The Committee reviewed and approved the Scheme of Delegation in respect of the Mental Health Act 1983. This contains the functions which are delegated to TEWV Hospital Managers, TEWV Mental Health Legislation Officers and TEWV staff. **Associate Hospital Managers Policy and Hospital Manager Procedure** These were both approved and will now go forward for formal ratification. **CQC Mental Health Act Inspections** There were seven CQC MHA inspections in the last quarter since reporting to Committee. There were over 40 actions currently underway, and assurance was provided that actions are being taken forward and monitored through the governance layers, including Quality Assurance, Improvement Group, Care Group Boards and the Quality Assurance Programme. **Discharge from Detention** There are no exceptions from the data during Quarter 2. The Trust continues to provide comprehensive reports and offer clear evidence to support the reasons for recommending continued detention/community treatment, despite this there are still occasions when the Tribunal and Hospital Managers disagree with the clinical team and proceed to discharge the patient – this continues to be in a minority of cases. **Section 136** There is ongoing work with Urgent Care Services and partner agencies to improve the S136 process and use of data. This will enable sharing of information and will improve local processes, together with complimenting the existing work to manage and share this data within the IIC. Once patients are in the care of TEWV, the legal requirements associated with S136 are being met and there is firm evidence to support this level of assurance. S136 is a police power, and the Trust has no control over when S 136 is used, consultation given or method of transport, however there is a process in place within the MHL team to feedback any breaches in the legislative requirements. **Section 132 – Information to Detained Patients** Following some extra focus on the escalation process, discussions with Modern Matrons, and weekly spot checks there has been some significant improvements on wards with patients being given their rights (S132). Minster and Ebor wards have shown marked progress, with a reduction in the use of the escalation process reducing from 16 times to 8 in recent months. For the majority, assurance can be evidenced that rights under section 132 are given on the same day as admission under the MHA and where this is not the case, this is being identified and rectified. **Section 5(2) and 4(4) – "holding powers"** From an assurance perspective, the Trust can demonstrate that it does capture information regarding the use of section 5 holding powers, but it is evident that improving the process for identifying the number of lapses can be improved. Areas to improve assurance include through reporting, support from IT and in collaboration with the Care Group Boards. This will help to capture feedback on any lapses and issues with the application of this section of law to clinical teams in a timely way.
2c	**Advise: The Committee advises the Board on the following:** **Human Rights, Equality & Diversity Information Review** This report demonstrates that the Trust detains higher numbers of people than the national average for black/black British origin compared to white backgrounds. This is something that has been an ongoing trend for TEWV.

	The Committee is seeking further assurance on this data and work will be undertaken, to a reasonable timescale, to review the validity of the data, considering geographical deprivation and socio-economic factors, together with comparisons with neighbouring MH Trusts. There is assurance that can be seen from the number of detentions that there is no evidence of any inappropriate detentions. **Mental Capacity Act** There is ongoing work to support MCA compliance in preparation for the Liberty Protection Safeguards implementation, although it is likely that this date may now be deferred to 2024. There are plans to re-design the MCA eLearning package in line with the national training platform within NHS England. This will be a positive move forward and a Practice Development Facilitator will take up post in January 2023 to support this work. Plans are underway to explore how MH legislation operational issues can be discussed with partner agencies and both ICS' as a holistic approach is needed with all key stakeholders present. These meetings ceased during Covid. One of the key areas that these meetings will support is addressing the issue of patients requiring assessment of their capacity prior to admission to determine the legal authority needed to authorise admission. A Trust wide audit on MCA commenced in April 2022 with a focus on the evidence of assessing capacity to consent to informal admission and so far, the results indicate that the audit will be red. Action plans have been developed in response; however it is difficult for the MHL team to influence clinical practice unless specific cases are highlighted for advice. **Honorarium Pay for Hospital Managers** Following a request from the former Chair of the MHL Committee, Richard Simpson to the MHL team, the Medical Director will seek the views of the Executive Directors on raising the fees currently paid to Hospital Mangers and bring this to the attention of the appropriate Committee. This was last discussed at MHLC in January 2019 when increases to pay were approved.	
2d	**Review of Risks**	There are no risks considered that need to be escalated to the Board of Directors

Recommendation: The Committee proposes that the Board:
i) Note the ongoing development work of the Committee, including efforts to improve the conduit between data presented to Committee and the operational impact on patient care, together with some amendments to the terms of reference.
ii) Note the focus on risks, three identified, which are "moderate", with mitigations and controls in place, which will be discussed further at the Risk Subgroups of the two Care Group Boards.
iii) Note the update on Mental Capacity Act and that it is unlikely that the new legislation will be passed until 2024 on Liberty Protection Safeguards. (Note: the Board will receive two briefing papers on this matter to ensure Executives are kept informed).
iv) Note that work will be undertaken to look deeper into the data relating to being a national outlier for detaining black/black/white groups under the Mental Health Act.
v) Note that the revised policy and procedure were approved following some minor amendments.
vi) Note that the Scheme of Delegation was approved.

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

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 24 November 2022	**Report of: People, Culture and Diversity Committee**	
Date of last meeting: 7 November 2022	The meeting was quorate, there were apologies for absence from Sarah Dexter Smith, Director of People and Culture and Patrick Scott, MD for DTVF Care Group	
1	**Agenda: The following agenda items were considered during the meeting:** • Colleague Story • Corporate Risk Register Board and Assurance Framework • Workforce Delivery Plan • Executive Sub-Group People, Culture and Diversity – Feedback • Integrated Performance report • Outcome of Counter Fraud Cases relating to Staff working whilst on Sick Leave • Apprenticeship Quarterly Report • Staffing Establishment and Actions to Maintain Daily Safety (including Mandatory and Statutory training) • Update on Staff Exit Interviews • Freedom to Speak Up – changes to National guidance and implications for Trust Policy • Staff Networks update • EDI data related to staff	
2a	**Alert** **The Committee alerts members of the Board that:** **Corporate Risk Register** • Of the 8 risks assigned to the Committee, 4 were overdue review at the end of October 2022, accordingly limited assurance is provided; • With the exception of Risk 1102, which was concerned with a risk of being unable to disclose staff emails in relation to subject access or Freedom of Information requests, the Committee notes the theme of the remaining risks concerns the shortages of staff. • In future, in order to see at a glance the status of risks and where the Committee needed to focus its attention and identify necessary mitigations, the Committee requested: o a more concise format for risk reporting which clearly sets out what the Committee is being asked to do (the purpose of the report stated that it was for discussion, but the recommendations asked the Committee to consider the risks and seek assurance over controls and mitigating actions); o a summary risk table that sets out the risk, a basic description, impact level for every quarter (hence highlighting any changes to scores over the various quarters); and o an Executive Summary to include subheadings of New Risks, Score Changes and Updates since the previous report. **Staffing Establishment and Actions to Maintain Daily Safety (including Mandatory and Statutory training)** Further to reviewing the report previously considered by the Board of Directors on Safe Staffing in October 2022, the Committee notes that the overall size of the Trust workforce has grown by 1,000 and recruitment and retention remains one of the Trust's biggest challenges. The Staff side representative drew the Committee's attention to Safe Staffing requirements (CQC Regulation 18) and times when there was no Senior Nurse available on shifts because this person was also covering the Duty Nurse Co-ordinator role (who may be called away from the Ward to a 'blue light' or assault incident) and stated that staff were expressing concerns around this issue. The Committee notes the challenges for all Ward staff when there are insufficient experienced Qualified Nurses to cover all the required roles. The Committee recognises the priority given to maintaining quality of care and safety, through Daily Lean Management processes, using Agency and other staff where required on a short-term basis and through implementing innovative approaches to recruitment and retention. The Committee acknowledges that this situation would be investigated and highlighted at Board level.	

2b	**Assurance** **The Committee assures members of the Board that:** **Board Assurance Framework** The Committee welcomes the new format for the Board Assurance Framework (BAF) which is helpful, particularly in relation to the provision of risk trajectories for the risk profiles in the report. The Committee supports the proposed split between recruitment and retention into two separate risks (BAF 1 and BAF 5). In particular, it draws attention to the importance of ensuring that the risk description for retention highlights ALL staff, not just those who are newly recruited, as experienced staff have significant knowledge which it is important for the Trust to retain as they are able to train the incoming staff. The Committee agrees that the controls should be strengthened and notes that there was good liaison with neighbouring Trusts to benchmark terms and conditions and the 'offer' overall with further work planned to reduce competition and develop consistency of approach. The Committee notes the commencement of work on describing the sources of assurance using the "three lines model" (formerly the "three lines of defence model") and looks forward to the completion of this as it will provide a more robust basis for identifying gaps in assurance. The Committee looks forward to further development work to more effectively link together the Corporate Risk Register and the BAF. **Integrated Performance Report** The Committee expresses concern about the limitations with the data provided due the number of available data points, whilst understanding that reports will be more frequent in future. The data for the staff leaver rate stated that from a total of 6789.71 staff in post, 909.17 (13.39%) had left the Trust in the 12-month period ending September 2022. The Committee welcomes the focus of work to enable leavers to have an independent route to participate in 'leaver's interviews' so the Trust understands the reasons why and can identify any themes and issues which need to be addressed. The Committee notes that the Communications and People and Culture Teams are developing an intranet page to ensure that all staff know the different ways of accessing a 'leaver's interview' by the end of November 2022 and an 'exit interview' proforma on 'Microsoft forms would be available on the intranet page for staff to complete. The data will then be analysed in a consistent way by the Organisational Development Team and reported to the Committee. The Committee requests a target be set from April 2023, in relation to the completion of exit interviews for Trust staff. In relation to the Board request of 29 September 2022, the Committee has asked for assurance in the form of a performance tables, setting out the staffing establishment numbers across the Trust by Care Group and at the various management levels with an analysis of the number of staff vacancies, sickness rates and appraisal/mandatory and statutory training compliance, plus a summary highlighting the key actions to be taken to address any issues.
2c	**Advise** **The Committee advises the Board that:** **Colleague Story** The Committee notes that where groups in the workforce have been discriminated against in the past through societal attitudes and in law, for example LGBTQI, it is important for colleagues to pay due regard to the language which they might use in everyday conversations and not make assumptions. The colleague spoke very powerfully about ensuring that people who have the same legal rights are treated with the same courtesy and respect. Examples included, referring to married lesbian couples as 'Mrs' (where this was their preferred form of address) rather than 'Ms' and to their wife rather than partner. This was about making everyone feel safe and equal as humans and comfortable about being themselves at work. The Committee notes that there is a low proportion of people being willing to declare their sexuality on ESR and in other surveys due to concern about the way in which they may be treated. This may indicate an unwillingness to come forward on other issues as well. **Workforce Delivery Plan: 'Our People Journey Delivery Plan'** The Committee welcomes the overarching goal of this 'working document': 'To co-create a great experience for our colleagues, so they will be Proud, Involved, Well Led and Fit for Purpose'. The Committee notes that the activity to support this will be aligned to the national people plan and achieved

through the following: (i) Compassionate and Inclusive Culture; (ii) More People; and (iii) Working Differently. The Committee is pleased to see the focus on workforce planning training, with 16 sessions delivered to staff to date. The Committee notes that much of the early work links to Health and Well-being, for example, the vaccination programme. The Committee acknowledges that at this stage there were gaps in 'ownership' of elements of the Delivery Plan and looked forward to giving the Board further assurance in this regard over the months to come, along with identifying 'Critical Success Factors' for the Plan.

Apprenticeship Quarterly Report
The Committee notes that following the Ofsted inspection in September 2021, the Trust no longer delivers in-house apprenticeships and holds quality assurance meetings with the 20 different providers 3 times per year. The Trust has 25 different apprenticeships ranging from Level 2 to Level 7 (over a 3-5 year period) run by external partners and continues to use the Apprenticeship Levy to support this. The Committee acknowledges the risks which were set out in managing the number of Apprenticeships, for example: (i) ensuring that there are regular reviews of the 447 individuals to maintain relationships reduce attrition; and (ii) effectively allocating HCA Apprentices across Wards to ensure access to appropriate mentors and training.

The Committee was given reassurance regarding the management of those risks and acknowledges that further development work is taking place on Induction and E-roster which will improve the position for Apprentices and other staff ensuring appropriate skill mix within the context of high levels of acuity and agency staffing. The Committee welcomes the positive relationship with the HCA Council.

Freedom To Speak Up Guardian Report
The Committee notes that there has been an increase in new cases of 83% between Q1 and Q2 (from 18 to 33 cases) - a return to pre-pandemic levels. There are 51 'current' cases, as there are some delays in getting cases 'signed off' by reviewers. The Committee welcomes further recruitment of Ambassadors who had a dual role in relation to 'Speaking Up' and the 'Bullying and Harassment Policy', with one re-launch event having taken place and another event being planned. The Speak Up training was now on ESR and 85 people had completed this. The Committee notes the experience of learning from feedback following interviews the FTSU team supported with 28 ALD staff over a few days following an individual concern raised at the end of May with the CQC about the safety of working in the ALD Inpatient Services. The Committee acknowledged firstly that the Team found that most staff agreed with the concerns raised with the CQC, secondly, that a comprehensive and well communicated action plan was put in place and thirdly, that whilst the service pressures remain challenging, that on revisiting the FTSU found evidence that staff felt listened to saw some improvement. The Committee reflected upon the benefits of such approaches.

Quarterly Equality, Diversity and Inclusion Report
The Committee notes that the EDI data in the current quarter for current staff make up of DTVF is: 90% White British; 81% female; 51%; Christianity; 76% no disability; 86% Heterosexual/Straight, whilst for NYYS it is: 88% White British; 81% female; 45% Christianity; 82% no disability; 85% Heterosexual/Straight. The staff make up of Board is: 75% White British; 63% female; 50% Christianity; 90% no disability; and 81% Heterosexual/Straight.

In relation to EDI data for recruitment for DTVF the key data was as follows: White applicants 3.65 times more likely to be recruited than BAME applicants; Females 1.29 times more likely to be recruited than Male; The age groups least likely to be appointed were 20-24, 25-29 and 45-49; Hinduism had lowest likelihood ratio compared to other religions; Mental Health Condition had the lowest appointment rate compared to other disabilities, followed by Long standing illness; and Sexuality of Bisexual associated with the lowest likelihood ratio compared to other groups.

The position for NYYS EDI data was: Asian/Asian British Indian applicants least likely to be recruited compared to other groups; White applicants 2.41 times more likely to be recruited than BAME; Female 1.61 times more likely to be recruited than Males; Age groups 25-29, 45-49 and 50-54 least likely to be appointed; Atheism and Sikhism had the best likelihood ratios of appointment; No one with a mental health problem was appointed (21 applied, 6 shortlisted); applicants 1.36 times more likely to be appointed without a disability than with; and Sexuality of Bisexual had the best likelihood ratio of recruitment.

With regard to corporate recruitment, EDI key data was as follows: White applicants 1.44 times more likely to be appointed than BAME; Female 1.71 times more likely to be recruited than Males; Age groups 30-34

	and 50-54 least likely to be appointed; Religion of Islam and Buddhism least likely to be appointed; Learning disability/difficulty least likely to be appointed; Bisexual or not stated had the best likelihood ratio of recruitment. The Committee notes that 7 National Domains of deprivation provide an Index of Multiple Deprivation Score. The Deprivation domains include: Income, Employment, Education, Health, Crime, Environment and income and the score is assigned to staff post-code. A decile score is allocated with 1 being most deprived and 10 being least deprived. The deprivation data for our Care Group areas is as follows: • DTV-F: 26% of staff live in the most deprived areas (deciles 1 & 2) and 16% in the least deprived (deciles 9 & 10) • NYYS: 8% of staff live in the most deprived areas (deciles 1 & 2) and 31% in the least deprived (deciles 9 & 10). No data was available for turnover/staff sickness and staff experience or disciplinary and grievances within Quarter 2. The Committee intends to use this information to inform future work programmes, the aim being to use the EDI data sets as a baseline to identify any issues and to devise equality objectives and targets for each Care Group. Gaps could then be identified and the Trust's progress, as an employer can be monitored. **Annual Forward Plan/General** The Committee asks that an Annual Forward Plan be compiled and circulated to the PCDC. The Committee also requests that report packs are distributed a minimum of seven days in advance, report formats are consistent, concise and written for the reader, making it clear to the Committee what is being asked of them and that updates are accurate and timely, with no gaps.	
2d	**Risks**	Safe Staffing (CQC Regulation 18 requirements) in relation to Staff Side comments above on the doubling up of the Senior Nurse role with Duty Nurse Co-ordinator role The Committee supports the proposed split between recruitment and retention into two separate risks (BAF 1 and BAF 5). In particular, it draws attention to the importance of ensuring that the risk description for retention highlights ALL staff, not just those who are newly recruited. Experienced staff have significant knowledge and skills which are essential for the Trust to retain to ensure consistent high-quality care is provided and to support the development of new incoming staff. The Committee agrees that the controls should be strengthened and acknowledges that recruitment and retention are key priorities for the Trust.

Recommendation: The Board is asked to note the contents of this report.

3	**Any Items to be Escalated to another Board Sub-Committee/Board of Directors**	• Safe Staffing (CQC Regulation 18) issue above to QUAC • An agreed process for referring matters between Committees of the Board where there was an identified overlap of interests eg matters raised in QUAC which were relevant to PCDC and vice versa
4	**Report compiled by:** *Deborah Miller,* ***Corporate Governance Manager*** Jillian Haley, ***Non-Executive Director/Interim Deputy Chair (Committee Chairman)*** Kate North, **Deputy Director of People and Culture** Minutes are available from: *Deborah Miller*	

Strategy & Resources Committee: Key Issues Report	
Report Date: 24 November 2022	**Report of:** Strategy & Resources Committee
Date of last meeting: 8 November 2022	**Membership Numbers:** Quoracy: met Apologies: none received

1	**Agenda: The Committee considered the following:** • Board Assurance Framework • Business Planning • Cyber Security • Performance of Trust Charitable Funds • Finance Report – Revenue & Capital • Integrated Performance Dashboard
2a	**Alert: The Committee alerts members of the Board to the following:** <u>Cyber Security</u> • The Committee received a report, which outlined the Trust, ICS, regional and national context for cyber security. The report alerted that investment would be required to ensure that evolving cyber risk was mitigated and that the Trust would include current priorities for investment in the 2022/23 business planning cycle and to inform financial planning for subsequent periods. <u>Finance Report – Revenue & Capital</u> Please see confidential board report. <u>Integrated Performance Dashboard</u> • Bed occupancy remains a significant challenge at an overall combined level of 100% and with some out of area bed placements (additional). • Areas of concern were identified in relation to the size and management of caseloads 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. • Financial pressures have been largely driven by the use of independent sector beds and agency costs (LD care packages, inpatient occupancy/vacancies/sickness and medic vacancy cover). The Trust is a significant outlier on agency metrics and the deficit and agency position will result in an overall use of resources rating of 3 presently.
2b	**Assurance: The Committee assures members of the Board about the following:** <u>Cyber Security</u> • Development of a Trust Cyber Strategy will mitigate the risk that was added to the BAF in July 2022 (Risk 8: "A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage"). • An initial proposed basket of priorities for investment will be further developed, phased and prioritised, should resources be available through Trust business planning prioritisation processes. <u>Finance Report – Revenue & Capital</u> Please see confidential board report <u>Integrated Performance Dashboard</u>

	• Bed occupancy – once the October position is understood, discussions will take place with the Medical Director, the Bed Oversight Group and the Care Group Boards on mitigation. In addition, the Bed Oversight Group will be completing a long term assessment of bed requirements across the estate and will seek to manage operational in year pressures; this will include collaboration with Local Authorities and the wider system in relation to actions to tackle increased lengths of stay driven by delayed transfers of care. • A sub-group of Executive Strategy & Resources Group has been established to consider caseload concerns and a significant piece of analysis will be completed to understand the position across all teams in order to identify where a response should be focused. The Committee acknowledged that this is a priority area and noted that a scoping exercise had commenced; this will feed into development of a timeline, which will take account of current capacity. • In respect of providing the Board with assurance and timescales, M Brierley and S Theobald advised that the development of the performance and controls assurance framework, linked to the BAF, will help to identify where assurance is provided. The framework will be an evidence based tool to understand direction of travel against SPC, forecast or national benchmarking data.
2c	**Advise: The Committee advises members of the Board that:** <u>Board Assurance Framework</u> (BAF) • Amendments were made to the BAF in relation to the dates for the achievement of the target risks scores for BAF risks 10 [Influence] and 14 [CITO]. • As part of the continuing development of the BAF the following amendments were made to the risk profiles: o The inclusion of charts highlighting the expected trajectory of the risk scores. o The commencement of work on describing the sources of assurance using the 3 lines model, which will support the identification of gaps in assurance and form the basis of the Board and Committee's business cycles. o There are no areas of concern to draw to the Board's attention. <u>Business Planning</u> • The Committee received a presentation which set out the process for the development of the Trust's Business Planning Framework for 2023/24. The Committee agreed with the proposed approach, noting that: o A Board planning workshop would take place on 13 December 2022 followed by stakeholder workshops in February 2023. o Some preparatory work would need to take place with governors and carers to ensure they understood and supported the process; and o That the Trust draw on the support of Non-Executive Directors (NEDs) in relation to engagement with governors. • The Committee agreed that the draft strategic journey documents scheduled for the Board meeting on 24 November 2022 be deferred to 26 January 2023 in order to: o Check consistency and interdependency issues between the 5 Journeys; o Consider whether the Journeys may be over promising in the light of business plan discussions taking place in December 2022; o Complete Journey Plans; and o Discuss content with NEDs in an informal setting before formal approval. <u>Cyber Security</u> • A Trust 'Cyber Strategy' is currently in the final drafting stages, building on inputs from a credible external cyber specialist and cyber framework. To accompany the strategy a series of prioritised investments in training, technology tools and services, and to bolster limited internal staffing have been proposed. • Proposed investments will be included for consideration in Business Planning resource prioritisation processes. • The Committee supported the proposed approach; the final draft Cyber Strategy will be presented for formal approval at the next Committee meeting in February 2023.

	Performance of Trust Charitable Funds
	• The Committee received a paper, which set out the financial position for Charitable Trust Funds for the period 1 April 2022 to 30 September 2022, noting that:
	  o An exercise would be carried out to ensure that all approved Health and Wellbeing costs had been allocated correctly to the Captain Tom fund.
	  o Executive Directors Group had discussed and agreed that uncommitted balances would be allocated to support proposals through the Staff Wellbeing Council. Given limited capacity presently this would be a key focus.
	  o Little active fundraising has taken place; this will be considered again once there is capacity within teams, including how involvement activity could support fundraising.
	• Suggestions were put forward as to how to engage with staff on how funds were used and how this could be provided longer term:
	  o The possibility of funding a dedicated post and communications officer to provide support.
	  o Consider an opportunity to create an identity that staff would support through organised team fundraising activities and events such as the Great North Run.
	
	Finance Report – Revenue & Capital
	
	Please see confidential board report.
	
	Integrated Performance Dashboard
	• The Committee received the quarterly report, which set out the Trust's position at 30 September 2022 and agreed that it would be important to brief the Private Board in November on the strategic implications of the Financial Forecast discussion.

Recommendation: That the Board: *i. Note the key issues report following the S&R Committee meeting held on 8 November 2022.* *ii. Note the risks as identified in the report referred to in section 2.*	
3	**Report compiled by:** Liz Romaniak, Director of Finance, Information & Estates/Facilities; and Sharon Ross, Corporate Governance Manager

ITEM No.11

Trust Board

DATE:	24th November 2022
TITLE:	Corporate Risk Register
REPORT OF:	Kendra Marley, Head of Risk Management
REPORT FOR:	Assurance

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

Executive Summary:

Purpose

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

Key Highlights

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

This paper presents to the Board the 15+ risks on the Corporate Risk Register as of 11th November 2022.

- There are currently 22 risks on the Corporate Risk Register, this is a decrease of 1.
- The 1 risk removed has been closed.
- There are 2 risks that have had the score reduced to less than 15.
- Risk review compliance against risks on the Corporate Risk Register is at 95%.

As this paper has been produced prior to the Executive Risk Group taking place, the changes reflected, namely the removal of a risk which has been closed, and the removal of the two reduced risks has not yet been formally agreed.

Recommendations:

The Trust Board are asked to:

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

MEETING OF:	**Trust Board**
DATE:	**24th November 2022**
TITLE:	**Corporate Risk Register**

1. Introduction and Purpose

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

The Corporate Risk Register is reviewed and approved by the Executive Risk Group. This paper presents to the Board the 15+ risks on the Corporate Risk Register as of 11th November 2022.

As this paper has been produced prior to the Executive Risk Group taking place, the changes reflected, namely the removal of a risk which has been closed, and the removal of the two reduced risks has not yet been formally agreed.

2. Background Information and Context

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

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

3. Purpose of the Corporate Risk Register

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

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

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

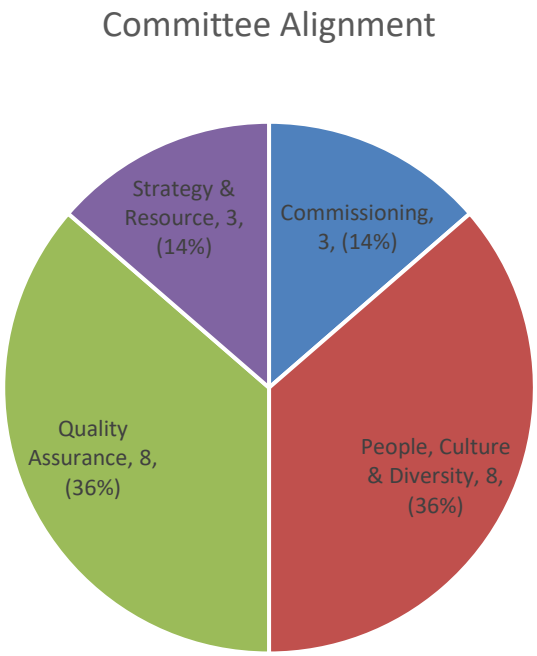
The Executive Risk Group will for the first time at its meeting on 22nd November review all risks on the Corporate Risk Register to confirm their ongoing inclusion, as well as reviewing all new 15+ risks and agreeing whether they are to be included.

4. Current Corporate Risk Register

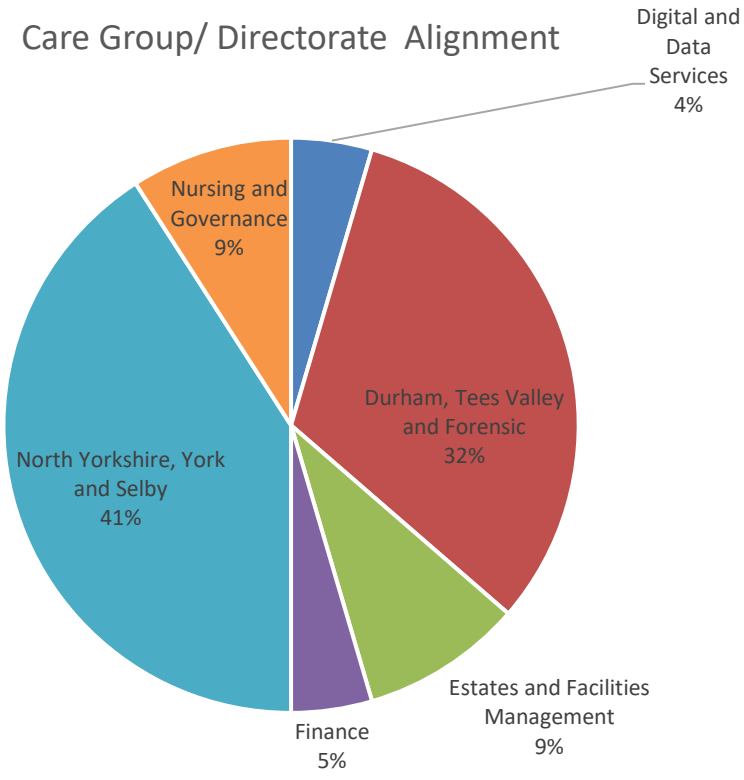
As of 11th November 2022, there were a total of 22 risks on the Corporate Risk Register, a decrease of 1. These form the main register that is reported to the Board and Committees. This does not automatically include new or increased risks of 15+ which have been added to registers in the intervening period until they have been reviewed and agreed for inclusion by the Executive Risk Group.

The current risks on the register align to the main Board Committees as shown in the following chart. This shows that there is an even split between Quality Assurance Committee and People, Culture and

Diversity Committee both with 36% of the risks, with Commissioning Committee at 17% and Strategy and Resources Committee at 14%.

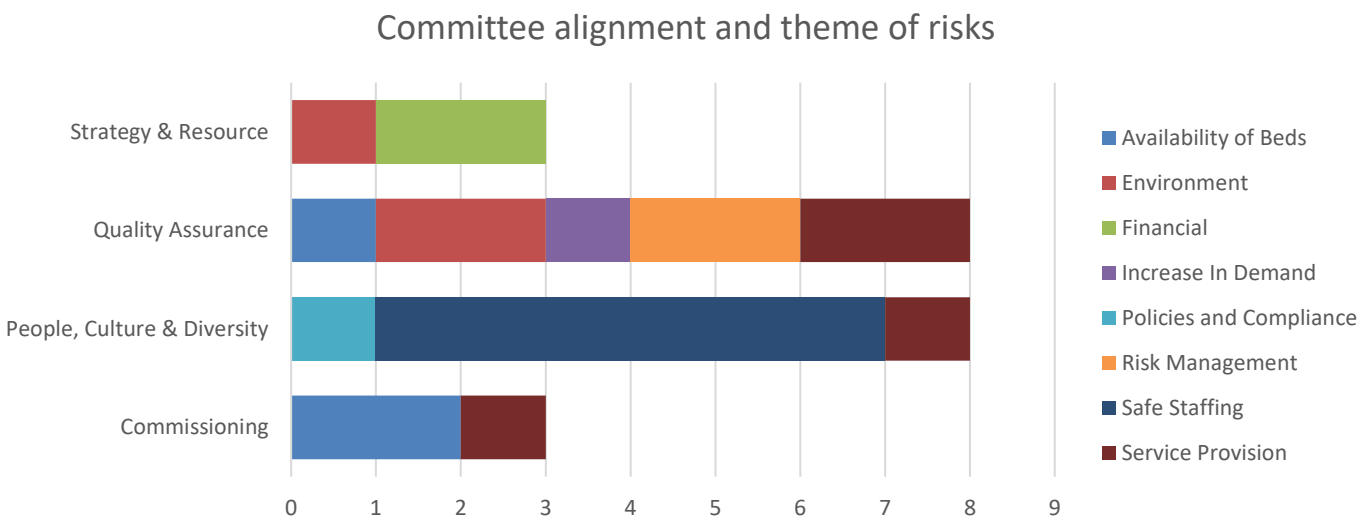


Focussing on the Care Group and Directorate breakdown of the corporate risk register shows us that 41% of the current corporate risk register is made up of risks from North Yorkshire York & Selby Care Group and 3%2 from Durham Tees Valley and Forensics Care Group.



4.1 Risk Themes

The 22 risks fall under the following themes within the Committee Alignment.



The below table shows the changes in the period.

Themes	Commissioning	People, Culture and Diversity	Quality, Assurance & Improvement	Strategy & Resources	Total	Change/ previously
Availability of Beds	2		1		3	↓ 4
Environment			2	1	3	↔ 3
Financial				2	2	↔ 2
Increase In Demand			1		1	↔ 1
IT Systems					0	↔ 0
Policies and Compliance		1			1	↔ 1
Risk Management			2		2	↔ 2
Safe Staffing		6			6	↔ 6
Service Provision	1	1	2		4	↔ 4
Total	4	8	8	3	22	23

There has been little movement as only one risk removed.

4.2 Overview and Movements

The 1 risk that has 'dropped' from the corporate risk register has been closed by the owner. This is shown below and removed from the register, however it is acknowledged that formal agreement by the Executive Risk Group will take place at the meeting on 22nd November.

Risk ID	Location	Risk Description	Current Rating	Update
1069	North Yorkshire, York and	There is a risk due to NYYS LD being unable to provide appropriate accommodation based on clinical need or having the staffing to be able to support increased level of service	15	The risk is no longer present as the service user is no

Risk ID	Location	Risk Description	Current Rating	Update
	Selby - NYY&S Learning Disabilities Services -	demand. This is due to increased acuity and demand with a number of service users requiring 5:1 or above staffing leading to reduction in multiple occupancy inpatient provision elsewhere in the Trust, resulting in patient needs not met in a timely way, reduced availability of LD beds trust-wide, and impact on the wider staffing resource.		longer an in-patient.

2 risks still shown on the Corporate Risk Register have been reduced to below the 15+ threshold. These are shown below and formal agreement to remove from the Corporate Risk Register will be made by the Executive Risk Group.

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating
People, Culture & Diversity	1. Recruitment and Retention	People	1076	North Yorkshire, York and Selby - NYY&S Child and YP -	There is a risk in Northallerton CAMHS due to delays in assessment and treatment for patients, with staff carrying high caseloads as a result of reduced staff levels. This is resulting in reduced quality and safety for patients as well as impact on staff wellbeing and absence/leaving the service.	20	9	9
People, Culture & Diversity	1. Recruitment and Retention	People	1090	Durham, Tees Valley and Forensic - Health and Justice (HJ) -	There is a risk that we may have to run services with less than minimum staffing levels at HMP Northumberland. This is due to reduced staff availability as a result of being unable to recruit to clinical lead vacancies. This results in an increased potential for patient and staff safety issues, reduced quality, poor experience, and impact on staff wellbeing.	20	12	9

4.3 Risk and Action Review Compliance

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

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

Following the launch of the new policy and working with the Care Groups and Directorates, work is still underway to ensure all risks currently on the registers are still valid and an update undertaken to comply with the policy as required.

Of the risks on the corporate risk register, only 1 of the 22 had passed its review date, indicating 95% compliance.

Monitoring and reporting of review compliance, including action delivery compliance will be undertaken and reported at all levels to aid awareness of risk review processes.

5. Implications

5.1 Compliance with the CQC Fundamental Standards

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

5.2 Financial/Value for Money

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

5.3 Legal and Constitutional (including the NHS Constitution)

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

5.4 Equality and Diversity

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

5.5 Other implications

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

6. Risks

This paper includes organisation risks of 15+ that are included in the Corporate Risk Register.

7. Conclusions

Risks on the Corporate Risk Register continue to be updated to reflect current circumstance and any progress in mitigation. 95% of risks were reviewed within the required timescale with 1 closed and 2 reduced to below 15. These will be reviewed and formally removed from the Corporate Risk Register at the Executive Risk Group on the 22nd November 2022.

8. Recommendations

The Trust Board are asked to:

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

Kendra Marley - Head of Risk Management

November 2022

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Commissioning	2. Demand	Quality & Safety	276	Identified - 15/06/16 Last reviewed - 24/10/22 Next review due - 24/11/22	Durham, Tees Valley and Forensic - DTV&F Adults -	Owner - Dominic Gardner - Manager - Thomas Hurst	There is a risk that we may be unable to admit DTV patients due to bed unavailability as a result of (over) occupancy levels, resulting in patients being admitted out of area potentially affecting treatment pathway and patient experience. There is also a potential impact on patient safety and our partner organisations if admissions are delayed. We also may not be able to maintain colleague wellbeing due to the impact of over occupancy resulting in increased sickness absence rates.	20	Trust performance framework Daily bed management teleconference Occupancy and acuity to be monitored through daily SITREP	OOA performance report - managed daily Bed occupancy 4 acute admission wards Dec 2020= 98.14% 11/02/21 Occupancy reported to quag 94% 15/4/21 It was reported in QuAG on 15/4/21 that as on 21/03/21 Bed occupancy 4 acute admission wards Jan21 = 92%; Feb21 = 99%; Mar21=99% 15/7/21 Acute Bed Occupancy levels Apr-21 = 107.63% May-21 =109.29% June-21 = 105.75% 17/8/21 July-21 = 103.52% 26/10/21 Aug-21 = 105.67% Sep-21 = 111.82% Oct-21 = 107.3% 16/12/21 Nov-21 = 107.27%	Demand is 24/7 and limited beds Trust-wide to meet demand Trust-wide lack of visual live bed state to support admission processes lack of knowledge as to increased length of stay and impact of PIPA process.	15	Proactive bed management processes at a site and Trust level - monitoring 30/60 days discharges, identifying potential blocks to discharge, formal identification DTOCs, etc There is currently an EMT project reviewing the bed pressures and processes to understand the Locality pressures and flows Weekly bed paper circulated and acted upon at OMT QUAG to review and agree with risk manager further actions required to recruit 2 additional bed managers to provide additional support to bed managment processes Develop an electronic live visual bed state in conjunction with ITand our digitaljourney to change Undertake PIpA refresh/relaunch Continue development of central bed management team in line with planned phase 2 of project plan Processes to monitor and progress to discharge inpatient stays of more than 90 days and delayed discharges to be evaluated for impacts Execute overall beds occupancy reduction plan Retain minimum of 2 male and 2 female beds for Tees	05/07/2021 18/02/2021 30/07/2021 31/12/2022 31/12/2022 23/09/2022 30/11/2022 31/01/2023 08/03/2017	Elspeth Devanney Dominic Gardner Dominic Gardner Elspeth Devanney Deborah Wright Simon Lancashire Hayley Stewart Simon Lancashire Hayley Stewart Thomas Hurst Dominic Gardner	05/01/2021 20/04/2022 28/02/2020 17/06/2021 20/04/2022 24/10/2022 28/06/2019	3
Commissioning	2. Demand	Quality & Safety	532	Identified - 27/02/18 Last reviewed - 11/11/22 Next review due - 09/12/22	Durham, Tees Valley and Forensic - Secure Inpatient Service (SIS) -	Owner - Naomi Lonergan - Manager - Richard Hand	There is a risk that patients in the secure service may continue to have extended lengths of stay and/or delayed discharges due to the lack of CCG and Local Authority provided single occupancy/bespoke accommodation for individuals with complex challenging presentations including Autism/LD/PD, resulting in delayed transfers of care, the number of patients waiting for a bed, and a negative impact on patient experience.	20	Weekly internal bed management meetings Weekly Provider Collaborative bed management meetings Weekly DTOC reporting Bi-weekly Provider Collaborative senior operational group meetings	The Bed Management process and the Care Navigators continue to review and monitor discharge plans for all inpatients. This will be reported through bed management and local governance processes. Weekly performance meetings will ensure DTOCs are monitored and formal escalation takes place appropriately.	MM ruling still impacting and there is no regional/national resolution Appropriate community placements is limited	16	Delayed Transfers of Care (DTOCs) to be reviewed across the service. To trial a Clinical Bed Manager post for 3 months. For Care Director to meet with NHSE/I about 3 specific patients Participate in the Regional project through North East North Cumbria (NENC) For bed management kaizen to be completed To take to DTOC paper to QAIG For Service Managers to attend LD&A Operational Delivery Group with local authority and commissioning colleagues to inform future commissioning needs Provider Collaborative to complete a bed census to identify individual patients who may be ready for discharge The service is proposing an investment in alternative accomodation for patients who require non hospital placements.	07/10/2022 26/10/2021 11/09/2022 28/02/2023 30/11/2022 08/09/2022 31/12/2022 31/12/2022 31/10/2019	Richard Hand Clare Abley Naomi Lonergan Naomi Lonergan Richard Hand Richard Hand Kelly Small Dr Anne Aboaja Paul Cartmell	09/09/2022 14/03/2022 08/08/2022 09/09/2022 14/03/2022	9
Commissioning	2. Demand	Quality & Safety	1087	Identified - 21/04/21 Last reviewed - 03/11/22 Next review due - 03/01/23	Durham, Tees Valley and Forensic - DTV&F Learning Disabilities Services -	Owner - Jennifer Illingworth - Manager - Sarah Gill	There is risk that there will not be sufficient specialist ALD beds to meet the demand. This results from a national reduction in bed availability post Transforming Care, a high level of inpatient acuity (many of whom currently require single-occupancy care), and a lack of community providers to facilitate discharge. This leads to the service being unable to accept admissions. Also includes risks relating to CQC S31 activity in June 2022	20	CTRs development of the pathway and interface with case management Enhanced community model and 7 day working flexible transition plans and pathways to discharge through working alongside providers. daily huddles ALD trust wide bed management process - HoS/CDs/Matrons and LM collectively review admission requests where there are local pressures and inability to safely admit. Cross site working and support. DToC monitoring through the above meetings initiated trust wide inpatient review project - program support manager appointed and commencing June 2021. Whilst we are in the position of having a small amount of capacity (2 beds) moved to formal business continuity and closed to admissions due to the inability to safely staff further complex admissions. inpatient design event with short and long term plans developed to address some of the estates and capital issues over the coming few months. external support in relation to current models of care that is informing current development plan	Sitreps - minimum twice weekly and increased to daily when required weekly case management DDTP sitrep Governance groups - reporting into new processes DToC report Project group formed mandated inpatient reports and audits BC meetings 3 times per week.		20	Developed and implementing s31 Action Plan post design event, participate in project group and progres with the implementation of the estate reccomendations. Escalation to exec team participate in the trust wide ALD inpatient redesign project develop pathway for accessing emergency and crisis respite provision as an alternative to hospital admission	31/10/2022 10/09/2021 08/10/2021 11/10/2021	Sarah Gill Sarah Gill Sarah Gill Sarah Gill Tracy Whitelock	09/08/2022 16/08/2021 08/10/2021 08/10/2021	9

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
People, Culture & Diversity	1. Recruitment and Retention	People	1001	Identified - 20/10/20 Last reviewed - 30/09/22 Next review due - 30/11/22	North Yorkshire, York and Selby - NYY&S Management -	Owner - Dr Tolulope Olusoga - Manager - Dr Tolulope Olusoga	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20	Mitigation is all via locums and mind the gaps though there are increasing pressures with the mind the gap arrangements. Promoting the Trust at Royal College of Psychiatrists events, Trust recruitment event in London and York in January 2022 and Feb 2022. Trust-organised Leadership Programme for Aspiring New Consultants in 2022. Actively reaching out to colleagues and existing networks promoting TEWV. Redesigning job descriptions to be more flexible to support LTFT colleagues. Participate in teaching sessions to higher trainees in Yorkshire Deanery promoting benefits of working in TEWV. Regular touch points to engage with existing medical workforce to support retention (bimonthly visits to bases/local meetings – impacted by Covid but alternative arrangements via MS Teams) and ensure leadership visibility. Ensuring our consultant trainers maintain capacity to train core trainees and higher trainees (to ensure supply route into consultant posts). Addressing place based service issues to improve attractiveness of locations/teams as a good place to work. Engaging with local high schools via careers events promoting psychiatry and TEWV. Developing well being programmes to support retention of medical staff including flexible working and remote working.	Expressions of interest in posts through promotion of TEWV and engagement with trainees through teaching. Reduction of costs for agency through monthly budget reports Monitoring staff wellbeing through sickness levels of medical staff. We have recruited 4 new substantive consultants in the last 12months. Monitor long-term sickness absence	At the time the risk was identified, there were 12.5 WTE vacant Consultant posts (out of 63 total across AMH, MHSOP, CAMHS and LD services), covered by 11 agency locum medical staff in addition to our local staff mind the gap arrangements. It results in an annual agency spend in excess of 1.4 million pounds. Failure to recruit to these vacancies will pose further significant risks to Trust reputation from impact on safe care delivery and will make it more difficult to attract and recruit new staff. We need to identify and implement recruitment options to attract medical staff to NYY eg use of recruitment premium, recruitment of doctors from overseas, review sessional job plans to support working across the locality, implement a middle grade on call rota, propose additional SpR posts. Develop skills across other professions such as non-medical ACs and	16	Recruiting CESR/SAS doctors from overseas Develop non-medic colleague skills to ensure consistent service delivery Sessional job plans to support working across the locality (utilising technology where possible) Explore and encourage group job planning to increase flexibility of the workforce supporting interests of the consultant workforce Putting in place a middle grade oncall rota to support medical staff retention proposal to get approval for 8 additional funded Higher Trainee posts (SpRs) in NYY to increase number of front line clinicians and improve pipeline for consultant posts Approval for the use of recruitment premium	09/02/2022 09/02/2023 09/02/2022 09/02/2023 29/12/2022 09/02/2023 01/10/2020	Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga	07/04/2022 07/04/2022 10/12/2021	9
People, Culture & Diversity	1. Recruitment and Retention	People	1063	Identified - 08/03/21 Last reviewed - 02/11/22 Next review due - 01/12/22	North Yorkshire, York and Selby - NYY&S Child and YP -	Owner - Melanie Woodcock - Manager - Siobhan Smart	There is a risk that patients may not be able to access timely psychiatric care including medication initiation following ADHD diagnosis, and reviews across NYY CAMHS due to high vacancy levels and gaps in cover arrangements resulting in potential for patient harm and poor experience, negative impact on staff wellbeing and staff retention.	20	Mind the gap and locum arrangements are providing a degree of cover across the locality. Gaps in Scarborough and resulting gap in Harrogate covered with MTG and cross cover. Consultants have used small amounts of annual leave to provide locum days into Selby CAMHS prior to a locum being appointed Substantive posts will continue to be readvertised Locums being actively sought for vacant posts. NMP roles being developed using short term finding from medical budgets, with a plan to move to nurse led ADHD services in the longer term.	Medical staffing risks reviewed monthly at QUAG. Risk also monitored monthly by specialty senior leadership group. Standing agenda item on monthly Consultant meeting.	No locum identified for Northallerton No interest in advertised jobs to date and no likely future candidates increasing delays in accessing psychiatry case discussions in Northallerton Reduction in hours requested by psychiatrists will impact on provision of psychiatry in Harrogate and Northallerton As at March-21, the service was operating with 65% vacancies resulting in Psychiatry caseloads being very high. Recruitment, Mind the Gap and locum/agency are mitigating to an extent but a more robust option is needed to attract contracted staff. This will address the significant impact on capacity and impact on the wellbeing of the existing workforce, such as referrals to Occupational Health, requests for reduction in hours, and some are leaving the service.	15	BCP planning Plan to re-advertise substantive posts in Scarborugh, Northallerton, Harrogate and Selby in September., dependant on reviews of job pland and neeed for College approval. Adertise NMPpost in Selby asap. development of specialty doctor posts advertise NMP 8a post in Selby review of Selby locum and agree likely time scale	01/12/2022 07/10/2021 07/10/2021 02/09/2022 05/05/2022 02/06/2022	Siobhan Smart Siobhan Smart Rob Berry Siobhan Smart Nicola Everett Siobhan Smart	02/12/2021 29/06/2022 09/08/2022 29/06/2022 12/05/2022	9

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
People, Culture & Diversity	1. Recruitment and Retention	People	1076	Identified - 29/03/21 Last reviewed - 14/10/22 Next review due - 01/12/22	North Yorkshire, York and Selby - NYY&S Child and YP -	Owner - Melanie Woodcock - Manager - Keri Brearey	There is a risk in Northallerton CAMHS due to delays in assessment and treatment for patients, with staff carrying high caseloads as a result of reduced staff levels. This is resulting in reduced quality and safety for patients as well as impact on staff wellbeing and absence/leaving the service.	20	Appointed .45 WTE receptionist. Further hours to be re advertised Appointed band 6 appointed to Recruited 2 x band 5 CAMHS clinicians recruited a band 4 Assistant Psychologist permanently and a fixed term band 4 Volunteer recruited to - focus on waiting room environment and participation with families to improve this FFT feedback will also factor in to her role. Medic case discussions are now June 2022 – this is impacting on throughput , team wellbeing and caseload sizes. Increased complaints due to wating for case discussions. There are 28 cases waiting for school observations which would then require a case discussion for a diagnosis of ADHD, this will not happen before June 22. 60% of case discussions are around ADHD. Due to staffing levels we can give sufficient resources to man an efficient duty rota. letters to GPs planned to update on waiting list position letters to families planned to update in waiting list position trial of agency worker to do initial assessments - 6 months; TM monitoring escalated to BCP	Monitor it through daily team manager's report out, weekly performance reporting and discussions at QUAG	Effective recruitment plan that results in additional clinicians providing capacity within the team. An example of what this will address is current high caseloads (eg Adv Practitioners who have more demand for assessments than slots available) and increased capacity for CNS to plan and implement transitions. Robust plan needed to cover CAMHS medical input to EIP caseload.	9	Ongoing recruitment Siobhan Smart covering EIP cases on 1PA	01/12/2022 19/05/2022	Keri Brearey Siobhan Smart		9
People, Culture & Diversity	1. Recruitment and Retention	People	1090	Identified - 26/04/21 Last reviewed - 02/11/22 Next review due - 09/12/22	Durham, Tees Valley and Forensic - Health and Justice (HJ) -	Owner - A&C Lisa Taylor - Manager - Kayleigh Parris	There is a risk that we may have to run services with less than minimum staffing levels at HMP Northumberland. This is due to reduced staff availability as a result of being unable to recruit to clinical lead vacancies. This results in an increased potential for patient and staff safety issues, reduced quality, poor experience, and impact on staff wellbeing.	20	-RAG review of caseloads to ensure patients are managed on clinical risk presentations -Using social media to adverts to target candidates. -Advertisement review -Support from wider regional prison teams (where available) -Use of agency staff - Review of processes from referral to caseload - Use of regular phone support for patients - Request to CNTW for secondment - unsuccessful - An temporary R&R incentive payment has been put in place for all staff recruited within a specific three month window.	Waiting times monitored through Service IDG and Quality and Safety meeting. Weekly action plan meeting in place.	The service continue to work with recruitment to attract applicants to posts and continue to use agency staff.	12	Successfully engage agency staff SUpport from wider prison teams Recruit x 5.6 wte B6 Nurses Team Process review Request to CNTW for secondment opportunity B5-6 development roles Recruitment of B7 ANP and B8a Psychologist RRP paper OD support to the team Review of RRP paper for ongoing recruitment issues	30/09/2021 14/05/2021 28/11/2022 01/07/2021 29/04/2022 05/11/2021 31/08/2022 29/04/2022 21/06/2022 03/08/2022	Kayleigh Parris Kate Muter Dallum Ryan Kayleigh Parris Richard Hand Kayleigh Parris Kayleigh Parris Kayleigh Parris Kayleigh Parris Kayleigh Parris	26/09/2021 30/06/2021 20/07/2021 11/04/2022 07/12/2021 09/08/2022 17/05/2022 11/04/2022 09/08/2022	9
People, Culture & Diversity	5. Culture and Wellbeing	People	1102	Identified - 01/04/21 Last reviewed - 13/10/22 Next review due - 14/11/22	Digital and Data Services - IT& Systems -	Owner - Chris Reynolds - Manager - Andrea Shotton	There is a risk that we are unable to disclose staff emails in response to subject access or freedom of information requests.	20	If the matter is one of bullying and harassment DPA Manager will also ask for email accounts to be copied so that any complaints of dishonesty can be investigated. Emails are records and should not be deleted within retention periods. This is stated within corporate record keeping policy and promoted via the SIRO network. The leavers process specifies that emails which are Trust records must be handed over to the staff member's manager.	Responses to SAR requests and evidence of any complaints made.	NHS Digital control the NHS Mail system so harvesting of emails has to be on an individual email account basis. DPA staff cannot be sure that emails requested wont have been destroyed. Staff already delete emails just to manage inboxs so deletion is not always sinister	16	Communication/awareness Review possible O365 tools	29/04/2022 29/04/2022	Andrea Shotton Andrea Shotton	10/08/2022 10/08/2022	8

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
People, Culture & Diversity	1. Recruitment and Retention	People	1143	Identified - 23/08/21 Last reviewed - 03/11/22 Next review due - 01/12/22	North Yorkshire, York and Selby - NYY&S Child and YP -	Owner - Melanie Woodcock - Manager - Nicola Everett	There is a risk that TEWV CAMHS and FIRST Service patient care will be compromised due to the FIRST service not having the staff in place to deliver services. Support being provided by CAMHS team and this diluting levels of services for all patients, resulting in potential patient safety and quality issues.	20	Meeting in place with CYC and CCG commissioner to review current offer to families and agree multi-agency plan for all children on caseload. First Staff to develop care plans for reduced offer to guide generic team clinicians on on-going offer to families remaining in service. N.b. the children are generally known and have on-going involvement with the psychiatry team for medication reviews which will continue. Vacant post to be advertised asap. CAMHS will set up a peer support group for staff members providing support to young people currently in receipt of support from FIRST. Ensure new band 5 LD nurse is closely integrated with CAMHS team and has strong links with Children's LA services to ensure they are involved in care packages for children typically in receipt of FIRST. FIRST will not accept any new referrals until the staffing situation is improved.	Monthly review at QUAG Task and Finish group to be established with TEWV, CYC LA and VoY Commissioners to review future FIRST offer in both the short and longer term given high levels of demand Young people with complex needs continue to have multi-agency oversight via the Dynamic Risk Support register on a monthly basis.	All children on existing caseload to have a forward plan in place prior to the psychologist's maternity leave commencing. All partner agencies to be involved in this care planning to ensure effective communication with families to help contain any anxieties re. this change. Psychologist job to be advertised asap. Without appropriately qualified staff, the children and families will no longer receive this specialist service. These children and families have high levels of need i.e. Learning disability and/or ASC and are at risk of either their home or school placement breaking down. FIRST offers an enhanced service, above and beyond the offer of the generic team. TEWV CAMHS will need to continue to provide support to these children and families from the generic CAMHS Team, which will be an increased offer	16	Advertise vacant psychologist post multi-agency meeting to review all care plans for existing caseload to be held on 31st August 2021 Task and Finish group established. First meeting 28/04/2022. Service to provide impact report	09/09/2021 09/09/2021 01/12/2022	Rob Berry Carol Redmond David LovedaySims	04/11/2021 04/11/2021	12
People, Culture & Diversity	1. Recruitment and Retention	People	1208	Identified - 14/12/21 Last reviewed - 11/11/22 Next review due - 09/12/22	Durham, Tees Valley and Forensic - Secure Inpatient Service (SIS) -	Owner - Naomi Lonergan - Manager - Richard Hand	There is a risk that we may be unable to provide safe and consistent staffing levels for registered and non-registered staff in Secure Inpatient Services due to overall absence levels resulting in potential patient safety and quality issues and impact on staff health and wellbeing and embedding wider culture work.	25	Daily operational and safety meeting SafeCare and red flag system to re-allocate resources required Supervisory DNC Group hubs Safe staffing escalation process Daily sitrep Implementation of BCP International Nursing Recruitment Senior leadership visibility	Establishments are being monitored - actual versus planned via established governance routes. Sickness absence is monitored and managed. Staff experience is measured. A recruitment and retention plan is being developed for the service. A review of budgets has been undertaken with Health Roster and Finance and all re-aligned. A service specific induction programme has been successfully developed. A Forensic specific staff side meeting has been implemented.	Establishment data varies according to source (HR, Workforce Information).	20	Recruitment campaign Retention Programme Submit SIS ward staff retentia premia Submit request off framework agency nurses Cultural and OD work is underway within the service including the Ward Manager Development Programme Service is placing a focus on wellbeing including provision of snacks and reviewing staff break areas, etc Senior leader visibility is being increased in the secure perimeter To work with Workforce team to on board the 40 HCAs safely and secure training. Plan needs to come to service for review. Review all staffing rosters up to 31/1/23 to optimise use and minimise risk Agreed workforce workstream to look at joint recruitment initiative and international recruitment	09/12/2022 31/01/2023 30/12/2022 23/06/2022 31/10/2022 09/12/2022 09/12/2022 31/03/2023	Fiona Robinson John Savage Naomi Lonergan Richard Hand Richard Hand Richard Hand Naomi Lonergan Fiona Robinson David Grocott Naomi Lonergan	08/08/2022 08/08/2022 13/09/2022 11/07/2022 11/07/2022	9
People, Culture & Diversity	1. Recruitment and Retention	People	1218	Identified - 01/02/22 Last reviewed - 03/11/22 Next review due - 01/12/22	North Yorkshire, York and Selby - NYY&S Child and YP -	Owner - Melanie Woodcock - Manager - Nicola Everett	There is a risk that services are unsustainable across the two York CAMHS teams due to staffing currently below commissioned levels resulting in high caseloads, interface issues with SPA team due to high number of referrals and demands, and excessive duty calls to clinicians, impacting on patient safety and quality, and staff morale and wellbeing.	20	STL meeting agreed: Mitigating actions in place – Case load management tool, case load refresh, QIS event for SPA will benefit flow into generic team. Huddles, drop in surgery daily for staff, reflective practice. SPA have offer of support from team and psychology. OD team have recently conducted Staff listening/discovery event to facilitate staff concerns/feedback to improve services in future as part of ongoing OD work and service improvement. Use of participation/ recovery lead to help manage feedback to families. Standard letter to go to GPs re position of waiting list discuss with adult teams early transfer of nearly 18s WiMT to offer short term interventions into York CAMHS. Additional mitigations added WIMT helping with lower risk cases Transitions to adult service expedited as appropriate	Staffing/ recruitment reviewed on weekly basis Use of IIC weekly to review performance e.g. waiting times; referral rates Follow-u STL will track progress and escalate as required. Weekly monitoring of Staff sickness. 27/6/22 weekly meetings with care group directors	iThrive model to be progressed and implemented across the system. It is anticipated this will result in reduced referrals to the CAMHS team although capacity and planning to progress, internal and external to TEWV, is an issue. Associated mitigating action to be added at next review in 08/22	16	Initiate Stop the Line Process review STL process with monthly meetings	29/04/2022 01/12/2022	Carol Redmond Nicola Everett	12/05/2022	9

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Quality Assurance	2. Demand	Quality & Safety	785	Identified - 06/09/19 Last reviewed - 20/10/22 Next review due - 17/11/22	North Yorkshire, York and Selby - NYY&S MHSOP -	Owner - Bridget Lentell - Manager - Bridget Lentell	There is a risk due to waiting times for memory services. Demand has outstripped capacity within finite resources, resulting in potential patient deterioration, strain on carers, impact on patient, families and staff and breach of RTT (Referral to Treatment) targets.	15	People waiting are prioritised according to changing need and not length of wait. Dementia coordinators placed in some GP practices ensuring more appropriate referrals sent from GPs and early advice and signposting provided to patients/carers before they enter services/assessment. Harrogate memory: York memory; b7 staff sharing diagnosis in MDT without consultant Increased MDT approach. Pilot - working with GPs to assist them to make/share diagnosis. Clinics being provided to improve access in Wetherby and Ripon. Wetherby commenced. Ripon shortly. Exploring the use of briefing assessment process (DIADEM) for a cohort of patients. Recruited with CCG spending review monies - b6 nurse + team manager for 2 memory teams. Teams routinely make contact with patients by telephone during wait time in order to triage, check patient safety and prevent unnecessary deterioration Criteria for triage has been reviewed in order to accurately assign patients to appropriate team without delay.	Memory Service Dev group now established to monitor risk and review internal management/ mitigations of long waits, such as greater MDT diagnosis. Number of people waiting for initial assessment to be reported to QUAG Average time waiting for initial appointment to be reported to QUAG if over 4 weeks. Dementia diagnosis rates Complaints	Even with Extra hours the capacity is not meeting demand. Needs a system wide approach to understand capacity and demand plus options to improve current situation	15	Set up Memory Service Development group Review pathway to include virtual assessment Diagnosis process reviewd General Manager, AMD and D of Ops to meet to discuss escalation within the Care Group and with CCG around MAS with a finite resource within MHSOP currently Senior Leadership Team time out to discuss what can be stepped back in order to rescope our current model of provision Risk is being escalated due to increasing demand Review of memory services planned across NY&Y Job vacancies out to advert and posts reviewed if unable to recruit to.	15/04/2021 01/10/2020 01/10/2020 25/08/2022 30/11/2022 22/08/2022 30/10/2020 23/09/2022	Jeffrey Whiley Dr Venkatesh Muthukrishnan Rachel Hogarth Bridget Lentell Bridget Lentell Bridget Lentell Rachel Hogarth Jeffrey Whiley	04/03/2022 04/03/2021 03/08/2021 18/08/2022 20/09/2022 29/10/2020 21/07/2022	3
Quality Assurance	7. Infrastructure	Quality & Safety	903	Identified - 01/06/20 Last reviewed - 11/08/22 Next review due - 11/11/22	Estates and Facilities Management - Estates -	Owner - Simon Adamson - Manager - Simon Adamson	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.	15	Suicide Prevention and Environmental Risk Assessment Procedure Supportive Engagement and Observation Policy Harm Minimisation Policy (Risk Assessment and Management) Environmental Risk Group Care Rounds Body Camera pilot Oxehealth (extension of installation on further wards agreed) Significant investment in staffing MDT Report Out Individual Safety Summaries Team Risk Logs Estates Work Log System Capital Work Programme Capital Investments Group Capital Planning Group Harm Minimisation Training Programme RPIW risk documentation and guides for staff Monthly reporting to the Quality Assurance and Improvement Group Contractual meetings with contractors to monitor the programme of estates work.	1.Harm minimisation training show high levels of competency. 2.Suicide prevention survey and risk assessment procedure log demonstrates that the majority of individual teams have been reviewing their surveys and they include risk mitigation. 3.Responded and compliance with NPSA ligature alert released in March 2020 and the ESA low lying ligature alert released in 2019. 4.Remedial action taken within 24hr by PFI providers following near miss incidents being identified. 5.Ligature Programme of works is reviewed at the Environmental Risk Group. 6.Phase one of the ligature works programme completed 2021/22 at a cost of £2.8m. 7.Phase 2 programme of ligature reduction works have been agreed and finances allocated in 2022/23 capital plan.	Known risks within clinical services have been assessed and mitigating actions are in place. However, there remains the possibility that patients may create ligatures without an anchor point which could cause severe harm and or unexpected death. Limitations have been identified in relation to detailed knowledge of all ligature points amongst some staff. CQC inspections of Acute AMH and PICU wards undertaken in January 2021 highlighted gaps in relation to risk assessment documentation and management.	15	Complete phase 1 of the ligature reduction programme of estates works to remove exsiting ligature points particularly in en-suites Undertake a clinical audit to gain assurance from clinical areas regarding the awareness and appropriate management of ligature risks. Estates to undertake a review of ward/department environmental risk logs to determine if recently identified risks within the clinical area have been logged within estates for action. A standard specification for each speciality to be developed in regards to anti-ligature equipment. Put in place a system of procurement to ensure clinical services order goods from a pre-approved list. Agree phase 2 of the ligature reduction programme (this will focus on bedroom doors) Implement phase 2 of the ligature reduction programme Roll out of Oxehealth technology to be extended for additional Inpatient Wards across the trust. Roll out of the Body Camera pilot to additional inpatient wards	31/07/2021 17/06/2020 31/08/2020 31/03/2022 31/03/2022 31/03/2022 31/01/2022 31/03/2023 31/10/2021	Simon Adamson Elizabeth Moody Simon Adamson Elizabeth Moody Elizabeth Moody Paul Foxton Simon Adamson Elizabeth Moody Elizabeth Moody	29/11/2021 03/03/2021 03/03/2021 11/08/2022 21/09/2022 07/03/2022 29/11/2021	10

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Quality Assurance	6. Safety	Quality & Safety	1067	Identified - 17/03/21 Last reviewed - 18/10/22 Next review due - 15/11/22	Durham, Tees Valley and Forensic - DTV&F Learning Disabilities Services -	Owner - Sarah Gill - Manager - Tracy Whitelock	There is a risk that staff will be injured in ALD inpatient services. This results from high levels of acuity in the units and the need for a minimum number of staff in core teams, especially males. This is in addition to needing staff who are familiar with the patient and appropriately trained to PAT L2. Where these requirements cannot be met, this can lead to high levels of staff assault and injuries through physical intervention.	20	agreed minimum staffing according to inpatient with agreed use of agency over staffing on a weekend to provide clinical leadership and response agreed number of PAT level 2 trained staff on shift support from community services staff working into the unit. additional PAT training for community staff increased support to monitor staff wellbeing staffing to be considered as part of the inpatient review project given the sustained level of increased staff to respond to the heightened acuity across the site. 28th June 2021 - unit invoked formal business continuity to manage the potential impact of insufficient staff on site. review of recruitment strategy, increased support from temporary staffing, consideration given to stopping planned services to support inpatient acute services. Additional recruitment in August, October and further recruitment planned in November. this includes fast track training for those appointed as part of their inductions whilst waiting for checks to be completed.	daily sitrep daily staff roster meetings across all ALD team managers when needed Review of acuity and incidences - RIDDOR reports 3 times per week formal BC meetings with 7 day per week safe staffing reporting.		16	review of staffing levels 1067 Embed the process of putting new recruits through the necessary training whilst going through the checks and prior to starting. BCP arrangements to include monitoring of staffing levels Advertise for male only staff	18/03/2021 16/04/2021 30/11/2022 30/09/2021 30/09/2022	Karla Sharif Karla Sharif Jemma Hill RMN Joanna Yarker Tracy Whitelock	18/03/2021 14/05/2021 08/10/2021 18/10/2022	9
Quality Assurance	2. Demand	Quality & Safety	1131	Identified - 26/07/21 Last reviewed - 01/11/22 Next review due - 09/12/22	North Yorkshire, York and Selby - NYY&S Management -	Owner - Brian Cranna - Manager - Liz Herring	There is a risk that people will have a long waits for their calls to the all age crisis/mental health support line to be answered due due to current capacity available to support the volume of calls, resulting in our inability to filter and assess the level of need of each call stream people to the right level of need.	20	Trust wide crisis & urgent response policy Crisis operating standard for a 4hours response for face to face assessment call handling information to reflect % call answered; Number of call handlers required per team	% of call answered each month (32%) volume of calls each day - 125 number of vacant posts across the crisis teams - 27.43wte	Level of service funding & Workforce capacity to meet demands ability to recruit into vacant posts & availability of temp staffing time lost creating record fro each call	16	responded to Trust-wide improvement group requirement for creating safety summary (SS) & safety plan (SP) for non-crisis calls the alignment of staff resource to meet service demand to increase service capacity through the use of support workers alognside registerd professional to align call to staffed capacity Divert function divert function shared rota across crisis teams potential for link with third sector phome responses to work with CCG regarding additional funding for alternative model & capacity	30/11/2022 31/08/2022 30/09/2022 30/09/2021 31/08/2021 31/08/2021 31/08/2021 17/09/2021 30/09/2021 30/11/2022	Liz Herring Andrew Knox Rachael Hill Andrew Knox Andrew Knox Andrew Knox Andrew Knox Andrew Knox Andrew Knox Liz Herring	07/09/2022 12/06/2022 05/11/2021 05/11/2021 05/11/2021 25/08/2021 07/12/2021 05/11/2021	6
Quality Assurance	7. Infrastructure	Quality & Safety	1223	Identified - 16/02/22 Last reviewed - 31/10/22 Next review due - 30/11/22	Nursing and Governance - Nursing -	Owner - Nurse Carole Rutter - Manager - Nurse Carole Rutter	There is a risk that medical devices may not be available/ or safe to use due to the potential for devices being obsolete, out of date, poor working condition etc. when needed most i.e. emergency situation, resulting in patient harm.	16	Medical device policy clearly states the roles and responsibilities of the wards in relation to medical devices. Central asset register held in the Estates Department National Safety Alerts actioned Medical devices group	The number of SI's that have a root cause or contributory finding in relation to medical devices. The number of incidents citing medical devices Monitoring of works to be undertaken around medical devices via the medical devices group	Medical devices safety officer not in situ. Format and content of existing asset register	16	Appointment of a Medical Devices Safety Officer Re-establishment of the Medical Devices Group with appropriate representation across the trust Undertake a baseline assessment of medical devices stored within operational services to ascertain working condition of device Carry out a review of the current Medical Devices Policy	31/03/2023 30/04/2022 31/03/2023 31/03/2023	Nurse Carole Rutter Nurse Carole Rutter Nurse Carole Rutter Nurse Carole Rutter	12/08/2022	3

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Quality Assurance	2. Demand	Quality & Safety	1226	Identified - 07/03/22 Last reviewed - 07/11/22 Next review due - 08/12/22	Nursing and Governance - Nursing -	Owner - Elizabeth Moody - Manager - Sarah Gill	There is a risk that LD patients may not be placed in the best environment to support their care due to a local and national shortage of LD beds, resulting in complex patients cared for within temporary ward environments supported by agency nursing staff and potential adverse pateint safety and quality outcomes.	20	Daily safe staffing oversight Daily SitRep call occurring Enhanced MDT and Matron oversight (Monday to Friday) Additional senior nurse oversight at night Safety checks being completed Support from the Positive and Safe Team Support with discharge pathways from NHSE Mersey Care review and input from HOPEs team Additional medication management training has been undertaken Locality Manager managing the wrap around timetable Work has been undertaken with the temporary staffing service to ensure regular agency staff to ensure consistency Escalated through the trusts governance process with weekly report through EDG (ward to board) Psychology support obtained to review debriefs (daily Monday to Friday) Safeguarding oversight	Monitor and report on restrictive intervention usage Monitor and report on patient safety incidents Weekly monitoring of safe staffing (roster work being undertaken)) Monthly Matron report is compiled monthly and forms part of the QA2 and QA3 Ongoing monitoring through Care Group and EDG Bed management is being monitored within NYY Locality Manager and Commissioner Daily report out and weekly MDT review meetings Safety and Wellbeing review has been completed Long Term Segregation reviews Delivery of improvement plan	Temporary nature of staffing Suitable alternative provision Bed management across the trust	16	Support for discussions with commissioners (esp. Yorkshire) to identify and fund appropriate non-hospital placement New matron supporting staff training, resilience and formulation Architects floor plans signed off for reconfiguration of Ramsey into 3 single occupancy flats Assess and Monitor the temporary staffing usage Investigate suitable alternative provisions Monitor the bed management position within the Trust	31/08/2022 31/08/2022 30/12/2022 30/12/2022 31/08/2022 30/12/2022	Janet Telford Jemma Hill Janet Telford Sarah Gill Rob Berry Tracy Whitelock	08/11/2022 08/11/2022 08/11/2022 08/11/2022 08/11/2022	9
Quality Assurance	2. Demand	Quality & Safety	1238	Identified - 19/05/22 Last reviewed - 20/10/22 Next review due - 17/11/22	North Yorkshire, York and Selby - NYY&S MHSOP -	Owner - Bridget Lentell - Manager - Bridget Lentell	There is a risk to being able to provide quality of care and patient experience for North Yorkshire & York patients need admission due to admission of out of locality and out of specialty patients into NYY MHSOP beds. There is high demand from out of locality and out of specialty, variable control process across the trust, resulting in increased work and pressure on teams, communication difficulties with community teams, increased LOS, impact on patients and families for visiting.	15	Matrons screening and gatekeeping during the day to ensure admissions are safe, and asking for assurance that risk assessments have been complete. 1045 sitrep - identify current situation and flow with bed managers.	Risk assessment for each inpatient admission.	No local process to monitor our out of locality patents.	15	Review daily in sitrep and bed capacity call feeding into bed oversight meeting	27/10/2022	Bridget Lentell	20/10/2022	9
Quality Assurance	6. Safety	Quality & Safety	1257	Identified - 25/04/22 Last reviewed - 11/11/22 Next review due - 09/12/22	Durham, Tees Valley and Forensic - Secure Inpatient Service (SIS) -	Owner - Naomi Lonergan - Manager - John Savage	There is a risk that patient care documents do not accurately reflect risks, risk management plans, risk of incidents and risk of harm due to lack of training or understanding, and workload pressure, resulting in potential for patient or staff harm.	20	Quality assurance schedule is in place	- Audit demonstrates that safety summaries and plans are in place and that they effectively identify the appropriate risks and mitigations - Increase in clinical leadership to support quality assurance processes - Validation audits to strengthen quality assurance processes - Audits and risk management plans - Quality assurance schedule	Need to identify the roles of the SDM and PDPs in this process Quality assurance schedule is self assessed instead of peer review	16	Taking into account the improvement work already undertaken, ensure that the Trust wide work in relation to safety summaries and plans is embedded and consideration of further quality improvement work	31/10/2022	John Savage		4
Strategy & Resource	12. Roseberry Park	Regulation	295	Identified - 08/09/16 Last reviewed - 11/08/22 Next review due - 11/09/22	Estates and Facilities Management - Estates -	Owner - Liz Romaniak - Manager - Simon Adamson	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	15	MIST system now installed into roof voids of all in patient areas to safeguard and reduce fire load and spread of flame until rectification works complete. Block 16 (decant) construction now complete. Phase 1 practical completion achieved, commissioning underway (blocks 5 & 10). Week. Phase 2 programming and procurement options are in train.	Weekly huddles take place to oversee progress of rectification works. RPH sub-group of the board convened as needed to oversee progress with regular CEO briefings to the board.	Agreed programme of works which resolve all the defects in the design and construction of Roseberry Park Hospital. Unknown quantum and type of defects in individual occupied blocks.	15	Achieve contract resolution to the satisfaction of the Trust Gain commitment to the programme of work to address fire stopping issues across the whole site Gain commitment to the programme of works, where possible to be co-ordinated with fire stopping works, to resolve 19 outstanding construction defects requiring mitigation Agreement of recourse to legal processes should commitment to works and commercial settlement not be appropriate Review of Capitec (independent consultants) report Full condition survey of Roseberry Park Establish facilities management special purpose vehicle Determine most appropriate route to defect rectification (complete phase 1 and identify phase 2 programme).	30/11/2022 31/12/2016 31/12/2016 31/12/2016 31/12/2016 30/04/2017 28/11/2017 31/01/2023	Simon Adamson Brent Kilmurray Brent Kilmurray Brent Kilmurray Brent Kilmurray Brent Kilmurray Brent Kilmurray Simon Adamson	31/01/2017 31/01/2017 31/01/2017 31/01/2017 02/01/2018 28/11/2017	10

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Strategy & Resource	15. Financial Sustainability	Financial	1072	Identified - 18/03/21 Last reviewed - 04/11/22 Next review due - 04/12/22	North Yorkshire, York and Selby - NYY&S Management -	Owner - Zoe Campbell - Manager - Zoe Campbell	There is a risk that we exceed our allocated budget due to overspending linked to over-establishment against core budget, high use of agency staffing and a lack of funding for key operational services (crisis line, IAPT trainees etc) non-recurring funding streams and reduced partnership investment via MHIS against 3 year plans from 19/20, resulting in not delivering cash releasing efficiency savings and achieving the wider achieving financial position of NY&Y and the Trust.	20	NYYS staffing group in place with HR & project lead staffing escalation process -community & inpatient E-rostering maintenance & rollout Contract management & annual planning Making sure that team managers have the necessary financial awareness knowledge and skills - budget review meetings Workstream in place re agency spend with finance support and operational leads. HNY ICS engagement re future opportunities for transformational funding via CMHTF/ other funding streams. Exit strategy for non recurrent funded roles discussed and agreed cross specialty	NYYS financial dashboard and forecast reviewed monthly at EBD and acre group board CMHF & MHIS investment proposals against LTP targets. Partnership review of finance monthly at commissioning groups and NYY MHLD Partnership Board.	Available funding via partnerships in NYY to address shortfall in funding to key services including IAPT and the Crisis Line. Gaps in rota to support SafeCare requirements	16	Workforce Recruitment and Retention Improve e rostering - Inpatient Agree MHIS Investment Priorities for 22/23 Exit strategy re Non recurrent funding 21/22 e-Roster roll out for coimmunity teams IAPT over establishment - trainee impact 0800 - all age funding	30/11/2022 30/04/2022 31/03/2022 31/03/2022 30/12/2022 31/10/2022 31/10/2022	Irene Steer-Richards Thomas Hurst Naomi Lonergan Naomi Lonergan Nicky Scott Liz Herring Liz Herring	 07/04/2022 07/04/2022 	9
Strategy & Resource	15. Financial Sustainability	Financial	1260	Identified - 17/06/22 Last reviewed - 19/10/22 Next review due - 18/11/22	Finance - Financial Management -	Owner - Liz Romaniak - Manager - Wendy Griffiths	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality of services.	20	2022/23 financial plan. Existing contracts and MHIS/SDF prioritisation processes via MH Partnership Boards and/or CMB. Alignment of Business Planning and budget setting processes. Financial monitoring/reporting processes including new governance arrangements (Care Group, Executive Directors and FSB). Internally reported monthly to Care Group Resource and Business Development Groups and Care Group Boards, the former reports into Exec Strategy and Resources Group (all monthly) - supports identification of variance from plan and actions required to mitigate. Workforce plans, controls and monitoring in place. SFIs / SOs and scheme of delegation (updated to reflect new structures) supported by procurement approvals hierarchy. Financial recovery meetings are established to identify and monitor required actions to deliver financial plan.	Financial monitoring reports submitted monthly to NHSE/I and ICB (Mth 5 performance reported year to date position behind plan, and forecast position on plan). Trust dashboard includes relevant metrics to support monitoring and delivery. Budget meetings are held with managers to support the delivery of financial plan, identification and mitigation of variances. Effectiveness is discussed at the Care Groups Financial Recovery Meetings.	Trust 2022/23 financial plan £1.16m surplus (including residual 43% of 21/22 Covid funding – non recurrent) approved by Board June 22. ICS 2022/23 financial plans reflect breakeven position; however, pay award is greater than national tariff funding which has generated a financial pressure for providers. Month 6 deficit £4.3m (behind planned £0.3m deficit, which requires run rate improvements including via CRES). Since March 22 run rates for staffing and Independent Sector Beds have increased. Of this £1.25 relates to months 1-6 pay award funding gap fr the increase above 2%. Possible additional funding could support this, subject to ICB / NHSE discussion. At point of plan submission, underlying recurrent financial position estimated to be IRO £24m deficit. Above run rates if	20	Manage delivery of 22/23 financial plan including run rate pressures and £13.8m CRES requirements EDG to re-consider business plan priorities / opportunity for slippage or deferral Validate run rate pressures monthly and potential additional actions required Undertake downside risk and mitigation assessment as part of finalising June 2022 financial plan resubmission Review bank pay rates to support bank staff growth as an alternative to agency Scope Smart working cost pressures (home working policy implications) and/or forward efficiency opportunities (travel/premises) Review non recurrent mitigations, including discretionary expenditure controls/approval routes (hospitality, conferences, non clinical agency/overtime)	28/04/2023 18/07/2022 28/04/2023 20/06/2022 30/09/2022 30/12/2022 28/04/2023	Liz Romaniak Liz Romaniak Wendy Griffiths Wendy Griffiths John Chapman John Chapman Wendy Griffiths	11/08/2022 17/06/2022 13/07/2022	12

ITEM NO. 12

Confidential

Meeting of:	**Board of Directors**
Date:	**24 November 2022**
Title:	**Business Plan Milestone Progress Q2 22/23**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Kathryn Ord, Chris Lanigan**

Report for:				
	Assurance	**x**	**Decision**	
	Consultation		**Information**	

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	x
2: To co-create a great experience for our colleagues	x
3: To be a great partner	x

Contribution to the delivery of the Strategic Goal(s):
This report explains the progress made achieving the 22/23 milestones set out in the Trust's Business Plan. It also outlines mitigatory actions being taken for priorities where progress has slipped behind expected timescales.

Strategic Risks relating to this report:

BAF ref no.	Risk Title	Context
		The Business Plan relates to the whole BAF and not to individual risks

Executive Summary:

Purpose:

This report updates the Board on the progress made in delivering the agreed milestones in the 22/23 Business Plan as at the end of Q2 (30/9/22).

It notes the potential explanations for the low level of achievement at the end of Quarter 2 and outlines the consequent Business Plan review process which is currently underway.

Overview:

The current business plan consists of 231 unique actions (this includes 17 actions added that related to the Quality Account which we added upon approval of that document by the Board of Directors in June).

These actions were developed during 21/22 under the Trust's previous governance and within the old Locality managerial structure.

A total of 56 actions were due for completion during Q2. Only **29%** (16) of these were achieved successfully

For the 71% (40 of 56) not achieved the appropriate Executive subgroup and / or program boards have approved changes. None of the changes requested are of strategic significance that would require Board of Director (BoD) approval. Appendix One shows the red rated initiatives.

Feedback suggests that a small number of factors explain the level of non-achievement of the plan. These are:

- Impact that structural changes had have on ongoing relevance / ownership of actions and timescales
- Journey development, which has led to a realisation that original plan milestones are suboptimal
- Redirection of capacity to focus on supporting and responding to regulatory inspections / Intensive Support Team assessment

In response to this, the Assistant Chief Executive has launched a review of all of the actions within the current plan. This review will be reported to Executive Development Group on 7 December. A revised Business Plan will then be put in place for the rest of this financial year, subject to Board approval (January 2023)

Business Planning for 23/24 has commenced utilising the new governance / managerial structure and influenced by the early drafts of the new Strategic Journeys (which will be considered by the Board of Directors in January 2023). A "whole initiative" / project-based risk/exception approach to reporting will be introduced, along with a greater focus on measurable impact.

Prior Consideration and Feedback: Care Groups and programme boards have discussed the relevant milestones that Executive Development Group has considered the overall position and agreed to the in-year review approach.

Implications: In this case, non-achievement of the plan mostly reflects services adapting quickly to a rapidly changing environment rather than non-delivery of Our Journey to Change. The current in-year review of the plan is identifying potential impacts of non-delivery and potential changes to the plan in more detail.

Recommendations: The Board of Directors is requested to:

a) Note the low level of achievement of milestones due in Q2
b) Note that an in-year review of the Business Plan is underway
c) Note that planning for 23/24 has commenced using the new governance/managerial structures and the

early drafts of the Strategic Journeys, and that an update will be provided in January 2023.

ITEM NO. 13

Confidential

Meeting of:	**Board of Directors**
Date:	**24th November 2022**
Title:	**Accelerating Our Clinical, Quality & Safety Journey to Change**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Mike Brierley, Assistant Chief Executive**

Report for:				
	Assurance	√	***Decision***	
	Consultation		***Information***	√

Strategic Goal(s) in Our Journey to Change relating to this report:

1: To co-create a great experience for our patients, carers and families	√
2: To co-create a great experience for our colleagues	√
3: To be a great partner	√

Contribution to the delivery of the Strategic Goal(s):

This report proposes a way forward to ensure that we design and deliver the right projects needed to implement the strategic objectives set out in our five Strategic Journeys. This includes how we can prioritise work needed to consistently deliver the fundamental standards of care and to address the concerns of our regulators and system partners. By doing this we will deliver all three Goals of Our Journey to Change (OJTC).

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1-11, 14, 15		**The proposed new arrangements will have a positive mitigatory impact for all BAF risks other than West Lane and Roseberry Park. They also reflect the limited tolerance for regulatory risks (BAF 9).**

Executive Summary:

Purpose:

This report sets out how we are focussing our resources to improve planning and delivery on the most urgent improvements required over the next 18-24 months that sit within the 5 Strategic journeys we have developed. By advancing the planning and delivery of quality / safety and clinical strategic objectives in 22/23 we will reduce the regulatory risks to the organisation and be more confident of delivering the priority projects that we have identified.

Alongside this we will continue to develop detailed business cases that will be brought on line (pipeline) once we have capacity released form the delivery of identified projects within the

advancing programme thus delivering further strategic objectives in 2024/25 and onwards.

Following the cancelled 2-day event back in September due to the sad death of Her majesty The Queen, the 5 journey strategies are currently being finalised as full strategy documents and we are working on pulling out strategic objectives, benefits and deliverables which will feed into new programmes, immediate projects and pipeline of future project development. This will ensure we capture everything that needs to be done but clearly sets out a clear programme of work recognising we cannot do everything all at once.

A series of business planning workshops will be planned over the next 4 months to involve a wide range of stakeholders to develop our plans in the context of addressing our regulatory concerns and planning within a wider newly emerging integrated care system that has significant financial constraints.

There are other big programmes of work across the trust and working with system partners that will continue alongside the Advancing Our Clinical Quality & Safety Journey to Change.

Examples of these are the Community Mental Health Framework, Trust wide Autism Project, Adult Learning Disability Inpatient model

Our workforce strategy is critical to every programme of work we plan and take forward, this cannot be understated.

Appendix One details work that has been delivered whilst we have been developing our long terms journey strategies

Moving from Strategy Development to Delivery:

The main focus of our business plans for the next 2 years is to ensure we have a clear focus on our clinical, quality & safety work by establish a dedicated programme of work in the form of an Advancing our Quality, Safety and Clinical Programme Board (AOQSC). This will:

- Identify, develop, and review business cases / plans for each project required to deliver the Quality/Safety and Clinical Journeys
- Identify dependencies between projects
- Develop a balanced plan which sets out the resources (money and staff), key milestones, and benefits
- Include Care Group and corporate departmental members as well as clinical and quality leaders

The AOQSC Programme is to include the most urgent improvements required over the next 18 months. To do so we have:

- Identified the highest priority cross-cutting projects from within the Clinical and Quality and Safety Programmes specifically and extracted these into the AOQSC Programme.

- Considered other projects that are aligned to Quality, Safety and Clinical outcomes that are within the Cocreation, People and Culture and Infrastructure Programme Boards, and took a view on their inclusion in the AOQSC Programme.
- Identified resources – The Programme management Office has deployed its resource to support the Advancing Our Journey programme which will provide relevant clinical quality and programme / project management expertise.

The focus to advance our clinical, quality & safety initiatives is not creating any new work or deviating for any of the current cocreated initiatives.

The acceleration is required to deliver clear must do's related to CQC action plans, Intensive Support Team (IST) feedback and national timescales for specific implementation of patient safety reporting systems.

First and foremost, this is about moving existing agreed work into a dedicated programme of focussed effort to ensure delivery.

Careful consideration is required to ensure we continue to communicate our business planning intentions, continue to have cocreation at the heart of it and to provide assurance that other important more discrete work will not stop.

We need to ensure that we link everything we do back to how they contribute to the 3 Goals that we have in Our Journey to Change; and we need to step up our collective effort to publish and celebrate Our Journey to Change and demonstrate at every level how we are doing and where we are on the journey which is vital to enabling and ensuring we move back to a Good CQC rating and beyond.

Service Users and Carers input has been and continues to be vital to developing our strategic journeys. Therefore, this must AND will continue as we now focus on delivering on our priorities for the next 18-24 months; remembering we are not proposing introducing new work or changing already agreed cocreated strategies.

We will constantly undertake routine reviews of all strategic journeys (which in turn will lead to new initiatives and projects being identified for scoping).

Summary:

Our Journey to Change is ready to move into turning strategy into reality and our approach for the next 18-124 months will address the:

- importance of making rapid progress on core quality requirements and of demonstrating this to external stakeholder and regulators.

- close connections between the clinical and quality strategic journeys and the need to avoid delivering them in silos.
- relatively low percentage of “Trust-wide” Trust Business Plan milestones delivered during 21/22 and to date in 22/23 which suggests that a different planning and governance approach is needed.
- identified short-comings in the current Programme Board structures regarding clear line of sight and silo working on cross-cutting projects with interdependencies.

This paper is based primarily on gaining traction on priority projects that will deliver against regulatory requirements and national must do’s (e.g. the delivery of the new Patient Safety Incident Reporting Framework). It cannot be overstated that this next phase of Our Journey to Change is not any proposed deviation from currently agreed strategic journeys. It also incorporates best practice in portfolio and programme management resource and expertise that the organisation has invested in to ensure we deliver required benefits and impact.

We need to ensure we wrap clear communication around our plans for the next 18-24 months. CoCreation will remain at the heart of everything we do.

Our workforce strategy is vital and underpins everything that we need to do to get back to CQC rating of good, and deliver our Journey to Change

Recommendations: Board of Directors are asked to:

1) Consider the report
2) Agree and support the business planning approach for the next 18-24 months which will align to Our Journey to Change

Appendix One

What have we done to deliver "Our Journey to Change"

Enabling

- Re-organised the whole clinical and operational structure to support a better-connected simplified approach
- Corresponding improvements into the governance and operational escalation structure
- Improved corporate communication approach – getting key messages to people
- Leadership development programmes for clinical and operational leaders
- New Board with an associated development programme supported by Deloitte
- Increased programme capacity including some senior clinical leaders brought in to support delivery
- New community bases opened in Selby, Northallerton and York
- New rehab unit to be opened in Shildon
- Increased in peer reviews – Merseycare, Intensive Support Team diagnostic

Co-creating a great patient and carer experience

- Reduced CAMHS waiting times to 27 days for first contact and 86 days for treatment – from over 200 days to treatment.
- Completed latest phase of ligature reduction programme, investing over £3m
- Installed assistive technology into all adult female wards, rolling out into secure – national leader in terms of breadth of deployment – improving safety, privacy and dignity
- Improved and update to new format 55,000 safety plans
- Rolled out Care Planning training to staff
- Rolled out new therapeutic approaches following a detailed review of thematic issues from self-harm incidents
- Early implementer of the Patient Safety Incident Response Framework – improving the quality of incident reviews, engagement of patients and families and resulting in clearer actionable learning
- Focussed on bed management – reduced out of area placements from circa40 to 4

Co-creating a great colleague experience

- Increased headcount by 700
- Over 1500 recruitment episodes
- Successfully on boarded first international recruits into Scarborough in advance of second cohort
- Recruited peer workers to each adult ward (40 plus) and rolling out into other service areas. Lived experience roles being appointed to at all levels including Director level – promoting cultural change and a real time focus on patient experience
- Rolled out Safecare as a module of our e-rostering to ensure that staffing levels reflect clinical acuity and issues

- Successive successful batch recruitment campaigns for support workers. EG Onboarded 60 new staff during September
- Improving staff satisfaction scores on quarterly Pulse surveys – most areas improved

Being a great partner

- CAMHS community transformation projects complete in Stockton, ready launch in Derwentside.
- Selby CAMHS piloted new ways of support ASD/ADHD in schools
- Mental health teams in schools roll out now 50% complete
- CAMHS T4/social care secure solutions being developed for Durham and Darlington
- AMH Community Transformation hubs live in Hartlepool and York. Durham progressing. Catterick to launch in new year
- Extended independent sector blocked book arrangements to meet service pressures – strong local partnership, stood down currently
- Joint transformation and collaborative posts recruited to in NENC to:
    - Complete a review of secure pathways
    - Oversee and facilitate LD and Autism pathways transformation
    - Network and share mental health best practice
    - Deliver the regional suicide prevention strategy
    - Manage the health and care workforce (and extending to all blue light) health, wellbeing and resilience hubs
- Contracting with VCS organisations to support crisis transformation – e.g. Time to Talk in Tees Valley and Communi-tea in Selby

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 1: To co-create a great experience for our patients, carers and families.	Co-creation	N/A	N/A	Develop an Involvement and Leadership structure to support the Trust's services (our ambition is that Patients and carers are involved, as equal partners, in all aspects of service planning, design, implementation, delivery and evaluation and also in all aspects of the assurance process and at all levels to ensure that our services are safe, effective, caring, responsive and well led)	Co-creation Framework	Development of the co-creation Framework	**Q2 22/23**	RED Time	The cocreation working group have agreed the plan to develop the cocreation framework, this involves a series of webinars and workshops on a monthly basis to discuss a topic/ chapter of the framework. This means that all of the chapters will not be complete until early Q4 ready for sign off. This will ensure cocreation of the framework. Currently chapter 1- (value and behaviours) is in draft and out for consultation and due to be signed off by programme board in July. Chapter 2 (Definitions) currently being developed in draft.	Extend to Q4 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	Digital & Data	N/A	Delivery of the digital aspects of our infrastructure journey	**Cito**	Complete work required for CITO to feed data reporting systems	**Q2 22/23**	RED Time	Awaiting a decision from the Board which will be expected in December 22.	Extend to Q1 23/24
Goal 2: To co-create a great experience for our colleagues.	N/A	Digital & Data	N/A	Delivery of the digital aspects of our infrastructure journey	**Cito**	Complete phase 1 roll-out of CITO	**Q2 22/23**	RED Time	Awaiting a decision from the Board which will be expected in December 22.	Extend to Q2 23/24
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	Durham, Tees Valley & Forensic	Children and Young People's Services	Care Group Plans	**Undertake formal review of the new Durham neurodevelopmental pathway process**	Formal review of new pathway complete	**Q2 22/23**	RED Time	The review of the neurodevelopmental pathway for Darlington has commenced, led by Nik Childs, commissioner lead. She is also leading the review of the TEWV diagnostic element of the pathway in Durham. Alison Ayres is undertaking the review of the wider system pathway in Durham and due to availability of stakeholders and timescales to survey parents, stakeholders, analyse feedback etc,	Extend to Q3 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	Durham, Tees Valley & Forensic	Adult Mental Health services	Care Group Plans	**Improve substance misuse / dual diagnosis services**	Develop proposals for increased investment into Durham services	**Q2 22/23**	RED Time	A limited resource has been identified and services have identified ideas, to be prioritised and confirmed,	Extend to Q3 22/23
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	Durham, Tees Valley & Forensic	Adult Learning Disability Services	Care Group Plans	**Continue to implement the recommendations from the Trust Learning Disability bed redesign event**	Complete work to create single occupancy unit at Lanchester Road Hospital (Ramsey Ward)	**Q2 22/23**	RED Time	Board agreed to do a stocktake and revisit the design event, to take place on 13 October, scoping meeting on 14th October with CNTW to understand the regional picture. We expect there will then be a 2-day event later this year to reconfirm the business case requirements. The business case for seclusion which had been separate is now to be included back into the FBC.	Exact timescale tbc

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	Durham, Tees Valley & Forensic	Adult Learning Disability Services	Care Group Plans	**Continue to implement the recommendations from the Trust Learning Disability bed redesign event**	Complete staffing establishment reviews	**Q2 22/23**	RED Time	Workforce workstream has paused until visioning is finalised.	Extend to Q4 22/23
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	Durham, Tees Valley & Forensic	Children and Young People's Services	Care Group Plans	**Evaluate the Durham and Darlington Mental Health Support Teams**	Evaluation of impact of these teams produced	**Q2 22/23**	RED Time	Meeting has been held with Teesside University to agree resource required to evaluate, the next month will be used to agree the plan for the evaluation with it expected to commence in Q4.	Extend to Q4 22/23
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	Durham, Tees Valley & Forensic	Adult Learning Disability Services	Care Group Plans	**Improve the experience of patients transitioning from CYP LD services into Adult LD services**	Identify the technology utilised by patients within children's services and how its use can be continued on transition	**Q2 22/23**	RED Time	16-25 transitions group in place. Also linked into Durham LA group.	Extend to Q3 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	Durham, Tees Valley & Forensic	Adult Learning Disability Services	Care Group Plans	**Continue to implement the recommendations from the Trust Learning Disability bed redesign event**	Submit proposal to remodel Unit 3 and 4 within Bankfields Court that will accommodate single occupancy requirements	**Q2 22/23**	RED Time	Board agreed to do a stocktake and revisit the design event, to take place on 13 October, scoping meeting on 14th October with CNTW to understand the regional picture. We expect there will then be a 2-day event later this year to reconfirm the business case requirements. The business case for seclusion which had been separate is now to be included back into the FBC.	Exact timescale tbc
Goal 2: To co-create a great experience for our colleagues.	N/A	Digital & Data	N/A	Enabling Digital Projects	**Network refresh**	Network Refresh Completed	**Q2 22/23**	RED Scope	Networks project is currently being scoped / planned and will be taken to DPB in November 2022 for approval. This project will incorporate remaining work within the Wi Fi project, continue on network requirements from the LAN project, look at Patient access to the internet and other network issues.	Q4 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	Durham, Tees Valley & Forensic	Adult Learning Disability Services	Care Group Plans	**Continue to implement the recommendations from the Trust Learning Disability bed redesign event**	Agree a new long-term plan for recruitment into LD services	**Q2 22/23**	RED Scope	Workforce workstream has paused until visioning is finalise.,	Extend to Q4 22/23
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	NYY&S	Children and Young People's Services	Care Group Plans	**Evaluate approach taken to treating Child Eating Disorders during the covid surge period**	Identify further needs across the system e.g.: post covid complex needs	**Q2 22/23**	RED Time	Would expect this to be available by the end of Q3 as IIC now back up	Extend to **Q3 22/23**
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	NYY&S	Children and Young People's Services	Care Group Plans	**Work with NYCCG and VoY CCG and partner agencies to develop a neurodevelopmental pathway, which could include and expansion of FIRST into North Yorkshire**	Service model and implementation plan developed	**Q1 22/23**	RED Time	Need to develop service collaboratively with partners and requires more time to do this to ensure we get the right offer in place	Extend to **Q4 22/23**

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	NYY&S	Children and Young People's Services	Care Group Plans	**Develop a specific service approach for 16-25 years olds (in partnership with Adult services)**	Hold a design event	**Q2 22/23**	RED Time	More time required to ensure engagement of wider partners	**Q4 22/23**
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	NYY&S	Adult Mental Health services	Care Group Plans	**Increase active involvement of people with lived experience in our decision-making groups**	Increased numbers of active people with lived experience in the new governance groups compared to the past	**Q2 22/23**	RED Time	The recent restructure & new people in post has impacted progress with this.	**Q3 22/23**
Goal 2: To co-create a great experience for our colleagues.	N/A	Medical Development	N/A	Staff Experience	**Improvements to trainee / junior doctor rest facilities at Roseberry Park and Lanchester Road Hospitals**	all required capital team documentation completed	**Q2 22/23**	RED Time	Request to extend to Q3 22/23 Plans drawn up to build new site at LRH. RPH discussions held between relevant departments to review position	Q3 22/23
Goal 1: To co-create a great experience for our patients, carers and families.	N/A	NYY&S	Mental Health Services for Older People	Care Group Plans	**Develop-proposals for investment to reduce waiting times for memory services**	Proposals developed for commissioners which, if agreed, will reduce waiting times for this service	**Q2 22/23**	RED Time	This action was agreed locally for delivery by Q4 22/23 and remains on track to be achieved by then. Request therefore to change within the Trust plan to Q4 22/23	Q4 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 2: To co-create a great experience for our colleagues.	N/A	Durham, Tees Valley & Forensic	Health and Justice	Care Group Plans	**Review and improve the current infrastructure provision within the service (to improve staff experience)**	Infrastructure (including IT) needs of prison-based and other staff reviewed and communicated to the appropriate corporate services	**Q2 22/23**	RED Time	work has commenced on review and a working solution has been identified resulting in a need to purchase additional hardware/tokens. work will then need to be undertaken to utilising the solution where difficulties are being encountered Request to extend to Q3 22/23	Q3 22/23
Goal 2: To co-create a great experience for our colleagues.	N/A	Durham, Tees Valley & Forensic	Secure Inpatient Services	Care Group Plans	**Develop a future workforce model**	Review of potential for Lived Experience workers completed, and (if agreed to have these roles) planning for them commenced	**Q2 22/23**	RED Time	Request to Care Group to extend to Q3 B6 peer coordinator post to advert but will not be in post until Q3. Once in post coordinator will determine plan and lead recruitment of further posts during Q3	Q3 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 2: To co-create a great experience for our colleagues.	N/A	Durham, Tees Valley & Forensic	Adult Learning Disability Services	Care Group Plans	**Introduce a structured volunteer programme across the service**	Volunteer opportunities and roles identified within each service	**Q2 22/23**	RED Time	there has been some progress to introduce volunteers; Tees Community - Limited progress due to other priorities; however contact made to the VSD to meet to consider options available Inpatient - Meeting arranged with lived experience director to progress, limited progress due to need to prioritisation other issues RDR - Team Managers have been in contact with volunteer services and are awaiting starts . REQUEST TO EXTEND TO Q4	Q4 22/23
Goal 2: To co-create a great experience for our colleagues.	N/A	NYY&S	Children and Young People's Services	Care Group Plans	**Apply the principles of the trust wide wellbeing strategy on a local level within the CYP service**	CYPMHS locality plan developed	**Q2 22/23**	RED Time	To complete locality plan need time to hold meeting and work with champions to ensure plan is collectively developed and owned	**Q3 22/23**

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 3: To be a great partner	N/A	NYY&S	Children and Young People's Services	Transforming CYP services	**Develop integrated services with local authority colleagues and other partner agencies**	A 'whole pathway' approach to meet the emotional wellbeing and mental health needs of children and young people in N Yorkshire and York based on the Thrive framework is agreed by TEWV, NYCC, CoYC and NHS commissioners	**Q1 22/23**	RED Time	Job description and agreement as to host organisation has taken time to agree with partner agencies.	**Q2 23/24**
Goal 3: To be a great partner	N/A	CMHTP Tees Valley	N/A		**Implementation of the Hartlepool community system hub**	Hartlepool community system hub mobilised	**Q2 22/23**	RED Time	Ext to Q3 22/23 Mobilisation is progressing and is set to go live October 3rd. ICT systems in the hub are not working due to LA setting which require resolving. Staff are working intermittently but have not fully integrated due to this issue.	Q3 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 3: To be a great partner	N/A	CMHTP	N/A		**Reconfiguration of TEWV teams – merging Affective and Psychosis teams (Hartlepool)**	CMHT mobilised	**Q2 22/23**	RED Time	Ext to Q3 22/23 NSC was initially on track but now highlighted a QIA needs to be completed. Therefore until submitted and approved NCS has been paused. All staff preferences have been undertaken following LCC approval and new teams will form following the QIA and NSC completion (due October)	Q3 22/23
Goal 3: To be a great partner	N/A	CMHTP	N/A		**Deliver phase 2 and 3 of population health management profiles to support implementation**	Profiles produced	**Q2 22/23**	RED Time	Extension to Q3 22/23 Phase 2 complete, Phase 3 delayed due to capacity within NECS.	Q3 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 3: To be a great partner	N/A	CMHTP	N/A		**Working with the AED Provider Collaborative, develop model to support people presenting with ARFID**	Model developed	**Q2 22/23**	RED Time	Extension to Q3 22/23 NENC workshop held in July hosted by the NENC CYP and AED Provider Collaboratives. Outputs being collated with a plan to establish a task and finish group before the end of Q2. Delayed due to capacity. Local places developing immediate pathway based solutions within existing resource for CYP	Q3 22/23
Goal 3: To be a great partner	N/A	CMHTP	N/A		**Agree transformation plan to support increase in access to psychological therapies**	Plan developed	**Q2 22/23**	RED Time	Ext to Q3 22/23 Delayed to allow new Care Group structures time to embed. Work to recommence with Care Group Director of Therapies. Some new posts introduced through HEE schemes	Q3 22/23
Goal 3: To be a great partner	N/A	CMHTP	N/A		**System workforce plan developed**	Plan developed	**Q2 22/23**	RED Time	Extension to Q3 22/23 High level plan developed with support from HEE. Further work required to refine specific details	Q3 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 3: To be a great partner	N/A	CMHTP	N/A		**Development of Specialist service model, recruitment of specialist and place-based roles to meet NHSE requirements. Establishment of Clinically lead workstream, linking with ICS. Recruitment of Trauma informed practitioners supporting whole system across NYY**	2x B8a, 2.6x B7 in post	**Q1 22/23**	RED Time	B8a posts in role. 1x B7 post recruited (Vale), 2xB7 currently readvertised workstream established	Q3 22/23
Goal 3: To be a great partner	N/A	CMHTP	N/A		**Development of Specialist service model, recruitment of specialist and place-based roles to meet NHSE requirements. Establishment of Clinically lead workstream, linking with ICS.**	2.2x B7 Specialist practitioners in place	**Q1 22/23**	RED Time	2xB7 Team Managers out to advert (readvertised). Discussions with Collaborative to establish Year 3 posts (FREED).	Q3 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 3: To be a great partner	N/A	CMHTP	N/A		**Development of Specialist service model, Expansion of services/learning from pilot scheme in SWR to inform development of model and recruitment of specialist and place-based roles to meet NHSE requirements. Establishment of Clinically lead workstream, linking with IPS. Development of wrap-around services at place**	Clinically led workstream in place. Evaluation and share and spread of learning informing development of new models at place across NYY. VCSE commissioning commencing from Q1 22/23	**Q2 22/23**	RED Time	Planned event to relaunch workstream in Q2/3	Q3 22/23
Goal 3: To be a great partner	N/A	CMHTP	N/A		**Development of PH Strategy in partnership with Primary Care. Support Workers increasing interoperability across City & Vale of York**	PHC SMI project Support Workers in place	**Q1 22/23**	RED Time	Admin posts out to recruitment (readvertised)	Q3 22/23
Goal 3: To be a great partner	N/A	CMHTP	N/A		**increased representation and opportunities for engagement and provision of necessary support to engage**	Increased representation, chairmanship of governance groups. Financial support available to increase engagement.	**Q2 22/23**	RED Time	Good engagement across partners. Working to create VCSE Alliance in NYY. Lead recruited in York.	Q3 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 3: To be a great partner	N/A	Durham, Tees Valley & Forensic	Children and Young People's Services	Care Group Plans	**Develop proposals to improve support to County Durham and Darlington Foundation Trust's paediatric clinicians**	Subject to the proposal being supported, additional capacity and expertise will be provided to support complex CYP within paeds at CDDFT	**Q2 22/23**	RED Cost	The CDDFT and TEWV senior leadership group has met to consider the paper which contains a range of proposals. Agreement that the TEWV programme Manager and CDDFT equivalent will set up a working group to prioritise and set up workstreams to progress. In relation to investment there is no new investment identified and unclear the route to access .	Q4 22/23
Goal 3: To be a great partner	N/A	Durham, Tees Valley & Forensic	Mental Health Services for Older People	Care Group Plans	**Compare different approaches to providing support to care homes / crisis and home-based treatment across Durham and Teesside and adopt best practice across the care group**	Best practice identified and plan for adoption produced	**Q2 22/23**	RED Time	This action will be taken forward by the new GM who commenced in September, so request to extend the timescale to end Q4	Q4 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 3: To be a great partner	N/A	Durham, Tees Valley & Forensic	Mental Health Services for Older People	Care Group Plans	**Review and consider reconfiguration of current Acute Liaison service**	Acute Liaison services reviewed and any required plan for reconfiguration agreed	**Q2 22/23**	RED Time	The service has experienced capacity issues. The service has been supporting DD AMH crisis during BCP and Tees liaison service, issues remain with accommodation and not full staff complement. The service is making links with CDDFT and the 100 day challenge. Proposal to introduce nurse triage at A&E (via non recurring monies - winter pressures, to support improved flow. The frailty element of this priority will be progressed via MHSOP. Liaison has moved to a new service line and new management structure and need time to embed and to have a stable staff complement before consideration of the next development stage of the service.	Q4 22/23

Appendix One - Actions Reporting RED – Not Achieved by end Q2 22/23 (30/9/22)

Goal	Programme	Care Group / Corporate Directorate	Service	Priority	Key Projects	Milestone / Outputs	Current deadline for delivery from 1/7/22	Q2 Status And Reason (RAG)	Update on status and rationale (If request for change ensure separate form is submitted)	Request being made
Goal 2: To co-create a great experience for our colleagues.	N/A	Digital & Data	N/A	Staff Experience	**On Call**	Business Case implemented (internal digital and data)	**Q2 22/23**	RED Time	Ongoing work developing the options paper	Q3 22/23
Goal 2: To co-create a great experience for our colleagues.	N/A	Digital & Data	N/A	Enabling Digital Projects	**Cyber strategy**	Cyber strategy agreed	**Q2 22/23**	RED Time	Strategy currently still under development	Q3 22/23
Goal 2: To co-create a great experience for our colleagues.	N/A	Digital & Data	N/A	Enabling Digital Projects	**Cloud first strategy**	Cloud First strategy agreed.	**Q2 22/23**	RED Time	Strategy currently still under development	Q3 22/23

ITEM NO. 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 November 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 Walkabouts (formerly known as Directors' visits).

2 **Background**

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

2.2 From a Board perspective, the walkabouts provide an opportunity to meet with team members 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 Service areas and their teams have really embraced this new approach and welcomed the pre-visit reflective time to really focus on the big tickets issues they face which helps to make efficient use of their time.

3 **Speciality areas visited**

3.1 The Leadership Walkabouts took place face-to-face on Monday 14 November 2022 across mental health provision and treatment within prison services including:

- HMP & YOI Low Newton
- Primrose Service
- HMP Frankland
- PIPE

- Derwentside IRC

A visit to Scarborough Whitby Rydale Crisis Team also took place which was rescheduled from October. This report focuses on feedback to prison visits.

4 **Key Issues**

4.1 Feedback from the leadership walkabouts is summarised below.

Strengths:

- Teams worki well together and feel supported, motivated and committed – staff are really proud of the work they do, and make a conscious decision to work in these settings.
- Real focus on relational approach to building trust with many who have been subject to significant trauma, enabling services users to feel valued, that they belong, and have choices, with clear boundaries and mutual respect.
- Staff playing an active role in the general welfare the service users, not only from a mental health support perspective but generally working with all services operating in the centre too.
- Good MDT working across TEWV services, as well as strong partnerships particularly with the probation service and primary care.

Challenges:

- Support and training for wider prison staff in terms of awareness of mental health, providing them with reassurance, insight and confidence.
- Lack of access to TEWV IT systems, which led to workarounds such as having to access systems from home.
- The reliance on teams in other parts of the prison system through more effective shared working and sharing of knowledge and skills.
- Staffing and recruitment can be really challenging, particularly ensuring the right mix of specialities that make up a multi-disciplinary team.
- Teams feeling separate or isolated from the Trust and wider service areas.

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 14 November 2022.

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 17

FOR GENERAL RELEASE
Board of Directors

DATE:	**24 November 2022**
TITLE:	**Ockenden – Independent Review of Maternity Services – Update**
REPORT OF:	**Elizabeth Moody: Director of Nursing and Governance**
REPORT FOR:	**Assurance**

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

Executive Summary:

The Ockenden Final Report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published 30 March 2022. A brief regarding the report findings was presented to the Board in April 2022.

All Trust Boards have a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening within their organisation / local system.

This report provides the Board with an update regarding the internal review of the key recommendations of the Ockenden Report (March 2022) against the report's four key pillars:

- Safe staffing levels
- A well-trained workforce
- Learning from incidents
- Listening to families

The report includes an overview of assurance against these recommendations and potential delivery risks.

There are established controls and relative assurance evidence which demonstrates the Trusts commitment to make improvements in relation to the four key pillars of the report.

Recommendations:

The Board is requested to note the content of this report and agree that further assurance regarding the Trust's approach and impact of changes be reported to the Quality Assurance Committee alongside the closed cultures work.

MEETING OF:	**Board of Directors**
DATE:	**24 November 2022**
TITLE:	**Ockenden – Independent Review of Maternity Services – Update**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to provide the Board with an update regarding the internal review of the key recommendations of the Ockenden Report (March 2022). The report provides an overview of assurance against these recommendations and also identifies potential delivery risks.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 A brief presenting the key findings of the Ockenden report (March 2022), an Independent Review of Maternity services at The Shrewsbury and Telford Hospital NHS Trust, was presented to the Board in April 2022.

2.2 The Board recommended that:

- The detail of the Ockenden Report be further considered by the Organisational Learning Group to agree any additional actions to mitigate any risks identified and develop robust plans where required, paying particular attention to the report's four key pillars.

- Further assurance regarding the Trust's approach and impact of changes be reported to the Quality Assurance Committee.

Furthermore, it was agreed that any potential actions required in response to the Ockenden Report recommendations be aligned to existing Trust programmes of work rather than being established as a standalone action plan.

2.3 All NHS Trusts have been requested by the NHSE National Mental Health Director to review controls in place to detect and prevent abuse. This was formally received by the Trust in a letter which was shared following the exposure of failures identified at the Edenfields Centre in Prestwich and the response to which is also on the November Board agenda. Both reports provide opportunities for learning and improvement in relation to the Trusts safety culture.

3. KEY ISSUES:

3.1 Further internal review and gap analysis of the Ockenden Report recommendations has been undertaken. This has involved review and consideration of a range of evidence sources, including qualitative and quantitative information and the findings of recent Trust external reviews. This has identified key themes for which there are established workstreams and actions being progressed.

3.2 The Ockenden report has been presented to the Organisational Learning Group and the key findings reviewed. Issues raised by the report are widely acknowledged by the Trust and work is actively progressing in relation to the report's four key pillars.

3.3 In line with the Trust's Journey to Change Programme, there are established controls and relative assurance evidence which demonstrates the Trusts commitment to make improvements in relation to the four key pillars:

- **Safe staffing levels** - including substantial investment in enhanced multi-disciplinary safe staffing establishments, workforce planning and sustainability. This is supported by significant targeted recruitment and further roll out of SafeCare. There is also enhanced MDT working arrangements and risk escalation processes.

  Areas for further improvement:
  - Consideration of 7 day a week senior leadership presence on inpatient wards
  - Further embedding of safe care
  - Recruitment and retention challenges
- **A well-trained workforce** - including enhanced training needs analysis processes. Specifically, there has also been training delivered in quality governance and assurance, incident reporting, Speak Up processes and risk assessment and management, in addition to improvements in mandatory and statutory training levels.

  Areas for further improvement:
  - Inpatient skills and training to support the delivery of safe and effective care. The Trust will actively participate in NHSE forthcoming Inpatient Quality and Safety Programme and is looking at an enhanced skill mix to provide greater practice leadership, consultancy and supervision to its inpatient workforce.
  - Multidisciplinary leadership within inpatient settings with a focus on delivery of good care and speaking out.
- **Learning from incidents** - including improved systems and processes for serious incident investigation and learning, such as establishment of rapid reviews to identify immediate learning, thematic reviews of serious incidents, mortality reviews, patient safety bulletins and established organisational learning mechanisms (including the Trust wide Organisational Learning Group and the Learning Library).

  Areas for further improvement:
  - Further advancing our Clinical, Quality and Safety Journeys.
  - Continued transformation to the new national Patient Safety Incident Response Framework (PSIRF).
  - Further promoting harm free care through strengthening existing workstreams with PMO support.
- **Listening to families** – including the establishment of Lived Experience Directors as core members of Care Group Boards, a review of complaints processes, Empathy Training. Alongside this, families are now involved in agreeing the Terms of Reference for serious incident investigations and there are opportunities for families to share their lived experiences to further enhance learning.

  Areas for further improvement:
  - Continuing to embed Triangle of Care and assessing the impact of the Carers Charter.
  - Continuing to implement the National Quality Standards for PSIRF which will facilitate greater patient and family involvement.

3.4 The Trust has improved systems and processes for identifying and mitigating organisational quality and safety risks. This includes improvements to risk registers which support enhanced oversight, assurance and management of risks.

It is recognised that there remain some identified risks and challenges to the ongoing delivery of the Ockenden Report recommendations as follows:

- **Safe Staffing** – recruitment and retention of appropriately qualified numbers of staff remains a national and local issue and is a key priority for the organisation and wider system. The People and Culture Committee maintain oversight of key risks and are actively working to deliver programmes of work which will support progress in this area.
- **Learning from incidents** – whilst there have been improvements made to the systems and processes for improving the management of patient safety incidents (in line with the new Patient Safety Incident Reporting Framework), there remain challenges regarding the capacity of the Central Approvals and Patient Safety Teams. The Executive Directors Group maintain weekly oversight of this position and progress against actions to mitigate potential risks associated.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

There are patient safety, clinical effectiveness and patient experience risks associated with failure of the Trust to ensure adequate controls to detect and prevent abuse in line with the CQC Fundamental Standards.

4.2 Financial/Value for Money:

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

Following structured staffing establishment reviews, there has been significant financial investment by the Trust to improve safe staffing.

4.3 Legal and Constitutional (including the NHS Constitution):

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

4.4 Equality and Diversity:

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

5. RISKS:

In respect of potential risks resulting from the analysis of the Ockenden Report recommendations, it is important that Trusts are not complacent and are vigilant in their ongoing commitment to detect and prevent abuse and to protect patients from avoidable harm by consistently meeting the CQC Fundamental Standards.

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

BAF 4: We might not always provide a good enough experience for those who use our services, their carers and their families, in all places and all of the time.

BAF 5: Pockets of poor culture or low staff wellbeing could undermine our ability to provide a safe and sustainable service as well as putting individual staff and patients at risk of harm.

There are planned programmes of work and actions identified to mitigate potential risks. These include those actions identified following the inspection of Trust core services and actions undertaken in response to the recently published independent reviews.

6. CONCLUSIONS:

6.1 The Trust is reviewing the controls in place to detect and prevent abuse in response to the letter received from the NHSE National Mental Health Director regarding learning from the Edenfields Centre.

6.2 A closed culture risk assessment review has been established to support the Trust in the early identification and management of any areas where closed cultures may develop.

7. RECOMMENDATIONS:

The Board is requested to note the content of this report and agree that further assurance regarding the Trust's approach and impact of changes be reported to the Quality Assurance Committee alongside the closed cultures work.

Leanne McCrindle,
Associate Director of Quality Governance, Compliance and Quality Data

Background Papers:

- Findings, conclusions and essential actions from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (published 30/03/22)

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 18

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**24 November 2022**
TITLE:	**Organisational response to findings identified at Edenfield Ward, Greater Manchester Mental Health NHS FT and communication from NHSE National Director for Mental Health regarding 'closed cultures'**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
REPORT FOR:	**Assurance**

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

Executive Summary:

Following the findings of patient abuse identified by panorama at Edenfield Ward, the National Director for Mental Health wrote to all NHS Trusts to request specific areas were reviewed by Trust Boards. In addition to this, the North East and North Cumbria Integrated Care System (NENC ICS) and Humber and North Yorkshire (H&NY ICS) has also requested that we review the mitigations we have in place to prevent closed cultures developing.

This report outlines the Trusts initial response as well as identifying a number of areas for continuous improvement in order to ensure we take every opportunity to learn, act and reflect on our safety culture.

The nature of inpatient service provision for people with a mental health problem, learning disability and/or autism means that there are inherent risk factors of closed cultures developing. The Trust is aware that if we fail to put effective controls in place to detect and prevent harm and/or abuse there is a risk of closed cultures developing and patients being harmed.

We have developed a cultural risk assessment tool in relation to the risk of closed cultures developing and having populated this we are now embarking on a series of 'see, hear and feel' visits (announced and unannounced) to those areas prioritised as a result of the risk assessment.

The report details an initial desk top review undertaken to identify areas and opportunities for further improvement that the Trust can take to strengthen controls to detect and prevent harm or abuse to our patients. This will be shared with care groups, with service users and carers and through executive quality and people groups to consider and as appropriate oversee implementation of areas identified for further improvement. Therefore areas identified in this report will evolve as we shape how they are implemented.

In reviewing the specific indicators of closed cultures we have identified some key areas of work to be progressed, which are summarised below:

- Progress the cultural risk assessment and 'see, feel and hear' visits to understand the impact and staff/service user experience of the risks identified
- Leadership and training programmes to be updated and conducted to reflect the learning from closed cultures and recent events
- The use of intelligent data to support triangulation of key workforce, safety, patient experience information to target leadership visibility and where additional support needs to be prioritised and put in place (the cultural risk assessment tool will support this)
- Continue to embed raising concerns and Freedom to Speak up Processes
- Recognise the moral injury and compassion fatigue challenge across patient facing inpatient ward teams and continue to ensure team de-briefs and good clinical supervision compliance/access to specialist supervision

Recommendations:

- Note the actions being taken by the Trust to identify and mitigate the risks of closed cultures areas as good assurance in response to the findings at Edenfield.
- Note that the areas identified in this report will evolve as we shape how they are implemented with staff, patients and carers.
- Agree that the Quality Assurance Committee will oversee the progress against delivery.

MEETING OF:	**Board of Directors**
DATE:	**24 November 2022**
TITLE:	**Organisational response to findings identified at Edenfield Ward, Greater Manchester Mental Health NHS FT and communication from NHSE National Director for Mental Health regarding 'closed cultures'**

1. INTRODUCTION & PURPOSE:

Following the findings of patient abuse identified by panorama at Edenfield Ward, the National Director for Mental Health wrote to all NHS Trusts to request specific areas were reviewed by Trust Boards. In addition to this, the North East and North Cumbria Integrated Care System (NENC ICS) and Humber and North Yorkshire (H&NY ICS) has also requested that we review the mitigations we have in place to prevent closed cultures developing.

This report outlines the Trust's initial response to these requests as well as further reflections and actions of the executive team in developing our organisational response following further television documentaries highlighting poor practice and abuse regarding care for vulnerable patients.

2. BACKGROUND INFORMATION AND CONTEXT:

The Care Quality Commission set out four key indicators where inherent risks are identified:

Indicators	Inherent Risk factors
People may experience poor care, including unlawful restrictions	• People in a service are highly dependent on staff for their basic needs. • People in a service are less able to speak up for themselves without good support, for example, in learning disability or children's services or care homes for people with dementia. • Restrictive practices are used in a service. • People remain in a service such as a mental health unit for months or years.
Weak leadership and management	• The service sometimes runs without a manager or leader. Reasons for this include frequent changes in management and management responsibility for more than one site. • The workforce comprises members of staff who are either related or friends, causing 'cliques' to form. • There is a lack of openness and transparency between managers, staff, people using the service and external professionals and organisations. • Managers do not lead by example and governance is poor.
Poor skills, training and supervision of staff	• There is a high turnover of staff. • There are consistent staff shortages. • There is a lack of suitable induction, training, monitoring and supervision of staff.
Lack of external oversight	• The service is in an isolated location resulting in people using the service having limited access to community services and facilities and less opportunities for friends and family to visit. • The provider is operating at scale and/or nationwide with regional managers covering large areas.

The CQQ indicators above have been developed into a cultural risk assessment tool that has been populated through triangulation of existing Trust data sources. This risk assessment tool has been shared with ICB Directors of Nursing who have collectively agreed to provide assurance to the ICB Quality Committee against the relevant domains of quality identified.

The next stage of this work is to undertake 'see, hear and feel' visits' prioritising those wards who are deemed using the tool to have the highest risk of developing a closed culture. These visits will include people with lived experience and focus predominantly on service user and staff experience. Announced and unannounced visits will be undertaken, and the focus will be on supporting teams. The tool has also been designed to identify cross cutting themes or areas for improvement across the Trust where a more strategic approach may need to be taken. A more detailed report showing early findings will be taken to the December QUAC. A copy of the tool can be seen at appendix 1.

An initial desk top review has also been undertaken and this report identifies areas and opportunities for further improvement that the Trust can take to strengthen controls to detect and prevent harm or abuse to our patients. This will be shared with care groups and through executive quality and people groups to consider and as appropriate oversee implementation of areas identified for further improvement. It is not proposed that an additional action plan is developed, alternatively we will ensure the areas are linked into and where necessary updated as part of our core programmes of work across workforce, safety and quality.

In reviewing the specific indicators of closed cultures, the areas identified for further improvement in this report have been summarised utilising some of the quality statements/domains used in the cultural risk assessment tool referred to above.

3. KEY ISSUES:

3.1 Well-Led:

The Trust has a number of controls in place to guide and support the delivery of safer care including safety critical policies. Over the last 18 months we have reviewed these policies to reflect Our Journey to Change, Trust values and goals.

Seclusion Policy & Long-Term Segregation - The seclusion policy sets out the Mental Health Act code of practice and how this is applied across the Trust with a focus on least restrictive practice. The use of seclusion is monitored through the Mental Health Legislation Committee and alongside other restrictive interventions at the QUAC.

Supporting behaviours that challenge - This policy sets out a Trust-wide agreed philosophy and approach to reducing restrictive interventions with a focus on prevention, human rights and trauma informed care supported by accredited training.

Suicide Prevention Environmental Survey and Risk Assess Procedure (our ligature risk assessment process) was reviewed and updated in October 2020. This procedure strengthens our ability to respond effectively and urgently mitigate identified risks. Training has recently commenced on ligature management to support both relational and physical safety. Compliance with key elements of this policy is monitored through the environmental risk group.

Supportive Observation and Engagement Policy - We have reviewed and updated this policy with a greater emphasis on restrictive practice and human rights. We introduced a competency-based assessment and audit arrangements through the quality assurance schedule.

Freedom to speak up and raising concerns/whistleblowing procedures and policy - These policies have been reviewed to support staff with raising concerns and ensuring concerns are acted on. They are used, promoted and reported on along with the Freedom to Speak up activity to the People, Culture and Diversity Committee and Board of Directors. The Trust also has an anonymous concerns process where issues, questions and responses are published on the intranet.

Following a governance review in March 2021, and the comprehensive public engagement exercise that followed, a new TEWV organisational and governance structure was put in place from 1 April 2022 with simplified governance processes and strengthened reporting from teams through two new care groups directly to the Trust's Board, embedding increased line of sight and oversight from ward to Board. As part of this, we have recruited two lived experience directors into our leadership team to make sure the patient voice is heard at the very highest level in the organisation.

Aligned to the organisational restructure, the Trust has been working on updating its core leadership offer, which has focussed on the importance of collective leadership and also has compassionate leadership as a core component.

3.2 Safe:

3.2.1 Safeguarding:

Mitigations and controls in place	Areas for further improvement
• Safeguarding concerns and issues are reported to the weekly Care Group patient safety and learning group to improve the quality of reporting to prevent patients from harm or abuse • Safeguarding practitioners from the corporate safeguarding and public protection team are basing themselves within inpatient services to provide practice leadership, increase visibility and offer live supervision and reflection • Dip sampling in secure inpatient services to improve the identification, reporting and effective management of concerns • Safeguarding practitioners offer high quality supervision for both Adults and Children in complex cases • The delivery of sessions that focus on staffs role in delivering good care and speaking out: • Boundaries training developed by an Associate Director of Nursing is being delivered in 3 hour facilitated sessions. This	• Triangulation of safeguarding reporting trends alongside restrictive interventions, patient experience and key people measures (allegations, sickness, vacancies) • Increase dip sampling across all inpatient areas (proposed for inclusion within the quality assurance schedule) • Systematic approach to training on boundaries, safeguarding from abuse, speaking up and staffs role in this using Trust examples • Review staff allegations including 'low level' concerns that do not reach the threshold for a safeguarding concern or formal disciplinary process • Co-production with staff to develop guidance for proactive use of CCTV • Collective oversight of peer review processes

includes self-reflection activities, group work on types of abuse and what this could means within their care setting. Specific focus on 'banter', how we can lose our way with boundaries, how to prevent it and reporting concerns. This evaluates very well and is being rolled out at all levels withing care groups by ADNs and GND's • Reflective sessions on Whorlton Hall, Winterbourne, Panorama have been recently delivered to preceptees and through Fundamental Standards group including professional standards • Use of proactive CCTV for learning and educational practice • Ward peer review programme • PLACE assessments • Director visits	

3.2.2 Reducing restrictive interventions (RRI) and practice:

Mitigations and controls in place	Areas for further improvement
• The Trust has a comprehensive Positive and Safe plan which targets restraint reduction and positive practice. This is underpinned by supporting policies and is reported quarterly to QUAC. • The Trust reports on all components of restrictive practice and physical interventions to identify hot spots and areas for improvement. • The Trust has in place a weekly Long Term Segregation panel which formally reviews all LTS cases. • A peer review by Mersey Care has provided an external lens and an agreed improvement plan is in place to further reduce restrictions with continued support and a revisit • The Trust is rolling out the HOPEs model and has also commissioned the Challenging Behaviour Foundation to work with individual patients • RRI assurance panels have been established to review excess seclusion, restraint and rapid tranquilisation incidents. • Oversight has been strengthened within care groups • A gap analysis of the Trusts implementation of the 2018 Mental Health units Use of Force Act is underway to conclude in	• There are opportunities to use the RRI data more consistently at ward level to inform patient care • The Merseycare report identified a lack of resource to roll-out and embed reducing restrictive interventions approaches at pace • Review of current PAT training models to enhance practice leadership • Consideration of lived experience/family experience and advocacy into RRI/LTS panels • Improve compliance with staff who have undertaken PAT training under the new standards • Review the quality of post intervention debriefs • Roll out and embed the HOPEs model across all specialties where LTS is in use • Refresh the safe wards programme and seek to understand the impact within our own services • Increase Board visibility to where care is being provided in the most restrictive settings including long term segregation • Increase Board understanding of the impact of restrictive practices and HOPEs model • Collective oversight of issues and themes from Care and Treatment Reviews

December 2022 • RRN accredited training in place with lived experience trainers in place • The Nurse Consultant, Positive and Safe is now able to review all episodes of Prone restraint and mechanical restraint use due to the significant reductions in numbers • Safe Wards, an evidence based intervention has been rolled out across all inpatient areas	

3.2.3 Safe and Effective Staffing

Mitigations and controls in place	Areas for further improvement
• Monthly safe staffing reports highlights ward staffing 'hot spots' including monitoring of shifts worked over 13 hours, missed breaks, planned versus actual staffing, staffing related incidents • Six monthly staffing reports triangulate key safety metrics including patient experience against staffing levels • Increase of inpatient staff registered skill mix and baselines • Significantly improved focus on workforce through People, Culture and Diversity executive and Board sub-committees • Strengthened organisational structures and focus to support workforce development, recruitment and retention • Duty Nurse Coordinator roles provide on-site clinical support to inpatient wards out of hours at nights and weekends. With manager on call rotas this supports visibility of leadership and timely escalation • The roll out of safe care to provide live and retrospective staffing oversight based on patient need and complexity	• Continue to identify wards where greater support is needed due to availability of staff, percentage of temporary staff being used and ward leadership capacity and capability • Improve visibility of staffing and triangulation with other key safety metrics by the introduction of ward dashboards/ safe staffing dashboards • Continue to embed the safe care tool and explore 'real time' functionality • Consideration of Ward Leadership presence 7 days a week

3.3 Patient and Carer experience

Mitigations and controls in place	Areas for further improvement
• Accreditation and progress with Triangle of Care and Carers Charter • Appointment of Lived Experience Directors and Head of Co-creation • Working with advocacy • Development of a peer support infrastructure and appointment of peer	• Continue to embed Triangle of Care and assess impact of carers charter • Review advocacy provision and uptake/ awareness to ensure every patients has access to advocacy • Use of advocacy feedback to triangulate with patient and carer feedback and key safety

support workers • Complaints included in the weekly care group patient safety and learning group • PALS activity • Themes from complaints are reported through quality governance structures • The Trust consistently provides one of the highest returns of any MH Trust to the Friends and Family Test • Use of patient experience team quality visits and '15 steps' by people with lived experience (users or carers) • External delivery of Empathy training to support a compassionate culture –well evaluated • Regular patient surveys undertaken, electronic system available across ward areas to support anonymous feedback	metrics • Continue progress with the development of the peer support role into every inpatient ward • Ensure the voice of peer support workers is included in post interventions where restrictions or restraint has been used • Peer reviews-to consider how family/carer feedback can be used as part of the process • Continue to progress empathy training • Triangulation of ward areas with poor or no responses with other key patient safety and workforce data

3.4 Healthy, flourishing and engaged staff

Mitigations and controls in place	Areas for further improvement
• Improved reporting/line of sight on staff turnover and workforce data • Leadership programmes focusing on compassionate and collective leadership • Director visits in place to support visibility and recognition of staff • Staff well-being offers • Staff awards and recognition • Trust preceptorship programme • Report of Guardian of Safe working to the Board • Systems in place for student feedback to be triangulated with raising concerns and other safety data/intelligence • Robust processes in place for support and investigations in relation to maintaining professional standards for all professions	• Prioritise developments to report workforce data at ward level and in a way it can be triangulated with key safety metrics • Prioritise leadership development for Health Care Assistants to include closed culture work (RCN programme) • Roll out HCA council across other areas of the Trust • Consideration of ward accreditation schemes • Recognise the moral injury and compassion fatigue challenge across patient facing teams and continue to ensure team de-briefs and good clinical supervision compliance • The embedding of high quality supervision including expert supervision at ward level should be prioritised recognising the emotional impact of working in some clinical areas or with individual people • Continue to encourage attendance at Schwarz rounds • Protection and facilitation of ward development • Review repeat misconduct themes for all professions

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
The actions and mitigations identified in this report will support the identification of closed cultures where inherent risks are present as identified by CQC and support compliance with fundamental standards.

4.2 **Financial/Value for Money:**
There are financial and reputational implications associated with failure to maintain high quality care and treatment standards. 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):**
The actions and areas for improvement in this report support the 6 values of the NHS constitution and will support the organisation to deliver the best possible care for patients.

4.4 **Equality and Diversity:**
The actions outlined in this report will support vulnerable people to have a voice and deliver care in line with peoples human rights

5. RISKS:

The nature of inpatient service provision for people with a mental health problem, learning disability and/or autism means that there are inherent risk factors of closed cultures developing.

If we fail to put effective controls in place to detect and prevent harm and/or abuse there is a risk of closed cultures developing and patients being harmed.

6. CONCLUSIONS:

Throughout this report we have identified where there are opportunities for further improvement. In reviewing the specific indicators of closed cultures we have also identified some key areas of work to be progressed, which are summarised below:

- Progress the cultural risk assessment and ‘see, feel and hear’ visits to understand the impact and staff/service user experience of the risks identified
- Leadership and training programmes to be updated and conducted to reflect the learning from closed cultures and recent events
- The use of intelligent data to support triangulation of key workforce, safety, patient experience information to target leadership visibility and where additional support needs to be prioritised and put in place (the cultural risk assessment tool will support this).
- Continue to embed raising concerns and Freedom to Speak up Processes
- Recognise the moral injury and compassion fatigue challenge across patient facing inpatient ward teams and continue to ensure team de-briefs and good clinical supervision compliance/access to specialist supervision

7. RECOMMENDATIONS:

The Board of Directors are asked to:

- Note the actions being taken by the Trust to identify and mitigate the risks of closed cultures areas as good assurance in response to the findings at Edenfield
- Note that the areas identified in this report will evolve as we shape how they are implemented with staff, patients and carers.
- Agree that the Quality Assurance Committee will oversee the progress against delivery

Author: Elizabeth Moody
Title: Executive Director of Nursing and Governance

Background Papers:
CQC – Closed Cultures:

How CQC identifies and responds to closed cultures - Care Quality Commission

NCISH – Safer Wards References:

display.aspx (manchester.ac.uk)

HOPEs Model

HOPE(S) Model :: Mersey Care NHS Foundation Trust

Letter from Claire Murdoch

Letter from Claire Murdoch to ICBs re M

Appendix 1

Closed Cultures assessent tool .docx

Classification: Official

To: ICB CEOs
CC: Regional SROs
NHS Mental Health Provider CEOs

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

By email.

7 June 2022

Dear Colleagues,

Call for evidence for new 10-year plan to improve mental health

As you will be aware, the Government are seeking views to inform a new 10-year mental health plan to level up mental health across the country and put mental and physical health on an equal footing through a call to evidence.

Along with the public and those with lived experience of mental ill-health, health and care professionals have until 5 July to share views on how support and services should adapt for the future.

As systems leaders it is imperative you, your ICP and Mental Health Providers have the opportunity to contribute to this new 10-year plan for mental health and wellbeing across the health and social care sector and beyond. The governments focus, across departments, on the mental health and wellbeing of our communities is welcome, particularly in light of the past two years whereby the pandemic has put a greater strain on mental health and led to increased prevalence of mental health needs across the lifespan.

This 10-year plan builds on the Long Term Plan and is an opportunity for us to look beyond and consider how we, and our valuable partners across the VCSE and the communities we serve, can support people with mental health problems to access care early, and be supported to live well in their communities. We are particularly pleased to see the cross-department focus of this plan, enabling a broader look across people's communities as well as a focus on health and social care. We will continue to support the government to engage with Experts by Experience, Clinicians and our brilliant VCSE partners at a national level, however, we also want to ensure your voice as system leaders is heard as part of this engagement.

Should you have any questions or wish to discuss further please do not hesitate to get in contact with my team: england.mentalhealthpmo@nhs.net

Yours sincerely,

Claire Murdoch
National Mental Health Director
Senior Responsible Officer for Mental Health and Learning Disabilities and Autism
NHS England and NHS Improvement

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Closed Cultures Assurance Tool

Organisation	
Name	
Title	
Date	

NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

Patient Experience – Organisational wide indicators

Indicator	Questions	Provider Response
1. Friends & Family Test	➢ Are all in patient areas capturing FFT reporting?	
	➢ Are actions taken as a result?	
	➢ How is FFT monitored at organisational level?	
2. Peer Support Workers/ volunteers	➢ Do inpatient areas employ peer support workers?	
	➢ Do volunteers work on the inpatient units?	
3. Patient Advocacy	➢ Do patients have access to advocacy	
	➢ Do advocates know how to raise concerns?	
4. Monitoring patient experience	➢ Do in patient areas undertake patient surveys?	
	➢ Is there a line of sight on numbers and themes from PALS/complaints?	
	➢ How are the results taken forward?	
5. Peer Reviews	➢ Is there a peer review process or something similar in place for each in patient area where the views of patients/family/carers are captured?	
6. Patient Experience & Engagement Groups	➢ Do all in patient areas have a forum or means for patients to speak up and discuss any concerns they may have/influence their care and service improvements?	

Well led

Indicator	Questions	Provider Response
1. Visibility of leaders	➢ Are Ward managers based within wards?	
	➢ Do Matrons spend 50% of working time within designated clinical areas?	
2. Freedom to speak up	➢ Are there systems to understand if staff feel it is safe to speak up or if there is a 'blame culture'?	
	➢ Is there evidence that staff feel safe to raise concerns without reprise?	
	➢ Are all staff aware of Freedom to Speak Up Guardian?	
3. Knowledge and skills	➢ Do all inpatient wards have staff who have the experience, knowledge and skills to carry out to practice safely and effectively	

Training and development

Indicator	Questions	Provider Response
1. Training and development	➢ % Inpatient staff in post >12 months with current appraisal	
2. Training and development	➢ Does the organisation provide autism training appropriate to role for inpatient staff o % compliance to recommended standard	
3. Training and development	➢ Is the organisation using BILD accredited training (either as a provider or as an affiliate) o % of staff trained o is there a process in place for checking training of bank/agency staff	
4. Training and development	➢ Is the Trust Training programme developed based on organisational learning from serious incidents/data analysis of service user experiences and staff feedback.	
5. Training and development	➢ Does training content include contributions from people with lived experience of having restraint or other restrictive practices used on them	

Safety

Indicator	Questions	Provider Response
1. Leadership team turnover	➢ Tell the story of the board turnover in last 2 years?	
	➢ What is the turnover rate % for inpatient area ○ Matrons 8a ○ Band 7s in ward area	
	➢ Summary of actions taken to address hot spots	
2. Number of Incidents of Rapid Tranquilisation	➢ Is there a line of sight on RT incidents at ward level?	
	➢ What is the trend?	
	➢ Summary of actions and progress to address them?	
3. Number of Episodes of Seclusion	➢ Is there a line of sight on seclusion incidents at ward level?	
	➢ What is the trend?	
	➢ Summary of key actions and progress to address?	
4. Incidents of physical intervention/ restraint	➢ Is there a line of sight on seclusion incidents at ward level?	
	➢ What is the trend?	
	➢ Summary of key actions and progress to address?	
5. Number of Self Harm incidents	➢ Is there a line of sight on seclusion incidents at ward level?	
	➢ What is the trend?	
	➢ Summary of key actions and progress to address?	
6. Levels of violence (patient to staff)	➢ Is there a line of sight on seclusion incidents at ward level?	
	➢ What is the trend?	
	➢ Summary of key actions and progress to address?	

Healthy, flourishing and engaged staff– Organisational wide indicators

Indicator	Questions	Provider Response
1. Clinical Supervision levels	➢ Are all in patient areas reporting clinical supervision levels?	
	➢ Is there a ward to Board line of sight through Trust governance processes?	
	➢ Are Trusts reporting compliance numbers or are quality measures being used?	
	➢ How is supervision monitored at an organisational level, can the Trust see poor performing wards?	
	➢ What is this data telling the Trust?	
	➢ Summary of actions being taken	
2. Percentage sickness absence rate	➢ What is the Trust average rate of inpatient sickness?	
	➢ Are those areas above organisational rate readily identified?	
	➢ What is the data telling the Trust (trends, hot-spots, reasons for sickness, specialties) and summary of actions are being taken to address these	
3. Staff Survey	➢ What is this telling the organisation about its inpatient services?	
	➢ Is the staff survey being progressed and monitored at ward level to identify poor performing teams?	
	➢ Summary of key issues and actions being taken with regard to staff engagement and satisfaction measures	