MEETING OF THE BOARD OF DIRECTORS

23 February 2023

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

AGENDA

A break will be held at approximately 3pm.

Standard Items (1.00 pm – 1.15 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 the last ordinary meeting held on 26 January 2023	-	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 (1.15 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 Report Appendix A – Integrated Performance Report Appendix B – Board Committee 3A Reports	Asst CEO	Report
11	To ratify the Risk Appetite Statements	Co Sec	Report
12	To consider the Corporate Risk Register	DoN&G	Report

Goal 1: To co-create a great experience for our patients, carers and families (2.00 pm – 2.35 pm)

13	To consider the Leadership Walkabouts Report	DoCA&I	Report
14	To consider the report of the Chair of Quality Assurance Committee *(See agenda item 10 appendix B for the Committee Key Issues Report)*	Committee Chair (BR)	Verbal
15	To consider the report on learning from the independent investigation report into Maternity and Neonatal Services in East Kent - Reading the Signals.	DoN&G	Report
16	To consider the report of the Chair of Mental Health Legislation Committee *(See agenda item 10 appendix B for the Committee Key Issues Report)*	Committee Chair (PH)	Verbal

Goal 2: To co-create a great experience for our colleagues (2.35 pm – 3.00 pm)

17	To receive a report from the Freedom to Speak up Guardian	Dewi Williams	Report
18	To consider the report of the Chair of People, Culture & Diversity Committee *(See agenda item 10 appendix B for the Committee Key Issues Report)*	Committee Chair (JH)	Verbal
19	To consider the Gender Pay Gap report	DfP&C	Report
20	To consider the Equality Delivery System 2022 Report	DfP&C	Report
21	To consider a report on Equality Objectives 2023-2027	DfP&C	Report

Exclusion of the Public:

21	**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.*	**Chair**	**Verbal**

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

David Jennings
Chair
17 February 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 26 JANUARY 2023 AT WEST PARK HOSPITAL, EDWARD PEASE WAY, DARLINGTON AND VIA MS TEAMS, COMMENCING AT 1.00 PM

Present:
D Jennings, Chair
B Reilly, Non-Executive Director and Deputy Chair
R Barker, Non-Executive Director
C Carpenter, Non-Executive Director
J Haley, Non-Executive Director
P Hungin, Non-Executive Director
J Maddison, Non-Executive Director
J Preston, Non-Executive Director and Senior Independent Director
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
K Kale, Medical Director
E Moody, Director of Nursing and Governance and Deputy Chief Executive
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)
S Dexter-Smith, Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary
C Reynolds, Chief Information Officer

Observers/members of the public:
M Booth, Governor
H Griffiths, Governor
G Restall, Governor
M Discombe, HSJ
R Farmer, Liaison Group
Member of the public

23/207 CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the first meeting of the year and suggested that the board's collective resolution for the coming year would be to deliver and build on the foundation of work that had taken place in recent years, evidence and exemplify changes and capture this and future priorities in Our Journey to Change.

The Chair noted the circulation of a supplemental agenda and proposed that in future papers be circulated by the agreed deadline or deferred to the following month. Committee chairs were invited to consider a similar approach.

23/208 APOLOGIES FOR ABSENCE

Apologies for absence were received from B Kilmurray, Chief Executive.

23/209 DECLARATIONS OF INTEREST

None.

23/210 THE MINUTES OF THE LAST ORDINARY MEETING ON 24 NOVEMBER 2022

Agreed: *That the minutes of the last ordinary meeting held on 24 November 2022 be agreed as an accurate record and signed by the Chair, subject to the correction of B Reilly in the list of attendees.*

In response to a query, K Christon outlined the process for completion of the board action log.

23/211 THE MINUTES OF THE LAST ORDINARY MEETING ON 24 NOVEMBER 2022

Agreed: *That the minutes of the special meeting held on 21 December 2022 be agreed as an accurate record and signed by the Chair, subject to the correction of 'In respect of falls, H Crawford noted…..'* [page 2 item 4]

23/212 BOARD ACTION LOG

The board reviewed and noted the Board Action Log and in discussion the following points were raised:

(1) It was proposed that board lunch and learn briefings be included alongside the board seminars and development workshops for 2023/24. These would be drop in sessions that would provide for in-depth discussion on subjects that were pertinent to the board's areas of interest. The proposal was welcomed by the Chair.

(2) The Chair noted that the board was committed to the inclusion of a patient story on the board agenda and further work would take place to ensure the format was appropriate [action: 22/186].

(3) In respect of the contribution to Quality Assurance Committee meetings (QuAC), the committee Chair confirmed the action related to the inclusion of care group related items on the committee agenda [action: 22/196].

(4) In respect of the Duty Nurse Co-ordinator, P Scott and E Moody provided assurance that the registered nurse on duty would not entirely step out of their role on the ward but acknowledged there would be an impact on capacity and suggested there was an opportunity to review and strengthen the ability to provide the Duty Nurse Co-ordinator role. J Haley requested confirmation of the position in writing [action 22/199].

Action: P Scott/E Moody

(5) Noting his attendance at a number of meetings, J Preston reported that the improvement in the crisis line had been well received.

23/213 CHAIR'S REPORT

The Chair presented the report, which provided a summary of work undertaken since the last meeting. He highlighted a further recent visit to the CAMHS team at Easington and welcomed their proactive approach and sense of ownership of issues as they arose. He also noted and welcomed a similar approach by staff based at Auckland Park.

J Haley also welcomed the positive approach taken by the CAMHS team at Easington. She commented on a recent visit to Chester-le-Street and praised the holistic approach taken to support individuals in the community.

Reflecting on visits he had attended, P Hungin suggested that teams had also displayed independence and he queried if teams were reluctant to set out any weak points and if the format of the visits needed to change for this to be understood. In response, the Chair suggested that there were staff who had the confidence to raise issues with board.

A Bridges advised that a new approach had been taken to visits in 2022 with teams invited to consider questions before the visit and submit paperwork in advance. She suggested that she had found teams to be open and honest about their strengths and challenges and noted that Executive Directors had a duty to follow-up on key issues raised.

P Scott went on to comment on how the trust was reenergising its approach to organisational development in order that teams felt empowered to deliver improvements. The ambition was for all teams to have an improvement plan and to be able to speak confidently about improvements they had made.

Z Campbell advised that the North Yorkshire Care Group had commenced an audit of support provided to services by Quality Improvement, to support the Care Group Board understand any patterns or themes.

Drawing the discussion to a close, the Chair suggested that the new format of visits had been helpful, and he welcomed the time teams had to reflect. He proposed that at visits the board would need to ensure there was a discussion on what teams were proud of, what they would change and the extent to which the trust supported and empowered them.

Action: Board Members

23/214 MATTERS RAISED BY GOVERNORS

None.

23/215 BOARD ASSURANCE FRAMEWORK SUMMARY

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

In presentation, P Bellas drew the board's attention to development of the report to include information on: the assurance ratings of individual controls; the positive and negative assurances identified since the last meeting; and how material reports at the meeting would impact on the management of relevant risks. He also noted further development work that would be completed by the end of April.

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

(1) The Chair welcomed the investment of time in development of the BAF, as a vehicle the board used to understand areas of concern and seek assurance that controls and mitigation were in place. He went on to suggest there would be merit in the inclusion of a table to detail the target level of risk, actual risk level and gap, in order that the board would be able to focus its quarterly discussion on those areas furthest away from target, with individual accountability held by the relevant Executive Director.

Action: P Bellas

(2) J Maddison noted that the BAF would continue to be work in progress and he welcomed the input of P Bellas and Executive Directors in its development. He went on to suggest that the BAF was used constructively by the board and its committees and as Chair of Audit and Risk Committee he was assured on its development.

(3) P Hungin echoed the comments of J Maddison and welcomed the progress that had been made. He referenced three key areas – recruitment, retention and CITO – as areas of focus for the board.

(4) J Haley also welcomed the development of the BAF to provide accurate and timely information and she noted those risks relevant to People, Culture and Diversity Committee on which she would work closely with the Director for People and Culture. She went on to raise a query about the reported demand in services/high caseloads and in response, the board was advised that innovative solutions, such as voice recording of notes, would be explored to address the current position.

(5) J Preston drew attention to areas where the trust had no control and suggested it would wish to consider how it would seek to influence the sub-regional, regional or national agenda. The Chair acknowledged the point raised and also referred to the impact of society and system issues on services, which the trust was not able to address.

Commenting further, L Romaniak suggested the board consider lobbying in respect of increased caseloads, the absence of national mental health recovery funding and access to a fair share of ICB resources. In response, the Chair suggested that the points raised would contribute to stakeholder mapping to inform conversations held by the board.

Action: A Bridges

(6) B Reilly acknowledged the work that had taken place, but she cautioned that the board would need to understand and have confidence in controls to be fully assured. Responding, P Bellas advised that committee business cycles had been developed for the coming year to ensure that controls were reported into the relevant committee.

(7) J Maddison reminded the board of the purpose of the summary document; that risks would be brought to the forefront and considered throughout the board agenda, and he suggested that, given the process, it would be a surprise if risks were not already highlighted.

(8) R Barker concurred with previous comments and raised a query on how long a high risk with limited control would be tolerated without reaching a resolution. In response, the Chair invited Executive Directors and committees to scrutinise the position to understand how long risks had remained at their current level and what related action was proposed. E Moody also noted that the new board report format supported authors to consider actions that would be taken to manage risk.

Action: Committee Chairs, Executive Directors

23/216 CHIEF EXECUTIVE'S REPORT

The board received and noted the Chief Executive's Report, which aimed to highlight topical issues that were of concern.

In presentation, E Moody drew the board's attention to:

(1) NHSE national planning guidance.

M Brierley commented on the three core priorities and reference the guidance had made to reducing inequalities, mental health, learning disability and autism. He noted the financial challenge for the trust to deliver long term plan priorities alongside its own priorities and that the trust would work with the system to manage that.

Commenting further, L Romaniak referenced the tight deadline for the planning round and advised that the ICB had received a financial allocation which it would work through with partners. She went on to highlight that systems were expected to return, via a convergence glidepath, to pre-covid financial arrangements, representing a system efficiency ask, and noted the additional national tariff efficiency target of 1.1% and the further reduction in covid funding.

M Brierley advised that the total uplift for mental health services was expected to be in the region of 5%, including net inflation. Reference was made to an NENC ICB Resource Allocation Steering Group, of which L Romaniak was a member. This had been established to focus on how to maximise the financial allocation to the ICB and how resources should be deployed for 2023/24 and in the longer-term.

(2) Use of the board's emergency powers to approve the Annual Report and Accounts of the Charitable Trust Funds 2021/22.

(3) The outline findings and recommendations from the governance review. M Brierley confirmed that the full report would be presented to the board in February.

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

(1) In response to a query from P Hungin on autism diagnostic waiting times, Z Campbell advised waiting times can be up to two years and waits of 12 months were not unusual.

M Brierley noted that a number of waiting list initiatives had been piloted. The position was common across ICS' and had been an area of focus, but there was a sense that all options had been explored and a new needs led approach was required to support families and individuals while they waited to access services. Commenting further, P Scott advised that there was an opportunity to learn from other services that had introduced this approach and suggested that this would be a priority for the system.

The Chair suggested the trust was in a unique position to compare and contrast provision across both Integrated Care Systems, and review historical decisions taken.

J Preston suggested that carers would indicate they found initial access to triage to be good and that such waiting times were not uncommon. In respect of staff training on autism, he noted that the trust was ahead of others with 50% of staff now trained.

J Haley noted the potential to learn from good practice.

(2) B Reilly noted that the next Quality Assurance Committee meeting would consider the Clinical Journey to Change and an update on workforce planning and queried how they related to the development of an ICS workforce plan.

In response, M Brierley suggested that both were required and would be complementary, with priorities from the trust fed into the ICS plan, which would be focused on general planning and contracting.

Commenting further, S Dexter-Smith advised that workforce planning was already considered at an ICS level, where there had been a focus on common challenges.

(3) B Reilly suggested that there was an opportunity improve writing for assurance and triple A reporting. In response, E Moody advised that alongside the governance review members of the IST would provide a critical friend review of reporting arrangements.

(4) P Hungin queried the reported level of staff who had indicated they had clear objectives and that it had helped them to do their job.

In response S Dexter-Smith advised that work had taken place to understand and improve the process through use of Workpal, which had built on learning from recent appraisals. Workpal would support staff to build objectives during the year to inform the conversation with their line manager. It was expected that it would lead to a significant improvement.

Commenting further, C Carpenter suggested the Integrated Performance Report was not clear on the measures that would be taken to address the position and when an impact would be expected and highlighted that information would be available from the staff survey to indicate where an interim response was required.

In response, S Dexter-Smith noted that the confidential report would assist the board on this matter. She advised that the BAF would be updated to reflect that there was limited assurance but that this would improve once controls were in place. She went on to confirm that staff survey results would be considered, but this did not provide information on teams below 10 staff.

The Chair noted that the board would see greater evidence of action outlined in the BAF and Integrated Performance Report, to enable progress to be monitored against expected trajectory.

23/217 INTEGRATED PERFORMANCE DASHBOARD

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

In presentation, M Brierley drew the board's attention to:

(1) Proposals to report information one month in arrears from April 2022, which required changes to the schedule of board and committee meetings. In the interim, the most recent intelligence had been included in the report to support the metrics, which were reported at November 2022.
(2) Alignment of the dashboard to the BAF in order to focus on key issues and provide the board with assurance that appropriate action had been taken.
(3) Appraisals [measure 21] where assurance had been provided to Executive Directors Group that the 85% target would be achieved by the end of March 2023.
(4) Unique caseloads [measure 23] where an increase had been noted due to factors beyond just those of demand. A working group had been established to understand the position and until then limited assurance was available.
(5) Staffing pressures, which remined a concern and where there continued to be a significant focus by care groups on safe staffing levels.
(6) The Quality Assurance Programme where monthly improvements had been noted since its launch in 2022.

(7) The sad death of an inpatient in December 2022. A rapid review had been completed and no immediate areas of actionable learning had been identified. A full independent review would be commissioned.
(8) Inpatient pressures, where there remained fluctuating use of independent sector beds due to factors such as delayed transfers and discharges. The Bed Occupancy Group continued to focus on actions to reduce bed occupancy and it was noted that funding and support from the wider system would be required to respond to the 100-day national initiative by NHS England.
(9) Care group concerns about the environment and pressures on inpatient services.
(10) The significant improvement in the performance of the North Yorkshire Crisis Line, where 92% of calls were now answered, following the introduction of a triage service by the voluntary sector.

The Chair welcomed the improved position and, in response to a query, P Scott noted that there were trust wide arrangements in place to share learning.
(11) The main risks that ran through the report, which included: recruitment and retention, where work would be undertaken through the Workforce Strategy; agency expenditure and bed occupancy, which continued to drive the financial position; waiting times within the Children and Young People Neurodevelopmental service; and financial recovery.

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

(1) P Scott highlighted a concern of the Durham, Tees Valley & Forensics Care Group Board in respect of the level of patients who reported that they felt safe whilst in the trust's care. He noted that in response, cocreation events had been organised in February and work would take place to involve carers and patients in the governance of services, including to consider the impact of services and outcomes.

(2) J Maddison welcomed the ongoing development of the report, including narrative on progress, which provided a means by which the board would seek assurance on the impact of related actions.

(3) In response to a query on the financial position, L Romaniak advised that following discussion at the last meeting, additional funding had been received from HEE and from commissioners, and the national discount rate for provisions at the year-end had been provided, which would have a favourable impact. Taking this into account and alongside recovery actions, it was expected that the trust would be able to self-mitigate the £3m residual financial risk reported at the two previous meetings and to ICS partners, subject to ongoing pressures such as staff sickness and bed occupancy levels remaining as projected.

(4) Noting the increase in inflation, J Maddison proposed that the Strategy and Resources Committee explore the financial position for 2023/24 to give assurance to the board on the level of risk and potential financial gap, including in relation to excess inflation.

Action: L Romaniak

In response, L Romaniak advised that some non-recurrent resources had been provided during 2022/23 to support providers with inflation in excess of tariff. Costs for 2023/24 would be clarified during the business planning process, with funding allocations yet to confirmed.

(5) B Reilly welcomed the reported improvement in the Crisis Line service, as an area of concern raised by governors. She went on to query the allocation of a CRES target to the

service and in response, L Romaniak advised that target was not an expenditure reduction, but a commissioner funding related issue only.

(6) B Reilly noted that the board had met to seek assurance following the recent inpatient death.

(7) In respect of safe staffing, B Reilly expressed concern about the ratio of Health Care Assistants to Registered Nurses on wards and noted feedback from director visits that suggested the skill mix was an area of concern. Reference was made to the report which indicated a decrease in agency expenditure and assurance was sought that financial considerations would not impact on the appointment of Registered Nurses.

In response, E Moody advised that requests for Registered Nurses exceeded what the agency was able to provide. The trust operated with a rostered skill mix that was 50/50 Health Care Assistant to Registered Nurse but had struggled to fill vacant posts and wards had operated with one Registered Nurse on shift. The position was closely monitored, and good escalation processes were in place, including daily capacity meetings. The outcome of this was reflected in reports that patients did not feel safe, and this was due to inconsistency of staff.

(8) P Hungin queried the waiting times for memory assessment services and action that had taken place to resolve the position, as an area of concern highlighted by governors.

Z Campbell acknowledged the impact that significant waiting lists had on service staff, despite work that had taken place. She noted the national increase in demand and advised that a number of solutions had been explored, including working more closely with primary care.

Commenting further L Romaniak noted that the Long Term Plan had led to welcome investment in community services but unintended consequences for a number of other services, including core inpatient, austism and memory assessment services. She noted that the memory assessment service had been an exemplar through Covid in respect of the level of diagnostic assessments completed and as a result more people had waited to access the service.

It was noted that the report would be corrected to show that demand had outstripped capacity [page 9].

(9) J Haley discussed the opportunity to develop the dashboard to provide smart objectives, including who was responsible, the desired outcome and progress updates. In response M Brierley noted that the IPR would continue to develop towards the use of smart objectives and reporting one month in arrears. P Scott advised that there had been a focus in care groups on anticipated impact assessments.

Drawing the discussion to a close, the Chair welcomed the continued investment in development of the IPR and requested that detail be included to provide clarity on smart objectives, outcomes and impact.

Action: M Brierley

The Chair suggested the report provided an opportunity for the board to highlight areas where targets had been consistently missed and alternative options would need to be considered.

The Chair noted that the workforce was an underlying issue throughout board reports and concluded that work should be finalised as soon as possible.

23/218 REPORT FROM THE AUDIT AND RISK COMMITTEE

The board received and noted the report from the Chair of Audit and Risk Committee, which aimed to alert, advise and assure the board on matters raised at the last committee meeting.

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

(1) Committee had recognised that further work was required following feedback from the NHSE/I Intensive Support Diagnostic and recommended that this be incorporated into the governance review.
(2) Committee had agreed changes to the Internal Audit Plan.
(3) Positive assurance had been received in respect of counter fraud.
(4) There had been a significant reduction in tender waivers and J Maddison thanked the team for their efforts in this regard.
(5) Committee had recommended to the board the approval of the Annual Report and Accounts of the Charitable Funds for 2021/22, which the board had subsequently dealt with under emergency powers due to timescales.
(6) A quarterly meeting of committee Chairs had been established to consider cross-cutting matters.
(7) Committee had been assured on the progress made in relation to risk oversight and management.
(8) Committee would monitor actions in respect of the completed HfMA Financial Sustainability Self-Assessment and outstanding recommendations of the ICO report.

Commenting further, L Romaniak noted an improved position in respect of the reported ICO submission, with two outstanding actions in progress and one on hold and noted that this was pending ICO feedback.

23/219 LEADERSHIP WALKABOUTS REPORT

The board received and noted the Leadership Walkabouts Report, which provided high-level feedback from recent leadership walkabouts to services.

Presenting the report, A Bridges commented on the partnership approach taken by Hartlepool CHMT Community Interface Team and the opportunity and benefit of co-locating services with partners. Reference was made to recruitment and retention challenges and the impact on skill mix and she welcomed the appointment of Care Navigators to support early triage. It was suggested that the current focus be continued for the following two visits and that governors continued to be invited.

The Chair welcomed the ongoing involvement of governors in visits.

23/220 REPORT FROM THE QUALITY AND ASURANCE COMMITTEE

The board received and noted the report from the Chair of Quality Assurance Committee, which aimed to alert, advise and assure the board on matters raised at the last committee meeting.

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

(1) That the board may wish to be sighted on themes arising from the culture risk assessment work, approved by the board in November 2022.
(2) Committee had been concerned about the lack of progress and limited assurance in respect of outstanding serious incidents.

(3) There had been limited assurance in relation to safe staffing in community and inpatient services.
(4) In relation to complaints and compliance with the 60 day target, the current position was felt to be unacceptable.
(5) Committee had discussed the performance of the Crisis Line and the committee Chair welcomed the improvement reported at the board meeting.
(6) Committee had received significant assurance in respect of the workload and capacity of the Patient Safety Team but considered that the recruitment process remained longer than was acceptable.

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

(1) E Moody noted that complaints had reached 40% compliance and concurred that the position was not where the trust would wish to be. In respect of compliance with CQUIN targets for cirrhosis and fibrosis, the targets may not be achieved but positive progress had been noted against the new measures and reliable processes were in place.

(2) E Moody acknowledged the points raised at the committee meeting in respect of patient safety and discussed the challenge that the serious incident backlog presented. She advised that significant improvement and transformation work was underway and there was capacity to meet future demand. The trust had worked with the ICB and NECS to identify capacity to progress the backlog and in the interim all historic SI's had been themed, with few new themes or immediate learning identified.

The Chair welcomed the honest update and referenced the board discussion earlier in the meeting on tolerance of risk where limited progress had been made. He encouraged that alternative options be considered and proposed that clarity be provided through the Quality and Assurance Committee on when progress would be expected.

Action: E Moody

(3) J Preston noted the board had agreed it would not tolerate risk in relation to service delivery and queried if external support had been sought to address the backlog and risk that learning from serious incidents was not captured.

In response, E Moody advised that 14 cases from the backlog had been allotted to NECS and two had been completed to date. The ICB and partners had been approached for mutual aid, however there was a shortage of individuals with the necessary skills to carry out the work. In the interim, a prioritisation process was in place.

23/221 LEARNING FROM DEATHS

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

In presentation, E Moody highlighted the following points:

(1) That there was good assurance in respect of reporting and learning in line with national guidance.
(2) Seven main themes had been identified and these were in line with the new Patient Safety Incident Response Framework. Themes and the impact of action taken was discussed by the monthly NHSE Quality Board.

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

(1) B Reilly raised a query in respect of consistent themes and how progress to address them would be measured.

In response, E Moody advised that the themes were as expected and would be those seen by other mental health trusts. She proposed that a report be provided to Quality Assurance Committee on detailed work completed. Audits had shown consistent progress in relation to risk management and clinical record keeping, with softer intelligence from patient and family feedback.

(2) Commenting on the three lines of defence assurance model, the Chair proposed that Executive Directors Group and Quality Assurance Committee reflect on the themes identified and what this indicated about the first line of defence and the trust's culture and the oversight and accountability of staff to their line manager.

Action: E Moody

In response and as an example of work carried out, E Moody highlighted that a safeguarding practitioner had been placed in services three days per week for staff to raise concerns and to incorporate safeguarding into everyday language, and a named Doctor had been identified for safeguarding adults. A review of related policies had also been completed.

(3) K Kale advised that consistent themes would be expected and proposed a focus on the number of times themes occurred as a measure of improvement.

Action: E Moody

(4) B Reilly proposed that future reports be considered by the Quality Assurance Committee for assurance to be provided to the board.

Action: E Moody

23/222 WINTER PREPAREDNESS

The board received and noted the report on winter preparedness 2022-23, which provided assurance on the trust's position against the standards and suggested requirements and appraised the board of the actions and potential mitigation in place where standards were not met.

E Moody presented the report and suggested that reasonable assurance was provided. She went on to highlight that the trust's ability to manage pressures in the event of a winter surge would be a challenge and drew attention to the reported areas that required further consideration in order to strengthen assurance.

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

(1) P Hungin commented on pressures created by increased energy bills. In response, E Moody advised that some fixed contracts were in place but other had increased and the impact of this would be highlighted during the business planning process.

(2) E Moody acknowledged the timing of the report and suggested that the principles would apply throughout the year.

(3) The Chair suggested he was reassured by the information provided. He noted that the underlying issue of staff availability had been highlighted and this remained a key area of concern for the board.

(4) B Reilly noted that the exercise was a requirement of NHS England and suggested there was reasonable assurance in regard to inpatient safe staffing, but wider than that she was not assured as no information had been provided.

In response, E Moody accepted that there was not the same visibility of community services. She indicated that work had taken place on a community roster and suggested that there was some assurance as community escalation procedures were in place. Commenting further P Scott, noted that daily staffing calls were completed, and areas of risk would be escalated in order to consider staff redeployment.

(5) B Reilly noted the level of vacancies in CAMHS in North Yorkshire. In response, Z Campbell advised that a successful recruitment exercise had recently been completed.

Agreed: *That the board confirm the level of assurance as reasonable.*

23/223 DATA QUALITY OF EXTERNAL SUBMISSIONS

The board received and noted the report which described external data flows, controls in place to ensure consistent data was provided and validation checks to ensure accurate data. This responded to a request from the ICB that the board should assure itself regarding the on-going and sustained quality of data submitted into national systems.

In presentation, M Brierley advised that data quality audits would be completed periodically to provide assurance and mitigation work had taken place in areas where concerns had been identified.

In discussion, the board agreed that it was assured that a data quality process was in place.

Agreed: *That the board was assured that a data quality process was in place in regard to data submitted into national systems.*

23/224 GUARDIAN OF SAFE WORKING

The board received and noted the quarterly report that provided assurance that Junior Doctors were safely rostered and working hours were safe and in compliance with the terms and conditions of service.

In presentation, J Boylan advised there were no significant areas of concern over the last quarter to draw to the attention of the board. He noted that intensity levels in some non-residential areas continued to be monitored, particularly in Teesside and Scarborough, although there had been a fall in exception reporting. He went on to welcome the engagement of junior doctors in the trust wide review of on-call rotas.

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

(1) Z Campbell noted that the trust had struggled to fill vacancies in Scarborough and all avenues had been explored. Commenting further, K Kale advised that there were less trainees in Scarborough and it had been a challenge to provide a non-residential shift rota.

(2) K Kale confirmed that the review of on-call rotas related to non-residential rotas in Scarborough and Teesside, which needed to be managed in a different way to that of residential rotas, with particular requirements for rest time. Trainees were encouraged to submit exception reports in order that the trust would be aware of the position.

(3) J Boylan advised that the review of on-call rotas would consider the potential to move toward residential on-call rotas where appropriate, but this may lead to an increase in junior doctors in some localities. He noted that the outcome of the review was expected in Spring 2023.

(4) The Chair welcomed the review as the opportunity to rethink current arrangements in order to achieve a different outcome.

The Chair thanked J Boylan for attending and for championing this area of work.

23/225 WORKFORCE STRATEGY UPDATE

The board received and noted the report, which presented details of the assurance mechanisms in place for workforce issues and the immediate plans in place to address key service risks, in particular the staffing establishment across services.

In presentation, S Dexter-Smith drew the board's attention to the following:

(1) That reasonable assurance would be taken from the controls proposed and further detailed information would be provided in the board's confidential session.
(2) The proposal would be to develop three reports on workforce measures linked to the People Journey. They included: trust wide and care group/corporate director level data; general management/corporate level data; and People & Culture operational data and workforce delivery plan update.
(3) The general management report would provide data on the establishment vacancy and posts in recruitment, which would be supported by analysis by profession or service. This would be considered by Executive Directors Group each month.
(4) A board report would be a combination of the three reports, with a focus on risk and mitigation and a clear line of sight to the BAF and IPR.

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

(1) The Chair welcomed the update and sought clarity on how the proposed reporting arrangements would ensure the board was able to take assurance that services had appropriate levels of staff and gaps had been addressed within acceptable timescales. In response, S Dexter-Smith indicated that further information would be available in the confidential board session.

(2) M Brierley referenced the importance of availability of data at the right level within the trust in order that managers would understand the position and mitigation that was required.

(3) J Haley proposed that the board report be received on a quarterly basis and in discussion it was noted that this would fit well with quarterly meetings of People, Culture and Diversity Committee and the monthly meeting of Executive Directors Group.

Agreed that: *the board to receive the workforce report on a quarterly basis, but this would be subject to review, once the first report had been provided.*

23/226 STAFF MANDATORY AND STATUTORY TRAINING UPDATE

S Dexter-Smith provided a verbal update and noted an increase in compliance across all services. She advised that:

(1) Trajectory work had taken place and it was expected that services would meet safe training levels before CITO training took place.
(2) Against the 85% target, 28 areas were below target and 18 had achieved or overachieved.
(3) The position had improved each month and patient related training had continued to be closely monitored.

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

(1) L Romaniak advised that in respect of the target of 95% for information governance training compliance had reached 90%, but the trust needed to attain the target by the end of February to be compliant with the DSPT.

(2) J Haley confirmed that updates would be provided to People, Culture and Diversity Committee.

23/227 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 5:40pm.

Board of Directors
Public Action Log

ITEM NO. 5

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	Mar-23		Update provided to the SRC on 17/8/22 (see conf item 7). Update Jan-23: Report to board in March 2023
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	Mar-23		Nov-22: Chair of QuAC to raise at next meeting and provide feedback to the board in 2023. To be discussed by QuAC in Mar-23
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: Update provided.
29/09/2022	22/139	Staff survey	People, Culture & Diversity Committee to carry out a deep dive into the reductions in the percentage of staff who would recommend the trust as a place to work and the percentage of staff who responded to the survey.	DfP&C	tbc		
29/09/2022	22/144	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 and lunch and learn events	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 26/01/2023	22/179 23/C/211	Staffing and workforce	Summary report to be provided on work in progress on sustainable staffing levels and skills.	DfP&C	Quarterly		Jan-23: Quarterly workforce report to be provided to BoD, subject to review once the first report had been provided - to include information on turnover and culture

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
24/11/2022	22/186	Patient/Staff/Partner Story	The next patient/staff/partner story to be held at the January 2023 board meeting.	DoN&G	tbc		Work to take place on the format to ensure it meets the needs of the BoD and is a positive experience for those involved.
24/11/2022 26/01/2023	22/190 23/217	Integrated Performance Report development	Nov:22: Report to be developed to include a forward view on actions required to ensure progress is made. Jan-23: Detail be included in the IPR to provide clarity on smart objectives, outcomes and impact.	ACEO	tbc		
24/11/2022	22/191	Corporate Risk reporting	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, Co Sec	Mar-23		New report format introduced February 2023
24/11/2022	22/196	QuAC	Contribution at QuAC from executive directors and senior managers to be considered. Jan-23 update: Exec Director to ensure the agenda appropriately reflects care group discussions	DoN&G	ongoing		
24/11/2022 26/02/2022	22/199 23/213	Duty Nurse Coordinator - staff capacity	Assurance to be provided at Jan-23 board meeting on staff capacity to undertake the Duty Nurse Coordinator Role and impact on safe staffing.	DTVCG MD DoN&G	Feb-23		Jan-23: Assurance provided. Written confirmation to be provided to PCDC Chair.
26/01/2022	23/203	Leadership Walkabout visits	Board to ensure there is a discussion at visits on what teams are proud of, what they would change and the extent to which the trust supported and empowered them.	Board Members	Ongoing		
26/01/2023	23/215	BAF	Format to be reviewed to consider potential for a table detailing the target level of risk, actual risk and gap	Co Sec	May-23		
26/01/2023	23/215	BAF - lobbying	Stakeholder mapping to be completed to inform conversations held by the board.	DoCA&I	tbc		
26/01/2023	23/215	BAF - tolerance of high risks	Executive Directors and committees to scrutinise the position to understand how long high risks had remained at their current level and what related action was proposed.	Exec Directors, Committee Chairs	May-23		Next cycle of committee meetings will be May 2023
26/01/2023	23/217	2023/24 Financial position	Strategy & Resources Committee explore the financial position for 2023/24, to give assurance to the board on the level of risk and potential financial gap.	DoF&I	May-23		Next cycle of committee meetings will be May 2024
26/01/2023	23/220	Serious Incidents	Clarity be provided through the Quality and Assurance Committee on when progress would be expected.	DoN&G	tbc		
26/01/2023	23/221	Learning from Deaths	Executive Directors Group and Quality Assurance Committee to reflect on the themes identified and what this may indicate about the first line of defence and the trust's culture and oversight and accountability of staff to their line manager.	DoN&G	Apr-23		
26/01/2023	23/221	Learning from Deaths	Future reports to be considered by QuAC for assurance to be provided to the board. To include a focus on the number of times themes occurred as a measure of improvement.	DoN&G	Apr-23		

Chair's Report : 13th January 2023 – 16th February 2023.

Headlines:

External:

- Meeting with Humber & North Yorks ICS Chairs
- Meeting with North Tees & South Tees Chair
- Meeting North East & North Cumbria ICB Board & FT Chairs
- North East & North Cumbria ICB Development Session, including East Kent Maternity findings
- Weekly MH Chairs' Network including National Rapid Review of in patient data
- Meeting Darlington MP
- Board to Board with NHSE and North East & North Cumbria ICB colleagues
- Meeting with North East & North Cumbria ICB Chair
- Meeting North Tees & South Tees NHS Trust Chair

Governors

- Meetings with one Governor

Internal

- Judging, and giving, Living the Values Awards
- Leadership Walkabouts
- Visit to Auckland Park
- Visit to Easington CAHMs
- Visit to North Moor House MHSOP Community MH Team
- Various meetings & discussions with executive officers
- Chief Nurse appointment interviews

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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:	**23rd February 2023**
Title:	**Board Assurance Framework – 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 Board Assurance Framework supports the Board discharge its overall responsibility for internal control.

Executive Summary:

Purpose: The purpose of this report is to support discussions at the meeting by providing information on the risks included in the Board Assurance Framework (BAF).

Proposal: Board Members are asked to take the strategic risks, included in the BAF, into account during discussions at the meeting.

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

A summary of the BAF is attached. This includes information on the strategic risks and related key controls and positive and negative assurances relating to them which have been identified since the last meeting. It also describes the impact of material reports due for consideration at the meeting in the context of the management of the relevant strategic risks.

A report on the full BAF is provided with the confidential agenda.

During the consideration of that report the Board is asked to consider whether discussions at the meeting have highlighted:

(a) Any further gaps in control or assurance which need to be addressed urgently.
(b) Any new or emerging risks which impact on the BAF.
(c) Any issues relating to the operation of controls so that reports can be scheduled within its business cycle.

Prior Consideration and Feedback	The BAF is subject to review by the Board's Committees prior to presentation to the Board.
Implications:	None relating to this report.
Recommendations:	The Board is asked to take the strategic risks into account during its discussions at the meeting.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3									
1	✓	✓		**Recruitment** Inability to recruit sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services	DoP&C	PCDC	High ↔	Low (Dec 23)	Good ↑	Establishment Reviews Recruitment Oversight Group Recruitment & Selection Procedure↑ "A great place to work" Partnerships with Education and Training Providers Planning beyond the Crisis↑	**Positive:** Partnerships with education and training providers have improved with events through apprenticeship week. There is evidence of an increase in the positive experiences of apprentices. **Negative:**	
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)	QuAC	High ↔	Moderate (Mar 23)	Good ↑	Partnership Arrangements↑ Surge Modelling ↑ Operational Escalation Arrangements Integrated Performance Reporting↑ Establishment Reviews↑	**Positive:** IPR - Bed Occupancy (measure 8) now has positive controls assurance (previously negative assurance). **Negative**: IPR - Number of new unique patients referred (measure 22) now has neutral controls assurance (previously positive assurance). QuAC - Bed occupancy remains a concern being up to 113% in Teesside – the ambition being 85%.	
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	QuAC	Moderate ↔	Moderate (Mar 23)	Good ↓	Revised Executive and Organisational Leadership Structure Business Plan (Co-creation priorities) Co-creation Programme Board (New)	**Positive:** PCDC - Good assurance confirmed regarding the consultation process used to develop the equality objectives involving service users and carers, staff networks and other staff. **Negative:**	
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))	DoCA&I	QuAC	High ↔	Moderate (Mar 23)	Reasonable	Complaints Policy Friends and Family Test/Patient Experience Survey Patient and carer engagement and involvement structures and processes Our Quality and Safety Strategic Journey	**Positive:** QuAC – ▪ Good progress is being made towards the approval of Our Quality and Safety Journey following its review by the Committee. Once approved by the Board in March 2023 it will enable the Board to monitor progress our key clinical, quality and safety plans and ensure our goals are achieved in line with OJTC. ▪ Recognition that there is a clear	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3								escalation protocol where concerns about staffing are identified. **Negative:** QuAC – ▪ Staffing levels remain a concern. There continues to be a low fill rate for registered nurses and high usage of bank and agency staff in some areas. ▪ The current temporary closure of adult learning disabilities admissions has led to several LD related admissions in adult services which does not provide an appropriate environment with suitably skilled staff. ▪ Reasonable assurance that individuals with a learning disability and/or autism in long term segregation have had their care independently reviewed.	
5	✓	✓		**Staff Retention** Multiple factors could contribute to staff not choosing to stay with the Trust. This will undermine the provision of safe and sustainable services as well as putting individual staff and patients at risk of harm.	DoP&C	PCDC	High ↔	Moderate (Dec 23) ↑	Good	Understanding the cultures that exist across the organisation Health and Wellbeing Group and offers Ensuring staff are able to raise concerns in a safe and constructive way Work with services to resolve problems in relationships and culture, based on ABC model of wellbeing 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 Cultural embeddedness in communities we serve Understanding why people choose to leave the trust or move roles	**Positive:** **PCDC** – ▪ Good assurance that the Trust has robust processes in place for staff from protected groups to allow them the opportunity to raise concerns and for these to be heard and acted on via Staff Networks. ▪ Assurance on the operation of the control on understanding why people leave has been strengthened with information from the new independent process now included in the monthly workforce report for the first time. A KPI of 20 interviews per month in February and March, and then a more high profile launch in April, has been agreed. **Negative:** IPR **–** ▪ Percentage of staff recommending the Trust as a place to work (measure 16) now assessed as having limited performance assurance (previously reasonable) ▪ Percentage of staff feeling they are able to make improvements happen in their area of work (measure 17) now assessed as having limited performance assurance (previously reasonable)	**Public Agenda Item 20 – Equality Delivery System 2 Report** This report, and the sophisticated data analysis by the analyst team, has provided a very clear understanding of where there are issues down to the very specific experiences of specific protected groups at specific parts of their employment journey or experience of care. This means the Trust's EDI objectives for the year can be much more targeted.

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3									
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	DoN&G	QuAC	**High** ↔	**Low (Mar 23)**	**Good**	Incident management policies and procedures Governance arrangements at corporate, directorate and specialty levels Performance Management of Serious Incident Review Organisational Learning Group (OLG)	**Positive:** QuAC – NICHE Assurance Actions: the governance processes in the approach to learning from the deaths of three young women in 2019/20 have been agreed. **Negative:**	**Public Agenda Item 15 - East Kent Maternity Review/Kirkup** This report draws the Board's attention to the failures and supports the management of patient safety risks through increased engagement and discussion with staff as well as identifying any further actions to address patient safety within the Trust.
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	SRC	**Moderate** ↔	**Low (2025)**	**Good**	Estates Master Plan (EMP) ERIC PLACE national annual reporting / benchmarks and Green Plan submission and monitoring Premises Assurance Model	**Positive:** **Negative:**	
8	✓	✓	✓	**Cyber Security** A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage	DoF&I	SRC	**High** ↔	**High (Mar 24)**	**Reasonable** ↑	Controls information not provided due to security concerns	**Positive:** The Trust is in a relatively good position compared to peers (top 20% nationally) for cyber security. Excellent progress has been made using cyber defence tools provided by NHS England/Digital. The Trust's windows device exposure score is currently 26/100 (a low score indicates that systems are less "exposed" and hence more secure) compared to scores of between 30 and 80 for other NHS organisations. **Negative:**	**Confidential Agenda Item 8 – Cyber Strategy** The strategy was developed with the support of external cyber experts to consider gaps in the Trust's cyber responses in the context of an evolving cyber risk and to ensure this is mitigated appropriately through phased investment over the next 3 years (with annual reviews). The introduction of Centre for Internet Security Controls, comprising 56 measurements (defined on industry cyber standards) will strengthen a wide range of cyber processes. The Cyber Assurance Framework will be used to assess our top 10 most critical systems and ensure robust counter measures. Subject to annually available funding, the Strategy supports investment in technology solutions and staffing.

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3									
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	QuAC	High ↔	Moderate (Mar 23)	Good ↑	Senior secondments and interim appointments Relationship Management Arrangements with the CQC ↑ CQC Action Plan	**Positive:** QuAC – ▪ The inpatient culture assessments have been completed and reported to QuAC. Seeing, hearing and feeling the experiences and environments that staff and patients are working in has provided positive assurance and also identified themes and areas where improvement actions can be taken. ▪ There continues to be good assurance relating to system oversight and delivery of the CQC action plans with no new gaps in assurance. ▪ There is good assurance on the completion of actions relating to communication, engagement and overall processes included in the Adult Learning Disabilities Improvement Plan by the service; however, remaining actions require support from within the Trust and the wider system. **Negative:**	
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	SRC	Moderate ↔	Low (Mar 23)	Substantial	ICS level governance arrangements Specific Local Partnership Boards and Contact Management Boards Provider Collaborative Boards (PCB) Monitoring of the External Environment Business Planning framework Executive and Operational Organisational Leadership and Governance Structure	**Positive:** **Negative:**	**Confidential Agenda Item 13 – Outcome of the Governance Review** The Executive Directors meeting now has a formal monthly agenda item to bring in external strategic intelligence and information for discussion with the executive directors and management group. This will inform the Trust's response to ICB and local place based initiatives and planning requirements
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	QuAC	High ↔	Moderate (Mar 23)	Good	GGI Well-Led Implementation Plan Executive and Operational Organisational Leadership and Governance Structure Quality Improvement Approach and Team	**Positive: -** ▪ Good assurance provided by the QuAC, SRC and PCDC on the management of the strategic risks included in the BAF. ▪ Good assurance provided by the QuAC and SRC that there are effective controls in place to manage the corporate risks relating to their functions.	**Confidential Agenda Item 13 – Outcome of the Governance Review** The recommendations of the governance review will make changes to how information flows through the organisation to provide evidence based assurance up to the board and then back down through the organisation.

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3							Senior Leadership Group Arrangements	**Negative:** QuAC **-** Lack of progress on Serious Incident backlog (escalated to the Board). A recovery strategy has been developed and has been to EDG that involves additional external leadership and capacity to reduce this. Concerns expressed over the lack of requested support to help alleviate the number of backlog cases. MHLC – Inability to provide assurance on the number of uses of the Mental Health Act due to renewals being recorded as new detentions and distorting the numbers of actual patients to whom the Act is applied. This is being reviewed. PCDC – Inability to provide assurance on the management of risks in the corporate risk register due to concerns about reporting and the accuracy and timeliness of the information provided	Further work around the impact assessment of the changes is being undertaken within care groups and through the Quality Improvement and assurance meetings. An accountability framework has now been developed and agreed by both care group boards and EDG to support the principles of ensuring consistency; to describe the autonomy for care groups to act; and to provide clarity on where decisions are made in the organisation and where information is shared to ensure all necessary contributors are engaged with.
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**	**Board**	**High** ↔	**Moderate (Jan 26)**	**Good**	Roseberry Park Rectification Programme External Technical Expert Support Capital Programme Legal Support External Audit	**Positive:** **Negative:**	
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**	**WLPC**	**High** ↔	**20 (Jan 26)**	**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**	**SRC**	**High** ↓	**Moderate (Summer 2024)**	**Good**	Project Governance ↓ Staff CITO Awareness and Training Clinical Safety	**Positive:** **Negative:**	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3							Clinical Capacity to support the development and implementation of CITO CiTO supplier Clinical and Technical Support ↑		
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	SRC	High ↔	Moderate (2025 – review)	Reasonable ↑	Mental Health Partnership Boards ICP/ICB Funding Arrangements Provider Collaboratives Business Planning and Budget Setting Framework ↑ Financial Sustainability Board	**Positive:** IPR - Financial Plan SOCI – Financial Accounts – Surplus/Deficit (measure 24) now assessed as having reasonable performance assurance (previously limited) The intention to deliver the planned 2022/23 £1.16m surplus position (confirmed at January Board meeting), meaning that the Trust does not invoke NHSE Reporting protocol / statutory breach of financial duties, now submitted to NHSE. **Negative:** No MH Recovery funding in national 2022/23 financial arrangements. Intelligence from draft financial planning suggests significant trust and NENC financial and efficiency challenge. Significant non recurrent actions/mitigations in 2022/23 mask known and increasing underlying financial deficit.	**Confidential Agenda Item 7– Finance Report** This report includes the DoF letter in response to the ICB confirming forecast/recovery actions for 2022/23, but also highlighting concerns in relation to 2023/24 re resource allocation and absence of MH recovery fund. These issues were also raised with NHSE & ICB representatives via Board to Board meeting in February 2023, where NHSE/ICB colleagues suggested some opportunity for flexibility on resourcing / trajectories. The report outlines next steps to develop final plans for 2023/24, noting challenging timeline / ongoing resource allocation work across both ICBs.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 9

For General Release

Meeting of:	**Board of Directors**
Date:	**23 February 2023**
Title:	**Chief Executive's Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Brent Kilmurray**

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*
All	**-**	***The report highlights important matters which the Chief Executive wishes to bring to the attention of the Board. It provides information which might contribute to the Board's understanding of the strategic risks and the operation of key controls.***

Executive Summary:

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

Proposal: Board are invited to receive and note the contents of this report.

Overview:

<u>NHS England North East North Cumbria and Humber North Yorkshire ICBs and TEWV Boards to Board</u>

On Thursday 9th February representatives from the Board of Directors and senior TEWV colleagues met with Executives from the regional NHSE team and Executives from each of the Integrated Care Boards.

This was a formal review meeting. The agenda covered updates on the Trust's improvements and achievements, quality and safety matters, issues related to governance and "well led", performance and issues associated with the NHS Oversight Framework.

As this stands the Trust has been reported as SOF 3 rating on the NHS oversight scale. This means that we are subject to scrutiny and required to demonstrate improvements and engage mandated

support. All stakeholders are clear that it is the aim to move the Trust to a rating of 2.

Colleagues were pleased with the progress the Trust is making in its improvements. It was clear that there a number of ongoing risks to be managed and some key milestones – such as the publication of the Niche Governance report in March – to come. It was determined that a further review will take place in 6 months when the Trust should focus on progress with workforce plans, digital and data and financial outlook. There will also be a requirement for us to further update on our quality and safety work, governance and other associated ongoing issues from inspections and reports.

University of Teesside Strategic Partnership

In late November 2022 the Chairman and I met with Prof Tim Thompson, Dean of the School of Health at the University of Teesside. We agreed that we would explore the possibility of building on the great partnership working between the two organisations and look towards the agreement of a Strategic Partnership Agreement.

I met with Tim and his senior team, along with representatives of our Executive in early February. It was clear that there is already a lot going on between our organisations. Indeed, Teesside is one of the largest providers of registered staff to the Trust including nurses and clinical psychologists.

We have a number of research initiatives that are jointly led in the area of food poverty, inequalities and mental health. This has led to a nomination for a Bright Ideas in Health Award. We have some joint posts in this area too. We have other activity in the area of physical activity and severe mental illness – this work involves our other academic partners at the University of York and York St John University as part of the regional group.

To build on this excellent work we agreed that we would:

- Bring our research teams together to look for further alignment of existing priorities. We would work together to development deliver a research seminar programme for Trust staff to assist with identifying new projects and funding opportunities.
- We would investigate the potential for new research fellowships
- We would work together on curriculum development – thinking about the workforce needs of the future, the development of key skills including inter disciplinary working, leadership, research skills, mentoring opportunities, widening placement opportunities as part of the core offer for those training for qualified roles.
- We would co-ordinate recruitment activities. Looking for role models from our workforce to promote health and care careers and training in schools.
- Look to identify international networks to expand our knowledge base and learning opportunities. We would look to engage our clinical networks in seeking international best practice and to promote our expertise on a wider footprint.

- Darlington Health Campus – the university has kindly offered us access to their facilities in Darlington, offering a range of excellent and creative spaces for us to meet in, bring staff to and use as workspaces.

Tim and I will work on developing a memorandum of understanding between the two organisations to capture these key pieces of work and will develop a joint steering group to oversee progress.

Chief Nurse Appointment

I was delighted to announce on 31st January that we had appointed Beverley Murphy the role of Chief Nurse. Beverley joins us from Sheffield Health and Care NHS FT. She has held similar roles in a number of Trusts around the country. Beverley has 38 years experience.

Beverley will join us during February to start her induction. She will take up her role formally as Chief Nurse on 1st May 2023.

Elizabeth Moody has been Director of Nursing and Governance since 2015 and will stand down from the role on 30th April.

I am sure you will join me in extending a very warm welcome to Beverley. We will have plenty of opportunity as we move towards the end of April to give our thanks and best wishes to Elizabeth.

Our Journey To Change Workshop

Directors will have participated in the planning workshop that took place on Monday 20th February by the time we meet on 23rd. The event is the opportunity to bring together over 100 senior leaders, govenors, patients, carers and involvement partners and stakeholders together to consider our plans for 2023/24. The event will outline progress on our journey, discussions on co-creation, clarity on the key constraints and context – including the planning guidance and financial outlook, outline the proposed priorities and plans for our Care Groups. We will be seeking feedback on these aspects of the planning process through interaction and group work. The outputs of the process so far and the contributions of colleagues at the event will be pulled together into our final draft business plan for consideration of Strategy and Resources Committee and the Board of Directors in March.

Our Journey to Change Leadership Events

During the first week of February we ran our first round of leadership events for senior clinical, operational and corporate leaders from across the Trust. These events will now run quarterly and will be targeted at colleagues who work in leadership roles. The idea is that these will be useful forums for communication and engagement, co-creation and identification of key issues and challenges.

We hosted four sessions and met with approximately 170

colleagues. The agenda for the first round included an update and discussion on our quality and safety programmes, discussion on our work on Closed Cultures and a presentation on the outcome of the Kirkup Review into failing in maternity services in East Kent. Colleagues also received a briefing on our Clinical Journey.

The events have received positive feedback. We have asked colleagues to consider any specific themes they would like to cover in the future.

National Mental Health, Learning Disability and Autism Quality Transformation Programme

NHSE has launched an improvement programme based on learning taken from inpatient culture reviews, safe and wellbeing reviews in learning disabilities and from a review of best practice. The objective of the programme is to "cultural change and introduce a bold, radical, reimagined model of care for the future".

The programme will follow three themes:

1. Localising and realigning impatient services, harnessing the potential of people and communities
2. Improving culture and supporting staff
3. Supporting systems and providers facing immediate challenges

The programme is underpinned by £36m over three years. A roadmap has been set out that starts with the publication of the culture reviews.

Given our pressures and the lessons we have learnt I am keen that we position ourselves in the forefront of this improvement work within the Trust and within the systems we work in.

Prior Consideration and Feedback n/a

Implications: No additional implications.

Recommendations: The Board is invited to receive and note the contents of this report.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 10a

BOARD OF DIRECTORS

DATE:	**23rd February 2023**
TITLE:	**Board Integrated Performance Report as at 31st December 2022**
REPORT OF:	**Mike Brierley, Assistant Chief Executive**
REPORT FOR:	**Assurance**

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

Report:

1 Purpose:

1.1 The purpose of this report is to provide oversight of the quality of services being delivered for the period ending **31st December 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 Executive Summary is split into two distinct sections: the first section focuses on the latest IPR (which also incorporates the relevant Board Sub Committee reports this month) and the second section focuses on the broader key issues/work in relation to Quality, Inpatient Pressures, People & Culture 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:

- **Bed Occupancy (measure 8)** now has positive controls assurance (previously negative assurance)
- **Percentage of staff recommending the Trust as a place to work (measure 16)** now assessed as having limited performance assurance (previously reasonable)
- **Percentage of staff feeling they are able to make improvements happen in their area of work (measure 17)** now assessed as having limited performance assurance (previously reasonable)
- **Number of new unique patients referred (measure 22)** now has neutral controls assurance (previously positive assurance)
- **Financial Plan SOCI – Financial Accounts – Surplus/Deficit (measure 24)** now assessed as having reasonable performance assurance (previously limited)

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) **Percentage of staff recommending the Trust as a place to work (measure 16)** The Trust is in the lowest performing quartile (a position of concern); 48 out of 51 Mental Health & Learning Disability Trusts. Whilst our People and Culture Journey work could have a positive impact in this area, we currently have limited assurance in terms of specific actions to improve this position.

b) **Staff in post with a current appraisal (measure 21)** We continue to have special cause concern at Trust level and in both Care Groups; however, we are now back within the process control limits which is positive. Routine monitoring is continuing and all areas below the agreed standard of 85% have a trajectory/timescale of when they will achieve this. There is currently limited assurance pending completion of the actions identified to improve the position.

c) **Unique Caseload (measure 23)** We continue to have special cause concern at Trust level and in both Care Groups. The Executive Strategy & Resources Group received initial high-level analysis in January 2023 showing those 6 team types (by Care Group) accounting for the majority (84%) of the Trust-wide caseload increase (5-6 team types) and also the percentage and absolute increase for each team type (in isolation of workforce changes). The caseload data has been overlaid with whole time equivalent staffing information and historical service changes, to understand how teams have changed structurally since the 1st April 2021. This work was targeted to complete by end January 2023. The next step is to review analysis to understand reasons for the increase in caseloads compared to increases/decreases in staffing (funded and contracted) and changes to contracts. This will include linkage with the services to gather general intelligence on other factors that may be impacting the teams, including sickness. This work will be completed by the end of February 2023, with an interim update to Strategy and Resources Committee on 7th February 2023. There is currently limited assurance pending completion of this further analysis and the identification of related improvement actions.

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

Most measures where we have reasonable performance assurance and negative controls assurance are being managed via various programmes of work; however please note the following updates discussed at Executive Directors Group (EDG):

a) **Financial plan (measure 24)** The Trust is not in line with its year-to-date financial plan; with a year-to-date deficit of £5.0m (£5.2m worse than plan) and including unfunded pay award pressures. However, mitigating action plans, confirmed contract changes, national year-end guidance and the impacts of schemes approved against national discharge funding have materially improved forecasts to the extent that the Trust now expects to achieve the £1.16m planned surplus.

There have been 3 consistent key operational 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). If remitted on the nationally allocated basis of a 1.66% contract uplift, the Trust would have a £2.5m year to date pressure (included in the Month 9 position, or £3.3m full year, assumed fully funded before adjusting for National Insurance reduced c contributions).

Due to escalating financial pressures and risks to delivery of the planned surplus, the Board considered papers in private session in both November and December 2022 on the best and most probable case forecast outturn positions, and next steps to mitigate and/or manage the position, including working closely with NENC ICS system partners.

Board colleagues had considered the prospect that, subject to discussions regarding pay award funding and/or mitigation of the £3m recovery risk, the Trust may need to invoke the NHSE 'Protocol for changes to in-year revenue financial forecast' (constituting a breach of statutory duty), and consequential Board assurance statements in that event.

Via month 9 reporting, pursuit/completion of recovery actions, confirmed contract and education funding and confirmed national year-end guidance relating to the discount rate, the Trust's forecast has improved materially, to the extent that the Trust's probable case mitigates the previously expected £3m plan risks and would deliver the £1.16m planned surplus.

The Trust Board met again in Private in January 2023 and agreed to maintain a forecast of the £1.16m planned surplus, based on the probable case forecast outturn. On this basis the new NHSE Reporting Protocol would not need to be invoked.

b) EDG feels the current level of assurance is reasonable in relation to the latest Long-Term Plan ambitions and there are no specific areas to highlight from the System Oversight Framework that are not already covered within this summary.

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. The relevant Board Sub Committee reports are contained in Appendix B.

3.2 Part 2: Broader Key Issues/Work

3.2.1 Quality

Safe Staffing
Business Continuity Arrangements remained in place during December 2022 for the following service areas: Secure Inpatient Services, Durham & Darlington Crisis Team, the AMH wards at RPH Dalesway (4 admission wards and PICU), CAMHS Community York, CAMHS Community Northallerton, CAMHS CRHT, and DTV&F Inpatient Adult Learning Disability Services. These service areas continue to be closely monitored within the care groups who also report to the Executive Directors Group regarding workforce figures.

Registered Nurse fill rates continue to remain consistently low across a significant number of wards (37) for day shifts. The number of wards with low fill rates for RN

night shifts have also increased but are as significant as seen on days shifts. There are 22 wards reporting as less than or equal to two thirds of their RN fill rate, 11 of which are adult wards (including PICUs). It is noted that Thistle ward was closed from the 14th December 2022.

HCA fill rates for day shifts show there are a significant number of wards with high fill rates for HCAs, 20 wards are exceeding 150% of their budgeted establishment – 13 of these wards are AMH wards - the highest being the PICUS (Bedale and Cedar) having fill rates of 420% and 346% respectively. HCA fill rates for night shifts similarly show a significant number of wards with high fill rates for HCAs, with 28 wards exceeding 150% of their budgeted establishment – 12 of these wards are AMH wards, with the highest being the Bedale at 533%.

The high HCA fill rates are due to:

- where additional HCAs have been rostered over the funded establishments to fill RN deficits.
- 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

The number of missed breaks has increased over the previous month, alongside a small decrease in shifts worked that were greater than 13 hours. Red flags show an increase over the previous month despite seeing the same amount of Datix reports for staffing levels as per November. We are undertaking work to enable improved granularity regarding the number of wards impacted with an individual Datix report for staffing levels. This will also reduce administrative overheads for clinical staff without losing the required detail and aims to improve reporting outcomes.

Temporary staffing requests however continue to remain high over the last 6 months. December has seen reduction in the number of unfilled temporary staffing shifts with a corresponding increase of agency filled shifts – bank has remained static in its fill rate.

Environmental Risks
In response to the Niche recommendations and our continuous improvement work in relation to environmental risk assessments we have been reviewing the environmental survey procedure and strengthening processes between services and EFM and clarifying escalation processes. A procedure has been developed that supports the identification prioritisation and management of works that have arisen from an environment risk survey or patient safety event.

3.2.2 Inpatient Pressures

Bed Occupancy
In December 2022 a revised bed occupancy reduction plan and suite of metrics were presented by the Durham, Tees Valley operational team. The aim of this revised plan is to reduce the independent sector beds usage to 4 and release an efficiency saving of £360K whilst also addressing the requirements of the NHS England 100-day discharge challenge, all with a delivery date by 31st March 2023.

The production of a revised plan has initiated the undertaking of a second deliverability diagnostic assessment, the results of which showed no change to the original RAG rating: Amber ‘medium risk’ (60% probability of delivery).

The plan and intended impact are to be monitored by the Beds Oversight Group, via a scorecard. The scorecard has been developed for testing, comprising the agreed primary and secondary metrics these include:

- Number of Independent Sector bed day usage (primary metric)
- Actual Spot Purchase spend per month (primary metric)
- % Bed Occupancy (primary metric)
- Average Length of Stay (secondary metric)
- % Delayed Transfers of Care (secondary metric)

Metric baseline data has also been identified and where applicable a measure of improvement (target) applied. In addition, several indicators that will have an interdependency on the impact of this plan have also been identified for monitoring purposes only i.e., admission rates, readmission rates etc. Other interdependent metrics such as PICU transfers and repatriation numbers may need to be considered in this data set when reviewing the impact on bed occupancy levels.

The Beds Oversight Group will continue to monitor the impact of the plan whilst immediate consideration is given to the identification of other potential short-term actions to bolster the Durham, Tees Valley Adult Mental Health plan and help delivery of the agreed outcomes as well as other actions that may need to be taken Trust-wide (supported by the Beds Oversight Group, Programme Management Office and Advancing Our Clinical & Quality Safety Journey Sub-portfolio Programme Board).

Further areas of work (medium to long term) that are being considered for further scope by the Beds Oversight Group are:

- Development of other speciality bed occupancy level reduction plans
- Admissions pathway (plus activity linked to CMHF plans and timelines)
- Readmissions pathway
- Discharge pathway (linked to Crisis)
- Length of Stay
- Rehabilitation pathway (inpatients)
- Bed modelling
- Clinical decision making

3.2.3 People & Culture

Workforce Planning

The Trust's biggest challenge and risk is the recruitment and retention of it's workforce, which is echoed widely both regionally and nationally. The introduction of Strategic Workforce Planning will enable the Trust to design and deliver the right workforce, with the right skills, in the right place at the right time. To understand critical gaps and plan for the workforce we need in the short, medium and long term to deliver the right quality of care and to ensure our staff are supported, valued and have both career pathways and opportunities that will encourage them to stay. Safe staffing levels whilst critical for quality of care, hugely affect staff experience, health and wellbeing and the creation of effective teams which impact upon recruitment, retention and also staff absence levels.

Currently Workforce Planning capability and capacity within the Trust is limited, however demand is high. A new workforce planning function has been built into the

Improvement and Design Service to align closely with the Workforce Information and Quality Improvement (QI) teams to provide the quantitative and qualitative information we need to build effective workforce plans together with our managers and services. In October and November 22, a series of thirteen "Introduction to Workforce Planning Sessions" were delivered virtually over MST which were well received. Work has also started with Services to identify priority areas and a Toolkit Guide developed to support managers with a consistent, evidence-based approach. Linking closely with our regional workforce planning leads in the NENC and H&Y, building networks and undertaking specific national training has helped to increase capability, however capacity remains an issue, to meet increasing demand within services and the frequency and complexity of national workforce planning submissions/data requests. To increase capacity and resource, a new workforce Planning and Redesign Lead post has been developed and is currently being advertised, with the aim for the post to be filled early into the new financial year 23/24.

3.2.4 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 of around £7.8m due to the disproportionate impacts from funding via national annual 'tariff' uplifts applied to provider contract values. The impact of the outcome of the 2022/23 Pay Review Bodies was estimated by all organisations within the NENC Integrated Care System (ICS) to be a composite shortfall of £20m 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 have generated an additional in-year pressure for the Trust because a higher percentage of our cost base is pay. NENC ICB worked responsively with all providers to review the funding methodology and explore alternate mechanisms that better reflect actual provider costs. NENC ICS partners 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).

As part of recent forecasting work coordinated via NENC Finance Directors and ICB discussions with NHSE, additional non-recurrent ICB funding has been secured to mitigate ICS partner pressures.

3.2.5 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 and include the development of an action plan in AMH services which includes the recruitment of 2 Senior Peer Worker posts (Lived Experience roles) to support our inpatient services. These are currently out to advert. A plan is to be developed in MHSOP services and will be in place by March 2023. Further work has commenced to triangulate the different aspects of the "feeling safe" workstream including mutual expectation, patient safety learning, feeling safe focus groups, etc.
- Pressures on our inpatient services are continuing; our bed occupancy remains high within our adult and older people wards although we are starting to see

some reductions alongside a significant reduction in our use of independent sector beds. Actions within our Bed Occupancy reduction plan have been mapped against those of the National 100 day discharge challenge and new actions added to support this work.

- 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 have been completed and service reviews remaining ongoing working with commissioning colleagues.
- Within the Long-Term Plan, we continue to see improvements within our Children's Eating Disorders service however we are keen to continue these. Several actions remain ongoing including working with County Durham and Darlington Foundation Trust around the provision of dieticians, a workshop will take place before the end of January to develop a decision-making matrix of care to ensure roles and responsibilities of each trust are defined. The development of a temporary Service Level Agreement continues to progress following feedback from CDDFT.
- Fewer people are accessing our IAPT service than we would like. Further work is ongoing to understand this in more detail and enable us to set actions.

The areas of positive assurance identified within the IPD:

- Within our IAPT services we are achieving the standard for patients achieving recovery and 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. We have also achieved standards around 72 hour follow ups following discharge from our inpatient facilities and the number of patients within our EIP service who are treated with NICE approved care packages within 2 weeks of referral
- 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 services, 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. A new approach to screening has been developed with training currently being rolled out for a pilot in D&D AMH crisis team. The process will be implemented within this team on 30th January 23.

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 12th January 23

we have 1 patient in an independent sector bed.

- 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.
- Memory waiting times is impacted as capacity is outstripping demand and with no further investment to improve capacity. A demand and capacity exercise was due to commence in December, this has been delayed due to sickness and service demands, this will therefore commence at the end of January 23 which will inform next steps.

The areas of positive assurance identified within the IPD:

- Within Long Term Plan as at the end of December 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 hours follow up standard is achieved for North Yorkshire Sub-ICB locations and Child Eating Disorder service has achieved 100% for urgent referrals during the month of December 22.

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

- All-age Crisis phone line remains a risk, daily oversight remains in place to ensure planned staff are in place to respond to the 0800 calls, although short notice staffing gaps continues to have an impact daily. Within NYY, the percentage of calls responded to was 48%. A number of actions are in place including safe screening of calls by any practitioners, is in the final stages of development, (led by the Trust urgent care lead) as well as the case note and activity requirements for any filtered call. This will reduce the call duration and record requirements as triage is not required for all.
- System wide pressures are ongoing. The CGB have identified pressure/underfunded areas during annual planning. Discussions are ongoing within the system

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.

- EDG confirmed there were no "new" emerging risks as its meeting on the 25th 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.

Appendix A

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st December 2022

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

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

CONTENTS

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/plan is achievable is now included for a number of measures. Standards for the remaining ones will be reviewed in the new financial year.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS Foundation Trust

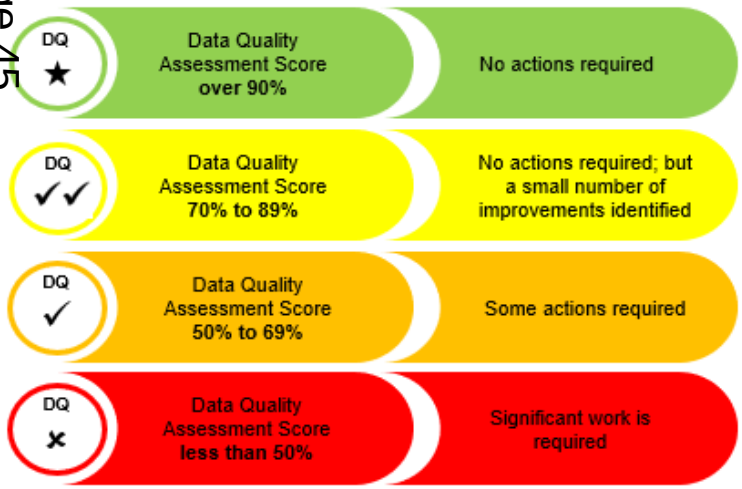
Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. Work is underway to understand the resources and timescales required to establish a local audit framework; therefore, the audit element has been omitted from the initial assessment.

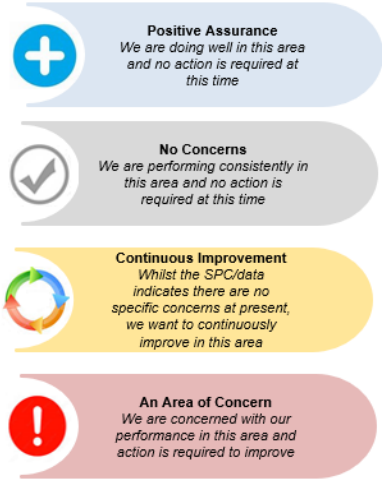
Please note an assessment has not yet been undertaken on the following new measures. An assessment of these will be included in the March 2023 report.

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 a Statistical Process Control chart we look at the current variation depicted within the chart, how our performance is compared to what we are trying to achieve, whether we have assurance that we will achieve the standard (if applicable) and whether our performance over time is improving.





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	*Bed Occupancy (AMH & MHSOP A & T Wards)	
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 *Percentage Sickness Absence Rate *New unique patients referred	*Staff feeling they are able to make improvements happen in their area of work
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 *Staff Leaver Rate *Compliance with ALL mandatory and statutory training *Financial Plan: SOCI - Final Accounts - Surplus/Deficit	*Staff recommending the Trust as a place to work *Staff in post with a current appraisal *Unique Caseload (snapshot) *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		?	92.00%	91.78%
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		?	75.00%	71.76%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	57.26%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	F	35.00%	24.25%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	46.83%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC		F	50.00%	44.57%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	20.22%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	L			99.03%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			431
10)	The number of Serious Incidents reported on STEIS	QAC				94
11)	The number of Incidents of moderate harm and near misses	QAC				1,462
12)	The number of Restrictive Intervention Incidents	QAC				5,853
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				10
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				2
15)	The number of uses of the Mental Health Act	MHLC				3,214

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			12.92%
19)	Percentage Sickness Absence Rate (month behind)	PC&D				6.21%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L	P	85.00%	85.13%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	L	?	85.00%	82.95%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				74,520
23)	Unique Caseload (snapshot)	S&RC	H			62,300

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	-216,000	4,718,089
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	F	7,245,937	16,285,967
25b)	Agency price cap compliance	S&RC	F	100%	64%
26)	Use of Resources Rating - overall score	S&RC	F	2	3
27)	CRES Performance - Recurrent	S&RC	F	8,242,000	6,482,000
28)	CRES Performance - Non-Recurrent	S&RC	P	1,044,000	1,044,000
29)	Capital Expenditure (CDEL)	S&RC	F	7,492,000	6,262,000
30)	Cash balances (actual compared to plan)	S&RC	F	72,630,000	70,734,000

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.

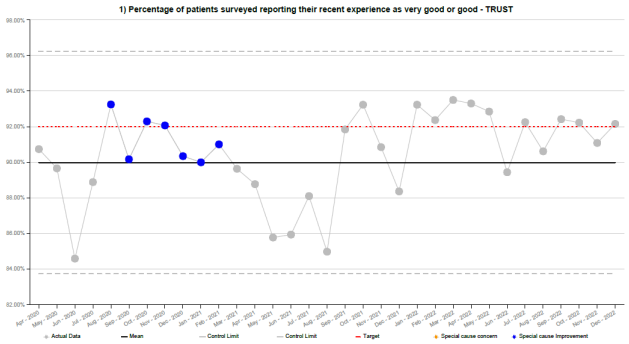
During December, **803** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **740 (92.15%)** scored "very good" or "good"

No significant change in the data during the reporting period shown

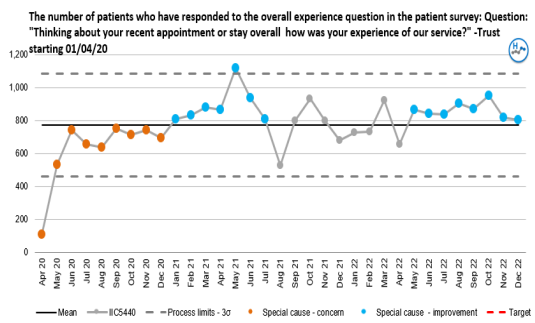
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ★ 93%

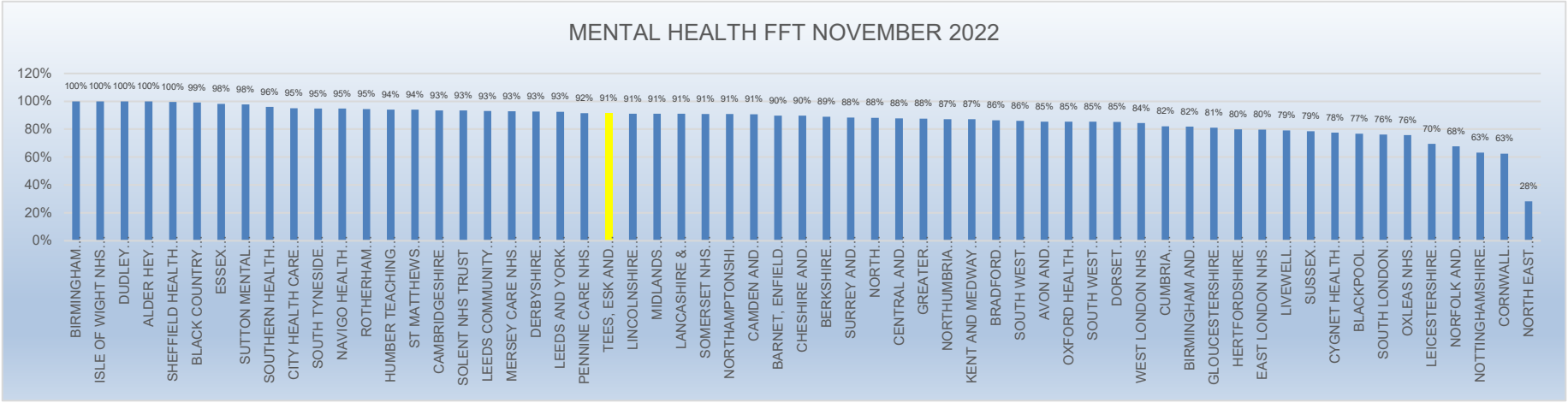
Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



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



National Benchmarking - Mental Health Friends and Family Test (FFT) data - November 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 **84%**, our Trust is identified by the yellow bar in the chart below. We are ranked 23 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

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 the end of ~~January~~ March 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 December, **241** carers responded to the question in the carer survey: Question: “Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?”. Of those, **171 (70.95%)** scored “yes, always”.

No significant change in the data during the reporting period shown

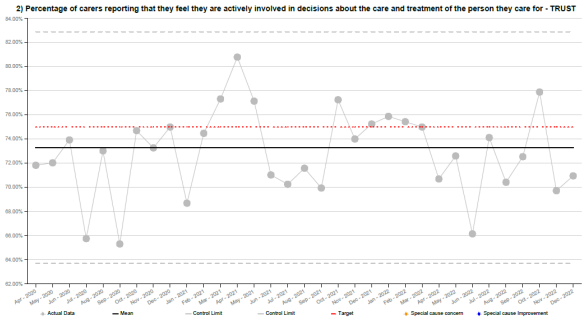
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ

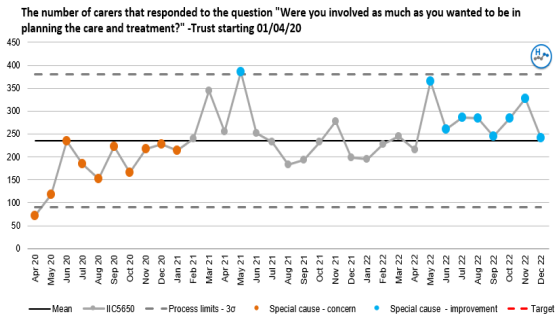
87%

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



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

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.

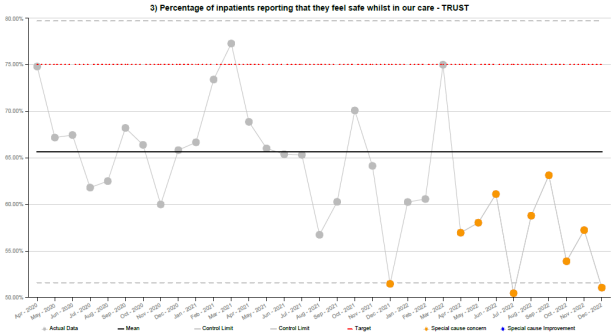
During December, **141** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **72 (51.06%)** scored “yes, always"

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

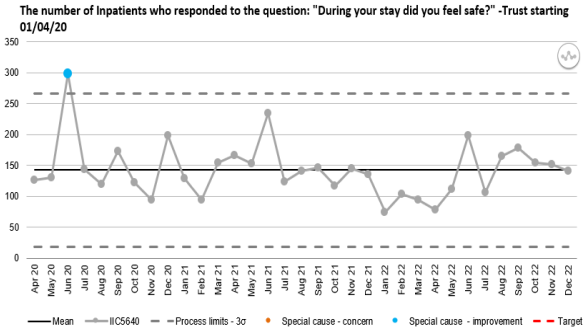
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ★ 93%

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



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



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 by the end of 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*: 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 the end of January 2023.	*Please see update in respect of 01) Percentage of Patients surveyed reporting their recent experience as very good or good*	
	***NEW** Enabling action:* The Patient Experience Team are to expand the focus groups to Mental Health Services for Older People and Learning Disabilities during February; findings will be reported to the Care Boards in March 2023.		

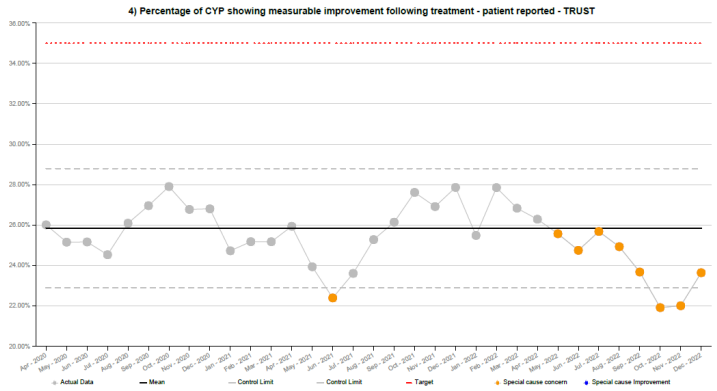
04) Percentage of CYP showing measurable improvement following treatment - patient reported

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 December, **702** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 166 (23.65%)** 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	Assurance
TRUST	L	F
DURHAM, TEES VALLEY AND FORENSIC	L	F
NORTH YORKSHIRE, YORK AND SELBY		F

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

Our system is expected to consistently fail the target/expectation

93%

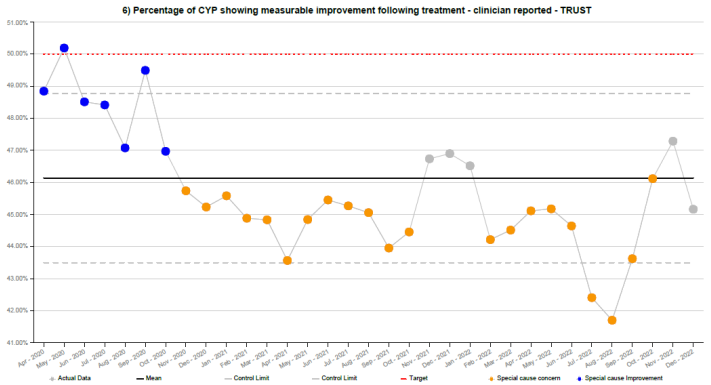
An Area of Concern
We are concerned with our performance in this area and action is required to improve

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 December, **817** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 369 (45.17%)** 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	Assurance
TRUST		F
DURHAM, TEES VALLEY AND FORENSIC	H	F
NORTH YORKSHIRE, YORK AND SELBY	L	?

No significant change in the data during the reporting period shown

Our system is expected to consistently fail the target/expectation

93%

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

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
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. 8 staff attended the monthly session in December; 5 Durham, Darlington and Teesside, 3 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.	**Complete.** The 3 refresher sessions have now been delivered, with approximately 40 staff attending the final session in January 2023.	
To support continuous improvement there is a focus on the completion of ROMs to support clinical practice within Caseload Management Supervision	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.	The tool is available on IIC and the training programme is being finalised. Live reporting will be available from 1st April 2023.	

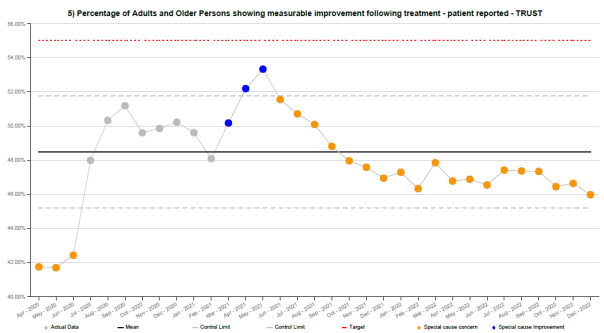
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

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 December, **2001** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 920 (45.98%)** made a measurable improvement.

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



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

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

Our system is expected to consistently fail the target/expectation

DQ ★ 93%

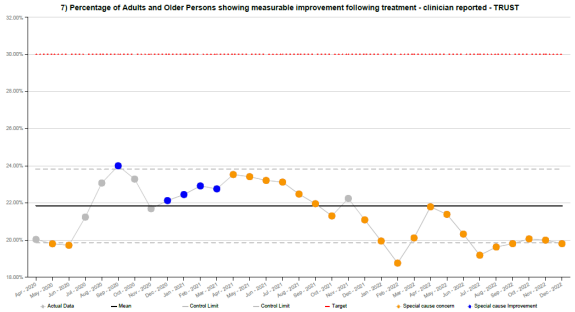
An Area of Concern
We are concerned with our performance in this area and action is required to improve

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 December, **3160** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 626 (19.81%)** made a measurable improvement.

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



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

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

Our system is expected to consistently fail the target/expectation

DQ ★ 93%

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

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
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.	**Complete.** The group is meeting regularly and work is continuing to scope the development of a new clinical outcomes dashboard in the IIC.	
	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.	Services have been asked to identify their specific requirements. Timescales for completion of the dashboard will be confirmed once scoping work is complete.	
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.	**Complete.** Medical Directors from Durham Tees Valley & Forensics and North Yorkshire, York & Selby are the agreed representatives.	
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 tool is available on IIC and the training programme is being finalised. Live reporting will be available from 1st April 2023	

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

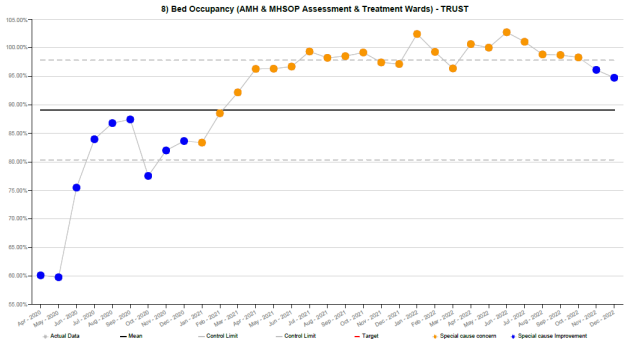
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important 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 December, **11,098** daily beds were available for patients; of those, **10,518 (94.77%)** were occupied.

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

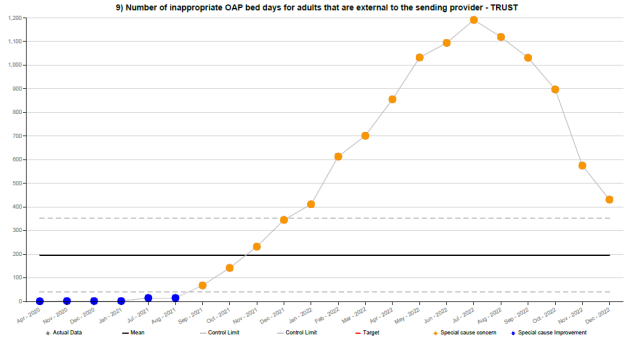
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending December, **431** 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	Dec	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	10,585	**100,119**
	Number of available bed days	10,578	11,253	10,890	11,253	11,253	10,890	11,098	10,740	11,098	**99,053**
	Percentage Bed Occupancy	**103.29%**	**102.51%**	**104.24%**	**103.80%**	**102.12%**	**100.17%**	**100.83%**	**97.30%**	**95.38%**	**101.08%**

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

NHS
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.	To date, 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. A scorecard detailing the metrics has been developed and will be shared at the AOCQSJ Sub-Programme Board Meeting in January and then discussed at the Beds Oversight Group in February.	
NEW We are committed to learning from the national 100 day challenge to ensure that people who are clinically ready to leave a hospital bed in a mental health or community health inpatient service setting are not delayed.	The General Manager (Durham & Tees Valley Adult Mental Health Urgent Care) to review the Care Group Bed Reduction Occupancy Plan to ensure it supports the initiatives of the 100 day challenge.	**Complete.** The plan has been finalised and shared with the Integrated Care Board.	
	Enabling action: North Yorkshire, York & Selby General Managers to work with the Integrated Care Board to assess services against the 10 good practice points by the end of January 2023, with a view to developing an action plan if required.		

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

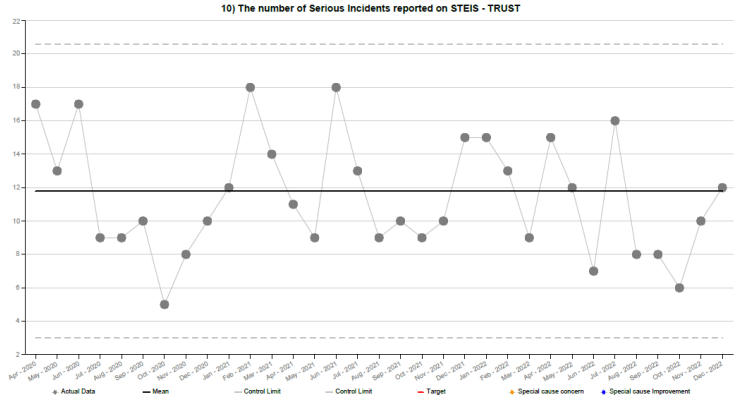
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

12 serious incidents were reported on the Strategic Executive Information System (STEIS) during December.

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	

There were no specific themes in the 12 serious incidents reported in December. Any issues identified at specialty level are being addressed by the Care Groups.

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

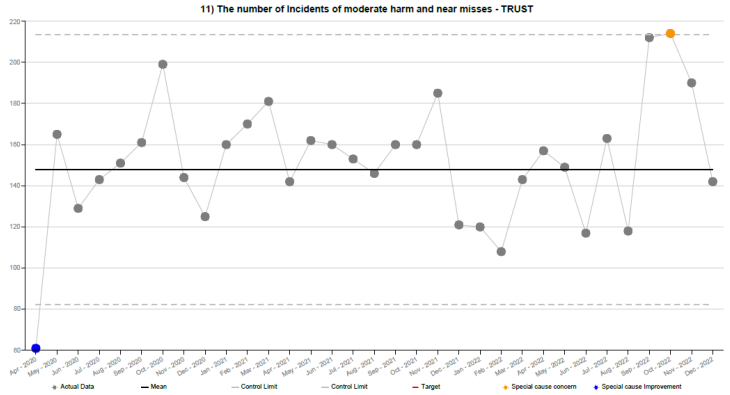
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

142 incidents of moderate harm or near misses were reported during December.

No significant change in the data during the reporting period shown

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



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

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.

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.

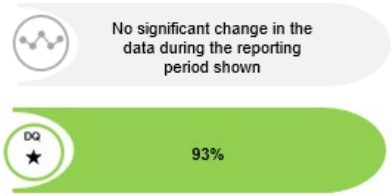
Progress on the crisis offer is discussed at Executive level on a weekly basis and we will continue to review the data to ensure that we address any emerging issues. We are confident that we are taking all possible steps to improve our crisis line answer rates.

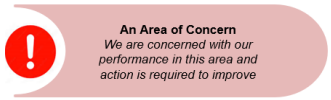
12) The number of Restrictive Intervention Incidents

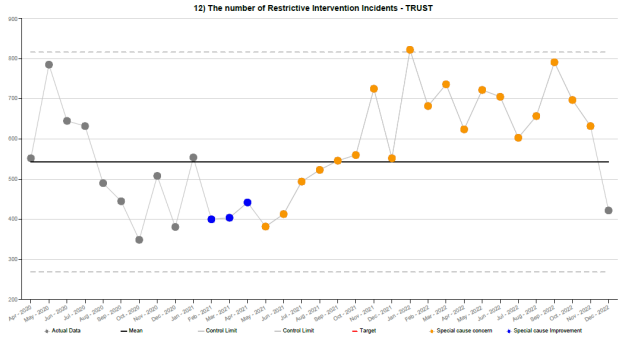
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

422 number of Restrictive Intervention Incidents took place during December.







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.	One patient at Lanchester Road Hospital has been discharged to their community placement, although they will remain open to the Trust under section care until February 2023. There are currently 7 patients ready for discharge: • 2 patients from Bankfields have had their discharges delayed and will be discharged by the end of April and May 2023. One of these patients is currently on leave from the ward. • 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. • 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 both units 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

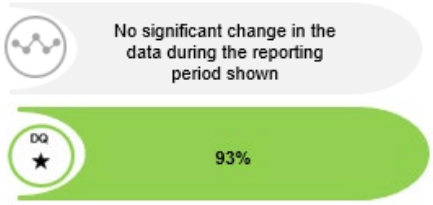
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Following feedback from the Care Quality Commission, we have identified a training need within our Adult Learning Disability services.	The General Manager and Associate Clinical Director to ensure all Adult Learning Disabilities Inpatient staff attend the bespoke training by December 22.	51% of all staff have been trained. The Learning Disabilities Service is confident that all staff that required training have now been trained and approval will be sought at the Care Group Quality Assurance & Improvement Group in February 2023 to close this action within the Care Quality Commission Action Plan.	
We must be assured that we have a robust Restrictive Intervention Reduction Programme that meet national standards and reflects best practise	*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.	
	Enabling action: The Nurse Consultant for Positive and Safe Care to table the gap analysis on the currently agreed Restrictive Intervention Reduction workstreams at the Care Group Positive & Safe meetings in January and February 2023, 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.	**Complete.** The business case has been developed.	
	Enabling action: The Nurse Consultant for Positive and Safe Care to share the business case for additional resources with the Care Groups during January and February 2023 to agree the next steps prior to submitting for approval.		

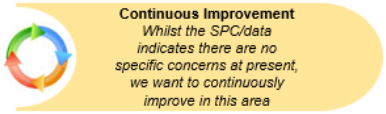
13) The number of Medication Errors with a severity of moderate harm and above

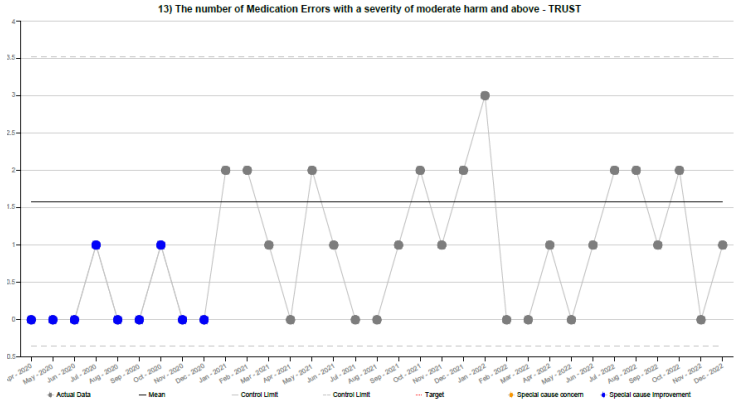
Tees, Esk and Wear Valleys NHS Foundation Trust

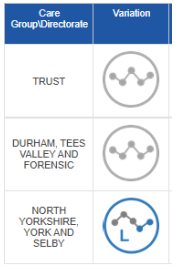
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When medication errors occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

1 medication error has been recorded with a severity of moderate harm, severe or death during December.









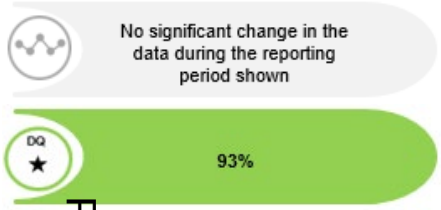
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Clozapine is a “high-risk” medication and was being taken in 6 of the incidents above. We need to improve staff education and introduce effective resources that enable high quality discussions with patients reducing incidents of 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. Some capacity challenges within the Pharmacy Team have meant that the remaining 9 have not progressed. 2 of these actions are being prioritised for completion by end of February 2023.	
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 the end of January 2023.	There are 8 improvement actions identified. Of these, 6 have been completed and the remaining 2 are on track for delivery. The completed action was the priority action to revise the Trust depot procedures. These are now published.	

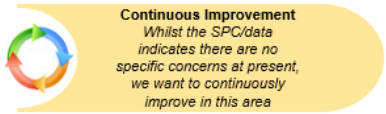
14) The number of unexpected Inpatient unnatural deaths reported on STEIS

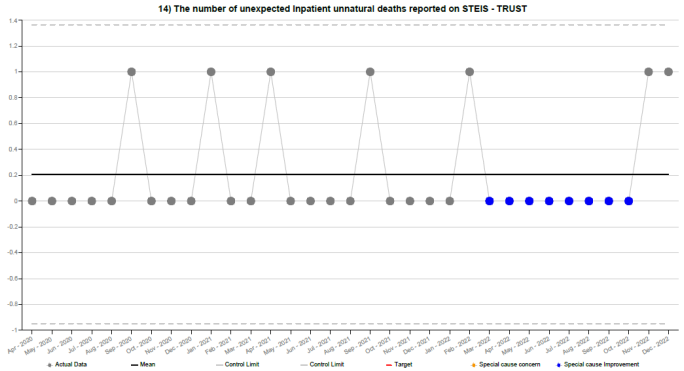
Tees, Esk and Wear Valleys NHS Foundation Trust

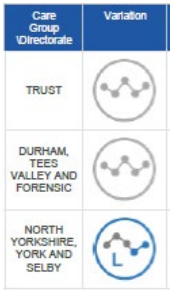
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements 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 death was reported on the Strategic Executive Information System (STEIS) during December.









Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
A Quality Governance-led collaborative review with clinical services has indicated that whilst the quality of risk assessments has improved across the organisation, 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

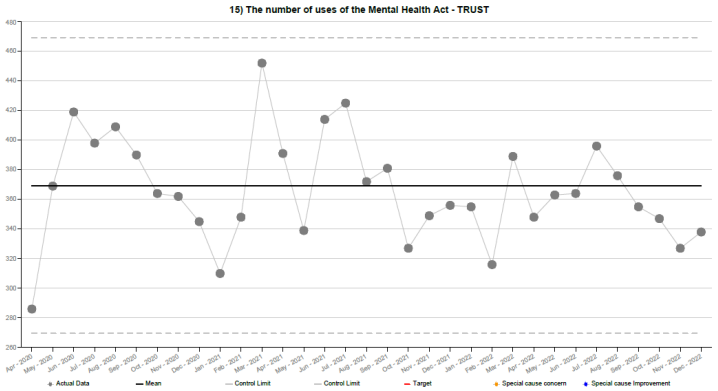
We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers,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

There were **338** uses of the Mental Health Act during December.

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%



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
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.		

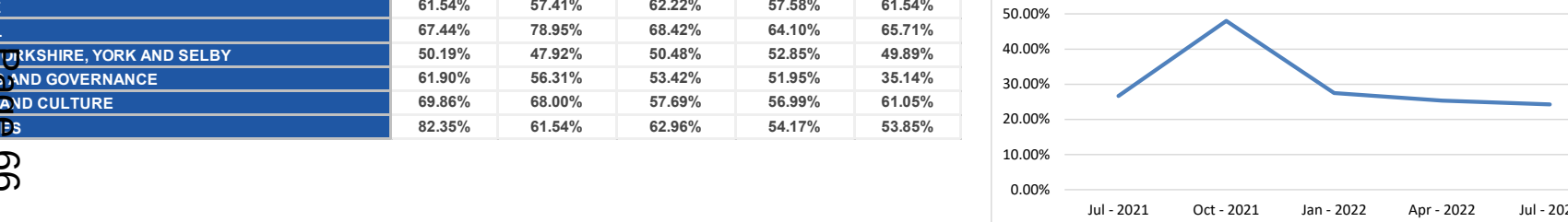
16) Percentage of staff recommending the Trust as a place to work

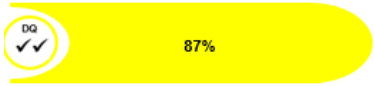
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

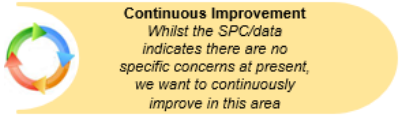
We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise staff recommending the Trust as a place to work is an indication of a high level of job satisfaction 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	Oct - 2021	Jan - 2022	Apr - 2022	Jul - 2022
TRUST	54.23%	52.46%	52.54%	55.01%	53.60%
ASSISTANT CHIEF EXEC	69.23%	60.94%	51.61%	61.29%	47.83%
DIGITAL AND DATA SERVICES	68.09%	60.50%	70.13%	68.00%	57.65%
DURHAM, TEES VALLEY AND FORENSIC	51.50%	50.76%	50.72%	54.63%	54.64%
ESTATES AND FACILITIES MANAGEMENT	57.14%	52.43%	46.92%	50.38%	50.76%
FINANCE	61.54%	57.41%	62.22%	57.58%	61.54%
MEDICAL	67.44%	78.95%	68.42%	64.10%	65.71%
NORTH YORKSHIRE, YORK AND SELBY	50.19%	47.92%	50.48%	52.85%	49.89%
NURSING AND GOVERNANCE	61.90%	56.31%	53.42%	51.95%	35.14%
PEOPLE AND CULTURE	69.86%	68.00%	57.69%	56.99%	61.05%
THERAPIES	82.35%	61.54%	62.96%	54.17%	53.85%







Response rates for the Quarter 2 2223 NHS Pulse Survey ranged between 0.10% and 52.08%.
Note: October 2021 in the chart reflects the annual Staff Survey that is undertaken by Picker

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

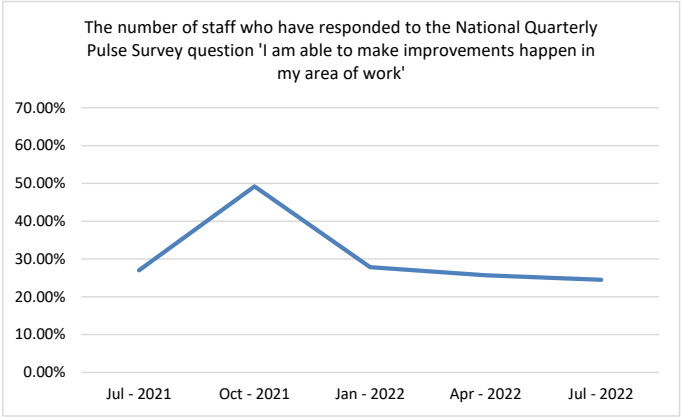
We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise that having the ability to suggest improvements and a high level of job satisfaction within our workforce 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	Oct - 2021	Jan - 2022	Apr - 2022	Jul - 2022
TRUST	57.10%	57.11%	57.50%	58.76%	59.12%
ASSISTANT CHIEF EXEC	76.92%	67.19%	67.74%	74.19%	65.22%
DIGITAL AND DATA SERVICES	65.96%	72.27%	74.03%	72.00%	65.88%
DURHAM, TEES VALLEY AND FORENSIC	56.23%	54.59%	57.00%	57.98%	58.94%
ESTATES AND FACILITIES MANAGEMENT	55.24%	26.04%	53.08%	52.67%	51.52%
FINANCE	65.38%	61.11%	64.44%	69.70%	71.79%
MEDICAL	67.44%	73.68%	81.58%	79.49%	68.57%
NORTH YORKSHIRE, YORK AND SELBY	54.44%	56.48%	54.35%	56.45%	55.77%
NURSING AND GOVERNANCE	61.90%	66.99%	65.75%	63.64%	59.46%
PEOPLE AND CULTURE	78.08%	77.60%	73.08%	73.12%	69.47%
THERAPIES	94.12%	58.97%	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



Response rates for the Quarter 2 2223 NHS Pulse Survey ranged between 0.10% and 52.08%.
Note: October 2021 in the chart reflects the annual Staff Survey that is undertaken by Picker

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.	Two invitations to complete the survey have been sent; however, the response rate has been very low to date from the pilot areas, potentially due to technical issues impacting access to the survey. Work is currently underway to improve functionality for the February survey request.	
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.	**Complete.** The Trust maintained a good staff survey response rate compared to a number of other trusts who saw a much higher fall in response. A roadshow approach and incentives were offered for the main survey.	
	Enabling action: Organisational Development to review the option of offering incentives for the quarterly pulse by the end of March.		

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

Additional Intelligence in support of continuous improvement

The Trust has embarked on a 5-year stepped approach to Quality Improvement (QI) Training to support staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements. The aims of the programme are to:

- Enable 100% of staff to access Foundation training, which highlights why we have a QI approach, some basics of QI and how to get involved. Foundation level consists of three 6 minute video clips that people can access at their own pace.
- To have trained 50% of staff at Intermediate level, which is designed to provide a good overview of the fundamentals of Quality Improvement. This course is a blend of workbook-based activities and virtual webinars.
- To have15% of staff trained at Leader level. The QI Leader programme builds on the learning from QI Intermediate with a consolidation of the QI tools and concepts already taught, explores some of those in greater depth, as well as an introduction to some additional QI tools. It is a mix of webinar and workbook based tasks, and with the support of a QI mentor staff work through and deliver a QI project within their own service
- To have 1% of staff trained at Expert level. QI Expert level training builds upon previous QI training and develops skills in supporting people through QI activity, facilitating QI activity and how to prepare for formal QI activities (1-5 day events). It is a mix of classroom based learning, workbook based tasks and an assessed 5 day RPIW. As part of the Expert level training, staff will also be expected to either already be a Master coach or internally accredited coach or to undertake internal accreditation as part of their expert journey

Trust-wide communication for the launch of the Foundation training was scheduled from the week commencing the 30th January 2023.

18) Staff Leaver Rate

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

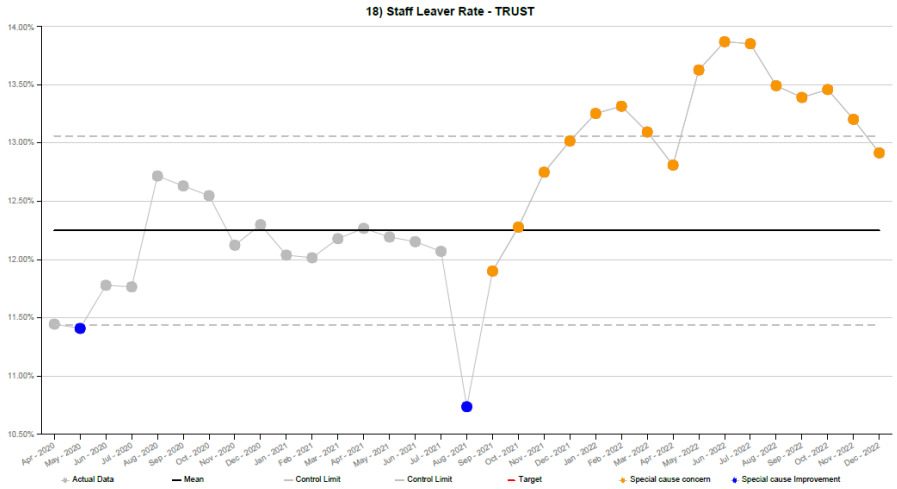
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

From a total of **6457.61** staff in post, **834 (12.92%)** had left the Trust in the 12 month period ending December.

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

DQ 80%

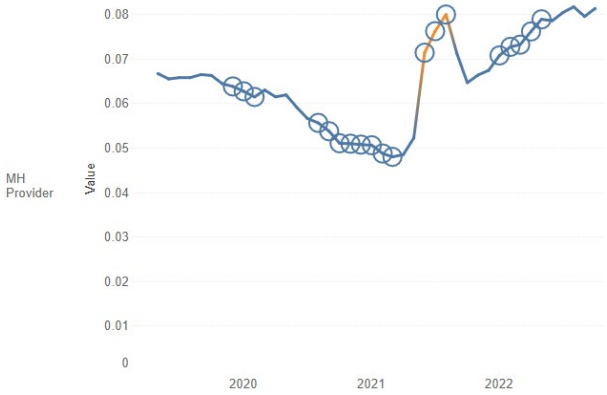
An Area of Concern
We are concerned with our performance in this area and action is required to improve



Care Group \Directorate	Variation	Care Group \Directorate	Variation
TRUST	H	FINANCE	H
ASSISTANT CHIEF EXEC		MEDICAL	H
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 – September 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 17 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:* Organisational Development to combine the data from the forms that come in, the group and the independent interviews and produce shared learning.	**Complete.** The initial analysis on received forms has been completed and was shared with Trust Board in January. Analysis is now being undertaken monthly with data from any feedback route and forms part of the monthly workforce updates. Numbers are relatively low coming through the new process and at the People & Culture Subcommittee this month, a target of 20 per month was agreed with a major launch in April once the process has been reviewed. Our People Partners are engaging with services about the new process and how to access it, as well as the outcomes	
	NEW *Enabling action:* Human Resources to review the Leavers Policy by the end of February 2023 to ensure the processes available for submitting feedback are up to date.		
	NEW *Enabling action*: Upon completion of the Leaver Policy, Organisational Development and Human Resources to ensure all staff are aware of the processes available within the Trust to submit their feedback		

Additional Intelligence in support of continuous improvement

- Work has been undertaken to strengthen the Trust Preceptorship Programme to minimise the number of newly qualified nurses leaving our service. We have implemented a 3-week training programme prior to placing our nurses on inpatient wards, strengthened our local inductions and established bi-monthly check-ins with a view to support nurses that may be thinking of leaving the Trust. It is too early at this stage to see whether this will reduce the number of newly qualified nurses leaving our Trust; however the success of the programme is being monitored.
- Work is underway to provide clarity on local induction for all services and a new starter managers guide has been approved for use.
- Short videos on working in the Trust have been developed so that people joining the Trust have a better understanding of what it is like to work here.
- The new staff handbook is being well received by new starters and is now being disseminated to all staff.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

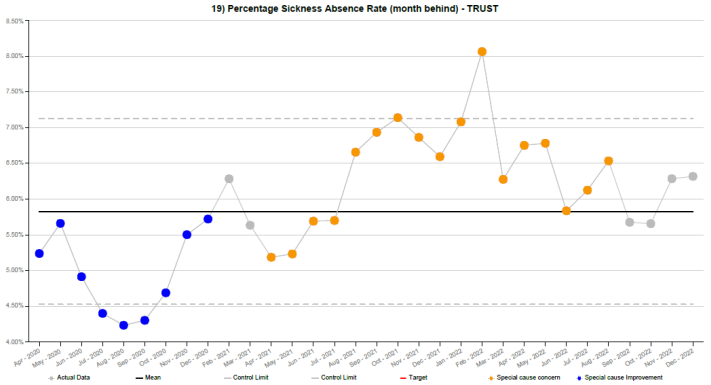
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

There were **215,809.68** working days available for all staff during November (reported month behind); of those, **13,635.72 (6.32%)** 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

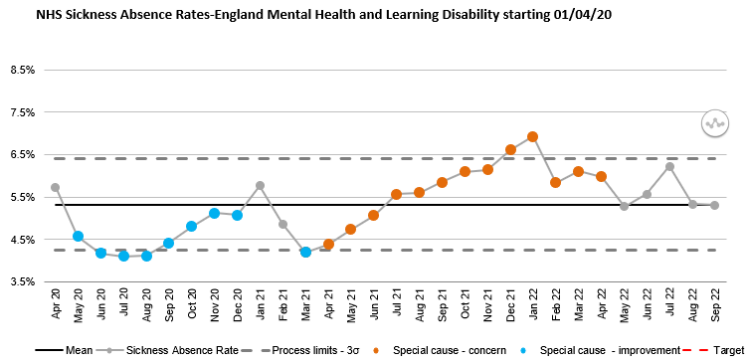
DQ 87%



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

NHS Sickness Absence Rates published 26th January 2023 (data ending September 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 5.89%.

Regional Benchmarking: We have seen a rise in our sickness absence rates during November and as at the 17th January 2023, 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 19th January 2023, sickness absence is 7.41% for January 2023.

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.	High level information has been shared, including the support and interventions currently in place to address increased absence. The group is focusing on the top 10 services/teams with the highest absence and reviewing the action plans in place with a view to this continuing this on a quarterly basis.	
	Enabling Action: Deputy 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 started in January, initially at Improvement & Delivery group level. This will feed up through the Care Group People, Culture & Diversity Group and into the Executive People, Culture & Diversity Group on a monthly basis.	

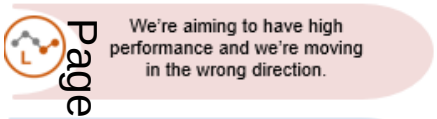
20) Percentage compliance with ALL mandatory and statutory training

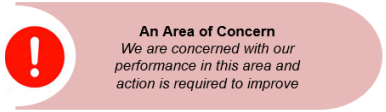
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

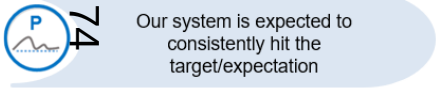
We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our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

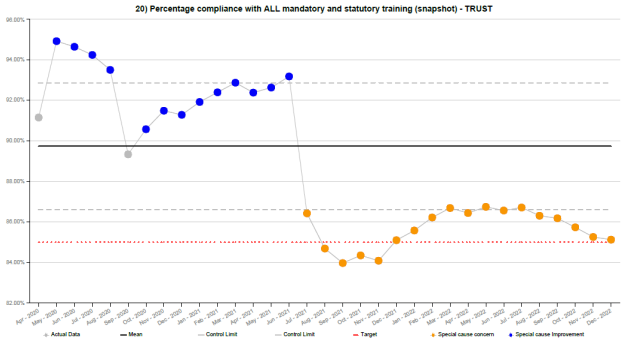
121,700 training courses were due to be completed for all staff in post by the end of December. Of those, **103,602** (**85.13%**) courses were actually completed.

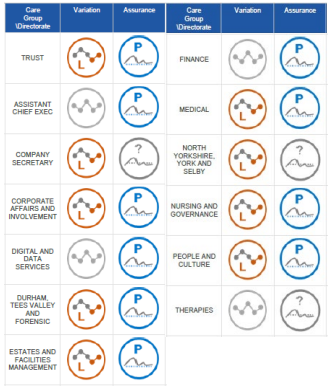
Percentage Compliance with Information Governance & Data Security Training. As required by the Information Governance Tool Kit the Trust must achieve 95% staff compliance by December 2022. As at end of December, **7230** were due for completion, **6561 (90.75%)** were actually completed.











NOTE: we failed to achieve the Information Governance Tool Kit requirement to achieve 95% staff compliance by the 31st December 2022. We have been granted an extension to the 28th February 2023 and will be issuing increased communications to all staff.

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*: 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.	There are no plans to proactively contact all teams with less than 85% compliance. As we continue to embed the People Partners, monitoring reports will be embedded into the monthly Improvement & Delivery Groups.	

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
Information Governance training – Data Security Awareness Level 1 compliance has been impacted due to clinical/operational pressures	Information Governance team to offer face to face Information Governance training out of hours during January and February 2023 to support staff improved compliance. New dates are to be published once a technical issue has been resolved		

21) Percentage of staff in post with a current appraisal

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.

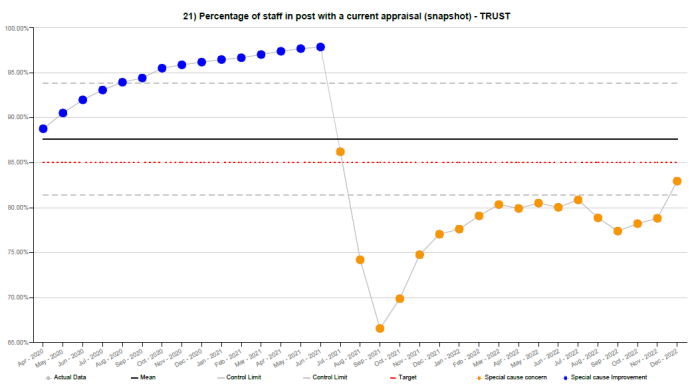
Of the **6388** eligible staff in post at the end of December; **5299** (**82.95%**) had an up to date appraisal

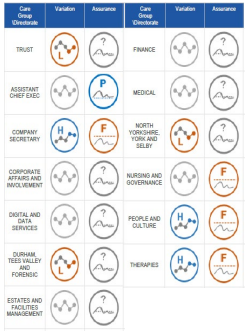
We're aiming to have high performance and we're moving in the wrong direction.

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:* 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.	86 managers have been identified, accounting for 348 staff. An initial finding is that a number of managers were unaware of their responsibility of adding this to the Electronic Staff Record; guidance has been distributed.	
	Enabling action: Organisational Development to link in with all teams performing at less than 75% to identify whether there is any specific support required. This work will be completed by the end of February 2023.		

22) Number of new unique patients referred

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.

7270 patients referred in December that are not currently open to an existing Trust service

No significant change in the data during the reporting period shown

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

DQ ★ 93%

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

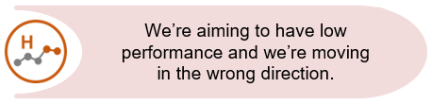
There are currently no specific trends or areas of concern identified within this measure.

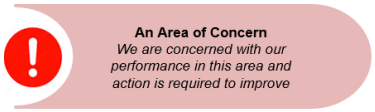
23) Unique Caseload (snapshot)

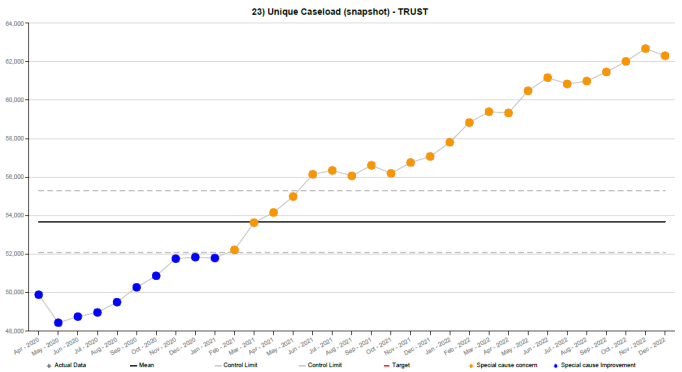
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

62,300 cases were open, including those waiting to be seen, as at the end of December 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.	**Complete.** Newly developed team-level SPC charts have been validated. A number of individual teams were highlighted for further investigation to be able to confirm they are a concern.	
	Enabling action: Task & Finish Group to complete the gathering of wider intelligence by the end of January 2023. This will include aligning the data gathered with whole time equivalent staffing changes over the relevant periods and with performance intelligence to understanding the implications of the analysis.		

Additional Intelligence in support of continuous improvement

The Executive Strategy and Resources Committee met on 17th January and received additional analysis of high level locality, speciality and team type caseload changes, with 6 locality team types accounting for 89% of the composite unique caseload increase (North Yorkshire York & Selby Autism/Attention deficit hyperactivity disorder (ADHD) and Child & Adolescent Mental Health Services (CAMHS) and Durham, Tees Valley Adult Community, Adult Autism/ADHD , CAMHS community and CAMHS neurodevelopmental). Potentially with the exception of the Durham, Tees Valley adult community teams (largest increase proportionately), these pinch points have been highlighted previously.

23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

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 the Scarborough Community and Attention Deficit Hyperactivity Disorder teams has commenced in January and will be followed by one in Selby.The Caseload Management Policy within Adult Services has been rolled out in January 2023.

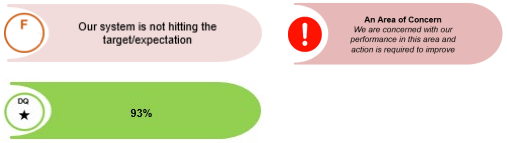
24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit

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 **£5.0m** deficit (to break even) to 31st December 2022 against a planned year to date surplus of **(£0.2m),** resulting in a **£5.2m** 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 **£5.0m** against a planned year to date surplus of **(£0.2m),** resulting in a **£5.2m** variance to plan, representing **higher than planned expenditure.** Key observations for December were:

- **Independent sector beds** - the Trust required 98 bed days during December 2022 (155 for November 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 66 bed days. Year to date expenditure was £3.1m, or £2.8m 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 December 2022 is £16.3m, which is £9.0m 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 £1.8m ahead of plan. This is partly offset by a surplus to plan on computer software and maintenance of (£1.15m), resulting in a net deficit to plan of £0.65m. The associated recovery action for capitalisation of IT hardware (where appropriate) has been accelerated from M12 to M9 with a benefit to the revenue position at M9 of £0.7m.
- **Planned CRES performance** as at December 2022 is behind plan by £3.2m, however unplanned schemes to the value of £1.5m provide a partial offset, resulting in net CRES performance that is £1.7m 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 £5.0m to month 9, resulting in a net pay award pressure of £2.5m (£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 £0.1m in Month 9. Future months costs are still to be determined with a business case in train.
- There have been improvements in M9 to the previously reported deficit position relating to additional interest income received, additional income from commissioners and Health Education England and a reduction in independent sector expenditure for a patient where costs are not the responsibility of TEWV

To deliver plan requirements the Trust needs to mitigate bed pressures and elevated temporary staffing run rate pressures in addition to planned CRES and recovery actions.

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 on 5th December 2022 (DTVF) and 20th December 2022 (NYYS) Approval assurance in train relating to agency rule breaches (off framework, above £100 per hour or under £100 but 50% above price cap)	Run rates for complex packages reduced following discharge. (Expected to reduce further with transition to reduced rate on framework agency). An increase of 504 agency shifts in December compared to November.
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. Recovery action for capitalisation of IT hardware (where appropriate) has been accelerated from M12 to M9	Centralised CIO / Deputy CIO level approvals for all hardware to improve resource and asset management Capitalisation of revenue expenditure of £0.8m
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*		

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 £16.3m is £9.0m **(125%)** 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 £16.3m is £9.0m (125%) 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 £7.2m YTD resulting in a breach of this cap by £9.0m.

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.

Page 82

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 December 2022 there were 4,541 agency shifts worked, with 2,914 shifts compliant **(64%).**

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 December 2022 4,541 agency shifts were worked (504 more than November).

Of these, 2,914 or 64% shifts were compliant (66% compliance prior month).

Of the non-compliant shifts 1,321 or 29% breached price caps (up from 1,097 shifts and 27% prior month) and 306 or 7% breached framework compliance (up from 276 shifts and 7% 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.

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		

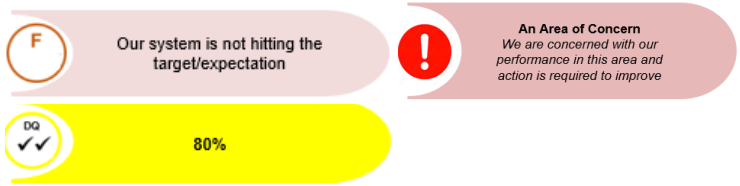
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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 31st December 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 0.30x, which is 1.14x or £6.0m 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 25.1 days; this is behind plan by 5.3 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 1.42%, this is worse than plan by £4.9m and is **rated as a 4**.
- The **agency expenditure** metric assesses agency expenditure against a capped target for the Trust. Costs of £16.3m are £9.0m (125%) 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 31st 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

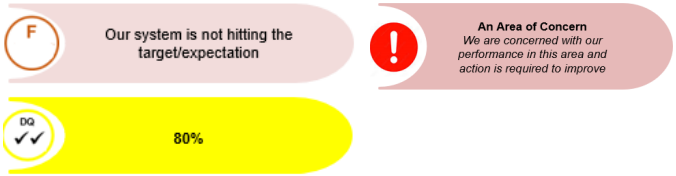
27) CRES Performance - Recurrent

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 **£8.2m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£6.5m**.

£1.7m 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 £1.7m behind plan with specific performance noted as:

- £0.7m CRES for OAPs contracted bed elimination is behind plan
- £2.0m 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
- £1.0m 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.

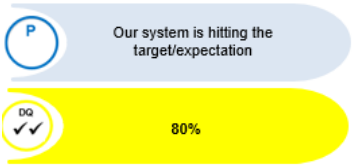
28) CRES Performance – Non-Recurrent

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 **£1.0m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£1.0m**.

(£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.

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 December was **£6.3m** against planned expenditure of **£7.5m**

£1.2m underspend against plan.

Summary

Capital expenditure at the end of December was **£6.3m**, and is **£1.2m** lower than plan of **£7.5m**. This includes slippage on health and safety works and LD Environment changes, which are partially 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. Networked IT assets have been capitalised in December, back dated to April 22 (which has resulted in a benefit to the revenue position).

The Trust is in discussion with ICB colleagues to manage system delivery of financial targets. The Trust has received confirmation of £3.5m additional capital funding to develop Crisis and Liaison services, and £1.7m capital funding to support IT frontline digitisation spend. The full balance must be spent during 2022/23 financial year.

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. All schemes have now commenced.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Not spending the full capital allocation in year could lead to pressure in future years as annual plans are managed at ICS level.	The Capital Development Team continue to review the forecast and deliverability of schemes alongside central ICB colleagues to manage projected aggregate spend. Key residual actions include evidence collection to support capitalisation of IT grouped network assets. This will be completed by the 31st March 2023	Current forecast is to breakeven with plan. Frontline digitisation funding has been confirmed in line with requested amount (£1.7m this year).	

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 **£70.7m** against a planned year to date cash balance of **£72.6m.**

£1.9m adverse variance from plan

Summary

Cash balances were **£70.7m** at 31st December 2022, which is **£1.9m** lower than plan of **£72.6m**. 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 31st December 2022 was £6.0m. This has increased from November as material NHS contract variations reached final agreement and could be raised as an invoice. The amount over 90 days overdue is higher than targeted (£0.5m excluding amounts being paid via instalments and PIPS loan repayments), but this has again reduced in month, and 5 suppliers account for 70% of total debts greater than 90 days old. We have not been notified of challenge for any outstanding debt values, and progress continues to be made to receive payment for the older debts.

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?

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_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	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	1031	431	431
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	1031	431	431
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours.	85%	91.56%	88.60%	86.59%	88.86%
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 **6** measures that have not been delivered 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	2480	7517
IAPT: The proportion of people who are moving to recovery	50.00%	52.97%	52.54%	48.71%	51.49%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	28.43%	30.70%	14.65%	25.14%
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%	68.75%	68.75%
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%	90.32%	90.32%
Number of people accessing IPS services as a rolling total each quarter	169 at Quarter End	140	138	129	

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.	**Complete.** The 3 applicants are now in post and the additional workshop started in January.	We would anticipate seeing the impact as the workshops progress.

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
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.	**Complete**. The service reviewed all patients and identified increase acuity of patients as a result of concerns around cost of living and winter heating anxiety and physical ill health concerns.	
NEW We need to ensure that as many patients as possible who use our service achieve recovery.	The Service Manager to review the possibility of specialist supervision for staff to enable them to adapt therapy to the cost of living crisis. Review work will be complete by the end of January 23.		
	Enabling action: The Service Manager to ensure the recovery tracker, which details the pathway of all patients that do not achieve recovery, is updated by all therapists on a weekly basis with immediate effect. This will enable the service to understand why our patients do not achieve recovery and identify any improvement actions.		
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.	

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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
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			
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.	
	NEW The General Manager for Children & Young People's Services to represent the service at a workshop with CDDFT to develop a decision-making matrix of care for the two Trusts to follow to ensure joined up working, with clear responsibilities identified The workshop will take place by the end of January 23.		
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.	**Complete.** All incorrect coding has now been corrected and all IPS advisors are aware of the correct codes to use.	
	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 **7** measures that have not been delivered 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	501	1537
IAPT: The proportion of people who are moving to recovery	50.00%	52.41%	54.14%	49.84%	52.18%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	30.05%	33.60%	18.03%	27.89%
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	150	
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%	84.36%	87.96%

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.	**Complete.** A new standard process has rolled out from January 2023.	We would anticipate seeing the impact as the process becomes embedded

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 **5** measures that have not been delivered at quarter 3, all 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	8272	1676	1816	1812	5304
IAPT: The proportion of people who are moving to recovery	50.00%	50.05%	49.23%	42.52%	47.28%
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%	64.91%	64.91%
Number of people accessing IPS services as a rolling total each quarter	123 at Quarter End	67	82	92	
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 71 Q2 142 Q3 213 Q4 284	70	96	125	125

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.	**Complete.** IAPT Marketing material has been refreshed and a marketing tool kit has been created including posters, social media posts, website QR codes and IAPT banner added GP practice websites.	We would anticipate seeing a positive impact as awareness increases.

Long Term Plan Ambitions – North Yorkshire Sub-ICB Location

NHS
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.	**Complete.** The deep dive was completed in December.	
NEW The deep dive into to understand why a number of our patients were not moving to recovery identified that a number would have achieved recovery if they had been offered more sessions.	*Enabling action:* Team managers to establish a daily recovery huddle by the end of January 2023 to ensure patients are offered all opportunities to move to recovery when they are close to treatment completion.		
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.	**Complete.** North Yorkshire, York & Selby Quality Assurance & Improvement Subgroup has approved the business case and this will be rolled out with immediate effect	We would anticipate seeing a positive impact as use of the referral form increases.
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.	1 clinical nurse is recruited and will start in post in June 23, the Specialist Psychological therapists have been recruited and are due to start in March and the team manager has been recruited and is awaiting start date. 1.6 Clinical Nurse posts are being readvertised in January.	
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.

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	6282	1441	1405	1734		4580
Percentage of people who have waited more than 90 days between first and second appointments	<10%	17.65%	15.52%	12.34%		15.34%
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%	60.94%		60.94%
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 60 Q2 120 Q3 180 Q4 240	49	72	93		93
Percentage of people experiencing a FEP treated with a NICE approved care package within 2 weeks of referral	60%	63.33%	77.78%	48.84%		61.00%

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, which is expected by the end of January 2023.	

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. 1.4 HIT posts have been re-advertised. 1 HIT trainee will start in post in January and a further trainee post is to be re-advertised in January.	
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 1.4 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.	Following recruitment challenges, all 3 posts have been re-advertised in January. To mitigate the risk staff are being offered overtime and support is being provided by the North Yorkshire EIP teams.	
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			

Chapter 3

NHS Oversight Framework

NHS Oversight Framework

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Introduction:

The NHS Oversight Framework is built around five national themes:

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

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

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

Summary:

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

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

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

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

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

1) Quality, Access & Outcomes: Mental Health

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

Tees, Esk & Wear Valleys NHS Trust	Oversight Standard	Q1	Q2	Q3	Latest National Position
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	0	1094	1031	431	

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

North East & North Cumbria ICB	Oversight Standard	Q1	Q2	Q3	Latest National Position
Access rate for IAPT services	100.00%	93.23%	71.93%	81.07%	Lowest performing quartile (a position of concern) as at September 2022 36 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100.00%	112.57%	111.28%	111.46%	
Access rates to community mental health services for adult and older adults with severe mental illness	100.00%	225.41%	228.48%	231.74%	

Humber & North Yorkshire ICB	Oversight Standard	Q1	Q2	Q3	Latest National Position
Access rate for IAPT services	100.00%	85.67%	88.53%	97.46%	Interquartile range as at September 2022 21 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100.00%	145.29%	149.66%	148.93%	
Access rates to community mental health services for adult and older adults with severe mental illness	100.00%	258.94%	250.05%	244.73%	

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

NOTE: Following the release of new guidance, we have revisited the construction of the **Access rates to community mental health services for adult and older adults with severe mental illness** measure currently reported within this report. The examples provided have changed our interpretation of the original guidance and we are now taking action to amend the construction of our measure and the refreshed data will be presented in the March report.

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

Quality of care, access and outcomes; Safe, high-quality care	Oversight Standard	Q1	Q2	Q3	Latest National Position
National Patient Safety Alerts not completed by deadline	0	0	0	0	Data as at November 2022
Consistency of reporting patient safety incidents	100.00%	100.00%	100.00%	100.00%	Data as at November 2022 Highest performing quartile (a positive position) as at September 2022 (100%) 1 out of 72 Trusts
Overall CQC rating	N/A	Requires Improvement			Lowest performing quartile (a position of concern) as at November 2022 54 out of 69 Trusts
NHS Staff Survey compassionate culture people promise element sub-score		6.9	6.9	6.9	Lowest performing quartile (a position of concern) as at 2021 survey 63 out of 70 Trusts
NHS Staff Survey raising concerns people promise element sub-score		6.7	6.7	6.7	Interquartile range as at 2021 survey 49 out of 70 Trusts

Leadership and Capability; Leadership

Leadership and Capability; Leadership	Oversight Standard	Q1	Q2	Q3	Latest National Position
NHS Staff Survey compassionate leadership people promise element sub-score	As per staff survey benchmarking	7.17	7.17	7.17	
CQC well-led rating	N/A	Requires Improvement			Lowest performing quartile (a position of concern) as at August 2022 56 out of 69 Trusts

People; Looking after our people

People; Looking after our people	Oversight Standard	Q1	Q2	Q3	Latest National Position
Staff survey engagement theme score	As per staff survey benchmarking	7.00	7.00	7.00	Lowest performing quartile (a position of concern) as at 2021 survey (6.79) 64 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking	8.00%	8.00%	8.00%	Interquartile range as at 2021 survey (8.33%) 32 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	As per staff survey benchmarking	14.00%	14.00%	14.00%	Interquartile range as at 2021 survey (13.80%) 28 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	As per staff survey benchmarking	25.00%	25.00%	25.00%	Interquartile range as at 2021 survey (24%) 20 out of 70 Trusts
NHS Staff Leaver rate	None	13.87%	13.39%	12.91%	Highest performing quartile (a positive position) as at September 2022 (8.13%) 14 out of 71 Trusts
Sickness absence rate (working days lost to sickness)	None	6.45%	6.11%	6.09%	Interquartile range as at July 2022 (6.53%) 49 out of 71 Trusts

People; Belonging in the NHS

People; Belonging in the NHS	Oversight Standard	Q1	Q2	Q3	Latest National Position
Proportion of staff in senior leadership roles who a) are from a BME background b) are women c) disabled staff					
BME background	12%	1%	1%	1%	
Women	62%	66%	67%	64%	Interquartile range as at June 2022 (66.88%) 42 out of 69 Trusts
Disabled staff	3.20%	4%	4%	6%	
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	As per staff survey benchmarking	56.00%	56.00%	56.00%	Interquartile range as at 2021 calendar year (60.50%) 28 out of 70 Trusts

Finance and use of resources

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

Finance and use of resources	Oversight Standard	Q1	Q2	Q3	Latest National Position
Financial efficiency - variance from efficiency plan - Recurrent	N/A	£1,208,577	£3,871,945	£6,482,000	Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.
Financial efficiency - variance from efficiency plan - Non-Recurrent	N/A	£361,173	£722,346	£1,044,000	
Financial stability - variance from break-even	N/A	£1,296,930	£4,290,781	£4,718,089	
Agency spending: Agency spend compared to the agency ceiling	100%	Not currently available	208.23%	224.76%	
Agency spending: Price cap compliance	100%	Not currently available	64%	64%	

Tees, Esk and Wear Valleys NHS Foundation Trust

ITEM NO. 10b

Committee Key Issues Report		
Report Date to Board of Directors – 23 February 2023		
Date of last meeting: 2 February 2023		**Report of: The Quality Assurance Committee**
		Quoracy met: Apologies from Z Campbell
1	**Agenda**	The Committee considered the following matters: • The management of relevant risks included in the BAF • Risks relating to Quality and Safety • Executive Quality, Assurance & Improvement Group (EQAIG) • Progress on delivery of the CQC Action Plans • Integrated Performance Dashboard & Trust Level Quality & Learning Report • Trust Quality and Clinical Journeys • NICHE Actions Assurance Report • Update on Safety Alerts (matter escalated by Audit & Risk Committee) • Internal Audit Reports: (matter escalated by Audit and Risk Committee) • Safe staffing • Update report on TEWV's response to findings identified at Edenfield Ward, Greater Manchester MH NHS FT – 'closed cultures' • Adult Learning Disability Services (ALD) Improvement Plan • Long term seclusions ICTRs
2a	**Alert** Leading	The Committee alerts the Board on the following matters: **1. Executive Quality, Assurance & Improvement Group (EQAIG)** Work continues to improve the flow of information through this group for more streamlined governance and to avoid duplication. The key alerts raised at the Group were: The lack of progress with serious incident reviews. Executive Directors will be considering seeking external agency support and are developing a recovery plan. Some assurance can be provided that each SI is reviewed on an individual basis in daily huddles where, if necessary, a rapid review can be commissioned so that early learning can be identified and actioned. Members expressed their concerns over the lack of requested support to help alleviate the number of backlog cases. Current temporary closure of adult learning disabilities admissions has led to several LD related admissions in adult services, which isn't the appropriate environment with the suitably skilled staff. Discussion took place that the most appropriate place may need to be an out of area bed in such circumstances. Bed occupancy remains a concern with up to 113% in Teesside – the ambition being 85%. The bed oversight group are monitoring this closely however together with staffing levels this presents a risk to the delivery of high-quality care. **2. Safe Staffing (attached as Appendix a)** There is little change to the ongoing challenges for safe staffing, which was related to December 2022 data. There is a positive development as staff can now view data at ward level. A significant risk remains in relation to appropriate skill mix. There remains a low fill rate for registered nurses in some areas. The two PICU's are demonstrating exceptionally high fill rates for Health Care Assistants (420% and 346%) impacting negatively on skill mix. 13 wards had more than 25% of bank staff fulfilment which is a risk to the delivery of safe care. Agency use remains high with 41 teams use of greater than 4% (an increase of 6 since last month)

		Staffing levels remain a concern. For both in patient and community services, there are clear escalation protocols. **3. Adult Learning Disabilities Improvement Plan** QUAC received a very clear update from the Care Group and noted that the temporary closure of two in patient units at Lanchester Road has been delayed, with one patient remaining, where an external review has been commissioned to ensure the appropriate care plan is in place. Assurance was detailed in the paper in terms of communication, engagement and overall processes, with good progress 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. Members welcomed a further upcoming visit to the services from colleagues from Mersey Care NHS MH Trust. **4. Update on Safety Alerts (matter raised at Audit & Risk Committee)** Following concerns raised by ARC, The Chair of QuAC asked to receive an update on our approach and overall position in relation to the management of safety alerts across the Trust. The Committee received reasonable assurance on the design, compliance and control of our processes in relation to the management of safety alerts. However, our performance is disappointing and therefore the Committee agreed that there was overall limited assurance, impacted by capacity and capability. The Chair will advise ARC of the outcome and actions at its next meeting on 17 March 2023.
2b	**Assurance**	The Committee wishes to draw the following positive assurances to the attention of the Board: **1. Board Assurance Framework (BAF)** That there is good assurance that the strategic risks assigned to the Committee are being managed effectively. However, the Chair advised that the Committee need to see positive movement in some areas going forward. The full review with Executive Directors will take place during February 2023. The Committee approved the reviewed risk appetite statements agreed informally by Board in December 2022. **2. Delivery of the CQC Action Plan 2021 and CQC Inspection 2022** There continues to be good assurance relating to system oversight and delivery of the action plans with no new gaps in assurance or the mitigating actions. The proposal to extend deadlines to three actions from the Core Service and Well Led 2021 inspection were supported to 30 June 2023, as delivery is interdependent on a Trust wide workstream. **3. Risks to Quality and Safety** Following review by the Executive Risk Group of all risks on the Corporate Risk Register (CRR), there has been positive movement in the overall position. Good assurance can be provided that there are effective controls in place to manage the corporate risks assigned to the Quality Assurance Committee. It was reported that there had been a significant drop in performance of the number of risks that were overdue for review from 95% compliance to 50%. On questioning, it was acknowledged that it was over the Christmas period. It was also noted that the organisational cultural visits were operationalized, which was a priority agreed by Board and QUAC. There may have also been IT issues with a delay in alerts. The Committee were advised that the overdue reviews have been picked up, and performance will improve again. Overall members recognised there have been considerable improvements made in the last year on managing risks and the focus is now to roll out corporate risk training. **4. NICHE Assurance Actions (relating to BAF risk 12)** The Committee agreed the outlined governance processes in the approach to learning from the deaths of three young women in our services in 2019/20. A fourth governance report is imminent.

		NHSE/I have commissioned NICHE to return to the Trust within six months of publication of all the reports (by the end of May 2023), to undertake an assurance review against the actions taken by the Trust in response to the recommendations. Internal Audit are undertaking an audit and the Trust has also commissioned an independent review around Duty of Candour from NECS. The Committee should have this by April 2023. **5. Internal Audit Reports: Providing assurance to the Audit and Risk Committee (ARC)**Following discussions with Internal Audit and Chair of ARC a cycle of reporting will be agreed to ensure that the relevant Committees of the Board have sight on the outcome of internal audit reports, and where appropriate, receive updates on areas of concern for consideration. **6. Update report on TEWV's response to findings identified at Edenfield Ward, Greater Manchester MH NHS FT – 'closed cultures' (attached as Appendix b)** The Committee welcomed this very important piece of work that has been supported by the Board in relation to the Trusts response to reports from Edenfield Centre, Greater Manchester Mental Health Trust. In total, 48 wards have received cultural visits over a short period of time. The results have been presented to the Executive Directors Group. An overview report was presented to the Committee. Overall, a lot of positive assurance was received around visibility of leaders, staff knowing their patients, kind and compassionate care being observed, however some recommendations, including some environmental issues will be taken forward via the Care Groups. The feedback has been themed into the following domains: Leadership and management, experience of service users, experience of staff, environment, use of restrictive interventions and oversight. Further consideration of how such an approach can be used to triangulate quality information along with the quality assurance schedule will be given. The Chair, on behalf of the Committee thanked teams for the monumental effort of covering such a large geographic area of ward areas in such a short time and noted the open, honest and transparent next steps.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **1. Trust Clinical and Quality Journeys** Members of the Committee welcomed the two documents presented. Both had been subject to significant journeys, having emanated from The Big Conversation and then Our Journey to Change. *i) The Clinical Journey be recommended to the Board of Directors for approval, subject to referencing more strongly the need for improved system partner working and the effective engagement for children and adult LD services.* *ii) The Quality Journey is still subject to further consultation, but the Committee provided feedback and supported the recommendation that it be approved by the Board of Directors, following some wider consultation.* **2. Integrated Performance Dashboard (QuAC) and Trust Level Quality & Learning Report** These items were taken together on the agenda as five of the 10 metrics relate to both and a suite of metrics will combine both reports in future. Recent serious incidents in November and December 2022 in CAMHS were noted. The four quality and safety indicators showing cause for concern, incidents, incidents per 1000 caseload, seclusion and feeling safe were all considered with overall good assurance relating to the CQC domains. Reporting of the IPR through to Care Groups is having a positive impact with further work underway to streamline the Quality and Learning report information to that level in the governance structures. The Committee welcomed this proposal and asked for an update at a future meeting. **3. Update on long term seclusions (ICETR Themes)** This second update report to the Committee provided reasonable assurance that individuals with a learning disability and/or autism in long term segregation have had their

		care independently reviewed. (Currently 14 patients within long term segregation or prolonged seclusion). Eight of these patients are in LD services and the remaining patients within Secure Inpatient Services at Roseberry Park Hospital. Of these patients, four have no diagnosis of a learning disability and are therefore exempt from the ICTR process. Seven patients have had an ICTR reviewed with one awaiting a date and a further two waiting agreement with commissioners. For each of the patients who have received an ICTR, there have been agreed patient actions. Themes include access to speech and language assessment and treatment, sensory assessment and dietetic input, consistent application of positive behaviour support plans, staff to have training in autism and trauma informed care, access to appropriate housing (each of the seven are delayed in their discharge). Further work to develop standard processes for identification, escalation and assurance of ICTR processes and in collaboration with the Integrated Care Boards is underway. Nine out of the 14 patients continue to have their care reviewed by the Reducing Restrictive Interventions panels. A separate piece of work requested by QuAC to review 317 incidents of restrictive interventions categorised as "other" has provided the Committee with the relevant background information. Within datix there are 14 different types of restrictive intervention with seven of these being condensed into an 'other' category for reporting processes (this has now been renamed as 'all other forms of restrictive intervention'. To provide assurance to QUAC, the Nurse Consultant for Positive and Safe reviewed 317 incidents that had in a previous report to QUAC been recorded as other. This work provided the committee with good assurance through a breakdown of the type of restrictions used and to follow up data quality issues in 67 of the incidents and re-categorise these, as well as picking up areas for further training.
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. However, the Board is asked to consider the report and where applicable, seek clarity and assurance. The Board should also note the importance of the cultural reviews that have taken place, the Chair of the Committee commends the work and advises Board members to ensure they have sight of the work that is being undertaken as part of our cultural journey.
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

Item 14

FOR GENERAL RELEASE

QUALITY ASSURANCE COMMITTEE

DATE:	**2nd February 2023**
TITLE:	**To consider the "Hard Truths" monthly Nurse Staffing Exception Report - January 2022 using December 2022 data**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Assurance / Information**

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:

Business Continuity Arrangements remained in place during December 2022 for the following service areas: Secure Inpatient Services, Durham & Darlington Crisis Team, the AMH wards at RPH Dalesway (4 admission wards and PICU), CAMHS Community York, CAMHS Community Northallerton, CAMHS CRHT, and DTV&F Inpatient Adult Learning Disability Services. These service areas continue to be closely monitored within the care groups who also report to the Executive Directors Group regarding workforce figures.

50 wards were considered in the report. Registered Nurse fill rates continue to remain consistently low across a significant number of wards (37) for day shifts. The number of wards with low fill rates for RN night shifts have also increased but are as significant as seen on days shifts. There are 22 wards reporting as less than or equal to two thirds of their RN fill rate, 11 of which are adult wards (including PICUs). It is noted that Thistle ward was closed from the 14th December 2022.

HCA fill rates for day shifts show there are a significant number of wards with high fill rates for HCAs, 20 wards are exceeding 150% of their budgeted establishment – 13 of these wards are AMH wards - the highest being the PICUS (Bedale and Cedar) having fill rates of 420% and 346% respectively.

HCA fill rates for night shifts similarly show a significant number of wards with high fill rates for HCAs, with 28 wards exceeding 150% of their budgeted establishment – 12 of these wards are AMH wards, with the highest being the Bedale at 533%.

Contributing factors towards high HCA fill rates include, backfill for the low RN substantive numbers; high patient acuity and dependency which are seen to require 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

All the above factors contribute to the low skill mix (RN to HCA %s) seen across the wards, i.e., where we see all areas other than Health and Justice inpatients are considerably below the MHOST benchmark values, with PICUs are seen as significantly low. 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 poor culture contributing to low staff. The Trust continues to mitigate this risk through daily operational processes as identified below and a continued focus on recruitment and retention.

Budgeted skill mix values approach the MHOST benchmark values, however the ongoing national issues seen with the availability of registered nurse for recruitment and increased patient acuity seen on the wards negatively impact the actual staffing skill mix seen on the wards.

Staffing requirements are supported with local actions such as, staff working additional unplanned hours either as extra shifts or longer working days; cross covering of wards from local staff dependent upon availability; utilising bank and agency staffing resources; prioritising essential activities; support from the ward manager and multi-disciplinary team fulfilling ward duties additional to their normal expected job role; monitoring of staffing levels via daily huddles

The Care Hours Per Patient Day (CHPPD) figures presented here are presented against the available figures from the Model Health System. We can see that, as per previous months, all but the PICU, Eating Disorders (Birch) and LD services are below the peer median. ALD inpatient services continue to show significantly higher levels of staffing per individual patient than peer Trusts, this reflects the need of the service users currently being cared for at this current time receiving individual care packages. Similarly, PICU's high CHPPD will be influenced by the high fill rates for HCAs.

We see the number of missed breaks has increased over the previous month, alongside a small decrease in shifts worked that were greater than 13 hours. Red flags show an increase over the previous month despite seeing the same amount of Datix reports for staffing levels as per November. We are undertaking work to enable improved granularity regarding the number of wards impacted with an individual Datix report for staffing levels. This will also reduce administrative overheads for clinical staff without losing the required detail and aims to improve reporting outcomes.

Temporary staffing requests however continue to remain high over the last 6 months. December has seen reduction in the number of unfilled temporary staffing shifts with a corresponding increase of agency filled shifts – bank has remained static in its fill rate.

For each ward, measuring actual hours worked on bank and agency against the total hours worked (fulfilment), we see that there has been the same number of teams (13) with more than a 25% bank staff fulfilment than the previous month of November 2022. Whereas agency fulfilment however continues to be significantly higher than the Trust threshold of 4% this month. There are 41 teams (72% of all teams considered) that are using greater than 4% agency staff – this number of teams is an increase of 6 over the previous month.

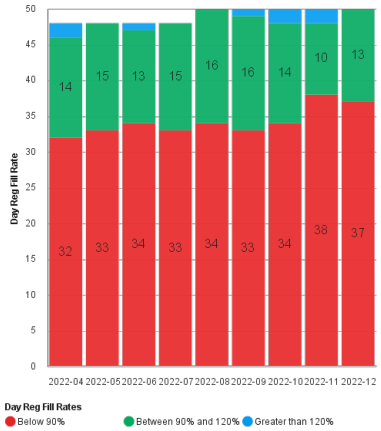
Registered nurse shortages continue to be a national issue, and to support the Trust RN requirements we are continuing with an international recruitment programme. The current pipeline currently has 3 recruits that have passed OSCEs and are set to commence in Scarborough. A further 3 recruits will be resitting their OSCEs in February 2023 and are expected to be successful. Two additional recruits are to work in York with OSCEs planned for April. There are 3 more additional recruits, potentially 5, to progress with the view to joining SIS and are due to arrive later this month (January 2023). A business case is to be presented to the Executive Board this month regarding the ongoing and required commitment from the Trust to successfully manage the international recruitment and the recruits.

Recommendations:

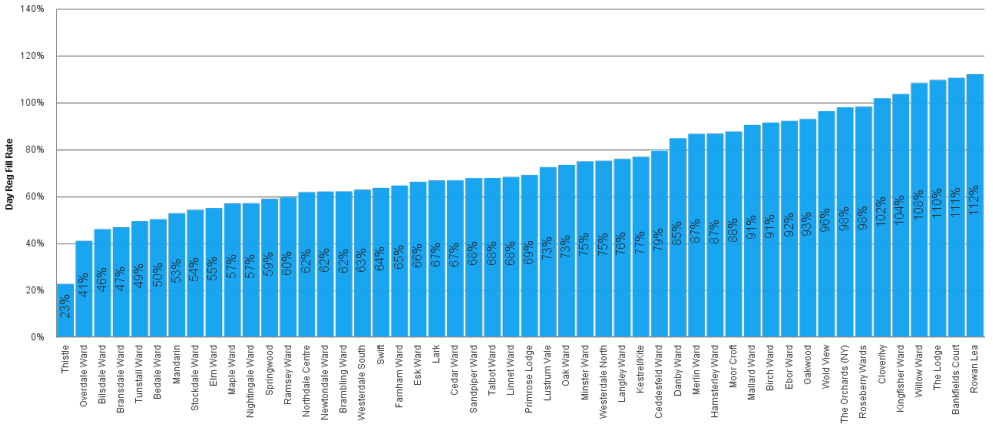
That the Quality Assurance Committee receives the report as notes the actions taken to maintain safe staffing levels. The report provides good assurance of controls in place to monitor and mitigate staffing risks recognising that optimum staffing levels are not always being achieved due to a depleted workforce.

FILL RATES - REFERS TO INPATIENT AREAS ONLY

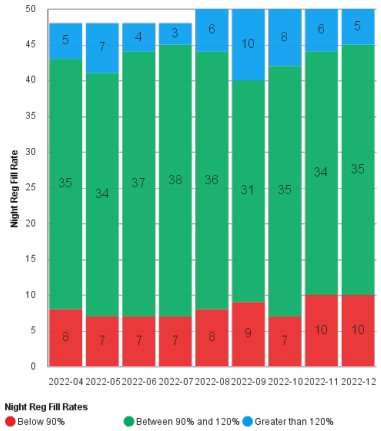
REGISTERED FILL RATES DAYS



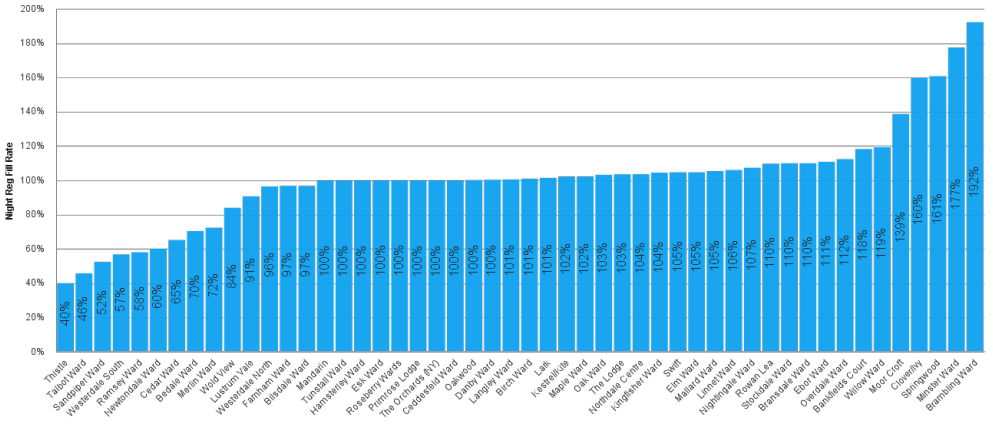
REGISTERED FILL RATES DAYS BY TEAM FOR DECEMBER-2022



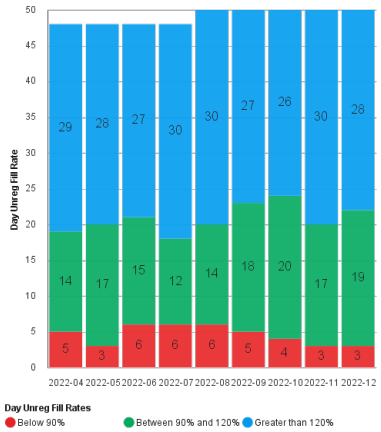
REGISTERED FILL RATES NIGHTS



REGISTERED FILL RATES NIGHTS BY TEAM FOR DECEMBER-2022



UNREGISTERED FILL RATES DAYS



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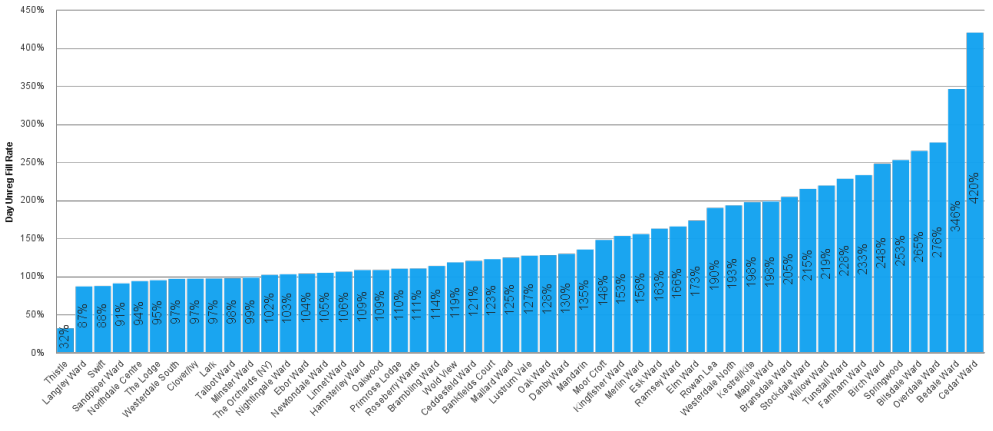
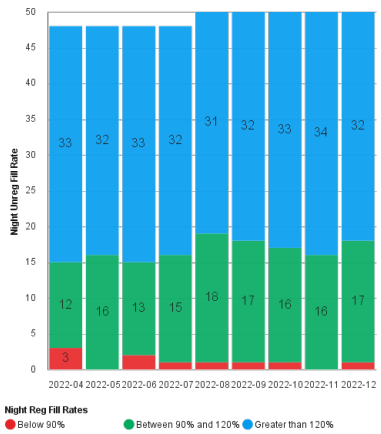


UNREGISTERED FILL RATES NIGHTS



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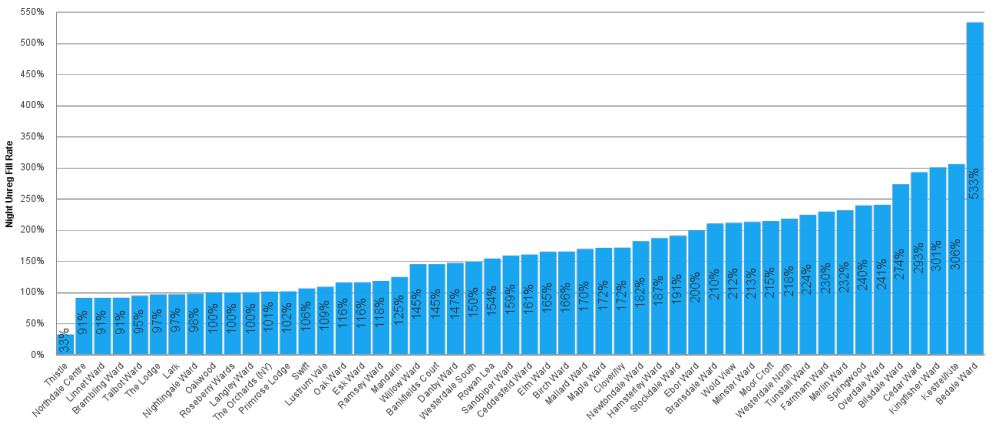
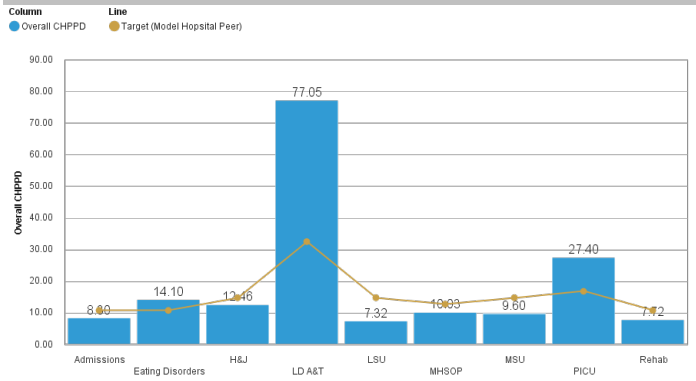
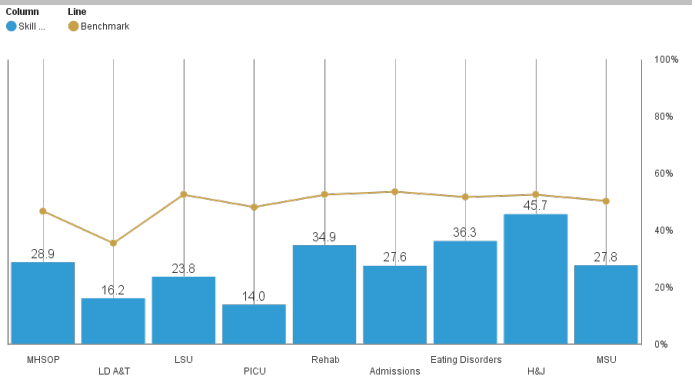


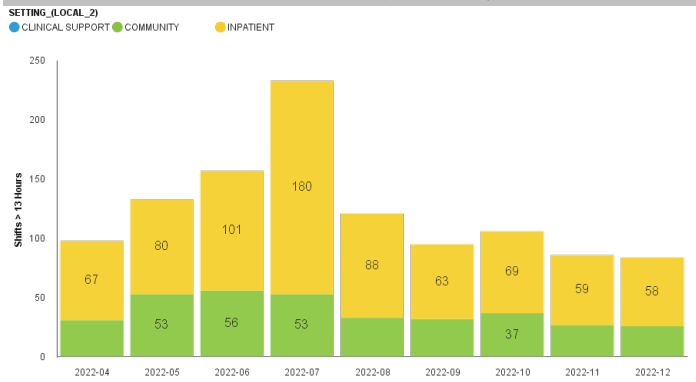
CARE HOURS PER PATIENT DAY (CHPPD) (Inpatient Only)



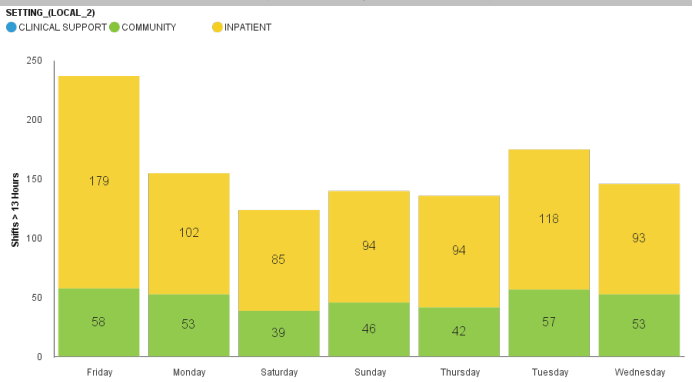
SKILL MIX (Inpatient Only)



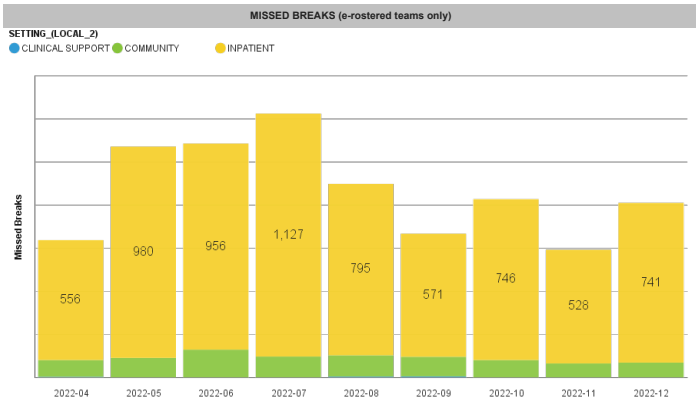
SHIFTS GREATER THAN 13 HOURS (e-rostered teams only)



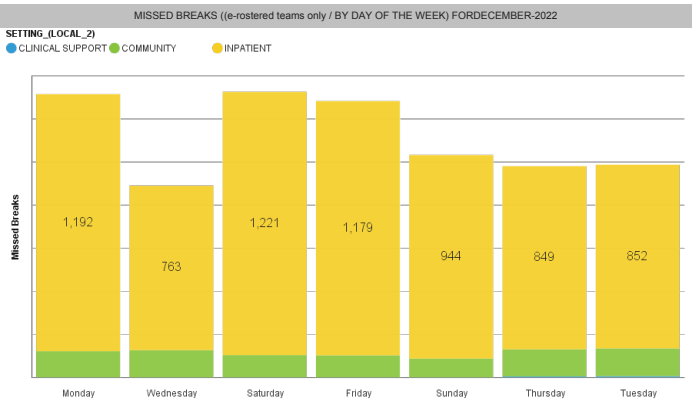
SHIFTS GREATER THAN 13 HOURS (e-rostered teams only / BY DAY OF THE WEEK) FOR DECEMBER-2022



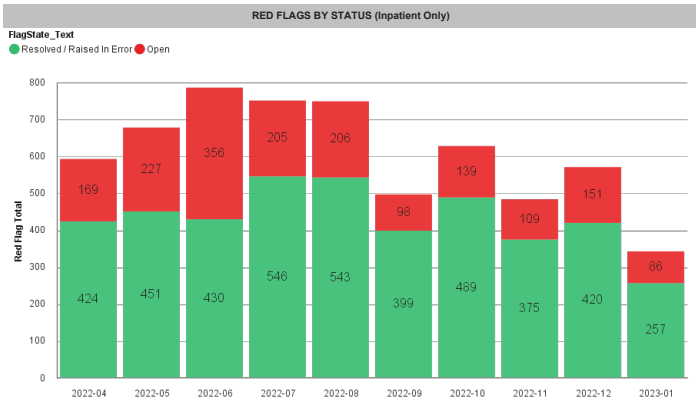
MISSED BREAKS (e-rostered teams only)



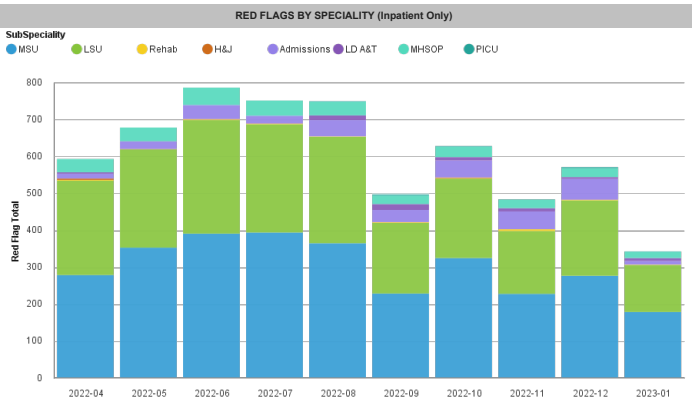
MISSED BREAKS ((e-rostered teams only / BY DAY OF THE WEEK) FORDECEMBER-2022



RED FLAGS BY STATUS (Inpatient Only)



RED FLAGS BY SPECIALITY (Inpatient Only)



RED FLAGS (TOP 10) FOR PERIODS SHOWN IN CHART ABOVE

Description	Red Flag Total
Ward Unable to Provide Response in Zone	2093
Unable to Take Break	1816
There are less RN on shift that is required by the demand of the Service	764
More than 50% Non Regular Staff	331
Less than 2 registered nurses present on a ward during any shift.	239
Unable to support Non-Essential Leaves	187
Unable to support Other Essential Leave	176
Male staff numbers below minimum identified level	115
Staff moved out of group (SIS)	98
Insufficient PAT Trained Worker on shift	80

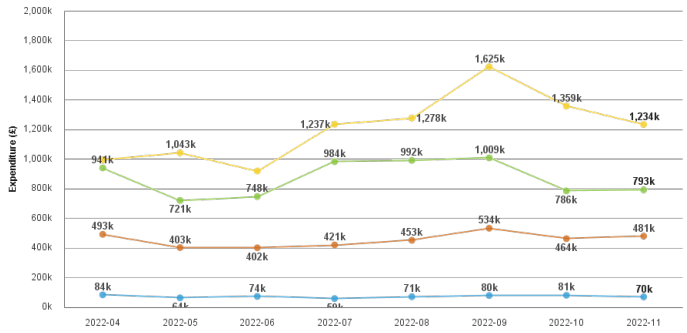
Team	Red Flag Total
Clover/Ivy - 431078	511
Springwood Community Unit - 432742	510
Kestrel/Kite - 430687	506
Merlin Ward - 430611	430
Nightingale Ward - 430656	397
Brambling Ward - 430662	396
Sandpiper Ward - 430647	383
Northdale Centre - 431065	383
Linnet Ward - 430658	378
Thistle - 430685	357

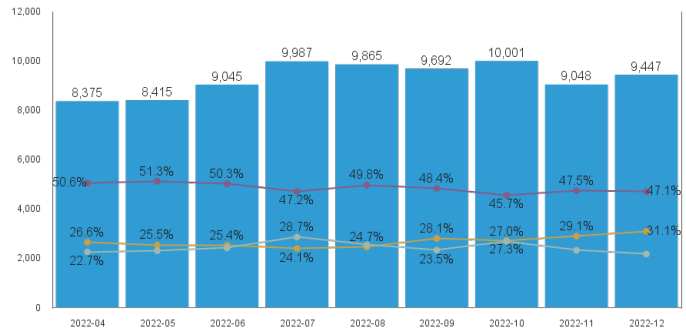
RED FLAGS TOP 10 FOR DECEMBER-2022

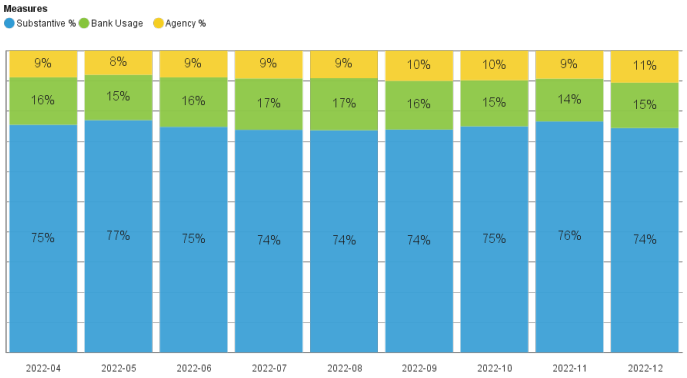
Description	Red Flag Total
Unable to Take Break	188
Ward Unable to Provide Response in Zone	182
There are less RN on shift that is required by the demand of the Service	76
More than 50% Non Regular Staff	42
Less than 2 registered nurses present on a ward during any shift.	24
Unable to support Non-Essential Leaves	11
Unable to support Other Essential Leave	9
Male staff numbers below minimum identified level	9
Unable to support Non-Essential Visits	8
Unable to support Hospital Appointment	5
Staff moved out of group (SIS)	5
Unable to support Other Essential Duties	5
Unable to complete Seclusion Reviews	5
Unable to complete Observation Levels	5

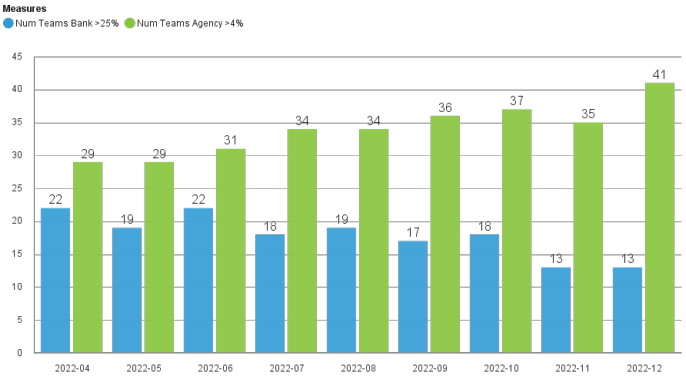
Team	Red Flag Total
Merlin Ward - 430611	51
Kestrel/Kite - 430687	47
Springwood Community Unit - 432742	42
Clover/Ivy - 431078	42
Sandpiper Ward - 430647	41
Northdale Centre - 431065	40
Nightingale Ward - 430656	38
Brambling Ward - 430662	37
Kingfisher Ward - 430712	31
Mallard Ward - 430646	30

FLEXIBLE STAFFING USAGE

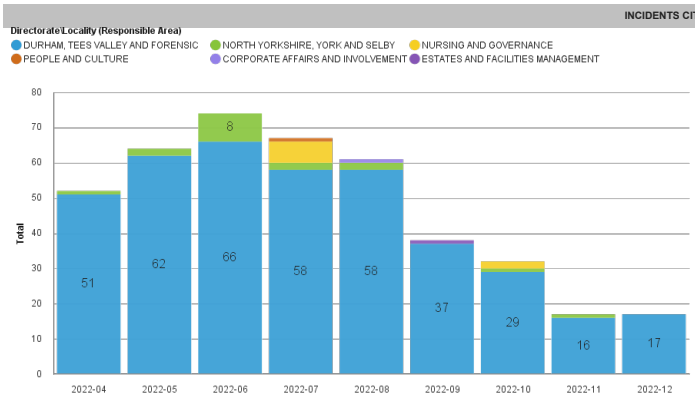


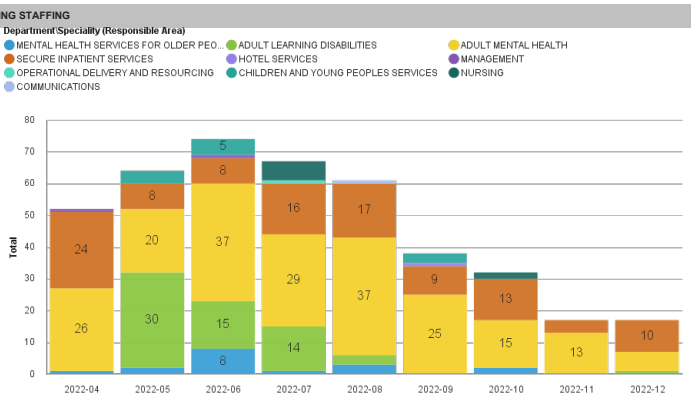




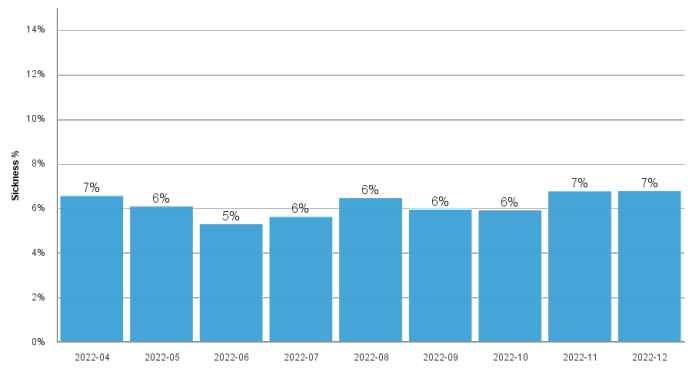


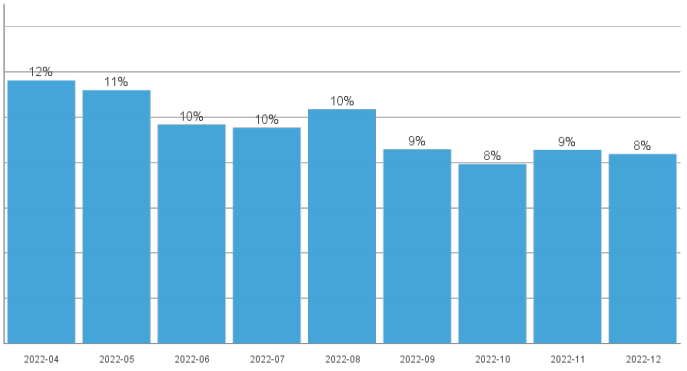
INCIDENTS CITING STAFFING





SICKNESS





ITEM NO. 15

Confidential/For General Release

Meeting of:	**Quality Assurance Committee**
Date:	**2 February 2023**
Title:	**To consider an update report on the organisational response to findings identified at Edenfield Ward, Greater Manchester Mental Health NHS FT regarding 'closed cultures'**
Executive Sponsor(s):	**Elizabeth Moody**
Author(s):	**Elizabeth Moody**

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***
4	We might not always provide a good enough experience for those who use our services, their carers and their families, in all places and all of the time	The Trust has a cautious appetite for risks relating to quality with a preference for risk avoidance**.** The exercise outlined in this paper provides positive assurance in relation to improved visibility and line of sight from ward to Board. The 'see, hear and feel' approach provides direct assurance by testing out at patient care level the factors that impact on patient and staff safety and experience thus impacting on culture. It is acknowledged that the examination of a range of quality data and ward reviews alone will not inform the Trust of 'closed cultures' however they do support identification of early warning signs of poor cultures and therefore are effective at mitigating risks when seen in conjunction with a wider quality assurance approach.
6	Failure to effectively undertake and embed learning could result in repeated serious incidents.	
11	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	

Executive Summary:

Purpose: This report details the actions taken by the Trust in response to recent concerns highlighted at Edenfield Centre, Greater Manchester NHS Foundation Trust. The Quality Assurance Committee is asked to take assurance regarding our approach regarding the identification of poor and/or closed cultures and note the areas for further action and improvement.

Proposal: That the Quality Assurance Committee receive the paper as good assurance that following the completion of the cultural checklist or 'trigger tool' that 48 ward areas have been visited independently by Trust staff independent from the ward. All of the feedback received has been entered into an excel spreadsheet where each ward areas full feedback can be reviewed and positive and negative themes or sections can also be filtered. Any immediate concerns or areas for escalation were highlighted immediately in order that remedial action could be taken.

Next steps are proposed:

- That the Care Groups take the information through their own governance structures to identify any further individual actions for improvement (February 2023)
- That where concerns were raised/escalated in relation to staff attitude/bed pressures/gaps in staffing that immediate action is taken to ensure appropriate actions have been taken and additional oversight and support is in place (February 2023)
- That feedback is shared with all wards (both individual and themes) (end of February 2023)
- That themes are reviewed for appropriate action within and across Care Groups and agreed actions are identified (February 2023)
- That feedback is shared at Clinical Leaders Group for awareness and any improvement actions to be identified
- That estates issues are escalated in order that actions can be taken in relation to areas highlighted around maintenance works, heating and lighting. This includes the need for improved processes for reporting and escalating estates works at ward level.
- That further triangulation of the data and outputs is considered with input from those with lived experience, advocacy and carers.
- That consideration should be given to how this approach could work across a wide, geographical range of community services.

Overview: Following the findings of patient abuse identified by panorama at Edenfield Ward, the National Director for Mental Health wrote to all NHS Trusts to request specific areas were reviewed by Trust Boards. In addition to this, the Humber and North Yorkshire Integrated Care System also requested that providers within the Mental Health, Learning Disability and Autism Provider Collaborative review the mitigations in place to prevent closed cultures developing.

Recognising that many of our areas are at inherent risk of developing a closed culture due to the nature of services provided where some people are not free to leave and have multiple vulnerabilities, for the Trust, this includes all of our inpatient services due to the nature of our people and that they may be treated under the Mental Health Act.

For this purpose, a cultural assessment or 'trigger tool' was created within the Nursing and Governance directorate, based on those known factors for identifying services at risk of developing a 'closed culture' including learning from CQC. Following a desk top exercise where this was populated, a series of ward review visits were undertaken initially to those areas identified at most risk. Following this an agreement was reached to visit all wards in order to carry out a 'see, hear and feel' visit. These visits/ward reviews were coordinated by Care Groups and involved a range of multidisciplinary senior professionals from both clinical and corporate services. Unfortunately due to time constraints it was not always possible for someone with lived experience to attend which was the preferred approach and this should be considered in relation to next steps. Visits were undertaken in both a planned and unannounced manner and typically took upwards from 2 hours spent on the ward with opportunities to speak to staff, some families and service users. The staff guidance tool is attached at **Appendix 2.**

This report outlines the collective response by the Trust to these visit, and both negative and positive themed feedback from the ward reviews can be seen at **Appendix 1.** We have reported back under the domains of leadership and management, experience of service users, skills and experience of staff, environment, use of restrictions and restraint and oversight.

This report is focussed on a high-level overview of where we feel we have areas for shared learning, further triangulation and continuous improvement to make in order to collectively ensure every opportunity to learn, act and reflect on our safety culture is taken.

The majority of feedback from both staff and service users and observations of practice suggested many aspects of good practice and high visibility of compassionate, caring staff.

Whilst the exercise has been felt by teams and reviewers to be beneficial and worthwhile, no closed cultures were identified and it is acknowledged that these are very difficult to spot, therefore this exercise should be seen as part of a need for wider and ongoing surveillance to identify these risks and address poor cultures emerging at an early stage.

Key areas for improvement are set out in the right hand column detailed 'actions and areas for further improvements' but can be summarised and prioritised as: environmental issues (heating, lighting, repairs), bed occupancy and staffing pressures/movement affecting staff (including high use of agency staff causing dissatisfaction). Immediate action has been taken to address some of the agency issues however further work is needed to ensure agency workers are supported and embedded into teams where we have high usage. Some training needs were identified and service user feedback in a

small number of wards needs to be addressed with urgency alongside further exploration of staff attitudes. There is a need in some areas for increased awareness of managers above ward/team level within the new structures.

Overall it is felt that this has been a valuable piece of work to review quality data that may help to identify wards or teams which may be at risk of closed cultures. Work is now underway to make this data available and easily accessible at ward level for teams to use to inform good care and ward leadership as well as oversight at Care Group and Trust level through a dashboard. Opportunities will now be taken to further triangulate findings with other key quality information, input from those with lived experience and partners such as advocacy, health watch, carers and families to ensure the approach is embedded into our quality assurance approach.

Prior Consideration and Feedback

The feedback has been collated in a way that it can now be easily shared with Care Groups in a thematic way as well as maintaining the detail. Due to time constraints this will need to happen following QUAC. The Executive Directors Group considered the feedback on 1st February 2023.
Any immediate areas for escalation have been raised and actions taken.

Implications:

It is acknowledged that the examination of a range of quality data and ward reviews alone will not inform the Trust of 'closed cultures' however they do support identification of early warning signs of poor cultures and therefore are effective at mitigating risks when seen in conjunction with a wider quality assurance approach.

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.

A failure to effectively act and embed learning from this feedback could result in poor or closed cultures emerging.

Recommendations:

The Quality Assurance Committee are invited to confirm the level of assurance as good regarding the Trusts regarding the approach taken to identifying poor or closed cultures and improvement actions proposed.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM. 10b

Mental Health Legislation Committee (MHLC): Key Issues Report	
Report Date: 23 February 2023	**Report of: Mental Health Legislation Committee (MHLC)**
Date of last meeting: 7 February 2023	Full quoracy was met

1 Agenda: The Committee considered the following agenda items during the meeting

- Risks identified relating to Mental Health Legislation
- Integrated Performance Dashboard, (31 December 2022 position)
- CQC Mental Health Act Monitoring Activity – November 2022 – January 2023
- Mental Health Act Discharges from Detention
- Section 136
- Section 132b – Information to detained patients (Section 132 Mental Health Act 1983)
- Absent Without Leave data
- Section 15a Medical and Administrative Scrutiny
- Section 23 (2) (a) Notification of Discharge by Nearest Relative
- Mental Capacity Act Update
- Human Rights, Equality & Diversity: Detention Rates – Deep Dive
- Revised Policies & Procedures:
  - i) Missing Patient's Procedure
  - ii) Section136 Policy
  - iii) Allocation of responsible clinician policy
  - iv) Section 135(2) Procedure
  - v) Section 136 Monitoring Form

2a Alert: The Committee alerts members of the Board on the following:

CQC Mental Health Act Monitoring Activity (BAF ref 11: Governance)
The key themes raised during three site inspections to Cedar, Overdale and Oakwood Wards were linked to: restrictive practices, care support and treatment, care planning and the environment. Environmental (including estate) issues were also noted in the recent culture visits across 40+ wards. Assurance was sought by the Committee on what was being done to deal with these and the members are satisfied that progress is being made with appropriate oversight.

It was noted that there had been an improvement regarding Section 17 use and completions in relation to patients' leave from hospital.

In reviewing data on the uses of the MHA it was discovered that renewals are being recorded as new detentions, distorting the numbers of actual patients to whom the Act is applied. A specific review relating to BAME patients, requested by the Chair, also confirmed this. This apparent anomaly may be the reason why our Trust appears near the top in national data comparisons and, in the case of BAME patients, second highest in the country. The likely reason is the way numbers are transposed from PARIS for IIC purposes. The Committee has now urgently sought clarification on this data recording, handling, and processing within the Trust as well as a comparison with other trusts and clarification of national recording policies.

2b Assurance: The Committee assures members of the Board on the following:

Integrated Performance Report (IPR)
The IPR for the MHL Committee contains one measure: "The number of uses of the Mental Health Act". There were 338 uses of the MH Act during December 2022, compared with352 during September. As a result of analysing this measure it has been identified through the IPA process that renewals of detentions are being captured as new detentions The Head of Performance is working with the MHL team and Head of Business Intelligence to review.

	Thus, the Committee is unable to provide assurance that reported data is accurate but action is being taken to resolve this (see above). **Discharge from Detention** There are no exceptions from the data during Quarter 3. **Section 136** Further refinement to reporting on Section 136 will include the number of individuals detained in relation to bed availability, the time taken for the first doctor to assess and, the details and outcome in anyone under 18 years. The process that supports patients sectioned with a 136 will be reinforced by sharing a briefing with Doctors and Executive leads. A more detailed analysis has been requested to ascertain why numbers of individuals placed on a S136 are higher in some localities compared with others within our Trust.
2c	**Advise: The Committee advises the Board on the following:** **Moderate Risks relating to MH Legislation** There has been no change in the last quarter to the risks relating to mental health legislation - risk of failing to comply with the Mental Capacity Act (Ref. 1300), unlawful deprivation of a patient's liberty (Ref. 1299) and unlawfully depriving a patient of their liberty when Liberty Protection Safeguards come into place (Ref. 1298). All will continue to report to the Risk Subgroups of the Care Group Boards for discussion and shared ownership. Following the Executive Risk Group meeting, Risk 1304 on the Corporate Risk Register will be aligned to the MHLC, which relates to mitigations to help reduce pressure on A&E Trusts and an update will be reported to the MHL Committee in May 2023. **Operational links with Care Group Boards** With representation at MHLC meetings from the Care Group Boards, more effective communication in relation to operational matters is driving the ability to look beneath the data to seek assurances on the remedial actions their outcomes. Members acknowledge the importance of every "number" in the data being seen as an individual deserving a good experience whilst in the care of TEWV. The escalation process to support Section 132 (reading patients their rights) occurs more frequently on some wards than others. The Committee has sought further assurance at its next meeting on those hot spot wards and the mitigations in place to ensure the process is followed. **Bringing Lived Experience and Co-creation into the MHL Committee** In seeking Oversight and assurance on the delivery of the Trust's goal to co create a great experience for our patients and carers, (section 2.1 of the Committee's terms of reference), it was agreed to strengthen the relationship with the Care Group Boards by extending an invitation to the Lived Experience Directors to a meeting, on a trial basis. **Detention Rates – deep dive (as above)** It has been established that the Trust, in reporting numbers of detained patients has been counting repeated detentions as further episodes. TEWV has historically been known for many years, as reporting high numbers of detentions, being ranked the second highest nationally. This raised alarm amongst members who requested a deeper understanding of the numbers. Further work on refreshing the numbers and data cleansing will report at the next meeting. It is anticipated that the data will show a substantial reduction in MHA numbers. **Absent without Leave** The information reported shows that there are some wards where AWOL rates are higher than others. Overall, during nine months there were 183 AWOLs, with one individual accounting for 42% of them. Further refinement of data collection with IIC is being explored to ensure that only the designated four categories of AWOL are recorded; over the previous reporting period there were 72 categories, making it difficult to understand underlying reasons.

	Mental Capacity Act The newly appointed Practice Development Facilitator will support ongoing work in preparation for the implementation of Liberty Protection Safeguards. This will also require corporate support. Training and development initiatives are progressing well with an overhaul of the e-learning package relating to the Mental Capacity Act. **Section 15a Medical and Administrative Scrutiny** Assurance: Evidence confirmed there are robust systems to identify invalid detentions. Avoiding unnecessary administrative errors from using obsolete forms, a problem because of doctors attending from different settings will be reduced through communication in the Medical Directors Bulletin. **Section 23 (2) (a) Notification of Discharge by Nearest Relative** Assurance: Evidence - the processes supporting the eight notifications to discharge by a near relative were all managed effectively. **Honorarium Pay for Hospital Managers** Following an informal discussion with Executive Directors, a business case will be produced with some proposals for suggested uplift in pay for Hospital Mangers, which will report back to the MHL Committee for approval. **Revised Policies and Procedures** were considered and approved.	
2d	**Review of Risks**	A potential risk uncovered is the use and dissemination of inaccurate data on detentions with implications in relation to managing and planning care and also to reputation. This risk is being urgently followed through.

Recommendation: The Committee proposes that the Board:

The MHLC is increasingly going beyond receiving data alone, to ascertain reasons for anomalies or inconstancies and identifying means of strengthening performance and is promoting closer liaison with operational colleagues and service users.

i) Note the positive direction of travel for the effectiveness of the Committee, including assurance reporting and looking beyond the data and statistical information.

ii) Note the focus on risks, with mitigations and controls in place, which will continue to be discussed at the Risk Subgroups of the two Care Group Boards, with further alignment of a corporate risk to be reported into Committee in May 2023.

i) Note the progress with operational matters through the relationships with the Care Group Boards.

ii) Support the intention to extend an invitation, initially on a trial basis, to the Lived Experience Directors to bring co-creation and patient experience to the Committee, in accordance with adhering to its terms of reference (section 2.1).

iii) Note that further work is needed to cleanse the data to ensure accurate recording and reporting of detentions and that assurance cannot be provided that current figures are accurate as they almost certainly represent gross over-reporting.

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

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 10b

People, Culture and Diversity Committee: Key Issues Report	
Report Date: 23 February 2023	**Report of: People, Culture and Diversity Committee**
Date of last meeting: 6 February 2023	The meeting was quorate, there were apologies for absence from Zoe Campbell, MD for NYYS Care Group

1 **Agenda: The following agenda items were considered during the meeting:**

- Colleague Story
- Key Issues Report
- Corporate Risk Register
- Board Assurance Framework
- People Strategic Journey and Workforce Delivery Plan
- Executive Sub-Group People, Culture and Diversity – Feedback
- Integrated Performance report
- EDS 2022
- Equality Objectives
- Gender Pay Gap
- Staff Network update
- EDI Data
- Apprenticeship Quarterly Report

2a **Alert**

The Committee alerts members of the Board that:

Corporate Risk Register

The PCDC key issues report recommendations from 7 November meeting, had not yet been actioned, and the Chair underlined the ongoing importance of a timely response to these recommendations.

Of the 8 risks initially aligned to this Committee, 6 have been removed, and 1 new risk has been added, leaving 3 risks aligned to the Committee. Of these 1 has had the current risk rating reduced below the threshold of 15+ and will be reviewed by Executive Risk Group for removal. No evidence or trend analysis was provided to the committee regarding those risks removed and to back up the Executives decisions. A request was made by the Committee Chair that in all future meetings an 'audit trail' is available to the Committee to show the evidence and judgments behind any risks removed from the Committee CRR.

The Committee notes that for the 3 risks which align to it, one of which also aligns to Strategy & Resources Committee and 1 is assigned to Quality Assurance Committee. The key themes these relate to are: Policies and Compliance – 1; Safe Staffing – 2. In terms of risk movement, the Committee notes that a new risk has been added to the Risk Register as follows: there is a risk that patient safety and quality of care will be compromised due to an increased usage of bank and agency staff across both ALD inpatient sites. The Committee comments that the structure of the report inhibits understanding of the risk movement between Committee meetings and there is more to do to offer the required evidence to the committee, that mitigating controls have been designed effectively and are operating sufficiently within agreed tolerances

The Committee expresses concern that 8 of the 16 risks on the Corporate Risk Register had passed their review date at 3 January 2023, indicating that review compliance had dropped from 95% in September to just 50%. This problem was also previously highlighted on 7 November when 50% of the PCDC risks were overdue.

The Chair of the PCDC has written to the Chair of Audit and Risk Committee, to highlight her concerns and to progress a discussion about what further refinements are needed to ensure the risk and assurance process work effectively in reporting PCDC assigned risks.

2b

Assurance

The Committee assures members of the Board that:

Board Assurance Framework

The Committee considers that there is "good" assurance that the strategic risks continue to be managed effectively based on: (1) Positive assurance provided by the Internal Auditors and previous judgements made by the Board and the Audit and Risk Committee in regard to the processes supporting the management of the BAF; (2) All the risks having been recently reviewed by the Director of People and Culture (the Executive Lead); (3) Mitigations, generally, being delivered to plan. Where slippage has occurred, there is evidence of progress being made; (4) The present risk score of BAF risk 5 continuing to be aligned to its trajectory. It is recognised that the present score of BAF risk 1 has not reduced in line with its trajectory. However, Members of the Committee note that controls have been strengthened over the last quarter. The Committee confirms that the proposed wording of the risk appetite statement, which has been changed from 'open' to 'seek' in recognition of the need to take forward innovation, is appropriate.

The committee commented on the importance of a robust risk management framework to underpin the BAF.

EDS 2022

The EDS assists NHS organisations to meet the requirements of the Public Sector Equality Duty of the Equality Act 2010 through providing an assessment framework and improvement tool. It comprises eleven outcomes spread across the following three domains: (1) Commissioned or provided services; (2) Workforce health and well-being; and (3) Inclusive leadership. To assess the Trust's position on domain 1 the Trust had to choose 2 services which the data indicated teams were doing well or not so well, which were Tees CAMHS Community Team and Durham Crisis Team respectively and a team whose performance was not known for these metrics - Adult AHDD/ Autism diagnostic. The Committee confirms the assessment scores for the domains as set out in the report.

The Committee notes robust approach taken to providing the evidence to complete the framework and that fewer Trusts are participating in this process due to the level of work involved. The Committee notes the Trust's overall score of 21 which breaks down for the 3 domains as follows:

Domain 1 - Commissioned or provided services – 10 (out of possible 12);
Domain 2 - Workforce health and well-being – 6 (out of possible 12); and
Domain 3 - Inclusive leadership – 5 (out of possible 9).

The total provides a rating which locates the Trust in the 'Developing' category.
The completed version of the EDS must be published on the Trust's website by 28 February 2023.

Equality Objectives

The Committee confirms good assurance regarding the consultation process used to develop the equality objectives involving service users and carers, staff networks and other staff, Trade Unions, Care Group People, Culture and Diversity Groups. In addition, the following themes are selected for publication on the Trust website, subject to Trust Board approval: (i) To monitor the experiences of staff and service users who identify as Trans or non- binary and identify actions to improve their experience; (ii) Pilot a central team to ensure, that where agreed, staff who require a reasonable adjustment have these put in place in a timely manner and that there is consistency of approach across the Trust; (iii) Ensure we support and respond to staff who experience verbal aggression and proactively reduce the number of incidents of verbal aggression from service users, carers, and members of the public towards staff; (iv) Working in partnership with other stakeholders to explore how to improve access to mental health, learning disability and Autism services for the Gypsy, Romany and Traveler community. The Committee highlights the importance of undertaking further work on staff experience of hate crime and involving staff in this discussion.

Gender Pay Gap

The Committee notes that annual reporting on gender pay differences (specific measures) is a statutory requirement of the Equality Act 2010. The report shows a slight increase in the gender pay gap, between males and females, for the period 2022 – the first time this has occurred since 2018. The gender profile of female staff within the Trust has increased in the last five years from 77% to 79%. The mean gender pay gap between male and female pay has increased slightly in the past year from 10.66% to 10.73%. From

	an hourly rate perspective this equates to a mean gender pay difference from £1.93 per hour to £2.02 per hour less than males. The median gender pay gap has increased slightly from 7.27% to 7.58% which from an hourly rate perspective equates to a median gender pay gap increase in the past year from £1.11 per hour to £1.22 per hour less than males. There has been a notable increase in staff choosing to contribute to salary sacrifice schemes which is one of the factors which impacts on an employee's basic pay. Bonus payments include Clinical Excellence Awards made to Consultant Medics and long service awards made to staff on reaching 25 years' service. Further data analysis has been suggested to understand this increase and identify actions to address to any inequalities in gender pay. The findings from this analysis are to be published on the Trust and government website by 30 March 2023. **Staff Networks** The Committee notes that there is good assurance that the Trust has robust processes in place for staff from protected groups to allow them the opportunity to raise concerns and for these to be heard and acted on via Staff Networks, including BAME, Long Term Health Conditions, Rainbow, Neuro-Divergent and Armed-Forces. Future reports are to include the Menopause Matters group's activities.
2c	**Advise** **The Committee advises the Board that:** **Key Issues Report 7 November 2022 – Safe Staffing (CQC Regulation 18) – follow on actions and assurance statement** Further to the investigation requested in the Key Issues report provided to the Board of Directors on 27 November 2022, the Committee received the following Assurance Statement from Patrick Scott, MD of Durham, Tees Valley and Forensics Care Group Board in relation to Safe Staffing: '*The core responsibilities of the DNC role comprise a support function to the wards in their area and Site Coordination alongside bed managers including visible on-site support. It does occur on a more regular basis than we would like that the DNC across the care groups takes charge of a ward as our primary responsibility is to ensure that each ward has a registered nurse in charge. This would never mean they leave the wards without any RN cover. It does have an impact on their ability to support the tactical on call and to respond to wider service issues and there is some evidence that this is impacting on the work of both the tactical and strategic on call members of staff. The On-Call structure is being reviewed as part of the restructure review through to the end of March 2023 and this will be a key element of that review. We have reviewed Datix and spoken to the DTVF General Managers and there are no reported incidents either through Datix or daily escalation of any instances of wards being left without RN cover. All are in agreement that the impact would be that the DNC would not be able to respond to issues away from the ward that they are covering.'* The Committee, notes that further discussions will be required with Staff-side representatives on the detail of the issues in this regard outside of the meeting. The Chair, MD DTVF and Director of People and Culture undertook to respond to Staff-side in due course. **People Strategic Journey and Workforce Delivery Plan** The Committee approves the People Strategic Journey and Workforce Delivery Plan. The Committee notes that the metrics are at an early stage of development and requests that specific North-East statistics are provided for future versions of the PESTLE in Appendix 1 and definitions of the acronyms. **Integrated Performance Report** The Committee acknowledges the current and developing position in relation to linking the strategic people journey, operational workforce delivery plans and local learning together. The Committee notes that the next iteration of this report will integrate the People Journey metrics and the Workforce Delivery plan. **Apprenticeship Quarterly Report** The Committee notes that the Trust is supporting National Apprenticeship Week and will be highlighting this through social media and other campaigns. During Q3 a total of 31 new Apprentices have started with the Trust, the majority of whom were Senior Healthcare Support Worker (L3, n=20). In addition, a new work experience project is about to commence for T-level students from East Durham College in Peterlee

	with two placements hosted by the CAMHS team. This is a new way of working and a potential alternative recruitment route for under 18s into a clinical setting. **Quarterly Equality, Diversity and Inclusion Report** The Committee notes that the EDI data in the current quarter for current staff make up of DTVF is: 91% White British; 81% female; 51% Christianity; 77% no disability; and 86% Heterosexual/Straight, whilst for NYYS it is: 88% White British; 81% female; 44% Christianity; 82% no disability; 85% Heterosexual/Straight. 82% White British. For the Trust Board, the staff make up is: 53% female; 53% Christianity; 90% no disability/Not Declared; 82% Heterosexual/Straight. In relation to EDI data for recruitment for DTVF the key data was as follows: White applicants 1.20 times more likely to be recruited than BAME applicants; Females 1.06 times more likely to be recruited than Male; the age group least likely to be appointed was 55-59; Islam had the highest likelihood ratio of being appointed compared to other religions; Long standing illness had the lowest likelihood of being appointed; Sexuality of Bisexual was associated with the lowest likelihood ratio for being appointed, followed by gay/lesbian compared to other groups. The position for NYYS EDI data was: Black or Black British-African least likely to be recruited compared to other groups. White applicants 1.79 times more likely to be recruited than BAME; Female 1.96 times more likely to be recruited than Males; Age groups under 20, 20-24, 45-49 and 50-54 were least likely to be appointed; Atheism had the lowest likelihood ratios of appointment; Long standing illness were least likely to be appointed; People were 1.91 times more likely to be appointed without a disability than with; no obvious bias in recruitment based on sexuality. With regard to corporate recruitment, EDI key data was as follows: Asian or Asian British Indian least likely to be appointed; White applicants 1.46 times more likely to be appointed than BAME; Female 1.32 times more likely to be recruited than Males; Age groups 25-29, 35-39, 50-54 and 65+ least likely to be appointed; Religion of Islam and Buddhism least likely to be appointed; Learning disability/difficulty least likely to be appointed; Bisexual or not stated had the best likelihood ratio of recruitment. The Committee notes that 7 National Domains of deprivation provide an Index of Multiple Deprivation Score. The Deprivation domains include: Income, Employment, Education, Health, Crime, Environment and income. The Score is assigned to staff post-codes. A decile score is allocated with 1 being most deprived and 10 being least deprived: • DTV-F: 26% of staff live in the most deprived areas (deciles 1 & 2) and 15% in the least deprived (deciles 9 & 10) • NYYS: 7% of staff live in the most deprived areas (deciles 1 & 2) and 31% in the least deprived (deciles 9 & 10) No data was available for turnover/staff sickness and staff experience or disciplinary and grievances within Quarter 3. The Committee requests summary information in a tabular format for submission to the Care Groups.	
2d	**Risks**	No new risks identified. The Committee comments that the structure of the report inhibits understanding of the risk movement between Committee meetings.
Recommendation: The Board is asked to note the contents of this report.		
3	**Any Items to be Escalated to another Board Sub-Committee/Board of Directors**	The Chair of the PCDC has written to the Chair of Audit and Risk Committee, to highlight her concerns and to progress a discussion about what further refinements are needed to ensure the risk and assurance process work effectively in reporting PCDC assigned risks

4	**Report compiled by:** Deborah Miller, ***Corporate Governance Manager*** Jillian Haley, ***Non-Executive Director/Interim Deputy Chair (Committee Chair)*** Sarah Dexter-Smith, **Director of People and Culture** Minutes are available from: Deborah Miller

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 11

For General Release

Meeting of:	**Board of Directors**
Date:	**23rd February 2023**
Title:	**Risk Appetite**
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	Risk appetite is an import element of the Trust's governance and risk management arrangements as it supports effective and informed decision-making.

Executive Summary:

Purpose: The purpose of this report is to enable the Board to agree the Trust's risk appetite.

Proposal: That the revised risk appetite statement as set out in Annex 1 to this report be approved.

Overview: Risk appetite can be defined as 'the amount and type of risk that an organisation is prepared to pursue, retain or take' in the delivery of its strategic objectives.

It is key to achieving effective risk management and represents a balance between the potential benefits of innovation and the threats that change inevitably brings. It should be at the heart of an organisation's risk management strategy – and indeed its overarching strategy.

Prior Consideration and Feedback The Board reviewed its risk appetite at the business planning event held on 13th December 2022. The discussions took into account the present and future context and position of the Trust and the level of innovation which will be appropriate if the strategic goals are to be achieved. The appropriate risk level for each risk type was agreed in principle.

Lead Directors were asked to draft risk appetite statements taking into account the discussions at the event and to ensure that they

reflected local circumstances.

The draft risk appetite statements were considered by the Quality and Assurance, People Culture and Diversity and Strategy and Resources Committees during February 2023. All the Committees provided their support for the relevant parts of the draft risk appetite statement.

Implications: The application of risk appetite should support consistent decision-making by ensuring that both erratic or inopportune risk-taking or an overly cautious approach which may stifle growth and development are avoided.

Recommendations: The Board is asked to approve the revised risk appetite statement set out in Annex 1 to this report.

Annex 1

Draft Risk Appetite Statement

Risk appetite is an expression of the type and amount of risk the Trust is willing to accept. It promotes consistent, 'risk informed' decision-making aligned with the strategic objectives of "Our Journey to Change". It also supports robust corporate governance by setting clear risk taking boundaries.

Our risk appetite is defined as follows:

Quality and Safety (including innovation)

Quality and Safety drive all major decisions in the organisation. Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls and mitigations are in place.

Score 2 (Cautious)

Financial and Business

We are prepared to accept the possibility of limited financial risk where needed to mitigate risks to quality, or staff and patient safety, progress invest-to-save opportunities, or mitigate significant risks including cyber security. We will ensure all actions represent value for money and will assess the implications of managed risk-taking on our underlying cost base and in our regulatory context.

Score 2 (Cautious)

Regulation

- We will only tolerate minimal exposure to regulatory risks including to our CQC ratings.
- We will tolerate some exposure to wider contractual and national targets including the consequential implications of prioritising quality and safety over operational performance

Score 1 (Minimal)

Reputation

- In recognition of its three strategic objectives, we have a moderate appetite for exposure to reputational risk.
- The level of impact which we are willing to accept with any of its key stakeholders (patients, staff, partners and regulators) will be assessed on a case-by-case basis.

Score 2 (Cautious)

People

We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce (but not for our clinical delivery) but could improve the skills and capabilities of our staff. We recognize that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.

Score 4 (Seek)

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ITEM NO.12

For General Release

Meeting of: **Board of Directors**
Date: **23 February 2023**
Title: **Corporate Risk Register**
Executive Sponsor(s): **Elizabeth Moody, Director of Nursing and Governance**
Author(s): **Kendra Marley, Head of Risk Management**

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 – related risks covered in this paper**
1	Recruitment	1001
2	Demand	1131, 1226, 1238, 1311
6	Safety	1120, 1136, 1257, 1289, 1304
7	Infrastructure	903, 1223
8	Cyber	952
9	Regulation	1017, 1324
12	Roseberry Park	295
15	Financial Sustainability	1260

Executive Summary:

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

Provide assurance over the risk management processes.

Overview: This paper presents to the Board the 15+ risks on the Corporate Risk Register as of 1st February 2023.

The Corporate Risk Register is reviewed and approved by the Executive Risk Group, and was last reviewed by them at the January meeting, and changes agreed are reflected in this paper.

There are currently 17 risks on the Corporate Risk Register. This is a decrease of 5, due to the addition of 9 risks and removal of 14.

Prior Consideration and Feedback	All risks are considered at service level meetings for review and agreement prior to finalisation on the risk register. All risks then go for a second moderation via the Care Group Risk Group/ Directorate, where all new risks and closures are reviewed and challenged as appropriate. 15+ risks from across the Trust are reviewed at the Executive Risk Group, being considered for inclusion onto the Corporate Risk Register.
Implications:	Risks may impact on the delivery of individual services, patient safety and quality of care, and overall impact the achievement of the Trust aims and objectives.
Recommendations:	The Board are asked to: • Review the risks and actions and discuss and seek further information relating to risks as appropriate. • Take assurance over the ongoing management of risk.

MEETING OF:	**Board of Directors**
DATE:	**23 February 2023**
TITLE:	**Corporate Risk Register**

1. Introduction and Purpose

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

The Corporate Risk Register is reviewed and approved by the Executive Risk Group. This paper presents to the Board the 15+ risks on the Corporate Risk Register as of 1st February 2023.

2. Background Information and Context

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

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

3. Purpose of the Corporate Risk Register

The Corporate Risk Register should be reflective of the highest risks affecting the organisation in the delivery of its objectives. It should also enable the Board to easily understand the highest risks that they need to be aware of.

The Trust has changed the approach to the corporate risk register, and instead of including all 15+ risks, is now only including risks of 15+ where they also have a trust-wide impact or impacted directly on a trust goal. This will mean that not all 15+ risks will be included on the corporate risks register, however the Executive Risk Group will still have full oversight and moderation of these. Additionally, the Executive Risk Group are agreeing the Committee alignment and agreed that some risks sit across more than one Committee. As such the alignment and overview of this will change.

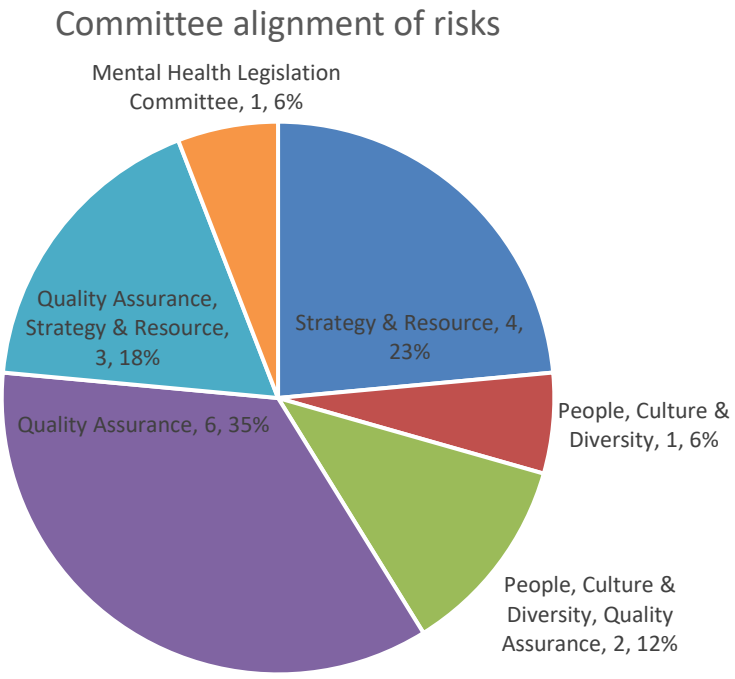
This will ensure that the Board and its Committees have clear sight of those risks impacting on strategic goals, while removing duplicative team and service level risks that link to higher level risks already reflected. Risks will be aligned to the Board Assurance Framework.

4. Current Corporate Risk Register

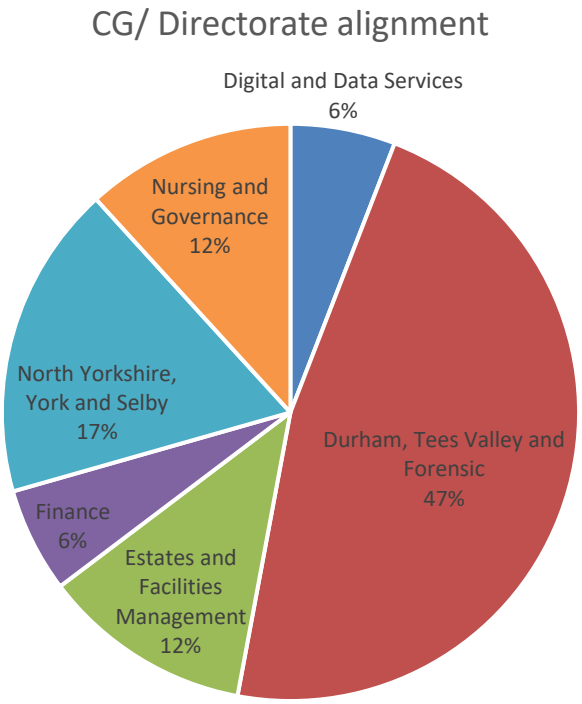
As of 1st February 2023, there were 17 risks on the Corporate Risk Register, a decrease of 5, due to the addition of 9 risks and removal of 14. These form the main register that is reported to the Board and Committees. The Executive Risk Group review and approve additions and removals.

The current risks on the register align to the main Board Committees as shown in the following chart. It should be noted that they may align to more than one Committee.

This shows that there are now 11 risks that align to the Quality Assurance Committee, 3 of which also align to Strategy and Resource and 2 to People, Culture and Diversity, making up over 50% of risks on the Corporate Risk Register. Strategy and Resource have 7 aligned risks, 3 of which also align to Quality Assurance. People, Culture and Diversity now have 3 aligned risks, 2 of which align to Quality Assurance. Mental Health Legislation Committee now have 1 aligned risk.

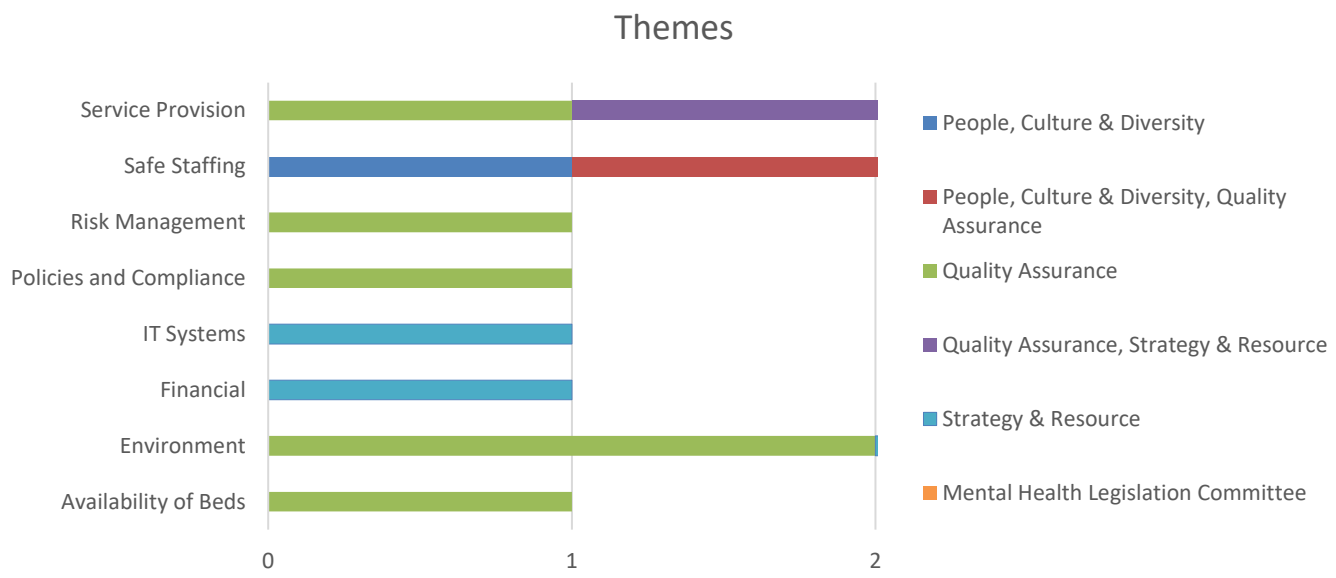


Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 47% of the current Corporate Risk Register is made up of risks from Durham Tees Valley and Forensics Care Group, 17% from North Yorkshire York & Selby Care Group,12% from both Nursing and Governance and Estates and Facilities Management, and 6% from Digital and Data Services and Finance.



4.1 Risk Themes

The 17 risks fall under the following themes within the Committee Alignments.



The below table shows the changes in the period.

Themes	PCD	PCD & QAC	QAC	QAC & S&R	S&R	MHLC	Total	Change/ previously
Availability of Beds			1				1	↓ 3
Environment			2		1		3	↔ 3
Financial					1		1	↓ 2
IT Systems					1		1	↔ 1
Policies and Compliance			1				1	↔ 1
Risk Management			1				1	↓ 2
Safe Staffing	1	2					3	↓ 6
Service Provision			1	3	1	1	6	↑ 4
Total	1	2	6	3	4	1	17	22

4.2 Risk Movements

The Executive Risk Group reviewed all risks that were previously included on the Corporate Risk Register at the meeting in November 2022, to revise the inclusion to meet the criteria of 15+ risks that have a wider trust-wide impact or directly impact on a trust objective. This review, alongside the review and consideration of new or escalated 15+ risks from across the organisation has resulted in significant movement to the Corporate Risk Register. This included 6 new additions and removal of 12 risks.

Subsequent review at the January meeting resulted in 3 new additions and the removal of 2 risks that had been reduced below the 15+ threshold.

New Risks

There are 8 new risks on the Corporate Risk Register, and these are summarised below. One risk not shown here was added in November but subsequently removed in January as reduced to below the 15+ threshold.

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating
People, Culture & Diversity, Quality Assurance	6. Safety	Quality & Safety	1120	DTVF - LD	There is a risk that patient safety and quality of care will be compromised due to an increased usage of bank and agency staff across both ALD inpatient sites. This results from high levels of patient acuity and complexity which can only be managed by a higher staffing ratio which include familiar and trained staff. Also includes risks relating to CQC S31 activity June 2022.	20	16	6
Quality Assurance	6. Safety	Quality & Safety	1136	Nursing & Governance	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the incident backlog and reduced staffing capacity resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	20	15	10
Quality Assurance, Strategy & Resource	6. Safety	Quality & Safety	1289	DTVF – H&J	There is a risk that the commencement of the contract for mental health service delivery in HMP Hull and HMP Humber that waiting lists and service provision are not at the standard that TEWV services would expect. This may result in difficulties with service delivery and patient safety.	16	16	6
Strategy & Resource	8. Cyber Security	Regulation	952	Digital & Data – IT & Systems	Cause: IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical controls, audit and assurance. Event: Cyber attack on Trust Impact: Trust is not able to identify, isolate and rectify the source of attack to prevent loss of data and or access to trust systems	25	20	12
Strategy & Resource	9. Regulatory Action	Regulation	1017	DTVF - LD	There is a risk that the Tees respite services (Unit 2 BFC and Asygarth) will breach CCG contractual requirements. This results from a CQC inspection highlighting that the current estate provision does not meet the MSA regulations. This would lead to a significant reduction in service provision, potential for further involvement by the Secretary of State and reputational damage to the Trust.	20	15	6

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating
Mental Health Legislation Committee	6. Safety	Quality & Safety	1304	Durham, Tees Valley and Forensic - DTV&F MHSOP -	AMH Tees Liaison Risk - Delays in MHA being completed in a timely manner along with a suitable bed being identified for admissions poses a risk to the patient safety and is impacting on level of recorded incidents in the ED department. Risk also to relationship and reputation of TEWV.	20	16	6
Quality Assurance, Strategy & Resource	2. Demand	Quality & Safety	1311	Durham, Tees Valley and Forensic - DTV&F Child and YP -	There is a risk that young people being referred for specialist neurodevelopmental assessment face unacceptable waits for commencement and conclusion. This is due to a significant increase in referral demand post-pandemic and exacerbated by the backlogs created during the national lockdowns; resulting in a dissatisfactory experience for families, complaints, knock on effect of long waits for diagnosis-specific support, & reputational damage for TEWV.	20	15	8
People, Culture & Diversity, Quality Assurance	9. Regulatory Action	Regulation	1324	Durham, Tees Valley and Forensic - DTV&F Child and YP -	There is a risk that some children and families in North and South Durham will be subjected to unacceptable waits for mental health assessment and treatment, caused by significant staffing pressures in those teams (particular issues with medic, nursing and psychology workforce) in addition to lack of alternatives in community provision, resulting in patient deterioration/risk, patient dissatisfaction, complaints and reputational damage and potential CQC breaches.	20	15	6

There have also been 13 risks removed from the corporate risk register, 11 of these were considered to be care group level risks, notwithstanding that 2 were identified as requiring a trust-wide level risk adding to the risk register. 1 of these was closed as there was duplication with another risk. These are shown in the following table. 1 risk was also removed as it was reduced to below the 15+ threshold.

The first table shows 11 risks removed as they are not trust-wide risks, the group acknowledged that while aspects raised within these risks at team or service level may be of trust-wide concern, i.e. staffing, these are captured in either the main Board Assurance Framework (BAF) risks, or other risks on the Corporate Risk Register.

The table also included the risk closed due to duplication.

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating	Update
Commissioning	2. Demand	Quality & Safety	276	DTVF - Adults	There is a risk that we may be unable to admit DTV patients due to bed unavailability as a result of (over) occupancy levels, resulting in patients being admitted out of area potentially affecting treatment pathway and patient experience. There is also a potential impact on patient safety and our partner organisations if admissions are delayed. We also may not be able to maintain colleague wellbeing due to the impact of over occupancy resulting in increased sickness absence rates.	20	15	3	Risk agreed to be Care Group level risk, however a Trustwide risk reflecting trustwide and system wide issues and strategic approach to be reflected and owned by Medical Director, with oversight from the Bed oversight Group. Risk 1374 to be added.
Commissioning	2. Demand	Quality & Safety	532	DTVF - SIS	There is a risk that patients in the secure service may continue to have extended lengths of stay and/or delayed discharges due to the lack of CCG and Local Authority provided single occupancy/bespoke accommodation for individuals with complex challenging presentations including Autism/LD/PD, resulting in delayed transfers of care, the number of patients waiting for a bed, and a negative impact on patient experience.	20	16	9	Reviewed and ERG and agreed to be CG level risk - however a trust wide risk - 1375 to be completed and added.
Commissioning	2. Demand	Quality & Safety	1087	DTVF – LD	There is risk that there will not be sufficient specialist ALD beds to meet the demand. This results from a national reduction in bed availability post Transforming Care, a high level of inpatient acuity (many of whom currently require single-occupancy care), and a lack of community providers to facilitate discharge. This leads to the service being unable to accept admissions. Also includes risks relating to CQC S31 activity in June 2022	20	20	9	Closed, merged to risk 1226.

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating	Update
People, Culture & Diversity	1.Recruitment & Retention	People	1063	NYYS – C&YP	There is a risk that patients may not be able to access timely psychiatric care including medication initiation following ADHD diagnosis, and reviews across NYY CAMHS due to high vacancy levels and gaps in cover arrangements resulting in potential for patient harm and poor experience, negative impact on staff wellbeing and staff retention.	20	15	9	Executive Risk Group reviewed and agreed that this was a Care Group level risk.
People, Culture & Diversity	1.Recruitment & Retention	People	1076	NYYS – C&YP	There is a risk in Northallerton CAMHS due to delays in assessment and treatment for patients, with staff carrying high caseloads as a result of reduced staff levels. This is resulting in reduced quality and safety for patients as well as impact on staff wellbeing and absence/leaving the service.	20	9	9	Executive Risk Group reviewed and agreed that as now reduced below 15, this could be removed from the corporate risk register, and reflected that this was a Care Group level risk.
People, Culture & Diversity	1.Recruitment & Retention	People	1090	DTVF – H&J	There is a risk that we may have to run services with less than minimum staffing levels at HMP Northumberland. This is due to reduced staff availability as a result of being unable to recruit to clinical lead vacancies. This results in an increased potential for patient and staff safety issues, reduced quality, poor experience, and impact on staff wellbeing.	20	12	9	Executive Risk Group reviewed and agreed that as now reduced below 15, this could be removed from the corporate risk register, and reflected that this was a Care Group level risk.
People, Culture & Diversity	1.Recruitment & Retention	People	1143	NYYS – C&YP	There is a risk that TEWV CAMHS and FIRST Service patient care will be compromised due to the FIRST service not having the staff in place to deliver services. Support being provided by CAMHS team and this diluting levels of services for all patients, resulting in potential patient safety and quality issues.	20	16	12	Executive Risk Group reviewed and agreed that this was a Care Group level risk.

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating	Update
People, Culture & Diversity	1.Recruitment & Retention	People	1208	DTVF - SIS	There is a risk that we may be unable to provide safe and consistent staffing levels for registered and non-registered staff in Secure Inpatient Services due to overall absence levels resulting in potential patient safety and quality issues and impact on staff health and wellbeing and embedding wider culture work.	25	20	9	Executive Risk Group reviewed and agreed that this was a Care Group level risk.
People, Culture & Diversity	1.Recruitment & Retention	People	1218	NYYS – C&YP	There is a risk that services are unsustainable across the two York CAMHS teams due to staffing currently below commissioned levels resulting in high caseloads, interface issues with SPA team due to high number of referrals and demands, and excessive duty calls to clinicians, impacting on patient safety and quality, and staff morale and wellbeing.	20	16	9	Executive Risk Group reviewed and agreed that this was a Care Group level risk.
Quality Assurance	2.Demand	Quality & Safety	785	NYYS - MHSOP	There is a risk due to waiting times for memory services. Demand has outstripped capacity within finite resources, resulting in potential patient deterioration, strain on carers, impact on patient, families and staff and breach of RTT (Referral to Treatment) targets.	15	15	3	Executive Risk Group reviewed and agreed that this was a Care Group level risk.
Quality Assurance	6.Safety	Quality & Safety	1067	DTVF - LD	There is a risk that staff will be injured in ALD inpatient services. This results from high levels of acuity in the units and the need for a minimum number of staff in core teams, especially males. This is in addition to needing staff who are familiar with the patient and appropriately trained to PAT L2. Where these requirements cannot be met, this can lead to high levels of staff assault and injuries through physical intervention.	20	16	9	Executive Risk Group reviewed and agreed that this was a Care Group level risk.

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating	Update
Strategy & Resource	15.Financial Sustainability	Financial	1072	NYYS - Management	There is a risk that we exceed our allocated budget due to overspending linked to over-establishment against core budget, high use of agency staffing and a lack of funding for key operational services (crisis line, IAPT trainees etc) non-recurring funding streams and reduced partnership investment via MHIS against 3 year plans from 19/20, resulting in not delivering cash releasing efficiency savings and achieving the wider achieving financial position of NY&Y and the Trust.	20	16	9	Executive Risk Group reviewed and agreed that this was a Care Group level risk.

Removals below 15+ threshold

A further risk was removed having been reduced to below the 15+ threshold, this is shown below.

Risk ID	Location	Risk Description	Initial rating	Previous rating	Current rating	Target rating	Update
1102	DADS – IT Systems	There is a risk that we are unable to disclose staff emails in response to subject access or freedom of information requests.	20	16	12	8	29/12/2022 AS/CR: Reviewed risk rating in line with revised risk policy and amended the consequence of the risk being realised to be moderate based on experience of incident occurring.

Risks below 15+ threshold on current Corporate Risk Register

There are currently 2 risks on the Corporate Risk Register that are below the 15+ threshold.

The first 1238 was considered by the Executive Risk Group in January, however additional information to support the reduction shown in the risk was requested and the Group agreed that the risk should remain on the Corporate Risk Register and would be reviewed again at the March meeting.

Risk ID	Location	Risk Description	Initial rating	Previous rating	Current rating	Target rating	Update
1238	NYYS - MHSOP	There is a risk to being able to provide quality of care and patient experience for North Yorkshire & York patients need admission due to admission of out of locality and out of specialty patients into NYY MHSOP beds. There is high demand from out of locality and out of specialty, variable control	15	15	9	9	17/01/2023 ERG requested supporting information for the reduction of this risk be provided. To be reviewed in March. 14/12/2022 Likelihood reduced to "possible" due to reduction in OOA admissions this month.

Risk ID	Location	Risk Description	Initial rating	Previous rating	Current rating	Target rating	Update
		process across the trust, resulting in increased work and pressure on teams, communication difficulties with community teams, increased LOS, impact on patients and families for visiting.					

A second risk, 1260, has been reduced this month and will be reviewed by the Executive Risk Group in March for consideration and agreement to remove.

Risk ID	Location	Risk Description	Initial rating	Previous rating	Current rating	Target rating	Update
1260	Finance - Financial Management -	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality of services.	20	20	12	8	31/01/2023 Risk has reduced as the Trust is forecasting to outturn in line with plan this financial year. There are dependencies to deliver this, but the risk of slippage decreases as we get closer to financial year end, and have more certainty over projections.

4.3 Risk and Action Review Compliance

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

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

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

Of the risks on the Corporate Risk Register at 1st February 2023, 6 of the 17 have passed their review date, indicating that review compliance has slightly increased from 50% in January to 65%.

Monitoring and reporting of review compliance, including action delivery compliance will be undertaken and reported at all levels to aid awareness of risk review processes. Overall risk review compliance across the Trust has increased to 77% over the last month (was 58%).

The need for regular updates will continue to be highlighted to leads.

5. Implications

5.1 Compliance with the CQC Fundamental Standards

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

5.2 Financial/Value for Money

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

5.3 Legal and Constitutional (including the NHS Constitution)

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

5.4 Equality and Diversity

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

5.5 Other implications

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

6. Risks

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

7. Conclusions

Risks on the Corporate Risk Register have been fully reviewed by the Executive Risk Group to agree what will remain on the Corporate Risk Register and which risks will have local management. All new or escalated 15+ risks are reviewed by the Executive Risk Group and considered for addition.

8. Recommendations

The Trust Board are asked to:

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

Kendra Marley - Head of Risk Management
February 2023

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Committee/ Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Strategy & Resource	12. Roseberry Park	Regulation	295	Identified - 08/09/16 Last reviewed - 11/08/22 Next review due - 11/09/22	Estates and Facilities Management - Estates -	Owner - Liz Romaniak - Manager - Simon Adamson	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	15	MIST system now installed into roof voids of all in patient areas to safeguard and reduce fire load and spread of flame until rectification works complete. Block 16 (decant) construction now complete. Phase 1 practical completion achieved, commissioning underway (blocks 5 & 10). Week. Phase 2 programming and procurement options are in train.	Weekly huddles take place to oversee progress of rectification works. RPH sub-group of the board convened as needed to oversee progress with regular CEO briefings to the board.	Agreed programme of works which resolve all the defects in the design and construction of Roseberry Park Hospital. Unknown quantum and type of defects in individual occupied blocks.	15	Achieve contract resolution to the satisfaction of the Trust Gain commitment to the programme of work to address fire stopping issues across the whole site Gain commitment to the programme of works, where possible to be co-ordinated with fire stopping works, to resolve 19 outstanding construction defects requiring mitigation Agreement of recourse to legal processes should commitment to works and commercial settlement not be appropriate Review of Capitec (independent consultants) report Full condition survey of Roseberry Park Establish facilities management special purpose vehicle Determine most appropriate route to defect rectification (complete phase 1 and identify phase 2 programme).	30/11/2022 31/12/2016 31/12/2016 31/12/2016 31/12/2016 30/04/2017 28/11/2017 31/01/2023	Simon Adamson Brent Kilmurray Brent Kilmurray Brent Kilmurray Brent Kilmurray Brent Kilmurray Brent Kilmurray Simon Adamson	31/01/2017 31/01/2017 31/01/2017 31/01/2017 02/01/2018 28/11/2017	10
Quality Assurance	7. Infrastructure	Quality & Safety	903	Identified - 01/06/20 Last reviewed - 11/08/22 Next review due - 11/11/22	Estates and Facilities Management - Estates -	Owner - Simon Adamson - Manager - Simon Adamson	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.	15	Suicide Prevention and Environmental Risk Assessment Procedure Supportive Engagement and Observation Policy Harm Minimisation Policy (Risk Assessment and Management) Environmental Risk Group Care Rounds Body Camera pilot Oxehealth (extension of installation on further wards agreed) Significant investment in staffing MDT Report Out Individual Safety Summaries Team Risk Logs Estates Work Log System Capital Work Programme Capital Investments Group Capital Planning Group Harm Minimisation Training Programme RPIW risk documentation and guides for staff Monthly reporting to the Quality Assurance and Improvement Group Contractual meetings with contractors to monitor the programme of estates work.	1.Harm minimisation training show high levels of competency. 2.Suicide prevention survey and risk assessment procedure log demonstrates that the majority of individual teams have been reviewing their surveys and they include risk mitigation. 3.Responded and compliance with NPSA ligature alert released in March 2020 and the ESA low lying ligature alert released in 2019. 4.Remedial action taken within 24hr by PFI providers following near miss incidents being identified. 5.Ligature Programme of works is reviewed at the Environmental Risk Group. 6.Phase one of the ligature works programme completed 2021/22 at a cost of £2.8m. 7.Phase 2 programme of ligature reduction works have been agreed and finances allocated in 2022/23 capital plan.	Known risks within clinical services have been assessed and mitigating actions are in place. However, there remains the possibility that patients may create ligatures without an anchor point which could cause severe harm and or unexpected death. Limitations have been identified in relation to detailed knowledge of all ligature points amongst some staff. CQC inspections of Acute AMH and PICU wards undertaken in January 2021 highlighted gaps in relation to risk assessment documentation and management.	15	Complete phase 1 of the ligature reduction programme of estates works to remove exsiting ligature points particularly in en-suites Undertake a clinical audit to gain assurance from clinical areas regarding the awareness and appropriate management of ligature risks. Estates to undertake a review of ward/department environmental risk logs to determine if recently identified risks within the clinical area have been logged within estates for action. A standard specification for each speciality to be developed in regards to anti-ligature equipment. Put in place a system of procurement to ensure clinical services order goods from a pre-approved list. Agree phase 2 of the ligature reduction programme (this will focus on bedroom doors) Implement phase 2 of the ligature reduction programme Roll out of Oxehealth technology to be extended for additional Inpatient Wards across the trust. Roll out of the Body Camera pilot to additional inpatient wards	31/07/2021 17/06/2020 31/08/2020 31/03/2022 31/03/2022 31/03/2022 31/01/2022 31/03/2023 31/10/2021	Simon Adamson Elizabeth Moody Simon Adamson Elizabeth Moody Elizabeth Moody Paul Foxton Simon Adamson Elizabeth Moody Elizabeth Moody	29/11/2021 03/03/2021 03/03/2021 11/08/2022 21/09/2022 07/03/2022 29/11/2021	10

Committee/ Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Strategy & Resource	8. Cyber Security	Regulation	952	Identified - 10/06/20 Last reviewed - 18/01/23 Next review due - 01/03/22	Digital and Data Services - IT& Systems -	Owner - Chris Reynolds - Manager - Steven Forster	Cause: IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical controls, audit and assurance. Event: Cyber attack on Trust Impact: Trust is not able to identify, isolate and rectify the source of attack to prevent loss of data and or access to trust systems	25	Microsoft Defender Endpoint Manager is a tool which can manage a number of alerts being able to both identify and isolate devices. The tool has proven invaluable in identifying incidents and potential cyber breaches.	The is a Cyber Security Group setup to monitor Cyber security and risks. Alerts are provided by CAN to TEWV along with monthly reports from NHSD. A quarterly Cyber Board Assurance Framework update is submitted to report on current progress.	-The Trust does not currently have a Cyber security strategy and has limited maturity which has been highlighted in a number of areas. -The draft Cyber security strategy began March 2022 and is currently under awaiting approval via resources commitee (scheduled feb 23). -Technical deficit grows year on year as digital technologies and threats advance. The Trusts cyber security manager left the organisation March 2022 and a dedicated manager has not yet been fully recruited. -No Network Detection and response system in place to understand if cyber attack/infection occur across the network. -There are limited security tools for monitoring and providing higher levels of observability. A consequence of this means breaches could go undetected for months or years while malicious individuals could potentially be operating with the network. The Technical teams are making some use of the national Microsoft Defender for Endpoint tenancy and score in the top 20% of equivalent size NHS Trusts/bodies when comparing secure score (A risk assessment of	20	Develop and implement cyber strategy	28/02/2023	Chris Reynolds		12
People, Culture & Diversity	1. Recruitment and Retention	People	1001	Identified - 20/10/20 Last reviewed - 26/01/23 Next review due - 27/02/23	North Yorkshire, York and Selby - NYY&S Management -	Owner - Dr Tolulope Olusoga - Manager - Dr Tolulope Olusoga	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20	Mitigation is all via locums and mind the gaps though there are increasing pressures with the mind the gap arrangements. Promoting the Trust at Royal College of Psychiatrists events, Trust recruitment event in London and York in January 2022 and Feb 2022. The Trust has also recently completed a recruitment programme internationally recruiting 11 doctors who have commenced the process of relocation to the UK likely due in late spring 2023. Trust-organised Leadership Programme for Aspiring New Consultants in 2022. Actively reaching out to colleagues and existing networks promoting TEWV. Redesigning job descriptions to be more flexible to support LTFT colleagues. Participate in teaching sessions to higher trainees in Yorkshire Deanery promoting benefits of working in TEWV. Regular touch points to engage with existing medical workforce to support retention (bimonthly visits to bases/local meetings – impacted by Covid but alternative arrangements via MS Teams) and ensure leadership visibility. Ensuring our consultant trainers maintain capacity to train core trainees and higher trainees (to ensure supply route into consultant posts). Addressing place based service issues to improve attractiveness of locations/teams as a good place to work. Engaging with local high schools via careers events promoting psychiatry and TEWV. Developing well being programmes to support retention of medical staff including flexible working and remote working	Expressions of interest in posts through promotion of TEWV and engagement with trainees through teaching. Reduction of costs for agency through monthly budget reports Monitoring staff wellbeing through sickness levels of medical staff. We have recruited 2 new substantive consultants in the last 12months. Monitor long-term sickness absence Exit interviews to understand why people leave.	At the time the risk was identified, there were 12.5 WTE vacant Consultant posts (out of 63 total across AMH, MHSOP, CAMHS and LD services), covered by 11 agency locum medical staff in addition to our local staff mind the gap arrangements. It results in an annual agency spend in excess of 1.4 million pounds. Failure to recruit to these vacancies will pose further significant risks to Trust reputation from impact on safe care delivery and will make it more difficult to attract and recruit new staff. We need to identify and implement recruitment options to attract medical staff to NYY eg use of recruitment premium, recruitment of doctors from overseas, review sessional job plans to support working across the locality, implement a middle grade on call rota, propose additional SpR posts. Develop skills across other professions such as non-medical ACs and Physician Associates	16	Recruiting CESR/SAS doctors from overseas Develop non-medic colleague skills to ensure consistent service delivery Sessional job plans to support working across the locality (utilising technology where possible) Explore and encourage group job planning to increase flexibility of the workforce supporting interests of the consultant workforce Putting in place a middle grade oncall rota to support medical staff retention proposal to get approval for 8 additional funded Higher Trainee posts (SpRs) in NYY to increase number of front line clinicians and improve pipeline for consultant posts Approval for the use of recruitment premium	09/02/2022 09/02/2023 09/02/2022 09/02/2023 29/12/2022 09/02/2023 01/10/2020	Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga	07/04/2022 07/04/2022 10/12/2021	9

Committee/ Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Strategy & Resource	9. Regulatory Action	Regulation	1017	Identified - 21/10/20 Last reviewed - 31/01/23 Next review due - 28/02/23	Durham, Tees Valley and Forensic - DTV&F Learning Disabilities Services -	Owner - Amanda Jane Hazelwood - Manager - Sarah Gill	There is a risk that the Tees respite services (Unit 2 BFC and Asygarth) will breach CCG contractual requirements. This results from a CQC inspection highlighting that the current estate provision does not meet the MSA regulations. This would lead to a significant reduction in service provision, potential for further involvement by the Secretary of State and reputational damage to the Trust.	20	Revised service model in place offering family a reduction in nights. Project group for respite services meets regularly, aiming to establish an estates solution for existing service users and a secondary goal of establishing a future clinical model for new referrals. CCG involved in project group and receive regular reports and reviews re plans for an estate solution.	As above. 22/12/20 presented to LMGB. No MSA breaches as COVID 19 restrictions remain in place however this reduces occupancy to below normal service provision. 26/1/20 no MSA breaches reported. Carer concerns re service provision to provided to monitor effectiveness of controls 23/2/21 Continue to operate at reduced capacity no MSA accommodation breaches. 23/3/21 continue to operate at reduced capacity therefore no MSA breach, no formal complaints received, informal concerns raised b carers as to the continued lack of resolution. 27/4/21 Reviewed at LMGB continue to operate at reduced capacity therefore 0 MSA Breaches 0 complaints	Lack of estates solution to enable the service to increase to pre-covid capacity. lack of assurance that the services are correctly registered with CQC given the nature and type of service in comparison to the registration details.	15	Discussion with CQC re registration of the respite service to be facilitated Review and revise the outreach function to mitigate the risk associated for those service users not being able to access the phsyical health monitoring and interventions as they usually would one to one consultation sessions with families and carers Discuss new service model proposal with the commissioners Paper for SLG describing current CQC registration challenges, estates challenge, actions taken to date and potential future options. Revalidation of the work undertaken in 2020 confirming the impact of the CQC instruction on the delivery of the service due to current accomodation congifuration review the current booking process to ensure current estates and places can be optimised in line with family carer wishes. Review of the estates options appraisal for updating the current buildings to be MSA compliant. review the current IPC arrangements in place for respite and explore if these could be revised to increase service provision now. Update on current position	26/02/2021 26/02/2021 11/06/2021 26/02/2021 31/12/2020 18/03/2021 13/05/2022 30/09/2022 30/04/2021 09/01/2023	Sarah Gill Tracy Whitelock Sarah Gill Dominic Gardner Sarah Gill Sarah Gill Joseph Walker Sarah Gill Tracy Whitelock Sarah Gill	18/03/2021 18/03/2021 11/06/2021 18/03/2021 04/01/2021 06/04/2021 26/04/2022 14/05/2021	6
People, Culture & Diversity, Quality Assurance	6. Safety	Quality & Safety	1120	Identified - 29/06/21 Last reviewed - 31/01/23 Next review due - 28/02/23	Durham, Tees Valley and Forensic - DTV&F Learning Disabilities Services -	Owner - Amanda Jane Hazelwood - Manager - Tracy Whitelock	There is a risk that patient safety and quality of care will be compromised due to an increased usage of bank and agency staff across both ALD inpatient sites. This results from high levels of patient acuity and complexity which can only be managed by a higher staffing ratio which include familiar and trained staff. Also includes risks relating to CQC S31 activity June 2022.	20	Formal business continuity invoked 29th June 2021 which includes a minimum of daily reporting and action log. safe staffing escalation protocol for inpatients daily staffing reports 3 x per week meetings with the other localities in relation to bed management across LD inpatient and also staffing support. this includes review of DToCs stop admissions that require additional staff to the current numbers development of recruitment plans and step down of other activity to create capacity two packages have identified agency with regular staff is in place. rapid induction plans developed for agency and bank workers	daily business continuity meetings to review action log progress and mitigations for short term, medium term and long term goals health roster Datix reports recently introduced daily staffing calls across the DTV&F care group.		16	additional recruitment review service spec for NYY commisoned beds and explore opportunties for recovering aditional expenditure Alignment of agreed workforce model, health rosters and budgets establish formal process for BC To develop a clear framework that supports coming out of business continuity Developed and implementing s31 action plan Mapping of establishments against vacant posts and leavers	30/11/2022 08/04/2022 30/09/2022 30/09/2021 12/07/2021 28/02/2023	Tracy Whitelock Sarah Gill Sarah Gill Sarah Gill Sarah Gill Sarah Gill Kathryn Ord	09/08/2022 03/11/2022 08/10/2021 16/08/2021 09/08/2022	6
Quality Assurance	2. Demand	Quality & Safety	1131	Identified - 26/07/21 Last reviewed - 28/12/22 Next review due - 03/02/23	North Yorkshire, York and Selby - NYY&S Management -	Owner - Brian Cranna - Manager - Liz Herring	There is a risk that people will have a long waits for their calls to the all age crisis/mental health support line to be answered due due to current capacity available to support the volume of calls, resulting in our inability to filter and assess the level of need of each call stream people to the right level of need.	20	Trust wide crisis & urgent response policy Crisis operating standard for a 4hours response for face to face assessment call handling information to reflect % call answered; Number of call handlers required per team	% of call answered each month (31%) volume of calls each day - 110 number of vacant posts across the crisis teams - 27.43wte	Level of service funding & Workforce capacity to meet demands ability to recruit into vacant posts & availability of temp staffing time lost creating record for each call	16	the introduction of a listening service as part of the NYYS IVR choice to understand the measured impact of the mental health support IVR choice Trust-wide improvement group - call filtering and HAP roles to the line requirement for creating safety summary (SS) & safety plan (SP) for non-crisis calls the alignment of staff resource to meet service demand to increase service capacity through the use of support workers alongside registerd professional to align call to staffed capacity Divert function divert function shared rota across crisis teams potential for link with third sector phome responses to work with CCG regarding additional funding for alternative model & capacity	13/01/2023 31/03/2022 31/01/2022 31/08/2022 30/09/2022 30/09/2021 31/08/2021 31/08/2021 31/08/2021 17/09/2021 30/09/2021 31/05/2023	Liz Herring Rachael Hill Liz Herring Andrew Knox Rachael Hill Andrew Knox Andrew Knox Andrew Knox Andrew Knox Andrew Knox Andrew Knox Liz Herring	28/12/2022 07/09/2022 12/06/2022 05/11/2021 05/11/2021 05/11/2021 25/08/2021 07/12/2021 05/11/2021	6

Committee/ Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Quality Assurance	6. Safety	Quality & Safety	1136	Identified - 08/08/22 Last reviewed - 08/11/22 Next review due - 07/12/22	Nursing and Governance - Nursing -	Owner - Lesley Munshi - Manager - Lesley Munshi	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the incident backlog and reduced staffing capacity resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	20	Incident reporting policy and timescales for review. Central approval team of reviewers (1 lead, 4 team reviewers and 2 admin support) Temporary staffing used to mitigate some gaps in team. Training given to those assisting in the review of incidents 2-step process implemented so CG reviewing own incidents in step 1. Assistance obtained from wider N&G Corporate Teams Prioritisation of incidents to ensure those of a more serious nature are reviewed over and above those of low harm.(but miss any categorised incorrectly) Robust scrutiny of all deaths and hot spot areas, EMSA breaches, anchored ligatures.	Weekly monitoring of those incidents that are in the holding area awaiting review to be reported to the Executive Quality Assurance and Improvement Group & Executive Director Group. IIC reports to give services/ CG overview of position. A report has been built within the IIC to view those accessing the Incidents Dashboard. Weekly check audit on stage 1 review and those outside this process.	Central approval team (1 reviewer LTS, 1 vacant, and 1 vacant admin) 3 posts advertised twice, unable to recruit	15	Recruitment of temporary staffing to assist in the backlog of incidents Recruitment of a B5 Datix Reviewer (permanent) Training to be given to Corporate Staff assisting in the reviewing of incidents Weekly report out at QAIG Datix Incident training (recording and Reporting) to be delivered trust wide SOP to be developed on how to review incident data within the IIC Monitoring of the IIC incident Dashboard Notification of Incidents Expand existing system to include a 2 stage approval process Auditing of those incidents being approved outside of the CAT team The recording and reporting of incidents to be included as mandatory training Communicate trustwide of the inclusion of datix incidents recording and reporting within the mandatory training criteria Review team structure and recruit as required	30/11/2021 30/09/2021 30/11/2021 30/11/2021 30/09/2021 30/09/2021 31/12/2022 30/11/2021 31/12/2022 30/11/2021 30/09/2022 30/11/2021 31/03/2023	Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi	08/08/2022 08/08/2022 08/08/2022 08/08/2022 08/08/2022 08/08/2022 08/08/2022 08/08/2022 08/08/2022 08/08/2022	10
Quality Assurance	7. Infrastructure	Quality & Safety	1223	Identified - 16/02/22 Last reviewed - 31/10/22 Next review due - 30/11/22	Nursing and Governance - Nursing -	Owner - Nurse Carole Rutter - Manager - Nurse Carole Rutter	There is a risk that medical devices may not be available/ or safe to use due to the potential for devices being obsolete, out of date, poor working condition etc. when needed most i.e. emergency situation, resulting in patient harm.	16	Medical device policy clearly states the roles and responsibilities of the wards in relation to medical devices. Central asset register held in the Estates Department National Safety Alerts actioned Medical devices group	The number of SI's that have a root cause or contributory finding in relation to medical devices. The number of incidents citing medical devices Monitoring of works to be undertaken around medical devices via the medical devices group	Medical devices safety officer not in situ. Format and content of existing asset register	16	Appointment of a Medical Devices Safety Officer Re-establishment of the Medical Devices Group with appropriate representation across the trust Undertake a baseline assessment of medical devices stored within operational services to ascertain working condition of device Carry out a review of the current Medical Devices Policy	31/03/2023 30/04/2022 31/03/2023 31/03/2023	Nurse Carole Rutter Nurse Carole Rutter Nurse Carole Rutter Nurse Carole Rutter	12/08/2022	3
Quality Assurance, Strategy & Resource	2. Demand	Quality & Safety	1226	Identified - 07/03/22 Last reviewed - 12/12/22 Next review due - 12/01/23	Durham, Tees Valley and Forensic - DTV&F Management -	Owner - Patrick Scott - Manager Amanda Jane Hazelwood	There is a risk that LD patients may not be placed in the best environment to support their care due to a local and national shortage of LD beds, this results from a national reduction in bed availability post Transforming Care, a high level of inpatient acuity (many of whom currently require single-occupancy care), and a lack of community providers to facilitate discharge. resulting in complex patients cared for within temporary ward environments/ inappropriate beds, supported by agency nursing staff and potential adverse patient safety and quality outcomes. Also includes risks relating to CQC S31 activity in June 2022	20	Informal escalation arrangements with system partners, both to find beds and gain resources for staffing	Regular meetings with system partners during these situations CE advised	Lack of national and local beds Potential closure of LRH further impacting bed provision Suitable alternative provision	20	Support for discussions with commissioners (esp. Yorkshire) to identify and fund appropriate non-hospital placement New matron supporting staff training, resilience and formulation Architects floor plans signed off for reconfiguration of Ramsey into 3 single occupancy flats Assess and Monitor the temporary staffing usage Investigate suitable alternative provisions Monitor the bed management position within the Trust	31/08/2022 31/08/2022 30/12/2022 30/12/2022 31/08/2022 30/12/2022	Janet Telford Jemma Hill Janet Telford Sarah Gill Rob Berry Tracy Whitelock	08/11/2022 08/11/2022 08/11/2022 08/11/2022 08/11/2022	20

Committee/ Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Quality Assurance	2. Demand	Quality & Safety	1238	Identified - 19/05/22 Last reviewed - 14/12/22 Next review due - 17/03/23	North Yorkshire, York and Selby - NYY&S MHSOP -	Owner - Bridget Lentell - Manager - Bridget Lentell	There is a risk to being able to provide quality of care and patient experience for North Yorkshire & York patients need admission due to admission of out of locality and out of specialty patients into NYY MHSOP beds. There is high demand from out of locality and out of specialty, variable control process across the trust, resulting in increased work and pressure on teams, communication difficulties with community teams, increased LOS, impact on patients and families for visiting.	15	Matrons screening and gatekeeping during the day to ensure admissions are safe, and asking for assurance that risk assessments have been complete. 1045 sitrep - identify current situation and flow with bed managers.	Risk assessment for each inpatient admission.	No local process to monitor our out of locality patents.	9	Review daily in sitrep and bed capacity call feeding into bed oversight meeting Bed management policy event 7 December	27/10/2022 09/12/2022	Bridget Lentell Rachel Hogarth	20/10/2022 14/12/2022	9
Quality Assurance	6. Safety	Quality & Safety	1257	Identified - 25/04/22 Last reviewed - 09/01/23 Next review due - 02/02/23	Durham, Tees Valley and Forensic - Secure Inpatient Service (SIS) -	Owner - Naomi Lonergan - Manager - John Savage	There is a risk that patient care documents do not accurately reflect risks, risk management plans, risk of incidents and risk of harm due to lack of training or understanding, and workload pressure, resulting in potential for patient or staff harm.	20	Quality assurance schedule is in place	- Audit demonstrates that safety summaries and plans are in place and that they effectively identify the appropriate risks and mitigations - Increase in clinical leadership to support quality assurance processes - Validation audits to strengthen quality assurance processes - Audits and risk management plans - Quality assurance schedule	Need to identify the roles of the SDM and PDPs in this process Quality assurance schedule is self assessed instead of peer review	16	Taking into account the improvement work already undertaken, ensure that the Trust wide work in relation to safety summaries and plans is embedded and consideration of further quality improvement work Produce a CITO training plan in conjunction with IT to enable CITO rollout PDPs to roll out a service-level induction	28/02/2023 28/02/2023 28/02/2023	John Savage Jane Keenan John Savage		4
Strategy & Resource	1&5 Financial Sustainabi lity	Financial	1260	Identified - 17/06/22 Last reviewed - 31/01/23 Next review due - 20/02/23	Finance - Financial Management -	Owner - Liz Romaniak - Manager - Wendy Griffiths	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality of services.	20	2022/23 financial plan. Existing contracts and MHIS/SDF prioritisation processes via MH Partnership Boards and/or CMB. Alignment of Business Planning and budget setting processes. Financial monitoring/reporting processes including new governance arrangements (Care Group, Executive Directors and FSB). Internally reported monthly to Care Group Resource and Business Development Groups and Care Group Boards, the former reports into Exec Strategy and Resources Group (all monthly) - supports identification of variance from plan and actions required to mitigate. Workforce plans, controls and monitoring in place. SFIs / SOs and scheme of delegation (updated to reflect new structures) supported by procurement approvals hierarchy. Financial recovery meetings are established to identify and monitor required actions to deliver financial plan.	Financial monitoring reports submitted monthly to NHSE/I and ICB. Forecast reported at month 9 was to outturn in line with the £1.16m surplus plan for 2022/23, though this is reliant on a number of non recurrent items that are materially supporting the Trust financial position. Processes are now in train to develop financial plans for 2023/24, albeit noting that revenue allocations are still being considered by the ICB (alongside ICS partners). Trust dashboard includes relevant metrics to support monitoring and delivery. Budget meetings are held with managers to support the delivery of financial plan, identification and mitigation of variances. Effectiveness is discussed at the Care Groups Financial Recovery	Trust 2022/23 financial plan £1.16m surplus (including residual 43% of 21/22 Covid funding – non recurrent) approved by Board June 22. ICS 2022/23 financial plans reflect breakeven position; however, pay award is greater than national tariff funding which has generated a financial pressure for providers. Month 9 deficit £5.0m is an improved position, with run rates support the planned financial surplus. The £1.16m forecast surplus is dependant on continued improvement in run rates, funding being received to support the gap in pay award, and releasing flexibilities from the balance sheet. The exit run rate (underlying financial position) could deteriorate to up to £36.5m if the Trust is unable to resolve funding for complex care packages, reduce agency spending, recruit to all current net vacancies, recover 2022/23 CRES plans, or address delayed transfers with partners and eliminate Independent Sector spending. The below are circumstances that could lead to the risk being realised: Under-achievement of recurrent efficiency	12	Manage delivery of 22/23 financial plan including run rate pressures and £13.8m CRES requirements EDG to re-consider business plan priorities / opportunity for slippage or deferral Validate run rate pressures monthly and potential additional actions required Undertake downside risk and mitigation assessment as part of finalising June 2022 financial plan resubmission Review bank pay rates to support bank staff growth as an alternative to agency Scope Smart working cost pressures (home working policy implications) and/or forward efficiency opportunities (travel/premises) Review non recurrent mitigations, including discretionary expenditure controls/approval routes (hospitality, conferences, non clinical agency/overtime)	28/04/2023 18/07/2022 28/04/2023 20/06/2022 31/03/2023 31/08/2023 28/04/2023	Liz Romaniak Liz Romaniak Wendy Griffiths Wendy Griffiths John Chapman John Chapman Wendy Griffiths	11/08/2022 17/06/2022 13/07/2022	8

Committee/ Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Quality Assurance, Strategy & Resource	6. Safety	Quality & Safety	1289	Identified - 11/08/22 Last reviewed - 13/01/23 Next review due - 10/02/23	Durham, Tees Valley and Forensic - Health and Justice (HJ) -	Owner - A&C Lisa Taylor - Manager - Stephanie Potter	There is a risk that the commencement of the contract for mental health service delivery in HMP Hull and HMP Humber that waiting lists and service provision are not at the standard that TEWV services would expect. This may result in difficulties with service delivery and patient safety.	16	Revised pathway to incorporate Mental Health Assessment referral and allocation to staff inclusive of the timescales required for assessment 24hrs and four working days implemented.	Team Managers/Modern Matron to undertake a clinical audit to provide assurance that the new pathway is embedded in the service. PDP support has commenced to uplift staff skills in record keeping and a training profile has been developed to support staff.	Do not have a good understanding of the current provision. The audit as detailed above is to be undertaken.	16	Baseline audit to be undertaken. Formalised clinical audit to be undertaken in Q4 by Modern Matron/Team Managers At HMP Humber to review the root cause of delays in the 4 day waiting standard.	16/12/2022 31/03/2023 10/02/2023	Susan Sirrell Stephanie Potter Stephanie Potter	14/12/2022	6
Mental Health Legislation Committee	6. Safety	Quality & Safety	1304	Identified - 01/07/22 Last reviewed - 02/12/22 Next review due - 01/02/23	Durham, Tees Valley and Forensic - DTV&F MHSOP -	Owner - Thomas Hurst - Manager - Helen Phoenix	AMH Tees Liaison Risk - Delays in MHA being completed in a timely manner along with a suitable bed being identified for admissions poses a risk to the patient safety and is impacting on level of recorded incidents in the ED department. Risk also to relationship and reputation of TEWV.	20	Acute trust has added delays to the risk register for monitoring. TEWV Daily bed management huddles in place. Liaison to attend P&Qs and V&A task and finish group within the acute trust. Training offered on MHA/DOLs. EDT central log now in place recorded at daily sitrep.	Regular meetings with ED - to maintain positive relationship General manager to oversee log and meet with EDT to look at improving relationship and response. Feedback on training offered. Trust-wide bed management on going work.	EDT sits within social care outside of TEWV.	16	EDT delays	13/01/2023	Thomas Hurst		6
Quality Assurance, Strategy & Resource	2. Demand	Quality & Safety	1311	Identified - 01/04/21 Last reviewed - 31/01/23 Next review due - 31/03/23	Durham, Tees Valley and Forensic - DTV&F Child and YP -	Owner - Amanda Jane Hazelwood - Manager - James Graham	There is a risk that young people being referred for specialist neurodevelopmental assessment face unacceptable waits for commencement and conclusion. This is due to a significant increase in referral demand post-pandemic and exacerbated by the backlogs created during the national lockdowns; resulting in a dissatisfactory experience for families, complaints, knock on effect of long waits for diagnosis-specific support, & reputational damage for TEWV.	20	Openness and transparency of position and issues with all key stakeholders. Improvement plan, codeveloped with key stakeholders including patients/carers, to try to reduce demands on pathway. Commissioning of needs-led autism or 'suspected autism' support services to meet need while families are waiting for assessments. Any co-existing mental health needs are picked up by separate CAMHS teams who are performing well in relation to waits for assessment and treatment. Keeping in Touch process in place	Performance reports monitored at monthly partnership forums and improvement and delivery groups.	Demand far outstrips capacity currently. Teams are delivering the expected number of assessments as was originally commissioned. Recruitment challenges with regards to new and existing posts.	15	SDF investment Completion of multi agency improvement plan - see T drive for full plan	31/03/2023 30/06/2023	James Graham Mita Saha		8
People, Culture & Diversity, Quality Assurance	9. Regulatory Action	Regulation	1324	Identified - 01/04/22 Last reviewed - 31/01/23 Next review due - 28/02/23	Durham, Tees Valley and Forensic - DTV&F Child and YP -	Owner - Amanda Jane Hazelwood - Manager - James Graham	There is a risk that some children and families in North and South Durham will be subjected to unacceptable waits for mental health assessment and treatment, caused by significant staffing pressures in those teams (particular issues with medic, nursing and psychology workforce) in addition to lack of alternatives in community provision, resulting in patient deterioration/risk, patient dissatisfaction, complaints and reputational damage and potential CQC breaches.	20	Keeping in touch process. Overtime is being offered. Caseload deep dive to free up team capacity. Alternative roles being recruited to and agency utilised.	Waiters dashboard (assessment and treatment) in IIC monitored through improvement and delivery groups and reported to care group board.	Some team functions are role specific and effect of controls are limited. Lack of alternatives in community provision in Durham area.	15	Capacity and demand review Waiters data validation Progress all actions in relation to the CQC s29 action plan - see T drive for plan	31/03/2023 31/03/2023 31/03/2023	James Graham James Graham James Graham		6

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 13

For General Release

Meeting of: **Board of Directors**
Date: **23 February 2023**
Title: **Feedback from Leadership Walkabouts**
Executive Sponsor(s): **A Bridges, Director of Corporate Affairs & Involvement**
Author(s): **A Bridges**

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***
	1 – Recruitment 2 – Demand 5 – Staff retention 6 - Safety	The report highlights high level feedback from recent leadership walkabouts, which can contribute to the Board's understanding of strategic risks and the operation of key controls.

Executive Summary:

Purpose: The purpose of this report is to enable the Board to consider high-level feedback from recent Leadership Walkabouts.

Proposal: n/a

Overview:

1 **Background**

1.1 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.

1.2 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 Speciality areas visited

2.1 The Leadership Walkabouts took place face-to-face on Monday 9 January 2023 across Community Mental Health Transformation (CMHT) teams offering Mental Health Services for Older People (MHSOP) across the Trust including:

- Hambleton and Richmondshire MHSOP CMHT
- Knaresborough CMHT and MHSOP Crisis and Memory Teams
- Middlesbrough Community MHSOP CMHT
- Darlington and Teesdale MHSOP CMHT
- Derwentside MHSOP MHSOP CMHT

3 Key issues

3.1 Feedback from the leadership walkabouts is summarised below.

Strengths:

- Patient care: all teams reported how patients at the heart of everything they do, and teams strive to respond to the needs of patients, carers and their families, feeling able to try out new ways of working, which benefits the patient experience. Really positive feedback received through FFT's, and few complaints.
- Teamwork / collective leadership: teams expressed how well they work together with strong MDT approach, and expressed the compassion shown to one another, particularly in challenging times. Standing down face to face support for patients in Covid wasn't an option for their patients and families, and teams pulled together to support service users, carers and each other.
- Partnerships: good partnership working reported across teams, particularly with Alzheimer's Society and Age UK, and care home sector. One team had 7-day accessible service, which function as a one-stop-shop amalgamating care home liaison, intensive working, crisis management and both functional and organic care within one CMHT - good MDT approach and have good relationships with primary care colleagues. Some learning across teams would be beneficial.

Challenges:

- Staffing / recruitment: staffing establishment (clinical and admin) does not reflect the rising complexity of patients who need these services and the increased referral rate. Recruitment of band 6 nurses also reported as challenging with some teams reporting advertising roles 4-5 times, mirroring national healthcare crisis. Cost of living also acknowledged as a barrier.

- Demand in service / high caseloads: this was reported across the many teams (not all – different circumstances in some due to changes brought by change to care group model). Some patients needing crisis services due to waiting lists, compounded more complex presentations.
- IT systems / paperwork: high caseloads increased paperwork, and IT systems sometimes are glinchy. Duplication across PARIS can be frustrating and time consuming, as well as restricted access to care plans / summaries from GPs.

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

Prior Consideration and Feedback n/a

Implications: No additional implications.

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 13 February 2023.

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Tees, Esk and Wear Valleys NHS Foundation Trust

ITEM NO. 15

For General Release

Meeting of:	**Trust Board**
Date:	**23 February 2023**
Title:	**Learning from the Independent Investigation Report into Maternity and Neonatal services in East Kent – Reading the Signals (Kirkup Oct 2022)**
Executive Sponsor(s):	**Elizabeth Moody, Director of Nursing & Governance**
Author(s):	**Leanne McCrindle, Associate Director of Quality Governance, Compliance and Quality Data** **Elizabeth Moody, Director of Nursing and Governance**

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*
4	**Experience**	The report sets out the key issues and learning from the national independent investigation into maternity and neonatal services, recognising that this is not unique to East Kent Trust or only Trust's delivering maternity services. Patient safety and patient experience are key features of learning within the report and a failure to implement learning from the report could relate to the following BAF risks: **BAF 4:** We might not always provide a good enough experience for those who use our services, their carers and their families, in all places and all of the time. **BAF 5**: Pockets of poor culture or low staff wellbeing could undermine our ability to provide a safe and sustainable service as well as putting individual staff and patients at risk of harm. **BAF 6**: Failure to effectively undertake and embed learning could result in repeated serious incidents.
5	**Staff Retention**	
6	**Safety**	

Executive Summary:

Purpose:
Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation was published in October 2022. The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families who used these services.

Although the report reconfirms the requirement for Trust boards to remain focused on delivering personalised, safe and compassionate maternity and neonatal care, the key messages have a wider application for all Trust Boards to consider, regardless of the type of service offered. The letter accompanying the publication (attached at Appendix 2) details the need for the experiences bravely shared by families with the investigation team to be a catalyst for change.

The purpose of this report is to provide the Board with an overview of the 5 key findings of the report and its 4 recommended areas for action. The paper and supporting presentation on the Board agenda invites Board members to examine the culture within the organisation and how we listen and respond to staff, service users and their families, as well as how we assure ourselves and the communities we serve that the leadership and culture across the organisation positively supports the care and experience we provide.

Proposal:
It is shocking to read of the patient experiences and breakdown in team working, culture and attitudes that prevailed, however this is not the first report into maternity services that has highlighted such tragedies and nationally we have had other examples of poor cultures and behaviours highlighted to us, including more recently into mental health services at Edenfield Hospital. We know that good quality and safe patient care is provided when colleagues across our multi-disciplinary teams work openly, honestly and supportively within a just culture and that the opposite can occur when poor or closed cultures prevail. The report highlights the importance of culture and the need for patient safety to be an priority for all Boards. Therefore, this report and any improvement actions should be considered in conjunction with the significant work the Trust has undertaken in relation to 'Our Journey to Change' and the related Clinical, Quality and Co-creation journeys that are coming to the Board for sign off in March 2023. Also, importantly the people plan and journey which taken together will help us to establish common purpose, values, objectives and training to improve the development of teamworking and fundamental changes in our approach to patient safety.

Boards are asked to review the findings of the Kirkup report at their public board meeting, to be clear about the actions being taken, how effective assurance mechanisms are at 'reading the signals' and agree any additional actions to be taken.

Appendix 1 sets out in more detail the key issues and areas of learning for the Trust as well as mitigating actions being taken to reduce the risk of such events occurring here.

Overview:
The Kirkup Report from the independent review of Maternity and Neonatal services in East Kent was published in October 2022 (**Reading the signals**). The report reviewed 202 cases of families who received care in East Kent between 2009 to 2020. It identified that the individual and collective behaviours of those providing services were visible to senior managers and the Trust board in a series of reports right through the period 2009 to 2020, furthermore, it concluded that the inactivity in response to these lay at the root of the pattern of recurring harm.

It found a clear pattern of sub-optimal care which led to significant harm. In 69 of 97 cases it was predicted that the clinical outcome should reasonably have been different. Of the 65 baby deaths, 45 may have lived if they had been offered nationally recognised standards of care.

The report found that there were 'gross failures of teamworking' including a culture of tribalism among different professionals which hindered the ability to recognise problems and was fundamental to the care being delivered.

The report identified eight clear separate missed opportunities, both internally and externally, when these problems could and should have been acknowledged and tackled effectively. It found that the Trust treated problems as limited one-off issues, rather than acknowledging the systemic nature of the challenges and confronting the issues head on. When issues were brought into public focus, it found the Trust focussed on reputation management, reducing liability through litigation and a 'them and us approach'. This got in the way of patient safety and learning.

Failures identified by the review team included:

- **Failures of Professionalism** - the report found 'clear and repeated failures' in professional standards including staff being 'disrespectful to women' and 'disparaging about the capabilities of colleagues in front of women and families.' Staff were found to 'deflect responsibility' when something went wrong and patients 'blamed for their own misfortune'.
- **Failures of Compassion** - Authors of the report were 'shocked' by 'many examples of uncompassionate care.'
- **Failures to Listen** - there were repeated failures to listen some of which resulted in a different clinical outcome. A pattern of 'dismissing what was being said' was found to have significantly contributed to poor outcomes and experience.
- **Failures after Safety Incidents** - It was found that 'the same patterns of dysfunctional teamworking and poor behaviour marred the response by staff after safety incidents'. Staff denied responsibility for what happened and even that anything untoward had occurred.
- **Failures in the Trust's Response, including at Trust Board Level** - The Trust gave the impression of 'covering up the scale and systemic nature of problems' by blaming junior and locum staff. The report calls out the Trust Board for endorsing a succession of action plans which masked the true scale and nature of problems and perpetuated a cycle prohibiting improvement. A high turnover of staff at many levels including Chief Executives were found to encourage this cycle.

There were 4 key areas for action identified within the report as follows:

1. **Monitoring safe performance and identifying poorly performing units** – finding signals among noise.
2. **Standards of clinical behaviour** – giving care with compassion and kindness, technical care is not enough.
3. **Team working with a common purpose** – rather than flawed teamworking, pulling in different directions,
4. **Organisational behaviour** – looking good while doing badly. Responding to challenge with honesty rather than focussing on reputation management.

All Trust Boards have a duty to prevent the failings found at East Kent Hospital NHS Trust happening within their organisation / local system. Trusts are expected to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes.

The report sets out the key issues and learning from the national report, recognising that this is not unique to East Kent Trust or only Trusts delivering maternity services. The paper suggests how learning from this report should be taken forward to mitigate risks to quality and safety. It also includes an overview of assurance against the recommendations and potential delivery risks.

Prior Consideration and Feedback:
This report has been considered within the Trust Organisational Learning Group.

The Trusts medical director attended a recent ICB Board meeting where the author of the report, Bill Kirkup presented his findings. Over the last two weeks, presentations summarising the findings and key messages from this have been given at 4 'time-out leadership development days' to Care Group and Corporate Leads and senior and general management across both Durham and Tees Valley and North Yorkshire and York areas. The presentation is attached at appendix 3 and stimulated a healthy discussion amongst attendees. Staff identified with the key areas for action and suggested a number of opportunities for further learning and improvement such as: sharing the presentation with wider groups of staff across clinical and corporate teams, incorporating themes into Trust induction and leadership development programmes as well as clinical supervision, protected time for team reflection, using data to support early identification of issues

Implications:
The report focuses on 5 key themes that are consistent with many other serious patient safety enquiries and national reports. It sets the wider context and highlights the need for a fundamental transformation in our approach to patient safety. There are regulatory risks and well as risks to the delivery of our three strategic goals if we fail to consider the report and take effective actions.

Recommendations:
The Board as asked to review the findings of this report regarding the actions being taken, how effective assurance mechanisms are at 'reading the signals' and agree any additional actions to be taken.

Appendix 1 – Kirkup report published (October 2022)

1. KEY ISSUES:

1.1 The failures identified by the review team were as follows:

1.1.1 Failures of Team Working:

- Gross failures of team working, with a series of problems between disciplines involved in care delivery.
- Evidence of tribulism, lack of mutual trust and a disregard of other points of view.
- Discouragement of escalation of clinical concerns, leading to the wrong people with the wrong skill sets carrying out interventions and compromising safety.
- Evidence of 'big egos' and 'cliquey behaviour' being played out in front of the women, with clear messages about who to blame if things go wrong.

1.1.2 Failures of Professionalism:

- Evidence of staff being disrespectful to the women and disparaging about the capabilities of colleagues in front of them.
- Evidence of staff not in the 'clique' being allocated high risk patients and challenged to achieve delivery without the necessary skills or experience

1.1.3 Failures of Compassion:

- Evidence of uncompassionate care delivery, whereby women gave examples of being told 'to look things up on google'; women who pointed out their epidural was not effective and that they were in pain ignored or disbelieved.

1.1.4 Failures to Listen:

- Evidence of staff ignoring or discounting what the women were reporting and being dismissive of their concerns or minimising their symptoms.

1.1.5 Failures after Safety Incidents:

- Evidence that the same patterns of dysfunctional team working and poor behaviour marred the response by staff after safety incidents, including those that led to death or serious damage. This was such a common feature, it was considered to be part of the culture of the Trust.
- Evidence that staff not only failed to show compassion, they also denied responsibility for what happened or even that anything untoward had occurred.
- Lack of transparency and open communication with families after an incident.
- Safety investigations conducted in a very tightly focussed and defensive manner and not designed to achieve learning.
- When the Trust had to take responsibility for an incident, a junior obstetrician or midwife was often found who could be blamed.

1.1.6 Failures in the Trust's Response, including at Trust Board level:

- Evidence that the Trust's responses to incidents and minimising or deflecting responsibility gives the appearance of covering up the scale and systemic nature of its problems.
- Evidence that the lack of effectively managing bullying and poor culture issues led to staff leaving and failing to speak up.
- Limited ability to challenge consultant colleagues compared to other disciplines and an acknowledgement that Trusts had limited mechanisms to address poor behaviour, either through professional regulation or HR process.

- Replacement of staff in key managerial roles who identified and challenged poor behaviour, leaving those who either personified the poor culture or who were prepared to live with it rather than question it in place.
- The Trust Board was faced with other challenges. Some of these concerned other hospital services, particularly the Accident and Emergency Department, and the failure to meet targets. Those other challenges, though considerable, did not constitute a good enough reason for failing to put right the way in which maternity and neonatal services were operating.

1.2 Key actions being taken by the Trust to mitigate risks:

1.2.2 Monitoring safe performance and identifying poorly performing units– finding signals among noise:

Processes in place:

- Use of team cultural assessments on all inpatient wards – using a combination of hard and soft intelligence
- Positive and Safe Dashboard – which is openly accessible to all staff
- Development of the integrated dashboard to monitor performance and use of SPC charts to track changes over time
- Existing KPIs and on-going developments in partnership with the ICBs
- Speciality 'Spotlight' sessions and deep dives into services with repeated performance issues
- Patient Safety training (L1 awareness)
- Improved accountability and line of sight through new care group structures and revised governance

Areas for further Improvement:

- A common theme that comes up repeatedly in inquiries is a failure to listen to patients when they raise concerns about care, which is key to patient safety. This requires commitment and a willingness from all staff to proactively seek the insights of those with lived experience to be successful. The Trust have invested in two new Lived Experience Director posts and are committed to the development of peer workers however further work is still needed to assure patients and families that patient safety is our core purpose and that their voices and experience are heard to provide a better experience and prevent future harm.
- Application of learning from Cultural Assessments into the OJTC Programme and supporting change through the Trust's Quality Assurance Schedule, Board reporting and review of the Integrated Dashboard.
- Continue to develop clear and published safety objectives or goals for patient safety with Board focus and oversight on reducing patient harm (through our Advancing Programme)
- Work is ongoing to triangulate quality, safety and workforce information and present this in a way that can be readily accessed by teams and throughout tiers of the organisation to identify hot-spots

1.2.3 Standards of clinical behaviour – giving care with compassion and kindness, technical care is not enough:

Processes in place:

- The establishment of Lived Experience Directors as core members of Care Group Boards
- A full review of the Trust Complaints processes

- Delivery of Empathy Training (including to SI Reviewers and Complaints Investigators)
- Revised processes for greater family/ carer involvement in incident review processes including e.g. families now being involved in agreeing the Terms of Reference for serious incident investigations
- Increased opportunities for families to share their lived experiences to further enhance learning.
- Peer worker posts established within clinical teams
- Improved levels of supervision delivery
- Introduction of Schwarz Rounds

Areas for further improvement:

- Continuing to embed Triangle of Care and assessing the impact of the Carers Charter.
- Continuing to implement the National Quality Standards for PSIRF which will facilitate greater patient and family involvement.
- Oversight of supervision compliance data and improving the quality of supervision
- A fully review of Duty of Candour is underway with plans to address policy implementation and support staff to be open and honest with patients when something goes wrong

1.2.4 Team working with a common purpose – rather than flawed teamworking, pulling in different directions:

Processes in place:

- Collective Leadership and management training for all tiers of staff within the new management and clinical leadership organisational structure.
- Clinical networks and increased investment in Speciality Development Managers to support consistent care delivery across the care groups.
- Promotion and ongoing Trust-wide engagement in the Journey for Change workstreams
- Staff councils and professional networks in place
- Raising awareness of the importance of effective teamworking and culture through leadership and development days, webinars

Areas for further improvement:

- Inpatient skills and training to support the delivery of safe and effective care. The Trust will actively participate in NHSE forthcoming Inpatient Quality and Safety Programme and is looking at an enhanced skill mix to provide greater practice leadership, consultancy and supervision to its inpatient workforce.
- Multidisciplinary leadership within inpatient settings with a focus on delivery of good care and speaking out
- Interdisciplinary training
- The development of clear standards and outcome measures for all teams
- Understanding the impact of OD support to teams where problems have been identified
- Protecting time for team and inter-disciplinary development
- Supporting a culture where poor behaviours can be ‘called out’

1.2.5 Organisational behaviour – looking good while doing badly. Responding to challenge with honesty rather than focussing on reputation management:

Processes in place include:

- Improved systems and processes for serious incident investigation and learning, such as establishment of rapid reviews to identify immediate learning, thematic reviews of serious incidents, mortality reviews, patient safety bulletins and established organisational learning mechanisms (including the Trust wide Organisational Learning Group and the Learning Library).
- Enhanced training needs analysis processes. Specifically, there has also been training delivered in quality governance and assurance, incident reporting, Speak Up processes and risk assessment and management, in addition to improvements in mandatory and statutory training levels
- Multidisciplinary leadership within inpatient settings with a focus on delivery of good care and speaking out.
- Cultural Assessments of all inpatient teams – 'looking under the surface'
- Improved systems for learning-themed workstreams from serious incidents

Areas for further improvement:

- It is vital that the Trust has an open and fair culture that enables patient safety issues to be raised, discussed and addressed. The presence of a 'blame culture' that results in people covering up errors is a consistent theme in major patient safety events. It is essential that the Trust continues to encourage speaking up and where bullying or blame is evident that efforts are taken to tackle this effectively. The NHS staff survey shows that too many staff still do not feel safe to speak up about errors, patient safety events and near misses.
- Further advancing our Clinical, Co-creation, Quality and Safety Journeys.
- Continued transformation to the new national Patient Safety Incident Response Framework (PSIRF) to improve the quality of investigations and family involvement in these processes
- Further promotion of harm free care through strengthening existing clinical, quality and safety workstreams with PMO support
- Developing a culture of shared learning with recommendations for system changes based on a human factors approach

1.3 The Trust has improved systems and processes for identifying and mitigating organisational quality and safety risks. This includes improvements to risk registers which support enhanced oversight, assurance and management of risks. Furthermore, the Trust has a dedicated Quality Assurance Programme which focuses on key quality and safety issues and is informed by incident themes and learning.

2 CONCLUSIONS:

This paper outlines the failings and key learning in the Kirkup report. It should be recognised that there are wider implications for learning and improvement across the Trust in relation to the areas for action despite us not delivering maternity services. Work is in progress in relation to closely monitoring performance, understanding the cultural environments within our services, learning from incidents and changes to the Trusts investigation processes (especially regarding the involvement and experience of families), however it is timely to review the report in detail and identify any further opportunities for improvement.

Background Papers:

- **Reading the signals:** Maternity and neonatal services in East Kent – the Report of the Independent Investigation. (Kirkup report published Oct 2022)

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Classification: Official

Publication reference: PR2099

NHS England

To:
- Trust Chief Executives
- Trust Chairs
- ICB Chief Executives
- LMNS Chairs

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 October 2022

cc.
- Regional Directors
- Regional Chief Nurses
- Regional Medical Directors
- Regional Chief Midwives
- Regional Obstetricians

Dear colleagues

Report following the Independent Investigation into East Kent Maternity and Neonatal Services

Yesterday saw the publication Reading the Signals; Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation.

The report sets out the devastating consequences of failings and the unimaginable loss and harm suffered by families for which we are deeply sorry.

This report reconfirms the requirement for your board to remain focused on delivering personalised and safe maternity and neonatal care. You must ensure that the experience of women, babies and families who use your services are listened to, understood and responded to with respect, compassion and kindness.

The experiences bravely shared by families with the investigation team must be a catalyst for change. Every board member must examine the culture within their organisation and how they listen and respond to staff. You must take steps to assure yourselves, and the communities you serve, that the leadership and culture across your organisation(s) positively supports the care and experience you provide.

We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

The report outlines four areas for action:

- To get better at identifying poorly performing units

- Giving care with compassion and kindness
- Teamworking with a common purpose
- Responding to challenge with honesty.

NHS England will be working with the Department of Health and Social Care and partner organisations to review the recommendations and implications for maternity and neonatal services and the wider NHS.

In 2023 we will publish a single delivery plan for maternity and neonatal care which will bring together action required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust, and NHS Long-Term Plan and Maternity Transformation Programme deliverables.

The publication of the delivery plan should not delay your acting in response to this report and the actions you are taking in response to the report of the independent investigation at Shrewsbury and Telford NHS Foundation Trust. Immediate and sustainable action will save lives and improve the care and experience for women, babies and their families.

Yours sincerely,

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer
NHS England

Professor Stephen Powis
National Medical Director
NHS England

Tees, Esk and Wear Valleys
NHS Foundation Trust

Learning Review

The Independent investigation into East Kent Maternity services: Missed opportunities 2009-2020, Bill Kirkup

Kedar Kale

Medical Director

10 February 2023

Review process

202 families came forward

Individual meetings with families

Case assessment panel

45 of 65 baby deaths

Underlying themes

Tees, Esk and Wear Valleys
NHS Foundation Trust

- Failure of team working
- Failure of professionalism
- Failure of compassion and listening
- Failure after safety incidents

Failure of team working- a group with different goals is not a team

- Lack of trust and respect
- Dominant egos
- Bullying and intimidation
- Inexperienced clinicians being isolated
- Lack of common purpose
- Conflicts played out publicly

Failure of professionalism- if you want to look for blame you should be looking at the obstetrician not me

Tees, Esk and Wear Valleys NHS Foundation Trust

- Disrespecting women
- Shifting blame to colleagues
- Blaming women for outcomes

Failures of compassion and listening– listen to the patient, they are are telling you the diagnosis

- Examples in every account they heard
- Dismissive and uncaring attitudes
- Not listening-foetal movements

Failures after safety incidents

- Denial, dismissal, deflection , dishonesty, defensiveness
- Failure to learn

Missed opportunities- failing to read signals

Started in 2010- MD identified increased neonatal admissions

Disbelief, denial and deflection

Arrogance- the best trust in the country

Hostility and aggression-”why are you here”

All is well – or good enough for East Kent

Action- 4 areas

Tees, Esk and Wear Valleys
NHS Foundation Trust

- Different approach
- No detailed operational recommendations
- Multiple national documents already in place and if adhered to will help improve services

Area 1- maternity signalling system- finding signals amid the noise

Tees, Esk and Wear Valleys NHS Foundation Trust

- We have plenty of data but limited focus on outcomes
- We analyse it poorly
- Data needs to be meaningful, available and timely
- SPCs- look for outliers
- Look at the standard of incident reports

Area two- standard of behaviour

- Maternity staff under strain
- No excuse for aggression, hostility, rudeness
- Consultant issues
- Effective clinical leadership

Area three- flawed teamwork

- Within and across professional groups
- Bullying and intimidation
- Unsupported trainees
- Lack of common purpose
- Leadership and training – shared goals

Organisational behaviours

Tees, Esk and Wear Valleys NHS Foundation Trust

- Denial , deflection, dishonesty
- Under the guise of reputation management
- Duty of candour- ineffective

Conclusion

- Owe it to the patients and families that we learn and improve

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 17

For General Release

Meeting of:	**Board of Directors**
Date:	**23 February 2023**
Title:	**Report of the Freedom to Speak up Guardian Information**
Executive Sponsor(s):	**Sarah Dexter- Smith**
Author(s):	**Dewi Williams**

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	
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*
5	**Staff Retention**	The Freedom to Speak Up Guardian is part of the key control on ensuring staff are able to raise concerns in a safe and constructive way. At present it is considered that there is good assurance that this control is operating effectively.
6	**Safety**	Failure to effectively undertake and embed learning could result in repeated serious incidents and adversely affect worker experience. Recommendations within this report highlight learning and improvements that have been identified from those who have chosen to speak up.

Executive Summary:

Purpose: The purpose of this report is to inform the Board about the last 6 months of the Freedom to Speak Up (FTSU) role. The report outlines developments and activity to date. It will demonstrate the impact we have made, how through joint working we have responded to speaking up from a range of other people, and demonstrate how we work with care groups to learn lessons and develop action plans which help those who spoke up feel listened to and valued.

Proposal: Board Members are asked to note this report and consider the recommendations made within.

Overview: The role of the FTSUG was created in response to the

recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).

The FTSUG supports staff who have raised concerns, as well as delivering mandatory training to managers (band 7 and above) about how to appropriately handle any concerns that have been raised. He also works alongside the Trust board to help develop more ways to empower and encourage staff to raise their concerns.

Information on the activities of the FTSUG service is attached.

This shows that:

- Over the last quarter there has been a steady increase in the number of people speaking up through the service.
- The highest proportion of staff choosing to speak up within Quarter 3 were from a Nursing and Midwifery profession and accounted for 37% of the cases received . Similarly in Quarter 2, the highest profession were also from a Nursing and Midwifery profession accounting for 27% of the cases received.
- From those providing feedback, 92% of those staff raising a concern stated that they would speak up again.

  A keyissues for the Board to determine is that, to date, when people who have spoken up report experiencing detriment or demeaning behaviour, we have to date treated this as a new case. However, the national guardian's office suggests that perhaps it should trigger a referral to the non-executive lead for speaking up. The board are asked to comment on whether this would be an appropriate mechanism or whether we should manage this through the executive lead for the service.
- Compliance with speak up and listen up training is at 80%; however, technical issues, at a national level, are impacting on availability.
- The development of training and support for our speak up champions is continuing.
- The monthly speak up forums continue to be held and the soft intelligence shared enables the service to provide a proactive approach by supporting staff in services where challenges have been noticed.
- The service can demonstrate it has had a positive impact particularly in relation to the Trust responding to concerns raised by staff working in prisons.

Work also continues to be undertaken on the development of the service. The provision of the FTSU team against other trusts in NENC has been benchmarked and a very high level of support in terms of colleague time in the Guardian office is

provided. In order to maintain this level of support an options appraisal for how we take the office provision forward on a sustainable basis**.** It is also intended to use the national guardian's Reflection toolkit review our provision. A paper on this will be presented to the executive People Culture and Diversity Group in March and to executive Directors in early April 2023.

The Board of Directors are asked to note the following lessons which have been earnt during Quarter 3:

- Many staff have spoken up about unmanageable workloads and unsympathetic managers, who either minimise their concerns or at worse make the worker feel that they are not competent.
- Many issues we receive are initially raised with managers however, staff often come to us because they feel that they had either not had a timely response, no response at all or any effective action plan.
- The importance of continued improvement plans and culture audits being undertaken.

Prior Consideration and Feedback

Unusually this month, the report has not been to the PCD committee before coming to board. The flow of the reporting will be synchronised again for the next board report. The themes of the report have been discussed in the People and Culture leads meetings, executive People, Culture, and Diversity group and the Speak up meeting.

Implications:

The changes to the FTSU provision in the last six months have noticeably strengthened our ability to work with other services in the organisation and speed up our response when concerns are raised. Work planned over the next three months will ensure we have a sustainable model that helps drive service improvement for staff and those using our services.

Recommendations:

The Board of Directors are asked to note the recommendations within this report and consider any improvements and actions that may be required.

The board are also asked to decide on the response to those staff who feel they have experienced demeaning treatment as a result of speaking up.

Further information

Report Title: Report of the Freedom to Speak Up Guardian

(1) Caseload

We have experienced a steady increase in the numbers of people speaking up through the service with 38 cases received by the Guardian (compared to 33 cases during Quarter 2).

The table below displays the figures for ongoing cases over the last 6 months. As these are ongoing cases there is duplication across months e.g. some of the people we were working with in July will also show in the figures for December

	Quarter 2	Quarter 3
Total Cases Received	33	38
Bullying and Harassment	7	4
Worker Wellbeing	6	6
Patient Safety/Quality	8	12
Inappropriate Behaviours	10	8
Other	9	9
Demeaning Treatment	2	4

(individual cases received often include multiple themes)

(a) Assessment of Cases

The highest proportion of staff choosing to speak up within Quarter 3 were from a Nursing and Midwifery profession and accounted for 37% of the cases received. Students, Additional Professional Services and Estates accounted for 3% which was the lowest representative profession choosing to speak up.

6 cases were received anonymously during this period.

(2) Impact on those Speaking Up

Following the closure of each FTSU case, those who have spoken up are asked to provide their feedback on their experience of accessing the FTSU service. We ask specifically, if they have encountered any demeaning treatment because they spoke up and would they speak up again in the future.

Of the 12 people who responded, 11 said that they would speak up again and 1 said that they would not speak up, however they were unable to say if FTSU could have done anything further.

(3) Service Development

We constantly review our effectiveness through analysis of cases measured against expectations set out in our policy. We also use our regional guardian's forum to benchmark our activity levels and ways of working.

Following a CQC recommendation in summer 2021 we increased guardian availability to full time. This allowed us time to appoint a band 5 guardian officer to provide effective cover, to support the increased work load, ways of working, and allow the guardian to return to working 4 days a week. Since the officer took post we have increased our proactive work to include more site visits, meeting with teams, delivering training and other promotional work. This work and the improvement in our communications presence has encouraged an increase in staff feeling able to speak up. The quarterly increase is shared below

2022/23

Quarter 1	22
Quarter 2	33
Quarter 3	38
Quarter 4	18 cases received in January

2021/22

Quarter 1	26
Quarter 2	9
Quarter 3	22
Quarter 4	24

We have benchmarked the provision of the FTSU team against other trusts in NENC and we provide a very high level of support in terms of colleague time in the Guardian office. However, one of those posts is fixed term and we are in the process of developing an options appraisal for how we take the office provision forward on a sustainable basis. We have already commissioned an external review of our working processes and will use the regional guardian's forum to benchmark ourselves to look at guardian availability, workloads, and perception of ability to meet the current need. We also intend using the national guardian's Reflection toolkit currently being considered by the board to review our provision. This paper will be going to the executive People Culture and Diversity Group in March and to executive Directors in early April 2023.

(4) Training

It is mandatory for all staff to complete the Speak up, and Listen up, eLearning modules developed by the NGO and NHSE. Speak up compliance is at 80%, but unfortunately there remains a national technical issue that has continued to disable the 'listen up and follow up modules. This is being resolved with the national team.

We continue to provide bespoke training for teams or individuals on request, and specialist training for senior staff wishing to undertake reviews.

We continue to develop training and support for our speak up champions

(5) Support networks

We continue to hold our monthly speak up forum with colleagues from across corporate services who work across multiple teams. We share soft intelligence and then agree how best to feed this information through to the services to ensure early notice of challenges so we are dependent on individuals to come forward. This also triggers guardian visits to services to ensure staff know their speaking up options. The guardian remains very grateful for the support provided by the guardian officer. The additional support has enabled us to provide more proactive support to services much earlier after hearing initial concerns from the wider group

Opportunities for learning lessons occurs with the forum. We also use Facebook to share anonymised case examples, primarily to share the message that it is worth speaking up, and the trust does listen and act on concerns raised by our staff.

(6) Impact

In the last 6 months 4 people have spoken up about demeaning treatment received as a result of speaking up as follows, 3 are ongoing in AMH/MHSOP DTVF and 1 withdrew as action was already being taken to address the concerns:

We have received a number of concerns from staff working in our various prison services. Most relate to a shared cultural feeling that it is not a safe place to speak up, and that if you do there will be negative consequences. Our support for those speaking up has triggered comprehensive Organisational Development involvement with staff interviews and feedback sessions. There is now a broader report being compiled by the principal people partner for the service looking into what it is like to work in these environments. However, despite intervention we are still hearing from staff who say it does not feel safe and are choosing to leave. I am hopeful the current review of ‘closed cultures’, will provide further guidance to integrate to this piece of work.

We continue to receive concerns from Bank and Agency workers who choose to speak up when complaints are made about them. The implications for the staff member means that at times, they may not be permitted to pick up any further shifts while the concern is investigated. The FTSU Guardian has met with the Equality and Diversity Lead and also Temporary Staffing Services. Work is ongoing to ensure that responses to these concerns are concluded at the earliest opportunity and there is a specific piece of work looking in more detail at one AMH ward and the experience of all staff who work there.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 19

For General Release

Meeting of:	**Trust Board**
Date:	**23 February 2023**
Title:	**Gender Pay Gap 2022**
Executive Sponsor(s):	**Sarah Dexter Smith, Director of People & Culture**
Author(s):	Sarah Dallal, Strategic Equality, Diversity, Inclusion and Human Rights Lead & Voluntary Services Lead Beverley Vardon-Odonker, Strategic Lead Workforce Information and Assurance Helen Cooke, Equality, Diversity, Inclusion and Human Rights Officer

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*
5	**Staff Retention**	The Trust has a minimal appetite for risks relating to quality Although the present score is above tolerance, an acceptable level of exposure can be achieved. Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels
1	**Recruitment**	The Trust is prepared to accept some workforce risks where they provide the potential for improved recruitment and developmental opportunities for staff. Although present score is significantly above tolerance, it is considered that an acceptable level of exposure can be achieved. There is scope to strengthen controls. This is required at pace, through the delivery of mitigations, to reduce risk to tolerance

Executive Summary:

Purpose: The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

	The purpose of the report is to demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation along with further context to explain any gender pay differences with a view to demonstrate our commitment to equality. A more detailed document is appended to this report including the required reporting fields, associated context and proposed actions.
Proposal:	The purpose of the report is to demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality. The Trust Board is asked to confirm that it has good assurance that a robust process has been undertaken when completing the Gender Pay Gap report, including the proposed actions and comment accordingly. The Trust Board is asked to agree to the publication of Gender Pay Gap data on the Trust and government website.
Overview:	Reporting on gender pay differences is a statutory requirement of the Equality Act 2010. This must be completed annually, reporting on the specific measures. The proposal for good assurance is based on the information in the appendix which demonstrates that that the following has been reported upon in line with national guidance: • The mean gender pay gap • The median gender pay gap • The mean bonus gender pay gap • The median bonus gender gap • The proportion of males and females receiving a bonus payment • The proportions of male and female in each quartile of pay That the Trust Board agree with the proposed actions identified within the report or comment accordingly. That the Trust Board agree findings from this analysis are to be published on the Trust and government website by 30 March 2023.
Prior Consideration and Feedback	The Gender Pay Gap report has gone through the appropriate approval routes, Executive People Culture and Diversity Group (2 February 2023) and People Culture and Diversity Committee (6 February 2023)
Implications:	Failure to complete and publish the Gender Pay Gap report in accordance with the requirements of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 may have regulatory consequences
Recommendations:	To confirm that the Trust has good assurance that the Trust is meeting its statutory requirements by producing data in relation to gender pay differences that exist within the organisation.

To agree to the actions identified and to the publication of the gender pay information on the Trust and government website as is required.

Gender Pay Gap 2022

1.0 INTRODUCTION & PURPOSE:

1.1 The Trust has been required to produce and publish a Gender Pay Gap Report since April 2018. The attached report is based on a snapshot date of 31st March 2022 and is required to be published by 30th March 2023.

1.2 The purpose of the report is to demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality.

2.0 BACKGROUND INFORMATION AND CONTEXT:

2.1 Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

2.2 The Trust is required to publish the details of the specific measures on the Government Gender Pay Gap Service website. The following report includes the details of the measures plus narrative to explain what may be contributing to any differences in pay identified.

3.0 KEY ISSUES:

3.1 The report shows a slight increase in the gender pay gap for the period 2022, with the gap between male and female pay slightly increasing for the first time since 2018.

- The gender profile of female staff within the Trust has increased in the last five years from 77% to 79%.
- The mean gender pay gap between male and female pay has increased slightly in the past year from 10.66% to 10.73%. From an hourly rate perspective this equates to a mean gender pay difference from £1.93 per hour to £2.02 per hour less than males.
- The median gender pay gap has increased slightly from 7.27% to 7.58% which from an hourly rate perspective equates to a median gender pay gap increase in the past year from £1.11 per hour to £1.22 per hour less than males.
- There has been a notable increase in staff choosing to contribute to salary sacrifice schemes which is one of the factors which impacts on an employee's basic pay.
- Bonus payments include Clinical Excellence Awards made to Consultant Medics and long service awards made to staff on reaching 25 years' service. The narrative included in the report

goes some way to explain the significant differences in awards between female and male employees.

4.0 IMPLICATIONS:

Compliance with the CQC fundamental Standards:
It is a requirement of the CQC fundamental standards that the Trust meets its obligations with regards to its public sector equality duties

4.1 **Financial/Value for Money:**
Financial penalties can be incurred for non- compliance with the legislative requirements of the Equality Act. This may result in reputation loss for the Trust.

4.2 **Legal and Constitutional (including the NHS Constitution).**
The Trust is required to publish information demonstrating its compliance with the public sector duties of the Equality Act 2010. The Gender Pay Gap report will meet that legal requirement and as Equality Act compliance is a pre-requisite of Care Quality Commission registration will maintain Trust registration.

4.3 **Equality and Diversity:**
The Trust must demonstrate compliance with statutory and contractual equality requirements. Failure to do so may result in legal action and subsequent financial penalties and damage to the Trust's reputation.

4.4 **Other implications:**
None have been identified.

5.0 RISKS:

5.1 There is a potential that increasing gender pay differences could impact on the Trusts ability to recruit and retain staff, as well as impact on our ability to be a great place to work. The report provides the context for the gender pay differences evident and the proposed actions identified.

6.0 CONCLUSIONS:

6.1 The Gender Pay Gap Report for 2022 is showing slightly increased gap for the first time since 2018. Further data analysis has been suggested to understand this increase and identify actions to address to any inequalities in gender pay.

7.0 RECOMMENDATIONS:

7.1 To note the contents of the report and to comment accordingly.

7.2 To approve and ratify the Trust's Gender Pay Gap report prior to publication.

Sarah Dexter-Smith, Director of People and Culture

Sarah Dallal, Strategic Equality, Diversity, Inclusion and Human Rights Lead & Voluntary Services Lead
Beverley Vardon-Odonker, Strategic Lead Workforce Information and Assurance
Helen Cooke, Equality, Diversity, Inclusion and Human Rights Officer

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Foundation Trust Gender Pay Gap Report – 2022

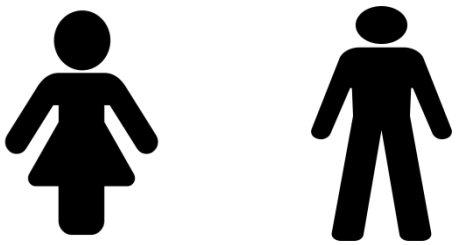
The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

This is the sixth report and is based upon a snapshot date of **31st March 2022.** We are required to publish data on the Government Equalities Office website and on the Trust website by 30th March 2023 and annually going forward.

The gender pay gap differs from equal pay in the following way. Equal pay deals with the pay differences between men and women who carry out **the same jobs, similar jobs or work of equal value**. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women.

The following report includes the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality. The Trust is committed to understanding any differences identified in the gender pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

The gender profile of the Trust is



79.0% **21.0%**

The gender profile split in the Trust has increased from 78% female and 22% male during the last 12 months. There has been a 2% increase in favour of females since we started to report in March 2017. The gender split at that time was 77% female and 23% male.

Please note these figures exclude bank workers. The remainder of the report includes data pertaining to substantive staff plus any bank workers who worked on 31 March 2022. This is in accordance with the Gender Pay Gap reporting requirements.

Mean and Median Gender Pay Gap

The mean gender pay gap and median gender pay gap for **all employees** is detailed below. Gross pay calculations are used for these purposes.

Mean Gender Pay Gap

10.73% less than males -
equating to £2.02 per hour less

Median Gender Pay Gap

7.58% less than males -
equating to £1.22 per hour less

The mean gender pay gap linked to the amount a female is paid has increased slightly in the past year from 10.66% to 10.73%. From an hourly rate perspective this equates to a mean gender pay gap increase in the past year from £1.93 per hour to £2.02 per hour less than males.

The median gender pay gap has increased slightly from 7.27% to 7.58% which from an hourly rate perspective equates to a median gender pay gap increase in the past year from £1.11 per hour to £1.22 per hour less than males.

The table below highlights the mean and median gender pay gap reported figures between March 2017 and March 2022. The general trend since 2018 has been a decrease in the gender pay gap difference with the exception of 2022 where a slight increase is evident.

	2017	2018	2019	2020	2021	2022
Mean gender pay gap	14.9%	16.3%	14.65%	12.16%	10.66%	10.73%
Median gender pay gap	9.34%	10.24%	10.14%	8.91%	7.27%	7.58%

There are number of possible contributory factors which can influence the gender pay gap differences. The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car.

The table below highlights the number of staff by gender contributing to the schemes. As you would expect, in line with the gender split within the organisation, the majority of staff opting to participate in one or more salary sacrifice schemes are female. The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median gender pay gap and will be a contributory factor which may be causing the differences being reported.

There has been an increase of **21.4%** in the number of staff contributing to the lease car salary sacrifice scheme compared to March 2021. Based on the average monthly sacrifice of £256 this will reduce the gross pay of a female member of staff by approximately £3096 per annum. It is also worth noting a proportion of staff contribute to more than one salary sacrifice scheme.

There has been a notable increase in the number of staff accessing salary sacrifices linked with electronics in the past year. Last year 210 females had electronic related deductions and 63 males had electronic based deductions. The tables below shows the significant increase for both male and females for this type of salary sacrifice and comparisons with March 2021 data.

March 2022

Salary Sacrifice Schemes	Child Care Vouchers	Lease Car Scheme	Cycle to Work Scheme	Electronics
Female	105 (80%) average sacrifice per month £106	468 (72%) average sacrifice per month £256	110(68%) average sacrifice per month £28	538 (77%) average sacrifice per month £52
Male	27 (20%) average sacrifice per month £76	180 (28%) average sacrifice per month £328	51 (32%) average sacrifice per month £52	157 (23%) average sacrifice per month £47

March 2021

Salary Sacrifice Schemes	Child Care Vouchers	Lease Car Scheme	Cycle to Work Scheme	Electronics
Female	150 (81.5%) average sacrifice per month £89	369 (72.5%) average sacrifice per month £233	119(76.6%) average sacrifice per month £30	210 (76.9%) average sacrifice per month £43
Male	34 (18.5%) average sacrifice per month £77	140 (27.5%) average sacrifice per month £263	49 (23.4%) average sacrifice per month £45	63 (23.1%) average sacrifice per month £35

Agenda for Change and Executive Pay

The mean gender pay gap and median gender pay for those staff **employed on Agenda for Change** terms and conditions and Executive Pay shows the difference in rate to be lower when medical and dental staff are excluded.

Mean Gender Pay Gap (AfC & Executive Pay)

Median Gender Pay Gap (AfC & Executive Pay)

3.52% less than males -
equating to £0.57 per hour less

4.56% less than males –
equating to 0.66p per hour less.

The mean gender pay gap has increased from the previous year of 2.97% (£0.48 per hour) to 3.52% (£0.57 per hour). The median gender pay gap has a notable increase from 0.85% (£0.12 per hour) to 4.45%, (£0.66 per hour). Further analysis on this is proposed to understand this better.

Medical and Dental

The information below highlights the mean gender pay gap and median gender pay gap for those staff employed on **Medical and Dental terms and conditions**. The figures include the Clinical Excellence Awards payments that are paid to eligible medical staff.

Mean Gender Pay Gap (M&D)

10.70% less than males -
equating to £4.31 per hour less

Median Gender Pay Gap (M&D)

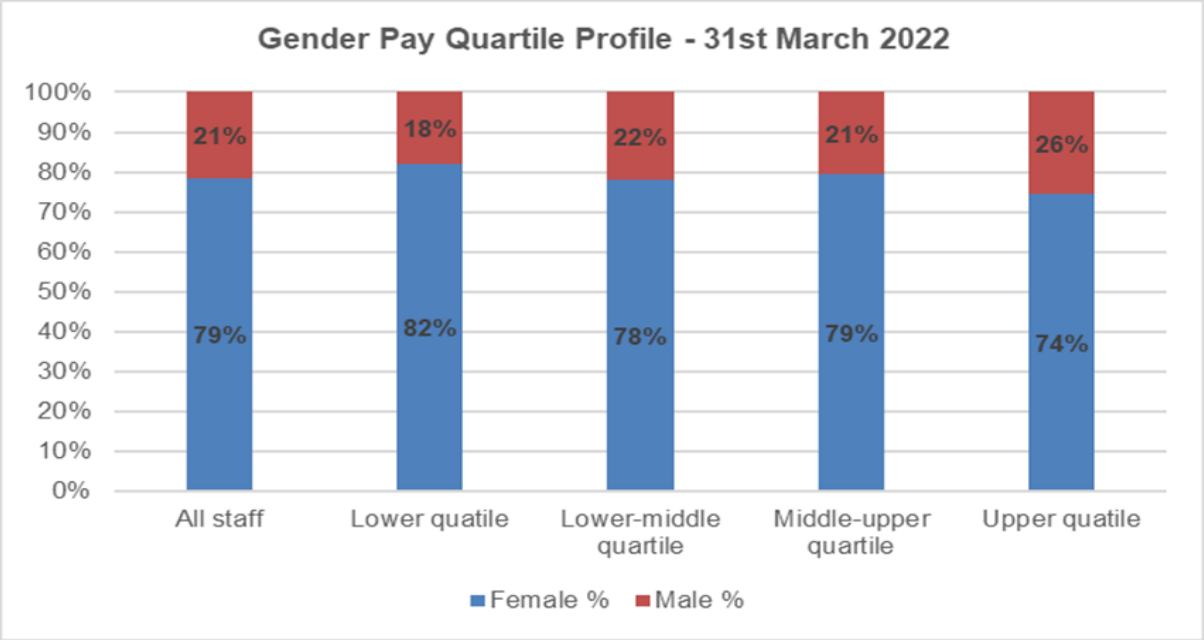
3.31% less than males –
equating to £1.50 per hour less

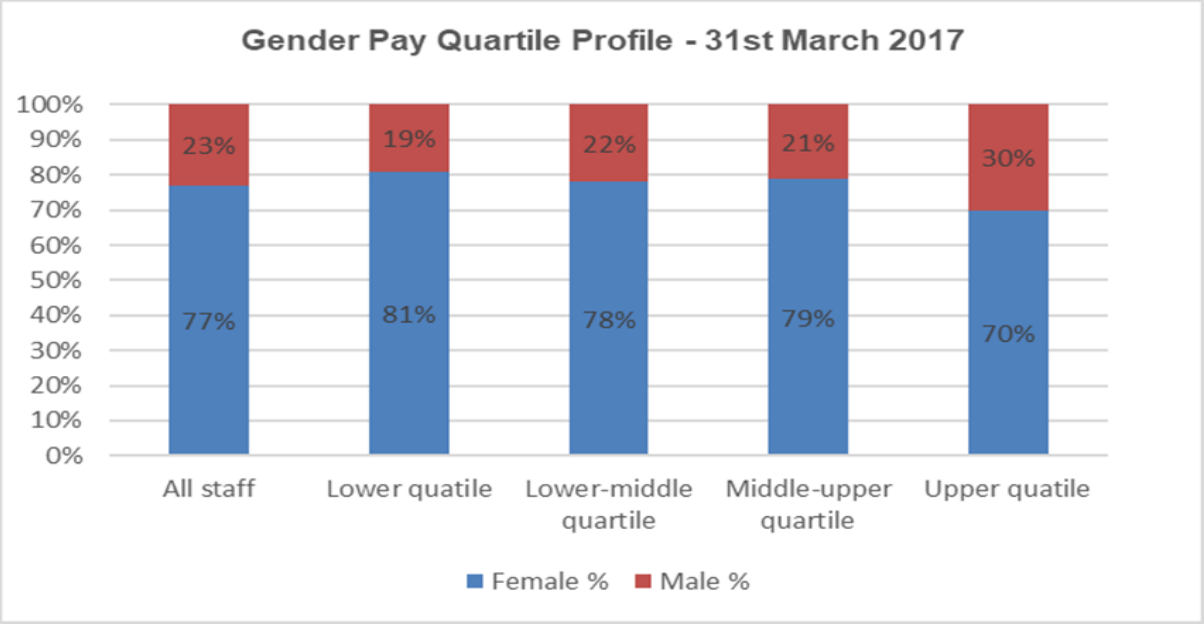
The mean gender pay gap has increased from 9.05% (£3.94 per hour) in 2021 to 10.7% (£4.31 per hour) in 2022. The median gender pay gap has also increased between male and females in the past year from 3.17% to 3.31%. This equates to females experiencing an increased difference in hourly pay to male counterparts from £1.45 per hour less to £1.50 per hour less.

Gender Pay Quartile Profile

The following graph shows the proportion of males and females in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile, with the highest proprotion of females within the lower quartile.

82% of employees in the lower quartile are female, compared with 74% in the upper quartile. Of note is the upper quartile has seen the proportion of females increase from 70% to 74% since 2018. The remaining quartiles have remained broadly the same. A quartile profile from 2017 is included on the following page to allow for comparisons.





Bonus Payments

Under the national Medical & Dental terms and conditions Consultants are eligible to apply for Clinical Excellence Awards (CEA). These awards recognise individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role and are part of a commitment to the continuous

improvement of the NHS. The table below highlights the mean and median bonus pay linked to clinical excellence awards.

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£13,066	£12,065
Female	£9,916	£7,009
Difference	£3,149	£5,596
Pay Gap %	24.10%	46.4%

At the time of reporting the Trust was operating a local clinical excellence award scheme based on the national terms and conditions. For the 2021 award year it was agreed locally following guidance that the same process would be followed as that which took place in 2020. This meant that the Trust could again stand down the usual formal process of application and review for CEA's. Instead, the money could be divided equally between all eligible individuals, and they received a non-consolidated and non-pensionable payment for the year. Therefore, everyone received the same amount of award for 2022.

There are also however a number of individuals receiving historic awards from 2017 which are recurrently paid each year. Once an award had been made the Consultant continues to receive that level of award going forward. A further submission may be made the following year and as a consequence progression through the varying payment levels occurred. This may account for one of the reasons for the significant difference being reported.

There were more males receiving larger monetary amounts than females.

Proportion of eligible Consultants receiving a CEA

100%

100%

All 145 eligible Consultants received a Clinical Excellence Award in the reporting year.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 129 staff received an award. **98 females and 31 males** received an award, equating to 76% of females which is lower than the Trust gender breakdown. In the previous year more females received an award (133) and marginally more males (39).

Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above. Guidance from ACAS states that such payments with a monetary value should be included.

The table below provides **combined details of the clinical excellence awards and long service awards**.

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£6,682	£6,498
Female	£2,031	£100
Difference	£4,651	£6,398
Pay Gap %	70.0%	98.5%

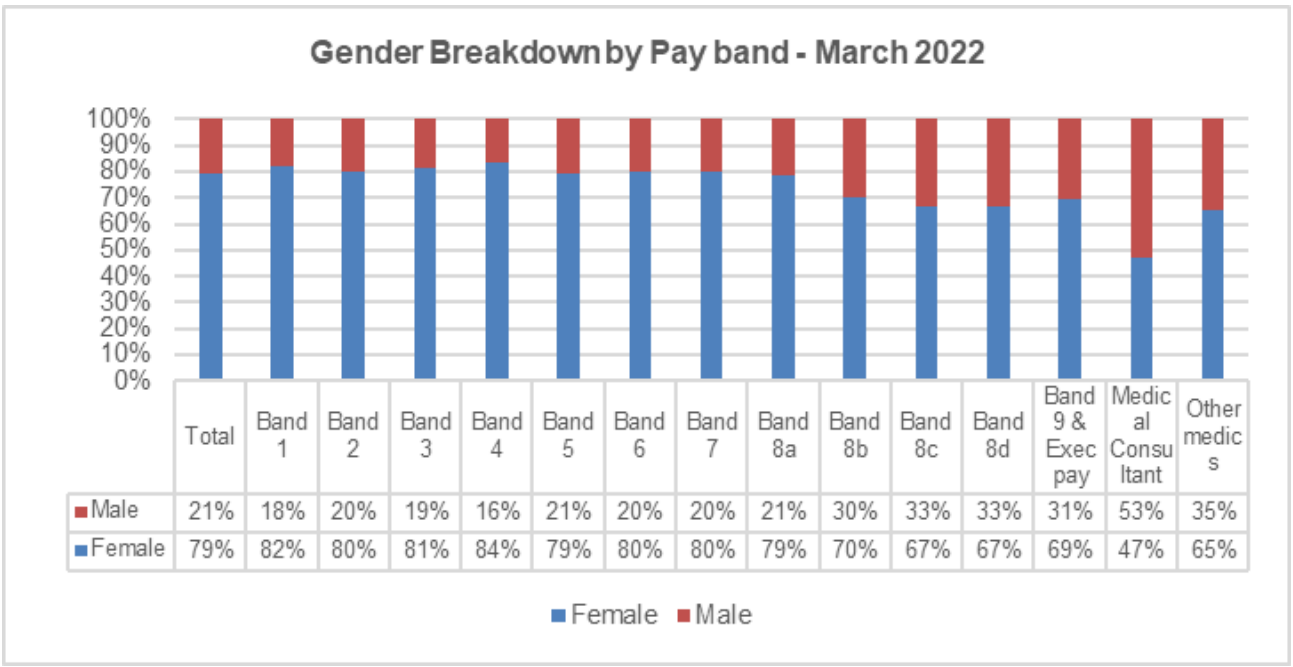
It is important to recognise when combining the bonus awards in this way the data is skewed as long service awards are predominantly paid to women with a higher proportion of males receiving clinical excellence award payments.

Gender Breakdown by Pay Band

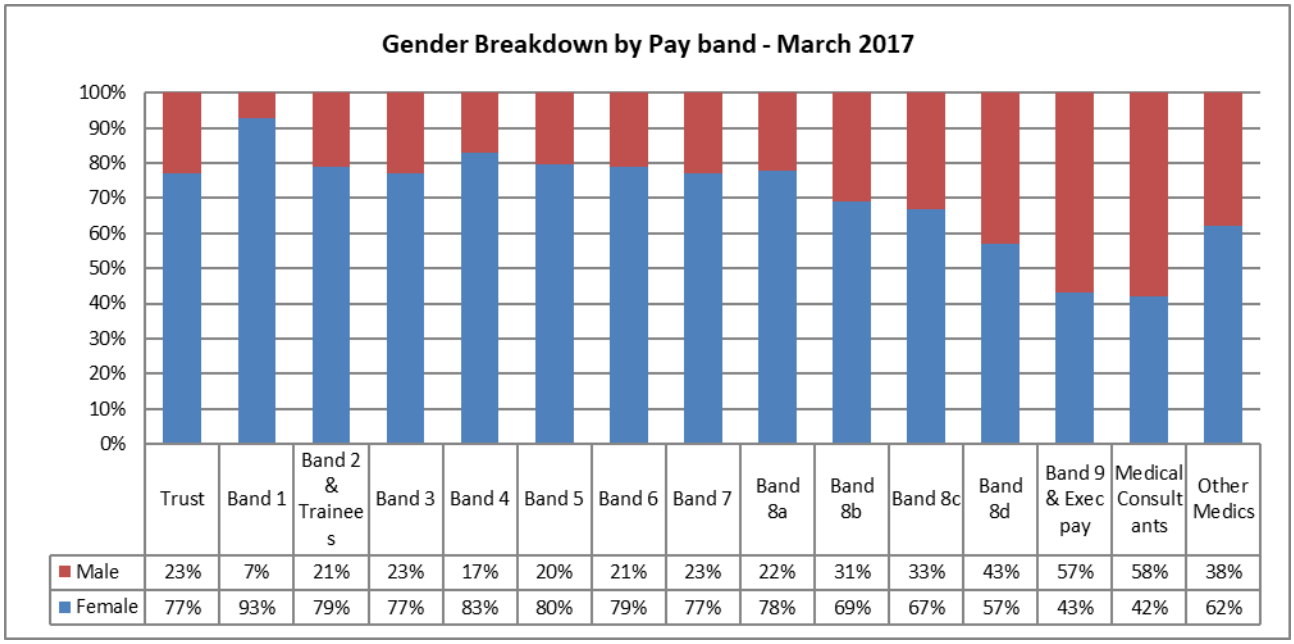
The following two graphs provide a gender profile breakdown by pay band as at March 2022 and March 2017. The graphs highlight the changes in the profile of male / female ratio's within the bands, in the past 5 years.

There has been increases in the ratio of female staff within Bands 3 and 7 by 3% and 4 respectively. More significant positive increases are evident within bands 8d, 9 and Executive pay and Medical Consultants.

Band 1 was closed to new entrants from 1 December 2018, therefore the number of overall staff in this banding will continue to reduce**.**



	Total	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultant	Other medics
Male	21%	18%	20%	19%	16%	21%	20%	20%	21%	30%	33%	33%	31%	53%	35%
Female	79%	82%	80%	81%	84%	79%	80%	80%	79%	70%	67%	67%	69%	47%	65%



	Trust	Band 1	Band 2 & Trainees	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultants	Other Medics
Male	23%	7%	21%	23%	17%	20%	21%	23%	22%	31%	33%	43%	57%	58%	38%
Female	77%	93%	79%	77%	83%	80%	79%	77%	78%	69%	67%	57%	43%	42%	62%

Update on Progress from Gender Pay Report 2021

In previous years following the publication of the Gender Pay Report further work has been undertaken to better understand the reasons for differences in gender pay. Due to the impact of the Covid pandemic following the publication of the report in March 2021 further work was not identified to be undertaken.

Proposed Areas for Further Action based on 2022 report

- Undertake analysis of leavers by gender and their respective point on the scale comparing this with new starters by gender and their point on scale. This may provide more understanding around the percentage of female leavers and joiners and their average hourly rates, taking into account national pay structures.
- Carry out further analysis in respect of how salary sacrifices impact on the gender pay gap, including age profiles
- Review the potential impact of the new Trust management structure
- Review the Clinical Excellence Awards and what proportions of males / females have higher levels of CEA or national awards.

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Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 20

For General Release

Meeting of:	**Board of Directors**
Date:	**23rd February 2023**
Title:	**Equality Delivery System (EDS) 2022**
Executive Sponsor(s):	**Sarah Dexter- Smith**
Author(s):	**Sarah Dallal**

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***
5	**Staff Retention**	The Trust has a minimal appetite for risks relating to quality Although the present score is above tolerance, an acceptable level of exposure can be achieved. Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels
4	**Experience**	The Trust has a minimal appetite for risks relating to quality. Although the present score is above tolerance, an acceptable level of exposure can be achieved

Executive Summary:

Purpose:

This paper is presented to BoD to provide assurance that the Trust is meetings its obligations under the NHS contract to complete EDS 2022.

A more detailed document is attached to this report identifying the scores that have been agreed for the Trust and any areas of concern.

Proposal:

The Board is asked to confirm that it has good assurance that the Trust has followed a robust process in completing EDS 2022 and is meeting its obligations in regard EDS 2022
The Board is asked to ratify the scores of EDS 2022 and to agree to the publication of EDS 2022 on the Trust website as is required.

Overview:

EDS 2022 is a requirement of the NHS contract and must be completed annually using the evidence available for each of the outcomes. The proposal for good assurance is based on the information in the appendix which demonstrates that:

- Appropriate evidence has been gathered for each outcome
- Consultation on the draft scoring has taken place as laid down in the technical guidance
- EDS 2022 has gone through the appropriate approval routes – PCDC and then to Board of Directors

The Trust has scored 1(developing) for 3 criteria and further detail on this and plans to improve the scoring are contained in the Appendix. The Trust's overall score is 21 (developing).

Prior Consideration and Feedback

The scoring for EDS 2022 has gone through a thorough consultation process with service users and carers, staff, including staff networks, trade unions, JCC, chaplains, care group People and Culture groups and where appropriate external verification. All those involved in the consultations have agreed on the scoring

The paper was considered by the Executive PC group on 24th January 2023.
The paper was considered by the People, Culture and Diversity Committee on 6th February 2022 who agreed to recommend to the BoD that it ratifies the scoring of EDS 2022 and agrees to its publication on the Trust website

Implications:

Failure to complete EDS 2022 in accordance with the requirements of the NHS contract may have regulatory consequences.

Recommendations:

The BoD is asked to confirm that it has good assurance that a robust process has been undertaken when completing the proposed scoring and evidence for EDS 2022.
The Board is asked to ratify the scores of EDS 2022 and to agree to the publication of EDS 2022 on the Trust website as is required

EDS 2022

1. BACKGROUND INFORMATION AND CONTEXT.

1.1 EDS 2022 has been developed by NHS England and NHS Improvement and supported by the NHS Equality and Diversity Council as an improvement tool to support NHS organisations to review and develop their services, workforces, and leadership. The completed version must be published on the Trust's website by 28th February 2023 following approval at Board level. EDS 2022 should be carried out annually

1.2 It comprises eleven outcomes spread across three Domains, which are:

1. Commissioned or provided services
2. Workforce health and wellbeing
3. Inclusive leadership

1.3 Each outcome is evaluated, scored, and rated using available evidence and insight which assure or point to the need for improvement. The scoring system for each outcome is as follows:

- Undeveloped activity 0
- Developing activity 1
- Achieving activity 2
- Excelling activity 2

1.4 The scores are aggregated into an overall score for the organisation:

- Those scoring 8 or below are rated undeveloped
- Those scoring between 8 and 21 are rated developing
- Those scoring between 22 and 32 are rated achieving
- Those who score 33 (the maximum score) are rated excelling

1.5 For domain 1 the Trust had to choose 3 services. This was done by the Assistant Chief Executives team. The categories of service and the services chosen are:

- One which where data indicates it is doing well Tees CAMHS community team
- One where data indicates a service is not doing so well Durham Crisis team
- One where its performance is unknown Adult AHDD/ Autism diagnostic

1.6 The rating process is as follows:

- Domain 1 is rated by service users, the VCSE sector and NHS organisations

- Domain 2 is rated by staff, staff networks, trade unions, and organisations

- All scoring in Domain 3 must be independently tested, by a third party with no direct involvement in managing or working for the organisation. Chris Rowlands the EDI Lead for CNTW undertook this role for the Trust.

2. KEY ISSUES

The key issues for consideration are as follows: -

2.1 The full rating scorecard and action plan is included at Appendix 1.

2.2 The Trust has scored 2 (achieving) for the majority of outcomes with the following exceptions:

- Outcome 2 B (score 1) – When at work, staff are free from abuse, harassment, bullying and physical violence from any source. During consultation with staff and trade unions it was recognised that a lot of work was going on in this area, but it was felt that staff with protected characteristics were not adequately supported to report patients who verbally or physically abuse them. Further work on this will be led by the Violence Reduction strategy.

- Outcome 2D (score 1)– Staff recommend the organisation as a place to work and receive treatment. In the 2021 staff survey 52.8% of staff recommended TEWV as a place to work and 53.7% were happy for a friend or relative to be cared for by the Trust. To score a 2 over 70% of staff would recommend the organisation as a place to work and receive treatment.

- Outcome 3A (score 1)- Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities. Whilst the commitment of Board members to these issues was recognised – chairing lunch and learn sessions, attending and sponsoring staff networks and including these issues in blogs to score a 2 the Leadership Framework for Health Inequalities Improvement would need to be implemented. This work is ongoing and will be in place when the EDS is next completed.

2.3 The Trust's overall score for EDS 2022 is 21 which is classed as developing. The action plan at the back of the attached score card details actions the Trust will take in the next year to improve its score.

Author: - **Sarah Dexter- Smith, Director of People and Culture**

Sarah Dallal, Strategic Lead for Equality, Diversity, Inclusion and Human Rights and Volunteering.

Classification: Official

Publication approval reference:

NHS Equality Delivery System 2022

EDS Reporting Template

Third Version (test)

Version 0.8, 18 February 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation	**Tees Esk and Wear Valleys NHS Foundation Trust**	**Organisation Board Sponsor/Lead**
		Sarah Dexter-Smith
Name of Integrated Care System	North East & North Cumbria ICB & Humber & North Yorkshire ICB	

EDS Lead	Sarah Dallal		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	Staff networks – 29th Nov 22 Staff side – 29th Nov 22 Freedom to Speak up team – 1st Dec 22 Chaplaincy Team – 6th Dec 22 People, Culture & Diversity subgroups – 16th Dec 22 JCC – 10th Jan 23		**Individual organisation**	Tees Esk and Wear Valleys NHS Foundation Trust
			Partnership* (two or more organisations)	County Durham and Tees Valley Mental Health, Learning Disability and Autism Partnership
			Integrated Care System-wide*	Reviewed by Cumbria, Northumberland, Tyne and Wear Foundation Trust

Date completed	16.1.2023	**Month and year published**	

Date authorised		**Revision date**	

Completed actions from previous year	
Action/activity	**Related equality objectives**
N/A	

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance with scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Summary Domain 1 – Please see detailed ratings and evidence for the three services chosen

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Stockton CPY:** Achieving national & local access rates Triage system to find most appropriate service – agreed in team huddle Assessments with 4 weeks (more urgent seen quicker) Recovery model – no gaps in pathway 4 initial appointments – comprehensive assessment involving young person & family Adjustments are made based on individual	3	Sonia Ayre – Team Manager James Graham – General Manager
		D&D AMH Crisis: Access to service is 24 hrs per day 7 days per week Service has struggled to meet target to contact within 4 hrs – improvement work to address this Daily incident management calls	2	Annette Kelly – team manager. Tom Hurst – General Manager
		ADHD: All referrals go through screening and protected characteristics are inputted Reasonable adjustments are made following a diagnostic assessment	2	Allison Cook – Service Manager

			Average score: 2	
	1B: Individual patients (service users) health needs are met	**Stockton CPY:** Support for parents Meeting needs of people from protected characteristic groups Access to interpretation/translation services Holistic assessment/formulation process **D&D AMH Crisis:** Comprehensive assessment & formulation Home treatment element for periods of crisis Wider health needs assessed 4 peer support workers **ADHD:** Holistic psychosocial approach Patients are involved in assessment to meet needs	3 2 2 **Average score: 2**	Sonia Ayre – Team Manager James Graham – General Manager Annette Kelly – team manager. Tom Hurst – General Manager Allison Cook – Service Manager
	1C: When patients (service users) use the service, they are free from harm	**Stockton CPY:** Comprehensive risk assessment Safeguard is central to delivery Joint working – schools, social care, VS **D&D AMH Crisis:**	3 3	Sonia Ayre – Team Manager James Graham – General Manager

		Formulation on individual basis – safety summary & safety plans, involving patient Holistic approach Crisis management recorded on patient record **ADHD:** Risk management systems to record and monitor risks Service improvement initiatives Work in partnership with key stakeholders	3 **Average score: 3**	Annette Kelly – team manager. Tom Hurst – General Manager Allison Cook – Service Manager
	1D: Patients (service users) report positive experiences of the service	**Stockton CYP:** CORES, ORES & RCDA used and share, co-produced Young person's & parents participation groups Involvement in interview processes & quality improvement events FFT offered – 100% responses rate good/very good 6 complaints/6 PALS issues (12 months) **D&D AMH Crisis:** 2 BAME leads to improve access FFT 80% responses good/very good 4 complaints/35 PALS issues (12 months) **ADHD:** Act upon FFT feedback	3 3 3	Sonia Ayre – Team Manager James Graham – General Manager Annette Kelly – team manager. Tom Hurst – General Manager Allison

		FFT 85.7% responses good/very good No complaints 3 PALS issues	**Average score: 3**	Cook – Service Manager
Domain 1: Commissioned or provided services overall rating			**Average score: 10**	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Occupation Health Provision • Employee Support Service/Employee Psychology Service • PAM Assist (counselling service) • VIVUP wellbeing platform • Long Term Health Conditions staff network • Achieved Better Health at Work bronze level – campaigns have included mental wellbeing, Menopause, Cervical Cancer, physical health & exercise • Long term sickness absence team • Nutrition and weight management programmes • Over 200 Health & Wellbeing (H&W) champions • H&W newsletter • H&W pages on the staff Intranet • Smarter Working project • Reasonable adjustments • Staff Mindfulness Programme • H&W coordinator (D&D)	2	Sarah Dallal

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Verbal Aggression procedure • Indicator 5 WRES • Indicator 6 WRES • Indicator 4 WDES • Indicator 5 SOWES • Indicator 6 SOWES • Publication of information Staff survey results Q14a & 14c (harassment, bullying & abuse) - Age and Gender • WRES/WDES/SOWES action plans • Equality objectives (include verbal aggression actions) • Disciplinary data • Support offered after Datix • Hate crime campaigns • Staff Support – Speak Up Guardian, ESS, EPS • Training available including in leadership programmes	1	Sarah Dallal

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• The Trust has a EDIHR Team • 4 active staff networks • Freedom to Speak Up Guardian embedded & increase in capacity for Freedom to Speak Up with the FTSU Officer • Employee Support Service, PAM Assist, VIVUP platform, Employee Psychology Service • Actively work with Unions • Equality Impact Assessments completed on all policies/procedures • WRES/WDES/SOWES & Publication of Information data led to actions • Chaplaincy Team • A relaunch of the Speaking Up Ambassadors • QI event has taken place. • Speaking Up policy and includes information on how workers can access support for their wellbeing and Equality Impact Assessments these are also applied to other related policies.	2	Sarah Dallal

	2D: Staff recommend the organisation as a place to work and receive treatment	• Staff Survey Q21c & Q21d – Age, Ethnicity, Gender, LTHC, Sexual Orientation. • Overall recommend as a place to work: 52.7% • Overall happy for friend or relative to be cared for: 53.7% • Reasons for leaving data broken down by demographics • Disciplinary data broken down by demographics • Recruitment data by demographics	1	Sarah Dallal
Domain 2: Workforce health and well-being overall rating			**6**	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	Brents Blogs/Vlogs include EDI BoD & committees – EDI & Health Inequalities discussed (minutes) Board members & senior leaders sponsor & attend staff networks EDI Lunch & Learn sessions sponsorship from BoD and Senior Leaders.	1	Sarah Dexter-Smith
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	EDI & Health inequalities are discussed at BoD (minutes) BAME staff risk assessments were completed during the pandemic EIA's are complete for policies & procedures and projects	2	Sarah Dexter-Smith
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	BoD and committees monitor Gender Pay Gap, WRES (including Model Employer), WDES & SOWES, EDS, leavers information	2	Sarah Dexter-Smith
Domain 3: Inclusive leadership overall rating			**5**	

Third-party involvement in Domain 3 rating and review	
Trade Union Rep(s): JCC approval	**Independent Evaluator(s)/Peer Reviewer(s): Chris Rowlands CNTW**

EDS Organisation Rating (overall rating): 21
Organisation name(s): Tees, Esk and Wear Valleys NHS Foundation Trust
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Sarah Dallal	2023/24
EDS Sponsor	**Authorisation date**
Sarah Dexter-Smith	

Domain	Outcome	Objective	Action	Completion date

Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**D&D AMH Crisis:** Increase clinical capacity of team to maximise availability of staff to improve access **ADHD:** Increase clinical capacity of team to maximise availability of staff to improve access	**D&D AMH Crisis:** Continue and complete improvement work in line with QI action plan **ADHD: I**mplementation of needs based assessment process learning from CAMHS developments Develop and communicate ADHD assessment and diagnosis service specification and remit with referrers and patients Develop proposal with commissioners to increase capacity for both assessment, diagnosis and titration including dedicated pharmacy technician time.	Review April 2023 September 2023 March 2023

	1B: Individual patients (service users) health needs are met	**D&D AMH Crisis:** Increase clinical capacity of team to maximise availability of staff to meet patient need **ADHD:** Increase clinical capacity of team to maximise availability of staff to meet patient need	**D&D AMH Crisis:** Continue and complete improvement work in line with QI action plan Review impact of the winter funded VCSE provided support for home treatment in preparation of developing a longer term solution to develop additional practical and social support **ADHD:** Implementation of Keeping In Touch Model – reduce administration burden on colleagues to increase capacity for assessments Implementation of needs based assessment process learning from CAMHS developments	Review April 2023 September 2023 September 2023
	1C: When patients (service users) use the service, they are free from harm	Maintain current standards as a minimum	All staff following all operational policy and trust policy guidance.	Ongoing
	1D: Patients (service users) report positive experiences of the service	Maintain current standards as a minimum	All staff following all operational policy and trust policy guidance.	Ongoing

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To promote and provide innovative initiatives for work-life balance, healthy lifestyles, encourages and provides opportunity to exercise.	The Health and Wellbeing Team will run specific wellbeing campaigns on specific conditions such as COPD, Asthma and weight management (obesity) in the coming year (2023).	
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Ensure we support and respond to staff who experience verbal aggression and proactively reduce the number of incidents of verbal aggression from service users, carers, and members of the public towards staff	To include this objective as one of the Trust's 2023-2026 Equality Objectives. To develop an action plan to KPI's for this equality objective.	
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Explore protecting time for staff to attend staff networks.	Communications plan to target managers about the importance of staff networks and the Trusts commitment to support staff to attend.	

	2D: Staff recommend the organisation as a place to work and receive treatment	To improve the % of staff reporting that they would recommend the organisation to work or receive treatment.	Link this objective to The Great Place to Work workstream and actions.	

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To implement the Leadership Framework for Health Inequalities Improvements.	BoD to work with Health Inequalities Lead in the Trust to implement the Leadership Framework for Health Inequalities Improvements.	
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To implement the NHS Oversight and Assessment Framework	BoD to implement the framework and use this to develop approaches and build strategies for equality and health inequalities related impacts.	
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	For Board members and senior leaders to monitor key EDI and health inequalities tool.	BoD to implement the NHS Oversight and Assessment Framework. To review that all the following are monitored: WRES (including Model Employer), WDES, NHS Oversight and Assessment Framework, Impact Assessments, Gender Pay Gap reporting, staff risk assessments (for each relevant protected characteristic), SOM, end of employment exit interviews, (EDS	

			subject to approval), Accessible Information Standard, partnership working – Place Based Approaches.	

Domain 1 - detailed ratings & evidence

Stockton CYP

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Stockton CYP getting more help service – The service achieves both the locally contracted access target and the national access rate. the service runs along the I-Thrive model. Patients are referred into SPOC (single point of access) – this is followed by a triage appointment involving family and the young person. In the case of younger children, the work is often with family/parents primarily rather than child. Based on triage findings, the decision as to most appropriate service is taken through twice weekly huddles to agree best route. Complex cases are directed to the getting more help service. All cases are assessed within 4 weeks but those deemed to be urgent will be seen more quickly and may be supported by the CYP specialised crisis team. As the patient moves to recovery the model means that they can step up or down into different parts of the system and the principle of warm transfer is utilised which eliminates	3	Sonia Ayre – Team Manager James Graham – General Manager

		internal referrals meaning that there are no gaps in the pathway for the patient and a trusted assessor model is in place between all parts of the system as appropriate to minimise repeated assessments. Four initial appointments are offered by the getting more help service. This is to allow comprehensive assessment, risk, care planning and agree formulation with family and YP. Most cases are joint worked with other parts of the system (health, education, social care and VCSE partners). Individual needs of child are central to all work. Needs in relation to sign language for deaf patients or parents and interpreters are addressed through contracts with third party interpreting services and it is recognised that this adds complexity to the process and can limit flexibility of the offer.		
	1B: Individual patients (service users) health needs are met	Support to parents is central to the work of the team. Support is focussed on education and practical help. The service is experienced in meeting the needs of people with protected characteristics and for example a significant number of patients with issues relating to sexuality and gender uncertainty are referred and are supported appropriately and sensitively. Under normal circumstances, access to interpreters is not a problem but there have been rare instances where appointments	3	Sonia Ayre – Team Manager James Graham – General Manager

		have had to be rearranged where the interpreter cancels. In some instances, the patient has better language skills than the parent which requires individual consideration to ensure that the whole family can be supported. The holistic needs of the patient and family/carers are considered as part of the routine assessment and formulation process.		
	1C: When patients (service users) use the service, they are free from harm	Comprehensive risk assessment is undertaken and maintained throughout the patient journey. Safeguarding is central to the delivery of the service. All staff are trained appropriately. Joint work with schools, social care and the voluntary sector is routine for the service.	3	Sonia Ayre – Team Manager James Graham – General Manager
	1D: Patients (service users) report positive experiences of the service	Outcome measures CORES, ORES and RCAD are routinely used and shared with the patient and family to monitor and share progress throughout treatment. These are co-produced with the patient and family to inform care planning and treatment through the journey of care. A young person's participation group and a separate parents participation group meet monthly. These inform service developments and give views on delivery. Both are very well attended and have good feedback. Members of both groups are routinely called upon for interviews as well as quality	3	Sonia Ayre – Team Manager James Graham – General Manager

		improvement work and developing services. There is no paid participation lead in Teesside, in some areas, VCSE organisations are commissioned to undertake this role. Friends and Family Tests are offered to all, this is through hang held devices in waiting rooms as well as paper versions sent out. The service actively encourage feedback. This is shared with user participation groups to help consider service improvements. 100% of responses are rated as very good or good. A total of 6 complaints have been received in the last 12 months about the service of which one was partially upheld relating to referral of a child who was too young for assessment. Additionally, there were 6 concerns raised with PALS, all of which are concluded. The operational policy for the service is currently in draft form having been recently reviewed with the help and support of patients and carers		
Domain 1: Commissioned or provided services overall rating			12	

Durham & Darlington AMH Crisis Service

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Durham and Darlington AMH Crisis service The service target is that All referrals are screened within 4 hours, seen within 24 hours and have a formulation in 72 hours. Risk of delay if person requires an interpreter and that language isn't readily available within the required timescale. Commissioned interpreting service from Everyday Language Solutions. In exceptional cases the service has used family members for interpreting, but this presents challenges. Access to the service is 24 hours per day, 7 days per week. Performance data shows that the service have routinely struggled to meet the 4-hour target where capacity of the team was unable to meet demands of the service. This has been the subject of a raft of improvement work both internally and with other stakeholders and we are starting to see improved performance in relation to the access target and feedback from referrers and commissioners. Daily incident	2	Annette Kelly – team manager. Tom Hurst – General Manager

		management calls have been in place to support the service, alongside new team management and ongoing recruitment initiatives.		
	1B: Individual patients (service users) health needs are met	People referred to the service undergo a comprehensive assessment and formulation. The service has a home treatment element which offers intensive support during the period of crisis. Patients wider health needs are also assessed, and the team routinely Use AUDITC for alcohol screening and DUDIT for drug use screening. To identify any needs relating to substance misuse to signpost on to appropriate support. There are 4 peer support workers integrated into teams, commissioned from humankind, a VCSE organisation to offer support with wider social needs.	2	Annette Kelly – team manager. Tom Hurst – General Manager
	1C: When patients (service users) use the service, they are free from harm	Service main aims are people at risk of suicide/self-harm, risk to others and acutely mentally unwell in a crisis situation. Advice given back to referrer in all cases whether the person remains with the service or not. Formulation on individual basis. All people will receive a safety summary and safety plan. A plan is agreed with the patient involving self-help, when to get help, when you are at	3	Annette Kelly – team manager. Tom Hurst – General Manager

		your best, triggers and predisposing factors to crisis, coping mechanisms and individual crisis plan. All plans are individualised and personal to the individual service user. Information is added to the individual patient record on system relating to crisis management. Holistic approaches are undertaken to include factors relating to protected characteristics and access to services where relevant.		
	1D: Patients (service users) report positive experiences of the service	The service has identified 2 BAME leads who have protected time to support the BAME agenda and ensure standards of access are maintained. 4 formal complaints received in the previous 12 months, 2 of which were partially upheld in relation to response of the service. 35 PALS issues raised in the same period, all resolved. Friends and Family test feedback is routinely sought with 80% of responses being good or very good and 8% poor or very poor.	3	Annette Kelly – team manager. Tom Hurst – General Manager
Domain 1: Commissioned or provided services overall rating			10	

ADHD

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	First data gathering - All referrals are screened by access teams in first instance to input protected characteristics. We would make reasonable adjustments following this when meeting with the team when diagnostic assessment carried out.	2	Allison Cook – Service Manager
	1B: Individual patients (service users) health needs are met	We adopt a holistic psychosocial approach for all of our assessments by engaging with the patient and exploring all of their concerns. This can take place over a period of time – adapting to their needs in order to get a full history working around the patient's needs.	2	Allison Cook – Service Manager
	1C: When patients (service users) use the service, they are free from harm	Use of our Datix system harm has been reported. We follow trust protocols in relation to patient safety. We utilise risk management systems to record and monitor identified risks.	3	Allison Cook – Service Manager

		We carry out service improvement initiatives and continuing monitor our performance to ensure we deliver high quality care. We work in partnership with key stakeholders – recent activity with Integrated Care Board to continually review for improvement.		
	1D: Patients (service users) report positive experiences of the service	We continually monitor trust FFT system (Meridian) with quantitative and qualitative feedback and act upon comments / suggestions – and produce actions plans for any areas for improvement. We follow trust complaints / PALS process. FFT response – 85.71% report good or very good. 0% poor or very poor The service has received no complaints during the past 12 months and 3 PALS issues were raised, all resolved	3	Allison Cook – Service Manager
Domain 1: Commissioned or provided services overall rating			10	

Patient Equality Team
NHS England and NHS Improvement
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Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 21

For General Release

Meeting of:	**Board of Directors**
Date:	**23rd February 2023**
Title:	**Equality Objectives 2023 - 2027**
Executive Sponsor(s):	**Sarah Dexter- Smith**
Author(s):	**Sarah Dallal**

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***
5	**Staff Retention**	The Trust has a minimal appetite for risks relating to quality Although the present score is above tolerance, an acceptable level of exposure can be achieved. Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels
4	**Experience**	The Trust has a minimal appetite for risks relating to quality. Although the present score is above tolerance, an acceptable level of exposure can be achieved

Executive Summary:

Purpose:

This paper is presented to the Board to provide assurance that the Trust is meetings its obligations under the Equality Act 2010 to develop and publish Equality Objectives every 4 years.

A more detailed document is attached to this report identifying the objectives and explaining the reasons for selecting them.

Proposal:

The Board is asked to confirm that it has good assurance that the Trust has followed a robust process in developing its equality objectives and is meeting its Equality Act duties regarding the development and publication of equality objectives.

The Board is asked to ratify the equality objectives and agree to their publication on the Trust website as is required.

Overview:	The preparation and publication of one or more equality objectives every four years is one of the specific public sector duties in the Equality Act 2010. The proposal for good assurance is based on the information in the appendix which demonstrates that: • A robust analysis has been carried out on the EDI data the Trust currently has available. • Consultation on the proposed objectives has taken place as suggested by the Equality and Human Rights Commission • The Equality objectives 2023 - 2027 have gone through the appropriate approval routes – PCDC and then to Board of Directors
Prior Consideration and Feedback	The development of the equality objectives 2023 - 2027 has gone through a thorough consultation process with service users and carers, staff, including staff networks, trade unions, JCC, chaplains, care group People and Culture groups. All those involved in the consultations have agreed on the proposed Equality Objectives The paper was considered by the Executive People, Culture and Diversity group on 24th January 2023. The paper was considered by People, Culture and Diversity Committee on 6th February 2023. The Committee recommended that BoD ratify the proposed Equality objectives and agree to their publication on the Trust website
Implications:	Failure to develop Equality Objectives every 4 years in accordance with the requirements of the Equality Act 2010 may have regulatory and statutory consequences.
Recommendations:	The Board is asked to confirm that it has good assurance that a robust process has been undertaken when developing the proposed Equality Objectives and to comment accordingly. The Board is asked to ratify the objectives and agree to their publication on the Trust website.

Equality Objectives 2023 - 2027

1. BACKGROUND INFORMATION AND CONTEXT:

1.1 The Public Sector Equality Duty of the Equality Act 2010 requires public bodies to:

- Have due regard to the need to eliminate discrimination, harassment, and victimisation
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between those who share protected characteristics and those who do not.

1.2 The specific public sector duties in the Equality Act are intended to assist public sector bodies to comply with the general duty. One of these is that public bodies must prepare and publish one or more equality objectives which they think they should achieve to do any of the things listed in the general duties. These must be reviewed and published at least every four years

1.3 The Trust last published equality objectives in January 2020 as part of the Human Rights, Equality and Diversity strategy. The strategy runs until 2023 The objectives were:

- Ensure that where it is agreed, staff that require a reasonable adjustment have these in place.
- To ensure we support and respond to staff who experience verbal aggression and that we take actions that reduce the number of incidents of verbal aggression towards staff.
- To ensure we have a suitably trained and skilled workforce to address the needs of Trans patients and staff
- To increase the recording of disability and sexual orientation on Paris and ESR of patients and staff
- To increase the number of BAME service users who access services within the trust and report a positive experience.

1.4 Very shortly after the publication of the strategy and objectives the pandemic began, and it was not possible to make as much progress with the objectives as had originally been hoped and some of the themes identified in 2020 are still priorities.

2. KEY ISSUES:

2.1 Striking the right balance between addressing patient and workforce equality and diversity issues within the new objectives is important. It is believed that this balance is reflected by the four objectives that are included within this paper.

2.2 As part of the development of these objectives strategy consultations were held with service users, carers, staff including staff networks, Care Group People, Culture and Diversity groups and Trade Unions during 2022. There was an encouraging level of engagement in the consultation exercise. Several very clear themes emerged from this consultation and these themes have helped to shape the objectives

2.3 Metrics for each objective have been developed and are included in Appendix 1. These will be reported on annually to the Equality, Diversity, Inclusion and Human Rights steering group and from there to the People, Culture and Diversity Committee. Updates will also be provided to the Care group People and Culture groups.

2.4 Action plans will be developed for each objective, and these will be reported by exception to the Equality, Diversity, Inclusion and Human Rights steering group and from there to the People, Culture and Diversity Committee,

3. DETAILED RATIONAL FOR OBJECTIVES AND PROPOSED METRICS

Objective 1. Disability - Pilot a central team to ensure that, where agreed, staff who require a reasonable adjustment have these put in place in a timely manner and that there is consistency of approach across the Trust

The work that was done as part of the 2020 equality objectives identified the need for a centralised reasonable adjustment team and funding has been obtained to pilot this for a year. The 2021 staff survey identified hat 31.8% of those who completed the staff survey identified that they had a long-term health condition and of those 28% advised that the Trust had not made the adjustments that they need at work to carry out their role.
Consultation has overwhelmingly supported this objective.

Proposed Metrics

- An improvement in the average time taken to implement IT equipment adjustments for staff who require a workplace adjustment.
- Implementation of a central recording system to monitor the number and timeliness of adjustments implemented, their associated costs and money reclaimed from Access to Work grants
- The percentage of staff stating that their employer has made adequate adjustment(s) to enable them to carry out their work

Objective 2. Trans and non-binary - To monitor the experiences of staff and service users who identify as Trans or non – binary and to identify actions to improve their experiences

The LGBTQ+ training that has been carried out over the last 2 years has been very well received. There have been an increasing number of queries from clinicians about all aspects of caring for service users who identify as Trans or non- binary. There have also been several PALs issues and complaints around gender identity. The Trust's Rainbow network have highlighted the need to understand the experiences of Trans and non- binary staff and service users by adding these as fields in the demographic options in the surveys sent out to service users and to

staff. Actions for improvement will be identified from the analysis of feedback. This was supported in the consultation

Proposed Metrics

These will be developed following analysis of the feedback from the staff and service user surveys.

Objective 3. Verbal aggression - Ensure we support and respond to staff who experience verbal aggression and proactively reduce the number of incidents of verbal aggression from service users, carers, and members of the public towards staff

Training on the Trust's verbal aggression procedure is now regularly available and the responses from the staff survey show some reduction in the number of staff reporting harassment, bullying or abuse from service users, their relatives, or members of the public. However more work is needed on this. The figures from the 2021 staff survey show the following differences in relation to the level of harassment, bullying or abuse from service users, their relatives, or members of the public towards staff from protected groups compared to their colleagues: White 24% BAME 32%; disabled 28% non- disabled 23%; Gay man or gay woman 33%, Bisexual 33%, Heterosexual 24%.

There was strong agreement that this work needed to be prioritised which was also confirmed during the EDS 2022 consultation

Proposed Metrics

- A reduction in the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months as reported in the NHS national staff survey.
- A reduction in the percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months as reported in the NHS national staff survey.
- A reduction in the percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months as reported in the NHS national staff survey.
- A reduction in the percentage of LGB staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months as reported in the NHS national staff survey.

Objective 4. Working in partnership with other stakeholders to explore how to improve access to mental health, learning disability and Autism services for the Gypsy, Roma, Traveller community

The Equality and Human Rights commission stated that the Gypsy, Roma Traveller community are one of the most discriminated against groups in the UK. It is very likely that the Gypsy, Roma, Traveller community is the largest ethnic minority group across the whole Trust.

We know that travellers are 6 times more likely to die from suicide than non-Travellers and that this likelihood increases to 7 times when focused on Traveller men. 11% of Traveller deaths are from suicide.

According to research the health of the Gypsy Roma and Traveller community is significantly worse than the rest of the population and is made worse by their

living conditions, accommodation insecurity and discrimination they experience. A recent analysis of Trust data showed those identifying as Gypsy, Roma or Traveller had long lengths of stay in hospital, the highest level of disengagement of any ethnic group and significant deterioration in relation to HONOS scores. This suggests that the current methods of engagement and treatment with this community are not appropriate

This is supported by the experience of Durham County Council who have found that the Gypsy, Roma, Traveller community are less likely to engage in traditional services but will engage with local, bespoke services.

This work would need to be done in partnership with the Trust's consultant in public health and other organisations in particular public health and the local authority engagement function and good practice and learning shared across the Trust.

This will also support the Trust when the Patient and carers race equalities framework (PRCEF) is implemented:

The PCREF is expected to consist of three core components:

- It will set out national expectations on all mental health trusts in fulfilling their statutory duties under core pieces of legislation, such as the Health and Social Care Act, and the Equalities Act.
- It will include a competency framework, in line with the original vision, to support trusts to improve patient and carer experience for ethnic minorities. It is expected these competencies will be similar to those referenced in the independent review (for example, staff capability, data and monitoring). The framework will aim to capture what good looks like, and how to achieve improvements over time.
- A patient and carers feedback mechanism, to embed patient and carer voice at the heart of the planning, implementation and learning cycle.

Each mental health trust will in time have its own PCREF. This will provide an opportunity for patients, carers, communities and NHS staff to voice their experiences and ideas on how to reduce inequalities for ethnic minority communities

Again, there has been support for this work during the consultation process

Proposed Metrics

- Reduction in disengagement scores for those identifying as Gypsy, Roma or Traveler
- Improvement in HONOS scores for those identifying as Gypsy, Roma or Traveler
- Reduction in length of stay in hospital for those identifying as Gypsy, Roma or Traveler.