Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

25 May 2023

The Boardroom, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS and via MS Teams at 1.30 p.m.

AGENDA

Standard Items (1.30 pm – 2.00 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 27 April 2023	-	Draft Minutes
5	To receive the Board Action Log	-	Report
6	To receive the Deputy Chair's Report	Deputy 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 23 May 2023*	Board	Verbal

Strategic Items (2.00 pm – 3.10 pm)

8	To consider the Board Assurance Framework Summary Report	CEO	Report
9	To receive the Chief Executive's Report	CEO	Report
10	To consider the Integrated Performance Report	Asst CEO	Report
11	To consider the Corporate Risk Register	CN	Report

Goal 1: To co-create a great experience for our patients, carers and families (3.10 pm – 3.20 pm)

12	To consider the Leadership Walkabouts Report	DoCA&I	Report

Goal 2: To co-create a great experience for our colleagues (3.20 pm – 3.30 pm)

13	To receive a verbal update from the Chair of People, Culture & Diversity Committee	Committee Chair (JH)	Verbal

Exclusion of the Public:

14	**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
19 May 2023

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

Tees, Esk and Wear Valleys NHS Foundation Trust

ITEM NO. 4

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 27 APRIL 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
E Moody, Director of Nursing and Governance and Deputy Chief Executive
L Romaniak, Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley 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
J Boylam, Guardian of Safe Working
K Christon, Deputy Company Secretary

Observers/members of the public:
G Berry, CQC
S Dronsfield, CQC
B Murphy, Chief Nurse designate
N Vaidya, Corporate Governance Officer

23-24/1 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and noted the attendance of S Dronsfield and G Berry from the CQC, and N Vaidya, Corporate Governance Officer.

23-24/2 APOLOGIES FOR ABSENCE

None.

23-24/3 DECLARATIONS OF INTEREST

None.

23-24/4 MINUTES OF THE MEETING HELD ON 30 MARCH 2023

Agreed: *the minutes were an accurate record of the meeting for signature by the Chair, subject to the following amendments:*

- *Correction - 'Executive Directors had been invited to review…' (page 5, para 3)*
- *Correction - '…and use of off framework staffing had been terminated…' (page 8, para 1)*
- *Removal of B Murphy from the list of attendees*

23-24/5 BOARD ACTION LOG

The Chair welcomed the inclusion of narrative on work in progress and in discussion the following points were noted:

(1) [Ref 23/215 – tolerance of high risks] C Carpenter proposed that prior to the BAF review in August, narrative be included in the BAF on the target level of risk.

Action: P Bellas

(2) [Ref 23/242 – Kirkup report] B Kilmurray advised that a video of B Kirkup's presentation to the ICB was available to be shared, but given his limited availability, no separate approach had been made. The Chair supported this revised action and K Kale indicated that there may be an opportunity to progress the action if that was subsequently required.

(3) [23/244 – Freedom to speak up] S Dexter-Smith noted that proposals would be brought forward alongside the workforce report in June. This would articulate how the trust would respond to staff concerns that they had suffered detriment as a result of speaking up.

23-24/6 CHAIR'S REPORT

The Chair introduced the report and in discussion the following points were raised:

(1) The Chair drew attention to his visit to the York Mental Health Hub, where he had been impressed with the service and the opportunity for outcomes that it offered for patients and families. He proposed the board consider holding a session to reflect on what transformation might mean for services in future. **Action: P Bellas**

B Kilmurray welcomed the service as a positive example of mental health transformation, where different approaches had been taken, including with the voluntary sector, to respond to local need.

(2) Responding to a query on visibility, the Chair suggested that there had been positive engagement with leadership visits, with staff pleased and proud to discuss their services.

(3) B Reilly noted from recent visits she had attended, that there was evidence of ongoing interaction between staff and the leadership team.

(4) M Brierley welcomed the value and additional perspective that visits brought to board decision making.

(5) J Preston queried the potential for additional ad-hoc visits by the executive team, where that was possible and the Chair noted the board's aspiration to be transparent and open to staff and he highlighted a discussion by governors on their right to roam, where that would not disrupt services.

(6) P Scott welcomed a mixed approach and noted that visits provided an opportunity for staff to showcase their services and for the board to understand the challenges the organisation faced.

(7) K Kale commented on planned and unplanned visits he had undertaken, which had provided the opportunity to discuss pressing issues that required support. He went on to note that community transformation was also underway at Malton.

(8) A Bridges noted that leadership walkabouts had evolved over time and advised that teams were invited to consider strengths and challenges in advance of a visit. She suggested that teams felt they could be open and honest, and reference was made to a recent 'warts and all' conversation with the patient safety team.

23-24/7 QUESTIONS RAISED BY GOVERNORS

None.

23-24/8 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.

P Bellas presented the report and drew attention to additional detail that had been included on the first line of defence. The Chair welcomed this and noted that that report provided a helpful summary of the trust's strategic risks, key controls and level of assurance. He then invited executive leads to comment.

<u>Recruitment and retention</u>

S Dexter-Smith advised that the impact of action taken was expected to be noted in quarter 2, with the biggest change expected to be evidenced by the staff survey, which would be reported in February 2024. Recruitment across all vacancies had been accelerated and an improvement was expected to be noted from September and work had started on revised job descriptions, to respond to concerns on that qualification requirements had been too rigid.

In respect of sickness absence, she advised that levels were consistent at approximately 5.5%. People partners would work closely with services with higher rates of sickness, with results expected 3-4 months following their intervention.

Reference was also made to positive staff side engagement in a recent cocreation event.

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

(1) R Barker queried the impact that the financial position may have on mitigation and in response S Dexter-Smith advised that there would be a focus on staff retention and sickness and improved workforce planning, rather than an increase in staffing per se.

(2) K Kale advised that a recruitment and retention workshop had been held with medical staff to develop a workforce plan and further international recruitment would take place with a view to a reduction in locum expenditure.

Demand

P Scott advised that strong controls were in place and following a governance review, measures would be introduced to strengthen escalation arrangements and daily oversight. He proposed that the risk be repurposed to factor in quality and safety issues and noted that system alignment and collaboration was required, alongside a continued focus on effective and efficient services. He suggested that there had been progress and updates would be provided to Quality Assurance Committee on the impact of measures that would reduce the risk rating over time.

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

(1) Responding to a query about efficiency measures, P Scott advised that there were a number of metrics within the transformation programmes, including unique caseloads.

(2) B Reilly sought assurance on progress that had been made in respect of bed management and in response K Kale advised that a workshop had been held to understand increased occupancy and use of independent sector beds. He suggested that community transformation work would impact in the long term, meanwhile measures that would avoid the need for admission, for example homebased treatments and measures to reduce length of stay, would be considered.

(3) P Scott indicated that significant work had taken place to understand the issues that had an impact on bed management in order to achieve sustained improvement.

(4) K Kale advised that following discussion at the last board meeting, use of independent sector inpatient beds had reduced to 16.

Involvement and Engagement and Experience

A Bridges highlighted that cocreation was a theme across all five Our Journey to Change strategic documents. She suggested that the trust's ambition, to hear and listen to service users at all levels, was significant and would take time to achieve, and she noted progress that had been made to date including a 350% increase in involvement activity and the employment of lived experience directors. She advised that a cocreation framework would be rolled out to articulate what good cocreation looked like at different involvement levels, with support and training to ensure service users and staff were able to facilitate those discussions.

In respect of complaints, she noted there had been a significant increase in the volume and complexity and advised there would be a comprehensive review of the PALs and complaints, in line with new NHS complaints standards and the ambition to provide a more timely, compassionate and restorative response.

In respect of feedback from the friends and families test, she noted themes around care and communication and commented on the need to triangulate all feedback the trust received.

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

(1) Responding to a query on outcomes, A Bridges advised that there was an aspiration to increase the diversity and number of lived experience roles to 60 in the next 18 months and embed further learning in the organisation.

B Kilmurray suggested timescales would be difficult to determine, but key outcomes would be culture change and improved experience and that key to this would be how well supported individuals were when carrying out cocreation activity.

The Chair suggested that the development of key performance indicators would be important to understand if progress had been made.

(2) B Reilly expressed concern about progress on complaints and in response A Bridges confirmed that the review of the complaints and the PALs service was underway, and a revised policy would be cocreated and developed by January 2024.

(3) J Preston suggested that revised structures ad processes would not guarantee success and the trust would need to measure the views of families and service users to determine if the outcome had been achieved.

Safety

In respect of organisational learning, E Moody advised that good controls and mitigations were in place. Feedback would be provided from the CQC inspection, but the trust had observed that front line staff had a clear understanding of learning from recent incidents, and this strengthened the first line of defence.

Themed work had taken place in relation to serious incidents and there was clarity on those aspects that, if right every time, would reduce harm. In respect of the serious incident and Datix backlog, she advised this was largely due to capacity within the patient safety team and to mitigate this, additional leadership and reviewer capacity and been provided. To support learning, a two stage process for Datix had been rolled out and feedback suggested teams now had a better understanding of their incidents. It was anticipated that the backlog and transformation work around the investigation of incidents, would be completed by March 2024.

She went on to note that progress had been made to identify key performance indicators, but further work would be required to understand how impact would be demonstrated.

In discussion, B Murphy advised that, in follow up to recent incidents, there had been increased leadership involvement in quality assurance processes and clinical leaders within care groups were more sighted on variances. This had led to increased confidence in the first line of defence and its impact.

Bringing the discussion to a close, the Chair welcomed the update and suggested that these be provided on a quarterly basis.

23-24/9 CHIEF EXECUTIVE'S REPORT

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

B Kilmurray introduced the report and drew attention to the following matters:

- The current CQC inspection and the well-led inspection at the end of May, on which the trust would receive a report later in the year.
- The appointment of B Murphy as Chief Nurse from 1 May 2023, following a handover period with E Moody and he invited the board to approve the transfer of statutory roles and designations from the Director of Nursing and Governance to the Chief Nurse.

- The announcement of further industrial action by nurses. He noted that systems would be in place to provide mitigation and to support other trusts, should mutual aid be requested. The current position of other unions was unclear, and he suggested that the trust had a positive relationship locally with the staff side.

  Z Campbell advised that although the strike action by nurses would finish one day earlier than planned, the trust would maintain its incident room for longer in order to respond to any ongoing challenges.

  E Moody noted that additional physical health nurses and medical colleagues would be on site over the weekend to minimise the risk that a patient needed to access A&E.

Agreed: *the board approve the transfer of the following statutory roles and designations from the Director of Nursing and Governance to the Chief Nurse on 1 May 2023.*

Role	***Ref***
CQC Nominated Individual	*Regulation 6, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*
Director of Infection Prevention and Control	*"Winning ways: working together to reduce healthcare associated infection in England" (DH 2003)* *Health & Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance*
Duty of Candour	*Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20*
Learning from deaths/mortality	*National Guidance on Learning from Deaths (National Quality Board – March 2017)*
Safeguarding and prevent	*Children Act 2011* *NHS E/I "Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework"*
Executive Director with responsibility for patient safety	*Referenced in "The NHS Patient Safety Strategy"*
Responsible person – use of force	*Mental Health Units (Use of Force Act) 2018*

23-24/10 INTEGRATED PERFORMANCE REPORT

The board received the Integrated Performance Report (IPR), which aimed to provide oversight of the quality of services delivered and assurance to the board on actions taken to improve performance in required areas.

M Brierley presented the report and drew the board's attention to:

- The reported positive improvement and increased assurance in respect of incidents of moderate harm and near misses, the percentage of staff recommending the trust as a place to work, staff leaver rates and sickness absence rates.

- Areas of concern, where limited performance assurance and negative controls assurance had been reported. This included: unique caseloads, agency expenditure, agency price cap compliance, use of resources rating and CRES performance.
- The development of performance improvement plans (PIPs) where there had been underperformance across a three month period or where the trajectory in the long term plan had not been achieved. PIPs were not intended to be a punitive process but would include smart objectives and provide clarity on where improvements were required.
- Concerns in respect of bed occupancy rates, out of area placements, adult and children autism waiting times and the current position of the Crisis Line, although an improvement had been noted.
- Development of additional committee level measures to support assurance, which would start to be rolled out from May 2023.
- Further development of the culture assessment tool in order that it would be used as part of a basket of indicators and heat maps by wards and wider teams.

The Chair noted that the IPR had received scrutiny from care groups, executive directors and committees, prior to consideration by the board and he invited Z Campbell and P Scott to comment.

Z Campbell suggested that the trust was more sophisticated in how data was used to drive improvement and provide assurance on impact, and she commented on arrangements in North Yorkshire and York that allowed for the triangulation of data at monthly, weekly and daily meetings. She welcomed the introduction of PIPs as an opportunity for the organisation to come together to consider what action was required and commented on the use of deep dives in response to areas of concern.

She advised that there was close scrutiny of safe staffing and the North Yorkshire, York and Selby Care Group had worked closely with people and culture on this, and although progress would take time, some improvement had been noted.

She welcomed the revised governance arrangements for care groups, which had resulted in clarity on the remit of meetings and provided the opportunity for greater focus.

B Kilmurray advised that PIPs would be linked to the accountability framework and provided an opportunity for close scrutiny to determine if progress had been made.

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

(1) J Maddison welcomed the report as a key document, alongside the BAF, by which the board would be assured, and he noted that it provided examples of positive assurance and on the first line of defence. He suggested that there were areas where further assurance was required and expressed an interest in clarity on progress and impact.

He went on to query the reported deterioration in outcomes following treatment for children and young people, and actions to respond to lengths of stay over 60 days.

P Scott advised that the PIPs provided an opportunity to focus on areas of concern, their mitigation and impact, which would strengthen the IPR. There were a number of aspects to the reported deterioration in outcomes and the response to that would sit within the clinical network.

K Kale suggested that a preferred approach would be to measure improvement noted by a reduction or change in symptoms, rather than an overall improvement in a condition and he noted the intention to hold a board session on outcome and assessment measures.

P Hungin supported the described approach.

(2) B Reilly queried compliance with training including that of basic life support and sought assurance in respect of actions to improve the position where there may be pockets of lower levels of compliance.

M Brierley confirmed that compliance data was available at a team level and was part of a suite of indicators that would be discussed at cell and team meetings.

S Dexter-Smith confirmed that information on non-compliance and trajectories were provided at team level and noted that rosters would include information on staff that had completed safety training. P Scott went on to advise that daily operational discussions would consider the balance of adequately trained staff.

E Moody advised that the basic life support training provided by the trust met national standards for immediate life support and she noted that People, Culture and Diversity Committee had proposed the training be renamed to match that used nationally.

Responding to a query, E Moody noted that the proposed action related to a name change only and the level of staff trained remained a challenge.

The Chair proposed that the action log be updated, and a short summary of the position be circulated to the board to provide further assurance. **Action: B Murphy**

J Haley, as Chair of People, Culture and Diversity indicated that the committee had more detailed knowledge on the matter and had noted a positive trajectory on this and also on sickness and recruitment levels.

E Moody, confirmed that the board was already sighted on the matter and noted that, in respect of safe staffing, the board had received a briefing on operational processes in place to ensure daily oversight and escalation. She suggested that the increase in red flags would be welcomed as it demonstrated appropriate use of the system.

Commenting further, B Murphy referenced a CQC report on a trust in the North West, that suggested that their board was not aware of red flags on staffing. In comparison, TEWV board was sighted on and openly debated staffing issues.

(3) B Reilly noted the work undertaken by the trust on risk management and expressed concern that funds had not been agreed for a risk management system lead. In response, E Moody advised that the post was intended to support future development of the risk management system and would be reviewed once the system had been implemented, and future capacity requirements were known.

B Kilmurray suggested the new risk management system would be more efficient than current arrangements and that current capacity was appropriate for its implementation.

(4) P Hungin highlighted the deterioration in the reported unexpected inpatient unnatural deaths and cautioned on the interpretation of the data.

E Moody suggested that the report provided an opportunity to draw the board's attention to areas of risk and mitigation, regardless of overall numbers involved and noted that Quality Assurance Committee would seek assurance on highlighted concerns.

B Reilly noted assurance work done in respect of unnatural deaths and suggested that they would continue to be a concern of Quality Assurance Committee and the board

(5) L Romaniak advised that the trust had submitted the annual accounts for 2022-23 and noted that, despite reported challenges from quarter two, the final position was slightly above the required surplus, due to recovery actions. She suggested that the position represented a significant trust achievement and that the board had been clear that this must be without an impact on safety and safe staffing.

The Chair and B Kilmurray welcomed the position and thanked staff for their hard work, in what was a complicated NHS financial framework.

Bringing the discussion to a close the Chair noted the progress made on development of the IPR. He welcomed the development of PIPs to give focus to mitigation, outcomes and timescales and proposed that the board be kept appropriately sighted on progress.

23-24/11 OUR JOURNEY TO CHANGE DELIVERY PLAN

The board received the Our Journey to Change Delivery Plan 2023/24 for approval.

M Brierley presented the report and noted that:

- The plan had been derived from the five cocreated strategic journeys and reflected the external environment and financial position.
- The plan acknowledged that the trust would not be able to deliver all priorities at once, and activity had been planned across the year with a number of areas already in progress.
- A quarterly report would be provided to the board to measure progress against key deliverables, with committees to receive detailed assurance reports.

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

(1) J Maddison advised that Strategy & Resources Committee (S&RC) had reviewed the draft plan and he noted the current financial position and the impact of the late national financial plan submissions for 2023/24. He proposed that the quarterly report to the board included an assessment of the financial impact on delivery of proposals. **Action: M Brierley**

The Chair concurred and also requested that the extent to which the financial position would impact on priorities for 2023/24 be reflected in the Board Assurance Framework and the Corporate Risk Register. **Action: P Bellas, L Romaniak, B Murphy**

C Carpenter welcomed the clarity this would provide and advised that S&RC would discuss financial risk to delivery of the plan at a future meeting. She proposed that progress on the plan also be presented to the committee but in a way that avoided duplication of the board report. **Action: M Brierley**

(2) Responding to a query from J Preston, M Brierley advised that the deliverables within the plan would not be included within the IPR but delivery would impact on performance that was monitored through the IPR.

(3) J Preston welcomed the inclusion of Autism within the delivery plan and in relation to the neuro-development assessment service, he advised that the Autism Task & Finish Group had invited colleagues from the Integrated Care Board to its next meeting to discuss waiting lists. The Chair proposed that feedback from that discussion be shared with the board.

Action: J Preston

(4) B Kilmurray advised that further work would take place to ensure there was a common approach to delivery of the plan and to ensure there would be no duplication of effort.

Bringing the discussion to a close, the Chair welcomed the development of the plan and the clarity it provided. He suggested that target deadlines be set for outstanding areas, and all targets be reviewed to ensure they were appropriate. **Action: M Brierley**

The Chair proposed that consideration be given to how the quarterly progress report would be provided to S&RC and the board and how the agreed plan would be reported to governors, as it provided a means by which they were able to hold the board to account.

Action: M Brierley

Agreed: *the board approve the Our Journey to Change Delivery Plan 2023/24 and authorised the communication of it to partners, staff, service users and carers.*

23-24/12 LEADERSHIP WALKABOUTS

The board received the report, which summarised feedback from the April leadership walkabouts to Community Mental Health Transformation teams offering learning disability services, including respite support, to support the board's understanding of strategic risks and the operation of key controls.

A Bridges presented the report and highlighted:

- Strengths that had been observed, including that services worked closely with carers and families to provide patient centred care.
- The impact of under capacity in the wider system, which had a significant impact on learning disability services.
- Challenges in respect of recruitment and retention and she noted that this would be a focus for the next themed visits.

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

(1) P Hungin queried the mechanism for translating reported challenges into positive action and in response A Bridges advised that feedback had been provided to the relevant directorate and work was underway to triangulate challenges with feedback from serious incidents, complaints and PALs, to identify common themes.

As an example, K Kale advised that queries raised in respect of space in GP surgeries had been provided to estates to respond to and that contact had been made with the acute trust in relation to A&E concerns.

P Scott suggested the trust was already sighted on challenges that were often raised and would respond, outside of the need for a formal action plan.

(2) In respect of community learning disability services, B Kilmurray advised that work was underway with partners to review the pathway, as part of the transforming care programme.

He suggested that the board may wish to return to a strategic conversation in respect of respite care.

(3) R Barker reflected on a visit to services in Knaresborough where she suggested the service seemed isolated from the rest of the trust. In response, Z Campbell indicated that she was not aware of this but noted the concern raised and she advised that the service was part of a wider learning disability team.

(4) J Haley suggested the board would take reported challenges seriously and she noted that in follow up to a visit to Flatts Lane, she had brokered a conversation with a supported housing organisation who had local vacancies.

The Chair welcomed this approach and acknowledged that this was an advantage from a board with a range of skills.

The board then had a short break.

23-24/13 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

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

B Reilly, Chair of the committee, summarised the report and highlighted:

- There continued to be a serious incident backlog and committee had been alerted to an increase in seclusion incidents.
- There had been an increase in patients feeling unsafe on wards in Durham, Tees Valley and Forensics and committee would receive a further report at its next meeting.
- Committee had requested a progress report in June on the Crisis Line, and it was expected that an update would be provided to the Council of Governors next meeting.
- There remained significant challenges in respect of safe staffing and the Hard Truth's Nurse Staffing Report had been appended to the committee report.
- Committee would receive a report in June on the outcome of work that had been commissioned from internal audit and NECS in respect of duty of candour.
- Positive feedback that had been received from MerseyCare in respect of adult learning disability inpatient services and it was expected that committee would agree to stand this down from regular reporting, at the next meeting.
- There had been a significant improvement in the timeliness of reviews and updates included in the Corporate Risk Register.
- Committee would hold a development session in May to consider its role and remit, one year on from the new structure and following the recent governance review.

Commenting further, E Moody advised that a review of progress against the recommendations of the three Niche reports was expected in May 2023. Substantial progress had been made and an initial review of evidence had not highlighted any risks. A final report would be provided from West Lane Project Committee, after which, reports would be provided to Quality Assurance Committee.

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

(1) In response to a query, B Kilmurry advised that the findings of the review would be presented back to the NHS England Quality Board. E Moody also noted other agencies

would be involved in providing evidence, where recommendations had required a multiagency response.

(2) J Preston queried the ability to measure the impact of improvement and in response E Moody suggested it was a challenge to measure where there had been a positive outcome and instead there would be a focus on themes and learning. She noted that the trust had greater levels of compliance with standards and increased line of sight on hot spot areas, which suggested there had been an improvement.

Commenting further, B Murphy suggested that it was not possible to demonstrate cause and effect. The trust had taken action to implement learning from the Niche reviews and had not seen a reoccurrence of the same themes in recent incidents.

K Kale suggested there was potential to review the numbers of incidents related to a particular theme, in order to demonstrate impact.

(3) C Carpenter suggested that the trust was very good at reviewing serious incidents and learning from deaths, but the board was not always sighted on what action had been taken in response.

The Chair welcomed the opportunity for the board to close the loop on reported incidents and invited a further discussion on how that could be achieved.

Action: B Murphy

23-24/14 HARD TRUTHS NURSE STAFFING REPORT

[The report was included as an appendix to the Quality Assurance Committee and further detail had been provided within the Establishment Reviews report]

23-24/15 LEARNING FROM DEATHS REPORT

The board received the report, which aimed to provide assurance that the trust's approach to learning from deaths, was in line with national guidance.

E Moody presented the report and highlighted:

- A detailed report had been provided to Quality Assurance Committee on the improvement plan in respect of the period where a heightened number of deaths had been reported.
- There had been several areas of focus, which included a reduction in variation and the ligature reduction programme. No systemic issues had been identified in relation to risk assessment and management.
- A weekly patient safety huddle was held to provide oversight on patient safety incidents and the trust's improvement programme.
- Planning was underway for an annual safety summit in June.
- In line with transition to the new risk framework, a systems based approach to learning had been taken, which recognised that in complex areas there was rarely a single cause.
- Progress against key milestones would be reported to Quality Assurance Committee.
- There had been a significant focus on the quality assurance schedule and tools in inpatient services, which would be rolled out to community services.

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

(1) C Carpenter welcomed the report and proposed that additional information be included to show what action had been taken from the previous report. The Chair supported this request. **Action: B Murphy**

(2) B Reilly advised that the report had not been considered by Quality Assurance Committee, but that elements of it had been received via other reports and queried if Quality Assurance Committee should review the report to provide assurance to the board.

E Moody proposed that this be discussed at the committee development session and suggested there would be a benefit to this if timescales would allow.

(3) Commenting on the safety summit in June, B Kilmurray advised that Liz Durrant had expressed an interest in attending and he highlighted the potential to launch the improvement programme at the same time.

23-24/16 GUARDIAN OF SAFE WORKING ANNUAL REPORT

The board received the report, which aimed to provide assurance that the terms and conditions of the junior doctors' contract had been adequately fulfilled by the trust.

J Boylan, Guardian of Safe Working, presented the report and highlighted:

- The trust continued to fulfil the requirements of the contract and had maintained clear lines of communication for junior doctors to raise concerns.
- There continued to be high levels of work intensity in Teesside, Scarborough and York and it was anticipated that the introduction of residential on call rotas would help to obviate this.
- Recent industrial action had been well managed, with cover and support provided by senior medical staff and there had been no reported consequences.
- The trust had struggled to maintain the senior medical workforce at a sufficient level in some areas to support supervision for junior doctors. This would on the impression that trainee doctors had of the trust and may impact on their interest in future employment.

Commenting further, K Kale advised that:

- The trust had developed a medical charter, to respond to staff requirements.
- Work was underway in respect of on call rosters, although the trust was not a significant outlier when compared to others.
- The trust had a significant level of senior medical vacancies and this impacted on capacity for supervision and alternative options had been considered, which included additional international recruitment.

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

(1) Responding to a query on the morale of junior doctors, J Boylan advised that junior doctors were well cared for, but there was some of dissatisfaction, and they were concerned for their immediate circumstances as well as their future prospects. He suggested this echoed the national position and proposed that the trust triangulate data from exit interviews with the wider views of senior doctors.

(2) B Kilmurray suggested that the charter would support engagement and improve the experience of medical staff and he acknowledged that the position needed to be monitored.

(3) P Scott advised that dissatisfaction and the level of staff leaving was also of concern to care groups and discussed in weekly cell meetings with medical directors. He suggested that whilst the charter was important, the trust also needed to put in place tangible action to show intent.
(4) Responding to a query, B Kilmurray suggested that the new NHS workforce strategy would include the mental health workforce.

The Chair brought the discussion to a close. He advised that the board had noted the two key issues raised by J Boylan and feedback from K Kale, and he welcomed an update with the next report. **Action: J Boylan**

23-24/17 OUTCOME OF THE ESTABLISHMENT REVIEW

The board received the report, which aimed to provide assurance on the trust's clinical team staffing establishments reviewed over the period September 2022 to February 2023, in line with national regulatory requirements.

E Moody presented the report and drew the board's attention to:

- Low registered nurse (RN) fill rates and high health care assistant (HCA) fill rates in psychiatric intensive care units and adult mental health admission wards.
- The RN to HCA skill mix across services, which had been impacted by the high use of temporary staff to meet acuity and complexity of patients.
- That average bed occupancy often exceeded 100% in adult mental health inpatient services and psychiatric intensive care units and the impact of this on staffing requirements.
- That despite increased headroom for RN following the last review, there remained teams who had not met the target and therefore struggled to manage unavailability such as study leave and sickness.
- The reported improvement in inpatient teams that were rated as red and red/amber, which had dropped from 30 to 5. Further analysis of this would be completed but it was considered to be indicative of increased oversight and operational mitigation.
- The reported improvement in community services that were rated as red and red amber, which had dropped to 9.
- The reported improvement in breaks missed.
- The actions outlined by care groups to address risks highlighted in appendix 5 of the report.
- Proposed further consideration by the Executive People, Culture and Diversity Group and financial modelling to respond to requirements and to support changes to the learning disability and older persons staffing requirements, approved in September 2022, which would be reported to the board for approval.
- The proposal for People, Culture and Diversity Committee (PCDC) to carry out a review to provide assurance on actions undertaken.

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

(1) The Chair welcomed the opportunity for review by PCDC and suggested that the report should not be viewed in isolation from other activity.

He noted the length of the report and the ability of the board to easily understand underlying themes and areas of concern and proposed that the next iteration summarised actions that were proposed to mitigate risks highlighted and outlined the level of assurance provided to the board. **Action: B Murphy**

B Reilly concurred with this proposal.

(2) J Haley provided reassurance that PCDC was sighted on the issues raised in the report and advised that PCDC and S&RC were due to receive workforce planning reports, which would be driven by in-depth knowledge of vacancies and the clinical journey.

(3) L Romaniak commented on the need to reflect on the differences between immediate safer staffing issues highlighted in the paper, and longer term recurrent ward establishment requirements. Currently, staffing requirements reflected a significant financial pressure due to higher than funded occupancy and pressures related to adult learning disability care packages. The recurrent staffing establishments would need to consider ongoing staff requirements, making best use of resources and actions that would lead to a reduction in occupancy levels and length of stay.

(4) C Carpenter welcomed the reduction in teams rated as red and red amber and noted that the outcome was still not where the trust would wish to be.

She proposed that the workforce reports to PCDC and S&RC comment on the assumptions or mitigation that would be required to achieve the financial plan. **Action: S Dexter-Smith**

(5) J Maddison welcomed the improvement in teams rated as red and red amber. He noted the impact from working under pressure during Covid and queried how the trust was able to future proof its position, to take account of demand and how that would be managed through transformation.

He welcomed the reports to PCDC and S&RC and proposed a board seminar be held, as the workforce was fundamental to safe delivery and patient care. **Action: P Bellas**

(6) B Murphy advised that there was no required format for the report and proposed that, if the board was able to manage its curiosity, a more concise report setting out the analysis, risk assurance and proposals could be provided.

Bringing the discussion to a close, the Chair suggested the report highlighted issues that were well known to the trust and were part of its current strategy, with short term actions in place to manage risk and business continuity and medium term actions to ensure the skill mix between RN and HCA and other professions.

23-24/18 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 6.45 pm.

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Chair
25 May 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
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 results of a trustwide deep dive. **May-23: Completed - Discussed by PCDC - all directors have plans in place that align with the workforce delivery plan.**
29/09/2022 22/10/2022 27/04/2023	22/144 22/174 23-24/06	Topics for board seminars	a) Mental Capacity Act b) Reported outcomes following treatment c) what transformation may mean for future services	MD CEO Co Sec	Jun-23		Apr-23: proposed board & committee dates circulated w/c 24 April for consultation **May-23: the seminar programme will be developed to take account of topics identified by the board during the year.**
24/11/2022	22/186	Patient/Staff/Partner Story	The next patient/staff/partner story to be held at the January 2023 board meeting.	CN	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 **May23: the CEO and CN have agreed a proposd approach and stories will recommence from June 2023.**
24/11/2022	22/190	IPR	Report to be developed to include a forward view on actions required to ensure progress is made.	ACEO	May-23		**See agenda item 10**
26/01/2024	23/217		Detail be included in the IPR to provide clarity on smart objectives, outcomes and impact.	ACEO	May-23		**See agenda item 10**
23/02/2023	23/237		IPR to be updated to include: a) Updated information on the position in respect of serious incidents to be captured by the IPR. b) IPR to include information on actual impact c) improvement plan to be developed for staff appraisals	CN ACEO DfP&C	May-23		**May23:** **In respect of a) and b), Ensuring the IPD reflects the required information floor to board, has been considered by QuAC and the next step is for EQAIG to stand back and review. It is anticipated that this action will be complete in July-23** **c) A Performance Improvement Plan has been completed**
26/01/2023	23/215 23-24/5	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

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
26/01/2023	23/215		Risk tolerance - 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	Jun-23		Mar-23: Discussed by QuAC in March-23 Next cycle of committee meetings will be May 2023
27/04/2023	23-24/11		BAF report to reflect the impact of the financial position on delivery of priorities for 2023/24	Co Sec DoFI&E	Jun-23		**May23: Linked to full review of the BAF due to commence in May-23**
26/01/2023	23/215	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
23/02/2023	23/239	Corporate Risk Register	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.	CN	May-23		**May23: Completed**
23/02/2023	23/239		Action to be taken in respect of actions that had passed their review date.	CN	May-23		**May23: Completed - Addressed by the Exective Risk Group on 23-May-23**
25/04/23	23-24/11		CRR to reflect the impact of the financial position on delivery of priorities for 2023/25	CN DoFI&E	May-23		**May23: Completed**
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	Jun-23		April-23: Report to be combined into a broader paper to the board in June. **May-23: A report will be presented to the next meeting of PCDC. This includes the agreement, clarified with the NED Champion and P&C team, about how we will respond to concerns about detriment.**
27/04/23	23-24/10	Basic life support training	Briefing to be circulated to the board on the current position, to provide assurance	CN	May-23		**Completed: included in the letter of response to the CQC dated 18/05/23 and included in the board papers May-23**
27/04/23	23-24/11	Our Journey to Change Delivery Plan	Quarterly report to the board to include an assessment of the financial impact on delivery of proposals	ACEO	Jul-23		
27/04/23	23-24/12	Autism T&F Group	Update to be provided from the T&F group discussion with the ICB on waiting times for the neuro-development assessment service.	J Preston	Jun-23		**May23: Update to be provided following the T&F meeting on 28 May.**

Tees, Esk and Wear Valleys NHS Foundation Trust

Deputy Chair Public Board Report

May 2023

May has been an incredibly busy month for the Trust both internally and externally. I have attended the usual events on behalf of our Chair:

Core Business

- Mental Health Chairs weekly call facilitates by NHS Providers topics included prevention and population health management and The Hewitt Review.
- Board seminar on our upcoming Well Led inspection.
- Non Executive Directors meeting which provides a forum for discussion and updates with the Chair.
- Committee Chairs meeting where we discuss cross cutting themes across each committee. The focus this month was how we manage risks that align to one Committee, but are also pertinent to other Committees.
- Several catch ups with the CEO on key issues.
- Attendance at the Audit and Risk Committee.
- Humber and North Yorkshire Chairs meeting.
- April Living Our Values judging
- Meeting and awarding prizes for Living Our Values awards

As well as Core business, there are three elements I wish to draw out from the last month.

Quality Assurance Committee Development Session

As Chair of the Quality Assurance Committee, I requested that we have a facilitated development session which allowed members to have a "stock take" of where we are as a year has passed since our organisational restructure was implemented and we have had an internal governance review. We have also had feedback from our Intensive Support Team colleagues. The session focused on our role and purpose, membership, focus, underpinning structures and expectations. The Chief Nurse as Executive sponsor and I, will have responsibility for taking forward the agreed actions to ensure our journey to improvement continues.

Our Admin Journey to Change

On a recent visit to Eastfield Clinic in Scarborough, I met Diane Burlingham, Professional Administration Lead for North Yorkshire Learning Disability Services. Di gave me an insight into some of the fabulous work that is underway with "Our Admin Journey to Change". I have had a follow up Teams meeting with her and now have a great insight into how important this work is and how valued our staff feel. Having worked in the NHS for 36 years I do not think I have seen anything as meaningful as this for admin colleagues. As well as the main group (which has gone from 6 people with interest to over 70), there are sub groups underpinning covering:

- Training, development and talent management
- Supervision
- Job description reviews
- Recruitment retention and apprenticeships
- Communication

They are about to have their own intranet page and I have offered to attend a “coffee break” session. Ive also suggested that they take over Brents Blog….if he allows! Thank you to Sarah Dexter Smith, Director for People and Culture for your leadership with this, it is clearly valued by our staff.

Visit to Lanchester Road Hospital

The Chief Executive, Sheila Halpin, General Manager for Learning Disabilities and Autism and I hosted a welcome visit to Lanchester Road Hospital from Councillor Chris Hood, Health and Well-Being Board Chair and Portfolio Holder for Adult and Health Services and Councillor Patricia Jopling, Adults, Well-being and Health Overview and Scrutiny Committee Chair.

We visited our Adult Learning Disability wards and our Adult Female Mental Health ward. The visit was most welcomed by our Councillor colleagues. Our staff could not have been more passionate about the care they provide to our patients, often under difficult circumstances. Huge thanks to Ward Managers Amy and Daniel for their time, transparency, insight and advocacy. Thanks also go to the patients who took the time to speak with us too.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 8

For General Release

Meeting of:	**Board of Directors**
Date:	**25th May 2023**
Title:	**Board Assurance Framework – Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Phil Bellas, Company Secretary**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
11	Governance & Assurance	The Board Assurance Framework supports the Board discharge its overall responsibility for internal control.

Executive Summary:

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

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

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

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

The full BAF is provided under confidential agenda item 9.

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

Recommendations: The Board is asked to take the strategic risks into account during its discussions at the meeting.

BAF Summary

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
1	✓	✓		**Recruitment** Inability to recruit sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services	**DoP&C**	**PCDC**	**High** ↓	**Low (Dec 23)**	**Good** ↑	Recruiting Managers Recruitment Team	Establishment Reviews Recruitment Oversight Group Recruitment & Selection Procedure "A great place to work" Partnerships with Education and Training Providers↑ Planning beyond the Crisis↑	**Positive: -** **Negative: -**	
2	✓			**Demand** Demand for our services, particularly as a result of the post-Covid surge, might result in us not being able to meet patient/carer expectations or commissioner requirements	**MD (DTV&F)**	**QuAC**	**Moderate** ↓	**Moderate (Mar 23)**	**Good** ↑	Ward and team managers Bed Management function Daily Lean Management Huddles Daily staffing calls Daily bed management calls	Partnership Arrangements Surge Modelling Operational Escalation Arrangements↑ Integrated Performance Reporting Establishment Reviews	**Positive: -** **Negative**: -	
3	✓			**Involvement and Engagement** A fragmented approach to service user and carer engagement and involvement might prevent us from co-creating a great experience	**DoC&I**	**QuAC**	**Moderate** ↔	**Moderate (Mar 23)**	**Good** ↓	I&E Team Lived Experience Directors Service managers	Revised Executive and Organisational Leadership Structure Business Plan (Co-creation priorities) Co-creation Programme Board Co-creation Journey (new) Lived Experience Advisory and Reference Network (new)	**Positive: -** **Negative: -**	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3										
4	✓			**Experience** We might not always provide a good enough experience for those who use our services, their carers and their families, in all places and all of the time (see also BAF refs 1 (recruitment) and 6 (Learning))	**DoCA&I**	**QuAC**	**High** ↔	**Moderate** (Mar 23)	**Reasonable**	Frontline staff operating in accordance with the Trust's values and policies and procedures Peer Support Workers Patient Experience Team	Complaints Policy Friends and Family Test/Patient Experience Survey Patient and carer engagement and involvement structures and processes Our Quality and Safety Strategic Journey	**Positive: -** **Negative:** **IPR:** Metric 9 - Number of inappropriate OAP bed days for adults that are 'external' to the sending provider – *Reduced assurance*	
5	✓	✓		**Staff Retention** Multiple factors could contribute to staff not choosing to stay with the Trust. This will undermine the provision of safe and sustainable services as well as putting individual staff and patients at risk of harm.	**DoP&C**	**PCDC**	**High** ↔	**Moderate (Dec 23)**	**Good** ↑	Ward and team managers Guardian of Safe Working Freedom to Speak Up Guardian Organisational Development Team EDI Team Communications Team Employee Support Service Trust Health and Wellbeing Leads	Understanding the cultures that exist across the organisation Health and Wellbeing Group and offers Ensuring staff are able to raise concerns in a safe and constructive way Work with services to resolve problems in relationships and culture, based on ABC model of wellbeing Ensure that we provide multiple spaces where staff can explore difficult and complex situations with each other safely and in line with our Trust values Cultural embeddedness in communities we serve Understanding why people choose to leave the trust or move roles↑	**Positive: -** **Negative:** **IPR:** Metric 18 - Staff Leaver Rate – *Deterioration in performance*	
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	**DoN&G**	**QuAC**	**High** ↔	**Low (Mar 23)**	**Good**	All frontline staff Patient Safety Team Complaints and PALS team Legal Services Team (claims) Communications Team	Incident management policies and procedures Governance arrangements at corporate, directorate and specialty levels Performance Management of Serious Incident Review Organisational Learning Group (OLG)	**Positive: -** **Negative:** **IPR:** Metric 11 - The number of Incidents of moderate harm and near misses -*Deterioration in performance*	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3										
7	✓	✓	✓	**Infrastructure** Poor quality physical or digital infrastructure could impede our ability to co-create a great experience both for staff and for patients [excludes CITO (see risk 12), Cyber security (see risk 8) and RPH (see risk 14)].	DoF&I	SRC	**Moderate** ↔	**Low (2025)**	**Good**	Ward and team managers and staff Estates Directorate Management Team IT staff Digital Programme Board Digital Performance & Assurance Group Capital Project Steering Group	Estates Master Plan (EMP) ERIC PLACE national annual reporting / benchmarks and Green Plan submission and monitoring Premises Assurance Model	**Positive: -** **Negative:**	
8	✓	✓	✓	**Cyber Security** A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage	DoF&I	SRC	**High** ↔	**High (Mar 24)**	**Reasonable** ↓	All staff trained and acting in compliance with Trust IG policies CIO and Deputy CIO Technical Delivery Manager and technical team Communications Team Digital Programme Board Digital Performance & Assurance Group	Controls information not provided due to security concerns	**Positive: -** **SRC:** Cyber Strategy – assurance provided that despite the revised investment the Trust would remain safe. **Negative: -**	
9	✓	✓	✓	**Regulatory Action** Further regulatory action could result in loss of confidence and affect our reputation among service users, staff, and other key stakeholders (see also BAF ref. 11 – Governance and Assurance)	CEO	QuAC	**High** ↔	**Moderate (Mar 23)**	**Good**	All staff delivering services in line with approved governance policies Policy authors ensuring compliance with best practice Ward and team managers ensuring awareness of regulatory requirements amongst staff	Senior secondments and interim appointments Relationship Management Arrangements with the CQC CQC Action Plan	**Positive: -** **Negative: -**	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3										
10			✓	**Influence** Changes in the external environment, and insufficient capacity to respond or to align our objectives with those of partners, might lead to loss of strategic influence and reputation	Asst CEO	SRC	**Low** ↓	**Low (Mar 23)**	**Substantial** ↑	Trust representatives on partnership bodies and groups	ICS level governance arrangements↑ Specific Local Partnership Boards and Contact Management Boards↑ Provider Collaborative Boards (PCB) Monitoring of the External Environment Business Planning framework Executive and Operational Organisational Leadership and Governance Structure	**Positive: -** **Negative: -**	
11	✓			**Governance & Assurance** The absence of a clear line of sight from ward to Board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risks to patients	CEO	QuAC	**Moderate** ↓	**Moderate (Mar 23)**	**Good** ↑	Executive Directors Co Sec Dept Members of the tiers of governance in the Trust All staff re compliance with policies and procedures including escalations Head of Risk Management	GGI Well-Led Implementation Plan Executive and Operational Organisational Leadership and Governance Structure↑ Quality Improvement Approach and Team Executive Leadership Group Arrangements	**Positive**: - **Internal Audit:** ▪ Compliance audit of Risk Management and Board Assurance Framework (Draft) – Good Assurance ▪ Interim Independent Assessment of the Data Security and Protection Toolkit: ▪ Overall risk assessment against the 10 National Data Guardian Standards - *Moderate* ▪ Confidence level in the veracity of the self-assessment – *Substantial* **Negative**:	
12	✓	✓	✓	**Roseberry Park** The necessary Programme of rectification works at Roseberry Park and associated legal case could adversely affect our service quality/safety and financial, reputational and regulatory standing	DoF&I	Board	**High** ↔	**Moderate (Jan 26)**	**Good**	Director of Finance, Information and Estates/Facilities Management Programme Director, Programme Manager and team re rectification programme RPH weekly Huddle Capital Project	Roseberry Park Rectification Programme External Technical Expert Support Capital Programme Legal Support External Audit	**Positive:** **Negative:**	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3							Steering Group			
13	✓	✓	✓	**West Lane** The outcome of the independent enquiry, coroners' investigations, and civil legal actions could affect our reputational and regulatory standing if the Trust is not able to demonstrate the necessary improvements and approach	CEO	WLPC	High ↔	20 (Jan 26)	Good	Director of Nursing and Governance West Lane Project Director Communications Team Clinical network	Controls information subject to legal privilege	**Positive: -** **Negative: -**	
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	DoFI	SRC	High	Moderate (Summer 2024)	Good	CITO Delivery Team CITO Clinical Sub-Group CITO Project Board Digital Programme Board	Project Governance ↑ Staff CITO Awareness and Training Clinical Safety↓ Clinical Capacity to support the development and implementation of CITO CiTO supplier Clinical and Technical Support	**Positive: -** **Negative: -**	**Confidential Agenda Item 3 – CITO Update Report** This report provides an update on the CITO project and covers: ▪ Key milestones – Training Course Delivery / Minimum Viable Product ▪ Progress on training ▪ Go Live Planning ▪ Dress rehearsal Planning ▪ Civica Delivery ▪ Communications
15	✓	✓	✓	**Financial Sustainability** Failure to gain a fair share of resources for the Trust and mental health could impact on the delivery of Our Journey to Change and the sustainability of services	DoFI	SRC	High ↔	Moderate (2025 – review)	Good ↑	Financial Sustainability Board Budget Managers	Mental Health Partnership Boards ICP/ICB Funding Arrangements ↑ Provider Collaboratives Business Planning and Budget Setting Framework Financial Sustainability Board	**Positive:** **SRC**: ▪ Financial outturn 2022/23 – The Trust has reported an operational surplus based on a favourable variance from plan before fixed asset impairments and peppercorn lease depreciation, subject to external audit review. ▪ National IT Bids – Assurance on the appropriate spend of the national Frontline Digitisation Funding within 2022/23 and use of resources in 2023/24. **Negative**: - **SRC**: See Committee 3As report (confidential agenda item 6)	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 9

For General Release

Meeting of: **Board of Directors**
Date: **25 May 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***
4	Experience	• The supply of good quality food is an essential part of the inpatient experience. As such the item on the catering contract has a material impact on this risk area.
1	Recruitment	• International recruitment is a major part of our approach to addressing recruitment challenges. It is important it is done ethically and results in high quality colleagues joining us.
5	Retention	• Terms and conditions – including pay are a key an acknowledge pressure on staff and impact on their experience. It is reported some staff are leaving due to the levels of pay. The pay deal goes some way to addressing this.
9	Regulatory Action	• It is important that the Trust demonstrates progress in this current inspection. A key part of the context we operate in is the ongoing legal cases the CQC has brought.

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:	Inpatient Catering Contract International Nurse Recruitment Pay Agreements CQC Well Led Inspection CQC Prosecution
Prior Consideration and Feedback	n/a
Implications:	No additional implications.
Recommendations:	The Board is invited to receive and note the contents of this report.

Inpatient Catering Contract

We have previous briefed the Board that Tillery Valley Foods (TVF), the provider of our inpatient food was in financial difficulties. It has now been confirmed that they have sadly entered administration. The service was procured through NHS Supply Chain. Through that framework the are contingency and business continuity arrangements available. To this end, the Trust is now transferring its contract to Yearsley, an alternative provider for a period of 6 months (plus 3 months extension option). This will allow us to consider future options.

The Trust's command arrangements kicked in and there is a phased transition in place and is now being carefully managed. The Trust is content that there is now continuity of supply in place, and we will now start to work with Yearsley to ensure that there is good quality control, choice and special dietary needs are accommodated.

The Executive is being briefed by exceptions and through a weekly update at Executive. We will keep the Strategy and Resources Sub-Committee appraised of progress and the plans to develop a forward plan.

International nurse recruitment

The Nursing and Midwifery Council (NMC) have informed Trusts that data from a Nigerian CBT test centre (site 53579) had come to light that was showing some anomalies which has in turn put doubt on the centre's creditability.

To date 512 nurses currently on the NMC national register are believed to have used this test centre and these were all written to by NMC and informed they must inform their respective organisations should they receive a letter. There are thought to be 1400 applicants currently going through the process that have used this test centre and the NMC are looking into. The NMC advised that we continue with recruitment and any individuals found to have used this test centre will be offered the opportunity to re-sit the assessments.

TEWV have a small number of nurse applicants from Nigeria at various stages of the process. The NMC have been very clear that we are to continue as normal while they investigate. It would, in any case, be difficult for us to identify if our staff are affected without NMC involvement as we are not given the CBT testing site number.

Pay Agreements

The NHS Staff Council has agreed by majority vote to settle the pay dispute. The Government had tabled an offer on 2nd May for Agenda for Change staff covering 2022/23 and 2023/24. This is included a non-consolidated amount of a minimum £1,655 for 2022/23 and a consolidated increase of 5% for 2023/24. There were other measures in the offer for Bands 1 and 2 staff.

The Royal College of Nursing (RCN) and Unite voted against the offer. The RCN is about to start balloting members nationally on potential further industrial action.

In a linked development, the British Medical Council is currently balloting Consultant medical staff on possible industrial action. As yet, there is still no resolution to the dispute with Junior Doctors.

Care Quality Commission Well Led and Core Services Inspections

As previously reported to the Board the CQC has commenced inspections of the Trust. The well led inspection will be between 24th to 26th May. This has automatically triggered a range of core services inspections.

I attached a letter setting out some initial feedback from the CQC. Whilst there are some key issues for us to consider, it is clear that the CQC has acknowledged important improvements in a number of important areas.

There are some themes for us to consider as a Board going into our well led inspection, that the CQC's feedback highlights, most of which are covered through our Board Assurance Framework, Corporate Risk Registers, Quality Assurance and Integrated Performance Framework and our Annual Delivery Plan.

The main themes identified are:

- Supervision
- Mandatory Training
- Basic Life Support

We have written back to the CQC with some supporting information, as well as some clarifications. We have sought some clarifications on points they have made to ensure we can give them the clearest response.

I attach the letter from the CQC at appendix 1. We will share our response with the Board later.

Care Quality Commission Prosecution

I attended Teesside Magistrates Court with colleagues on 17th May. As the Board is aware the CQC is prosecuting over alleged breaches to Regulation 12. The proceedings were adjourned until 2pm 26th September to enable further expert reports to be submitted. The adjournment was submitted to the Court with the agreement of the CQC.

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Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By Email

Brent Kilmurray
Chief Executive
Tees Esk and Wear Valleys NHS Foundation Trust
West Park Hospital
Edward Pease Way
Darlington
DL2 2TS

05 May 2023

CQC Reference Number: INS2-15061504161

Dear Brent Kilmurray,

Re: CQC inspection of:

Acute wards and psychiatric intensive care units
Mental health wards for older people
Wards for people with a learning disability or autism
Community mental health services for people with a learning disability

Following our verbal feedback meetings with your colleagues, I thought it would be helpful to give you written feedback as highlighted at the inspection(s). As discussed, I am reissuing the feedback letter with amendments to the section in relation to wards for people with a learning disability or autism. I have now also included the feedback in relation to the inspection of community mental health services for people with a learning disability.

This letter does not replace the draft report we will send to you, but simply confirms what we fed-back and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report, this correspondence should be used to inform discussions with the board.

An overview of our feedback

Acute wards and psychiatric intensive care units:

Areas for improvement / further corroboration:

- We found that patients had limited access to therapeutic activities.
- Not all staff understood how to support patients who self harmed regularly and they were not clear on the self harm pathways in use within the trust.
- Staff told us that clinical supervision was not always available.
- Staff told us that they were not compliant with mandatory and statutory training.
- We had concerns about the environment on Cedar ward at West Park Hospital. The distance of the benches from the low roof in the courtyard created a climbing risk. We also noted that the seclusion room on this ward was at the end of the male bedroom corridor and were concerned about the impact of privacy and dignity for patients being escorted through a bedroom corridor.
- On Cedar ward, staff were not wearing uniforms which meant they were not identifable to the inspection team and patients.

Areas of good practice:

- There was an improved safety culture on the wards, which included improved systems to share and understand patient risk. We found that daily ward safety briefings supported staff teams to mitigate and understand risks.
- Report out meetings involved all relevant members of the multi-disciplinary teams.
- The addition of oxehealth, replacement bathroom doors and the programme of updating ward bedroom doors had improved the environmental safety of some wards.
- Staff were able to discuss learning from recent incidents and changes made as a result.
- Practice development nurses were supporting staff through audit and clinical leadership.

Inpatient mental health wards for older people

Areas for improvement / further corroboration:

- Staff told us that clinical supervision was not always available.
- Staff told us that they were not compliant with mandatory and statutory training. We were concerned that staff did not all have up to date training in moving and handling.
- At Westerdale north we noted a blind spot on the bedroom corridors, where the bedroom door access is recessed, this was not covered by a mirror to mitigate risk.
- There had been a safeguarding concern in relation to one patient admitted via a CMHT to Westerdale north which was not followed up by the ward team.
- Not all patient care plans were holistic and personalised and the quality was variable across the service.
- On Wold view and Moorcroft at Foss Park there were some issues with the quality of documentation. For example, we saw some blank capacity assessments and unsigned best interests documentation.
- On Hamsterly ward at Auckland park, the AED was showing as battery low.
- At Springwood, staff shared that staffing pressures could be significant on this ward.
- We were concerned about the environment on Roseberry ward due to the lack of ensuite facilities for patients and the small number of shared bathrooms available for patients.

Areas of good practice:

- All of the ward environments were clean and well maintained.
- Staff were caring, compassionate and had clear understanding of patient's needs and risks.
- Feedback from all patients was extremely positive.
- The culture and atmosphere of the wards was positive with clear positive and proactive leadership.
- Multi-disciplinary teamwork was high quality and teams worked in collaboration to support patient care.
- We saw evidence of innovative practice including the falls intiative and Namaste room pilot.
- Staff described leaders as supportive, effective and caring.
- We saw evidence of staff teams working closely with external services to benefit the recovery of patients.

Wards for people with a learning disability or autism.

Areas for improvement / further corroboration:

- Some staff told us that they did not have up to date training in moving and handling.
- There were staffing challenges, and use of agency staff was raised as a concern by one family member we spoke with.
- We found that the patient placed at Lanchester Road did not have a high quality care plan in place despite their complex needs. Care needs were well expressed in daily notes rather than in care planning documentation.
- Dates on care plans were not always documented which meant that it was difficult to understand when they were last updated.
- The NEWS tool was not always being completed correctly, we saw that scores were sometimes incorrectly calculated and so observations were not being carried out as often as they should.
- Out of date photographs were in place on patients' cover sheets for missing persons documentation.
- The environment at Unit 2 respite was not in good condition. We observed paint peeling from walls in places, curtains which were not on rails properly, and window restrictors which had been removed from a window as they were broken. The window did not fully open but it moved more than the HSE recommended 10cms. The team did action this immediately.

Areas of good practice:

- We were able to identify improvements since the last inspection.
- Medicines records, administration and storage was noted to be well managed across all sites.
- We saw evidence of effective multi-disciplinary team working.
- Staff were caring, knowledgeable and worked in a person centred manner.
- Staff gave positive feedback about leaders and the changes that had been implemented since the previous inspection.
- Staff had delivered care and treatment to patients which had made a significant difference to the lives of individual patients.
- At Bankfields court, care plans were holistic and detailed, particularly in relation to communication needs and positive behavioural support plans. They included some evidence of patients being involved in the creation of their own care plans.
- Staff told us how they had reduced the use of restrictive practices and had increased S17 leave.
- Teams had supported patients to make significant progress towards ending long term segregation.

- Staff were supporting people to be discharged from the service. However several patients have delayed discharges from the service.

Community mental health services for people with a learning disability

Areas for improvement / further corroboration:

- In North Tees patient's access to therapy was impacted by staffing challenges associated with psychology.
- Staff in York and North Yorkshire told us of difficulties in accessing face to face training because of the travel distances required.
- The internet connectivity at The Orchard impacted on staff's ability to access systems.
- Two care records systems were in place in Durham which made access to service user records complex.

Areas of good practice:

- Staff were kind and highly passionate about their roles.
- Staff knew people well and provided person centred and individualised care.
- Staff were keen to talk with us about the improvements they had made to the service.
- Staff were responsive and there was a strong sense of inter-agency working.
- There was innovative work ongoing which included the Dynamic Support Register, seeking accreditation, and the provision of learning disability link nurses in the acute hospitals.
- Staff provided high quality easy read information in line with accessible information standards.
- There was a strong and effective MDT approach with seamless referral processes between teams.
- The daily huddles in place gave staff good oversight of risks.
- The service provided at The Orchard was highly person centred with an individualised and person centred approach which took into account people's individual sensory needs.

We also noted some concerns which were an issue across all services we visited and may impact across the trust. These included:

- The trust continues to be impacted by significant staffing challenges. Staffing establishment levels differ across the wards and service areas. Some wards are managed with only nurse per shift. Patients told us that this impacted on their opportunities for one to one time with their named nurse. We were concerned that one nurse may have difficulty completing all nursing tasks during a shift and provide clinical leadership to staff. Staff told us that staffing continued to be a challenge.
- Staff told us that they were in receipt of basic life support training but not immediate life support training. We were concerned that this was not in line

with National Institute for Health and Care Excellence (NICE) guidance. This recommends that any setting where restrictive interventions (rapid tranquilisation, restraint or seclusion) are used have immediate access to staff trained in immediate life support (ILS).

- The trust's observation policy does not outline the manner in which staff should record observations of patients who are on enhanced levels of observation.

We note that further evidence has been requested from the trust in relation to our findings and we will review this in due course.

A draft inspection report will be sent to you once we have completed our processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to NHS England.

Could I take this opportunity to thank you and your teams once again for the arrangements that you made to help organise the inspections, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Sarah Dronsfield
Deputy Director, Network North

Gemma Berry
Operations Manager, Network North

c.c. Chair of Trust

NHS England

Executive Chief Nurse, ICB

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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:	**25th May 2023**
Title:	**Board Integrated Performance Report as at 31st March 2023**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Ashleigh Lyons, Head 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

Proposal:

It is proposed that the Board of Directors receives 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 have been developed for some of the issues that are impacting on performance and are in the process of being developed for others.

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:

- Number of inappropriate OAP bed days for adults that are 'external' to the sending provider – *reduced assurance*
- The number of Incidents of moderate harm and near misses - *deterioration in performance*
- Staff Leaver Rate – *deterioration in performance*

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 April, Performance Improvement Plans have been developed for each of the following issues that are impacting on performance:

- Agency Expenditure – facilitated by the Agency Reduction Group
- Safe Staffing – facilitated by the Safe Staffing Group
- Bed Pressures including OAPs – facilitated by the Bed Oversight Group

Initial drafts have been shared with Executive Directors Group and feedback has been shared. Further work is now being undertaken to ensure the actions are Sustainable, Measurable, Achievable, Realistic and Timely (SMART). These will be finalised for the April 2023 report, with progress against the delivery of the plans being provided in subsequent reports.

Performance Improvement Plans for the caseload measure is currently being developed by the two operational Care Groups and will be reported to Board in June 2023.

Performance Improvement Plans are now being developed for each of the following issues that are reporting **negative controls assurance and reasonable performance assurance** to support improvement and increased assurance:

- Percentage of inpatients reporting they feel safe whilst in our care - to be facilitated by the Durham, Tees Valley & Forensic Care Board
- Percentage of CYP showing measurable improvement following treatment - patient reported - to be facilitated by the Durham, Tees Valley & Forensic Care Board
- Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported* - to be facilitated by the North Yorkshire, York & Selby Care Board
- Percentage of CYP showing measurable improvement following treatment - clinician reported - to be facilitated by the North Yorkshire, York & Selby Care Board
- Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported* - to be facilitated by the North Yorkshire, York & Selby Care Board
- Percentage compliance with ALL mandatory and statutory training – to be facilitated by the Executive People, Culture & Diversity Sub-Group
- Percentage of staff in post with a current appraisal – to be facilitated by the Executive People, Culture & Diversity Sub-Group

The draft Performance Improvement Plans will be considered by Executive Directors Group on the 24th May 2023 and then included in the Board IPR in June 2023.

In addition to the above areas of concern, we have also reviewed each of the 3 unexpected inpatient unnatural deaths reported on STEIS in March 2023 to identify any immediate learning. Immediate actions identified form part of an overarching improvement plan and have been reported to the Trust Board and system partners.

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

been developed for North Yorkshire and York Services and an initial draft has been shared with Executive Directors Group and feedback has been shared. Further work is now being undertaken to ensure the actions SMART. This will be finalised for the April 2023 report, with progress against the delivery of the plan being provided in subsequent reports. A plan is currently being developed for County Durham and Tees Valley Services and will be provided in the April 2023 report for consideration by Executive Directors Group on the 24th May 2023 and subsequent reporting to Board.

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

- Adult Learning Disability Services, Responsive Patient Safety Assurance, Serious Incident Backlog
- Bed Occupancy
- Safer Staffing
- 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.

The IPR also provides progress against the NHS Oversight Framework (the regulatory framework), including the latest national benchmarking position.

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.

Appendix A

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 **31st March 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 NHS 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 IPD Key Changes

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

- **Number of inappropriate OAP bed days for adults that are 'external' to the sending provider (measure 9)** is assessed as having reasonable performance assurance (previously good)
- **The number of Incidents of moderate harm and near misses (measure 11)** now has neutral controls assurance (previously positive)
- **Staff Leaver Rate (measure 18)** now has negative controls assurance (previously neutral)

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. Both Care Groups have been asked to develop a Performance Improvement Plan which identifies the key issues and improvement actions that will be undertaken. Development of these plans has been delayed and these will now be completed for the April Integrated Performance Report. 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, further planned discharges, 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 subgroups 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 measure 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 25a and 25 b have impacted agency metrics resulting the UoRR measure being capped at a 3 rating.

- **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 over achievement); 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) have been developed for each of the following issues that are impacting on performance to support improvement and increased assurance:

- **Agency Expenditure** – facilitated by the Agency Reduction Group
- **Safe Staffing** – facilitated by the Safe Staffing Group
- **Bed Pressures including OAPs** – facilitated by the Bed Oversight Group

Initial drafts have been discussed with Executive Directors Group and feedback has been shared. Further work is now being undertaken to ensure the actions are Sustainable, Measurable, Achievable, Realistic and Timely (SMART). These will be finalised for the April 2023 report, with progress against the delivery of the plans being provided in subsequent reports.

Performance Improvement Plans are now being developed for each of the following issues that are reporting **negative controls assurance and reasonable performance assurance** to support improvement and increased assurance:

- **Percentage of inpatients reporting they feel safe whilst in our care** - to be facilitated by the Durham, Tees Valley & Forensic Care Board
- **Percentage of CYP showing measurable improvement following treatment - patient reported** - to be facilitated by the Durham, Tees Valley & Forensic Care Board
- **Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported*** - to be facilitated by the North Yorkshire, York & Selby Care Board
- **Percentage of CYP showing measurable improvement following treatment - clinician reported** - to be facilitated by the North Yorkshire, York & Selby Care Board
- **Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported*** - to be facilitated by the North Yorkshire, York & Selby Care Board
- **Percentage compliance with ALL mandatory and statutory training** – to be facilitated by the Executive People, Culture & Diversity Sub-Group
- **Percentage of staff in post with a current appraisal** – to be facilitated by the Executive People, Culture & Diversity Sub-Group

* These plans will be combined.

These Performance Improvement Plans will be considered by Executive Directors Group on the 24th May 2023 and included in the Board IPR in June 2023.

In addition to the above areas of concern, we have also reviewed each of the 3 **unexpected inpatient unnatural deaths (measure 14)** reported on STEIS in March 2023 to identify any immediate learning. Immediate actions identified form part of an overarching improvement plan and have been reported to the Trust Board and system partners.

3.1.3 IPR Other points to note

Integrated Performance Dashboard

As part of our assurance to the Board we undertake a bi-annual data quality assessment on each measure being reported in the IPD. The latest assessment has been completed on all IPD measures and the results incorporated within the IPD this month.

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 achieved its operational £1.16m financial plan surplus at the financial year-end.

  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, which have been non-recurrently supported in 2022/23 by North East & North Cumbria commissioners.

  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, these cost pressures were mitigated.

  Long Term Plan ambitions
  In terms of the Long-Term Plan ambitions, we did 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, Vale of York)
- Number of women accessing specialist community PMH services (County Durham, North Yorkshire and Vale of York)

  As part of the new Accountability Framework, a Performance Improvement Plan has been developed for North Yorkshire and York Services. A plan is currently being developed for County Durham and Tees Valley Services and therefore, a number of actions in relation to improving performance are contained within the Long-Term Plan section of the IPR. The Performance Improvement Plan for County Durham and Tees Valley Services will be provided in the April 2023 report.

  The IPR also provides progress against the NHS Oversight Framework (the regulatory framework), including national benchmarking positions where available.

  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 B.

3.2 Part 2: Broader Key Issues/Work

3.2.1 Quality

Adult Learning Disability (ALD) Services
Mersey Care re-visited the ALD service on 21st March for 2 days. Feedback was extremely positive, recognising overall significant improvement and including reduced restrictive practices, increased Section 17 leave and patient to patient interaction, improved staff morale and practice leadership being fully embedded. We await the formal written feedback.

Responsive Patient Safety Assurance
Following learning from Serious Incidents that were previously reported to the Board, the Trust has continued to work proactively to deliver improvements. Using our existing Quality Assurance framework, we built a focussed clinical framework to measure practice against key quality standards across harm minimisation, observation and engagement, patient leave and suicide prevention.

Prioritised the five wards associated with recent incidents. We observed supporting processes – report out, safety huddles and handovers and engaged directly with staff (methodology, results and actions taken reported to The System Risk Escalation meeting on 27th March 2023). The audit cycle extended to the remaining adult mental health acute and older persons functional wards utilising a random sample of 3 patients per ward which was completed by the 7th April and initial findings reported to the Trusts newly convened patient safety huddle on Wednesday 12th April 2023.

In total 125 patient care records were reviewed.

The findings identified that we need to address the variance in meeting our quality standards and the outcome we are driving for: **High quality care every day, every ward, every person we work with.**

Where we identified risks to patient safety through non-compliance with standards, we checked that immediate remedial actions had been taken.

An improvement plan has been developed and was reported to risk escalation meeting on the 5th April 2033 and is oversighted via the weekly huddle. 2 clinical areas, Bedale ward and Oak ward, were identified as requiring more focused support and immediate action was taken to put this in place. Key areas of the improvement plan that have progressed include the following:

- Care Group Plans that increase the visibility and presence of our senior clinical staff from across the Care Groups on each inpatient Adult Mental Health (acute and PICUs) and Mental Health Services for Older People functional wards is now in place
- We have initiated some focused work surrounding patient leave –scope and timescales being agreed
- Reflective meetings with ward Multi-Disciplinary Teams have been completed.
- Plans for a focused reaudit taking place starting 5th May are underway and will be supported by external partners and development of the audit tool is progressing well.
- Environmental risk assessments have been updated
- Key areas of variation being addressed through standard work e.g. shift allocation process and admission process

- A ward buddy system is in place

Serious Incident (SI) Backlog
Good progress is being made with the recovery plan for the Serious Incident back log. The external strategic and operational support is now in and following a baseline assessment has now initiated the SI Improvement Programme (Cohort 1 only).

As of the 31st March 2023 **43% (21/47)** SIs have been allocated to external SI reviewers. The team are currently in the process of accessing Trust laptops and undertaking PARIS training.

The Patient Safety Consultant/Programme Lead and the external team are working collaboratively on standardising processes and procedures to support completion of SIs within the 60 working day framework. The programme also aims to support the TEWV Patient Safety Team (PST) staff whilst undertaking their day-to-day roles.

3.2.2 Inpatient Pressures

Bed Occupancy
Delivery of the £360K efficiency saving and reduction in bed occupancy to 95% was not achieved by the 31st March 2023. The number of Out of Area Placements saw a deteriorating position with bed occupancy remaining above 100% on Adult Assessment & Treatment wards.

The weekly bed pressures meeting that was introduced in February continues to take place where all delays and long lengths of stay are monitored. Due to the planned strike action and limited resource available we were unable to complete a full peer review of all cases, this is having to be rescheduled for the end of April/ beginning of May.

Weekly meetings are being established with local authorities to discuss individual cases where delays to discharge have been identified, helping where possible to expedite the discharge, and meetings are starting to progress with partners to explore possible future solutions to help reduce barriers to discharge.

A beds workshop took place on the 4th April to help identify key priorities, actions and milestones, which has formed the development of a first draft high-level Trust-wide Out of Area Reduction Plan which is currently being reviewed before signoff. Once approved each key action will require a detailed delivery plan which will be assessed using the Deliverability Assessment Tool supported by the Programme Management Office.

As mentioned in the previous report, a proposal paper with recommendations on a new approach to support the delivery and oversight of the work has been developed. It was anticipated that approval for the approach would have been obtained by the end of March, unfortunately this has been delayed. This delay, however, has provided an opportunity to refine and strengthen the proposal to align to the outputs of the workshop.

3.2.3 People & Culture

Safer Staffing
With workforce continuing to be the biggest risk for the Organisation, the Safer Staffing Group has been set up to provide oversight of assurance and risk regarding the safe and sustainable staffing of the Trust's clinical workforce. The following key

focus areas: E-Roster Effectiveness, Staffing Establishments, Temporary Staffing, Agency Reduction and Flexible Working have each been assigned to a Sub Group, reporting into the Safer Staffing Group.

The Safer Staffing Group launched in April and has been working together to agree Terms of Reference, membership and fully scope the work to be undertaken, with further work underway to launch each of the Sub Groups and co-produce robust, targeted Performance Improvement Plans (PIPs). Overall aims will be to ensure safer staffing ratios, reduction in agency spend and exploration of innovative and flexible workforce models to improve quality patient care, employee experience, retention and recruitment.

This Group will be co-chaired by the Deputy Director of People & Culture and the Deputy Chief Nurse and will report monthly into the Executive People, Culture and Diversity Committee.

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. North East & North Cumbria (NENC) Integrated Care Board (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 NHS England, 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:

- A number of Performance Improvement Plans are being developed within the Care Group relating to 6 areas of focus, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance. The 6 areas are:
  - Percentage of inpatients reporting that they feel safe whilst in our care
  - Percentage of CYP showing measurable improvement following treatment - patient reported
  - Unique caseload
  - LTP –Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy and

Percentage of people who have waited more than 90 days between first and second appointments (IAPT)
- LTP - The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment and The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment
- LTP - Number of people accessing Individual Placement and Support

- 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 additional actions have been taken to link activity of planned and urgent care teams to help improve flow led by our care group medical director. All actions are reported monthly through the Trust-wide Beds Oversight Group. In addition, the is a Trust-wide Performance Improvement Plan which is included in this report.
- 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. Our People and Culture leads within the Care Group will be making a recommendation on actions to Care Group Board in May.
- 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 that the key reason for underperformance is data quality and actions have been put in place to address this. These were put in place early April and will be monitored.

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 also continue to achieve 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. A 5-day design event with partners is being planned for April 23 in order to develop an operational model which maximises staff capacity to care and provides a quality, safe and consistent service for patients, a good experience and promotes the wellbeing of staff and a good experience for stakeholders. The current answer rates are 59% in Durham and Darlington team and 64% 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. As at end of March 23, we have 7 patients in independent sector beds. Performance Improvement plans have been developed at Trust level to define the actions being taken to support improvement and increased assurance.
- Unique caseload Performance Improvement Plan is in development but has not been provided at this stage for amalgamation of the IPR.
- Compliance with mandatory training remains a concern due to ongoing issues with staff capacity because of high caseloads, staff leavers, recruitment challenges and day to day operational pressures. There is a Trust wide Electronic Staff Record group looking at data quality issues. Actions are in place to support the continuous improvement for this measure.
- Memory waiting times is impacted as capacity is outstripping demand and with no further investment to improve capacity. A demand and capacity exercise is now underway, data has been provided and the Planning Manager is remodelling the report to suit Memory Service. A meeting took place with the MHSOP General Manager and the Planning Manager on 13th April to progress this work. QI are mapping the pathway to start identifying improvements with a view to an Rapid Process Improvement Workshop.
- The outcome measures within our CYP and AMH services are not where we would like them to be. CYP clinician reported outcomes has seen improvement since January 23.

The areas of positive assurance identified within the IPD:

- Appraisals have been achieved for end of March **(85.05%)**
- Within Long Term Plan as at the end of March 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 North Yorkshire Sub-ICB.
- 72 hour follow up standard is achieved for both North Yorkshire and 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:

- Previous pressures continue to exist within MHSOP Therapies continue to have an adverse impact on service delivery. In particular recruitment into Psychology positions remains a challenge.
- Staffing issues, including vacancies and sickness, have placed increased pressure on the adult community mental health and crisis teams covering Harrogate and Ripon. We have brought additional support in from the Northallerton community team and have established weekly meetings, supported by CGB leadership, to provide support for the teams and to monitor the situation until the staffing issue are addressed

3.3 **Summary of Key Risks**

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

(BAF Risk 15) Financial Sustainability & (CRR risk 1260) There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality

- Failure to reduce inpatient staffing costs and Trust wide agency (in particular Medical and LD premium rate) utilisation (volume and rate reductions to reduce related premium costs)
- Failure to reduce lengths of stay, including through work with system partners, to reduce adult A&T and PICU bed occupancy and eliminate unfunded adult Independent Sector bed placements, maintain nil older adult Independent Sector bed placements and reduce safer staffing requirements for inpatient wards
- Failure to negotiate equitable recurrent funding mechanism for in-year and accumulated prior year AFC pay deal and nationally negotiated 2022/23 pay deals (tariff-based) pressures
- Failure to agree funded alternative clinical models as an alternative to unsustainable high-cost complex packages of care
- Failure to retain permanent staffing, including as a consequence of acute cost of living pressures

(BAF Risks 1 and 5) Recruitment and Staff Retention There is a risk that our inability to recruit and retain sufficient qualified and skilled staff (a common risk shared by all providers) might jeopardise our ability to provide high quality/safe services. In addition, there are multiple factors that could contribute to staff not choosing to stay with the Trust once we have recruited them. This will undermine the provision of safe and sustainable services as well as putting individual staff and patients at risk of harm. Oversight and escalation processes are well embedded to maintain safe staffing levels.

Appendix B

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st March 2023

Report Produced by: Ashleigh Lyons, Head of Performance
Date the report was produced: 21 April 23

For any queries on the content of this report please contact: Ashleigh Lyons, Head of Performance
Contact Details: Ashleigh.lyons@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

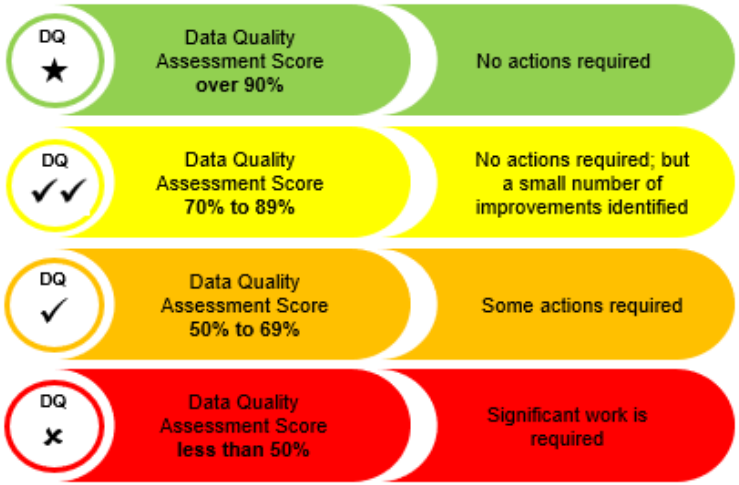
Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The latest assessment on all measures has been completed during February 2023 and the results incorporated within this report.

The audit element has been omitted from this assessment as a delay to the development of a local assurance framework has been approved by the Executive Strategy & Resources Sub Group, due to several significant Trust-wide digital workstreams both underway and planned during 2023/24. The development will now be completed in quarter 4 2023/24, with a view to undertaking the first assessments in quarter 1 2024/25.

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.

Data Quality Assessment status



Action status

Performance & Controls Assurance Overview

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 *CRES Performance – Non-Recurrent		
Neutral		***Incidents of moderate harm and near misses** *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 *Percentage Sickness Absence Rate *New unique patients referred	
Negative			*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 ***Inappropriate OAP bed days for adults that are 'external' to the sending provider** *Bed Occupancy (AMH & MHSOP A & T Wards) *Unexpected Inpatient unnatural deaths reported on STEIS ***Staff Leaver Rate** *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

***NOTE**: green text indicates changes in assurance*

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%	92.16%
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%	72.44%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	55.57%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	F	35.00%	24.22%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	46.21%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	L	F	50.00%	44.26%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	19.87%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H			98.39%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			951
10)	The number of Serious Incidents reported on STEIS	QAC				143
11)	The number of Incidents of moderate harm and near misses	QAC				2,119
12)	The number of Restrictive Intervention Incidents	QAC				7,923
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				13
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC	H			9
15)	The number of uses of the Mental Health Act	MHLC				4,321

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				54.48%
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				59.08%
18)	Staff Leaver Rate	PC&D	H			12.31%
19)	Percentage Sickness Absence Rate (month behind)	PC&D				6.36%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L	P	85.00%	84.38%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	L	?	85.00%	84.93%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				101,113
23)	Unique Caseload (snapshot)	S&RC	H			64,595

Rep Ref	Our Finance Measures	Committee Responsible for Assurance	Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	P	-1,160,000	-1,207,855
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	F	9,288,999	20,745,956
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	P	12,326,303	9,963,681
28)	CRES Performance - Non-Recurrent	S&RC	P	1,391,697	3,754,319
29)	Capital Expenditure (CDEL)	S&RC	F	10,051,074	9,684,274
30)	Cash balances (actual compared to plan)	S&RC	P	64,592,000	75,171,000

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

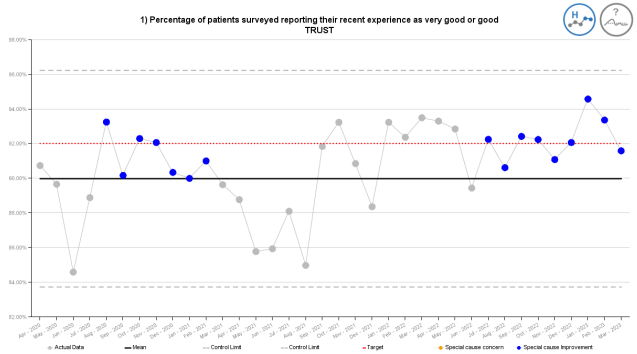
During March, **1058** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **969 (91.59%)** scored "very good" or "good".

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

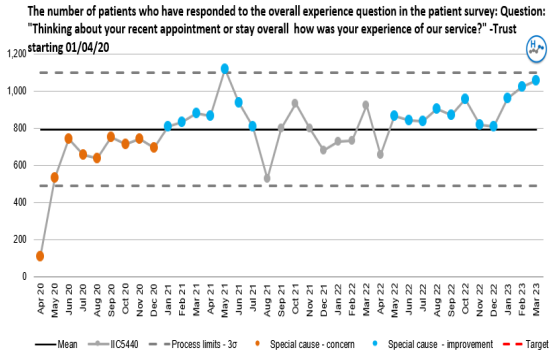
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ★ 93%

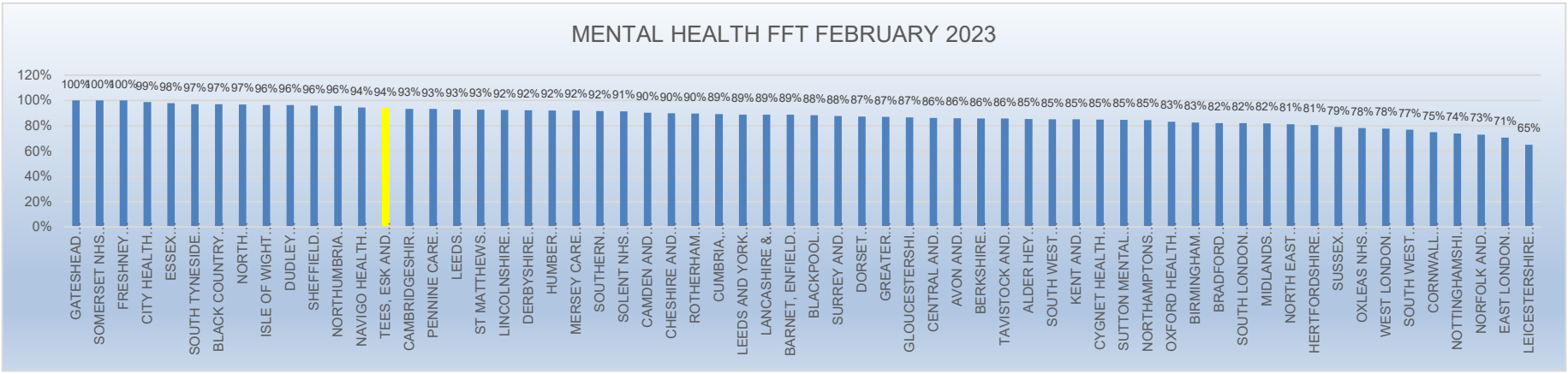
Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



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 - February 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.	**Closed**. This work will be progressed in the Patient Experience Group. (*See following action*)	
	NEW *Enabling action:* Executive Director of Corporate Affairs to establish a Trust-wide Patient & Carer Experience Group by the end of May 2023 to improve patient and carer experience. The group will report into the Executive Quality Assurance & Improvement Group and membership will include Patient Safety, service users, carers and representation from the Care Groups.		

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

NHS
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.

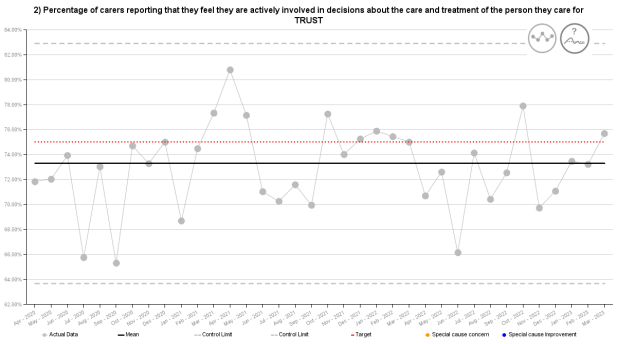
During March, **329** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **249 (75.68%)** scored "yes, always".

No significant change in the data during the reporting period shown

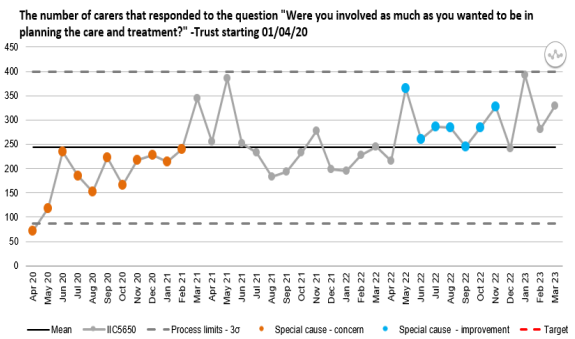
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

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		



Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
NEW An emerging theme is that staff are not engaging with carers on the grounds of patient confidentiality.	*Enabling action:* Patient & Carer Experience Team to undertake promotional work to raise awareness of the rights of carers to be involved and included. This will be disseminated via a variety of forums, including the Carers Hub and Trust website and will be completed by the end of May 2023.		
	Enabling action: Patient & Carer Experience Group to conduct a deep dive into the involvement of carers by the end of June 2023, triangulating data from multiple sources, including Patient & Carer Experience, Patient Advice & Liaison Service, Complaints and Patient Safety, with a view to identifying any improvement actions.		
NEW Improvements are required within Secure Inpatient Services to ensure staff effectively engage with carers to capture feedback on how actively involved in decisions.	*Enabling action:* Service Manager to develop a carers feedback improvement plan by the end of April 2023, with a view to improving carer involvement in decision-making.	An action plan has been developed and is to be reviewed at the April Improvement Group Meeting.	

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

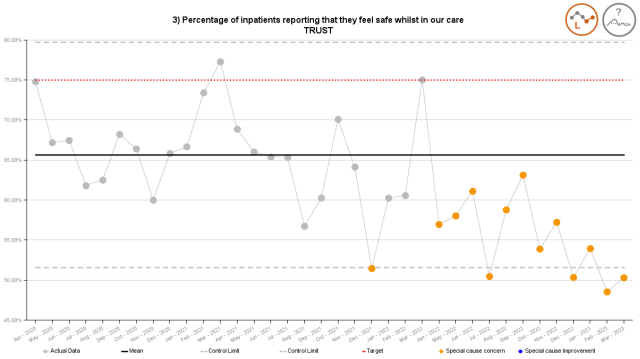
During March, **165** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **83 (50.30%)** scored “yes, always"

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

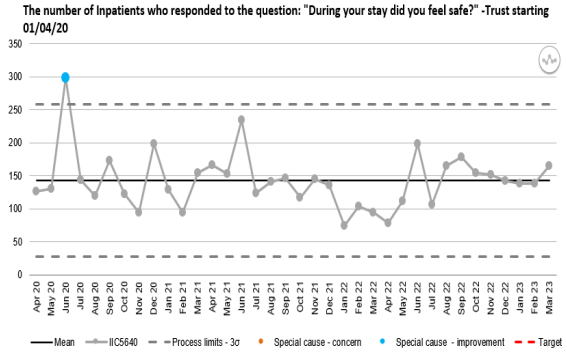
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ
87%

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.	**Closed.** *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.	**Complete.** Findings have been shared and improvement actions are currently being considered 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

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.	**NEW** *Enabling action:* The Patient Experience Team to revisit the focus groups in Adult Mental Health Services and Secure Inpatient Services by the end of June 2023, to revisit the findings and progress from previous groups, with a view to learning from successes and identifying any further improvement actions. Findings will be reported to the Executive Quality Assurance & Improvement Group.		
NEW We are concerned that a number of our inpatients do not feel safe whilst in our care.	*Enabling action:* Durham, Tees Valley & Forensic Care Group Executive Director to facilitate a Performance Improvement Plan by the 24th May 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on the management of our caseloads.		

Additional Intelligence in support of continuous improvement

Focus groups have been held in Health & Justice. Good practice has highlighted the use of a 'positive and safe' tree on Langley Ward, whereby patients are able to indicate anonymously if they are feeling unsafe Staff will then call a meeting with all patients and staff on shift to explore what is happening on the ward at the time.

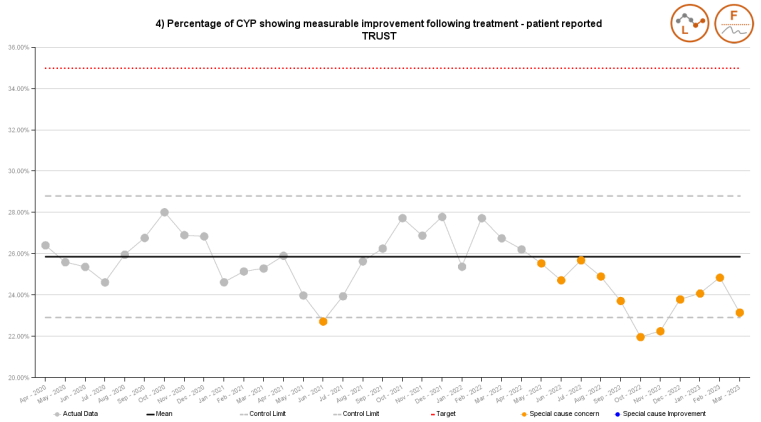
04) Percentage of CYP showing measurable improvement following treatment - patient reported

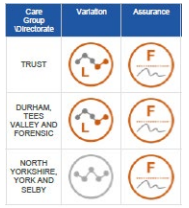
Tees, Esk and Wear Valleys NHS Foundation Trust

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

For the 3 month rolling period ending March, **691** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 160 (23.15%)** 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%

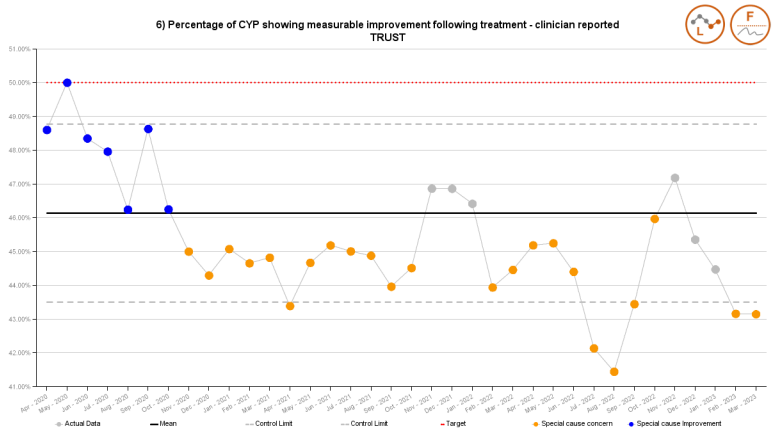
An Area of Concern
We are concerned with our performance in this area and action is required to improve

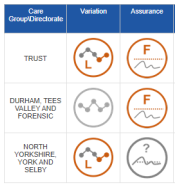
06) Percentage of CYP showing measurable improvement following treatment - clinician reported

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 March, **788** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 340 (43.15%)** 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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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 March, 7 (out of 8) staff attended the monthly training sessions from Durham & Tees Valley; 2 (out of 3) 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.	**Complete.** Trust-wide reporting commenced in April 2023. This is now being adopted in teams to enable staff to review their caseloads, pathways and interventions, to better understand our patient outcomes, and to identify when interventions need to be adjusted to meet patient need.	No visible impact to date; however, improvements can be expected as the tool is embedded.
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.	**Complete.** The findings were discussed at the March CAMHS Outcomes Group and it was agreed to refine and continue with training, maintain live conversations at all relevant forums and within clinical and caseload management supervision.	No visible impact to date; however, improvements can be expected as conversations continue.
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.	**Complete.** The analysis has been completed and initial findings indicate the different team structures are impacting on our ability to compare like for like, a potential concern in North Yorkshire, York & Selby in respect of untimely completion of Clinician Rated Outcome Measures, and inconsistent scoring across the Care Groups.	
	NEW *Enabling action:* The Specialty Development Manager to raise the findings at the April 2023 CAMHS Outcomes Group to identify any improvement actions.		

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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.	**Complete.** The guide has been completed and shared with Team Managers.	No visible impact to date; however, improvements can be expected as use of the guide increases.
	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.	Sessions have commenced and included revisiting HoNOSCA training with teams to assist in timely completion and a consistent level of scoring.	
NEW We are concerned that a number of our children and young people are not showing the level of improvement in their patient-related outcome measures as we would expect.	*Enabling action:* Durham, Tees Valley & Forensic Care Group Executive Director to facilitate a Performance Improvement Plan by the 24th May 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on the management of our caseloads.		
NEW We are concerned that a number of our children and young people are not showing the level of improvement in their clinician-rated outcome measures as we would expect.	*Enabling action:* North Yorkshire, York & Selby Care Group Executive Director to facilitate a Performance Improvement Plan by the 24th May 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on the management of our caseloads.		

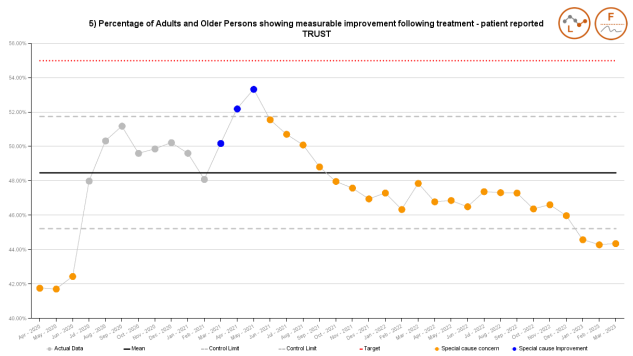
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

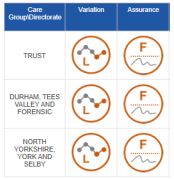
Tees, Esk and Wear Valleys NHS Foundation Trust

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 March, **1991** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 883 (44.35%)** made a measurable improvement.

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





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

Our system is expected to consistently fail the target/expectation

93%

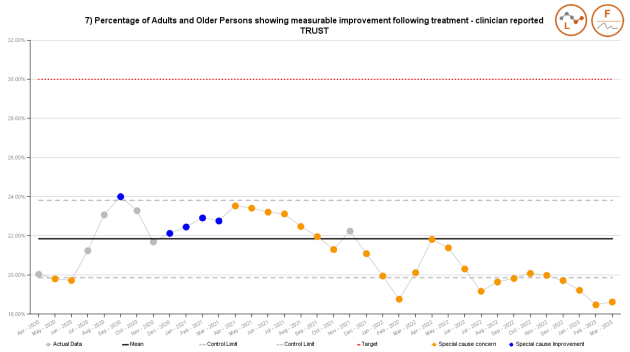
An Area of Concern
We are concerned with our performance in this area and action is required to improve

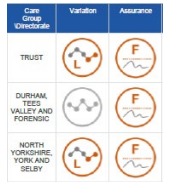
07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

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 March, **3200** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 596 (18.62%)** made a measurable improvement.

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





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

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

Outcomes: 05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported and 07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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.	**Complete.** Trust-wide reporting commenced in April 2023. This is now being adopted in teams to enable staff to review their caseloads, pathways and interventions, to better understand our patient outcomes, and to identify when interventions need to be adjusted to meet patient need.	No visible impact to date; however, improvements can be expected as the tool is embedded.
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~~ 12th May 2023.	The training video has been created; however, there are a few small changes being actioned.	
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		
NEW We are concerned that a number of our children and young people are not showing the level of improvement in their outcome measures as we would expect.	*Enabling action:* North Yorkshire, York & Selby Care Group Executive Director to facilitate a Performance Improvement Plan by the 24th May 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on the management of our caseloads.		

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

Tees, Esk and Wear Valleys NHS Foundation Trust

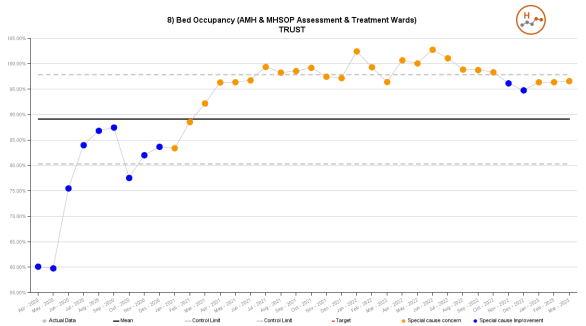
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important 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 March, **11,098** daily beds were available for patients; of those, **10,719 (96.58%)** 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 73%



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

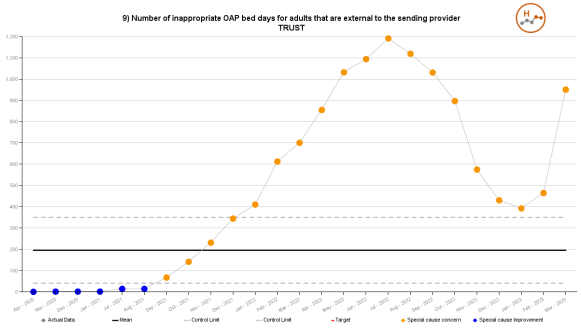
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending March, **951** 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%



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Supporting Measure

	2022 - 2023												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	FYTD
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	9,856	11,272	**132,144**
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	11,098	**131,273**
Percentage Bed Occupancy	**103.29%**	**102.51%**	**104.24%**	**103.80%**	**102.12%**	**100.17%**	**100.83%**	**97.30%**	**95.38%**	**98.19%**	**98.32%**	**101.57%**	**100.66%**

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

We recognise that occupancy of our assessment & treatment beds within Adult and Older People Services is an area of concern and is impacting on our ability to meet the needs of our patients. To address this, we have developed a **Performance Improvement Plan** that defines the actions being taken to support improvement and increased assurance.

The primary focus over the next few months is on reducing the lengths of stay within our adult and MHSOP wards, focusing on those patients that are clinically ready for discharge and patients with an extended length of stay. This comprises a review of and adaptation to our admission, discharge and transfer processes to ensure the effectiveness of the process and application of a standard approach. Together these should enable us to facilitate timely discharge of patients, thereby releasing capacity on our wards and reducing our reliance on independent sector beds.

The initial draft has been shared with Executive Directors Group and feedback has been shared. Further work is now being undertaken to ensure the actions are Sustainable, Measurable, Achievable, Realistic and Timely (SMART). These will be finalised for the April 2023 report, with progress against the delivery of the plan being provided in subsequent reports.

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

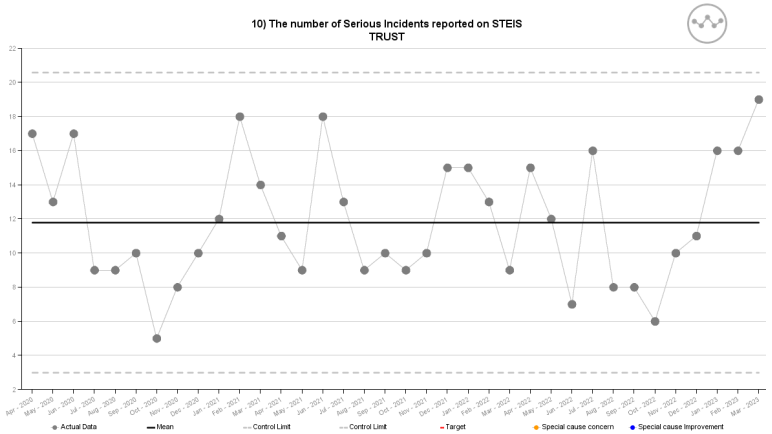
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

19 serious incidents were reported on the Strategic Executive Information System (STEIS) during March.

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%



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All 19 serious incidents reported in March have been reviewed at the daily Patient Safety Huddle. Two types of incidents, namely fatal overdoses of insulin by insulin-dependent diabetics and the increased risk of suicide for people undergoing or waiting for investigations into memory loss, require further analysis to establish if there are recurring themes.

The Patient Safety Consultant is currently working with the Trust to oversee and manage the reduction of the backlog of serious incidents.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

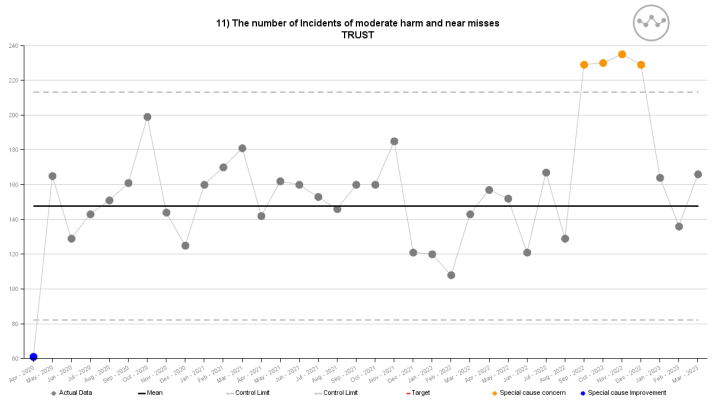
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

166 incidents of moderate harm or near misses were reported during March.

No significant change in the data during the reporting period shown

DQ 80%

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



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NORTH YORKSHIRE, YORK AND SELBY	

A review of the incidents is undertaken at the daily patient safety huddle with attendance from subject matter experts and the relevant clinical teams. Where any early learning is identified immediate actions are agreed and monitored until completion.

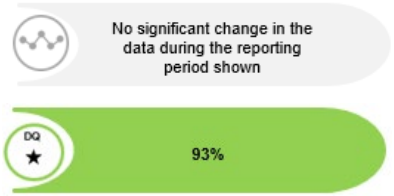
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
To provide better insight into incidents of moderate harm caused by anchored ligatures, the Environmental Risk Group commissioned a review of those incidents reported throughout November 2022 to December 2022.	*Enabling action*: 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.	**Complete**. Of the 34 incidents reviewed, 25 occurred on Bransdale Ward with three patients accounting for the majority of these incidents. The service reported appropriate escalation of these behaviours and active plans to address and reduce self harming behaviours. This includes oversight by the local senior leadership team. These findings have been reported to the Environmental Risk Group and Executive Quality Assurance & Improvement Group in March.	

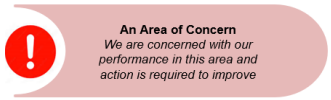
12) The number of Restrictive Intervention Incidents

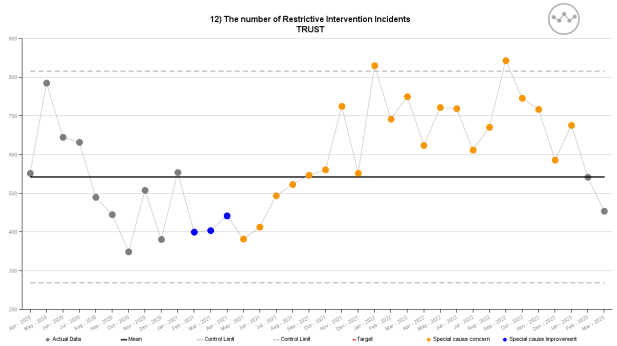
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

454 Restrictive Intervention Incidents took place during March.







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 Durham, Tees Valley & Forensic Care Group Director for Children & Young People and Learning Disability Services 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.	1 patient was discharged in March 2023. We have identified an error with number of patients clinically ready for discharge from our learning disability wards in previous months. All records have been reviewed and we and can confirm there are currently 4 patients ready for discharge: • 2 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. There is one further patient within our care at Lanchester Road Hospital. This patient is not clinically ready for discharge patient and an independent review is currently being considered to determine the most appropriate package of care for the patient. The service is receiving bespoke support on a weekly basis 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

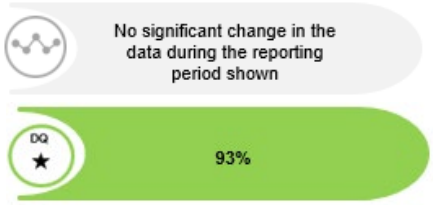
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We require greater assurance locally from Care Boards on the implementation of the Restraint Reduction Plan	*Enabling action:* Care Boards to ensure delivery of the Restraint Reduction Plan by 31st ~~March~~ May 2023.	A draft plan has been completed and is currently with the Care Group Positive & Safe Groups for consultation. An away day is scheduled for the 9th May 2023 to consult on the new Policy and agree the final Trust-wide Plan.	
	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.	One Hopes Practitioner has commenced and confirmation of funding has been received for an Associate Nurse Practitioner. Agreement is still to be confirmed for 2 Advanced Practitioners, 2 Peer Workers and 2 Clinical Skills Trainers that will be aligned to the Care Groups.	

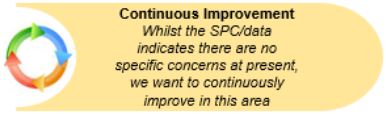
13) The number of Medication Errors with a severity of moderate harm and above

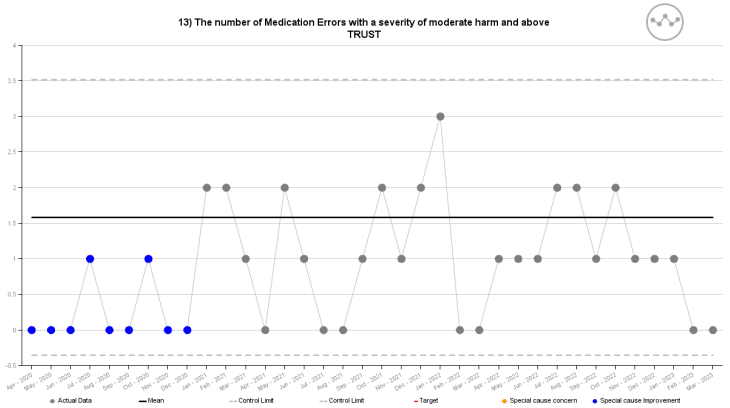
Tees, Esk and Wear Valleys NHS Foundation Trust

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 March.







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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, 23 have been completed, including the dissemination of constipation posters & Standard Operating Procedure revisions. Of the outstanding 4 actions, 1 will be completed within the next 4 weeks, 2 are on track and 1 is under review.	
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

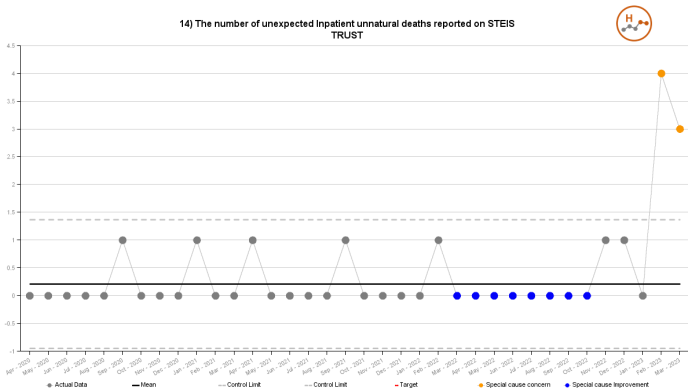
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements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

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

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	

In March we reported 3 unexpected inpatient unnatural deaths. 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. Immediate actions identified form part of an overarching improvement plan and have been reported to the Trust Board as well as system partners (NHS England & Improvement, Care Quality Commission and Integrated Care Boards). We are monitoring the delivery of actions through Care Groups and our quality governance structures.

15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

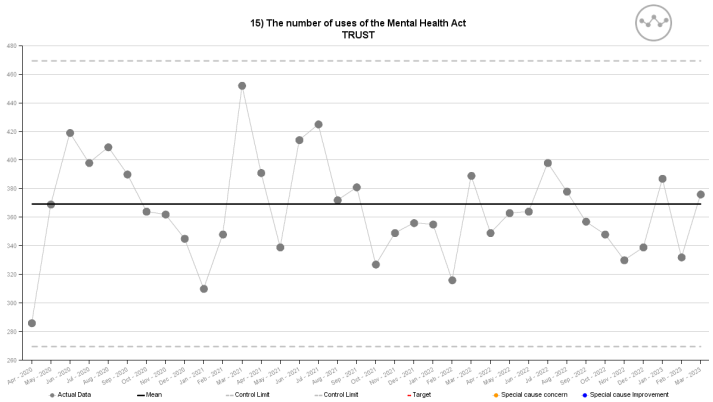
We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers,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

There were **376** uses of the Mental Health Act during March.

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
73%



Care Group/Directorate	Variation
TRUST	
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 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.	The KPI change has been completed and amendment of the measure is now being progressed through the Trust Change Advisory Group.	

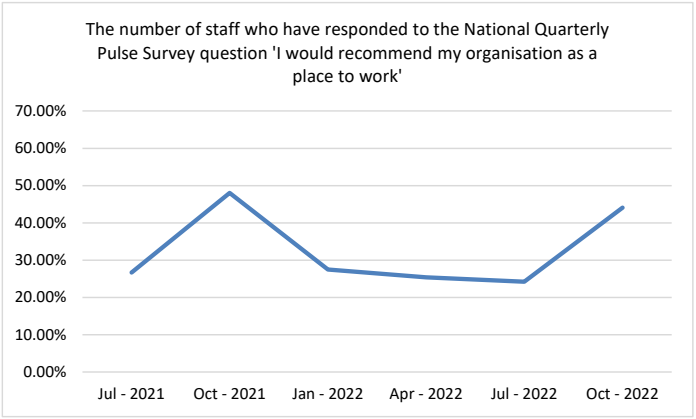
16) Percentage of staff recommending the Trust as a place to work

Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

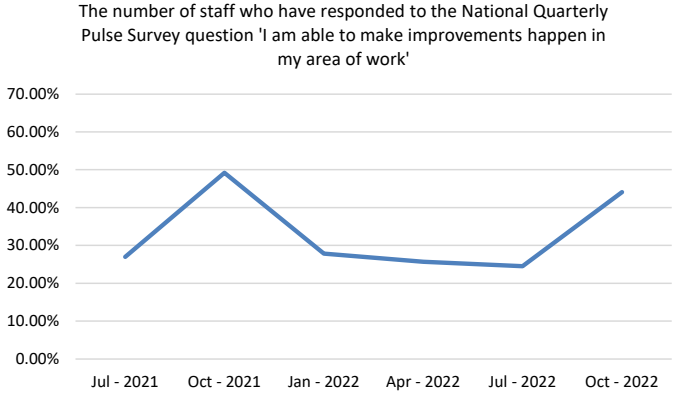
We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise that having the ability to suggest improvements and a high level of job satisfaction within our workforce 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~~ April 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.	**Closed**. There are no plans to offer incentives for the pulse survey, as there is no evidence to suggest that the incentives improved the annual staff survey response rate and funding is not available.	
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.	**Complete.** All directors have received relevant staff survey data and have been contacted by the Executive Director of People & Culture. At this point no improvement actions have been identified.	
	Enabling action: Executive Director of People & Culture to review the central Workforce Delivery Plan by end ~~March~~ May 2023 to ensure the forward plan will address those areas where we have dropped or not increased in score.	Engagement is currently underway with the Care Groups.	

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 11.04.2023	
Enable **100%** of staff to access Foundation training	**13%**	(960 out of 7603 members of staff)
To have trained **50%** of staff at Intermediate level	**11%**	(803 out of 7603 members of staff)
To have **15%** of staff trained at Leader level	**4%**	(325 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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

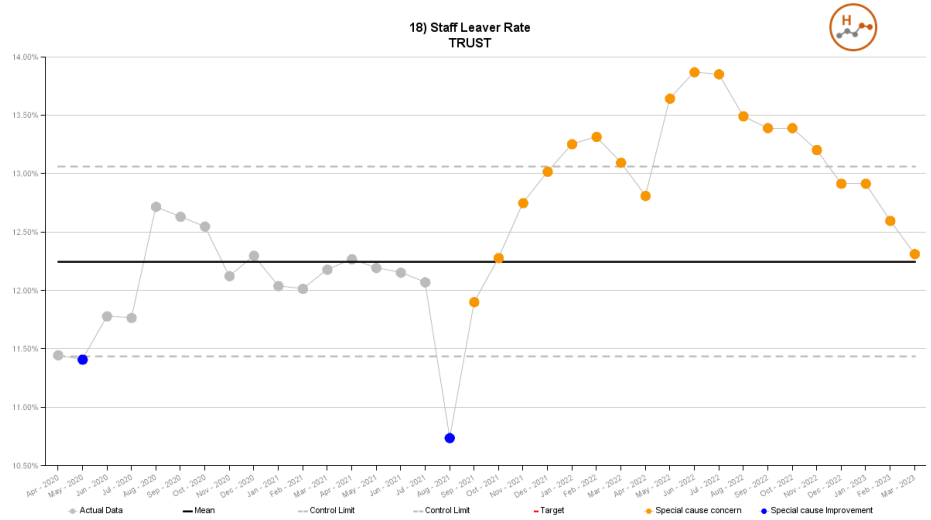
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

From a total of **6833.73** staff in post, **841.42 (12.31%)** had left the Trust in the 12 month period ending March.

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

DQ
80%

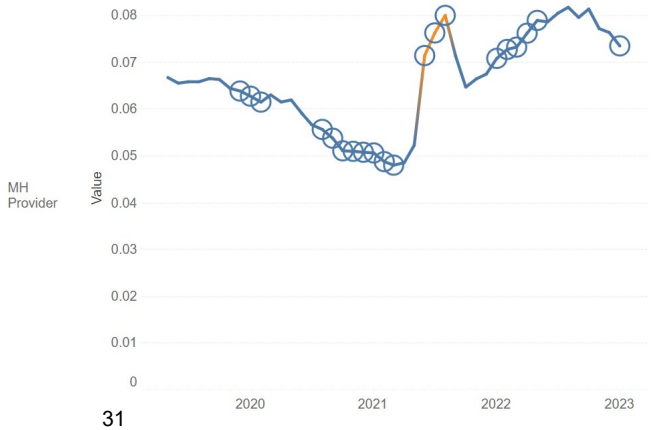
An Area of Concern
We are concerned with our performance in this area and action is required to improve



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

National Benchmarking: NHS Staff Leaver Rate - England Mental Health and Learning Disability – December 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 7 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.		
NEW Detailed analysis has identified a trend in female clinical staff between the ages of 30-35 years leaving the Trust.	*Enabling action:* Deputy Director of People & Culture to develop a focused action plan by the end of July 2023, which will triangulate the reasons for staff leaving and include benchmarking across the Integrated Care System, with a view to improving retention of this staff group.		

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

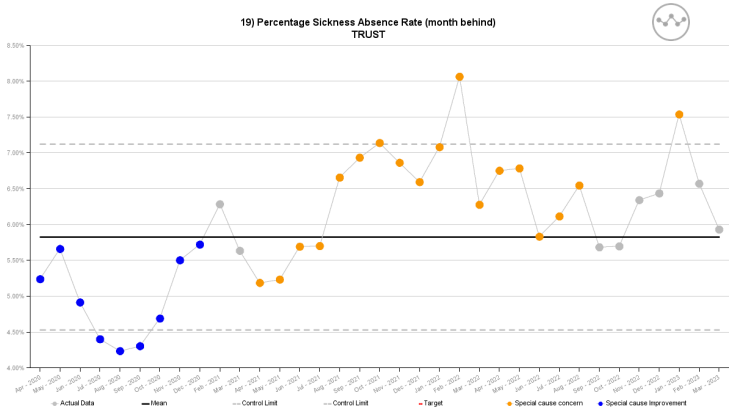
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

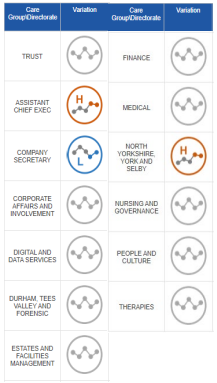
There were **204,590.15** working days available for all staff during February (reported month behind); of those, **12,135.79 (5.93%)** days were lost due to sickness.

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 73%

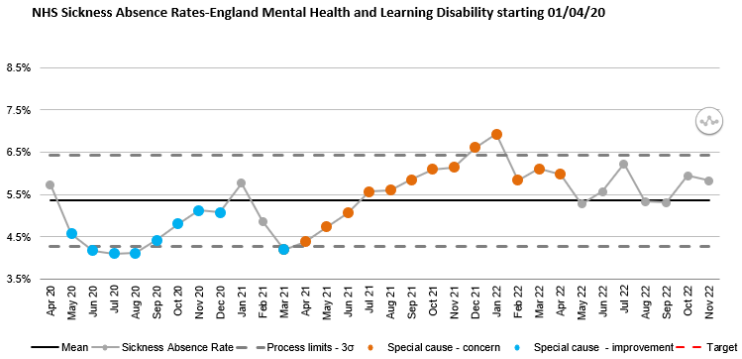




National Benchmarking: NHS Sickness Absence Rates - England Mental Health and Learning Disability – November 2022.

NHS Sickness Absence Rates published 2nd March 2023 (data ending November 22) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.36% compared to the Trust mean of 5.92%.

Regional Benchmarking: We have seen a rise in our sickness absence rates during November and as at the 11th April 2023, we were positioned 4th (out of 31) for sickness absence within the region's mental health, acute and ambulance trusts.



Update

As at the 16th April 2023, sickness absence is 5.55% for April 2023.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to ensure we have strategic oversight of sickness absence so we can target interventions appropriately as well as share learning across the trust.	*Enabling Action*: 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.	**Complete.** The process is established and will be undertaken on a monthly basis and reported to the Executive People & Culture Subgroup.	
	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.		
	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.		

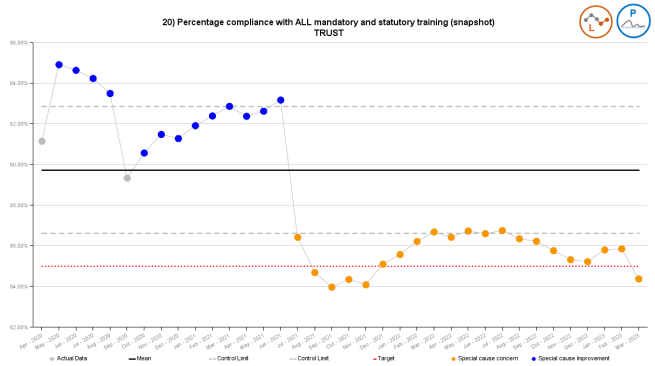
20) Percentage compliance with ALL mandatory and statutory training

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.

129,630 training courses were due to be completed for all staff in post by the end of March. Of those, **109,382** (**84.38%**) courses were actually completed.

Percentage Compliance with Information Governance & Data Security Training. As required by the Information Governance Tool Kit the Trust was expected to achieve 95% staff compliance by the 28th February 2023. As at end of March, **7330** were due for completion, **6819 (93.03%)** were actually completed.



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

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

Our system is expected to consistently hit the target/expectation

93%

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.	**Complete.** 6 sessions were held during March; however, only 5 people attended.	

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 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~~ May 2023.	Discussions are being progressed to understand the level of training needed to determine the additional resource required.	
	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.	Relevant contacts for the sites have been approached and Workforce Development are awaiting confirmation.	
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.	Meetings have been scheduled throughout April 2022 to progress the mapping exercise.	
NEW We are concerned that there remains a significant number of staff that are not compliant with their mandatory & statutory training.	*Enabling action:* Executive People & Culture Group to facilitate a Performance Improvement Plan by the 24th May 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on the management of our caseloads.		

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

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

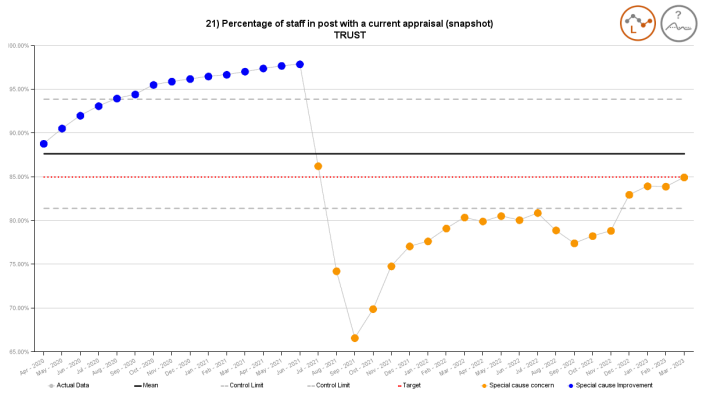
Of the **6464** eligible staff in post at the end of March; **5490** (**84.93%**) had an up to date appraisal

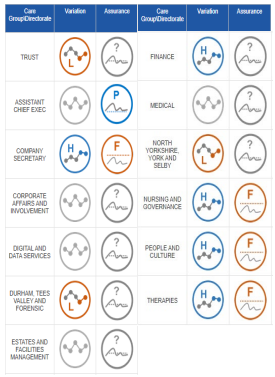
We're aiming to have high performance and we're moving in the wrong direction.

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
NEW We need to promote the use of Workpal to support the timeliness and quality of appraisals.	*Enabling action:* Leadership & Talent Lead to establish monthly reviews of appraisals completed on Workpal with a view to proactively contacting service leads to improve usage of the system. The process will be established by the end of May 2023.		
NEW We are concerned that there remains a significant number of staff that have not received a timely appraisal.	*Enabling action:* Executive People & Culture Group to facilitate a Performance Improvement Plan by the 24th May 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on the management of our caseloads.		

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

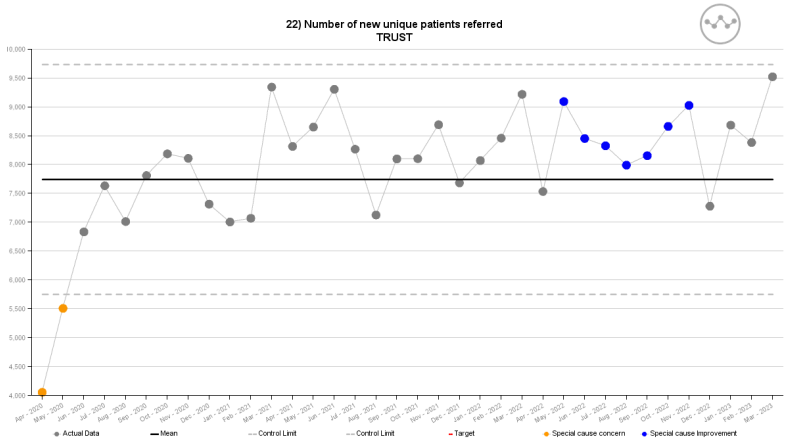
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

9522 patients referred in March that are not currently open to an existing Trust service

No significant change in the data during the reporting period shown

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

DQ ★ 93%



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

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

23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

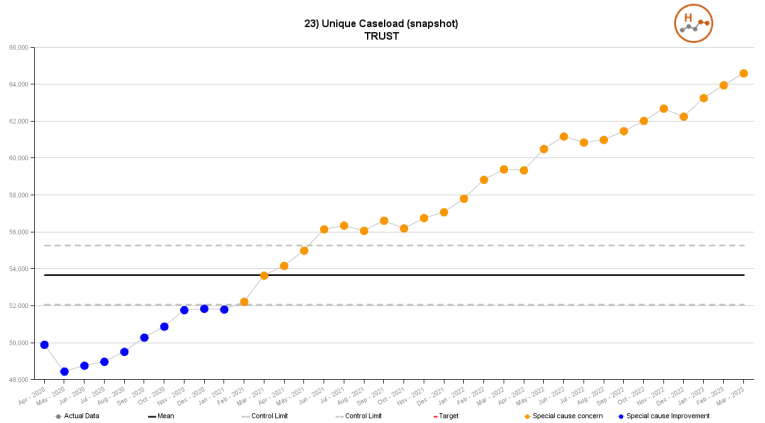
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

64,595 cases were open, including those waiting to be seen, as at the end of March 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 ★ 100%



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)

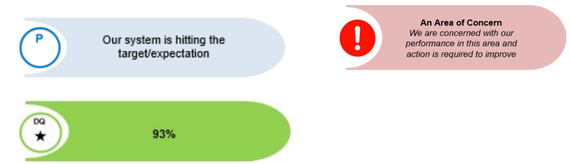
Tees, Esk and Wear Valleys NHS Foundation Trust

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~~ 24th May 2023, encompassing SMART actions and the expected impact, to support improvement and provide increased assurance on the management of our caseloads.		

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 **(£1.208m) surplus** (to break even) to 31st March 2023 against a planned year-end outturn surplus of **(£1.16m),** resulting in a **£0.048m** variance to plan. This is before fixed asset impairments (£8.08m) and peppercorn lease depreciation (£0.405m), both of which are excluded when assessing NHS provider financial performance, and contribute to a composite £7.27m deficit.



Summary

The draft financial position at 31st March 2023 is an operational surplus of **£1.208m** against a planned year to date surplus of **(£1.16m),** resulting in a **£0.048m** variance to plan. This is before fixed asset impairments (£8.08m) and peppercorn lease depreciation (£0.4m), both of which are excluded when assessing NHS provider financial performance, and contribute to a composite £7.27m deficit. The trusts year end position is subject to external audit review. Key observations for March were:

- **Independent sector beds** - the Trust required 560 bed days during March 2023 (213 for February 2023) at a cost of £0.357m (includes estimates for unvalidated periods of occupancy and average observation levels pending billing). This was an increase of 347 bed days. Year to date expenditure was £3.7m, or £3.4m 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 leading into the new financial year.
- **Agency expenditure** as at March 2023 was £20.5m, which was £11.3m 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 £1.7m 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 £0.5m. The associated recovery action for capitalisation of IT hardware (where appropriate) has been fully enacted at M12 with an overall benefit to the revenue position of £1.4m.
- **Planned CRES performance** as at March 2023 is behind plan by £4.7m, however unplanned schemes to the value of £4.7m provide an offset to this, resulting in net CRES performance that is in line with plan. Key variances relate to agency and independent sector bed pressures driving run rates significantly above 2021/22 levels.
- **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 £5.5m to month 12, resulting in a net pay award pressure of £3.0m. The Integrated Care Board considered alternative methodologies for distributing funding and escalated system level funding pressures to NHS England for their consideration. During March 2023 the trust received £2.8m from the Integrated Care Board towards the pay award cost pressure.
- **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.
- There have been improvements in M12 to the previously reported deficit position largely relating to the 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.	We have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. The initial draft has been shared with Executive Directors Group and feedback has been shared. Further work is now being undertaken to ensure the actions are SMART. These will be finalised for the April 2023 report, with progress against the delivery of the plan being provided in subsequent reports.		
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. The associated recovery action for capitalisation of IT hardware (where appropriate) has been fully enacted at M12 with an overall benefit to the revenue position of £1.4m.	Centralised CIO / Deputy CIO level approvals for all hardware to improve resource and asset management Capitalisation of revenue expenditure of £1.4m at 31st March.
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 an Agency 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. *See above narrative in respect of the Performance Improvement Plan.*	

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
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 have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. The initial draft has been shared with Executive Directors Group and feedback has been shared. Further work is now being undertaken to ensure the actions are SMART. These will be finalised for the April 2023 report, with progress against the delivery of the plan being provided in subsequent reports.	
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 £20.746m is £11.457m **(123%)** higher than target.

Summary

Agency expenditure of £20.7m is £11.5m (123%) 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 resulting in a breach of this cap by £11.5m.

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.	We have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. The initial draft has been shared with Executive Directors Group and feedback has been shared. Further work is now being undertaken to ensure the actions are SMART. These will be finalised for the April 2023 report, with progress against the delivery of the plan being provided in subsequent reports.		

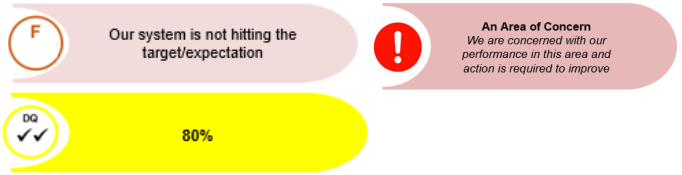
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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 March 2023 there were 4,484 agency shifts worked, with 2,818 shifts compliant **(63%).**



Summary

During March 2023 4,484 agency shifts were worked (542 more than February).

Of these, 2,818 or 63% shifts were compliant (63% compliance prior month).

Of the non-compliant shifts 1,565 or 35% breached price caps (compared to 1,402 shifts and 36% prior month) and 101 or 2% breached framework compliance (compared to 76 shifts and 2% 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.	We have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. The initial draft has been shared with Executive Directors Group and feedback has been shared. Further work is now being undertaken to ensure the actions are SMART. These will be finalised for the April 2023 report, with progress against the delivery of the plan being provided in subsequent reports.		

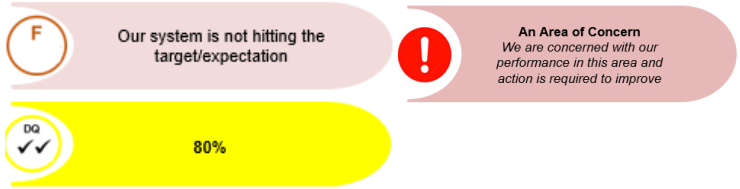
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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.

The overall rating for the trust is a **3** for the period ending 31st March against a planned rating of **2**.



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 1.93x, which is 0.36x or £2.6m better plan and is **rated as a 2**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 25.9 days; this is behind plan by 1.4 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 0.25%, this is worse than plan by £0.1m and is **rated as 2**.
- The **agency expenditure** metric assesses agency expenditure against a capped target for the Trust. Costs of £20.5m are £11.3m (121%) higher than plan and would be **rated as a 4**.

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

The Trust's financial performance results in an **overall UORR** of **3** for the period ending 31st March and **is worse than plan** owing to agency performance against cap being rated 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.	Confirmed all UoRR individual metric ratings except agency improved in March, reflecting delivery of planned position (except for reducing agency spend). Due to agency breach and override, overall UoRR therefore remained at 3. UoRR was reported in private T Board paper based on draft accounts position.

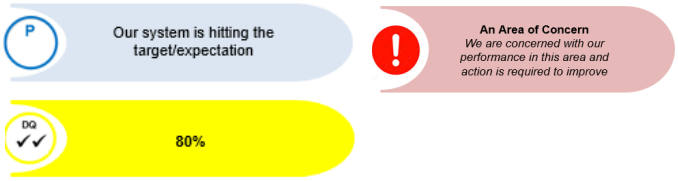
27) CRES Performance - Recurrent

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 **£12.3m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£10.0m**.

(£2.3m) favourable 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 for the year is on track and plan with specific performance noted as:

- £1.1m CRES for OAPs contracted bed elimination is behind plan
- £3.0m CRES for agency rate compliance and usage reduction is behind plan
- £0.3m CRES for Crisis Line support from Vale of York CCG is behind plan
- £0.3m CRES for reduction in covid measures is behind plan
- £1.7m CRES for interest receivable and is ahead of plan
- £2.3m CRES for slippage linked to vacancies & corporate services (Non-recurrent)
- £0.4m CRES for PDC
- £0.3m 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 has been 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.

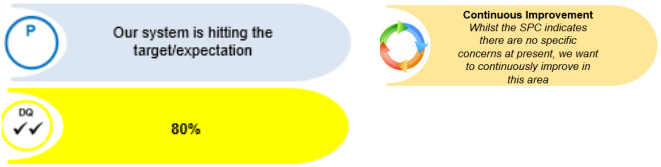
28) CRES Performance – Non-Recurrent

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 **£1.4m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year and have delivered **£3.7m**.

(£2.3m) 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 mitigated in-year the recurrent adverse variance to CRES targeted plan (£2.3m).

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 March was **£9.7m** against planned expenditure of **£10.1m** resulting in a **£0.4m** underspend against plan.

Summary

Capital expenditure at the end of March was £9.7m, and is £0.4m lower than allocation of £10.1m.

Networked IT assets have been capitalised, back dated to April 22 (which has resulted in a benefit to the revenue position of £1.4m).

The Trust collaborated with ICB colleagues to manage system delivery of financial targets.

The year underspend, supported the Trust to replace end of life defibrillators throughout the Trust (£0.3m).

The Trust received £3.0m additional capital funding to develop Crisis and Liaison services, of which £2.9m was spent during the financial year and £1.7m capital funding to support IT frontline digitisation spend which was fully expended by the end of the year.

All delays to health and safety schemes have been escalated to Environmental Risk Group as soon as they became known to manage / mitigate any risks to clinical safety and quality. Installation of patient doors will be completed next financial year, but all doors are recorded as on site, or in store at at 31 March 23.

LRH medical suite development slipped to 23/24 as funding for revenue consequences has not yet been identified.

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.

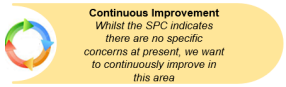
30) Cash balances (actual compared to plan)

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 **£75.2m** against a planned year to date cash balance of **£64.6m.**

£10.6m positive variance from plan



Summary

Cash balances were **£75.2m** at 31st March 2023, which is **£10.6m** higher than planned **£64.6m**, largely as a result of higher than anticipated creditors and accruals at the financial year-end.

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 31st March 2023 was £4.7m of which £2.1m is current debt raised prior to year end. The value of debt over 90 days is in the sum of £0.4m (excluding amounts being paid via instalments and PIPS loan repayments), an increase of £0.2m compared to debt over 90 days as at 28 February 2023. Six government organisations account for 29% 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			

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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	FYTD
13a: Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	Q1 606 Q2 185 Q3 0 Q4 0	1094	1031	431	951	951
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	951	951
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%	87.03%	88.40%
Data Quality Maturity Index	93.00	97.50	97.30	97.30	97.10	97.10

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 that have not achieved the agreed trajectories in the Long-Term Plan; these are outlined in the following pages. As part of the new Accountability Framework, we have developed a **Performance Improvement Plan** for our North Yorkshire & York commissioned services that defines the actions that are being taken to support improvement and increased assurance. The initial draft has been shared with Executive Directors Group and feedback has been shared. Further work is now being undertaken to ensure the actions are Sustainable, Measurable, Achievable, Realistic and Timely (SMART). These will be finalised for the April 2023 report, with progress against the delivery of the plan being provided in subsequent reports. A plan for County Durham and Tees Valley services is currently being developed and will be included within the April 2023 report.

Long Term Plan Ambitions - County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **6** measures that have not been delivered at quarter 4 and for the financial year.

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	Q4	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	2710	10232
Percentage of people who have waited more than 90 days between first and second appointments	<10%	<10%	28.43%	30.70%	14.63%	13.02%	21.79%
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%	82.35%	82.35%
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%	81.25%	81.25%
Number of people accessing IPS services as a rolling total each quarter	1058 ICS Ambition	169 at Quarter End	133	137	124	95	
Number of women accessing specialist community PMH services in the reporting period (cumulative)	529	Q1 114 Q2 228 Q3 342 Q4 456	226	288	359	432	432

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.	**Closed**. IAPT will be included within the Care Group Performance Improvement Plan, which will be developed for the May report.	

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.	The trial has now commenced.	
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.		
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.	The work will commence on the 1st May 2023; timescales for delivery will be finalised at that point.	
The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment **The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment**			
The CED service is currently providing dietetic support into County Durham and Darlington Foundation Trust (CDDFT) paediatric wards to support patients presenting with an eating disorder, which is further impacting staff capacity.	Care Group Director to progress a temporary Service Level agreement with CDDFT.	The SLA has been finalised and agreed in principle. A date for sign-off is pending.	

Long Term Plan Ambitions - County Durham Sub-ICB Location

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Number of people accessing IPS services			
We need to better understand our data for Individual Placement & Support (IPS) service, to identify the underlying reasons for not meeting our locally agreed trajectories with commissioners.	Head of Performance to work with the Service Manager and Finance and Business Intelligence colleagues to develop an evidenced-based paper by the end of November 2022, to inform next steps.	**On hold.** Following discussions and detailed analysis, a data quality issue has been identified that must be resolved before the paper can be completed.	
A number of interventions have been recorded using incorrect codes; these require resolution to enable us to understand the impact on this measure.	*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.	**Complete**. The amendment has been actioned and all data within the report refreshed.	No visible 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.	1 vacancy has been filled and a start date is pending. Interviews for the remaining 2 posts will be held in April 2023.	
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

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **5** measures that have not been delivered at quarter 4 and for the financial year.

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	Q4	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	544	2082
Percentage of people who have waited more than 90 days between first and second appointments	<10%	<10%	30.05%	33.60%	18.03%	15.61%	24.69%
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	74.44%	80.85%	83.17%	88.89%	88.89%
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%	57.14%	57.14%
Number of people accessing IPS services as a rolling total each quarter	1058 ICS Ambition	216 at Quarter End	166	176	148	132	

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

Long Term Plan Ambitions – North Yorkshire Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **6** measures that have not been delivered at quarter 4 and for the financial year.

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	Q4	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	1880	7180
IAPT: The proportion of people who are moving to recovery	50.00%	50.00%	50.05%	49.23%	42.44%	52.85%	48.65%
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%	75.47%	75.47%
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	61	79	88	76	
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	149	149

Actions being taken to support improvement and increased assurance are being implemented as part of the Performance Improvement Plan. This will be finalised for the April 2023 report, with progress against the delivery of the plan being provided in subsequent reports.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **5** measures that have not been delivered at quarter 4 and for the financial year.

Measure	Oversight Standard/ National Ambition	Agreed Sub-ICB location Ambition	Q1	Q2	Q3	Q4	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	1627	6210
Percentage of people who have waited more than 90 days between first and second appointments	<10%	<10%	17.65%	15.52%	12.45%	11.21%	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%	78.33%	78.33%
Number of people accessing IPS services as a rolling total each quarter	559 ICS Ambition	92 at Quarter End	52	63	66	70	
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	115	115

Actions being taken to support improvement and increased assurance are being implemented as part of the Performance Improvement Plan. This will be finalised for the April 2023 report, with progress against the delivery of the plan being provided in subsequent reports.

Chapter 3

NHS Oversight Framework

NHS Oversight Framework

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Introduction:

The NHS Oversight Framework is built around five national themes:

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

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

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

Summary:

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

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

- Access rate for IAPT services (North East & North Cumbria)*
- Overall CQC rating
- NHS Staff Survey compassionate culture people promise element sub score
- NHS Staff Survey compassionate leadership people promise element sub score
- CQC well led rating
- Staff survey engagement theme score
- Proportion of staff in a senior leadership role who are from a BME background

**Please see the relevant sections within the Integrated Performance Report, Long Term Plan and Performance Improvement Plans*

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

1) Quality, Access & Outcomes: Mental Health

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

Tees, Esk & Wear Valleys NHS Trust	Oversight Standard	Q1	Q2	Q3	Q4	Latest National Position
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	0	1094	1031	431	951	Interquartile range as at December 2022 (500) 23 out of 56 Trusts

Please see the Bed Pressures section within the Integrated Performance Dashboard from slide 18 and the Performance Improvement Plan.

North East & North Cumbria ICB	Oversight Standard	Q1	Q2	Q3	Q4	Latest National Position
Access rate for IAPT services	100.00%	93.23%	71.93%	81.23%	88.50%	Lowest performing quartile (a position of concern) as at December 2022 32 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100.00%	114.52%	113.38%	113.65%	112.47%	
Access rates to community mental health services for adult and older adults with severe mental illness	100.00%	211.22%	211.49%	214.24%	217.97%	

Humber & North Yorkshire ICB	Oversight Standard	Q1	Q2	Q3	Q4	Latest National Position
Access rate for IAPT services	100.00%	85.67%	88.53%	97.43%	96.39%	Interquartile range as at December 2022 21 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100.00%	148.90%	153.31%	153.10%	154.21%	
Access rates to community mental health services for adult and older adults with severe mental illness	100.00%	239.47%	231.06%	227.55%	218.56%	

Please see the relevant measures within the Long Term Plan section from slide 55 and the Performance Improvement Plans.

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

Quality of care, access and outcomes; Safe, high-quality care	Oversight Standard	Q1	Q2	Q3	Q4	Latest National Position
National Patient Safety Alerts not completed by deadline	0	0	0	0	0	Data as at January 2022
Consistency of reporting patient safety incidents	100.00%	100.00%	100.00%	100.00%	100.00%	Data as at January 2022 Highest performing quartile (a positive position) as at September 2022 (100%) 1 out of 71 Trusts
Overall CQC rating	N/A	Requires Improvement				Lowest performing quartile (a position of concern) as at February 2023 53 out of 69 Trusts
NHS Staff Survey compassionate culture people promise element sub-score		6.9	6.9	6.9	6.8	Lowest performing quartile (a position of concern) as at 2021 survey 63 out of 70 Trusts
NHS Staff Survey raising concerns people promise element sub-score		6.7	6.7	6.7	6.7	Interquartile range as at 2021 survey 49 out of 70 Trusts
Adult Acute Length of Stay Over 60 Days	0%	10.87%	13.43%	11.07%	12.93%	Highest performing quartile (a positive position) as at December 2022 (12.1%) 6 out of 50 Trusts
Older Adult Acute Length of Stay Over 60 Days	0%	33.59%	33.81%	40.15%	28.28%	Interquartile range as at December 2022 (32.4%) 15 out of 50 Trusts

Leadership and Capability; Leadership

Leadership and Capability; Leadership	Oversight Standard	Q1	Q2	Q3	Q4	Latest National Position
NHS Staff Survey compassionate leadership people promise element sub-score	As per staff survey benchmarking	7.17	7.17	7.17	7.3	Lowest performing quartile (a position of concern) as at 2021 survey 65 out of 70 Trusts
CQC well-led rating	N/A	Requires Improvement				Lowest performing quartile (a position of concern) as at February 2023 55 out of 69 Trusts

People; Looking after our people

People; Looking after our people	Oversight Standard	Q1	Q2	Q3	Q4	Latest National Position
Staff survey engagement theme score	As per staff survey benchmarking	7.00	7.00	7.00	6.80	Lowest performing quartile (a position of concern) as at 2021 survey (6.79) 64 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking	8.00%	8.00%	8.00%	7.00%	Interquartile range as at 2021 survey (8.33%) 32 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	As per staff survey benchmarking	14.00%	14.00%	14.00%	14.00%	Interquartile range as at 2021 survey (13.80%) 28 out of 70 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	As per staff survey benchmarking	25.00%	25.00%	25.00%	23.00%	Interquartile range as at 2021 survey (24%) 20 out of 70 Trusts
NHS Staff Leaver rate	None	13.87%	13.39%	12.91%	12.31%	Highest performing quartile (a positive position) as at December 2022 (7.34%) 7 out of 71 Trusts
Sickness absence rate (working days lost to sickness)	None	6.44%	6.11%	6.16%	6.71%	Interquartile range as at October 2022 (6.33%) 51 out of 71 Trusts

People; Belonging in the NHS

People; Belonging in the NHS	Oversight Standard	Q1	Q2	Q3	Q4	Latest National Position
Proportion of staff in senior leadership roles who a) are from a BME background b) are women c) disabled staff						
BME background	12%	1%	1%	1%	1%	Lowest performing quartile (a position of concern) as at 2021 calendar year (1.99%) 64 out of 69 Trusts
Women	62%	66%	67%	64%	65%	Interquartile range as at December 2022 (62.3%) 29 out of 47 Trusts
Disabled staff	3.20%	4%	4%	6%	6%	
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	As per staff survey benchmarking	56.00%	56.00%	56.00%	63.00%	Interquartile range as at 2021 calendar year (60.50%) 28 out of 70 Trusts

Finance and use of resources

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

Finance and use of resources	Oversight Standard	Q1	Q2	Q3	Q4	Latest National Position
Financial efficiency - variance from efficiency plan - Recurrent	N/A	£1,208,577	£3,871,945	£6,482,000	£9,963,681	Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.
Financial efficiency - variance from efficiency plan - Non-Recurrent	N/A	£361,173	£722,346	£1,044,000	£3,754,319	
Financial stability - variance from break-even	N/A	£1,296,930	£4,290,781	£4,718,089	-£1,207,855	
Agency spending: Agency spend compared to the agency ceiling	100%	Not currently available	208.23%	224.76%	221.14%	
Agency spending: Price cap compliance	100%	Not currently available	64%	64%	63%	

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ITEM NO. 11

For General Release

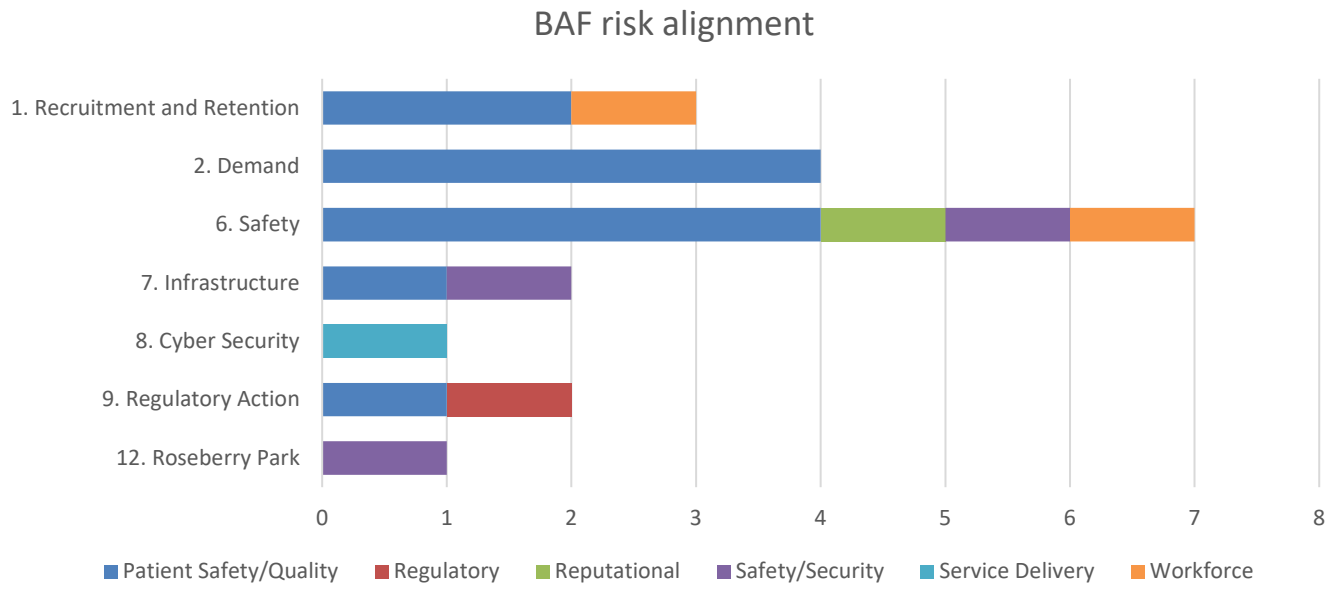
Meeting of:	**Board of Directors**
Date:	**25th May 2023**
Title:	**Corporate Risk Register**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Kendra Marley, Head of Risk Management**

Report for:				
	Assurance	✓	Decision	
	Consultation		Information	✓

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

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

Strategic Risks relating to this report:



Executive Summary:

Purpose: To sight the Board on organisational wide risks that are rated as high risk in the Corporate Risk Register.

For Board consideration to determine level of assurance it can take regarding the risk management processes.

Overview: This paper presents to the Board the risks that are rated >15 on the Corporate Risk Register as of 1st May 2023.

The Corporate Risk Register is reviewed and approved by the Executive

Risk Group and was last reviewed by them at the March meeting, and changes agreed are reflected in this paper.

There are currently 20 risks on the Corporate Risk Register. This is an increase of 3 risks as a result of 4 new additions and 1 removal as follows:

Risks added

1229 – DTVF - Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered. (15)

1371 – DTVF Adults - Due to the length of time current level 2 positive and safe training takes staff away from clinical work, there is a risk that compliance continues to reduce across the service which may also result in reduced ability to respond correctly to incidents. (20)

1427 – Medical Pharmacy - The is a risk of compromised patient safety, due to reduced capacity within the pharmacy leadership team, resulting in; reduced service management, reduced governance, reduced response times, reduced oversight. (16)

1429 – Nursing &Governance - There is a risk of delays in reviewing serious incidents due to ongoing backlog and low staffing resulting in avoidable hard to service users and staff, delayed or lost learning, poor patient or carer experience and resultant phycological harm. (16)

Risk removed

1260 – Finance - There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality of services.

Prior Consideration and Feedback

All risks are considered at service level governance.

All risks are considered by the Care Group Risk Group/ Directorate.

The Trust Executive Risk Group consider all risks rated as >15.

Implications:

Risks may impact on the delivery of individual services, patient safety and quality of care, and overall impact the achievement of the Trust strategic aims and objectives.

Recommendations:

The Board is asked to:

- Review the risks and actions and consider if the risk management is sufficient.
- Determine level of assurance it can take regarding the risk management processes.

MEETING OF:	**Board of Directors**
DATE:	**25th May 2023**
TITLE:	**Corporate Risk Register**

1. Introduction and Purpose

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

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

2. Background Information and Context

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

- Responsible for ensuring the Trust has effective systems for managing risk.
- Receipt of the Corporate Risk Register to consider and determine the level of assurance it can take regarding the risk management processes.

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

The Trust has changed the approach to the Corporate Risk Register, and instead of including all 15+ risks, is now only including risks of 15+ where they also have a trust wide impact or impacted directly on a trust goal. This will mean that not all 15+ risks will be included on the Corporate Risk Register, however the Executive Risk Group will still have full oversight and moderation of these.

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

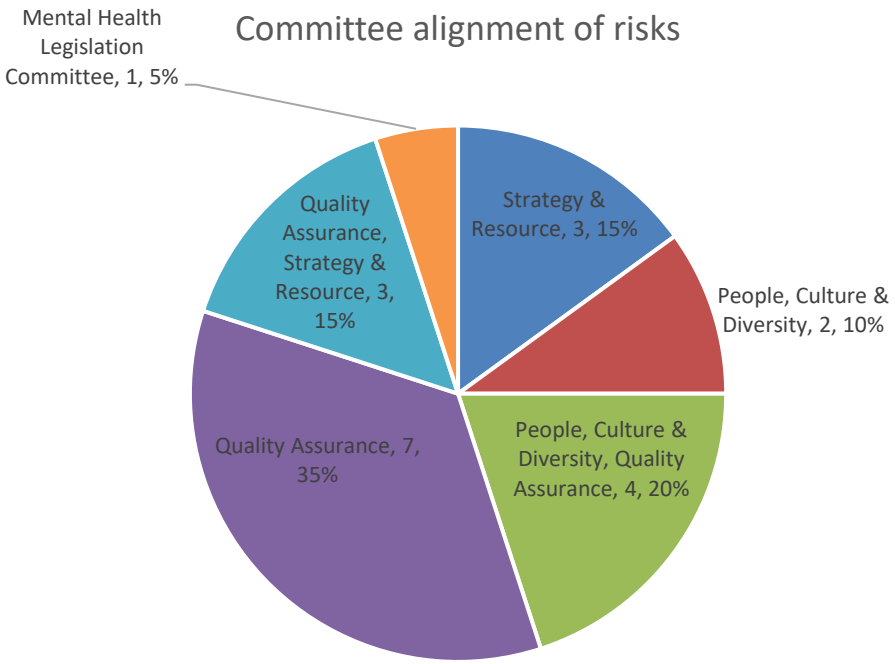
3. Current Corporate Risk Register

As of 1st May 2023, there are 20 risks on the Corporate Risk Register. These form the main register that is reported to the Board and Committees.

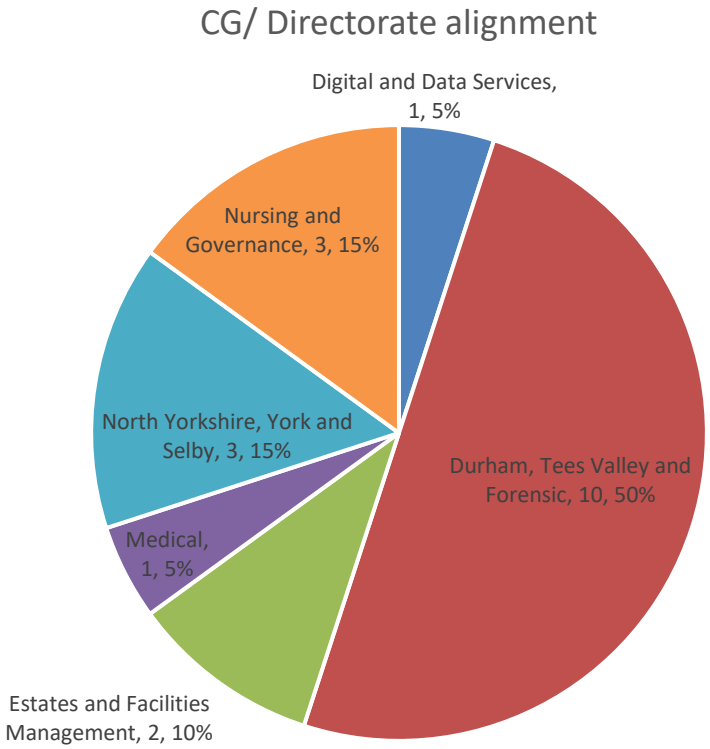
The Executive Risk Group last reviewed and approve additions and removals in March 2023. As a result of this review 4 risks were added to the Corporate Risk Register and 1 removed.

The current risks on the register align to the main Board Committees as shown in the following chart. (Risks may align to more than one Committee) This shows that there are;

- 14 risks that align to the Quality Assurance Committee, 3 of which also align to Strategy and Resource, and 4 to People, Culture and Diversity, making up over 50% of risk on the Corporate Risk Register.
- 6 risks align to the Strategy and Resource Committee, 3 of which also align to Quality Assurance.
- 6 risks align to the People, Culture and Diversity Committee, 4 of which also align to Quality Assurance.
- 1 risk that aligns to Mental Health Legislation Committee.

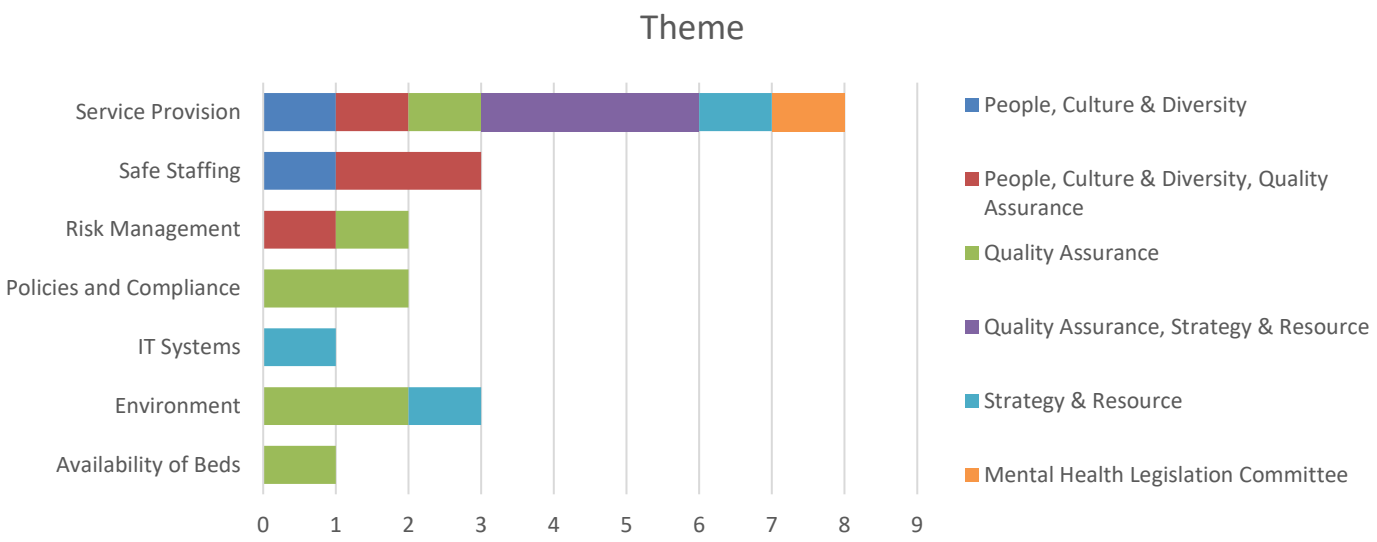


Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 50% of the current Corporate Risk Register is made up of risks from Durham Tees Valley and Forensics Care Group, with 15% North Yorkshire York & Selby Care Group and Corporate Directorates making up the other 35%.



3.1 Risk Themes

The 20 risks fall under the following themes within the Committee Alignment.



The below table shows the changes in the period.

Themes	PCD	PCD & QAC	QAC	QAC & S&R	S& R	MHLC	Total	Change/ previously
Availability of Beds			1				1	↔ 1
Environment			2		1		3	↔ 3
Financial							0	↓ 1
IT Systems					1		1	↔ 1
Policies and Compliance			2				2	↑ 1
Risk Management		1	1				2	↑ 1
Safe Staffing	1	2					3	↔ 3
Service Provision	1	1	1	3	1	1	8	↑ 6
Total	2	4	7	3	3	1	20	17

3.2 Risk Movements

The Executive Risk Group reviewed 15+ risks and the risks already on the Corporate Risk Register in March 2023, agreeing additions and removals. This resulted in 4 additions and 1 removal.

Risks added to the Corporate Risk Register

A number of risks were considered by the Executive Risk Group in March 2023, with 4 being identified for addition to the Corporate Risk Register.

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating	Notes

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating	Notes
People, Culture & Diversity	6. Safety	Quality & Safety	1229	DTVF	Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered.	15	15	9	This risk had been escalated to 15 from 12 due to limited assurance around current levels of compliance. Supervision continues to be a focus at Fundamental standards group however there are ongoing challenges around visibility of compliance and as such limited assurance
People, Culture & Diversity, Quality Assurance	6. Safety	Quality & Safety	1371	DTVF - Adults	Due to the length of time current level 2 positive and safe training takes staff away from clinical work, there is a risk that compliance continues to reduce across the service which may also result in reduced ability to respond correctly to incidents.	20	20	9	New – Identified as a local service risk. Recognition that this is a wider trust issue to address.
Quality Assurance, People, Culture & Diversity	1. Recruitment and Retention	Quality & Safety	1427	Medical - Pharmacy	The is a risk of compromised patient safety, due to reduced capacity within the pharmacy leadership team, resulting in; reduced service management, reduced governance, reduced response times, reduced oversight.	16	16	4	New – Pharmacy. Recognition that the impact of this is trust wide.
Quality Assurance	1. Recruitment and Retention	Quality & Safety	1429	Nursing & Governance	There is a risk of delays in reviewing serious incidents due to ongoing backlog and low staffing resulting in avoidable hard to service users and staff, delayed or lost learning, poor patient or carer experience and resultant phycological harm.	20	16	8	New – service level risk. Impacts trust wide.

Agreed removals from the Corporate Risk Register

1 risk that had been reduced to below the threshold of 15 has been removed from the Corporate Risk Register, this is shown in the following table.

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating	Update

Committee Alignment	BAF link	Theme	Risk ID	Location	Risk Description	Initial rating	Current rating	Target rating	Update
Strategy & Resource	15. Financial Sustainability	Financial	1260	Finance	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality of services.	20	12	8	Risk was reduced as the Trust is forecasting to outturn in line with plan this financial year. There are dependencies to deliver this, but the risk of slippage decreases as we get closer to financial year end, and have more certainty over projections. Risk relating to 23/24 financial year to be assessed and a new risk added. This risk was agreed for removal from the Corporate Risk Register.

Risks that had previously been reduced

There had previously been changes to the current risk score of a risk on the register, reducing this to below the 15+ threshold used for the Corporate Risk Register.

This was reviewed by the Executive Risk Group in at the March meeting, however, was not considered for removal as this had been increased and again sits at 15. The detail is shown below for completeness.

Risk ID	Location	Risk Description	IRR	PRR	CRR	TRR	Update
1238	NYYS - MHSOP	There is a risk to being able to provide quality of care and patient experience for North Yorkshire & York patients need admission due to admission of out of locality and out of specialty patients into NYY MHSOP beds. There is high demand from out of locality and out of specialty, variable control process across the trust, resulting in increased work and pressure on teams, communication difficulties with community teams, increased LOS, impact on patients and families for visiting.	15	15/9/12	15	9	This risk came to the group in January as it had been reduced to a 9. And the commentary added reflected - 14/12/2022 Likelihood reduced to "possible" due to reduction in OOA admissions this month. However, this was queried by the group as to whether the reduction was based on a reduction in admission in just 1 month as this would not be sufficient to reflect any successful mitigation of risk or reduced demand. The risk has been increased again following deteriorating position.

Additional reductions on the current Corporate Risk Register

1 risk has been reduced during March to below 15, and this will be reviewed by the Executive Risk Group at their next meeting in May for consideration to remove from the Corporate Risk Register.

Risk ID	Location	Risk Description	IRR	PRR	CRR	TRR	Update
1289	Durham, Tees Valley and Forensic - Health and Justice (HJ) -	There is a risk that the commencement of the contract for mental health service delivery in HMP Hull and HMP Humber that waiting lists and service provision are not at the standard that TEWV services would expect. This may result in difficulties with service delivery and patient safety.	16	16	9	6	16/3/23 - scored reduced due to waiting list now below 4 working days for Hull and Humber prisons.

3.3 Risk and Action Review Compliance

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

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

Of the risks on the Corporate Risk Register at 1st May 2023, 6 of the 20 had passed their review date, indicating that review compliance had reduced from 90% to 70%. Overall risk review compliance across the Trust has reduced from 91% last month to 78% this month. (77% reported in February paper and 58% prior to that).

Monitoring of review compliance, including action delivery compliance is undertaken and reported at all levels to aid awareness of risk review processes. Manual email reminders are continuing to be sent to help prompt owners.

4. Implications

4.1 Compliance with the CQC Fundamental Standards

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

4.2 Financial/Value for Money

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

4.3 Legal and Constitutional (including the NHS Constitution)

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

4.4 Equality and Diversity

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

4.5 Other implications

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

5. Risks

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

6. Conclusions

The current Corporate Risk Register as at 1 May 2023 is provided and there are 3 new additions and 1 removal. 1 risk is currently on the register that is now below the threshold of 15+.

Review timeliness and update on the system for Corporate Risk Register risks has decreased this month, as has overall review compliance, although this is still slightly better than that previously reported in February.

7. Recommendations

The Trust Board are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- To consider and determine the level of assurance the Board can take over the ongoing management of risk.

Kendra Marley - Head of Risk Management
May 2023

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 12

For General Release

Meeting of:	**Board of Directors**
Date:	**25 May 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 9 May 2023 and was a themed visit to target those team who have had issues recruiting staff, as well as the recruitment team itself, and included

- York Crisis Services
- Teesside AMH and SIS
- Durham / Darlington Crisis Services
- Corporate Recruitment Team

3 Key issues

3.1 Feedback from leadership walkabouts is summarised below.

Operational services:

- Demand v's capacity was an issue across the teams.
- Different arrangements for handling crisis calls across different geographies re crisis line speciality areas.
- Legacy issues around COVID-19 having an impact in terms of demand, but also around setting up 0800 number during the pandemic, and now what that means for teams eg volume of calls, triage, assessment, home based treatment.
- Patient flow / discharge highlighted across all operational services visited as an area of concern, and link with community teams.
- Struggling to recruit the right staff, in the right speciality area – challenges include incentives and 'fishing from the same pond' as neighbouring trusts, as well local employers offering better salaries (can't match wider NHS benefits).
- Teams keen to celebrate when things go well – patient feedback / experience is largely positive.

Corporate Services (recruitment team):

- Committed and supportive team who strive to offer robust, open and transparent recruitment processes across the Trust, to support those recruiting and the candidates, to comply with NHS Standards.
- High volume and pace of recruitment can be challenging to meet the needs of the organisation.
- Brought in additional capacity to support eg pre-employment checks / digitisation, references etc.
- Time and capacity to train recruiting managers would help speed things up – lots of resources, tutorials etc that are simple to follow, time pressure a barrier.
- People Partner roles in the care groups helping identify areas where recruitment is an issue, and cocreating innovative ideas and solutions.
- Need to put our people at heart of our recruitment campaigns – personal stories are really powerful.

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 9 May 2023.

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