MEETING OF THE BOARD OF DIRECTORS

26 January 2023

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

AGENDA

Standard Items (3.20 pm - 1.30 pm)

1.	Chair's welcome and introduction	Chair	Verbal
2.	Apologies for absence	Chair	
3.	Declarations of Interest		Verbal
4.	To approve the minutes of:		
	a) The last ordinary meeting on 24 November 2022		Draft minutes
	b) The special meeting on 21 December 2022		Draft minutes
5.	To receive the Board Action Log		Report
6.	To receive the Chair's Report	Chair	Report
7.	To consider any matters raised by Governors	Board	Verbal

Strategic Items (1.30 pm - 2.00 pm)

8.	To receive the Board Assurance Framework Summary Report	Co Sec	Report
9.	To receive the Chief Executive's report	CEO	Report
10.	To consider the Integrated Performance Dashboard	Asst CEO	Report
11.	To consider the report of the Chair of Audit & Risk Committee	Cmt Chair (JM)	Report

Goal 1: To co-create a great experience for our patients, carers and families (2.00 pm - 2.40 pm)

12.	To receive the Leadership Walkabouts Report	DoCA&I	Report
13.	To consider the report of the Chair of Quality Assurance Committee	Cmt Chair (BR)	Report
14.	To consider the Learning from Deaths Report	DoN&G	Report
15.	To receive a report on winter preparedness	DoN&G	Report
16.	To consider a report on data quality of external data submissions	Asst CEO	Report

Goal 2: To co-create a great experience for our colleagues (2.40 pm - 3.15 pm)

17.	To consider the report of the Guardian of Safe Working	Dr J Boylan	Report
18.	To receive an update on the Workforce Strategy	DfP&C	Report
19.	To receive an update on staff mandatory and statutory training	DfP&C	Verbal

Exclusion of the Public

Item 20. The Chair to move:

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

Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office holder or applicant to become an office-holder under, the Trust.

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

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

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

David Jennings
Chair
20 January 2023

Contact: Karen Christon, Deputy Company Secretary
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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 24 NOVEMBER 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
B Riley, Deputy Chair
R Barker, Non-Executive Director
C Carpenter, Non-Executive Director
J Haley, Non-Executive Director
J Maddison, Non-Executive Director
J Preston, Non-Executive Director & Senior Independent Director
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
L Romaniak, Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley & Forensics Care Group
A Bridges, Director of Corporate Affairs and Involvement (non-voting)
M Brierley, Assistant Chief Executive (non-voting)
S Dexter-Smith, Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary
A Lowery, Director of Quality Governance (attending on behalf of E Moody)
J Nadkarni, Care Group Director of Therapies (attending on behalf of H Crawford)
K Passmore, Consultant Psychiatrist (attending on behalf of K Kale)

Observers/members of the public:
H Griffiths, Governor
M Ovens, Governor
J Wardle, Governor
S Double, public
P Slinger, Lead Improvement Support

22/181 APOLOGIES FOR ABSENCE

Apologies for absence were received from P Hungin, Non-Executive Director, H Crawford, Director of Therapies, K Kale, Medical Director and E Moody, Director of Nursing and Governance.

22/182 CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and noted the attendance of P Slinger who would observe the meeting in follow up to support provided by the Intensive Support Team.

22/183 DECLARATIONS OF INTEREST

None.

22/184 MINUTES OF THE LAST ORDINARY MEETING ON 27 OCTOBER 2022

Agreed: *that the minutes of the last ordinary meeting held on 27 October 2022 be agreed as an accurate record and signed by the Chair, subject to the inclusion of E Moody, who was present at the meeting.*

22/185 BOARD ACTION LOG

The board reviewed and noted the Board Action Log.

In discussion, the following points were raised:

(1) Action 22/139 [Quality Assurance Committee (QuAC) to review that services, particularly secure inpatient services, are provided in a way that is respectful of an individual's affirmed gender].

B Reilly, Chair of QuAC noted that she would raise the matter at the next committee meeting and agreed to provide feedback at a future meeting.

(2) Action 22/139 [Workforce Delivery Plan to be presented to a future board meeting].

J Haley, Chair of People, Culture and Diversity Committee (PCDC) indicated that progress had been made towards provision of a range of workforce related data and information from exit interviews and she welcomed the development of separate risks on recruitment and retention.

S Dexter-Smith advised that a report would be presented to PCDC and the board in February 2023 and agreed to present any urgent matters to the board in the interim.

(3) Action 22/139 [PCDC 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].

J Preston expressed disappointment at the reduction in participation and queried how time would be created to ensure staff were able to take part. B Kilmurray acknowledged the position and highlighted additional forms of engagement that took place including the quarterly pulse survey, where benchmarking suggested there was a positive response rate.

(4) Action 22 /144 [Training to be provided to the board on the Mental Capacity Act].

It was noted that a briefing had been circulated to the board and the Chair requested that this be re-circulated.

Action: K Christon

(5) Action 22/172 [Dates to be circulated for board meetings for 2023/24].

The Chair noted the position reported and requested that firm dates be circulated as soon as possible.

(6) Action 22/172 [Options to be given for future board seminars]

It was noted that the ongoing development of seminars would be informed by IST feedback.

(7) 22/174 [Discussion at a future board development session on the level of reported outcomes following treatment].

It was agreed that timescales would be confirmed with the Medical Director.

Action: K Christon

(8) 22/179 [Summary report to be provided on work in progress on sustainable staffing levels and skills]

The Chair noted that the current staffing challenge was a thread that ran through all reports at the meeting and remained a priority for the board.

22/186 CHAIR'S REPORT

The Chair presented the report which provided a summary of work undertaken since the last meeting. He highlighted and welcomed the support that B Reilly, Deputy Chair, had provided to a patient in distress and noted there had been a positive outcome.

J Maddison discussed the opportunity to return to the inclusion of patient/staff stories at board meetings. In response, A Lowery advised that the approach to this had been considered but work had paused due to other priorities. The Chair noted that there was an opportunity to learn from other trusts.

It was agreed that the next patient/staff/partner story would take place in January 2023.

Action: E Moody

22/187 MATTERS RAISED BY GOVERNORS

None.

22/188 CHIEF EXECUTIVE'S REPORT

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

In presentation, B Kilmurray drew attention to:

(1) The recent publication of independent reports into the sad deaths of three women at West Lane Hospital/Lanchester Road Hospital. He reiterated an unreserved apology for the failings of the trust at that time and referenced the published Assurance Statements and detailed assurance work that would ensure the board was sighted on implementation of all recommendations.
(2) Delivery and promotion of the Flu and Covid vaccination programme to ensure increased take-up.
(3) International recruitment activity as part of a delegation supported by Humber and North Yorkshire ICB, from which positive feedback had been received.

Responding to a query on timescales, B Kilmurray advised that the process was expected to take 10-12 weeks, with appointments commencing from April 2023. In the interim work would be carried out to ensure support was in place, including on accommodation and training. He acknowledged that the exercise was only part of the answer and its success would be reviewed.

(4) Consultation on the Draft North East and North Cumbria Integrated Care Strategy (ICS), which included an emphasis on severe mental illness as one of the key priorities linked to improving health inequalities. A strategy was also expected for Humber and North Yorkshire.

B Reilly welcomed the focus of the ICS and its ambitious targets, if supported by appropriate funding, and noted the strategy would need to be considered as part of the trust's decision making processes.

B Kilmurray advised that the Integrated Care Partnership (ICP) would hold the Integrated Care Board (ICB) to account for the prioritisation of resources. L Romaniak also noted that the ICP had a statutory duty to work together to deliver outcomes and discussed the need to influence the national conversation, which had focused on acute trust targets and physical health trajectories.

J Haley expressed concern that the ICS lacked recognition of equality, diversity and inclusion priorities and the Chair suggested that this be incorporated into the trust's response to the draft strategy.

The Chair welcomed the ICS and acknowledged its importance as part of the trust's business plan process.

P Scott provided a briefing on the Crisis Service and noted that a detailed report would be presented to the next Quality Assurance Committee. He advised that activity had been aligned into an improvement programme that would consider the screening process, staff capacity and roles, the administration burden, communications and telephony infrastructure. In response to a query, he confirmed that the trust had met with the North East Ambulance Service to learn from their established 111 arrangements.

He advised that Durham and Tees Valley call rates continued to be a challenge and noted that a recent audit had shown that of callers spoken to, 56% did not require the Crisis Service. The new model would provide capacity by staff who had met agreed competencies to ensure quality was maintained, supported by registered practitioners.

Z Campbell provided a summary of the position in North Yorkshire, noting there had been a similar level of genuine crisis calls, with most calls to the 0800 number to ask a general question or to contact a service. Despite attempts to recruit, there remained 24 vacancies. The new model would align the service to that operated by local authority and voluntary sector partners to increase capacity and an improvement was expected in December.

In discussion, the following matters were raised:

(1) A Lowery referred to feedback from staff who were concerned that calls would be answered by individuals with no local knowledge. She also suggested that a caller may consider they were in crisis when the trust did not.

(2) J Preston queried how patients would perceive the service if they thought they had called TEWV but had reached a voluntary organisation.

P Scott and Z Campbell acknowledged that a clear marketing and communications plan was required, and Z Campbell noted that learning that had been taken from the voluntary sector and the rapid response teams operated by adult social care partners. She acknowledged that there would be callers who would perceive themselves to be in crisis and the priority was to answer as many calls as possible.

(3) M Brierley noted the investment in infrastructure that would be required, regardless of where calls were answered.

(4) B Reilly acknowledged that a different approach was required and queried if the proposed changes would make access more difficult and if there had been any evidence of harm in relation to those calls not answered. She advised that a progress report would be presented

to the next Quality Assurance Committee (QuAC) and feedback would be provided to the board.

Bringing the discussion to a close, the Chair acknowledged that significant transformational change was required and he welcomed a progress update from QuAC at the next board meeting.

22/189 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

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

In discussion the following matters or points of clarification were raised:

(1) B Reilly raised a query on the governance and assurance of high risk areas included in the BAF that were not included on the board's agenda.

P Bellas welcomed views on risks that the board would wish to consider at each meeting. He referenced development of the three lines report and how that would be used to inform development of the board and committee business cycles.

(2) J Maddison noted the full report on the private agenda and queried the purpose and frequency of the summary report and if there was the opportunity to discuss the full report in the public meeting.

(3) C Carpenter concurred with comments raised. She suggested that the summary report be amended to reference those agenda items that would substantially provide assurance to the board or would move a matter forward where a gap had been identified.

(4) P Bellas welcomed views from the board on the format of the new detailed BAF report, which would assist in populating information on the summary report. He noted that the full BAF report would be presented to the board on a quarterly basis, alongside the Integrated Performance Report.

(5) The Chair commented on the purpose of the BAF, which was to highlight key risks, controls in place to mitigate risk and to identify when risk would be mitigated to an acceptable level. He suggested that the report was work in progress and a summary report would be available with the public agenda.

(6) J Maddison welcomed the development of the BAF report and the Integrated Performance Report. He suggested that the summary report was helpful as an aide memoire and queried if it should also provide some detail on assurance.

Bringing the discussion to a close, the Chair noted that the full BAF report provided an opportunity for Executive Directors to outline the position and provide assurance on action taken. He considered that a summary report should be included on the public agenda, with assurance provided through the detailed report. He noted that board would encourage Executive Directors to continue to push boundaries and make progress towards the shared goals and this should not be seen as a criticism.

22/190 INTEGRATED PERFORMANCE DASHBOARD REPORT

The board received and noted the Integrated Performance Dashboard Report, which provided oversight of the quality of quality of services delivered during the period ending 30 September 2022 and provided assurance on actions taken to improve performance in the required areas.

M Brierley thanked his team and the Company Secretary who had supported the development of the new Performance and Controls Assurance Framework Assessment and he drew the board's attention to the following:

(1) The assurance framework assessment, linked to the BAF, which provided an assurance rating on individual metrics based on intelligence about what had driven the current position and action that was required. The framework would be reported quarterly and developed to include additional metrics.
(2) Metrics identified as areas of concern included those where limited assurance had been identified as further evidence was required on action taken and improvements made, or where performance had deteriorated or had not improved.
(3) Unique caseloads [metric 23] where phase one work had commenced.
(4) The financial plan [metric 24] where there remained significant financial implications from agency costs, delayed transfers, out of area placements and complex packages of care. It was noted that use of independent sector beds had dropped significantly to an average of four per month and work had continued to understand the remaining position.

In discussion the following matters or points of clarification were raised:

(1) C Carpenter welcomed the summary provided by the covering report. She noted that the majority of metrics with limited assurance, were finance related and cautioned that this had potential to distort priorities away from the board's biggest area of risk - the trust's relationship with staff and implications this had on quality and safety, where a financial cost was accepted.

The board was advised that the framework reported on the 30 metrics measured in the Integrated Performance Report (IPR) and B Kilmurray acknowledged that whilst the trust would need to ensure financial controls were in place, patient safety and care remained a priority. He suggested that there would be potential to develop the report to show interaction between those areas.

(2) B Reilly concurred with the comments made by C Carpenter and queried how the framework would capture other areas where there was limited assurance, for example the Crisis Service. She also cautioned against a report that provided a significant level of information, without detail on what action had taken place.

M Brierly indicated that the framework would be developed to ensure that wider issues were captured and noted that its content would be underpinned by intelligence on evidence based actions.

(3) Responding to a concern about providing too much information, the Chair confirmed the board had a collective view that it would not get drawn into detail but would be agile where needed.

(4) J Maddison requested that clarity be provided on actions and related trajectories.

(5) The Chair acknowledged the development of the BAF and IPR, to support the board in its focused conversations. He suggested that the assurance framework was one litmus test that would be used alongside the BAF and deep dives carried out by each of the

committees and he proposed that the quarterly report be supplemented with a forward view of what actions were required to ensure progress was made.

Responding, M Brierley confirmed this was the next step and noted the aim to reduce the reporting period to the board to one month.

Action: M Brierley

(6) J Haley discussed the need to improve the overall level of staff engagement in order to improve the benchmarked position, noting that staff who would respond positively would be less likely to participate.

A Bridges advised that significant work had been carried out to encourage front line staff and those without access to ICT to take part. She suggested that the wider context for the trust would have an impact on participation rates, which were similar to other trusts. Pulse surveys had a higher response rate as they were considered to be more localised.

(7) B Reilly queried how the assurance framework would receive independent challenge prior to the board and how and when the board would be sighted on the impact of actions highlighted in the IPR.

M Brierley advised that work was underway to develop the IPR and suggested that a monthly report would not provide sufficient space for the board to note progress made. The governance review would consider the flow of assurance and the best forum for those discussions.

(8) The Chair referred to key metrics in the report including the run rate, level of agency staffing and delayed discharges and queried if Executive Directors felt measures were in place that would make a difference. He suggested that clarity on timelines would provide confidence to the board, external regulators and stakeholders.

B Kilmurray advised that there was a relentless focus on measures to improve the metrics and Executive Directors would continue to develop reporting arrangements. Work had progressed in all areas, but some metrics would take longer to achieve or were not solely within the gift of the trust.

The Chair welcomed the individual and collective response of Executive Directors.

(9) The Chair queried if the proposal to post the exit interview online for staff to complete, was the most appropriate approach.

(10) The Chair commented on the importance of the business planning process to provide clarity on key priorities and to support dialogue with the system on appropriate funding and staffing requirements.

(11) B Reilly raised a query in relation to support that would be offered to organisations in segment 3 of the NHS oversight framework.

Responding, B Kilmurray welcomed the attendance of P Slinger at the meeting. He advised that a support proposal had been rejected by NHS England and the ICB due to lack of funding, but the trust had secured resources to carry out a piece of work with support from members of the Intensive Support Team. In contrast, he noted the intensive support that had been provided by the system to another trust with regulatory challenges.

(12) The Chair requested that a progress update be provided on compliance with mandatory and statutory training and measures that had been taken, in order that the board could consider if a deep dive was required.

Action: S Dexter-Smith

(13) J Maddison highlighted that metrics would be disaggregated for each committee to consider and noted that the board would need to triangulate that information.

Bringing the discussion to a close, the Chair referred to the deep dives that committees would undertake on specific areas of concern. He noted the agreement that the quarterly report would be developed to include a forward looking element and commented on the interrelation with the trust's financial position. He acknowledged that a significant amount of work was underway to improve the position and noted that where the board was not assured on progress, it would seek clarity on trajectories and how improvements would be achieved.

Agreed:

(i) That the level of oversight in the report was sufficient and the board was assured on the actions taken to improve performance in the required areas.

(ii) To the future inclusion of the new Performance and Controls Assurance Framework.

(iii) The proposed standards including:

- *Appraisal and mandatory training – 85%*
- *Percentage of patients surveyed reporting their recent experience as very good or good – 92%*
- *Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for – 75%*
- *Percentage of inpatients reporting that they feel safe whilst in our care – 75%*
- *Percentage of children and young people showing measurable improvement following treatment – patient reported – 35%*
- *Percentage of adults and older persons showing measurable improvement following treatment – patient reported – 55%*
- *Percentage of children and young people showing measurable improvement following treatment – clinician reported – 50%*
- *Percentage of adults and older persons showing measurable improvement following treatment – clinician reported – 30%*

22/191 CORPORATE RISK REGISTER

The board received and noted the Corporate Risk Register, which provided information on risks rated as high that had an organisational wide impact.

A Lowery introduced the report, noting that the register included 22 risks rated at 15 and above. She drew the board's attention to risks that had been removed and reduced and referred to the roll out of risk related education and training.

Commenting further, B Kilmurray suggested that the report would be developed to provide a consolidated strategic overview for the board.

In discussion the following matters or points of clarification were raised:

(1) Referring to the reduction of the CAMHS risk, B Reilly queried if there had been inconsistency with information reported to QuAC.

B Kilmurray advised that the CAMHS risk reported related to a specific team, whereas the risk reported to QuAC related to wider service position. Commenting further, Z Campbell noted that service level risk would change quickly, and in this instance, changes had been implemented to reduce caseloads.

(2) Responding to a query about the format and content of the risk register, L Romaniak advised that the register captured the chronology of action taken and suggested this level of detail may not required by the board.

(3) J Haley suggested that clarity be provided on the purpose of the report – if it was for assurance or decision – and that summary information be included to confirm what changes had taken place since the previous report.

Bringing the discussion to a close, the Chair noted that the risk process would respond to executive requirements and suggested that the board report be developed to allow the board to get to the nub of key risks and mitigation, linked to the BAF.

Action: E Moody

The Chair varied the agenda to discuss agenda items 12 and 13 together.

22/192 PROGRESS AGAINST 2022/23 BUSINESS PLAN
22/193 ACCELERATING OUR CLINICAL, QUALITY & SAFETY JOURNEY TO CHANGE

The board received and noted the Business Plan Milestone Progress Q2 2022/23 report, which outlined the progress made to achievement of the 2022/23 milestones set out in the trust's business plan and the report on Accelerating Our Clinical, Quality and Safety Journey to Change, which proposed a way forward to ensure that the trust designed and delivered the right projects to implement the strategic objectives.

In presentation, M Brierley highlighted:

<u>Progress against 2022/23 business plan</u>

(1) Low completion rates at quarter two, noting that a mechanism was in place to agree revised deadlines via the relevant executive sub-group and delivery was anticipated by the year end.

(2) That a risk based piece of work would be completed in advance of the business planning process to determine ongoing relevance, achievability and impact in the context of IST feedback, structural changes, development of the strategic journeys and redirection of capacity into key areas.

(3) The business plan would be supported by delivery plans at care group level within the accountability framework.

<u>Accelerating our clinical, quality and safety journey to change</u>

(4) Work that had taken place to understand the key priorities, following engagement on Our Journey to Change and feedback from the IST and in the context of regulatory requirements and national imperatives.

(5) The proposed approach acknowledged that the trust was not able to progress everything at once and would focus on a number of key priorities. A pipeline of other activity would be developed to be brought forward as and when capacity was available.

(6) It was recognised that the workforce was critical to every element of the programme and priorities would need to respond to related issues.

(7) The trust would need to consider its interaction with the wider health and care system and commissioners, including services it would provide.

(8) Our Journey to Change would be the golden thread through all communications on business planning process.

B Kilmurray commented on the approach as one that would provide clarity on priorities including areas of transformation where greater oversight was needed.

P Scott referenced work completed with service users and within the care group to review the current business plan and priorities for the following year.

In discussion the following matters or points of clarification were raised:

(1) The Chair noted that he expected the process to provide clarity on who, what, when, where and how, with delivery cascaded through the Chief Executive's objectives down to all staff, in order that they understood their role in delivery.

(2) The Chair welcomed an honest review of the current business plan, which included why milestones had not been achieved, for learning to be taken into the following year.

(3) In response to a query on timescales and engagement, M Brierley advised that a wider stakeholder event on business planning would be held following the board discussion on 13 December 2022. A Bridges confirmed that cocreation was a golden thread that ran through the process and would provide assurance to the organisation.

(4) M Brierley acknowledged that alongside a focus on workforce and quality and safety, the trust needed to ensure appropriate infrastructure was in place and was sighted on the financial implications.

Agreed: *The business planning approach for the next 18-24 months, aligned to Our Journey to Change.*

22/194 LEADERSHIP WALKABOUT REPORT

The board received and noted the Leadership Walkabout Report, which provided high-level feedback from recent leadership walkabouts to mental health provision and treatment within prison services.

Presenting the report, A Bridges commented on the holistic approach taken by staff to build trusted relationships with patients in order that they felt valued. She drew the board's attention to the strengths and challenges reported and highlighted concerns about accommodation and staff who felt separated from the trust and other services and noted the role of Executive Directors in escalating issues.

Reference was also made to Mersey Care's subsequent visit to Durham and the positive feedback received about the service values, direction, honest approach and professionalism of staff.

In discussion the following matters or points of clarification were raised:

(1) B Reilly highlighted the importance of providing feedback to service staff.

A Bridges acknowledged this was an important element of the visit and advised that draft reports were circulated for comment and feedback was provided.

(2) The Chair queried if the prison service was aware of the poor standard of accommodation provided at Holme House and what further action would be taken. He also noted that as a contracted service, the trust would be able to set out its minimum requirements.

L Romaniak confirmed that action had been taken to understand the current position. She advised that the prison Governor was aware, and the trust would work with them to respond to immediate concerns.

(3) B Kilmurray expressed concern about accommodation across prison services and advised that the trust would raise this at a senior level.

22/195 REPORT FROM THE QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of the committee, advised that P Hungin had chaired the meeting in her absence. She noted that there were no risks for escalation to the board and highlighted the following points:

(1) Further work that was required to embed risk management and deliver associated training.
(2) Committee would receive a report on the increased use of seclusion in secure inpatient services at the next meeting.
(3) The welcome reduction in prone incidents.
(4) Clarity had been sought on the current position on use of restrictive intervention.
(5) Committee remained concerned about the capacity of the Patient Safety Team, where it was suggested that information on the reduction in serious incident reviews was not consistent.
(6) A report would be provided at the next meeting on outstanding CQC recommendations.
(7) An update had been provided on a patient's care and committee would ensure that the trust responded to promises made to his family.

B Kilmurray highlighted that progress had been made in respect of use of restrictive intervention but acknowledged that some hotspots remained.

Commenting on the meeting, J Maddison queried why the majority of responses had been provided by the Director of Nursing and Governance or the Director of Quality Governance, when delivery was more widespread. The Chair requested that the contribution of staff to QuAC meetings be reviewed.

Action: E Moody

22/196 REPORT FROM THE MENTAL HEALTH LEGISLATION COMMITTEE

J Preston, member of the committee, noted that there were no risks for escalation to the board and highlighted the following points:

(1) Membership had been expanded to include care group Managing Directors, to allow committee to be assured on progress made to narrow the gap between legislation and procedures.

(2) Assurance had been provided that the trust was well placed to respond to changes to the Mental Health Act.
(3) Committee had noted that the trust detained a high proportion of individuals of black/black British origin per head of population and this was higher than the national average.

22/197 RECOMMENDATIONS IN THE OCKENDEN REPORT

The board received and noted the report, which provided an overview of assurance against the recommendations and potential delivery risks outlined in the Ockenden Report.

In discussion the following matters or points of clarification were raised:

(1) The Chair welcomed the report noting that it reflected areas the board had discussed, including staff mandatory and statutory training. He queried how cocreation would be built into learning from incidents and how the Trieste Model had been taken into account.

A Lowery advised that there were a number of opportunities to hear the voice of families. In respect of the Trieste Model, B Kilmurray confirmed that this was part of the trust's philosophy.

(2) The Chair raised a query on how learning from incidents was captured.

In response, A Lowery advised that the trust had moved to a decentralised reporting model, where staff would report and own an incident. Whilst this was positive change, it was recognised that it would result in additional work and learning for clinical staff. The change formed part of the Quality Safety Journey and would be implemented immediately with support from the Quality Improvement Team. She noted that capacity challenges had led to a backlog in dealing with Serious Incidents.

(3) B Reilly queried the purpose of the proposed report to QuAC, noting that the impact would be reported elsewhere.

In response, A Lowery suggested that a report be provided to the next meeting for QuAC to discuss.

22/198 RESPONSE TO THE NATIONAL MENTAL HEALTH DIRECTOR, NHS ENGLAND

The board received and noted the report, which outlined the trust's response to the National Director for Mental Health in relation to mitigation that was in place to prevent the development of closed cultures.

A Lowery presented the report, drawing the board's attention to the development of a risk assessment tool and key performance indicators for all inpatient wards. It was proposed that areas identified as high risk would be visited by a team that included a Director of Lived Experience, Associate Director of Nursing and a clinical staff member. Visits would focus on how the team would be supported.

In discussion, the following matters or points of clarification were raised:

(1) Responding to a query, B Kilmurray advised that feedback from visits would be provided to Executive Directors and the Quality Assurance Committee, and he noted the intention to align proposals with existing visits.

(2) The Chair welcomed the proposal as an opportunity for the organisation to be sighted on the current position and offer support where it was needed.

(3) P Scott acknowledged the need to respond quickly. He cautioned that the proposal would need to align with existing closed culture work and noted that it provided an opportunity to strengthen the current approach and bring in other partners to contribute.

Agreed: *that the Quality Assurance Committee would oversee progress against delivery.*

22/199 REPORT FROM THE PEOPLE, CULTURE AND DIVERSITY COMMITTEE

J Haley, Chair of the committee, advised that the report was larger than usual, reflecting the number of issues to highlight to the board and attention was drawn to the following:

(1) The proposed change to the format of risk reporting to committee to provide an 'at a glance' view on risk and mitigation. It had also been proposed that the cover report be amended to provide clarity on committee recommendations.
(2) Committee had welcomed the increase in recruitment and the separation of recruitment and retention in the BAF.
(3) Assurance had been requested on staff numbers, analysis of vacancies, sickness rates, completed appraisals and training compliance.
(4) Committee had welcomed the opportunity to hear an LGBTQI colleague story.
(5) Work underway to benchmark the organisation on equality, diversity and inclusion to identify further actions and objectives for each care group.
(6) The high number of individuals supported through the apprenticeship programme.
(7) A concern was raised for QuAC to consider, in relation to cover provided by senior nursing staff for the role of Duty Nurse Coordinator and the impact this had on the safe staffing requirements [CQC Regulation 18].
(8) A concern was raised for the board to consider, in respect of the referral process between committees, where there was an identified area of overlap.

In discussion, the following matters or points of clarification were raised:

(1) In respect of referral between committees, J Maddison, Chair of Audit & Risk Committee (ARC), suggested that the committee reports to the board provided the opportunity for discussion and offered to discuss the matter at the next meeting of ARC.

(2) S Dexter-Smith noted the concern raised about the Duty Nurse Coordinator and undertook to review the position and provide assurance at the next board meeting. P Scott also advised that he would raise the matter through the care group.

Action: S Dexter-Smith/P Scott

20. CONFIDENTIAL MOTION

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

Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

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

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

Following transaction of the confidential business, the meeting concluded at 5:15pm.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 21 DECEMBER 2022 VIA MS TEAMS, COMMENCING AT 8.00 AM

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
R Barker, Non-Executive Director
J Haley, Non-Executive Director
P Hungin, Non-Executive Director
J Maddison, Non-Executive Director
J Preston, Non-Executive Director & Senior Independent Director
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
K Kale, Medical Director
E Moody, Director of Nursing and Governance
L Romaniak, Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley & Forensics Care Group
A Bridges, Director of Corporate Affairs and Involvement (non-voting)
M Brierley, Assistant Chief Executive (non-voting)
H Crawford, Director of Therapies (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary
P Moore, Deputy Chief Information Officer
K North, Associate Director of People and Culture – attending for S Dexter-Smith
C Reynolds, Chief Information Officer

Observers/members of the public:
H Griffiths, Governor

22/202 APOLOGIES FOR ABSENCE

Apologies for absence were received from B Reilly, Deputy Chair, C Carpenter, Non-Executive Director, S Dexter-Smith, Director for People & Culture and from J Preston, Non-Executive Director for leaving early.

22/203 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

22/204 DECLARATIONS OF INTEREST

None.

22/205 CHIEF EXECUTIVE'S REPORT

B Kilmurray drew the board's attention to:

(1) Positive feedback that had been received from the Annual General and Members' Meeting and the recent Star Awards.
(2) Winter pressures, which had presented a challenge for discharge planning. He also noted that the trust had secured some funding to support additional winter measures.
(3) Positive progress that had been made on flu and covid vaccination programmes, with take up expected to be similar to 2021.

(4) The impact of RCN industrial action on trusts in the North East, which would compound existing organisational pressures.
(5) Publication of the Niche Governance Review report, which was expected mid-January and on which the trust had engaged with NHS England in relation to a number of areas.

Commenting further on challenges across the system, Z Campbell advised that ambulance services in the trust area had declared a critical situation and would only respond to category one calls or category two calls in a public place. Internal communications had been circulated to all staff and information had been displayed on the intranet. Audits had been completed on wards and services to identify staff trained in resuscitation and to confirm the location of appropriate equipment. A virtual incident room had been established and twice daily silver command meetings would be held by care groups. Medics and clinicians would be available where needed and detailed patient records maintained throughout.

In discussion the following matters or points of clarification were raised:

(1) Taking account of the ambulance services' position, the Chair sought assurance that current out of hours arrangements were sufficient to ensure patient safety.

Responding, H Crawford advised that enhanced arrangements were in place and a pool of staff were available to support the on-call team if required.

(2) In respect of assistance the trust had provided to support the system, H Crawford confirmed that the trust had participated in local planning to prepare for potential strike action and would respond if a trust required mutual aid.

(3) B Kilmurray advised that an urgent ambulance response to TEWV was not typical but had occurred in respect of falls and incidents of self-harm. The impact on other related services, such as the patient transport service, had also been considered.

(4) The Chair queried how patient safety would be ensured if there was an incident of self-harm.

In response, K Kale advised that doctors had been identified for each site and their contact details had been circulated to staff. Some on-call arrangements had also been extended to ensure appropriate overnight capacity.

E Moody confirmed that the trust would receive an ambulance response to a category 1 call. All plans had been reviewed to ensure that, where there was an increased risk, appropriate arrangements were in place. Wards also had access to equipment and first aid facilities.

In respect of falls, H Campbell noted that Physiotherapists were located across the trust and their contact details had been circulated.

(5) B Kilmurray advised that there was potential for further NHS strike action in January 2023 and preparatory work had taken place should there be an impact at TEWV.

K Kale noted that all consultants and medics had been alerted to the potential of strike action and advised that leave, study leave or training may be re-arranged.

22/206 EXCLUSION OF THE PUBLIC

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 10:00am.

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Board of Directors

Public Action Log

RAG Ratings:

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

Date	Ref No.	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)
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	Feb-23		Nov-22: Chair of QuAC to raise at next meeting and provide feedback to the board in 2023
29/09/2022	22/139	Workforce Delivery Plan	Workforce Delivery Plan to be presented to a future board meeting.	DfP&C	Feb-23		Draft plan presented to PCDC in Nov-22. Final report to PCDC and the Board in Feb-23. Jan-23 - see agenda
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	Feb-23		
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 and 15-Dec. To be scheduled as part of the BoD briefing sessions during 2023. Dates subject to outcome of the governance review
22/10/2022	22/172	Board meetings	Dates be circulated for board meetings for 2023/24	Deputy Co-Sec	Feb-23		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		Dates for May23-Apr24 are pending the outcome of the governance review
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		To be scheduled as part of the BoD briefing sessions during 2023. Dates subject to outcome of the governance review.
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)

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
24/11/22	22/186	Patient/Staff/Partner Story	The next patient/staff/partner story to be held at the January 2023 board meeting.	DoN&G	Jan-23		Scheduled for Feb-23. Work to take place on the format to ensure it meets the needs of the BoD and is a positive experience for those involved.
24/11/22	22/188	Crisis Line	Update to be provided following discussion at QuAC	Chair, QuAC	Feb-23		
24/11/22	22/190	Integrated Performance Report	Report to be developed to include a forward view on actions required to ensure progress is made.	ACEO	Mar-23		
24/11/22	22/190	Staff training	Progress update to be provided on compliance with mandatory and statutory training and measures taken, in order that the board can determine if a deep dive is required.	DfP&C	Jan-23		See Jan-23 board agenda
24/11/22	22/191	Corporate Risk Register	Board report be developed to allow the board to get to the nub of key risks and assurance on mitigation, linked to the BAF.	DoN&G	Mar-23		
24/11/22	22/196	QuAC	Contribution at QuAC from executive directors and senior managers to be considered.	DoN&G	Jan-23		
24/11/22	22/199	Duty Nurse Coordinator - staff capacity	Assurance to be provided at the next board meeting on staff capacity to undertake the Duty Nurse Coordinator Role and impact on safe staffing.	DfP&C	Jan-23		Verbal update to be provided at Jan-23 board meeting under matters arising

Chair's Report : 25th November 2022 – 12th January 2023.

Headlines:

External:

- Meetings with West Lane Families
- Meeting with Humber & North Yorks ICS Chair
- Meeting with North Tees & South Tees Chair
- Weekly MH Chairs' Network
- Meeting Teesside MP
- Visit to CommuniTea Group, Selby
- Visit to Worsley Court, Selby
- Meeting with Teesside University
- Durham Care Partnership event

Governors

- Council of Governors Development Day

Internal

- Judging, and giving, Living the Values Awards
- STAR Awards
- Leadership Walkabout Positive & Safe Team, Lanchester Road
- Session on Cyber & Digital
- Various meetings & discussions with executive officers

- Two weeks self-isolating with COVID January 2023.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 8

For General Release

Meeting of:	**Board of Directors**
Date:	**26th January 2023**
Title:	**Board Assurance Framework – Monthly Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Phil Bellas, Company Secretary**

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	✓

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
11	Governance & Assurance	The Trust has a minimal appetite for regulatory risks and has recognised that, whilst exposure will remain above tolerance, urgent action needs to be taken to strengthen controls.

Executive Summary:

Purpose:

The purpose of this report is:

(a) To support discussions at the meeting by providing information on the risks included in the Board Assurance Framework (BAF) and related key controls; and positive and negative assurances relating to them which have been identified since the last meeting.

(b) Describe the impact of material reports due for consideration at the meeting in the context of the management of the relevant strategic risks.

(c) Provide an update on the action to be taken to support the future management of the BAF.

Proposal:

Board Members are asked to note this report and provide feedback on the revisions to the summary report and the proposals for the future management of the BAF.

Overview:

The BAF brings together all relevant information about risks to the delivery of the Trust's Strategic Goals.

The Board receives:

- Quarterly reports on the full BAF following review by its assurance committees.
- Monthly summary reports.

This report focusses on the monthly summary reports; the next full

report being scheduled to be considered by the Board in February 2023.

Previously the summary reports sought to provide an aide memoire for Board Members on the alignment the BAF risks and the matters to be discussed at a meeting.

Following discussions at the last ordinary Board meeting, and subsequently, a revised approach has been developed. The key changes are:

- The provision of information on the assurance ratings of individual controls.
- The inclusion of information on the positive and negative assurances identified since the last meeting to provide some currency on the position on the BAF risks between the full reviews.
- The inclusion of information on how material reports, due for consideration at the meeting, will impact on the management of relevant risks.

The first iteration of the revised summary report is attached. It is recognised that further development is required; however, at this time, feedback on the format and approach would be useful.

Board Members are also asked to note that the development of the BAF is continuing. By the end of April 2023 it is intended:

- To undertake an annual refresh/cleansing of the BAF e.g. to remove closed gaps in assurance and control and completed mitigating actions.
- To review the BAF risks in the light of the development of the Business Plan.
- To amend the risk profiles to provide visibility on those mitigations which directly impact on the risk scores.
- To complete the Board and committee business cycles which will detail the alignment of the BAF risks and the matters due for consideration at meetings. The business cycles have been prepared, in draft, and will be subject to discussions with the Executive Leads and Committee Chairs.
- Undertaken further work to align the BAF and the Corporate Risk Register.

Prior Consideration and Feedback

Positive feedback on the format and content of the summary report has been received from the Chair of the Trust, the Chair of the Audit and Risk Committee and some Executive Directors.

Implications:

Ensuring the effectiveness of the BAF is a “must do” action arising from the last CQC well-led inspection.

Recommendations:

The Committee is asked to:

(1) Note the BAF summary report (attached) and consider its contents during discussions at the meeting.
(2) Provide feedback on the format of the summary report.
(3) Note the further work to be undertaken on the development of the BAF.

BAF Summary

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Present Risk Grade	Indicative Controls Assurance Rating	Key Controls	Controls Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
1	✓	✓		**Recruitment** Inability to recruit sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services	**DoP&C**	**High**	**Good**	Establishment Reviews	Good	**Positive:** Initial results of the Annual Staff Survey **Negative:** Leadership Walkabouts to CMHTs in January 2023 highlighted challenges in recruiting to band 5/6 nursing roles; issues with having the right skill mix; and high use of agency staff or carrying vacancies for a significant period of time	**Workforce Strategy (public agenda item 18/private agenda item 9)** The reports provide details of reporting on workforce matters, aligned to the BAF, CRR and locality risk registers at three levels within the organisation: • Trustwide and care group/ corporate directorate • General Management / corporate level • People and Culture operational data and workforce delivery plan update This approach will improve visibility and assurance throughout the governance structure and enable any issues and risks to be identified, escalated and mitigated
								Recruitment Oversight Group	Good		
								Recruitment & Selection Procedure	Reasonable		
								"A great place to work"	Reasonable		
								Partnerships with Education and Training Providers	Reasonable		
								Planning beyond the Crisis	Limited		
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**	Partnership Arrangements	Reasonable	**Positive: -** **Negative:** Leadership Walkabouts to CMHTs in January 2023 reported demand in services/high caseloads across the majority of the teams.	
								Surge Modelling	Reasonable		
								Operational Escalation Arrangements	Reasonable		
								Integrated Performance Reporting	Reasonable		
								Establishment Reviews	Reasonable		
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**	Revised Executive and Organisational Leadership Structure	Good	**Positive:** Inaugural meeting of the Co-creation Programme Board held on 22 November 2022 **Negative: -**	
								Business Plan (Co-creation priorities)	Good		
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**	Complaints Policy	Reasonable	**Positive:** IPD - Percentage of CYP showing measurable improvement following treatment clinician reported (measure 6) now has neutral controls assurance (previously negative assurance) **Negative: -**	
								Friends and Family Test/Patient Experience Survey	Reasonable		
								Patient and carer engagement and involvement structures and processes	Reasonable		
								Our Quality and Safety Strategic Journey	Reasonable		
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**	Understanding the cultures that exist across the organisation	Reasonable	**Positive:** Initial results of the Annual Staff Survey **Negative: -**	**Workforce Strategy (public agenda item 18/private agenda item 9)** The reports provide details of reporting on workforce matters, aligned to the BAF, CRR and locality risk registers at three levels within the organisation: • Trustwide and care group/ corporate directorate • General Management /
								Health and Wellbeing Group and offers	Reasonable		
								Ensuring staff are able to raise concerns in a safe and constructive way	Good		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade	Indicative Controls Assurance Rating	Key Controls	Controls Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3								
								Work with services to resolve problems in relationships and culture, based on ABC model of wellbeing	Reasonable		corporate level • People and Culture operational data and workforce delivery plan update This approach will improve visibility and assurance throughout the governance structure and enable any issues and risks to be identified, escalated and mitigated
								Ensure that we provide multiple spaces where staff can explore difficult and complex situations with each other safely and in line with our Trust values	Good		
								Cultural embeddedness in communities we serve	Reasonable		
								Understanding why people choose to leave the trust or move roles	Reasonable		
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	DoN&G	High	Good	Incident management policies and procedures	Reasonable	**Positive:** • "Good" assurance provided by the Internal Audit review of safeguarding • IPD - The number of Incidents of moderate harm and near misses (measure 11) now assessed as having reasonable performance assurance (previously limited) **Negative:** • "Limited" assurance provided by the Internal Audit review of Digital and Data Project Management: Clinical Safety • IPD - The number of Unexpected Inpatient unnatural deaths reported on STEIS (measure 14) is now assessed as having good performance assurance (previously substantial) and has neutral controls assurance (previously good) • QuAC (1/12/22) highlighted that concerns remain about capacity in the Patient Safety Team	
								Governance arrangements at corporate, directorate and specialty levels	Reasonable		
								Performance Management of Serious Incident Review	Reasonable		
								Organisational Learning Group (OLG)	Substantial		
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	Estates Master Plan (EMP)	Reasonable	**Positive: -** **Negative:** Leadership Walkabouts to CMHTs in January 2023 reported issues with infrastructure including building locations, appropriateness, and condition, as well as IT issues around connectivity and accessibility.	
								ERIC PLACE national annual reporting / benchmarks and Green Plan submission and monitoring	Good		
								Premises Assurance Model	Reasonable		
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	Controls information not provided due to security concerns		**Positive: -** **Negative: -**	
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	Senior secondments and interim appointments	Good	**Positive:** • No enforcement action currently in place against the Trust. • QuAC (1/12/22) took good assurance on the oversight, management and delivery of the CQC action plans. Negative: -	
								Relationship Management Arrangements with the CQC	Reasonable		
								CQC Action Plan	Good		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade	Indicative Controls Assurance Rating	Key Controls	Controls Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3								
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**	ICS level governance arrangements	Reasonable	**Positive: -** **Negative: -**	
								Specific Local Partnership Boards and Contact Management Boards	Reasonable		
								Provider Collaborative Boards (PCB)	Substantial		
								Monitoring of the External Environment	Substantial		
								Business Planning framework	Substantial		
								Executive and Operational Organisational Leadership and Governance Structure	Good		
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**	GGI Well-Led Implementation Plan	Good	**Positive: -** **Negative: -**	
								Executive and Operational Organisational Leadership and Governance Structure	Reasonable		
								Quality Improvement Approach and Team	Good		
								Senior Leadership Group Arrangements	Good		
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**	Roseberry Park Rectification Programme	Reasonable	**Positive: -** **Negative: -**	
								External Technical Expert Support	Good		
								Capital Programme	Reasonable		
								Legal Support	Good		
								External Audit	Good		
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**	Controls information subject to legal privilege		**Positive: -** **Negative: -**	
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	**DoFI**	**High**	**Good**	Project Governance	Good	**Positive: -** **Negative:** "Reasonable" assurance provided by the Internal Audit compliance review of record keeping	
								Staff CITO Awareness and Training	Reasonable		
								Clinical Safety	Good		
								Clinical Capacity to support the development and implementation of CITO	Limited		

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade	Indicative Controls Assurance Rating	Key Controls	Controls Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3								
								Contract	Limited		
								Clinical and Technical Support	Good		
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	Mental Health Partnership Boards	Reasonable	**Positive:** Internal Audit review of "HFMA Improving NHS Financial Sustainability" checklist found that 11 of 12 questions reasonably self-assessed **Negative:** • IPD - Capital Expenditure (measure 29) maintains neutral controls assurance however the latest data now showing lower (negative) than plan • IPD - Cash balances (measure 30) now has negative controls assurance with the latest data now showing lower (negative) than plan	
								ICP/ICB Funding Arrangements	Limited		
								Provider Collaboratives	Good		
								Business Planning and Budget Setting Framework	Limited		
								Financial Sustainability Board	Reasonable		

Tees, Esk and Wear Valleys
NHS Foundation Trust

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday 26 January 2023**
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.

NHS England National Planning Guidance 2023/24

NHSE published national planning guidance on 23rd December 2022. The guidance sets out three core priorities:

- Recovering our core services and improving productivity
- Make progress on delivering Long Term Plan ambitions
- Continue transforming the NHS for the future

The document consistently refers to reducing health inequalities and has a section each on mental health and learning disability and autism.

The key issues regarding mental health, learning disability and autism are:

- New requirement for ICBs to produce a plan by March 2024 to "**localise and align mental health and learning disability inpatient services over a 3 year period**"
- The need to achieve MHIS and the MH / LD / Autism long term plan aspirations
- Probable NHSE attention on **autism diagnostic waiting times**, and on action being taken to address these (whether in the form of additional resources or innovations in pathways)

- Expectation that mental health **data** will become more robust and able to illuminate equalities issues and the impact of investment
- Confirmation of the requirement to produce **ICS level MH workforce plans**

The document also specifically says that progress should be continued with the delivery of the relevant LTP ambitions on the following areas:

a) Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
b) Increase the number of adults and older adults accessing IAPT treatment
c) Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
d) Work towards eliminating inappropriate adult acute out of area placements
e) Recover the dementia diagnosis rate to 66.7%
f) Improve access to perinatal mental health services
g) Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
h) Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
i) Continue to address health inequalities and deliver on the Core20PLUS5 approach (across all NHS work)

Technical financial guidance is following. However, key points to note are: the Autumn statement announced an extra £3.3 billion in both 2023/24 and 2024/25 for the NHS to respond to pressures. At a national level ICB allocations are flat in real terms. The Mental Health Investment Standard is retained. The approach to capita will be similar to this current year. ICBs will be working with place based partners and provider collaboratives/partnerships to support the planning round. This proces is well underway with deadlines for submission in late February and at the end of March.

Annual Report and Accounts of the Charitable Trust Funds 2021/22

Due to the annual leave of the External Audit partner, it was necessary to approve the Annual Report and Accounts of the Charitable Trust Funds 2021/22 under emergency powers so that the document could be submitted to the Charity Commission by the deadline of 31st January 2023.

Governance Review

It was agreed that following the launch of our new governance structure we would undertake a review at the six month point. The purpose of the review is to assess if our new governance structure supports the provision of evidence based

assurance to enable the organisation to have the ability to have meaningful interrogation of themes and trends to identify and respond to emergent risks and ensure safe and high-quality care for patients.

The findings and recommendations have been derived from observing the following meetings.

- Care Group sub groups
- Care group Improvement & delivery groups
- Care group Boards
- Executive Group
- Executive sub groups
- Board sub-committees
- Board

Additional feedback and information has been gathered from 1-1 discussions with various senior leaders, meeting chairs, NEDS, service managers.

The actions and recommendations proposed following the observations and subsequent findings are based on some short term adjustments and longer term changes subject to a quality Impact assessment of the proposed changes. A full report will go to Board of Directors in February 2023.

The recommendations are proposed to be actioned over the short and medium term. Short term quick win recommendations to be implemented immediately that will remove unnecessary production of information and tighten up agendas to be more focussed. Medium term recommendations to be impact assessed ahead of any change to be made in the new financial year April 23.

- Move to one month behind IPR reporting to the board- this will require re-scheduling of meeting dates for committees and board – April 23 change recommended
- Agree formal report templates –- Immediate change recommended
- Agree new agenda format and stricter production of agenda and submission of papers in advance - Immediate change recommended
- **Impact Assessment to be Undertaken for this Recommendation** - Replace the three care group sub groups with one combined meeting with a purposeful agenda and a schedule of information flow supported by a workplan – April 23 change recommended
- **Impact Assessment to be Undertaken for this Recommendation** - Consider the same for the exec subgroups - April 23 change recommended
- Move to a weekly themed Executive Directors Group – Immediate Change recommended
    - Week One – Quality & Safety
    - Week two – Workforce, Co-Creation, Strategy
    - Week 3 – Management group with more purposeful agenda – Part 1 – Clinical Networks, Part 2 – Finance, general business
    - Week 4 – IPR Performance, Trust delivery plan assurance & oversight (programme updates)

    - Quarterly oversight – care groups and corporate reporting via Accountability Framework
- Stop using Triple A reporting except for sub-committee to board – Immediate Change recommended
- IST team to work through the Quality governance flow as part of ongoing IST input and support – April 23 change recommended

Vaccination Programme Update

Nationally the current flu vaccination uptake is 50.7%, and regionally for North East and Yorkshire it is 56%. The Trust has 52.5% of staff vaccinated for flu. Last season's flu uptake rate for the Trust was 52.9%, therefore we are at a similar rate to last year and above the national rate. We are highly unlikely to hit the threshold in regard to the CQUIN target, as the minimum payment requires a 70% vaccination rate to be achieved by 28 February 2023.

Regarding covid vaccinations, nationally the uptake is 50.2%, and regionally for North East and Yorkshire it is 54.5%. The Trust has 46.8% of staff vaccinated against covid.

Since 9 January 2023, the Trust had scheduled around 50 drop-in clinics across various sites for staff offering both flu and covid vaccines. The Trust were advised on 10 January 2023 that secondary care Trusts across the region would no longer be directly supplied with covid vaccines for staff once existing supplies were used / expired. The Trust's vaccines expired on 15 January 2023.

The clinics from 16th January onwards are still planned to go ahead, offering flu vaccines only but will be reviewed based on demand as recent clinics are evidencing low uptake. Staff and teams have also been advised to contact the generic flu fighter inbox directly if they still would like a flu vaccine. This will help the vaccinations programme team to plan clinics more effectively.

Due to the short notice of the changes to covid vaccine supplies, we were not able to provide any forewarning to staff who still may have been wishing to have a covid vaccination. They are now directed to their GP or to the NHS covid vaccination web page. As the Trust covid and flu vaccination rates for staff are lower than hoped this may have a potential consequence on staff sickness absence, or potential transmission likelihood which could in turn, impact on our winter response ability.

Workpal

Workpal is an online performance platform, supporting our colleagues to thrive in their role. Aligned to TEWV's values, behaviours and strategic goals, all appraisals and performance evidence will be completed and recorded in Workpal, meaning everything is streamlined, in one place and easily accessible on-the-go. Staff will be able to provide and request feedback to drive continuous improvement and there will be a manager's dashboard to keep track of your team's performance.

We currently use a trust wide paper-based appraisal form to complete our appraisals and record talent management conversations. And as we strive to make TEWV a

great place to work, we must nurture our talent, record great work and continue to develop our workforce. With this in mind, the trust will move over to Workpal by the end of March 2023.

We have limited sight of people's paper based appraisal and in our latest staff survey 83.8% of our staff said they had one, but only 30.9% said they had clear objectives, and 19% said it helped them to do their job.

Recommendations:
To receive and note the contents of this report.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

BOARD OF DIRECTORS

DATE:	**26th January 2023**
TITLE:	**Board Integrated Performance Report as at 30th November 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 November 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 month's Executive Summary is split into two distinct sections: the first section focuses on the latest IPR and the second section focuses on the broader key issues/work in relation to Quality including Safe Staffing, Inpatient Pressures and Finance which is supplemented by the two Care Board Summaries.

3.1 Part 1: Integrated Performance Report

3.1.1 **IPD Key Changes**

The following section highlights the **key changes** in the IPD from the previous report:

- **Percentage of CYP showing measurable improvement following treatment clinician reported (measure 6)** now has neutral controls assurance (previously negative assurance)
- **The number of Incidents of moderate harm and near misses (measure 11)** now assessed as having reasonable performance assurance (previously limited)
- **The number of Unexpected Inpatient unnatural deaths reported on STEIS (measure 14)** is now assessed as having good performance assurance (previously substantial) and has neutral controls assurance (previously good)
- **Capital Expenditure (measure 29**) maintains neutral controls assurance however the latest data now showing lower (negative) than plan
- **Cash balances (measure 30)** now has negative controls assurance with the latest data now showing lower (negative) than plan

3.1.2 **IPD Areas of Concern**

The following section highlights the areas of concern within the IPD where we have **limited performance assurance** and **negative controls assurance.**

a) **Staff in post with a current appraisal (measure 21)** We continue to have special cause concern at Trust level and in several Corporate Services/Care Group level. Routine monitoring is continuing however actions to date have had little overall impact. All areas below the agreed standard of 85% have been asked to provide a trajectory/timescale of when they will achieve this; however, there is currently limited assurance pending the provision of this information and the actions being taken to improve the position.

b) **Unique Caseload (measure 23)** We have an increasing position at both Trust and Care Group level. The Executive Strategy & Resources Subgroup established a task and finish group to undertake analysis at team level to identify which specific teams are indicating a concern and to subsequently triangulate this with a range of staffing information. Analysis has highlighted that c 60 (of 324) teams are indicating special cause concern that warrants further investigation. Those teams account for an overall caseload increase of c13,305 however a further 218 teams account for a decrease of c 10,300 in caseload. Some of these may result from new teams being formed (or merged), meaning the investigation is essential to correlate any relevant intelligence. Around 43 additional teams have special cause concern, but either are very low absolute numbers (high percentage), or were formed during the period, or had one month with a particularly large increase. Work is underway by the Performance team to identify any relevant service changes for the 60 teams with special cause concern to inform the volume of work required, this will report back in early to mid-January. There is currently limited assurance pending this analysis and the identification of related improvement actions.

c) **Financial plan (measure 24)** The Trust is not in line with its financial plan and unless mitigating action plans are delivered, achieving the £1.16m planned surplus will prove extremely challenging. There are 3 key drivers of financial performance: elevated bed occupancy/delayed transfers of care, independent sector bed utilisation and elevated agency staffing pressures. In addition, adverse financial impacts of the nationally negotiated pay review body outcomes on NHS staff pay

have been reported since month 6 (effective payment date). The distribution of associated ICS-level funding has been subject to ICS discussion to ensure the most equitable distribution of available resources. Trust plans for 2022/23 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 would have a £2.2m year to date pressure (included in the month 8 position, or £3.3m full year, assumed fully funded). Allocations are expected to be confirmed as part of month 9 processes to consider risks to delivery of individual organisation, and the composite ICS, financial positions.

Whilst quarter 1 performance was broadly on plan (£1.3m deficit), financial plans assumed 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, underlying costs increased from the start of 2022/23, and stepped cost reductions have also not therefore been achieved in full. Performance since month 4 has been consistently worse than planned, with adverse variances for months 4 to 8 totalling £5.91m against a planned surplus of £1.58m for the same period, or £7.49m worse than plan (including £2.2m pay award funding gap).

Non delivery of cost reductions principally relates to agency and Independent Sector bed placements, with costs in 2022/23 significantly higher than in 2021/22.

With mounting pressures, detailed work commenced to agree recovery actions, trajectories, and consider delivery risks. Following several detailed reviews by Executive Directors in October-November, and consideration at the November Strategy & Resources Committee, the Board scheduled time to review the position, forecast and implications in private in November and December 2022. This included an assessment of risk-rated rated plans and forecast scenarios for key financial 'hot spots'.

Recovery of the financial position, in the context of ongoing operational and workforce pressures and moving towards winter, feels significantly challenging. Income lines of enquiry have also been explored, including for access to social care discharge funding.

NHSE issued a 'Protocol for changes to in-year revenue financial forecast' in early November 2022. This introduced significant consequences where forecasts deteriorate, e.g. restricted access to funding and staged revenue approval processes. Activating the protocol represents a breach of statutory duty and consequently the Protocol also confirms pre-activation steps that must be taken. Trust Board agreed to meet again in December to consider the forecast to be submitted at Month 9, and any related Board Assurance Statement requirements should the new reporting protocol need to be invoked.

d) **Financial plan: Agency Expenditure (measure 25a)** 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 relating to some reductions in the use of off-framework agency staffing assignments following the successful discharge of an individual with a complex care package, and due to actions to move away from the most expensive off-framework agency supplier for Learning Disability services (without impacting quality or safety). 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 Trust Care Packages.

e) **Financial plan: Agency price cap compliance (measure 25b)** 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.

f) **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 (except for liquidity).

g) **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 limited assurance we have for agency and OAPs. 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.

3.1.3 IPR Other points to note

The measures where we **have reasonable performance assurance** and **negative controls assurance** are being managed via various programmes of work therefore there is nothing further Executive Directors Group (EDG) wishes to highlight at this point, with one exception. Data Security Awareness is a sub-set of **compliance with all mandatory statutory training (measure 20)** which has a standard of 95%. As we did not achieve this standard within the Data Security & Protection Toolkit (DSPT) in June 2022, we were required to submit an action plan to achieve this by 31st December 2022. A revised action plan was submitted on 30th December which outlines the additional actions being taken (e.g. to support staff in completing their training, we are planning to hold Teams sessions where we will go through the content using a combination of short Meta Compliance videos, presentation and discussion using practical examples during January and February) with the aim to achieve by 29th February 2023. Our compliance is reported to the Care Quality Commission (CQC), Department of Health & Social Care and NHS England. Our DSPT status is also used during tender processes and referenced in our annual governance statement.

Whilst EDG feels the current level of assurance is reasonable in relation to the latest Long-Term Plan ambitions, a specific action has been agreed in relation to 72 hour follow up, for Care Groups to review any patients not followed up within the timescale and ensure processes are robust in relation to discharge and follow up given this is a key measure of quality and safety.

The more detailed assurance supporting the Integrated Performance Dashboard (IPD) including the latest IPD Performance and Controls Assurance Framework Assessment and Long-Term Plan ambitions is contained in Appendix A.

3.2 Part 2: Broader Key Issues/Work

3.2.1 Quality

Safe Staffing

Business Continuity Arrangements remained in place during October 2022 for the following service areas: Secure Inpatient Services, Durham & Darlington Crisis Team, the AMH wards at RPH (4 admission wards and PICU), CAMHS Community York, CAMHS Community Northallerton, and DTV&F Inpatient Adult Learning Disability Services.

Registered Nurse fill rates continue to remain consistently low across a significant number of wards for day shifts, fluctuating between 33 and 34 wards over a 6-month period. There is a slight increase in the number of wards using more than 120% of their budgeted RN staff on days and nights despite the shortfall on day shifts. It is noted that both PICUs are reporting low RN fill rates for days and nights.

HCA fill rates for day shifts show there are a significant number of wards with high fill rates for HCAs, 18 wards are in excess of their 150% of their budgeted establishment – 12 of these wards are AMH wards - the highest being the PICUs (Bedale and Cedar) having fill rates of 360% and 357% respectively. HCA fill rates for night shifts similarly show a significant number of wards with high fill rates for HCAs, where 28 wards are in excess of 150% of their budgeted establishment – 14 of these wards are AMH wards, with the highest being the Bedale PICU at 619%. The other areas are SIS (6 wards), MHSOP (7 wards) and Bankfields Court (LD).

High HCA fill rates are due to:

- backfill for the low RN substantive numbers
- high patient acuity and dependency requiring additional staff – this can be seen to impact the skill mix on the wards
- limited RN availability on the bank and agency, which will then be filled by the more available HCA resource

Low skill mix can lead to the potential increase of risk towards the ability to provide safe and quality care to patients, reduced leadership performance, and staff retention. They are acknowledged as a factor and risk where closed cultures may develop. The Trust continues to mitigate this risk through daily operational processes and a continued focus on recruitment and retention. In terms of closed cultures, this has been included within the closed culture risk assessment and ‘see, feel and hear’ visits are being undertaken to ward areas on a prioritised basis to further explore the impact of staffing in triangulation with other risks.

Inpatient agency expenditure has seen a marked decrease during October compared to September, however, remains high when viewed across a longer period. Bank expenditure has also decreased for October to levels comparable to May and June 2022, which is seen in the low fill rate for bank staffing in October. Agency fulfilment (14.08%) continues to be significantly higher than the Trust threshold of 4% this month. There are 36 teams (72% of all teams considered) that are using greater than 4% agency staff – this number of teams is an increase of 1 over last month.

We continue to work to proactively address shortages in registered nurses which also continues to be 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 recently engaged with a recruitment event based in India (November 2022). This is in addition to maximising student nurse placements across the Trust in conjunction with our 6 HEI partners.

The number of missed breaks has increased over the previous month, alongside a small increase in shifts worked that were greater than 13 hours. There is a reduction in the number of Datix reports for staffing levels. We are undertaking work to enable improved granularity regarding the number of wards impacted with an individual Datix report for staffing levels.

Quality Assurance Programme

The Trust expanded the Quality Assurance Programme in March 2022 to include assessment of community services. It is positive to report there has been month on month improvement across the areas of care quality assessed, with high levels of compliance in the main. One key area for further improvement relates to documented evidence that the patient has been offered and provided with a copy of their safety plan. Following the workshops held to agree the key changes to be made across the suite of inpatient quality assurance tools (informed by performance data, learning and emerging risks), progress has been made on making all of the relevant changes to the assessment tools, database and report templates. A communication plan and implementation schedule has been developed to support the successful transition that will go live across January 2023.

Serious Incident- Inpatient death

Sadly, in December the Trust had an unexpected inpatient death. A rapid review of care was undertaken with no immediate areas of actionable learning identified at that time. A Patient Safety Review Meeting is being held on 4th January, involving service teams and supported by corporate patient safety colleagues. All relevant system partners have been notified. An experienced external patient safety reviewer will be commissioned to undertake the full independent Serious Incident review and report.

3.2.2 Inpatient Pressures

The Bed Usage Oversight Group continues to focus on the reduction of Independent Sector (IS) bed usage (target 4 beds) and delivery of an efficiency saving of £360K (as of 22nd December 2022 it was 2 IS beds).

The work that has been undertaken to triangulate the Durham Tees Valley Adult Mental Health bed occupancy reduction plan (short term) to the financial recovery plan and key metrics, will be presented to the Beds Usage Oversight Group in January along with the results of the deliverability diagnostic assessment that is being undertaken, which currently shows Amber ‘medium risk’ (60% probability of delivery).

Key pieces of work that are still to be undertaken in January include:

1. identification of baselines against each metric and activity targets
2. identify any risks associated with the plan that may impact upon achievement of the financial target (360K), along with mitigation plans.

3. exploring the potential development of a dashboard to include data that is not currently obtainable via the Integrated Information Centre (IIC).

Discussions at the Beds Oversight Group in early January considered other key lines of enquiry to help inform the development of medium to longer term plans post March 2023, to address bed occupancy (reducing to 85%) including:

- The accuracy of DTOC reporting
- The challenges by services to discharge safely following several outbreaks
- The need to absorb patients from IS beds, repatriation of out of area patients and those in PICU beds which would therefore not reduce occupancy
- The latest benchmarking reports
- Combining the bed occupancy action plan with specific discharge related actions to reflect the 100-day challenge from NHSE

3.2.3 Finance

Agenda for Change (AFC) and Other Pay Awards

The Trust has an existing accumulated funding shortfall relating to impacts of 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. 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. Pending the outcome of this review (expected at reporting month 9), 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 from Month 6 (the initial effective payment date).

Financial Forecast 2022/23

Due to escalating financial pressures and risks to delivery of the planned surplus, the Board has considered papers in private session in both November and December 2022 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.

3.2.4 Care Board Summaries

Durham Tees Valley and Forensic Care Group

Key Areas of Concern identified from the Integrated Performance Dashboard (IPD) with triangulation of any other relevant information

- The Percentage of inpatients reporting that they feel safe whilst in our care is a concern for us. Key actions are in place, with our Director for Lived Experience working with services and patient experience feedback to implement safe ward models. Key feedback is around issues with our estates and the need for additional sensory stimulation on the wards, as well as availability of staff. The safety of staff, service users and visitors within our inpatient services is a priority we are looking to take forward as a single programme of work.
- Pressures on our inpatient services are continuing; our bed occupancy remains high within our adult and older people wards. We have Care Group level

workstreams for AMH and MHSOP services which report into the Trust-wide bed oversight group. Actions within our Bed Occupancy reduction plan include a relaunch of PIPPA processes in the new year and the development of a new bed management system with further quality improvement events planned in relation to other elements of the value stream. Work has begun to review all DTOCs and meetings are now in place with Local Authority leads to establish a more proactive, collective response.

- The outcomes within our CYP and AMH services are not where we would like them to be, although we have seen improvements in CYP clinician reported outcomes. Actions are in place across all specialties and continue to progress.
- We continue to have long waiting times for assessment within our CYP neurodevelopmental service. Action plans remain in place with commissioning colleagues and include a service review. In addition we continue discussions with Adult neurodevelopmental services to consider the potential to look at an all-age neurodevelopmental service internally and with system partners.
- Within the Long Term Plan, we are concerned about our waiting times within Children's Eating Disorders; however, we continue to see improvements. Several actions remain ongoing including working with County Durham and Darlington Foundation Trust around the provision of dieticians and the development of a temporary Service Level Agreement around this.
- Fewer people are accessing our IAPT service and moving to recovery than we would like. Further work will be undertaken to understand these in more detail.

The areas of positive assurance identified within the IPD

- Within our IAPT services we continue to have excellent waiting times, achieving the 6 and 18 week standards for accessing our services.
- We continue to exceed standards consistently for The Number of people who receive two or more contacts from NHS or NHS-commissioned community mental health services for adults and older adults with severe mental illnesses and the Number of CYP aged under 18 supported through NHS-funded mental health with at least one contact.
- The Percentage of staff feeling they are able to make improvements happen in their area of work and who would recommend the Trust as a place to work have improved across all specialties other than ALD. We are looking at shared learning from areas that have shown the greatest improvement.

Other key information, issues, and risks (not already included in the IPD) that the Care Group wishes to highlight and/or escalate

- Within our Crisis service, a daily incident management approach has been implemented with key workstreams identified. The call pick up rate has increased to 59% from 28% in Durham and Darlington. Work remains ongoing and a quality improvement event took place w/c 12/Dec/22 to look at service redesign that would increase capacity and our ability to respond to people in crisis.
- As part of the bed Occupancy reduction plan we are also focusing on patient flow within our Psychiatric Intensive Care Units (PICU) as this is a concern alongside our Assessment and Treatment wards.

North Yorkshire, York & Selby Care Group

Key Areas of Concern identified from the Integrated Performance Dashboard (IPD) with triangulation of any other relevant information

- Pressures on our inpatient services are continuing; our bed occupancy remains high within our adult, older people and adult learning disability wards however,

collective effort has retained the reduction of the number of patients admitted to the independent sector for North Yorkshire, York & Selby. As at 22nd December we don't have any patients in independent sector beds.

- Whilst we have seen some improvements in compliance with mandatory training and appraisals, issues remain with staff capacity as a result of high caseloads, staff leavers and recruitment challenges and day to day operational pressures. Software issues impacting completion of e-learning is now resolved and continuous work is progressing including addressing work required around where staff have completed e-learning, but their compliance isn't updated, and options are to be agreed as to how this is progressed. Further work is progressing in relation to identifying additional venues for Mandatory and Statutory Training with the Quality Improvement Manager and Business manager.
- Memory waiting times is impacted as capacity is outstripping demand and no further investment to improve capacity. This is impacting on wellbeing of clinical and operational managers of teams. Following an options appraisal, the option to change the documentation requirements of memory services (low risk) has been discussed further with the Digital and Data team and Associate Director of Performance. Though this option will reduce administrative burden it will not have the impacted initially expected. Additionally, the possibility of implementing an additional option where memory service staff would see non-complex within a virtual primary care setting with all assessment recorded within primary care system is currently not viable. A demand and capacity exercise is underway which will inform next steps.

The areas of positive assurance identified within the IPD

- Within Long Term Plan as at the end of November 22, we continue to have excellent waiting times within IAPT and are achieving the 6 & 18 week standards for accessing our services and are meeting the IAPT access and recovery standard for Vale of York Sub-ICB location. 72 hour follow up standard is achieved for both Sub-ICB locations and Child Eating Disorder service has achieved 100% for urgent referrals during the month of November 22.

Other key information, issues, and risks (not already included in the IPD) that the Care Group wishes to highlight and/or escalate

- There is a risk relating to the increased demand within the All-age Crisis phone line which has resulted in a reduced response rate; Daily oversight to ensure planned staff are available to respond to the 0800 calls, is in place and work is underway to introduce a Listening Service to reduce the overall Crisis Line call volume. Work is in its final stage to develop a safe filtering service for all calls received and the frequent caller's dashboard is ready to go live, with training being provided to the AMH crisis teams; this will assist with a call back function and proactive support to patients and carers. The Integrated Care Board commissioners have agreed to fund the listening service as part of the existing telephone number; this will be with existing providers.
- System wide pressures including lack of care home places continue to result delays in discharging patients and contributing to bed pressures within our MHSOP services. Currently no CBT therapists in MHSOP, and only few dieticians in AMH. Care Group Board wish to reiterate the lack of Therapies provision in NYYS, which ultimately impacts on admissions, length of stay, and a positive ethos and culture on the wards. There is no clear overarching plan and inconsistent commissioning approaches across care groups relate to diagnosis of Autism in adult mental health and adult learning disability service.

3.3 **Summary of Key Risks**

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

- **(BAF Risk 15) Financial Sustainability & (CRR risk 1260)** There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality
    a. Failure to reduce inpatient staffing costs and Trustwide agency (in particular Medical and LD premium rate) utilisation (volume and rate reductions to reduce related premium costs)
    b. Failure to reduce lengths of stay, including through work with system partners, to reduce adult A&T and PICU bed occupancy and eliminate unfunded 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

- **(BAF Risks 1 and 5) Recruitment and Staff Retention** There is a risk that our inability to recruit and retain sufficient qualified and skilled staff (a common risk shared by all providers) might jeopardise our ability to provide high quality/safe services. In addition, there are multiple factors that 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. Oversight and escalation processes are well embedded to maintain safe staffing levels.

- DG confirmed there were no “new” emerging risks as its meeting on the 4th January 2023.

Recommendations:

The Board of Directors is asked to confirm whether the level of oversight in this report is sufficient and if it is assured on the actions being taken to improve performance in the required areas.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Appendix A

Board Integrated Performance Report

As at 30th November 2022

Report Produced by: Ashleigh Lyons, Head of Performance
Date the report was produced: 23 December 22

For any queries on the content of this report please contact: Sarah Theobald, Associate Director of Performance
Contact Details: sarah.theobald@nhs.net

journey to change

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Chapter 1

Integrated Performance Dashboard (IPD)

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS 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 only included for a small number of measures. Work is continuing to develop the standards for the remaining measures.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys 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. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. We are currently in the process of establishing a local audit framework; therefore, the audit element has been omitted from the initial assessment.

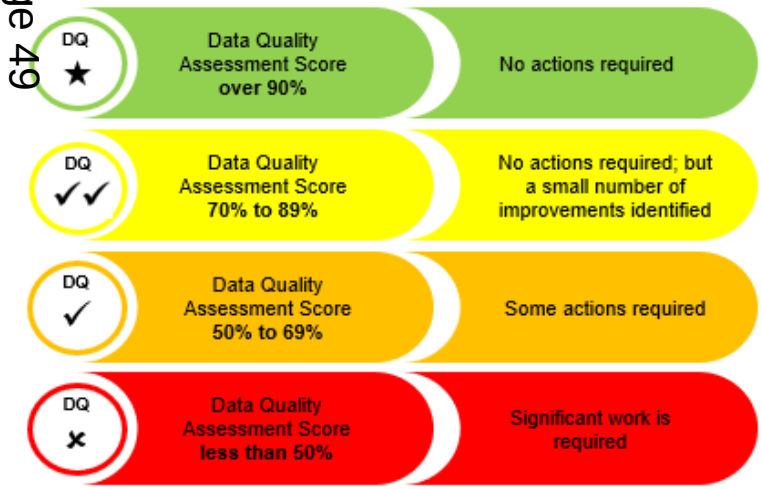
Please note an assessment has not yet been undertaken on the following new measures:

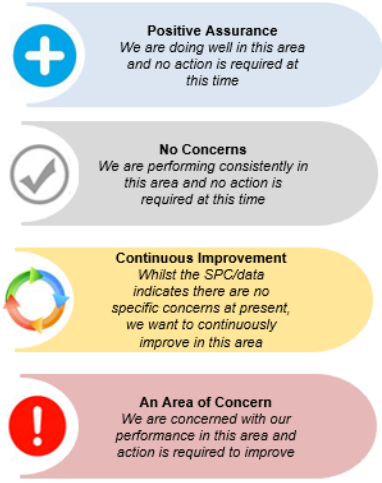
11) The number of Incidents of moderate harm and near misses
25a) Financial Plan: Agency expenditure compared to agency target
25b) Agency price cap compliance

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 a number of the measures, the action status has been determined upon the current variation depicted within the Statistical Process Chart and/or other relevant information.





Performance & Controls Assurance Overview

Tees, Esk and Wear Valleys NHS Foundation Trust

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive		*CRES Performance – Non-Recurrent	*New unique patients referred	
Neutral		*Serious Incidents reported on STEIS *Restrictive Intervention Incidents *Medication Errors with a severity of moderate harm and above *Unexpected Inpatient unnatural deaths reported on STEIS *Capital Expenditure (Capital Allocation)	*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 *CYP showing measurable improvement following treatment - clinician reported *Incidents of moderate harm and near misses *Uses of the Mental Health Act *Staff feeling they are able to make improvements happen in their area of work *Percentage Sickness Absence Rate	
Negative		*Inappropriate OAP bed days for adults that are 'external' to the sending provider *Cash balances (actual compared to plan)	*Inpatients reporting that they feel safe whilst in our care *CYP showing measurable improvement following treatment - patient reported *Adults and Older Persons showing measurable improvement following treatment - patient 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

Board Integrated Performance Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC				91.75%
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				71.84%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L			57.54%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L			24.34%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L			46.93%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC				44.52%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L			20.27%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H			99.57%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			575
10)	The number of Serious Incidents reported on STEIS	QAC				82
11)	The number of Incidents of moderate harm and near misses	QAC				1,237
12)	The number of Restrictive Intervention Incidents	QAC				5,132
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				8
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				1
15)	The number of uses of the Mental Health Act	MHLC				2,873

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
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			13.20%
19)	Percentage Sickness Absence Rate (month behind)	PC&D				6.18%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L	P	85.00%	85.25%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	L	?	85.00%	78.78%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC	H			67,235
23)	Unique Caseload (snapshot)	S&RC	H			62,650

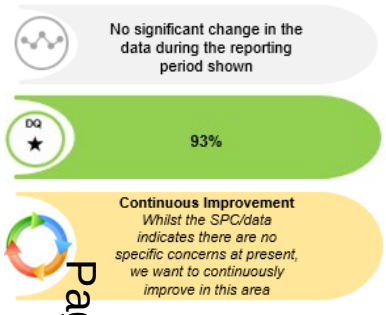
Rep Ref	Our Finance Measures	Committee Responsible for Assurance	Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	F	-280,000	6,922,539
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	F	6,563,945	14,325,747
25b)	Agency price cap compliance	S&RC	F	100%	66%
26)	Use of Resources Rating - overall score	S&RC	F	2	3
27)	CRES Performance - Recurrent	S&RC	F	7,142,000	5,509,000
28)	CRES Performance - Non-Recurrent	S&RC	P	927,800	927,800
29)	Capital Expenditure (CDEL)	S&RC	F	6,460,000	5,046,907
30)	Cash balances (actual compared to plan)	S&RC	F	77,213,000	74,821,384

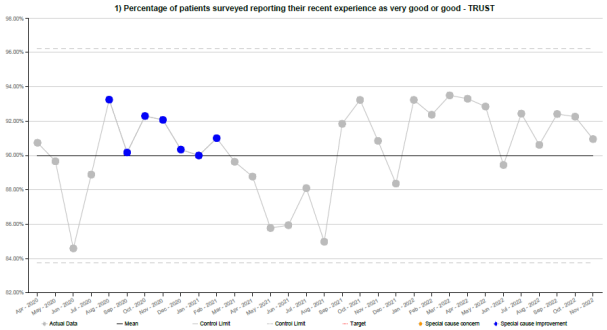
01) Percentage of Patients surveyed reporting their recent experience as very good or good

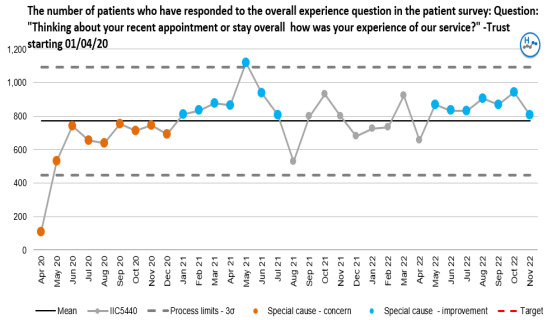
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

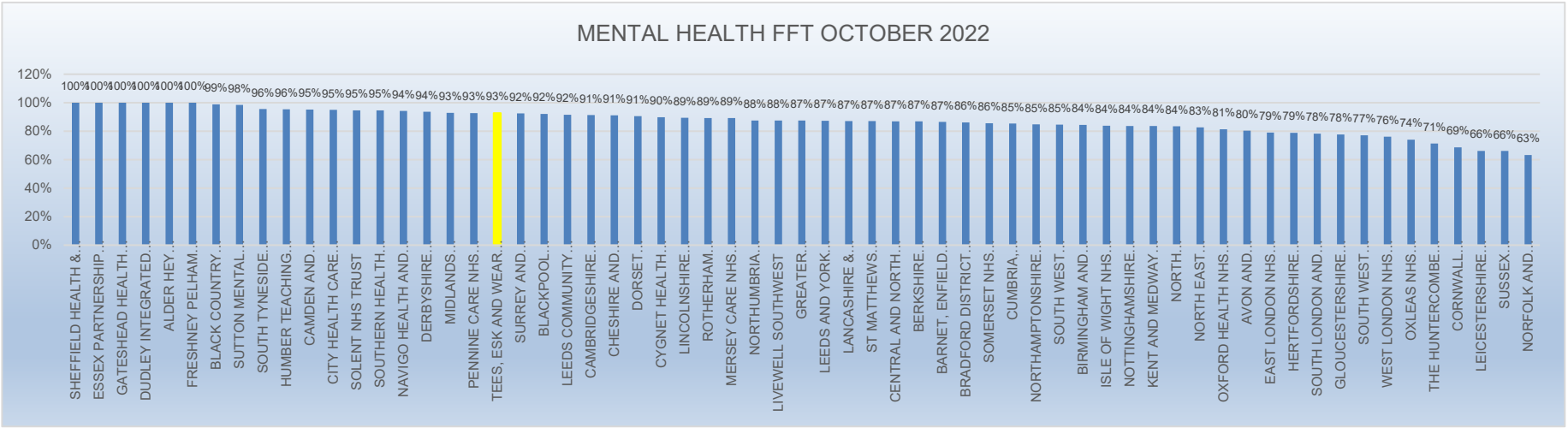
During November, **807** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **734 (90.95%)** scored "very good" or "good"







National Benchmarking - Mental Health Friends and Family Test (FFT) data - October 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 is identified by the yellow bar in the chart below. We are ranked 19 in the list of providers shown.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Update

At its November 2022 meeting, Trust Board agreed to implement a 92% standard for the percentage of patients surveyed reporting their recent experience as very good or good . This standard will be implemented from the 1st December 2022.

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:* Patient Experience Task & Finish to establish a service improvement action plan, including a set of clearly defined improvement actions, for each Care Group Board by January 2023.		

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 Foundation Trust

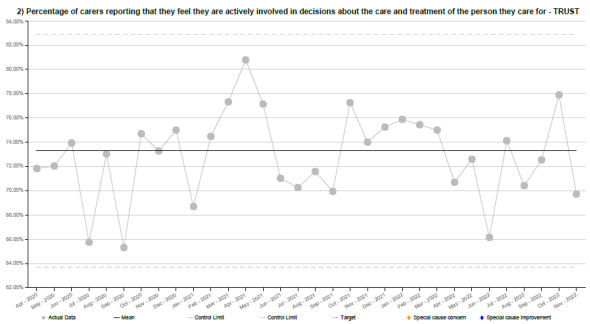
We are all committed to co creating a great experience for patients, carers and families by including carers in any decisions about the person they care for and working with them to provide quality care, and that carers will tell us this is the case from their experience.

During November, **327** 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, **228 (69.72%)** scored "yes, always".

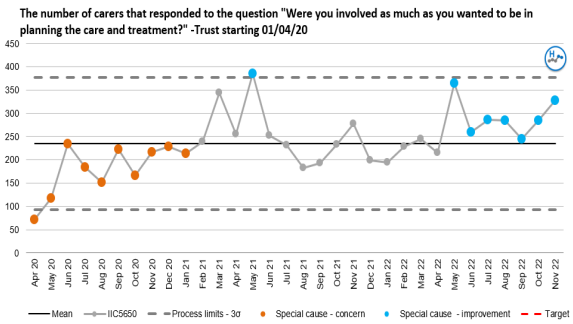
No significant change in the data during the reporting period shown

87%

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

At its November 2022 meeting, Trust Board agreed to implement a 75% standard for the percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for. This standard will be implemented from the 1st December 2022.

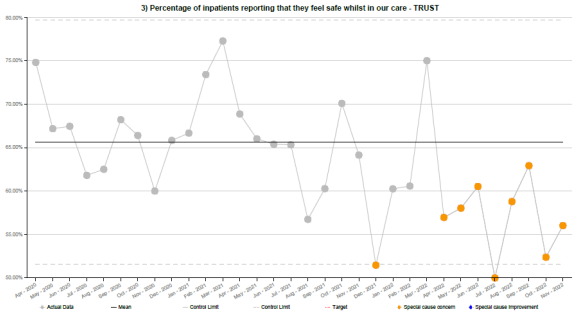
There are currently no specific trends or areas of concern identified at Trust or Care Group level. Any issues identified at specialty level are being addressed by the Care Groups.

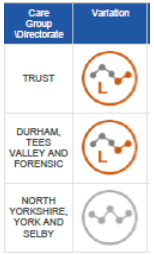
03) Percentage of inpatients reporting that they feel safe whilst in our care

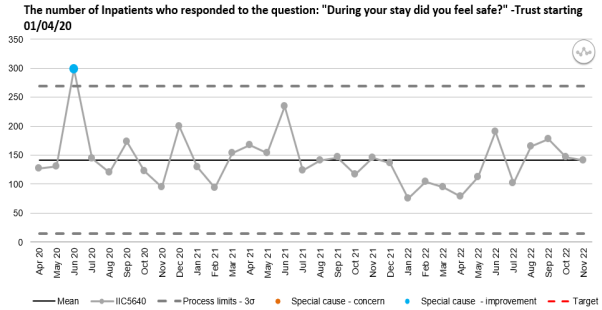
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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 November, **141** patients responded to the overall experience question in the patient survey: Question: "During your stay, did you feel safe?". Of those, **79 (56.03%)** scored "yes, always"







Update

At its November 2022 meeting, Trust Board agreed to implement a 75% standard for the percentage of inpatients reporting that they feel safe whilst in our care. This standard will be implemented from the 1st December 2022.

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. Originally delayed to December 2022, this will now be completed in January 2023.		
'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 complete 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 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*	

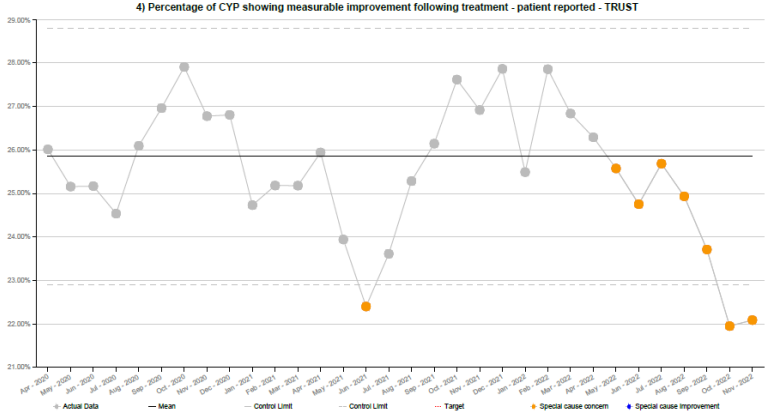
04) Percentage of CYP showing measurable improvement following treatment - patient reported

NHS
Tees, Esk and Wear Valleys
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 November, **747** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 165 (22.09%)** 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	L
DURHAM, TEES VALLEY AND FORENSIC	L
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

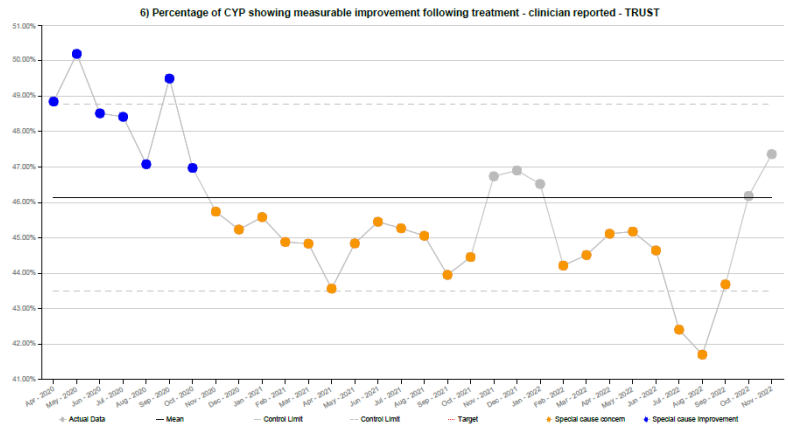
DQ ★ 93%

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 November, **853** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 404 (47.36%)** 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	
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	L

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

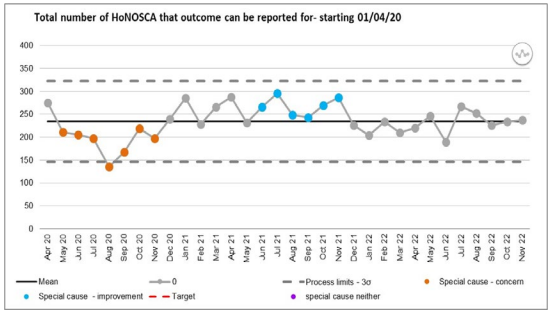
DQ ★ 93%

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

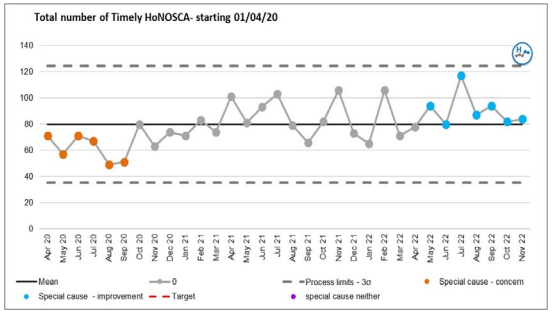
Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Measures

The number of patients that have a paired measure recorded over-time. Whilst there was a reduction denoting the start of the covid pandemic, 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.



Update

At its November 2022 meeting, Trust Board agreed to implement a 35% standard for the percentage of CYP showing measurable improvement following treatment - patient reported and a 50% standard for the percentage of CYP showing measurable improvement following treatment - clinician reported. These standards will be implemented from the 1st December 2022.

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. 11 staff have attended the monthly session in November - 9 Durham, Darlington and Teesside, 2 North Yorkshire and York.	
	Enabling action: The CYP Specialist Practitioner in Clinical Outcomes Development will provide 3 refresher sessions for all staff by January 2023.	Two sessions have been completed with a further one planned for January 2023.	

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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 4 pilot areas (Easington, Stockton, Northallerton, Scarborough) between October-December 2022.	**Complete.** The Caseload Management Pilot is complete.	
	CYP Services to roll out the Caseload Management tool in all teams by the end of March 2023 to support clinical practice and ensure that ROMs are completed.		

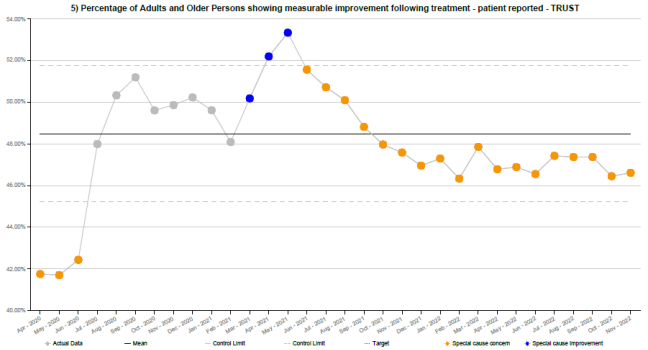
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

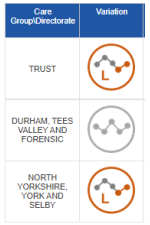
Tees, Esk and Wear Valleys NHS Foundation Trust

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 November, **1976** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 921 (46.61%)** made a measurable improvement.

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





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

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

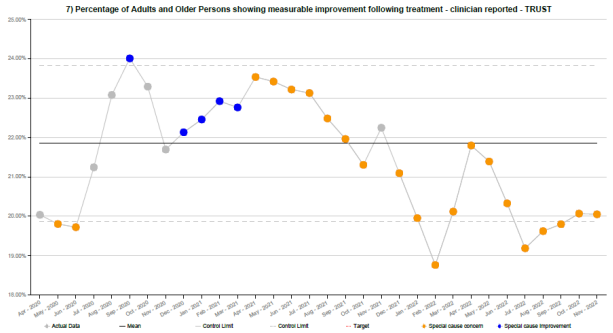
93%

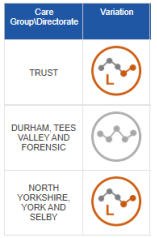
07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

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 November, **3207** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 643 (20.05%)** made a measurable improvement.

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





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

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

93%

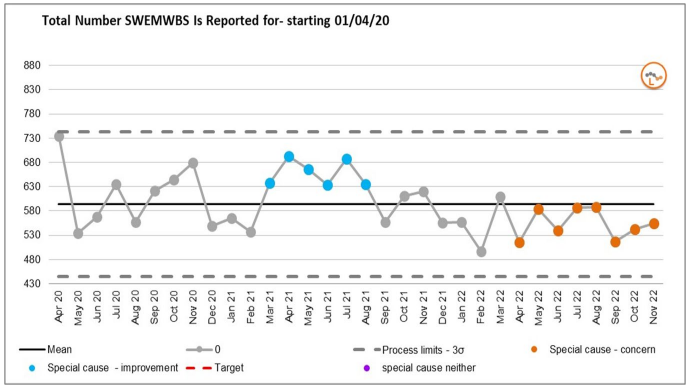
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

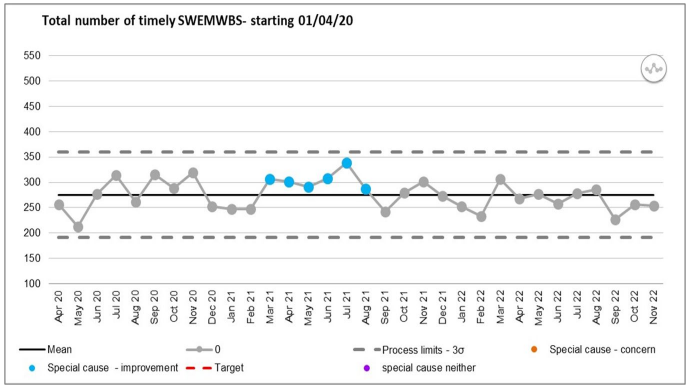
Tees, Esk and Wear Valleys NHS Foundation Trust

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. 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. Whilst the SPC is indicating common cause (no significant change) 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.





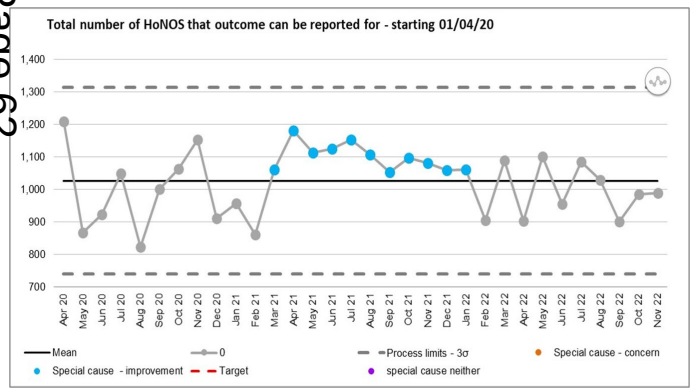
07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

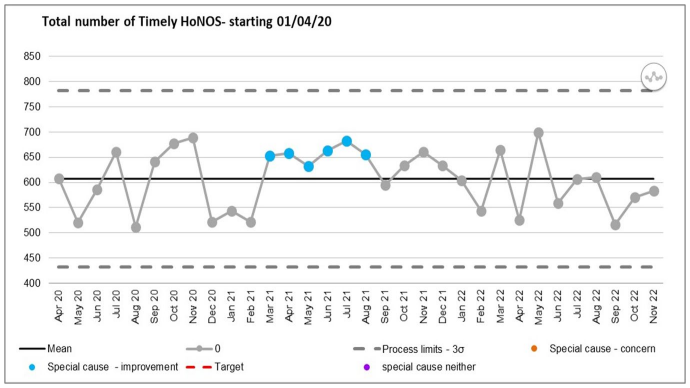
Tees, Esk and Wear Valleys NHS Foundation Trust

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 Foundation Trust

Update

At its November 2022 meeting, Trust Board agreed to implement a 55% standard for the percentage of adults and older persons showing measurable improvement following treatment - patient reported and a 30% standard for the percentage of adults and older persons showing measurable improvement following treatment - clinician reported. These standards will be implemented from the 1st December 2022.

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.	**Complete.** The briefing was completed and circulated to the November 2022 Trust-wide Outcomes Steering Group and in the November bulletin, and has been shared with both Care Groups in December 2022.	
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 group is meeting regularly and initial work has incorporated scoping a development that will bring all information that supports improved outcomes into one Integrated Information System dashboard.	
	The Cross-Specialty Task & Finish Group to oversee the development of an easily accessible and meaningful 'Outcomes Dashboard' focused on the needs of clinicians and services users. Timescale to be confirmed.		

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
There needs to be appropriate care group representatives at the Trust Clinical Network meetings 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.	It has been agreed that the AMH Care Group Medical Directors and the North Yorkshire, York & Selby MHSOP Lead Psychiatrist will attend the Clinical Network meetings. The Durham, Tees Valley & Forensics representative will be agreed at the January Clinical Network Meeting.	
Clinical teams should have regular oversight of their progress regarding outcome measures.	*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.	The Caseload Management Pilot is complete and the tool is being rolled out throughout January to March, with live reporting from April 2023.	

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

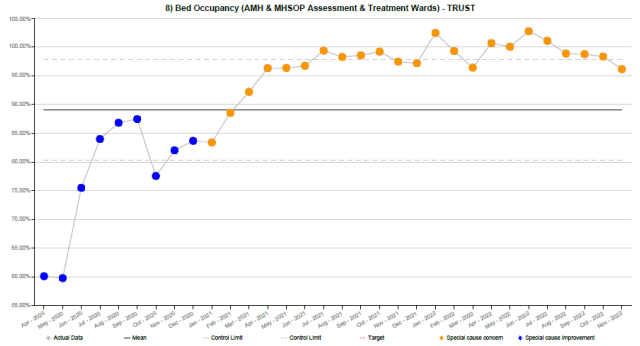
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important 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 November, **10,740** daily beds were available for patients; of those, **10,327 (96.15%)** 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

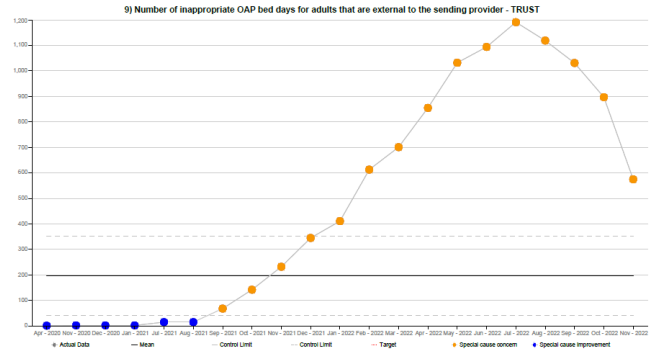
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending November, **575** 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	

Supporting Measure

		2022 - 2023								
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	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	11,190	10,450	**89,534**
	Number of available bed days	10,578	11,253	10,890	11,253	11,253	10,890	11,098	10,740	**87,955**
	Percentage Bed Occupancy	**103.29%**	**102.51%**	**104.24%**	**103.80%**	**102.12%**	**100.17%**	**100.83%**	**97.30%**	**101.80%**

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 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.	The Bed Oversight Group to oversee a full review of current bed allocation and develop new proposals for the number of beds, type, location and resource/staffing impact across the next 5 years by the end of June 2023.		
We need to ensure that our inpatient pathways are effective and support efficient management of patients from referral to discharge.	*Enabling action:* The General Manager (AMH Urgent Care) supported by the Quality Improvement Team to lead a 2-day Trust-wide rapid improvement event to redesign and relaunch the Purposeful Inpatient Admission process by the end of January 2023.		
The Advancing Our Clinical, Quality and Safety Journeys (AOCQSJ) Programme is designed to support Trust teams to improve the quality of care they deliver while making efficiency savings as per the financial recovery plan and to improve performance within key areas to enable the overarching Journey to Change.	*Enabling Action:* Programme Management Office to support the Durham and Tees Valley Adult delivery teams to manage risk to delivery by: • Assessing plans using agreed criteria • Prioritising areas that are high risk • Facilitating teams to strengthen existing plans • Facilitating data intelligence and benchmarking to establish concept and rationale, and identify top 5 actions for delivery This work will be completed by the end of March 2023.	Work has been undertaken to triangulate the Durham Tees Valley Adult Mental Health bed occupancy reduction plan (short term) to the financial recovery plan and key metrics. This will be presented to the Beds Usage Oversight Group in January 2023 with the results of the deliverability diagnostic assessment that is being undertaken.	

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

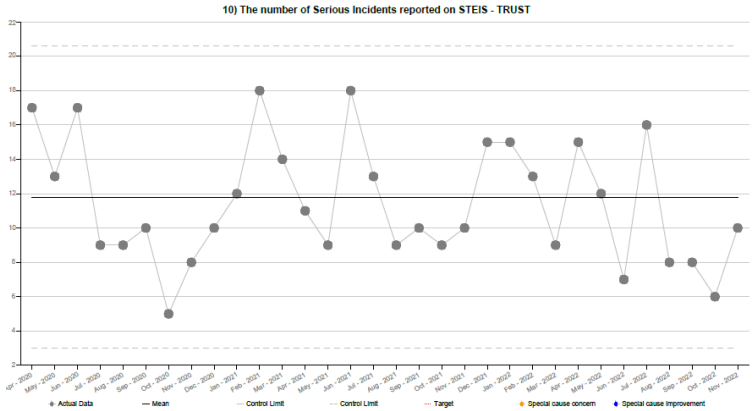
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

10 serious incidents were reported on the Strategic Executive Information System (STEIS) during November.

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%



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

Additional Intelligence in support of continuous improvement

There were no specific themes in the 10 serious incidents reported in November, although 7 were male patients. We continue to work proactively to reduce the number of Serious Incidents.

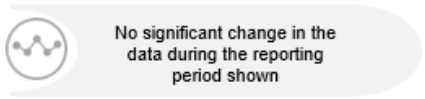
- Whilst all self-harm incidents do not lead to serious incidents, a key objective of our journey to safer care is to reduce suicide and self-harm. Having a greater understanding of our patterns and themes from self-harm will support us to reduce more serious harm from occurring. A review was commissioned 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. Some further work is to be undertaken to look at Tunstall Ward as an outlier in terms of lower numbers of incidents compared to other female wards, which may identify some areas of good practice and/or under reporting. Assurance was received regarding the actions that had been taken to reduce self-harm which included environmental improvements, protocols to guide practice and safety briefings from the review of themes. A further report will be presented to the Committee in due course on the actions to review individual patients with the highest number of incidents, which will inform and shape processes and escalation procedure. Positive feedback was received from the Quality Assurance Committee regarding this work and it is felt that it would be beneficial to share this with other MH Trusts. To oversee that work a Task & Finish Group had been established, which would report to the Quality & Safety programme, through the Suicide and Self-harm Reduction Group and then through to Quality Assurance & Improvement Group and Quality Assurance Committee.

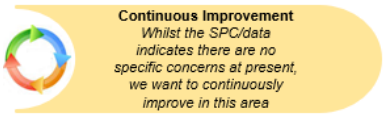
11) The number of Incidents of moderate harm and near misses

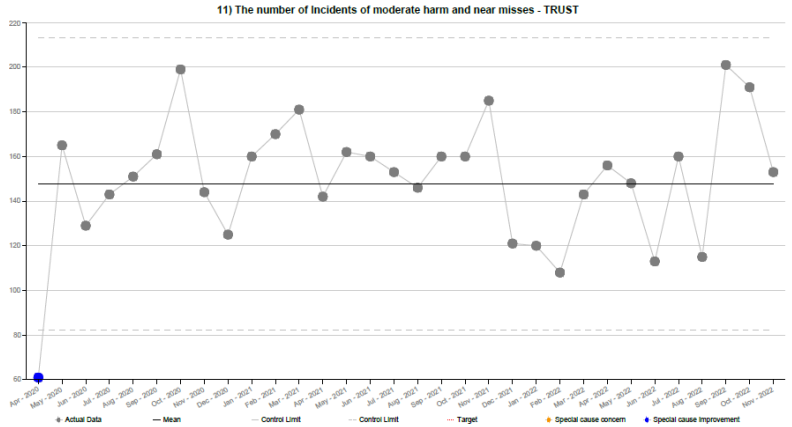
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.

153 incidents of moderate harm or near misses were reported during November.







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
The number of incidents being reported is being impacted by the decline in the percentage of crisis calls answered since the crisis lines were introduced, due to a range of issues including capacity and demand, system wide challenges, staff sickness and recruitment challenges. We need to better understand whether this is impacting this measure.	*Enabling action:* Head of Performance to engage to with the Urgent Care Pathways Lead and the Patient Safety Team during November 2022 to identify whether this is a concern and the improvement actions that are being established.	**Complete.** Engagement with the Urgent Care Pathways Lead and the Patient Safety Team has confirmed this is a factor impacting on our incidents of moderate of self harm; however data analysis has been unsuccessful in identifying any specific concerns.	

Additional Intelligence in support of continuous improvement

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 Project Management Office support. This work reports 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.

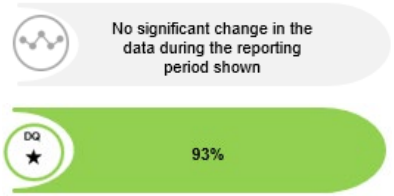
Progress on the crisis offer is discussed at Executive level on a weekly basis and we will continue to review the data to ensure that we address any emerging issues. We are confident that we are taking all possible steps to improve our crisis line answer rates.

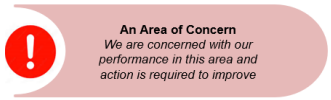
12) The number of Restrictive Intervention Incidents

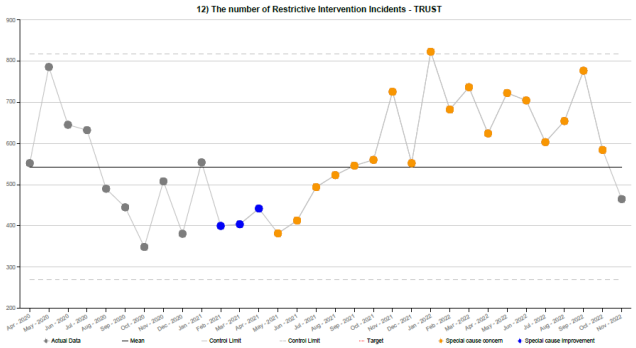
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

465 number of Restrictive Intervention Incidents took place during November.







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: • 2 patients from Bankfields will be discharged by the end of January and February 2023 respectively. • 1 patient at Lanchester Road will be transferred to Bankfields, pending the discharge of the patients above. However, a community placement is the preferred option and is still being actively explored; a provider is in place but a placement has not been confirmed. • 1 patient at Lanchester Road Hospital will now be discharged in January 2023, provided a support team can be recruited by the identified provider. • 2 further patients within Bankfields have identified providers and placements; transition plans are being developed and discharge is expected to be in quarter 1 2022/23. • 1 patient has an identified provider but no placement • 1 has no provider or placement identified. The service is receiving bespoke support in Bankfields from an independent provider to expedite transfers. The Positive & Safe Dashboard has confirmed that the majority of the interventions are in respect of 3 patients with complex needs.	

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS Foundation Trust

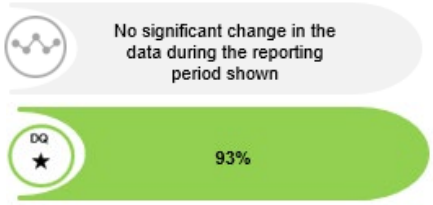
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Following feedback from the Care Quality Commission, we have identified a training need within our Adult Learning Disability services.	The General Manager and Associate Clinical Director to ensure all Adult Learning Disabilities Inpatient staff attend the bespoke training by December 22.	51% of staff have now been trained. Additional training events have been established and the Positive & Safe Care Team are working with the services to prioritise attendance and ensure all staff are fully trained by the end of January 2023.	
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	**Complete.** Independent Assurance Panels have been in place for three months and an initial review indicates these have had a positive impact in supporting clinical teams, identifying immediate concerns and providing teams with alternatives they may want to consider. Initial feedback has indicated it is valuable to continue these panels over the next 12 months with routine reviews undertaken as part of the Trust Positive and Safe Plan.	
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.	**Complete.** The gap analysis has been completed and will be tabled at the Care Group Positive & Safe meetings in January, following which any improvement actions will be identified.	
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 & Safe Groups at Care Board level are established and are on track 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. A business case will be developed by the end of December 2022.		

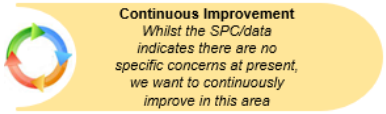
13) The number of Medication Errors with a severity of moderate harm and above

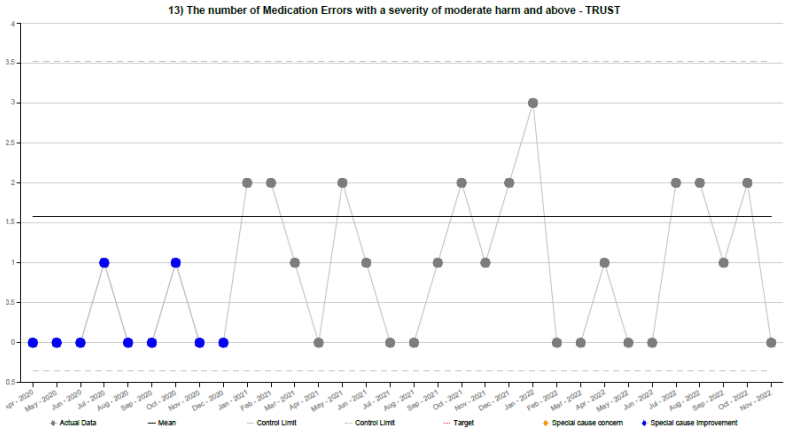
Tees, Esk and Wear Valleys NHS Foundation Trust

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 November.







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 27 overall improvement actions identified. Of these, 17 have been completed and the remaining 9 are all on track for delivery (1 new action and 1 completed since last month).	
Depot antipsychotic injections are linked to 3 of the incidents above.	The Safe Medication Practice Group has co-created a set of depot-focused improvement actions. This will include a complete revision of the depot procedures by January 2023.	There are 8 improvement actions identified. Of these, 5 have been completed and the remaining 3 are on track for delivery.	

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

Tees, Esk and Wear Valleys NHS Foundation Trust

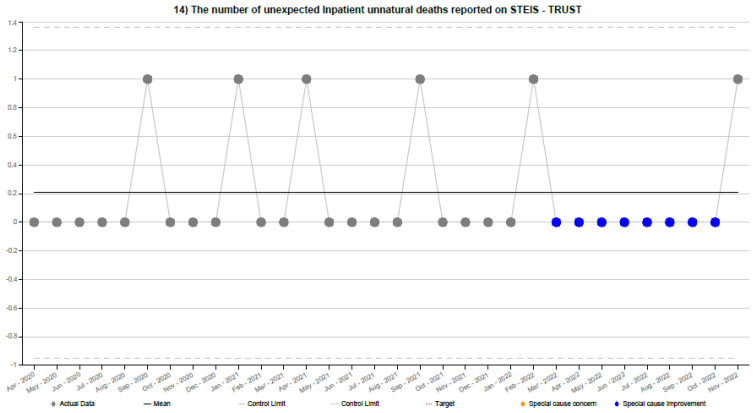
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements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

1 unexpected Inpatient unnatural deaths reported on the Strategic Executive Information System (STEIS) during November.

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
Quality Governance has led a collaborative review with clinical services to refresh the tools within the Quality Assurance Schedule. This included consideration of new themes emerging from a review of the cohort to serious incidents, feedback from clinical services and practice standards that have been consistently achieved (and can be therefore removed from the schedule at this time). From that review and individual patient risk assessments from recent serious incidents, it is evident that the quality of risk assessments has improved across the organisation. However, there is new evidence emerging that leave plans are not always sufficiently robust.	*Enabling action:* Quality Governance team to review a sample of leave plans as part of the Quality Assurance Schedule work on a monthly basis from January 2023 to enable any immediate improvement actions to be identified and undertaken by inpatient teams.		

15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

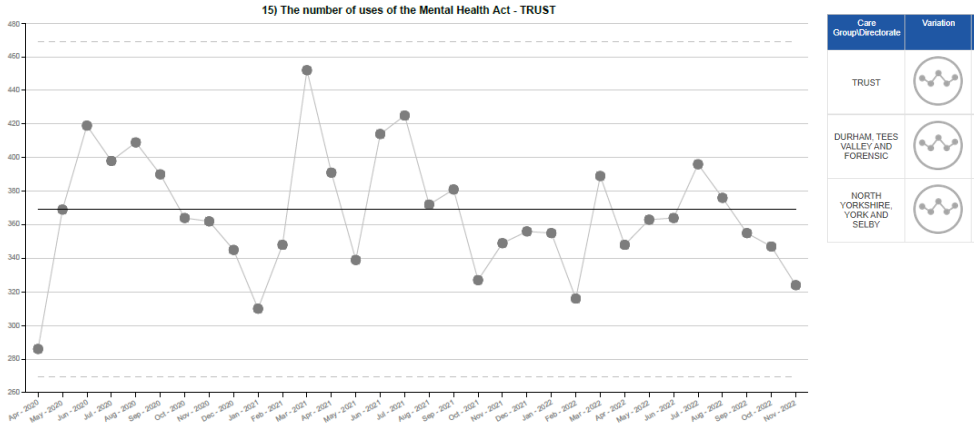
We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers,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

There were **324** uses of the Mental Health Act during November.

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
As a result of monitoring and analysing this measure, we have identified through the IPA process, that some refinement is required.	Head of Performance to engage with the Head of Business Intelligence and Mental Health Act teams by the end of January 2023 to review the measure proforma and action a change request.		

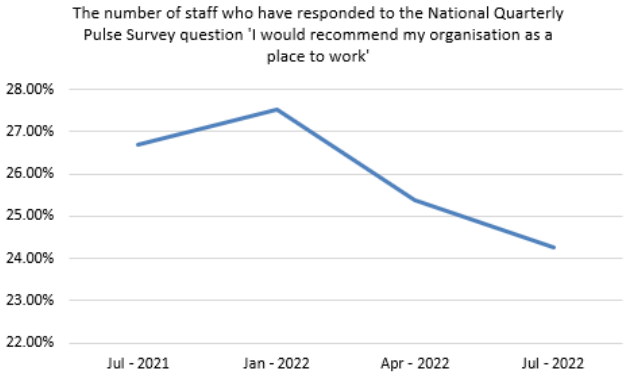
16) Percentage of staff recommending the Trust as a place to work

Tees, Esk and Wear Valleys 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.

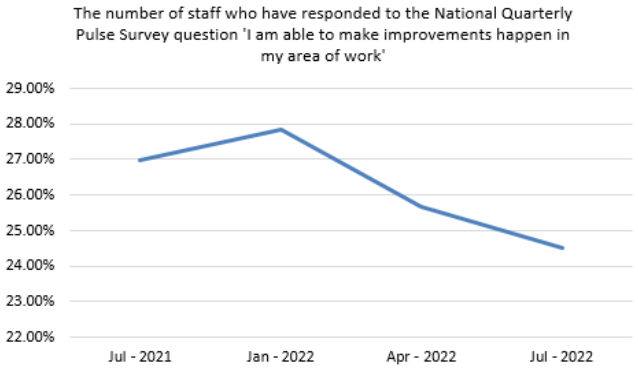
17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS 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

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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 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~~ December 2022 for a period of 3 months.		
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 has completed final participation was 43.22%. Analysis is still to be undertaken to assess whether the incentive schemes were successful but whilst the response rate is lower than 2021, there were a number of different factors influencing that.	
	Enabling action: The Organisational Development Facilitator – Staff Experience to lead an awareness campaign throughout October and November 2022 to encourage staff to complete the staff survey.	**Complete.** All site visits were completed to help staff understand how speaking up using the various forums across the Trust can help shape change.	

18) Staff Leaver Rate

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

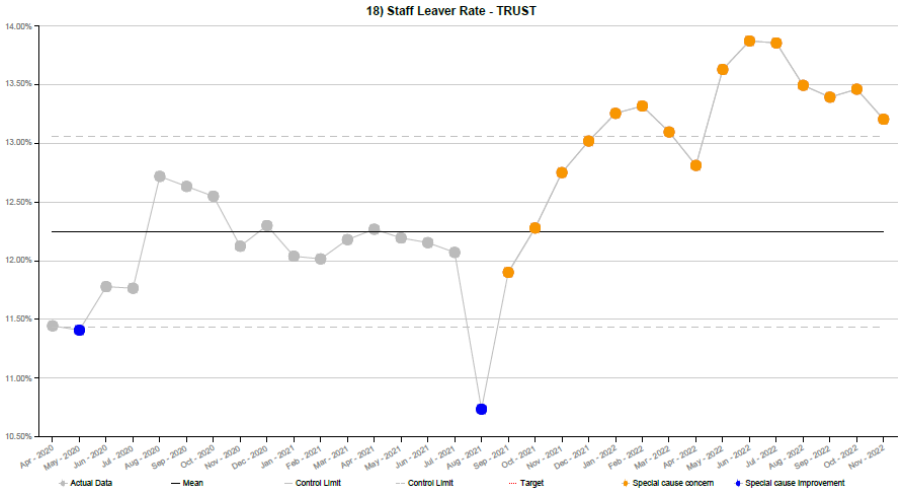
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

From a total of **6818.66** staff in post, **900.25 (13.20%)** had left the Trust in the 12 month period ending November

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

DQ
80%

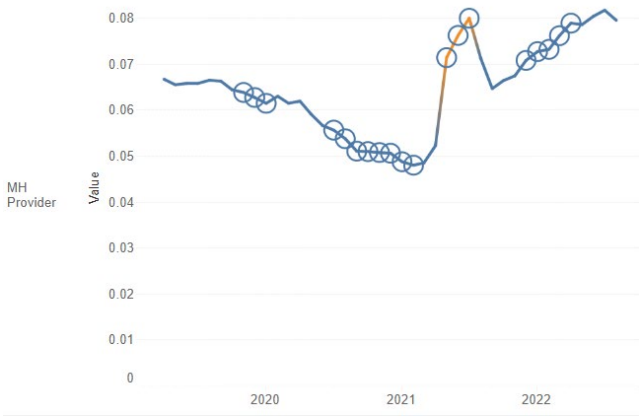
An Area of Concern
We are concerned with our performance in this area and action is required to improve



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	L	NURSING AND GOVERNANCE	H
DIGITAL AND DATA SERVICES	H	PEOPLE AND CULTURE	L
DURHAM, TEES VALLEY AND FORENSIC	H	THERAPIES	H
ESTATES AND FACILITIES MANAGEMENT	H		

National Benchmarking: NHS Staff Leaver Rate - England Mental Health and Learning Disability – August 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. We were ranked 11 of 71 Trusts (1 being the best with the lowest leaver rate) and are placed in the highest performing quartile range.



18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
To understand whether the “thinking about leaving” group is having an impact on staff who may be considering leaving	*Enabling Action:* Employee Support Service to combine the data from the forms that come in, the group and the independent interviews and produce shared learning. Timescales for completion of this work are to be confirmed.		

19) Percentage Sickness Absence Rate

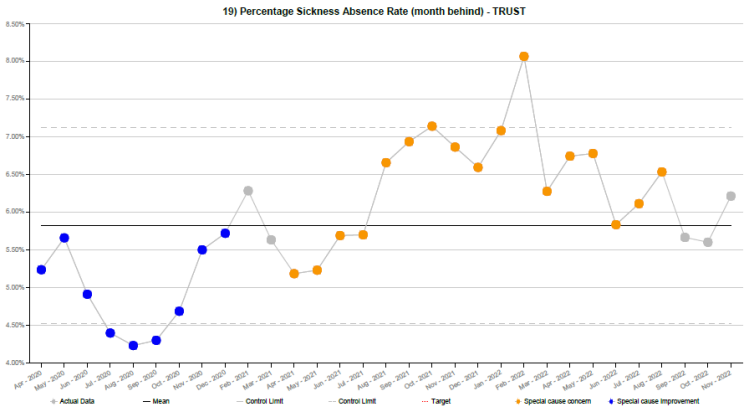
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

There were **222,013.74** working days available for all staff during October (reported month behind); of those, **13,795.89 (6.21%)** 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

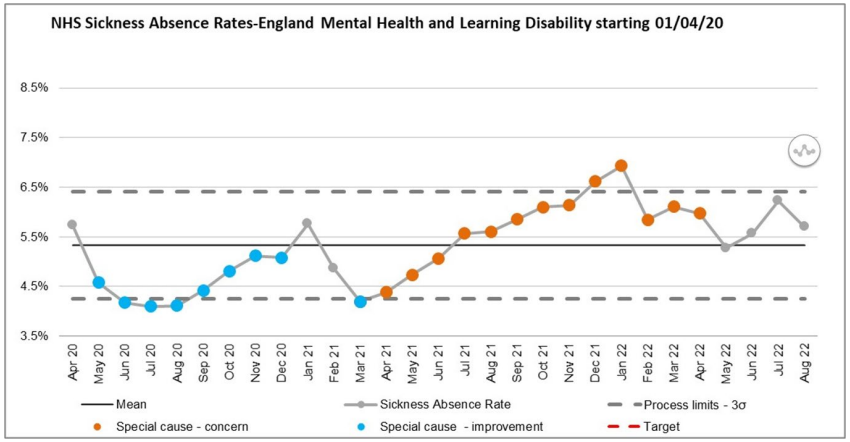
DQ 87%



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

NHS Sickness Absence Rates published 5th January 2023 (data ending August 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 5.32% compared to the Trust mean of 5.7%.

Regional Benchmarking: We have seen a rise in our sickness absence rates during November and as at the 20th December 2022, we were positioned 5th (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), it is now above the 5.83% mean (average) for the period shown and 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 21st December 2022, sickness absence is 6.25% for December 2022.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys 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.	The review has started in December 2022, with an initial action identified below.	
	Enabling Action: Associate Director of People & Culture and Associate Director of Operational Delivery and Resourcing to oversee the implementation of increased monitoring of sickness data and trends from January 2023 with a view to providing targeted interventions and support for teams struggling with sickness.	Increased monitoring is underway with support to be in place for identified teams by the end of January 23.	
We need to better understand improvements made in some areas to enable lessons learned to be shared with other services.	*Enabling Action:* The Executive People Culture & Diversity group to identify improved support for teams that have a number of members of staff absent from work due to sickness at the same time, by the end of December 2022.	**Complete.**	

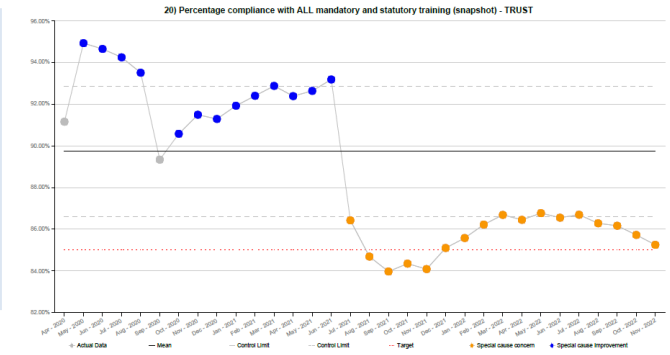
20) Percentage compliance with ALL mandatory and statutory training

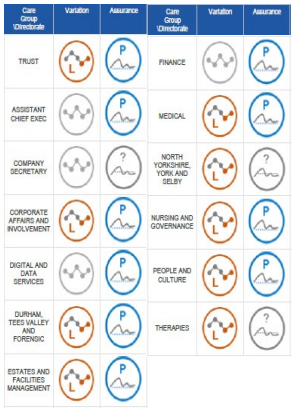
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.

106,707 training courses were due to be completed for all staff in post by the end of November. Of those, **90,972** (**85.25%**) 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 November, **6746** were due for completion, **6067 (89.93%)** 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

Our system is expected to consistently hit the target/expectation

93%

Update

An issue has been identified this month in respect of the Observations & Engagement training, which was incorrectly allocated to some staff. This has been corrected immediately and will be reflected in the December 2022 report.

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.	**Complete.** Trust-wide Mandatory Training reports are shared with the Care Groups and Corporate Directors on a fortnightly basis.	

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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 to review the information being provided to General Managers at the December 2022 meeting to ensure they are receiving the information they need to support improved compliance.	**Complete.** All information has been reviewed and streamlined to enable Managers to support improved compliance levels.	
	Enabling action: Workforce Team to proactively contact all teams with less than 85% compliance for their overall training and those services where face to face/ patient safety training is under 85% from December 2022, with a view to supporting increased compliance.	The Principle People Partners are linking in with the Workforce Development Team to ensure those teams with lower levels of compliance are supported to achieve their trajectories.	
Information Governance training – Data Security Awareness Level 1 compliance has been impacted due to clinical/operational pressures	Education and Training team to offer face to face Information Governance training out of hours during January and February 2023 to support staff improved compliance.		

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys 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.

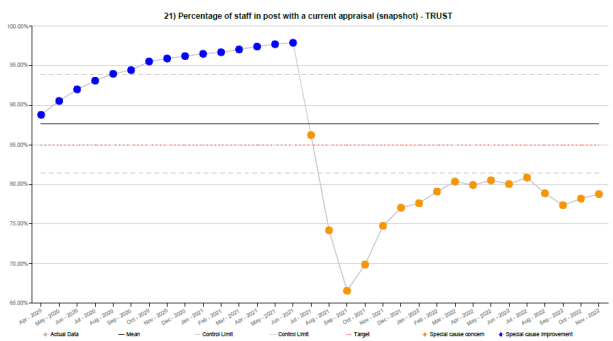
Of the **6361** eligible staff in post at the end of November; **5011** (**78.78%**) had an up to date appraisal

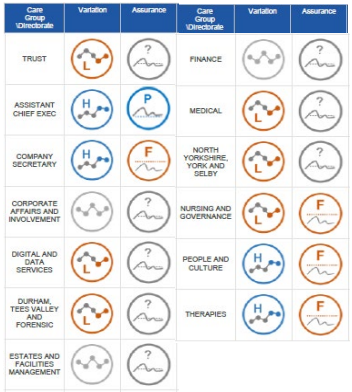
We're aiming to have high performance and we're moving in the wrong direction.

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

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

DQ 93%





Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to better understand why appraisals are not being undertaken in a timely manner in a number of our services.	*Enabling action:* Executive Director for People, Culture & Diversity to contact all Directors whose directorates are not achieving 85% compliance during December 2022, to understand the underlying reasons for non compliance with a view to identifying key improvement actions.	**Complete.** Directors were contacted in December; no particular themes or concerns were identified.	
	Enabling action: Organisational Development to review all teams with compliance rates between 75% - 85% by the end of February 2022, to identify any specific areas of support that are required.		

22) Number of new unique patients referred

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

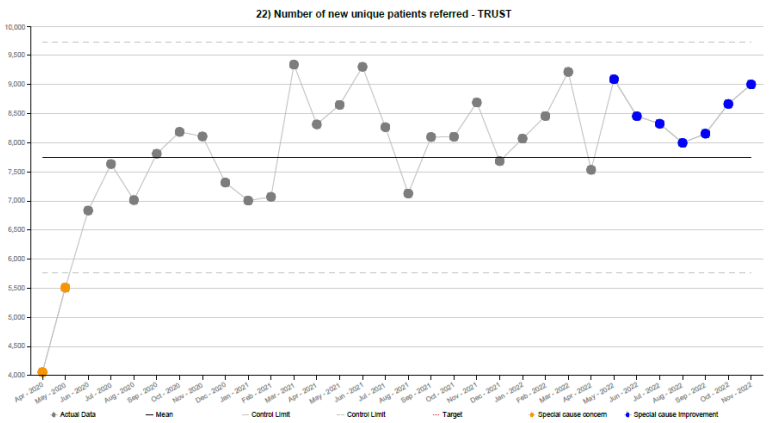
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

9003 patients referred in November that are not currently open to an existing Trust service

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

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	

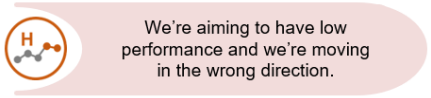
There are currently no specific trends or areas of concern identified within this measure.

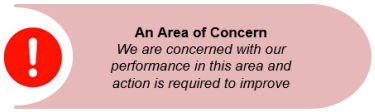
23) Unique Caseload (snapshot)

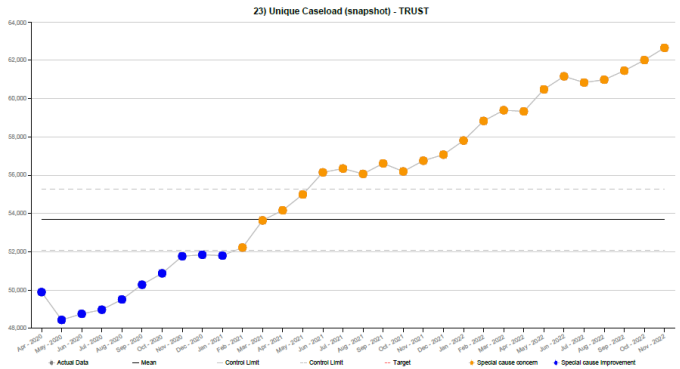
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

62,650 cases were open, including those waiting to be seen, as at the end of November 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*: Task & Finish Group to progress the first phase of analysis at team level to identify which specific teams are indicating a concern. Timescales to complete this phase will be confirmed once the initial scoping has been completed by Digital and Data Services.	The team-level Statistical Process Control charts have been validated and a number of teams highlighted for further investigation in order to be able to confirm they are a concern. This wider intelligence gathering will be complete during January 23.	

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. The programme of team caseload 'deep-dives' is nearing completion for a number of teams in CAMHS; that in Scarborough will start in January and will be followed by one in Selby. Feedback on the Caseload Management Policy within Adult Services has been positive and the pilot will be completed in December and rolled out in January 2023.

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 **£6.9m** deficit (to break even) to 30th November 2022 against a planned year to date surplus of **(£0.3m),** resulting in a **£7.2m** 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 **£6.9m** against a planned year to date surplus of **(£0.3m),** resulting in a **£7.2m** variance to plan., representing **higher than planned expenditure.** Key observations for November were:

- **Independent sector beds** - the Trust required 164 bed days during November 2022 (246 for October 2022) at a cost of £0.1m (includes estimates for unvalidated periods of occupancy and average observation levels pending billing). This was a reduction in 82 bed days. Year to date expenditure was £3.0m, or £2.7m above plan. Plans assumed no use of spot purchased beds during 2022/23 and no block contracted beds beyond quarter one (£0.3m costs assumed in quarter one only). Block contracting was terminated from the 1st October, with additional capacity being spot purchased. This remains a key area of clinical and management focus.
- **Agency expenditure** as at November 2022 is £14.3m, which is £7.8m ahead of plan and includes material costs linked to inpatient occupancy and rosters, medical cover and complex specialist packages of care.
- **Computer hardware, software and maintenance** Computer Hardware is £2.3m ahead of plan. This is partly offset by a surplus to plan on computer software and maintenance of (£1.0m), resulting in a net deficit to plan of £1.3m, with mitigating actions in train.
- **Planned CRES performance** as at November 2022 is behind plan by £2.8m, however unplanned schemes to the value of £1.1m provide a partial offset, resulting in net CRES performance that is £1.6m 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.
- **Pay Award** – Since September 22 Trusts have accounted for the nationally negotiated pay awards (including arrears for month 1 to 5 in month 6). Costs are partly offset by an inflationary tariff uplift of 1.66%, or £4.5m to month 8, resulting in a net pay award pressure of £2.2m (£3.3m full year). 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.
- **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.
- **International Recruitment** – Exceptional costs associated with international recruitment of £0.047m in Month 8. Future months costs are still to be determined with a business case in train.

To deliver plan requirements the Trust needs to mitigate 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 commenced in October and will be ongoing with risks and mitigations to the deliverability of the planned surplus identified. Care Group Inpatient Roster review meetings took place 5th December 2022	Run rates for complex packages reduced following discharge. (Expected to reduce further with transition to reduced rate on framework agency). 40 fewer agency shifts in November compared to October.
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 cost of Computer Hardware is high and we need to mitigate overspend in this area.	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.	Comms released w/c 28th November to support centralised asset management processes.	Centralised CIO / Deputy CIO level approvals for all hardware to improve resource and asset management
Independent Sector Bed and agency staffing pressures 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 - 25a) Agency & 27) CRES Performance – Recurrent*		

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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 £14.3m is £7.8m **(118.25%)** higher than target.

F Our system is not hitting the target/expectation

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

Summary

Agency expenditure of £14.3m is £7.8m (118.25%) higher than target. Expenditure limits have been set for each ICB derived from 2022/23 provider financial plans, but with a minimum reduction of 10% from 2021/22 and maximum of 30%. The Trust's plans assumed agency costs of £9.3m (fixed as our share of the ICB agency cost cap) for 2022/23 or £6.6m YTD resulting in a breach of this cap by £7.8m.

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.

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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 November 2022 there were 4,037 agency shifts worked, with 2,664 shifts compliant **(66%).**

F Our system is not hitting the target/expectation

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

Summary

During November 2022 4,037 agency shifts were worked (40 fewer than October).

Of these, 2,664 or 66% shifts were compliant (66% compliance prior month).

Of the non-compliant shifts 1,097 or 27% breached price caps (an improvement of 1,185 shifts and 29% prior month) and 276 or 7% breached framework compliance (up from 216 shifts and 5% prior month).

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.

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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		

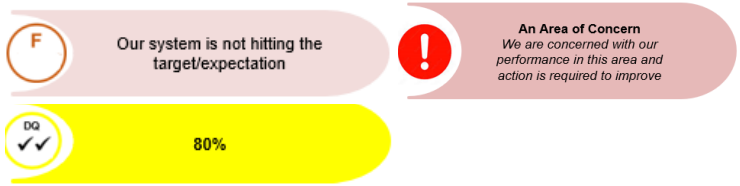
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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 November 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. The Trust has continued to assess the UoRR based on plan submissions compared to actual performance.

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity of minus 0.29x, which is 1.74x £8.3m behind plan and is **rated as a 4**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 24.7 days; this is behind plan by 6.5 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 2.3%, this is worse than plan by £7.2m and is **rated as a 4**.
- The **agency expenditure** metric assesses agency expenditure against a capped target for the Trust. Costs of £14,326k are £7,762k (118.25%) higher than plan, and would be **rated as a 4**.

Specifically for agency please refer to **25a) Financial Plan: Agency expenditure compared to agency target & 25b) Agency price cap compliance**

The Trust's financial performance results in an **overall UORR** of **3** for the period ending 30th November 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

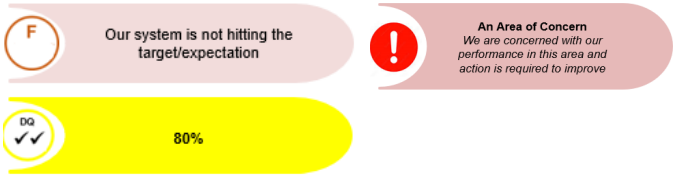
27) CRES Performance - Recurrent

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 **£7.1m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£5.5m**.

£1.6m 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 £1.6m behind plan with specific performance noted as:

- £0.6m CRES for OAPs contracted bed elimination is behind plan
- £1.7m CRES for agency rate compliance and usage reduction is behind plan
- £0.2m CRES for Crisis Line support from Vale of York CCG is behind plan
- £0.3m CRES for reduction in covid measures is behind plan
- £0.7m CRES for interest receivable and is ahead of plan
- £0.3m CRES for PDC
- £0.2m 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.

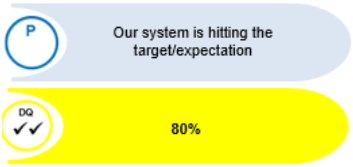
28) CRES Performance – Non-Recurrent

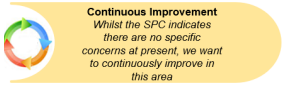
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 **£0.9m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£0.9m**.

(£0.0m) favourable 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.

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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 November was **£5.0m** against planned expenditure of **£6.5m**

£1.5m underspend against plan.

Summary

Capital expenditure at the end of November was **£5.0m**, and is **£1.5m** lower than plan of **£6.5m**. This includes slippage on lifecycle and health and safety works, which are offset by an overspend on Teesside patient safety works. Work on LD environments (Park House and Bankfields Court) is forecast to defer into next financial year as the Trust's proposed model of care is revisited. Slipped health and safety works schemes have been re-programmed and are overseen at Environmental Risk Group.

The Trust expects to capitalise grouped, networked IT assets and to deliver capital expenditure in line with plan, but with some risks relating to planning approvals for U&EC externally funded capital schemes. Subject to pending confirmation of new in-year funding for Frontline Digitisation, the Trust may underspend against overall capital allocation.

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.

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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 have reviewed the forecast to accommodate accounting for grouped IT assets and central ICB management of a projected aggregate over spending. Subject to pending confirmation of new in-year funding for Frontline Digitisation, the Trust may under spend against overall capital resources. ICB to be made aware of forecast implications to manage position at partner level.	Initial review completed with feedback provided to ICB partners to inform collective risk management. Key residual actions include evidence collection to support capitalisation of IT grouped network assets. Current forecast is to breakeven with plan.	

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

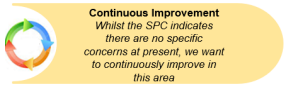
30) Cash balances (actual compared to plan)

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 **£74.8m** against a planned year to date cash balance of **£77.2m.**

£2.4m adverse variance from plan



Summary

Cash balances were **£74.8m** at 30th November 2022, which is **£2.4m** lower than plan of **£77.2m**. This is linked to the Trust's deficit financial position, which is being offset by underspends on capital and working capital variances to plan.

The Trust did not achieve the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of NHS suppliers, but did to meet the target for non-NHS suppliers during November, achieving a combined BPPC of 94%. 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 at 30th November 2022 was £2.9m. The amount over 90 days overdue is higher than targeted (£0.6m excluding amounts being paid via instalments and PIPS loan repayments), but 5 suppliers account for 70% of this total and we have not been notified of challenge for the values. Progress is being made to receive payment for the remainder.

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

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

NHS
Tees, Esk and Wear Valleys
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?

NHS
Tees, Esk and Wear Valleys
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?

NHS
Tees, Esk and Wear Valleys
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 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 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	Q3 (Oct-Nov)	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	1029	575	575
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	1094	1029	575	575
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours.	85%	91.69%	88.60%	85.85%	88.97%
Data Quality Maturity Index	93.00	97.50	97.30	97.00	97.00

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 Foundation Trust

There are **5** measures at risk of delivery at quarter 3, of which **4** are at risk of delivery for the financial year.

Measure	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	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	2209	1788	6825
IAPT: The proportion of people who are moving to recovery	50.00%	52.97%	52.54%	47.99%	51.60%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	28.43%	30.70%	15.30%	26.23%
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%	37.50%	52.05%	64.62%	64.62%
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)	Q1 55% Q2 75% Q3 95% Q4 95%	73.91%	88.89%	91.18%	91.18%
Number of people accessing IPS services as a rolling total each quarter	169 at Quarter End	140	138	116	

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy Percentage of people who have waited more than 90 days between first and second appointments			
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.	**Complete**. 1.4 wte agency PWP is now contracted until the end of June 2023; however further recruitment has been placed on hold at this point pending system-wide discussions to address the recruitment challenges. Pending further recruitment the trainee cohorts are being used to support these posts.	Whilst a slightly increasing position is visible since September 2022 when the first trainee cohort started, this does not denote an actual improvement.

Long Term Plan Ambitions - County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy Percentage of people who have waited more than 90 days between first and second appointments			
We are concerned that the recruitment challenges are masking any further issues that may be impacting on our access rates.	*Enabling Action*: Senior Performance Manager and IAPT Service Manager to conduct an in-depth review by the end of January 2023 to understand all circumstances impacting on our achievement of the agreed trajectories and to identify any further improvement actions.		
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.	3 applicants are now progressing through recruitment. In the interim, an additional workshop will be provided in January and will be supported by the current Trainee PWP cohort.	
IAPT: The proportion of people who are moving to recovery			
We need to understand why a number of our IAPT patients are not moving to recovery.	*Enabling Action*: IAPT Team managers to conduct a deep dive of November data by end of January 23 to gain an understanding of any underlying issues and identify any improvement actions that need to be put in place.		
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment			
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 (CDDFT) 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.	CDDFT have raised a number of queries in respect of the proposed agreement, which the Service are addressing. The Service response will be provided by the end of January 2023.	

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Number of people accessing IPS services			
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.	**On hold:** Following discussions and detailed analysis, a data quality issue has been identified that must be resolved before the paper can be completed.	
A number of interventions have been recorded using incorrect codes; these require resolution to enable us to understand the impact on this measure.	IPS Service Manager to facilitate correction of those IPS contacts that have been incorrectly coded by the end of January 2023, to ensure all IPS staff are correctly recording their activity.	Over 50% of incorrect coding has been corrected and all IPS advisors are now aware of the correct codes to use and have been shown how they can verify the information they have entered.	
	Enabling action: Paris Team to investigate options to enable IPS staff to be easily identified within Paris by the end of January 2023. This will facilitate improved reporting, ensuring that only IPS contacts by IPS staff are counted within this measure.		

Long Term Plan Ambitions – Tees Valley Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **6** measures at risk of delivery at quarter 3, of which **4** are at risk of delivery for the financial year.

Measure	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	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	436	358	1394
IAPT: The proportion of people who are moving to recovery	50.00%	52.41%	54.14%	47.69%	51.91%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	30.05%	33.60%	18.96%	29.04%
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%	85.29%	85.29%
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%	66.67%	66.67%
Number of people accessing IPS services as a rolling total each quarter	216 at Quarter End	166	186	132	
Percentage of adults discharged from Sub-ICB location-commissioned mental health inpatient services receive a follow-up within 72 hours.	85%	89.93%	89.97%	82.69%	87.97%

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Percentage of adults discharged from Sub-ICB location-commissioned mental health inpatient services receive a follow-up within 72 hours			
We need to understand why a number of our patients in our Adult Mental Health Service have not been followed up within 72 hours of discharge from our adult inpatient services.	*Enabling action:* Business Manager to establish a consistent, robust process for weekly monitoring across all teams with a view to improving compliance. The process will be tabled at the December Improvement and Delivery Group for approval.	A new standard process has been agreed and is being piloted in a small number of teams. Feedback from the pilot will be shared at the January AMH Urgent and Planned Care Improvement & Delivery Groups with a view to rolling out across the speciality.	

Long Term Plan Ambitions – Tees Valley Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

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 Foundation Trust

There are **9** measures at risk of delivery at quarter 3, of which **5** are at risk of delivery for the financial year.

Measure	Agreed Sub-ICB location Ambition	Q1	Q2	Q3 Oct-Nov		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	8272	1676	1816	1296		4788
IAPT: The proportion of people who are moving to recovery	50.00%	50.05%	49.23%	43.52%		48.00%
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Q1 55% Q2 60% Q3 70% Q4 80%	57.81%	58.93%	63.16%		63.16%
Number of people accessing IPS services as a rolling total each quarter	123 at Quarter End	60	78	74		
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 71 Q2 142 Q3 213 Q4 284	70	96	118		118

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy			
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 to GP practice websites. To improve referrals from these practices, the service have created a plan and are awaiting feedback from commissioners prior to progressing.	

Long Term Plan Ambitions – North Yorkshire Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
IAPT: The proportion of people who are moving to recovery			
We need to understand why a number of our IAPT patients are not moving to recovery.	*Enabling Action:* North Yorkshire IAPT Team managers to conduct a deep dive of October data by end of December 2022 to gain an understanding of any underlying issues and identify any improvement actions that need to be put in place.		
Percentage of people who have waited more than 90 days between first and second appointments			
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).	2 HIW posts remain vacant and are to be readvertised. The recruitment for the PWPs has been placed on hold at this point to avoid over-establishment as the service is in the process of recruiting 9 trainee PWPs to start with the service in March 2023.	
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment **The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment**			
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.	

Long Term Plan Ambitions – North Yorkshire Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment			
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.	The business case is complete. This was due to be presented to the December 2022 North Yorkshire, York & Selby Quality Assurance & Improvement Subgroup, but has been delayed to January 2023.	
Number of women accessing specialist community PMH services			
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.	Three members of staff have been recruited; 2.6 have been readvertised, 1 of which is being interviewed during December 2022.	
Percentage of people experiencing a FEP treated with a NICE approved care package within 2 weeks of referral			
We need to minimise the delay in allocating a care coordinator for our Early Intervention in Psychosis (EIP) patients.	EIP Service Manager and Team Managers to embed the requirements of the standard through the weekly performance huddles in November 2022, to increase staff awareness with a view to minimising the delays.	**Complete.** A refresher session to understand the EIP standard took place on the 15th November. Performance will now be monitored closely by the Service Manager through the weekly EIP performance huddle.	No visible impact; however it will take time for the process to be embedded.
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 Foundation Trust

There are **5** measures at risk of delivery at quarter 3, of which **4** are at risk of delivery for the financial year. **1** further measure is at risk of delivery at financial year.

Measure	Agreed Sub-ICB location Ambition	Q1	Q2	Q3 Oct-Nov		FYTD
Total access to IAPT services - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	6282	1441	1405	1216		4062
Percentage of people who have waited more than 90 days between first and second appointments	<10%	17.65%	15.52%	12.74%		15.62%
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	Q1 55% Q2 60% Q3 70% Q4 80%	56.34%	60.00%	58.33%		58.33%
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 60 Q2 120 Q3 180 Q4 240	49	71	86		86
Percentage of people experiencing a FEP treated with a NICE approved care package within 2 weeks of referral	60%	63.33%	77.78%	55.17%		65.12%

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
IAPT: The proportion of people who are moving to recovery			
We have a significant number of patients under the age of 25 that are not moving to recovery.	*Enabling Action:* Service Manager to agree a pilot with commissioners by the end of November 2022 for a new service pathway for under 25s that will include increased face to face appointments, with a view to improving recovery rates.	We are awaiting confirmation from commissioners to progress the pilot.	

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Percentage of people who have waited more than 90 days between first and second appointments			
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. 2 HIT posts were due to commence in January, one has now withdrawn. 1.4 posts will be readvertised in January 2023. 3 trainee PWPs were recruited in October and these will support the team's capacity from January 2023.	
There are currently administrative vacancies within the team, which are impacting clinical capacity as clinical staff must factor time into their day to arrange appointments.	Service Manager to lead recruitment of 1.6 wte Administrator. This will be completed by January 2023.		
Percentage of people experiencing a FEP treated with a NICE approved care package within 2 weeks of referral			
The team's capacity to assess and commence treatment for people experiencing a first episode of psychosis is currently being impacted by 3 staff vacancies, maternity leave and long term sickness absence.	Pending recruitment to the substantive vacant posts, the York & Selby team manager to recruit 3 agency members of staff to improve staffing capacity from December 2023.		
For all Access to IAPT commentary, please see the Long Term Plan section for North Yorkshire Sub-ICB Location			
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			

Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report

Report Date: January 2023	**Report of: The Audit and Risk Committee (ARC)**
Date of last meeting: 12th December 2022	**Membership Numbers: 5** Quoracy met up until 12.25pm. Informal meeting continued until 12.53pm

Agenda: The Committee considered the following matters:

Cross Cutting issues
An update from the Executive Risk Group.
Risk Management Framework
Monitoring of the implementation of the new Risk Management Policy across the Care Group Boards
Board Assurance Framework
Outcome of counter Fraud Cases relating to staff working whilst on sick leave
Report on the long-standing issues relating to patient property, money and valuables
Outcome of the Financial Sustainability Review
Outcome of the NHSE/I Diagnostic Review
Tender Waiver Report
Progress with the Quality Assurance Programme (Clinical Audit)
The Counter Fraud Progress Report
The Internal Audit Progress Report
The External Audit Progress Report
Summary report of the findings for TEWV General Charitable Fund
The Annual Report and Accounts of the Charitable Funds 2021/22
For information – the Information Commissioners Office (ICO) Audit Action Plan
Internal Audit Benchmarking Exercise on Audit Committee Agendas
The Committee's Assurance Tracker

2a	**Alert**	The Committee wishes to alert the Board to the following issues: • Considering the feedback from NHSE/I Intensive Support Diagnostic, the Committee recognises that there is further work required – this includes developing a robust workforce plan, re-energizing improvement work, expanding the quality assurance systems, continuing with restrictive intervention support and training and coaching be provided to members of the Board of Directors and Sub-Committees. Three members of the Support team will continue to work with the Trust until the end of March 2023. The Committee sought further assurance that the current review underway of the governance arrangements and embeddedness of the organisational structure be reflected in the recommendations. • The Counter Fraud Progress Report highlighted updates on the three tasks outstanding relating to local proactive exercises (LPE's) within the areas of 'Anti-Bribery Management Systems (AMBS)' manipulation of ERostering/Timesheets and reciprocal authorisation of bank shifts, which have all had implementation dates extended to January 2023. • There are two new allegations of fraud, both relating to a patient altering a prescription to obtain more medication, which have been referred to the police. • The **Committee approved changes to the agreed 2022/23 Internal Audit Plan** relating to serious incident investigation/management, Integrated Information Centre (IIC) cyber incident response process and CiTO – system readiness: staff training.

		• Two issued final audit reports relate to 'Temporary Staffing and Patient Experience' with "good assurance" and 'Quality Framework', an advisory audit, which is not assigned an assurance rating but has been given five medium priority recommendations for management action, namely duplication of reporting to the Quality Assurance Committee through the Trust level quality and learning report and reports from Care Group Board level.
2b	**Assurance:**	**The Committee wishes to draw the following positive assurances to the attention of the Board:** • Based on the recommendations from **Counter Fraud relating to staff working whilst on sick leave,** the sickness absence procedure has been updated. The return-to-work document contains a personal declaration to state that a member of staff has not been working during a period of sickness absence. In the last twelve months there were two cases of potential fraud relating to staff working whilst on sick leave, that have not resulted in the pursuit of criminal investigation. • **Tender waiver use has reduced by 95%** from the level reported two years ago by preventing contracts bypassing Standing Financial Instructions (SFIs). In the last financial year, the reduction in the number of approved waivers went down to five from 15 (66% reduction). During the period April to November 2022, five requests to waive SFIs were approved for contracts worth £766k. • The Committee received the review of the **Annual Report of the Charitable Funds and the adoption of the Annual Accounts for 2021/22** and agreed that they be recommended to the Board of Directors for approval. Mainly due to expenditure on patient welfare activities the Charitable Trust Fund has decreased in the last year by £22k with an overall balance of £596k at 31st March 2022.
2c	**Advise:**	**The Committee wishes to advise Members of the Board that:** • Following discussion amongst the Non-Executive Directors, they have agreed that it will be useful for the **Chairs of each of the Committees reporting to the Board of Directors to meet on a quarterly basis** to discuss overlapping issues, in particular risks that are aligned to more than one Committee. The Assistant Chief Executive will attend the first meeting to share the findings of the governance review, following which he plans to do a "roadshow" to share the outcome more widely. • The **Executive Risk Group report** supports the Committees understanding of the present position on the maintenance of an effective system of integrated governance, risk management and the internal controls across the organisation's activities. • The Committee were assured that there has been some good progress made in relation to **risk oversight and management**, with further work required to review the risks included in the CRR and some consolidation of the 15+ risk register, for example to include only one staffing risk, rather than multiple separate risks on staffing relating to individual services. The EREG report is welcomed by ARC as the information presented provides the overarching position, rather than the detail required at Care Group Board level, with development and progress of the risk management processes and systems, which aligns to ARC's terms of reference. • The Committee took assurance from the progress being made with the development and embeddedness of the **risk management framework** with

		governance structures and risk reporting is now in line with policy. Care Group Boards are now triangulating intelligence to be able to consolidate themed risks. The current risk management IT systems does not meet the needs and a business case is being considered for a new system. Risk management training via Microsoft Teams has now started and e-learning modules will be rolled out in Q4. User guides have been produced and intranet materials are being developed. • The Committee was satisfied with the statement that there is "good" assurance that the **BAF** is being managed effectively. Further development of the BAF will include potential changes to risks arising from the refresh of the Business Plan, consolidation of risks in the CRR as agreed by ERG and any matters arising from the governance review. • Following a three-day quality improvement event, it is anticipated that there will be sig**nificant improvements to the handling of patient monies, valuables and property** with the introduction of a more robust supportive process. A review will be undertaken in January 2023 to test the new processes which will include staff and patient's feedback. • The Committee agreed the action plan to support the achievement of a minimum score of 4 across all categories that the Trust has strong financial sustainability processes in place. **The HfMA Financial Sustainability Self-Assessment** completed by the Trust, was reviewed by AuditOne who supported 11 out of 12 of the key questions with a proposal to strengthen one action which was agreed during the audit. The aim of the self-assessment is for organisations to plan a return to break even and to re-establish pre-pandemic ways of working and financial management disciplines. • Following review of the **Quality Assurance Programme (Clinical Audit) mid-year progress update**, the Committee sought further assurance from the information contained in the report that it should include advice on whether the systems and governance structures for review and oversight of the Programme, which is via the Executive Quality, Assurance & Improvement Group and the Quality Assurance Committee are being effective and that they were satisfied that the Programme activities are being delivered. This will support the Audit & Risk Committee to take an overview on whether EQAIG and QuAC are pursuing any outstanding recommendations or overdue actions. • The Committee took assurance from the completed actions in response to the 2021 ICO audit with 27 out of the 40 recommendations closed, with a further eight planned in January 2023 and rationale for non-completion of the remaining five actions, which will remain 'open' at the point the ICO audit is closed with monthly monitoring through DPAG. • The **Assurance Tracker** provides an overview of the lines of assurance from the suite of papers presented to the Committee. • The **benchmarking report from Audit One** on Audit Committee agendas will help inform the review of the Audit & Risk Committee's terms of reference in early 2023.
2d	**Review of Risks** The Committee was satisfied with the progress being made in relation to risk management and the embedding of the Risk Management policy and associated processes and were content with the level of controls in place to mitigate against the risks in the BAF.	

3	**Actions to be considered by the Board:** Following the receipt of satisfactory assurances, there are no specific actions to be considered by the Board. **Recommendation:** *(i) That the report of the Audit & Risk Committee, from its meeting held on 12th December 2022 be noted.* *(ii) That the Annual Report of the Charitable Funds and the adoption of the Annual Accounts for 2021/22 be approved.*	
4	**Report compiled by**	*John Maddison, Chair of Committee, Donna Keeping, Corporate Governance Manager*

Tees, Esk and Wear Valleys NHS Foundation Trust

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26 January 2023**
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.

2 **Background**

2.1 The Trust undertakes a monthly programme of regular leadership walkabouts to services. These visits are not inspections but enable teams to hold conversations directly with Board Members and Governors 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 9 January 2023 across Community Mental Health Transformation (CMHT) team across the Trust including:

- Easington CMHT Team
- York Adult CMHT Team
- Chester le Street CMHT Team

- Hartlepool CMHT: Community Interface Team
- Harrogate IHT
- Richmondshire CMHT

4 **Key Issues**

4.1 Feedback from the leadership walkabouts is summarised below.

Strengths:

- Leadership: visible and collective leadership approaches across clinical and operational team, responsiveness to change, and support to develop.
- Healthy communities: huge focus on putting patients at the heart of all they do and looking a whole approach to support needed – no 'wrong front door'
- Partnerships: real value of working across multiple TEWV services and co-location with specialist areas, as well as working with partners in primary care and in local authorities, with examples shared are housing and GP surgeries.
- Shared vision: real focus on continuous transformation driven by common goals and shared vision, supported compassionate staff focused on wellbeing of the patients and each other.

Challenges:

- Recruitment and retention: all teams reported challenges in recruiting in band 5 / 6 nursing roles particularly where other areas are offering more ££, and cost of living crisis kicking in. However having the right skill mix was an issue too. Some teams had high use of agency staff and others had been carrying vacancies for significant lengths of time (leading to caseload backlogs).
- Demand in service / high caseloads: this was reported across the majority of the teams post-pandemic, including triaging referrals and managing transition from existing referral routes and waiting times. Some innovative solutions reported around 'care navigators' roles.
- Infrastructure: including building locations, appropriateness, and condition, as well as IT issues around connectivity and accessibility.
- Promotion: teams would benefit from support to promote their services and what CMHT is, which would also support and enhance recruitment.

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 9 January 2023.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 26 January 2023		
Date of last meeting: 1st December 2022		**Report of: The Quality Assurance Committee**
		Quoracy met: Apologies from Z Campbell, P Hungin and J Preston (NB John Maddison, Non-Executive Director attended to ensure quoracy was achieved)
1	**Agenda**	The Committee considered the following matters: • 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) • Quality Account Improvement Actions Progress Update • Long term seclusions ICTRs • Safe Staffing • Findings at Edenfield Ward, Greater Manchester MH NHS FT – 'closed cultures' • Okenden Report – independent review of maternity services • HMPPS Update • Update on the Crisis Line Service • Safeguarding and Public Protection Annual Report
2a	**Alert**	The Committee alerts the Board on the following matters: **1. Executive Quality, Assurance & Improvement Group (EQAIG)** Timing issues with meeting schedules gives limited time to prepare the report from EQAIG to QuAC. Concerns were expressed about the volume on the agenda of EQAIG. The feedback is being considered by the Assistant CEO as part of the organisational governance review. Key alerts to raise are in relation to the ongoing backlog with serious incidents with additional resource planned. There are over one thousand unapproved incidents on Datix, compliance with CQUIN targets for cirrhosis and fibrosis with an improvement plan underway and only 9% compliance with achieving the 60 target for responding to complaints. **2. Safe Staffing** The Committee highlighted that analysis of safe staffing is only in relation to inpatient areas. There is little change to the ongoing challenges for safe staffing, which was related to October data, but assurance is taken from the demonstration of keeping wards safe on a shift-by-shift basis, having over established rosters with the right skill mix. NEDs stressed the importance of being open and transparent on the management of risks associated with staffing. **3. Trust Level Quality and Learning Report** As reported previously to Board, there remains concern about capacity within the Patient Safety Team with ongoing concerns for their workload and resources. There have been some interviews for vacant posts, however getting people into position through the recruitment process remains longer than is acceptable. Restrictive interventions remain high in a small group of areas in ALD, SIS and PICU. QUAC were advised that a Task and Finish Group has been established.

		Whilst EQAIG receive the Trust wide report and discuss the areas of concern, there needs to be clear evidence of this via each Care Group QAIG, with analytical support. **4. Crisis Line Service** The Chair specifically asked for this to be an agenda item as there was significant concern raised by some of the Governors at the last Council of Governors (CoG). Whilst the Board had received a verbal update in November, QUAC received a detailed paper. It was very clear that much work had been undertaken and more was planned, However, the position in North Yorkshire, York and Selby Care Group remains unacceptable. QuAC requested that given the degree of concern raised by Governors, an update be provided to the December CoG Development session. **5. Adult Learning Disabilities Improvement Plan** QUAC received a very clear update from the Care Group. QUAC supported the clinically led decision to temporarily close the two in patient units at Lanchester Road. Assurance was detailed in the paper in terms of communication, engagement and overall processes. There is good assurance on the actions completed by the service but as Board and regulators are aware, the actions remaining require wider support from within the Trust and the wider system.
2b	**Assurance**	The Committee wishes to draw the following positive assurances to the attention of the Board: **1. Board Assurance Framework (BAF)** The members of QuAC use the BAF as an aide memoir in considering the reports presented at the meeting, they welcome the addition of trajectories for risks, which were agreed by the Board of Directors, which will enable progress to be monitored. It was noted that a full review is expected to take place with Executive Directors during February 2023. QuAC will continue to see the BAF each month. **2. Delivery of the CQC Action Plan and CQC Inspection 2022** Good assurance was provided in relation to oversight, management and delivery of the CQC action plans. The Committee approved the amendment of action 21, the Core Service Action Plan (AMH Community) which will require a joint Trust and Commissioner review of ADHD and ASD assessment, scheduled for February 2023. **3. Risks to Quality and Safety** There are no significant changes to the risks aligned to QuAC. It was evident that the management of risk is progressing but QUAC are looking for assurance on the impact of the mitigations. **4. Findings identified at Edenfield Ward, Greater Manchester MH NHS FT – closed cultures** Assurance was taken from the actions being taken by the Trust to identify and mitigate the risks of closed cultures. Board had previously received this report and supported the cultural risk assessment tool. QUAC approved the priority areas and timescales for the physical cultural visits. QUAC also received some contemporaneous feedback from two of the visits. Board will be sighted on this. **5. Ockenden – Independent Review of Maternity Services** The Committee received an overview of assurance against the recommendations and potential risks to delivery of mitigations in response to the duty of the Trust to prevent the failings found at Shewsbury and Telford Hospitals NHS FT. Linked to BAF risks 4 – experience, 5 – poor culture and 6 – failure to embed learning, which could result in repeated serious incidents. There are established controls and relative assurance evidenced through more robust systems and processes, mitigating quality and safety risks,

		together with improvements to the risk registers. The ongoing work will be monitored by the established improvement workstreams. **6. Quality Account Improvement Actions – Progress Update** From the three improvement priorities: Personalising care planning, improving safety on wards and implementing the new National Patient Safety Incident Framework, nine of the 17 actions (53%) are green of which 5 are fully complete, five actions (30%) are amber and three actions (18%) are red.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: 1. **HMPP Update** This is an area that QuAC are seeking assurances on the mitigations to keep mental health patients safe in Prisons. The helpful update covered a detailed briefing on the provision of services to understand the roles and responsibilities of the Trust within the prison services that we serve, with some positive practice examples from patients and feedback received from an external agency commissioned by Health and Justice Commissioners. **3. Safeguarding and Public Protection Annual Report** The Committee took assurance on the discharge of the Trust's statutory duties in relation to the range of safeguarding legislation from the year at a glance and safeguarding achievements for 2021/22. **4. Update on long term seclusions (ICETR Themes)** This first report to QuAC following an announcement by the Secretary of State for Health and Social care that all people with a learning disability and/or autism in long term segregation have their care independently reviewed. QUAC were assured that all patients had been reviewed and there is an effective system in place to ensure continued compliance with this important requirement.
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.
3	**Actions to be considered by the Board**	There are no specific actions to be considered by the Board. It is recommended that the Board note the report and the concerns raised in relation to: 1. Serious incident position 2. Performance of complaint responses 3. Safe staffing in non-in-patient services 4. Crisis line performance in NYYS 5. Continued capacity within the Patient Safety Team
4	**Report compiled by**	Bev Reilly, Non-Executive Director, Deputy Chair of the Trust, Chair of the Committee, Elizabeth Moody, Director of Nursing & Governance, Donna Keeping, Corporate Governance Manager

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**26 January 2023**
Title:	**Learning from Deaths**
Executive Sponsor(s):	**Elizabeth Moody, Director of Nursing & Governance**
Author(s):	**Lesley Munshi, Associate Director of Patient Safety**

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

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**

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
BAF 6	Failure to effectively undertake and embed learning could result in repeated serious incidents.	There is a risk that if we fail to embed key learning from deaths, patient safety and quality will be compromised and the people we serve will lose confidence in the services we provide. This paper sets out key processes for mortality reviews and learning from deaths and serious incidents across the Trust in order to reduce and mitigate this risk.

Executive Summary:

Purpose: The national guidance on learning from deaths requires each Trust to collect and publish specific information on a quarterly basis. This report covers the period from October 22 to December 2022. The Board is receiving the report for information and assurance of the Trust's approach in line with national guidance.

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

Proposal: That the dashboard and the learning points are provided as good assurance of reporting and learning in line with national guidance.
It is recognised that current backlogs in the Patient Safety Team to

undertake Serious Incident reviews and mortality reviews continues to impact on timely learning. To mitigate that risk, rapid review processes and daily patient safety huddles where early learning can be recognised and shared and acted on are in place.
An independent Duty of Candour review is underway to determine the effectiveness of our current processes and seek further improvement.
A replacement risk management system is currently being procured that will bring additional benefits in terms of triangulation of learning and oversight of serious incident action plans.

Overview: In line with National Guidance the Learning from Deaths Dashboard at appendix 1 details Quarter 3 information for the Trust and includes 2021/22 data for comparison.

- During Q3 469 deaths were recorded. In addition, the deaths of 16 people with a learning disability and 2 people with autism were reported. These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were currently open to the Trust's caseload (>70,000) as reported on datix.
- 5 of the total number of deaths were in-patient deaths. 3 of these in-patient deaths related to physical health. 2 have been reported on the national Strategic Executive Information System (StEIS); 1 was also reported to LeDeR.
- In addition, 21 unexpected community deaths were also reported on StEIS .
- 12 Part 2 Structured Judgement Reviews (SJRs) were requested which includes the 3 physical health related in-patient deaths. 19 Part 1 reviews and 4 SJRs were completed.
- All deaths of people with either a learning disability or a diagnosis of autism have been reported to LeDeR in line with national requirements.

From the review of deaths within this timeframe, there are clear areas of learning identified and themed with ongoing improvement. Appendix 3 sets out in detail the specific areas of learning, Trust themes, progress within the Quality Assurance programme and structures to support and embed learning. Where a new theme has emerged such as dual diagnosis, these have been discussed at relevant clinical forums and further analysis is being undertaken.
The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG). Agenda items have included discussions around the Quality Assurance Annual report, identification of emerging themes
and effectiveness of associated actions and the Learning from Deaths Improvement work with the Better Tomorrow Programme. Several TEWV staff attended the North-East North Cumbria Learning from the Lives & Deaths of People with a Learning Disability and Autistic People in November 2022. The Learning & Sharing Event Resource Pack will be discussed in the OLG in January 2023.

Any significant issues identified by the OLG are escalated to the Executive Quality Assurance and Improvement Group for further discussion and or actions.

9 urgent Patient Safety Briefings were circulated Trust wide during this reporting period, examples included:

- Anti-barricade doors and the obstruction of door locks Curtain hooks
- Keeping patients safe and well through carrying out supportive observations, specifically in relation to staff ensuring that patients' heads are visible, and nothing is impeding breathing
- Safe use of anti-tear clothing
- Circulation of national alerts regarding potential ligatures

The Quality Assurance Programme continues to evidence sustained improvement in risk assessment, risk management and contingency planning in in-patient areas.

In Q3, 11 serious incidents for unexpected community deaths were completed. To improve learning and measure progress against the Trusts 7 main themes all learning is captured as actionable learning.
The themes from the actionable learning were as follows:

- Lack of consideration of Safeguarding (PAMIC)
- Lack of robust assessment/risk assessment
- Gaps in clinical records
- Lack of carer/family involvement
- Care Planning
- Communication between services in relation to assessment outcome
- Lack of adherence to the trusts Did Not Attend/Was Not Brought policy.

These were all community cases. Due to a backlog of serious incidents and delays in completion, some of these incidents occurred prior to commencement of improvement work in community teams so will not always reflect more recent and ongoing improvement. Evidence provided from the Quality Assurance Programme and rapid reviews suggests that learning continues to be embedded in our community services.

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

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

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

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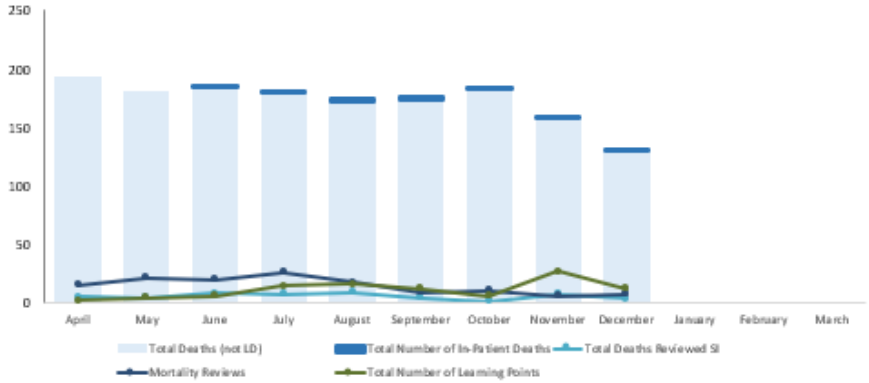
Appendix 1: Learning from Deaths Dashboard

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

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

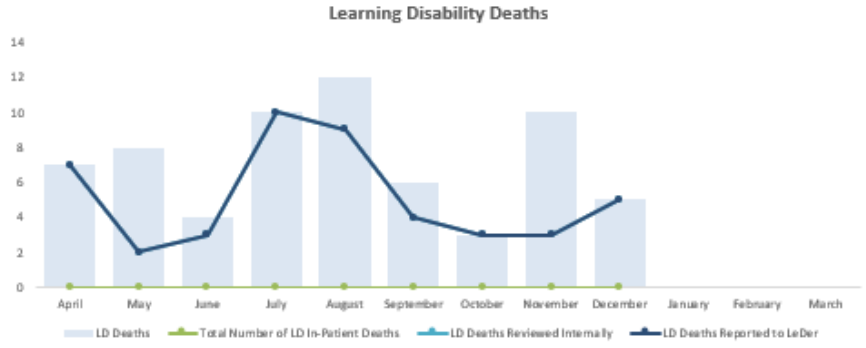
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
Q1	558	↗ 486	1	↘ 8	17	↘ 23	56	↘ 78	12	↘ 43
Q2	524	↘ 557	7	↔ 7	20	↗ 18	52	↗ 50	42	↗ 15
Q3	469	↘ 639	5	↔ 5	11	↘ 15	23	↘ 105	45	↗ 42
Q4		557		6		12		37		5
YTD	1551	↘ 2239	13	↘ 26	48	↘ 68	131	↘ 270	99	↘ 105



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

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

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
Q1	19	↗ 18	0	↔ 0	12	↘ 29	12	↘ 34
Q2	28	↗ 26	0	↔ 0	23	↗ 16	23	↗ 12
Q3	18	↘ 23	0	↔ 0	11	↘ 18	11	↘ 25
Q4		28		0		18		25
YTD	65	↘ 95	0	↔ 0	46	↘ 81	46	↘ 96



Appendix 2

Mortality Reviews 2022/2023

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

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

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

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

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

Appendix 3

1. Mortality Reviews and Learning

Mortality Review 2022/2023

In Q3 2022/2023, 19 Part 1 reviews and 4 Part 2 Structured Judgement Reviews (SJRs) were completed under the mortality review process. 12 Part 2 SJRs were requested. Details on the locally agreed criteria for Mortality reviews and SJRs can be found in Appendix 2.

** NB due to capacity issues not all cases for Q3 have been reviewed which reflects the lower numbers currently recorded. These figures will be amended when the dashboard is updated for Q4 2022/23*

Mortality Reviews
During Q3, there were 469 deaths. In addition, the deaths of 16 people with a diagnosed learning disability and 2 people with a diagnosis of autism were reported. There were 3 expected in-patient deaths within MHSOP services; all were related to physical health problems. These deaths will be reviewed via a SJR under the mortality review process.

The deaths of people with a diagnosis of learning disability and/or Autism have also been reported to the LeDeR programme. The Trust has established a good working relationship with one of the region's LeDeR reviewers to facilitate wider learning.

Due to long term sickness, there is a back log of 67 structured judgement reviews awaiting completion. These reviews have had an initial review to identify any immediate learning. There is a recovery plan in place to address this backlog. The 67 cases are currently being analysed to identify key themes; this will facilitate a thematic approach to learning which will be shared Trust-wide. This work is being overseen by the Speciality Development Manager (SDM) from MHSOP. Subject Matter Advisors will be requested to participate in thematic reviews where appropriate.

4 structured judgements reviews were discussed and reviewed by the Mortality Review Panel during Q3.

Actionable learning points were identified as follows:
- Lack of engagement and involvement with relatives and or carers specifically in relation to the patient's plan of care.
- Failure to consider physical characteristic (obesity) that could lead to an increased risk to the patient of developing serious physical illness such as diabetes or heart disease.
- Lack of health promotion information shared.

Learning from actions/assurance
- Findings from SJRs are fed back to the clinical networks, where appropriate, to ensure that learning feeds into existing improvement work. Outcomes are captured in minutes at the following mortality review panel.
- Where the learning identified is related to the work of a specific professional group, for example Pharmacy, the relevant mortality review panel member ensures this is actioned and shared Trust-wide. Good examples of assurance can be evidenced from the workstreams related to Clozapine, Lithium and Depot Injections.
- Learning for individuals is also shared with operational teams where appropriate and addressed via supervision and local governance processes.

Learning from mortality reviews often demonstrate similar themes identified during serious incident reviews. The themes from mortality reviews are triangulated with learning from serious incidents reviews to establish any new themes occurring.

During a meeting with the Better Tomorrow Programme on 25/10/2022 an update was provided to changes made to the mortality review process and the mortality review panel to strengthen learning from deaths and how we use this learning to improve care for the living. The impact of changes made by the Trust was shared. Representatives from the Better Tomorrow Programme indicated that they would use the improvement work carried out by TEWV as a case study and would share work completed as good practice. We continue to network via the National Mortality Leads meetings and the NHS Futures Community of Practice.

As reported in Q2, deaths of people with a dual diagnosis appears to be increasing. The deaths of 6 people with a dual diagnosis were discussed at the Trust's Drug and Alcohol Strategy task and finish group on 7th November to identify common themes and to understand any factors that hinder our ability to adhere to Trust standards, values and behaviours when working with this group of people. It was agreed that further analysis is required as part of a thematic piece of work; an update will be provided in Q4.

1.2 Learning from deaths and serious incidents

Significant work has been undertaken during 21/22 and 22/23 to identify areas of learning from the thematic review of historical serious incidents and to determine whether the actions we are taking are making a difference to patient safety and the standard of care and services we provide. We continue to review and monitor learning from recent serious incident reviews against the 7 themes to ensure improvements are being sustained.

The top 7 themes were identified as:

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

The Trust also report progress on these thematic workstreams to the NHSE Quality Board on a monthly basis (2 themes a month).

During the reporting period, there is evidence from the Quality Assurance Programme that improvements in risk assessment, risk management and contingency planning in in-patient areas have remained consistent. Practice Development Practitioners have observed MDTs engaging in quality discussions around risks, observation levels (100% compliance for 109 meetings observed) and the rationale for how the level of risk should be mitigated for each patient (90% compliance 98 meetings observed out of 109). At 55% compliance (99 cases out of 181 reviewed), the sharing of care plans with patients requires further work however, this seems to reflect more of a record keeping issue given that there is 79% compliance (123/155 cases reviewed) in coproducing care plans with patients and 87% compliance (164/188 cases reviewed) for involvement of patient and carer views in care plans.

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The themes from the actionable learning were as follows:

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These were all community cases. Due to a backlog of serious incidents and delays in completion, some of these incidents occurred prior to commencement of improvement work in community teams so will not always reflect more recent and ongoing improvement. Evidence provided from the Quality Assurance Programme and rapid reviews suggests that learning continues to be embedded in our community services.

The Quality Assurance programme and associated tools were reviewed in December 2022; this work was supported by both Care Groups. Changes made to the tools have been informed by our significant improvements to date including Quality Assurance programme results, key learning themes and identified risks from patient safety events, safeguarding issues, clinical audit findings and importantly our patient and staff feedback. Examples of changes include more qualitative questions and alignment of the tools to support validation and triangulation of findings.

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

Practice Development Practitioners are now integrated into the Care Group Fundamental Standards meetings where wider learning and good practice can be shared to facilitate improvements Trust-wide.

1.3.2 Organisational Learning

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG). Agenda items have included discussions around the Quality Assurance Annual report, identification of emerging themes and effectiveness of associated actions and the Learning from Deaths Improvement work with the Better Tomorrow Programme. Several TEWV staff attended the North-East North Cumbria Learning from the Lives & Deaths of People with a Learning Disability and Autistic People in November 2022. The Learning & Sharing Event Resource Pack will be discussed in the OLG in January 2023.

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- Circulation of national alerts regarding potential ligatures

The briefings circulated are specific about the assurance required from services. On receipt of confirmation of completed actions, this is registered in the learning database. The effectiveness of learning is monitored via the database and reviewed at the Organisational Learning Group.

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

1.3.3 Preventing Suicide and Self harm Group

During 2022 the preventing suicide leads for the Trust undertook an engagement exercise on a Trust-wide plan for the prevention of suicide within TEWV. A proposed framework based on existing evidence was developed to aid engagement. There were 17 bespoke meetings held with staff, carers, and people with lived experience. The team also attended 12 existing Trust meetings and 6 multiagency Suicide Prevention Network/Alliance meetings. Feedback from this exercise has directly informed the development of a 2-page summary to be embedded as part of the clinical and safety journey and a proposed framework for action for consideration by the Trust's clinical leader's group; the consultation period ended 13/01/2023. The framework recommends action across the following domains:

- Delivering safe care
- Working in partnership
- Providing support
- Always learning

All actions and priorities build on the extensive work already undertaken in response to the deaths of patients under our care.

In addition to the development of the framework for action, priorities for the preventing suicide team to date have included:

- Developing and implementing processes in relation to 'Concerns for individuals & groups' where there is a potential for contagion or a 'number of suicides in a particular community setting.
- Developing the Trusts role in real time alert systems and establishing timely information flows between the police, coroners, and the Trust. This has included proactive action in addressing potential multiple suspected suicides, self-harm, and related concerns.
- Supporting daily patient safety huddles and rapid reviews for early learning
- Engaging with local authority and public health leads to integrate action plans and promote multi-agency working.

- Roll out of Post Incident Peer Support meetings for staff (utilising the Critical Incident Stress Management Model) across the Trust.

Current governance of this work is through monthly self-harm and preventing suicide Trust wide meetings which reports into the clinical leaders' group.

1.3.4 The Environmental Risk Group

This group receives monthly reports of incident data involving ligatures and other risks where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is disseminated Trust-wide via Patient Safety Briefings or SBARD's (Situation, Background, Assessment, Recommendation) communications. Examples for Q3 are detailed above in para 3.3.2.

The annual Environmental survey programme with a multi professional input from estates, health and safety and clinical services continue. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures.

1.3.5 Serious Incident Investigation

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

Background Papers:

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

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

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For General Release

Meeting of:	**Trust Board**
Date:	**26/01/2023**
Title:	**Winter 2022-23 preparedness: Nursing safer staffing.**
Executive Sponsor(s):	**Elizabeth Moody**
Author(s):	**Elizabeth Moody, Joe Bergin, Stephen Parry**

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**

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	Inability to recruit sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services.	The Trust is prepared to accept some workforce risks where they provide the potential for improved recruitment and developmental opportunities for staff but not that impact on quality of patient care. Although the present score is significantly above tolerance, it is considered that an acceptable level of exposure can be achieved. Good assurance is being received regarding mitigating actions related to safe staffing such as establishment reviews and progress has been made in relation to oversight of risks through people, culture and development structures and groups that would support the effective oversight of winter pressures. However the ability to effectively mitigate surge pressures is a challenge due to a depleted workforce and high risk areas across the Trust. The Trust has a minimal appetite for risks to quality and the risk is above tolerance. Reasonable assurance has been received in relation to escalation and demand however as governance and operational structures are becoming more embedded this is improving oversight and mitigation of safe staffing. The bed management service is now in place and supports the effective management of demand out of hours in conjunction with on-call processes. However the ability to meet patient/carer expectations and/or commissioner requirements as a result of surge pressures remains a challenge due to a depleted workforce and high risk areas across the Trust.
2	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.	

Executive Summary:

Purpose: The aim of this report is to provide an insight into the Trust position and to seek assurance measured against the standards and suggested requirements set down in the NHS (2022) “Winter 2022 preparedness” report and to appraise the Board of the actions and potential mitigations in place where the standards are not met.

Overview: The NHS continues to experience significant levels of pressure. The continued impact of managing COVID-19, plus the recovery of services and relative return to usual or increased activity levels has led to a challenging year, especially in the context of constrained capacity due to sickness and other workforce issues.

Trust board members are collectively responsible for workforce planning, practice and safeguards. The recent Staffing Assurance Framework (NHS, 2022), see Appendix One, details actions focussed upon the preparedness, decision making and escalation processes to support safer nursing staffing as the winter period approaches. It builds on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance.

Whilst the actuality of winter pressures is more significantly experienced in the acute medical and ambulance services, the principles of the NHS (2022) paper (Appendix 1) remain of equal importance regarding the staffing pressures seen in the Trust. As such the Trust needs to be assured that systems and controls are in place for managing and supporting services in the delivery of care for patients and identify any gaps which need further attention.

Using the provided “Assurance Framework” tool (NHS, 2002) this report provides an initial view of the Trust’s position in terms of the controls in place, assurance levels, further action needed, and what ongoing monitoring / review is in place (Appendix 2). The report was received by the Board in response to Winter pressures in 20/21 and therefore the appendix 2 has been updated in relation to areas of negative or positive assurance and in response to where the guidance itself has been updated (as highlighted in appendix 1).

Proposal:
The report provides reasonable assurance that controls are in place to maintain safe staffing and that where standards cannot be maintained that appropriate escalation and mitigation is in place. Appendix 2 sets out negative and positive assurances as well as corrective actions and mitigations being taken or proposed to address gaps in assurance/negative assurances.

Positive Assurances:
Positive assurances can be seen in more detail in Appendix 2 but key areas of assurance that systems and controls are in place for managing and supporting services in the delivery of care for patients are:

- Incident Management controls such as the establishment of Gold, Silver, and Bronze command structures are able to be implemented as appropriate by the Trust in response emergencies as they arise

- The establishment of the bed management team

- The implementation and embedding of the SafeCare acuity monitoring tool across inpatient services

- Daily staffing huddles and capacity management calls

- Inpatient and Community escalation procedures

- Enhanced risk oversight meetings now in place including care group and executive risk groups

- Improved ward/team to Board governance and escalation processes

- The Trusts relationship and active involvement as a partner within both integrated care systems

- The Trust met in December and discussed the Trust risk appetite which is yet to be ratified but remains cautious for risks to quality. It is proposed that we are willing to take risks which may have implications for our workforce (but not for our clinical delivery).

Key areas highlighted from the initial review of guidance (Appendix 2) that require further actions or consideration to strengthen assurance are:

- The “risk management approach” in the BAF profiles highlights where the risk score can or cannot be mitigated to tolerable levels. Both strategic risks highlighted above that relate to our winter preparedness approach are not currently within the Boards tolerances for quality, safety and workforce risks. However there is good and/or reasonable assurance for a number of mitigating actions and controls detailed within the BAF that are in place relating to winter preparedness as detailed further in appendix 2.

- Staff wellbeing support structures and processes are in place across the Trust, however it is not clear how well they are directly aligned to inform upon workforce related issues. The key indicators at present regarding staff wellbeing in the clinical areas appear to be related to sickness absence and a subsequent reliance upon temporary staffing measures to support the absence. It is felt that further involvement and development of measures relating to staff wellbeing will provide additional key information to the workforce planning agenda.

- Demand and capacity modelling for community teams is still in realtively early stages within a community system approach. The Safe Staffing team are currently underway with the rollout of community e-roster, (as required by national requirements), which will further support demand and capacity work, which will benefit from additional support from senior service managers and directors to ensure a timely and smooth implementation; this rollout is currently behind schedule due to competing demands on both services and the team.

- The appointment to a permanent substantive Emergency Planning Lead/Officer will strengthen and support the Trusts position regarding emergency preparedness.

- Further work is required to support the Quality Impact Assessment approach to all staffing changes and requirements to both ensure that all risks are considered, documented, and signed off as required by National mandate. This is currently in place across the Trust regarding changes to team rosters but requires further work and support to embed this process.

- Business Continuity Plans require a process to continually review and update thresholds. Once a new emergency planning lead is in post they will lead on a review of plans and methods used to manage the emergency response during the pandemic.

  Areas for further consideration include:
  - a review of ownership of the plans was suggested by the Operational Support Managers.
  - the way in which critical incidents or events may impact on staffing requires improved engagement and levels of awareness. These areas are captured in the Risk Register and need to be consistently considered at a more granular level within the BCPs and it is suggested that they could be more explicit and defined for clarity.
  - plans regarding the established nursing workforce and their roles, skills and responsibilities are not consistent across all areas and need further detail to drill down to skills and responsibilities.
  - contingency plans for situations in which the nursing workforce is compromised, understaffed or redeployed requires plans to be aligned to the safe staffing escalation process. This requires a review of action cards that are aligned to staffing escalation and it is suggested that these continue to be embedded in all areas.
  - Further embedding the consistency of approach to wards and teams entering and de-escalating from BCP (a review of staffing escalation procedures is underway to address this)

- Processes and structures are in place across the Trust to support governance and assurance of the workforce, however detailed oversight and triangulation of workforce and quality metrics at ward/team level is not yet consistently available.

Recommendations

- For the Trust Board to confirm the level of assurance as reasonable.
- For the Trust Board to review and comment on the report and agree any further actions or potential mitigations needed where the standards are not met in support of the above decision.

Classification: Official

Publication reference: PR2072

Key actions

Winter 2022 preparedness: Nursing and midwifery safer staffing

November 2022, Version 2, Updates to version 1 are highlighted.

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

Planning

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

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

- Executive directors of nursing should ensure that all forecast staffing plans are reviewed weekly or more frequently as required by the operating context and changing circumstances. Executive directors of nursing are expected to work with the Board and with ICBs/ICSs to align system approaches to workforce planning.

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

- Redeployment should be voluntary where possible and individual risk assessments must be undertaken with staff prior to any redeployment.
- Now that ICBs/ICSs are operational, Trusts must consider whether system level solutions are appropriate

Decision making and escalation

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

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

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

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

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

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

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

Staff training and wellbeing

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

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

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

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

Indemnity and regulation

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

- The UK's Chief Nursing Officers, the CQC and the NMC have published a joint letter on how staff will be supported over the winter period.

- Working in partnership with people receiving care and their fellow professionals remains of utmost importance; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. Trust boards must be assured that wherever possible these standards are met.

Governance and assurance

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

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

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

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

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

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

- PEOPLE FIRST is an online resource available on CQC's website for system leaders and service providers. It presents suggested actions for individual services and the wider system to help manage the challenges in urgent and emergency care and includes a section on staffing and staff training.

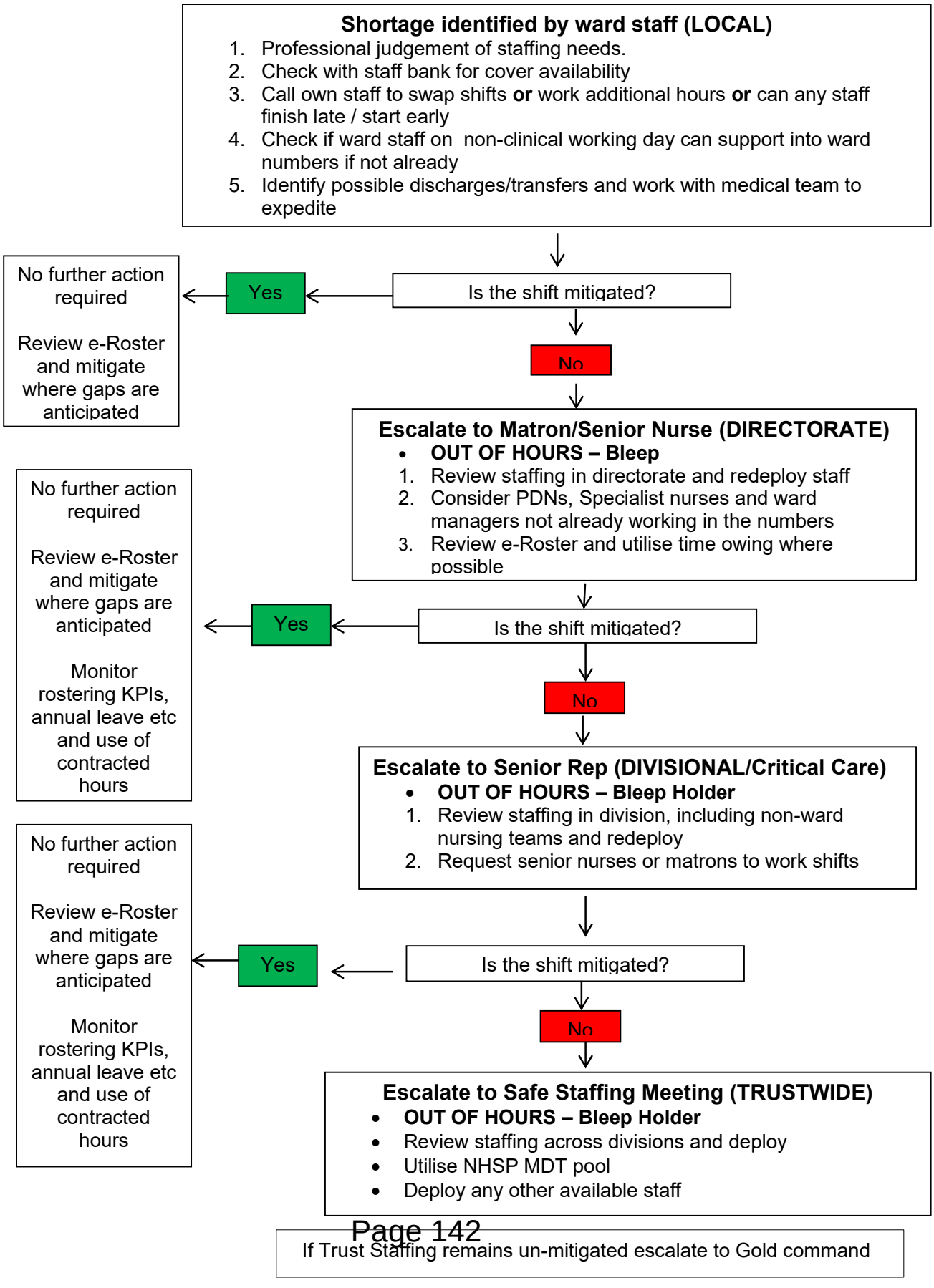
Useful links:

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

Planning • NHS England – Respiratory syncytial virus preparedness: Children' safer nurse staffing framework for inpatient care in acute hospitals • Safe staffing in maternity settings • NHS England e-Rostering and e-Job Planning • Preparedness for potential industrial action in the NHS	**Staff training and wellbeing** • NHSX: Digital staff passport • NHS People: Support and wellbeing resources • NHS Horizons: Caring for NHS people • NHS Employers: Risk assessment for all staff
Decision making and escalation • Appendix 1: decision and escalation framework tool • Appendix 2: Quality Impact Assessment • Appendix 3: Staffing escalation (SBAR) • Appendix 7: EPRR escalation and alerting	**Governance, assurance and reporting** • Appendix 4: Risk appetite statement • Appendix 5: Assurance Framework • Appendix 6: Safe staffing Governance framework • NQB Safe Sustainable and Productive staffing guidance • Developing Workforce Safeguards Care Quality Commission

Appendix 1: Decision tool and escalation framework

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



LEVEL 1 Required staffing levels achieved across most wards Required CHPPD met Activity can continue as planned	Local redeployment of staff within and across Divisions has mitigated staffing requirements Activity unaffected “Business as usual can continue”
LEVEL 2 Staffing levels remain below planned across most wards CHPPD across organisation are not met Staff are able to deliver a basic level of care May affect or delay patient flow Patient experience at risk of being affected Activity continues as planned but further staffing reductions may impact planned activity. Monitoring must continue.	Follow Level 2 protocol Non – ward based nursing teams across divisions are supporting patient care All available temporary staffing solutions explored, authorised and booked. Study leave reviewed and stood down where possible. Rosters reviewed for shift swaps and overtime etc. Any staff working non-clinical days reviewed Identify possible patient discharges and transfers in collaboration with medical teams. Consider bed closures. Escalate, and utilise flexible temporary staffing pool.
LEVEL 3 Staffing levels remain considerably lower than planned despite mitigation **Nurse to Patient ratios 1:8 on adult wards, 1:6 on Childrens wards, and nurse 1&2 model in critical care and respiratory high care** Significant deficiency in required CHPPD across organisation Activity cannot continue as normal. Ability to deliver all aspects of patient care affected Patient flow will be significantly delayed Staff likely to miss breaks	All other protocol exhausted-. **Step down of all non-urgent meetings** **Study leave cancellation mandated** **Urgent meeting of Divisional Directors of Nursing with Head Nurse for Workforce to discuss any further possible mitigation.(If declared at the weekend Duty Manager to meet with ops and senior representative from each division)** **Review all planned elective and emergency activity to prioritise care and deployment of staff, consider regional support** **Trust wide deployment of indirect patient care staff considered to support delivery of direct care.** **As with OPEL 4, all effort will be focussed until step down to level 1 or 2 has been achieved.**

Appendix 2: Example quality impact assessment

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

Appendix 3: Example staffing SBAR Tool

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

Staffing Escalation SBAR

SITUATION:

Ward:

Date, Shift and Band that require covering:

Number of beds:

Acuity and dependency score:

Describe your concern, include Safety/Quality concern:

BACKGROUND:

Current problem:

Reason for problem on shift:

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

How long has the shift been out to Framework Agency:

ASSESSMENT:

My assessment of the situation is:

Current concern:

Describe actions have been taken to solve the current problem:

RECOMMENDATION:

Based on my assessment I request that you approve:

Things to consider:

Explain what you need:

Appendix 4: Example risk appetite statement

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

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

Appendix 5: Assurance framework – nursing and midwifery staffing

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

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

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

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

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

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

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

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

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

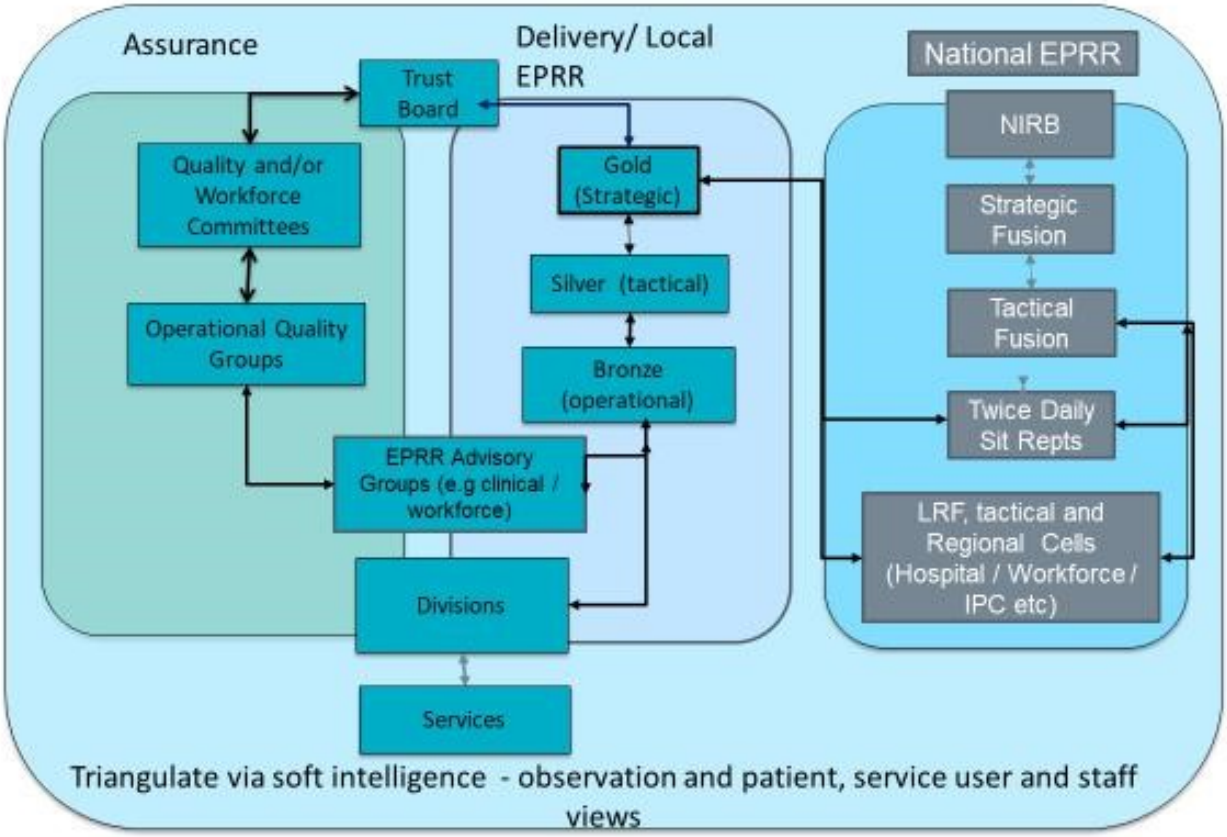
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus						
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges						

Appendix 6: Example safe staffing governance framework

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

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

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



Appendix 7: EPRR escalation and alerting

Extracted from NHS England EPRR Framework

Level 1 – Organisation level response
Coordinating organisation: NHS-funded organisation

If the following applies the incident may need to be escalated to Level 2:

- Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by the provider
- A Business Continuity Incident that threatens the delivery of patient services (in line with ISO 22301)
- Responding to a declared Major Incident or Major Incident standby
- A media or public confidence issue that may result in local, regional or national interest
- A significant operational issue that may have implications wider than the organisation e.g. public health outbreak, suspected high consequence infectious disease (HCID), security incident, Hazmat incident

Level 2 – Local level response
Coordinating organisation: ICB with NHS England (Region)

If the following applies the incident may need to be escalated to Level 3:

- Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by the ICB
- A Critical Incident that threatens the delivery of **critical** services or presents a risk of harm to patients and/or staff
- Responding to a declared Major Incident or Major Incident standby
- A media or public confidence issue that may result in local, regional or national interest
- A significant operational issue that may have implications wider than the local ICS e.g. public health outbreak, suspected HCID, security incident, Hazmat/CBRN incident

Level 3 – Regional level response
Coordinating organisation: NHS England (Region)

If the following applies the incident may need to be escalated to Level 4:

- Capacity and demand reaches, or threatens to surpass, a level that requires national coordination or NHS mutual aid e.g. need for ECMO, HCID, burns treatment or other specialist functions
- A Business Continuity Incident that threatens the delivery of an **essential** NHS England function or a protracted incident effecting one or more NHS England site
- A Critical Incident with the potential to impact on more than one ICB
- A declared Major Incident which may have a significant NHS impact and/or the establishment of an NHS England Incident Coordination Centre
- A media or public confidence issue that may result in regional, national or international interest
- A significant operational issue that may have implications wider than the remit of one NHS England region e.g. flooding, security incident, Hazmat/CBRN incident, Critical National Infrastructure, collapse of a commissioned supplier that provides services to more than one region
- An incident that may require the request and activation of Military Aid to the Civil Authorities (**MACA**)

Level 4 – National level response
Coordinating organisation: NHS England National Team (with DHSC where appropriate)

If any of the following apply or are required, DHSC should be informed:

- Capacity and demand reaches, or threatens to surpass, a level that requires international coordination e.g. need for ECMO, HCID, burns treatment or other specialist function
- Invocation of central government emergency response arrangements
- Issues that may require **invocation of** 'Emergency Powers' to be invoked under the CCA 2004 or measures under sections 252A or 253 of the NHS Act 2006
- A Business Continuity Incident with the potential to impact on significant aspects of the NHS e.g. NHS Supply Chain, NHS Blood and Transplant
- A declared Major Incident which may have national and/or international implications e.g. CBRN, MTA
- A media or public confidence issue that may result in national or international interest
- A significant operational issue that may have implications wider than the remit of the NHS e.g. Critical National Infrastructure
- An incident that may require the request and activation of MACA

Appendix 2

REF	Detail	Controls	Assurance (Positive and Negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
Staffing Escalation / Surge and Super Surge Plans							
1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e. intensive care) or as per the NQB safe staffing guidance	The Trust staffing escalation procedure supports staff in decision making regarding response to staffing shortfalls. The recently implemented software solution, Safecare, to support ward oversight and assurance of staffing levels is now in place. Business Continuity Plans (BCP) are in place to support decision making regarding service need. Staffing Establishment reviews are being undertaken to support longer term staffing responsiveness and preparedness. Gold Command is stood up to respond to potential surge including in the wider system that may impact on the Trust or how we can support as a good partner.	Positive Assurance: Staff have used the BCP levels to trigger escalation of staffing pressures as required to highlight an increased demand. Silver and Gold Command stood up during ambulance strikes in December. Liaison staff deployed to support A&E Daily bed capacity calls where staffing is reviewed		Staffing Escalation procedure reviewed to include Safecare, an acuity based software tool as part of this process. Work to continue to report chronic staffing issues. BCP protocols are under review to ensure standardisation across the organisation and communication of process.	Emergency Planning officer is an interim appointment at present. Ongoing recruitment process remains an issue.	Operational Management structures e.g. daily staffing huddles and capacity calls alongside QuAIG and Care Group reporting Dependent upon emergency response level, these escalations would include Silver and Gold command reporting structures Monthly Safe Staffing report and reporting via the Trust quality governance structure
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.	Staffing Escalation procedure reviewed – with acuity based software tool as part of this process. Work to continue to report chronic staffing issues. BCP protocols are under review to ensure standardisation across the organisation and communication of process. OPEL procedure has been reviewed during 2021 to consider increased pressures and reporting structure.	Reporting processes in place although there is a potential risk that due to consistent staffing pressures, this may conversely lead to under reporting of staffing pressures. A recent update to the Datix system allows for increased granularity of reporting without adding an admin burden to reporting approach		Staffing Escalation procedure reviewed - acuity based with software tool as part of this process. Work to continue to report chronic staffing issues BCP protocols are under review to ensure standardisation across the organisation and communication of process. Work is underway to review escalation processes to strengthen controls particularly around review of teams who are 'in BCP'		Operational Management structures e.g. daily staffing huddles and capacity calls alongside QuAIG and Care Group reporting QuAIG and Care Group. Dependent upon emergency response level, these escalations would include Silver and Gold command reporting structures Monthly Safe Staffing report and reporting via

							the Trust quality structure.
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	Prior consultation was undertaken via the Right Staffing Programme Board and agreed, during which staff side representatives were present.	Staffing Escalation procedures are available to all staff via the Trust Intranet. Negative Assurance - The Trust continue to promote the procedure to ensure that all staff are aware of the Staffing Escalation procedure and embed this into day to day practice.		The Trust will continue to monitor the DATIX reporting system. Liaison with Operational Services to promote the completion of DATIX in relation to staffing shortfalls. Recent update to Datix reporting allows for increased granularity of reporting without admin overhead		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report all DATIX reports in relation to staffing related pressures.
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	Quality Impact Assessments are in place and the embedding of this process is ongoing.	Quality Impact Assessment are reviewed by CN/MD. Evidence of these being completed for ward closures, increase of beds and in line with staffing establishment reviews Negative Assurance - The Trust continue to promote the procedure to ensure that all staff are aware of the Staffing Escalation procedure and embed this into day to day practice for local changes in skill mix		Ongoing education and training regarding QIA use and requirements to complete the documentation to support decision making		Safe Staffing team will lead on the review of the documentation and continue to support services in completion of same.
2.1	There are clear processes for review and escalation of an immediate safer staffing shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via daily staffing huddles.	Staffing reviews are undertaken on a shift by shift basis and any staffing pressures are escalated via software solution or local solutions, whereby the software is not currently in use. Staffing Escalation procedure provides a risk assessment template to support decision making at a local level.	Staffing Escalation processes including daily huddles 7 days a week in place. These are increased in frequency as required. The use of acuity and dependency based rostering software is monitored by Safe Staffing team and reports by exception that are available via the monthly safe staffing report to Operational Managers and Directors in		Ongoing monitoring and compliance reports to embed the use of the software aligned to staffing escalation procedure. Complete IIC dashboard for Red flag status		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report regarding all DATIX reports in relation to staffing related pressures. The Trust continue to review the process of reporting via the governance structures.

			conjunction with local mitigation process. Monitoring of DATIX reports. Dependent upon emergency response level, these escalations would include Silver and Gold command reporting structures				
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via service level and care group. Where a Trust wide response is needed this is escalated. Dependent upon emergency response level, these escalations would include to Silver and Gold command. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful, and that safe care is sustained.	Staffing calls are carried out on a daily and weekly basis whereby any shortfalls or potential risks to staffing levels are highlighted and mitigation takes place from a Trust wide position via redeployment of staffing.	Local procedures in place which are escalated to Operational Managers and Directors. Dependent upon emergency response level, these escalations would include to Silver and Gold command. Local processes in place to respond to staffing pressures. As required the Trust will move towards a site management process, whereby senior staff are present to support staffing decisions. This was evident during the ambulance strike where doctors, nurse practitioners and other professions were deployed onto sites to ensure the delivery of safe care.		To continually review and update determine thresholds based on patient acuity and need.		Review of Safe Care through staffing huddles and escalation processes. For 'high risk' services in BCP enhanced surveillance of staffing in place through Care Groups
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient can meet their individual care needs	Shift lengths and timings are embedded to allow for a comprehensive patient handover to be completed. This is completed at the start and end of each span of duty between the Nurse In Charge and the staff team.	The Trust have a system in place which outlines the minimum requirements of a patient handover. Daily Safety Huddles are in place Trust wide which supports Patient handover. Negative Assurance: high		No Further Action required		Local procedures in place to ensure that Daily Safety Huddles are completed, and these are stored centrally and supported by the Practice Development Practitioners.

			use of temporary and agency staff who may be unfamiliar with individual patients. Small number of shifts where agency 'in charge'. Patient experience feedback regarding availability and continuity of staff				
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.	Staff are supported and encouraged to raise and concerns regarding their own skills and ability to provide adequate patient care, whilst also acting as a lead for the staff team. Staff have access to the incident reporting process to record any concerns regarding staffing levels.	Staff Whistleblowing Procedure in Place and On Call both in and out of hours manager system in place to support staff experiencing concerns, as aligned to the Staffing Escalation Procedure.		No Further Action required		Oversight of all datix reports by safe staffing team.
2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	Agency staff are supported by the Temporary Staffing Team during induction and 'onboarding' to ensure minimum standards of competence and compliance training. Local inductions are carried out at a team level to support agency staff.	Records of Induction are retained for registered staff. Additional training being made available for regular agency staff Negative Assurance: some concerns raised would indicate that local induction has not been robust and/or insufficient response at ward level to concerns		Further work to be undertaken to ensure that agency staff feel part of the local staffing team and clear expectations of Trust culture. Further work with agencies in terms of expected standards of conduct.		Monitoring is carried out by Temporary Staffing Services.
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice.	Staff are supported and encouraged to raise and concerns regarding their own skills and ability to provide adequate patient care, whilst also acting as a lead for the staff team. Staff have access to the Freedom to Speak Up Guardian and DATIX reporting.	Trust 'You Said We did' process in place. Freedom to Speak up guardian in place and whistleblowing procedure. Negative assurance that staff who have concerns are raising these with the organisation. Complex case reviews and external support are in place where the patients needs require additional support to be provided e.g. LD wards		No Further Action required		Ward Managers, Matron, Service Managers and Duty Nurse Coordinators are in place to monitor the safe and effective care delivery

2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff, and leaders have taken action to address these risks to minimise the impact on patient care.	Staff on inpatient ward areas use a software tool to raise red flags and in addition staff have access to raising concerns procedure and DATIX	DATIX reporting and lessons learned shared via managers, matron, and service managers. Duty Nurse coordinators are available to take immediate action to maintain staff and patient safety.		No Further Action required		All incidents are reviewed, and the daily safety huddles highlight any areas of concern or immediate actions required. Local area reviews are undertaken and DATIX reporting and reviews are completed.
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care	Staff well-being is supported via the Employee support officers and the provision of Staff Retreats and benefit packages. Staff individual risk assessment process is in place.	Staff attendance at events and contact with employee support service is monitored. Staff feedback via Staff Survey is responded to		Continue to support and seek new and innovative ways to support staff well-being		Ongoing monitor takes place to assess and respond to the challenges faced by staff regarding well-being.
2.9	The trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care. These mechanisms consider both those staff who are absent from clinical duties due to required self-Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence	Staff reporting is carried out at a local and trust level to provide the SLG with a report on any staffing pressures which includes a breakdown absence and if these are Coved related or not.	Current reporting process in place to review and monitor staffing absence at a granular level and the potential impact on patient care		E-rostering roll out to 90% of the clinical workforce will further support and enhance this process.		
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g. use of arrest or peri arrest debriefs,	Staff are supported to report any staffing pressures via Datix and following any incidents staff are encouraged and supported to complete a rapid review debrief. Staff are encouraged to utilise the available support if any incidents have a lasting impact via Employee Support Service.	Staff reporting of pressures are reviewed via the DATIX system. Negative assurance-potential under reporting due to staff time required to report a staffing shortfall however Safecare is also now in		No Further Action required		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report regarding the DATIX in relation to staffing related pressures. The Trust continue to review the process of reporting via

	use of outreach team feedback etc) and learns from this intelligence		place to respond in a timely way to staffing shortfalls				the governance structures.
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver and Bronze to provide the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings	Staff well-being group is in place which considers all aspects of staff well-being and informs strategic long-term initiatives.	An internal restructure including h&wb leadership has been undertaken. A specific project is underway developing a framework of how we evaluate and make decisions about H&WB offers based on the national evidence base and impact in terms of significance and scale of staff reached (and in the context of the health inequalities of the communities our staff live in		Staff Well-Being requires further embedding to support the daily approach to well-being		Ongoing monitoring and review via PCDG
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).	Immediate staffing challenges are (or would be) discussed and escalated at a local and site wide level daily and a Trust wide level weekly at Silver and Gold command	Ward Managers, Matron and Locality Managers and Duty Nurse Coordinators escalate staffing pressures as required to Local governance structure and report by exception via Silver and Gold command (dependent upon emergency response level). Negative Assurance regarding the impact of staffing challenges on patients		No Further Action required		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system	The trust has an electronic rostering system in place to support daily staffing reviews at a Trust wide level which can be analysed on at a team by team level. Safe Staffing monthly report	OPEL system scoring is utilised within the Trust to support alignment to National reporting mechanisms.		Current Emergency Planning Officer is temporary posting and therefore permanent recruitment required.		Ongoing monitoring and review via PCDG

	reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	which incorporates fill rates. Report via the Trust governance routes and escalation by exception					
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.	The trust has an electronic rostering system in place to support daily staffing reviews at a Trust wide level which can be analysed on at a team by team level. Safe Staffing monthly report which incorporates fill rates. Report via the Trust governance routes and escalation by exception	Monitoring of the acuity and dependency-based software is completed. Staffing redeployment is in line with identified needs. There is evidence of timely escalation in order that Trust incentives and movement of staff can be put in place (SIS December 2022)		The Trust continue to review the impact of staffing shortfalls on patient experiences of service delivery. Demand and Capacity modelling has commenced and will support review of staffing resource. The development of the safe staffing dashboard to strengthen oversight		Safe Staffing team continue to review as part of the monthly and 6 monthly staffing report regarding the DATIX in relation to staffing related pressures. The Trust continue to review the process of reporting via the governance structures.
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short- and medium-term solutions to mitigate the risks.	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception	Minutes and papers are available		No Further Action required		Regular safe staffing reports to QuAC and Board Seminar on workforce (November 2022)
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	Safe Staffing monthly report, 6 monthly staffing report this incorporates the CQI and an addition exception report via the Trust governance routes and escalation by exception. Staffing Establishment Review report is provided from ward to board level The IPR includes staffing and other quality metrcs	QuAC and EQAIG Minutes and papers are available		No Further Action required		
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics.	Trust Integrated Information Centre has a specific dashboard which supports reporting of COVID related pressures.	Reports and Access to the dashboards available to all Trust staff as required. Triangulation		No Further Action required		

	COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges		and reports are carried out in the Safe Staffing reports.				
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception. This report also highlights Key areas of Risk, Mitigation in place and unresolved issues	Minutes and papers are available		No Further Action required		
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis.	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception. This report also highlights Key areas of Risk, Mitigation in place and unresolved issues	Minutes and papers are available		No Further Action required		
4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception. This report also highlights Key areas of Risk, Mitigation in place and unresolved issues	Minutes and papers are available		No Further Action required		
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process	Safe Staffing monthly report, 6 monthly staffing report and an addition exception report via the Trust governance routes and escalation by exception. This report also highlights Key areas of Risk, Mitigation in place and unresolved issues. Staffing risks are identified on the Trust risk registers.	Minutes and papers are available Enhanced risk oversight meetings now in place including care group and executive risk groups Head of Risk in place and supporting the strengthening of operational risk identification, escalation and management Board Seminar on safe		No Further Action required		

			staffing and escalation processes has taken place				
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e. risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	Business Continuity plans are in place and these outline the response of the organisation to highlight issues of risk and mitigation plans.	Discussed and monitored at Executive Management, Care group and the Quality Improvement Board Dependent upon emergency response level, these escalations would include to Silver and Gold command.		To continually review and update determine thresholds based on patient acuity and need.		
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework	BAF risk 1 Recruitment and Retention refers to this risk	BAF discussion at Board BAF and corporate risks relating to staffing/workforce discussed at PCDG and QuAC Establishment review reporting to Board as part of BAF risk 1 mitigation				BAF discussion at Board BAF and corporate risks relating to staffing/workforce discussed at PCDG and QuAC Establishment review reporting to Board as part of BAF risk 1 mitigation
4.10	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges	The Trust has a quality board in place at present to discuss any staffing pressures and the impact this may have on patient care. Workforce and risk escalation are standing agenda items	OPEL system scoring is utilised within the Trust to support alignment to National reporting mechanisms and the Quality Board. Example of LD staffing in reports to Quality Board monthly and system support to discharge patients		No Further Action Required		
4.11	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus	Reflected in Board agendas and discussion of BAF and monthly QuAC update to Board	Board agendas				

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Tees, Esk and Wear Valleys NHS Foundation Trust

FOR INFORMATION

Digital and Data Services – Business Intelligence and Clinical Outcomes

DATE:	**7 December 2022**
TITLE:	**Data Quality of External Data Submissions - Summary**
REPORT OF:	**Brian Cole, Head of Business Intelligence and Reporting**
REPORT FOR:	**Information**

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

1. INTRODUCTION & PURPOSE:

On 01 December 2022 the North East & North Cumbria ICB issued a letter to request:

"that Boards assure themselves regarding the on-going and sustained quality of data submitted by your organisations into national systems. In particular, Boards are asked to consider the measures they have in place to assure the data quality of the daily situation reports their Trust submits for the winter metrics"

With the aim to:

"confirm [to the ICB] the data relating to these areas are reported in a timely, accurate and your boards are assured on the data quality"

The letter is provided in full below:

002LD_SA_Provider_Chair_CEO_Data_Qu

This document describes the external data flows which are currently provided by the Business Intelligence and Clinical Outcomes (BICO) section of the Data and Digital Services department, the controls which are in place to produce consistent data routinely, and validation checks which are in place to ensure accurate data. Any "soft intelligence" the BICO section are aware of regarding this data has also been included.

2. SCOPE:

2.1 This document only covers data which flows externally to the Trust, and primarily into National systems where analysis can be performed

2.2 The focus is data submissions linked to “Winter Pressures” directly or indirectly (e.g. the KH03 return is provided throughout the year, but includes bed availability/occupancy information which could be used specifically for analysis of winter pressures).

2.3 This document does not cover all information flows provided by BICO.

2.4 This document provides an assessment of the controls in place to ensure the data produced accurately reflects the data stored within the primary record systems. Whilst many returns are directly validated with clinical services to identify any issues in record-keeping (e.g. Out of Area Placements, Delayed Transfers of Care), others (e.g. MHSDS) are validated solely for accuracy to the clinical record due to the volume of data involved.

2.5 Data is visible throughout the organisation in many forms, including the Integrated Performance Dashboard and through the IIC system. This document is focussed on the specific validation processes surrounding the production of the data submitted into National Systems, but there are many other opportunities throughout the organisation to have oversight of the data which may be contained within these returns.

3. Winter Pressure Related Data Submissions into National Systems

Submission	Frequency	Assurance of Data Quality	Data Quality Concerns
NE&C OAPs Sitrep	Ad-hoc, submitted to NECS every time we're notified of a change (new or discharged) Durham or Tees patient	Assurance validation undertaken with the clinical services every Monday (or Tuesday for bank holidays) via emails to Bed managers requesting confirmation our records for their areas are correct.	
OAPs CAP Portal	Monthly	Validated as per OAPs update above, and submitted via the NHS Digital Clinical Audit Platform	
OAPS Snapshot	Monthly	Validated as per OAPs update above and submitted as a survey each month to NHSE	
DTOC	Weekly	Patients recorded as "delayed" in Paris sent out to the clinical service responsible for the patient every Tuesday for validation	If a patient is not marked as a "Delay" in Paris, they will not be validated as part of this process. Comments have been received by services that not all delays are accurately recorded in the Paris system. This concern was raised at the Data Quality Working Group in

			July 22 and Digital Training provided some support for the guidance of recording delays on PARIS. We monitor those inpatients who have the ICD-10 code of Z751 recorded against their Finished Consultant Episode. These are checked to see if a Delay was recorded for the patients and if any themes of issues are present. This is currently being monitored to assess if the action has resulted in a reliable improvement.
HCV OAPs SitRep (inc. DTOC)	Weekly	For HCV the OAPs are validated with the service twice a week, every Monday and Thursday via emails to Bed managers requesting confirmation our records for their areas are correct.	As above for the DTOC element of this submission
KH03	Quarterly	Bespoke report from IIC, validated against Inpatient Dashboard published in the IIC	
MHLDA SitRep submission (split by covid and non-covid)	Daily	The figures for this come from services – usually the Business Managers – completion of templates and collated for a trust position.	This is a manual collation exercise via spreadsheet which has been in place since the start of the COVID pandemic. We have limited oversight of how robustly these spreadsheets are updated.
LFT Stocks submission	Weekly	These figures are provided by the operational support manager	This is a manual collation exercise which was put in place during the COVID pandemic. We have limited oversight of how robustly these figures are updated.

LFT results submission	Weekly	The results come from services (wards) and are collated	This is a manual collation exercise which was put in place during the COVID pandemic. We have limited oversight of how robustly these figures are updated.
MHSDS	Monthly	The latest Data Quality Maturity Index (DQMI) score for TEWV MHSDS is 97.50%. This is reported into Digital Performance and Assurance Group and monitored monthly. Dataset file is produced via an automated process monthly and validated by the Business Intelligence Operational Team against expected volumes of data, and validity of data within fields.	The MHSDS submission accurately reflects the clinical record. Any issues with clinical record keeping timeliness or quality will be accurately represented in the dataset.
Safe Staffing	Monthly	Goes to right staffing team for validation prior to submission	

4. NON-Winter Pressure Related Data Submissions into National Systems:

Submission	Frequency	Assurance of Data Quality	Data Quality Concerns
Children's Eating Disorders Waiters	Quarterly	Weekly validation with the clinical services and Performance using trackers	
FGM dataset	Quarterly	Information provided from the Safeguarding Team who are informed by the service	
IAPT Dataset	Monthly	Validated by BI Operational team and DQ work with IAPT service	The IAPT submission accurately reflects the clinical record. Any issues with clinical record keeping timeliness or quality that fall outside of the regular data quality work with the services will be accurately represented in the dataset.
KO41 Complaints	Annual	Complaints team involved in the process prior to submitting	
Mixed Sex Accommodation Breach	Monthly	Direct from Datix, normally nil return, any breaches are sent to Patient Safety for approval prior to submitting	
National Patient Survey	Annual	Validation from contractor to query demographic outliers from previous year, internal validation within BICO team	
NRLS	Weekly	Extract direct from Datix and uploaded straight into portal. Monthly DQ reports downloaded and sent to Central Approval Team	

Patient FFT	Monthly	Patient Experience team are sent data prior to submission	
Smoking Return	Monthly and Quarterly	Validated by BI Operational team, smoking leads involved in initial setup	

5. GLOSSARY OF TERMS:

Term	Description
HCV	Humber, Coast and Vale
NE&C	North East and Cumbria
OAPs	Out of Area Placements
CAP	Clinical Audit Platform
DTOC	Delayed Transfers Of Care
SitRep	Situation Report
MHLDA	Mental Health, Learning Disabilities and Autism
MHSDS	Mental Health Services Data Set
IAPT	Improving Access to Psychological Therapies
FGM	Female Genital Mutilation
KH03	Bed Availability and Occupancy collection
FFT	Friends and Family Test
KO41	Written hospital and community health service complaints
NHSE	NHS England
NRLS	National Reporting and Learning System
LFT	Lateral Flow Test

6. CONCLUSIONS:

All routine data flows described in this document undergo standardised production routines and validation, ensuring the “sustained quality of data” requested in the originating letter.

Some issues are identified regarding the quality/accuracy of data recorded into the primary systems. These issues should be validated against other organisational “soft intelligence” and consideration should be given as to whether steps are required to improve this position.

7. RECOMMENDATIONS: To note the contents of this document and provide feedback about any further detail or actions required.

North East and North Cumbria

Pemberton House
Sunderland
SR5 3XB

Ref: LD/SA_002

01 December 2022

NENC Provider Chairs and Chief Executives

Dear colleagues,

Data Quality

Following the publication of the national guidance on Next steps in increasing capacity & operational resilience in urgent & emergency care ahead of winter (Aug 22) and Going further on our winter resilience plans (Oct 22) there is now, understandably, a very significant focus on reported data. This has increasingly involved very detailed scrutiny of individual Trust data at both a regional and national level.

We therefore write to ask that Boards assure themselves regarding the on-going and sustained quality of data submitted by your organisations into national systems. In particular, Boards are asked to consider the measures they have in place to assure the data quality of the daily situation reports their Trust submits for the winter metrics.

Specific key metrics from the winter plan are shown below as a guide, but this list is not exhaustive.

1. General and acute bed capacity plans and actuals as reported through the SITREP e.g., bed capacity, occupancy and closures.

2. Urgent and Emergency Care related measures, including 2 hour community response and ambulance handover.

3. Discharge related metrics including patients with no criteria to reside.

4. Elective metrics including the Waiting List Minimum Data Set, Cancer PTLs and elective recovery via SUS.

5. Out of area placements (mental health).

We would appreciate if you could confirm the data relating to these areas are reported in a timely, accurate and your boards are assured on the data quality.

Yours sincerely,

Professor Sir Liam Donaldson
Chair
North East & North Cumbria ICB

Samantha Allen
Chief Executive
North East & North Cumbria ICB

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Trust Board of Directors

DATE:	**19th January 2023**
TITLE:	**Guardian of Safe Working Quarterly Report - January 2023**
REPORT OF:	**Dr Jim Boylan - Guardian of Safe Working**
REPORT FOR:	**Assurance**

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

Executive Summary:

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

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

The North and South Junior Doctor Forums were held in December 2022 with reduced representation of Juniors from all localities, probably related to seasonal leave taking and exam preparations . There were no new significant concerns reported by trainee reps from any sector during this quarter. Some continuing issues were discussed including access to LYPFT clinical information systems for TEWV based trainees in the South sector – there were no updates on this issue but monitoring will continue. There were no reports of particular difficulties in any of the on-call rotas in this quarter and plans are in place for a trust-wide review of on-call rotas for trainees during 2023.

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

Recommendations:

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

MEETING OF:	**Trust Board**
DATE:	**26th January 2023**
TITLE:	**Quarterly Report by Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

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

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

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

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

3. KEY ISSUES:

- **Appendices 1 and 2** provide more details for North (Durham & Teesside) and South (York and North Yorks) sectors respectively for the quarter October to December 2022 with a short narrative explaining the data from the relevant

medical staffing officer for each area. The relevant appendices are shared with the corresponding Health Education England body for the different sectors.

- From these appendices we can see that during this quarter there was a reduction in exceptions reported in the North sector (35 vs 47 in the previous quarter) with a continuing focus on Teesside (24 out of the total 35). In the South the exceptions remained level (27 compared to 27 in previous quarter) with the majority being in the Scarborough locality (20 out of 27). Teesside continues to be the locality with highest work intensity. The number of separate breaches requiring fines for this quarter fell significantly from the previous quarter (21 separate fines in this quarter compared to 47 in the last quarter).

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

- There was a report that alternative on-call accommodation at Lanchester road is still awaitin action and medical staffing are investigating this issue. We continue to monitor progress for the further development of facilities on the Roseberry Park site.

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

- There were no specific reported concerns about the availability of Crisis Team staff out of hours in County Durham or elsewhere to support the Section 136 assessments by Higher Trainees during out of hours assessments during this last quarter.

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

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

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

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

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

4.2 Financial/Value for Money:

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

4.3 Legal and Constitutional (including the NHS Constitution):

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

4.4 Equality and Diversity:

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

4.5 Other implications:

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

5. RISKS:

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

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

In terms of promoting recruitment and retention of doctors into more senior positions within the trust it is important for the board to continue active support for the development of resources and facilities for the accommodation and educational provision of trainees. Failure to do so is likely to risk a negative influence on

decisions by our high quality trainee workforce to consider a future position within the organisation.

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

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

In the context of the current requirements for social distancing our normally robust structures for Junior Doctor Forums and meetings between senior medics are potentially more challenged, although there is continuing evolution in the availability and use of technology for remote linkage.

6. CONCLUSIONS:

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

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

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

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

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7. RECOMMENDATIONS:

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

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

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

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

High level data

Number of doctors / dentists in training (total):	67
Number of doctors / dentists in training on 2016 TCS (total):	53
Amount of time available in job plan for guardian to do the role:	1 PA
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st October up to 31st December 2022

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	4	4	0
F2 –North Durham	0	2	2	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	14	14	0
CT1-2 –North Durham	0	2	2	0
CT1-2 – South Durham	0	5	5	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	5	5	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	2	2	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	1	1	0
Total	**0**	**35**	**35**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	19	19	0
Teesside & Forensic Senior Registrars	0	5	5	0
North Durham Juniors	0	4	4	0
South Durham Juniors	0	5	5	0
South Durham Senior Registrars	0	1	1	0
North Durham Senior Registrars	0	0	0	0
Durham & Darlington CAMHS Senior Registrars	0	1	1	0
Total	**0**	**35**	**35**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	0	6	13	0
Teesside & Forensic Senior Registrars	0	1	4	0
North Durham Juniors	0	0	4	0
South Durham Juniors	0	2	3	0
South Durham Senior Registrars	0	0	1	0
North Durham Senior Registrars	0	0	0	0
D&D CAMHS Senior Registrars	0	0	1	0
Total	0	9	26	0

Narrative for Exception Reports

Both North and South Durham junior doctor rotas are resident, so the exception reports received from both rotas were in relation to those doctors working additional time and extending their normal working day. The exception reports received from the Senior Registrars were in relation to claiming additional time worked over and above the time included in their work schedules.

In Teesside, 20 reports were from on call working above the schedule. The remaining 4 were for shadowing and extensions of the normal working day. There may be more exceptions report to come as the December NROC period is still on going.

Work schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	19	5	0	278.25	24.5
	CT1/2/GP	14	20	0	135	267.75
	CT3	8	4	0	95	65
	Trust Doctor	0	12	0	0	151
	SPR/SAS	20	20	0	368	368
North Durham	F2	0	0	0	0	0
	CT1/2/GP	10	10	0	82	82
	CT3	7	7	0	45.5	45.5
	Trust Doctor	0	0	0	0	0
	SPR/SAS	43	43	0	692.5	692.5
South Durham	F2	1	1	0	4.5	4.5
	CT1/2/GP	19	19	0	150.75	150.75
	CT3	2	2	0	25	25
	Trust Doctor	0	0	0	0	0
	SPR/SAS	47	47	0	750.5	750.5
Total		190	190	0	2627	2627

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Special Leave	3	3	0	12	12
COVID isolation	9	9	0	124	124
Maternity leave	0	0	0	0	0
On call cover	88	88	0	1402	1402
Vacancy	49	49	0	654.25	654.25
Sickness	41	41	0	434.75	434.75
Bank Holiday	0	0	0	0	0
Total	190	190	0	2627	2627

Vacancies

Vacancies by month						
Locality	**Grade**	**October 2022**	**November 2022**	**December 2022**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	1	1	0	0.67	0
	F2	1	1	0	0.67	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	1	0.33	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
South Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	1	1	1	0.67	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		3	3	1	2.34	0

Narrative - A number of the vacancy shifts in Tees area were due to gaps on the SR rota due to a delay in a SAS getting section 12 and a SAS joining the consultant rota, plus existing gaps on the rota.

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	8	£1570.80
North Durham	0	£00.00
South Durham	0	£00.00
Total	**8**	**£1570.80**

Narrative – there may be more fines to be added in as the NROC period overlaps the end of this report. Also, as the doctor receives a portion of the fine, the amount below accounts for the guardian portion only.

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
£2,874.29	**£4,316.56**	**£1,403.39**	**£5,787.46**

Purchases:

The following purchases have been made:

Date	Item	Location	Cost
10/10/2022	Coffee Pods	Jr Doctors Office WPH	£248.86
10/10/2022	Coffee Pods	Jr Doctors Office, RPH	£248.86
10/10/2022	Coffee Pods	Jr Doctors Office, LRH	£248.86
14/11/2022	Radiator	Jr Doctors Office, RPH	£47.95
30/12/2022	Coffee Pods	Jr Doctors Office, LRH	£248.86
		Total Spent	**£1,043.39**

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

High level data

Number of doctors / dentists in training (total):	0
Number of doctors / dentists in training on 2016 TCS (total):	0
Amount of time available in job plan for guardian to do the role:	1 PA
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st October 2022 up to 31st December 2022

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	10	10	0
F1 - York	0	0	0	0
F2 - York	0	0	0	0
CT1-2 - Northallerton	0	0	0	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	6	6	0
CT1-2 - York	0	2	2	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	4	4	0
CT3/ST4-6 – York	0	5	5	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	0	0	0
Trust Doctors - York	0	0	0	0
Total	**0**	**27**	**27**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton/ Harrogate/ York	0	7	7	0
Scarborough	0	20	20	0
Total	0	27	27	0

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Northallerton/ Harrogate/ York	1	3	3	
Scarborough	2	14	4	
Total	**3**	**17**	**7**	

Narrative around Exception Reports

Northallerton/Harrogate/York rota – only 3 exception reports were submitted during this period. 2 were to claim for additional payment following submission of the 8 week NROC monitoring form and one to report inadequate rest while on call. The other was to report a late finish to the normal working day.

Scarborough rota – majority of exception reports to report late finishes to the normal working day. There were also 6 to claim additional payment following submission of the 8 week NROC monitoring form and 3 to report inadequate rest while on call.

Middle tier rota – there were 2 exception reports to claim for additional payment following submission of the 8 week NROC monitoring form and 2 to report inadequate rest while on call.

Work Schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Northallerton/	F2	3	3	0	38.5	38.5

Harrogate/ York	CT1/2/GP	22	21	0	250.5	246.5
	CT3	8	8	0	118	118
	Trust Doctor	0	0	0	0	0
	ST4-6/SAS	14	12	0	232	212
Scarborough	F2	0	0	0	0	0
	CT1/2/GP	0	0	0	0	0
	CT3	5	5	0	88	88
	Trust Doctor	0	0	0	0	0
	ST4-6/ SAS	89	88	0	1577	1561
Total		**141**	**137**	**0**	**2304**	**2264**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	100	99	0	1748	1732
Sickness	18	16	0	182	162
Other	23	22	0	374	370
Total	141	137	0	2304	2264

Vacancies

Vacancies by month						
Locality	**Grade**	**October 2022**	**November 2022**	**December 2022**	**Total gaps (average)**	**Number of shifts uncovered**
Northallerton/ Harrogate/ York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	1	1	1	1	11
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	2
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	7.2	7.2	7.2	7.2	87
	Trust Doctor	0	0	0	0	0
Total		**0**	**0**	**0**	**0**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	9	£836.17
North Yorkshire & York	4	£855.47
Total	**13**	**£1,691.64**

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£4,816.89	**£1,691.64**	**£1,533.11**	**£4,975.42**

Purchases

Date	Item	Location	Cost
10/10/2022	Coffee Pods	Jr Doctors Office, FPH	£248.86
10/10/2022	Coffee Pods	Jr Doctors Office, CLH	£248.86
21/11/2022	Coffee Pods	Jr Doctors Office, FPH	£248.86
21/11/2022	Coffee Pods	Jr Doctors Office, CLH	£248.86
15/12/2022	Radiator	Jr Doctors Office, FPH	£39.95
30/12/2022	Coffee Pods	Jr Doctors Office, FPH	£248.86
30/12/2022	Coffee Pods	Jr Doctors Office, CLH	£248.86
		Total Spent	**£1,533.11**

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: Trust Board
Date: 26th January 2023
Title: Workforce Strategy update
Executive Sponsor(s): Sarah Dexter-Smith
Author(s): Sarah Dexter-Smith / Kate North

Report for:				
	Assurance	**x**	***Decision***	**x**
	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	

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1 and 5	**Recruitment Retention**	The present scores for both risks are above tolerance. The plans and assurance mechanisms described in the report support the strengthening of controls, in accordance with their risk management approaches, and the achievement of acceptable levels of exposure.

Executive Summary:

Purpose:

This report presents details of the assurance mechanisms in place for workforce issues and the immediate plans in place to address the key risks, in particular the staffing establishment across our services. The board is asked to consider the current mechanisms and plans and advise on whether this provides the appropriate level of governance through the organisation to enable them to maintain oversight of this risk.

Overview:

In developing this report, the following factors have been taken into account.

The board has recently reviewed its appetite risk relating to workforce issues and agreed to increase the risk appetite from 'open' to 'seek', indicating that we are prepared to tolerate short term implications for our workforce (but not for clinical delivery) where the skills and capabilities of our staff are likely to be improved i.e. we will tolerate short term disruption with the possibility of long term gains.

Workforce issues are inherently broad and interconnected. The strategic driver is strategic goal 2: to co-create a great experience for our colleagues. This is comprised of three areas:

- More people
- Working differently
- Compassionate and inclusive culture

All three elements are relevant to this report.

The biggest risks on the BAF relate to recruitment and retention. The key impact of both being our ability to provide safe and effective care to our

communities when and where they need us.

The critical element of workforce issues that this report therefore focuses on is how the board can take assurance that services either;

- have the appropriate, skilled and effective staff in place or
- know where their gaps are, how those gaps are being addressed and the likely timescales of the gaps being resolved

Knowing what staff we need is complex in an organisation where need is often unpredictable, is rising post covid in level and complexity and where funding and outcomes are not based on single, named interventions. However, in all specialties there is a core of work to be done and a therapeutic model which then guides our workforce planning.

The three levels of report which are being put into place provide a high level of assurance in some areas such as levels of mandatory training completed, and trajectories over future months, or numbers of which nursing staff are present on which ward on a daily basis. However they require more nuanced understanding in other areas such as impact of trust and local culture, and provision of services by staff who cover multiple teams providing very specialist input.

The three central reports will provide increasingly specific levels of information but, crucially, include a narrative on how the various metrics come together to deliver clinical services within the resources available.

Proposal:

The plans being developed and ongoing work to address workforce issues as a whole demonstrate evidence and actions to provide a good level of assurance

However, assurance for staffing establishment is proposed as reasonable overall but with inconsistencies within that, for the reasons outlined above.

The three reports on workforce measures and metrics are all linked to the People Journey, the risk registers, and the workforce delivery plans held centrally and in services.

1. Trustwide and care group/ corporate directorate level data

- High level analysis of key trends across the trust
- Provided end of 2nd week of the month to services
- Generated by People and Culture leads, delivered by Director/ Deputy director of people and culture and Principle People Partners
- Risk alignment – BAF
- Associated Workforce delivery plan – central plan overseen by People and Culture directorate and executive People, Culture and Diversity sub group.
- Most workforce data provided monthly but Health and Wellbeing, Speak up and Equality Diversity and Inclusion data will be provided quarterly at this level

2. General Management / corporate level data

- Local analysis of people data, service trends, triangulation with other measures
- Provided end of 2nd week of the month to services
- Generated by People and Culture leads, delivered by People Partners aligned to local services
- Risk alignment –service risk registers
- Associated Workforce delivery plan – care group and corporate deputies plans

- Workforce data provided monthly including Speak up information with more detailed HR operations information added eg grievances, disciplinaries. Health and Wellbeing and Equality Diversity and Inclusion data will be provided quarterly at this level

3. People and Culture operational data and workforce delivery plan update

- To provide accountability of People and Culture provision to the Trust
- Provided 4th Wednesday of the month to Executive Directors Group
- Generated by People and Culture leads, delivered by Director of People and Culture
- Risk alignment – BAF
- Associated Workforce delivery plan – central plan overseen by People and Culture directorate and executive People Culture and Diversity subgroup.
- Internal People and Culture KPIs relating to performance, finance and impact. With additional narrative on key strategic issues for executive directors to consider especially where these cross more than one function or programme of work. And specifically reporting on staffing establishment and vacancy issues.

Trustwide Dashboard

Work is underway to build the above workforce metrics in a dashboard for any staff member to access at any point in time for specific additional reports. Development of measures in the dashboard has commenced and will run until the end of March. All draft technical specifications will be ready for review by 10th February.

Assurance to the board

Critically for assurance to the board, the flow of information about staffing vacancies, mitigation and impact will now start in report 2 and accumulate up through the workforce planning/recruitment/workforce development retention framework so that increasing levels of risk are highlighted at each stage.

Each general management cluster will be be provided with information and analysis by staff group on:

- Establishment and vacancies
- Numbers advertised, shortlisted, cleared
- Sickness levels – long and short term
- Training levels
- Agency use and bank fill rate

Using the above metrics we can easily see issues related to availability of staff to deliver a service and support teams to understand where a number of factors are contributing to effective provision.

Progress

All service management clusters have been asked to provide details of their current gaps in staffing, the numbers of times they have tried to recruit and the confidence in their plans to address these gaps. We are now pulling those together to identify critical gaps (either based on volume or specific safety issues) and plan how to support those services.

We are also putting into place a number of new actions to ensure that that data is routinely integrated into service and trust discussions and enables us to innovate our workforce models.

These plans are intended to raise the assurance level related to the knowledge of our gaps and trajectories by the end of the financial year. They are not guaranteeing to fill those gaps.

Specifically, this will:

- Introduce three levels of reporting to support governance and assurance in relation to workforce issues as outlined above.

- Monthly oversight, supported by the new people partners, of service perception of gaps compared to formal establishment gaps in the budget

- With the clinical networks, establish the core professions required in each clinical service and the areas of flexibility to meet community need.

- Identify those significant gaps in workforce (either professional group, specialty or service) that the services have not been able to address and develop plans within a workforce planning-recruitment-workforce development- retention cycle

- Provide clarity to board on level of confidence in being able to address those staffing gaps and, if not, the clinical implications of those gaps being sustained.

- the report does not go into the detail of each project in place to address staffing shortages eg international recruitment or work with local educational establishments

Prior Consideration and Feedback

Previous board discussions have highlighted the growing confidence in the understanding of compliance levels for training, appraisals and the daily staffing in inpatient settings. However, there is less confidence in the quality of appraisals and the staffing available in community services.

Discussion has been held with leads from the People and Culture, Finance and Nursing and Governance directorates, people partners, and clinical / lived experience directors in both Care Groups. This tells us that knowing what staff we have in which service is complicated by different definitions of a vacancy (eg. finance, ESR, recruitment, team), different oversight mechanisms (eg whether a staff group is on a roster), and understanding of the interplay between vacancy, absence and temporary staffing rates.

Implications:

Embedding this suite of workforce information at various levels of the organisation will ensure we are better able to understand our workforce data and to respond better to the day-to-day issues. It will also improve our ability to develop more longer term robust plans to develop the right workforce to meet future demands.

Recommendations:

The board is asked to

1. Consider the reporting mechanisms in place and the plans proposed to the end of this financial year
2. Agree the requirement for a routine workforce report into board and on what frequency is should be reported. .