Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

27 April 2023

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

AGENDA

Standard Items (1.00 pm – 1.15 pm)

1	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 30 March 2023	-	Draft Minutes
5	To receive the Board Action Log	-	Report
6	To receive the Chair's report	Chair	Report
7	To consider any questions raised by Governors in relation to matters included on the agenda *Questions to be received by 1pm on 25 April 2023*	Board	Verbal

Strategic Items (1:15 pm – 2.05 pm)

8	To consider the Board Assurance Framework Summary Report	Co Sec	Report *to follow*
9	To receive the Chief Executive's report	CEO	Report
10	To consider the Integrated Performance Report	Asst CEO	Report
11	To consider Our Journey to Change Delivery Plan	CEO	Report

Goal 1: To co-create a great experience for our patients, carers and families (2.05 pm – 2.35 pm)

12	To consider the Leadership Walkabouts Report	DoCA&I	Report
13	To consider a report from the Chair of Quality Assurance Committee	Committee Chair (BR)	Report *to follow*

14	To consider the Hard Truths Nurse Staffing Report	DoN&G	Report *to follow*
15	To consider the Learning from Deaths Report	DoN&G	Report

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

16	To consider a report from the Guardian of Safe Working	GOSW (Dr J Boylam)	Report
17	To consider a report on the outcome of the establishment reviews.	DoN&G	Report

Exclusion of the Public:

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

David Jennings
Chair
21 April 2023

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 30 MARCH 2023 AT WEST PARK HOSPITAL, EDWARD PEASE WAY, DARLINGTON AND VIA MS TEAMS, COMMENCING AT 1.00 PM

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
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
L Romaniak, Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley and 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
A Lowery, Director of Quality Governance (attending for E Moody)

Observers/members of the public:
B Murphy, Chief Nurse designate
P Slinger, Intensive Support Team
H Griffiths, Governor
R Swiers, Governor
J Wardle, Governor
D King, member of staff
S Double, public

23/255 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and, in the context of publication of the Niche Governance Report, he reiterated his unequivocal apology to patients and families, for the events at West Lane Hospital and he thanked staff for their continued commitment to the trust, its services and patients.

The Chair went on to highlight two patient stories, the first from a patient in relation to the support and care they had received to overcome their fear of giving blood, where they had welcomed the time and space they had been afforded and had noted that support had been provided at their pace, which had led to a successful outcome. The Chair proposed that the story highlighted the trust values of respect, compassion and responsibility

The Chair summarised a second patient story, where the trust's engagement with a patient had resulted in emotional hurt. The patient indicated that they not felt respected as a person and there

had not been a person focus to their care and they and their family and carers had not been listened to.

The Chair suggested the differing stories highlighted the trust's journey to change to ensure its values were consistently applied across the organisation.

23/256 APOLOGIES FOR ABSENCE

Apologies for absence were received from E Moody, Director of Nursing and Governance, and it was noted that A Lowery, Director of Quality Governance, was in attendance.

23/257 DECLARATIONS OF INTEREST

None.

[S Dexter-Smith later declared a potential conflict of interest and left the meeting during consideration of confidential agenda item 23/C/236]

23/258 MINUTES OF THE MEETING HELD ON 23 FEBRUARY 2023

Agreed: *the minutes were an accurate record of the meeting, for signature by the Chair.*

23/259 MINUTES OF THE MEETING HELD ON 14 MARCH 2023

Agreed: *the minutes were an accurate record of the meeting, for signature by the Chair, subject to correction of para 23/253 to show '… two thirds of eligible junior doctors had chosen to take part in strike action…'*

23/260 BOARD ACTION LOG

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

(1) The Chair requested that narrative on work in progress be provided against the recorded actions.

Action: Executive Directors

(2) [22/139 – staff survey] S Dexter-Smith noted that data related to the percentage of staff who would recommend the trust as a place to work, had been provided to each Executive Director to review and a further update would be provided to the board in May 2023.

(3) [23/232- Duty Nurse Coordinator] Z Campbell advised that the formal response had indicated that the Duty Nurse Coordinator would not leave a ward without a registered nurse and noted that she would be responsible for the action recorded at the last board meeting.

The Chair indicated that further concerns had been raised following the previous discussion and suggested there needed to be clear and consistent communications to staff on the position.

In response, P Scott acknowledged that the role was not able to be filled consistently and the care group had commissioned a piece of work to explore options. In the interim, a contact point for each site had been provided.

J Haley noted that concerns had initially been raised through the People, Culture and Diversity Committee and queried the position in respect of remuneration. In response, P Scott advised that this had been included within the scope of the commissioned work and he noted the involvement of the staff side.

(4) [23/231- Crisis Line] Z Campbell advised that an improved position had been noted in North Yorkshire and York with approximately 57% of calls to the crisis line and over 90% of overall calls answered. There remained capacity challenges and this would be considered in light of the recent national announcement that mental health calls received by the 111 service, would in future be directed to mental health trusts.

In respect of Durham and Tees Valley, P Scott advised that a six month quality improvement programme had started, and steps had been taken in February to increase team capacity which had led to an improved position.

B Reilly noted the continued concerns of governors, despite action that had been taken and suggested the position was unacceptable and would continue to be reviewed by Quality Assurance Committee.

In respect of the proposed change to 111 calls, Z Campbell advised that there was no clarity on the number of calls the trust would expect to receive and there had been no indication of additional resources. Discussions were underway with the ICS to understand what impact the change would have on the next stage of the improvement plan.

Responding to a query, B Kilmurray confirmed that the position had been reflected on care group risk registers and had been reviewed by the Executive Directors Group. He went on to note proposals to place mental health practitioners in ambulance service control rooms and a range of other related options that would result in an improved clinical decision making.

(5) [23/234 – Council of Governors' task and finish group] The Chair noted that the terms of reference had been drafted following discussion with governors.

(6) B Reilly expressed caution that the log contained a number of operational actions and the Chair proposed that once progress had been noted they could be removed.

23/261 CHAIR'S REPORT

The report was noted.

23/262 QUESTIONS RAISED BY GOVERNORS

None received.

23/263 BOARD ASSURANCE FRAMEWORK

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

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

(1) In response to a query, L Romaniak advised that there were no new risks, but the reported position of CITO reflected that work was at a critical phase and there were actions in April that were fundamental to delivery.

(2) In response to a query, P Bellas confirmed that the report outlined the current and target risk score and the date by which the target risk score was expected to be achieved. A quarterly update from executive directors would be reported to board committees prior to the board. This provided the opportunity for challenge and to seek assurance, including where a target date had not been achieved.

The Chair noted that the BAF provided a means by which the board would view the performance of the organisation, and the inclusion of realistic and achievable targets at the outset would support that understanding.

B Kilmurray advised that target dates would be actively reviewed and proposals to change a target would be subject to an approval process.

(3) B Reilly expressed concern about BAF risks reported to the Quality Assurance Committee, where little improvement had been noted and advised that committee would review the position at the next quarter update.

(4) B Kilmurray noted that the BAF included significant strategic risks that would impact on delivery of the trust's strategy and that despite action and mitigation some were ongoing issues that would not easily be resolved.

(5) L Romaniak advised that Audit and Risk Committee had considered BAF risks that continued to remain at the reported level and the role of the committees in undertaking a deep dive into areas of concern, to understand how risks were managed.

(6) J Maddison noted that similar controls also applied to the corporate risk register, where committees would be expected to ratify changes and identify issues for discussion by executive directors.

23/264 CHIEF EXECUTIVE'S REPORT

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

B Kilmurray reiterated the apology of the Chair in respect of historical events at West Lane Hospital and he advised that Niche was expected to revisit the trust from November 2023 to review progress against recommendations. He then went on to draw the board's attention to:

(1) The proposed BMA strike action during the week of 11 April 2023. In response, a control room and related processes would be established to plan for and respond to any operational and clinical challenges.
(2) The current CQC visit to review acute and PICU services, which included a review of services at Lanchester Road, Roseberry Park and West Park.

The Chair thanked Z Campbell and her colleagues for the work that had been completed in advance of and throughout the previous BMA strike action.

23/265 INTEGRATED PERFORMANCE REPORT

The board received the Integrated Performance Report (IPR) which provided oversight of the quality of services delivered for the period ending 31 January 2023 and assurance on action taken to improve performance in the required areas.

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

(1) The reported deterioration in bed occupancy. In response, care groups had maintained daily oversight and performance was monitored against key metrics and agreed improvement measures. Alongside this a review of the whole pathway would be completed to understand the key drivers behind the position.
(2) The deterioration in sickness absence, which would be discussed during the confidential session.
(3) Limited performance assurance and negative controls assurance in respect of the percentage of staff who would recommend the trust as a place to work. Executive directors had been invited the review their respective data and an update would be provided to the board in May.
(4) Agreement by Executive Directors Group that any area of underperformance across a three month period would require a performance improvement plan that detailed SMART actions and expected impact. Also, that care group performance improvement plans would be prepared where agreed trajectories in the Long Term Plan had not been achieved.
(5) Development of an improvement plan in respect of the reduction in the number of people who had accessed the IAPT service.
(6) The ongoing investigation into renewals under the mental health act.

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

(1) The Chair reiterated the process by which the IPR would be reviewed by Care Group Boards, Executive Directors Group and committees, prior to the board.

(2) J Maddison welcomed further development of the report and queried if there had been a correlation between sickness absence and flu and covid vaccinations and how take up of vaccinations would be encouraged.

In response, S Dexter-Smith advised there was no data to confirm a correlation and she noted that where people partners had worked alongside services there had been a rapid improvement in absence rates. A lesson learnt exercise would be held in respect of vaccination take-up.

(3) P Hungin queried the position in relation to out of area placements and in response K Kale noted that use of independent sector beds had increased to 28 from 2 in December 2022, though these were not necessarily outside of the trust's overall area. A weekly bed pressures meeting was held to consider the position of each patient and there had been peer challenge in respect of patients over 60 days, in the North Yorkshire and York care group area. There were several reasons long stays, including the ability to source appropriate community placements and further discussion would be held with the ICBs.

M Brierley noted that the trust target for use of independent sector beds was zero by March 2024 and the Chair suggested this would be a challenging target to achieve.

Commenting further, P Scott advised that the position was of concern at a care group level, and he noted several contributory factors including social care housing provision, ALD inpatient services flow and emerging issues in relation to the clinical model. A number of actions had been agreed to ensure that support packages for those with ALD and Autism were appropriate and the opportunity to use existing connections within the wider system to review patient flow, would be considered.

(4) B Kilmurray noted that the trust would be part of the national NHS improvement programme on inpatient care, a key benefit of which would be the opportunity for collaboration with trusts in the same position.

(5) B Reilly expressed concern that the report presented a deteriorating trajectory in relation to safe staffing and bed occupancy levels. She queried the need for performance plans and smart objectives in addition to risk management through the Board Assurance Framework and the Corporate Risk Register.

M Brierley noted the changeable nature of the reported metrics and the lag in reporting to the board. He advised that the introduction of performance plans would draw key information together for monitoring and assurance purposes and noted that the outcome of the recent governance review provided capacity to support this work.

(6) L Romaniak noted the challenges in respect of out of area placements and safe staffing levels and how that had contributed to increased financial pressures. In the context of an increased system focus on financial sustainability, she suggested that the trust would need to use its collective capacity to engage with partners on the impact of system level issues.

(7) J Haley welcomed the introduction of the improvement plans and queried the increase in use of the mental health act. In response, K Kale suggested there appeared to be no obvious reason for the increase.

Commenting further, P Hungin noted that Mental Health Legislation Committee had queried the collation of data and an update would be provided to the board following the next committee meeting.

Drawing the discussion to a close, the Chair noted the board did not wish to engage in operational level detail but welcomed the opportunity to discuss key challenges and to seek assurance on what action would be taken to support achievement of proposed trajectories.

23/266 STRATEGY JOURNEY DOCUMENTS

The board received the report, which sought approval to the strategic journey documents that had been produced to guide the development and delivery of Our Journey to Change (OJTC).

In presentation, M Brierley advised that:

(1) Initiatives included within the journeys would be incorporated into specific programmes and delivery against delivery plan milestones would be reported to the board each quarter.
(2) All journey documents had been approved by the relevant committee, with the exception of co-creation, which as a cross cutting journey, had been considered by Executive Directors Group.
(3) There would be a clear link between the strategy journeys and the delivery plan.

Commenting further, B Kilmurray welcomed the opportunity to take a different approach that embraced cocreation and noted that feedback received had suggested the proposed journeys resonated well. A review of the approach would be completed.

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

(1) In respect of the clinical journey, P Hungin suggested that there was potential to strengthen the drug and alcohol section, including clarification on the deliverer of services and their relationship with the trust.

K Kale advised that services would be provided through external partners with whom the trust would seek to collaborate to support patients to achieve their recovery.

L Romaniak highlighted that many drug and alcohol services had been decommissioned by local authorities but had since received significant funding. Commenting further, B Kilmurray noted that each police area now had an agreed drug and alcohol strategy.

(2) J Preston suggested that the clinical journey provide clarification that the trust was not directly commissioned to deliver autism treatment and the difference in ICB commissioning arrangements.

K Kale noted that the trust was required to make reasonable adjustments for those with autism and aimed to be an autism aware and autism informed trust.

The Chair brought the discussion to a close and welcomed the work that had taken place and the ambition to do so in a cocreation way. As this was the end of the process, he suggested that the board did not require the journeys to be rewritten but he invited lead executive directors to consider if the points raised had been adequately reflected in the journey to change documents.

Agreed: *that the five journey to change documents be approved.*

23/267 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

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

In presentation, B Reilly, Chair of the committee, highlighted:

(1) That committee had a significant agenda and members of the intensive support team had attended the last meeting to provide feedback.
(2) Concerns were noted about the length of the EQAIG agenda and the reoccurring themes of patients feeling safe, high bed occupancy rates and the increase in falls.
(3) Committee had received an update on the Crisis Line and considered that the position remained unacceptable and would continue to monitor progress.
(4) Additional assurance had been sought on ligature and environmental risks and it was noted that the board would receive a report on the confidential agenda.
(5) Discussion by the committee on safe staffing and if staff felt professionally compromised and were able to speak up, where there was high bed occupancy levels and patient acuity.
(6) Committee discussion on risk tolerance where it was noted that targets would not be achieved on issues related to safety, despite controls in place.
(7) Concern in respect of risks that had missed their review date, where committee had been clear that it expected a compliant position.

(8) Assurance that could be provided to the board on: progress made in relation to the backlog of serious incidents and the capacity of the Patient Safety Team; sexual safety; and delivery on the CQC action plan, where there remained a focus on ensuring changes were embedded.
(9) Committee would hold an informal meeting in May, to review its position and areas of focus, in the context of recent changes and the outcome of the governance review.

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

(1) In respect of safe staffing, B Kilmurray confirmed that the trust would seek to ensure that appropriate cover was provided across all services and shifts and suggested that current challenges would be addressed through the workforce strategy.

Commenting further, S Dexter-Smith advised that there had been a reduction in use of temporary staffing and use of off framework staffing was not expected to continue from April 2023.

(2) K Kale, chair of the last EQAIG meeting, acknowledged the concerns expressed about the length of the group's agenda and advised that alternative options had been considered, for example the addition of shorter focused weekly meetings.

(3) P Scott noted a quality improvement event held by Durham, Tees Valley and Forensics Care Group to consider governance arrangements and the development of a structure that would provide a greater level of confidence in oversight and management of quality and safety performance.

23/268 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 5.00 pm.

Chair
27 April 2023

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

Updates since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
31/03/2022	22/03/14/226	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	Apr-23		**See board agenda item 17**
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	May-23		Mar-23: Data provided to each Exec Director to review and a board update would be provided in May 2023. **Apr-23: in hand with directors' local actions. We now have the regional data so are able to do a broader comparison of redsults of a trustwide deep dive.**
29/09/2022	22/144	Mental Health Legislation	Training to be provided to the board on the Mental Capacity Act	MD	Apr-23		Briefing circulated to the board on 8-Nov and 15-Dec. To be scheduled as part of the BoD briefing sessions during 2023 - the programme will be circulated April-23 **Apr-23: proposed board & committee dates to be circulated w/c 24 April for consultation**
22/10/2022	22/172	Board meetings	Dates be circulated for board meetings, seminars and lunch and learn events for 2023/24	Deputy Co-Sec	Apr-23		Dates for May23-Apr24 are subject to discussion by the Board mar-23 (governance review) and will be circultated April-23 **Apr-23: proposed board & committee dates to be circulated w/c 24 April for consultation**
22/10/2022	22/174	Integrated Performance Dashboard	Discussion to be held at future board development session on the level of reported outcomes following treatment	MD	Apr-23		To be scheduled as part of the BoD briefing sessions during 2023 - the programme will be circulated April-23 **Apr-23: proposed board & committee dates to be circulated w/c 24 April for consultation**
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	Jun-23		Work to take place on the format to ensure it meets the needs of the BoD and is a positive experience for those involved. Feb23: In the interim the chair to provide a citation
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	May-23		Next quarterly report due May-23

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
24/11/2022 26/02/2023 23/02/2023	22/199 23/213 23/232	Duty Nurse Coordinator - staff capacity	Nov-22: Assurance to be provided at Jan-23 board meeting on staff capacity to undertake the Duty Nurse Coordinator Role and impact on safe staffing.	NYY&S MD	May-23		Jan-23: Assurance provided. Feb-23: Written confirmation provided to PCDC Chair. Feb-23: Review of the role and impact on services to be considered as part of the on call review to be completed April-23 **Apr-23: Two separate, but connected, reviews have started. One into the on-call process and one into the DNC role. There was a delay in starting both due to the latest industrial action. Updates will be provided to EDG on 10 May and then the board.**
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	Aug-23		**Apr-23: timescale changed to August 2023 to align with the outcome of the full review of the BAF due commence in May-23**
26/01/2023	23/215	BAF - lobbying	Stakeholder mapping being completed to inform conversations held by the board.	DoCA&I	Jun-23		**Apr-23: board report will be available in June**
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		Mar-23: Discussed by QuAC in March-23 Next cycle of committee meetings will be May 2023
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		**See agenda item 15**
26/01/2023	23/221	Learning from Deaths	Future reports to be considered by QuAC for assurance to be provided to the board. Reports to include a focus on the number of times themes occurred as a measure of improvement.	DoN&G	Apr-23		**See agenda item 15**
23/02/2023	23/237	IPR - staff appraisals	An improvement plan in respect of staff appraisals to be developed.	ACEO	Mar-23		Next quarterly report due May-23
23/02/2023	23/237	IPR - serious incidents	Updated information on the position in respect of serious incidents to be captured by the IPR.	DoN&G	May-23		Next quarterly report due May-23
23/03/2023	23/237	IPR - 'actual impact'	Information on 'actual impact' to be included within the report.	ACEO	May-23		Next quarterly report due May-23
23/02/2023	23/239	Corporate Risk Register - reporting	J Haley, K Marley and A Lowery to meet to explore the opportunity to for improvements in relation to consistency and report content.	A Lowery	Apr-23		**Apr-23: Meeting held**
23/02/2023	23/239	Corporate Risk Register - narrative	Additional narrative and timescales to be included within the CRR: i) The rationale where Executive Directors Group had agreed to change a risk score ii) Where a risk had been assigned to a care group iii) to clarify risks within the gift of the trust to respond to, including with partners.	DoN&G	May-23		Next quarterly report due May-23
23/02/2023	23/239	Corporate Risk Register	Action to be taken in respect of actions that had passed their review date.	DoN&G	May-23		Next quarterly report due May-23
23/02/2023	23/242	CEO report - Kirkup Report	Board to receive a further report in three months time, via QuAC on how the work had been adapted and taken forward to support OJTC. The video of the ICB meeting to be shared and B Kirkup to be invited to attend a learning webinar.	DoN&G	May-23		

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
23/02/2023	23/244	Freedom to Speak up	Board to receive a report on the proposal, linked to culture assessment work and which would respond to concerns raised that some of those who had spoken up had suffered detriment.	DfP&C	May-23		**April-23: the DoP&C to discuss with Chair/CEO the potential to combine this into a broader paper in June.**
30/03/2023	23/260	Action Log	Narrative on work in progress to be provided	Executive Directors	Apr-23		Completed

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ITEM NO. 6

Chair's Report: 3rd April – 30th April.

Headlines:

External:

- Weekly MH Chairs' Network
- Meeting NHS FT Chair North & South Tees NHSFT
- Meeting NHS NED
- Mentor meeting for DJ
- York Community Mental Health Hub Visit
- Yorkshire & Humberside Chairs Get Radical event

Governors

- Discussion with GGI after recent CoG Development Event
- Drafting & sharing Terms of Reference for CoG Task & Finish Group
- Various issues from Governors

Internal

- Various Living The Values Awards (Easington CAMHS, Lark Ward, Malton Community Team
- Board of Directors March 2023
- Leadership Walkabouts LD Respite Service Bankfields Court
- Visit Scarborough Cross Lane Hospital, Ellis Centre, and Eastfields Clinic
- Various meetings & discussions with executive officers
- CQC Preparation

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 9

For General Release

Meeting of:	**Board of Directors**
Date:	**27 April 2023**
Title:	**Chief Executive's Public 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*
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). The well led and associated core services inspections are underway. The CQC will review the ratings for each service inspected and consider compliance with fundamental standards.
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. Participation the national improvement programme for inpatients will support us with standard setting and support us with making key improvements to quality, safety and effectiveness of our services and improve the experience of our patients and carers. Similarly, learning more about NHS Impact will allow us to consider positive implications in terms of our own Quality Improvement System.

Executive Summary:

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

Proposal:	To receive and note the contents of this report.
Overview:	Updates on the CQC, the National inpatient programme, the launch of NHS Impact, Chief Nurse starting date.
Prior Consideration and Feedback	n/a
Implications:	No additional implications.
Recommendations:	The Board is invited to receive and note the contents of this report.

Care Quality Commission

The CQC has announced that it will undertake the well led inspection between the 24th and 26th May. In advance of this the CQC has started core services inspections across the Trust. At the point of writing, they have visited adult mental health inpatients and psychiatric intensive care units, wards for older adults and our adult learning disability inpatient wards. The Trust has also received a volume of data requests. We can expect that they will visit at least one set of community services. Core service inspections are unannounced, with community teams receiving 24 hours advanced notice.

The last time the Trust was inspected as part of the well led domain was in the summer of 2021. The report was published in December 2021. The overall rating at that point was Requires Improvement. There has been a good deal of change since that point, with service lines such as secure inpatients and CAMHS have been revisited since then and shown improvements.

We would expect to be able to demonstrate some key improvements since 2021, linked to Our Journey to Change, our structure and governance. We also look forward to describing to inspectors the work we have been doing on safety and quality improvement.

National Inpatient Improvement Programme

NHS England has announced that it will be delivering a national improvement programme focussed on inpatients services in mental health and learning disabilities services. I have previously briefed the Board on this, however, have had some further discussions on the content and next steps.

It has been confirmed that the programme will go live later this year. The programme will make available expertise in suicide reduction, trauma and autism informed care. There will also be elements that are focussed on making wards more therapeutic – building on developing the therapeutic relationship, relational security and culture change. As part of this there will be development sessions available for the Board of Directors, through to ward managers and Responsible Clinicians.

It has been confirmed that TEWV will be involved at the beginning of the programme. Liz Durrant, the NHSE Director leading this work will join us for a safety summit event in the summer where we will launch this.

NHS Impact

NHS England has completed a review of approaches to continuous improvement. At a meeting in London on 19th April, Amanda Prichard, CEO of NHSE launched NHS Impact. This is an approach to bringing together all of the improvement capabilities of NHSE including the Intensive Support Team, Getting it Right First Time. It will set out a skills set and tool kit, an approach to leadership and engagement that will underpin their delivery across the new operating model. This will mean that there will be a good deal of interaction on this with us through our systems working. We have a long-standing commitment to our Quality Improvement System. Based on lean methodology and historically through a long-term relationship with the Virginia Mason Medical Center in Seattle, we are current reinvigorating the approach, revisiting and updating our training and seeking to ensure it is properly established as our methodology.

Chief Nurse

Further to my previous report on the appointment of Beverley Murphy to the role of Chief Nurse, I wanted to put on record my thanks to Elizabeth Moody, who stands down from the Board on 30th April. Beverley takes up her role from 1st May.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 10

For General Release

Meeting of:	**Board of Directors**
Date:	**27th April 2023**
Title:	**Board Integrated Performance Report as at 28th February 2023**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Sarah Theobald, Associate Director of Performance**

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. 2. 3. 4. 5. 6. 9. 11. 15.	Recruitment & Retention Demand Involvement and Engagement Experience Staff Retention Safety Regulatory Action Governance & Assurance Financial Sustainability	The Integrated Performance Report is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks.

Executive Summary:

Purpose:

The Board Integrated Performance Report aims to provide oversight of the quality of services being delivered and to provide assurance to the Board of Directors on the actions being taken to improve performance in the required areas. Appendix A is the full Executive Summary and Appendix B the Integrated Performance Report.

Proposal:

It is proposed that the Board of Directors receive this report with **reasonable** assurance regarding the oversight of the quality of services being delivered. Whilst there are a small number of areas with **limited** assurance, Performance Improvement Plans are being developed for each of the issues that are impacting on performance.

Overview:

The overall **reasonable** level of assurance has been determined by management based on the Performance & Controls Assurance Framework for the Board Integrated Performance Dashboard (IPD) and progress against the Long-Term Plan Ambitions.

The **key changes** in the IPD this month are:

- ✓ The number of Incidents of moderate harm and near misses- *improvement in performance and increased assurance*
- ✓ Percentage of staff recommending the Trust as a place to work – *improvement in performance and increased assurance*
- ✓ Staff Leaver Rate – *improvement in performance*
- ✓ Percentage Sickness Absence Rate – *improvement in performance*
- × Percentage of CYP showing measurable improvement following treatment -

clinician reported – *deterioration in performance*

× The number of unexpected Inpatient unnatural deaths reported on STEIS – *deterioration in performance and reduced assurance*

The **areas of concern** within the IPD where we have limited performance assurance and negative controls assurance are:

- Unique Caseload
- Financial plan: Agency Expenditure
- Financial plan: Agency price cap compliance
- Use of Resources Rating – overall score
- CRES Performance Recurrent

All of the above measures were identified as having limited performance assurance and negative controls assurance in the very first assessment which was undertaken and included in the report as at 30th September 2022. As reported to Board in March, Performance Improvement Plans are being developed for each of the following issues that are impacting on performance:

- Agency Expenditure – to be facilitated by the Agency Reduction Group
- Safe Staffing – to be facilitated by the Safe Staffing Group
- Bed Pressures including OAPs – to be facilitated by the Bed Oversight Group
- Caseload – to be facilitated by the two operational Care Groups

The draft Performance Improvement Plans will be considered by Executive Directors Group on the 26th April 2023 and then included in the Board IPR in May 2023.

In addition to the above areas of concern, we have also reviewed each of the 4 unexpected inpatient unnatural deaths reported on STEIS in February 2023 to identify any immediate learning. Several improvement actions have been taken forward and assurances regarding these actions will be reported to the Quality Assurance Committee.

There are several areas where we will **not achieve the agreed trajectories** in the Long-Term Plan. As reported to Board in March, Performance Improvement Plans are being developed by each Care Group for consideration by Executive Directors Group on the 26th April 2023.

Broader key issues/work in relation to Quality, Inpatient Pressures, People & Culture and Finance this month are:

- Our Quality Journey, Serious Incident Backlog Recovery, Procurement of new Risk Management System and Safe Staffing
- Bed Occupancy
- Improvement work in relation to reporting, analysis and assurance around our Workforce issues
- Agenda for Change and other pay awards

The Care Board Summaries are included in the Executive Summary and include their areas of concern, positive assurances and other key information, issues and risks they wish to highlight or escalate.

Overall, there is good assurance on the quality of data supporting the information provided in the Board Integrated Performance Dashboard.

Prior Consideration and Feedback

The monthly Integrated Performance Report is discussed by Executive Directors Group and by the Care Group Boards (the latter at Care Group level)

Implications:

There are no identified implications in relation to receipt of this report to the Board of Directors.

Recommendations:

The Board of Directors is invited to confirm the level of assurance identified; 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.

EXECUTIVE SUMMARY

1 Purpose:

1.1 The purpose of this report is to provide oversight of the quality of services being delivered for the period ending **28th February 2023** 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 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 <u>IPD Key Changes</u>

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

Improvements

- **The number of Incidents of moderate harm and near misses (measure 11)** now has positive controls assurance (previously neutral) and is assessed as having good performance assurance (previously reasonable)
- **Percentage of staff recommending the Trust as a place to work (measure 16)** now has neutral controls assurance (previously negative) and is assessed as having reasonable performance assurance (previously limited)
- **Staff Leaver Rate (measure 18)** now has neutral controls assurance (previously negative)
- **Percentage Sickness Absence Rate (measure 19)** now has neutral controls assurance (previously negative)

Deterioration

- **Percentage of CYP showing measurable improvement following treatment -**

clinician reported (measure 6) now has negative controls assurance (previously neutral)

- **The number of unexpected Inpatient unnatural deaths reported on STEIS (measure 14)** now has negative controls assurance (previously neutral) and is assessed as having reasonable performance assurance (previously good)

3.1.2 IPD Areas of Concern

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

- **Unique Caseload (measure 23)** We continue to have special cause concern at Trust level and in both Care Groups. Analysis was shared with the Strategy & Resources Committee in February 2023 showing that a small number of services accounted for 84% of the aggregate Trust caseload increase, reflecting a gap between commissioned and actual workload. These will require a strategic approach to enable our services to respond to the increasing demand and pressures being experienced nationally in mental health services

  Local intelligence is currently being gathered for the remaining teams, which will be used to inform an operational approach to mitigate the impact of workload issues, e.g. staff vacancies and sickness. Both Care Groups have now been asked to develop a Performance Improvement Plan (see end of this section) which identifies the key issues and improvement actions that will be undertaken. There is currently limited assurance pending completion of this work and the identification of related improvement actions.

- **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). Agency Reduction and Safe Staffing sub groups of the Executive People and Culture Group have been established to deliver optimal e-rostering and target agency reductions. 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. International Recruitment impacts will not be seen until well into 2023/24.

- **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.

- **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), albeit that the variance to plan / deficit is reducing towards forecast (on plan).

- **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.

Performance Improvement Plans (PIPs)) are being developed for each of the following issues that are impacting on performance that support improvement and increased assurance:

- **Agency Expenditure** – to be facilitated by the Agency Reduction Group
- **Safe Staffing** – to be facilitated by the Safe Staffing Group
- **Bed Pressures including OAPs** – to be facilitated by the Bed Oversight Group
- **Caseload** – to be facilitated by the two operational Care Groups

These Performance Improvement Plans will be considered by Executive Directors Group on the 26th April 2023 and then included in the Board IPR in May 2023.

In addition to the above areas of concern, we have also reviewed each of the 4 **unexpected inpatient unnatural deaths (measure 14)** reported on STEIS in February 2023 to identify any immediate learning. A number of improvement actions have been taken forward and assurances regarding these actions will be reported to the Quality Assurance Committee.

3.1.3 IPR Other points to note

Integrated Performance Dashboard
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 update:

- **Financial plan (measure 24)** The Trust is not in line with its year-to-date financial plan; with a year-to-date deficit of £3.5m (£3.9m worse than plan) however this includes £2.6m unfunded pay award pressures (with £2.8m mitigating non-recurrent funding due to be received in March). Mitigating financial recovery actions, confirmed contract changes and national year-end guidance have materially improved forecasts to the extent that the Trust projects achievement of 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 recurrent 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 £2.6m year to date pressure (included in the Month 10 position, or £3.0m full year, assumed fully funded and adjusted for in-year National Insurance contribution reduction).

Due to escalating financial pressures and risks to delivery of the planned surplus, the Board has considered papers in private session since November alongside internal control total delivery and the most probable case forecasts.

Via improving financial performance, pursuit/completion of recovery actions, confirmed contract and education funding and confirmed national year-end guidance relating to the discount rate for provisions and profits on disposal, 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 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 (no breach of statutory duty).

Long Term Plan ambitions
In terms of the Long-Term Plan ambitions, we will not deliver our planned reduction in out of area placements and the agreed trajectories in the following areas:

- Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy (County Durham, Tees Valley, North Yorkshire and Vale of York)
- Percentage of people who have waited more than 90 days between first and second appointments (County Durham, Tees Valley and Vale of York)
- IAPT: The proportion of people who are moving to recovery (North Yorkshire)
- The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (County Durham, Tees Valley, North Yorkshire and Vale of York)
- The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (County Durham, Tees Valley and North Yorkshire)
- Number of people accessing IPS services (County Durham, Tees Valley and North Yorkshire)
- Number of women accessing specialist community PMH services. (North Yorkshire and Vale of York)

Whilst there are actions in relation to improving performance contained within the Long-Term Plan section of the IPR; it has been agreed that as part of the new Accountability Framework, Care Groups will develop a Performance Improvement Plan for consideration by Executive Directors Group on the 26th April 2023

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

3.2 Part 2: Broader Key Issues/Work

3.2.1 Quality

Our Quality Journey
During February there have been several leadership events which have taken place to share our new Quality Journey across the Trust. These have included how our plans are shaped by the National Patient Safety Strategy as well as national and local priorities for mental health and learning disabilities. Work on how these ambitions will be delivered is progressing, some of this is through the Advancing our Clinical and Quality Journey programme board. Services have asked for how we will work together on the delivery of these key priorities to be a key focus of the next senior leadership time out.

Progress continues to be made regarding meeting the national standards within the Patient Safety Incident Response Framework (PSIRF), the new national serious incident system. There are currently no concerns in achieving the national deadline of September 2023 and dedicated project support is in place. The root and branch review referenced within the SI recovery strategy will support the delivery of this work.

Serious Incident Backlog Recovery
In line with the approved recovery plan, the Trust have employed a Patient Safety Consultant who is currently working with the Trust to oversee and manage reduction of the Serious Incident backlog. They are undertaking a root and branch review to examine whether all aspects of the patient safety systems are working in the best way possible to deliver the desired function and to identify further reforms that will ensure we have a system that is fully fit for purpose

Further external support for review of Cohort 1 serious incidents has been identified and the Trust has signed a contract with North East Commissioning Support (NECS) for 6 months commencing 1st April 2023. We are also in the process of sourcing additional reviewers and agreeing contracts. Regular updates are being provided via Executive Directors Group.

Procurement of new Risk Management System
A business case for the procurement of a new system was approved by the Programme Board and Digital Assurance Group. This is for a system that will bring together not only the current processes in Datix, including Risk Management, Incident Reporting and Complaints and PALS, but also the Clinical Audit capability needed, CQC and NICE compliance, Safety Alerts, Policy Management, Board Assurance Framework as well as full Action Plan Management.

The recommendations report from Procurement identified a single supplier that met our requirements. This supplier and their products were discussed and agreed with each of the process leads prior to approval and sign off. The contract is currently with the supplier for signature, following which will need signature by the Trust before the governance checks by Digital and Data Services are then undertaken. The implementation plan will be developed jointly with the supplier and key leads from each process specialty, and Digital and Data Services Teams to ensure that any capacity considerations due to CITO implementation are considered. Implementation will take place between April and the end of September 2023, with each process applications development moving at a pace most suited to meet their complexity, scale of testing and user involvement. There are currently no concerns in relation to full delivery of the system, although ongoing development may be impacted as there is currently no funded role for a dedicated Risk Management System Lead.

Safe Staffing
Business Continuity Arrangements remained in place during January 2023 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 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 for day shifts although this is a slight improvement over recent months. The number of wards with low fill rates for RN night shifts remain on a relative par with the previous months. There are 17 wards reporting as less than or equal to two thirds of their required RN days fill rate, 10 of which are adult wards (including PICUs), 6 SIS wards and an LD ward. Newtondale (SIS) and Ramsey (LD) also have significantly low fill rates for RN night shifts too.

HCA fill rates for day shifts show there are a significant number of wards with high fill rates for HCAs, 29 wards are exceeding 120% of their budgeted establishment, with 11 of these wards exceeding 200% fill rates – 2 MHSOP wards 1 SIS ward and 8 AMH wards, most notably the PICUs (Cedar and Bedale) having the highest fill rates of 398% and 328% respectively. Both figures for the PICUs are less than the respective 346% 420% fill rates reported last month.

HCA fill rates for night shifts similarly show a significant number of wards with high fill rates for HCAs, with 32 wards exceeding 120% of their budgeted establishment – 15 of these wards exceed 200% fill rates – 4 MHSOP wards, 4 SIS wards and 7 AMH wards which also includes both PICUs, with the highest being the Bedale at 431% which is an improvement over the 533% reported last month.

Contributing factors towards high HCA fill rates continue to 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.

Red flags are higher than over the previous 2 months show an increase over the previous month together with a small increase in the number of Datix reports for staffing levels. We can see that SIS have fully embraced and incorporated the use of red flags into their daily staffing management and this shows that the common themes are being unable to take a break, unable to provide response within zone and less RNs on shift than required. It is noted that a significant number of these flags are reported as being addressed and mitigated. Further exploration within services should be followed up on regarding how well the utilisation of SafeCare and the use of red flags is being adopted.

Temporary staffing requests remain high, but we can see small reductions in the number of agency filled shifts and the number of unfilled shifts. This is also reflected in an increase of bank filled rates. Measuring total actual hours worked against bank and agency hours worked (fulfilment), we see the corresponding increase for the number of teams (17) with more than a 25% bank staff fulfilment over the previous month. Similarly, agency fulfilment - whilst still high – has seen a small reduction over December 2022.

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 have resat 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 6 more additional recruits joining SIS, 3 arrived end of January/beginning of February and 3 further nurses are due to arrive in March 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.

3.2.2 Inpatient Pressures

Bed Occupancy
The Beds Oversight Group continue to monitor the impact of the bed occupancy plan that is currently in implementation. The current position (as of the end of February 2023) shows that delivery of the £360K efficiency saving and reduction in bed occupancy to 95% is highly unlikely to be achieved by the given date of the 31st of March 2023. All key indicators are showing significant variation away from target.

Further to the immediate actions that were taken beginning of February to introduce a weekly bed pressure meeting to discuss all Long lengths of Stay, a peer review is to take place, taking an in-depth review of all cases with a length of stay over 60 days to identify if any further support and guidance could be offered, the aim being to help unblock any barriers to discharge and reduce the risk of causing avoidable harm to the patients recovery once deemed clinically ready for discharge. This will also provide an opportunity for further learning and identification of other areas that may require improvement or attention. It is anticipated that this review will take place by the end of March / beginning of April.

While colleagues continue to implement the Durham Tees Valley bed occupancy reduction plan, further work is being undertaken to develop a paper with recommendations on a new approach to support the eradication of Out of Area Placements through a joined-up Trust-wide plan with refined scope looking across the Adult Urgent and Emergency Care pathway. It is expected that the paper will be complete by end of March 2023 and submitted for approval.

3.2.3 People & Culture

Improvement work in relation to reporting, analysis and assurance around our workforce issues
One of our complex issues is the local gaps in service created by the interplay of our leaver rate/ profile, absence rate, and recruitment patterns and the impact on our use of agency and other temporary staffing which in turn underpins quality, financial and staff wellbeing issues.

A significant piece of work has been undertaken, reporting to board this month, to provide enhanced understanding of our vacancies, and workforce profile by age, gender, leaver profile, profession, and service. This has been combined with detailed information from the clinical networks mapping core roles for each specialty. This will now enable us to very specifically target different recruitment and retention strategies at specific staff groups at place rather than trust wide. This will be sustained on a monthly basis by the people partners in services and by the central team quarterly to track any fluctuations and the impact of work undertaken.

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. Several initiatives have been developed that whilst have brought some improvements, have not led to significant improvements overall, therefore we have agreed a priority programme with weekly oversight and delivery within the care group during quarter 2. We will also be asking Co-creation Board to do work on this area as one of its initial priorities once established, to see how we can strengthen the programme.
- Pressures on our inpatient services are continuing; our bed occupancy remains high within our adult wards; over the past three weeks this has become a deteriorating position. Actions within our Bed Occupancy reduction plan remain ongoing and are reported monthly through the Trust wide Beds Oversight Group. In addition, our group Medical Director is leading a piece of work to bring together and integrate improvement activities between the urgent and planned pathways. Plans will be presented to the Care group board by the end of March 23.
- We continue to be below where we would like in terms of our compliance with mandatory and statutory training and appraisals. We are establishing weekly oversight through refreshed governance arrangements to ensure delivery of compliance trajectories which are established with support from corporate colleagues.
- We note a deterioration in staff recommending the Trust as a place to work. We will be agreeing a piece of work to strengthen our understanding and actions in relation to this.
- Within the Long Term Plan, whilst we continue to see improvements within our Children's Eating Disorders service, we are keen to continue these. The team have identified some data quality issues over the last couple of months and have developed actions to address these. All patient referred during January

and February 23 were seen within the required timescales. The development of a temporary Service Level Agreement continues to progress following feedback from CDDFT, although this has experienced a delay, it should be finalised by the end of March 23.

- Fewer people are accessing our IAPT service than we would like. Further work and discussions are ongoing to with some additional actions agreed. A position statement will be brought to the Quality Impact and Assurance Meeting in April 23.

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. Following the implementation of key actions, we are also achieving the standard for people who are experiencing EIP are being treated with a NICE approved care package within 2 weeks of referral.

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, the 4 hour measure has now been relaunched and performance is more positive. The teams continue to monitor this closely to understand any areas of underperformance. Following the quality improvement event in December and the implementation of the new screening methodology, there are plans to increase the capacity further by adding two additional screener posts into the team. A 5 day design event with partners is being planned for April 23. Current answer rates are 50% in Durham and Darlington team and 71% in Tees team.

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 end of February 23, we have 4 patients in independent sector beds.
- Learning from the National 100-day discharge challenge is underway. MHSOP are in the process of developing an action plan in response to concerns identified with new actions added to support this work and are reported monthly through the Trust wide Beds Oversight Group.
- Whilst we have seen some improvements in compliance with mandatory training (84.06%) and Appraisals (83.00%) , issues remain with staff capacity as a result of high caseloads, staff leavers and recruitment challenges and day to day operational pressures.
- In relation to Mandatory Training, there is a Trust wide ESR group looking at data quality issues. A task and finish group has been established and will meet at the end of March to look at what current data is in place for Managers, what is useful and what else is needed.
- 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 March 23 which will inform next steps.

- The outcome measures within our CYP and AMH services are not where we would like them to be, although we have seen improvements in CYP patient reported outcomes since November 22.

The areas of positive assurance identified within the IPD:

- Within Long Term Plan as at the end of February 23, we continue to have excellent waiting times within IAPT and are achieving the 6 & 18 week standards for accessing our services.
- We are achieving recovery standard for both North Yorkshire and Vale of York Sub-ICB location and continuing to meet the IAPT access for Vale of York ICB.
- EIP 2 weeks standard has been achieved for both North Yorkshire and Vale of York Sub-ICB.
- 72 hour follow up standard is achieved for Vale of York Sub-ICB location.

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

- Staff capacity in Perinatal Teams has reduced due to vacancies and sickness levels. Business continuity plans have been put in place to ensure waiting lists do not build up and that assessments and referrals are not impacted; however, there is a distinct risk that the actions taken to ensure continuity of service will impact on recording and performance against targets (given the parameters of LTP measures). This has been communicated to commissioners and ways to mitigate recording and reporting issues are being explored.
- Pressures within MHSOP Therapies continue to have an adverse impact on service delivery. In particular recruitment into Psychology positions remains a challenge.
- Overall, across all specialisms and services, pressures regarding recruitment and vacancy rates remains a significant challenge to delivery against plan and performance measures.

Appendix B

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 28th February 2023

Report Produced by: Ashleigh Lyons, Head of Performance
Date the report was produced: 24 March 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

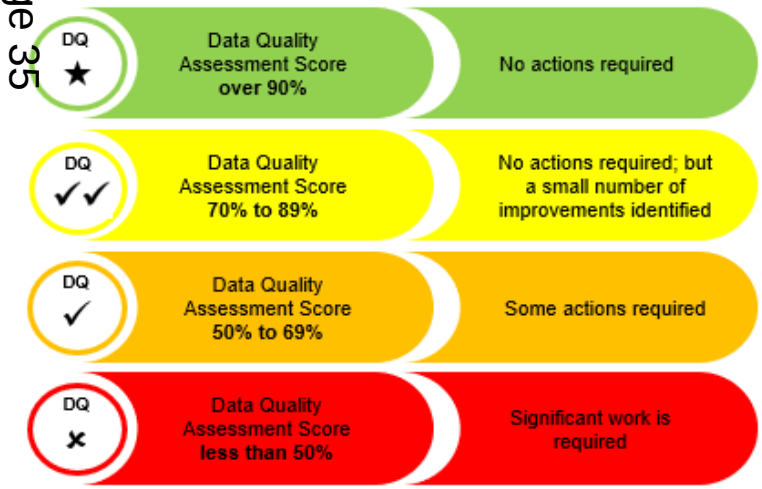
Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. Work is underway to understand the resources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

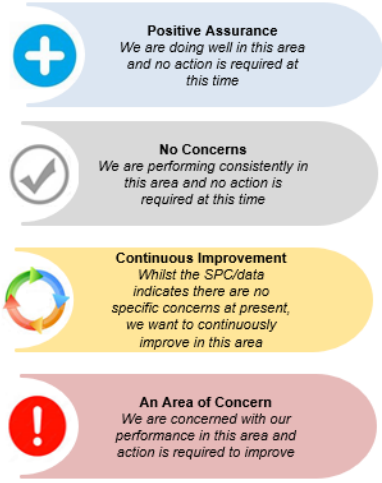
Please note an assessment has not yet been undertaken on the following new measures. An assessment of these will be included in the March 2023 report.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive		*Patients surveyed reporting their recent experience as very good or good *Incidents of moderate harm and near		
Neutral		*Restrictive Intervention Incidents *Medication Errors with a severity of moderate harm and above *Capital Expenditure (Capital Allocation) *Cash balances (actual compared to plan)	*Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for *Serious Incidents reported on STEIS *Uses of the Mental Health Act *Staff recommending the Trust as a place to work *Staff feeling they are able to make improvements happen in their area of work *Staff Leaver Rate *Percentage Sickness Absence Rate *New unique patients referred	
Negative		*Inappropriate OAP bed days for adults that are 'external' to the sending provider	*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 *CYP showing measurable improvement following treatment - clinician reported *Adults and Older Persons showing measurable improvement following treatment - clinician reported *Bed Occupancy (AMH & MHSOP A & T Wards) *Unexpected Inpatient unnatural deaths reported on STEIS *Compliance with ALL mandatory and statutory training *Staff in post with a current appraisal *Financial Plan: SOCI - Final Accounts - Surplus/Deficit	*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	H	?	92.00%	92.21%
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%	72.09%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	56.14%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	F	35.00%	24.31%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	46.37%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	L	F	50.00%	44.35%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	19.98%
8)	ded Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H			98.55%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			458
10)	The number of Serious Incidents reported on STEIS	QAC				125
11)	The number of Incidents of moderate harm and near misses	QAC	L			1,857
12)	The number of Restrictive Intervention Incidents	QAC				7,259
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				12
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC	H			6
15)	The number of uses of the Mental Health Act	MHLC				3,938

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				54.21%
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				58.75%
18)	Staff Leaver Rate	PC&D				11.68%
19)	Percentage Sickness Absence Rate (month behind)	PC&D				6.38%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L	P	85.00%	85.84%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	L	?	85.00%	83.87%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				91,580
23)	Unique Caseload (snapshot)	S&RC	H			63,949

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	-427,000	3,455,817
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	F	8,609,921	19,407,823
25b)	Agency price cap compliance	S&RC	F	100%	63%
26)	Use of Resources Rating - overall score	S&RC	F	2	3
27)	CRES Performance - Recurrent	S&RC	F	10,967,000	10,006,000
28)	CRES Performance - Non-Recurrent	S&RC	P	1,276,000	1,276,000
29)	Capital Expenditure (CDEL)	S&RC	F	9,344,000	5,308,000
30)	Cash balances (actual compared to plan)	S&RC	P	65,834,000	72,114,113

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

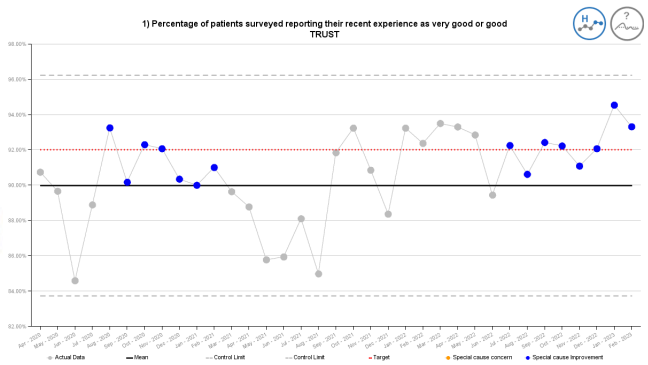
During February, **1017** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **949 (93.31%)** scored "very good" or "good".

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

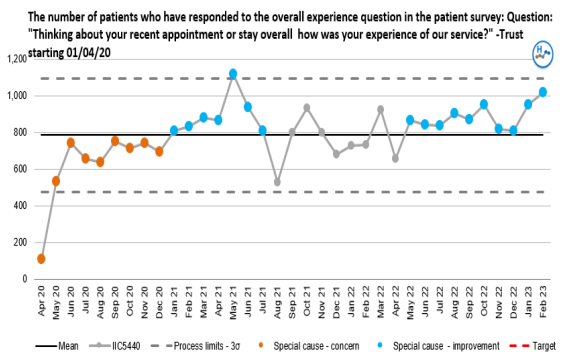
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ★ 93%

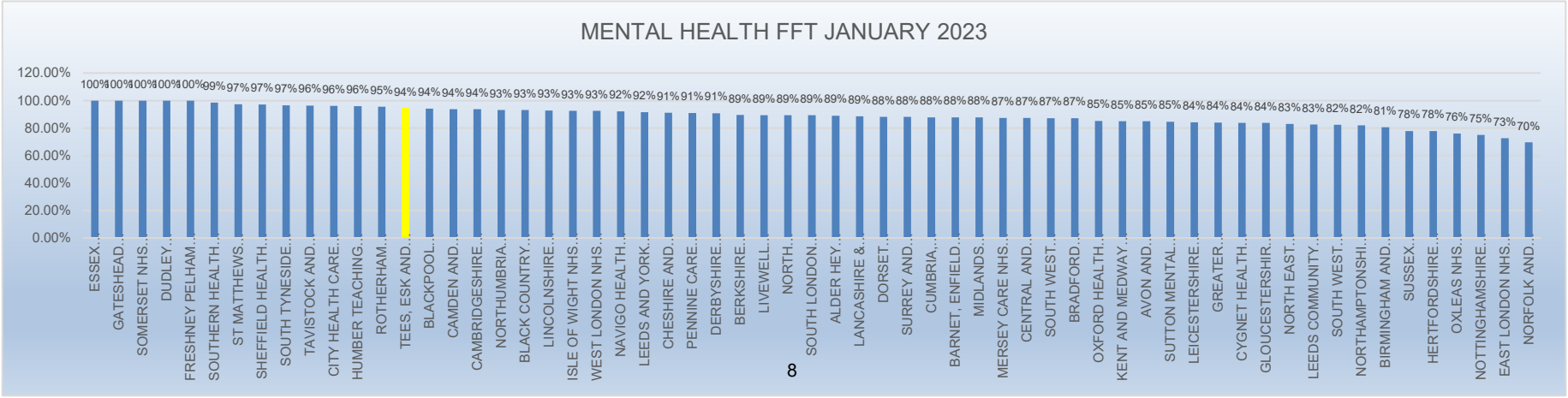
Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



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



National Benchmarking - Mental Health Friends and Family Test (FFT) data - January 2023 (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 **87%**, our Trust is identified by the yellow bar in the chart below. We are ranked 14 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.	To support this work a Framework has been established identifying 4 priority areas; Feeling Safe, increase in response rates, involvement of carers and recommendations following the Community MH Survey. Care Groups are establishing their action plans based on these priority areas.	

Additional Intelligence in support of continuous improvement

We aim to be an organisation that works in partnership with our patients, their families and their carers, recognising that our services and the care we provide will improve if it is co-created with the people who use them. We would hope that this involvement will help to ensure that our patients and carers have a good experience when using our services.

Between the 1st October 2022 and 28th February 2023, service users and carers have supported the co-creation portfolio in 157 involvement opportunities that are being progressed as part of Our Journey to Change. This includes:

- Hazard Workshop on 'virtual visits'
- CITO Workshops
- Bed Management Focus Groups
- DTV AMH Crisis Focus Group

Service users and carers continue to be involved in the recruitment of staff and will be part of the cocreation group looking at reviewing our recruitment Trust-wide.

We have recruited an Adult Learning Disabilities Involvement Facilitator, which will support increased awareness and opportunities for this service.

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 February, **279** 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, **204 (73.12%)** scored “yes, always”.

No significant change in the data during the reporting period shown

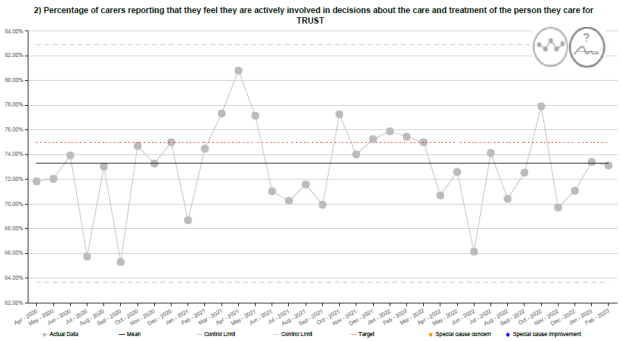
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ

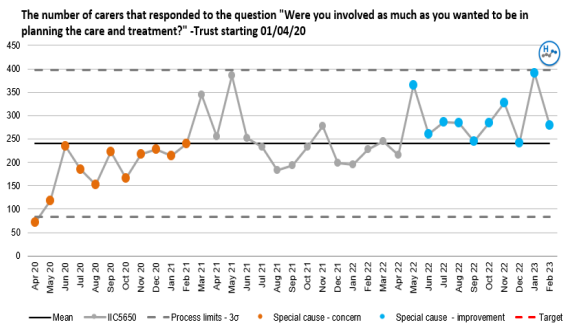
87%

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.

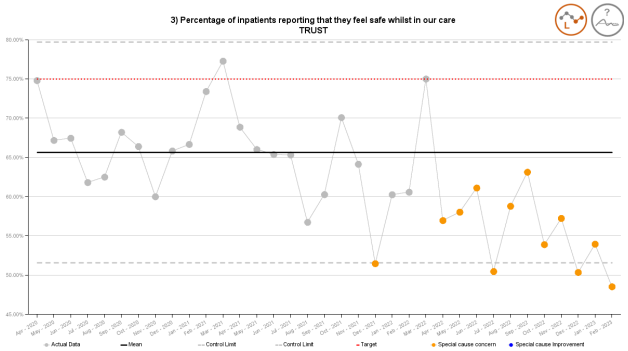
During February, **136** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **66 (48.53%)** scored “yes, always"

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

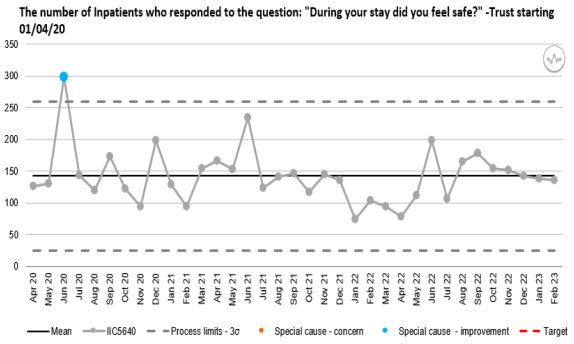
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

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



Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
‘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, 3 are complete and whilst 1 are not currently on track, risks to delivery are being managed by the teams working on these actions.	
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.	*Please see update in respect of 01) Percentage of Patients surveyed reporting their recent experience as very good or good*	
	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 Executive Quality Assurance & Improvement Group in March 2023 and the Care Boards in ~~March~~ April 2023.	The focus groups have been completed	

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Additional Intelligence in support of continuous improvement

The Advancing Our Clinical, Quality and Safety Journeys 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.

Within the programme we have several workstreams that we hope will have a positive impact on the care and safety of our patients. These include, but are not limited to:

- Sexual Safety
- Reducing Restrictive Interventions
- Suicide and Self harm Reduction
- Care Planning
- Safeguarding
- The new patient Safety Incident Response Framework
- The replacement of our current risk management system

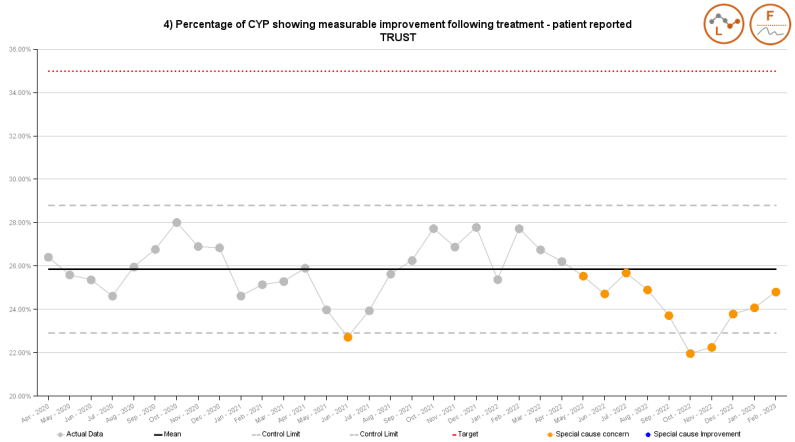
04) Percentage of CYP showing measurable improvement following treatment - patient reported

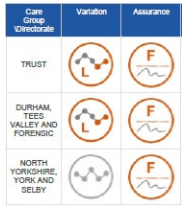
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

For the 3 month rolling period ending February, **649** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 161 (24.81%)** 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.





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%

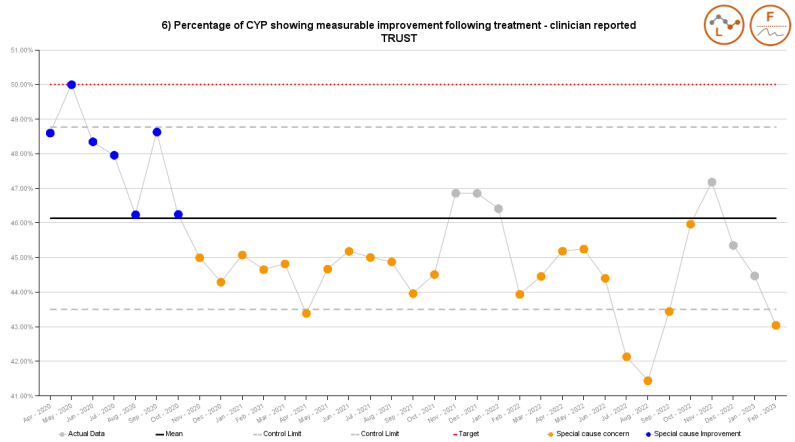
An Area of Concern
We are concerned with our performance in this area and action is required to improve

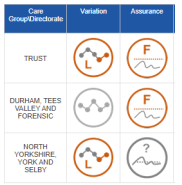
06) Percentage of CYP showing measurable improvement following treatment - clinician reported

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 February, **762** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 328 (43.04%)** made a measurable improvement.

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





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

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	In February, 3 (out of 6) staff attended the monthly training sessions from Durham & Tees Valley; 0 (out of 5) attended from North Yorkshire, York & Selby.	
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 underway. Trust-wide reporting will be live from April 2023, which will improve oversight of ROMs and their completion.	
Analysis has highlighted that our patient outcomes may be impacted by a variety of factors, including long waiting times, paired ROMs not being completed by the same clinician and disengagement of patients before planned discharge.	Specialty Development Manager to discuss the findings and agree improvement actions at the March Clinical Network Group.	Immediate enabling actions were agreed at the March Clinical Network (*see below*); improvement actions will be discussed at the CAMHS Outcomes Group on 22nd March 2022.	
NEW We need to understand the disparity in performance between the Care Groups in relation to measurable improvement of children and young people following treatment	*Enabling action:* The CYP Specialist Practitioner in Clinical Outcomes Development to undertake analysis of cases in both Care Groups to understand the underlying reasons for performance and identify any improvement actions. This work will be completed by the end of March 2023.		

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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
NEW We are concerned that our patients' improvement is not being captured by ROMs due to the timeliness of their completion in the patient journey.	*Enabling action*: Specialist Practitioner in CYP Outcomes Development to facilitate bespoke half day training sessions from the 26th April 2023 and quarterly thereafter until the 16th January 2024, focusing on themes identified in discussions with teams, Team Managers and ROMs Leads, with the aim of improving the timely completion of ROMs.		
	Enabling action: Specialist Practitioner in CYP Outcomes Development to develop a 'ROM on a Page' guide by the end of March 2023, with a view to improving the timeliness and standardisation of ROMs completion.		
	Enabling action: Assistant Psychologist to provide 1:1 sessions with ROMs Leads to support them to understand the underlying reasons for non-timely completion and to help develop local actions plans to improve completion. The sessions will be completed by the end of May 2023.		

Additional Intelligence in support of continuous improvement

Analysis has identified that the improvement of our patients is being impacted by the lengths of waiting times within our Children & Young People's Services.

With a view to improving our services, work has been undertaken between the 1st April 2022 and 28th February 2023 across all of the Trust's Getting More Help teams to understand capacity, clinical delivery and the complexities of patients within those teams and our ability to respond to demand. This work is continuing, but work identified to date includes:

- The development of actions plans in each of the teams where concerns have been identified in respect of capacity and waiting times
- Recruitment fayres have been planned with a view to increasing staffing, which would enable us to offer increased appointments and reduce our waiting times.
- 'Share and spread' events to be arranged to share good practice amongst out services, with a view to reducing our waiting lists.

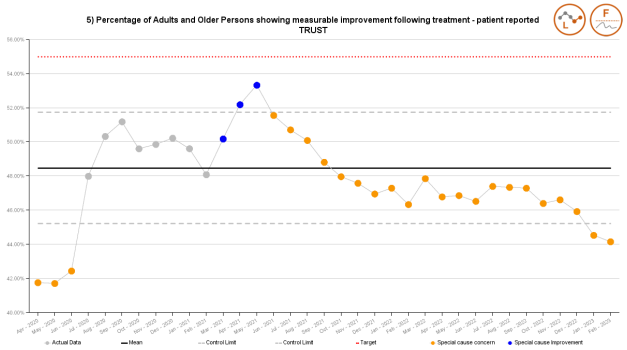
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

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 February, **1864** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 823 (44.15%)** 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%

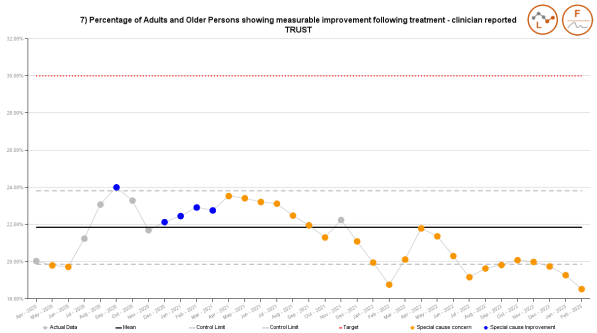
An Area of Concern
We are concerned with our performance in this area and action is required to improve

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 February, **3012** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 558 (18.53%)** 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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Clinical teams should have regular oversight of their progress regarding outcome measures.	*Enabling Action:* 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. Trust-wide reporting will be live from April 2023, which will improve oversight of ROMs and their completion.	
Staff require training and support to better understand when and how to monitor the aspects of outcomes	*Enabling action*: The Section Head of Research & Statistics to work with the Digital Training Team to create a training video based on the content of the outcomes webinars. This work will be completed by the ~~17th March~~ 21st April 2023.	Pending this work, bespoke outcomes sessions continue to be provided to teams on request.	
We need to understand whether the timeliness of completion of outcome measures for our North Yorkshire, York & Selby Adult Mental Health patients is impacting on the level of improvement that is being demonstrated.	*Enabling action:* IAPT Teams to share their knowledge and experience of improving outcome to the community team services managers by the end of April 2023, with a view to supporting improvements in generic Adult Mental Health Services		

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

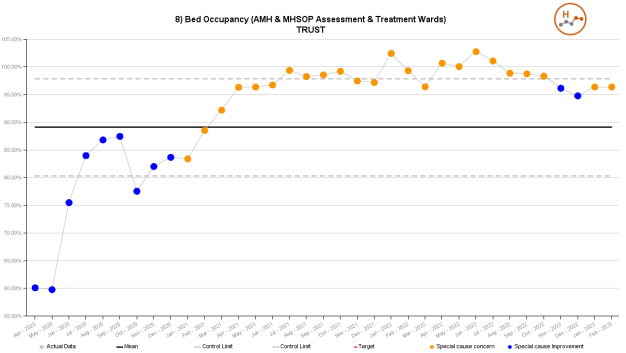
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important 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 February, **10,024** daily beds were available for patients; of those, **9661 (96.38%)** were occupied.

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

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

DQ ★ 93%



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

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

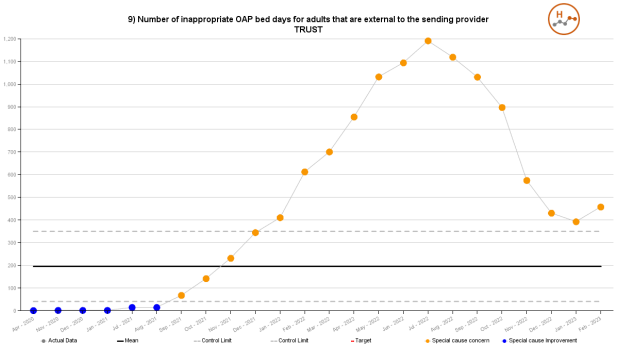
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending February, **458** 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
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DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	

Supporting Measure

		2022 - 2023											
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	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	10,897	9,849	**120,865**
	Number of available bed days	10,578	11,253	10,890	11,253	11,253	10,890	11,098	10,740	11,098	11,098	10,024	**120,175**
	Percentage Bed Occupancy	**103.29%**	**102.51%**	**104.24%**	**103.80%**	**102.12%**	**100.17%**	**100.83%**	**97.30%**	**95.38%**	**98.19%**	**98.25%**	**100.57%**

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to better understand capacity and demand for beds within the Trust, to understand where our pressures are and whether we have the correct number of beds available within our care groups.	The Bed Oversight Group to oversee a full review of current bed allocation and develop new proposals for the number of beds, type, location and resource/staffing impact across the next 5 years by the end of June 2023.		
We need to ensure that our inpatient pathways are effective and support efficient management of patients from referral to discharge.	*Enabling action:* The General Manager (AMH Urgent Care) supported by the Quality Improvement Team to lead an additional improvement event on the 9th February to address outstanding considerations not completed in the initial 2-day Purposeful Inpatient Admission improvement event.	**Complete:** The event took place on 9th February and a further event to ensure all work was completed took place on 8th March 23. Actions for Durham & Tees Valley have been added to their action plan; no improvement actions were required for North Yorkshire, York & Selby.	
	The General Manager (AMH Urgent Care) to monitor progress against the DTVF Beds Occupancy Reduction Action Plan, to ensure completion of actions by the end of May 2023.		
	Enabling action: The General Manager (AMH Urgent Care) to lead a number of focused, site-specific sessions within Durham & Tees Valley to relaunch the Purposeful Inpatient Admission process. These will be completed by the ~~31st March 2023~~ 31st May 2023.		

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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, plans have been assessed using the agreed criteria. The prioritisation of schemes has been informed by the NHSE 100 day discharge challenge, which has 10 key areas, therefore it has been challenging to focus resource on a small number of areas and work at pace.	
	NEW *Enabling Action:* Programme Manager to submit a proposal for a focused programme of work to manage our bed pressures. This will be shared with the Beds Oversight Group by the end of April 23 and will include recommendations to: • Implement a programme board • Amend the focus to Adult Mental Health, which is where our greatest pressures are • Implement 4 workstreams, focusing on admission/readmission avoidance, inpatients, discharges and digital & data		
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 and Strategic Lead Practitioner for MHSOP to develop an action plan in response to concerns identified in the 100 day challenge assessment. This will be presented to the Beds Oversight Group in ~~March 23~~ April 2023.		

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

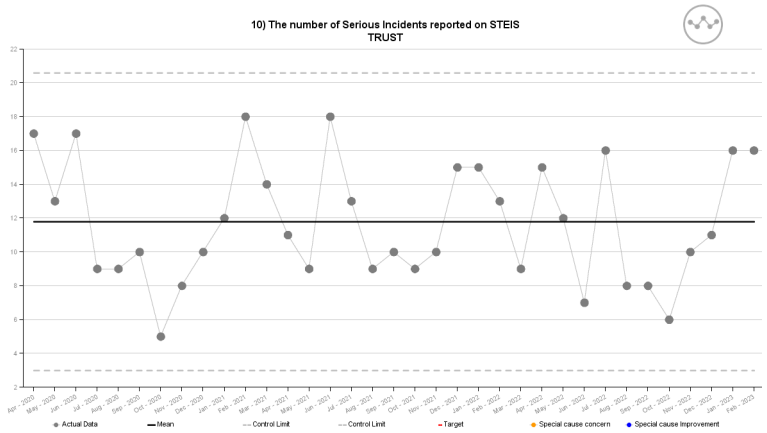
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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

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

All 16 serious incidents reported in February have been reviewed at the daily Patient Safety Huddle. Newly emerging learning includes the absence of a mental state examination of the patient and there remain some instances of lapses in care documentation, sharing of some care documents and next of kin details not being readily accessible.

At team level, learning is being addressed via the early learning review action plans. Learning is also shared at the weekly strategic Care Group Quality and Safety Meeting to ensure timely feedback and sharing of learning across all services. We continue to have oversight of these key care quality standards via the Trust's Quality Improvement and Assurance Programme.

The Patient Safety Consultant is currently working with the Trust to oversee and manage the reduction of the backlog of incidents that have not been approved. This work includes undertaking a root and branch review to examine whether all aspects of the patient safety systems are working in the best way possible to deliver the desired function, and to identify further reforms that will ensure we have a system that is fully fit for purpose.

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

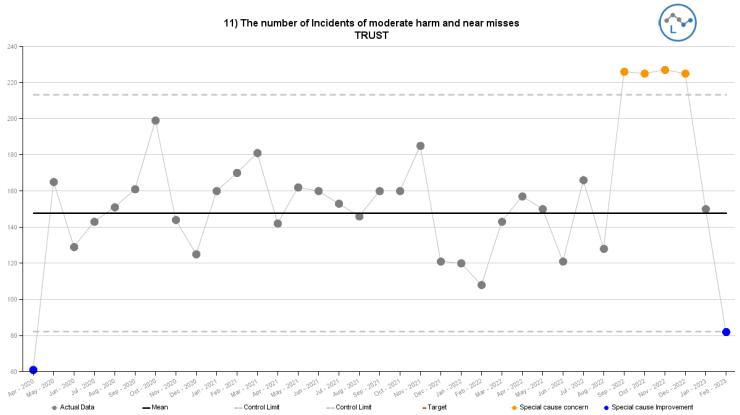
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

82 incidents of moderate harm or near misses were reported during February.

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

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	

Self harming behaviour continues to be the most frequently reported type of incident across services. Reducing self harm, restrictive practices and safeguarding incidents are all key components of the Promoting Harm Free Care workstream within Our Quality Journey priorities, to focus on continuous improvements in these key areas. Some of this work includes the implementation of the Merseycare HOPE model within Adult Learning Disabilities and the focused self-harm reduction work within female acute Adult Mental Health inpatient wards.

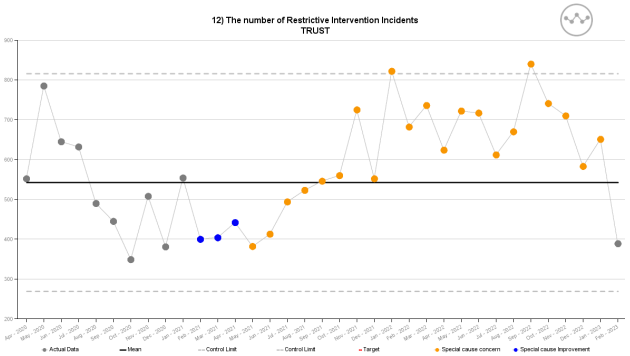
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
NEW To provide better insight into incidents of moderate harm caused by anchored ligatures, the Environmental Risk Group commissioned a review of those incidents reported throughout November 2022 to December 2022. Of the 34 incidents reviewed, 25 occurred on Bransdale Ward with three patients accounting for the majority of these incidents.	*Enabling action*: Associate Director of Quality Assurance, Compliance & Quality Data to present further analysis to the March Environmental Risk Group, including a review against the ligature reduction programme to consider any further works required or re-prioritisation of the programme works.		

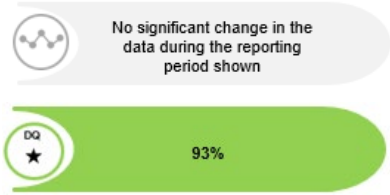
12) The number of Restrictive Intervention Incidents

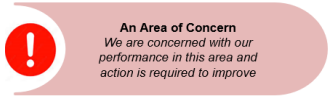
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

389 Restrictive Intervention Incidents took place during February.







Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We have a number of patients within our two Adult Learning Disabilities Inpatient Wards with complex needs that require discharge from hospital.	The General Manager and Associate Clinical Director to ensure there is a discharge plan in place for each individual patient, in order to progress a safe discharge from hospital as outlined in their plan.	There are currently 7 patients ready for discharge: • 1 patient at Lanchester Road is on Section 17 leave. Full discharge is anticipated before the end of March. • The transfer of 1 patient at Lanchester Road to Bankfields has been paused, pending the discharge of the patient 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. • 3 further patients within Bankfields have identified providers and placements; transition plans are being developed and discharge is expected to be in quarter 1 2023/24. • 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.	

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS Foundation Trust

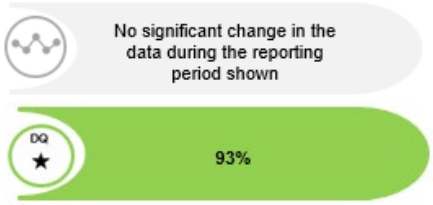
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We require greater assurance locally from Care Boards on the implementation of the Restraint Reduction Plan	*Enabling action:* Care Boards to ensure delivery of the Restraint Reduction Plan by 31st March 2023.	Positive & Safe Groups at Care Board level are established and are on track for delivering the Restraint Reduction Plan. (*See following action)*	
	NEW *Enabling action*: The Nurse Consultant for Positive and Safe Care to lead the development of a Positive & Safe Policy. This will be completed 30th April 2023.		
We require additional resource to support Care Boards with reduction of restrictive practices	*Enabling action:* The Nurse Consultant for Positive and Safe Care to 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.	The report has been shared with each Care Group Board and the Executive Management Group; confirmation on whether funding has been received is still outstanding.	

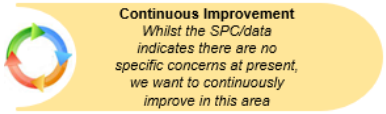
13) The number of Medication Errors with a severity of moderate harm and above

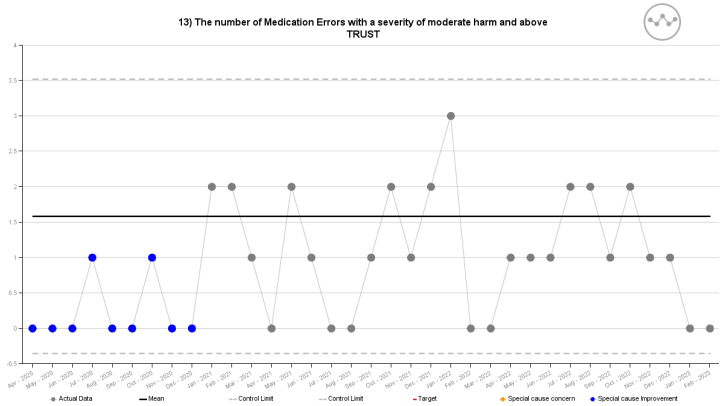
Tees, Esk and Wear Valleys NHS Foundation Trust

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

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







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

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Clozapine is a “high-risk” medication and was being taken in 6 of the incidents above. We need to improve staff education and introduce effective resources that enable high quality discussions with patients reducing incidents of the same type.	The Safe Medication Practice Group has co-created a set of clozapine-focused improvement actions, which will include the development of e-learning, provision of patient information and 5 quality standards that will be audited at the end of ~~2022/23~~ quarter 1 2023/24.	There are 27 overall improvement actions identified. Of these, 20 have been completed, including the publication of clozapine and constipation guidance since the last update. Of the outstanding 7 actions, 2 will be completed within the next 4 weeks and the remaining 5 are on track.	
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, including the complete revision of the depot procedures and the remaining 2 are on track for delivery.	

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

Tees, Esk and Wear Valleys NHS Foundation Trust

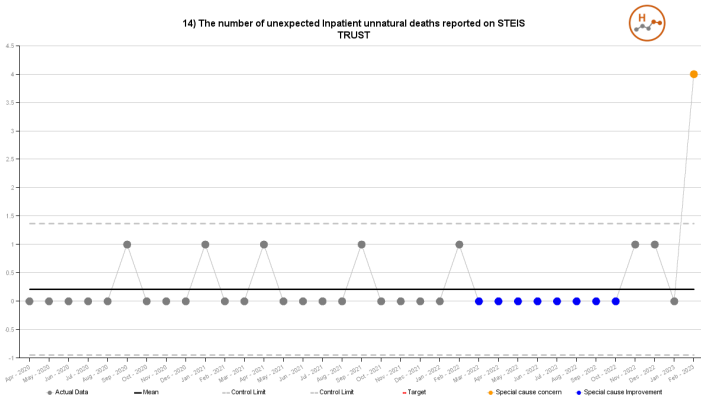
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety of our patients and to minimise the risk of any harm to them and distress to their carers and families.

4 unexpected Inpatient unnatural deaths were reported on the Strategic Executive Information System (STEIS) during February.

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

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

DQ
93%



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

In February we reported 3 unexpected inpatient unnatural deaths in Durham, Tees Valley and Forensic Care Group and 1 in North Yorkshire, York & Selby Care Group. Every unexpected inpatient death whether from natural causes or suicide/self-harm has a rapid review undertaken in order to identify early learning within 72 hours. Of the 4 deaths, we are still awaiting cause of death for 2 deaths and one has been found to be natural causes. Following recent serious incidents, a thematic review has been undertaken by a Director of Nursing and immediate actions identified have been reported to the Trust Board. We are monitoring the actions taken through Care Groups and our quality governance structures.

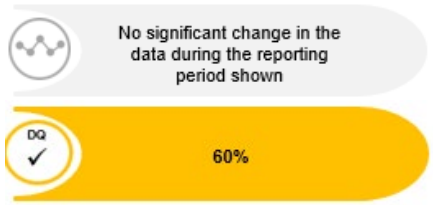
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
A Quality Governance-led collaborative review with clinical services has indicated that whilst the quality of risk assessments has improved across the organisation, leave plans are not always sufficiently robust.	*Enabling action:* 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.	**Complete.** Analysis based on January's data shows that approximately 93% of patients' leave plans showed that the leave plan accurately reflected the current prescription of leave/time off the ward granted to the patient. Results demonstrated that in s17 leave documentation 97% evidenced where the patients could go, 98% showed who they could go with and 96% included the duration of leave. This analysis will continue as a component of the Quality Improvement & Assurance Programme.	

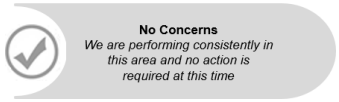
15) The number of uses of the Mental Health Act

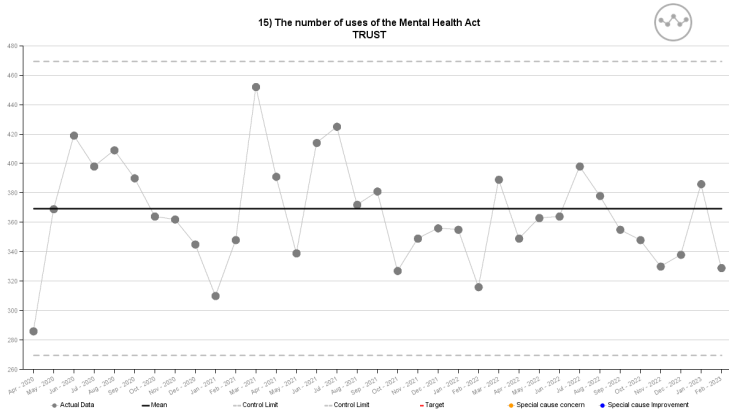
Tees, Esk and Wear Valleys NHS Foundation Trust

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 **329** uses of the Mental Health Act during February.







Care Group/Directorate	Variation
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DURHAM, TEES VALLEY AND FORENSIC	L
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.	The Head of Performance and Head of Business Intelligence to gather further intelligence to understand constructions used nationally and by other mental health providers, to ensure consistency, to inform any changes that need to be made to the measure. This work will be completed in February 2023.	**Complete.** Investigations have confirmed that a change should be made to the measure to ensure that section renewals are not counted as new uses. (*See following action*)	
	The Head of Performance to work with the Business Intelligence Operational Manager – PLICS & MHMDS to develop a KPI change by the end of March 2023, with a view to amending the measure for the April 2023 report.		

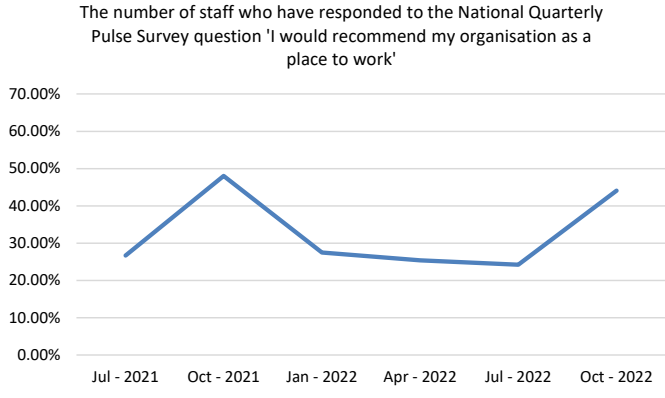
16) Percentage of staff recommending the Trust as a place to work

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.

3330 staff responded to the October 2022 National Staff Survey question "I would recommend my organisation as a place to work" Of those, **1800 (54.05%)** 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	Oct - 2022
TRUST	54.23%	52.46%	52.54%	55.01%	53.60%	54.05%
ASSISTANT CHIEF EXEC	69.23%	60.94%	51.61%	61.29%	47.83%	62.86%
DIGITAL AND DATA SERVICES	68.09%	60.50%	70.13%	68.00%	57.65%	60.50%
DURHAM, TEES VALLEY AND FORENSIC	51.50%	50.76%	50.72%	54.63%	54.64%	53.42%
ESTATES AND FACILITIES MANAGEMENT	57.14%	52.43%	46.92%	50.38%	50.76%	41.95%
FINANCE	61.54%	57.41%	62.22%	57.58%	61.54%	46.30%
MEDICAL	67.44%	78.95%	68.42%	64.10%	65.71%	63.64%
NORTH YORKSHIRE, YORK AND SELBY	50.19%	47.92%	50.48%	52.85%	49.89%	55.21%
NURSING AND GOVERNANCE	61.90%	56.31%	53.42%	51.95%	35.14%	49.14%
PEOPLE AND CULTURE	69.86%	68.00%	57.69%	56.99%	61.05%	61.34%
THERAPIES	82.35%	61.54%	62.96%	54.17%	53.85%	47.06%



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 and October 2022 in the chart reflects the annual Staff Survey that is undertaken by Picker

National Benchmarking – NHS Staff Survey 2022

- The **Picker average*** was **61%** of staff would recommend their organisation as a place to work.
- **54%** of staff from **our Trust** would recommend their organisation as a place to work (compared to **52%** in the 2021 NHS Staff Survey)
- National benchmarking data shows that we are ranked 47 out of 51 Mental Health & Learning Disability Trusts (1 being the best with the highest rating). Whilst we are placed at the lowest end of the inter-quartile range, this is a slight improvement to our ranking in 2021 (48 our of 51).

NB. *Picker carried out the NHS Staff Survey for 2022 on behalf of 25 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

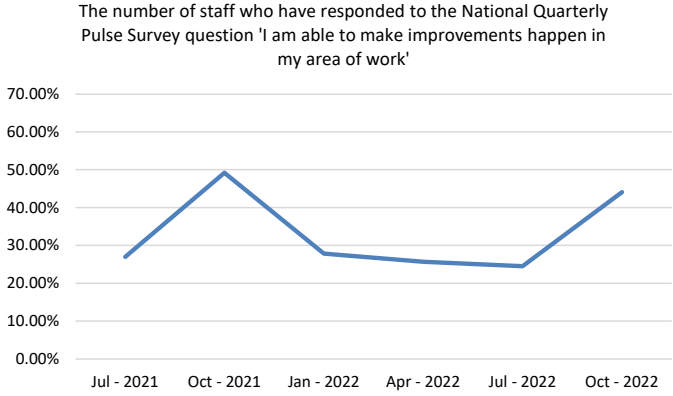
We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise that having the ability to suggest improvements and a high level of job satisfaction within our workforce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

3330 staff responded to the October 2022 National Staff Survey question "I am able to make improvements happen in my area of work" Of those, **1949 (58.53%)** 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	Oct - 2022
TRUST	57.10%	57.11%	57.50%	58.76%	59.12%	58.53%
ASSISTANT CHIEF EXEC	76.92%	67.19%	67.74%	74.19%	65.22%	80.00%
DIGITAL AND DATA SERVICES	65.96%	72.27%	74.03%	72.00%	65.88%	66.39%
DURHAM, TEES VALLEY AND FORENSIC	56.23%	54.59%	57.00%	57.98%	58.94%	57.60%
ESTATES AND FACILITIES MANAGEMENT	55.24%	26.04%	53.08%	52.67%	51.52%	46.55%
FINANCE	65.38%	61.11%	64.44%	69.70%	71.79%	53.70%
MEDICAL	67.44%	73.68%	81.58%	79.49%	68.57%	65.45%
NORTH YORKSHIRE, YORK AND SELBY	54.44%	56.48%	54.35%	56.45%	55.77%	57.26%
NURSING AND GOVERNANCE	61.90%	66.99%	65.75%	63.64%	59.46%	59.48%
PEOPLE AND CULTURE	78.08%	77.60%	73.08%	73.12%	69.47%	77.31%
THERAPIES	94.12%	58.97%	81.48%	70.83%	69.23%	47.06%

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 and October 2022 in the chart reflects the annual Staff Survey that is undertaken by Picker

National Benchmarking – NHS Staff Survey 2022

- The **Picker average*** was **60%** of staff feel able to make improvements happen in their area of work
- **59%** of staff from **our Trust** feel able to make improvements happen in their area of work (compared to **57%** in the 2021 NHS Staff Survey)
- National benchmarking data shows that we are ranked 38 out of 51 Mental Health & Learning Disability Trusts (1 being the best with the highest rating) and are placed in the inter-quartile range. This is lower than our ranking in 2021 (34 out of 51).

NB. *Picker carried out the NHS Staff Survey for 2022 on behalf of 25 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:* Organisational Development to evaluate the recent staff survey results and consider the option presented by York University colleagues as an alternative to the business intelligence approach by end March 2023.		
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:* Organisational Development to review the option of offering incentives for the quarterly pulse survey, including linking in with other organisations to understand what incentives are being offered to staff throughout the region, by the end of March.		
NEW We need to understand what the Staff Survey 2022 results are telling us about our staff and to identify any areas of improvement.	*Enabling action*: Organisational Development to link in with all Directors by the end of March 2023 to discuss their staff survey results, with a view to identifying any improvement actions that need to be established.		
	Enabling action: Executive Director of People & Culture to review the central Workforce Delivery Plan by end March 2023 to ensure the forward plan will address those areas where we have dropped or not increased in score.		

Staff Experience: 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 until November 2027 to support staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements.

Programme Aim	Position as at 16.03.2023	
Enable **100%** of staff to access Foundation training	**11%**	(838 out of 7603 members of staff)
To have trained **50%** of staff at Intermediate level	**10%**	(752 out of 7603 members of staff)
To have **15%** of staff trained at Leader level	**4%**	(334 out of 7603 members of staff)
To have **1%** of staff trained at Expert level	**0.58%**	(44 out of 7603 members of staff)

18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

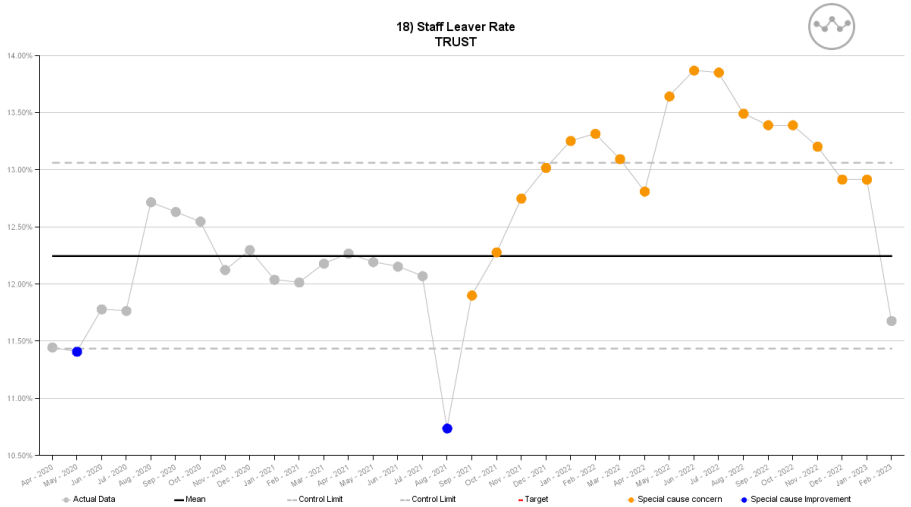
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

From a total of **6,401.96** staff in post, **747.61 (11.68%)** had left the Trust in the 12 month period ending February.

No significant change in the data during the reporting period shown

DQ 80%

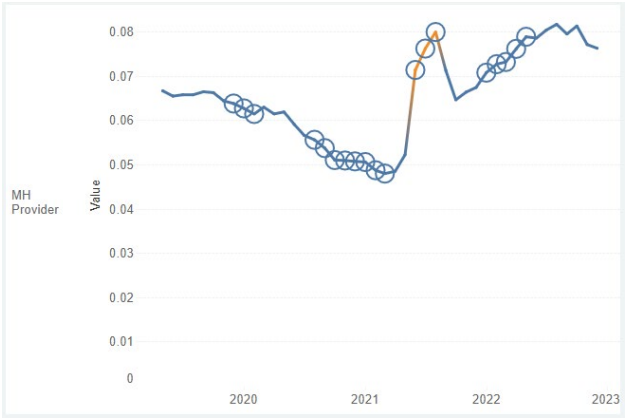
An Area of Concern
We are concerned with our performance in this area and action is required to improve



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

National Benchmarking: NHS Staff Leaver Rate - England Mental Health and Learning Disability – November 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 9 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
We need to understand the workforce profile of our leavers - professions, age groups, team, reasons – to better inform improvement actions.	*Enabling action:* Deputy Director of People & Culture to develop (with our Principle People Partners) an action plan based on the profile of our leavers by the end of June 2023, with a view to improving our staff retention.		

Additional Intelligence in support of continuous improvement

The retention of all our staff remains a key priority, from new starters through to those thinking of leaving. For those that do leave, we want them to leave feeling valued, listened to and to recommend TEWV as a great place to work. We listen to feedback, through our new 'Thinking of leaving' process, to ensure we understand why people choose to leave and wherever possible encourage them to stay.

The Trust is continually reviewing and developing the range of provision for staff to ensure that all new starters receive a warm TEWV welcome and that existing staff feel valued and their contribution recognised with opportunities for development.

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Some of this work includes:

- Continually evaluating and reviewing our Independent Leavers Process to understand the main reasons for people leaving, trends, hot spots.
- Undertaking analysis and triangulating information to identify professions, age groups and the profile of people leaving.
- Understanding trends in Staff Survey feedback to identify key issues, actions and link to staff appraisals.
- Regular reporting and oversight through People Partners and Care Groups up to EDG and Board.

19) Percentage Sickness Absence Rate

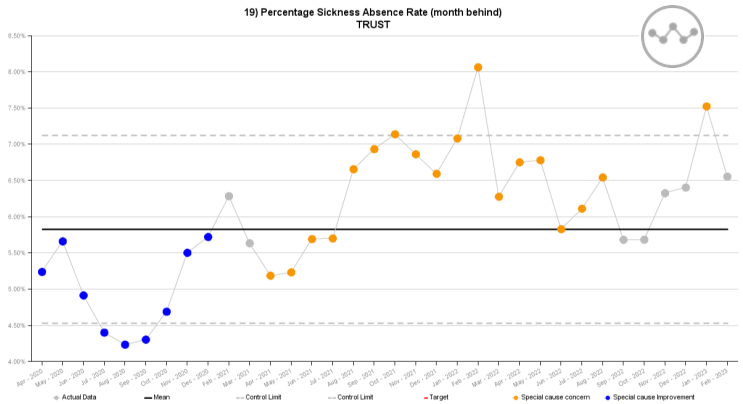
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

There were **224,899.48** working days available for all staff during January (reported month behind); of those, **14,739.74 (6.55%)** 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

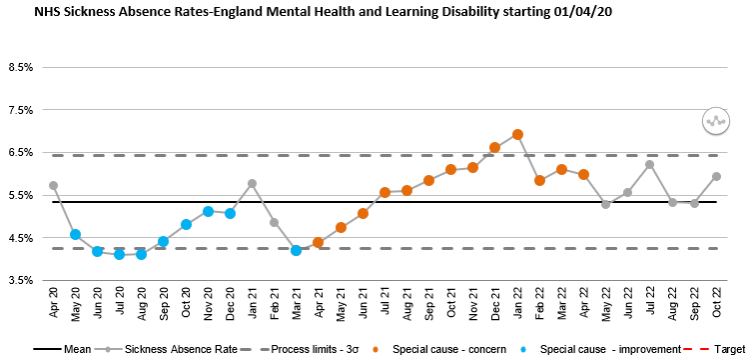
DQ 87%



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

NHS Sickness Absence Rates published 2nd March 2023 (data ending October 22) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.34% compared to the Trust mean of 5.91%.

Regional Benchmarking: We have seen a rise in our sickness absence rates during November and as at the 14th March 2023, we were positioned 6th (out of 31) for sickness absence within the region's mental health, acute and ambulance trusts.



Update

As at the 15th March 2023, sickness absence is 5.97% for March 2023.

19) Percentage Sickness Absence Rate

NHS
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.	**Complete.** Initial analysis has been shared with the Executive People, Culture & Diversity Group and the following actions agreed. The top 10 teams with the highest levels of sickness will be reported to the Group on a quarterly ongoing basis.	
	NEW *Enabling Action*: Clinical People Partners to establish a process to review the top 5 teams with the highest levels of sickness absence in their area, linking in with Service Managers to determine the improvement actions to be taken forward. This process will be established by the end of March 2023.		
	NEW *Enabling Action*: Corporate People Partners to implement the process to review the top 5 teams with the highest levels of sickness absence in their area, linking in with corporate Heads of Service to determine the improvement actions to be taken forward. This process will be established by the end of June 2023 once the partners are in post.		
	NEW *Enabling Action*: People Partners to establish a process to actively review all staff with 5 or more episodes of sickness within a 12-month rolling period, with a view to linking in with managers to provide support to follow the sickness procedure. This process will be established by the end of April 2023.		
NEW There have been a number of instances identified where the Sickness Absence Procedure has not been followed.	People Partners to provide additional training on the Sickness Absence Procedure to managers that have not followed the correct procedure, with a view to improving sickness management across the Trust. The first training sessions will be provided in March 2023.	**Complete**. Training on an individual basis has taken place for certain areas and is now being rolled out.	No visible impact to date; however, improvements can be expected as the training is embedded.

Additional Intelligence in support of continuous improvement

As part of ongoing support to managers and staff, the People Partners are providing sickness clinics for targeted areas, where the sickness procedure has not been followed or where managers require further support to manage sickness absence.

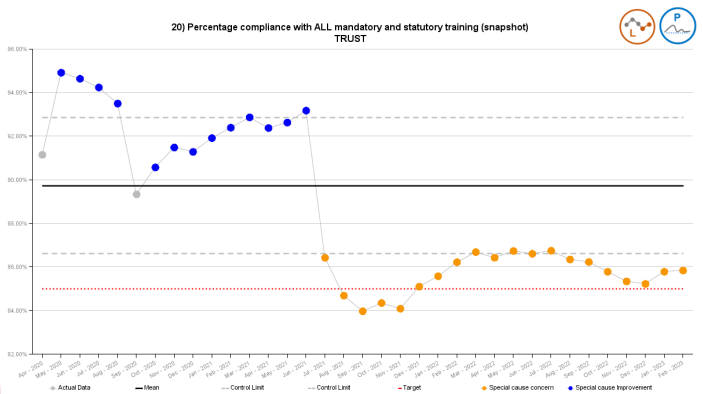
20) Percentage compliance with ALL mandatory and statutory training

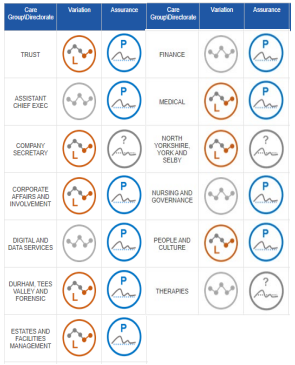
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

121,285 training courses were due to be completed for all staff in post by the end of February. Of those, **104,117** (**85.84%**) 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 the 28th February 2023. As at end of February, **7206** were due for completion, **6701 (92.99%)** were actually completed.





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

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

Our system is expected to consistently hit the target/expectation

DQ
93%

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. Following resolution of a technical issue dates will be advertised the week commencing 20th February 2023.	One face to face session has been held to date with 3 people in attendance; feedback has been very positive. Two sessions a week are scheduled until the end of March, at varied times of day to capture different working hours.	

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We are concerned that demand for some of our face to face training is exceeding the capacity of our trainers.	*Enabling action:* Workforce Team to conduct fortnightly reviews around the availability of courses to ensure we have sufficient capacity to meet demand. These reviews will be in place by the end of February 2023.	**Closed.** Capacity planning will now be completed every quarter.	
We are concerned that availability of our face to face courses is being impacted by staff booking a place on several sessions, in case they cannot attend on a given day. This is preventing other staff from being able to book on those sessions and is resulting in a number of unoccupied places on training sessions.	*Enabling action:* Workforce team to develop communications for Managers regarding the process for booking and attending key face to face training courses. This will be shared with both care groups via the people partners by the end of February 2023.	**Complete.** Workforce Development Team have developed a report that identifies staff booked duplicate training sessions and staff are being contacted and removed from the duplicate courses. This is being completed weekly, with a view to moving to fortnightly once established.	No visible impact to date; however, improvements can be expected as the training is embedded.
NEW We do not have sufficient capacity to provide support for Positive & Safe Care training.	*Enabling action:* Workforce Development Team have submitted a business case for increased resources to Executive Directors as part of the People & Culture Business Case, which will support the provision of this training. Approval to be sought by the end of March 2023.		
	Enabling action: Workforce Development Team to explore Huntington House and Acklam Road as potential training venues by the end of April 2023 to provide improved additional training venues for staff.		
NEW Feedback from some staff has identified that ESR is identifying training requirements for staff that is not appropriate for their job role.	*Enabling action:* Workforce Development to undertake a mapping exercise by the end of June 2023 to review the training demands for each corporate job role to ensure they remain relevant.		

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.

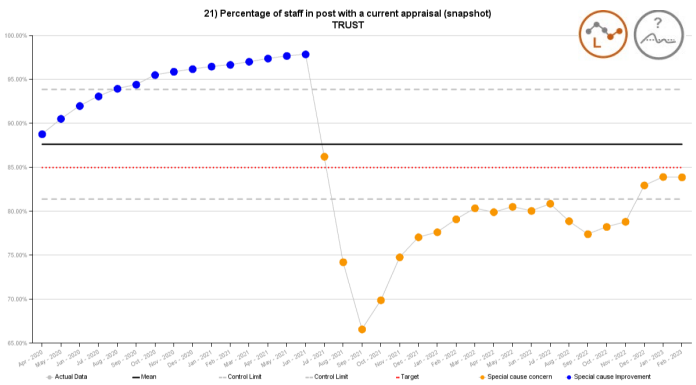
Of the **6423** eligible staff in post at the end of February; **5387** (**83.87%**) had an up to date appraisal

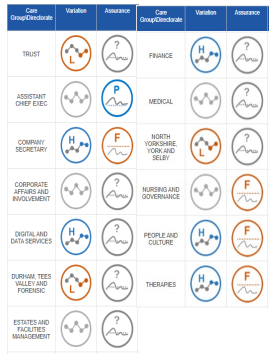
We're aiming to have high performance and we're moving in the wrong direction.

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.	Organisational Development to link in with all teams with compliance rates between 75% - 85% to identify whether there is any specific support required. This work will be completed by the end of February 2023.	**Complete.** All teams have been offered additional support where appraisal compliance rates were between 75-85%. No offers of support have been taken up.	

Additional Intelligence in support of continuous improvement

We want to improve the experience for all our colleagues so that our workforce feels valued, performs to the best of their ability, and feels confident to develop their careers. Integral to this is having an appraisal system that can easily record staff objectives, identify learning and development opportunities, and measure their performance against our Trust values and goals.

To support this, we have launched Workpal, our new appraisal system. Anecdotal feedback indicates that Workpal will drive engagement and therefore completion rates, increase effectiveness and improve efficiency, in addition to providing higher quality appraisals.

The rollout for Workpal is scheduled over 12 months and currently over 2000 staff have registered for Workpal.

Phase 2 work has now commenced to look at how Workpal can be used for clinical supervision.

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

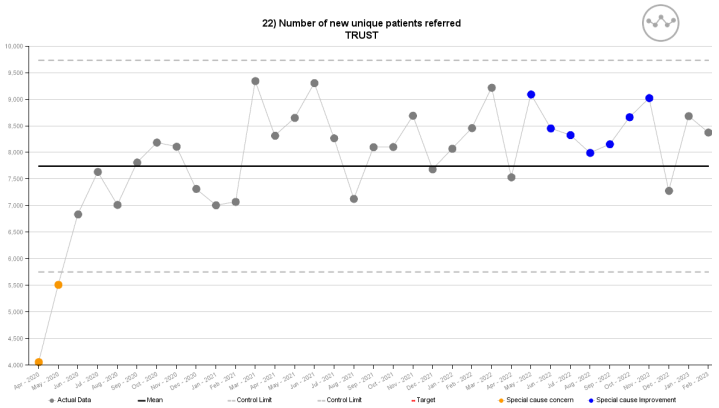
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

8376 patients referred in February 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.

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23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

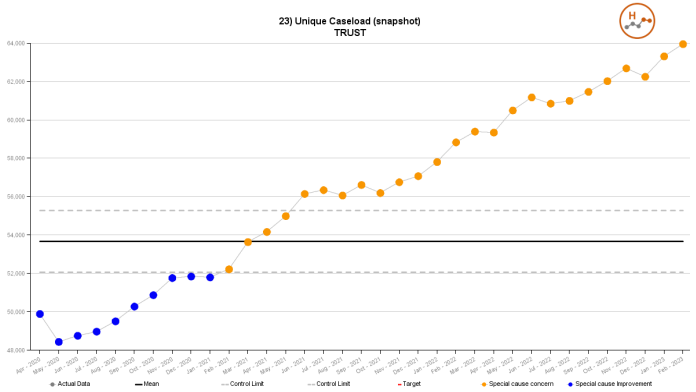
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

63,949 cases were open, including those waiting to be seen, as at the end of February 2023.

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

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

DQ 93%



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

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 share analysis with operational teams to establish the reasons for the increase in caseloads relative to increases/decreases in staffing (funded and contracted) and changes to commissioning contracts. This work will be completed by the end of February 2023.	Analysis was shared with the Strategy & Resources Committee in February 2023. This showed the following services accounted for 84% of the aggregate Trust caseload increase, reflecting a gap between commissioned and actual workload; Durham & Tees Valley adult community teams (43%), children's community and neurodevelopmental teams (16%) and older people community teams (67%) and North Yorkshire & York autism and Attention Deficit Hyperactivity Disorder teams (8%). These will require a strategic approach to enable our services to respond to the increasing demand and pressures being experienced nationally in mental health services. Local intelligence is currently being gathered for the remaining teams, which will be used to inform an operational approach to mitigate the impact of workload issues, eg staff vacancies and sickness.	

23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We are concerned that our high caseloads are impacting on the quality of the services we provide.	*Enabling action:* Care Group Executive Directors to facilitate a Performance Improvement Plan by the 26th April 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on the management of our caseloads.		

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. Workforce groups including HR, Operational Management, Nursing and Governance and Clinical Leaders, have now been established in each North Yorkshire, York & Selby area to review vacancies and any improvement actions that need establishing.

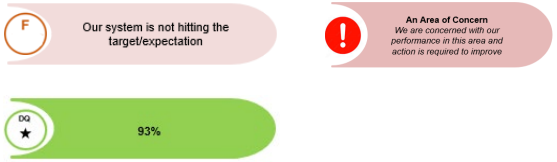
24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit

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 **£3.5m** deficit (to break even) to 28th February 2023 against a planned year to date surplus of **(£0.4m),** resulting in a **£3.9m** variance to plan.

We have had an exceptional unplanned benefit from the sale of an asset of **£0.3m** which is included when comparing performance against our planned operating surplus / deficit (previously excluded).



Summary

The year to date position is an operational deficit of **£3.5m** against a planned year to date surplus of **(£0.4m),** resulting in a **£3.9m** variance to plan, representing **higher than planned expenditure.** Key observations for February were:

- **Independent sector beds** - the Trust required 290 bed days during February 2023 (263 for January 2023) at a cost of £0.26m (includes estimates for unvalidated periods of occupancy and average observation levels pending billing). This was an increase of 27 bed days. The shorter months means on average 10 beds were required daily compared to 8 in January. Year to date expenditure was £3.5m, or £3.2m 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 February 2023 was £19.4m, which was £10.8m ahead of plan and includes material costs linked to inpatient occupancy and rosters, medical cover and complex specialist packages of care.
- **Computer hardware, software and maintenance** Computer Hardware is £1.6m ahead of plan. This is partly offset by a surplus to plan on computer software and maintenance of (£1.2m), resulting in a net deficit to plan of £0.4m. The associated recovery action for capitalisation of IT hardware (where appropriate) has been accelerated from M12 with a YTD benefit to the revenue position at M11 of £1.1m.
- **Planned CRES performance** as at February 2023 is behind plan by £4.1m, however unplanned schemes to the value of £3.1m provide a partial offset, resulting in net CRES performance that is £1.0m behind plan. Key variances relate to agency and independent sector bed pressures driving run rates significantly above 2021/22 levels. Further risks and mitigations are being identified to offset under performance of CRES.
- **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 £5.3m to month 11, resulting in a net pay award pressure of £2.8m (£3.0m 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 now included when comparing performance against planned operating surplus / deficit.
- **International Recruitment** – Exceptional costs associated with international recruitment of £0.1m in Month 9. The International Recruitment business case was presented to EDG during February and supported in principle pending further modelling of benefits of medical recruits being reduced from 6 months super nummary assumption
- There have been improvements in M11 to the previously reported deficit position largely relating to the accelerated IT capitalisation and commissioner contract variations.

To deliver sustainable financial plans 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 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). The impact of this will be evaluated at the financial year end. 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). A reduction of 547 agency shifts in February compared to January.
	Enabling action: The Safer Staffing Group to establish an agency reduction sub group to identify further actions required, and monitor progress and compliance.	**Closed.** These will now be progressed through the Care Group Resource & Business Development Sub Groups	
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	Centralised CIO / Deputy CIO level approvals for all hardware to improve resource and asset management Capitalisation of revenue expenditure of £1.1m at 28th February.

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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*		
We are concerned about the level of agency staff being used which is impacting on the quality of the services we provide and our financial plan.	*Enabling action:* Agency Reduction Group to facilitate a Performance Improvement Plan by the 26th April 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on the use of agency staff within the Trust.	CRES assumptions included within 2023/24 draft financial plan.	
We are concerned that the level of support required for complex packages of care for Adults with a Learning Disability, increased cover for medical vacancies, and staffing requirements for patient observations, sickness backfill and vacancies are impacting on the quality of the services we provide and our financial plan.	*Enabling action:* Safe Staffing Group to facilitate a Performance Improvement Plan by the 26th April 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on safe staffing.		
We are concerned that our high inpatient bed occupancy is impacting on the quality of the services we provide and our financial plan.	*Enabling action:* Advancing Our Journey to Change Programme to facilitate a Performance Improvement Plan by the 26th April 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on our Bed Pressures including our use of Out of Area Placements		

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers, families, staff and Partners by ensuring we can manage our resources and finances effectively.

Agency expenditure of £19.4m is £10.8m **(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 £19.4m is £10.8m (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 £8.6m YTD resulting in a breach of this cap by £10.8m.

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

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 February 2023 there were 3,942 agency shifts worked, with 2,464 shifts compliant **(63%).**

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 February 2023 3,942 agency shifts were worked (547 less than January).

Of these, 2,464 or 63% shifts were compliant (61% compliance prior month).

Of the non-compliant shifts 1,402 or 36% breached price caps (compared to 1,498 shifts and 34% prior month) and 76 or 2% breached framework compliance (down from 206 shifts and 5% prior month).

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

Further refinement of shift data relating to the above takes place up to the NHSI Temporary Staffing submission mid-month which may result in minor differences between reported data.

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		

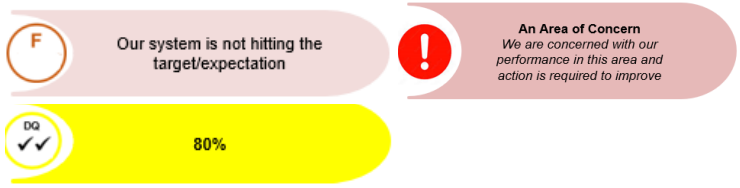
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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 28th February 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 0.70x, which is 0.77x or £5.1m 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 27.1 days; this is behind plan by 2.2 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 0.8%, this is worse than plan by £3.9m and is **rated as 4**.
- The **agency expenditure** metric assesses agency expenditure against a capped target for the Trust. Costs of £19.4m are £10.8m (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 28th February and is **behind plan by 1**.

Each metric has been assessed against forecast financial performance at 31st March and results in **a forecast 2022/23 overall UoRR of 2**, which will be in line with plan, despite agency performance being rated as 4.

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	Positive work to progress 2022/23 financial recovery actions is expected to improve individual UoRR metrics with the exception of agency at month 12.	

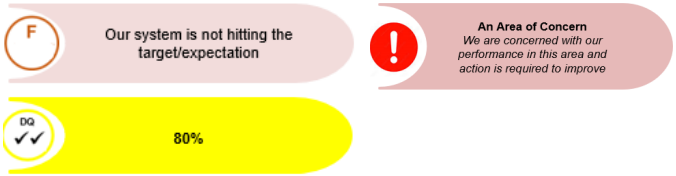
27) CRES Performance - Recurrent

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 **£11.0m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£10.0m**.

£1.0m variance to plan.



Summary

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

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

CRES delivery is £1.0m behind plan with specific performance noted as:

- £1.0m CRES for OAPs contracted bed elimination is behind plan
- £2.7m CRES for agency rate compliance and usage reduction is behind plan
- £0.2m CRES for Crisis Line support from Vale of York CCG is behind plan
- £0.3m CRES for reduction in covid measures is behind plan
- £1.4m CRES for interest receivable and is ahead of plan
- £1.2m CRES for slippage linked to vacancies & corporate services
- £0.4m 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*	CRES under-performance recurrently will be mitigated fully by over-performance on non-recurrent actions by the 31st March 2023.	Deterioration in underlying position recurrently (non-recurrent mitigation).

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

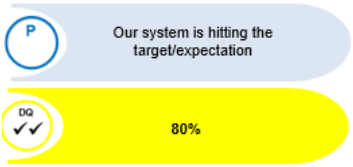
28) CRES Performance – Non-Recurrent

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 **£1.3m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£1.3m**.

(£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.
- Non-recurrent recovery actions expected during March will mitigate in-year the recurrent adverse variance to CRES targeted plan.

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 February was **£5.3m** against planned expenditure of **£9.3m.** PDC funding received for Crisis and Frontline digitalisation nets off expenditure by £4.7m, resulting in a **£4.0m** underspend against plan. Forecast outturn is to overspend against plan by £0.4m, due to March spend on patient safety doors, Stockton Crisis service modular build, and replacement of defibrillators Trustwide.

Summary

Net of PDC funding received during February capital expenditure at the end of February was £5.3m, and is £4.0m lower than allocation of £9.3m. This includes slippage on the Stockton Crisis service modular build, and patient safety works (mainly the installation of patient safety doors).

Networked IT assets have been capitalised, 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 ICB is projecting to underspend, so have supported the Trust to spend in excess of allocation to replace end of life defibrillators throughout the Trust (£0.3m).

The Trust has received confirmation of £3.0m 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. Current forecast is to breakeven with plan.

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

Crisis modular build is expected to deliver on or close to target completion in March, and patient safety doors have confirmed delivery date of March.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Not spending the full capital allocation in year could lead to pressure in future years as annual plans are managed at ICS level.	The Capital Development Team have reviewed the forecast to accommodate accounting for grouped IT assets and central ICB management of a projected aggregate over spending.	**Completed.** D&D and Concorde have provided evidence to support capitalisation of IT grouped network assets.	IT asset spend capitalised, and supporting evidence retained for External Audit.

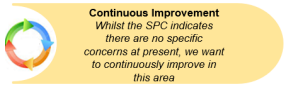
30) Cash balances (actual compared to plan)

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 **£72.1m** against a planned year to date cash balance of **£65.8m.**

£6.3m positive variance from plan



Summary

Cash balances were **£72.1m** at 28th February 2023, which is **£6.3m** higher than plan of **£65.8m**. This is linked to capital funding received to support developments that are anticipated to complete during March. The Trust's deficit financial position is being offset by underspends on capital and working capital variations.

The Trust did not achieve the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of Non NHS suppliers, but has met the target for NHS suppliers paid for the year to date, 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 28th February 2023 was £7.9m. Total debt is higher than planned, but £3.3m is with Health Education England, and £2.0m with Humber FT due to invoices being misplaced (full payment expected in March for both). The value over 90 days overdue is better than targeted (£0.2m excluding amounts being paid via instalments and PIPS loan repayments) and has again reduced in month. Three government organisations account for 65% 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 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			

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. Staff Retention	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. Staff Retention	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	Q4 (Jan-Feb)	FYTD
13a: Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	Q1 606 Q2 185 Q3 0 Q4 0	1094	1029	431	453	453
13b: Number of inappropriate OAP bed days for adults by quarter that are 'external' to the sending provider	Q1 606 Q2 185 Q3 0 Q4 0	1094	1029	431	453	453
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%	87.24%	88.57%
Data Quality Maturity Index	93.00	97.50	97.30	97.30	96.70	96.70

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. There are several areas will not achieve the agreed trajectories in the Long-Term Plan which are outlined in the following pages. These areas were discussed by Executive Directors Group on the 22nd February 2023 and it was agreed that as part of the new Accountability Framework, Care Groups would be asked to complete a Performance Improvement Plan for consideration by EDG on the 26th April 2023.

Long Term Plan Ambitions - County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **6** measures that are at risk of delivery for quarter 4, of which **5** are at risk of delivery for the financial year.

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	Q4 (Jan-Feb)	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	17787	12448	2828	2209	2485	1742	9264
Percentage of people who have waited more than 90 days between first and second appointments	<10%	<10%	28.43%	30.70%	14.63%	11.67%	22.42%
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Q1 50% Q2 75% Q3 95% Q4 95%	37.50%	52.05%	68.75%	77.27%	77.27%
The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Q1 55% Q2 75% Q3 95% Q4 95%	73.91%	88.89%	90.32%	83.87%	83.87%
Number of people accessing IPS services as a rolling total each quarter	1058 ICS Ambition	169 at Quarter End	140	138	129	70	
Number of women accessing specialist community PMH services in the reporting period (cumulative)	529	Q1 114 Q2 228 Q3 342 Q4 456	227	289	361	404	404

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 need to ensure that any improvement actions implemented to improve access rates do not adversely impact our waiting times and the flow of patients through our service.	*Enabling action:* IAPT Service Manager and General Manager for Adult Mental Health Planned Care to present a position statement and the proposed improvement actions to the ~~March~~ April 2023 Quality Assurance & Improvement Subgroup, with a view to agreeing the actions to be taken forward.		

Long Term Plan Ambitions - County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy			
Within the IAPT Service, people are not commencing a course of therapy with us because we do not offering sufficient choice of appointment for people that may be considering access to our service.	The Service Manager to lead a trial to use the Mayden choose and book system to enable patients to choose their own appointment time, with a view to increasing access to our service. This trial will start ~~on the 15th February 2023~~ before the end of March 2023.		
NEW To raise the profile of Talking Therapies in line with national developments and to remove barriers to access, the service will rebrand to 'NHS Talking Therapies'.	*Enabling action:* Team Managers to review marketing materials following the rebranding of IAPT to Talking Therapies, with a view to increasing access to the service. This review will be completed by the end of April 2023.		
NEW We need to better understand the spread of referrals across our local areas to identify those areas where referrals are lower and whether there are alternatives to IAPT available within those communities, to enable us to develop focused promotion.	*Enabling action:* Senior Therapist to lead an in-depth review of referrals to identify key areas where improvement actions are required to support increased access rates. Delivery and timescales for the work will be agreed by the end of March 23.		
IAPT: The proportion of people who are moving to recovery			
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~~ February 23.	**Complete.** The review was completed and the Clinical Leadership team now include these discussions in all supervision sessions with staff.	Performance remains in common cause; however the standard has been achieved for 3 consecutive months.

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**			
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.	**Complete.** All vacancies are now filled.	Improvement is visible for both measures, although both remain below standard.
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.	Joint working between clinicians from both Trusts continues and a meeting to finalise the agreement is scheduled for the end of ~~February 2023~~ March 2023.	
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.	*Enabling action:* Business Intelligence Team to amend the measure to ensure that only contacts by IPS staff are being included within the measure. This work will commence in the March 2023 sprint.		

Long Term Plan Ambitions - County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Number of women accessing specialist community PMH services.			
The Service has been impacted by a number of practitioner vacancies over 24 months, despite multiple attempts at recruitment.	Service Manager to lead the recruitment of 3 practitioners by the end of March 2023, with view to increasing resource within the team.		
We are concerned there is a lack of understanding of the role and care the service provides amongst our Adult Mental Health teams, resulting in fewer referrals than we would anticipate.	Service Manager, supported by team managers, to develop and implement a programme of education across all AMH teams by the end of June 2023, with a view to increasing awareness of the service and referrals.		
We are concerned there is a lack of understanding of the role and care the service provides within local GP practices and acute hospitals, resulting in fewer referrals than we would anticipate.	Service Manager to share marketing materials and provide training sessions to staff within local GP practices and acute hospitals by the end of June 2023, with a view to increasing awareness of the service and referrals.		

Long Term Plan Ambitions – Tees Valley Sub-ICB Location

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	Q4 (Jan-Feb)	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	22972	2260	600	436	502	360	1898
Percentage of people who have waited more than 90 days between first and second appointments	<10%	<10%	30.05%	33.60%	18.03%	13.92%	25.36%
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Standard	75.82%	82.29%	85.29%	89.25%	89.25%
The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Standard	66.67%	73.68%	66.67%	62.50%	62.50%
Number of people accessing IPS services as a rolling total each quarter	1058 ICS Ambition	216 at Quarter End	166	186	150	104	
Percentage of people experiencing a FEP treated with a NICE approved care package within 2 weeks of referral	60%	60%	68.49%	66.67%	78.57%	57.45%	68.77%

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Percentage of people experiencing a FEP treated with a NICE approved care package within 2 weeks of referral			
Achievement of our waiting times standard is being impacted by delays in screening referrals	Service Managers to ensure a standard process is in place by the end of February 2023 between the access and EIP teams to ensure initial screening in access takes place to on the day of referral and relevant referrals are passed to EIP on that same day.	**Complete.** Standard process tested and is in place across all teams.	No visible impact to date; however, standard was achieved for February and further improvements can be expected as these processes are embedded.
Achievement of our waiting times standard is being impacted by delays in staff recording the validation of assessments.	Service Managers to ensure an effective diary management system is in place by the end of February 2023 that will ensure all assessors include administrative time following each assessment to eliminate delays.	**Complete.** Agreed diary management is now in place for all assessors.	

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
Percentage of people experiencing a FEP treated with a NICE approved care package within 2 weeks of referral			
We have identified a potential concern within our Redcar & Cleveland team; however further investigation is required to understand if there are any underlying issues and whether improvement actions are required.	*Enabling action:* The Consultant Clinical Psychologist to undertake a deep dive to understand the underlying issues and to identity any improvement actions that need to be established. This work will be completed by the end of February 23.	**Complete.** The deep dive concluded there was no underlying concern requiring improvement actions; however are taking steps to ensure efficient diary management.	
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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

There are **6** measures that are at risk of delivery for quarter 4, of which **4** are at risk of delivery for the financial year. There is **1** additional measure at risk of delivery for the financial year

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	Q4 (Jan-Feb)	FYTD
Total access to IAPT services - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	11623	8272	1676	1816	1808	1257	6561
IAPT: The proportion of people who are moving to recovery	50.00%	50.00%	50.05%	49.23%	42.44%	53.99%	48.49%
Percentage of people who have waited more than 90 days between first and second appointments	<10%	<10%	8.59%	11.42%	7.75%	11.10%	9.51%
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Q1 55% Q2 60% Q3 70% Q4 80%	57.81%	58.93%	64.91%	70.59%	70.59%
The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Q1 50% Q2 60% Q3 70% Q4 80%	55.56%	55.56%	80.00%	66.67%	66.67%
Number of people accessing IPS services as a rolling total each quarter	559 ICS Ambition	123 at Quarter End	67	82	92	65	
Number of women accessing specialist community PMH services in the reporting period (cumulative)	398	Q1 71 Q2 142 Q3 213 Q4 284	69	95	125	140	140

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			
We have identified that we have a number of GP practices within the area that have high rates for prescribing high anti-depressants but have low referrals to our IAPT services.	*Enabling action:* Team Managers to review the success of the IAPT banners at the end of March 2023 to establish if this approach is having the desired impact.		

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
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy			
We need to improve service promotion on social media through the use of videos with a view to increasing the number of referrals to the service.	The Service Manager to work with the communications team to develop service videos that can be shared on social media. These will be developed and published by the end of ~~March 2023~~ June 2023.	**On hold.** This work has been placed on hold pending a full review of all marketing materials in line with the rebranding of the service. (*See below action)*	
We need to engage with local businesses to offer IAPT services in business premises with a view to increasing the number of referrals to the service.	*Enabling action:* Team Managers to review marketing materials following the rebranding of IAPT to Talking Therapies, with a view to then sharing these with local businesses. This review will be completed by the end of April 2023.		
NEW Team capacity is being impacted by maternity leave, which is impacting on the service's ability to offer appointments.	The Service Manager to recruit 3 staff on fixed term contract to mitigate the impact of staff on maternity leave by the end May 23.		
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).	**On hold.** The 1.2 HIW posts have been appointed. 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.	
	NEW Service Manager to recruit 2.4 High Intensity Workers by May 2023 to reduce the number of people waiting.		

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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
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.	**Closed** It has been agreed to stand down the second kaizen event to enable the Team Manager to focus on capacity and resources to meet the conflicting priorities at present.	
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.	Eating Disorder's Service Manager to engage with the communications team, commissioners and partner agencies to implement the CED specific referral form. This work is to be completed by May 23.		
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 vacancies.	The service manager to progress a recruitment exercise for 5.6 wte vacancies by the end of November 2022.	1 clinical nurse will start in post in June, the Specialist Psychological therapists and team manager will start in post in April. 1.6 Clinical Nurse posts remain to recruit and have been re-advertised following unsuccessful interviews in March 23.	
NEW Staff capacity in the Scarborough Perinatal Team has been significantly reduced due to sickness absence and there is a need to offer additional support to the team to ensure patient safety and reduce the impact on our patients.	The General Manager and Perinatal Service Manager to submit a proposal for the Scarborough Perinatal Service to implement business continuity plans from March 2023 for a period of 6 months to enable patient safety and enable recruitment of key posts within the service. This will adversely impact our ability to achieve the Sub-ICBL ambition.	Ways to mitigate the impact are currently being explored; the ability to assess and support patients is the main priority.	

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
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 **3** measures that are at risk of delivery for quarter 4, of which **2** are at risk of delivery for the financial year. There are **2** additional measures at risk of delivery for the financial year

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	Q4 (Jan-Feb)	FYTD
Total access to IAPT services - Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	9661	6282	1441	1405	1737	1093	5676
Percentage of people who have waited more than 90 days between first and second appointments	<10%	<10%	17.65%	15.52%	12.45%	9.75%	14.33%
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment (rolling 12 months)	95%	Q1 55% Q2 60% Q3 70% Q4 80%	56.34%	60.00%	60.94%	67.61%	67.61%
Number of people accessing IPS services as a rolling total each quarter	559 ICS Ambition	92 at Quarter End	82	100	105	81	
Number of women accessing specialist community PMH services in the reporting period (cumulative)	336	Q1 60 Q2 120 Q3 180 Q4 240	50	73	93	112	112

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			
We have identified that we have a number of GP practices within the area that have high rates for prescribing high anti-depressants but have low referrals to our IAPT services.	Team Managers to approach identified GP practices to discuss approaches to improving referral rates. These discussions will be complete by the end of ~~February 2023~~ June 2023.		
NEW Analysis has identified First Contact Mental Health Practitioners (FCMHP) are not clear on the referral criteria into IAPT resulting in low referral rate from GP practices.	IAPT Team Managers to feed back analysis findings to the FCMHP Team Manager by the end of June 2023, with a view to identifying further improvement actions.		

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
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.	Team Managers to pilot the new pathway in the last 2 weeks of March 2023 with the new cohort of patients under the age of 25.	A number of clinicians have already started to implement the new pathway; learning from this is to be reviewed to understand whether this pathway should be continue to be rolled out across the service. (*See following action*).	
New An increasing (improving) performance has been visible throughout quarters 3 and 4 2022/23 and there is a need to review performance to assess whether the new pathway has contributed to this.	*Enabling action.* Team managers to undertake a deep dive to understand what actions have been established that may need wider sharing, and the contribution of the new pathway for under 25s to the increase in recovery rates. This work will be completed by the end of April 2023.		
Percentage of people who have waited more than 90 days between first and second appointments			
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 recruit 1.4 wte Administrators by ~~January~~ February 2023 to reduce the number of people waiting more than 90 days between first and second appointments.	Interviews are scheduled for the 27th March 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 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.	The York & Selby team manager to recruit 3 members of staff to improve staffing capacity from December 2022.	**Complete** All 3 posts have been recruited to and have commenced in post.	No visible impact to date; however, standard has been achieved for two consecutive months and further improvements can be expected as staff are fully embedded within the team.
	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.	**Closed** The service was unable to recruit agency staff; however, following successful substantive recruitment this is no longer required.	
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 vacancies.	The service manager to recruit 5.6 wte vacancies by the end of ~~November 2022~~ May 2023 to increase the number of appointments we can offer.	1 clinical nurse will start in post in June, the Specialist Psychological therapists and team manager will start in post in April. 1.6 Clinical Nurse posts remain to recruit and have been re-advertised following unsuccessful interviews in March 23.	
Staff capacity in the York Perinatal Team has been significantly reduced due to sickness absence and there is a need to offer additional support to the team to ensure patient safety and reduce the impact on our patients.	The General Manager and Perinatal Service Manager to implement business continuity plans from January 2023 for a period of 6 months to enable patient safety and enable recruitment of key posts within the service. This will adversely impact our ability to achieve the Sub-ICBL ambition.	**Complete.** York Perinatal team was placed in business continuity from 25th January 2023. Commissioners have been informed of the impact by the Director of Operations.	

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
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			

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Tees, Esk and Wear Valleys NHS Foundation Trust

ITEM NO. 11

For General Release

Meeting of:	**Board of Directors**
Date:	**27 April 2023**
Title:	**Our Journey to Change Delivery Plan 23/24**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Chris Lanigan, AD Strategic Planning and Programmes**

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:

The *Our Journey to Change Delivery Plan 2023/24* is informed by an understanding of all of the BAF risks and the differential levels of risk appetite for each of the risks within it.

Executive Summary:

Purpose:

The *OJTC Delivery Plan* (Appendix 1) is being presented to the Board of Directors for approval. Setting out our 23/24 plans to implement OJTC will enable the Board to monitor delivery, and inform our communications with service users, carers, colleagues and partners.

Proposal:

It is proposed that the Board of Directors should approve the OJTC Delivery Plan, while acknowledging that in-year changes will be made through the appropriate governance as business cases are developed and the external environment changes.

Overview:

The OJTC Delivery Plan has been developed by the Trust's care groups and corporate services. All of the development work was focussed on how *Our Journey to Change* can best be practically implemented. The content was also influenced by the development of the 5 strategic Journeys (approved by the Board of Directors last month).

Some elements of the Plan, particularly those overseen by the Advancing OJTC Board require complex interdependencies to be identified and worked through, Rather than rushing the development of business cases in order to include in this version of this document, that development work will continue at an appropriate pace, and more detail will be added to the plan in-year once cases and associated detailed plans have been approved.

The Plan is based on the resources and capacity available – it is intended to be realistic, not aspirational. Delivery of Our Journey

to Change and the 5 strategic journeys was always intended to be an incremental, medium-term endeavour. However, delays to ICS led planning processes mean that contracts have not yet been signed and income and performance / quality trajectories have not been fully agreed. SDF funding by Place has also not been definitively allocated. This means that:

- It has not been possible to include performance trajectories and budget information in this document as intended
- The mobilisation of expected new investment into North Yorkshire and York IAPT, perinatal, CYP Eating Disorders, crisis and EIP services has not yet been included in the plan

However, there is sufficient certainty about core funding for the Trust from the NENC and HNY ICBs and the NENC specialist provider collaborative to enable this plan, as presented here to be produced, approved and published.

Quarterly reporting to the Board of Directors will show overall progress on the 17 priorities, note changes to plan made by Executive or Board Committees, and escalate issues and decisions which require full Board of Directors approval.

Prior Consideration and Feedback

Care Groups engaged staff, service users, carers and partners (including all of our commissioning groups) in their planning processes. There was also significant engagement in the development of the strategic Journeys and in the Board's OJTC stakeholder event, held at Great North Air Ambulance (20 Feb). As a result of this latter engagement, and subsequent Board discussion of these, we have made changes to the plan including:

- Integration of relevant care group actions into the priority tables
- Changing the "plan on a page" to clearly show the 3 priorities within the people journey, including "culture"
- Linking the plan to national and ICS priorities
- Reducing the use of jargon, and adding a glossary

Implications:

There is no legal or regulatory requirement for TEWV to approve and publish a Trust Delivery Plan. Therefore the Board could ask for the Plan to be revised before receiving final approval (noting the risks outlined in the overview). However, any delay will impede communication of our priorities and the commencement of the monitoring and escalation required to drive forward implementation of the plan. Approving the Plan does not prevent the plan being updated during the year in response to business case development or environmental change.

Recommendations:

The Board of Directors is recommended to approve the Our Journey to Change Delivery Plan 23/24 and to authorise the communication of this plan to partners, staff, service users and carers.

Board of Directors
27 April

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Our Journey to Change Delivery Plan

2023/24

Introduction

What is "TEWV"?

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) is a TEWV is a large and complex organisation with around 7,800 employees who provide a range of inpatient and community mental health and learning disability services for approximately 2 million people of all ages living in County Durham; the 5 Tees Valley boroughs of Darlington; Hartlepool, Stockton, Middlesbrough and Redcar and Cleveland; the Scarborough, Whitby, Ryedale, Hambleton, Richmondshire, Selby and Harrogate areas of North Yorkshire; the City of York; the Pocklington area of East Yorkshire; and the Wetherby area of West Yorkshire.

Our adult inpatient eating disorder services and our Secure Inpatient (Forensic) wards serve the whole of the North East and North Cumbria. TEWV also provides mental health care within prisons located within the North East North Cumbria; Humber North Yorkshire; and Lancashire and South Cumbria Integrated Care Systems.

We deliver our services through two Care Groups, which are supported by corporate services. These care groups are:

- North Yorkshire, York and Selby
- Durham, Tees Valley and Forensic

We had a "Big Conversation" with our partners, staff, service users and their families during 2020. Despite the lockdowns during that first year of the Covid pandemic we had more than 2,000 contributions. People were clear about why the Trust needed to change, and on where our journey to change should take us. They gave us our 3 big goals of improving the experience of service users and their families, TEWV colleagues and our partners. Our values of respect, compassion and responsibility are also based on that engagement. Our Journey to Change is summarised in the diagram on page 3. We have already made some progress on our journey, but this document looks forward to the actions we are taking during the financial year April 2023 to March 2024.

National and Integrated Care Systems' Priorities

The NHS has a Long Term Plan for Mental Health which identifies several priorities for NHS commissioners and providers. These include:

- Improving access to existing services such as talking therapies, crisis services and community mental health services for both adults and children
- Setting up and expanding new services such as perinatal, individual placement and support into work for people with severe mental health conditions
- Transformation of community mental health services through place-based partnerships

The national priorities for learning disability services (known as *Building the Right Support)* are to reduce the inappropriate use of hospitals, and to reduce over-medication. Autism priorities nationally include increasing NHS staff awareness of the adjustments that would help autistic people to access health care effectively. A revised Mental Health Bill is moving through its parliamentary stages and if approved, will eliminate the use of detentions for people who are autistic or have a learning disability but who are not mentally unwell.

The North East North Cumbria ICS and Humber North Yorkshire ICS have both developed integrated care strategies and "joint forward plans" HNY also approved a mental health, learning disability and autism strategy in 2021. These set out goals such as increasing life expectancy, improving health service quality and reducing health inequalities. For mental health and learning disabilities they reference principles such as the importance of prevention / tacking the determinants of ill-health, early intervention, trauma informed care and quality improvement. Workforce development and utilising community assets, including the voluntary sector are also common features.

This plan supports, and is informed by, national and ICS priorities.

Content of this Document

This *Our Journey to Change Delivery Plan* sets out:

- The role and importance of our Clinical, Quality, CoCreation, Workforce and Infrastructure journeys to change
- Our delivery priorities for 2023/24, including completion dates for key pieces of work and the impact we expect them to have
- The standards we have agreed with our commissioners and regulators, that we will deliver during 2023/24
- Our financial and workforce plans for the year ahead

If you have any questions about this document, please contact Chris Lanigan, Associate Director of Strategic Planning and Programmes at chris.lanigan@nhs.net

Our Clinical, Quality, Co-Creation, Workforce and Infrastructure Journeys

We have 5 Journeys which explain in more detail what Our Journey to Change means. Each of the Journeys sets out our ambitions – i.e. what is the clinical, quality, cocreation, workforce and infrastructure destination that we are journeying to. They also set out some of the principles that will guide our journey.

The individual journey documents are available at insert web address here in final version in April

There are different ways in which we will make the journey from where we are now to where we want to be. These include

1) Changes in everyday working practices and behaviours, which over time become cultural change
2) Incremental changes to our "business as usual", often achieved by teams formally or informally using Plan Do Study Act (PDSA) cycles, which will be prompted by data and risks discussed through the governance of our Trust
3) Developing projects / initiatives to create new services or to change existing services. Some of these are funded by new commissioning investment, but others use the resource already available to the Trust. Where plans involve efficiency savings or significant changes to services, they must pass a Quality Impact Assessment conducted by our Medical, Nursing and Therapies directors before implementation
4) Convincing our system partners to do things differently, in line with the ambitions of our Journeys

In the past, the Trust's Business Plans have focussed on the projects and initiatives developed by the Trust (category 3). But this OJTC Delivery Plan should reflect the wider range of things we are doing which will advance Our Journey to Change during 2023/24. All of these four aspects of making our journeys must be successful if we are going to successfully arrive at the destination of our journey to change.

Our "Advancing" Board is where we manage the most urgent and complex cross-cutting transformation projects. These receive additional support from the Trust's change and project management experts. In 23/24 we have purposefully put all of our immediate quality journey areas of focus under this Board along with work to help us reduce pressures on our mental health assessment and treatment and PICU inpatient beds. Personalising Care Planning also features because supporting and enabling service users to develop their own care plans, so that care is tailored to their personal needs and recovery goals is the way to make sure that cocreation is a reality for every person using TEWV's services.

2023/24 - Plan on a Page

journey to change

- **Clinical**
  - Community transformation
  - CITO implementation
  - Autism
- **Quality & Safety** — Advancing Board
  - Reducing inpatient pressures
  - Patient safety
  - Harm-free care
  - Personalising care planning
- **Cocreation**
  - Lived experience posts
  - Data collection & learning
  - Diversify & expand involvement
- **People** — Workforce Delivery Plan
  - More People
  - Inclusive and Compassionate Culture
  - Working Differently
- **Infrastructure**
  - One Team TEWV
  - Digital and data journey
  - Green Plan
  - Estates Masterplan

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

These will be underpinned by:

- Service user, carer, staff & partner engagement to inform plans & gather intelligence on impact
- Detailed plans (why, how, when, who)
- Measuring impact

Our three big goals

1. **Cocreate a great experience for our patients, carers & families**

2. **Cocreate a great experience for our colleagues**

3. **Be a great partner**

1. Community Transformation – leads: Care Group Managing Directors

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Adult / Older People's community mental health team transformation - DTV	To meet the requirements of the **national transformation model** and road map requirements to ensure the needs of those with a serious mental illness are met more effectively. To continue to work as a key system partner to **implement the required service, workforce and cultural change to deliver improved outcomes**	**March 2024**	• New roles introduced in agreed places (e.g. Teesside community navigators) , September 2023 • Changes required to provide a consistent rehabilitation and recovery service across DTV completed, September 2023 • Increase in people offered and accessing evidence-based interventions, December 2023 • New national PROMS (Patient Reported Outcome Measure) embedded and routinely reported, December 2023 • New transformed models for adults and older adults in place across the geography, in line with the national roadmap, March 2024 • A physical health care model in place and demonstrable increase in physical health checks, March 2024 • Increased compliance with new national 4 week waiting time standard, March 2024 • Move away from Care Programme Approach (CPA) embedded in practice, March 2024

Crisis - DTV	To deliver an **improved call answer rate** and a pathway which is integrated with North East Ambulance Service (NEAS) and offers improved signposting options and direct access for service users to alternative agencies where appropriate. An **enhanced workforce model** to introduce screening, and **improved access for comprehensive assessment** for those who need it. This will deliver **improved patient safety and staff and patient experience.** Working collaboratively with staff, partners and stakeholders to improve the responsiveness of the Durham and Darlington crisis service To complete the implementation the older person's crisis model	**June 2023**	• New access model is in place with NEAS with demonstrable improvement in call answer rate, responsiveness, signposting and assessment processes (June 2023) • Implementation of the agreed outputs following the Durham and Darlington crisis service improvement event to include measures for patient, staff and stakeholder stated improvements (June 2023) • Older person's crisis model fully implemented (June 2023)

I-Thrive - DTV	To Continue to support and influence the system so that a commissioning and delivery plan for a **comprehensive I-thrive model** is in place. We will implement an improved front door offer, which provides more comprehensive advice signposting and Getting Help. This will improve access to the Getting More Help Service for the most complex young people. We will continue to improve the pathways and interface with CDDFT to **support young people admitted to paediatric beds** The TEWV CYP services will have a clear role in the national **family hubs** programme as they develop	**March 2024**	• Implementation of year 1 actions from the I thrive transformation plan with an improved front door offer, increased focus on the getting help offer with partners to clarify current provision and gaps and family hub and school based models further embedded (March 2024) • Participation, oversight and delivery of the Alliance MH Action Plan with CDDFT will be achieved and improvement in operational and strategic relationships will be visible (March 2024) • A completed full CAMHS estate review (ensuring equipment, environment is suitable, 7-day access & availability) (Dec 2023) • To map and identify accommodation requirements within the respective family hub implementation programme in each place to ensure an increased range of accessible premises/community hubs are provided as the programme rolls out (Dec 2023)

Adult LD - DTV	**To deliver Community and inpatient pathway Transformation in line with CQC, peer review reports (Mersey Care) and national guidance .** This will include: • **New clinical model** that promotes **early intervention and prevention within mental and physical health** • Design and implementation of the **least restrictive care and treatment** options • Optimising **partnership and systems working**	**September 2024**	• Implementation of the respective improvement plans for inpatient and community provision (March 2024) • Working with the Trustwide Restrictive practice governance groups, to improve practice and reduction in use of restrictions will be evidenced (March 2024) • Established links with partners and shared map of respective service provision with network meetings in place for partners to come together to increase connectivity, relationship management and strengthen service provision across the system (March 2024) • Working with partners / regulators to develop to confirm the future respite service model (Sept 2024)
Forensics – Establishing a Community	• Addressing **regulatory** concerns. • Ensuring **equality of access** to services as would be available outside the secure hospital wards. • Providing **opportunities for service users** to benefit from activities, gain vocational qualifications, paid and volunteer roles. • Meeting the **physical health** needs of services users.	**September 2024**	• Baseline assessment of existing provision across all areas produced – June 2023 • Focus groups with service users and carers carried out to establish what they would like to have in place – September 2023 • Business case(s)/proposals produced as required – December 2023 • If business case(s) agreed, implementation plan developed – March 2024

Health and Justice – Reconnect, North Yorkshire	In line with provision currently across North East, commissioners in North Yorkshire will be rolling out implementation of the **Reconnect service** which aligns to Liaison & Diversion.	**July 2023**	• Staff recruited and in training (April/May 2023) • Ops policy to be agreed - TEWV/Rethink (June 2023) • Pathways to be agreed (June 2023) • Agree collaborative operational approach (TEWV/Rethink/Humankind) (May 2023)
Older People's community mental health team transformation – NYYS	To support '**place based' provision of care** across our care group geography in line with NHSE/ICS direction. Support a **system wide approach to rehabilitation and independence.** To align service structure with future investment proposals to develop a **resilient and sustainable Memory Service** across MHSOP.	**March 2024**	• Develop links with first contact MH worker team managers to support development of MDT working (June 2023) • Implement senior clinical leadership to build relationships with the hub(s), local medical councils and PCNs (Sept 2023) • **Capacity and demand analysis** (by end June 2023) i) Identify what is required to ensure ongoing oversight of waiting list. ii) identify capacity required to reduce waiting list. iii) Analysis to inform business case proposal for additional resource. • **Review the memory service offer** (Sept 2023) **-** to support development of a consistent memory offer across the care group – inc. medical and leadership provision • **Produce MAS business case** (March 2024)

Adult community mental health team transformation – NYYS	To improve the **lived experience** and life potential of those with enduring mental health Improve patient and carer experience through **seamless care,** making the most of system overhaul: Work closer and appreciate the value of our **partners** to bring about shared benefits for patients and carers.	**March 2024**	• Improved support to access health screening and physical health (Sept 2023) • Adopt system-wide approach to rehabilitation and independence (March 2024) • Progress the development of the community hubs across place-based settings (March 2024) • To progress the care of the homeless across all place-based areas (inc. implement CYC partnership for York Homeless Project) (March 2024) • Establish positive relationship and 'trusted partners' that means we stay in step with our partners (March 2024) • Strengthen the participation of active members of our partners in decision making (June 2023)
Crisis - NYY	To be able to deliver the best experience and outcomes for our patients and carers: - To have a fit for purpose **telephone mental health support and crisis offer** for patients and carers Improve **the consistency, quality and effectiveness** of crisis services in NYY	**March 2024**	• Improve All Age Crisis Telephone service by addressing service response rates and call retention. (LTP funding proposal submitted) (March 2024) • Implement listening service pilot with VCS partners for mental health crisis support lines to better understand the need for the service long term (implemented for 6 months through to end June 2023) • Review of models in other areas including the one used in Humber (June 2023) • Completion of options paper for submission to Care Group and decision on future model for CAMHS (Sept 2023) • Implementation of agreed model (March 2024)

I-Thrive - NYY	To ensure the **service offer** and model in specialist CAMHS is **clear and communicated** to our service users and partners Support partners to understand and contribute to implementation of the I-thrive model by enabling coproduction and buy in that supports **implementation across all system partners**.	**June 2024** **March 2024**	• To review Service Specifications with Commissioners (by June 2024) • To support the I-Thrive event planned by Commissioners and ensure we are key partners in any subsequent re-design work (by March 2024)

2. Cito – lead: Executive Development Group

Project Title	Aim / Reason Why	Deadline	Milestones
Cito	Delivery of **clinical record** Reduction in time clinical colleagues spend inputting information into **digital systems** and improvement in **data quality**	**3/7/23** **From July 2023 onwards**	Testing Sign off- May 23 Phase 1 Go Live Jul 23 (3/7/23) Phase 2 work will then follow once scoped.

3. Autism: Lead – Medical Director / Care Group Managing Directors

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Autism Training	• Deliver **Understanding Autism training** trust-wide to meet the requirements of the Autism legislation and CQC baselines • Autism **Diagnostic assessment training and clinical supervision** in Durham Tees Valley CMHTs. To increase the quality and quantity of Autism Diagnostic assessments in DTV CMHT's • Development and implementation of **bespoke autism training** in response to trust needs to meet the requirements of autism legislation and CQC baselines.	**March 2024**	• 12 sessions per month (March 2024) • Training course delivered 6 weekly, and clinical supervision offered on a monthly basis to individual teams to embed clinical knowledge and skills • As required
Autism Reasonable Adjustment support and coordination.	• The aim is for **all services to have ongoing access to clinical supervision and consultation when working with autistic people**. - This will ensure can provide care pathways that can be adjusted to meet the needs of autistic people within both inpatient and community services to meet the requirements of autism legislation and CQC baselines.	**March 2024**	• All AMH inpatient and community team areas will have completed an Autism Environmental checklist and have implementation plan in place (March 24) • All Inpatient working groups to meet monthly to work on the Implementation plan during the year.
Complex Autism case work	• To ensure that the trust can provide appropriate evidence based safe care for Autistic people where **needs** are more than reasonable adjusted care to **meet the requirements of autism legislation** and CQC baselines • Aims to provide **support** and consultation to **corporate services** in relation to patient safety, complaints and human resources to meet the requirements of autism legislation and CQC baselines.	**March 2024**	• Access to wrap around support from autism clinical experts trust-wide in acuity and complex cases (by March 24) • Resource in place for corporate services to ensure that they are complaint with autism legislation and CQC requirements (by March 2024)

Children and Young People Neuro-developmental Assessment Service - DTV	• To work with partners and commissioners to develop options for **sustainable provision which reduces/eliminates the waiting list** and maintains an effective accessible service going forward. • This will **address** the very significant **waits**, and detrimental impact on the wellbeing of children / young people and their families	**September 2023**	• Development of a paper to identify and evaluate a range of options to increase capacity to complete more diagnostic assessments (ADHD and ASD). Using learning from other organisations. (June 2023) • Implementation of the co – produced action plan to improve early support to families (by Sept 2023)
Adult Neuro-developmental Service - DTV	• To seek opportunities to widen provision via a collaborative approach to address the significant **waits** for access and intervention	**September 2023**	• Using improvement methodology and events to implement the single pathway to manage ADHD and ASD referrals (Sept 23)
Children and Young People Neuro-developmental Assessment Service - NYY	• To ensure we can provide a timely service to our YP and to clearly identify service gaps/challenges and communicate these to our Commissioning partners • Increasing demand for **neuro-developmental assessment** and the need to develop an appropriately **skilled workforce**	**Sept. 2023**	• To complete the data cleanse work on the manual PTL for ADHD (June 2023) • To work with Performance Team Colleagues to develop a dashboard for ADHD for Commissioners like the one we already provide for ASD (June 2023) • To develop a business case for ADHD to increase staffing resource commencing with the Scarborough Team (Sept 2023)
Adult Neuro-developmental Service - **NYY**	• Being better equipped to respond and adapt to the needs of people with ASD:	**March 2024**	• Introduction of a specialist team to support decision-making and intervention across AMH (Sept 2023) • Improved access to ASD expertise and capacity to support interventions supported by Increased ASD training uptake (March 2024)

4. Reducing Inpatient Pressures – Lead: Medical Director / Care Group Managing Directors

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Inpatient Flow – DTV AMH and MHSOP wards	To reduce bed occupancy through **reduction of delays in the patient journey**, to achieve the **elimination of out of area placements** by March 2024	**March 2024**	• A central bed management policy implemented, supported by refreshed PIPA (Purposeful Inpatient Admission) processes, June 2023 • Multi-Agency Discharge Forums with LA and other key partners in place and working effectively, June 2023 • Use of the exemplar ward framework within older people's wards, June 2023
Older adults pathway - NYYS - Ensure 7 day availability for Assessment & Treatment	To enable reduced admissions and an **alleviation in bed pressures**	**March 2024**	• Develop options appraisal for 7 day working for presentation to ICB (June 2023) • Produce operational policy and commence recruitment, progress through HR processes inc. LCC paper as organisational change (funding availability dependent and so date to be determined)
Reducing pressure on inpatient beds programme	To **reduce Out of Area Placements** in accordance with the agreed trajectory through the **reduction in Bed Occupancy**	**March 2024**	• Develop a Trust Wide programme plan (by end June 2023) • Zero out of area placements by March 2024
Implement bed configuration in line with NE&NC Secure Services Provider Collaborative Review	A **North East North Cumbria bed model** is being developed and TEWV must support this (to ensure the whole system provides high quality provision that meets demand within the available budget)	**October 2025**	• Bed model agreed – June 2023 • Implementation of pathway changes commenced in line with agreed project plan – June 2023 • Proposed developments – business cases developed as required

5. Patient Safety – Lead Director of Nursing and Governance

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Patient Safety Incident Response Framework (PSIRF)	To ensure TEWV **compliance with the Patient Safety Incident Response Framework** (PSIRF) National directive.	**April 2024**	• Governance and quality monitoring 31/05/2023 • Patient safety incident response planning 30/06/2023 • Curation and agreement of the patient safety incident response policy and plan 31/08/2023 • Transition - working under the patient safety incident response policy and plan 31/12/2023 • Embedding sustainable change and improvement 30/04/2024
LFPSE + InPhase	To ensure TEWV **compliance with the Learning From Patient Safety Events (LFPSE) National directive**. To replace the current Datix system with InPhase to support this compliance	**December 2023**	• Implementation of incidents LFPSE test system - 31/03/2023 • Implementation of incidents LFPSE to live system - 30/09/2023 • Implementation of system module onto system - 30/12/2023 • PSIRF module added to system – 30/10/2023 • Implementation of fit for purpose Risk and Quality management system 30/12/2023
Incident Reviews	To improve the **timeliness and effectiveness of reviews** so that they support learning and consequent avoidance of some future incidents	Date to be agreed	• Complete “root and branch” review (April 2023) • Approve plans for next steps and commence implementation (date tbc)

6. Harm Free Care – Lead: Director of Nursing and Governance

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Reducing the Use of Restrictive Interventions	To **reduce** the use of **restrictive interventions** by 50% by 31st March 2024	**31/03/2024**	To be agreed within the Advancing OJTC board - plans are currently being formulated
Safeguarding / Parental/Carer Mental Ill Health impact on children (PAMIC)	To minimise the **impact from parental/carer mental ill health** and behaviour **on children**	**31/03/2024**	To be agreed within the Advancing OJTC board - plans are currently being formulated
Reducing in Sexual Safety Incidents	To **reduce** the number of **sexual safety incidents to zero** by 31st March 2024**	**31/03/2024**	To be agreed within the Advancing OJTC board - plans are currently being formulated
Reducing suicide / misadventure	A target for the **reduction of suicide / misadventure related incidents** among people in the Trust's care is still being developed, although the ultimate ambition is zero suicide. We are also considering a target of reducing staff sick days that are attributed to suicide related incidents	**31/03/2024**	• Offer PIP support to at least 75% of staff involved in a Level 4 or 5 incident • Increase environmental audits undertaken against national standards • Increase proportion of national standard environmental work undertaken against all environmental work" • Increase Managing Distress Training in IP units (all staff incl. non-clinical) • Adhering to NICE Guidance re liaison follow up

7. Personalising Care Planning: – Leads: Medical Director / Director of Nursing and Governance

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
DIALOG+ full implementation through cito	To manage the **transition to DIALOG+** where all patients will have a **Care Plan** that is **coproduced** with them and their carers/family, which is managed via CITO. (this will mean that, patients will receive care that is formulated around their experiences and meets their needs. This is central to the community mental health framework and refocus of CPA. It should improve service user satisfaction and reduce suicide rates)	July 2023 initially	• cito and pre-cito dialogue training complete (June) • Planning workshop held (June) • 3 July 2023 CITO module goes live • A Shared Action Plan developed (by end September 2023) • Delivery of agreed actions within the Shared Action Plan (from Sept 2023)

8. Expand and Develop Lived Experience Posts – Lead: Director of Corporate Affairs and Engagement

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Expand and develop lived experience roles and leadership, including peer support workers.	Aim - Target **growth for peer support roles** across TEWV - 60 per year minimum across whole Trust Reason Why: Peer relationships can facilitate personal recovery and wellbeing. We should take steps to implement and support peer relationships, and diversity MDT workforce. By growing this workforce we can offer peer support across the whole range of places and services.	**Initial development by Dec 2023, but expansion will continue after this**	• Enhance and develop peer support operational and training infrastructure. Date? • Agree banding for leads and training and development roles – TBA date? • Develop proposal carer / autism peer support roles ongoing / TBA • Ensure staff lived experience is factored into development of peer support and lived experience roles .date? • Spaces for staff to safely consider and factor their lived experiences and how it may impact both positively / negatively on their work – June 2023 • Ensure [all? / clinical? / xxxx?] services received appropriate preparation / training to embed lived experience roles – work underway / ongoing. • Explore potential for discreet project work for involvement members / zero hours contracts / time limited - work underway – Dec 2023

9. Collecting and learning from Service User and Carer Data – Lead: Director of Corporate Affairs and Engagement

Project / Initiative Title	Aim / Reason Why	Deadline for whole initiative	Milestones
Improve and accurately capture patient experience data. **Review / transform PALS and complaints pathways in line with cocreation principals.**	Capturing, reviewing, and learning from **patient feedback** is central to outstanding **patient experience**. Good **complaint handling** provides a direct and positive connection between those who provide services and the people who use them. Complaints offer a rich source of learning to help improve services for everyone.	**January 2024**	• Formal scoping of work complete ~~30/04/23 -~~ May 2023 • Further QI work / refinement from consultation / proposals / policy development – Jul/~~Oct~~ Nov 2023 • Policy refreshed / launch **-** Jan 2024

10. Diversity and Expand Involvement – Lead: Director of Corporate Affairs and Engagement

Project / Initiative Title	Aim / Reason Why	Deadline for whole initiative	Milestones
Embed and grow cocreation across the organisation	Cocreation is one of our 3 Goals. By cocreating we will create an open, compassionate culture that **listens to patients and carers, and learns from their experience** as a central tenant of quality patient care. To facilitate increased cocreation some **process and capacity development** is needed, which this initiative focusses on. Care Groups have day to day responsibility for cocreating care with service users and carers.	Initial development by **October 2023** but work to embed and grow will then continue	• Develop cocreation governance structure – 30/04/23 • Develop / implement cocreation networks TEWV and wider partnerships - 31/05/23 • Develop shadow governance mechanism to work interdependently with new TEWV governance structures – 31/07/23 • Explore human rights informed approaches to be embed cocreation work and models of delivery – 31/10/23

11. More People – Lead: Director of People and Culture

Project	Reason Why / Aim	Deadline/ Who	Elements / Milestones
Joining the Trust	Reason: To address known issues around the current processes to ensure staff feel welcomed, supported and want to stay. Aims: To ensure all staff, and those that work for TEWV **experience a great welcome**, with the **necessary support, equipment, resources to do their job**. Improvement in staff experience, feeling valued to improve time and quality of care/productivity, recruitment, retention and attendance.	To be confirmed after scoping of work in May 2023	• In addition to improvements already made in 22/23, we will create a new starter steering group with meetings in place from April 2023 onwards. • Scoping of further phases of work by May 2023
International Recruitment	Reason**:** Inability to recruit sufficient qualified and skilled staff. Aim**:** The overall aim of this strategy is to **address** the **staffing shortfalls** which not only places our existing staff under continuing pressure but impacts on the care we provide, along with **reducing the reliance upon temporary staffing**.	To be confirmed once available resources are agreed and plan produced on that basis	• Business Case and level of funding to be agreed by Executive Development Group by end April • Implementation will follow with dates and number of medics and nurses dependent upon level of support funding in place.

Address persistent vacancies	Reason: although recruitment overall is positive (we have grown as a trust and KPIs are improving) we have some **areas where we persistently struggle to recruit (combinations of place and staff group).** Aims: to have detailed understanding of where those pockets are and clear plans in place to address those vacancies with each team or professional lead. To ensure that workforce planning and clinical models are working together to address current problems and not create future issues unnecessarily	**Sept 2023**	• Map vacancies across services with recruitment history was completed in 22/23 • Agree how we will offer other posts where we have extra appointable candidates – (end May 23) • Map gaps to clinical pathways to ensure future pathway work and workforce planning align (June 23) • Complete review of data on Clinical staff leaving at age 30-35: (May 2023)
Workforce Planning	Reason: Current demand and expectation for workforce planning is high across the Trust and we have not previously had dedicated and skilled leadership in this area. Aims: To design, implement and embed a **consistent and evidence-based approach to workforce planning** (WFP) across the Trust. Together with our services and people who use our services, to co-design effective, innovative workforce plans to **deliver the right staff, with the right, skills at the right time and place**.	**Sept 23**	• Introduce an improved level of visibility at board level regarding workforce data, trends etc (by end April 2023) • Hold a series of design workshops – (May 2023) • Strategic Lead for Workforce Planning in post (August 23) • Implement new workforce planning processes trustwide – (Sept 23) • Workforce plan for each general management group and corporate service (needs staggering so will vary by service)

New thinking about leaving/ moving process	Reason: previous leavers process relied on line manager and resulted in large gaps in data/ multiple 'unknown reason' which means we didn't know why people were leaving or have the opportunity to talk to them about alternative options Aim: to provide a range of independent **ways in which people can talk to us about moving or leaving**, that we **analyse** regularly Ensure that, when people choose to leave, we understand why, enable them to do that well and resolve what we can and that we support more staff to find solutions within TEWV	Fully established by **June 2023**	• New internet, communication and monitoring processes already put in place in 22/23 • Provide regular comms plan (by May 2023)
Maximise use of appropriate centralised recruitment and large scale recruitment events	Reason: we spend a significant amount of time recruiting to each individual post. This also misses the chance for us to talk to large groups of candidates about a range of options. Aims: to provide **regular routes for potential candidates to talk to members of the trust** about career options, specific posts and development opportunities across the trust whilst also **recruiting to our large staff groups**.	Ongoing	• Already in place for Health Care Assistants and Nurses. • Implement this approach for housekeeping roles (June 2023) • Map recruitment efforts and Further Education partnerships to areas of persistent vacancies (Sept 2023)

Ensure development opportunities create an environment that people want to join and develop within	Reason: we have a large variety of training offers across the organisation and scored well on this in the staff survey. However, the links between appraisal, objective and training are not always transparent in terms of supply and demand. We have also brought in a new structure and multiple new roles and our development opportunities need to align with this. Aims: to **ensure all training and development enables us to deliver our strategic journeys**.	Ongoing	• Three year leadership development programme underway – runs to March 2025 • Scope work using clever together platform for conversation about development/ talent across organisation (Dec 2023) • Implement workpal to enable tracking of development needs across organisation (initial implementation by June 2023 but full tracking by March 2024) • Run mid – career development course – pilot complete, regular programme in place by Dec 2023
Reduce bias in the recruitment process and improve inclusivity for non traditional routes	Reason: Although our staff survey and equality, diversity and inclusion (EDI) data is improving overall we want to do everything we can to **remove bias in our core employment processes**. We know from the research base that this is a key point at which bias occurs and also that there are practical and process ways of reducing this. Aims: To ensure that we have in place a range of evidence based processes to reduce bias and to ensure that we are an employer that our local communities feel welcomed into and within which individuals have **fair access to opportunities**. So that our services in turn benefit from this increased diversity of workforce.	**March 2024**	• Take part in the Aging Better UK project to reduce age bias (by Sept 2023) • Complete a review of all Job descriptions to reduce the variation and improve the balance of academic and experience (by end Dec 2023) • Complete work with Sussex University to understand and reduce bias – (Dec 2023)

Work with local communities to encourage more people to join the NHS	To strengthen our role an anchor institution by **providing good jobs for our diverse communities and supporting local skill development** where needed, thus supporting the Trust's approach to Health Inequalities	**Dec 2023**	• Produce videos of different roles: Health Care Assistant, admin, psychiatry, nursing, peer (Sep 2023) • Armed Forces: Make formal links with recruitment platforms and identified recruitment link (Sept 2023) and achieve gold award (Dec 2023) • Introduce measures to encourage working carers to apply to / work at TEWV e.g.: Information resource on intouch, use of carers passport, blog, survey re ability to attend appointments, carers confidence scheme and resourcing changes (Sept 23)

12. Compassionate and Inclusive – Lead: Director of People and Culture

Project	Reason Why / Aim	Deadline	Elements / Milestones
Leadership Development programme	Reason: We have a new structure and with that new expectations and new routes for career development. Aims: To understand and realign the Trust's **leadership development** offer to **align with Organisational values**. To design and deliver a refreshed leadership offer, working together to co-create opportunities for all our staff, teams and services to thrive.	**Ongoing**	• The recently redesigned leadership development programme will continue to be rolled out in 23/24 and 24/25 • Board induction and development plan reviewed – (by end June 2023) • Review quarterly sessions with leaders across the trust after May 2023 meeting (by end Sept 2023) • New / aspiring leaders offer scoped (by end December 2023)
Health and Wellbeing Council	Reason: The health and wellbeing of all our employees is vital to providing the best experience for our staff, impacting on the care we provide and our ability to partner in the wider system Aims: • Involve a **diverse network of people** (considering the varied experience of the communities within which our staff live) in decisions about how charitable funds are raised and allocated. • Communicating clearly to all colleagues how to **access funding for provision of Health and Wellbeing initiatives** with a proactive focus on ill-health prevention. • **Support fundraising events** in line with health promotion activities • **Promote** the activities of the **Health and Wellbeing Council** within their areas of work to build the sense of community in TEWV	**July 2023**	• Agree where the Health and Wellbeing Council will report into (May 2023) • Expressions of Interest set out to recruit members (May 2023) • Agree membership. Confirm Health and Wellbeing Champions (June 2023)

Reasonable Adjustment support	Reason: Accessing reasonable adjustment is an often complex and one off job for individual managers which leads to delays in the process Aims: 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	**December 2023**	• This was agreed in 2022/23 • Review of impact of new process by Dec 23
Ensuring all staff groups have a positive experience of working in TEWV	To monitor the experiences of **staff** who identify as **Trans or non – binary** and to identify actions to improve their experiences	**June 2023**	• Analyse feedback from staff surveys and identify actions from these (June 2023)
Violence and Aggression reduction	Reason: We need to review our approach to this in light of the clinical and people journeys and bring the different elements together. Aims: Ensure we **support and respond to staff who experience verbal and physical aggression** and proactively **reduce the number of incidents** from service users, carers and members of the public towards staff	**September 2023**	• Establish new working group and where it will report to (by end April 2023) • Review policies and establish one overarching document (by end September)
Review how all the raising concerns processes work together	Our needs from the **Freedom to Speak Up** (FTSU) team have changed as we have grown in size and complexity and the national context has developed regarding FTSU Aims: Ensure FTSU offer meets our needs now and in the future	**September 2023**	• Clarify how cases of “detriment” will be responded to – (June 2023) • Review of FTSU provision – (Sept 2023) • Review of raising concerns online process (Sept 2023)

H&WB – ensure offers are most effective use of resources	Reason: we offer a broad range of Health and Wellbeing (H&WB) support but not robust **coordinated oversight** of its **impact and use** of trust resource. The wellbeing hubs regionally are also an addition to this offer Aims: To have a framework for decision making regarding H&WB provision	**June 2023**	• The health and wellbeing support offers were mapped in 2022/23 • Devise evaluation framework – (end June 2023) • Training for having good H&WB conversations developed (by end June 2023) • Plan for roll out of training (to be confirmed depending on the content of the new training)
Ensure Occupational Health support is effective	Reason: Our occupational health contract is up for renewal in December 2023, and we need to make sure we assess whether the current "offer" fully meets TEWV's needs Aims: to have an occupational offer in place that supports our People Journey	**Dec 2023**	• Review contract along with regional approach (by end Dec 2023)
Describe and monitor the organisational culture	Our service users, carers and regulators rightly tell us that culture is very important, but we don't have a robust way of describing our current culture or monitoring how it is changing	To be confirmed	• To be determined

13: Working Differently – Lead: Director of People and Culture

Project	Reason Why / Aim	Deadline	Elements / Milestones
Workpal – changing how we link personal objective, appraisals, development and trust strategic goals	Reason: We do not currently have a clear line of sight from employee through to Board to **understand whether individual objectives are contributing** to Our Journey to Change and living the Trust values. Aims: Move from a paper-based system to an **online accessible 24/365 system**, with targeted personal development plans and staff experience of quality appraisals integrating national 'Scope for Growth' framework as early adopter.	Full implement ation by end **Feb 2024** (roll out started in Feb 2023)	• Over half of staff signed up by end April 2023 (our target is 4,500) • Align supervision policies, processes, recording (end June 2023)
Smarter Working	Reason: As we came out of covid we knew we needed to support colleagues to navigate a new hybrid approach to work place. Aims: The Smarter Working approach supports Our Journey to Change and a Great Place to Work, and the plan is to help the Trust to offer a **more flexible approach as to where, when and how a job could be done** to deliver better services and to organise work in ways that **improve the relationship between work and the rest of life.**	Phase 1 already complete Phase 2 – to be confirmed	• Phase 2 projects likely to include Projects to be scoped out but drafts high level ideas include ○ Room Booking System ○ Hot Desk equipment ○ Smarter meeting rooms ○ Smarter offices and buildings

Flexibility of employment	Reason: We know that flexibility of employment is important to a growing number of our staff and is sometimes a barrier to taking on substantive contracts with us. Aims: We will explore a number of different options that provide a framework within which leadership teams can **provide flexibility but also ensure services run effectively**	**March 2023**	• Introduce trial 9 day in DTVF Care Group– (end Sept 2023) • Introduce annualised hours, particularly to support staff who are currently only on bank shifts – (end September 2023) • Introduce zero hours contracts, particularly to support those in lived experience work / stepping up from involvement work – (end September 2023)
Combining risk assessments into one document	Reason: We have a number of different risks assessments in the trust and staff may need support from one or more at different points in their career. Having them as separate documents creates a risk of a silo approach and doesn't help a holistic conversation between employee and manager. Aims: To bring them into one document to **support colleagues to have more nuanced conversations about health, wellbeing and risk**. This will be supported by the associated **bitesize managers' training**	**Sept 2023**	• Work now being scoped
Establish clarity and transparency on how involvement members join the recruitment process across roles	Bringing a **lived experience** lens to our recruitment processes has been established for a number of years and is common practice for senior roles. However, we want to ensure that **expectations and support are clear** for all recruitment processes so that the role of those with lived experience is as effective as possible.	**March 2023**	• Launch of co-creation approach – April 23 • Complete scope of work May 23

Review how advanced clinical practice roles are developed and supported	Reason: **Advanced clinical practice roles** are a core part of the delivery and leadership of clinical services. Although we have supported staff into training in various services, we need a more strategic approach to their development and use. Aims: To **shape local training** so that it supports mental as well as physical health skills and to ensure the development of these posts aligns with our workforce plans	To be agreed	• Scoping work underway
Managers' bitesize training programmes	Reason: We understand that managers have had many different routes (both experience and training) before they take on these roles. Aims: We want to ensure that all managers and leaders are supported to **understand the frameworks that apply to employing and managing staff**. These bitesize sessions cover the core elements of **effective and compassionate management** in the NHS	**December 2023**	• This was put into place in Jan 2023 but tracking of how many managers have accessed bitesize training will be completed by end June 2023 • Evaluating impact of the bitesize training – by end December 2023
Review the staffing establishment setting review process	Reason: **e-rostering** is a core part of how we ensure safety on our wards. Whilst we are undertaking changes to ensure that we can e-roster across professions, the staffing establishment process takes too long to be **reported to the Trust Board** and so that they cannot respond before the next round commences. Aims: To make the process quicker, more agile and more inclusive.	To be agreed	• The scoping of quality improvement work needed to achieve this action must take place before detailed milestones can be developed

Transparent development process aligned to strategic goals	Reason: we have a mixed model of access to training, some provided centrally and some within/ by services. Aims: to develop a system of **access to development opportunities** that is aligned to our three strategic goals, **fair and transparent** and makes **best use of the resources** we have (money, staff time, training places).	**March 2024**	• Establish access to shared appraisal/ recording system in workpal – April 23 • Explore option of using Clever Together platform to support a "conversation" around training, talent, development –(by end June, but the actual "conversation" would take place later in 2023/24 if this approach is approved)
Clarify range of roles that sit alongside substantive 'traditional' employment	Reason: we have a range of opportunities to be involved with the trust e.g. involvement and volunteers but there is scope to provide more clarity and to broaden these opportunities. Aims: to ensure a **range of opportunities** for people to **engage with the trust** that meet the needs of services and provide opportunities for those who want to, to **progress into paid substantive roles**	Overall TBC	• Scope range of roles involved and membership of project work - Q1
People metrics	Reason: historically we have not had a suite of people metrics accessible to all managers and leaders in the trust Aims: to provide core metrics that are available to anyone to access through IIC and to ensure that standards reports are provided to services, executives, and board on an agreed basis/ format	**June 2023**	• Agree the final 4 metric definitions and do the required work within IIC to allow these to be reported (by end June 2023)

14 One Team TEWV– Lead: Director of Finance and Resources

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Robotic Process Automation- Mental Health Act Tribunal Monitoring Check	Automate the process to verify outcome and referral meetings set up and alerts adding **freeing up Mental Health Administrators**	**October 2023**	• 5 May Process confirmed • 29 September Development of process completed
Full review of corporate service staff lists, and reconciliation of data held on Oracle and ESR	To **improve budget management** and reduce re-work needed when staff lists on finance system are different to what is on ESR	**June 2023**	• 23rd June – Finance systems fully updated (i.e. staff all in correct cost centres)
Develop digital and data service standards	Having **clear standards** ensures TEWV staff are clear on the service they should be getting and will empower them when they are not getting this. Conversely it protects Digital and Data staff over unreasonable requests that might be made of them.	**January 2024**	• To be developed by Data Projects Assurance Group (DPAG)
Set up a new Corporate Services Leadership Group	Creates **one place where Care Groups or project leads can discuss issues with all corporate services** present. Also to **create a joined-up culture** among corporate leads	**July 2023**	• Terms of reference agreed by current deputies group / corporate reps at Exec Time Out session (May 2023)– • Terms of Reference and membership signed off by Exec (June 2023) • First formal meeting of new Corporate Leads Group (July 2023)
Voluntary and Community Sector provider grants scheme	To make it **easier for the Trust to fund voluntary sector provision** of non-clinical services for which a full procurement and contracting regime is disproportionate and / or likely to cause unnecessary delay to commencement.	**To be confirmed**	• Receive and consider legal advice on draft scheme (April 2023) • Scheme approved by Strategy and Resource Committee (9th May 2023) • New scheme in place and ready to be used by TEWV budget managers (3rd July 2023)

15. Digital and Data Journey Lead: Director of Finance and Resources

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Electronic Prescribing and Medicines Administration **(EPMA)**	The project will **deliver Electronic Prescribing and Medicines Administration** across the organisation for Inpatient and Community Services.	**March 25**	• Pilot goes live- May 23 • Go live Inpatient Services – Sep 23 • Post pilot implementation approach review – Jul 23 • PID for Community Services – Mar 24 • Complete roll out Inpatient Services - Jun 24 • Initiate and complete community roll out – Mar 25
Improving Connectivity	The project aims to **improve** the service available to colleagues regarding **network connectivity and network response times**, an updated **Wi-Fi** provision with replacement of aging access points across the Trust and the delivery for a new approach to how our **patients** can access the **internet**.	**Jul 23**	• Implement new LAN (Local Area Network) design – end Apr 23 • Wifi replacement of new controllers (Roseberry Park, West Park and Foss Park hospitals) – Apr 23 • Wifi replacement of new controllers (all sites) – end July 23 • Patient Access To The Internet (PATTI) Options appraisal – June 23 • Patient Access To The Internet - Business case- Sept 23
IIC re-procurement and migration	The project will deliver the **data migration** from the existing IIC platform to a cloud hosted environment, to ensure we future proof the IIC to be able to support us being a gold standard provider of Business Intelligence in healthcare services.	**Jul 23**	• Migration to Cloud – end Apr 23 • Sign off data stage – May 23 • Dashboards tested and signed off – May 23

RPA (Robotics)	Delivery of software that allows for the **automation of business processe**s through use of digital 'worker / bots' – these 'bots' can be taught to execute transactional tasks consistently thereby releasing time savings for existing staff and improving data quality.	**Transfer to BAU Oct 23**	• Sign off the Project Initiation Document – Mar 23 • Delivery into live environment of 6 processes – Oct 23 • Transitioned into business as usual through sign off a service delivery model– Oct 23
Enhancing collaboration	The Enhancing Collaboration Project will embed the use of the **Office 365** suite and its many applications and opportunities for communication, joint working and information sharing to colleagues across the organisation, to enable them to collaborate with each other and partners from within the NHS and wider health and social care community	**June 2023 but then ongoing**	• Document Management position statement Apr 23 • Targeted Communication and Support for main O365 Applications – Jun 23 • BAU support model established – Jun 23
Asset Management	The project will introduce **centralised asset management for IT equipment** into the organisation, **reducing delays in ordering and receiving equipment** for colleagues and delivering savings through improved lifecycle management and a consolidated approach to purchasing hardware and software licenses.	**March 24**	• Review & Refinement of New Asset Management Processes = Sept 23 • Establish CAM KPI's and Q1 Reports – Sept 23 • Development of Estate Asset Profiles (e.g. Model Office/Ward)– Sep 23 • Software management processes – Mar 24 • Telecommunications review – Mar 24

16. Green Plan Lead: Director of Finance and Resources

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Embedding the Green Plan and Carbon reduction	To reduce the environmental impact of our activities by **reducing direct and indirect carbon emissions**. There are regulatory, legal and financial reasons why we should do this (and doing what we can to improve the environment will "help people live their best possible lives")	The NHS Carbon Footprint for the **emissions we control directly**, **net zero by 2040** The NHS Carbon Footprint 'Plus' for the **emissions we can influence, net zero by 2045**.	• Produce options paper appraising models for delivery of the Trust Green Plan (by 31 May 2023) • Establish Green Plan 'community of interest' to lead and scope workstreams and co-produce a phased implementation plan which will work towards NHS Net zero by 2040 (by 30 September 2023)
Heat Decarbonisation Plan	The plan will focus on **replacing fossil fuel heating systems** with green renewable technologies	September 2023	• June-July site surveys, plan delivery September 2023. Capital bid for funding measures 2024/25 late 2023
Installation of additional electric charging points at trust properties	Continue to encourage the take up of **zero carbon vehicles** across the trust, cleaner air initiative	December 2023	• May surveys complete, June out to tender, carry out installations typical 3-month lead in time.
Trust Environmental Pledge - 'Pledge for Greener'	Look for top-down commitment for take up of **green measurable pledges** and launch trust wide	Ongoing throughout 2023/24	• Launch July 2023 with second phase initiative winter 2023
Look to address the carbon footprint from supplier to door when procuring goods	Consider travelled miles of supply and look to **engage more local providers** where possible	Ongoing throughout 2023/24	• Form small working group to consider select list as a pilot

17. Estate Masterplan Lead: Director of Finance and Resources

Project / Initiative Title	Aim / Reason Why	Deadline	Milestones
Health, Safety & Assistive Technology	To improve health, safety and resilience in our core **inpatient estate** for the benefit of service users, staff and members of the public, maximising the benefits of **new technology**.	**Rolling, multi-year programme**	• Complete the next phase of Tees Essential Safety Programme including procurement and delivery of significant capital works supported by enabling schemes. Business case for procurement of Phase 2 works and Phase 3 enabling strategy drafted for approval. (by 30 June) • Complete installation of next phase of assistive technology including sensor doors and Oxehealth) installations (by 31 March 2024). Evaluation of quality impact of technologies underway to inform prioritisation and scoping for next phase of programme.
New base for Stockton AMH services	To tackle inequalities in the quality of environment, **targeting buildings which are no longer fit for purpose** and making better use of our existing estate. This will enable the vacation of council properties which have been identified for disposal whilst supporting new clinical co-locations and avoiding new rental costs.	**June 2023**	• Purpose-designed modular building on Durham Road site, Stockton installed.
Medical Education Facilities	To support **medical recruitment and retention** and provide high-quality facilities in line with Health Education England recommendations.	**June 2023**	• Complete interim scheme at Roseberry Park • Develop business case for purpose-designed facility in D&D.

One Public Estate participation	The aim is to improve opportunities for education, employment, health and housing, through better quality, efficiency and sustainability of public services. By **collaborating with public sector organisations** across traditional organisational boundaries, we will be able to better use our region's public estate to benefit our population.	**ongoing**	• Active participation in the Tees Valley OPE Partnership to complete collective asset mapping across Tees Valley (by 30 June). Cushman and Wakefield appointed by Tees Valley Strategic Estates Group to complete asset mapping and identify emerging opportunities across the NHS, council and blue light estate. • Develop a pipeline of agreed local regeneration, growth and community cohesion opportunities in readiness for any funding opportunities (by 31 Dec 2023) One Public Estate funding secured to support partnership working between Stockton Council and TEWV. Multi-agency 'Discovery' work commenced in Hartlepool, exploring opportunities for vacant retail space. • Identification of OPE / multi-agency estates networks across North Yorkshire & County Durham. (by 30 Sept 2023). Tentative discussions commenced with Durham County Council regarding children and young persons' estate.
Strategic Estates Planning	To understand the **vision for the estate**, our needs and opportunities	**March 2024**	• TEWV Estates Masterplan developed for implementation (approval April/May 2023). • Provider Collaborative Estates Framework developed by Estates Directors across NENC ICB. This will inform an ICB-wide Estates Strategy (March 2024)

Glossary

Term	Description
24/7 or 24/7/365	24 hours, 7 days a week (and if 365 included, all year)
AMH	Adult Mental Health Services (i.e., services for people aged 18 to 64)
BAU	Business As Usual
Board	A decision-making body with significant responsibility for resources and / or policies or plans. The Trust has a Board of Directors, but both Care Groups also have their own Boards.
CAMHS	Child and Adolescent Mental Health Services
Care Group	The main way in which our services are organised / governed since April 2022. There be two care groups in TEWV (aligned to ICSs), which are 1) North Yorkshire, York and Selby and 2) Durham Tees Valley Forensics
Care Navigation / Care Navigators	Care navigators help service users and their families to "navigate" the different public or voluntary sector services that they may need to interact with to help them achieve their recovery goals.
Care Plan	A care plan is a document or electronic file which describes the services and support to be given to a person to meet their needs. It can include actions that the service user or their carers should take in particular circumstances.
CDDFT	County Durham and Darlington NHS Foundation Trust (who deliver services at University Hospital North Durham, Memorial Hospital, Durham City and Bishop Auckland General Hospital
cito	An IT system which TEWV is introducing to make it easier to input information into and extract information from our electronic patient record (PARIS)
CLD	Child Learning Disability services
CPA	Care Programme Approach

CQC	Care Quality Commission – body that regulates quality for NHS healthcare providers, including Mental Health Act inspections.
CMHT	Community mental health teams (can also be used as shorthand for “community mental health transformation” but only used in the former way in this document).
CYP / CYPS	Children and young people (birth to 18th birthday). The “S” is for “services”
DTV	Durham and Tees Valley (i.e. County Durham, Darlington, Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland)
Dual Diagnosis	The coexistence of a mental health issue and other health issue. In the context of Mental Health provision this most often refers to mental problems coinciding with drug / alcohol dependency / usage.
EIP or EiP	Early Intervention in Psychosis team / service
ePR or EPR	Electronic Patient Record
ESR	Electronic Staff Record (a national NHS system)
GP	General Practitioner – the “family doctor” who is usually the first contact with the NHS when a service user becomes ill.
Front door	A term that means “the first place that people who have physical or online contact with a service come into contact with the people running that service” (in the same way that if you visit a person who you don’t know well at their home, your first contact with them is at their front door). This can also be described as a “single point of access” where we have designed a service so that there is the same way “in” for everyone.
IAPT	Improving Access to Psychological Therapies – a national programme to make “talking therapies” available to people with milder forms of mental illness to reduce the proportion who go onto develop serious mental illness.
IIC	Integrated Information Centre – The Trust’s data repository which provides data for a variety of internal and external reporting.
Inpatient service / inpatients	Our services provided for service users who require treatment in a hospital for a period of time rather than treatment in the community.

ICS / ICB / ICP	Integrated Care System which since 1st July 2022 has consisted of an Integrated Care Board and Integrated Care Partnership. TEWV serves part of the North East North Cumbria ICS and part of the Humber and North Yorkshire ICS.
Journey	As well as Our Journey to Change (see below), TEWV has a number of sub-strategies that support the overall journey. These sub strategies are known as Journeys.
Learning Disability (LD)	People with an IQ below 70 are generally regarded as having a learning disability. People in this group are more likely to have a mental illness than other people.
Lived Experience	People who have had experience of being assessed and treated my mental health or learning disability services (or are the carer of someone with this experience
Local Authority	An elected body which commissions social care, public health and other services for a geographical area. Often also referred to as a *Council*.
MHSOP	Mental Health Services for Older People (generally 65 years or older, although MHSOP services can cover younger people with early onset dementia).
N&G	Nursing and Governance Directorate
NEAS	North East Ambulance Service
NICE	National Institute of Clinical Excellence
NHSE	NHS England
NY&Y	North Yorkshire and York (please note that this is not coterminous with the boundaries of North Yorkshire Council because this TEWV Locality covers the City of York, Pocklington (East Yorkshire) and Wetherby (Leeds) areas, and it does not cover the former Craven District (e.g. Skipton and Settle) Services to that part of North Yorkshire are provided by Bradford District Care Trust and commissioned by the West Yorkshire ICS).
OJTC	Our Journey to Change – this is TEWV's strategic framework which sets out the vision and mission for the Trust, its values and its goals.
Partners / Partnership	There are many things that TEWV cannot deliver on its own, or where it can do better working with "partners". Who these partners are depends on the context, but they can include commissioners, local authorities, voluntary and community sector organisations, other mental health trusts, primary care (GPs) or the providers of non-mental health hospital services

Pathway	A standard “route” through treatment for all service users with the same diagnosis. This can include choices of alternative evidence-based treatments at appropriate points in the pathway.
Place / Place-based	In the NHS “place” is usually used to mean the area of a local authority. Where there are very large local authorities, we sometimes use “place” to refer to a town or district, but the NHS sometimes uses “neighbourhoods” to mean this.
Peer workers	A person who has past personal insight into how it feels to be assessed / treated / supported and uses this insight to support the recovery of people currently being assessed / treated / supported in that kind of service. Peer workers can also be known as Lived Experience Workers
PMO	A team within TEWV dedicated to supporting the programme and project management of complex plans for change (and to supporting the development of project and programme management skills across the Trust)
Program or Programme	A long-term initiative that focuses on designing and embedding significant changes that will lead to benefits. A program consists of several projects or workstreams and is governed by a programme board.
Provider Collaborative	The term is used for any formal grouping of providers who work at system-level but in the context of “regional”, specialist or “tertiary” services such as secure inpatients, CYP inpatients and perinatal services are also a governance mechanism which allows providers to come together to determine the needs and plan the provision for these in their ICS area.
Project plan	A plan that sets out how a one-off change is going to be delivered, including deadlines for key actions (also known as “milestones.”)
Q	This stands for “quarter” of a year – Quarter 1 ends on 30th June; Quarter 2 on 30th September, Quarter 3 on 31st December and Quarter 4 on 30th April.
QI	Quality Improvement
QuAC	Quality Assurance Committee
STOMP	Stopping Over Medication of People with a Learning Disability
Tees / Teesside	Geographical area including the boroughs of Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland.
Tees Valley	Same geographical area as Teesside (see above) but also including the Borough of Darlington.
YAS	Yorkshire Ambulance Service
VCS	Voluntary and Community Sector. This includes charities and community interest companies.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 12

For General Release

Meeting of:	**Board of Directors**
Date:	**27 April 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***
All	1 – Recruitment 2 – Demand 5 – Staff retention 6 - Safety	The report highlights summarised feedback from the April 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 Tuesday 11 April 2023 across Community Mental Health Transformation (CMHT) teams offering learning disability (LD) services including respite support in the Trust including:

- South Tees LD Community Services
- Northallerton LD Community Services
- Respite LD Community Services, Bankfields Court
- Harrogate and District Community LD Services
- North Yorkshire and York LD Services

3 Key issues

3.1 Feedback from the leadership walkabouts is summarised below.

Strengths:

- Team dynamics: all teams reported the strength of how positively their team worked together and support for each other, and the mix of professional skills and knowledge, and the benefits that brought. Some advised the new governance structure had helped them feel less isolated from other teams.
- Patient-centred care: care offered is very much focused on each individual patients needs, many of whom often have very complex physical health problems. Teams are very responsive and creative, and adept at putting in place reasonable adjustments, bespoke interventions, and effective communication to ensure their service user can engage. This is reflected in the feedback they receive from carers and families in terms of a great experience they receive.
- Being a great partner: good partnership working internally and externally including with a wide range of health, social services, care providers, voluntary and private providers.

Challenges:

- External services / service providers: The impact by other (external) services in significant on these services. Many care homes are understaffed, have high levels of agency staff, and have inadequate skills / knowledge to meet the needs of the client group, exacerbated by social care crisis and staff shortages. These issues have a huge impact on LD services, meaning we have to hold people on case load for longer. Many services users may benefit from short stay interventions, but appropriate inpatient bed capacity is challenging. Some providers fail to recognise their limitations and despite escalating,

continue to accept complex clients.

- Staffing / recruitment / retention: whilst some teams had had some success in recruiting, many highlighted an issue in recruiting particularly LD student nurses, and others including AHPs to help develop MDT approach. Agency / bank staff not the best solution for small specialist service. Staff vacancies combined with sickness was a real challenge for some teams.
- Core business / commissioning: some teams did feel we need to review our service model around the delivery of these services, including respite, which have changed significantly over the last few years. Commissioning arrangements across the TEWV geography also very challenging. Requires whole system approach with partner buy-in.

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 11 April 2023.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 15

For General Release

Meeting of:	**Board of Directors**
Date:	**27th April 2023**
Title:	**Learning from Deaths**
Executive Sponsor(s):	**Elizabeth Moody, Director of Nursing & Governance**
Author(s):	**Lesley Munshi, Associate Director of Patient Safety**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

Purpose:
The national guidance on learning from deaths requires each Trust to collect and publish specific information on a quarterly basis. This report covers the period from January 2023 to March 2023. The Board is receiving the report for information and assurance of the Trust's approach in line with national guidance.

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

Proposal:
That the dashboard and the learning points are provided as good assurance of reporting and learning in line with national guidance.

Overview:
In line with National Guidance the Learning from Deaths Dashboard at appendix 1 details Q4 information for the Trust and includes 2021/22 data for comparison.

- During Q4 the Trust received 518 death notifications of patients who had been in contact with our services in the last 6 months. The Trust has reported 17 deaths of people with a learning disability in the time frame including 1 individual also diagnosed with autism These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were currently open to the Trust's caseload which is largely community and includes older people and memory services (>70,000).
- 10 inpatient deaths were reported. All deaths have either been reported on the national Strategic Executive Information System (StEIS) and will undertake further investigation or be investigated via the mortality review process under a Structured Judgement Review (SJR).
- Immediate Early Learning Reviews were conducted for all the above deaths and where appropriate, rapid improvements have been made to improve patient safety. A weekly Patient Safety Huddle chaired by the Medical Director provides oversight on patient safety incidents and the Trust wide improvement programme in relation to learning from patient safety events.
- A task and finish group is reviewing the current policy and processes related to patients having leave/time off the ward.
- 33 unexpected community deaths were reported on StEIS during the reporting period.
- 13 Part 2 Structured Judgement Reviews (SJRs) were requested which includes 3 physical health related in-patient deaths. 49 Part 1 reviews and 22 SJRs were completed.
- All deaths of people with either a learning disability or a diagnosis of autism were reported to LeDeR in line with national requirements over the reporting period.

Appendix 3 sets out in detail the specific areas of learning, Trust themes, progress within the Quality Assurance programme and structures to support and embed learning.

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

- Potential ligature risks x2
- Emergency rescue of a collapsed person
- Observation and Engagement/Care Rounds
- Guidance to support the identification and management of safeguarding (adult/child) cases
- Patient leave - sharing of relevant information and 'keeping in touch' plans.

In Q4, 15 serious incidents for unexpected community deaths were completed. To improve learning and measure progress against the Trusts 7 main themes, all learning requires a SMART action plan.
The themes from the actionable learning were as follows:

- Consideration of Safeguarding needs, including PAMIC
- Risk assessment/risk management
- Clinical record keeping
- Carer/family involvement
- Care Planning/Safety Planning
- Partnership working and communication with external agencies such as GP, alcohol services
- Adherence to the trusts Did Not Attend/Was Not Brought policy.
- Effective triage at the point of referral.

Key areas of learning remain consistent with a previous scoping exercise to identify the Trust's top patient safety themes in relation to learning from deaths. The Quality Assurance Programme and Early Learning Reviews of patient safety events continues to evidence sustained

improvement in risk assessment, risk management and contingency planning in both in-patient and community services however work is ongoing to continuously improve standards using feedback from serious incident reviews, clinical audit and supervision processes.

It is acknowledged that there is a risk to timely learning from patient safety incidents due to current backlogs in the Patient Safety Team. To mitigate this risk, Rapid Review meetings, Early learning Reviews and daily Patient Safety Huddles are in place. Additional senior leadership and oversight capacity as well as reviewers has been brought to the team.

An independent Duty of Candour review continues to determine the effectiveness of our current processes and to inform further improvement.

A replacement risk management system will bring additional benefits in terms of triangulation of learning and oversight of serious incident action plans. The risk management system providers are working with the Trust to prepare a detailed project plan. Consultation events are planned in to commence with relevant stakeholders. Provisional timescales are for the Risk module and Board Assurance Framework to be in place by June 2023, followed by serious incidents in September and complaints and PALS by the end of December 2023.

Prior Consideration and Feedback

Updates and assurance aligned to improvement work relating to learning from deaths is reported to the Quality Assurance Committee. This includes regular updates on the Quality Assurance schedule (providing assurance of compliance against key patient safety policies such as leave, clinical record keeping, risk assessment and management, observation and engagement) as well as updates on key projects that sit within our Advancing Our Quality and Clinical journeys that relate to themes from patient safety incidents such as progress towards implementation of the new patient safety incident response framework (PSIRF), reducing restrictive interventions.

Implications:

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

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

Recommendations:

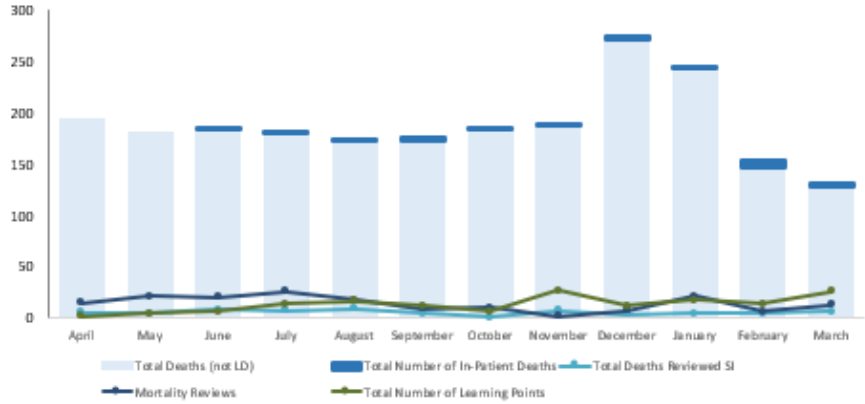
The Board is requested to note the content of this report, the dashboard and the learning points as good assurance of reporting and learning in line with national guidance and consider any additional actions to be taken.

Appendix 1: Learning from Deaths Dashboard Q4 2022/23

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

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

	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
Q1	558	↗ 486	1	↘ 8	17	↘ 23	56	↘ 78	12	↘ 43
Q2	524	↘ 557	7	↔ 7	20	↗ 18	52	↗ 50	42	↗ 15
Q3	643	↗ 639	6	↗ 5	11	↘ 15	19	↘ 105	45	↗ 42
Q4	518	↘ 557	10	↗ 6	14	↘ 21	40	↘ 60	57	↗ 21
YTD	2243	↗ 2239	24	↘ 26	62	↘ 77	167	↘ 293	156	↗ 121



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

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

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
Q1	19	↗ 18	0	↔ 0	12	↘ 29	12	↘ 34
Q2	28	↗ 26	0	↔ 0	23	↗ 16	23	↗ 12
Q3	18	↘ 23	0	↔ 0	10	↘ 18	9	↘ 25
Q4	21	↘ 28	0	↔ 0	17	↘ 22	15	↘ 29
YTD	86	↘ 95	0	↔ 0	62	↘ 85	59	↘ 100

Appendix 2

Mortality Reviews 2022/2023

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

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

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

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

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

Appendix 3

1. Mortality Reviews and Learning

Mortality Review 2022/2023

10 structured judgements reviews were discussed and reviewed by the Mortality Review Panel during Q4.

Actionable learning points were identified as follows:

- Lack of detail in case notes/gaps in care record/medication not documented
- Capacity decision delay
- Early discharge from team when on 117 after-care
- Staff not having discussions with family around giving unsuitable foods for a diabetic patient
- Liaison with external agencies e.g., Changing Lives
- Lack of Safeguarding involvement
- Safety plans/safety summary lacking relevant information
- Difficulties finding a suitable placement for a complex patient
- Care plans – lack of co-production
- Physical Health not consistently monitored

Learning from actions/assurance

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

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

1.2 Learning from deaths and serious incidents

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

The top 7 themes were identified as:

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

- Multi-agency working
- Medication Management

The Quality assurance programme continues to show sustained improvements in Risk Assessment and Management (Safety Summary/Plan/contingency planning). Identified improvement programmes supported by the project management office (PMO) include care planning, preventing suicide and self-harm and safeguarding/PAMIC. These areas of work have now been developed into projects with key performance indicators in order that progress and key milestones can be monitored and impact of actions assessed.

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

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

1.3.2 Organisational Learning

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG). Any significant issues identified by the OLG are escalated to the Executive Quality Assurance and Improvement Group for further discussion and or actions.

1.3.3 Patient Safety Incident Management/Investigation

The Trust has a continued focus on improving the quality of incident reporting, investigation, and identification of key actionable learning. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring they are compliant with the requirements of the National NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF).

The Patient Safety Incident Management Programme (PSIM) provides oversight on the serious incident backlogs, the Risk management system procurement, and transition to the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE) . The PSIM programme reports into the Advancing our Clinical, Quality and Safety Journeys sub-portfolio Board (AOCQSJ). Identified improvement programmes supported by the project management office include care planning, preventing suicide and self-harm and safeguarding/PAMIC. This improvement work is overseen by the AOCQSJ.

1.3.4 The Environmental Risk Group

This group receives monthly reports of incident data involving ligatures and other risks where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is distributed Trust-wide via Patient Safety Briefings or SBARD's (Situation, Background, Assessment, Recommendation) communications. The annual Environmental survey programme with a multi professional input from estates, health and safety and clinical services continue. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures. Significant investment has been dedicated to assistive technology in the form of Oxevision (Oxehealth) and door sensors to make wards safer. There are plans to

hold a Trust safety summit in June to further explore how our clinical models and approaches can support improved patient safety.

1.3.5 Recruitment and Retention/staffing establishment reviews

When looking at patient safety incidents through a systems and human factors lens, it can be seen that workforce pressures and capacity including community caseloads can impact on the quality of care delivered. Significant work is being undertaken to ensure that we have a suitably skilled and resourced workforce who can carry out their duties in a safe and compassionate way. Further details can be seen within the safe staffing and establishment review papers.

Background Papers:

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

ITEM NO. 16

For General Release

Meeting of: **Board of Directors**
Date: **27.04.2023**
Title: **Guardian of Safe Working for Postgraduate Medical Trainees**
Executive Sponsor(s): **Dr Kedar Kale**
Author: **Dr Jim Boylan – Guardian of Safe Working**

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	

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: This annual report is provided to the board for assurance that the terms and conditions of the Junior Doctors Contract 2016 are adequately fulfilled by the trust

Proposal: For the last quarter please refer to Appendices 1 and 2 for details of exception reporting and fines levied in Durham / Tees Valley and York/ N Yorks sectors; and Appendix 3 for an annual summary of the data trustwide.

Over the past year I am satisfied that the trust:

- Has continued to fulfil the requirements of the contract with respect to the working terms and conditions and the general

wellbeing of medical trainees on placement

- Has actively promoted and supported the process of exception reporting by junior doctors, and there are clear lines of communication and individual support for them to raise concerns if necessary.

Overview:

- Medical staffing has continued to provide prompt and constructive advice and support for trainees and to process exception reports in a timely and effective way.
- There is a well-functioning quarterly Postgraduate Trainees forum in both North and South sectors with good attendance by trainee reps from all localities across the trust.
- Continued monitoring or work intensity has consistently demonstrated Teesside and Scarborough / York City to be the areas with the heaviest workload for junior doctors.
- The recent introduction of a residential on call rota on Teesside should help alleviate the reported intensity and number of fines levied in that locality.
- Throughout the year where fines have been levied it has been almost entirely due to the 5-hour continuous rest rule being broken on Non Residential rotas. The introduction of more residential rotas where possible will help alleviate this situation.
- On-call rota gaps for junior doctors have consistently been covered without the need for agency locums throughout the year.
- Recent industrial action by junior doctors has been well managed by the trust and clinical services well supported by senior and non-striking junior staff. There were no additional significant concerns raised by juniors about additional workload consequently.
- Significant consultant vacancies across the trust and the increasing use of agency locums have raised concerns about the adequacy and availability of senior supervision for trainees in some areas and placed an additional workload for substantive consultant supervisors. Active efforts towards recruitment and retention of Consultants continue to be a priority for the Medical Director and senior Medical Management.
- The experiences of psychiatric trainees at all grades on placement within the trust will influence their decisions about choosing the trust as an employer for their senior career grade years.

Recommendations:

I commend this report of assurance to the board for acceptance and ask for the wider board to continue every possible support for the Medical Director and Directorate towards the recruitment and retention of senior medical staff across the trust.

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Annual data summary from 1st April 2022 to 31st March 2023

Vacancies

Locality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average wte)	Number of shifts uncovered (over the year)
North Durham	F1	0	0	0	0	0	0
	F2	1	0	0	0	0	0
	CT1	0	0	0	1	0	0
	CT2	0	0	0	1	0	0
	CT3	0	0	0.33	1	0	0
	ST4 -6	0	1.3	0	1	0	2
	GP	0	0	0	0	0	0
	Trust Doctor	0	0	0	0	0	0
South Durham	F1	0	0	0	1	0	0
	F2	0	0	0	0	0	0
	CT1	1	0.6	1	0	0	0
	CT2	0	0	0	0	0	0
	CT3	0	0	0	0	0	0
	ST4 -6	0	0.3	0	2	0	2
	GP	0	1	0	1	0	1
	Trust Doctor	0	0	0	0	0	0
Teesside & Forensics	F1	0	0	0.67	0	0	0
	F2	1	0	0.67	1	0	0
	CT1	0	0	0	1	0	0
	CT2	0	0	0	0.66	0	0
	CT3	0	0	0	0.33	0	0
	ST4 -6	0	1.3	0	3.33	0	0
	GP	0	0	0	1	0	0
	Trust Doctor	0	0	0	0	0	0
North Yorkshire & York	F1	0	0	0	0	0	0
	F2	0	0	0	2	0	0
	CT1	2.3	1.16	1	2.66	0	0
	CT2	1.2	0.4	0	0	0	0
	CT3	0	0	0	0.33	0	0
	ST4 -6	3.6	8.73	7.2	2.33	0	0
	GP	0	0	0	0	0	0
	Trust Doctor	0	0	0	0	0	0
Total		**10.1**	**14.79**	**10.87**	**22.64**	**0**	**5**

Fines

Locality	Quarter 1 Number of fines levied	Quarter 2 Number of fines levied	Quarter 3 Number of fines levied	Quarter 4 Number of fines levied	Annual Total
North Durham	0	0	0	2	**2**
South Durham	0	0	0	0	**0**
Teesside & Forensics	4	10	8	3	**25**
North Yorkshire & York	22	22	13	0	**57**
Total	**26**	**32**	**21**	**5**	**65**

Locality	Quarter 1 Value of fines levied	Quarter 2 Value of fines levied	Quarter 3 Value of fines levied	Quarter 4 Value of fines levied	Annual Total
North Durham	0	0	0	£401	**£401**
South Durham	0	0	0	0	**£0**
Teesside & Forensics	£528.20	£3,879.23	£1570.80	£348.5	**£6,326.73**
North Yorkshire & York	£2,956.15	£2,956.15	£1,691.64	0	**£7,603.94**
Total	**£3,484.35**	**£6,835.38**	**£3,262.44**	**£750**	**£14,331.67**

The following has been spent within the past year:

Date Purchased	Item Purchased	Location	Cost
04/03/2022	Beanbags	Jr Doctors Office's RPH, WPH, LRH, CLH, FPH	£ 645.00
04/03/2022	Plants	Jr Doctors Office's RPH, WPH, LRH, CLH, FPH	£ 516.96
06/05/2022	Mugs	Jr Doctors Office WPH	£ 22.43
06/05/2022	Teaspoons	Jr Doctors Office WPH	£ 2.40
06/05/2022	Coffee Pods	Jr Doctors Office, RPH	£ 55.60
31/05/2022	Coffee Pods	Jr Doctors Office, FPH	£ 55.60
13/06/2022	Black Pens	Jr Dr Office, WPH	£ 1.00
22/07/2022	Coffee Pods	Jr Doctors Office WPH	£ 248.86
22/07/2022	Coffee Pods	Jr Doctors Office, RPH	£ 248.86
22/07/2022	Coffee Pods	Jr Doctors Office, FPH	£ 248.86
22/07/2022	Coffee Pods	Jr Doctors Office, LRH	£ 248.86
22/07/2022	Coffee Pods	Jr Doctors Office, CLH	£ 248.86
02/09/2022	Coffee Pods	Jr Doctors Office WPH	£ 248.86
02/09/2022	Coffee Pods	Jr Doctors Office, RPH	£ 248.86
02/09/2022	Coffee Pods	Jr Doctors Office, FPH	£ 248.86

Date Purchased	Item Purchased	Location	Cost
02/09/2022	Coffee Pods	Jr Doctors Office, LRH	£ 248.86
02/09/2022	Coffee Pods	Jr Doctors Office, CLH	£ 248.86
16/09/2022	DAB Radio	Jr Doctors Office, WPH	£ 39.98
26/09/2022	Diffuser & Oils	Jr Doctors Office, CLH	£ 99.97
10/10/2022	Coffee Pods	Jr Doctors Office WPH	£ 248.86
11/10/2022	Coffee Pods	Jr Doctors Office, RPH	£ 248.86
12/10/2022	Coffee Pods	Jr Doctors Office, FPH	£ 248.86
13/10/2022	Coffee Pods	Jr Doctors Office, LRH	£ 248.86
14/10/2022	Coffee Pods	Jr Doctors Office, CLH	£ 248.86
14/11/2022	Radiator for Roseberry Park	Jr Doctors Office, RPH	£ 47.95
	Coffee Pods	Jr Doctors Office, CLH	£ 248.86
21/11/2022	Coffee Pods	Jr Doctors Office, FPH	£ 248.86
15/12/2022	Radiator for Foss Park	Jr Doctors, FPH	£ 47.95
30/12/2022	Coffee Pods	Jr Doctors Office, CLH	£ 308.76
30/12/2022	Coffee Pods	Jr Doctors Office, FPH	£ 248.86
30/12/2022	Coffee Pods	Jr Doctors Office, LRH	£ 248.86
17/01/2023	Hot Chocolate pods	Jr Doctors Office, RPH	£ 55.90
07/02/2023	Microwave	Jr Doctors Office, RPH	£ 124.25
10/02/2023	Toaster	Jr Doctors Office, FPH	£ 20.69
24/02/2023	Coffee Pods	Jr Doctors, LRH	£ 263.84
24/02/2023	Coffee Pods	Jr Doctors, FPH	£ 263.84
24/02/2023	Coffee Pods	Jr Doctors, CLH	£ 267.85
24/02/2023	Coffee Pods	Jr Doctors, WPH	£ 256.98
13/04/2023	Coffee Pods	Jr Doctors, LRH	£ 248.86
13/04/2023	Coffee Pods	Jr Doctors, FPH	£ 248.86
13/04/2023	Coffee Pods	Jr Doctors, CLH	£ 243.61
13/04/2023	Coffee Pods	Jr Doctors, WPH	£ 248.86
13/04/2023	Coffee Pods	Jr Doctors, RPH	£ 197.03

Total Spend £9,012.51

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

High level data

Number of doctors / dentists in training (total):	143
Number of doctors / dentists in training on 2016 TCS (total):	143
Amount of time available in job plan for guardian to do the role:	1 PA
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st January 2023 up to 31st March 2023

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	14	14	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	1	1	0
F2 - Teesside & Forensic Services Juniors	0	8	8	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	9	9	0
CT1-2 –North Durham	0	3	3	0
CT1-2 – South Durham	0	1	1	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	0	0	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	1	1	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	5	5	0
Total	**0**	**42**	**42**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	36	36	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	3	3	0
South Durham Juniors	0	2	2	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	1	1	0
Total	**0**	**42**	**42**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	4	7	25	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	2	1	0	0
South Durham Juniors	0	1	1	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	1	0
Total	**6**	**9**	**27**	**0**

Narrative for Exception Reports

Since 1st February 2023, the Teesside junior rota has become fully resident, therefore the number of exceptions for working above the work schedule has reduced considerably. A number of reports were made for other reasons (F1 – 10 late finishes, 3 missed teaching; F2 – 4 late finishes, 1 missed teaching, 1 missed break; CT1 – 1 late finish; CT2 – 1 late finish; TD – 3 late finishes). Supervisors and ADME were informed regarding these. There were no senior registrar exceptions, though some may not be reported yet due to the NROC periods.

There were 6 exception reports received for the D&D locality – 1 from a Sen Reg, 1 from a CT doctor, 1 from an F1 doctor and 3 from 2 GP Reg claiming payment for shadowing an on-call shift.

Work schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	3	3	0	12	20
	CT1/2/GP	31	26	0	250.5	197
	CT3	0	1	0	0	12.5
	Trust Doctor	0	4	0	0	33
	SPR/SAS	15	15	0	296	296
North Durham	F2	0	0	0	0	0
	CT1/2/GP	16	15	0	157	153
	CT3	12	12	0	115	115
	Trust Doctor	0	0	0	0	0
	SPR/SAS	36	32	0	660	600
South Durham	F2	4	4	0	50	50
	CT1/2/GP	28	27	0	214	201.5
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	SPR/SAS	54	52	0	951	911
Total		**199**	**191**	**0**	**2705.5**	**2589**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Special Leave	1	1	0	16	16
COVID isolation	8	8	0	66	66
Maternity leave	10	10	0	90	90
On call cover	20	17	0	222.5	190.5
Service Requirement	9	9	0	90	90
Vacancy	134	129	0	2100	2015.5
Sickness	9	9	0	60	60
Industrial Action	8	8	0	61	61
Extra support	0	0	0	0	0
Total	**199**	**191**	**0**	**2705.5**	**2589**

Vacancies

Vacancies by month						
Locality	**Grade**	**January 2023**	**February 2023**	**March 2023**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	1	1	1	1	0
	CT1	1	1	1	1	0
	CT2	2	0	0	0.66	0
	CT3	1	0	0	0.33	0
	ST4 -6	4	3	3	3.33	0
	GP	1	1	1	1	0
	Trust Doctor	0	0	0	0	0
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	1	1	1	1	0
	CT2	1	1	1	1	0
	CT3	1	1	1	1	0
	ST4 -6	1	1	1	1	2
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
South Durham	F1	1	1	1	1	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	2	2	2	2	2
	GP	1	1	1	1	1
	Trust Doctor	0	0	0	0	0
Total		**18**	**14**	**14**	**15.3**	**5**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	3	£348.5
North Durham	2	£401
South Durham	0	£00.00
Total	5	£749.5

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
£00.00	£00.00	£00.00	£00.00

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

High level data

Number of doctors / dentists in training (total):	74
Number of doctors / dentists in training on 2016 TCS (total):	74
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st January 2023 up to 31st March 2023

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - York	0	0	0	0
CT1-2 - Northallerton	0	0	0	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	7	7	0
CT1-2 - York	0	6	6	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	8	8	0
CT3/ST4-6 – Scarborough	0	4	4	0
CT3/ST4-6 – York	0	7	7	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	1	1	0
Trust Doctors - York	0	2	2	0
Total	**0**	**35**	**35**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton/ Harrogate/ York	0	23	23	0
Scarborough	0	12	12	0
Total	**0**	**35**	**35**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Northallerton/ Harrogate/ York	3	7	4	0
Scarborough	5	12	3	0
Total	**8**	**19**	**7**	**0**

Narrative around Exception Reports

The majority of exceptions were as a result of the NROC monitoring period and relating to doctors not achieving the minimum rest period. Six of these exceptions were submitted by Senior Registrars upon completion of a MHA assessment during the night.

5 exceptions were due to late finishes on a normal working day and 1 exception was the night shift doctor remaining at work for 50 minutes as the day shift doctor was on sick leave

Work Schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Northallerton/ Harrogate/ York	F2	15	21	0	130.5	214.5
	CT1/2/GP	32	44	0	406	436.5
	CT3	30	11	0	345	193
	Trust Doctor	0	0	0	0	0
	ST4-6/SAS	6	6	0	104	129
Scarborough	F2	3	7	0	56	128
	CT1/2/GP	9	5	0	160	88
	CT3	1	1	0	16	64
	Trust Doctor	0	0	0	0	0
	ST4-6/ SAS	85	85	0	1543	1495

Total	**181**	**180**	**0**	**2760.5**	**2748**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	71	71	0	1171	1171
Sickness	31	30	0	322.5	`210
Other	79	79	0	1267	1267
Total	**181**	**180**	**0**	**2760.5**	**2748**

Vacancies

Vacancies by month						
Locality	**Grade**	**January 2023**	**February 2023**	**March 2023**	**Total gaps (average)**	**Number of shifts uncovered**
Northallerton/ Harrogate/ York	F1	0	0	0	0	0
	F2	2	2	2	2	0
	CT1/2/GP	4	2	2	2.66	0
	CT3	0	0	0	0	0
	ST4 -6	3	2	2	2.33	0
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	0	0	0	0	0
	CT3	1	0	0	0.33	0
	ST4 -6	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		10	6	6	7.33	0

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	0	£0.00
North Yorkshire & York	0	£0.00
Total	0	£0.00

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 17

For General Release

Meeting of:	**Trust Board**
Date:	**27th April 2023**
Title:	**Annual Staffing Establishment Review**
Executive Sponsor(s):	**Elizabeth Moody, Executive Director of Nursing and Governance**
Author(s):	**Joe Bergin, Nurse Consultant, workforce standards**

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

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1	**Recruitment and Retention**	The staffing establishment review is a mitigating action against BAF risk 1

Executive Summary:

Purpose:
The purpose of this report is for information and assurance of the Trust's clinical team staffing establishments reviewed over the period September 2022–February 2023. This annual establishment review has been conducted in line with national regulatory requirements. An evidence-based tool, Mental Health Optimal Staffing Tool (MHOST) was used to benchmark all inpatient services and professional judgement was used to analyse and make recommendations.

Proposal:
Further consideration by the People, Culture and Diversity Group and financial modelling is required to support the requirements and requests from the General Manager tier service level reports and to support any proposed changes to the Learning Disability and Older Persons (MHSOP) staffing requirements initially approved at the September 2022 Trust Board. These models will be presented to the Board for further approval once reviewed.

Further review will take place within the People, Diversity and Culture Committee for independent assurance following the identified actions being undertaken with oversight from the People, Diversity and Culture Group.

Overview:
This report details the Trust approach to the mandated systematic review of staffing

resources to ensure safe staffing levels are met according to national workforce guidelines and standards as described in the NHS Improvement 'Developing Workforce Safeguards' (NHSE/I, 2018) and the National Quality Board (NQB) guidelines (NHS, 2018).

The report delivers against expectation 1 and 2 of the NQB requirements and discusses expectation 3 and outlines a set of mitigating actions to address the issues highlighted from service feedback and data analysis.

For the purposes of this annual establishment review, engagement with clinical and operational services sought professional judgement reports from the teams regarding their staffing establishments and supported by an evidence-based tool (MHOST). This followed the same approach determined by the agreed process from a QI event in 2019 which will be further reviewed 2023 to ensure the process remains robust following the restructure.

Key findings and areas of focus include:

- TEWV safer staffing fill rates are set within a standard of not falling below 90% and not above 120%. 67% of wards were below 90% for the period for registered nursing. Whilst many wards show poor RN fill rates and significantly high HCA fill rates this is most notable for the PICUs and AMH admission wards.
- A significant shortfall in the RN to HCA skill mix percentages (taken from actual hours worked) is demonstrated over most services against the national MHOST benchmark values. Budgeted staffing establishments show a much better position, but the skill mix seen on the wards in actuality is impacted by the correlation with the increased use of additional temporary staffing which is predominantly an HCA resource.
- Vacancies remain high for registered nursing and medical professionals particularly across adult mental health services
- In comparison to the reported position in 2021:
    - there is a shift from red and red/amber ratings for inpatient teams, going from a combined total of 30 teams in 2021 to just 5 teams in this 2022 review
    - the number of inpatient teams previously reporting as red and red/amber have moved to amber
    - 16% of inpatient teams are either amber/green or green
    - community teams positively report a decrease for teams reporting red and red/amber
    - urgent care (crisis and liaison) and specialist teams report a relatively significant increase in teams moving towards the red and red/amber end of the spectrum
- High levels of acuity across the care groups, leading to increased use of resources and enhanced observations compared to national benchmarks (standard profiles from MHOST)
- AMH Admissions and Rehab wards together with SIS LSU wards show as being below the peer median value for CHPPD when measured against peer trusts from the latest available Model Hospital inpatient data
- The required average bed occupancy of 85% is the threshold used in staffing establishment setting. Beyond this point is where safety and efficiency are at risk (BMA 2022). There is an increased bed occupancy that consistently exceeds this 85% threshold for AMH most specifically the admission wards (where values more than 100% are frequently seen) and the PICUs. MHSOP also show periods where this threshold is exceeded
- The number of admissions and discharges can also be seen as a significant factor in the increased staffing demand on AMH admissions

- A number of teams struggle to effectively meet their headroom requirements and/or effectively manage their ward unavailability such as Annual Leave, Study Leave, Working Day, Parenting, Sickness. There are also opportunities to improve rostering practices to support a more effective and efficient use of staff resources by level loading
- There are high numbers of individual wards exceeding the Trust thresholds for the percentage of temporary staffing usage (25% for bank and 4% for agency) on a month-by-month basis
- Inpatient trend analysis over 2 years shows a decreasing trend in supportive engagement and observations of a Trust wide value of approximately 50 per day for all wards to values of circa 35
- Missed breaks have shown an improving trend which is an important issue with regard to staff well-being

Where any gaps in assurance have been identified, requiring further information or detail, a plan of key actions and responsibilities has been designed.

Prior Consideration and Feedback

The staffing establishment review results have been discussed and signed off at Care Group Board level. Due to several competing priorities impacting on the staffing establishment review process, the findings require further discussion at Executive Directors Group. It is proposed that the People, Culture and Diversity Group in conjunction with Care Groups review the actions proposed at appendix 5 and coordinate further updates to the Board.

Implications:

The Board Assurance Framework recognises that 'Inability to recruit and retain sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services'.

The following clinical risks are associated with inadequate nursing and care staffing capacity and capability:

- Inadequate staffing numbers compromise safe and compassionate care.
- Poor monitoring of staffing capacity and capability can give rise to unacceptable patterns of inadequate staffing
- Not having the right skill mix in clinical environments can place unacceptable, additional demands upon staff and give rise to unsafe and ineffective care.
- If staff feel unable to speak out, then potentially unsafe staffing levels go undetected and reported and risks are not effectively mitigated
- Inadequate staffing numbers can compromise safe and compassionate care.

Adhering to NHSI requirements will provide compliance with CQC standards of which the professional judgment discussions within the team reports are based upon. Insufficient staffing and skill mix can negatively impact on ratings for the CQC 'safe' and 'well led' domains. This report aims to highlight areas where staffing shortfalls may need to be addressed or mitigated.

The Trust needs to consider and ensure baseline establishments are correct to provide high quality patient care. Recruitment and retention difficulties further compound issues regarding the lack of availability of staff from the registered MDT pool and is also influenced by the reduced levels of experience of new staff entering the Trust. These areas will challenge quality of care and patient safety and experience. As such the overall expectation

of the Trust is to provide a positive impact upon the following areas:

- Time to care – releasing nursing staff time to care
- Leadership and culture
- Enhance quality focus and skill mix
- Enhance patient experience and reduce incidents
- Support workforce development and retention
- Reduce the use of bank staff and reliance on overtime
- Support staff wellbeing

There are no issues highlighted regarding the areas of Legal and Constitutional (including the NHS Constitution), and Equality and Diversity.

Recommendations:
For the Trust Board to consider the report and agree the actions required to be undertaken in relation to staffing resources and mitigation of key issues raised.

The Trust Board to confirm its level of assurance from the report, advising if any further actions are needed to achieve the required assurance.

1. PURPOSE:

The purpose of this report is for information and assurance of the Trust's clinical team staffing establishments reviewed over the period September 2022 – February 2023. It outlines the current Trust approach to the required systematic review of staffing resources to ensure safe staffing levels are met according to national workforce guidelines and standards as described in the NHS Improvement 'Developing Workforce Safeguards' (NHSE/I, 2018) and the National Quality Board (NQB) guidelines (NHS, 2018). This report delivers against expectation 1 and 2 of the NQB requirements and discusses expectation 3.

The aims of the annual evidence-based staffing establishment review process are to:

- Strengthen assurance and accountability for safe, sustainable, and productive staffing
- Promote a consistent, systematic, and proactive approach to staffing decisions which supports CQC fundamental standards
- Improve governance processes from ward to Board regarding workforce and staffing
- Increase staff awareness, engagement, and participation in workforce solutions
- Support stronger Board engagement with workforce challenges and issues
- Ensure compliance with NHSE/I requirements
- Improve staff welfare, morale and well being
- Support a reduction in temporary staffing usage, particularly agency staff.

The review utilises the following approaches in its methodology:

- Professional Judgement
- The Mental Health Optimal Staffing Tool (MHOST) for Acuity/Dependency
- Care Hours Per Patient Day (CHPPD)
- Peer group validation
- Benchmarking and review of national guidance including Model Hospital data
- Review of e-Rostering data
- Review of ward-based metrics
- Review of patient related data

Further background and context can be found in appendix 1.

2. KEY FINDINGS:

Service's Professional Judgement Reports. In conjunction with operational services, 214 clinical teams were identified for inclusion in the 2022 establishment review process, 121 community teams (56%), 38 specialist service teams (18%) and 55 inpatient teams (26%).

Following the same process as 2021, team managers completed a professional judgement report (see appendix 2 for detail) correlated with team specific workforce and patient related data and provided RAG rating of their team based upon the criteria shown in Table 1.

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

Table 1: Professional Judgement RAG rating criteria

Following review of individual team reports General Managers compiled a service summary report and RAG rating then discussed at governance frameworks. The summary of the final team RAG ratings from the establishment reviews are shown in Table 2; teams in the Red and Red/Amber category are summarised in appendix 2a.

November 2022	RAG Rating					Grand Total
Service Setting	Red	Red Amber	Amber	Amber Green	Green	
Community	4	16	30	59	12	121
Inpatient	3	2	41	7	2	55
Urgent Care/Specialist	3	5	16	13	1	38
Grand Total	**10**	**23**	**87**	**79**	**15**	**214**

Table 2: RAG ratings for Clinical Teams from General Managers / SIDG

Table 3 highlights an improved picture based upon the RAG ratings of 2022 to that from the previous exercise done in 2021 despite some services remaining in BCP and experiencing ongoing staffing pressures. In comparison to the reported position in 2021:

- there is a shift from red and red/amber ratings for inpatient teams, going from a combined total of 30 teams in 2021 to just 5 teams in this 2022 review
- the number of inpatient teams previously reporting as red and red/amber have moved to amber which means only 16% of inpatient teams are either amber/green or green.
- community teams report a decrease for teams reporting red and red/amber.
- urgent care and specialist teams report a relatively significant increase in teams moving towards the red and red/amber end of the spectrum

RAG Rating - Comparison 2022 and 2021										
Service Setting	Red		Red Amber		Amber		Amber Green		Green	
Year	2022	2021	2022	2021	2022	2021	2022	2021	2022	2021
Community	4	8	16	17	30	39	59	46	12	10
Inpatient	3	8	2	22	41	19	7	5	2	3
Urgent Care/Specialist	3	2	5	1	16	7	13	12	1	4
Grand Total	**10**	**18**	**23**	**40**	**87**	**65**	**79**	**63**	**15**	**17**

Table 3: RAG ratings comparison for Clinical Teams - November 2022 vs November 2021

Table 4 shows that 9 teams of the 58 teams reporting Red and Red/Amber categories for 2021 remain in this category, most notably:

- 4 teams reporting a worsening status over this previous year, 1 team remains at Red status, whilst 3 other NYYS AMH community teams remain at Red/Amber
- Springwood has moved from Red to Red/Amber

Care Group	Speciality	Setting	Ward/Team	2021 RAG	2022 RAG
DTVF	LD	IP	ALD BANKFIELDS COURT THE LODGE	Red / Amber	Red
DTVF	LD	IP	ALD BANKFIELDS COURT	Red / Amber	Red
NYYS	AMH	CMHT	AMH RIPON COMMUNITY	Red / Amber	Red
NYYS	AMH	CMHT	AMH SCARBOROUGH COMMUNITY	Red / Amber	Red / Amber
NYYS	AMH	CMHT	AMH YORK AND SELBY MENTAL WELLBEING ACCESS TEAM	Red / Amber	Red / Amber
NYYS	AMH	CMHT	AMH YORK SOUTH CMHT	Red / Amber	Red / Amber
NYYS	AMH	UC/SPEC	AMH NYY PERINATAL	Red	Red
NYYS	CYPS	CMHT	CHILD AND YP NY AND Y CRISIS TEAM	Red / Amber	Red
NYYS	MHSOP	IP	MHSOP IP MALTON SPRINGWOOD	Red	Red / Amber

Table 4: Red & Red/Amber teams in 2021 remaining in this category for 2022

A summary of issues and risks identified from services are shown below and detailed in appendix 3.

- Safety and quality of service
- Recruitment and retention
- Leadership and skill mix
- Staff well-being
- Patient acuity, dependency, and complexity
- Staffing - demand and capacity
- Training, development, and support
- Environment
- Financial

The General Manager and team reports are detailed in appendix 4 and highlight the service specific issues, current work, and mitigating actions that are in place for each service area. These actions are also outlined in appendix 5 and it is recommended that these will be considered at PCDG and Care Group review to enable the development of a financial model and final action plan.

The Q2 22/23 establishment setting review presented to the Trust Board September 2022 resulted in the approval of the proposed uplift of staffing establishments for LD and MHSOP services to which appendix 6 details further. The posts were to be recruited to on a permanent basis with the aim to support clinical leadership, improve skill mix and to increase availability for nursing care time. The expectation was also to support a reduction in agency expenditure. The recruitment was stated to be at “at risk” due to the absence of assigned funding. Recruitment to these posts had been delayed by services due to changes in service models and provision and considerations towards further revision of requirements for both LD and MHSOP.

Further work has commenced in the development of a model to support the revised operational requirements which will require further approval at Trust Board at the appropriate and earliest possible time.

Assessment using the MHOST and LDOST (see appendix 7). MHOST assessments from inpatient wards during September 2022 excluded day units, wards undergoing closure, respite units, and single patient wards. Benchmarked average patient acuity profiles for each ward are shown in appendix 8. Ward acuity measured via MHOST is generally seen to be higher than that of the MHOST benchmark values, which correlates with ward reports. Appendix 9 gives details and narrative of the MHOST outcomes and financial discussion which shows that only 28 wards met the criteria for valid outcomes from MHOST and LDOST due to either not having 8 or more patients on the ward or did not meet the recommend minimum number of assessment days to ensure validity of the tool.

It is recommended that a further Trust wide education and assessment programme be initiated via the Safe Staffing team. This will be further addressed at the planned QIS event to review the staffing establishment process where key responsibilities will be identified and reinforced following a number of recent changes in staff in clinical and operational posts. There may be a consideration to the benefit from an interim repetition of the exercise

following re-education and operational support to provide an increased level of assurance regarding the validity and reliability of the MHOST results

Table 5 shows the results for MHOST outputs for wards (achieving valid output criteria). It shows a net result of 100.8 WTEs for those 28 wards and provides a clear indicator of where the further priorities lie - AMH admission wards and PICUs had 13 out of 14 wards successfully complete the assessment. This is also reflected in the high levels of bank and agency nurses (appendix 10) used to support staffing in AMH, reduced CHPPD against peer Trusts, high fill rates, high occupancy and admission rates, and reduced skill mix ratios. This provides further indication recommendations from MHOST needs further discussion regarding staffing levels and consideration towards those wards that have been excluded due validity reasons.

Service Area	WTE MHOST vs Budgeted RPs	WTE MHOST vs Budgeted SWs	WTE MHOST vs Budgeted Total	MHOST vs Budgeted RPs	MHOST vs Budgeted SWs	MHOST vs Budgeted Total (£)
Admission	47.3	23.2	70.5	£2,174,292	£867,323	£3,041,615
ED	-2.5	4.0	1.4	-£116,773	£148,992	£32,218
LDOSTA&T	9.4	18.6	28.0	£432,653	£697,751	£1,130,404
LSU	8.6	-20.8	-12.2	£394,766	-£779,719	-£384,952
MSU	6.1	-25.9	-19.8	£278,761	-£968,097	-£689,336
OlderPeople	1.0	-8.9	-7.9	£45,492	-£333,490	-£287,998
PICU	12.7	18.9	31.6	£584,505	£707,994	£1,292,499
Rehab	6.6	2.6	9.2	£304,513	£97,432	£401,944
Grand Total	89.1	11.7	100.8	£4,098,207	£438,187	£4,536,395

Table 5: MHOST recommended WTEs vs. budgeted WTEs and associated cost for AfC B5 and B3

Care Hours Per Patient Day (CHPPD) and Skill Mix. Appendix 11 demonstrates a significant shortfall in the RN to HCA skill mix percentages (taken from actual hours worked) over most services against the MHOST benchmark values. Budgeted staffing establishments show a much better position, but the actual skill mix seen on the wards impacted by the increased use of additional temporary staffing which is predominantly an HCA resource. This data also is supported by the shortfall of registered nurse's seen in the fill rate data.

Model Hospital benchmark data. CHPPD is based upon actual hours worked and is benchmarked against peer trusts from the latest available Model Hospital inpatient data which is December 2022 (and November 2022 for LD services). It shows clearly that AMH services (which includes adult admission wards, adult rehab wards, and eating disorders) are lower than other peer providers. Secure inpatient services (LSU) also see lower values than peer providers, but to a lesser degree than AMH although both services are in the second lower quartile. Other services are shown to sit above the peer provider median benchmark value. Model Hospital data shows a combined average for LSU and MSU wards

Fill Rates. Table 6 shows that the increased fill rate of HCAs across the shift patterns are compensating for the reduced availability of RNs. This presents risks in terms of CQC compliance and limits the quality and safety of interventions that can be offered from a registered nursing perspective as well as clinical leadership and oversight on the ward. Appendix 13 provides additional narrative and detail.

September 2022 - February 2023	RN Days	RN Nights	HCA Days	HCA Nights
Number of Wards < 90% Fill Rate	35 (67%)	9.8 (19%)	5.0 (10%)	1.7 (3%)
Number of Wards > 120% Fill Rate	1.5 (3%)	7.3 (14%)	28.5 (55%)	32.8 (63%)
Number of Wards Meeting Trust Fill Rate Target	15.5 (30%)	34.8 (67%)	18.5 (36%)	17.5 (34%)

Table 6: Fill rate Summary

Missed breaks and extended shifts times. Appendix 14 summarises below for rostered teams and shows the number of reported missed breaks are on a slight downward trend whereas the incidence of staff working an extended shift period shows no discernible pattern – Monday shows a higher incidence across both areas of missed break and long shift times

Headroom requirements and roster performance. For the rostered wards reviewed, the number of teams exceeding the headroom limit of 27.7% weekly over a 6 month period, showed that on average only about a quarter of the rostered teams were able to achieve remaining within their headroom value of 27.7%, clearly indicating that teams struggle to effectively meet their headroom requirements and/or effectively manage their ward unavailability such as Annual Leave, Study Leave, Working Day, Parenting, Sickness.

COVID-19 is still reported to have an impact upon staffing. Sickness levels (appendix 15) continues to challenge workload and availability of skilled staff, particularly so in the inpatient services, with ward leaders and the MDT required to be part of the staffing numbers to maintain safe staffing levels, which in turn can lead to a reduction in activities such as appraisals, training, and supervision.

Annual leave level loading remains an issue for both RNs and HCAs; on average about a quarter of teams for RNs and a third of the teams for HCAs achieve this. Publication of rosters in a timely manner sees roughly 40% of teams achieving the “6 weeks in advance” requirement. There are opportunities to improve in these areas which can contribute to better usage of temporary staffing usage if managed well. Further detailed analysis regarding is found in appendix 16.

Vacancies. The vacancy position (source finance data for February 2023) of budgeted WTEs to contracted WTEs for the clinical teams across is detailed in appendix 17. This clearly shows the major issues lie with vacancies for registered nurses and medical consultants This is most significant in adult mental health services.

Bed Occupancy. The required average bed occupancy of 85% is the threshold used in staffing establishment setting. Beyond this point is where safety and efficiency are at risk (BMA 2022). There is an increased bed occupancy that consistently exceeds this 85% threshold for AMH most specifically the admission wards (where values more than 100% are frequently seen) and the PICUs (appendix 18). MHSOP also show periods where this threshold is exceeded. High occupancy and increasing acuity are a constant strain upon clinical services to consistently meet the service and patient requirements where budgeted establishments are positioned to provide for an 85% occupancy level.

Ward Admission Rates. The number of admissions and discharges on adult mental health wards are significantly higher than on other ward specialities (appendix 18a). The number of admissions and discharges, increased acuity seen at admission together with increased

occupancy can be seen as a significant factor in the increased staffing demand on AMH admissions

Flexible/Temporary staffing expenditure. Table 7 shows a breakdown of flexible staffing pay expenditure (as of February 2023) shows agency (6.4%), bank (3.3%), overtime (1.8%), additional standard duty hours (0.4%). Inpatients (non-medical) shows flexible staffing expenditure accounts for over 28%.

Sum of Feb-23	FLEX STAFFING % EXPENDITURE OF TOTAL PAY (including Medical)				
Service	AGENCY	ASH	BANK	OVERTIME	TOTAL %
ADULT LEARNING DISABILITIES	6.3%	0.4%	3.5%	1.6%	11.8%
ADULT MENTAL HEALTH	6.1%	0.3%	3.3%	2.2%	11.9%
CHILDREN AND YOUNG PEOPLES SERVICES	2.5%	0.4%	0.3%	1.2%	4.5%
HEALTH AND JUSTICE	7.4%	0.7%	1.2%	1.2%	10.5%
MENTAL HEALTH SERVICES FOR OLDER PEOPLE	9.2%	0.4%	2.6%	1.3%	13.5%
SECURE INPATIENT SERVICES	7.9%	0.2%	9.9%	2.5%	20.5%
Grand Total	**6.4%**	**0.4%**	**3.3%**	**1.8%**	**11.8%**

Table 7: Flexible Staffing as a percentage of total pay expenditure for February 2023 (including medical)

Sum of Feb-23	NON MEDICAL FLEX STAFFING % EXPENDITURE OF TOTAL PAY				
Service	AGENCY	ASH	BANK	OVERTIME	TOTAL %
⊞ COMMUNITY	1.6%	0.3%	0.1%	2.1%	4.2%
⊞ INPATIENT	12.3%	0.4%	13.1%	2.6%	28.5%
Grand Total	**5.3%**	**0.3%**	**4.6%**	**2.3%**	**12.5%**

Table 8: Flexible Staffing as a percentage of total pay expenditure for February 2023 (not including medical)

Agency workforce costs have peaked during Q2 and Q3 2022/23 specifically so for nursing within the inpatient adult mental health service (appendix 19 and 20) in response to numbers of agency workforce required to meet additional patient needs requiring agency staff to be sourced at costs above the NHSE 'price cap'. It can also see that LD service agency costs have reduced, supported by the reduction in off framework agency.

Nursing Temporary Staffing Shift Requests Temporary staffing (nurse bank and agency) requests has seen a reduction in the peak of more than 11,000 seen in July 2022 to a steady state average value of approximately 10,000 per month since then - although this is recognised as being a 33% increase to the 7,500 seen at the start of 2021. Appendix 21 shows the temporary staffing requirement when measured against the total hours worked is a consistent value. However, it is remarked there are high numbers of individual wards exceeding the Trust thresholds for the percentage of temporary staffing usage (25% for bank and 4% for agency) on a month-by-month basis. Further narrative and detail are found in appendix 22.

SafeCare, Red Flags and Datix Reporting. When red flags are raised the matron and/or duty nurse coordinator will support teams with local actions to mitigate the issue(s). Staff still see staffing levels as a concern despite the reduction in the number of both SafeCare red flags and Datix reports over recent months. Ward-based medication error incidents reported via Datix show that AMH and SIS have the highest incidence and would benefit from further analysis on a more granular basis to understand the causative factors and if this is directly correlated to staffing issues. Further narrative and detail are provided in appendix 23.

Observation Levels. Inpatient trend analysis over 2 years shows a decreasing trend in supportive engagement and observations of a Trust wide value of approximately 50 per day for all wards to values of circa 35 (appendix 24). Further analysis is required at ward level to

understand how the dynamics of observation and engagement levels are managed to development a planned and strategic approach rather than a reliance upon a temporary staffing solution. Further consideration towards the potential impact of the vision-based patient monitoring system (Oxevision) in regard to observation levels should also be taken into account.

Patient Experience Patient feedback (appendix 25) regarding "feeling safe" fails to achieve the Trust target of 88%, reasons include "behaviour and aggression of fellow patients, understaffed, medication issues". Comments relating to the number of staff in community and inpatient settings were significantly negative and predominantly include comments relating to "more staff needed, consistency and continuity, time to care". Patient experience regarding feeling safe is a priority within the Trust's Quality Account with a range of work being undertaken to address these concerns working the Regional Patient Experience network and ward-based focus groups having taken place.

Further in-depth narrative and discussion relating to the themes derived from service reports and data analysis, the current mitigating work in progress and the planned mitigations represented by the key actions discussed in paragraph 2.7 can be found in appendix 26.

Progress on previous staffing establishment review

Following the previous staffing establishment setting exercise in March 2022, a further report was presented to the Board in September 2022 which provided updates to the March 2022 proposed models for MHSOP and LD services. This report was approved at Trust Board in September 2022 allowing the services to action and employ the additional staff on a permanent basis, albeit at financial risk due to lack of available funds to support the increase in budget for each of the two services. This is recapped in appendix 6.

Recruitment to the identified posts from both services had been delayed due to changes in service provision and considerations towards further revision of requirements for both LD and MHSOP. MHSOP NYY&S have begun to commence recruitment to these posts and further work is required to consider mapping any over establishments against the staffing approved in the report.

Discussion regarding MHSOP staffing and progressing work with the "Exemplar Ward" proposals (an initiative to standardise MHSOP provision across the Trust and be determined by the clinical pathway for patients - a process which will enable a clearer understanding of the staffing requirement. This will also include a review of zonal engagement currently employed in the MHSOP service and the associated workforce requirement will be considered in line with the clinical journey This may result in additional resource being required.

LD services for DTVF have commenced a deep dive observational piece of work to more closely understand staffing requirements to support the current patient group currently resident at Bankfields Court. Discussions continue regarding the service requirements for Bankfields Court and Lanchester Road LD provision and need to be considered in the service model redesign going forward.

All ongoing work in the development and refinement of a models to support operational requirements which will require further approval at Trust Board at the appropriate and earliest possible time.

Financial modelling is required to support the requirements and requests from the General Manager service level reports and to support any proposed changes to the LD and MHSOP staffing requirements approved at the September 2022 Trust Board. These models will be presented to the Board for further approval at that time.

Actions and next steps

1. Review staffing establishment process – a QIS event is in the planning phase which will consider amongst other factors:
    - governance pathway
    - timeline – review regarding length of process from "ward (team) to Board" and alignment to key milestones (internal and external) i.e., with commissioning requirements
    - identifying key responsibilities and requirements across care groups and corporate departments
    - agreement on metrics and benchmarks- source of data, format, availability
    - communication strategy and feedback mechanisms
2. MHOST/LDOST
    - Link in with key stakeholders to better understand the reasons for the recent reduced compliance with MHOST.
    - Develop a revised training plan and assessment package that will reinvigorate the uptake of the available training on offer and ensure that key staff are up to date with required processes.
    - Develop an audit plan to increase assurance of validity of scoring.
    - Enlist support of operational management to align processes to meet the requirements of the process – to be addressed at the above QIS event
    - Plan for a further interim MHOST/LDOST assessment following the above actions
3. MHSOP - further work with MHSOP services in respect to the previously approved model, determine revised requirements and develop a financial model that aligns with current service need.
4. Learning Disability Services – progress current ongoing work with LD services to better understand staffing requirements to meet patient demand and future service need. A revised set of requirements will inform the development of a financial model that will align with current service need.
5. AMH – adult admissions and PICUs require a further deep dive review from the indicators presented in this report. They show to have high acuity, high levels of bank agency usage and extremely high fill rates, high bed occupancy and high levels of admission rates. This is further supported by professional judgement being fed back regarding staffing pressures and the MHOST recommendations for these two service areas. Additional we see that AMH admissions and AMH rehab report as having low CHPPD values when compared to peer Trusts (via model

hospital). Suggested actions relating to AMH and PICU that have already commenced relate to changes in skill mix and banding across inpatient wards to strengthen retention, clinical leadership and advanced practice across professions.

6. SIS – work is currently underway with operational services and finance which is reviewing the current inpatient bed model for discussion with commissioners. Discussions are ongoing regarding analysis towards the MDT workforce and model for optimal deployment of staff to deliver the required safe and effective care.
7. Recruitment and retention - continued work on strategies outlined in appendix 26, supported by the national self-assessment exercise and international recruitment. Temporary staffing recruitment work in this area to continue.
8. Service level reports (appendix 4) - review and analyse with Care Groups, identifying the specific risk/issues/mitigating actions together with any additional workforce requirements. Outcomes from the analysis supported with financial models to be delivered to the executive PCDG and Care Group Boards for further discussion.
9. Health Roster and Safecare - engaging key stakeholders to support:
    - Embedding of SafeCare across all inpatient areas regarding compliance,
    - Increased focus upon e-rostering KPI's and efficient rostering.
    - Continued roll out of community e-rostering,
    - Increased focus on data quality within the e-rostering software
10. AHPs and Therapies – continue working with AHP professional leads and psychological therapy leads regarding service demand across both Care Groups.

The target timeline for these actions are within the next 6 months and with progress being monitored via the Safe Staffing group and therefore the executive PCDG.

3 RECOMMENDATIONS: -

- For the Trust Board to consider the report and agree the actions required to be undertaken in relation to staffing resources and mitigation of key issues raised.
- The Trust Board to confirm a reasonable level of assurance from the report, advising if any further actions are needed to achieve the required assurance.

Table of Contents

01. REFERENCES

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02. GLOSSARY OF TERMS

CHPPD

CHPPD is the metric currently advocated by the NHS to provide an average value of the staff hours available to each patient on the ward each day across the month. It is derived by dividing the sum of the staff time worked for each 24 hour period in the month as recorded on the health roster, by the sum of the daily head count of each patient at 23:59 for each day of the month. This metric is usually presented as an average across a calendar month period. Please see https://improvement.nhs.uk/resources/care-hours-patient-day-guides/ for further details regarding the CHPPD metric.

Model Hospital

The Model Hospital System (NHS Improvement - Model Hospital) is a data-driven digital tool provided by NHS Improvement and NHS England. It is designed to support improving patient outcomes, NHS productivity, quality and efficiency by providing a suite of tools that include the Model Hospital, Model Ambulance, Model Mental Health Trust and Model Community Trust. It allows for comparison across Peer NHS Trusts and other National NHS Trusts for the various collected metrics.

Headroom

Headroom, also referred to as 'uplift', 'downtime', 'time-out' or 'non-productive time' (Hurst, 2003; Drake, 2014b; McIntyre, 2016; NHS Improvement, 2018), is 'a budgeted allowance to cover annual leave, sickness, study leave, non-clinical working days and parenting' (NHS England and NHS Improvement, 2019b:12).

Actual Hours

The hours that are recorded as actually being on duty on the roster – this does not include headroom.

NB: When discussing from a payroll perspective this does include headroom, and accounts for pay for staff unavailability's.

Planned Hours

The hours that are recorded as being planned or expected to be on duty on the roster – this does not include headroom.

NB: When discussing from a payroll perspective this does include headroom, and accounts for pay for staff unavailability's.

Price Cap

The price cap established by NHSE seeks to limit premium charges for agency workforce by aligning to national pay scales however workforce pressures across sectors has in some cases has an inflationary effect on rates.

Registered Practitioner (RP)

Refers to a clinical MDT practitioner that has an entry on their professional register, for example a registered nurse, a registered physiotherapist, registered dietitian (this is not an exhaustive list). For the purpose of this report this does not include medical staff.

Support Worker (SW)

Refers to a clinical MDT practitioner that does not require an entry on a professional register, i.e. an unregistered staff member, for example a health care assistant, occupational therapy assistant (this is not an exhaustive list). For the purpose of this report this includes nursing associates and trainee nursing associates.

WTE

A Whole Time Equivalent (WTE) – also known as a Full-Time Equivalent (or FTE) – refers to the number of employee full-time positions. A full-time position for the Trust corresponds to 37.5 working hours per week.

As an illustration, 1 WTE position (equating to 37.5 hours) may be actually worked by:

- 1 person contracted for 37.5 hours
  OR
- More than one person, a case in example may be 2 people; with one person contracted to work 20 hours per week and the other person contracted to work 17.5 hours per week.

For the Medical workforce, 1.00 WTE equates to 40 hours per week which links to 4 contracted hours per session for 10 sessions

WTEs Budgeted

The number of WTEs the team has budget for - this includes headroom

WTEs Contracted

The number of WTEs contracted to work in the team - this includes headroom.

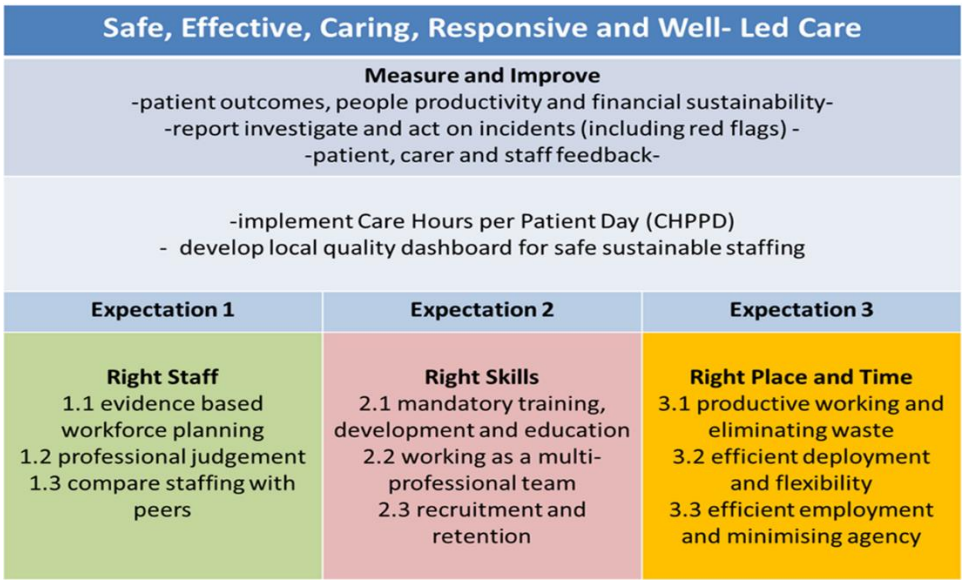
WTEs Variance

The contracted WTEs may not equal the budgeted WTEs. If Budgeted WTEs are subtracted from Contracted WTEs, a positive result will indicate a WTEs over-establishment; a negative figure will indicate a vacancy. i.e., 20 contracted WTEs minus 30 budgeted WTEs = -10 WTEs

WTEs Worked

The number of contracted WTEs that has worked for the team (and are to be paid) - this includes headroom, therefore includes staff that are on training, sickness absence, or on leave, e.g., annual leave, maternity leave. This also includes temporary staff, i.e., bank and agency.

03. APPENDIX 1



NQB Guidelines Expectations (NQB, 2018)

The National Quality Board (NQB) (2016) defined a set of guidelines to support recommendations set out in the Francis report (2013), Keogh (2013) and Hard Truths Report (2014) by providing a set of expectations (appendix 1) to deliver “safe, effective, caring responsive and well led care”, later updated for mental health specific guidance (NQB, 2018).

In 2018 NHS Improvement published ‘Developing Workforce Safeguards’ (DWS) guidance which sets out to support providers to deliver high quality care through safe and effective staffing. It builds upon the foundation of the National Quality Board recommendations broadened to all staff groups. DWS builds upon the NQB guidelines and provides a set of recommendations required to be formally delivered upon by NHS Trust Boards where it set out to ensure a consistent approach to safe staffing by describing good practice for:

- Effective workforce planning
- Deployment of staff by using evidence-based tools
- Governance considerations when redesigning roles/skills mix

DWS mandates specific actions for all Trusts to report back to NHSE/I via the System Oversight Framework (SOF) and annual governance statement which will potentially be subject to review as part of with other regulatory and advisory bodies such as NICE

In 2019 TEWV underwent a quality improvement process to establish a systematic, evidence based and triangulated methodological approach to reviewing its clinical staffing levels on an annual basis to support budget setting and staffing requirements.

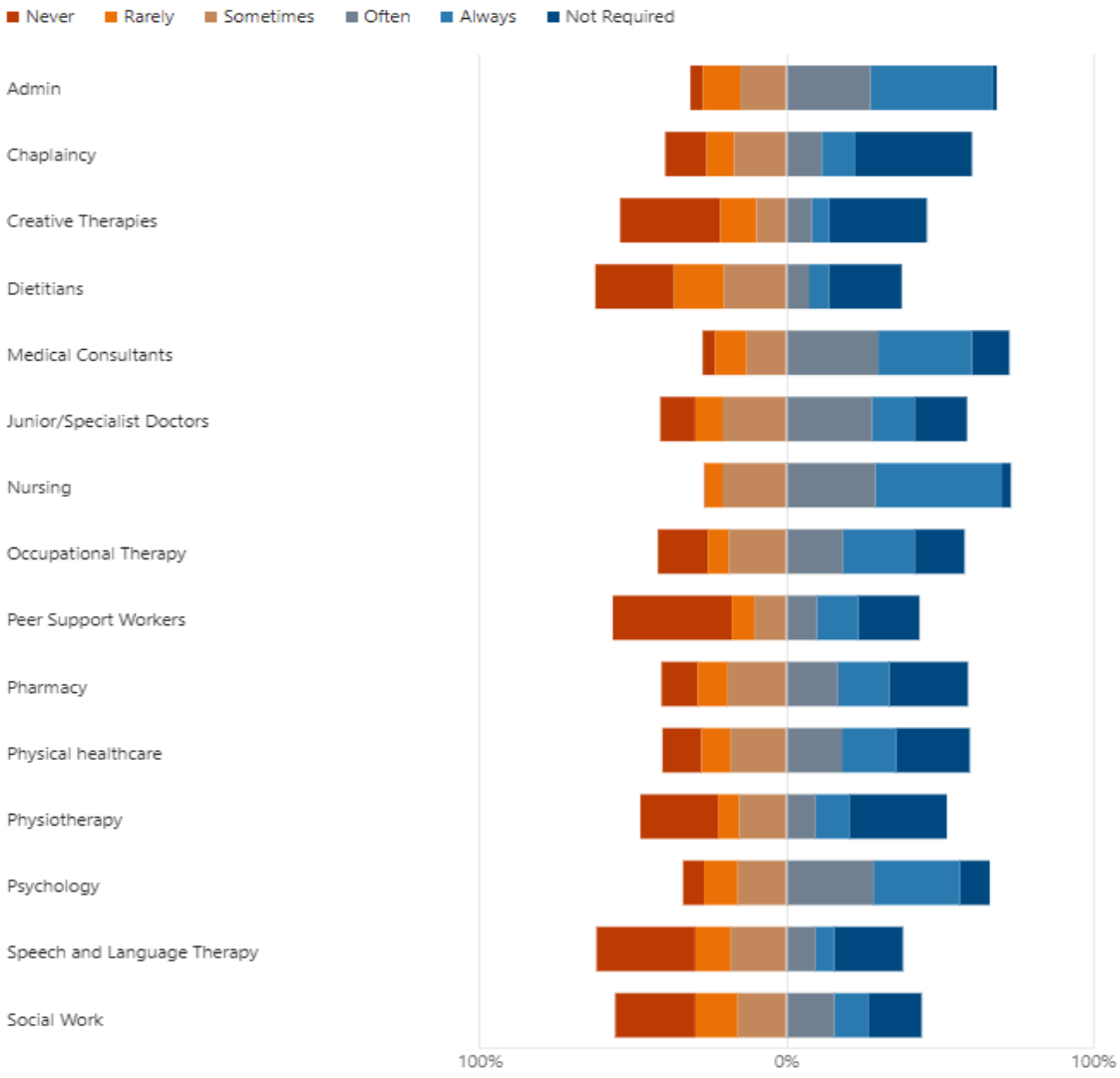
The Trust recently assessed its position against the RCN Nursing Workforce Standards (RCN, 2021) via a self-assessment gap analysis and against a review of the winter preparedness key actions (NHS, 2021) which are further referenced for information.

04. APPENDIX 2

NB Q1 one starts at step 15 as below – steps 1-14 provide details of team name, care group speciality. The graphs below are the responses from team managers from the professional judgement survey

15. The team has sufficient MDT availability for

More Details



16. Experience and Skill Mix

More Details

17. Temporary Staffing is used to Support

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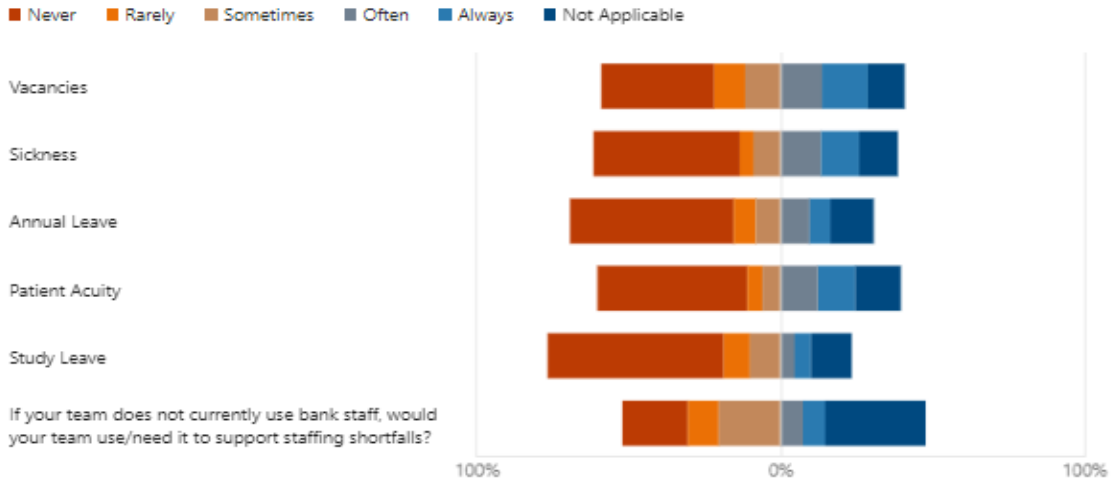

18. Student Placement

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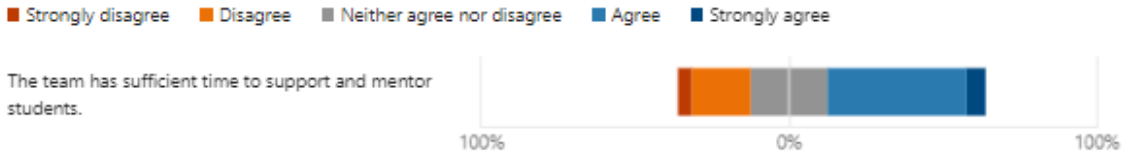
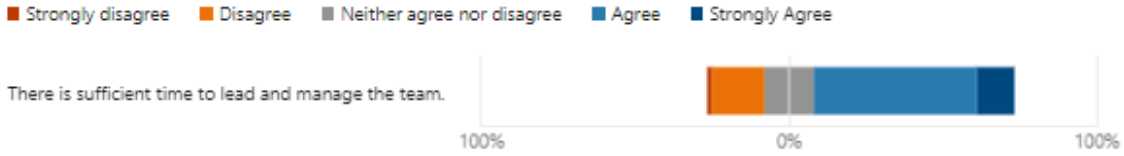


19. Leadership

More Details



20. Recruitment/Retention

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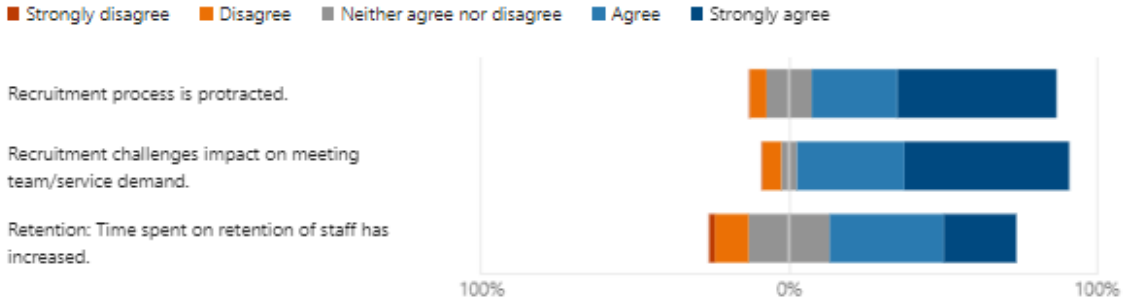
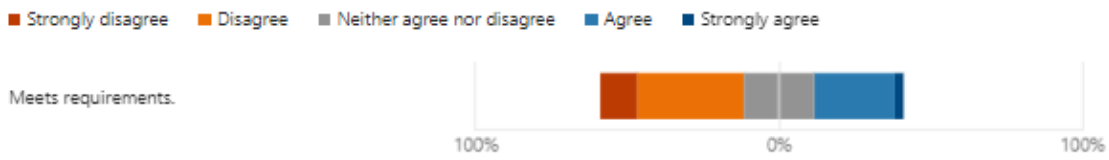


21. Team Staffing Budget

More Details



22. Technology

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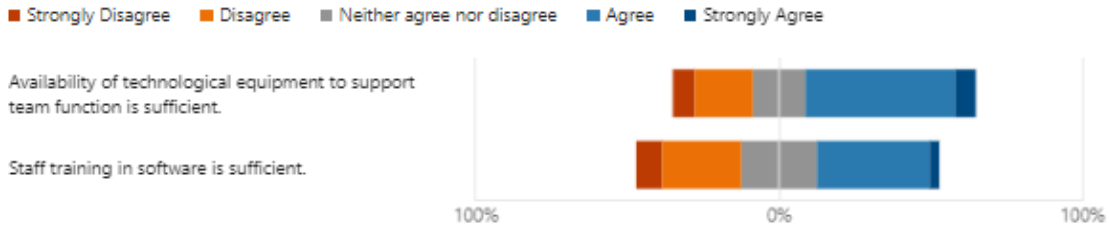

23. Training / Appraisals

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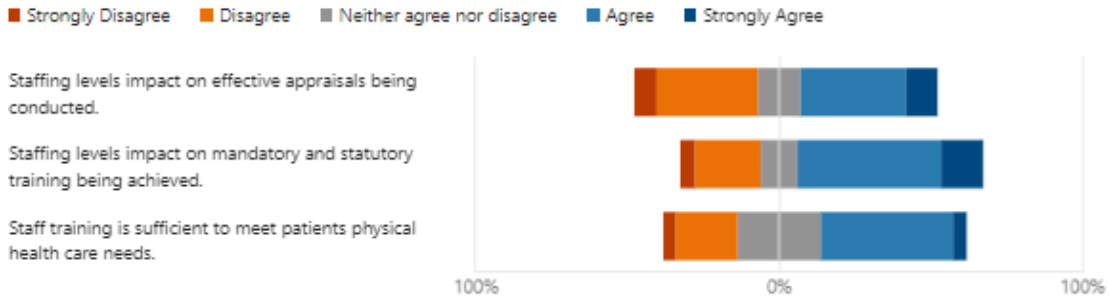

24. Local Induction

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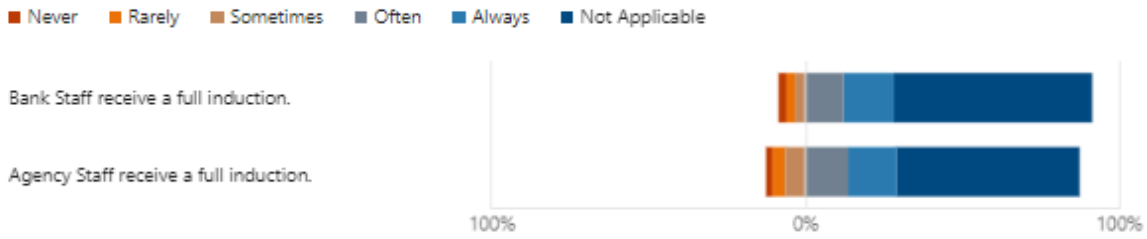

25. If you have not answered always to the previous question please indicate the main reason for this:

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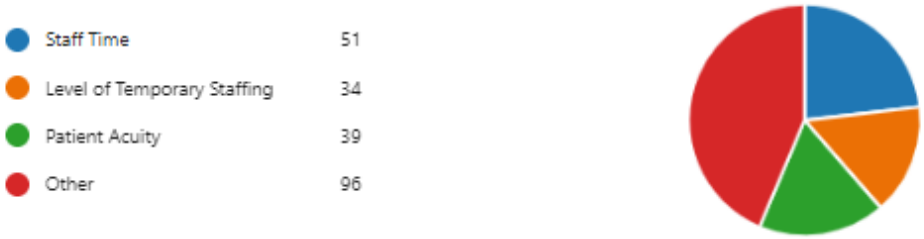
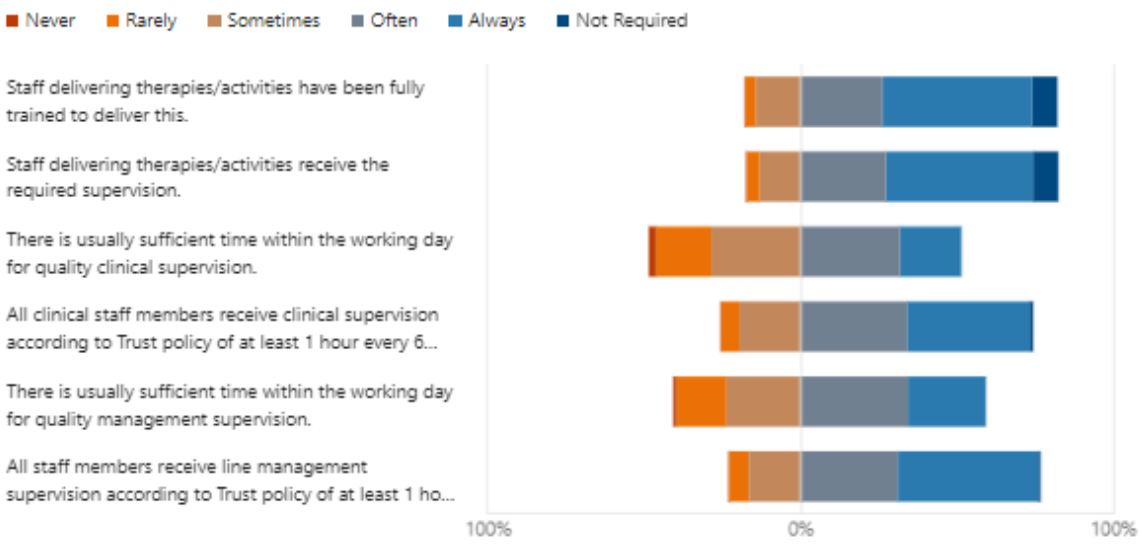


26. Staff Development

More Details

27. Staff Supervision

More Details

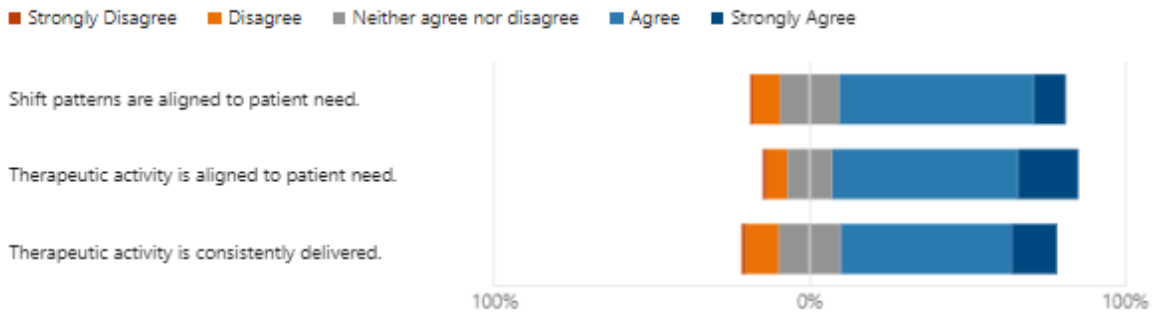


28. The environment?

More Details

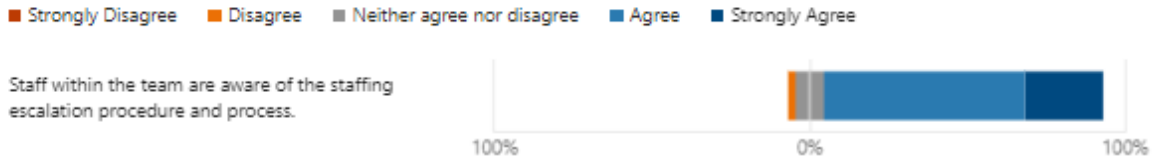
29. Shift Patterns

More Details



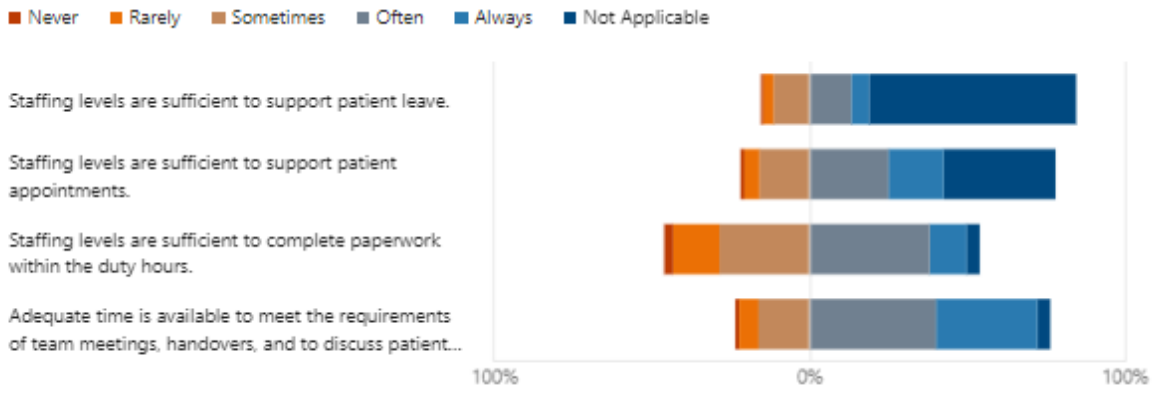
30. Staffing Escalation Procedure

More Details



31. Staffing levels

More Details



32. The 5 CQC domains which form the basis of CQC assessments are listed below (a-e)

a) Well-Led Domain - the leadership, management and governance of the ward ensures it is providing high-quality care that is based around the individual needs of the patient, that it encourages learning and innovation, and that it promotes an open and fair culture.

b) Responsive Domain - services are organised so that they meet the patient's needs.

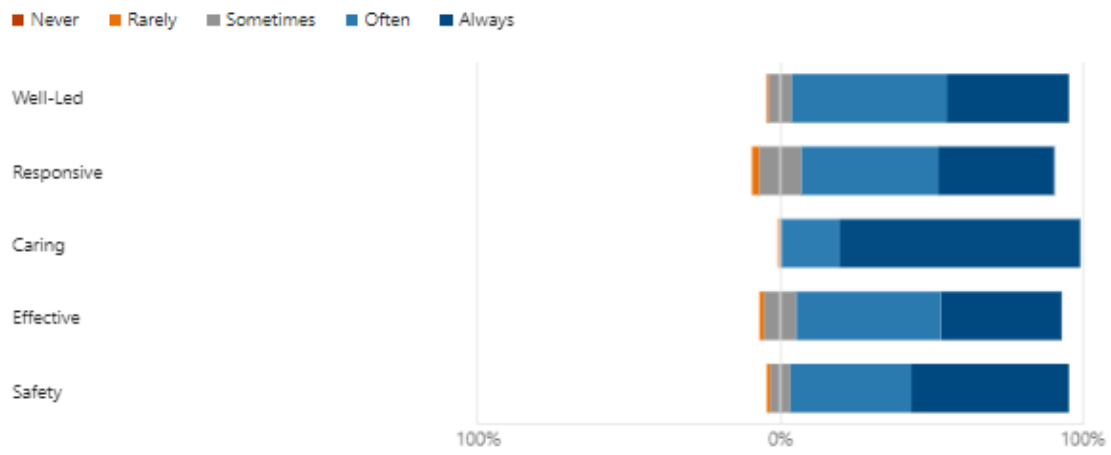
c) Caring Domain - staff involve and treat the patient with compassion, kindness, dignity and respect.

d) Effective Domain - the care, treatment and support delivered achieves good outcomes, helps the patient to maintain quality of life and is based on the best available evidence.

e) Safety Domain – the patient is protected from abuse and avoidable harm.

My team achieves the standards in each of these domains .....

More Details



33. Please provide a RAG rating for your specific ward or team as a whole, taking into consideration all of the above metrics

More Details

05. APPENDIX 2a

General Manager / SIDG RAG ratings and comments table for Red and Red/Amber Teams

Care Group	Speciality	Setting	Ward/Team	SIDG Rating	SIDG Comments
DTVF	AMH-PLA	CMHT	AMH EASINGTON AFFECTIVE DIS	Red	Rating agreed, The rating is impacted by: • BCP position – please refer to attached presentation
DTVF	AMH-PLA	IP	AMH WP WILLOW WARD	Red	Rating downgraded, the rating has been impacted by significant use of bank and agency and high acuity: • Fill rates for registered staff (days and nights) are above 100% • Fill rates for unregistered staff (days and nights) are above 100% • Behaviour incidents account for the majority or incidents – 104 of 116 • Enhanced visual 1:1 observations have remained at consistent levels throughout Sep – Nov • 2:1 observations (visual) doubled in October • FTE's are significantly lower than the MHOST FTE recommended workforce • Concern around MDT input into the Ward and clinical time available to patients The following actions have been agreed • Paper to be developed to outline staffing requirements for a High Dependency Unit – to include ASD requirements • Vision event for Rehab planned April 2023 • Staffing establishment and skills mix to be reviewed following event • Progression of Art Therapist for the service • MDT availability
DTVF	LD	IP	ALD BANKFIELDS COURT	Red	Rating agreed by ALD IDG. The current acuity and care packages currently in place which across the service there is a deficit of 50WTE against budget between BFC and the Lodge
DTVF	LD	IP	ALD BANKFIELDS COURT THE LODGE	Red	Rating agreed by ALD IDG. The current acuity and care package that is in place which across the service there is a deficit of 50WTE against budget between BFC and the Lodge
NYYS	AMH	CMHT	AMH RIPON COMMUNITY	Red	Rating revised by QBI The rating is impacted by: • Size of caseload • Number of people waiting for initial assessment • Number of agency staff in post • Number of senior community practitioner vacancies • Psychology and therapy vacancies • Team manager vacancy
NYYS	AMH	UC/SPEC	AMH NY EATING DISORDERS	Red	Rating revised by QBI The rating is impacted by: • No AED consultant psychiatrist funded • No psychology/therapist funded • Limited offer of service within core community • Non-compliant against NICE

NYYS	AMH	UC/SPEC	AMH NYY PERINATAL	Red	Rating revised by QBI The rating is impacted by: • Consultant psychiatry vacancy • Team manager vacancy • Psychology/therapist vacancies • Senior community practitioner vacancies • High sickness absence • Unable to cover ANP maternity leave
NYYS	AMH	UC/SPEC	AMH YORK AND SELBY EATING DISORDER SERVICE	Red	Rating revised by QBI The rating is impacted by: • No AED consultant psychiatrist funded • No psychology/therapist funded • Limited offer of service within core community • Non-compliant against NICE • No dedicated physical health care practitioners
NYYS	CYPS	CMHT	CHILD AND YP NY AND Y CRISIS TEAM	Red	Rating increased by QuAIG. The rating is impacted by: • Previous rating Amber and Red for ADHD which was reported separately last year • An improving picture with vacancy rates for non-medical staff improving although the geography continues to pose a recognised challenge • Recruitment of medical staff and on-going vacancies remains of concern due to retirement and sickness • The high numbers of waiters for ADHD following the transfer of cases from Paediatric services continues to impact with long wait times for assessment now in excess of 2 years • Strong team morale supportive • Staffing impacting on ability to complete appraisals and Stat/Man training
NYYS	CYPS	CMHT	CHILD AND YP SCARBOROUGH	Red	Rating agreed by QuAIG. The rating is impacted by: • Previous rating Amber/Red • Amber rating by team manager only due to commitment of the team • Excess overtime carried out by team to cover shifts with some shifts, particularly nights not adequately covered to ensure service delivery across the whole geography • Vacancies and difficulties with retention • Consider red rating but have seen some improvement with filling vacancies so increased to Amber/Red • Requires service redesign but currently no capacity within the team to do so, concerned position remains the same as last year with no change in the last 2 months
DTVF	AMH-PLA	CMHT	AMH DERWENTSIDE CLS AFFECTIVE		Rating agreed, The rating is impacted by: • Durham County Council staff vacancies (Social workers). • Budget realignment to meet staffing requirements. • High caseloads Actions agreed include • Implementation of both Caseload Supervision Policy and KIT process • Review of Care Planning Policy (CPA)

DTVF	AMH-PLA	CMHT	AMH NORTH DURHAM PSYCHOSIS		Rating agreed, the rating is impacted by: • Durham County Council staff vacancies (Social workers). • Budget realignment to meet staffing requirements. • High caseloads Actions agreed include • Implementation of both Caseload Supervision Policy and KIT process • Review of Care Planning Policy (CPA)
DTVF	AMH-PLA	CMHT	AMH SEDGEFIELD AFFECTIVE DIS		Rating agreed, The rating is impacted by: • Durham County Council staff vacancies (Social workers). • Budget realignment to meet staffing requirements. • High caseloads Actions agreed include • Implementation of both Caseload Supervision Policy and KIT process • Review of Care Planning Policy (CPA)
DTVF	CYPS	CMHT	CAMHS D AND D NORTH DURHAM		Rating agreed by SIDG. Staffing establishment and workforce availability issues are impacting safety and quality. Long waits and high caseloads. Planned actions include stop the line, caseload management and development of clear Getting More Help criteria. An increase of establishment is necessary to fully resolve.
DTVF	CYPS	CMHT	CAMHS D AND D SOUTH DURHAM		Rating agreed by SIDG. As above.
DTVF	CYPS	UC/SPEC	CAMHS D AND D NEURO ASSESSMENT		Rating agreed by SIDG. As above.
DTVF	CYPS	UC/SPEC	CAMHS NORTH TEES NEURO ASSESSMENT		Rating adjusted by SIDG. Significant risks with current establishment, approximately four times more referral demand per month than assessments the team can conclude within the month. Significant safety and quality concerns as a result of long waiting lists which are projected to be between 30-40 months currently for new referrals. Keeping in Touch (KIT), and support from other CAMHS teams for known high risk cases mitigates some of the risk. Planned improvement work expected to make pathways more efficient, timely and increase throughput but significant investment will be required to help clear significant backlogs and maintain a positive position.
DTVF	LD	CMHT	ALD D AND D SPECIALIST HEALTH TEAM		Rating adjusted by ALD IDG. This rating has been decreased. This is due to the number of vacancies, if these vacancies were filled then the rating would be Green. However the agreed rating of Amber Red on the basis that the vacancies are challenging to fill.
DTVF	SIS	IP	SIS RPH MALLARD WARD		Rating agreed by QuAIG. The rating is impacted by: Number of Registered nursing vacancies. Agency, bank and overtime being used to support shortfalls. High acuity upon ward. Increased observations. MDT member vacancies, psychology, SLT, dietetics. Vacancies within CTA's.

NYYS	AMH	CMHT	AMH HARROGATE COMMUNITY		Rating revised by QBI The rating is impacted by: • Size of caseload • Number of people waiting an initial assessment • Size of caseload • Team manager oversight of Ripon ICT • Senior community practitioner vacancies • Scale of agency use
NYYS	AMH	CMHT	AMH SCARBOROUGH COMMUNITY		Rating revised by QBI The rating is impacted by: • Locum consultant • ANP long-term sickness • Sustained vacancies of the senior community practitioners • Sustained weekend working to meet workload demand • Number of waiters to initial assessment caseload size
NYYS	AMH	CMHT	AMH YORK AND SELBY MENTAL WELLBEING ACCESS TEAM		Rating revised by QBI The rating is impacted by: • Volume of referral against team capacity • Size of caseload associated with number of people waiting for initial assessment • Psychology vacancy • Impact of counselling psychology students being removed
NYYS	AMH	CMHT	AMH YORK OUTREACH RECOVERY TEAM		Rating revised by QBI The rating is impacted by: • Consultant psychiatry vacancy • Mind the Gap • Number of CTO on caseload • Psychology vacancy
NYYS	AMH	CMHT	AMH YORK SOUTH CMHT		Rating agreed by QBI
NYYS	AMH	UC/SPEC	AMH HARROGATE CRISIS RESOLUTN		Rating revised by QBI The rating is impacted by: • Reduced hours and sickness of the consultant psychiatrist • Team manager vacancy • Number of senior crisis practitioner posts vacant • Number of crisis practitioner posts vacant • Call volume and care record requirements for the all-age line • Impact of CAMHS crisis vacancies
NYYS	AMH	UC/SPEC	AMH SWR CRISIS RESOLUTION		Rating revised by QBI The rating is impacted by: • Consultant psychiatry working in Danby ward • Mind the Gap • Team manager long-term sickness • ANP vacancy • High level of staff sickness • Number of senior crisis practitioner posts vacant • Number of crisis practitioner posts vacant • Call volume and care record requirements for the all-age line • Increasing volume of S136 presentations • Impact of CAMHS crisis vacancies

NYYS	AMH	UC/SPEC	AMH YORK AND SELBY CRISIS INTENSIVE HOME TREATMENT		Rating revised by QBI The rating is impacted by: • Consultant psychiatry vacancy • Number of senior crisis practitioner posts vacant • Number of crisis practitioner posts vacant • Call volume and care record requirements for the all-age line • Increasing volume of S136 presentations • Impact of CAMHS crisis vacancies
NYYS	CYPS	CMHT	CYPS YORK EAST AND CENTRAL COMMUNITY		Rating agreed by QuAIG. The rating is impacted by: • Previously reported as Red • On-going OD support being provided • Ongoing consultant vacancy • No Team Manager 12+ months impacting on staff morale and feelings of lack of support and containment • Gaps in staffing improving but further work required to realigning York budgets
NYYS	CYPS	CMHT	CYPS YORK WEST AND CENTRAL COMMUNITY		Rating agreed by QuAIG. The rating is impacted by: • Previously reported as Red • No Team Manager 6+ months • On-going OD support being provided • Ongoing consultant vacancy • Gaps in staffing – moving budgets ad aligning them both should be amber safe with moderate adjustment
NYYS	LD	CMHT	ALD York & Selby		Rating agreed by Leadership Team Impact of vacancy rate and inability to recruit to longstanding vacancies compromising team ability to provide full core service offer Staff absences impacting on overall morale of the team Focus on delivering care can impact on staff access CPD opportunities
NYYS	MHSOP	CMHT	MHSOP - HARROGATE MEMORY TEAM		Rating agreed by QuAIG. Amber/ Red. The rating is impacted by: Demand for Memory Assessments outstripped by available workforce resources to deliver timely support. Harrogate has the highest waiting list for memory assessment in TEWV, despite work undertaken by the team to look at using shortened assessment tools/ different ways of working and working with Dementia Forward to try and reduce this as much as possible. LTP staffing establishment requirements have been submitted for 23/24. Capacity and demand work due to be undertaken by Business planning.
NYYS	MHSOP	CMHT	MHSOP MEMORY SERVICE		Rating agreed by QuAIG for the reasons given above. Similar position for Harrogate in terms of waiting list pressure, verses demand, verses staffing establishment and medical pressures within the team; hence re rated to amber/red to highlight this need, reflected within the team's performance data on IIC.
NYYS	MHSOP	IP	MHSOP IP MALTON SPRINGWOOD		Rating agreed by QuAIG for the reasons given above. As detailed above SW is not currently used for it's formal commissioned purpose as it remains an internal organic transfer unit, originally in response to COVID and now to mitigate against bed pressures within the Trust. It's isolation remains an acute issue which is why it's been re-classified by QAIG as amber/ red as the

					availability of temp staffing against the HCA line is difficult also with MM, WM and CL often working into the numbers to support.

06. APPENDIX 3

Safety and quality of service

- Risk that staff will not be supported by the right level of clinical, management and caseload supervision each of which are portions to support their wellbeing and care to patients.
- Risk that staff will not have the benefit of shared clinical decision making for our most complex patients.
- Risk due to incorrect staffing establishments and budgets across wards and services.
- There is an increased risk to the inpatient cohort and ability to 'feel safe' with current staffing profile due to the behavioural presentations.
- There is a high risk to patients' mobility and selfcare ability due to the capacity to provide any physiotherapy support into the inpatient areas.
- The risk of not being able to deliver the right intervention effectively will delay the recovery for patients and transfer back into primary care if we are not able to recruit into vacant or new skilled posts.
- There is an ongoing risk associated with the resources attached to all-age crisis and mental health support line to the core service function of the CRHBT being compromised.
- Without additional investment into PNMH, EIP and AED, there is a moderate to high risk of patients not getting access to the interventional offer as detailed by the respective NICE guidance.
- Medical capacity is limited against high clinical acuity and increased clinical through put.
- There is a moderate risk that patient measured outcomes are affected by the workforce gaps and service capacity to deliver effective care.
- Continued use of locum, 'Mind the Gap', nursing bank, overtime and agency across all wards and teams above budgetary levels to meet required safe staffing levels.
- Impact on quality of patient care when using high levels of locum, nursing bank, overtime and agency, inconsistencies, unfamiliar staff, can be unreliable, security breaches.
- There is a risk that we are being ineffective in the way we communicate with people with ASD, due the limited offer of speech and language therapy to AMH.
- The ability to recruit into new and existing posts to deliver safe and effective care
- Due to the very significant difference in actual to budgeted establishment in inpatient services a high volume of agency and bank is being used to support care packages whilst all attempts are made to ensure these are consistent temporary staff, this is not always achievable.
- The lack of specialist service offers such as enhanced community support, specialist PBS support and access to inpatient beds risks the service not meeting the needs of our client group in providing the right level of support to meet their needs at the time it is required
- Concerns around physical healthcare checks across the service as issues remain with Primary Care not taking responsibility for annual health checks in some areas and our staff not feeling sufficiently trained to carry out this work
- Increased service user acuity and complexity combined with increased risk of placement breakdown and availability of suitable placements increases the ask on our teams to provide more support exceeding current team capacity

- Wait times for Neuro cases vary across teams and in some ADHD assessments waits are up to 2 years and ASC up to 1 year
- Skill mix in some teams requires re-alignment as not all modalities are covered e.g., CBT, Systemic work
- Caseload review completed in teams, but some are seeing numbers increase due to leavers and the need to share open cases within teams
- The impact of sufficient consultant psychiatry time resulting in the S136 Site at Cross lane not being open to young people and impacting on neuro waits for assessment
- The ongoing reliance on temporary staffing to support increased levels of acuity on the wards, increased admission rates over the last two-month period verses budgeted establishment, sickness, and vacancy rate.
- Wards have recently seen an increase in AMH admissions into MHSOP wards, where risk needs to be managed with additional staffing to support the majority of these admissions safely.
- Springwood remains an isolated unit currently used as a transfer unit for organic patients within Service to manage admission pressure on Rowan Lea and Wold View. It is working outside of its commissioned remit as a complex needs unit - a historic agreement (circa early 2020) in response to COVID and then the subsequent Trust-wide bed pressures.

Recruitment and retention

- Health and well-being of current staff within teams and associated challenge around ability to professionally develop and retain existing staff.
- Ability to recruit into both existing and new posts is a significant challenge to delivery of safe and effective care.
- Qualified nurses and consultant level medics are a particular challenge.
- Recruitment and retention difficulties across most teams to varying degrees.
- Not all teams have appropriate skill mix or appropriately trained, or experienced, staff due to recruitment and retention challenges.
- The wellbeing of staff and ability to professionally develop and retain existing staff.
- Having sufficient skill mix in teams due to recruitment difficulties.
- Insufficient newly qualified registered nurses qualifying, linked with high demand across the organisation and competition locally with other neighbouring Trusts and private healthcare providers
- High levels of band 5 vacancies across all wards –
- The recruitment process remains protracted and requires improvement.
- Vacancies in Specialist Health Team are impacting on the quality of care being delivered and the team's ability to keep service users safe.
- Staff across services are working additional hours to address deficits in staffing provision due to acuity, vacancy, and sickness. This is potentially going to impact on the wellbeing of staff in the long term if vacancies cannot be filled.
- There is high risk that the turnover rate will increase further
- The protracted recruitment process, in particular for internal posts, will further impact on our ability to recruit.
- Long standing vacancies in the teams, particularly in York in the nursing compliment, combination of vacancies, sickness and maternity leave increases the risk to our ability to adequately staff our teams

- Without the full complement of WTE staff we risk being unable to provide a full therapeutic offer. Skill mix gaps particularly around creative therapies, access to Positive Behaviour Support (BPS), social work posts in the team and dietetic support
- Increased risk if we continue to place too much focus on recruiting and placing band 5 nurses in inpatient settings with community offers for newly qualified nurses lacking experience impacting on future workforce

Leadership and skill mix

- Inpatient wards are a key area of concern particular senior nurse cover.
- High reliance on bank and agency nursing, particularly in inpatient wards.
- Matron cover is not available across all community teams in MHSOP in current structure.
- Continued use of bank and agency staff above establishment level to meet requirements and safe care on in-patient wards.
- The impact of gaps in clinical leadership team/ward roles on the support and containment of staff groups.
- Supervision - Within inpatient services it is also impacted significantly by the different between actual and budgeted establishment.
- Fill rate shows low registered nurse, impact on safe levels, increasing agency/bank usage.
- Across the services rated Red/Amber and Amber the impact of the qualified nurse vacancies is significant and not sustainable if we are unable to secure registered nurses to fill these gaps. The impact of these vacancies is likely to increase.

Staff wellbeing

- Increasing absence rates and sickness levels have a significant impact on our ability to deliver high quality safe and effective care across all areas.
- The impact of covid is still being felt and outbreaks still occurring.
- Cost of living crisis and impact on our staff
- Staff across services are working additional hours to address deficits in staffing provision due to acuity, vacancy, and sickness. This is potentially going to impact on the wellbeing of staff in the long term if vacancies cannot be filled and a risk to an increase in sickness absence due to staff fatigue and lack of job satisfaction
- Colleagues being more frequently moved from home ward to cover gaps outside their chosen area of expertise.
- Increasing missed breaks.
- Supervision and appraisals not always prioritised due to Team Management capacity and service pressures with clinical work taking priority
- Staffing vacancies and gaps impacting on team ability to complete stat/man training as timely as we would want
- The ability to deliver supervision is impacted by acuity, vacancy and sickness.
- Vacancies within key members of the MDT, slowing bed flow and delaying discharges.
- Increasing number of enhanced care areas or packages without appropriate levels of staffing or training.
- The impact of inconsistent staff on acuity and incidents has potential to increase staff sickness and retention.

- Wider workforce pressures such as psychology, ANPs and medical lack of resources impact on the resilience of some teams and their morale and ability to have in depth MDT, person centred discussions.
- Leadership cells still establishing and further work required to embed these especially in teams where membership may be reduced

Patient acuity, dependency, and complexity

- Acuity and increasing complexity.
- The changing profile of patients on caseload and being admitted to our rehabilitation wards and associated knowledge and skills gap that enables people to effectively support the increasing number of people being admitted with learning disability and autism
- The changing profile of patients on caseload and being admitted to our wards
- The lack of ongoing investment in the NYY&S ALD Teams has resulted in teams not keeping pace with the growing demand, acuity, and complexity of the local population
- The wellbeing of staff and ability to professionally develop and retain existing staff.
- Continued use of bank and agency staff above establishment level to meet requirements and safe care on in-patient wards.
- The increase in mental act assessments and detentions warranting admission, with insufficient capacity to admit, is generating a new risk to patients who are being safety planned in the community and pulling the crisis and home treatment teams from their core functions.

Staffing - demand and capacity

- Trust does not have bank provision for community teams which poses a challenge when trying to cover short term gaps safely and effectively.
- Disparity in staffing across areas, across care group and within care group
- Inadequate provision of admin staff to support the clinical and operational workforce with clinical time is being lost due to the inadequate level of admin support to clinical and clinical teams. There is a risk that the existing admin workforce will leave due to the increasing demands on their operating hours.
- High caseload numbers within community teams. High caseloads in some teams requiring targeted caseload management work.
- Increased referral demand, most notably for autism assessment.
- Capacity within teams to carry out timely assessment for both ADHD and ASD due to high demand and significant waiting lists
- Capacity within community teams especially where they are having to work intensively with package of care breakdowns.
- Access to inpatient beds; ensuring our patients are admitted to the correct bed at the correct time remains challenging given the organisational bed pressures.
- Inpatient bed pressures cause high level of anxiety and stress to community staff when accessing beds
- Availability of Band 5 posts within community teams

Training, development, and support

- Access to training provision for basic training requirements remains an issue.
- Reported feedback about lack of nursing progression within inpatient services.
- Associated knowledge and skills gap that enables people to effectively support the increasing number of people being admitted with learning disability and autism.
- Lack of access to one central system for supervision recording and monitoring to ensure required levels of supervision to support staff are met.
- Lack of consideration for skills and resilience of staff in patients and how we can more adequately train and support our staff to deal with the challenges they are faced with daily
- Training to embed new software not feeling supportive, too much focus on e-learning and F2F offer not enough risking staff not engaging and using new systems to their full potential. Needs more acknowledgment that people learn differently, and some will require more support than others
- Lack of training and development opportunities.
- The gap in an effective training needs analysis and workforce planning strategy or local plan will further impede staffs' professional development and growth.
- The skills gap that enables people to support the increasing number of people being admitted with learning disability and autism
- There is a moderate risk that patients will have an extended length of stay due to the limitations in staff knowledge and capability to deal with the complexity of the LD and ASD cases now presenting for admission and on community caseloads.
- Lack of physical healthcare resource in community teams.
- Inconsistent delivery of evidenced based interventions.
- Limited opportunities for development and progression for non-registered psychological practitioners
- Lack of assistant psychologists' access to appropriate supervisors
- The ability to deliver supervision across all ALD services is impacted by acuity, vacancy, and sickness.

Environment

- From a staff wellbeing perspective such as the availability of breakout rooms and access to a dedicated staff area to take breaks impacting on general staff wellbeing and the feeling of being valued
- From a patient perspective, low stimulus environments.
- The quality of the environment for clinical interventions and for staff wellbeing and comfort is not good in certain areas
- Due to ALD inpatient services being closed to admissions and the severely limited availability of robust community providers, the community teams have needed to provide intensive input into placements/providers which has impacted on the assessment, intervention and monitoring aspects of the team's overall caseload. There are no additional resources available to provide this level of input and as such teams feel budgets do not meet the requirements.
- Working to two Commissioning areas and the Collaborative within the ICB brings its own challenges whilst the ICB is going through its own change
- Balancing the place-based expectations with those of the ICB
- System pressures such as Acute Trusts' lack of beds and volume of patients presenting in ED have placed greater impact on AHLS, especially overnight. The

commissioned model of Core 24 agreed pre-COVID is struggling to respond as a 24/7 service, regularly breeching the 24 hr wait times.

- Springwood being an isolated unit, unable easily to draw from other inpatient / community units/ teams to staff as internal cover, resulting in high reliance on agency nurses that effect moral and consistency of care, although mitigations are in place to minimise this by the leadership on the unit.

Financial

- Continued use of bank and agency staff above establishment level to meet requirements and safe care on in-patient wards.
- Continued use of locum, 'Mind the Gap', bank/overtime and agency across all wards and teams.
- Overtime hours significant in teams such as Crisis to cover shifts
- Medical pressures and risk are mitigated via the use of Mind the Gap and high costs Locum cover.
- Significant levels of HCA bank and agency spend although fully and over recruited contributing to a significant overspend

07. APPENDIX 4

DTVF Care Group

Safe Staffing Reports
022023 SAFE STAFFING ESTABLISHMENT REPORT DTVF AMH PLANNED.pdf
022023 SAFE STAFFING ESTABLISHMENT REPORT DTVF AMH URGENT.pdf
022023 SAFE STAFFING ESTABLISHMENT REPORT DTVF CYPS.pdf
022023 SAFE STAFFING ESTABLISHMENT REPORT DTVF H&J.pdf
022023 SAFE STAFFING ESTABLISHMENT REPORT DTVF LD.pdf
022023 SAFE STAFFING ESTABLISHMENT REPORT DTVF MHSOP.pdf
022023 SAFE STAFFING ESTABLISHMENT REPORT DTVF SIS.pdf

SIDG/QuAIG Reports
022023 DTVF AMH Planned 2022 Staffing Establishment Review.docx
022023 DTVF AMH Urgent 2022 Staffing Establishment Review.docx
022023 DTVF CAMHS 2022 Staffing Establishment Review.docx
022023 DTVF HJ 2022 Staffing Establishment Review.docx
022023 DTVF LD 2022 Staffing Establishment Review.docx
022023 DTVF MHSOP 2022 Staffing Establishment Review.docx
022023 DTVF SIS 2022 Staffing Establishment Review.docx

NYYS Care Group

Safe Staffing Reports
022023 SAFE STAFFING ESTABLISHMENT REPORT NYY&S AMH.pdf
022023 SAFE STAFFING ESTABLISHMENT REPORT NYY&S CYPS.pdf
022023 SAFE STAFFING ESTABLISHMENT REPORT NYY&S LD.pdf
022023 SAFE STAFFING ESTABLISHMENT REPORT NYY&S MHSOP.pdf

SIDG/QuAIG Reports
022023 NYYS AMH 2022 Staffing Establishment Review.docx
022023 NYYS CAMHS 2022 Staffing Establishment Review.docx
022023 NYYS LD 2022 Staffing Establishment Review.docx
022023 NYYS MHSOP 2022 Staffing Establishment Review.docx

08. APPENDIX 5

Actions and Board requests from General Manager reports

DTVF AMH URGENT

To sustain and improve the RAG ratings of the AMH Inpatient DTV teams, there are a number of key actions required to be either considered or delivered against. They are:

- Increase of nurse progression
    - Band 5 – 6 development roles whereby people can work towards competencies of a band 6 role once out of their preceptorship and would gain band 6 once completed
    - Increase in band 6 roles and review to be a senior nurse on duty, coordinating and running a shift and supporting band 5's develop their skills
    - Band 7 clinical lead roles that would be clearly define and support with complex cases and allow ward managers increased time to complete operational tasks
    - Non-medical prescribing courses considered for band 7's in clinical roles

- Increase of HCA provision
    - From the apparent over recruitment but also the continued spend on bank and agency, it is clear the wards are utilising significant amounts more of HCA time than they are budgeted for. Need to understand this further and review the HCA establishments to create a baseline that is reflective of the change in the patient group and acuity across all of the services.

- Increased opportunity for HCA development
    - Look at opportunities for HCAs to develop their skills in different areas to support work on the ward i.e. SLT, gym

- Addition of other roles/clarification of current roles
    - Establishment of TNA for the acute wards (band 4) – this will allow the band 5 workforce to have support with medication and time to complete the tasks that they need to be able to complete as a registered nurse
    - Ensure that all roles are clearly communicated, and all MDT members understand the roles and functions across services
    - Carer roles whose main focus would be to engage in carer contact and support

- Consideration of specialist roles for PICU
    - Specialist OT to work across PICU
    - OTA dedicated to each PICU
    - band 6 post to be used for an LD nurse
    - PBS specialist role across both wards
    - Trainee psychologist roles to be considered

DTVF AMH Planned

To sustain and improve the RAG ratings of these Health and Justice teams, there are a number of key actions which have been taken by the service and plans to be delivered. The service has:

- To implement and embed Caseload Supervision Policy

    - Compliance against policy
    - Reduction in caseloads
- Community rehabilitation review
    - Improve access
    - Practice development
- Review of staffing establishment within rehabilitation and eating disorder inpatient services
- Delivery of CMHF implementation plan across DTVF
- ASD and Autism assessment review and implementation of recommendations
- Introduction of KIT model
- Review of Assistant Psychologists national guidance and employment support
- Review of delivery of psychological therapies across our community teams and associated staffing establishment
- Recruitment initiative in hard to recruit areas (Easington)
- Engaging in International medical / nursing recruitment

DTV MHSOP

To sustain and improve the RAG ratings of the MHSOP teams, there are a number of key actions required to be either considered or delivered against. They are:

- To implement and embed Caseload Supervision Policy.
- Review strategy to recruit and develop future leaders within MHSOP.
- Continue with engagement in and delivery of the CMHF across DTV MSHOP.
- Ensure compliance with mandatory training, appraisal, and supervision requirements to ensure all current workforce are fully equipped to deliver safe and effective care across MHSOP services.
- Alignment of MHSOP establishment budgets to ensure they are fit for purpose, vacancies can be recruited to where they exist and business cases can be developed where there are shortfalls in funding available to provide the required service.
- Focus on management of both short and long term sickness in MHSOP to ensure robust and appropriate management and support to staff.
- Review of psychology provision across MHSOP to ensure appropriate access to Psychological Therapies.
- Development of a business case for additional community matron capacity to ensure all MHSOP community services are supported with appropriate nursing leadership.
- Collaboration with HR and colleagues in adult services to develop recruitment strategy for hard to recruit areas such as Easington.
- Engage in international recruitment for hard to recruit disciplines.
- Ongoing development and refinement of crisis services for older people.
- Collaboration with corporate colleagues to ensure access to key training is available.
- Seek agreement for Band 5 – 6 progression roles to stabilise community teams.
- Review of N&D provision and allocation of resource across MHSOP services.
- Review of current demand profile and subsequent appropriate allocation of resource to core service need.
- Consideration given to ongoing development of peer support roles in MHSOP to support with delivery of care.
- Seek clarity around Trust supervision reporting requirements and systems.

- Confirmation required of funding available for previous staffing establishment review recruitment, and support to recruit to the additional roles required. This is inclusive of Practice Development Practitioners and Physician Associates.
- Ongoing commitment to further develop senior non-medical roles to provide career development and alternative models of care.

DTVF CAMHS

Board request:

- To note the under-establishment of North and South Durham Getting More Help Teams and the neurodevelopmental assessment teams and to consider any investment opportunities.

Service actions:

- Progression of speciality workplan, transformation and business plans to improve quality and patient experience
    - SPA/SPOC review of workforce composition and triage/assessment process
    - Partnership working and multi-agency pilots
    - Embed effective caseload management processes
    - Cocreate appropriate criteria for Getting More Help teams
    - QiS projects for ADHD assessment and treatment
- Workforce development
    - Complete and sign off CAMHS patient competency framework
    - Roll out nursing developmental posts
    - Review skill mix within teams to target recruitment
    - Implement psychological practitioner accreditation
    - Targeted development of some leadership cells
- Estates
    - Undertake full estate review

DTVF LD

To sustain and improve the RAG ratings of the DTVF Adult Learning Disabilities teams, there are a number of key actions required to be either considered or delivered against.

Board request:

- To note the under-establishment of Bankfields Court and The Lodge and to consider any investment opportunities.

Service Actions / Mitigations

- Community Teams manage issues and risks by applying some staffing flexibilities across teams when required and Team Managers step in to provide a level of clinical work to support their teams.
- Recruitment is ongoing and we are exploring focused recruitment work, such as recruitment days. Planned retire and return opportunities are utilised as part of the workforce skill mix.

- The inpatient wards work closely together to identify staffing gaps re shifts or to meet patient needs, in a solution focused way across the two sites. There is a daily staffing call each day which is utilised effectively to gain an overview of all inpatient activity and staffing levels.

- A business case has been developed to consider the proactive provider liaison team with additional investments to create an intensive community team. The team will be a pilot project to support placement breakdown and crisis intervention with the aim to reduce the need for admissions.
- Working with the clinical network to develop a skills matrix for ALD services.
- Ongoing realignment and budget work.
- Review of on call processes within the ALD community teams
- Review of enhanced community provision.
- Caseload management supervision to support clear pathway and discharge planning due to teams articulating the struggle of throughput.
- Visual control to monitor cancelled supervision and training
- Continual RAG rating of waiting list and implementation of prioritisation tool
- Scoping work of Acute Liaison Nurse in D&D is in process.
- Scoping of STOMP within Darlington
- Scoping of Transitions and how HFT could support the transitions process (health only).
- A number of wellbeing initiatives have been put in place to support staff:
  - Weekly staff support sessions with key staff to be visible and provide updates/ answer questions.
  - Providing weekly written comms to staff.
  - Supporting a staff wellbeing (or wobble) room at BFC which is now open and updating the wellbeing room at LRH for ALD staff.
  - Increasing the ward activity budgets to allow staff to provide high quality activities that will make a difference to patients' wellbeing.
  - Arranging to have regular meetings with the staff that look after JH at BFC.
  - Support from Resilience Hub.
  - We are operating a 'You said, We did' area at BFC and at LRH
  - Employee Support Service continues to be available on site and has arranged additional support sessions up to the date of the planned closure of LRH wards.
  - Targeted work with agency staff to address role and remit when on shift, and impact on our permanent staff when they are not fulfilling their roles

DTVF SIS

To sustain and improve the RAG ratings of the DTVF *Ridgeway Secure Service wards and* teams, there are several key actions required to be either considered or delivered against. They are:

Workforce

- Recruitment initiatives and drives, competitive offers within the wider marketplace, for example band 5 registered nurse retention premium.
- To support the submission of recruitment and retention premium paper.
- Increase B6 opportunities across all inpatient wards
- Work with the Trust to increase the pace of international recruits

Further investment and development of bespoke recruitment event in the place-based areas

- Work with the Trust to shorten the lead time for internal appointments
- Review of current vacancies which have been challenging to fill, skill mix……
- Standardise progression from B5 to B6 across inpatient / community re competence, experience, and skill.

- Development of clinical model and roles to support, such as ANP roles.
- Bed modelling work within the provider collaborative, review ward size and services provided.
- Workforce modelling as part of the provider collaborative to be review and recommendations considered.
- Deep dive into team modelling, skill mixing.
- Map the delay from recruitment to commencing role within service and unblock enabling issues.

Staff wellbeing and development

- Review of colleague's breaks and rest facilities across Ridgway, to support reduction in missed breaks.
- Review of Ridgeway estate to support new developments.
- Investment within QI to support culture of improvement and understanding of.
- To continue to support wards and teams to have development away days to strengthen their sense of team and development of team objectives.
- Review and support by People Partner of staff sickness across the service which is above the Trust threshold of 4.5%.
- Continued investment within service Well-being group.
- To celebrate and promote the high-quality work of the service, use of Greatix etc.
- Investment within training underpinned by the clinical model, promoting protected time to practice.
- Further embedding of both HCA and RN councils, to support the culture and ward to board approach.
- Continued and further investment within the Ridgeway Welcome for new colleagues.
- Onsite bespoke training, to support release of staff to attend and training within the environment they work within, i.e., BLS.

DTVF H&J.

To sustain and improve the RAG ratings of these Health and Justice teams, there are a number of key actions which have been taken by the service and plans to be delivered. The service has:

- The Adult Outreach team no longer exists, this is now the Forensic Community Service, which as been developed over the last year and received increased funding from the Provider Collaborative (in partnership with CNTW).
- Employed a dedicated recruitment manager to assist with focused recruitment to health and justice services.
- Considered skill mix across all services and within professions e.g. different posts; different grades and developmental posts.
- Allocated a member of staff to upload posts on to trac in order to release time from clinical staff doing this.
- Met with the recruitment department to discuss current vacancies and processes, in order to improve/speed up processes.
- an in-service monthly recruitment meeting to discuss and action any support required.

- Over recruited certain posts as experience has shown that e.g. B3 HCA's frequently turn down posts once offered (either due to length of time between interview and start date/offered posts in other organisations).
- Paid for police vetting from another region to assist with speeding up this process.
- Created a spreadsheet outlining the teams staffing establishments and vacancies which is held on a Teams channel for all managers to access, giving a "live" picture.
- Recruited additional admin posts over the last 3 months, to support teams and the overall services.
- Monitored sickness rates across Health and Justice which have shown an improvement since January 2023. These will continue to be monitored alongside our people partners to ensure support is provided to managers and staff to assist with return to work.
- Held bi-annual team manager development days.
- Monitored Leaver rates, which last month showed a decrease.
- Recently been informed that commissioners will fund further Speech and Language therapy resource in L&D, which will reduce the need for these staff to cover several teams.
- supported new roles e.g. recruiting an advanced clinical practitioner for the Durham L&D (within budget).
- Engaged in developing a relationship between the HCV SPA and the NY FOLs team, which should support referrals and transition.
- Reviewed Langley ward staffing establishment, which was based on higher bed numbers.
- New team manager recruited to Durham L&D.
- Leadership visits to all teams have been taking place and are arranged for the rest of the year.
- The service has engaged in the recent governance review, including how data will be reviewed.
- Weekly brief to all staff.
- Reviewing and improving the service welcome and induction packs and programmes.
- keeping in touch with newly recruited staff who are awaiting clearances.

NYYS AMH

To sustain and improve the RAG ratings of the NYYS AMH teams and wards, there are a number of key actions required to be either considered or delivered against. They are:

The impact of gaps in the clinical leadership team/ward roles

- To complete the recruitment of the inpatient leadership gaps at Cross Lane Hospital, this gap is being mitigated by joint working across the two wards, increased ward presence of the matron and use of the practice development practitioner to support allocated tasks of the ward manager.
- To improve the degree of compliance and monitoring of clinical, management and caseload supervision to be part of everyone's daily business, this is being supported by the role of the matrons and clinical leads on the wards as well as the clinical leadership set across community and crisis teams.

The wellbeing of staff and the ability to professionally develop and retain existing staff

- To continue to support teams and ward have away days to strengthen their sense of team and development of team objectives.
- To celebrate and promote the good work of the teams by holding bi-annual 'showcase events' with staff, patients, carers and partners. These are scheduled for June and November and are linked with the service planning cycle.
- To forward plan through Rosters to make sure that staff are able to get their breaks, through access to the nurse coordinators and wider support roles and that they able to finish work on time. This is also being assisted by the third nurse on nights at CLH and FPH.
- To promote access and protect time to allow staff to make use of the Post Incident Practice Support (PIPS), and remedial debrief session following significant patient events. Patient safety are to share and promote the use of PIPS as serious incidents are reported.
- To be supported with the review of the clinical estate and partnership offers to be able to accommodate the workforce and meet Royal College requirements.

The ability to recruit into new and existing posts to deliver safe and effective care

- To accelerate the programme of bespoke recruitment event in the place-based areas
- To revisit the view to remove the retention premium of the band 5 nurse on Danby and Esk wards
- To support the submission of recruitment and retention premium request for Foss Park wards and the HaRD community teams.
- Work with the Trust to increase the pace of international recruits.
- Work with the Trust to shorten the lead time for internal appointments.
- To finalise the organisational change process for SWR that will enable a nurse coordinator to be on shift during the day at weekends and bank holidays.
- To work with ICB commissioner regarding the workforce requirements provision of an effective ARMS pathway across NYYS, as this will become part of the EIP NCAP audit from 2024.
- We seek support to stop the offer of fixed term contracts, as they regularly do not get filled, and offer permanent post against a backdrop of a 14.84% leavers rate.

Inadequate provision of admin staff to support the clinical and operational workforce

- To support the introduction of the second Admin manager and professional leadership role to the SWR and York and Selby systems.
- Map the scale of the gap of admin support to the existing and expanding consultant workforce and receive and AMH proposals where we need investment in admin to the clinical areas. To assist with the gaps, we have appointed a peripatetic clerical admin post who is supporting teams with clinical records remotely using the slippage accumulated from vacancies.

The changing profile of patients on caseload and being admitted to our wards

- To support the introduction of an inpatient education programme that enhances the mental health skills and approaches to positively support risk behaviours and complex care needs of patients

The skills gap that enables people to support the increasing number of people being admitted with learning disability and autism

- To continue to with the ICB commissioners and to evaluate the benefits of the planned AMH ASD team alongside the Trust ASD service against IFR request, staff and patient/carer experience
- To expand the ASD education offer, which helps adapt the interventional offer for this cohort of patients and support to their carers.
- To complete the inpatient workstream regarding adaptive practices for people with ASD

NYYS MHSOP

To sustain and improve the RAG ratings of the MHSOP NYY teams, there are a number of key actions required to be either considered or delivered against. They are:

- Business case for unfunded HCA posts for SW to be developed to support unit and reduce agency costs against as invest to save.
- A Physical Healthcare Matron for York to support increased acuity against earlier discharges from the Acute Trust and provide supervision to the only B7 physical health care post in R&S – invest to save against the Trust's commitment to the unfunded inpatient investment posts.
- Go out to advert for 2/ 2.5 PDP posts -invest to save against the Trust's commitment to the unfunded inpatient investment posts.
- LTP/ MHIF Staffing Establishment requirements submitted to ICB re MAS future investment around increased demand.
- Need to review the AHLS provision in light of increased acuity and demand with all key partners posy pandemic for NYYS.
- MHSOP Trust-wide work on the Exemplar Model of care for inpatient services 23/22 and reviewing the staffing establishment against this model.

Staff wellbeing and development

- Supervision/ appraisals
- PDP plans/ coaching
- Workforce Development Groups, place based, where staff from across specialities are enabled to look at creating solutions to workforce planning.
- Resilience Hub – specific support around workforce/ high clinical acuity

NYY CAMHS

To sustain and improve the RAG ratings of the CAMHS Leadership Teams in the NYY&S locality, there are a number of key actions required to be either considered or delivered against. They are:

Ability to retain and recruit staff

- To promote the use of more targeted recruitment campaigns and to increase the specialist support available to local teams from the corporate recruitment team around better marketing, promoting our services and offering bespoke recruitment events in NYYS
- To continue to review and work to shorten the lead time for new recruitments and to being more responsive to innovative solutions offering more flexibility around recruitment
- To offer incentives in the same way other organisations do
- To ask that there is more parity in placing newly qualified nurses in the community teams versus inpatient services to increase the number of band 5 nurses and to encourage future growth

Staff wellbeing and development

- We will continue to support our teams with reflective space, away days, training opportunities and OH support
- We will continue to ensure our staff have a positive experience at work with good quality supervision, training, and development as a core value at the centre of our teams
- We will continue to provide a strong F2F leadership presence and for teams to know who the service wide leadership team is
- We will involve our staff in developing and redesigning our services
- To support and equip our Team Managers to carry out the role to a high standard with all the skills they require

The ability to provide safe and clinically effective care

- We will continue to work with our teams to complete a review of the existing services, systems, and processes
- We will continue to ensure caseloads are reviewed and remain within safe levels
- We will work with Commissioners to continue to implement the role out of iThrive and to further educate the wider system
- We will work with our service users, carers, and other partners to ensure any redesign is completed collaboratively

Working in a changing system

- Continue to develop good relationships with partners and have a presence in meetings to ensure TEWV is represented
- To promote the positive work carried out by TWEV teams
- To encourage good partnership working
- To ensure we work to service specifications and where appropriate we challenge requests to work outside of current specification

NYYS LD

To sustain and improve the RAG ratings of the LD Community Teams in NYY&S locality, there are a number of key actions required to be either considered or delivered against. They are:

Ability to recruit and retain staff

- To promote the use of more targeted recruitment campaigns and to increase the specialist support available to local teams from the corporate recruitment team around better marketing, promoting our services and offering bespoke recruitment events in NYYS
- To continue to review and work to shorten the lead time for new recruitments and to being more responsive to innovative solutions offering more flexibility around recruitment
- To offer incentives in the same way other organisations do
- To review recruitment and have a clear strategy to ensure we maximise the TEWV offer within local and other universities such as Teesside to ensure students see NYYS as a viable placement offer

Staff wellbeing and development

- We will continue to support our teams with reflective space, away days, training opportunities and OH support
- We will continue to ensure our staff have a positive experience at work with good quality supervision, training, and development as a core value at the centre of our teams
- We will continue to provide a strong F2F leadership presence and for teams to know who the service wide leadership team is
- We will involve our staff in developing and redesigning our services

The ability to provide safe and clinically effective care

- We will listen and support the need for better working environments and ensure improvements to our clinical and staff space where we can
- We will continue to work with our teams to complete a review of the existing community structure and offer to better inform the development of new enhanced services
- We will work with Commissioners to continue to develop the long-term plan for ALD services and to promote the need for further investment to bring the NYY&S teams in line with National standards
- We will work with our service users, carers, and other partners to ensure any redesign is completed collaboratively

Technology & Digital Offer

- We would ask the board to ensure more F2F training is made available and to better timetable the release of new software with new systems scheduled for release at different times.

09. APPENDIX 6

Following the previous staffing establishment setting exercise in March 2022, a further report was presented to the Board in September 2022 which provided updates to the previously March 2022 proposed models for MHSOP and LD services. This report was approved at Trust Board in September 2022 allowing the services to action and employ the additional staff on a permanent basis, albeit at financial risk due to lack of available funds to support the increase in budget for each of the two services. This is recapped below for each service information followed by a status update on the current position.

Mental health services for older people (MHSOP)

Review of Sept 2022 report

The service identified three key elements:

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

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

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

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

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

Planned additional cost is expected to replace unplanned cost (temporary staffing), provide better value for money and reduce reliance on premium rate agency staffing (and including for some of the highest premium rate off-framework assignments, although more specifically in Learning Disability services). However, as the proposal would seek roster changes to support the quality of care delivered, Temporary Staffing usage was required to be careful monitored and managed to achieve safe care and value for money.

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

										Additional Investment Proposed							
	Physician Associate B7		Additional Band 6 Clinical lead day shift		B3 Clinical team administrator		Activity Coordinators		Agreed Investmentment Priority 1		Practice Development Practitioners B7		Activity Coordinators		Physician Associates B7		Revised Investmentment Priority 1	
	5 days 7.5 hours exc cover		7 days 7.5 hours inc cover		5 days 7.5 hours inc cover		7 days 7.5 hours		SUB TOTALS		5 days 7.5 hours		7 days 7.5 hours		5 days 7.5 hours		TOTALS	
Immediate ask	WTE required	£	WTE required	£	WTE required	£	WTE required	£	WTE required	£	WTE required	£	WTE required	£	WTE required	£	WTE required	£
Roseberry	0.50	£26,386	1.79	£87,228	0.61	£16,433	1.79	£53,078	4.69	£183,125	1.00	£52,771	0.00	£0	0.00	£0	5.69	£235,896
Oak	0.50	£26,386	1.79	£87,228	0.38	£14,848	1.79	£53,078	4.46	£181,540	1.00	£52,771	0.00	£0	0.00	£0	5.46	£234,311
Ceddesfeld	0.50	£26,386	1.79	£87,228	0.78	£22,892	1.48	£43,886	4.55	£180,392	1.00	£52,771	0.00	£0	0.00	£0	5.55	£233,163
Hamsterley	0.50	£26,386	1.79	£87,228	0.78	£22,892	1.48	£43,886	4.55	£180,392	1.00	£52,771	0.00	£0	0.00	£0	5.55	£233,163
Durham & Darlington	**2.00**	**£105,544**	**7.16**	**£348,912**	**2.55**	**£77,065**	**6.54**	**£193,928**	**18.25**	**£725,449**	**4.00**	**£211,084**	**0.00**	**£0**	**0.00**	**£0**	**22.25**	**£936,533**
Westerdale North	1.00	£52,771	1.79	£87,228	0.28	£9,886	1.79	£53,078	4.86	£202,963	1.00	£52,771	0.00	£0	0.00	£0	5.86	£255,734
Westerdale South	1.00	£52,771	1.79	£87,228	0.28	£9,886	0.00	£0	3.07	£149,885	1.00	£52,771	1.79	£53,078	0.00	£0	5.86	£255,734
Teesside	**2.00**	**£105,542**	**3.58**	**£174,456**	**0.56**	**£19,772**	**1.79**	**£53,078**	**7.93**	**£352,848**	**2.00**	**£105,542**	**1.79**	**£53,078**	**0.00**	**£0**	**11.72**	**£511,468**
Moor Croft	0.00	£3,208	1.79	£87,228	0.28	£11,838	1.79	£53,078	3.86	£155,352	1.00	£52,771	0.00	£0	1.00	£52,771	5.86	£260,894
Wold View	0.00	£3,208	1.79	£87,228	0.28	£8,895	1.79	£53,078	3.86	£152,409	1.00	£52,771	0.00	£0	1.00	£52,771	5.86	£257,951
Springwood	0.00	£0	1.79	£87,228	0.48	£15,267	1.79	£53,078	4.06	£155,573	1.00	£52,771	0.00	£0	1.00	£52,771	6.06	£261,115
Rowan Lea	0.00	£0	1.79	£87,228	0.28	£13,575	1.79	£53,078	3.86	£153,881	1.00	£52,771	0.00	£0	1.00	£52,771	5.86	£259,423
North Yorkshire & York	**0.00**	**£6,415**	**7.16**	**£348,912**	**1.32**	**£49,575**	**7.15**	**£212,312**	**15.63**	**£617,214**	**4.00**	**£211,084**	**0.00**	**£0**	**4.00**	**£211,084**	**23.63**	**£1,039,382**
TOTAL	**4.00**	**£217,501**	**17.90**	**£872,280**	**4.43**	**£146,412**	**15.47**	**£459,318**	**41.80**	**£1,695,511**	**10.00**	**£527,710**	**1.79**	**£53,078**	**4.00**	**£211,084**	**57.59**	**£2,487,383**

Note : The above figures have not been adjusted for any pending pay awards.

Final Proposal MHSOP

The proposals outlined in the above table supported the initial request from MHSOP.

Learning Disability Services

Revised *Proposal Durham Tees Valley and Forensic Care Group*

The period of transition for Learning Disability Services has seen a recent reduction in 'single occupancy care packages'. As a result, the final revised proposal takes account of this and reflects the Trust response to a change in service alignment and the currently envisioned requirement for Durham Tees Valley and Forensic Care Group. The revised proposal outlined the requirement for a workforce that would operate across both sites based on patient need and acuity. The revised proposal outlined all roles that are essential to support the delivery of safe care. Requirements identified by the service for programme management roles were not progressed at this time pending further discussion and agreement on the future model. Additionally, dependent upon this future model, further consideration will need to be given regarding the identified "Green Light" role to support the management and review of persons admitted into adult or older people wards. This included non-rostered staffing elements equivalent to £409k which were excluded from the proposal for temporary roster change.

Proposal Details

The previous proposal for 52.08 WTE Unqualified Nurses was reduced to 32.88 WTE. Whilst this is a reduction, it was to be acknowledged that this remains above the current budgeted establishment. The request for 32.88 WTE was required to meet the immediate and long term need of the service. The successful over-recruitment (in reference to current budgeted establishment) had already seen **23 WTE already appointed as part of previous senior**

leadership/executive approval to over-recruit to the service to address the agency quality issues and financial premium pressure. Approval was sought to change the rostered elements on a temporary basis to reflect the remaining unqualified nurse proposal of 9.88 as these staff will need to be recruited. The total costing for unqualified nursing 32.88 WTE is £1,123,406 per annum. It is anticipated that increasing this substantive workforce would see a reduction in the agency expenditure across DTVF by swapping out expensive agency staff for substantive recruitment to HCA posts (where April 2022 to July 2022 agency expenditure for DTVF was £1,177,009) as well as improving quality.

In considering what immediate additional investment would be most beneficial to the delivery of safe and effective care the service identified the following areas in order of priority:

- B4 Healthy Living Advisor who will work alongside the physiotherapy and dietician team
- Band 4 Level 3 Trained fitness instructor to support the physical health and well-being of the patient's working alongside the physiotherapy
- Band 4 Physical Health Assistant to support the physical health doctors in supporting the physical health of patients
- Administration support would release nursing time to care, initially to 5 days per week plus cover
- Associate Nurse Consultant /Trainee Responsible Clinician and will provide support and oversight for patient care
- Therapy Assistant to support the AHP workforce
- Advanced Clinical Pharmacist for Learning Disability services working predominantly into inpatient areas whilst also providing support to community services
- Increased banding from a B6 to B7 Positive Behaviour Support Practitioner

Acknowledging the shortage in the availability of Band 5 and 6 nursing staff, the above proposals seek to maximise the existing nursing resource by freeing up 'time to care' whilst enriching skill mix in accordance with patient need as well as improving clinical leadership. It is anticipated that these developments will positively impact on length of stay, reducing restrictive interventions in response to recommendations within the Mersey Care report.

The service has identified that a team to support the Reducing Restrictive practice, Positive Behaviour Support and Positive and Safe agenda would be beneficial and support recommendations within the Mersey Care report in relation to reducing restrictive interventions and this would include the following roles:

- Behaviour Specialist Consultant - a role which will provide oversight and expertise in reducing restrictive interventions
- Behaviour Practitioners / Positive and Safe Leads / Autism Specialist- will support the psychological well-being and specific care needs of those patients with a diagnosis of Autism
- Assistant Behaviour Practitioner -will support the psychological well-being and specific care needs of those patients with a diagnosis of Autism
- Family Ambassador Role / Lived Experience Champion. This role will provide a different perspective within the MDT with their focus on the experience of care for family and patients, promoting the ethos of co-creation and collaborative accountability.

- Practice Development Practitioners (PDP) as per the current approach within AMH and SIS had been added to the original proposal as this approach supports best practice and oversight increasing clinical leadership and quality of care within services.

Whilst these roles may have limited impact on reducing temporary staffing costs, it is envisaged that they will be a quality investment, positively impacting on quality of care, length of stay, patient experience, patient safety and opportunity costs related to a reduction in restrictive interventions, improved morale and staff well-being resulting in a reduction in staff injuries and sickness. The temporary adjustment of rosters will allow the impacts to be assessed, including financially linked to agency reductions, with turnover and vacancies being a key risk mitigation.

The revised LD model taking into account the above discussion is shown below.

			A&T	
			DTV	
			Bankfields Court & Ramsey Talbot	
			15 & 6	
			11,5 + 6, 4	
Priority	**Band**	**Prioritised workforce investment**	**WTE Budget**	**Sum of Annual Budget**
High	B3	HCA Day (6 on shift)	16.44	£494,679
High	B3	HCA Night Shift (6 on shift)	16.44	£628,727
High	B4	B4 Healthy living advisor	1.00	£27,683
High	B4	Level 3 trained fitness instructor	1.00	£27,683
High	B4	Physical Health Assistant	1.00	£27,683
High	B4	Administration support	1.00	£27,683
High	B3	Administration support	1.00	£26,694
High	B8c	Associate Nurse Consultant post	1.00	£82,948
High	B4	Therapy Assistant (OT/SLT)	2.00	£55,366
High	B7	Top up the current B6 PBS practitioner to a B7 Behaviour Practioner	1.00	£58,178
High	B6	PBS lead on duty at all times	(1.00)	(£47,068)
High	**Totals**	**High**	**40.88**	**1,410,258**
Medium	8c	Behaviour consultant	1.00	£82,948
Medium	B7	1 Behavour practitioner on 7 days	3.00	£172,606
Medium	B4	1 Assitant behaviour practitioner - 7 days	3.00	£92,021
Medium	B4	Family ambassador role / lived experience champion	2.00	£55,366
Medium	B8a	Pharmacist	1.00	£59,186
Medium		**Medium**	**10.00**	**£462,127**
Low	B7	Practice development practitioners	2.00	£105,542
Low	**Totals**	**Low**	**2.00**	**£105,542**
ALL	**Totals**		**52.88**	**£1,977,927**

DTVF Care Group Proposal

Current position

Recruitment to these posts from both services had been delayed due to changes in service provision and considerations towards further revision of requirements for both LD and MHSOP.

MHSOP NYY&S have begun to commence recruitment to these posts and further work is required to consider mapping any over establishments against the staffing approved in the report.

LD services for DTVF have commenced a deep dive observational piece of work to more closely understand staffing requirements to support the current patient group currently

resident at Bankfields Court. Discussions continue regarding the service requirements for Bankfields Court and Lanchester Road LD provision and need to be considered in the model going forward.

Discussion regarding MHSOP staffing and progressing work with the “Exemplar Ward” proposals (an initiative to standardise MHSOP provision across the Trust and be determined by the clinical pathway for patients - a process which will enable a clearer understanding of the staffing requirement. This will also include a review of zonal engagement currently employed in the MHSOP service and the associated workforce requirement will be considered in line with the clinical journey This may result in additional resource being required.

All ongoing work in the development and refinement of a models to support operational requirements which will require further approval at Trust Board at the appropriate and earliest possible time.

10. APPENDIX 7

MHOST overview and background

The Mental Health Optimal Staffing Tool (MHOST) is a multi-disciplinary, evidence-based system that enables ward-based clinicians to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that ward establishments reflect patient needs in acuity and dependency terms. It has been approved by NHSE/I and advocated as the national tool for use within mental health services. It is licensed by Imperial College Innovations Ltd, and is free to use for NHS Trusts.

It is designed for use in any mental health hospital within the UK and covers a range of specialisms, such as: Working age adult admissions wards; Old age functional and dementia wards; Forensic (High and Medium secure wards); CAMHS Tier 4 wards; Eating Disorder wards; Perinatal wards; Psychiatric Intensive Care Units (PICU); and Low Secure & Rehabilitation wards.

Development of the MHOST was a large-scale project involving:

- 35 mental health organisations across England (including TEWV)
- 320 best practice wards (including TEWV)
- 303,350 clinical interventions
- 161,200 patients

MHOST is designed to support professional judgement discussions and triangulated with other workforce and patient data; it should not be a measure used in isolation.

Acuity describes the clinical presentation of a patient, in the case of MHOST, using a 'descriptor' which describes what a clinician may observe. Dependency is the workload (usually in time taken to provide care) which is associated with that acuity description. (Imperial College Innovations Ltd., 2019).

The MHOST Process Outline

The minimum assessment period identified by the MHOST and LDOST is 21 days. Trust aims aim for a 25 to 30 day census period (calendar dependent) as recommended by recent research for the Safer Nursing Care Tool.

The MHOST review process supports inter-rater reliability by ensuring that:

- Wards undergo the assessment scoring during the MDT report out led by the ward manager or clinical leads to ensure consistency.
- Where this is not achievable, scoring should be restricted to a limited set of three identified senior staff in each ward. The requirement being for them to complete the daily scoring for the full data collection period to maintain consistency in scoring.
- Ward Managers are to review scores where scoring not completed during MDT report out when next on duty.
- Matrons monitor, validate, and "sense check" the scores, challenging where appropriate on a minimum of a weekly basis across the data collection period. In

practice this is more frequent, and in some areas such as Secure Inpatient Services, it is done daily.

If the minimum assessment period is not met this will impact the validity and reliability of the results.

The results for small wards, or wards that had less than 8 patients resident on average over the census period, will similarly be negatively impacted and may produce inconsistent and erroneous results; this will then rely upon professional judgement to identify the staffing requirements.

The Older Peoples part of the tool was originally designed for organic and functional illness, and so can be seen a shortcoming of the tool as there is a significant variance in needs for these sub-specialities. It is understood that this will be considered in any subsequent review of the tool.

Training sessions with all staff participating in the MHOST and LDOST data collection remains ongoing, with sessions arranged to support teams with compliance, the requirements of the tools, and achieving reliable and valid results. Competency based assessments are being developed to further support levels of assurance in the assessment process.

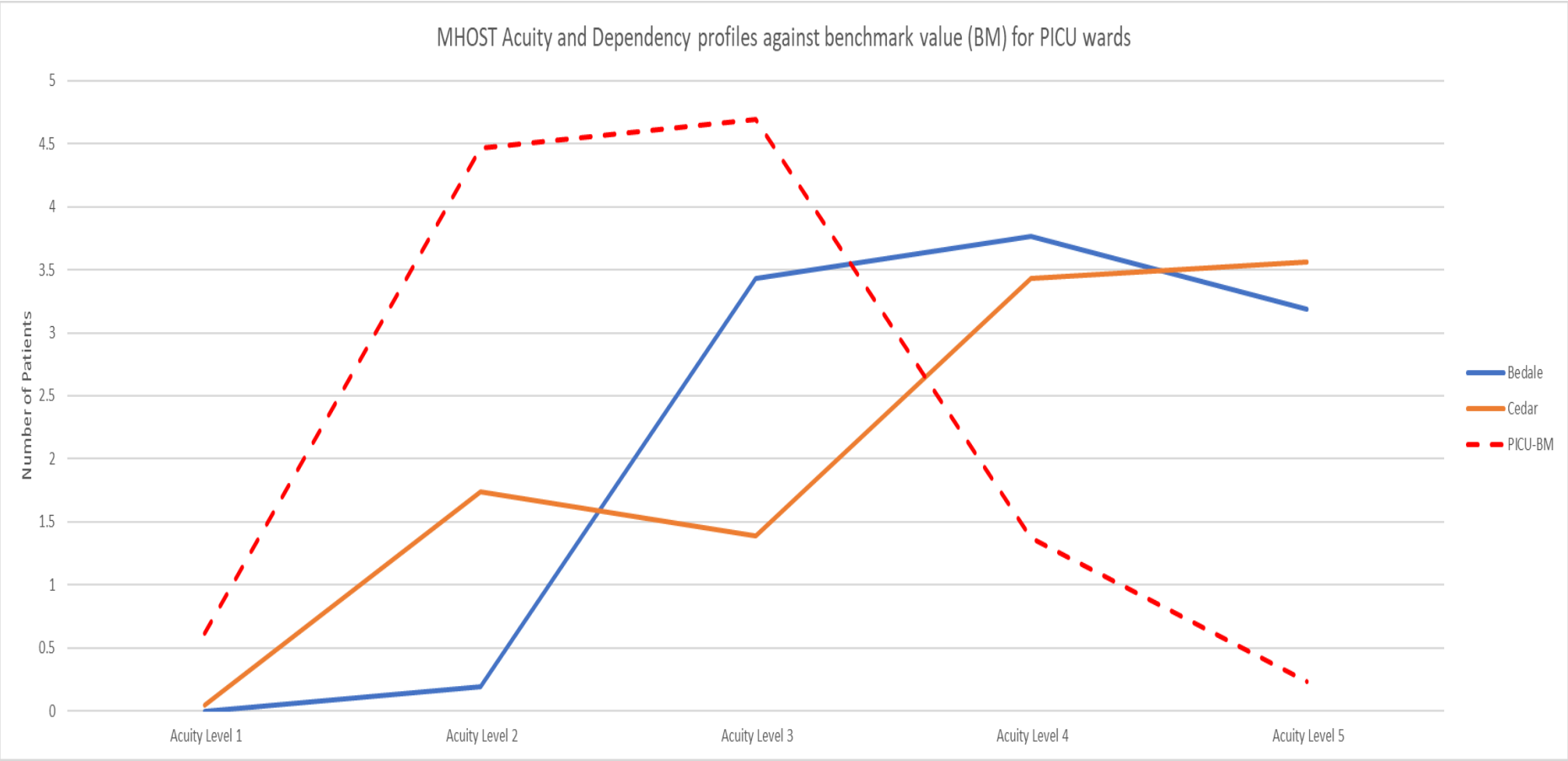
In summary The MHOST and LDOST (acuity/dependency models) have been used to model required staffing based on the national recommended staffing levels to provide quality care for each category of patient according to the acuity / dependency profile of the patient cohort. It provides a benchmark with which to compare the acuity profile of the ward and delivers a recommended WTE (aka FTE) for the ward based upon this acuity profile. The same principles are applied and now integrated into the health roster system as part of the SafeCare tool which, based upon a locally derived evidence based algorithm, provides information on acuity/dependency levels and corresponding staffing levels on a real-time basis converted into recommended care hours per patient day.

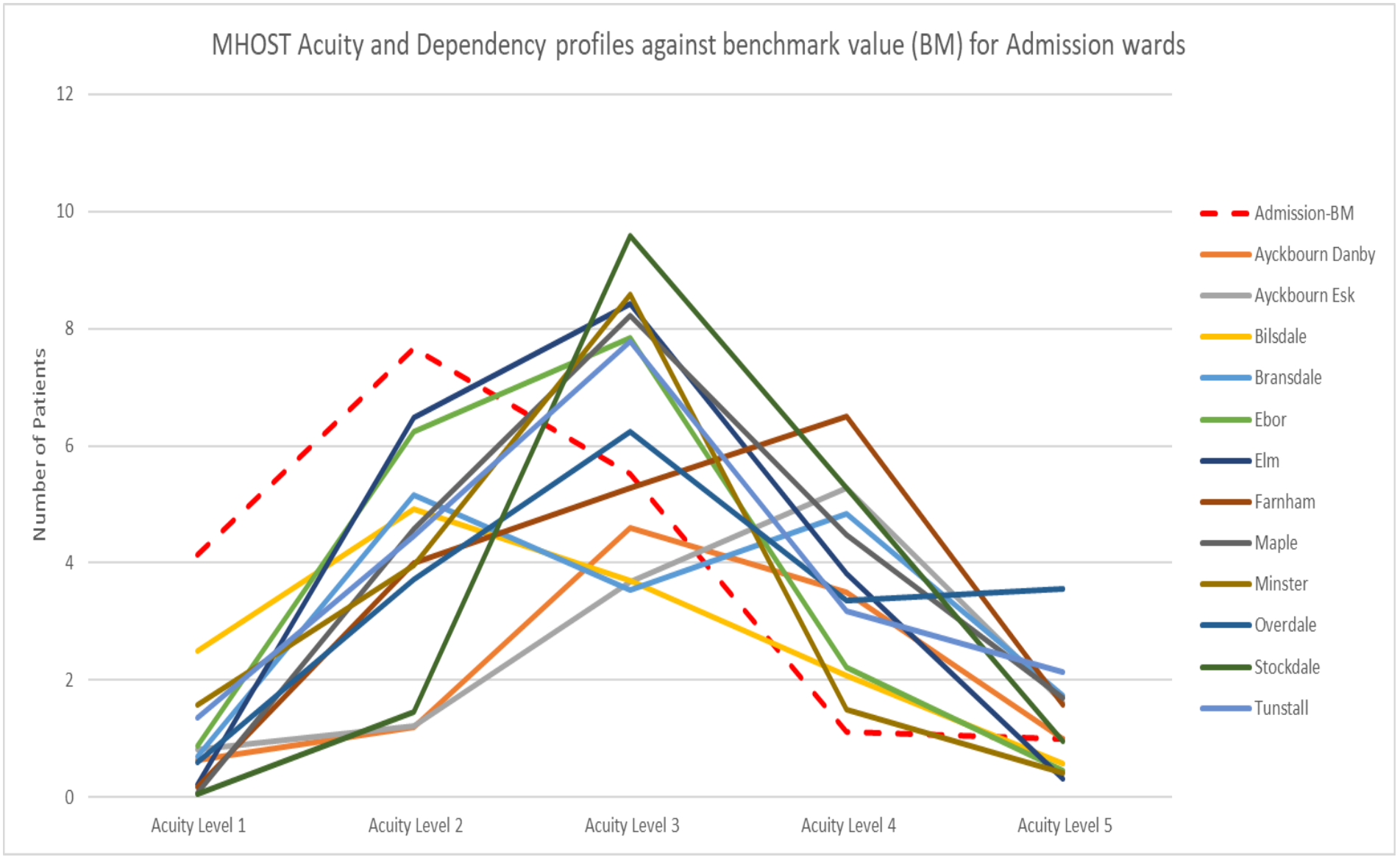
The Learning Disability Optimal Staffing Tool (LDHOST) operates in the same manner as MHOST but, whilst copyrighted, as yet remains unlicensed.

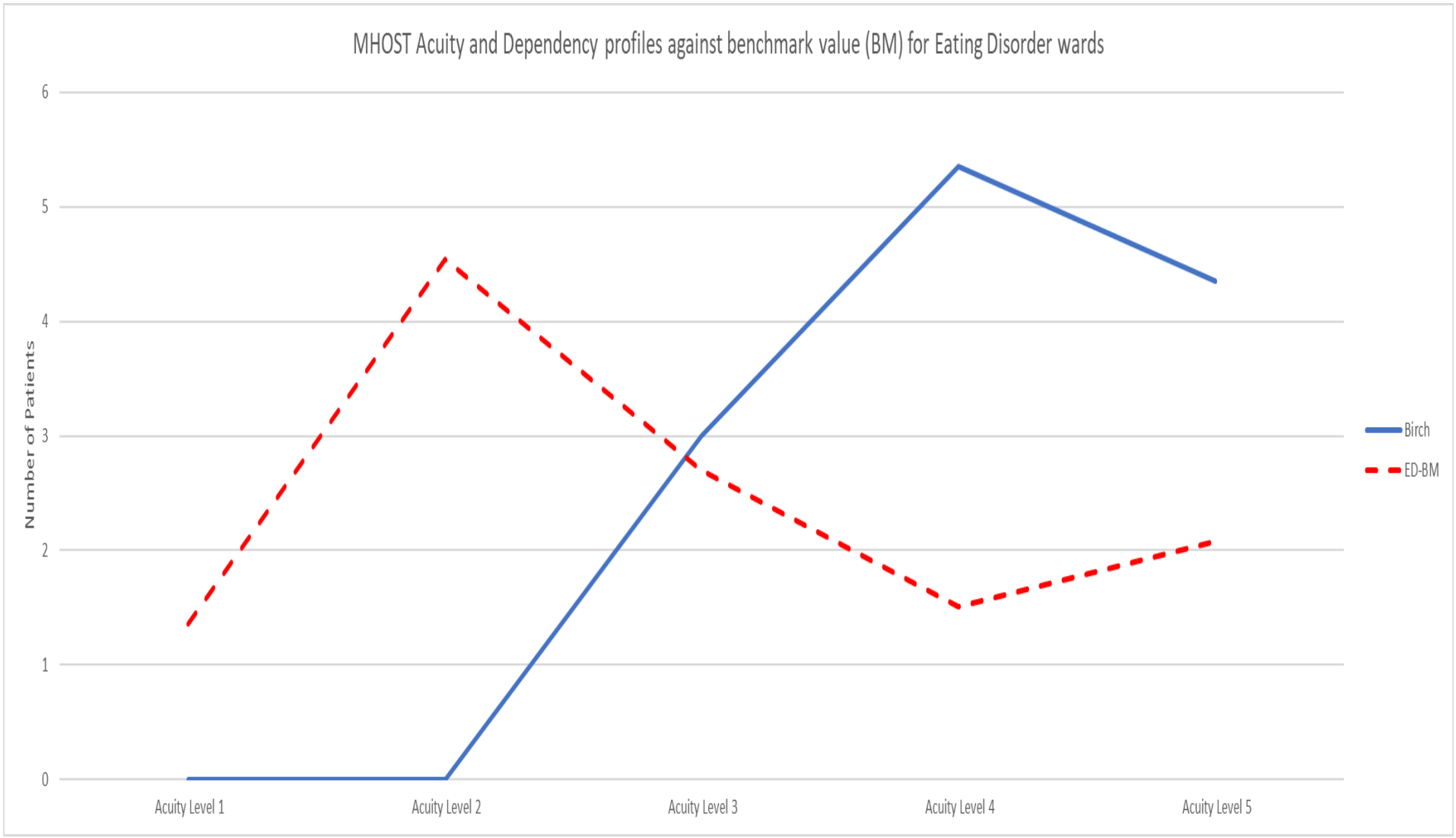
11. APPENDIX 8

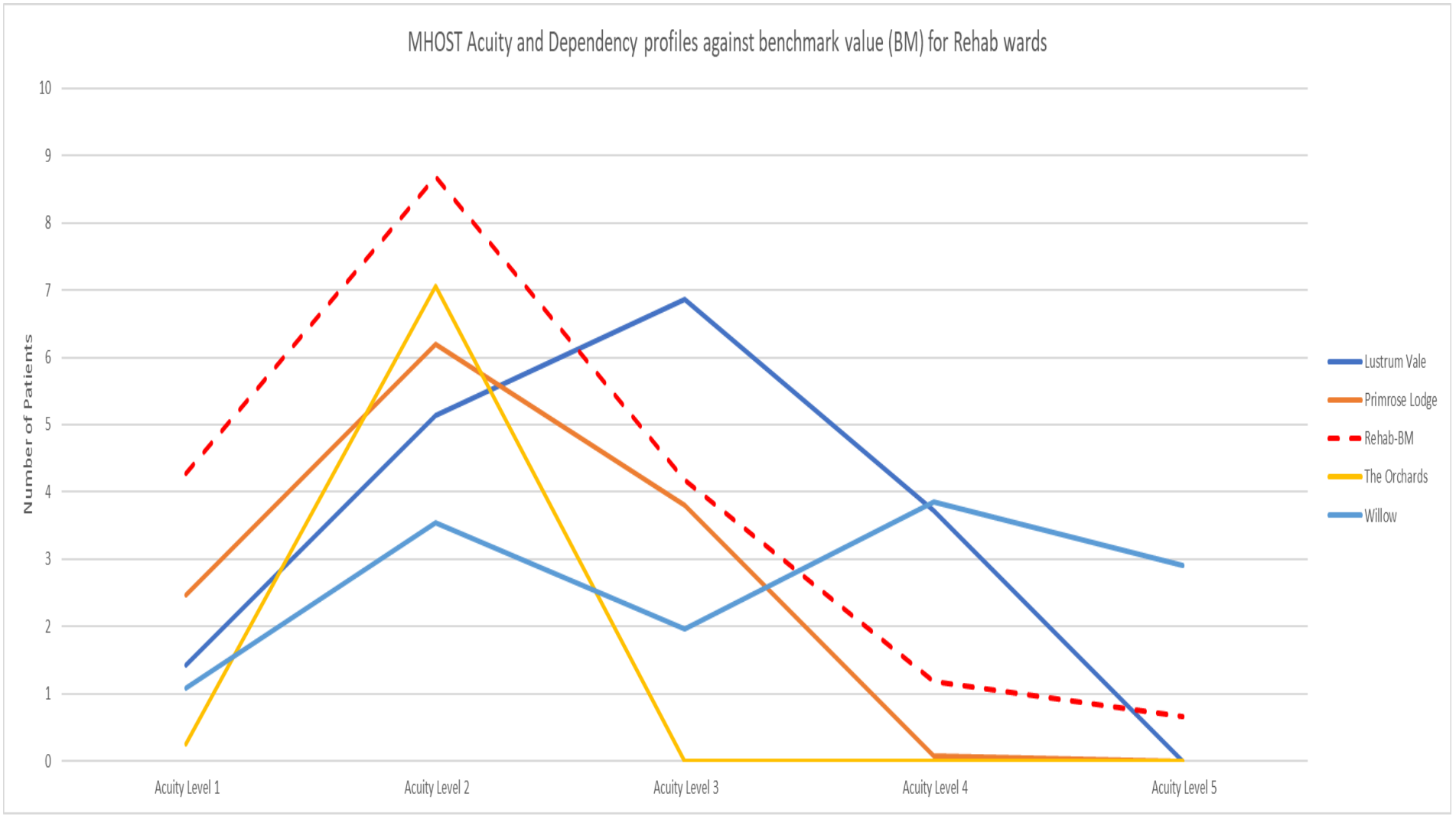
MHOST and LDOST Acuity Profiles September 2022

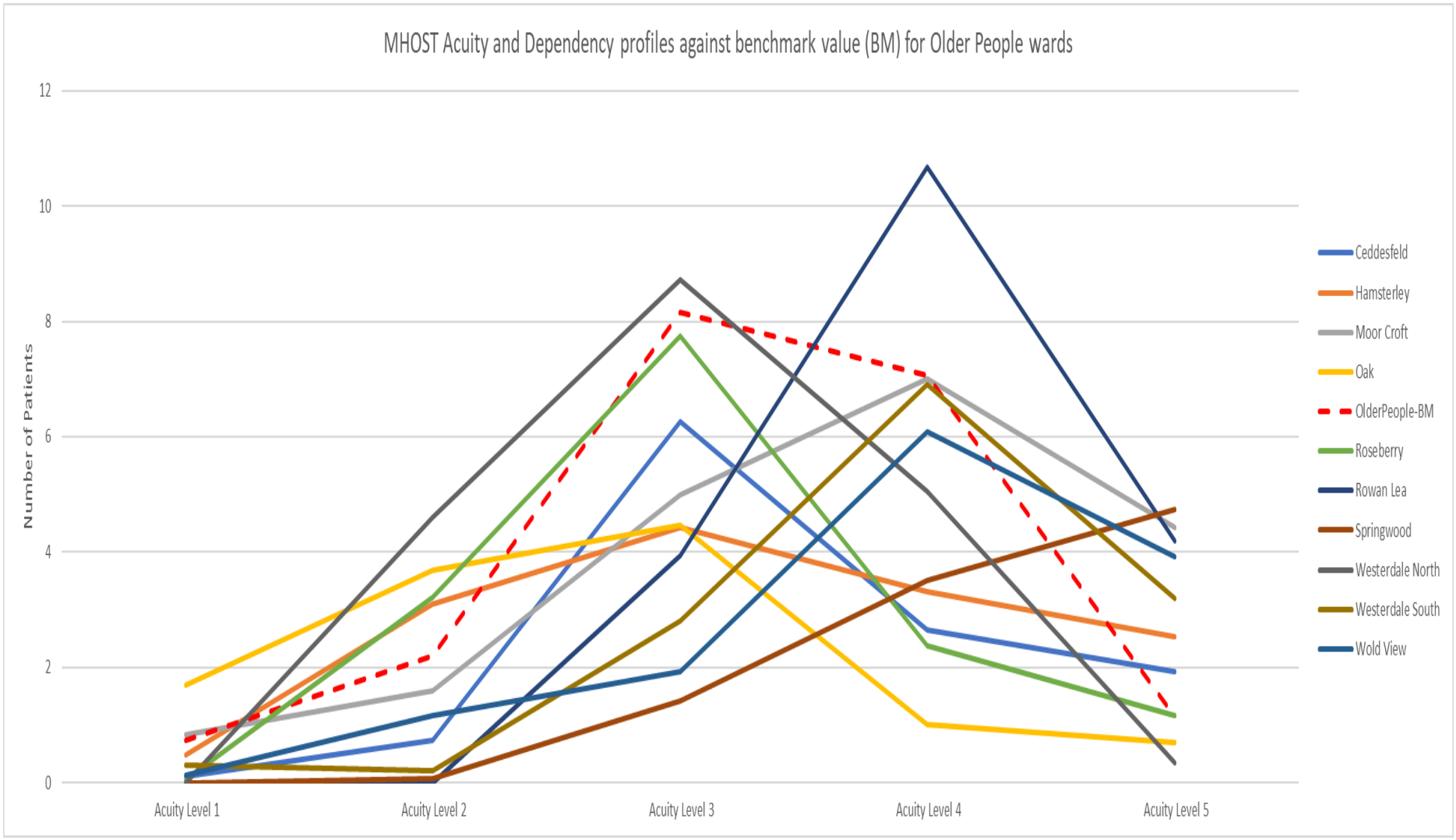
The acuity profiles shown here display the total daily average acuity and dependency scores alongside the national benchmark scores, adjusted pro rata to match the same number of occupied beds for comparison. This is shown for all wards irrespective of the number of days assessed.

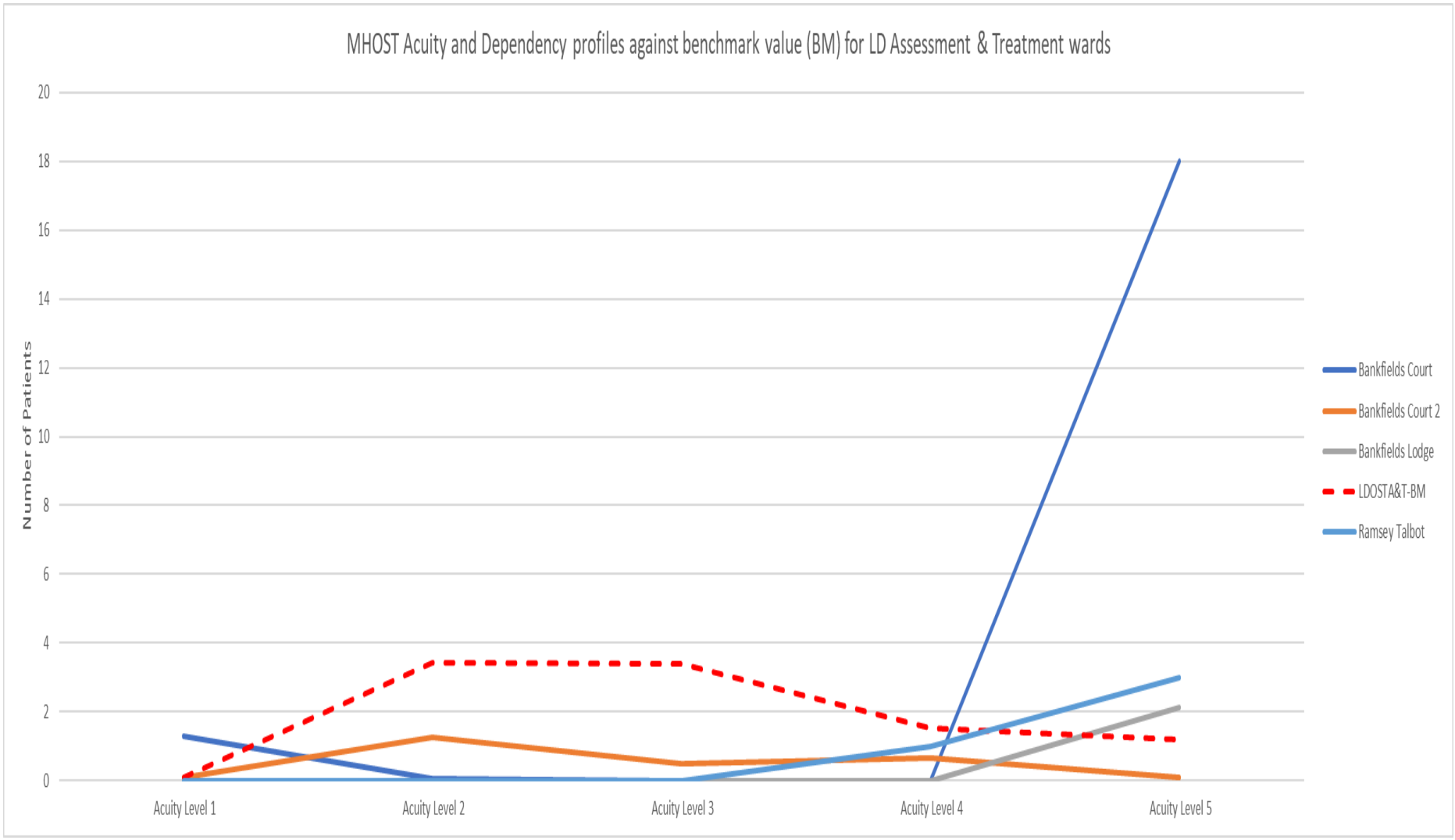


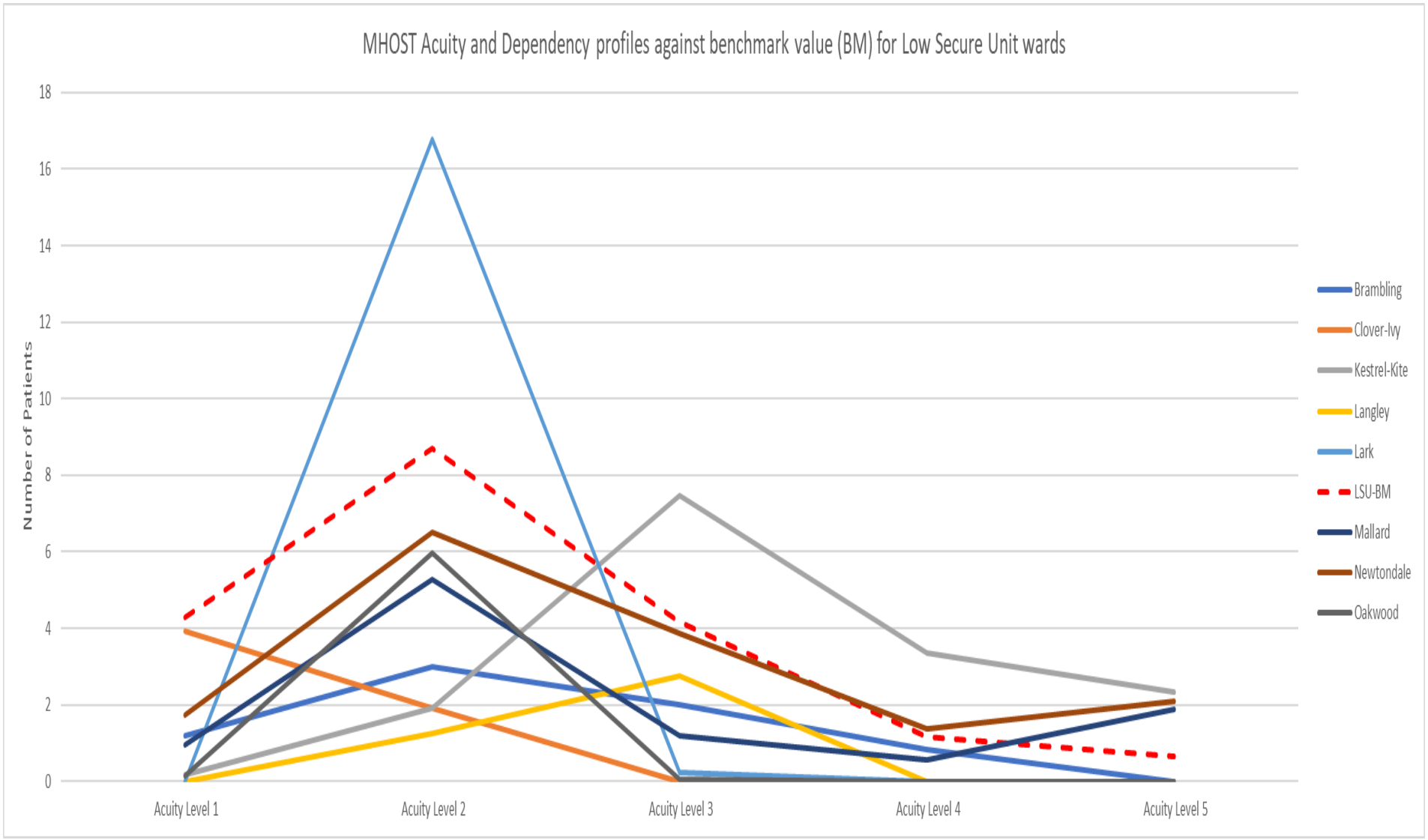

MHOST Acuity and Dependency profiles against benchmark value (BM) for Admission wards
Number of Patients
12
10
8
6
4
2
0
Acuity Level 1
Acuity Level 2
Acuity Level 3
Acuity Level 4
Acuity Level 5
Admission-BM
Ayckbourn Danby
Ayckbourn Esk
Bilsdale
Bransdale
Ebor
Elm
Farnham
Maple
Minster
Overdale
Stockdale
Tunstall

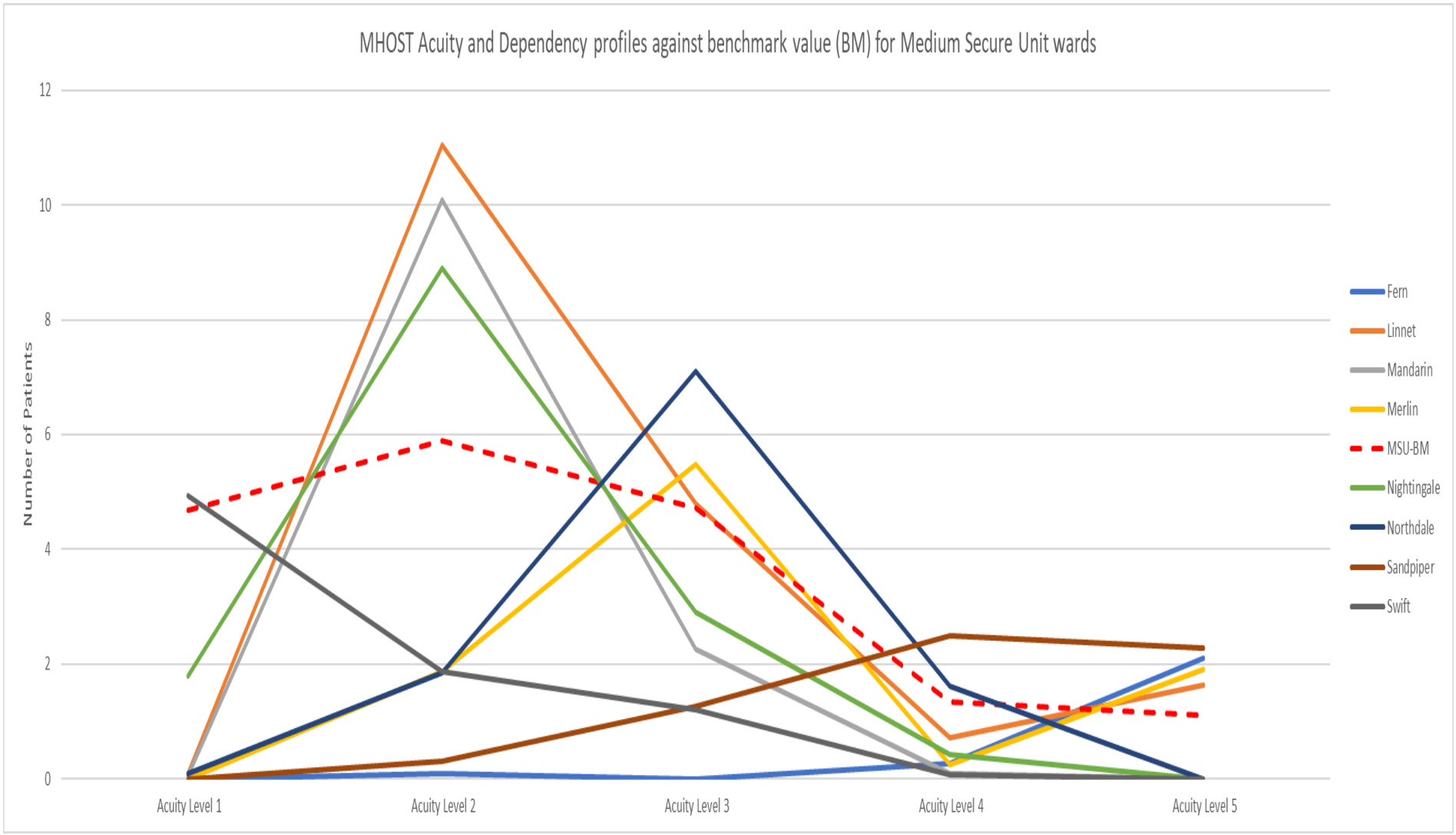

MHOST Acuity and Dependency profiles against benchmark value (BM) for Eating Disorder wards
Number of Patients
0
1
2
3
4
5
6
Acuity Level 1
Acuity Level 2
Acuity Level 3
Acuity Level 4
Acuity Level 5
Birch
ED-BM


MHOST Acuity and Dependency profiles against benchmark value (BM) for Rehab wards
Number of Patients
10
9
8
7
6
5
4
3
2
1
0
Acuity Level 1
Acuity Level 2
Acuity Level 3
Acuity Level 4
Acuity Level 5
Lustrum Vale
Primrose Lodge
Rehab-BM
The Orchards
Willow


MHOST Acuity and Dependency profiles against benchmark value (BM) for Older People wards
Number of Patients
12
10
8
6
4
2
0
Acuity Level 1
Acuity Level 2
Acuity Level 3
Acuity Level 4
Acuity Level 5
Ceddesfeld
Hamsterley
Moor Croft
Oak
OlderPeople-BM
Roseberry
Rowan Lea
Springwood
Westerdale North
Westerdale South
Wold View


MHOST Acuity and Dependency profiles against benchmark value (BM) for LD Assessment & Treatment wards
Number of Patients
20
18
16
14
12
10
8
6
4
2
0
Acuity Level 1
Acuity Level 2
Acuity Level 3
Acuity Level 4
Acuity Level 5
Bankfields Court
Bankfields Court 2
Bankfields Lodge
LDOSTA&T-BM
Ramsey Talbot


MHOST Acuity and Dependency profiles against benchmark value (BM) for Low Secure Unit wards
Number of Patients
18
16
14
12
10
8
6
4
2
0
Acuity Level 1
Acuity Level 2
Acuity Level 3
Acuity Level 4
Acuity Level 5
Brambling
Clover-Ivy
Kestrel-Kite
Langley
Lark
LSU-BM
Mallard
Newtondale
Oakwood


MHOST Acuity and Dependency profiles against benchmark value (BM) for Medium Secure Unit wards
Number of Patients
12
10
8
6
4
2
0
Acuity Level 1
Acuity Level 2
Acuity Level 3
Acuity Level 4
Acuity Level 5
Fern
Linnet
Mandarin
Merlin
MSU-BM
Nightingale
Northdale
Sandpiper
Swift

12. APPENDIX 9

Irrespective of these two specific issues described in Appendix 7 regarding wards with less than 8 beds and the Older People section of MHOST tool not differentiating between functional and organic services, it enables an evidence-based view of the acuity and dependency profiles of each ward and service rather than being reliant upon anecdotal references. When combined with the profiles and overview provided by SafeCare it further enables comparative trends and analysis to be more accurately achieved.

Despite the best efforts of staff it has been noted that the consistency of MHOST results over previous runs of the tool have been impacted by staffing pressures due to COVID. Staff have done their best in trying circumstances however it has impacted upon the assurance of the reliability of results during this period. A tool to assess staff knowledge and ability is being rolled out to provide assurance of competency regarding of MHOST/LDOST assessment scoring. It is required to have at least two sets of reliable and consistent scoring for validity of results. It is to be noted that wards providing assessments scores of less than 21 days will also provide results that are seen to be unreliable or have reduced validity.

The tables below detail the wards excluded from the results due to low bed numbers and insufficient assessment days recorded.

Care Group	Service	Results	No. Day
DTVF	AMH	Maple	15
DTVF	LD	Bankfields Court 2	12
DTVF	LD	Ramsey Talbot	1
DTVF	MHSOP	Hamsterley	19
DTVF	MHSOP	Oak	13
DTVF	MHSOP	Westerdale North	18
DTVF	MHSOP	Westerdale South	10
DTVF	Rehab	Lustrum Vale	7
DTVF	Rehab	Primrose Lodge	15
DTVF	SIS	Clover-Ivy	13
DTVF	SIS	Fern	11
DTVF	SIS	Lark	18
DTVF	SIS	Swift	15
NYY	MHSOP	Moor Croft	12
NYY	MHSOP	Rowan Lea	16
NYY	Rehab	The Orchards	16

Ward	Total Patients
Bankfields Court 2	2.58
Bankfields Lodge	2.14
Brambling	7.00
Clover-Ivy	5.85
Fern	2.45
Langley	4.00
Oakwood	6.14
Ramsey Talbot	4.00
Sandpiper	6.35
The Orchards	7.31

MHOST provides benchmark data for preferred Registered Practitioner (RP) to Support Worker (SW) ratios. Of the 49 MHOST wards 33% did not meet the benchmark for achieving 21 days minimum assessment days. Appendix 9a shows (excluding the wards with under 8 beds and teams that did not meet the 21 day assessment requirement) the recommended WTE requirement for the acuity and dependency recorded for each ward. This is compared to the current budgeted establishment for that ward for clinical staff

Appendix 9b (excluding the wards with under 8 beds and teams that did not meet the 21 day assessment requirement) shows the differences between the recommended WTEs from MHOST and the budgeted establishment and appendix 9c shows the associated costs for the recommendations.

Within this there are some key points:

- AMH and PICU show significant uplift in staffing requirements which is also reflected in the additional hours for bank and agency currently being utilised by these wards.
    - The recommendation also reflects the skill mix requirements
    - The total cost for AMH and PICU would be ~ £3.82M against budgeted establishments.
- LD – currently aspire to working to 5 RNs for a day shift and 3 RNs per night – and 20 HCAs per day and 17 HCAs per night which equates to approximately 123 WTEs required to cover this requirement.
    - LDOST recommends 95 WTEs for the acuity seen when this was undertaken in September 2022
- SIS – shows a significant reduction in the number of HCAs, 46.7 WTEs at a cost reduction of £1.75M, and has a required uplift of 14.7 RNs at a cost of £548K

It should be noted that these are indicative costs only to each service area as we have not analysed the full complement of wards due to the number of wards not achieving the required assessment days.

13. APPENDIX 9a

Table showing MHOST recommended WTEs versus budgeted WTEs with registered practitioner skill-mix

Service Area	RP Budget	RP Rec	SW Budget	SW Rec	Budgeted WTE	Total WTE Rec
Admission	**149.9**	**197.1**	**147.5**	**170.7**	**297.3**	**367.8**
Ayckbourn Danby	12.3	13.2	14.0	11.5	26.4	24.7
Ayckbourn Esk	13.5	17.0	14.0	14.7	27.6	31.7
Bilsdale	11.0	12.8	12.8	11.1	23.8	23.9
Bransdale	11.0	19.1	13.3	16.5	24.3	35.6
Ebor	18.1	16.1	15.2	13.9	33.3	30.0
Elm	14.2	18.3	12.5	15.8	26.7	34.1
Farnham	14.2	21.5	13.0	18.6	27.2	40.2
Minster	19.1	14.5	14.7	12.5	33.8	27.0
Overdale	11.0	23.4	12.8	20.2	23.8	43.6
Stockdale	11.0	19.8	13.3	17.2	24.3	37.0
Tunstall	14.2	21.4	12.1	18.5	26.3	39.9
ED	**21.7**	**19.2**	**13.8**	**17.8**	**35.5**	**37.0**
Birch	21.7	19.2	13.8	17.8	35.5	37.0
LDOSTA&T	**24.4**	**33.8**	**42.5**	**61.1**	**66.8**	**94.9**
Bankfields Court	24.4	33.8	42.5	61.1	66.8	94.9
LSU	**31.8**	**40.4**	**57.1**	**36.3**	**88.9**	**76.7**
Kestrel-Kite	9.1	16.1	22.5	14.5	31.6	30.6
Mallard	9.1	10.0	15.7	9.0	24.8	19.0
Newtondale	13.7	14.2	18.9	12.8	32.6	27.0
MSU	**50.9**	**57.0**	**82.2**	**56.3**	**133.1**	**113.3**
Linnet	10.1	16.9	15.2	16.7	25.3	33.6
Mandarin	10.1	8.7	12.2	8.6	22.2	17.3
Merlin	11.7	11.3	15.8	11.2	27.6	22.5
Nightingale	10.1	10.0	12.2	9.9	22.2	19.8
Northdale	9.1	10.1	26.8	10.0	35.9	20.1
OlderPeople	**52.3**	**53.3**	**69.5**	**60.5**	**121.7**	**113.8**
Ceddesfeld	10.8	10.8	19.4	12.3	30.2	23.2
Roseberry	11.7	10.6	12.8	12.1	24.6	22.7
Springwood	13.4	15.5	14.3	17.6	27.7	33.1
Wold View	16.4	16.3	22.9	18.6	39.3	34.9
PICU	**33.6**	**46.3**	**30.9**	**49.8**	**64.4**	**96.1**
Bedale	16.5	23.8	15.5	25.6	32.0	49.3
Cedar	17.1	22.5	15.4	24.2	32.4	46.7
Rehab	**9.6**	**16.2**	**11.9**	**14.5**	**21.5**	**30.7**
Willow	9.6	16.2	11.9	14.5	21.5	30.7
Grand Total	**374.1**	**463.2**	**455.3**	**467.0**	**829.4**	**930.3**

14. APPENDIX 9b

Table showing differentials of MHOST recommended WTEs versus budgeted WTEs with registered practitioner skill-mix

Service Area	WTE MHOST vs Budgeted RPs	WTE MHOST vs Budgeted SWs	WTE MHOST vs Budgeted Total
Admission	**47.3**	**23.2**	**70.5**
Ayckbourn Danby	0.9	-2.6	-1.6
Ayckbourn Esk	3.4	0.7	4.1
Bilsdale	1.8	-1.7	0.2
Bransdale	8.1	3.3	11.4
Ebor	-2.0	-1.3	-3.3
Elm	4.1	3.4	7.4
Farnham	7.3	5.6	12.9
Minster	-4.7	-2.1	-6.8
Overdale	12.4	7.5	19.8
Stockdale	8.8	3.9	12.8
Tunstall	7.2	6.4	13.6
ED	**-2.5**	**4.0**	**1.4**
Birch	-2.5	4.0	1.4
LDOSTA&T	**9.4**	**18.6**	**28.0**
Bankfields Court	9.4	18.6	28.0
LSU	**8.6**	**-20.8**	**-12.2**
Kestrel-Kite	7.1	-8.0	-0.9
Mallard	1.0	-6.7	-5.7
Newtondale	0.5	-6.1	-5.6
MSU	**6.1**	**-25.9**	**-19.8**
Linnet	6.9	1.5	8.3
Mandarin	-1.3	-3.6	-4.9
Merlin	-0.4	-4.6	-5.0
Nightingale	-0.1	-2.3	-2.4
Northdale	1.0	-16.9	-15.8
OlderPeople	**1.0**	**-8.9**	**-7.9**
Ceddesfeld	0.0	-7.1	-7.0
Roseberry	-1.1	-0.8	-1.9
Springwood	2.1	3.3	5.4
Wold View	0.0	-4.3	-4.4
PICU	**12.7**	**18.9**	**31.6**
Bedale	7.3	10.1	17.3
Cedar	5.4	8.9	14.3
Rehab	**6.6**	**2.6**	**9.2**
Willow	6.6	2.6	9.2
Grand Total	**89.1**	**11.7**	**100.8**

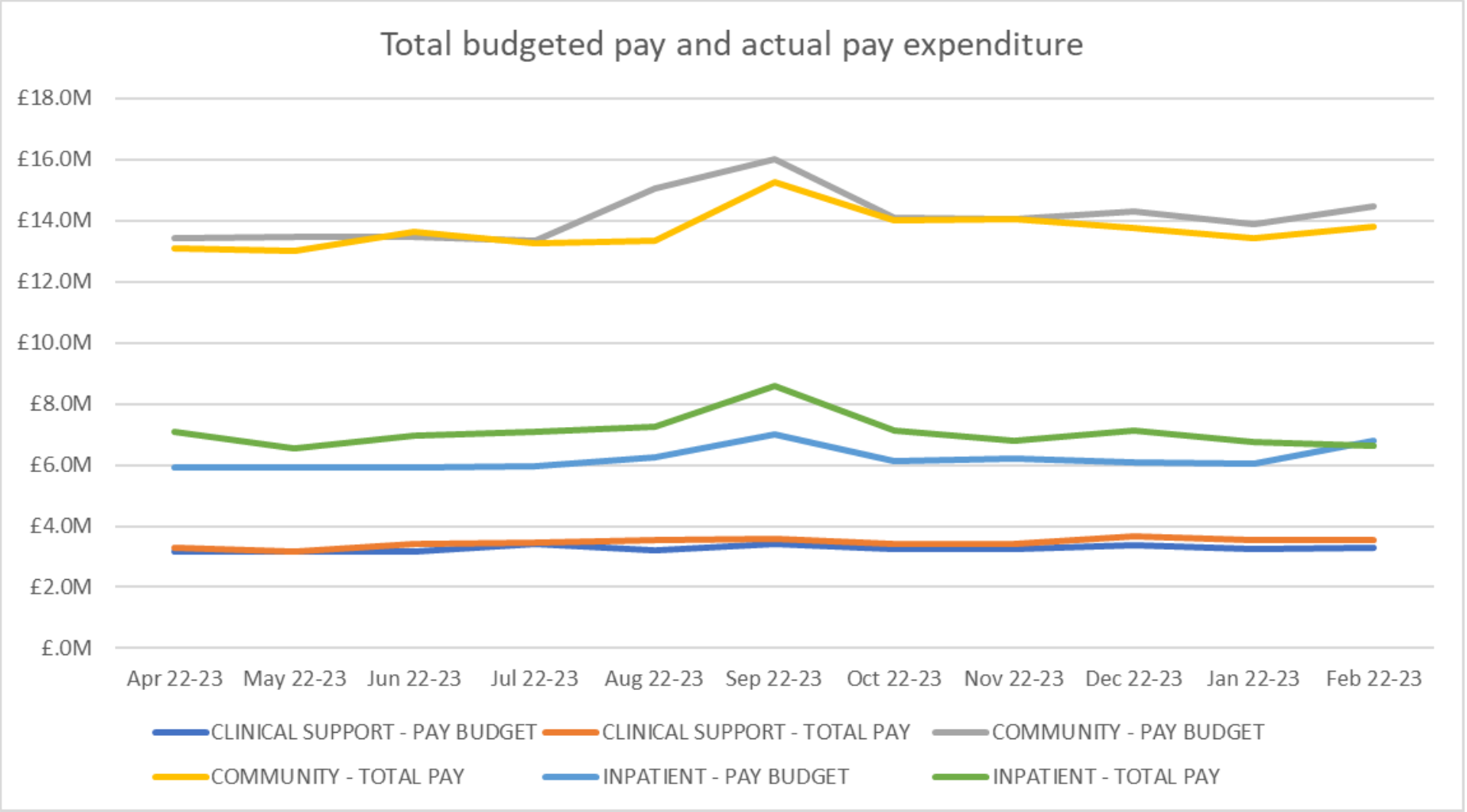
15. APPENDIX 9c

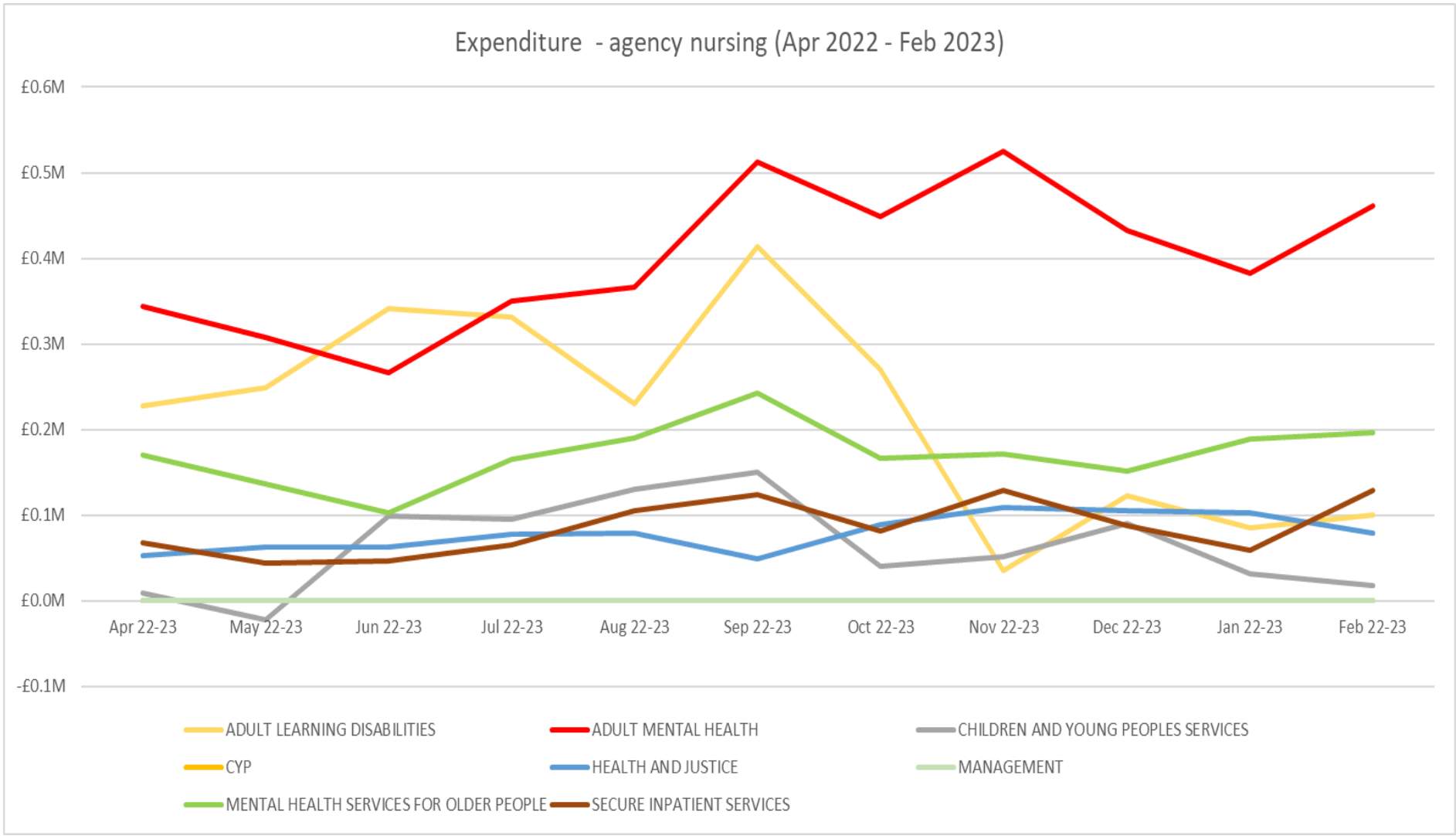
Table showing differentials of MHOST recommended WTEs versus budgeted WTEs with registered practitioner skill-mix with costings

Service Area	WTE MHOST vs Budgeted RPs	WTE MHOST vs Budgeted SWs	WTE MHOST vs Budgeted Total	MHOST vs Budgeted RPs (£)	MHOST vs Budgeted SWs (£)	MHOST vs Budgeted Total (£)
Admission	**47.3**	**23.2**	**70.5**	**£2,174,292**	**£867,323**	**£3,041,615**
Ayckbourn Danby	0.9	-2.6	-1.6	£41,651	-£95,601	-£53,950
Ayckbourn Esk	3.4	0.7	4.1	£158,524	£25,672	£184,196
Bilsdale	1.8	-1.7	0.2	£83,557	-£61,995	£21,562
Bransdale	8.1	3.3	11.4	£372,184	£122,730	£494,914
Ebor	-2.0	-1.3	-3.3	-£94,101	-£47,011	-£141,113
Elm	4.1	3.4	7.4	£187,283	£125,590	£312,873
Farnham	7.3	5.6	12.9	£335,635	£211,439	£547,075
Minster	-4.7	-2.1	-6.8	-£213,994	-£80,390	-£294,384
Overdale	12.4	7.5	19.8	£568,096	£279,543	£847,638
Stockdale	8.8	3.9	12.8	£406,367	£146,825	£553,192
Tunstall	7.2	6.4	13.6	£329,090	£240,522	£569,613
ED	**-2.5**	**4.0**	**1.4**	**-£116,773**	**£148,992**	**£32,218**
Birch	-2.5	4.0	1.4	-£116,773	£148,992	£32,218
LDOSTA&T	**9.4**	**18.6**	**28.0**	**£432,653**	**£697,751**	**£1,130,404**
Bankfields Court	9.4	18.6	28.0	£432,653	£697,751	£1,130,404
LSU	**8.6**	**-20.8**	**-12.2**	**£394,766**	**-£779,719**	**-£384,952**
Kestrel-Kite	7.1	-8.0	-0.9	£326,035	-£300,015	£26,020
Mallard	1.0	-6.7	-5.7	£45,197	-£251,413	-£206,217
Newtondale	0.5	-6.1	-5.6	£23,534	-£228,290	-£204,755
MSU	**6.1**	**-25.9**	**-19.8**	**£278,761**	**-£968,097**	**-£689,336**
Linnet	6.9	1.5	8.3	£315,002	£55,003	£370,006
Mandarin	-1.3	-3.6	-4.9	-£62,008	-£133,000	-£195,007
Merlin	-0.4	-4.6	-5.0	-£18,186	-£173,000	-£191,186
Nightingale	-0.1	-2.3	-2.4	-£3,673	-£86,068	-£89,741
Northdale	1.0	-16.9	-15.8	£47,626	-£631,034	-£583,408
OlderPeople	**1.0**	**-8.9**	**-7.9**	**£45,492**	**-£333,490**	**-£287,998**
Ceddesfeld	0.0	-7.1	-7.0	£355	-£263,960	-£263,605
Roseberry	-1.1	-0.8	-1.9	-£51,880	-£29,521	-£81,400
Springwood	2.1	3.3	5.4	£97,492	£122,648	£220,140
Wold View	0.0	-4.3	-4.4	-£475	-£162,657	-£163,132
PICU	**12.7**	**18.9**	**31.6**	**£584,505**	**£707,994**	**£1,292,499**
Bedale	7.3	10.1	17.3	£334,716	£376,478	£711,195
Cedar	5.4	8.9	14.3	£249,788	£331,516	£581,304
Rehab	**6.6**	**2.6**	**9.2**	**£304,513**	**£97,432**	**£401,944**
Willow	6.6	2.6	9.2	£304,513	£97,432	£401,944
Grand Total	**89.1**	**11.7**	**100.8**	**£4,098,207**	**£438,187**	**£4,536,395**

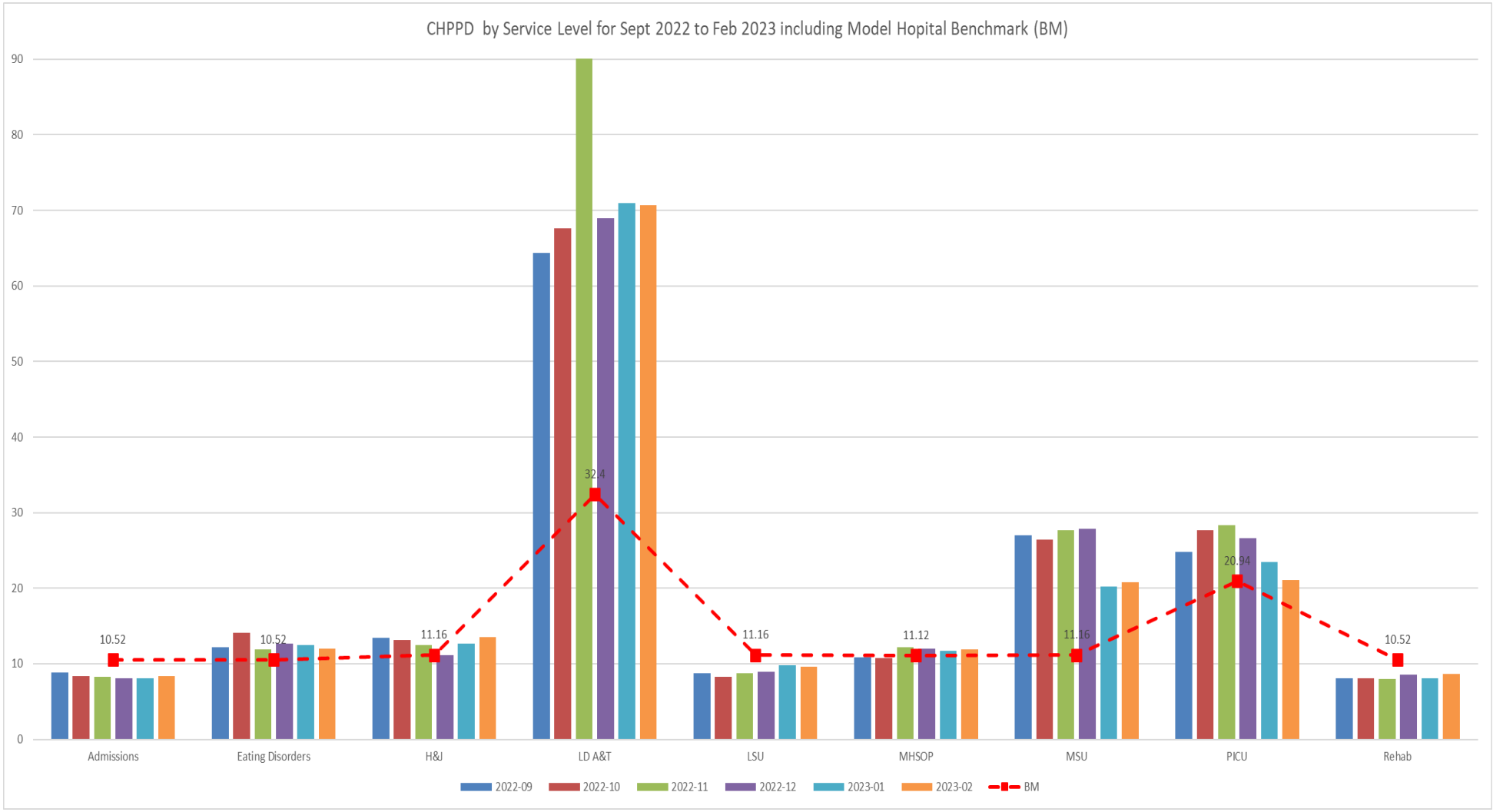
16. APPENDIX 10

Chart to show for clinical localities pay expenditure and pay expenditure budget by setting April 2022-February 2023

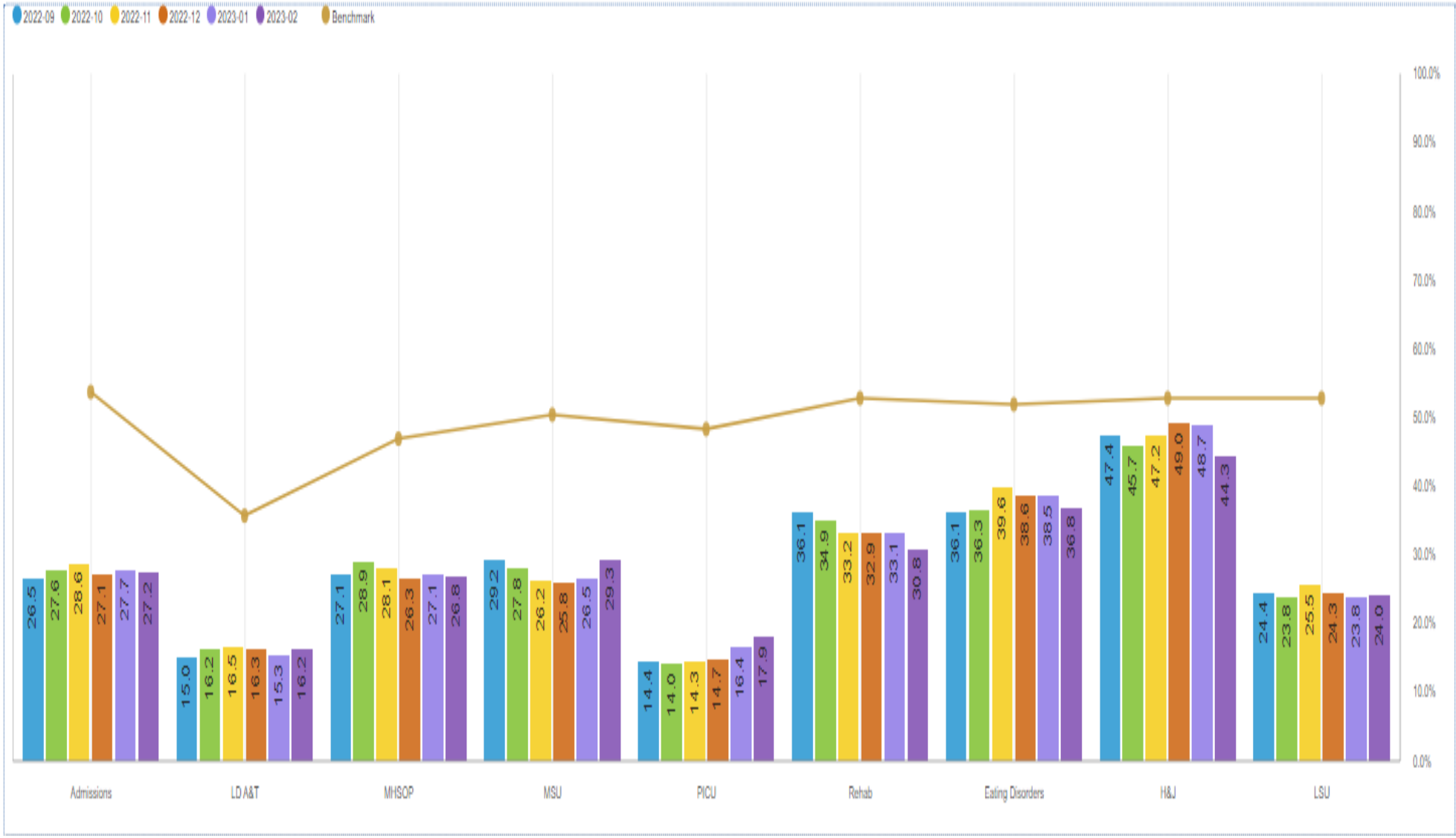



Expenditure - agency nursing (Apr 2022 - Feb 2023)
£0.6M
£0.5M
£0.4M
£0.3M
£0.2M
£0.1M
£0.0M
-£0.1M
Apr 22-23
May 22-23
Jun 22-23
Jul 22-23
Aug 22-23
Sep 22-23
Oct 22-23
Nov 22-23
Dec 22-23
Jan 22-23
Feb 22-23
ADULT LEARNING DISABILITIES
ADULT MENTAL HEALTH
CHILDREN AND YOUNG PEOPLES SERVICES
CYP
HEALTH AND JUSTICE
MANAGEMENT
MENTAL HEALTH SERVICES FOR OLDER PEOPLE
SECURE INPATIENT SERVICES

17. APPENDIX 11



Care Hours Per Patient Day (CHPPD) Sept 22 – Feb 22 with Model Hospital peer benchmark values ***{LD value for Nov 22 is 162}***

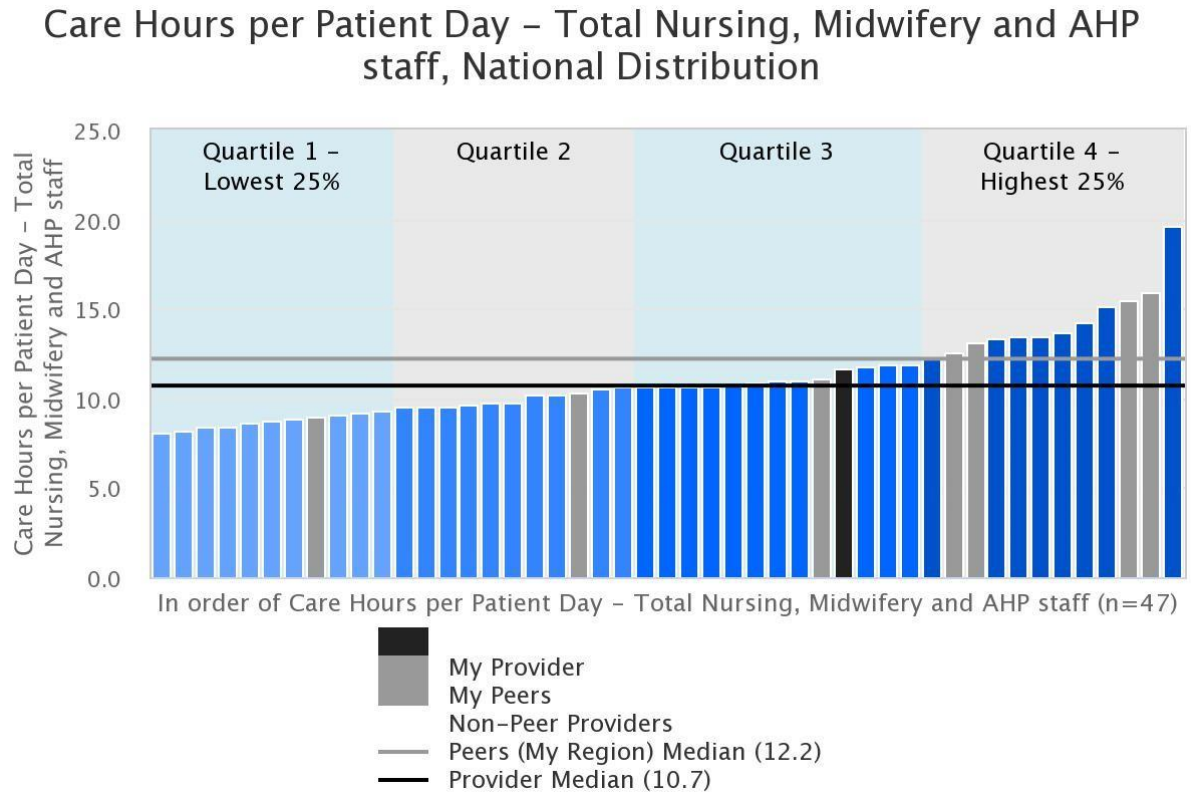


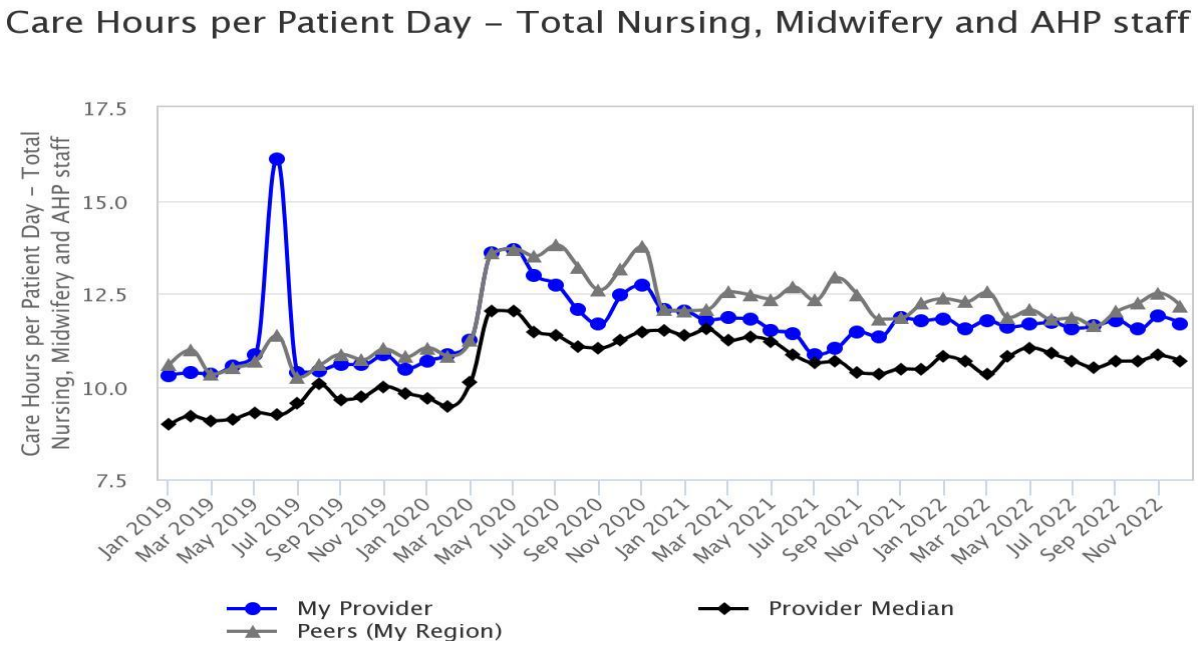
RN to HCA skill mix percentages based upon hours worked Sept 22 – Feb 22 with MHOST benchmark values

18. APPENDIX 12

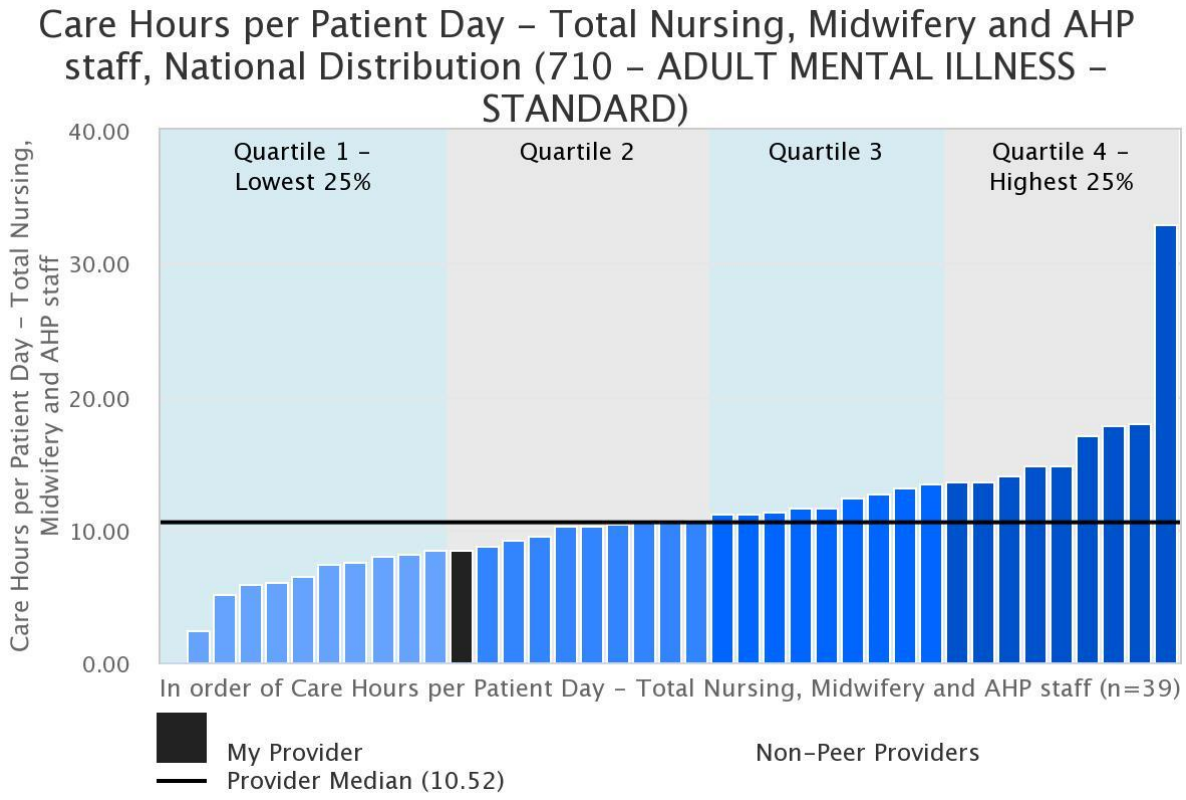
Model Hospital Benchmarks

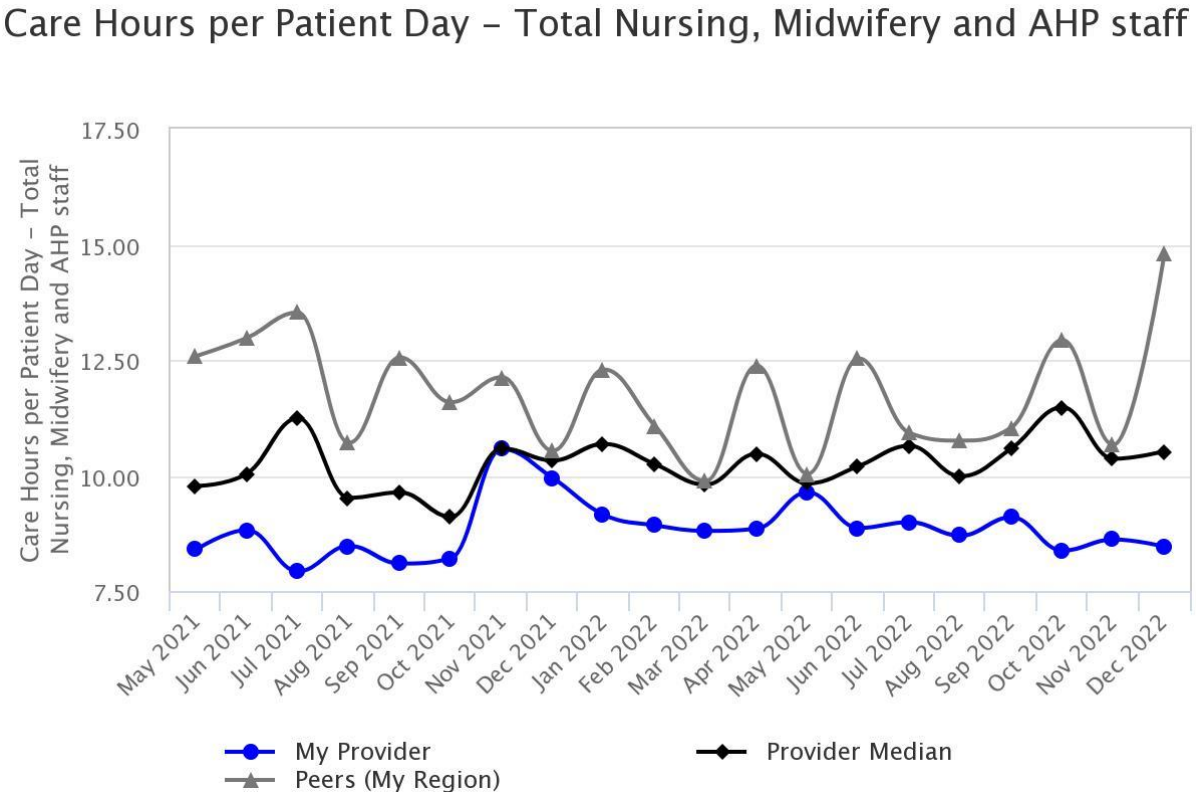
MODEL HOSPITAL BENCHMARK – TRUSTWIDE VIEW LATEST RESULTS JAN 2023



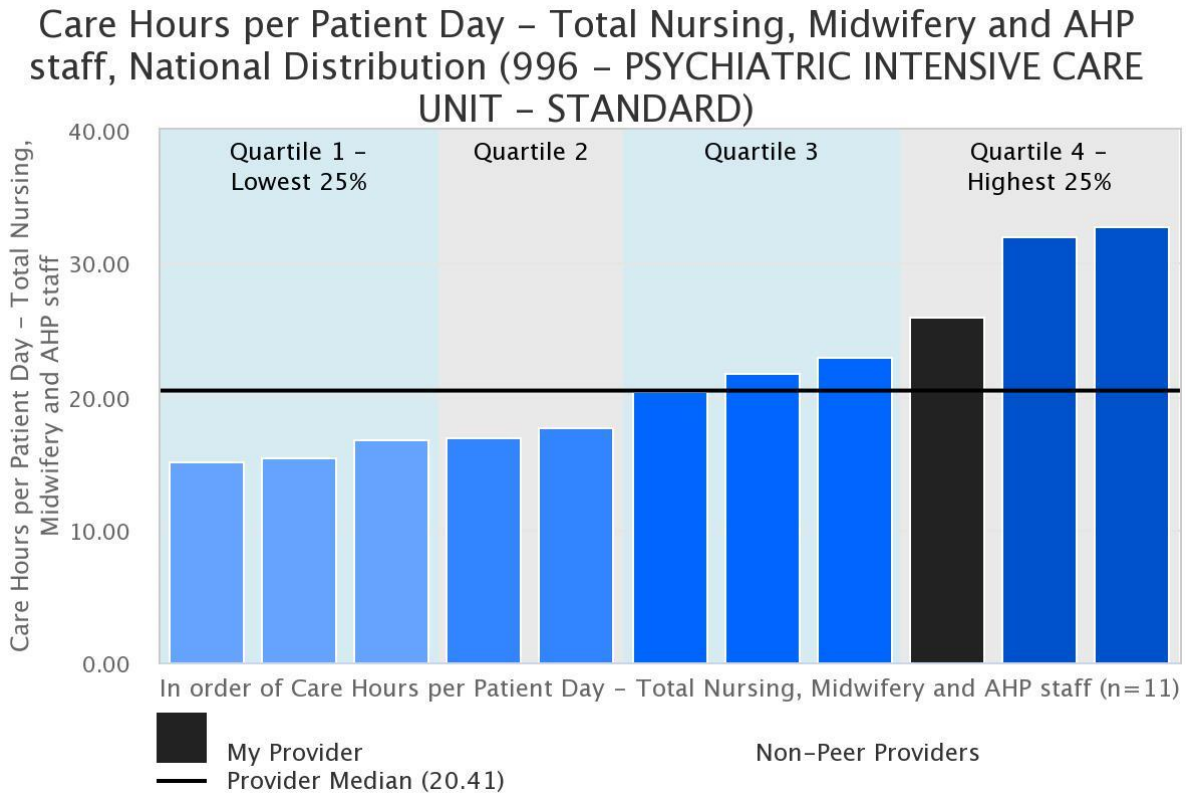


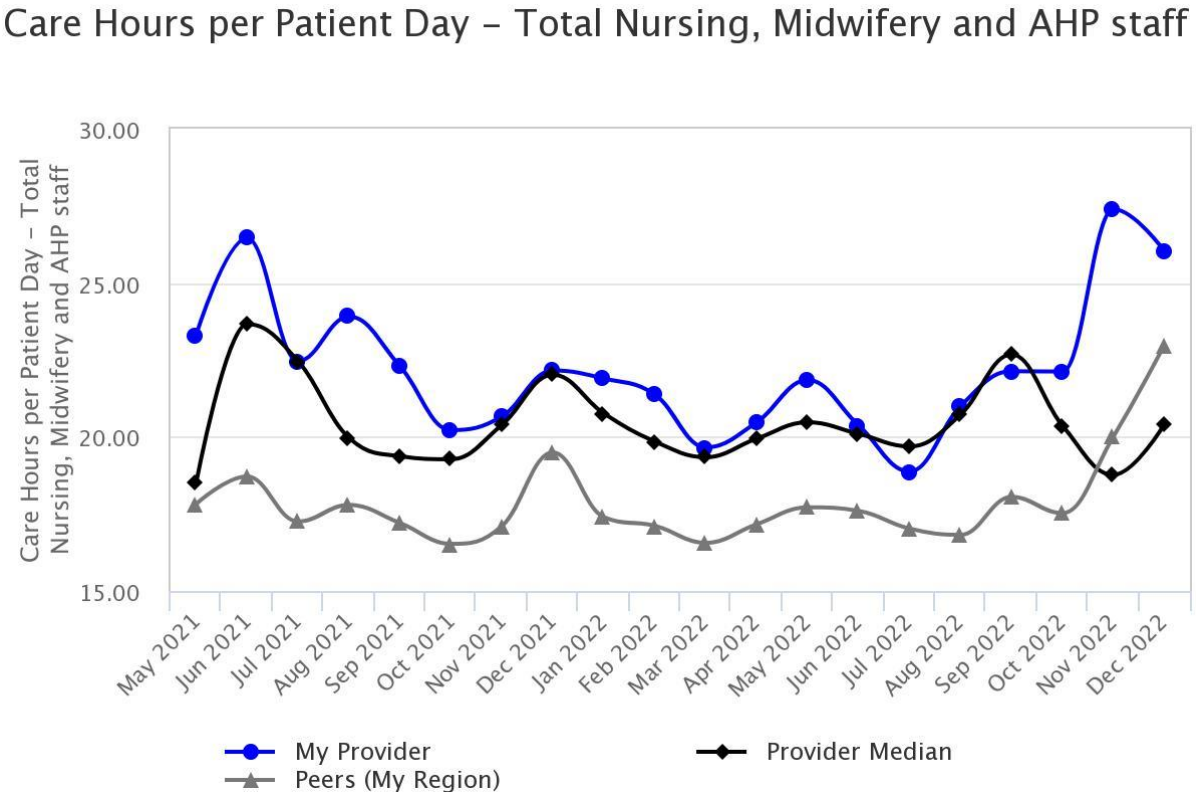
ADULT MENTAL HEALTH - LATEST RESULTS DECEMBER 2022



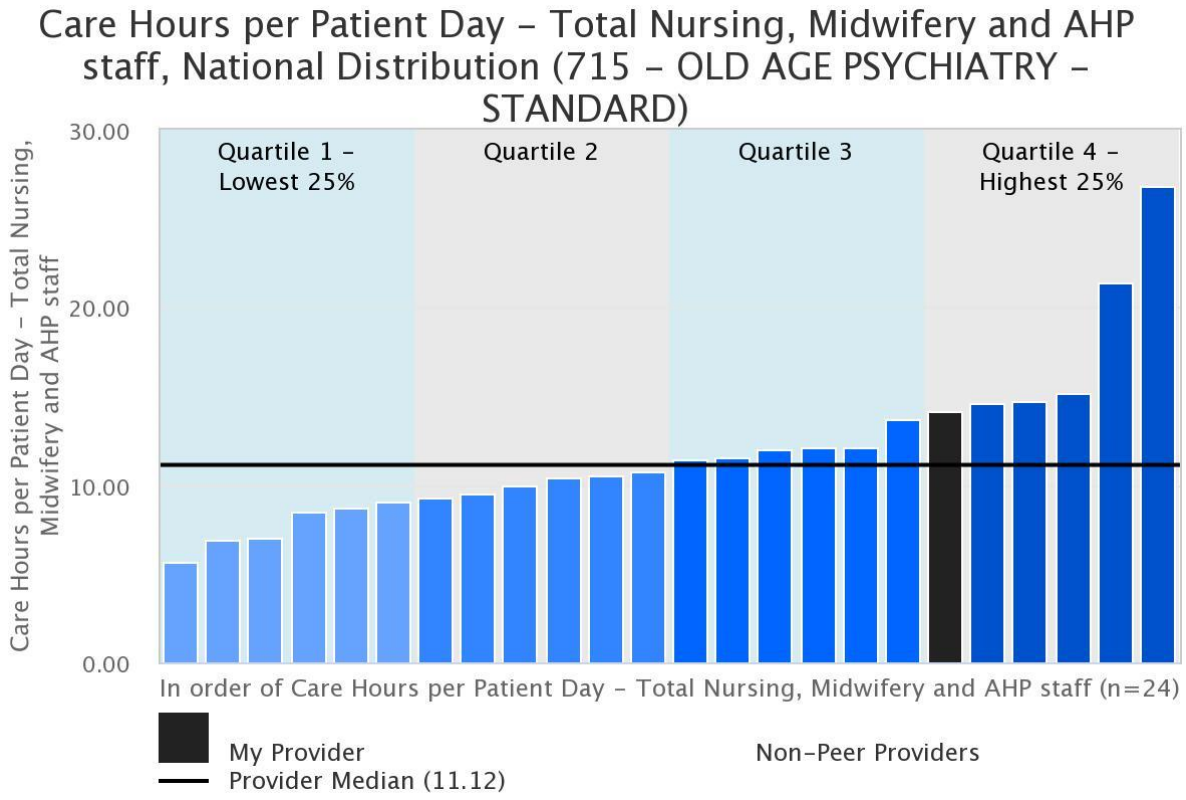


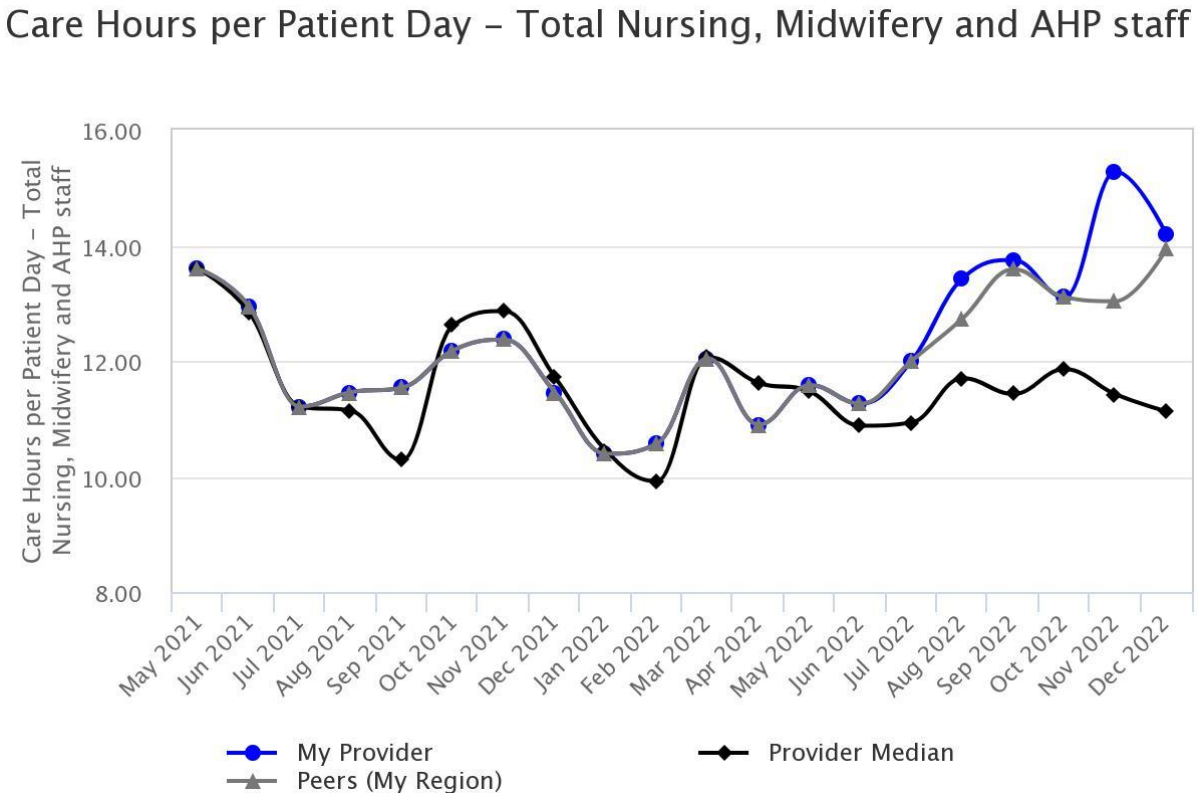
PICU - LATEST RESULTS DECEMBER 2022



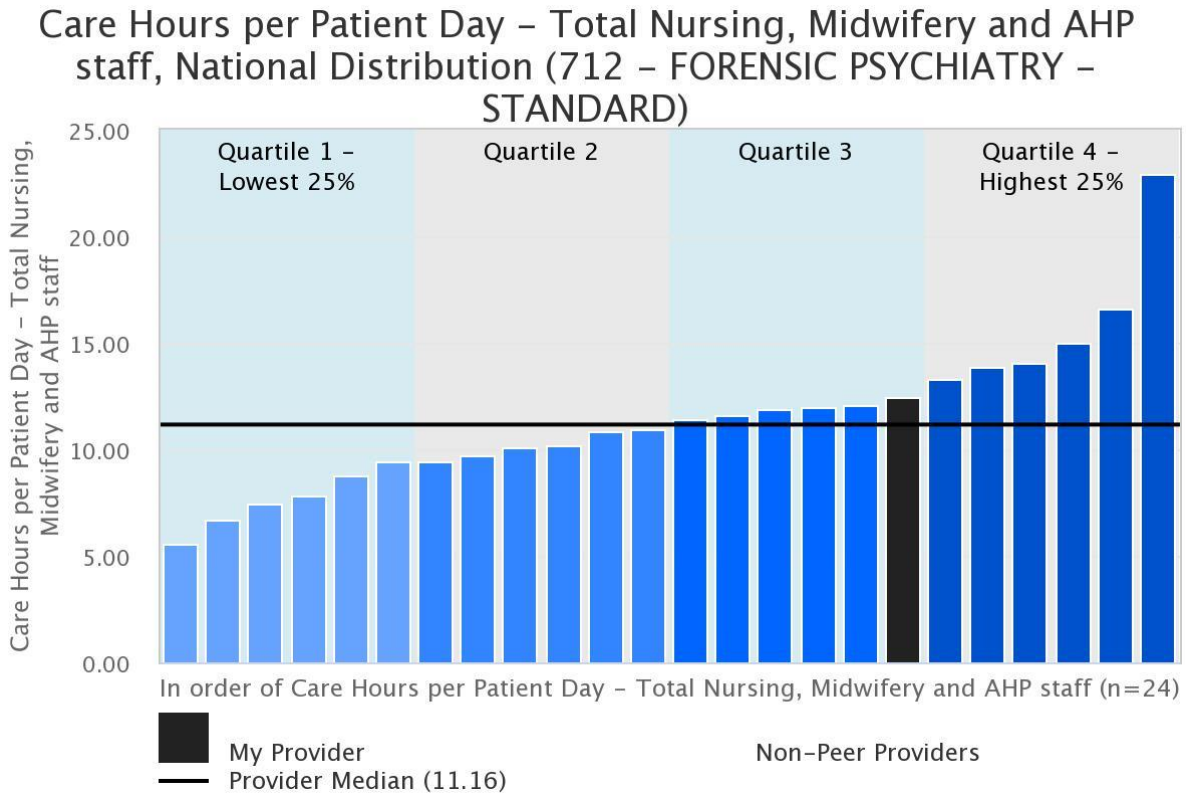


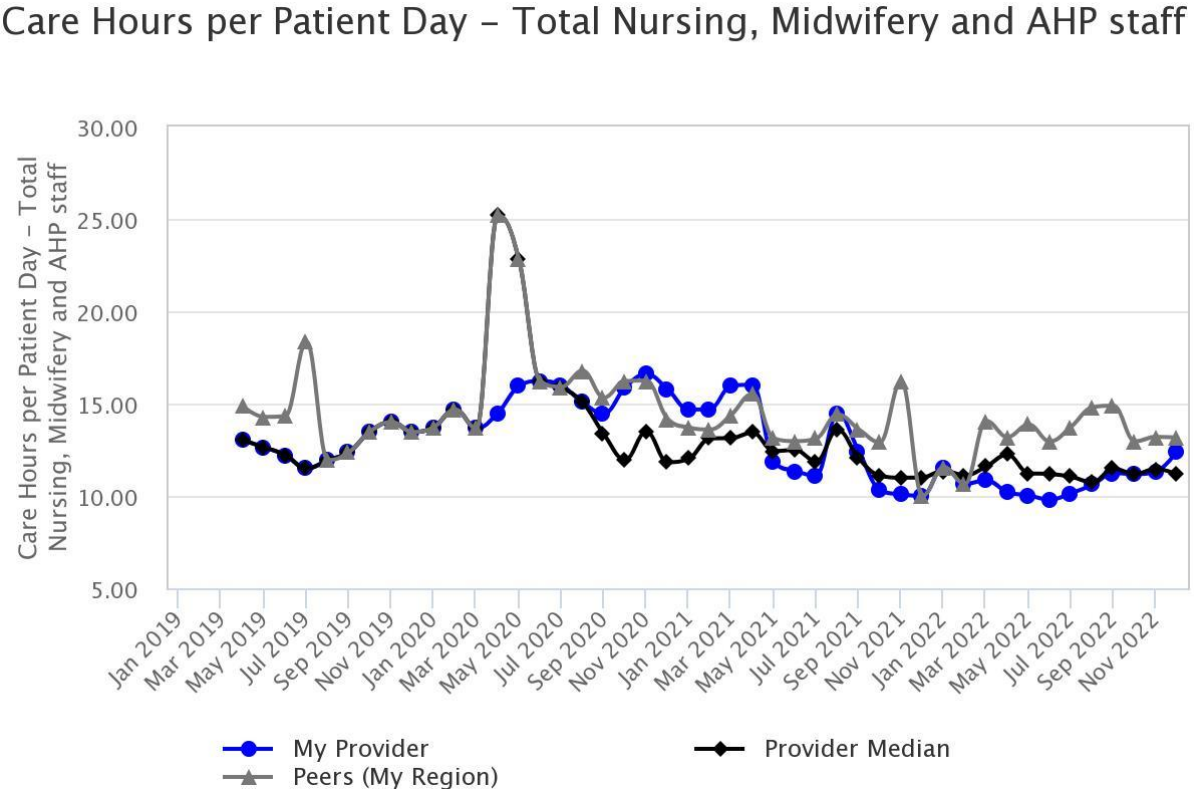
MHSOP - LATEST RESULTS DECEMBER 2022



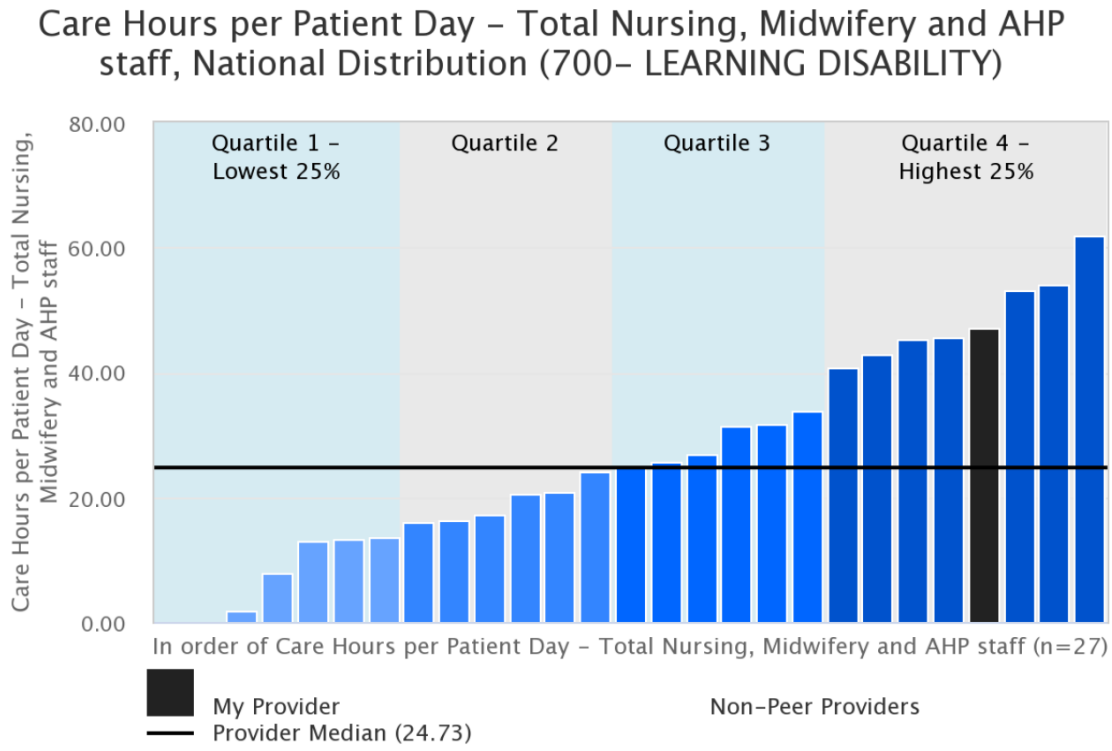


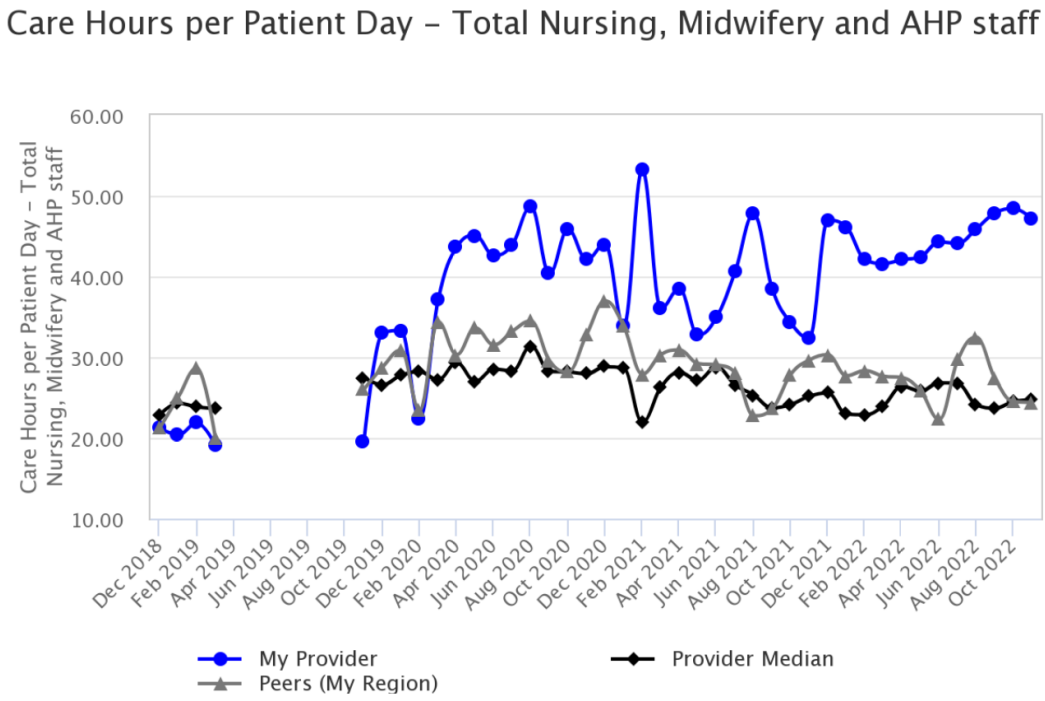
FORENSICS - LATEST RESULTS DECEMBER 2022



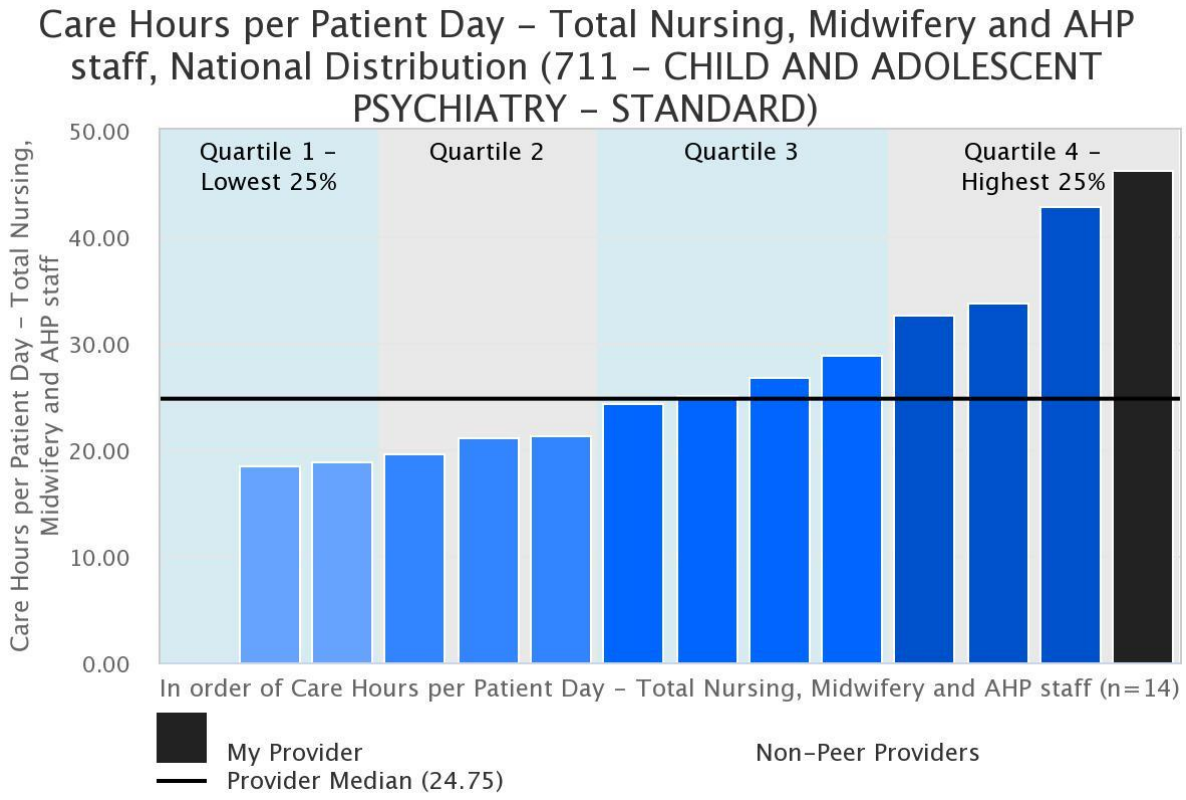


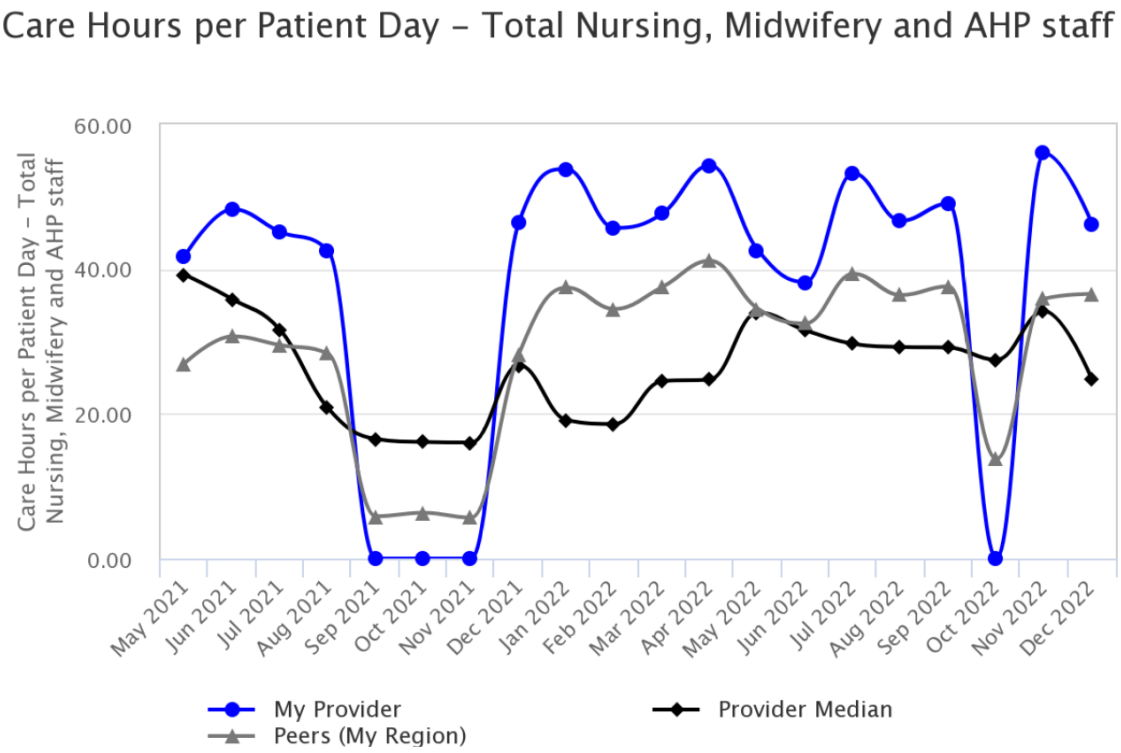
LEARNING DISABILITY - LATEST RESULTS DECEMBER 2022





CAMHS - LATEST RESULTS DECEMBER 2022





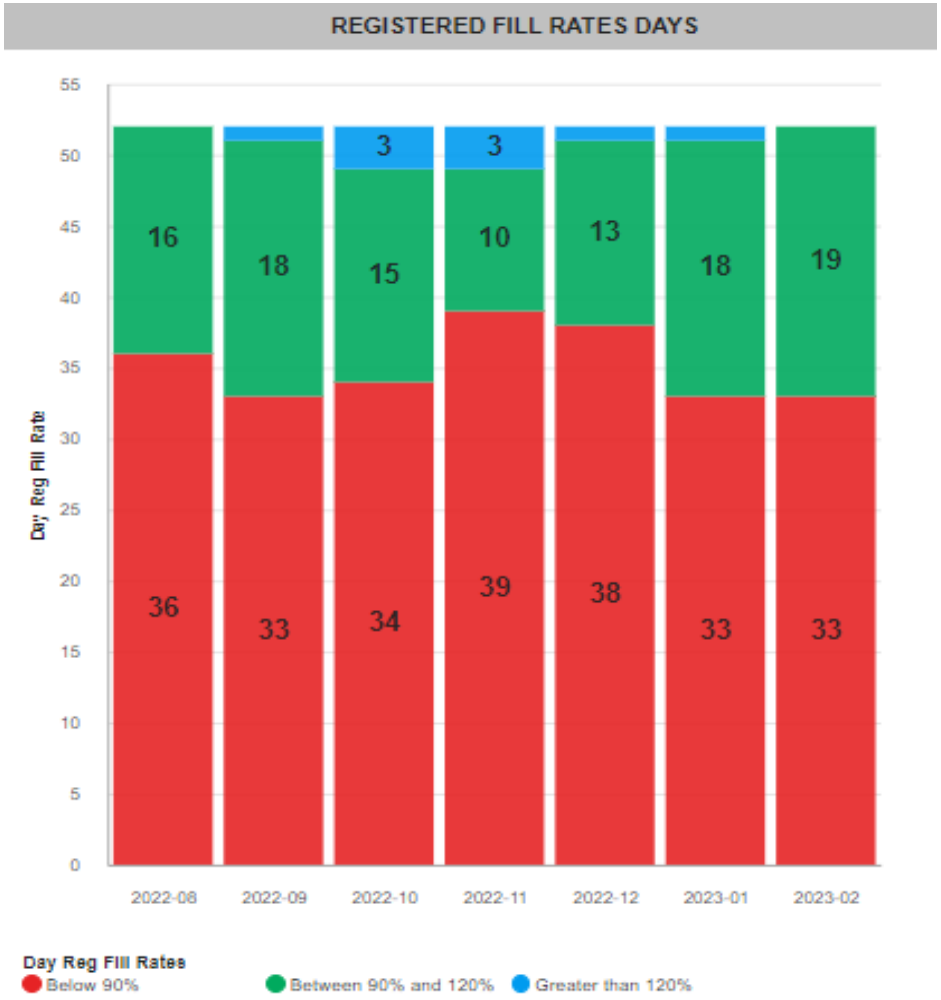
19. APPENDIX 13

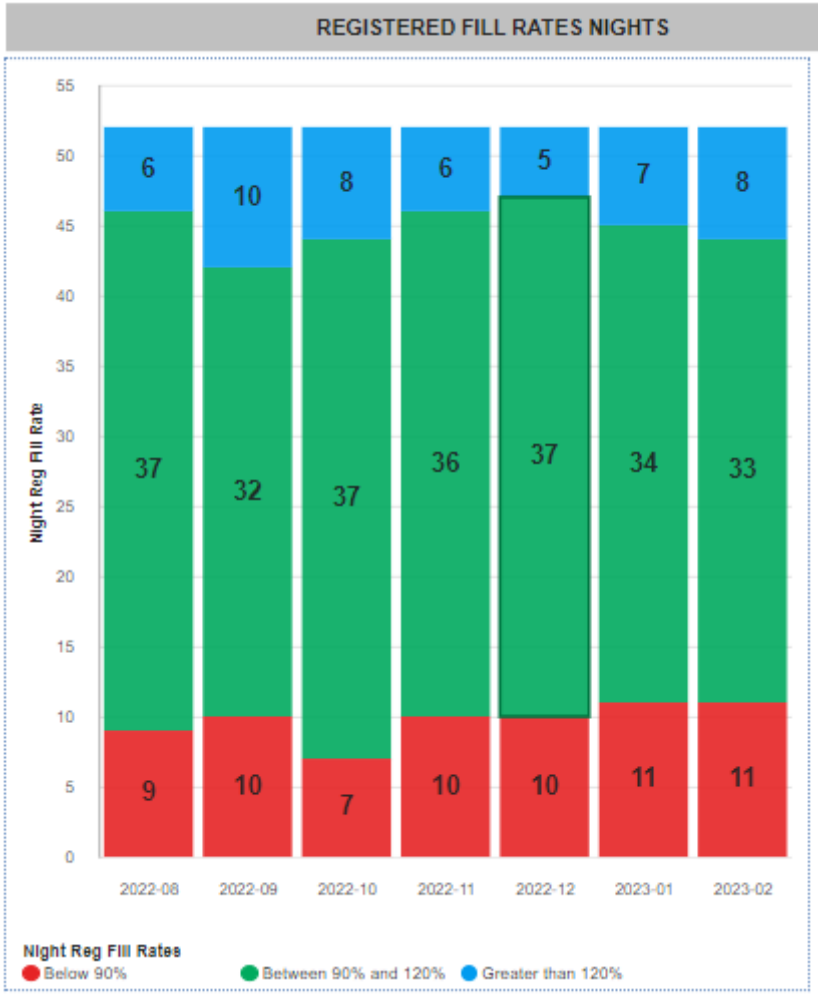
Fill rates are the measure of the planned (budgeted) staffing levels against the actual staff that worked on the ward - often referred to as “planned vs. actuals”. The Trust has target values that set a lower threshold of 90% and upper threshold of 120% to indicate variance from the planned staffing levels. A low fill rate would indicate an understaffing situation, and a high fill rate would indicate that an increased demand was placed upon the ward, such as increased levels of patient acuity and dependency and high incidence of enhanced observation and engagements.

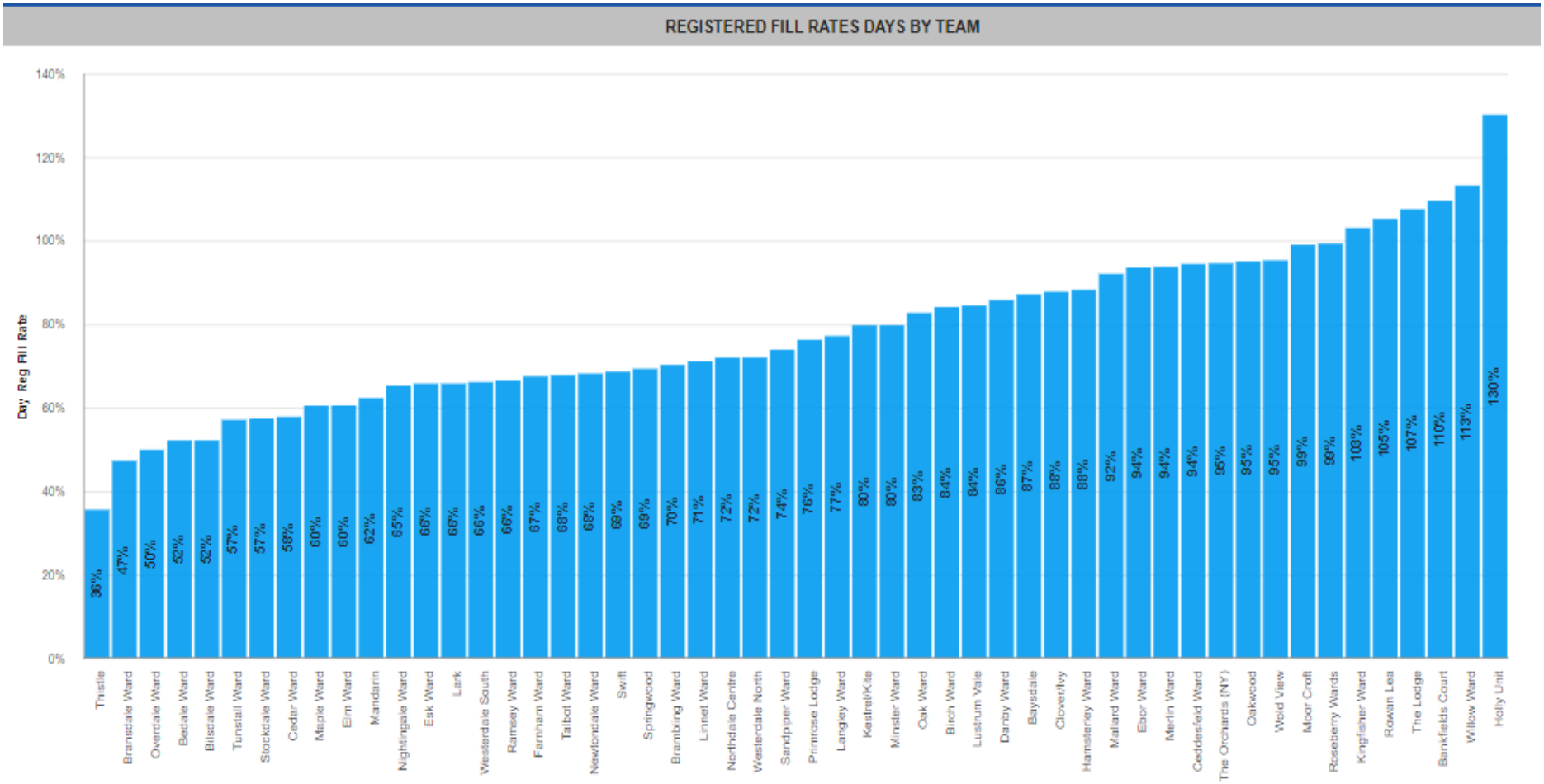
The graphs show by month the averages for the wards, whereas the graphs showing the teams by name are the fill rates averaged over the 6 month period 1st September 2022 to 28th February 2023. Registered and non-registered nursing staff across both day and night shifts are shown. It is noted that although Thistle ward is shown in these results, that it was closed for most this period.

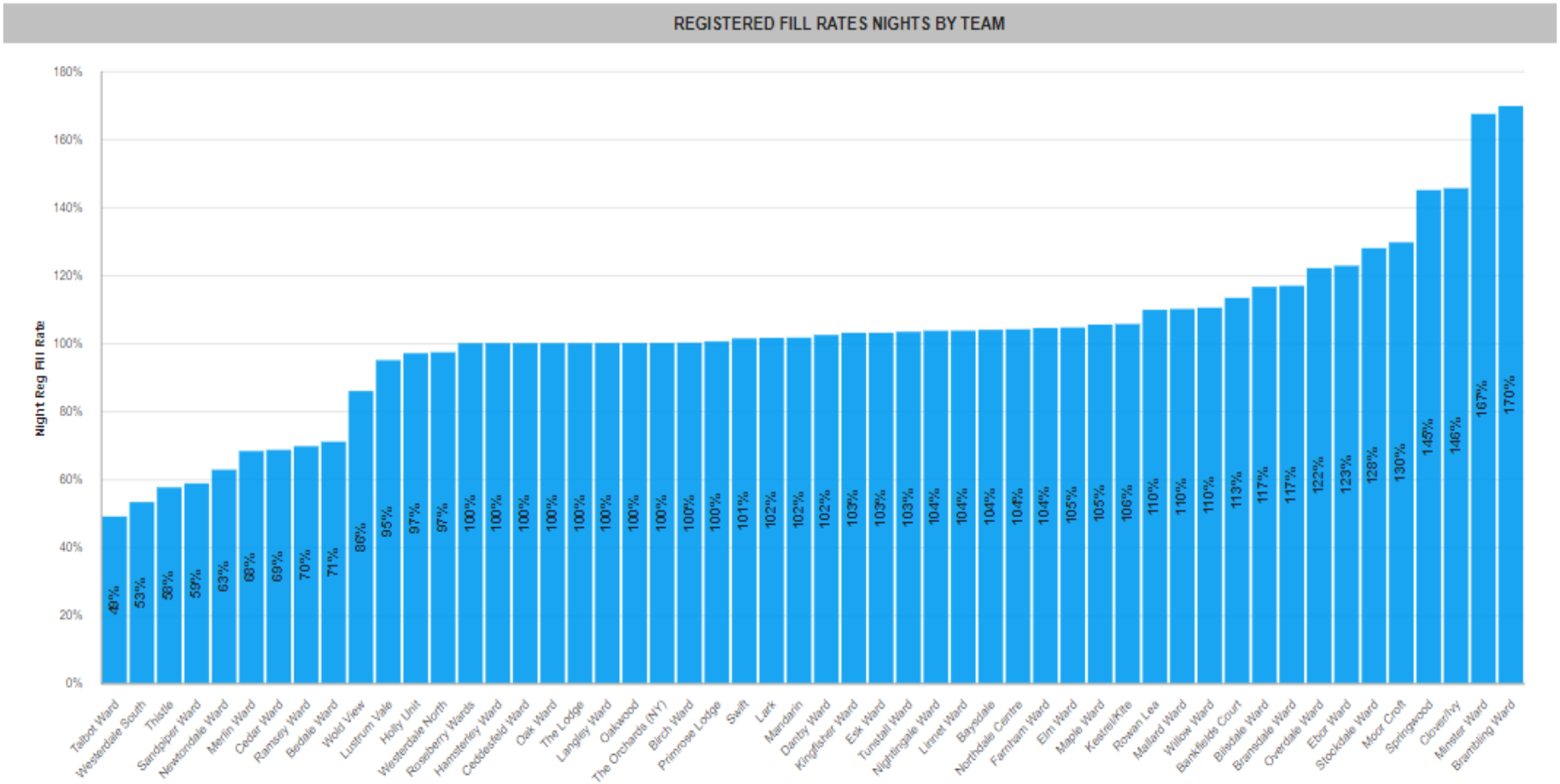
The charts shown on the following pages in this appendix shows RNs on day shift to be consistently low across the trust during this period with only 15 wards achieving an average above the 90% threshold during the reviewed period. The 2 PICUs also show to be consistently low on average for RN on nights during this same period. HCA fill rates showed a significant number of wards using beyond 120% of their establishment to support the shortfall in RNs and patient acuity.

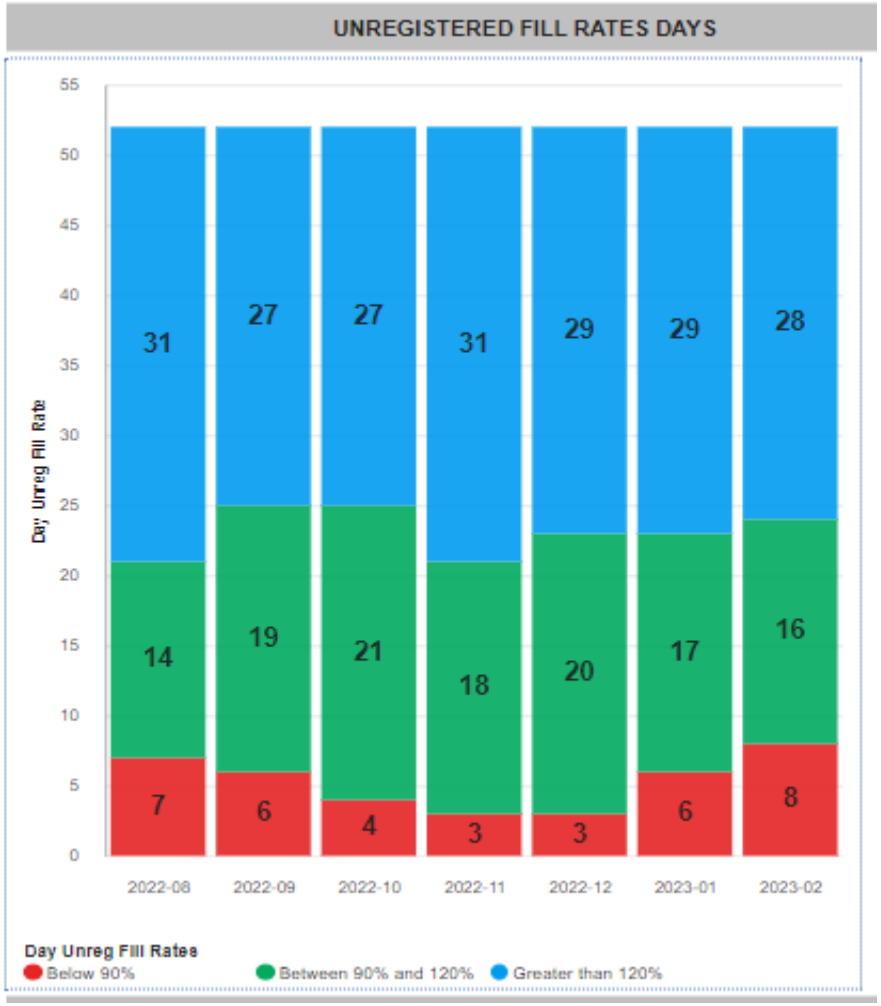
Whilst many wards show poor RN fill rates and significantly high HCA fill rates this is most notable for the PICUs and AMH admission wards.

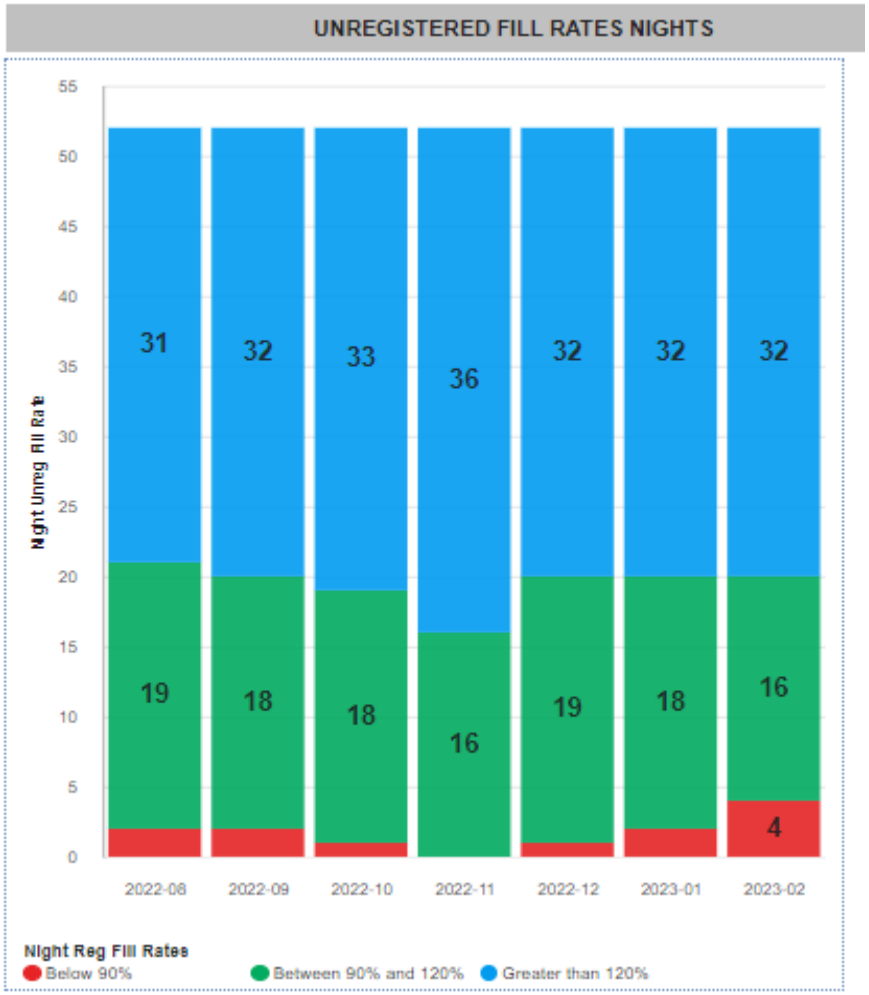

REGISTERED FILL RATES DAYS
Day Reg Fill Rate
55
50
45
40
35
30
25
20
15
10
5
0
16
18
3
15
3
10
13
18
19
36
33
34
39
38
33
33
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
Day Reg Fill Rates
Below 90%
Between 90% and 120%
Greater than 120%

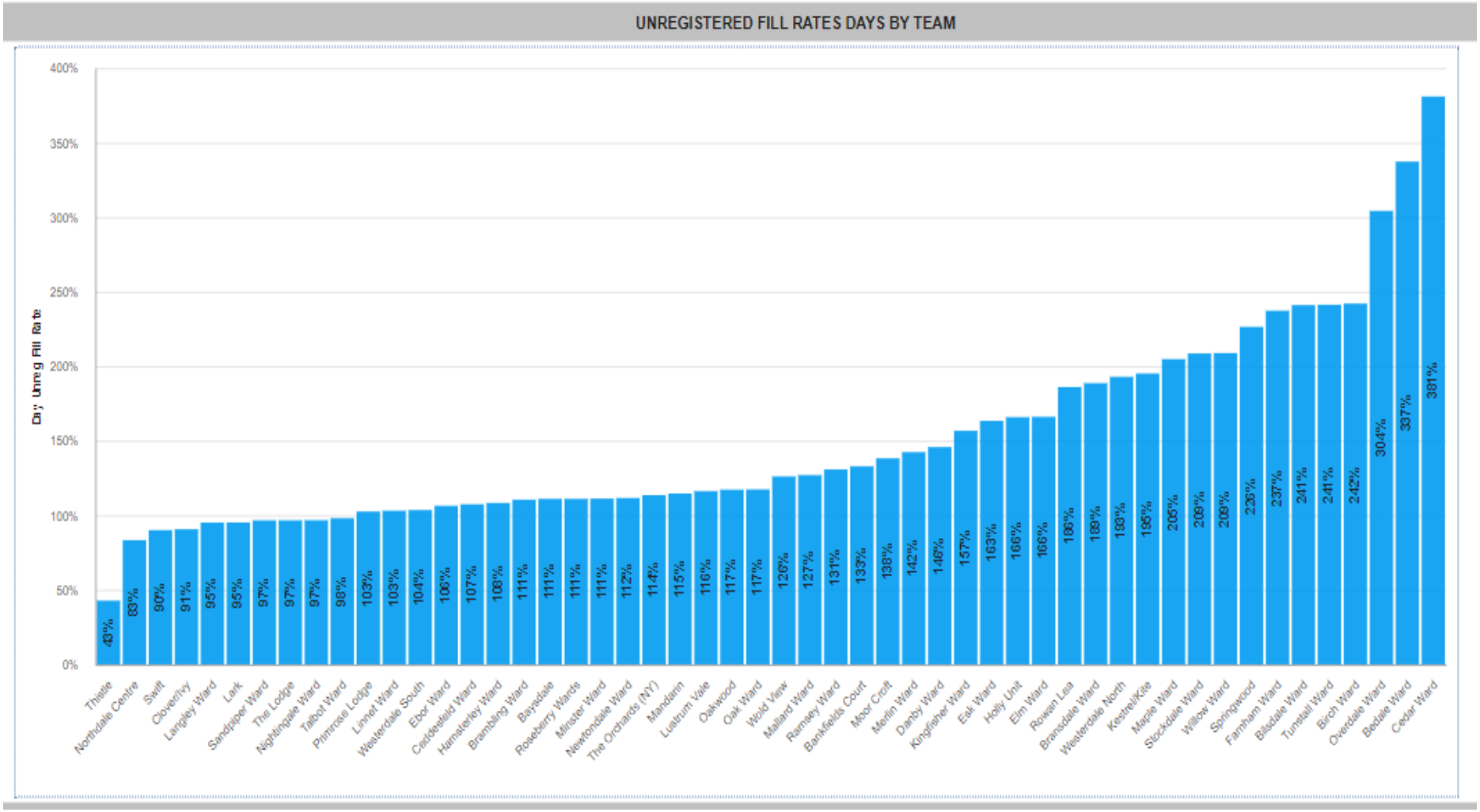

REGISTERED FILL RATES NIGHTS
Night Reg Fill Rate
55
50
45
40
35
30
25
20
15
10
5
0
6
10
8
6
5
7
8
37
32
37
36
37
34
33
9
10
7
10
10
11
11
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
Night Reg Fill Rates
Below 90%
Between 90% and 120%
Greater than 120%

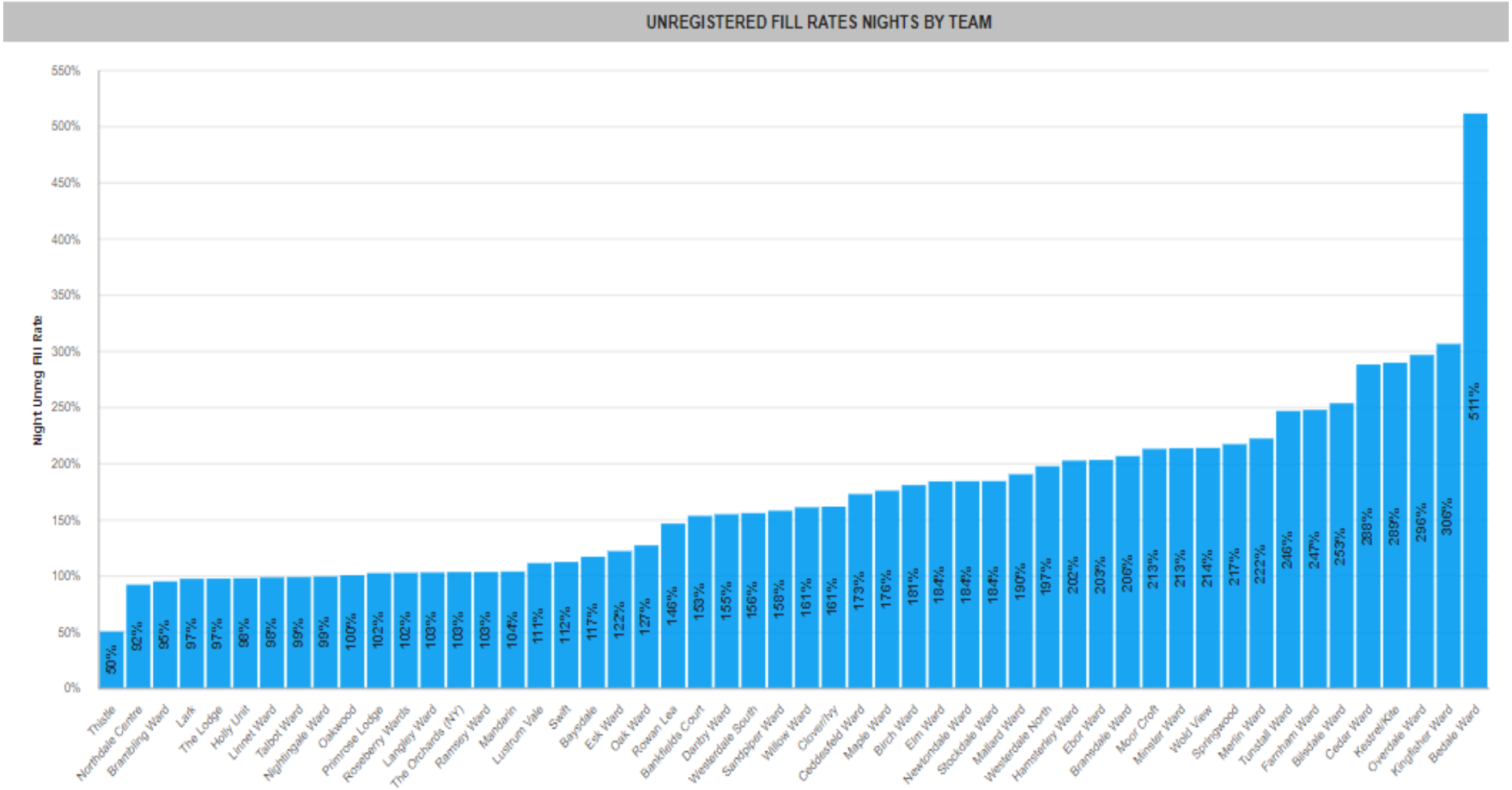

REGISTERED FILL RATES DAYS BY TEAM
Day Reg Fill Rate
140%
120%
100%
80%
60%
40%
20%
0%
36% Thistle
47% Brimstale Ward
50% Overdale Ward
52% Bedale Ward
52% Bilsdale Ward
57% Tunstall Ward
57% Stockdale Ward
58% Cedar Ward
60% Maple Ward
60% Elm Ward
62% Mandarin
65% Nightingale Ward
66% Esk Ward
66% Lark
66% Westerdale South
66% Ramsey Ward
67% Farnham Ward
68% Talbot Ward
68% Newtondale Ward
69% Swift
69% Springwood
70% Brambling Ward
71% Linnet Ward
72% Northdale Centre
72% Westerdale North
74% Sandpiper Ward
76% Primrose Lodge
77% Langley Ward
80% KestrelKite
80% Minster Ward
83% Oak Ward
84% Birch Ward
84% Lustrum Vale
86% Danby Ward
87% Bayside
88% CloverIvy
88% Hamsterley Ward
92% Mallard Ward
94% Ebor Ward
94% Merlin Ward
94% Ceddesfield Ward
95% The Orchards (NY)
95% Oakwood
95% Wold View
99% Moor Croft
99% Roseberry Wards
103% Kingfisher Ward
105% Rowan Lea
107% The Lodge
110% Bankfields Court
113% Willow Ward
130% Holly Unit


REGISTERED FILL RATES NIGHTS BY TEAM
Night Reg Fill Rate
180%
160%
140%
120%
100%
80%
60%
40%
20%
0%
49%
53%
58%
59%
63%
68%
69%
70%
71%
86%
95%
97%
97%
100%
100%
100%
100%
100%
100%
100%
100%
100%
100%
101%
102%
102%
102%
103%
103%
103%
104%
104%
104%
104%
104%
105%
105%
106%
110%
110%
110%
113%
117%
117%
122%
123%
128%
130%
145%
146%
167%
170%
Talbot Ward
Westerdale South
Thistle
Sandpiper Ward
Newtondale Ward
Merlin Ward
Cedar Ward
Ramsey Ward
Bedale Ward
Wold View
Lustrum Vale
Holly Unit
Westerdale North
Roseberry Wards
Hamsterley Ward
Caddesfield Ward
Oak Ward
The Lodge
Langley Ward
Oakwood
The Orchards (NY)
Birch Ward
Primrose Lodge
Swift
Lark
Mandarin
Danby Ward
Kingfisher Ward
Esk Ward
Tunstall Ward
Nightingale Ward
Linnet Ward
Bayadale
Northdale Centre
Farnham Ward
Elm Ward
Maple Ward
Kestrel/Kite
Rowan Lea
Mallard Ward
Willow Ward
Bankfields Court
Bilsdale Ward
Bransdale Ward
Overdale Ward
Ebor Ward
Stockdale Ward
Moor Croft
Springwood
Cloverlvy
Minster Ward
Brambling Ward


UNREGISTERED FILL RATES DAYS
Day Unreg Fill Rate
55
50
45
40
35
30
25
20
15
10
5
0
31
27
27
31
29
29
28
14
19
21
18
20
17
16
7
6
4
3
3
6
8
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
Day Unreg Fill Rates
Below 90%
Between 90% and 120%
Greater than 120%

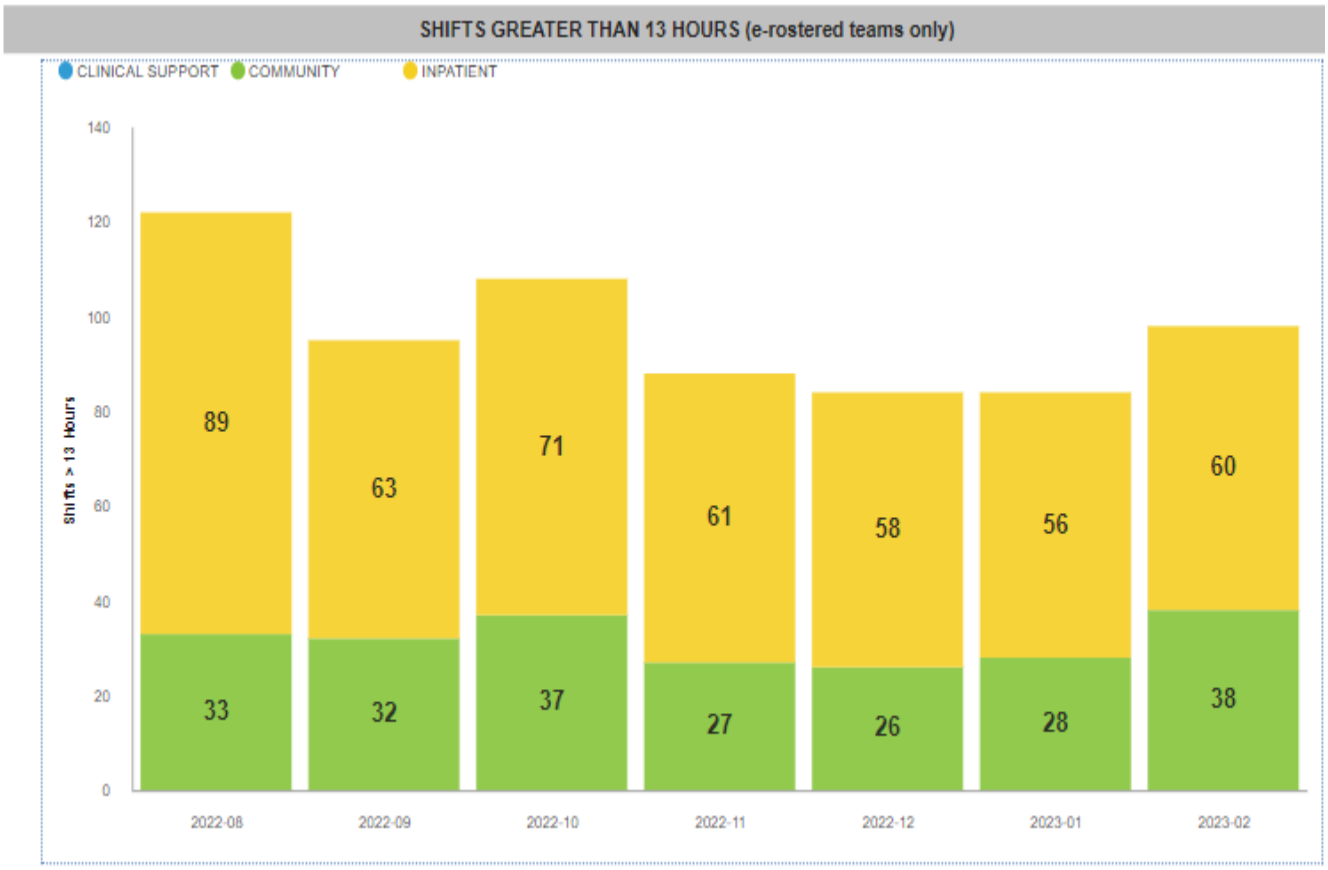

UNREGISTERED FILL RATES NIGHTS
Night Unreg Fill Rate
55
50
45
40
35
30
25
20
15
10
5
0
31
32
33
36
32
32
32
19
18
18
16
19
18
16
4
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02
Night Reg Fill Rates
Below 90%
Between 90% and 120%
Greater than 120%

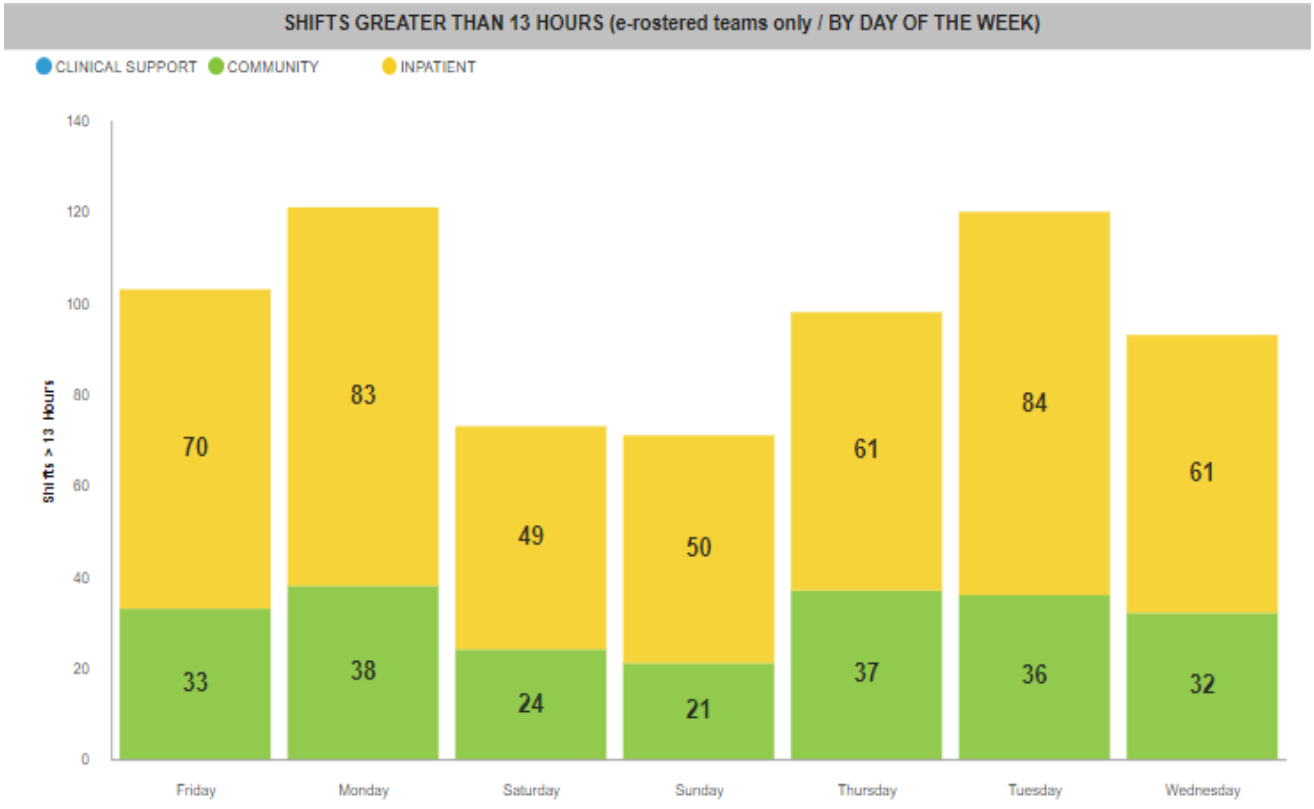

UNREGISTERED FILL RATES DAYS BY TEAM
Day Unreg Fill Rate
400%
350%
300%
250%
200%
150%
100%
50%
0%
43%
83%
90%
91%
95%
95%
97%
97%
97%
98%
103%
103%
104%
106%
107%
108%
111%
111%
111%
111%
112%
114%
115%
116%
117%
117%
126%
127%
131%
133%
138%
142%
146%
157%
163%
166%
166%
186%
189%
193%
195%
205%
209%
209%
226%
237%
241%
241%
242%
304%
337%
381%
Thistle
Northdale Centre
Swift
Cloverlivy
Langley Ward
Lark
Sandpiper Ward
The Lodge
Nightingale Ward
Talbot Ward
Primrose Lodge
Linnet Ward
Westerdale South
Ebor Ward
Caddesfield Ward
Hamaterley Ward
Brambling Ward
Baysdale
Roseberry Wards
Minster Ward
Newtondale Ward
The Orchards (NY)
Mandarin
Lustrum Vale
Oakwood
Oak Ward
Wold View
Mallard Ward
Ramsey Ward
Bankfields Court
Moor Croft
Merlin Ward
Danby Ward
Kingfisher Ward
Esk Ward
Holly Unit
Elm Ward
Rowan Lea
Bransdale Ward
Wealerdale North
Kestrel/Kite
Maple Ward
Stockdale Ward
Willow Ward
Springwood
Farnham Ward
Bilsdale Ward
Tunstall Ward
Birch Ward
Overdale Ward
Bedale Ward
Cedar Ward

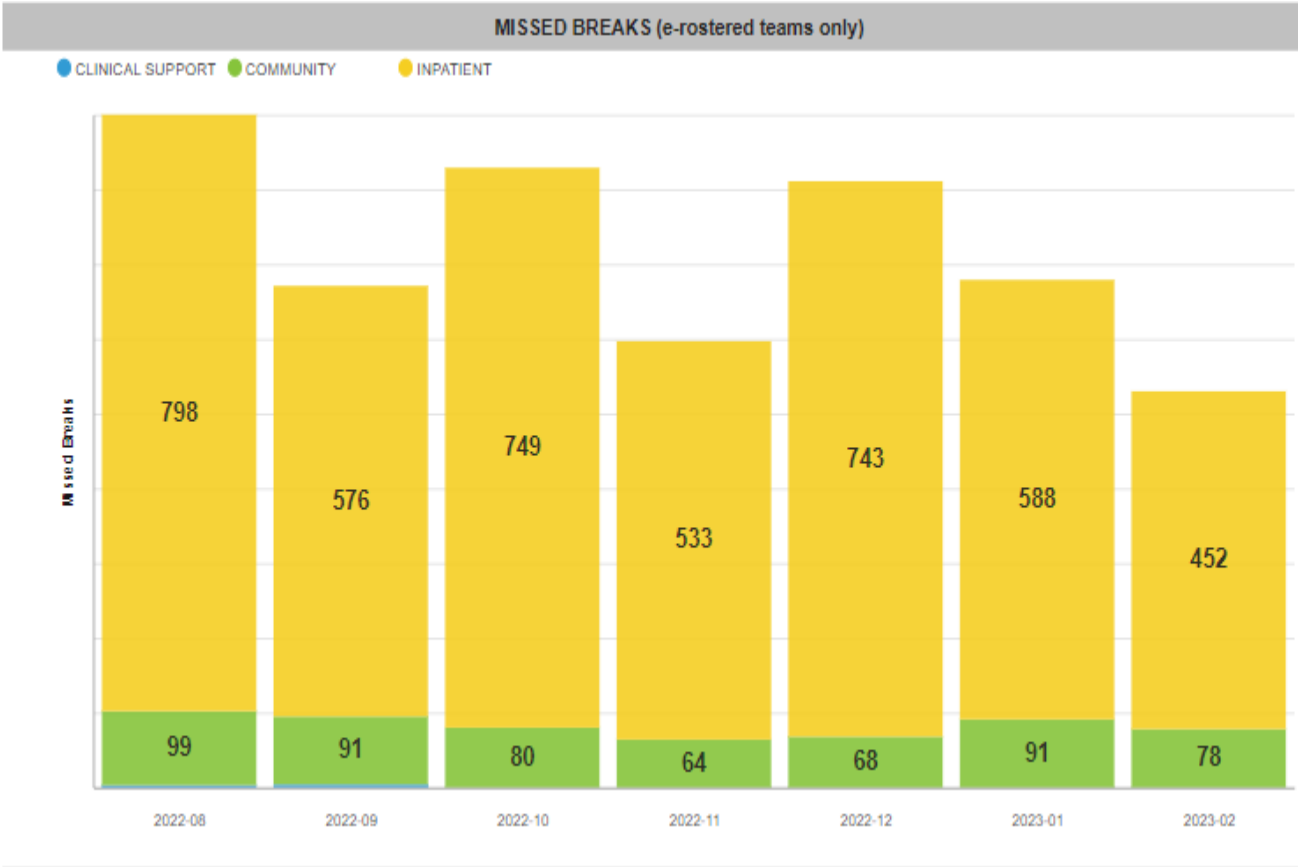


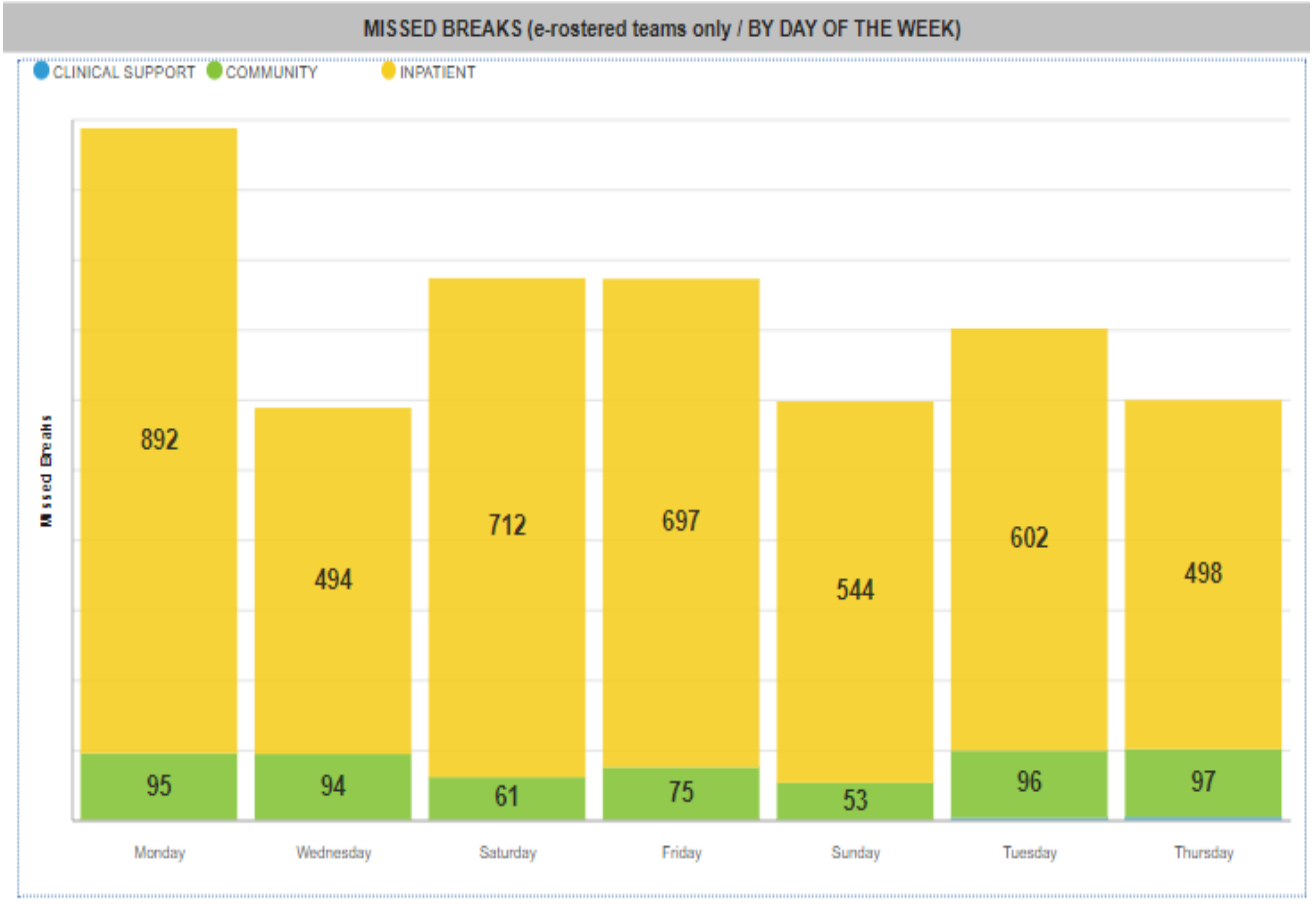
All fill rate figures above are averages over the period 1st Sept 2022 to 28th Feb 2023

20. APPENDIX 14



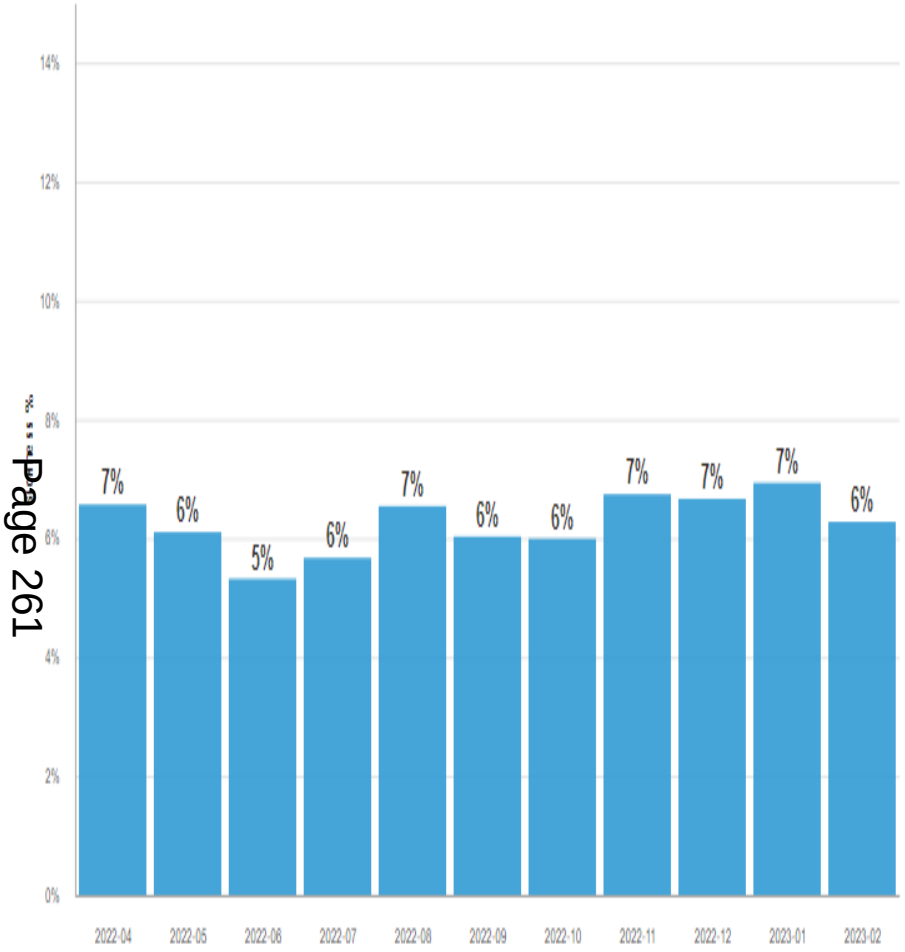



MISSED BREAKS (e-rostered teams only)
CLINICAL SUPPORT
COMMUNITY
INPATIENT
Missed Breaks
798
576
749
533
743
588
452
99
91
80
64
68
91
78
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02


MISSED BREAKS (e-rostered teams only / BY DAY OF THE WEEK)
CLINICAL SUPPORT
COMMUNITY
INPATIENT
Missed Breaks
892
494
712
697
544
602
498
95
94
61
75
53
96
97
Monday
Wednesday
Saturday
Friday
Sunday
Tuesday
Thursday

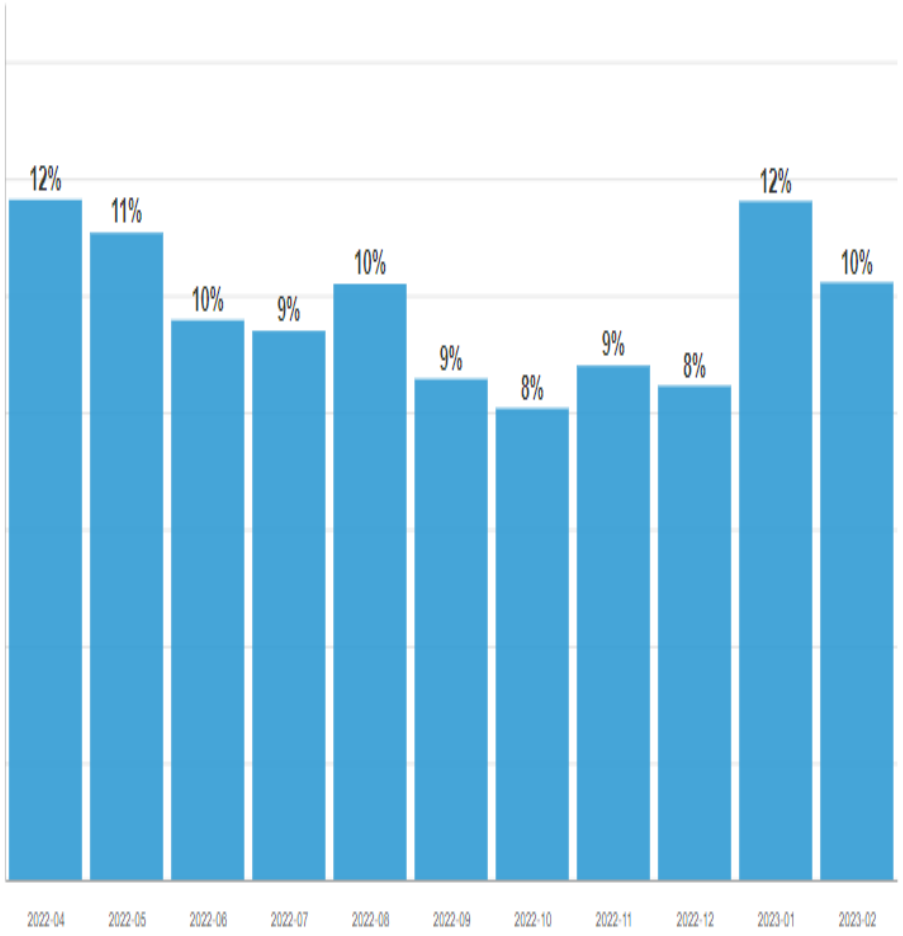
21. APPENDIX 15

Trust View



Trust Sickness Absence 2022 -2023 – (Data Source IIC – month behind)

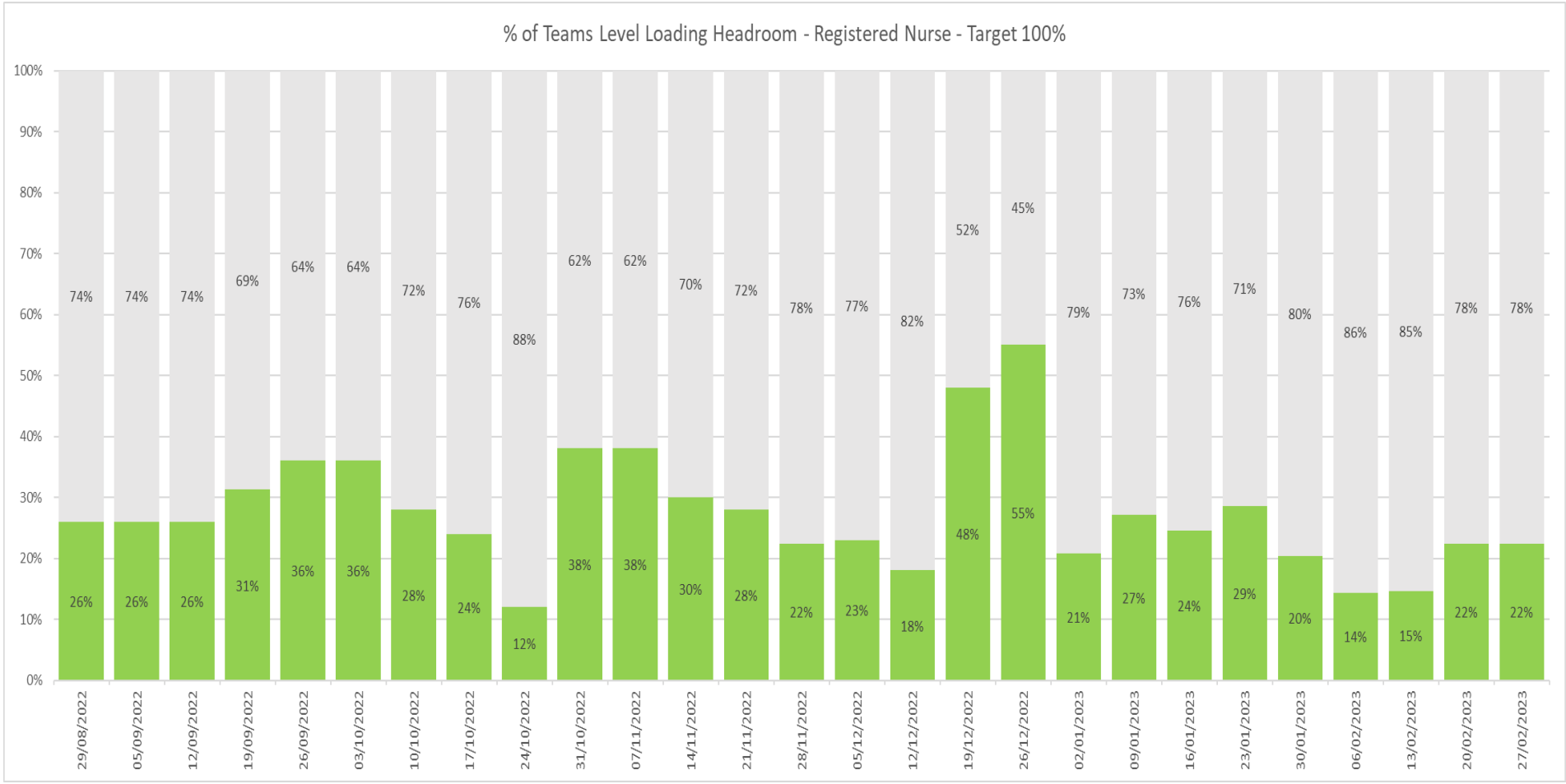
Inpatient Teams



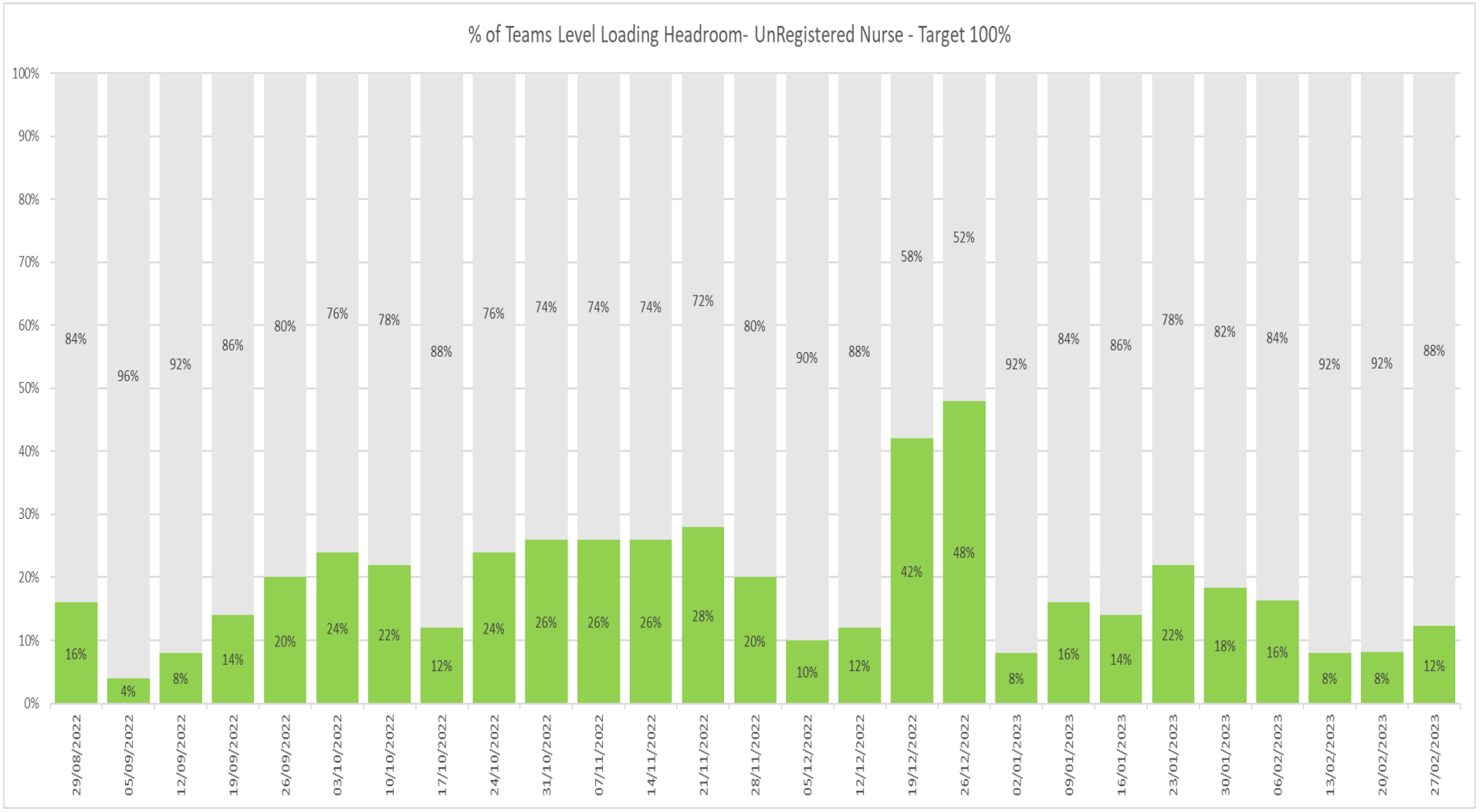
Inpatient Sickness Absence 2022 -2023 – (Data Source IIC – month behind)

22. APPENDIX 16

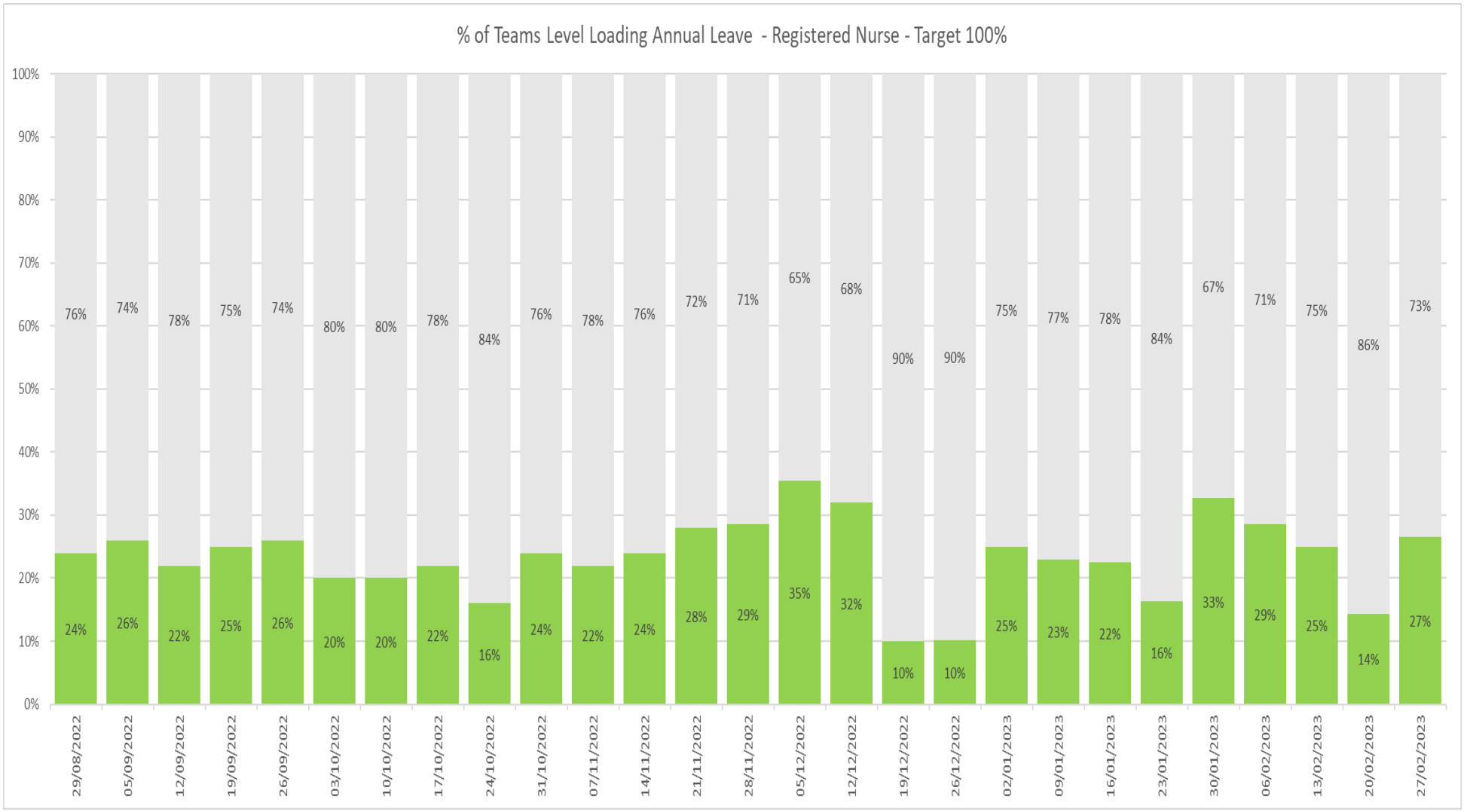
Inefficient and ineffective rostering, such as poor management of unavailability's and deployment of staff, will have a negative impact upon the ability to correctly staff the team according to its needs and so require the use of flexible staffing options such as bank, agency, and overtime to support this self-made shortfall.



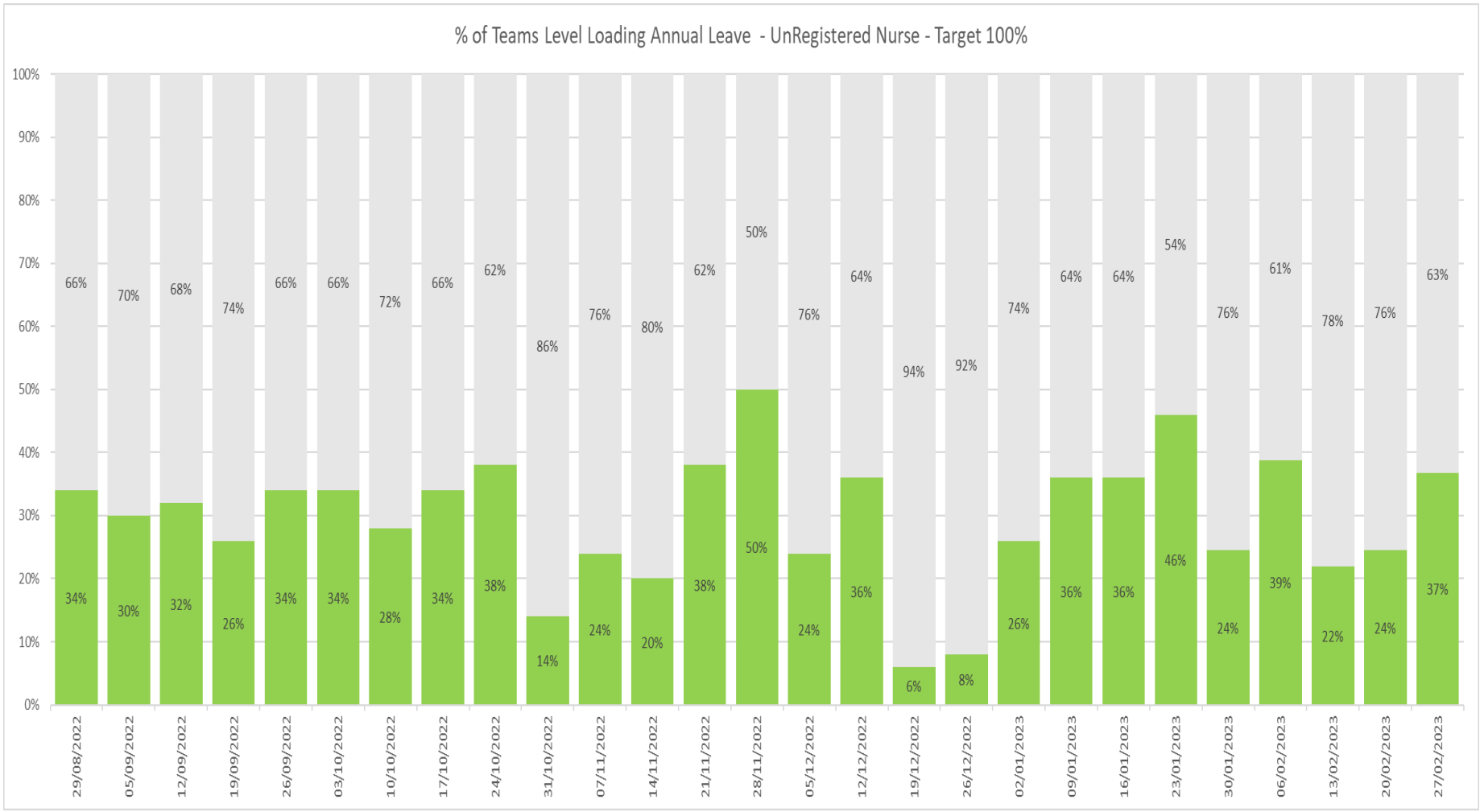
% of rostered teams within headroom threshold of 27.7% (for RNs)



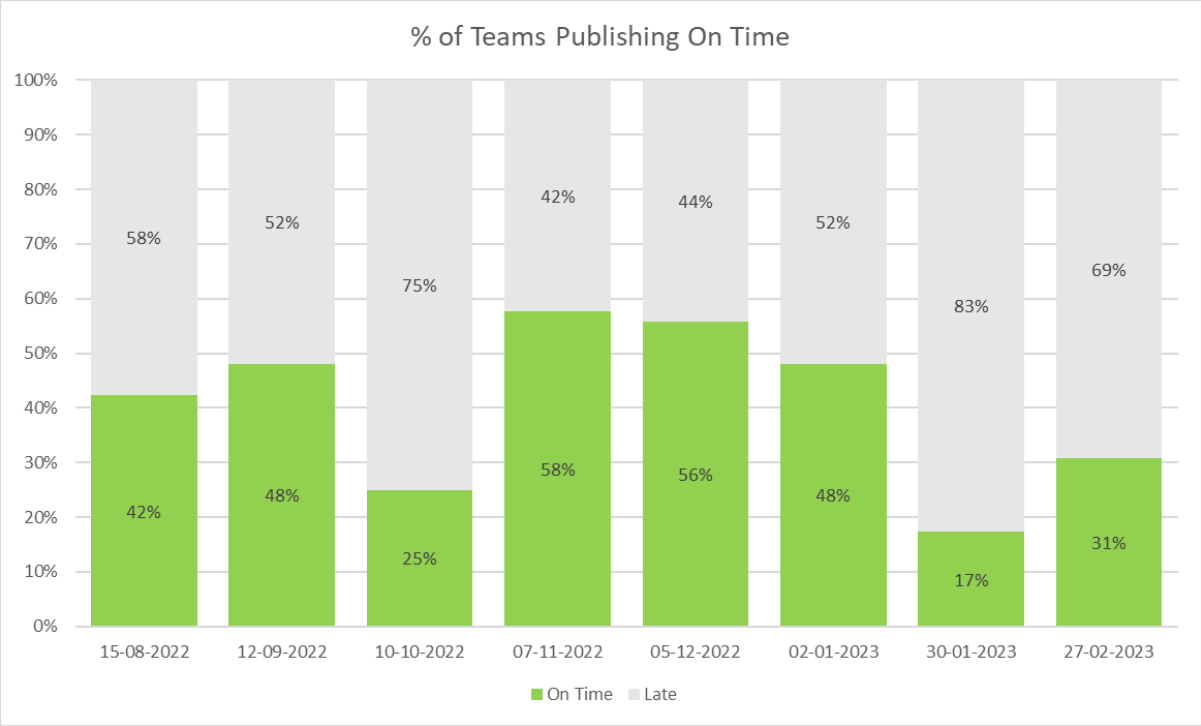
% of rostered teams within headroom threshold of 27.7% (for HCAs)



% for rostered teams achieving level loading of annual leave of 11% to 17% (of RNs)



% for rostered teams achieving level loading of annual leave of 11% to 17% (of HCAs)



% of rostered teams publishing on time for e-roster

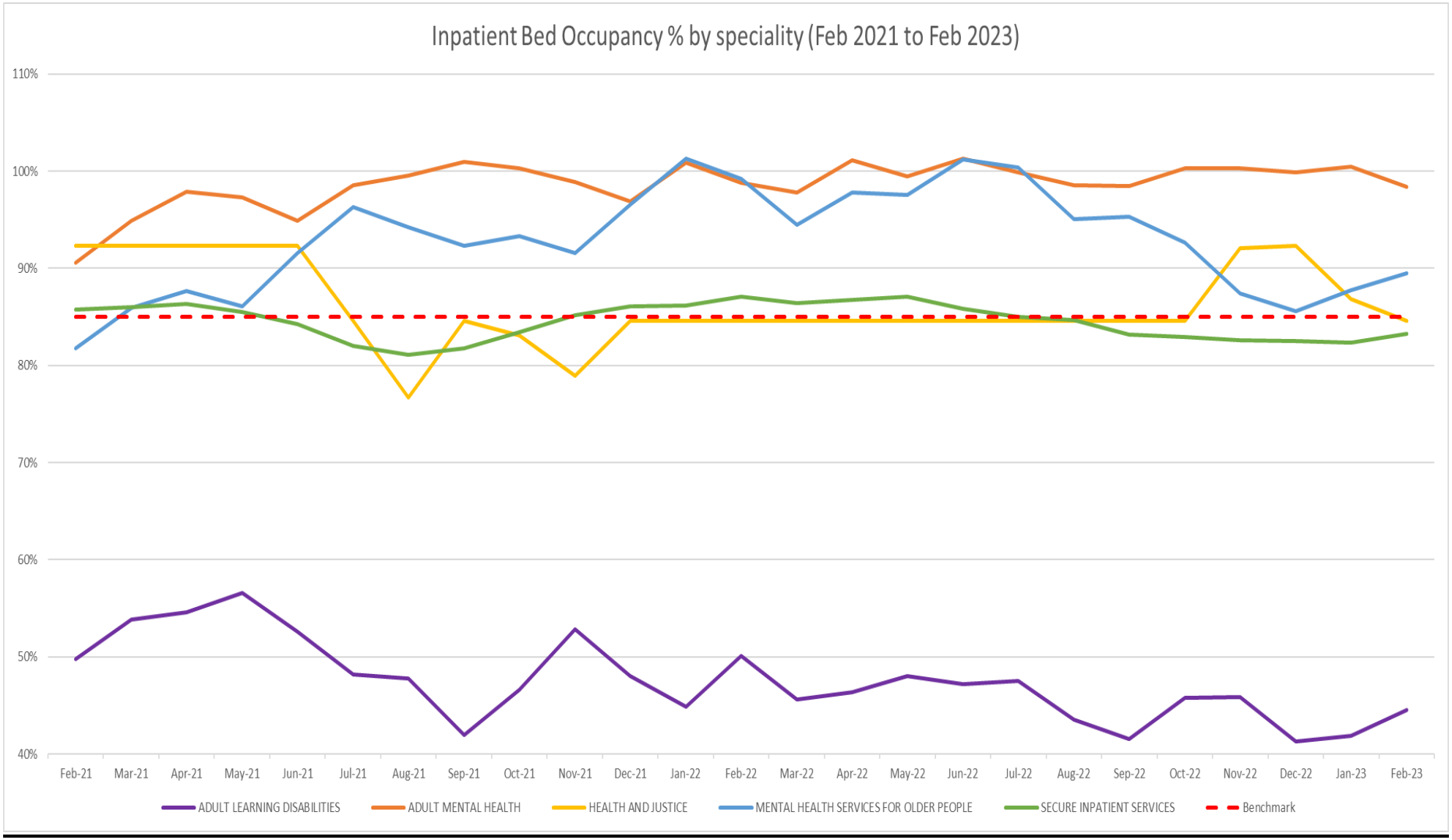
23. APPENDIX 17

NB – negative numbers indicate a vacancy, positive numbers indicate an over-establishment

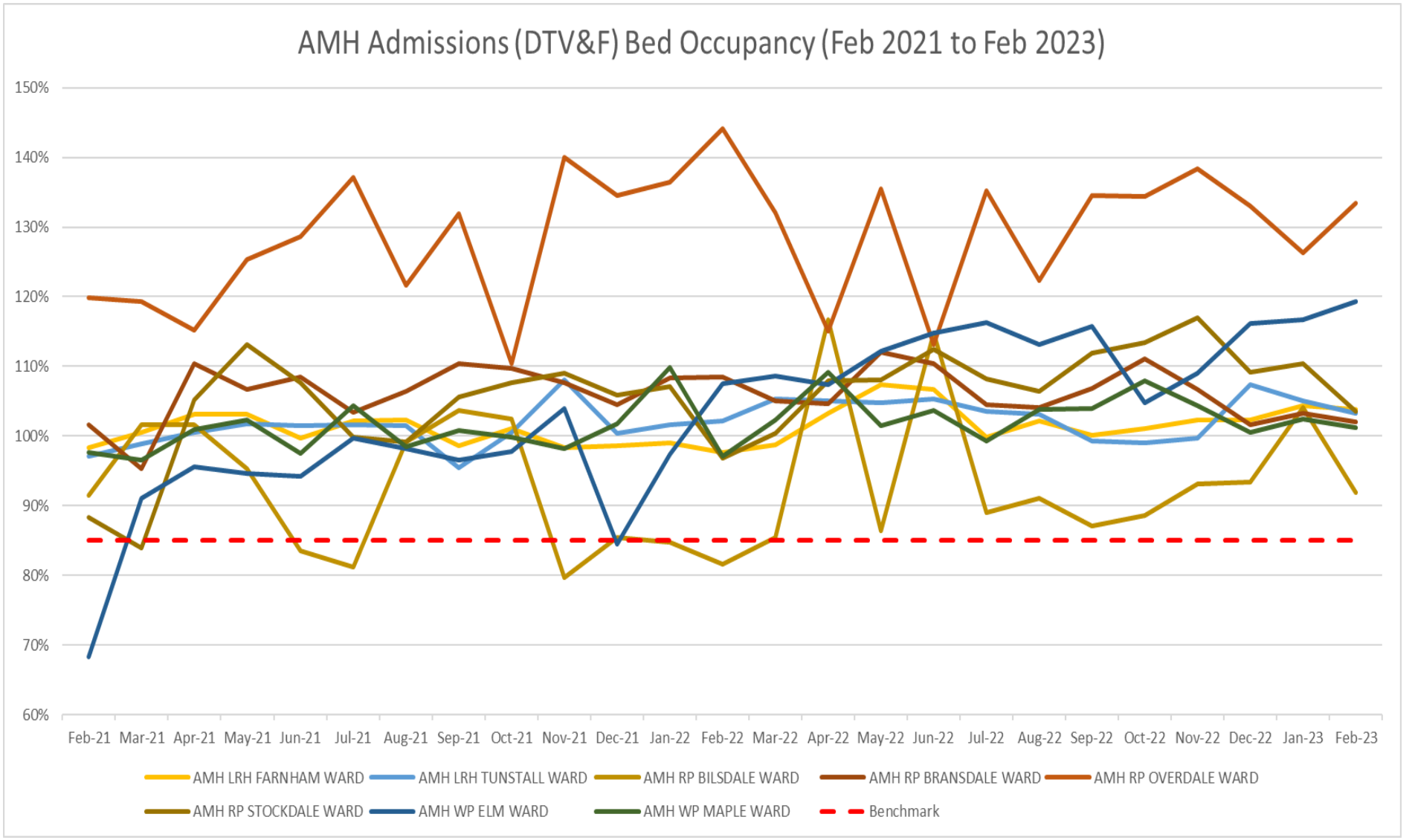
February 2023 - Contracted minus Budgeted WTEs	Staff Group								
Service and Setting	ADMINISTRATIVE AND CLERICAL	CONSULTANTS	QUALIFIED ALLIED HEALTH PROFESSIONALS	QUALIFIED NURSES / NURSE MANAGERS	QUALIFIED SCIENTIFIC THERAPEUTIC AND TECHNICAL	SUPPORT TO ALLIED HEALTH PROFESSIONALS	SUPPORT TO SCIENTIFIC THERAPEUTIC AND TECHNICAL	UNQUALIFIED NURSES	Grand Total
ADULT LEARNING DISABILITIES	**-1.08**	**-4**	**-12.48**	**-39.98**	**-4.39**	**1.01**	**-4.67**	**-23.01**	**-88.6**
CLINICAL SUPPORT	-3.21	-1.9	-2.4	-4	-0.97	1	-4	-6	-21.48
COMMUNITY	-3.97		-5.86	-9.29	-4.22	1.87	0.33	-7.95	-29.09
INPATIENT	-2.2		-3.8	-24.01	0.3	-1.86	-1	-9.06	-41.63
MANAGEMENT	8.3	-2.1	-0.42	-2.68	0.5			0	3.6
ADULT MENTAL HEALTH	**-8.83**	**-19.6**	**30.87**	**-218.23**	**89.76**	**-22.21**	**5.03**	**52.85**	**-90.36**
CLINICAL SUPPORT	-1.68	-11.21	-6.19	3	2	-1.65	2	0	-13.73
COMMUNITY	8.52	-3.49	28.75	-114.58	90.98	-2.89	0	22.36	29.65
INPATIENT	-11.91	-3.3	8.6	-89.64	-4.55	-16.67	2.5	28.89	-86.08
MANAGEMENT	-3.76	-1.6	-0.29	-17.01	1.33	-1	0.53	1.6	-20.2
CHILDREN AND YOUNG PEOPLES SERVICES	**34.22**	**-12.57**	**13.86**	**-31.73**	**15.58**	**0**	**20.42**	**38.86**	**78.64**
CLINICAL SUPPORT		-2.87							-2.87
COMMUNITY	33.31	-9.3	13.86	-39.26	13.39	0	16.42	32.58	61
INPATIENT	-1.59	0	0	0.66	0	0	0	-0.72	-1.65
MANAGEMENT	2.5	-0.4	0	6.87	2.19		4	7	22.16
HEALTH AND JUSTICE	**5.22**	**-4.57**	**-1.6**	**-26.65**	**-5.79**	**1.91**	**-2**	**-5.51**	**-38.99**
COMMUNITY	1.33	-0.9	0.5	-5.95	0.4	-0.09	-1	-0.15	-5.86
COMMUNITY	-0.5				-4				-4.5
INPATIENT	0			0.8	0	2		-2.56	0.24
MANAGEMENT	4.93	-2.5	-1.5	1	-0.1				1.83
PRISONS	-0.54	-1.17	-0.6	-22.5	-2.09	0	-1	-2.8	-30.7
MENTAL HEALTH SERVICES FOR OLDER PEOPLE	**2.5**	**-15.1**	**11.91**	**-37.49**	**10.28**	**7.14**	**7.4**	**35.37**	**22.01**
CLINICAL SUPPORT	-1.37	-13.8	0	0.8	4.21		0	0	-10.16
COMMUNITY	3.47	-1	7.84	-15.06	8.62	3.21	1.4	10.41	18.89
INPATIENT	1.92		0.72	-18.54	0.03	4.43	6	20.76	15.32
MANAGEMENT	-1.52	-0.3	3.35	-4.69	-2.58	-0.5		4.2	-2.04
SECURE INPATIENT SERVICES	**-17.37**	**-7.07**	**-12.32**	**-49.93**	**-4.94**	**-4.04**	**0**	**-54.55**	**-150.22**
CLINICAL SUPPORT	0	-6.87	-9.32	0	-5.94	-4.04	0	-6.38	-32.55
COMMUNITY	0			0.48				1	1.48
INPATIENT	-17.37		-3	-47.41	0	0		-49.17	-116.95
MANAGEMENT	0	-0.2	0	-3	1			0	-2.2
Grand Total	**14.66**	**-62.91**	**30.24**	**-404.01**	**100.5**	**-16.19**	**26.18**	**44.01**	**-267.52**

Vacancy rate for clinical teams by setting at February 2023 – (source finance payfile)

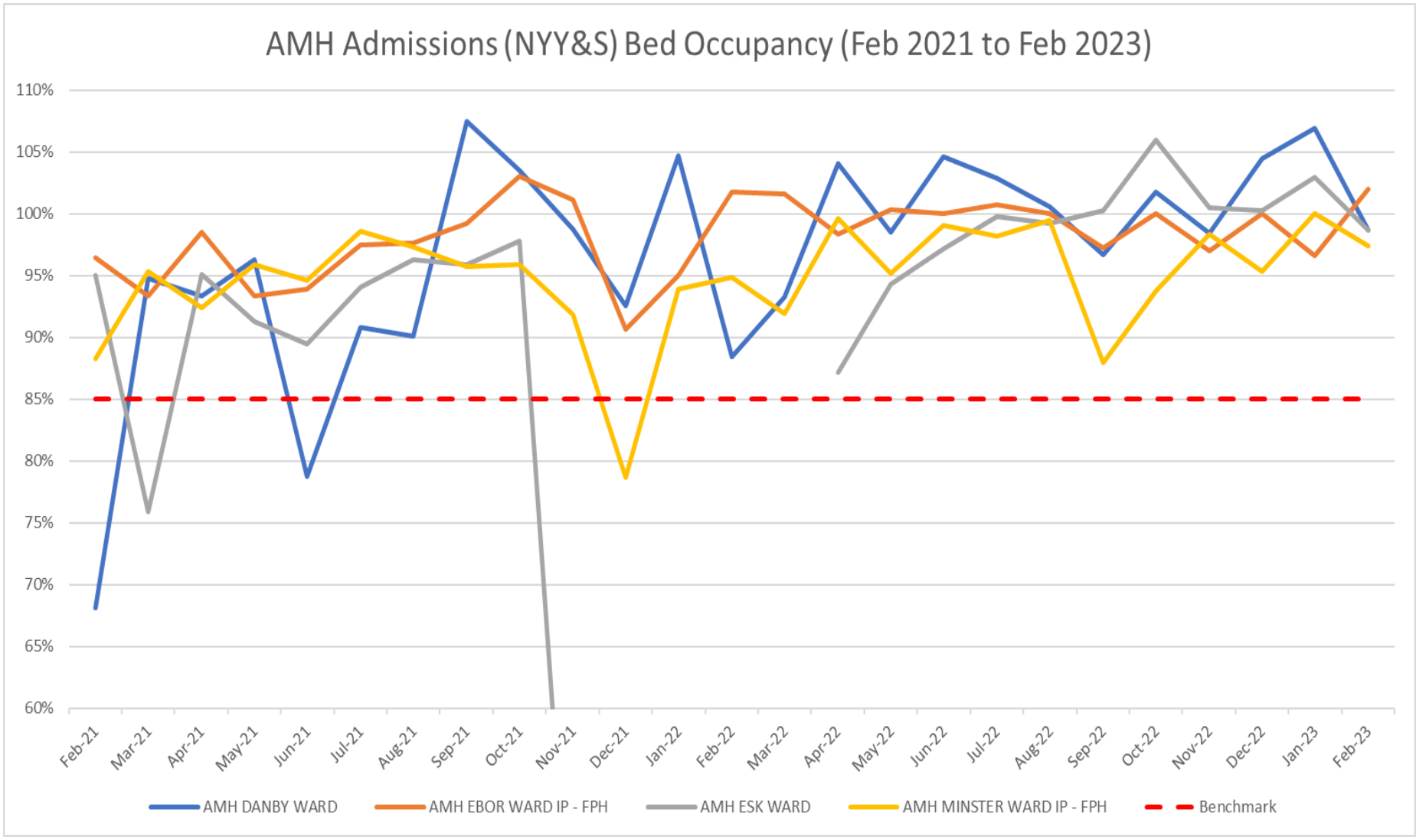
24. APPENDIX 18



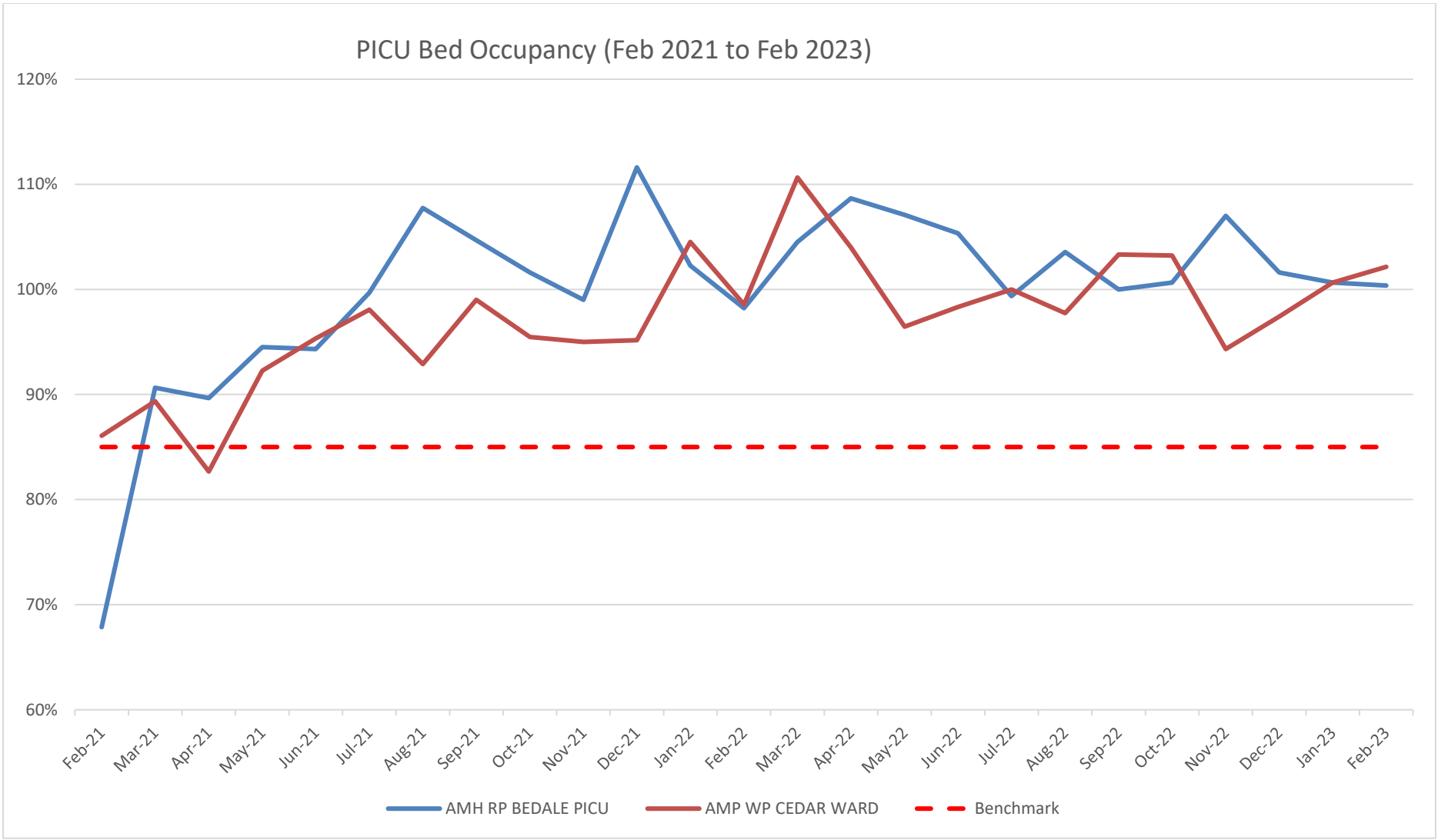
Bed Occupancy % by speciality (including Leave Feb 21 – Feb 23



Bed Occupancy % AMH Admissions DTV&F (including Leave Feb 21 – Feb 23



Bed Occupancy % Admissions NYY&S (including Leave Feb 21 – Feb 23



Bed Occupancy % PICU (including Leave Feb 21 – Feb 23

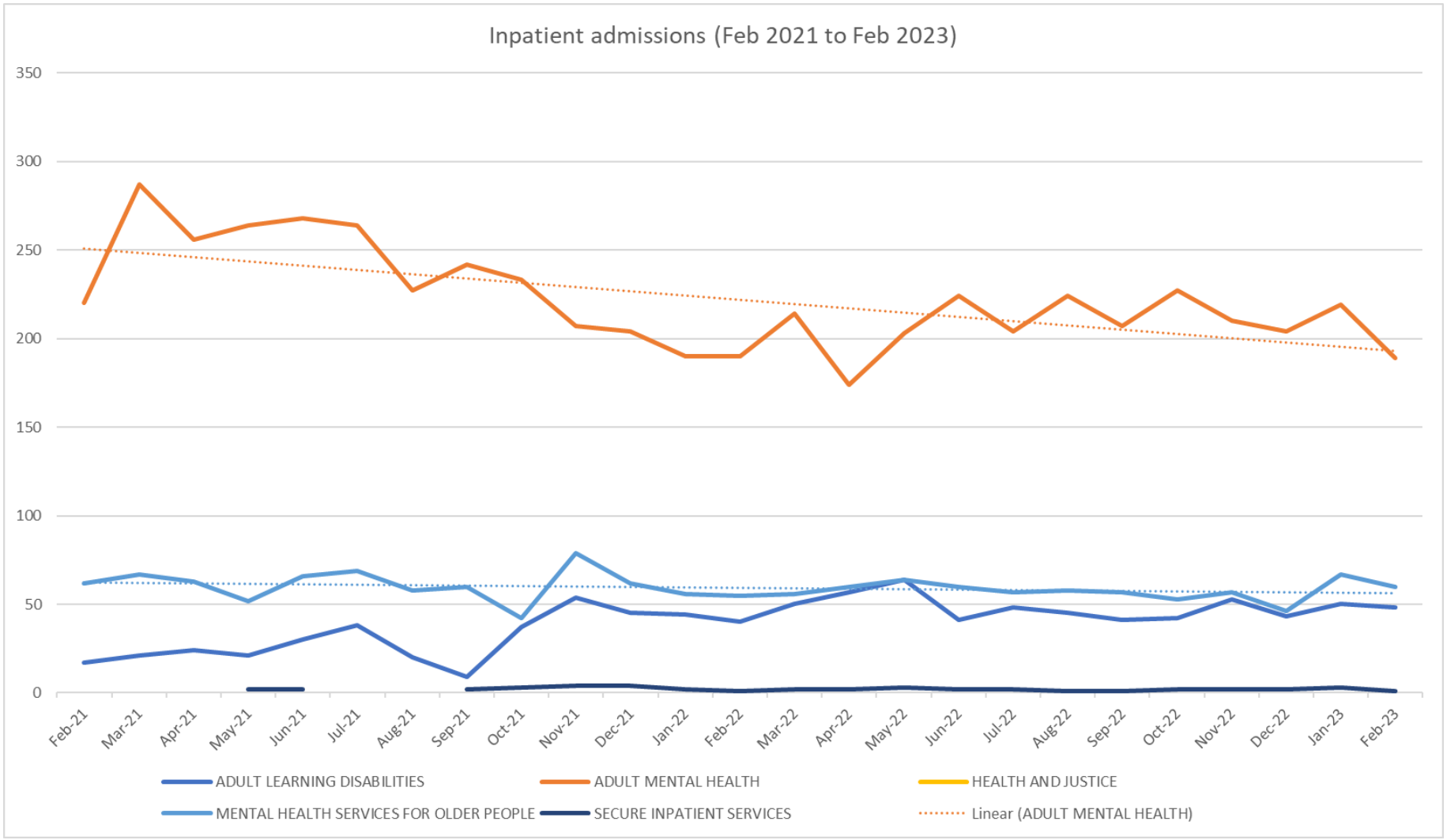
25. APPENDIX 18a

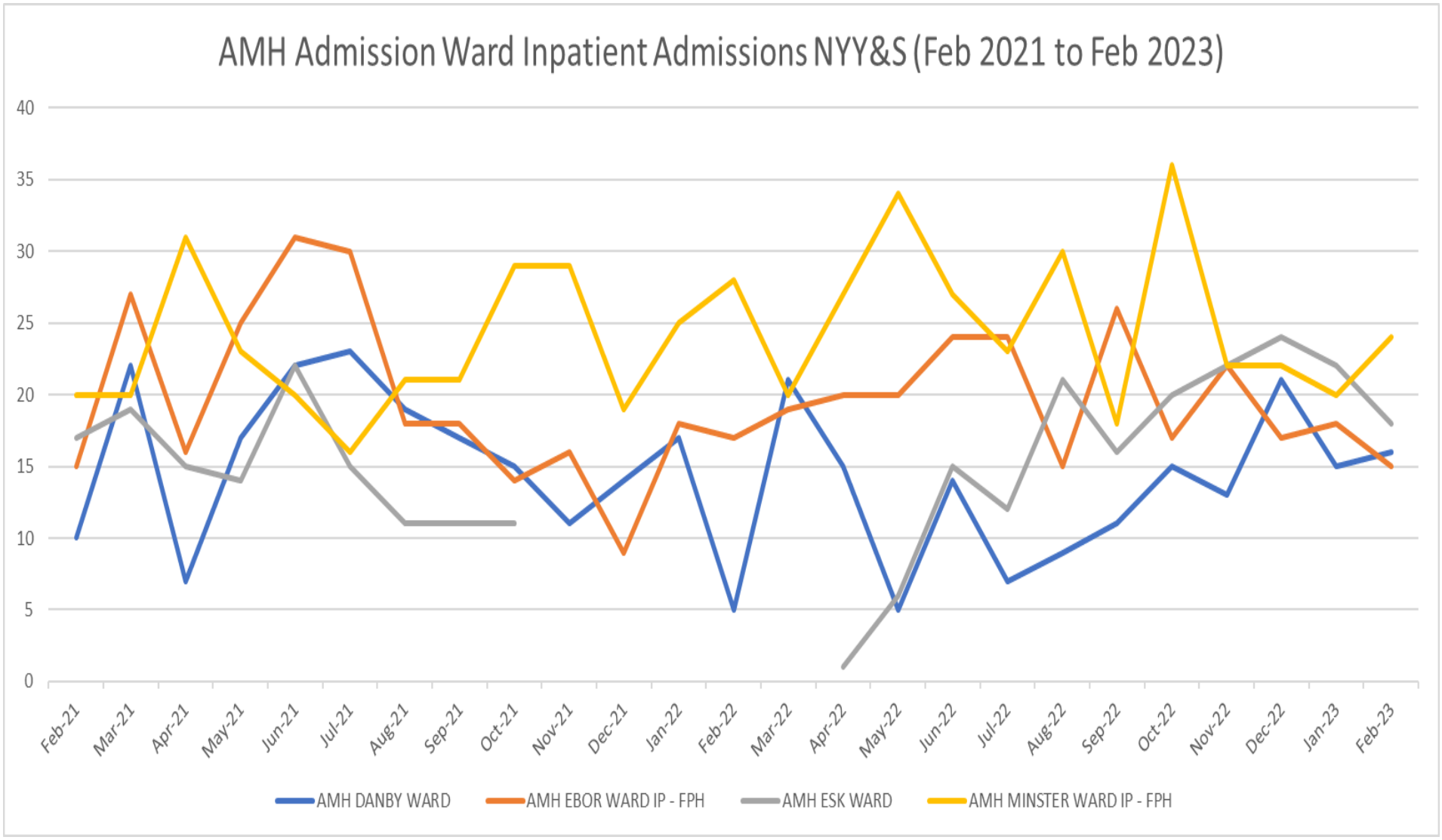
The number of admissions and discharges on adult mental health wards are significantly higher than on other ward specialities (shown in appendix 18a). There is an additional workload required to provide the initial assessment and treatment of newly admitted patients. It is noted that it is often the case that new admissions have the potential for increased acuity pending treatment where the expectation is that this acuity will reduce as treatment and discharge planning is implemented with the patient. The number of discharges will correlate with the number of admissions, where the discharge processes also see an increased level of patient-based activity to ensure a safe and timely discharge from the ward. Both essential processes require additional staff hours to fully support patient safety at these critical points.

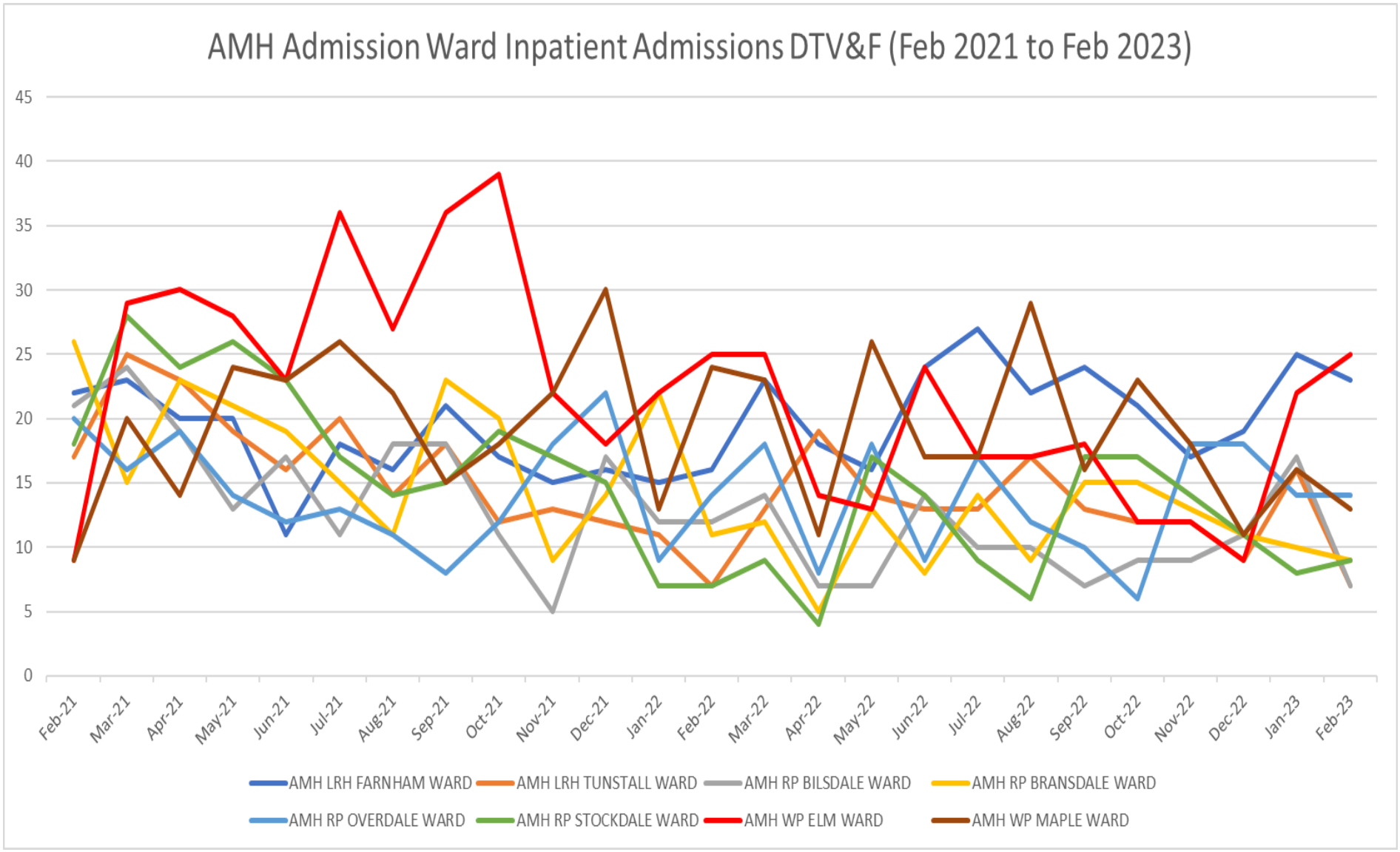
- Increased number of admissions and reduced length of stay
    - There is an additional workload required to provide the initial assessment and treatment of newly admitted patients. It is noted that it is often the case that new admissions have the potential for increased acuity pending treatment where the expectation is that this acuity will reduce as treatment and discharge planning is implemented with the patient.
    - The number of discharges will increase in accordance with the number of admissions. Discharge processes also see an increased level of patient-based activity to ensure a safe and timely discharge from the ward.
    - The number of admissions and discharges on adult mental health wards are significantly higher than on other ward services
    - Increased admission and discharge processes require additional staff hours to support the work required within these processes.

- Increased patient acuity and dependency
    - As patient acuity and dependency increases this is reflected in the necessity of an increased staffing requirement to support the care and treatment of the patient - whether the patient is on formal supportive observation and engagement, or otherwise.
    - Increased formal supportive observation and engagement will require additional staff input across the day and night shift patterns to support a safe environment for patients and staff.
    - Formal observations often require a static staffing resource to accommodate the needs of the patient. However, the case can be argued that a least restrictive approach to support an acutely unwell patient can sometimes require more staff support across the day the patient to prevent formal 1:1 (or more) supportive engagements.
    - Newly admitted patients have a high likelihood of presenting as acutely unwell prior to inpatient interventions, and so increased admissions could also contribute to increased acuity.

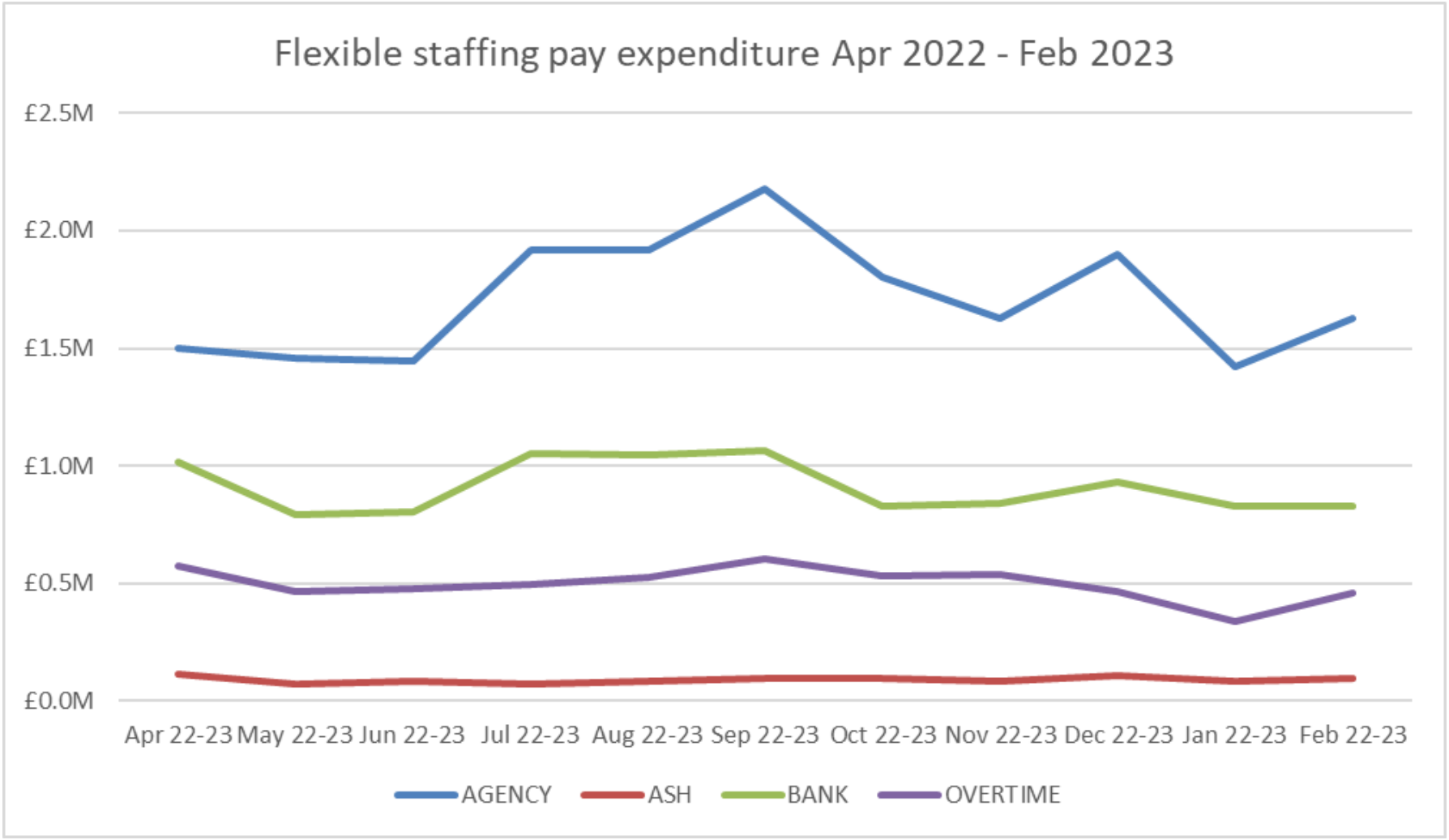
To support the additional occupancy, and on a pro rata basis the increase in acuity and number of admissions will be correlated to an increased occupancy, additional staff need to be employed to ensure this is as safe as possible for patients and staff alike.
Additional workload may also be seen in the temporary staffing requirements requested by the wards to support staffing levels


Inpatient admissions (Feb 2021 to Feb 2023)
350
300
250
200
150
100
50
0
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
ADULT LEARNING DISABILITIES
ADULT MENTAL HEALTH
HEALTH AND JUSTICE
MENTAL HEALTH SERVICES FOR OLDER PEOPLE
SECURE INPATIENT SERVICES
Linear (ADULT MENTAL HEALTH)


AMH Admission Ward Inpatient Admissions NYY&S (Feb 2021 to Feb 2023)
40
35
30
25
20
15
10
5
0
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
AMH DANBY WARD
AMH EBOR WARD IP - FPH
AMH ESK WARD
AMH MINSTER WARD IP - FPH


AMH Admission Ward Inpatient Admissions DTV&F (Feb 2021 to Feb 2023)
45
40
35
30
25
20
15
10
5
0
Feb-21
Mar-21
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
Feb-22
Mar-22
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
AMH LRH FARNHAM WARD
AMH LRH TUNSTALL WARD
AMH RP BILSDALE WARD
AMH RP BRANSDALE WARD
AMH RP OVERDALE WARD
AMH RP STOCKDALE WARD
AMH WP ELM WARD
AMH WP MAPLE WARD

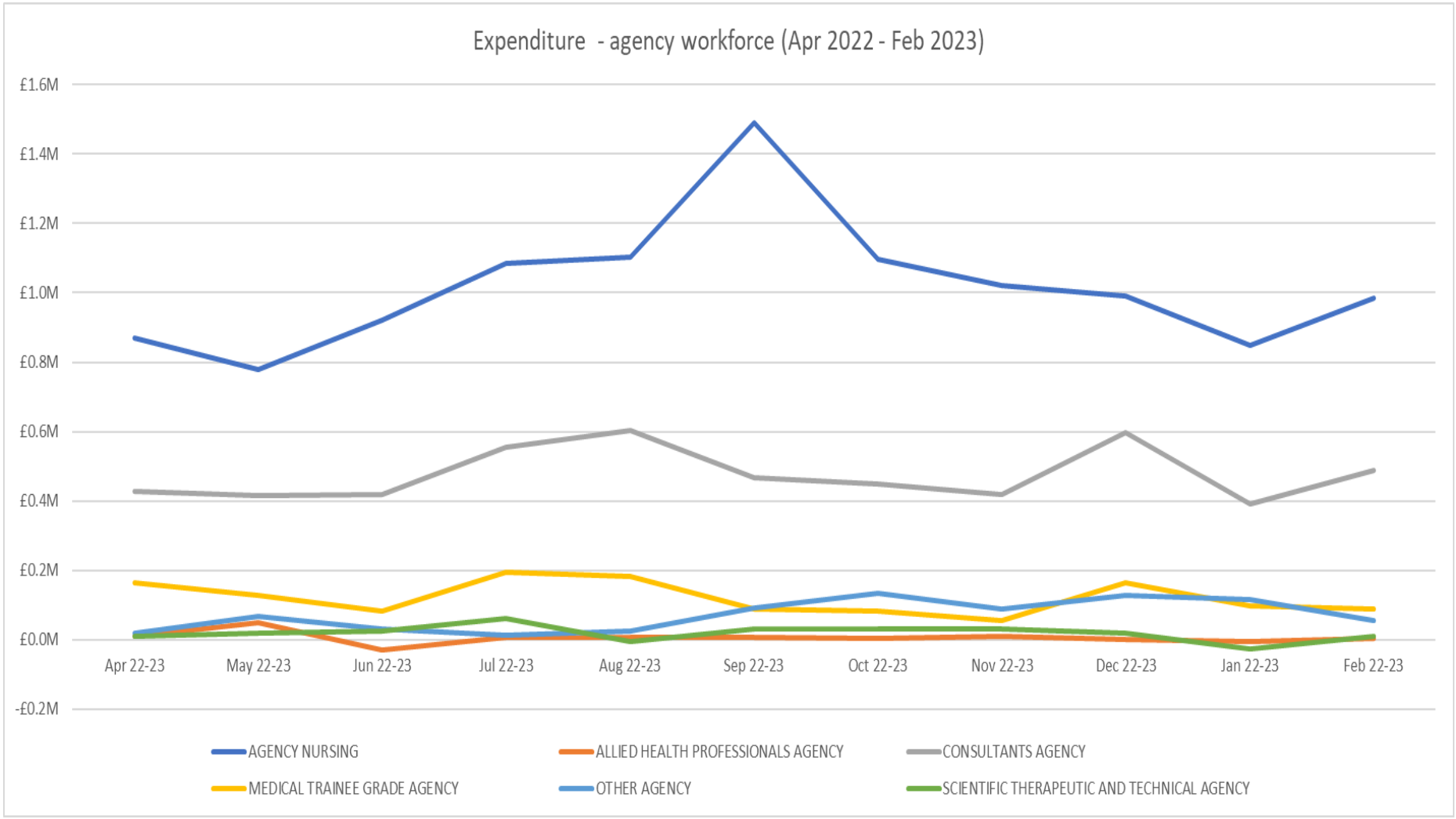
26. APPENDIX 19



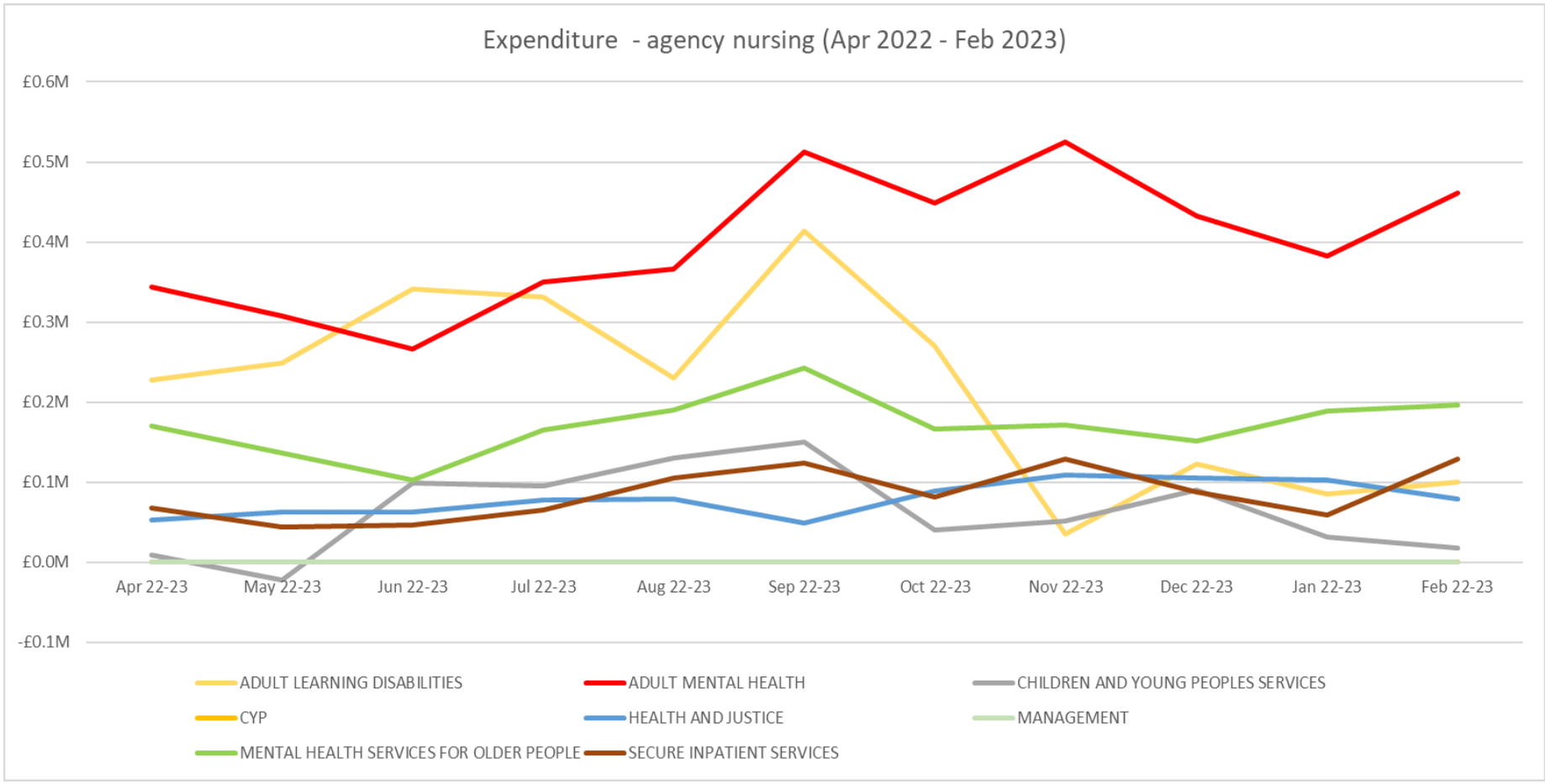
Flexible staffing expenditure costs for clinical teams April 2022-February 2023

Community vs Inpatient - Flexible staffing expenditure costs for clinical teams April 2022-February 2023

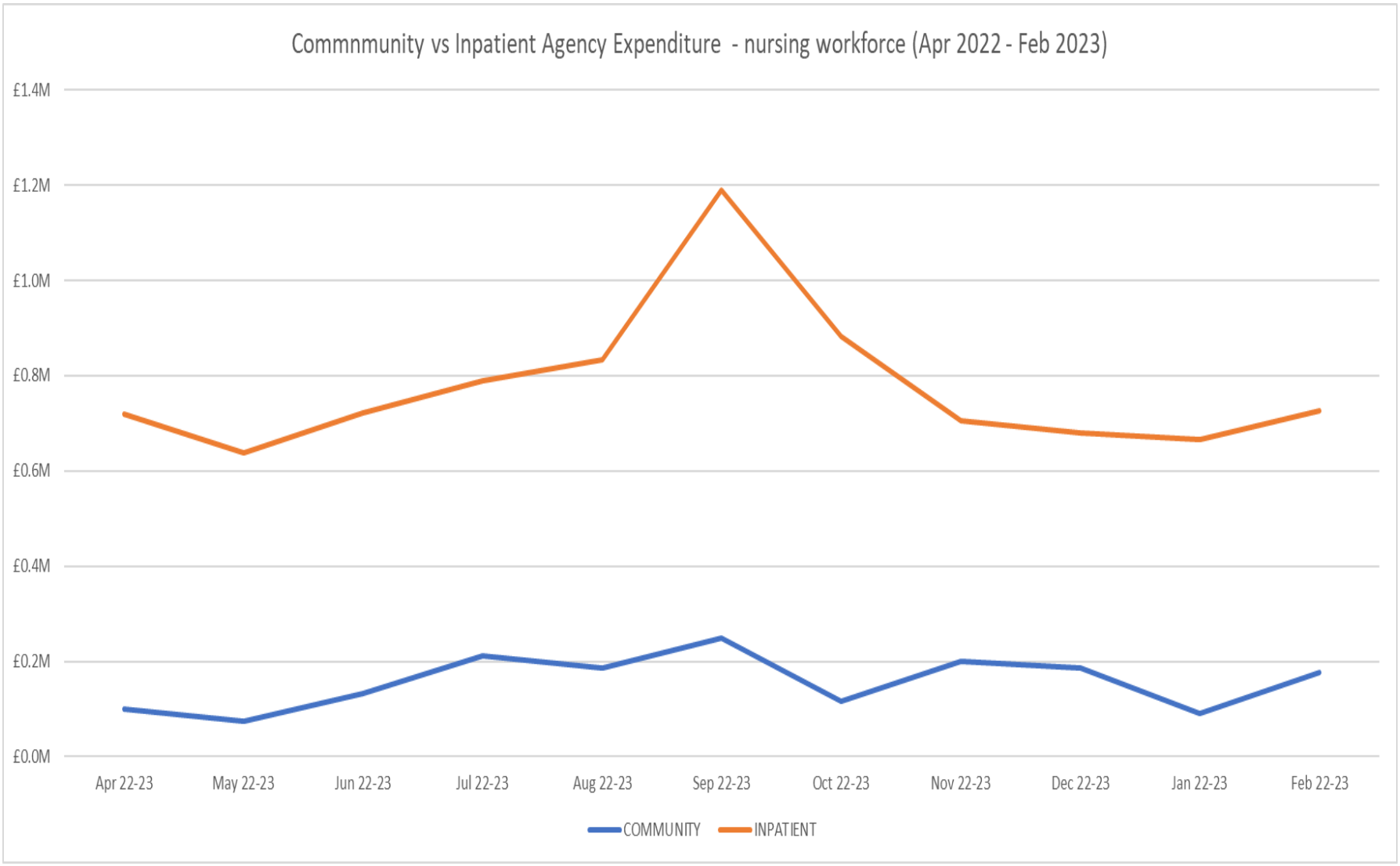
27. APPENDIX 20



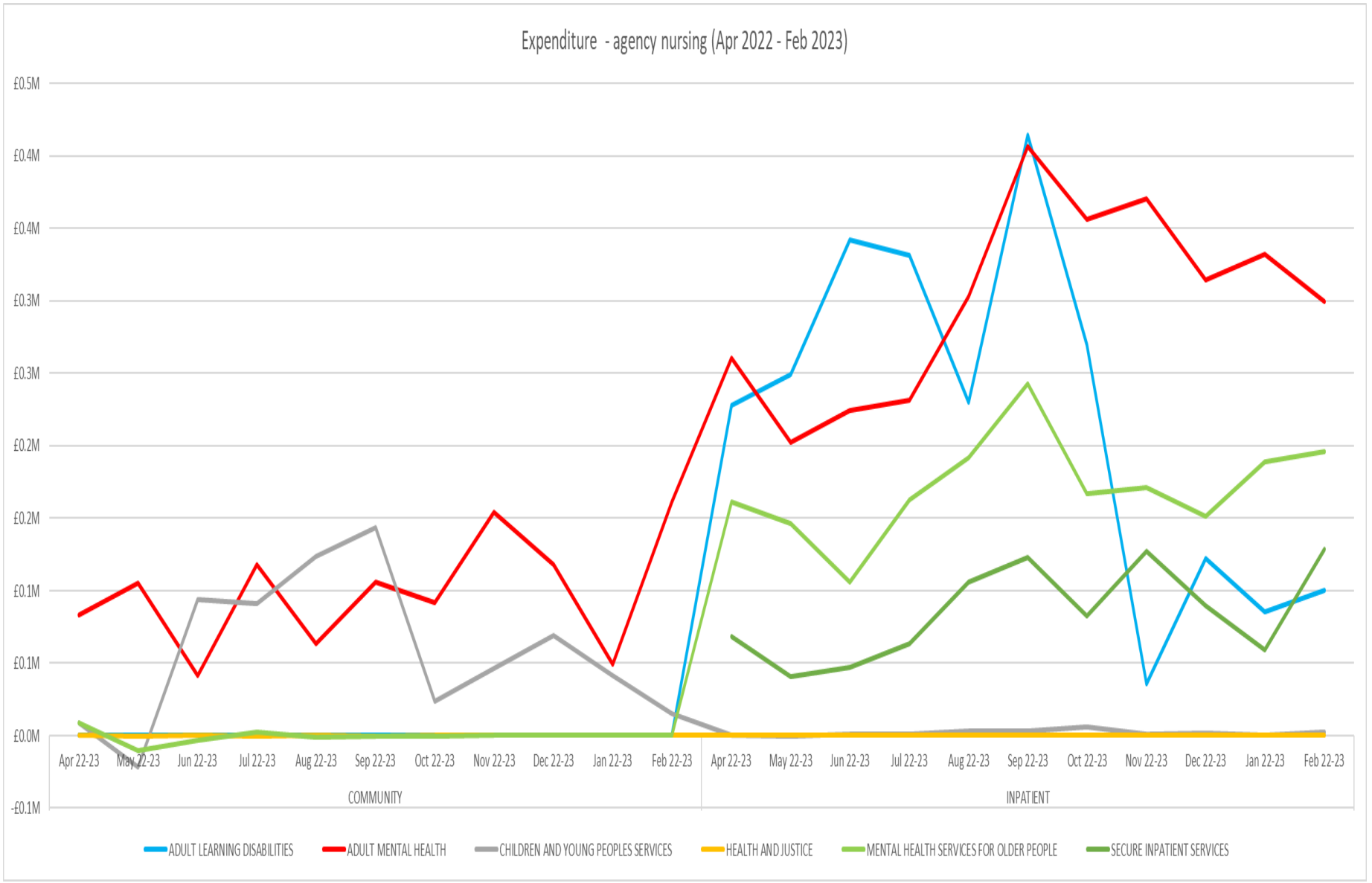
Agency expenditure costs by workforce group for clinical teams April 2022- February 2023



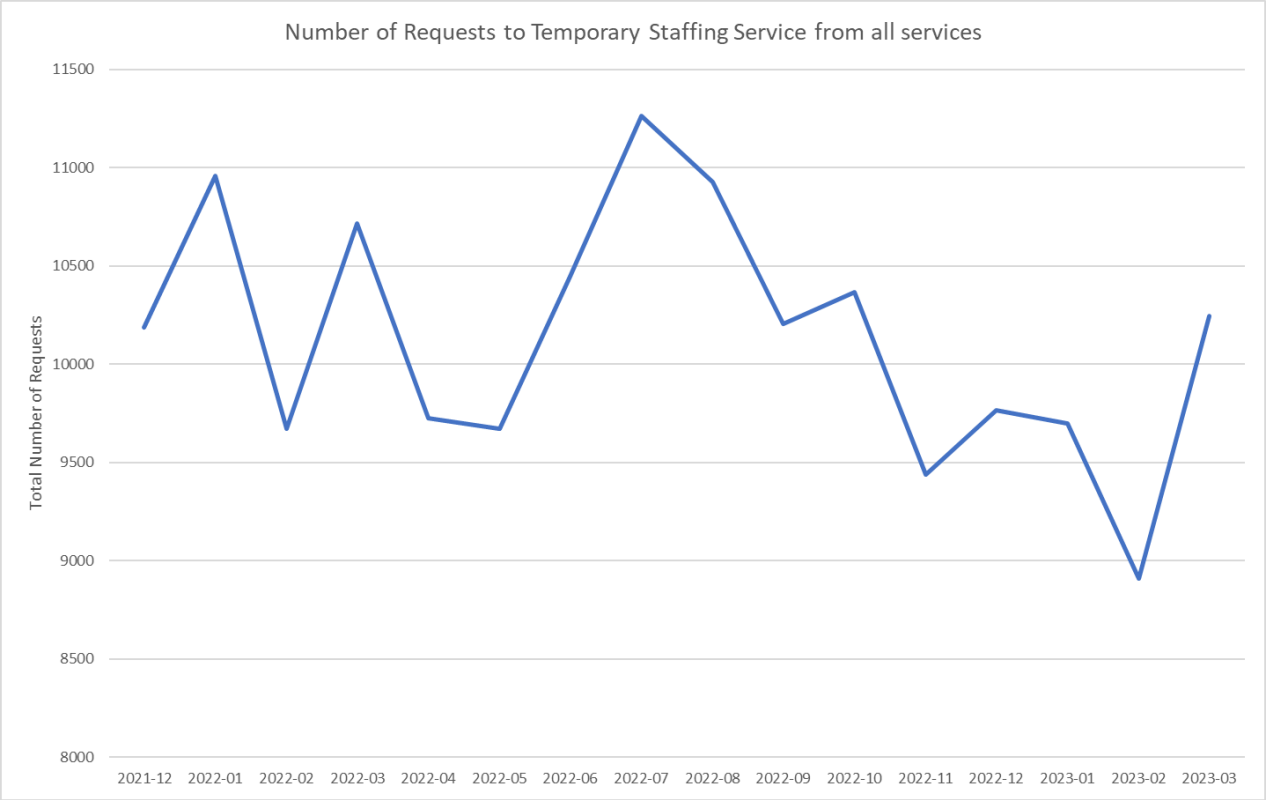
Agency nursing expenditure costs by service level for clinical teams April 2022- February 2023



Community vs Inpatient nursing agency expenditure costs clinical teams April 2022- February 2023

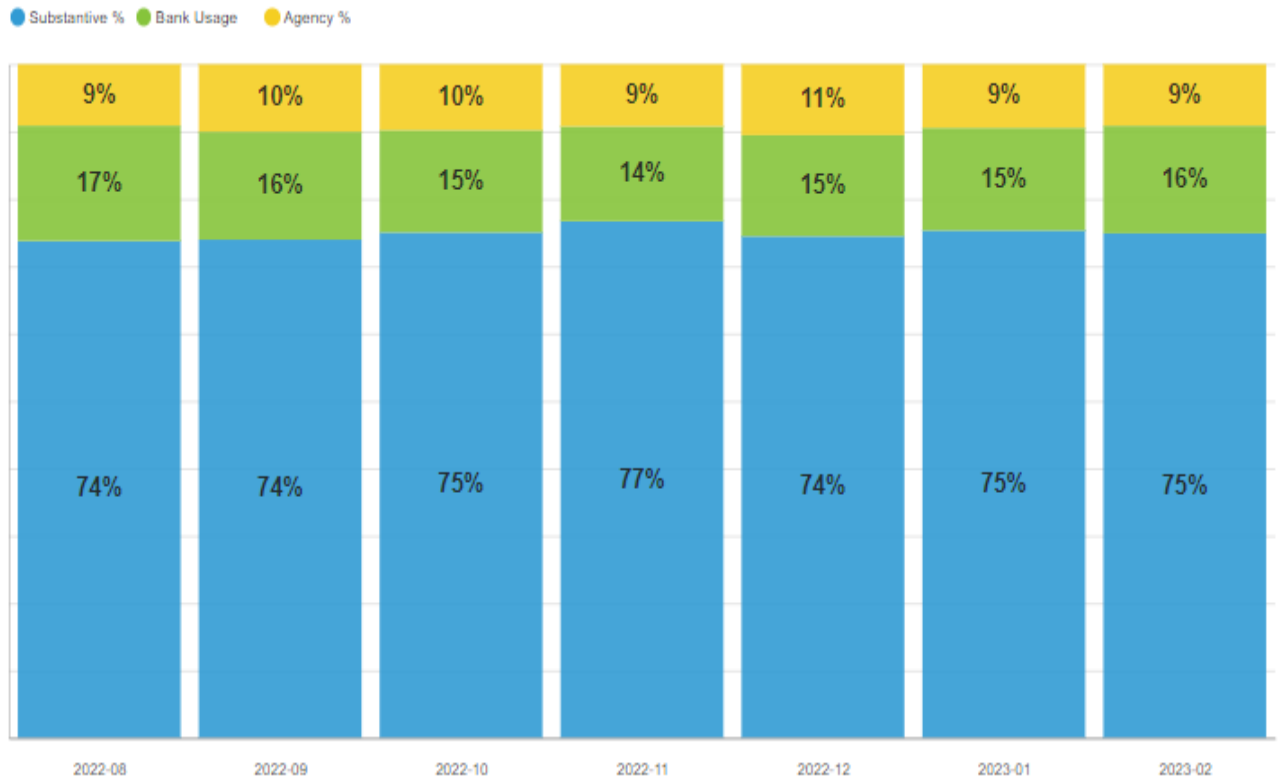

Expenditure - agency nursing (Apr 2022 - Feb 2023)
£0.5M
£0.4M
£0.4M
£0.3M
£0.3M
£0.2M
£0.2M
£0.1M
£0.1M
£0.0M
-£0.1M
Apr 22-23
May 22-23
Jun 22-23
Jul 22-23
Aug 22-23
Sep 22-23
Oct 22-23
Nov 22-23
Dec 22-23
Jan 22-23
Feb 22-23
Apr 22-23
May 22-23
Jun 22-23
Jul 22-23
Aug 22-23
Sep 22-23
Oct 22-23
Nov 22-23
Dec 22-23
Jan 22-23
Feb 22-23
COMMUNITY
INPATIENT
ADULT LEARNING DISABILITIES
ADULT MENTAL HEALTH
CHILDREN AND YOUNG PEOPLES SERVICES
HEALTH AND JUSTICE
MENTAL HEALTH SERVICES FOR OLDER PEOPLE
SECURE INPATIENT SERVICES

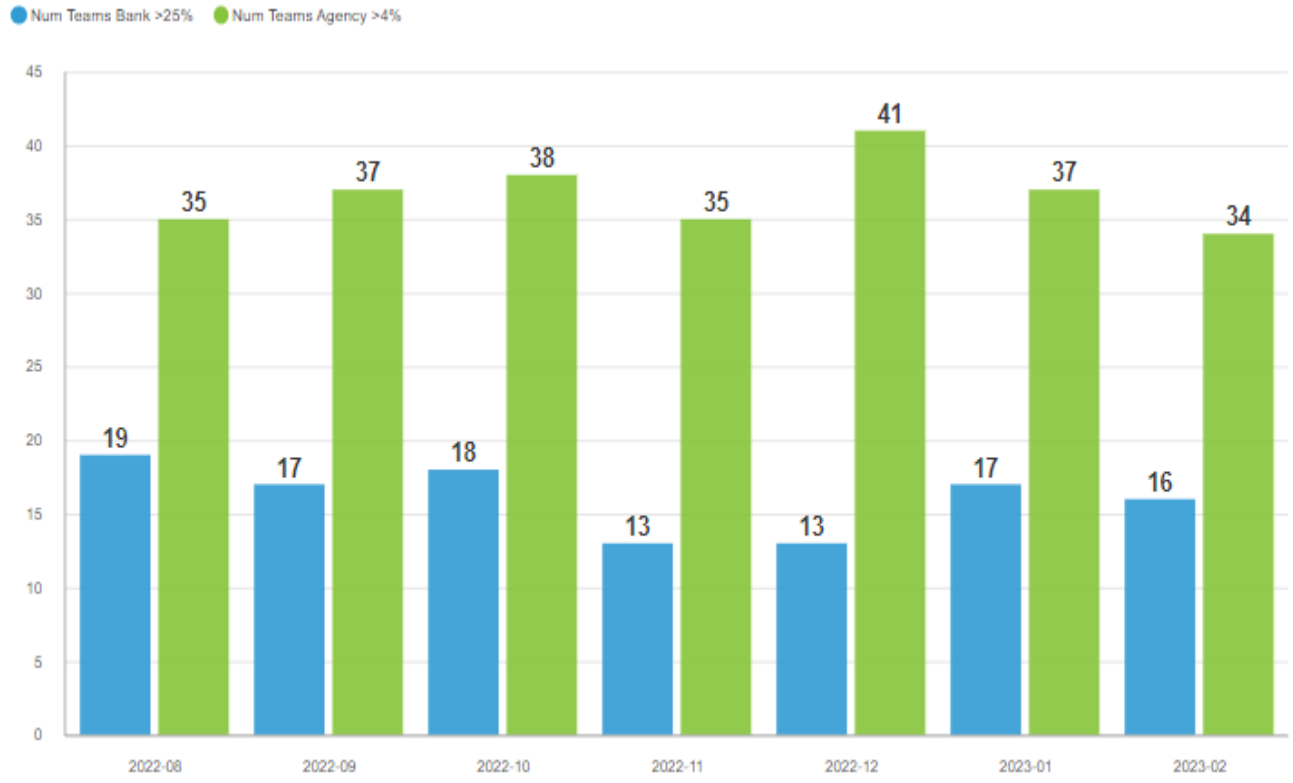
28. APPENDIX 21



Temp Staffing Service Requests for all teams

<u>Temporary Staffing Requests and Fulfilment for Inpatient Wards (next 3 charts)</u>


Substantive %
Bank Usage
Agency %
9%
10%
10%
9%
11%
9%
9%
17%
16%
15%
14%
15%
15%
16%
74%
74%
75%
77%
74%
75%
75%
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02


Num Teams Bank >25%
Num Teams Agency >4%
45
40
35
30
25
20
15
10
5
0
19
35
17
37
18
38
13
35
13
41
17
37
16
34
2022-08
2022-09
2022-10
2022-11
2022-12
2023-01
2023-02

29. APPENDIX 22

Temporary Staffing Shift Requests

Reasons for staffing shortfalls, include for example, increased demand to meet patient needs and supporting increased acuity and dependency, patient leaves/escorts, backfill for vacancies and unavailability's such as sickness absence, annual leave (note - this should not occur if leave is sufficiently level loaded), and training. Figures show that the number of hours usage of temporary staffing against actual hours worked remains a consistent 25%-26% requirement across the period reviewed which is reflected in the additional rostered duties (approximately 28-30%) created by rostered teams to meet the demand.

Overall, the Trust fill rate for temporary staffing across this period is 75%, which indicates that either the shift is filled with overtime or remains unfilled which would indicate a shortfall on the dynamic requirements of the ward to meet patient need.

Over the recent months the Temporary Staffing Service (TSS), working with operational and clinical staff, have successfully removed off nursing framework usage and have taken steps to ensure that nurses are accessed via "ON-framework" suppliers only. Whilst the initial deadline from NHSI/E has passed, the Trust had by taken a clear stance and committed to no longer accessing "OFF-framework" agencies in our Services by **31st March 2023**. Standing firm on this approach, collectively it leaves agencies with limited choice but to move onto approved frameworks if they want to continue supplying staff to the NHS. The contractual terms and conditions of the framework agreements protect us against poor agency behaviour as well as ensuring financial oversight of rates within cap limits.

All off framework usage within the package of care at Bankfields Court (BFC)has now been removed through a staged approach, and now use a single "ON framework" agency. There are currently 2 patients with packages of care at BFC, one requires 4 HCAs day and night, the other requires 2 HCAs day and night.

Community

The TSS has centralised the nursing community use to strengthen the assurance Trust wide and have already begun in providing reports to support this. For those community teams using Health Roster, the demand is on their own rosters and managed by the TSS; and for those awaiting Health Roster implementation a Community Agency Roster is in place which the TSS manages. With the continued roll out of Health Roster to community-based teams the TSS will be moving workers over onto their own rosters as they transition to electronic rosters. Communications have been provided to community services regarding the process. However, there remains a necessity to continue the strong links with Finance to provide the compliance and assurance required to remain within the process.

There is not a provision for a community nurse Bank at this current time, where a recent invest to save report did not achieve approval, however a small number of staff who work within the community services have made themselves available for support as a bank worker as they either work in the team substantively or they have previously worked there.

Recruitment

The TSS have a fast-track application process for agency workers who wish to join the bank. If they have worked for the Trust for 6 months or more via an agency without any concerns being raised, they can then apply to an advert without the requirement to be interviewed. All other pre-employment checks stand, supported by an additional reference from the service where they predominantly work.

There are Trust wide rolling adverts for both Bank HCA and Bank RN posts and find that there are applicants eager to join the bank. Challenges continue however in securing interview panels due to the pressures and staff availability from within clinical services. The Bank Recruitment Team are working closely with the newly recruited Recruitment Officers for each care group to maximise recruitment efforts which includes attending job fairs, most recently to an event in Scarborough 2023.

Demand

In July 2022 the TSS reached a peak of just over 11000 requests for the month, this has reduced steadily to just over 10,000 in October and has remained relatively consistent at this level since then. However, this remains a significant amount higher to that seen at the beginning of 2021 where there were just over 7,500 requests each month.

NYY&S demand has remained consistent over the previous 6 months, however a slight peak has been noted for March 2023 where the majority of requests have been for HCA cover. Despite the currently block booked Agency Nurses within NYYS and still have requests for both inpatient and community services outstanding.

DTV&F demand has reduced slightly over the previous 6 months, however March 2023 has seen a rise once more where we also see a number of agency nurses within AMH & SIS required to be block booked up until end of June 2023. To support increased RN cover from agencies TSS have enlisted more on framework agencies from the wider framework.

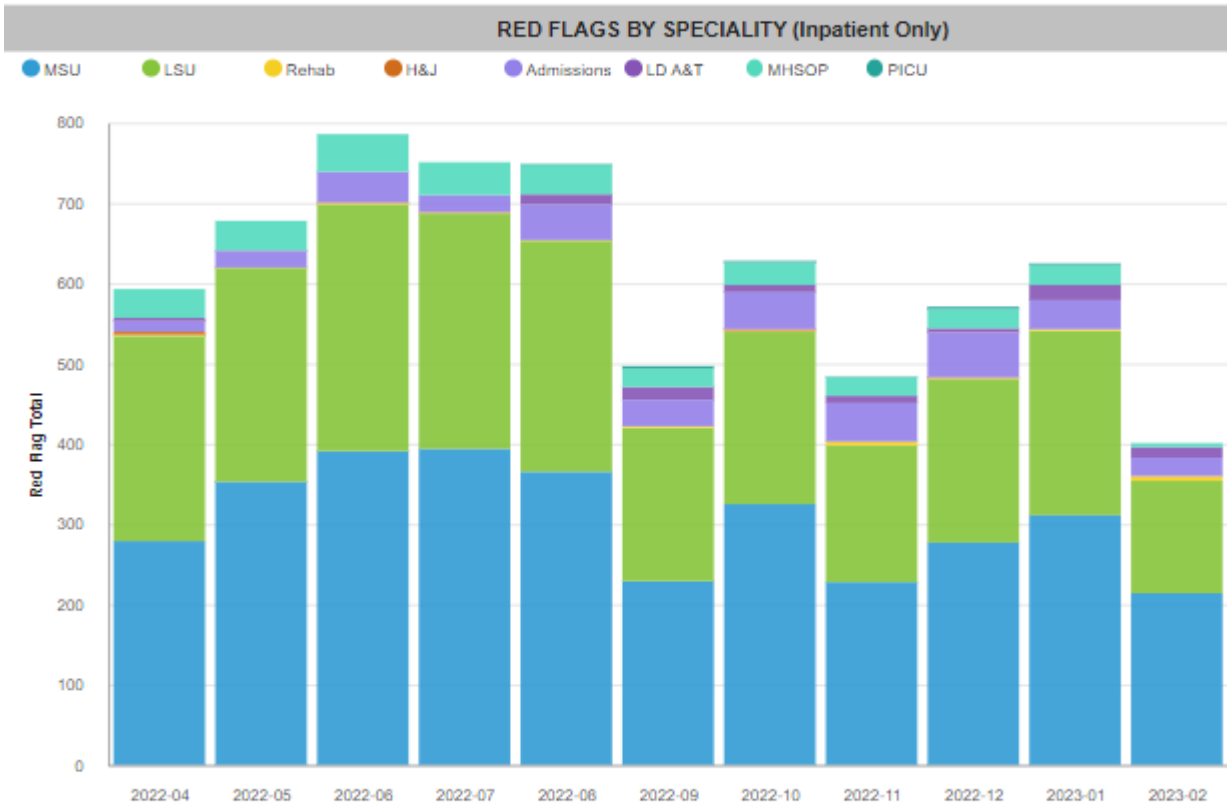
The TSS team are working hard to try and reduce the agency HCA use across all services by improving their own recruitment process and oversight and monitoring of lead time for shifts being sent to bank. Lead time refers to the number of days a shift has been sent to the temporary staffing service ahead of the actual date required for the shift. The greater the lead time the more opportunity the temporary staffing team will have to find a bank staff member to fill the request.

The TSS continue to support trying to ensure that regular bank staff are sent to wards wherever this is possible.

30. APPENDIX 23

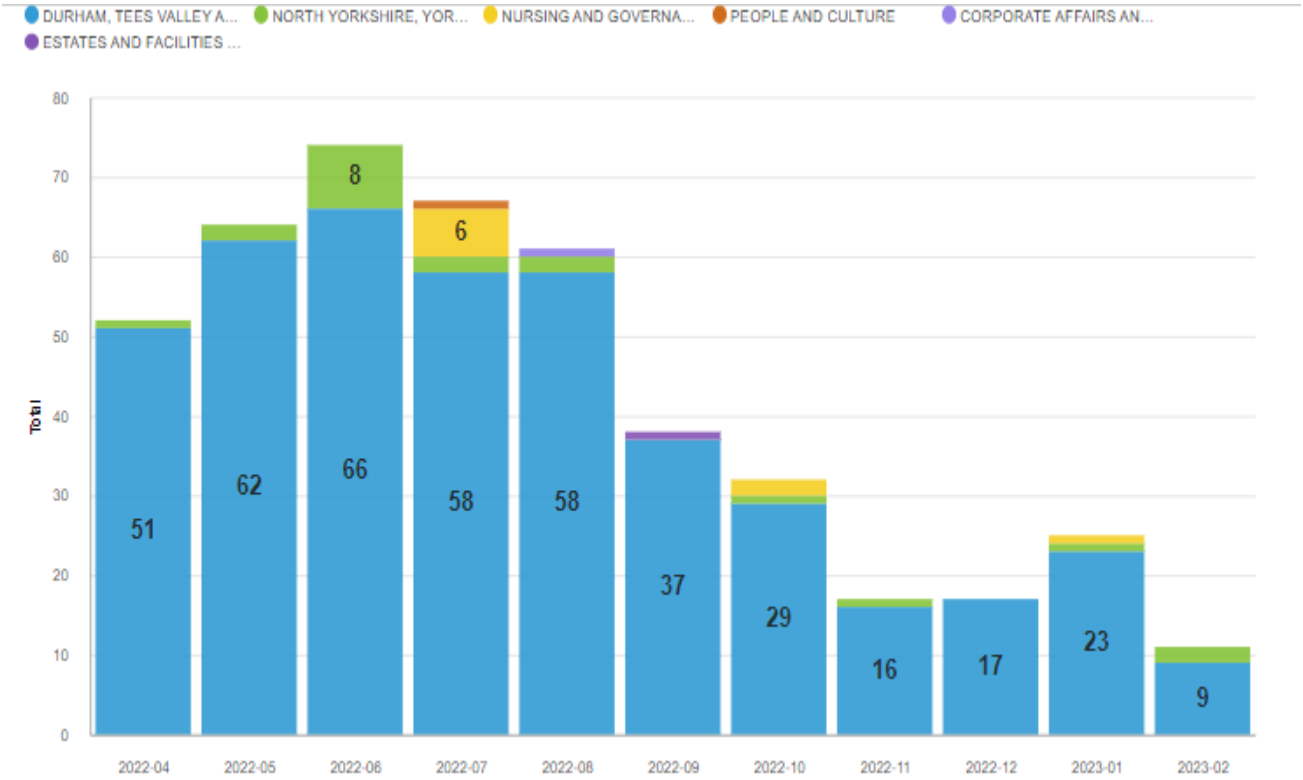
SafeCare is a 3rd party software product linked to the health roster and was implemented Trust wide on 1st September 2021. SafeCare allows for ward acuity and dependency to be recorded based on nursing assessment, red flags to be raised, staff attendance recording, and redeployment. The capture of patient acuity and dependency assessment scores gives an indication of the required staffing levels based upon identified CHPPD requirements, supporting the oversight of staffing and daily staffing allocations and deployment decisions in relation to safe patient care upon the wards.

Red flag analysis shows that SIS remain the teams that has significant utilisation of the system.

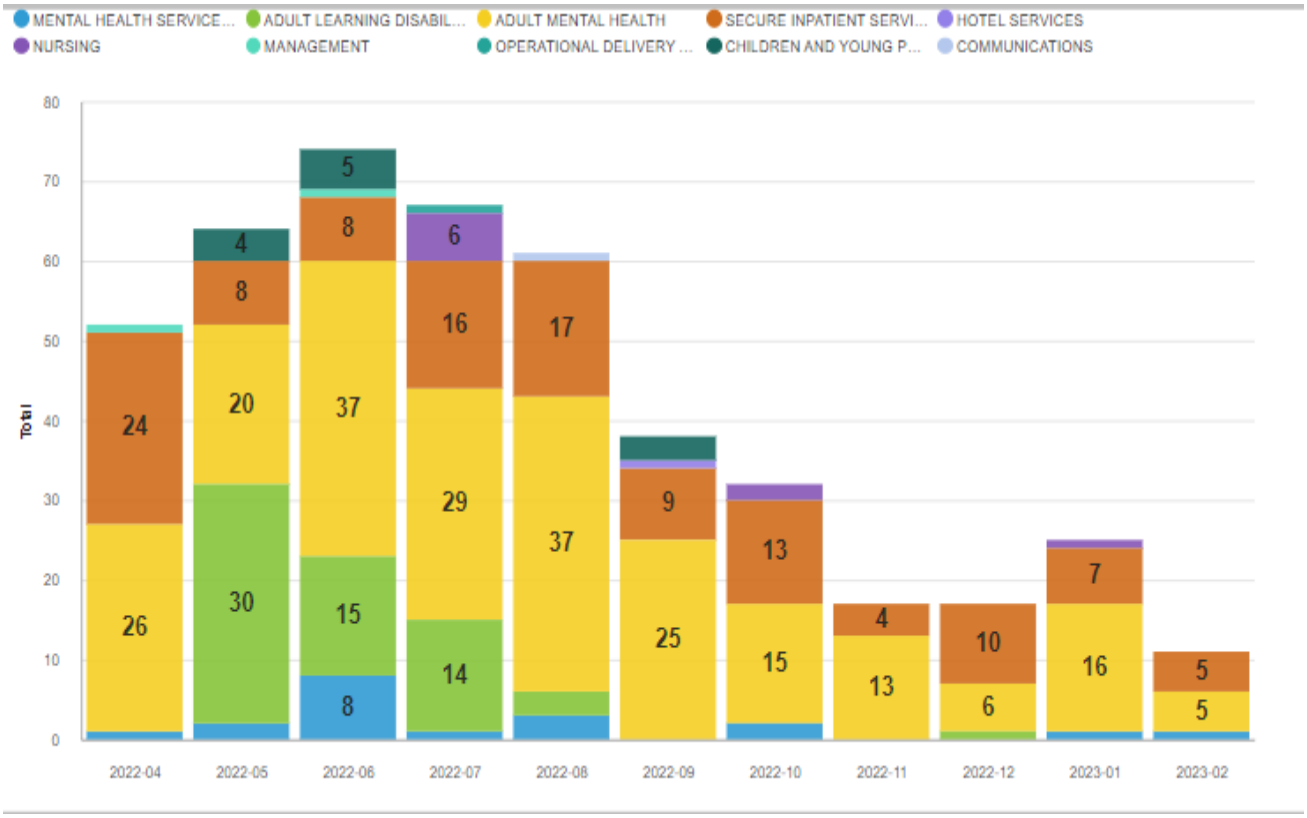


Breakdown of red flags raised by speciality

Staff continue to see staffing levels as a concern and following the introduction of SafeCare (September 2021) and the red flag system in within it, there was the potential for inpatient services to see a reduction in the number of Datix reports due to the increased utilisation of the red flag process in SafeCare. The graphs below do see a reduction in Datix incidents reported, however it remains unclear if this is correlated to the use of SafeCare.

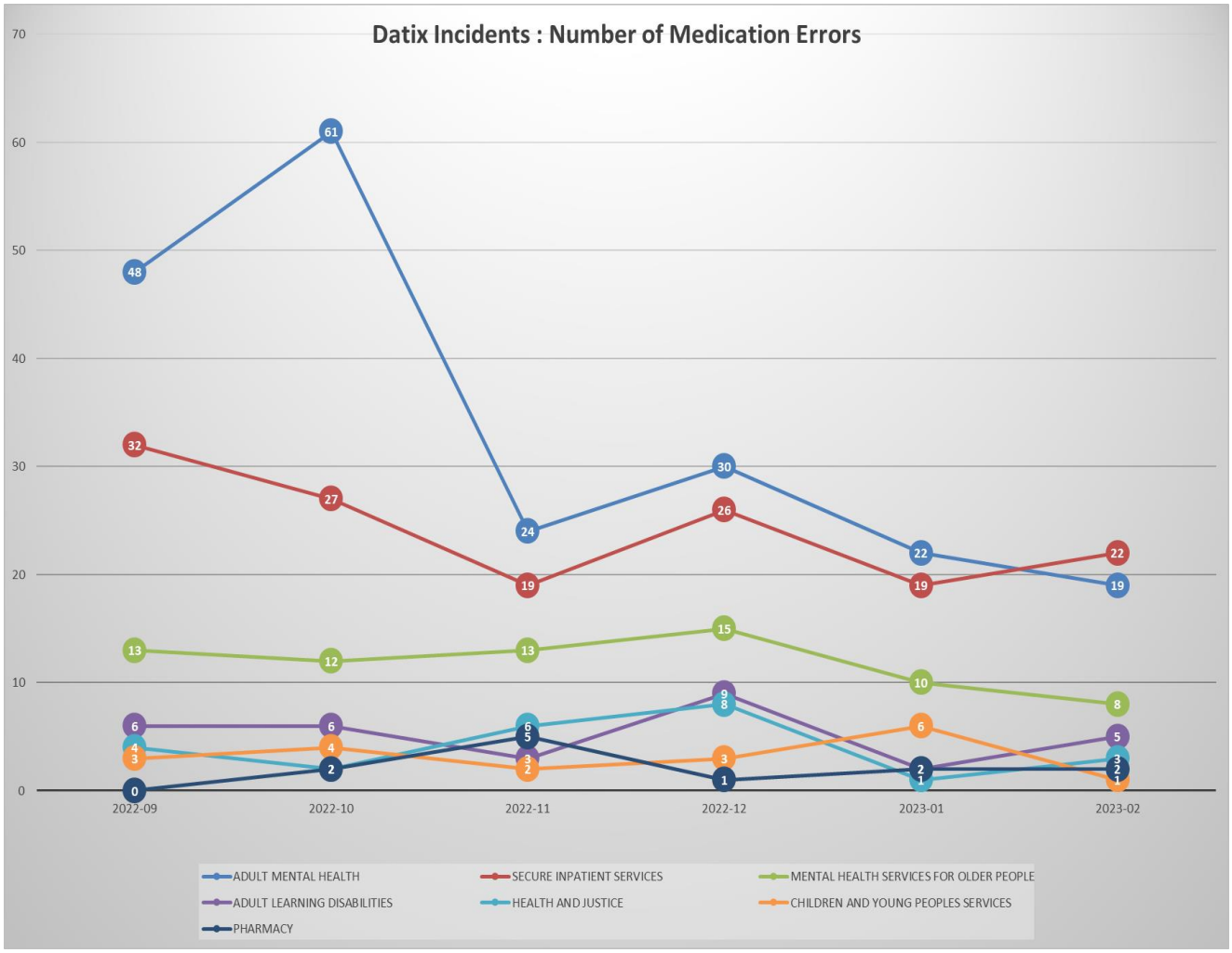


Breakdown of Staffing Level Incidents reported on Datix by directorate



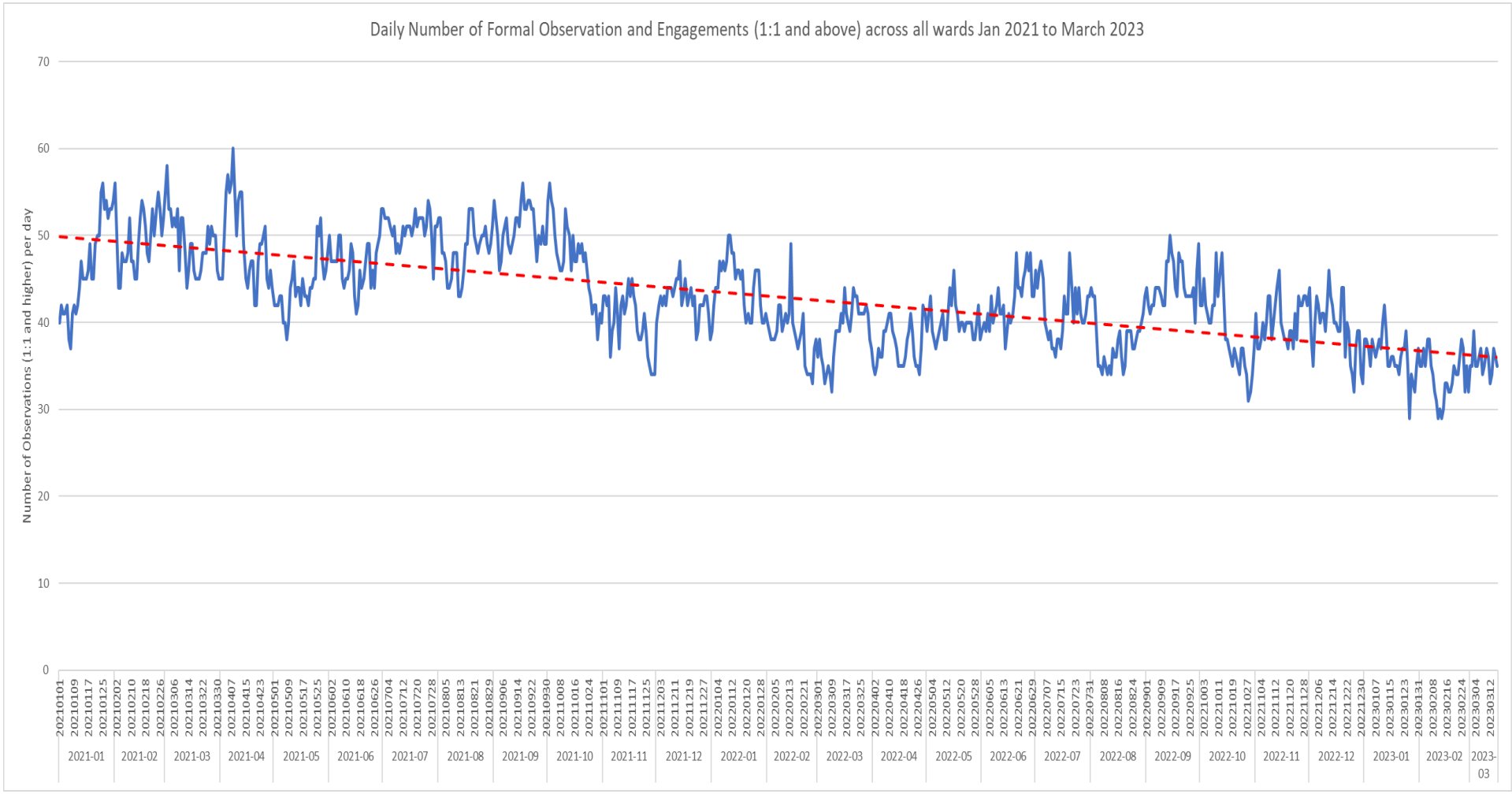
Breakdown of Staffing Level Incidents reported on Datix by speciality

Additionally, it is seen for this same period that the number of ward-based medication administration errors are generally highest on Adult and SIS wards.



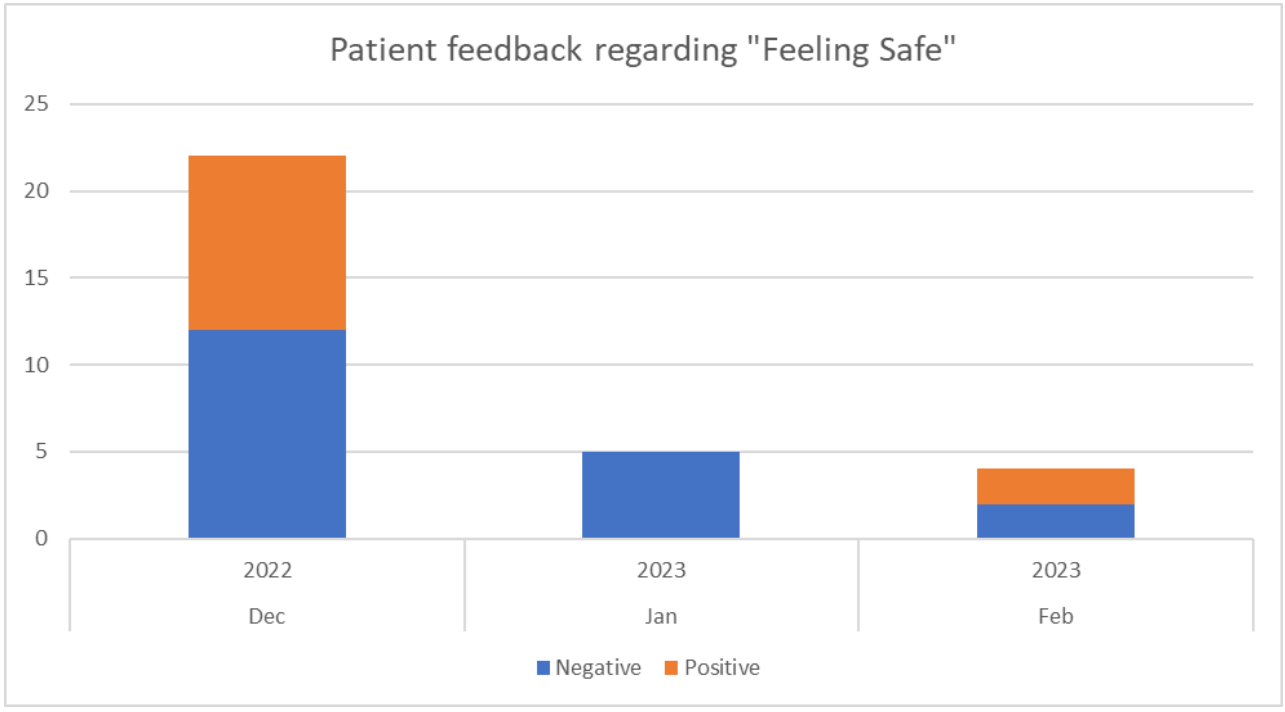
Medication Administration Incidents as Reported on Datix (Sep 2022 – Feb 2023)

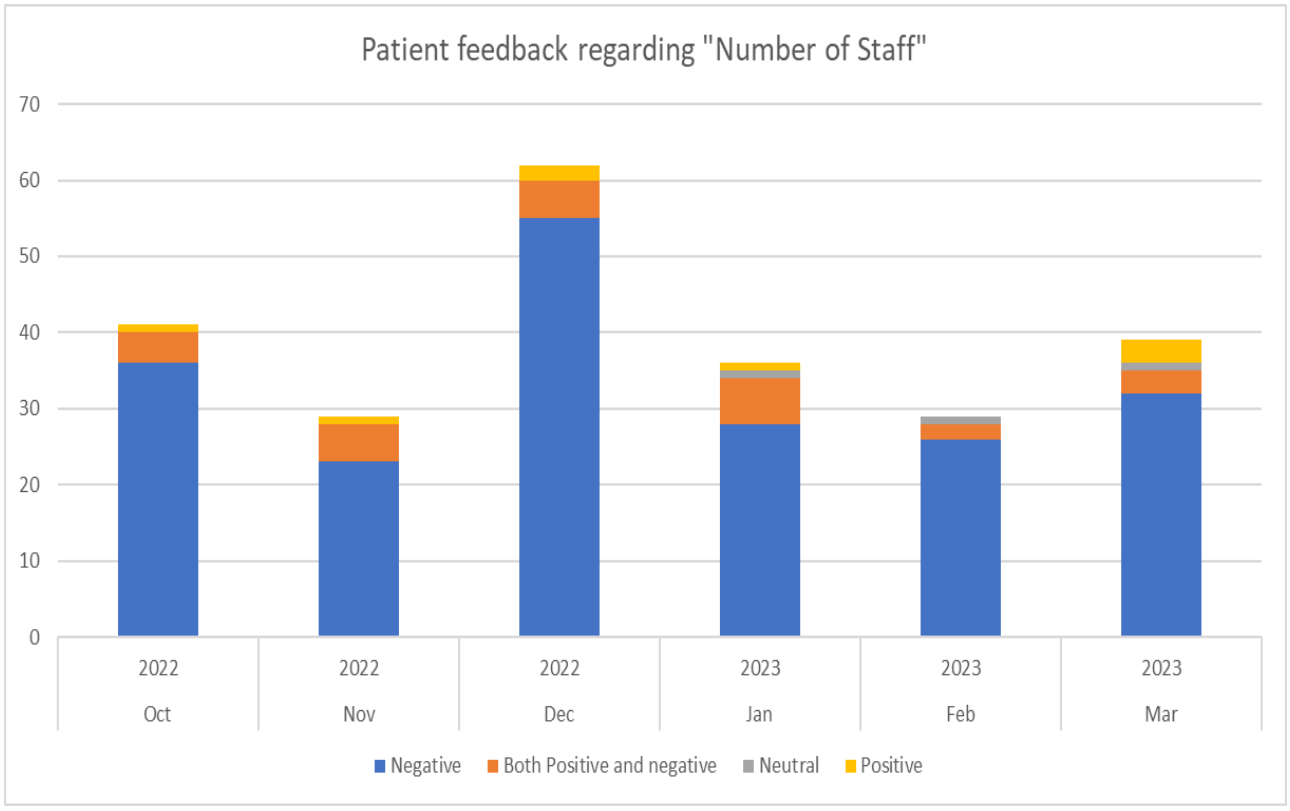
31. APPENDIX 24



Number of 1:1 Observation and Engagements over time from April 2020 to 30 Jan 2022

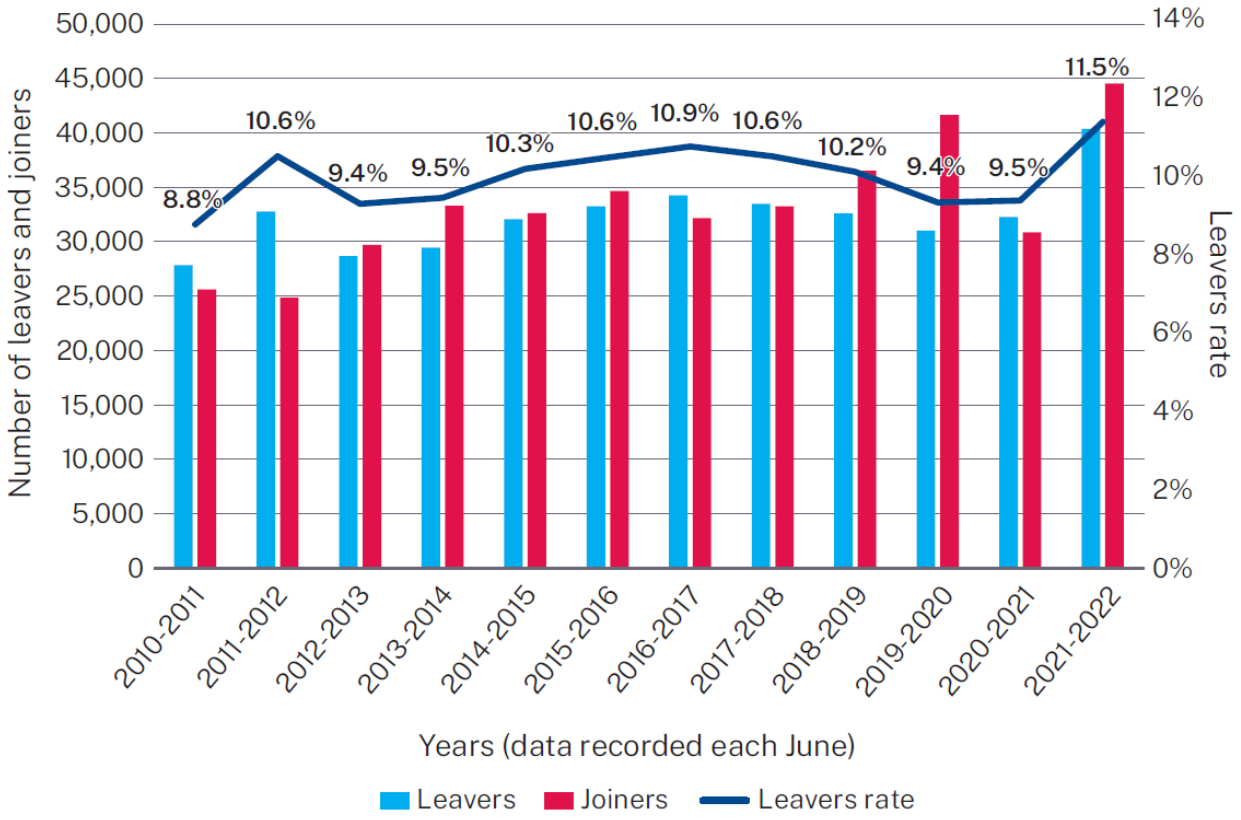
32. APPENDIX 25



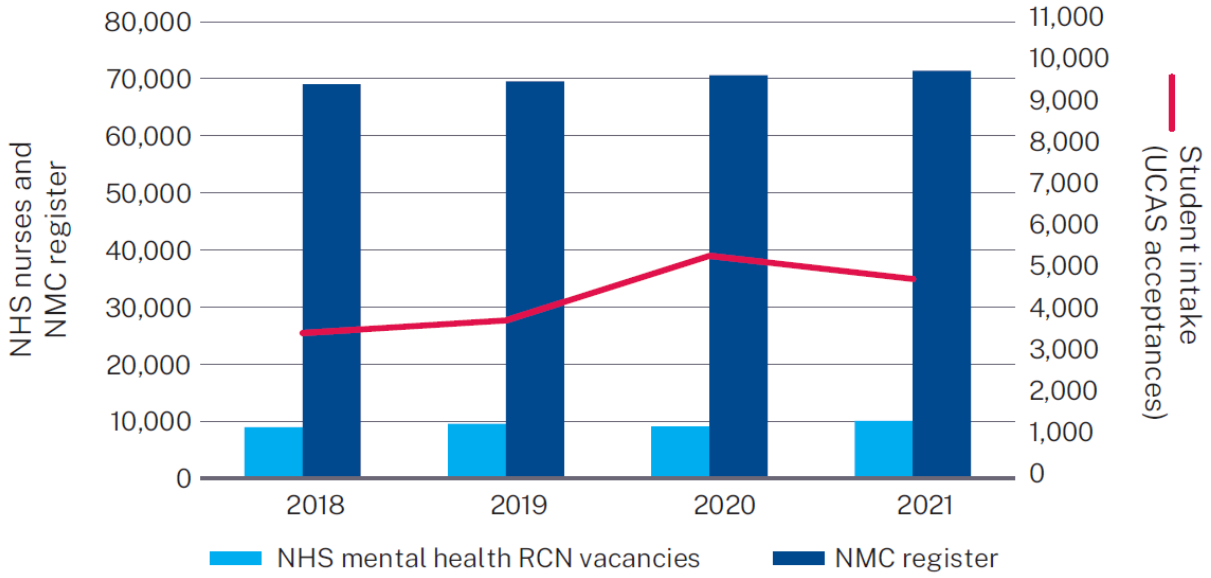


33. APPENDIX 26

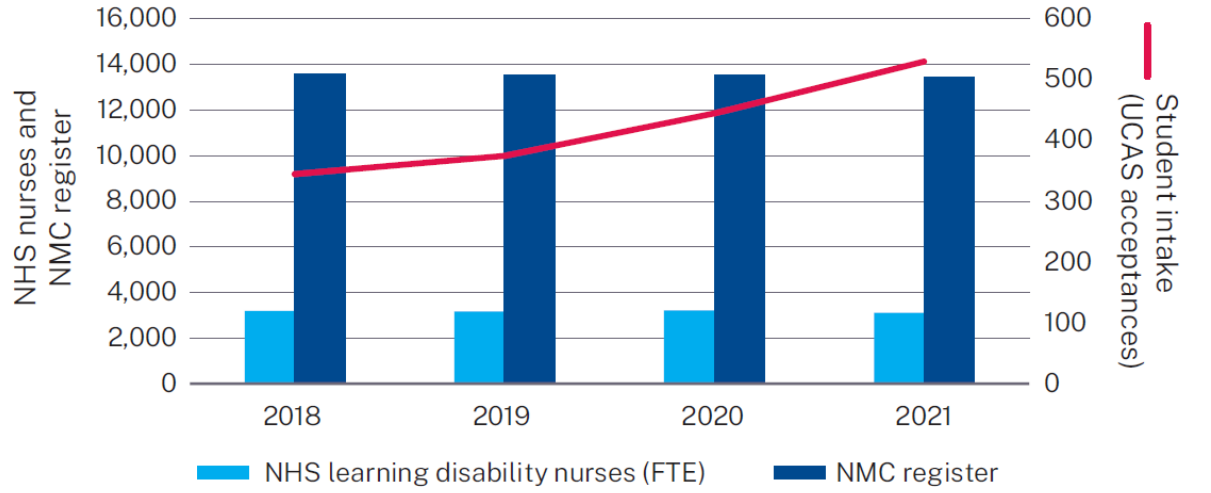
RCN (2022) report that latest data shows there will be 2,000 fewer graduating from education in 2025 than there will be in 2024, combined with the fact that the NHS sees increasing levels of leavers (see table below), and that there is a reliance upon international recruitment where 29% of people joining the NMC register are trained internationally.



From a mental health and learning disability perspective it is further stated that staff shortages (latest vacancy data from NHS Digital shows 13,254 registered nurse vacancies in the mental health sector in England) seen in mental health services should be viewed in the context of the increased pressures on the service due to the unprecedented demand. The resulting record numbers of people (including children) seeking mental health support during the COVID-19 pandemic has also seen a significant backlog as services have struggled to keep up with the demand. Despite the apparent increasing trend in LD student nurse intake, it is to be noted that this remains a low intake number of approximately 530 and is set against the actual decrease in LD nurses by 2.6% in this last year (RCN 2022).



Mental health nursing workforce and supply -NHS vacancy statistics (England), NMC Register and UCAS



Learning disability nursing workforce and supply - NHS Digital (England), NMC Register and UCAS

Registered nurses and health visitors leavers and joiners - NHS Digital workforce statistics (England)

Recruitment challenges apparent in the Trust include hard to fill posts which are impacted further dependent upon the locality. Issues have also been apparent in the processing of the current vacancies and job offers. The current position reported from recruitment reports that

- From 1st January to end of February 2023: 561 adverts have been published, 320 offers have been sent out, 393 people starting in new roles.
- In 2022 (January to December): 5,689 adverts published, 3,036 offers were sent out, 2,577 people were cleared of all employment checks to start.

Trust recruitment and retention plans

The Trust is committed and engaged in all regional and national workforce programmes including HCA recruitment and international recruitment to increase the numbers of both registered and non-registered nursing staff as well as other professions on our wards.

- **Over recruitment-** All adult wards in DTVF are fully recruited to ward establishments and are actively recruiting to 5 over establishment to support staffing and skill mix.
- **Nursing Apprenticeships-** The Trust seconds 20 trainee nursing associates and 20 registered nurse degree apprenticeships every year from our existing unregistered workforce as part of our 'grow our own campaign'. This has been in place for approximately 4 years now and we are seeing regular recruits transitioning to our registered nursing workforce
- **Trainee nursing numbers**-Over the past 5 years we have increased our 'feeder' HEI's (where we host pre-reg nursing students) from 2 (Teesside and York) to 6 (Teesside, York, Coventry and Scarborough, York St Johns, Sunderland and Open University). This has significantly increased our trainee nursing placements and we have again stretched our capacity this year. We employ the majority of our qualified nurses from these cohorts.
- **International Recruitment-**The Director of Nursing, Medical Director and Director of Therapies went to India last year as part of the Humber and NY international recruitment collaborative. We were successful in gaining 15 doctors and 11 registered nurses as well as establishing links with training academies for future pipelines of recruits. The current pipeline has 6 recruits that have passed OSCEs. Additional recruits are to work in York with OSCEs planned for April. There are 6 more additional internationally recruited registered nurses joining SIS. There are currently a further 9 International Nurses going through pre-employment checks and 16 awaiting interview.
- Our current time to hire (advertising start date to all employment checks complete) is 94 days and continue to seek improve upon this
- We are participating in **virtual recruitment fairs** across the region to actively promote the Trust and the vacancies we have available
- Working with **local Universities** offering final year students who are on placement with TEWV a guaranteed job on successful completion of their nurse degree
- **Developed marketing material** to support various recruitment campaigns including video's, staff testimonials. Social media channels being used more to promote vacancies and the Trust

It is of note that Griffiths et al (2019), whilst acknowledging the importance role health care assistants (Support Workers) play in maintaining safety of hospital wards, states emphatically that they cannot act as substitutes for registered staff, highlighting the potential consequences and negative impacts on patient safety. He further concludes that "the adverse consequences of RN shortages are unlikely to be remedied by increasing the numbers of lesser trained nursing staff in the workforce".

Ward leaders are central to creating a culture of high quality, compassionate care that strives to continuously improve (NHSI, 2018); enriching the RP to SW skill mix on the wards will support in improving the clinical leadership and subsequently the culture in teams. The current situation evident from the fill rates and that supported by service feedback regarding the recruitment and retention issues of registered staff and the levels of experience in certain areas will impact upon

the ability to provide effective leadership and positive impacts to the culture within the organisation.

To support clinical leadership and best practice within the Trust more recent investment and initiatives has seen the introduction of community matrons, site-based practice development practitioners, additional ward clinical leads, and ward based clinical team administrators to increase nurse time to care and lead. It is noted that due to increased work pressures these staff members have also been required to support staffing their local ward-based services.

NHS (2022) states that services should improve retention by delivering the NHS People Promise to improve the experience of our staff, through a focus on flexible working, health and wellbeing of staff, improve attendance by addressing the root causes of non COVID-related sickness absence and, where appropriate, supporting staff to return to work. An area of current focus in the Trust is staff retention, as whilst it is recognised that some areas and roles remain difficult to recruit into, one of the issues continues to be that of retaining staff. The Trust aims to support with the retention of staff and have recently undertaken the **NHS self-assessment for nurse retention** (appendix 26a) and gain an improved understanding of areas identified by our national colleagues as being important in supporting this key area. Further actions for this are to be progressed via the Executive People Culture and Diversity Group (PCDG).

Covid-19 pandemic, still reported as being influential within the workplace, has exacerbated long-term issues such as chronic excessive workload, burnout and inequalities experienced by staff from ethnic minority backgrounds (Kingsfund, 2022). Staff wellbeing in the Trust will be a key feature of the 'Great Place to Work' special interest groups and information from this will report will be used in that group to support staff retention.

Against the backdrop of the national and local nurse recruitment issues, further consideration will need to be given regarding how best to approach the issue of addressing the skill mix of RP to SW; whilst not appropriate to use a Nursing Associate (NA) to replace an RP, further consideration is required on how the Trust uses NA's and the potential of how NAs can be best utilised towards supporting a stepped approach to achieving the recommended RP staffing ratio. Similarly, other registered professions could be factored into ward-based establishments dependant on the assessed patient need, for example the broader MDT of AHPs and psychological therapies. The Trust already embraces the utilisation of new roles such as the introduction of peer support and activity workers on our wards increase engagement and improve meaningful and diversional activity on the wards, alongside the physician associate to support medical staffing shortages.

The chronic shortage of suitable and available doctors continues to provide a significant challenge to the medical directorate which has led to a reliance on temporary staffing measures to fulfil vacant posts which has led to increased costs from using agency as cover. The medical directorate continue to review workforce monitoring and reporting due to the Trust restructure, and its revised governance structure will focus on identifying the relevant workforce related metrics for consideration.

The medical workforce currently has several options for covering vacancies or gaps including mind the gap payments, agency cover, acting cover and fixed term contracts. Actions underway to provide the required focus to address this area of concern which include: -

- International Medical Graduate recruitment – Including our overseas CESR programme
- An IMG Tutor to oversee international recruitment and retention
- An International Congress recruitment event
- Development of the Trust doctor programme
- Re-commissioning of the agency contract and a review of KPI's to effectively reduce costs
- Retire and return process development which will support retention of experienced doctors with bespoke packages
- Use of Patchwork to support short term locum work and reduce agency costs
- Review of the mind the gap framework to ensure a focus on longer term sustainable options.
- Trust medical leadership programme
- SPR programme
- Investment in Educational development retention through the dedicated support role.

Key additional points to highlight in regard to medical staffing include:-

- Litmus neutral agency provider in place and focussed on maximising efficiencies and reducing spend. Examples include reductions in non-DE doctors which saves 20% on the hourly rate
- Work ongoing in developing our bank including Consultants now being on the Patchwork app and the potential to convert agency doctors to the bank and the savings that would incur.
- Medical staffing has a very productive overseas doctor recruitment programme and employed a DMD to oversee. We have recently recruited 10 Doctors as part of a partnership led by NAVIGO and are going through another recruitment process. They have also developed/broadened our GMC overseas sponsorship scheme.
- Medical staffing has created and developed the medical governance and leadership structure supported by a comprehensive workforce report covering, establishment/vacancy figures, temporary staffing data, sickness and turnaround.
- Development of "the pledge" a retention strategy developed by Doctor Jenny Forge.
- Development of coaching and mentoring for doctors.
- Recruitment events continue
- Mind the Gap has been highly effective but is being reviewed to streamline and simplify the process.

Risk mitigations

In addition to the aforementioned plans and actions, where the Trust is aware of being unable to meet the planned skill mix on a daily basis and has a range of Trust wide risk mitigations in place that include:

- **Business Continuity Protocols (BCP)** have been in place across various areas of the Trust during the recent period, most recently for February 2023 for the following service areas: Secure Inpatient Services, Durham & Darlington Crisis Team, the AMH wards at

RPH Dalesway (4 admission wards and PICU), DTVF Inpatient CAMHS and DTV&F Inpatient Adult Learning Disability Services. This has required staffing levels to continue to be monitored in daily huddles, and all BCP areas reporting to Gold Command one or more times across each week to provide oversight and assurance of safe staffing, highlighting any required mitigations and actions needed to support in staffing shortfalls in their planned versus actual staffing figures.

- **Daily operational processes**-The daily management of staffing is a key aspect of the daily work and there is robust daily management system to ensure safe staffing across all of our inpatient areas. Where sudden shortages of staff arise, there is a staffing escalation procedure to be followed. All sites have a duty nurse coordinator allocated across a 24-hour period that reviews skill mix across site, makes changes where necessary and can escalate any issues where required through management or the out of hours on call system. In hours, proactively there is a daily staffing call not just across acute and PICU but across all inpatient areas in the Care Group to review staffing figures, skill mix and competence across all service which is a mechanism to provide mutual aid and make any changes across the care group where this is deemed necessary
- **Duty Nurse Coordinators** – in 2018 we introduced Duty Nurse Coordinators (band 6 or 7 senior nurses) as 24/7 site-based senior support to supplement the skill mix at night and at weekends to ensure oversight of quality and safety, support patient care and rapid escalation of incidents
- **Ward Managers and Matrons** are not included in nursing numbers for the rostered skill mix outputs - as per NHS requirements for Unify returns. Each ward has a Ward Manager/Senior Nurse and a most Matrons have 2 wards (job description is to spend 50% minimum on wards) therefore they will drop into ward numbers during periods of high clinical activity as and when needed
- **Twilight shifts**- these shifts are in place to supplement staffing from early evening until the early hours of the morning to meet patient need
- Following the Trust restructure, the very recently re-established **Safe Staffing workgroup** currently has identified 5 workstreams that are; agency reduction, staffing establishments, e-rostering (and roster related tools), flexible working, and temporary staffing. This group will report directly into the Executive PCDG. Work recently undertaken, in process and being planned include:
    - Approved Quality Impact Assessments and finance sign off are required before changes are made to the budget and the roster template.
    - Roll out of community roster to support improved visibility and easier redeployment of staff across services and settings
    - Ongoing work towards setting roster standards across all units to improve staff deployment, visibility and transparency of staffing, level loading of absences such as training and annual leave, and the oversight and monitoring of core metrics such RN on duty, missed breaks, excess shift hours.
    - Development of roster dashboards
    - Quality improvement event to evolve the current staffing establishment process and governance pathways following the recent Trust restructure.
- **In house nurse bank** which improves nursing staff deployment and ensures thar regular staff, trained to a Trust standard are aligned to our wards.

- Whilst the focus is on staffing establishments, the Trusts has also implemented a number of “invest to improve” initiatives to ensure safer and more effective care can be provided and free up nursing time to care. These include:
    - **Zonal models of Care**-the introduction of zonal models of care and engagement have been shown to reduce the number of falls in our older persons unit, physical interventions related to violence and aggression and a reduction in the harm caused by sexual safety incidents on PICU
    - **Acuity based rostering (Safe Care)-** The introduction of the SafeCare tool to all inpatient areas which is now linked into the staffing escalation procedure. SafeCare enables the input of a daily acuity dependency assessment of the current cohort of patients on the ward which is then inputs into an algorithm to provide a picture of the staffing requirements to meet the dynamic need of the current patient group. As part of the work of the Safe Staffing group will include assurances regarding compliance with the requirements of the tool.
    - **Digital Care Assistant / Vision Based Patient Monitoring System (Oxevision)**-this technology is designed to assist staff by supporting physical health monitoring and risk management, observation, and oversight of our patients particularly during night shift
    - **Ward Clerk Review**- the introduction of 7 day a week admin support to wards to support the provision of an increase in the clinical time available to clinical staff. The impact of these developments has increased the quality of care and patient safety within the Trust and aims to improve upon staff well-being and staff retention.

For the wards at Roseberry Park under the business continuity arrangement, there are currently a number of specific actions taken above and beyond the service actions detailed above to support the delivery of safe and effective care. They are as follows:

- Regular service meetings to review and implement action plan agreed
- Updates and oversight on a monthly basis from care group board, with an opportunity to present any new requests for support
- Support from other areas of the care group, where staff have the relevant skills and experience (outside of acute and PICU wards) to support achieving adequate staffing figures and level loading vacancies across the care group. Staff members allocated to support for a period of at least 3 months for allow for consistency in the service.
- Block booking of agency staff, one staff member for each ward, to allow for consistency of staff on the wards. Robust induction periods provided by the service and staff have been with the service for over 6 months now and are consistent members of the team.
- Shift incentive for staff completing additional hours, has been used and can be applied for at times of particular pressure for the service
- Advertising and recruitment to roles such as Nursing Associate and Registered General Nursing to support the workforce with additional skills not routinely recruited for within the service
- Enhanced recruitment events and social media advertising are currently being arranged across the service
- Recruitment incentive paper is currently being prepared for inpatient services across Roseberry Park Hospital

In addition to actions taken, as part of BCP we have reduced the amount of 'non-urgent' meetings and tasks that need to be undertaken by the service to allow additional time for Ward Managers and Matrons to support wards.

From the team manager's professional judgment review, detailed in appendix 2, the feedback indicates most notably:

- Staffing budget does not meet requirements
- Software training is not sufficient
- Staffing levels do not allow enough time to complete required paperwork
- There is not enough time to perform effective clinical supervision
- A potentially conflicting statement saying that there is enough to lead and manage - this will need further review for a clearer picture
- Insufficient MDT colleagues in the team, most significantly
    - SALT
    - Dietitians
    - creative therapists
    - peer support workers
    - social workers
    - physiotherapists

Work has already commenced with the AHP professional leads to gain a fuller understanding of the equity in provision of service across the care groups. Also, to gain a fuller understanding of the actual demand that is currently being managed by the teams, but the potential hidden demand of the service we would want to provide but is not being addressed due to the ability to meet its requirements. This will allow the Trust to have a more informed position of what the Trust is able to provide to service users and better manage expectations.

Work currently underway with capacity and demand planning for CYPS community mental health teams (CMHT) will be considered for its validity in approach and scalability for other community team to support a better understanding of community team staffing requirements. This will be furthered more by discussion and exploration regarding the new caseload management supervision recording of complexity scores, community-based acuity and dependency assessments, potential use of the Management and Supervision Tool (MaST) (NHS, 2020).

A review of the previous year's assessment for winter preparedness, highlighted in appendix 26b for information, provides priority actions to consider such as the review and update of Business Continuity Plans, the approach to quality impact assessments, and staff well-being support structures which aligns with the *2022/23 priorities and operational planning guidance (NHS, 2022)* which outlines actions that include accelerating plans to grow the substantive workforce and ways of working differently whilst maintaining a focus on the health, wellbeing and safety of staff.

34. APPENDIX 26a

The self assessment tool - B1364_i-Nursin

This embedded document highlights the self-assessment jointly completed by People and Culture and Nursing and Governance. This was a required submission to the NHS team requesting this information.

35. APPENDIX 26b

Winter Preparedness report and position for 2022/23


Winter 22-23 Preparedness.pdf


Winter 22-23 Preparedness Appx 1.


Winter 22-23 Preparedness Appx 2.

Key areas highlighted from the initial review included

- The “risk management approach” in the BAF profiles highlights where the risk score can or cannot be mitigated to tolerable levels. Both strategic risks highlighted above that relate to our winter preparedness approach are not currently within the Boards tolerances for quality, safety and workforce risks. However, there is good and/or reasonable assurance for a number of mitigating actions and controls detailed within the BAF that are in place relating to winter preparedness as detailed further in appendix 2.
- Staff wellbeing support structures and processes are in place across the Trust, however it is not clear how well they are directly aligned to inform upon workforce related issues. The key indicators at present regarding staff wellbeing in the clinical areas appear to be related to sickness absence and a subsequent reliance upon temporary staffing measures to support the absence. It is felt that further involvement and development of measures relating to staff wellbeing will provide additional key information to the workforce planning agenda.
- Demand and capacity modelling for community teams is still in relatively early stages within a community system approach. The Safe Staffing team are currently underway with the rollout of community e-roster, (as required by national requirements), which will further support demand and capacity work, which will benefit from additional support from senior service managers and directors to ensure a timely and smooth implementation; this rollout is currently behind schedule due to competing demands on both services and the team.
- The appointment to a permanent substantive Emergency Planning Lead/Officer will strengthen and support the Trusts position regarding emergency preparedness.
- Further work is required to support the Quality Impact Assessment approach to all staffing changes and requirements to both ensure that all risks are considered, documented, and signed off as required by National mandate. This is currently in place across the Trust regarding changes to team rosters but requires further work and support to embed this process.
- Business Continuity Plans require a process to continually review and update thresholds. Once a new emergency planning lead is in post they will lead on a review of plans and methods used to manage the emergency response during the pandemic.

  Areas for further consideration include:
  - a review of ownership of the plans was suggested by the Operational Support Managers.
  - the way in which critical incidents or events may impact on staffing requires improved engagement and levels of awareness. These areas are captured in

the Risk Register and need to be consistently considered at a more granular level within the BCPs and it is suggested that they could be more explicit and defined for clarity.
    - plans regarding the established nursing workforce and their roles, skills and responsibilities are not consistent across all areas and need further detail to drill down to skills and responsibilities.
    - contingency plans for situations in which the nursing workforce is compromised, understaffed or redeployed requires plans to be aligned to the safe staffing escalation process. This requires a review of action cards that are aligned to staffing escalation and it is suggested that these continue to be embedded in all areas.
    - further embedding the consistency of approach to wards and teams entering and de-escalating from BCP (a review of staffing escalation procedures is underway to address this)
- Processes and structures are in place across the Trust to support governance and assurance of the workforce, however detailed oversight and triangulation of workforce and quality metrics at ward/team level is not yet consistently available.

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