Tees, Esk and Wear Valleys
NHS Foundation Trust

COUNCIL OF GOVERNORS
THURSDAY 15th JUNE 2023

VENUE: THE WORKPLACE, AYCLIFFE BUSINESS PARK, HEIGHINGTON LANE, NEWTON AYCLIFFE, DL5 6AH AND VIA MS TEAMS
AT 2.00 PM

AGENDA

1.	Apologies for absence	David Jennings Chair	Verbal
2.	Welcome and Introduction	David Jennings Chair	Verbal
3.	To approve the minutes of the meeting held on 9th March 2023	David Jennings Chair	Draft Minutes
4.	To receive any declarations of interest	David Jennings Chair	Verbal
5.	To review the Public Action Log	David Jennings Chair	Report
6.	To receive an update from the Chair	David Jennings Chair	Verbal
7.	To receive an update from the Chief Executive	Brent Kilmurray Chief Executive	Verbal
8.	Governor questions and feedback – a) Governor questions and answers session b) Governor feedback from events, including local issues, concerns and good news (please use the Governor Feedback template). *(All questions and feedback should be submitted in writing to the Corporate Affairs and Involvement Directorate at least 48 hours before the meeting. Please send them to tewv.governors@nhs.net).*	David Jennings Chair	Schedule of Governor questions, responses and feedback to be circulated
9.	Our Journey to Change Delivery Plan 2023/24	Chris Lanigan Associate Director of Strategic Planning and Programmes	Report

10.	To receive the following performance/compliance updates: a) Integrated Performance Dashboard Report as at 30th April 2023 b) Trust's Finance Report 2022/23 c) Trust's Financial Plan 2023/24 d) CQC Compliance Update Report	Ashleigh Lyons Head of Performance Liz Romaniak Director of Finance, Information & Estates/Facilities Beverley Murphy Chief Nurse	Report Report Report Report
11.	To receive the Trust's Quality Account 2022/23	Beverley Murphy Chief Nurse Avril Lowery Director of Quality Governance	Report
12.	To receive an update from Operational Services	Patrick Scott Managing Director for DTV&F Care Group Zoe Campbell Managing Director for NYY&S Care Group	Report Report
13.	Update from the CoG Involvement and Engagement Committee	Mary Booth Acting Chair of I&E Committee	Report
14.	Update on the Council of Governors' Autism Task and Finish Group	Jules Preston Non-Executive Director	Report
15.	CoG Task and Finish Group: The Role of a NHS Foundation Trust Governor	David Jennings Chair	Verbal
16.	Date of next meeting: Thursday 27th July 2023	David Jennings Chair	Verbal
17.	Exclusion of the public	David Jennings Chair	Verbal

	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:* *Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.* *Information which, if published would, or be likely to, inhibit -* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs".*		

David Jennings
Chair
15th June 2023

Contact: Phil Bellas, Company Secretary, Tel: 01325 552001, Email: p.bellas@nhs.net

MINUTES OF THE COUNCIL OF GOVERNORS' PUBLIC MEETING HELD ON 9TH MARCH 2023 AT 2.00PM

VENUE: THE WORKPLACE, AYCLIFFE BUSINESS PARK, HEIGHINGTON LANE, NEWTON AYCLIFFE AND VIA MS TEAMS

PRESENT:
David Jennings - Chair
Lynne Ackland - Public Governor, Durham (MS Teams)
Joan Aynsley - Public Governor, Durham (MS Teams)
Gemma Birchwood - Public Governor, Selby (MS Teams)
Mary Booth - Public Governor, Middlesbrough
Dr Martin Combs - Public Governor, York
Susan Croft - Public Governor, York (MS Teams)
John Green - Public Governor, Harrogate and Wetherby
Hazel Griffiths - Public Governor, Harrogate and Wetherby (MS Teams)
Dominic Haney - Public Governor, Durham
Christine Hodgson - Public Governor, York (MS Teams)
Lisa Holden - Public Governor, Scarborough and Ryedale (MS Teams)
Dr Judy Hurst - Public Governor, Stockton-on-Tees (MS Teams)
Joan Kirkbride - Public Governor, Darlington
Audrey Lax - Public Governor, Darlington (MS Teams)
Catherine Lee-Cowan – Appointed Governor, Sunderland University (MS Teams)
Heather Leeming - Staff Governor, Durham, Tees Valley and Forensics Care Group (MS Teams)
Jacci McNulty - Public Governor, Durham (MS Teams)
Alicia Painter - Public Governor, Middlesbrough
Jean Rayment - Public Governor, Hartlepool
Gillian Restall - Public Governor, Stockton-on-Tees
Graham Robinson - Public Governor, Durham (MS Teams)
Zoe Sherry - Public Governor, Hartlepool (MS Teams)
Stanley Stevenson - Public Governor, Hambleton and Richmondshire
Roger Tuckett - Public Governor, Hambleton and Richmondshire
Jill Wardle - Public Governor, Durham
Judith Webster - Public Governor, Scarborough and Ryedale (MS Teams)

IN ATTENDANCE:
Brent Kilmurray - Chief Executive
Sheena Bayley – Team Secretary
Phil Bellas - Company Secretary
Ann Bridges - Director of Corporate Affairs and Involvement
Mike Brierley - Assistant Chief Executive
Zoe Campbell - Managing Director for North Yorkshire, York and Selby Care Group (MS Teams)
Karen Christon – Deputy Company Secretary
Dr Hannah Crawford - Director of Therapies
Dr Sarah Dexter-Smith - Director for People and Culture
Prof. Pali Hungin - Non-Executive Director

Angela Grant - Corporate Governance Officer (CoG and Membership)
Jill Haley - Non-Executive Director (MS Teams)
Wendy Johnson –Team Secretary
Donna Keeping – Corporate Governance Manager
Elizabeth Moody - Deputy Chief Executive / Director of Nursing and Governance
Beverley Murphy – Chief Nurse
Jules Preston - Non-Executive Director
Liz Romaniak - Director of Finance, Information and Estates/Facilities
Beverley Reilly - Non-Executive Director
Patrick Scott - Managing Director for Durham, Tees Valley & Forensics Care Group

23/89 APOLOGIES

Apologies for absence were received from:

Lee Alexander - Appointed Governor, Durham County Council
Rob Allison - Appointed Governor, University of York
Sarah Blackamore - Staff Governor, North Yorkshire, York and Selby Care Group
Cllr. Moss Boddy – Appointed Governor, Hartlepool Borough Council
Emmanuel Chan - Staff Governor, Durham, Tees Valley and Forensics Care Group
Megan Harrison - Public Governor, Stockton-on-Tees
Kevin Kelly - Appointed Governor, Darlington Borough Council
Jane King - Staff Governor, Durham, Tees Valley and Forensics Care Group
Keith Marsden - Public Governor, Scarborough and Ryedale
Cllr. Mary Ovens – Appointed Governor, Redcar and Cleveland Borough Council
Cllr Ann McCoy - Appointed Governor, Stockton Borough Council (Lead Governor)
John Venable - Public Governor, Selby
Cllr Derek Wann - Appointed Governor, City of York Council
Alan Williams - Public Governor, Redcar and Cleveland

Roberta Barker - Non-Executive Director
Dr Charlotte Carpenter - Non-Executive Director
Dr Kader Kale - Medical Director
John Maddison - Non-Executive Director

23/90 WELCOME

The Chair welcomed attendees and confirmed that, as inclement weather had been forecast for later in the day, the aim would be to keep the meeting as succinct as possible.

23/91 DECLARATIONS OF INTEREST

There were no declarations of interest.

23/92 MINUTES OF PREVIOUS MEETINGS

Agreed – That the public minutes of the Council of Governors' meeting held on 17th November 2022, and the minutes of the Annual General and Members'

Meeting held on 25th November 2022, be approved as correct records and signed by the Chair.

23/93 PUBLIC ACTION LOG

Consideration was given to the Council of Governors' Public Action Log.

It was noted that:

- Action 22/28 (12/05/22) was closed as the Information Department would deliver a tutorial at a Governor Development session soon.
- Action 22/59 (13/10/22) was closed. The ICB consultation on delivery of the Health Inequalities Strategy had been circulated to Governors via email. The Chair confirmed that the email could be re-sent to Governors if requested.
- Action 22/71 (17/11/22) - An update on the Trust's Crisis Service would be included in the Quality Update at Item 9 on the agenda.
- Action 22/73 (17/11/22) was closed. Details of Care Quality Commission's (CQCs) ratings for services in the Trust had been circulated to Governors by email on 6th March 2023.

23/94 CHAIR'S UPDATE

Governors considered a short briefing document, circulated prior to the meeting, detailing events and meetings the Chair had attended between 25th November 2022 and 16th February 2023.

23/95 CHIEF EXECUTIVE'S UPDATE

Governors received a verbal report updating them on important topical issues that were of concern to the Chief Executive.

B. Kilmurray advised that:

- He wished to thank Governors who had been involved in the process for appointing the Trust's new Chief Nurse, Beverley Murphy. The Director of Nursing and Governance and Deputy Chief Executive, E. Moody, would be retiring on 30th April 2023 and B. Murphy's new role would commence on 1st May 2023. Both had been working together to ensure a thorough handover.
- He and other Board members had attended a Board to Board meeting with Executives from the regional NHS England (NHSE) team and from each of the Integrated Care Boards (ICBs). It had been a positive meeting, reflecting on the risk ratings of the Trust and how those risks ratings could be reduced. He had delivered a presentation on the Trust's position in its journey to change and had highlighted improvements, achievements and risks that caused concern. The main areas of concern had been workforce planning and digital data work. In summary, colleagues from NHSE and the ICBs had been content with the progress made by the Trust but planned to meet again with the Board to revisit matters discussed.

- An Independent Review Team had recently been appointed by the Secretary of State to carry out an eight-week review of the Trust's inpatient services. The review would focus on information quality and feedback from the review would be provided to Governors in due course.
- The Home Office had consulted with the Department of Health and Social Care (DoH&SC) regarding mental health in the community and a possible withdrawal of support in relation to the police service. He confirmed that the Trust needed to be fully involved in that consultation as the role of the police was essential to mental health services. Significant changes had been suggested and these needed to be carefully considered, particularly in terms of the impact on resources.

  The Chair added that the progress made on this matter would be of great interest to him.

It was noted that:

- Following a request from R. Tuckett that a summary of the matters discussed at the Board to Board meeting to be circulated to Governors, B Kilmurray confirmed that he would ensure Governors received that information.

Action – B. Kilmurray

- J. Wardle enquired as to whether the public would be included in the consultation by the Home Office on mental health services, and whether the consultation document could be shared.

  B. Kilmurray advised that he was not aware of any intention to involve the public in the consultation. The document was embargoed, however, as soon as it was available to share, he would circulate it to Governors.

Action – B. Kilmurray

23/96 GOVERNOR QUESTIONS AND FEEDBACK

Governors considered a schedule of Governor questions and responses, circulated prior to the meeting.

It was noted that:

- With regards to questions from A. Painter, relating to black staff and staff at Roseberry Park in Middlesbrough, J. Kirkbride questioned how such information had been obtained and what a Governor's responsibility would be to report such matters.

  A. Painter advised that she had worked on wards within the Trust as a member of bank staff and had spoken to a number of black colleagues who had experienced racism, including remarks from other staff. Those colleagues had raised concerns with their managers and A. Painter had sought

permission from them to bring the matter to the attention of the Council of Governors.

B. Kilmurray confirmed that Governors would always be encouraged to report concerns brought to their attention, as early as possible. They did not need to wait until a Council of Governors' meeting.

The Chair concurred with the Chief Executive and added that both Governors and the Board shared the same goal, for the Trust to provide the best services possible.

L. Holden questioned whether staff could escalate concerns under the Trust's Equality and Diversity Policy.

S. Dexter-Smith confirmed that they could, and that concerns would be addressed immediately by either operational services or the Equality, Diversity and Inclusion (ED&I) Team. The sooner matters were escalated, the better. However, it was clear that not everyone felt able to speak out.

- With regards to question four, J. Kirkbride sought clarity on how the Trust would remove paper copies of the Borderline Personality Disorder (BPD) Protocol from wards, as the response provided to the question had not addressed this issue.

  B. Kilmurray sought clarity on where paper copies could be found within Trust wards.

  A. Painter advised that she had been aware of copies on Bedale Ward but suggested that other wards could have copies and therefore should also be checked.

  P. Scott confirmed that he would ensure a check on wards within the Trust, for paper copies, would be carried out to ensure that none were retained.

Action – P. Scott

23/97 QUALITY UPDATE

Governors received a quality update from B. Reilly and E. Moody. It was noted that the report of the Quality Assurance Committee (QuAC) had been considered by the Board at its meeting on 23rd February 2023.

The Chair advised that in the future, Non-Executive Directors (NEDs) and Executive Directors would present some items jointly to demonstrate their accountability and provide examples of holding to account. This would also hopefully assist Governors in holding the NEDs to account.

Introducing the report, B. Reilly advised that:

- Two appendices to the report had not been included. She apologised for this and confirmed that they would be circulated to Governors as soon as possible after the meeting. Appendix A was the "Hard Truths" monthly Nurse Staffing Exception Report for January 2023 and Appendix B was an update on the organisational response to findings identified at Edenfield Ward, Greater Manchester Mental Health NHS FT regarding 'closed cultures'. Both appendices had been considered by the QuAC at its meeting on 2nd February.

Action – E. Moody

- E. Moody would update the Council of Governors' on closed cultures work, concerns relating to seclusion and patients feeling safe.
- As part of the organisational re-structure of the Trust, much of the information considered by the QuAC had been scrutinised and filtered by E. Moody to improve the quality of the data reported.
- Although not included in the report, an update on the Trust's Crisis service would be provided to address Action 22/71 (17/11/22) on the Public Action Log.
- Although the Trust was data rich, more needed to be done to streamline information and understand where to target resources and focus the Board's attention. This would then provide NEDs with the assurance they required.

E. Moody advised that:

- With regard to closed cultures, following the disturbing Panorama programme featuring footage from the Eden Field Unit in Manchester, Claire Murdoch, the National Mental Health Director at NHS England had written to trust's and encouraged them to consider closed cultures in their organisations and what action they were taking to address them (minute 22/59 (13/10/22) refers).
- As closed cultures were extremely difficult to identify, the Trust had developed a tool to assess wards and determine which ones were at risk of developing them. Questions within the tool were rated from 1-4, with a rating of 4 indicating that no risk existed. She stressed that the wards identified as being at risk had been recognised as having challenging environments where closed cultures could potentially develop. They were not 'bad' wards. The development of the tool had progressed quickly and although some improvements were required, a list of at risk wards had been produced.
- After identifying the 'at risk' wards, announced and unannounced visits and reviews had taken place in 43 of those identified. A range of staff from both care groups had been involved and lots of positive feedback received. Staff also received feedback from the reviews undertaken. She advised that wards with Covid-19 outbreaks had not been visited.
- Included in the feedback received from the ward visits, were concerns relating to language being used and it had been clear that some areas required more support than others. Estates issues had also been identified, including damage to wards, and some issues had not been rectified as quickly as the Trust would have liked. Staffing levels had caused challenges within wards and some concerns related to agency staff, and continuity of care, had been raised. Although good assurance had been provided, there was still work to

do to improve the tool and ensure rapid responses to concerns. This work would be included in the Trust's governance and there were plans to include data in an electronic dashboard to share with staff.

- With regard to Integrated Care Treatment Reviews (ICTRs) for service users with a learning disability, a report had been taken to the QuAC for the first time to show examples of the external assurance the Trust received. However, it was important to note that there were other systems in place to alert the QuAC to issues related to ICTRs being carried out.

It was noted that:

- J. Wardle welcomed all work that resulted in improvements for service users and staff, however as a Trust with a strong leadership structure, she questioned why a tool would be needed to understand where potential closed cultures existed.

  E. Moody confirmed that the tool had been developed and used in conjunction with existing assurance procedures. It reinforced information that the Trust already had and when the top 10 'at risk' wards had been identified, she had been reassured of the tool's effectiveness.

  Z. Campbell concurred with E. Moody's comments and advised that other intelligence regarding closed cultures was available, however, the tool had provided metrics and foresight in terms of early indications of risk and where to probe further.

  B. Reilly commented that the Trust needed to remain vigilant and not become complacent regarding closed cultures.

  B. Kilmurray added that it was important to use all intelligence available, to make leadership decisions.

- L. Holden questioned how easy Trust policies, such as its Whistle Blowing Policy, were to follow. She suggested that some staff may struggle to speak up against a colleague if their comments could result in someone losing their job.

  S. Dexter-Smith advised that there were three levels of national training available, relating to speaking up. All Trust staff had to undertake the first level. The impact, and possible consequences, of someone speaking were always considered in every case.

  The Chair reassured Governors that the Freedom to Speak Up Guardian had a 'direct line' to the Board.

- J. Kirkbride asked what additional interventions had been put in place by the Trust to support the top wards identified as being at risk of closed cultures.

E. Moody confirmed that none of the wards had been identified as requiring specific interventions. Services with the highest risk factors, such as the Psychiatric Intensive Care Units (PICUs), had appeared in the top 10 due to the nature of the service but no additional interventions had been identified.

With regard to the Trust's Crisis Line, P. Scott advised that:

- A significant amount of work had been undertaken, including quality improvement work in December 2022, to address concerns related to quality and pick up rates.
- The best pick up rate recorded since then had been 70% and 40% had been the worst, however those figures tended to fluctuate.
- The Trust had considered how to increase the capacity of skilled staff to pick up calls. There was also a design event planned to be held in April 2023, with system partners for the Durham, Tees Valley and Forensics (DTV&F) Care Group.

Z. Campbell advised that:

- A plan of action, with a staged approach, was now in place for the Selby Crisis Line and the Trust had been working closely with Commissioners and the Voluntary Sector.
- The previous 0800 number providing callers with a choice of a listening service or accessing the crisis line, had been replaced with a more direct route for callers. There was now a 98% pick up rate for the initial calls and 35-37% of calls directed to the crisis service had been answered.
- North Yorkshire, York and Selby crisis lines had both an answer phone and face to face service but there were four full time equivalent vacancies in the service which had impacted on the response rates. The Trust would work with the voluntary sector to increase response rates for this.

In response:

- R. Tuckett stated that he had been pleased to receive some assurance on improvements being made and noted that issues with the Trust's Crisis Service had existed for a long time. He suggested that questions should be asked as to why the service had not been scrutinised two years earlier and whether any lessons had been learned.

  The Chair confirmed that Directors would be considering such questions.

23/98 INTEGRATED PERFORMANCE DASHBOARD (IPD) REPORT

Governors considered the Trust's Integrated Performance Report as at 31st December 2022.

In introducing the report, M. Brierley advised that:

- Key areas of concern had included workforce pressures such as vacancy rates, use of agency staff and costs associated with staffing. They also included bed pressures, crisis lines and financial pressures relating to the cost of packages of specialist care for Learning Disability patients which were not commissioned.
- The Trust needed to work with ICB colleagues to improve waiting times for adults and children who were awaiting assessments for Attention Deficit Hyperactivity Disorder and autism.

  To provide assurance to Governors, the Chair advised that the Integrated Performance Report (IPR) was considered by Non-Executive Directors at Board committee meetings. Reports on the IPR were also considered and discussed by the Board.

Following discussions:

- J. Kirkbride suggested that, rather than listing the number of staff that had completed refresher training, it would be more helpful to understand what percentage of staff had completed the refresher.
- In response to a further question from J. Kirkbride regarding staff retention and exit interviews, S. Dexter-Smith advised that a new exit interview process had recently been introduced in the Trust to understand the reasons for people leaving. The biggest reason given had been issues with a person's manager or team. The Trust wanted to assist with this issue by moving staff elsewhere, rather than losing them.

23/99 FINANCE REPORT

Governors considered the Trust's Finance Report as at 31st January 2023.

L. Romaniak advised that:

- The Trust had reported a deficit of £3.98m for the period ending 31st January 2023, which had been £4.22m higher than planned. A £0.3m profit on disposals received in month 10 could also be included as part of the assessment of the Trust's financial performance.
- The target for the Trust's Financial Plan 2022/23 was a £1.16m surplus, excluding the impact of national pay review body awards which had been accounted for, from month 6.
- At month 10, higher than planned costs had been evident in several key areas including:
  - Adult mental health bed pressures relating to longer stays, increased delayed transfers to non-NHS settings and delayed care packages.
  - Premium agency costs that had increased due to higher than planned reliance on temporary staffing and required skilled staff to support complex care packages. This had also included increased vacancies in medical staffing and use of Locum Consultants.
  - Computer hardware and software.
  - Transport costs, including secure transport and taxi use.

- Cash balances had been £74m and £3.4m above plan, which reflected the receipt of national capital funding, slippage on programmed capital expenditure and working capital variations which offset the Trust's year to date revenue deficit, including a £2.6m unfunded pay award.
- Capital expenditure had been £7.1m and £1.6m below plan.
- At the Our Journey to Change conference, a presentation had been shared with colleagues on challenges to the Trust's financial position for 2023/24. Those slides would be shared with Governors for information.

Action – L. Romaniak

- With regard to the Financial Plan for 2023/24:
    - Non-recurrent national funding, provided since April 2020, would be reducing significantly as the NHS started to return to pre-Covid funding levels.
    - Draft plans had been submitted to NHSE on 23rd February 2023 and significant financial challenges for the Trust, and nationally, were expected in 2023/24.
    - Final plans would be considered by the Executive Directors' Group, Strategy and Resources Committee and Board of Directors during March to support the submission of the final plan for 2023/24 at the end of March 2023.
    - An update on expected financial deficits, linked to pressures faced by the Trust, would be provided to Governors when available.

23/100 CQC COMPLIANCE UPDATE

A presentation was circulated to Governors prior to the meeting, to update on the progress that had been made, as at 23rd February 2023, in relation to the Trustwide CQC Action Plan and re-inspection actions relating to a number of Trust services.

E. Moody advised that:

- Overall, good progress had been made in relation to all 'must do' actions within the action plan.
- Challenges existed in trying to staff wards, whilst also making it possible for staff to attend training.
- A well-led inspection had been imminent from April 2023 onwards and a culture review had been taking place in preparation for that.
- Key improvements had been made in a number of areas including safe staffing, training, ensuring staff had the right skill mix, reducing restrictive interventions and understanding which patients were facing high levels of seclusion. Good assurance had been provided from the Quality Assurance and Improvement Programme related to engagement and observation, the quality of safety summaries/plans and care planning. The Community Teams for Child and Adolescent Mental Health Services had oversight of the risks to young people on waiting lists.

23/101 COUNCIL OF GOVERNORS AUTISM TASK AND FINISH GROUP

Governors considered a report on the Council of Governors' Autism Task and Finish Group.

J. Preston, Chair of the group, advised that:

- Following its establishment, the group had met four times and details of discussions held within the first three meetings had been summarised in the report.
- The purpose of the report had been to reassure Governors that progress had been made against its Terms of Reference, to establish what Governors considered the Trust needed to achieve in order to be an exemplar provider of autism services.
- A long 'wish list' had been produced by the group in terms of what it wanted to focus on, however, some suggestions had been beyond those outlined in the groups original scoping document and would only be considered if timescales allowed. The group understood that autism was wide ranging but they would focus on what improvements were needed to existing provision in TEWV, commissioning and national policy.
- Representatives from the Trust's Autism Project Team had attended meetings, with useful discussions held. It had been hoped that their attendance would reduce or prevent duplication of work in the Trust. The group hoped that longer term funding for the Autism Project Team would be agreed.
- A mother and her autistic son, invited to the fourth meeting of the group on 3rd March 2023, had joined via Microsoft Teams. The mother had described difficulties her son had experienced in accessing TEWV mental health services and her son had also provided a moving account to the group. Following the meeting, the mother had emailed to thank the group for the invitation to speak and advised that they had found the meeting very insightful and thought provoking. Her son had also been thrilled that a group existed where he had not had to explain himself. Her comments had also focused on the lack of understanding about autism and how training was fundamental. He added that the email had reinforced how much the work, such as that carried out by the Autism Project Team and the group, was needed. It had become apparent during that meeting that everyone needed training to understand 'autistic burnout' and consistency from clinicians was essential, as this was essential to people with autism.

The Chair thanked J. Preston for his update and for the work he and the group had undertaken.

23/102 OPERATIONAL SERVICES UPDATE

Governors considered two reports providing updates on operational services in the Trust.

The Chair suggested that questions relating to the reports could be raised with the Care Group Managing Directors at Governor locality meetings.

23/103 INVOLVEMENT AND ENGAGEMENT COMMITTEE UPDATE

In the absence of the Committee's Acting Chairman, K. Marsden, M. Booth presented a report on the last meeting of the Council of Governors' Involvement and Engagement Committee, held on 19th January 2023.

She advised that:

- The Committee's previous Chair, G. Robinson, had stepped down from his role as Chair and was no longer a member of the Committee. His reasons for stepping down had been read out to the Committee at the beginning of its last meeting and the statement in full had been provided in the report.
- Topics discussed at the meeting had included:
    - Possible changes to the Committee's Terms of Reference. However, this was still under consideration and the Committee wished to wait until the Cocreation Framework had been agreed before making any decisions.
    - Annual General and Members' Meeting (AGM) 2023 feedback and future engagement events. Although the AGM had been held online, the event had been successful with over 200 people joining. The Committee wanted more face to face events to be held and for public member recruitment to be incorporated into engagement events.
    - Cocreation Journey updates.
    - The Committee's future priorities which were:
        - Planning engagement events and roadshows Trustwide, incorporating member recruitment and involving local services both internally and externally.
        - Periodically reviewing and refreshing the Committee's Terms of Reference.
        - Overseeing public member recruitment in the Trust.
        - Monitoring the delivery and implementation of the Trust's Cocreation Framework.
        - To consider the future approach to member and Governor communications.
- A replacement Chair would be sought at the next meeting of the Committee on 18th May 2023. In the interim, K. Marsden would be the Acting Chairman.

Following discussions, it was noted that:

- G. Restall had found the last meeting of the Committee to be very productive. She added that K. Marsden had chaired the meeting well.
- A. Bridges advised that she had been saddened to hear that G. Robinson had resigned as Chairman and from the Committee. The Committee had met only

once, prior to the meeting on 19th January 2023, and she had reached out to G. Robinson to try and understand his reasons for stepping down. As yet she had been unable to speak to him.

- R. Tuckett advised that he had found the situation most extraordinary and had questioned what action had been taken to address the issues raised by G. Robinson, suggesting that Governors should be updated on that.

  A. Bridges advised that she needed to know more about the reasons, before any learning could be identified.

- The Chair thanked G. Robinson for his time a Chair and hoped that, at some point, he would be ready to discuss his reasons for stepping down. He also thanked K. Marsden for chairing the Committee's last meeting.

23/104 ROLE OF THE LEAD GOVERNOR

Governors considered a report which provided clarity on the role of the Lead Governor. The Council of Governors were asked to approve the draft role description of the Lead Governor, attached as an appendix to the report.

In introducing the report, and in response to questions, P. Bellas advised that:

- Details of the approved role description of the Lead Governor would be included in the Trust's Constitution, as part of a full review of the document to be undertaken during 2023.
- The Chair of the Trust and the Trust's Senior Independent Director (SID) had been involved in the development of the draft role description. Consultation had also been undertaken with the current Lead Governor.
- A limit on the number of times a Governor could serve a term of office as the Lead Governor had not been considered, however if it were, any changes would need to be reflected in the Constitution.
- The interrelationship between the Lead Governor and the SID had been considered in the creation of the draft role description and no concerns had been identified.
- In accordance with the Code of Governance issued by NHS England (NHSE) (previously Monitor), Governor/s could approach NHSE directly, however, the role of the Lead Governor would usually be to act as a point of contact to facilitate communications between NHSE and the Council of Governors.

It was noted that:

- R. Tuckett suggested that a consultation and vote should be held with Governors before agreement to the role description of the Lead Governor. He also stated that Monitor had not wanted the Lead Governor to have more power that other Governors.

  The Chair confirmed that R. Tuckett's discomfort with approval of the draft role description at the meeting had been noted and he advised that the draft

role description had been included on the public agenda to enable discussion and to consider Governors' views.

- Following questions regarding appointed Governors being a Lead Governor and time limits for appointments, P. Bellas advised that the role would be subject to a re-appointment every three years and all Governors would have the opportunity to vote. Any changes with regard to limiting the number of times a Governor could be the Lead Governor, would be addressed as part of the planned review of the Consultation in 2023 and Governors would be consulted on this.

  J. Kirkbride suggested that there had been a reluctance to oppose the re-appointment of the current Lead Governor in previous years.

  The Chair confirmed that Governors had voted every three years for the appointment of the Lead Governor and they had been content with those appointments.

- J. Wardle questioned whether there was a limit to how long an appointed Governor could serve on the Trust's Council of Governors.

  P. Bellas advised that there was no limit and it was the decision of the organisation appointing an Appointed Governor, to decide who they wished to represent them, and for how long.

- S. Stevenson stated that all Governors had had the opportunity to nominate themselves as candidates for the position of the Lead Governor, however none had chosen to do so.

Vote held:

- 15 Governors agreed the draft role description and one opposed it.

Agreed – That the draft role description for the Lead Governor be approved, subject to there being a review of the Trust's Constitution in 2023.

23/105 TRUST'S ANNUAL REPORT AND ACCOUNTS 2021/22

Governors were provided with a link to the Trust's Annual Report and Accounts for 2021/22 on the Trust's website, prior to the meeting.

23/106 DATE OF NEXT MEETING

The next ordinary meeting of the Council of Governors was expected to be held in the week commencing 22nd May 2023, however, the date was yet to be confirmed.

23/107 CONFIDENTIAL RESOLUTION

Confidential Motion

"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 officeholder, former officeholder or applicant to become an officeholder under, the Trust.

Information relating to any 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.

The public session of the meeting closed at 3.55pm.

_____

David Jennings
Chair
15th June 2023

Public Action Log

ITEM 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 Council.
	Action outstanding and the timescale set by the Council having passed.
	Action superseded
	Date for completion of action not yet reached

Date	Minute No.	Action	Owner(s)	Timescale	Status
12/05/22	22/28	Consult with Trust's Information Department regarding difficulty in 'guests' accessing the chat function on MS Teams.	DoCA&I	-	IT department delivered briefing to Governors at Governor Development Session on 16/03/23
17/11/22	22/73	Table of CQC ratings for Trust services to be provided to Governors	DoN&G	-	Circulated to Governors on email 06/03/23
09/03/23	23/95	Summary of matters discussed at Board to Board meeting held with ICB and NHSE/I colleagues, to be shared with Governors.	CE	Jun-23	Confidential Agenda Item 5
09/03/23	23/95	Home Office and Department of Health consultation document, on mental health in the community, to be shared with Governors when possible.	CE	-	Open
09/03/23	23/96	Checks to be carried out on Trust wards to ensure all paper copies of the Borderline Personality Disorder Protocol are destroyed.	P. Scott	-	Completed 02/06/23
09/03/23	23/97	Appendices to Quality update to be provided to Governors. (Appendix A - "Hard Truths" monthly Nurse Staffing Exception Report and Appendix B - Report on the organisational response to findings identified at Edenfield Ward, Greater Manchester Mental Health NHS FT regarding 'closed cultures')	E. Moody	-	Circulated to Governors on email 10/03/23
09/03/23	23/99	A presentation, delivered at the Our Journey to Change Conference on the Trust's financial position for 23/24, to be shared with Governors.	DoFI	-	Circulated to Governors on email 13/03/23

Tees, Esk and Wear Valleys
NHS Foundation Trust

Agenda Item 8a

For General Release

Council of Governors

15 June 2023

Governor Questions

Q1: Mary Booth	**Question:** I understand TEWV are funding a service to help our inpatients with housing issues. I know it covers Stockton wards/residents but am not sure if other wards are included. The staff now understand that the contract with is not being renewed. Please confirm the wards served and the areas covered If it's true the contract is not being renewed can you explain why. It would have detail such as how long did the contract run, how was its outcomes measured. **Response:** The service is the Hospital Discharge Service provided by Home Group, a social housing provider specialising in housing for people with complex needs. TEWV isn't funding the service. It was initially funded by NHSE winter pressures funding a couple of years ago, and since then we have managed to keep it going with bits of slippage from the CCGs MH commissioning budget in between winter money that comes down from NHSE. However, from July 2022, CCGs were replaced by the ICB and our discretion as a commissioning team as part of the MHLDA went with it. As we no longer had devolved responsibility for the budget, decisions are taken at a North East North Cumbria level. This posed an existential threat to the Hospital Discharge Service as we no longer had access to such slippage, so the service was due to end on 31 March 2023. I have managed to secure funding from the ICB until end of June 2023 and have drafted and submitted a business case for the service to be funded recurrently from the Better Care Fund budget. I am still waiting for a decision from the leads for the Better Care Fund in regard to this. I am happy to respond to further queries. **John Stamp - Associate Director of Partnerships and Strategy**

Q2: Judy Hurst	**Question:** How many Health Care Assistants (HCAs) have the care certificate, local HCA competencies and diploma in health level 3? **Response:** The Trust has 1,328 HCAs in post. Of that, the Leadership and Talent Team are working with 540 HCAs moving them through various parts of the framework. For example, they may have Care Certificate but still working on Diploma. The Trust have both level 2 and 3 apprenticeships in Health and Social Care – dependant on the skills scan assessment at commencement of their role. This number is based on employed HCAs not bank or agency and or fixed term. It should be noted that if a HCA is appointed with an existing qualification, it is not something that Leadership and Talent would monitor. **Dr Sarah Dexter-Smith - Director of People and Culture** **Kathryn Atkinson - Associate Director of Leadership and Development**
Q3: Judy Hurst	**Question:** How is the lifelong learning partnership / pledge and group going? **Response:** During the pandemic, this group was stood down, having tried to meet unsuccessfully and as demands on time increased. The Trust restructure and moving of personnel in the organisation has meant the group has delayed a restart. However, the union lead and the Associate Director of People and Culture are in progressing this. **Dr Sarah Dexter-Smith – Director of People and Culture** **Kathryn Atkinson - Associate Director of Leadership and Development**

Q4: Judy Hurst	**Question:** What are the Trust statistics on numeracy and literacy levels for those who don't have the qualifications needed for JDs and how we offer these quals to support them? **Response:** The data is not available on numeracy and literacy or digital literacy at this time. However, any member of staff who would like support to develop can either have a Scope for Growth conversation with their line manager or one of the Leadership and Talent Team. We can source support from one of our partner organisations such as Derwentside College or Stockton Riverside College – which is the employee's choice. **Dr Sarah Dexter-Smith - Director of People and Culture** **Kathryn Atkinson - Associate Director of Leadership and Development**
Q5: Judy Hurst	**Question:** How are we managing the administration staff with their career development? **Response:** In September 2022, we officially started our Admin Journey to Change where we had some time out to consider what administrators needed to fulfil their current role and reach their full potential. This work has led to us doing the following: • Establish an Administration Professional Reference Group (APRG) that reports directly into the Executive People and Culture sub-group which then reports into the Executive Directors Group. • We are focussed on bringing all the administrators together as a family, to operate as a professional group. We will still work alongside, with and for services on the delivery of high-quality patient care and still report into the Care Groups as they are one of our key stakeholders. • To do this, we have the Administration Professional Reference Group that is chaired by myself and we are focusing on building a robust infrastructure for all administrators. The APRG comprises existing admin leads and other administrators, who are keen to get involved, and it is this group that orchestrates the work that needs to be done. • There are several task and finish groups that report directly into the APRG, these include: 1. Reviewing the admin structure, job descriptions and developing job plans. Develop a structure that

	supports career progression for administrators. It has just been agreed that we will now introduce some band 7 posts – Business Admin Managers. 2. Develop a workforce plan for administrators, design a centralised recruitment programme, review the local induction process and probationary periods. To also include how we recruit apprentices as part of our recruitment process where we can bring in new staff with the potential to grow and develop in the Trust. 3. Develop an effective management supervision and professional supervision process that is accessible to all administrators. 4. Review our approach and design a robust training needs analysis and training plan. Also included in this group is the development of a career progression plan, showing how administrators can progress into other corporate roles in addition to admin roles. Talent Management conversations, succession planning and how we mobilise our admin workforce to experience a range of opportunities so that they can fulfil their potential. 5. Communications group – establishing a communications infrastructure that includes developing an admin newsletter, intranet page and holding coffee breaks to have virtual two-way conversations with admin staff across the whole Trust. 6. Developing KPIs to understand admin staff's experience of working in the Trust. Our focus is for admin to be seen as a profession in its own right, and ensure we support our colleagues to get the right job done by the right person, at the right time for the benefit of our patients, carers and families. We are more than happy to come along to a Governor's meeting and tell you more. **Angela Collins – Deputy Director of Human Resources and Organisational Development**
Q6: Judy Hurst	**Question:** Which apprenticeships are offered to bands 1-4? **Response:** A range covering but not limited to: • Social Care and Health • Cleaning operative • Pharmacy technician • Property maintenance

	• Business Admin • Supervisor Team Leader • Accountancy • Horticulture • Carpentry • Data analyst • Operations manager • Nursing Associates • Assistant practitioners • OT Assistants • Physio Assistant **Dr Sarah Dexter-Smith - Director of People and Culture** **Kathryn Atkinson - Associate Director of Leadership and Development**
Q7: Judy Hurst	**Question:** What is the percentage of compliance with mandatory training and appraisal for all bands 1-4? **Response:** 83% **Dr Sarah Dexter-Smith - Director of People and Culture**
Q8: Judy Hurst	**Question:** What is the % of service users / carers on bands 1-4 recruitment panels? **Response:** This information is not recorded. Our current position on Lived Experience (LE) involvement in recruitment is primarily for more senior posts, however, we are doing work on LE involvement in different levels of recruitment this year. **Dr Sarah Dexter-Smith - Director of People and Culture** **Kathryn Atkinson - Associate Director of Leadership and Development**
Q9: Joan Kirkbride	**Question:** What are the criteria for placing people out of area? **Response:** Our bed management processes, and draft working policy advise that independent sector beds are only considered when there are no local Trust or other NHS beds available to admit someone

	needing admission too. An independent sector bed, in or out of the Trust's footprint, would only be considered if the person is assessed as requiring an emergency admission to hospital, and we have no suitable environment to support them in, and/or they cannot be safely cared for in a community setting whilst awaiting admission. If an independent sector bed was deemed suitable, our bed management team would seek to source the most appropriate bed as close to home. Sadly, there is not always suitable provision in our localities or region, and we need to consider admission elsewhere in the country. Whilst we appreciate this isn't always convenient, we must make the patient's safety and welfare our priority. Our bed management team monitor all admissions out of locality and also out of Trust on a daily basis, and coordinate repatriations to local ward as soon as this is possible. We also hold weekly MDT clinics led by our Associate Medical Director and bed managers, to monitor the progress of admissions out of Trust, to support prioritisation of repatriations, and also to make sure we have community services in-reaching (often remotely) to independent sector MDT meetings. The aim of this is to ensure continuity of care, allow liaison with loved ones and support discharge planning where appropriate. Although we appreciate this would not always be appropriate based upon individual circumstances, should a loved one wish to visit a service user in a ward out of locality or out of Trust, we do offer reimbursement for travel costs. These can be submitted directly to our payroll department. This reimbursement is calculated based upon miles travelled and could be applied to personal vehicle use or public transport. Our adult services continue to lead numerous workstreams to reduce reliance on independent sector beds and improve access to local hospital beds for people requiring emergency admission. **Tom Hurst - General Manager for Urgent Care Services and Central Bed Management**
Q10: Christine Hodgson	**Question:** What are Community Mental Health Transformation (teams) doing to stop people with autism and learning disabilities reaching crisis point and having to be admitted to hospital. What procedures are being put in place? **Response:** The Trust-wide Autism Project continues its work to provide training plus supervision/consultation to all TEWV community teams across all specialties. We are looking to develop our

	training to ensure that we provide the specific support that clinical staff need to work with all autistic children, young people and adults who access our services. We always align our training to the Health Education England Core Capabilities Framework for working with autistic people. The project has recently secured permanent investment which means that we will now be developing into a Trust-wide service, that is embedded throughout all specialities. As part of this, we have also been given funding to employ additional clinicians – two Applied Psychologists and an additional Higher Assistant Psychologist. This means that we will have much greater capacity (we will go from having 4.6 whole time equivalent (WTE) clinicians to, hopefully, up to 7.6 WTE clinicians – as long as we can recruit to the new posts full time). This will make a significant difference – although we are still quite a small resource across the entire Trust. There will be, through these posts, an emphasis not just on general reasonable adjustments but also moving on to the adaptation of governed psychological therapies. **Dr Elspeth Webb - Consultant Clinical Psychologist**
Q11: Alicia Painter	**Question:** The Niche reports into the care of three Trust patients* found multiple failings in care including abuse caught on CCTV. Have the individuals involved been held to account? *Patient names removed here. **Response:** Within the Niche reports, no single individual or group of individuals were solely to blame – it was a failure of our systems with tragic consequences. We have since undergone a thorough change in our senior leadership team and our structure. **Brent Kilmurray – Chief Executive**
Q12: Alicia Painter	**Question:** Since the Niche reports have been released, more patients have come forward via the media to talk about their experiences of poor care. Changes intended to improve care have been made, but how can we be confident they are effective? **Response:** There have been recent reports in the media where patients have come forward to talk about their experiences of poor care, which we know can be difficult to hear. When we received media enquiries of this nature, we speak with our PALS and complaints team to make sure we're aware of the any concerns being raised. Where we are not aware of any issues, we encourage the

	individual to get in touch so we can listen to them. Some of the experiences referred to here are historic, and do go back several years, when as an organisation we were in a very different place. That said, we know we have more to do and we are committed to providing safe and kind care for everyone. As you allude to, there is a lot of continued improvement work across our Trust and we're already seeing the positive impact of Our Journey to Change. We'll continue to share those improvements, and the difference they are making, with our Council of Governors and more widely with colleagues, partners and our communities. **Brent Kilmurray – Chief Executive**
Q13: Alicia Painter	**Question:** There was recently an article in the press where David Moore, father of a Trust patient* said that no director in the trust has been held accountable for the failings in his daughter's care. Is this accurate and if so, do you attend to hold the directors accountable? *Patient name removed here. **Response:** Within the Niche reports no single individual or group of individuals were solely to blame – it was a failure of our systems with tragic consequences. We have since undergone a thorough change in our senior leadership team and our structure. **Brent Kilmurray – Chief Executive**
Q14: Alicia Painter	**Question:** Staff have raised concerns about staff retention. What has been put in place to keep current staff? **Response:** Through the Big Conversation and the People Journey, the retention of staff has been a key focus, and is reflected in the People Journey Delivery Plan and the Board Assurance Framework (BAF). Our activities in relation to staff retention primarily sit in the People Journey priorities of 'Working Differently' and 'Compassionate and Inclusive Cultures' and alongside those in 'More People'. Those activities have covered: ▪ Flexible/ hybrid working. ▪ Leadership development programme and managers' bitesize training. ▪ Increased support and voice from staff networks. ▪ Improved support for reasonable adjustments.

	▪ Review of FTSU process to improve timeliness. ▪ Improving the experience of recruitment, induction, preceptorships (where appropriate). ▪ Appraisals and career development. ▪ New process to support those thinking about leaving or moving roles. There is clear evidence of impact from this work: ▪ The rate of people leaving the trust is falling steadily and consistently. ▪ We were the most improved mental health and LD trust in the Picker staff survey as far back as last September. ▪ In that survey, staff reported feeling more valued and recognised despite a significant drop in satisfaction with pay (a national issue). We know there is more to do. The People Journey Delivery Plan outlines the priorities and timescales for the next six months. **Dr Sarah Dexter-Smith - Director of People and Culture** **ALSO:** There are many areas of focus on retention which are detailed in the Trust Workforce Delivery plan, these include: • New process for those staff who are thinking about leaving which provides a range of independent ways in which people can talk to us about moving/leaving and discussions held as to whether there is anything we can do to retain the member of staff. • Our Health & Wellbeing offer including employee support, employee psychology service, a range of groups (burnout group, understanding self at work, bereavement group) • Ensuring our policies support wellbeing, such as flexible working, special leave, absence management • New reasonable adjustments post to ensure staff who require a reasonable adjustment have these put in place in a timely manner • Executive sponsorship of staff networks ensuring their voice leads to meaningful change • Violence and aggression reduction, ensuring we support and respond to staff who experience verbal and physical aggression and proactively reduce the number of incidents • Development opportunities and creating an environment that people want to be part of and develop within **Lesley Hodge - Associate Director of Operational Delivery and Resourcing**

Q15: Alicia Painter	**Question:** Autistic patients across the Trust are reporting that they have experienced diagnostic overshadowing. Their distress is being blamed on their Autism and they are denied care as a result. I am deeply concerned regarding this matter, and I am wondering if there is anything in place to reduce it? **Response:** The Trust-wide Autism Service recognises that diagnostic overshadowing is something than can occur for autistic people accessing our services. It is a topic that we ensure is covered as we continue our work providing training plus supervision / consultation to all TEWV clinicians across all specialties. Our Autism Awareness Training is delivered (by clinicians and service users) to all staff and covers the mental health difficulties often experienced by autistic people, and the strategies and reasonable adjustments that staff can make to support people. This includes thinking about diagnostic overshadowing. Our training is aligned to Health Education England's Level 1 and 2 of the Core Capabilities Framework for working with autistic people, and we are currently reviewing and updating the content and delivery. We train well over 150 staff per month, and we envisage that this will be an ongoing offer from our service. We are quite a small resource and there is a huge demand for the training which means that we are booked up well in advance. The Trust-wide Autism Service also provides supervision / consultation for clinical staff across all specialties. We will meet with individual clinicians to support their work and have also attend Multi-Disciplinary Teams/Care and Treatment Reviews etc. We also facilitate autism-informed formulations/complex case discussions, and we have started a 'drop in' supervision session for staff on the wards at West Park Hospital in Darlington as a pilot, and we are hoping to extend this to other sites. We ensure that in our discussions we continue to promote understanding of how autistic people can experience mental health difficulties including considerations of the impact of diagnostic overshadowing. What was previously the Trust-wide Autism Project has recently secured permanent funding which means that we are now an ongoing Trust-wide 'Service'. This demonstrates a significant commitment by the Trust to the work that we do. As part of this, we have been given funding to employ additional clinicians – two Highly Specialist Applied Psychologists and an additional Higher Assistant Psychologist. This means that we will have greater capacity (we will go from having 4.6 WTE clinicians up to 7.2 WTE clinicians in the team). This will make a significant difference – albeit we are still quite a small resource across the

	entire Trust. There will be, through these posts, an emphasis not just on broad reasonable adjustments for autistic children, young people and adults but also the adaptation of governed psychological therapies. **Dr Elspeth Webb - Consultant Clinical Psychologist**
Q16: Mary Booth	**Question:** I have been approached by a constituent about respite services for the families of adults with profound and multiple learning disability. Discussion with families about the future of these services I understand has been ongoing for 4 years or more. The families understand that the longer-term future of these services depends on commissioners. However, the larger group that included parents was disbanded in February. Can I and the parents have assurance that those now taking this forward have a full understanding of the level of disability. Could I also ask where co-creation is with this group. Co-creation would need to be with parents. **Answer:** This question was received with only a four-hour deadline to publication of this report. Patrick Scott, Managing Director for Durham, Tees Valley and Forensics Care Group, will give a verbal response to the question at Thursday's meeting and a more detailed response will be provided at a later date.
Q17: Alicia Painter	**Question:** In part 2 of the Quality Account, you said patients overall reported a positive experience of Oxehealth, however other patients have concerns over it on the grounds that it violates their privacy. Camden and Islington NHS Foundation Trust suspended the use of Oxehealth due to it being retraumatizing for survivors of sexual assault and this has been corroborated by Dr. Sweeney, an expert in trauma informed care. This also violates the NMC Code 1 'Treat people as individuals and uphold their dignity' and 5.1 'respect a person's right to privacy in all aspects of their care'. I understand its potential clinical benefits, but it is disrespectful and harmful to those who find it violating. How can you justify these concerns for patients who find the system intrusive? **Response:** This is a very important question. We are part of the national conversation about assistive technology, and we are listening very carefully and will take every

	opportunity to think about the steps we are taking and any unintended consequences they may have for people in our care. All people in our inpatient units where Oxehealth is in place will have the technology and how it works explained to them and there is the facility to disable it where there is need. We will continue to have this option available to people in our care, we have the guidance from the national forum and we are using it in the development of the TEWV policy. We have also undertaken a piece of research to look at the impact for service users. This work is in its final stages, and we will share it once available. Oxehealth is one tool we have to support people to be safe in our care. The therapeutic relationship and ward culture will never be replaced by technology. **Beverley Murphy – Chief Nurse**

ITEM NO. 9

For General Release

Meeting of:	**Council of Governors**
Date:	**15 June 2023**
Title:	**Our Journey to Change Delivery Plan 23/24**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Chris Lanigan, AD Strategic Planning and Programmes**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

Purpose: The *OJTC Delivery Plan* (Appendix 1) was approved by the Board of Directors at its April meeting. The document sets out our 23/24 plans to implement OJTC. It will enable the Board to monitor delivery, and inform our communications with service users, carers, colleagues and partners.

Proposal: Governors should review the plan, taking into account the financial and policy constraints the Trust has to operate within, highlight any areas that they would like to be addressed during the planning process for next year's plan.

Overview: During 22/23 the Trust developed the Clinical, Quality/Safety, Co-Creation, People and Infrastructure Journey documents. These are strategies to support OJTC and they set out ambitions and principles. These drive the identification of 17 priorities, which are shown on the "plan on a page" on page 5 of the Delivery Plan.

Some elements of the Plan, particularly those overseen by the Advancing OJTC Board require complex interdependencies to be identified and worked through, Rather than rushing the development of business cases in order to include in this version of this document, the development work has continued at an appropriate pace, and more detail will be added to the at the end of quarter 1.

The Plan is based on the resources and capacity available – it is realistic, not aspirational.

Delays to ICS led planning processes meat that:

- It was not possible to include performance trajectories and budget information in the document as intended
- The mobilisation of expected new investment into North Yorkshire and York IAPT, perinatal, CYP Eating Disorders, crisis and EIP services has not yet been included in the plan – these plans will be added at the end of quarter 1

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

Prior Consideration and Feedback

Care Groups engaged staff, service users, carers and partners (including all of our commissioning groups) in their planning processes.

All strategic journeys and the proposed priorities arising from them were tested at a workshop held on 20th February. All governors were invited to this workshop and 15 attended either "in person" at the Great North Air Ambulance base or online.

The discussions held at this event led to significant changes being made to the initial draft of the delivery plan such as:

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

Implications:

There is no legal or regulatory requirement for TEWV to approve and publish a Trust Delivery Plan.

The plan only includes developments which are achievable within existing resources. Since the plan was agreed by the Board of Directors the North East North Cumbria and Humber North Yorkshire financial plans have been agreed. These require all providers including TEWV to achieve savings targets during 23/24. The Trust will therefore develop additional cash releasing savings proposals, and where these represent a significant change to "business as usual" amend this delivery plan accordingly.

Recommendations:

It is recommended that governors:

- **Note the approval of this plan by the Board of Directors**
- **Note the involvement of governors in the development of the plan.**
- **Identify any process or content issues for consideration in developing the 24/25 delivery plan**

journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our Journey to Change Delivery plan

2023/24

Who we are and who we care for

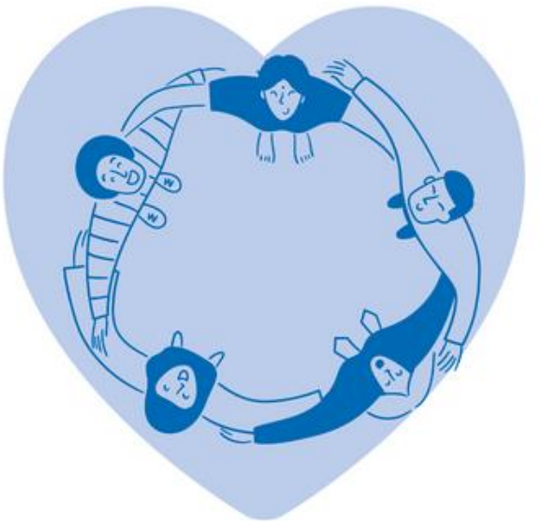
Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) was formed in April 2006 and was authorised as a foundation trust on 1 July 2008. We provide mental health and learning disability services for the people of County Durham and Darlington, Teesside, North Yorkshire, York and Selby.

From education and prevention to crisis and specialist care — our talented and compassionate teams work in partnership with our patients, communities and partners to help the people of our region feel safe, understood, believed in and cared for.

We're committed to new thinking that improves the wellbeing of our region, and connecting with our communities and partners to deliver mental health care.

We also provide mental health care within prisons, and an immigration removal centre, located in the North East, East Yorkshire, Cumbria and parts of Lancashire.

Almost 7,500 staff work across more than 90 sites, including Foss Park, a state of the art 72-bed hospital and research space in York which opened in 2020.



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

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

Most importantly, everything we do is guided by **Our Journey to Change** and our values.

Our Journey to Change sets out where we want to be and how we'll get there. It includes our goals that we co-created with patients, carers, colleagues and partners. We are working hard to embed our values and make sure everyone, in every role across our Trust, demonstrates respects and compassion and takes responsibility for the care we give.

journey to change

Launched in August 2020, Our Big Conversation was the biggest listening exercise in the history of the Trust. Over 2,100 people shared 35,800 ideas, comments and votes, exploring what could be possible if we got everything right and what we must do to achieve this.

We heard that some people had a good experience with the Trust but this wasn't consistent, and we heard that there is a lot we need to work on.

From the rich conversations and feedback, we received from Our Big Conversation, we developed big ideas for change and a new strategic direction called **Our Journey to Change**.

It sets out why we do what we do, the kind of organisation we want to be and how we will get there by delivering our three goals and living our new values of respect, compassion and responsibility all the time.

The big goals we have committed to deliver over the next five years are:
- to co-create a great experience for patients, carers and their families
- to co-create a great experience for our colleagues
- to be a great partner

Our Journey to Change will be at the forefront of everything we do, and all our decision making and 'supporting journeys' will be aligned to it.

We will have five underpinning journeys which are:
- clinical
- quality and safety
- people
- co-creation
- empowering infrastructure

National and Integrated Care Systems' priorities

The NHS has a long-term plan for mental health which identifies several priorities for NHS commissioners and providers, including:

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

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

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

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

Content of this document:

This Our Journey to Change (OJTC) delivery plan sets out:

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

If you have any questions about this document, please contact Chris Lanigan (associate director of strategic planning and programmes): chris.lanigan@nhs.net

Our clinical, quality, co-creation, workforce and infrastructure journeys

Each of our five journeys sets out our ambitions – i.e., what is the clinical, quality, cocreation, workforce and infrastructure destination that we are journeying to. They also set out some of the principles that will guide our journey.

There are different ways in which we will make the journey from where we are now, to where we want to be – including:

1) changes in everyday working practices and behaviours, which over time become cultural change
2) incremental changes to our 'business as usual', often achieved by teams formally or informally using the 'Plan Do Study Act' (PDSA) cycles, which will be prompted by data and risks discussed through the governance of our Trust
3) developing projects and initiatives to create new services or to change existing services. Some of these are funded by new commissioning investment, but others use the resource already available to the Trust. Where plans involve efficiency savings or significant changes to services, they must pass a quality impact assessment conducted by our medical, nursing and therapies directors before implementation
4) convincing our system partners to do things differently, in line with the ambitions of our journeys

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

Our 'advancing' Board is where we manage the most urgent and complex cross-cutting transformation projects. These receive additional support from the Trust's change and project management experts. In 23/24 we have purposefully put all of our immediate quality journey areas of focus under this Board along with work to help us reduce pressures on our mental health assessment and treatment and PICU inpatient beds.

Personalising care planning also features, because supporting and enabling patients to develop their own care plans, so that care is tailored to their personal needs and recovery goals is the way to make sure that co-creation is a reality for every person using TEWV's services.

journey to change

2023/24 - Plan on a Page

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

These will be underpinned by:

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

Our three big goals

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

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

3. **Be a great partner**

Community transformation

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

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

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

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

Health and Justice – Reconnect, North Yorkshire	In line with provision currently across North East, commissioners in North Yorkshire will be rolling out implementation of the Reconnect service which aligns to Liaison & Diversion.	**March 2024**	• Timescales TBC in line with Commissioner requirements • Proposal developed for consideration of commissioners which meets the specification and is cost effective • If proposal approved, implementation plan developed and mobilisation commenced • Service operational
Older people's community mental health team transformation – NYYS	To support 'place based' provision of care across our care group geography in line with NHSE/ICS direction. Support a system wide approach to rehabilitation and independence. To align service structure with future investment proposals to develop a resilient and sustainable memory service across MHSOP.	**March 2024**	• Develop links with first contact MH worker team managers to support development of MDT working - (June 2023) • Implement senior clinical leadership to build relationships with the hub(s), local medical councils and PCNs - (September 2023) • Capacity and demand analysis (by end June 2023) - identify what is required to ensure ongoing oversight of waiting list - identify capacity required to reduce waiting list. - analysis to inform business case proposal for additional resource • Review the memory service offer (September 2023) - to support development of a consistent memory offer across the care group – inc. medical and leadership provision • Produce MAS business case - (March 2024)

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

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

Cito

Project/initiative	Aim/reason why	Deadline	Milestones
Cito	• Delivery of clinical record • Reduction in time clinical colleagues spend inputting information into digital systems and improvement in data quality.	**From July 2023 onwards**	• Testing signoff – (May 2023) • Phase 1 go-live – (July 2023) • Phase 2 work will then follow once scoped

Autism

Project/initiative	Aim/reason why	Deadline	Milestones
Autism training	• Deliver understanding autism training trust-wide to meet the requirements of the autism legislation and CQC baselines. • Autism diagnostic assessment training and clinical supervision in Durham Tees Valley CMHTs. To increase the quality and quantity of autism diagnostic assessments in DTV CMHT's. • Development and implementation of bespoke autism training in response to trust needs to meet the requirements of autism legislation and CQC baselines.	**March 24** **March 24** **March 24**	• 12 sessions per month • Training course delivered six weekly, and clinical supervision offered monthly to individual teams to embed clinical knowledge and skills • As required

Autism reasonable adjustment support and coordination	• The aim is for all services to have ongoing access to clinical supervision and consultation when working with autistic people. • This will ensure can provide care pathways that can be adjusted to meet the needs of autistic people within both inpatient and community services to meet the requirements of autism legislation and CQC baselines.	**March 24**	• All adult mental health (AMH) inpatient and community team areas will have completed an autism environmental checklist and implementation plan in place – (March 2024) • All inpatient working groups to meet monthly to work on the implementation plan
Complex autism case work	• To ensure that the trust can provide appropriate evidence based safe care for autistic people where needs are more than reasonable adjusted care to meet the requirements of autism legislation and CQC baselines. • Aims to provide support and consultation to corporate services in relation to patient safety, complaints and human resources to meet the requirements of autism legislation and CQC baselines.	**March 24** **March 24**	• There will be access to wrap around support from autism clinical experts trust-wide in acuity and complex cases • There is a resource to corporate services to ensure that they are complaint with autism legislation and CQC requirements
Adult neurodevelopmental service - DTV	• To seek opportunities to widen provision via a collaborative approach to address the significant waits for access and intervention.	**September 2023**	• Using improvement methodology and events to implement the single pathway to manage ADHD and ASD referrals

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

Reducing inpatient pressures

Project/initiative	Aim/reason why	Deadline	Milestones
Inpatient flow – DTV AMH and MHSOP wards	To reduce bed occupancy through reduction of delays in the patient journey, to achieve the elimination of out of area placements by March 2024.	**March 2024**	• A central bed management policy implemented, supported by refreshed PIPA (Purposeful Inpatient Admission) processes – (June 2023) • Multi-Agency Discharge Forums with LA and other key partners in place and working effectively – (June 2023) • Consider how the exemplar ward framework can be used within older adults wards – (June 2023)
Older adults pathway - NYYS - ensure seven-day availability for assessment and treatment	To enable reduced admissions and an alleviation in bed pressures.	**March 2024**	• Develop options appraisal for seven-day working for presentation to ICB - (June 2023) • Produce operational policy and commence recruitment, progress through HR processes inc. LCC paper as organisational change (funding availability dependent and so date to be determined)
Reducing pressure on inpatient beds programme	To reduce out of area placements in accordance with the agreed trajectory through the reduction in bed occupancy.	**March 2024**	• Develop a trustwide programme plan – (June 2023) • Zero out of area placements – (March 2024)

Implement bed configuration in line with NE & NC secure services provider collaborative review	A North East, North Cumbria bed model is being developed and TEWV must support this (to ensure the whole system provides high quality provision that meets demand within the available budget).	**October 2025**	• Bed model agreed – (June 2023) • Implementation of pathway changes commenced in line with agreed project plan – (June 2023) • Proposed developments – business cases developed as required

Patient safety

Project/initiative	Aim/reason why	Deadline	Milestones
Patient safety incident response framework (PSIRF)	To ensure TEWV compliance with the patient safety incident response framework (PSIRF) national directive.	**April 2024**	• Governance and quality monitoring – (31/05/2023) • Patient safety incident response planning – (30/06/2023) • Curation and agreement of the patient safety incident response policy and plan – (31/08/2023) • Transition - working under the patient safety incident response policy and plan – (31/12/2023) • Embedding sustainable change and improvement – (30/04/2024)
LFPSE + InPhase	To ensure TEWV compliance with the learning from patient safety events (LFPSE) national directive. To replace the current Datix system with InPhase to support this compliance.	**December 2023**	• Implementation of incidents LFPSE test system – (31/03/2023) • Implementation of incidents LFPSE to live system – (30/09/2023) • Implementation of system module onto system – (30/12/2023) • PSIRF module added to system – (30/10/2023 • Implementation of fit for purpose Risk and Quality management system – (30/12/2023)
Incident reviews	To improve the timeliness and effectiveness of reviews to help support learning and avoid incidents.		• Complete “root and branch” review – (April 2023) • Approve plans for next steps and commence implementation – (date tbc)

Harm free care

Project/initiative	Aim/reason why	Deadline	Milestones
Reducing the use of restrictive interventions	To reduce the use of restrictive interventions by 50% by 31 March 2024.	**March 2024**	To be agreed within the advancing OJTC board - plans are currently being formulated
Safeguarding / parental/carer mental ill health impact on children (PAMIC)	To minimise the impact from parental/carer mental ill health and behaviour on children.	**March 2024**	To be agreed within the advancing OJTC board - plans are currently being formulated
Reducing in sexual safety incidents	To reduce the number of sexual safety incidents to zero by 31 March 2024.	**March 2024**	To be agreed within the advancing OJTC board - plans are currently being formulated
Reducing suicide/misadventure	A target for the reduction of suicide/misadventure related incidents among people in the Trust's care is still being developed, although the ultimate ambition is zero suicide. We are also considering a target of reducing staff sick days that are attributed to suicide related incidents.	**March 2024**	• Offer PIP support to at least 75% of staff involved in a Level 4 or 5 incident • Increase environmental audits undertaken against national standards • Increase proportion of national standard environmental work undertaken against all environmental work • Increase managing distress training in IP units (all staff including non-clinical) • Adhering to NICE Guidance re liaison follow up

Personalised care planning

Project/initiative	Aim/reason why	Deadline	Milestones
DIALOG+ full implementation through Cito	To manage the transition to DIALOG+ where all patients will have a Care Plan that is coproduced with them and their carers/family, that is managed via Cito. This will mean that, patients will receive care that is formulated around their experiences and meets their needs. This is central to the community mental health framework and refocus of CPA. It should improve patient satisfaction and reduce suicide rates.	**July 2023**	• Cito and pre-cito dialogue training complete – (June 2023) • Planning workshop held – (June 2023) • Cito module goes live – (3 July 2023) • A shared action plan developed - (September 2023) • Delivery of agreed actions within the shared action plan - (September 2023)

Expand and develop lived experience posts

Project/initiative	Aim/reason why	Deadline	Milestones
Expand and develop lived experience roles and leadership, including peer support workers	• Target growth for peer support roles across TEWV - TBA at executive level (60 per year minimum across whole Trust. • Peer relationships can facilitate personal recovery and wellbeing. We should take steps to implement and support peer relationships, and diversity MDT workforce. By growing this workforce, we can offer peer support across the whole range of places and services.	**Initial development by December 2023, but expansion will continue after this**	• Enhance and develop peer support operational and training infrastructure • Agree banding for leads and training and development roles • Continue to roll out carer/autism peer support roles • Ensure staff lived experience is factored into development of peer support and lived experience roles • Spaces for staff to safely consider and factor their lived experiences and how it may impact both positively and or negatively on their work – (June 2023) • Continue to ensure services receive appropriate preparation/training to embed lived experience roles • Explore potential for discreet project work for involvement members/zero hours contracts/ time limited – (December 2023)

Collecting and learning from patient and carer data

Project/initiative	Aim/reason why	Deadline	Milestones
Improve and accurately capture patient experience data **Undergo review and transform PALS and complaints pathways in line with cocreation principals**	Capturing, reviewing, and learning from patient feedback is central to outstanding patient experience. Good complaint handling provides a direct and positive connection between those who provide services and the people who use them. Complaints offer a rich source of learning to help improve services for everyone.	**January 2024**	• Formal scoping of work complete – (May 2023) • Further QI work/refinement from consultation/proposals/policy development – (November 2023) • Policy refreshed/launch – (Jan 2024)

Diversity and expand involvement

Project/initiative	Aim/reason why	Deadline	Milestones
Embed and grow co-creation across the organisation	Co-creation is one of our three goals. By co-creating we will create an open, compassionate culture that listens to patients and carers, and learns from their experience of quality patient care. To facilitate increased co-creation some process and capacity development is needed, which this initiative focuses on. Care Groups have day to day responsibility for co-creating care with patients and carers.	Initial development by **October 2023** but work to embed and grow will then continue	• Develop co-creation governance structure – (April 2023) • Develop and implement co-creation networks TEWV and wider partnerships – (May 2023) • Develop shadow governance mechanism to work interdependently with new TEWV governance structures – (July 2023) • Explore human rights informed approaches to be embed co-creation work and models of delivery – (October 2023)

More people

Project/initiative	Aim/reason why	Deadline	Milestones
New starters and onboarding	Making sure at the earliest opportunity information is gathered to support new starters gaining access to systems, equipment, information and resources to be productive for their first day at work.		• Under development
International recruitment	Inability to recruit sufficient qualified and skilled staff. Aim**:** The overall aim of this strategy is to address the staffing shortfalls which not only places our existing staff under continuing pressure but impacts on the care we provide, along with reducing the reliance upon temporary staffing.	**By December 2023 and then ongoing**	• Review international nurse recruitment process and set implementation plan – (June 2023) • Recruitment of full international recruitment team – (June 2023) • Delivery on batched cohorts of nurses as per implementation plan – (by December 2023 and then March 2024)
Workforce planning	Current demand and expectation for workforce planning high across the Trust with limited capability and capacity to deliver Aim: To design, implement and embed a consistent and evidence-based approach to WFP across the Trust. Together with our services, co-design effective, innovative workforce plans to deliver the right staff, with the right, skills at the right time and place.	**September 2023**	• Hold a series of design workshops – (May 2023) • Implement new workforce planning processes – (September 2023)

Compassionate and inclusive

Project/initiative	Aim/reason why	Deadline	Milestones
Leadership development programme	Currently need to understand and realign the Trust's leadership offer to align with organisational values. Aim: To design and deliver a refreshed leadership offer, working together to co-create opportunities for all our staff, teams and services to thrive.	**ongoing**	• The recently redesigned leadership development programme will continue to be rolled out
Health and wellbeing council	The health and wellbeing of all our employees is vital to providing the best experience for our staff, impacting on the care we provide and our ability to partner in the wider system. The aims of the new health and wellbeing council are to: • involve a diverse network of people (considering the varied experience of the communities within which our staff live) in decisions about how charitable funds are raised and allocated. • communicating clearly to all colleagues how to access funding for provision of health and wellbeing initiatives with a proactive focus on ill-health prevention. • support fundraising events in line with health promotion activities. • promote the activities of the council within their areas of work to build the sense of community in TEWV.	**March 2023, then ongoing**	• The new health and wellbeing council will meet for the first time in March 2023 and then every two months prior

Working differently

Project/initiative	Aim/reason why	Deadline	Milestones
Workpal	We do not currently have a clear line of sight from employee through to Board to understand whether individual objectives are contributing to OJTC and living the Trust values. Aim: move from a paper-based system to an online accessible 24/365 system, with targeted development plans and staff experience of quality appraisals.	**1 March 2023 go live and full implementation completed by end Feb 24**	• Implementation plan for embedding appraisal function of workpal within the organisation – (June 2023) • Enable reporting on appraisal completion and alignment (golden thread) via the IIC Q3 – (December 2023) • Embed use of appraisal within workpal throughout the origination – (March 2024) • Scope and set up implementation plan for the transfer of supervision recording onto workpal – (June 2023)
Smarter working	The smarter working approach supports Our Journey to Change and a 'Great Place to Work'. The plan is to help the Trust to offer a more flexible approach as to where, when and how a job could be done to deliver better services and to organise work in ways that improve a healthy work/life balance.	**Phase 1 already complete** **Phase 2 – to be confirmed**	Phase 2 projects likely to include: • room booking system • hot desk equipment • smarter meeting rooms • smarter offices and buildings

One Team TEWV

Project/initiative	Aim/reason why	Deadline	Milestones
Robotic process automation **Mental Health Act tribunal monitoring check**	Automate the process to verify outcome and referral meetings set up and alerts adding freeing up mental health administrators.	**October 2023**	• process confirmed – (5 May) • development of process completed – (29 September)
Full review of corporate service staff lists, and reconciliation of data held on Oracle and ESR	To improve budget management and reduce re-work needed when staff lists on finance system are different to what is on ESR.	**June 2023**	• Finance systems fully updated (i.e., staff all in correct cost centres) – (23 June 2023)
Develop digital and data service standards	Having clear standards ensures TEWV staff are clear on the service they should be getting and will empower them when they are not getting this – helping to protect digital and data staff with any unreasonable requests.	**January 2024**	• To be developed by data projects assurance group (DPAG)

Set up a new corporate services leadership group	Creates one place where Care Groups or project leads can discuss issues with all corporate services present. Also helps to create a joined-up culture among corporate leads.	**July 2023**	• Terms of reference agreed by current deputies group/corporate reps at exec time out session – (May 2023) • Terms of reference and membership signed off by execs – (June 2023) • First formal meeting of new corporate leads group – (July 2023)
Voluntary and community sector provider grants scheme	To make it easier for the Trust to fund voluntary sector provision of non-clinical services for which a full procurement and contracting regime is disproportionate and/or likely to cause unnecessary delay to commencement.	**To be confirmed**	• Receive and consider legal advice on draft scheme – (April 2023) • Scheme approved by strategy and resource committee – (May 2023) • New scheme in place and ready to be used by TEWV budget managers – (July 2023)

Digital and data journey

Project/initiative	Aim/reason why	Deadline	Milestones
Electronic prescribing and medicines administration (EPMA)	The project will deliver electronic prescribing and medicines administration across the organisation for inpatient and community services.	**March 2025**	• Pilot go live – (May 2023) • Go live inpatient services – (September 2023) • Post pilot implementation approach review – (July 2023) • PID for community services – (March 2024) • Complete roll out inpatient services – (June 2024) • Initiate and complete community roll out – (March 2025)
Improving connectivity	The project aims to improve the service available to colleagues regarding network connectivity and network response times, an updated Wi-Fi provision with replacement of aging access points across the Trust and the delivery for a new approach to how our patients can access the internet.	**July 2023**	• Implement new LAN (local area network) design – (April 2023) • Wifi replacement of new controllers (Roseberry Park, West Park and Foss Park) – (April 2023) • Wifi replacement of new controllers (all sites) – (July 2023) • Patient access to the internet (PATTI) options appraisal – (June 2023) • Patient access to the internet (business case) – (September 2023)

IIC re-procurement and migration	The project will deliver the data migration from the existing IIC platform to a cloud hosted environment, to ensure we future proof the IIC to be able to support us being a gold standard provider of business intelligence in healthcare services.	**July 2023**	• Migration to Cloud – (Apr 2023) • Sign off data stage – (May 2023) • Dashboards tested and signed off – (May 2023)
RPA (Robotics)	Delivery of software that allows for the automation of business processes through use of digital 'worker / bots' – these 'bots' can be taught to execute transactional tasks consistently thereby releasing time savings for existing staff and improving data quality.	**October 2023**	• Sign off the Project Initiation Document – (March 2023) • Delivery into live environment of six processes – (October 2023) • Transitioned into business as usual through sign off a service delivery model – (October 2023)
Enhancing collaboration	The enhancing collaboration project will embed the use of the Office 365 suite and its many applications and opportunities for communication, joint working and information sharing to colleagues across the organisation. This will enable them to collaborate with each other and partners from within the NHS and wider health and social care community.	**June 2023 (ongoing)**	• Document management position statement – (April 2023) • Targeted communication and support for main Office 365 applications – (June 2023) • BAU support model established – (June 2023)
Asset management	The project will introduce centralised asset management for IT equipment into the organisation. This will reduce delays in ordering and receiving equipment for colleagues and deliver savings through improved lifecycle management and a consolidated approach to purchasing hardware and software licenses.	**March 2024**	• Review and refinement of new asset management processes – (September 2023) • Establish CAM KPI's and Q1 reports – (September 2023) • Development of estate asset profiles (e.g., model office/ward) – (September 2023) • Software management processes – (March 2024) • Telecommunications review – (March 2024)

Green plan

Project/initiative	Aim/reason why	Deadline	Milestones
Embedding the green plan and carbon reduction	To reduce the environmental impact of our activities and direct and indirect carbon emissions. The NHS is the largest employer in the UK, responsible for around 4% of the nation's Green House Gas emissions. We have a moral duty to reduce these and help deliver the UK's carbon reduction goals.	The NHS carbon footprint for the **emissions we control directly - net zero by 2040** The NHS carbon footprint 'plus' for the **emissions we can influence - net zero by 2045**	• Produce options paper appraising models for delivery of the Trust's green plan – (31 May 2023) • Establish green plan 'community of interest' to lead and scope workstreams and co-produce a phased implementation plan which will work towards NHS Net zero by 2040 – (September 2023)
Heat decision plan	The plan will focus on replacing fossil fuel heating systems with green renewable technologies.	**September 2023**	• Site surveys – (June and July 2023) • Plan delivery – (September 2023) • Capital bid for funding measures 2024/25 (tbc)
Installation of additional electric charging points at trust properties	Continue to encourage the take up of zero carbon vehicles across the trust, cleaner air initiative.	**December 2023**	• May surveys complete • June surveys out to tender • Carry out installations (three months lead time)

Trust environmental pledge - 'pledge for greener'	Search for commitment for take up of green measurable pledges and launch trustwide.	**Ongoing throughout 2023/24**	• Launch July 2023 with second phase initiative winter 2023
Look to address the carbon footprint from supplier to door when procuring goods	Consider travelled miles of supply and look to engage more local providers where possible.	**Ongoing throughout 2023/24**	• Form small working group to consider select list as a pilot

Estates

Project/initiative	Aim/reason why	Deadline	Milestones
Health, safety and assistive technology	To improve health, safety and resilience in our core inpatient estate for the benefit of patients, staff and members of the public.	**Ongoing programme**	• Complete the next phase of Tees essential safety programme including procurement and delivery of significant capital works supported by enabling schemes. • Business case for procurement of Phase 2 works and Phase 3 enabling strategy drafted for approval. – (June 2023) • Complete installation of next phase of assistive technology including sensor doors and Oxehealth installations – (March 2024) • Evaluation of quality impact of technologies underway to inform prioritisation and scoping for next phase of programme
New base for Stockton AMH services	To tackle inequalities in the quality of environment, targeting buildings which are no longer fit for purpose and making better use of our existing estate. This will enable the vacation of council properties which have been identified for disposal whilst supporting new clinical co-locations and avoiding new rental costs.	**June 2023**	• Purpose-designed modular building on Durham Road site in Stockton installed

Medical education facilities	To support medical recruitment and retention and provide high-quality facilities in line with Health Education England recommendations.	**June 2023**	• Complete interim scheme at Roseberry Park • Develop business case for purpose-designed facility in Durham and Darlington
One public estate participation	The aim is to improve opportunities for education, employment, health and housing, through better quality, efficiency and sustainability of public services. By collaborating with public sector organisations across traditional organisational boundaries, we will be able to better use our region's public estate to benefit our population.	**ongoing**	• Active participation in the Tees Valley OPE partnership to complete collective asset mapping across Tees Valley – (June 2023) • Cushman and Wakefield appointed by Tees Valley strategic estates group to complete asset mapping and identify emerging opportunities across the NHS, council, and blue light estate • Develop a pipeline of agreed local regeneration, growth and community cohesion opportunities in readiness for any funding opportunities – (December 2023) • One public estate funding secured to support partnership working between Stockton Council and TEWV. • Multi-agency 'discovery' work commenced in Hartlepool, exploring opportunities for vacant retail space. • Identification of OPE/multi-agency estates networks across North Yorkshire and County Durham – (September 2023). • Tentative discussions commenced with Durham County Council regarding children and young person's estate.
Strategic estates planning	To understand the vision for the estate, our needs and opportunities.	**March 2024**	• TEWV estates plan developed for implementation – (approval April/May 2023) • Provider collaborative estates framework developed by estates directors across NENC ICB. This will inform an ICB-wide estates strategy – (March 2024)

Glossary

Term	Description
24/7	24 hours, 7 days a week
AMH	Adult mental health services (i.e., services for people aged 18 to 64)
BAU	Business as usual
Board	A decision-making body with significant responsibility for resources and / or policies or plans. The Trust has a Board of Directors, but both Care Groups also have their own Boards.
CAMHS	Child and adolescent mental health services
Care Group	The main way in which our services are organised and governed (as of April 2022). There will be two care groups in TEWV (aligned to ICSs), which are 1) North Yorkshire, York and Selby and 2) Durham Tees Valley and Forensics
Cito	An IT system which TEWV is introducing to make it easier to input information into and extract information from our electronic patient record (PARIS)
CLD	Child learning disability services
CPA	Care programme approach
CQC	Care Quality Commission – body that regulates quality for NHS healthcare providers, including Mental Health Act inspections.
CYP / CYPS	Children and young people (aged under 18). The “S” is for “services”
DTV	Durham and Tees Valley (i.e., County Durham, Darlington, Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland)

Dual Diagnosis	The coexistence of a mental health issue and other health issue. In the context of Mental Health provision this most often refers to mental problems coinciding with drug / alcohol dependency / usage.
EIP or EiP	Early intervention in psychosis service
ePR or EPR	Electronic patient record
ESR	Electronic staff record (a national NHS system)
GP	General practitioner – the 'family doctor' who is usually the first contact with the NHS when a patient becomes ill.
Foundation Trust (FT)	A group of hospitals / community health services. FTs are accountable to their local populations through their Membership and Council of Governors. They are regulated by NHS England and the Care Quality Commission (CQC) TEWV is an FT.
IAPT (now known as Talking Therapies)	Improving access to psychological therapies – a national programme to make talking therapies available to people with milder forms of mental illness to reduce the proportion who go onto develop serious mental illness.
IIC	Integrated information centre – The Trust's data repository which provides data for a variety of internal and external reporting.
Inpatient service / inpatients	Our services provided for patients who require treatment in a hospital for a period of time rather than treatment in the community.
ICS / ICB / ICP	Integrated Care System which since 1 July 2022 has consisted of an Integrated Care Board and Integrated Care Partnership. TEWV serves part of the North East North Cumbria ICS and part of the Humber and North Yorkshire ICS.
Journey	As well as Our Journey to Change (see below), TEWV has several sub-strategies that support the overall journey. These sub strategies are known as Journeys.
Learning Disability (LD)	People with an IQ below 70 are generally regarded as having a learning disability. People in this group are more likely to have a mental illness than other people.

Lived Experience	People who have had experience of being assessed and treated my mental health or learning disability services (or are the carer of someone with this experience
Local Authority	An elected body which commissions social care, public health and other services for a geographical area. Often also referred to as a *Council*.
MHSOP	Mental health services for older people (generally 65 years or older, although MHSOP services can cover younger people with early onset dementia).
N&G	Nursing and governance directorate
NICE	National Institute of Clinical Excellence
NHSE	NHS England
NY&Y	North Yorkshire and York (please note that this is not coterminous with the boundaries of North Yorkshire Council because this TEWV Locality covers the City of York, Pocklington (East Yorkshire) and Wetherby (Leeds) areas, and it does **not** cover the former Craven District (e.g., Skipton and Settle) services to that part of North Yorkshire are provided by Bradford District Care Trust and commissioned by the West Yorkshire ICS).
OJTC	Our Journey to Change – this is TEWV's strategic framework which sets out the vision and mission for the Trust, its values and its goals.
Pathway	A standard "route" through treatment for all patients with the same diagnosis. This can include choices of alternative evidence-based treatments at appropriate points in the pathway.
Place / Place-based	In the NHS, 'place' is usually used to mean the area of a local authority. Where there are very large local authorities, we sometimes use 'place' to refer to a town or district, but the NHS sometimes uses 'neighbourhoods' to mean this.
Peer workers	A person who has past personal insight into how it feels to be assessed / treated / supported and uses this insight to support the recovery of people currently being assessed / treated / supported in that kind of service. Peer workers can also be known as lived experience workers.
PMO	A team within TEWV dedicated to supporting the programme and project management of complex plans for change (and to supporting the development of project and programme management skills across the Trust).
Program or Programme	A long-term initiative that focuses on designing and embedding significant changes that will lead to benefits. A program consists of several projects or workstreams and is governed by a programme board.

Provider Collaborative	The term is used for any formal grouping of providers who work at system-level but in the context of regional, specialist or tertiary services such as secure inpatients, CYP inpatients and perinatal services are also a governance mechanism which allows providers to come together to determine the needs, and plan the provision for these in their ICS area.
Project plan	A plan that sets out how a one-off change is going to be delivered, including deadlines for key actions (also known as milestones.)
Q	This stands for quarter of a year – quarter one ends on 30 June, quarter two on 30 September, quarter three on 31 December and quarter 4 on 30 April.
QI	Quality Improvement
QuAC	Quality assurance committee
STOMP	Stopping over medication of people with a learning disability
Tees / Teesside	Geographical area including the boroughs of Hartlepool, Stockton, Middlesbrough and Redcar & Cleveland.
Tees Valley	Same geographical area as Teesside (see above) but also including the Borough of Darlington.
VCS	Voluntary and Community sector. This includes charities and community interest companies.

ITEM NO. 10a

For General Release

Meeting of:	**Council of Governors**
Date:	**15th June 2023**
Title:	**Board Integrated Performance Report as at 30th April 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 Council of Governors 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 based on the Performance & Controls Assurance Framework for the Board Integrated Performance Dashboard (IPD) and progress against the Mental Health Priorities, including National Quality Standards. (*See Appendix A highlighting key changes from previous months report.)*

(Important: Our assessment of performance is underpinned by Statistical Process Control (SPC) an evidenced based tool. In line with best practice, SPC analyses performance over time. This year, we are reviewing performance for each measure from the 1st April 2021 to the

current date whereas, last year we included performance from the 1st April 2020. By removing that year's activity, we have seen a number of measures 'improving' in performance, for example bed occupancy; however, this 'improvement' must be treated with caution as in most cases what has actually happened is a normalisation of performance and therefore, we continue to monitor these measures as areas of risk.)

IPD Areas of Concern

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

- Unique Caseload
- Financial Plan: Agency expenditure compared to agency target
- Financial plan: Agency price cap compliance
- CRES Performance Recurrent

(*See Appendix A for detail*)

Performance Improvement Plans

As part of our ongoing improvement journey around reporting for assurance and developing SMART actions for any areas where our performance is not where we want it to be; we have introduced Performance Improvement Plans (PIP) to demonstrate to the Board, that we are focussed on the right things and in a timely manner. PIPs have been developed and shared with Executive Directors for approval for the following issues that are impacting on performance and/or have negative controls assurance i.e. limited actions to affect any improvement:

- Agency Expenditure (Trust-wide)
- Safe Staffing (Trust-wide)
- Bed Pressures including OAPs (Trust-wide)
- Caseload (Care Groups)
- Percentage of CYP showing measurable improvement following treatment - patient reported (Durham, Tees Valley & Forensic)
- Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported (North Yorkshire, York & Selby)
- Percentage of CYP showing measurable improvement following treatment - clinician reported (North Yorkshire, York & Selby)
- Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported (North Yorkshire, York & Selby)
- Percentage compliance with ALL mandatory and statutory training (Trust-wide)
- Percentage of staff in post with a current appraisal (Trust-wide)

One remains to be facilitated by Durham, Tees Valley & Forensic Care Group:

- Percentage of inpatients reporting they feel safe whilst in our care

It must be noted that following the financial plan submission to the Integrated Care Board and NHS Improvement on 4th May 2023, work is ongoing to establish the relevant metrics to enable reporting of the Use of Resources Rating (UoRR). This will be included from May 2023 onwards and will include the relevant metrics associated for April.

Mental Health Priorities including National Quality Standards

There are 1 Trust and 6 commissioner priorities currently at risk of achievement (*See Appendix A*). PIPs have been developed by the Care Groups and have been shared with Executive Directors for approval.

Broader Key Issues

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

- Duty of Candour
- Bed Occupancy
- Staff Survey Action Plans
- Agenda for Change and other pay awards

(*See Appendix B for detail, including the Care Group Summaries)*

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

Summary of Key Risks

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 2023/24 pay deals (tariff-based) pressures
- Failure to retain permanent staffing, including as a consequence of acute cost of living pressures
- Failure to deliver a challenging back-end loaded CRES plan and trust-level vacancy factor
- Failure to manage the financial impact of excess inflation (compared to tariff)

(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.

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 Council of Governors.
Recommendations:	The Council of Governors is invited to receive this report for oversight and assurance on the actions being taken to improve performance in the required areas.

Appendix A

IPD Key Changes from the Previous Report

Measure	Key Change
Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for (measure 2)	Improved assurance
Bed Occupancy (AMH & MHSOP A & T Wards) (measure 8)	Improvement in performance
The number of Incidents of moderate harm and near misses (measure 11)	Improvement in performance
The number of Restrictive Intervention Incidents (measure 12)	Improvement in performance
The number of unexpected Inpatient unnatural deaths reported on STEIS (measure 14)	Improvement in performance
Staff Leaver Rate (measure 18)	Improvement in performance
Percentage of staff in post with a current appraisal (measure 21)	Improvement in performance
CRES Performance – Non-Recurrent (measure 28)	Improvement in performance

IPD Areas of Concern

There are 4 measures where we have limited performance assurance and negative controls assurance, for which Performance Improvement Plans have been developed for the issues that are impacting on performance to support improvement and increased assurance.

Measure	Comments
Unique Caseload	We continue to have special cause concern at Trust level and in both Care Groups. Performance Improvement Plans, identifying the key issues and improvement actions that will be undertaken, are being developed by both Care Groups; however, there is currently limited assurance pending the actions within those plans being progressed.
Financial Plan: Agency expenditure compared to agency target	The Trust agency expenditure is £0.1m lower than planned costs for 2022/23. Monthly run rates for agency staff costs remain high, and the financial plan includes CRES targets from Q2. 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 usage includes 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.
Financial plan: Agency price cap compliance	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. However, the flexible staffing team have obtained reduced rates above cap and continue to challenge agency suppliers on meeting framework terms and conditions.
CRES Performance Recurrent	The Trust is not achieving its recurrent CRES savings target. This is being compensated in part by good assurance on measure 28 (non-recurrent over achievement). 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. Planning of a trust wide CRES event is in train to take place during quarter 2.

Mental Health Priorities including National Quality Standards

We are at risk of not achieving our planned reduction in out of area placements and the agreed trajectories in the following areas:

Measure	Sub-ICB Location
Percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care	Vale of York
Percentage of service users experiencing a first episode psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	Vale of York
CED: Percentage of Service Users designated as routine cases who access NICE concordant treatment within 4 weeks	all Sub-ICB Location areas
CED: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within 1 week	all Sub-ICB Location areas
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	all Sub-ICB Location areas
Number of women accessing specialist community PMH services	North Yorkshire & Vale of York

Appendix B

Broader Key Issues/Work

Quality

The Duty of Candour
The Duty of Candour (DoC) is a professional, statutory and contractual requirement. The recent Niche review of Trust governance processes identified consistent issues with the application of the Duty of Candour at the Trust. A key recommendation was that the Trust should seek assurance that there are now mechanisms in place to assess that the Duty of Candour Policy is effectively implemented. Additionally, where there has been a death in service, whether through self-harm / suicide or homicide, that families are given appropriate, meaningful, timely and compassionate family liaison and support through personal contact with a nominated officer of the Trust.

Recognising that there is improvement work required to ensure Duty of Candour is fulfilled and in response to the Niche recommendations the Trust has since:

1. Commissioned an internal audit of compliance with the Duty of Candour Policy (April 2023). This gave a rating of limited assurance with 3 high risk and 4 medium risk actions. These priorities echoed the findings of the Niche and North of England Care System Support reviews with regard to Trust policy, standard processes and governance.

2. Commissioned the North of England Care System Support (NECS) to complete a short duty of candour review project to focus on:
   - Reviewing the current policy against best practice
   - Collating a range of staff understanding and thoughts around the DoC process through focus groups and discussions
   - Analysing key findings of the internal audit undertaken in April
   - Producing a final report including key recommendations.

Overall awareness and understanding were found to be generally good regarding professional Duty of Candour, however limited regarding the statutory and contractual requirements.

The NECS review recommended immediate actions in the following areas:
- Policy completion and approval
- Revision of standard / guidance letters and templates
- Ensure completion of doc sections on the Strategic Executive Information System (STEIS) (Serious Incident reporting portal)
- Reporting of Duty of Candour at service, Care Group and corporate levels.

In addition, further areas for attention identified are:
- Staffing education and training
- Review and updating of relevant DoC processes and supporting documentation and resources

In response to the findings of the recommendations made, the Trust has developed an improvement plan with actions that require quick turnaround. Quarterly update reports will be provided to the Quality Assurance Committee on its delivery. Progress has been made with the review of the DoC against best practice, the amended policy is currently out to consultation. A Trust DoC site has also been developed on the Trust Intranet where key guidance regarding the DoC can be found.

Inpatient Pressures

Bed Occupancy
Work is continuing within the Care Groups and the Beds Oversight Group to implement plans that will impact upon inpatient bed pressures. Currently the key focus is the minimisation of any barriers to discharge that will reduce the number of delayed transfers of care and reduce length of stay. Achievement of this would improve access to beds more locally, improve outcomes and reduce expenditure on the use of independent sector beds.

Key schemes of work that are in progress include:

- Review and refresh of the Delayed Transfer of Care Policy (Clinically Ready for Discharge) and roll out of training to all ward staff. This has also included the embedding of a weekly Delayed Transfer of Care meeting with Local Authority colleagues where cases are reviewed, and barriers identified to help develop plans to expedite the patient transfer from hospital to home.
- Review and refresh of the Purposeful Inpatient Admission (PIPA) and roll out of training to all ward staff.
- Weekly review of all extended Length of Stay for Adult Mental Health. Increasing use is being made of the Integrated Care Intensive Support Team for additional support to reduce barriers to discharge in complex cases.

In addition to the work outlined above, the Trust is in negotiation with North East Commissioning Services to implement a Mental Health Optimised Patient Tracking and Intelligence Choices Application (OPTICA). If successful the Trust will become a pilot site for the development and implementation of a Mental Health OPTICA, which would be managed in collaboration with the North East Commissioning Service (NECS), Palantir and Local Authority Partners. The OPTICA system would have significant benefits for the Trust some of which include reducing the number of days delayed for medically optimised patients, reducing delays due to interface issues, improving compliance with best practice, reducing out of area placements, reduce Independent Sector spend and free up staff to spend on patient care. If successful it is anticipated that this will be implemented by Q3 2023, although the implementation of the Trust-wide CITO / Electronic Patient Record implementation will have to be considered when planning for this.

Having undertaken a workshop to seek agreement on the primary drivers that impact upon Out of Area Placements and help identify potential schemes to address these, further work is underway to analyse admission data for Adult Mental Health and Mental Health for Older People. It is anticipated that the full report will be complete in readiness for the July meeting of the Beds Oversight Group. This will be reviewed to identify if there are any other actions we need to include within our plans.

<u>People & Culture</u>

Staff Survey Action plans
Focused work regarding the 2021-22 Staff Survey results continues with each directorate developing clear action plans through engagement with their senior leadership teams and wider staff groups through a range of different events, sessions and away days. These individual directorate plans contain overarching themes and highlight specific issues identified for improvement within their services, aligned with the central workforce delivery plan they set strong foundations to ensure the people journey continues to build in impact over this financial year.

Trust-wide priorities focus upon:

- Transparency of development opportunities underpinned by our new appraisal and performance tool, Workpal
- Quality of appraisals and the training undertaken by appraisers and appraisees
- Ensuring all our systems are aligned so that future staff surveys accurately represent the directorates in the new structure
- Flexibility of employment
- Centralised and more flexible recruitment
- Workforce planning across the Trust
- Improving how we co-create workforce priorities with staff and partners with lived experience
- Improving the experience of joining the trust and continuing work on understanding why people leave/ supporting them to stay
- Evaluation of health and wellbeing offers

Directorate level plan - People and Culture (example):
Actions relate to appraisal training to ensure both quality and value, mandating face to face meetings for quarterly supervision, 100% sign up to WorkPal, commencing a bimonthly P&C newsletter, launching P&C related lunch and learn sessions and celebrating NHS 75 together.

These individual directorate action plans are locally developed and owned. Once fully implemented they will significantly strengthen the experience of colleagues in TEWV.

The staff survey has been signed off by committee having also been to the Executive People, Culture & Diversity Group, the Care Group Boards, each directorate leadership team, the quarterly leadership and management sessions, and to Executive Directors Group. Progress will be reviewed, and assurance reported back through these groups.

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 £10.4m due to the disproportionate impacts from funding via national annual 'tariff' uplifts applied to provider contract values. The impact of the outcome of the 2023/24 Agenda for Change Pay Review Body which awarded 5% uplift versus 2.1% included at plan is being evaluated. Early indications suggest providers are to be allocated a flat rate percentage uplift of 1.6%. If this is the case, it would generate an additional in-year pressure for the Trust because a higher percentage of our cost base is pay. Both mental health providers in the North East & North Cumbria (NENC) Integrated Care Board (ICB) patch are working on a response to review the funding methodology and explore alternate mechanisms that better reflect actual provider costs. Without additional support the Trust would need to find further mitigations in order to deliver its financial plan.

Care Group 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:

- Pressures on our inpatient services are continuing; our bed occupancy remains high within our adult wards. Work is underway to align the work of the care group and the Trust wide beds oversight group into a single programme of work. There 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. Concern around moving and handling, Positive and Safe and Immediate Life support, mitigations are in place at team and service level and further actions being considered at Trust level.
- 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 have developed an action plan which will be progressed and monitored via the People and Culture section of the Care group Board meeting monthly.
- New Performance and Quality oversight meeting in now in place at Care Group Board level on a weekly basis to support the revised Daily Lean Management processes across the services. The meeting provides a focus on key areas of performance including improvement actions.

The areas of positive assurance identified within the IPD:

- Within our IAPT services we are achieving the standard for patients achieving recovery and we continue to have excellent waiting times, achieving the 6 and 18 week standards for accessing our services.
- We continue to exceed standards consistently for the number of people who receive two or more contacts from NHS or NHS-commissioned community mental health services for adults and older adults with severe mental illnesses and the number of CYP aged under 18 supported through NHS-funded mental health with at least one contact.

- Following the implementation of key actions, we are also achieving the standard for people who are experiencing EIP are being treated with a NICE approved care package within 2 weeks of referral and Patients discharged form our services, followed up within 72 hours.

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 took place during April 23 with an operational model having been developed to maximise 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. Within Durham and Darlington Team, the implementation of Band 6 call screening roles is underway. The current answer rates (1st – 16th May) are 58% in Durham and Darlington team and 58% 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 April 23, we had 6 patients in independent sector beds.
- Vacancies and staff absences impacting service delivery, response to patient risks and patient recovery and health outcomes. In particular, Medical staffing in AMH, Foss Park inpatients, Crisis and home-based treatment teams, HHR community, also CAMHS Selby has seen a further reduction in WTE due to leavers and lack of medical cover in Scarborough.
- Unique caseload Performance Improvement Plan is in development but has not been provided at this stage for amalgamation with 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. However, it is worth noting, ALD services are achieving the standard while remaining specialities are displaying an increase on March's position.
- Memory waiting times demand and capacity exercise has progressed. Planning and Quality Improvement are triangulating information and mapping the referral and triaging pathway to start identifying improvements with a view to an RPIW.
- The CYP Clinician Reported and AMH Clinician and Patient Reported outcomes are to become part of a Performance Improvement Plan.

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

- Crisis response home treatment capacity: the impact of staff absences and core vacancies across all four teams, in particular Harrogate and Rural and crisis response to the 0800 line.
- The viability of Danby ward has been secured from 22 May, with a planned review in 3 months and alternative support plans being put in place for the MPAC trainees
- Previous pressures that exist within MHSOP Therapies continue to have an adverse impact on service delivery. Recruitment into Psychology positions remains a challenge.

Appendix C

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 30th April 2023

Report Produced by: Ashleigh Lyons, Head of Performance
Date the report was produced: 31 April 23

For any queries on the content of this report please contact: Ashleigh Lyons, Head of Performance
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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

NOTE: This year, we are reviewing performance for each measure from the 1st April 2021 to the current date whereas, last year we included performance from the 1st April 2020. By removing that year's activity, we have seen a number of measures 'improving' in performance; however, this 'improvement' must be treated with caution as in most cases what has actually happened is a normalisation of performance and therefore, we continue to monitor these measures as areas of risk or areas for improvement.

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 progressed this 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.

Note: The development of the local audit/assurance framework to support the assessment will be completed in quarter 4 2023/24, with a view to undertaking the first assessments in quarter 1 2024/25. This element has, therefore, been omitted from the latest assessment.

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

DQ ★	Data Quality Assessment Score over 90%	No actions required
DQ ✓✓	Data Quality Assessment Score 70% to 89%	No actions required; but a small number of improvements identified
DQ ✓	Data Quality Assessment Score 50% to 69%	Some actions required
DQ ✗	Data Quality Assessment Score less than 50%	Significant work is required

Action status

Positive Assurance
We are doing well in this area and no action is required at this time

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

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

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

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 ***Incidents of moderate harm and near**		
Neutral		***Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for** *Medication Errors with a severity of moderate harm and above ***CRES Performance – Non-Recurrent** *Capital Expenditure (Capital Allocation) *Cash balances (actual compared to plan)	***Bed Occupancy (AMH & MHSOP A & T Wards)** *Serious Incidents reported on STEIS ***Unexpected Inpatient unnatural deaths reported on STEIS** *Uses of the Mental Health Act *Staff recommending the Trust as a place to work *Staff feeling they are able to make improvements happen in their area of work ***Staff Leaver Rate** *Percentage Sickness Absence Rate ***Staff in post with a current appraisal** *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 *Compliance with ALL mandatory and statutory training *Financial Plan: SOCI - Final Accounts - Surplus/Deficit	*Unique Caseload (snapshot) *Financial Plan: Agency expenditure compared to agency target *Agency price cap compliance *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%	92.62%
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%	72.97%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	50.96%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	F	35.00%	22.34%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	46.27%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	L	F	50.00%	41.85%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	18.82%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC				96.71%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			1,275
10)	The number of Serious Incidents reported on STEIS	QAC				10
11)	The number of Incidents of moderate harm and near misses	QAC	L			93
12)	The number of Restrictive Intervention Incidents	QAC	L			294
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				1
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0
15)	The number of uses of the Mental Health Act	MHLC				333

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				12.05%
19)	Percentage Sickness Absence Rate (month behind)	PC&D				5.55%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L	?	85.00%	85.79%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D		?	85.00%	82.96%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				7,741
23)	Unique Caseload (snapshot)	S&RC	H			64,368

Rep Ref	Our Finance Measures	Committee Responsible for Assurance	Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	F	1,321,000	1,485,636
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	P	1,834,000	1,697,531
25b)	Agency price cap compliance	S&RC	F	100%	70%
26)	Use of Resources Rating - overall score	S&RC	Metric not available for Month 1		
27)	CRES Performance - Recurrent	S&RC	F	621,083	337,000
28)	CRES Performance - Non-Recurrent	S&RC	P	0	0
29)	Capital Expenditure (Capital Allocation)	S&RC	F	1,246,000	1,029,000
30)	Cash balances (actual compared to plan)	S&RC	P	75,362,000	75,417,012

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

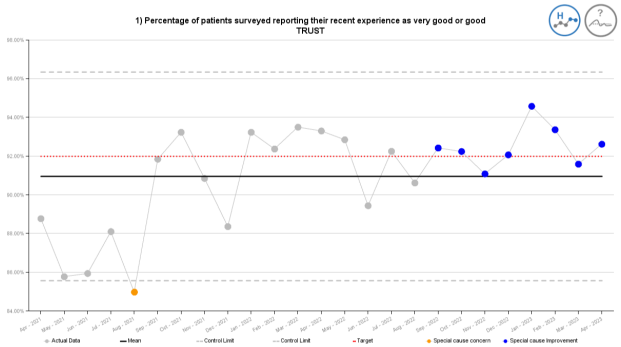
During April, **840** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **778 (92.62%)** scored "very good" or "good".

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

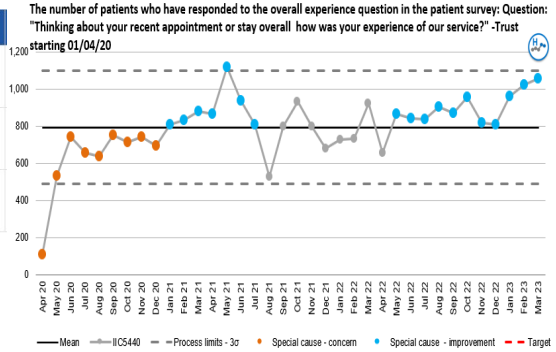
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ★ 93%

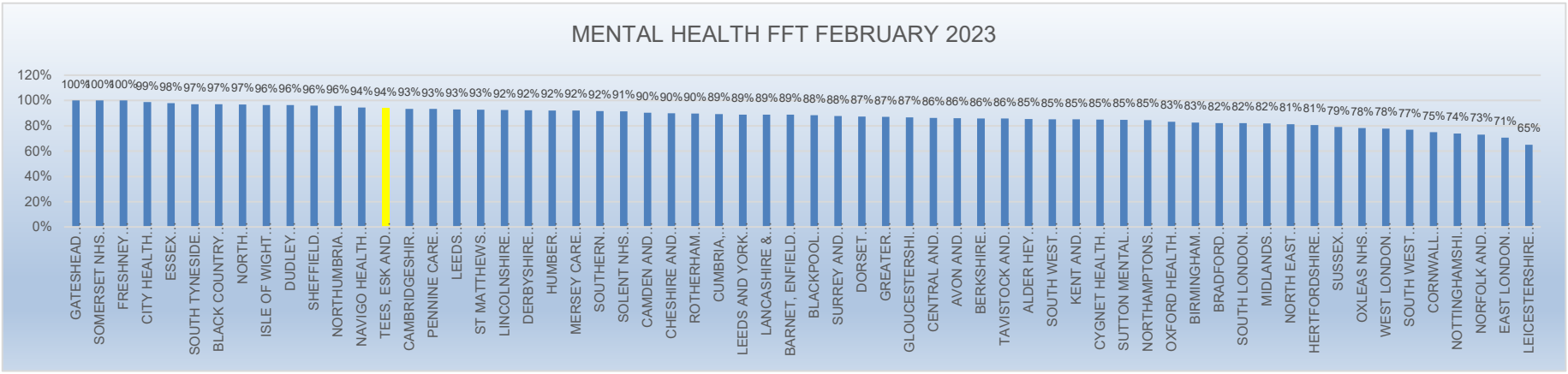
Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



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



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:* 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.	The Terms of Reference for the group have been developed and are currently being reviewed by the Director of Corporate Affairs & Involvement.	

Additional Intelligence in support of continuous improvement

A patient newspaper has been launched within Secure Inpatient Services (Ridgeway). Developed by the patients and supported by staff, the newspaper outlines activities on the wards, staff updates and good news stories. The aim is to improve patient experience and sense of community within the service.

An action plan has been developed by the North Yorkshire, York & Selby Care Group Directors to address those areas where scores have decreased or not improved. This will be monitored on a monthly basis through the Quality Assurance & Improvement Group and reported to Care Board.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

During April, **296** 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, **216 (72.97%)** scored “yes, always”.

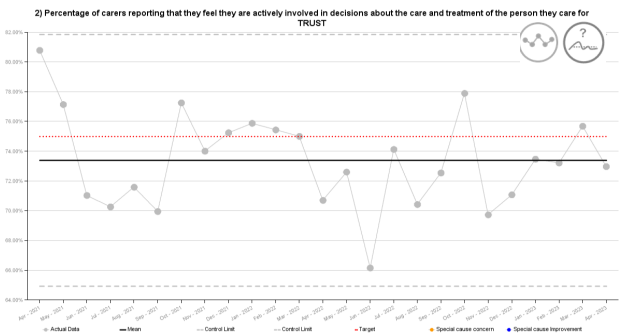
No significant change in the data during the reporting period shown

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

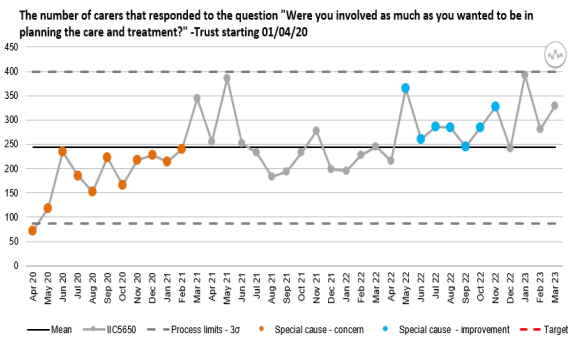
DQ

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
An emerging theme is that staff are not engaging with carers on the grounds of patient confidentiality.	*Enabling action:* Patient & Carer Experience (PaCE) 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.	**Complete.** The PaCE Key Message bulletin for March data was dedicated to Carer Rights verses Confidentiality.	
	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.		

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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.	**Complete**. An action plan has been developed and was agreed at the April Service Delivery and Improvement meeting, progress will be monitored at this meeting. The plan contains 8 actions, all of which are on track.to be completed by June 23.	

Additional Intelligence in support of continuous improvement

Following learning from serious incidents, joint training has been delivered by the Patient & Carer Experience and Information Governance and Data Protection teams to North Yorkshire, York & Selby services on “Sharing information with carers when consent is not provided”.

We have published our second issue of Together with friends, family and neighbours. Developed with carers and staff, this newsletter shares information from our Trust and local communities including the provision of support and resources. This quarter’s edition, includes invites to our Carers Week and to the various events for carers we are hosting around the Trust area, which will be held in June 2023.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

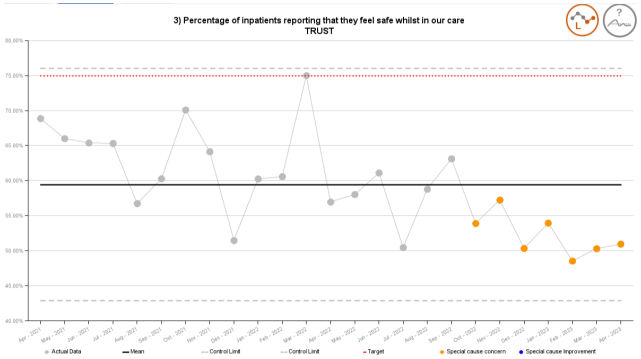
During April, **104** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **53 (50.96%)** scored “yes, always"

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

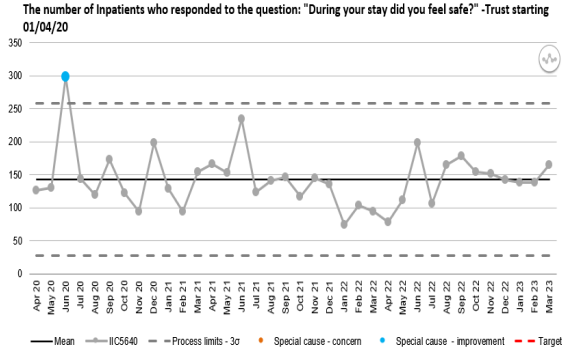
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

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, all have been progressed throughout 2022/23; however, work will continue to embed these during 2023/24.	
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:* 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.		

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

Tees, Esk and Wear Valleys NHS Foundation Trust

We strive to ensure that our patients receive safe care and treatment, and we are concerned that our patients within our Durham, Tees Valley & Forensic services do not always feel safe and secure within our inpatient wards. To address this the Care Group has developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. Further work is now being undertaken to ensure the actions are Sustainable, Measurable, Achievable, Realistic and Timely (SMART). These will be finalised for the May 2023 report, with progress against the delivery of the plan being provided in subsequent reports.

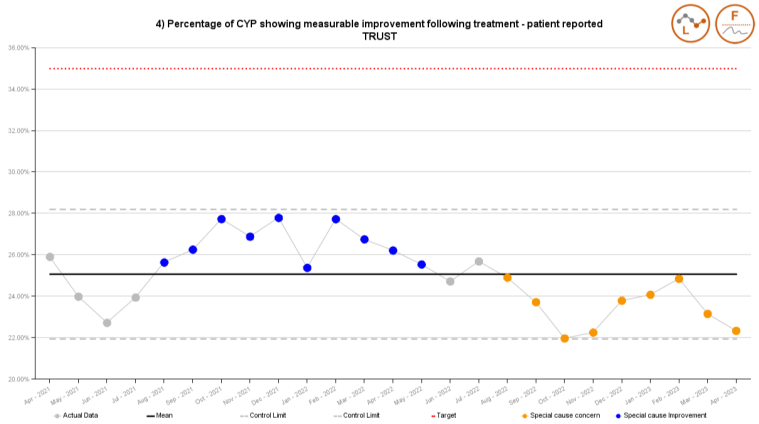
04) Percentage of CYP showing measurable improvement following treatment - patient reported

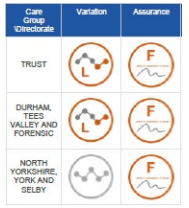
Tees, Esk and Wear Valleys NHS Foundation Trust

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 April, **676** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 151 (22.34%)** 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.



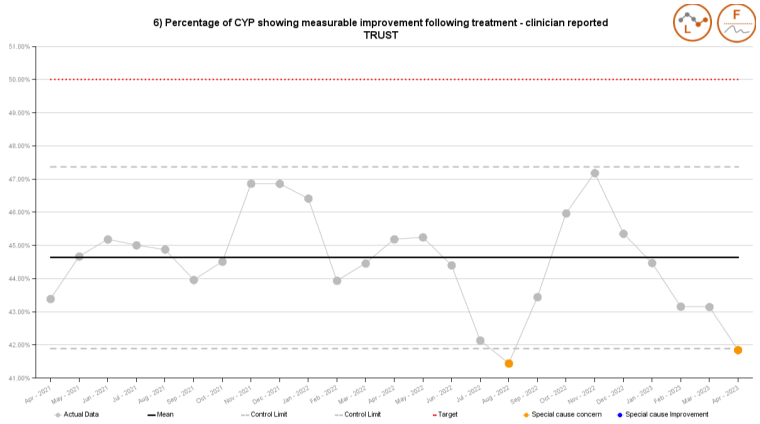


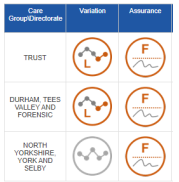
06) Percentage of CYP showing measurable improvement following treatment - clinician reported

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 April, **779** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 326 (41.85%)** 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)





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 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 April, 3 (out of 3) staff attended the monthly training sessions from Durham & Tees Valley; 5 (out of 8) attended from North Yorkshire, York & Selby.	
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 Specialty Development Manager to raise the findings at the ~~April~~ May 2023 CAMHS Outcomes Group to identify any improvement actions.		
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~~ July 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: 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.	**Complete.** Sessions are complete and the ROMS leads are meeting monthly to share good practice and actions identified.	No visible impact to date; however, improvements are anticipated as actions are progressed.

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

We are concerned that a significant number of patient-reported outcome measures within our Durham & Tees Valley services and clinician-reported outcome measures within our North Yorkshire, York & Selby services are not reflecting measurable improvements in our patients. To address this the Care Groups have developed **Performance Improvement Plans** that define the actions that are being taken to support improvement and increased assurance.

5 initial actions have been agreed, of which 2 are due to be delivered by the end of June 2023; no concerns have been raised regarding timely delivery.

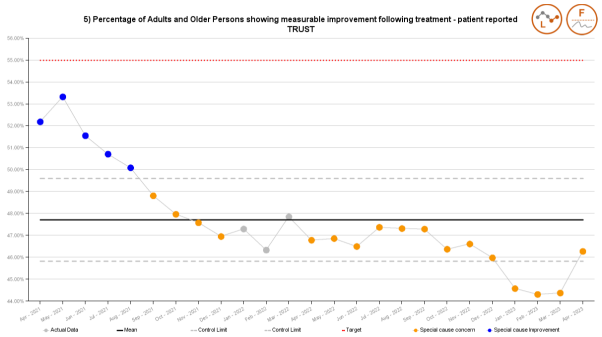
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

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 April, **1891** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 875 (46.27%)** made a measurable improvement.

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



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

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

Our system is expected to consistently fail the target/expectation

DQ 93%

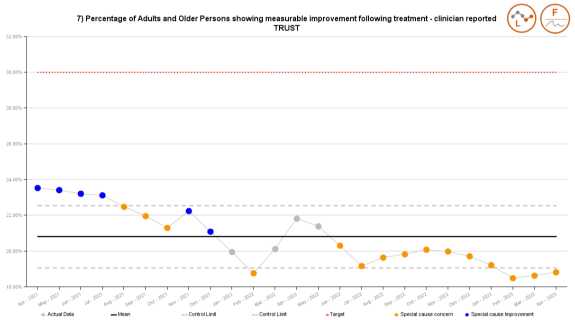
An Area of Concern
We are concerned with our performance in this area and action is required to improve

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

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

For the 3 month rolling period ending April, **3018** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 568 (18.82%)** made a measurable improvement.

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



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

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

Our system is expected to consistently fail the target/expectation

DQ 93%

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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~~ 31st 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	**Complete.** The session has taken place and teams are now embedding this understanding/knowledge into clinical practice. Progress will be monitored through clinical supervision.	
NEW We understand that the changes to PARIS, following the restructure of the Adult Teams in Durham and Tees Valley, may have adversely impacted the data	*Enabling action*: Business Intelligence Team to investigate if it is possible to mitigate this by the end of May 2023.		

We are concerned that a significant number of patient-reported and clinician-reported outcome measures within our North Yorkshire, York & Selby services are not reflecting measurable improvements in our patients. To address this the Care Group has developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

2 initial actions have been agreed, which are dependent on the rollout of CITO and the embedding of improved clinical and management supervisions.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

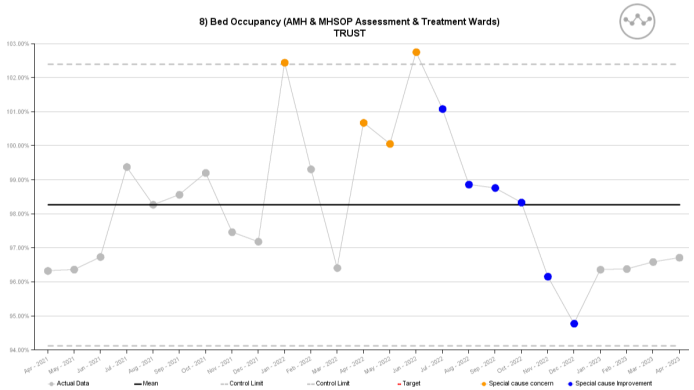
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important that our patients do not stay in hospital longer than they clinically need to and are discharged appropriately, as we know this can affect their recovery.

During April, **10,740** daily beds were available for patients; of those, **10,387 (96.71%)** were occupied.

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%



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

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

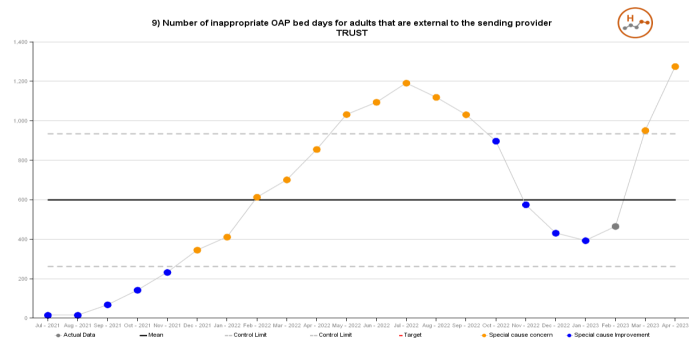
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending April, **1275** days were spent by patients in beds away from their closest hospital.

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

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

DQ 73%



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

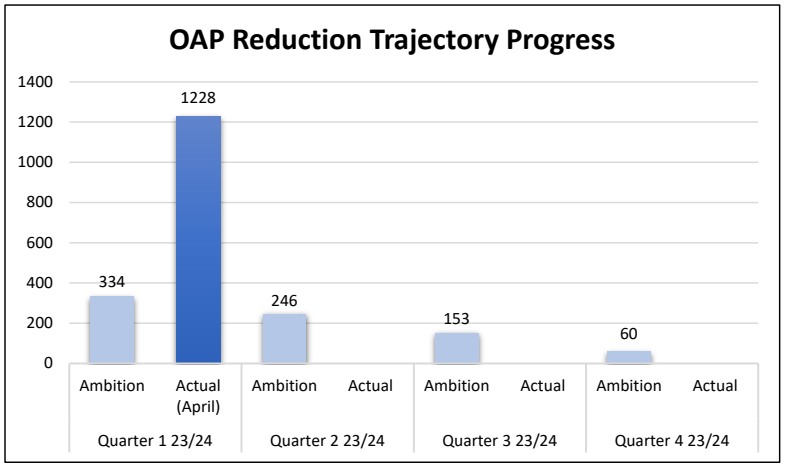
Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Measures

		Apr
Overall Occupancy including Trust, block booked (Priory) and independent sector bed usage	Number of occupied bed days	10,914
	Number of available bed days	10,740
	Percentage Bed Occupancy	**101.62%**

Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider	**Quarter 1 23/24**	
	Ambition	Actual (as at April)
North East & North Cumbria ICB	334	1028
Humber & North Yorkshire ICB	0	200



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.

16 initial actions have been agreed, of which 7 are due to be delivered by the end of June 2023; no concerns have been raised regarding timely delivery. 3 actions are longer term projects that require the Procurement and implementation of a fit for purpose electronic bed management / patient flow system and the adoption and implementation of the National OPEL framework.

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

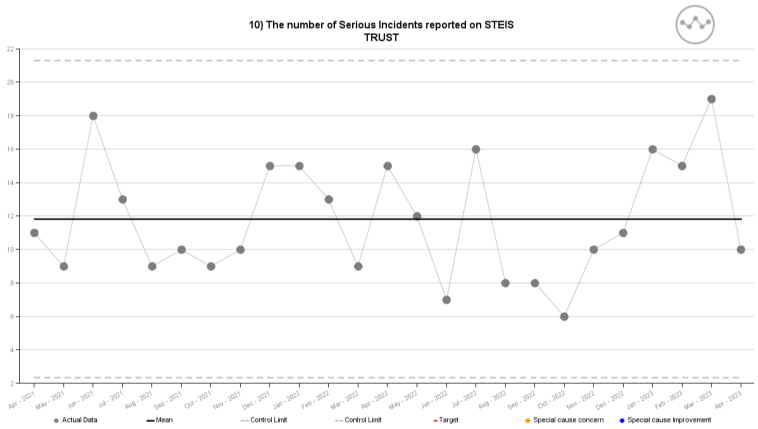
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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

No significant change in the data during the reporting period shown

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

DQ
87%



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

10 Serious Incidents were reported in April . Each incident has been subject to an early learning review within the patient safety huddle. Patient discharge processes have been highlighted as potential areas of learning and further work is being undertaken to asses this against previous serious incidents to determine if there are any emerging themes. An update on this will be provided via the monthly Quality & Learning Report .

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

Tees, Esk and Wear Valleys NHS Foundation Trust

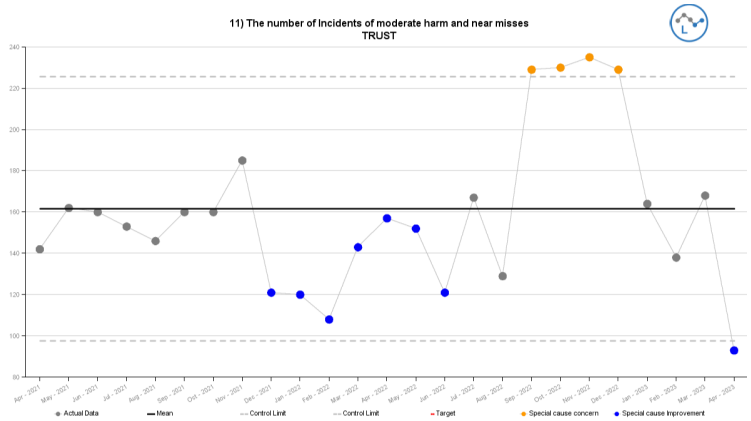
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

93 incidents of moderate harm or near misses were reported during April.

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

DQ 80%

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



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

From a review of the 93 incidents we have identified a number of key areas of good practice and potential areas of learning. Areas of good practice include communication, care planning and intervention, safety summaries and safety plans Areas for further analysis include safeguarding and record keeping

We are currently undertaking further analysis to better understand the issues under the key themes and will report progress to the Executive Quality Assurance & Improvement Group in June 2023 via the Quality & Learning Report.

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS Foundation Trust

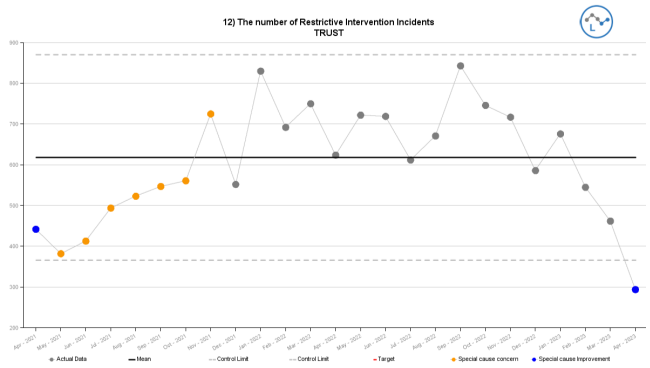
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When restrictive intervention incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented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

294 Restrictive Intervention Incidents took place during April.

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

93%

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



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

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
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.	There are currently 4 patients ready for discharge: • 1 patient within Bankfields commenced their transition to their new placement at the beginning of May and this is expected to be for a duration of 11 weeks • 1 patient has an identified provider and placement; a transition plan is being developed. • 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 concluded and plans in place 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.	The planned away day to consult on the new Policy and agree the final Trust-wide Plan will now take place on the 30th May 2023.	
	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~~ 31st May 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.	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.	

Additional Intelligence in support of continuous improvement

Within our Durham, Tees Valley & Forensic Learning Disabilities Service there has been a reduction in the number of restrictive interventions as a result of the progress of their Care Quality Commission action plan. These include:

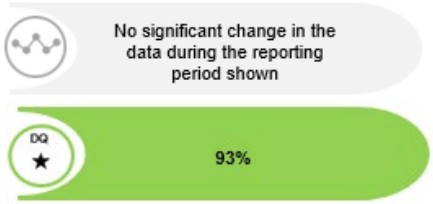
- HOPE(s) clinical lead practitioners working with the inpatient teams to support complex individuals to further develop the care and treatment provided, with a view to reducing restrictive practices.
- The development and implementation of a bespoke training plan, which includes training in effective handovers, reducing restrictive practice training using different mediums, bespoke positive and safe workshops, practice leadership sessions for senior clinical staff, HOPE(s) awareness training, Barrier to Change training, Environmental De-escalation training, SPELL (Autism) training, and Boundaries training.
- The multi-disciplinary team has undertaken a Barriers to Change checklist (HOPEs) with each patient which has informed an individualised care plan describing any individual restrictions in place. This plan also identifies actions and aims to reduce restrictive practice.

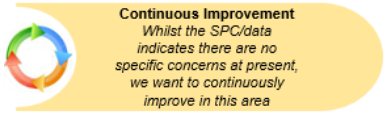
13) The number of Medication Errors with a severity of moderate harm and above

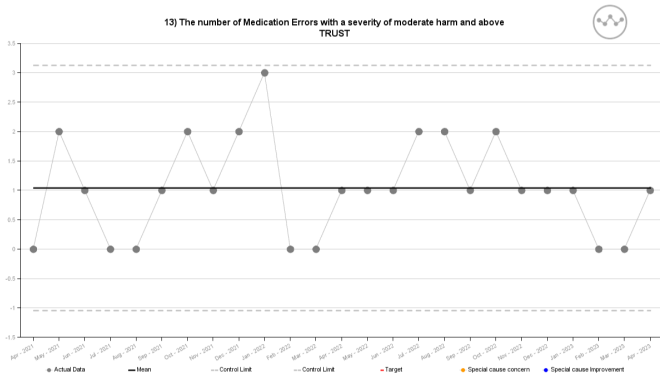
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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







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

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

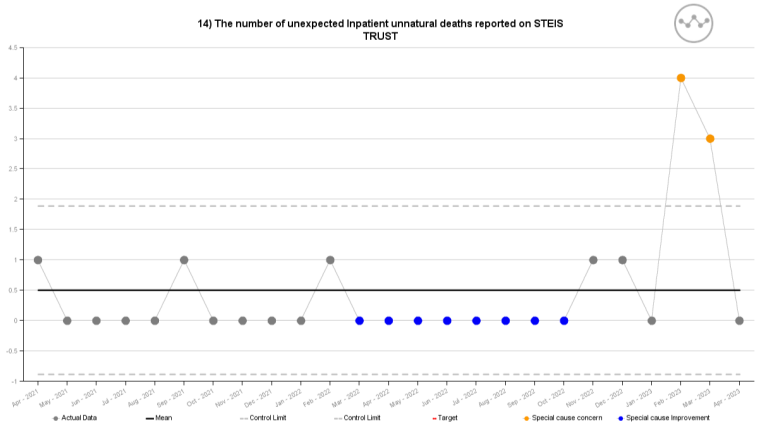
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements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

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

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 ★ 93%



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

There have been no unexpected unnatural inpatient deaths during April.

15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

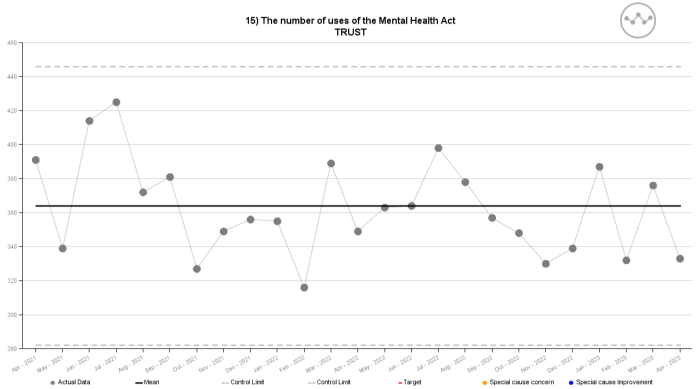
We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers,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

There were **333** uses of the Mental Health Act during April.

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	
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.	**On hold.** The number of uses of the Mental Health Act" measure is within the scope of being paused to facilitate the implementation of Cito (the Trust's new Electronic Patient Record system). The paper outlining these changes has been to Executive Directors Group for approval.	

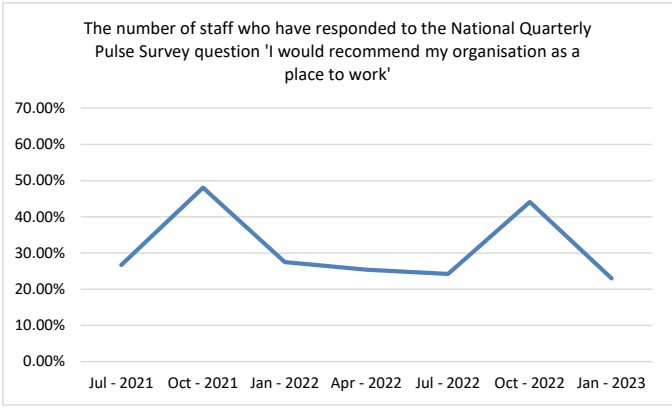
16) Percentage of staff recommending the Trust as a place to work

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.

1988 staff responded to the January 2023 Pulse Survey question "I would recommend my organisation as a place to work" Of those, **1104 (55.53%)** 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	Jan - 2023
TRUST	54.23%	52.46%	52.54%	55.01%	53.60%	54.05%	55.53%
ASSISTANT CHIEF EXEC	69.23%	60.94%	51.61%	61.29%	47.83%	62.86%	56.00%
DIGITAL AND DATA SERVICES	68.09%	60.50%	70.13%	68.00%	57.65%	60.50%	57.50%
DURHAM, TEES VALLEY AND FORENSIC	51.50%	50.76%	50.72%	54.63%	54.64%	53.42%	55.92%
ESTATES AND FACILITIES MANAGEMENT	57.14%	52.43%	46.92%	50.38%	50.76%	41.95%	46.00%
FINANCE	61.54%	57.41%	62.22%	57.58%	61.54%	46.30%	47.37%
MEDICAL	67.44%	78.95%	68.42%	64.10%	65.71%	63.64%	61.36%
NORTH YORKSHIRE, YORK AND SELBY	50.19%	47.92%	50.48%	52.85%	49.89%	55.21%	55.60%
NURSING AND GOVERNANCE	61.90%	56.31%	53.42%	51.95%	35.14%	49.14%	43.53%
PEOPLE AND CULTURE	69.86%	68.00%	57.69%	56.99%	61.05%	61.34%	52.17%
THERAPIES	82.35%	61.54%	62.96%	54.17%	53.85%	47.06%	67.86%



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.

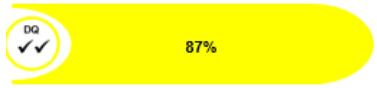
17) Percentage of staff feeling they are able to make improvements happen in their area of work

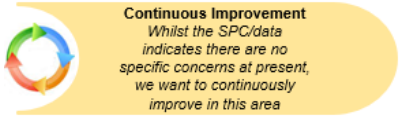
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

2013 staff responded to the January 2023 Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **1214 (60.31%)** 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	Jan - 2023
TRUST	57.10%	57.11%	57.50%	58.76%	59.12%	58.53%	60.31%
ASSISTANT CHIEF EXEC	76.92%	67.19%	67.74%	74.19%	65.22%	80.00%	88.00%
DIGITAL AND DATA SERVICES	65.96%	72.27%	74.03%	72.00%	65.88%	66.39%	65.00%
DURHAM, TEES VALLEY AND FORENSIC	56.23%	54.59%	57.00%	57.98%	58.94%	57.60%	57.35%
ESTATES AND FACILITIES MANAGEMENT	55.24%	26.04%	53.08%	52.67%	51.52%	46.55%	61.00%
FINANCE	65.38%	61.11%	64.44%	69.70%	71.79%	53.70%	57.89%
MEDICAL	67.44%	73.68%	81.58%	79.49%	68.57%	65.45%	70.45%
NORTH YORKSHIRE, YORK AND SELBY	54.44%	56.48%	54.35%	56.45%	55.77%	57.26%	59.12%
NURSING AND GOVERNANCE	61.90%	66.99%	65.75%	63.64%	59.46%	59.48%	69.41%
PEOPLE AND CULTURE	78.08%	77.60%	73.08%	73.12%	69.47%	77.31%	71.74%
THERAPIES	94.12%	58.97%	81.48%	70.83%	69.23%	47.06%	67.86%





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.	**Complete.** Information has been received from York University and this is being used to formulate the below action.	
	NEW *Enabling action*: Associate Director of Leadership & Development to evaluate the information received from York University and the options for engaging with staff more frequently and to develop a detailed plan by the end of September 2023, with a view to increasing staff participation in the survey.		
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*: 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.		

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 28.04.2023	
Enable **100%** of staff to access Foundation training	**13%**	(1000 out of 7603 members of staff)
To have trained **50%** of staff at Intermediate level	**11%**	(828 out of 7603 members of staff)
To have **15%** of staff trained at Leader level	**4%**	(328 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

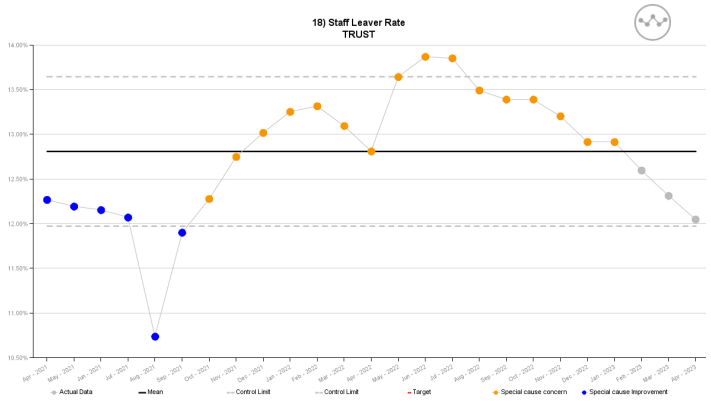
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

From a total of **6921.26** staff in post, **833.88 (12.05%)** had left the Trust in the 12 month period ending April.

No significant change in the data during the reporting period shown

DQ
80%

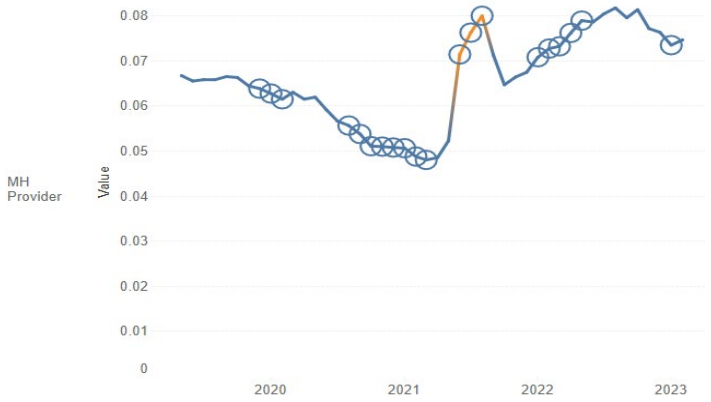
An Area of Concern
We are concerned with our performance in this area and action is required to improve



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

National Benchmarking: NHS Staff Leaver Rate - England Mental Health and Learning Disability – January 2023 (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 8 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~~ July 2023, with a view to improving our staff retention.		
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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

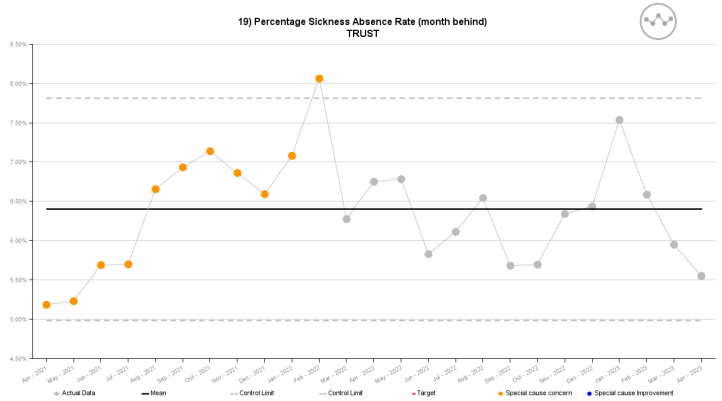
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

There were **227,348.14** working days available for all staff during March (reported month behind); of those, **12,627.33 (5.55%)** days were lost due to sickness.

No significant change in the data during the reporting period shown

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

DQ 73%

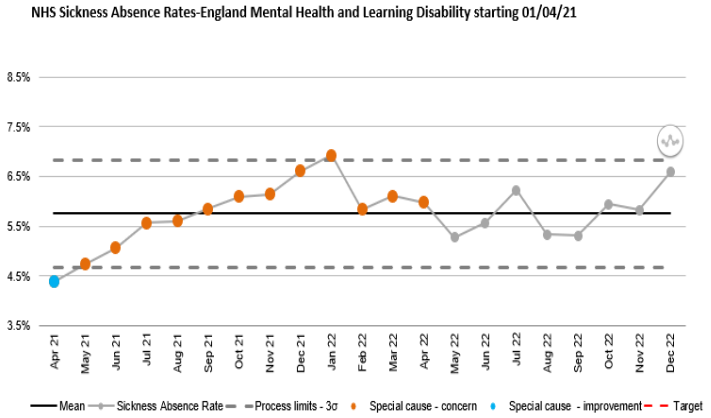


Care Group/Directorate	Variation	Care Group/Directorate	Variation
TRUST		FINANCE	
ASSISTANT CHIEF EXEC	H	MEDICAL	H
COMPANY SECRETARY		NORTH YORKSHIRE, YORK AND SELBY	
CORPORATE AFFAIRS AND INVOLVEMENT		NURSING AND GOVERNANCE	
DIGITAL AND DATA SERVICES		PEOPLE AND CULTURE	
DURHAM, TEES VALLEY AND FORENSIC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

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

NHS Sickness Absence Rates published 27th April 2023 (data ending December 22) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.76% compared to the Trust mean of 6.45%.

Regional Benchmarking: We have seen consistent performance in our sickness absence rates since March 2022 and as at the 16th May 2023, we were positioned 7th (out of 31) for sickness absence within the region's mental health, acute and ambulance trusts.



Update

As at the 29th May 2023, sickness absence is 5.44% for May 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*: 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.	**Complete.** This process is established and over 500 employees have been identified as having 5 or more episodes of absence. The People Partners have started reviewing the cases with the managers, initially focusing on those staff who have had 7 or more episodes. Work is ongoing with those managers who require further support.	Whilst performance remains consistent, April reported the lowest sickness absence rates since May 2021.

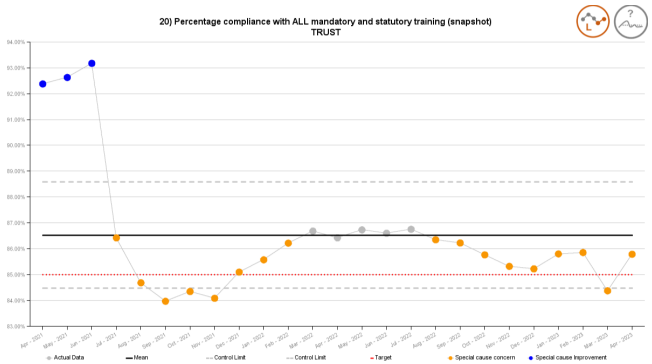
20) Percentage compliance with ALL mandatory and statutory training

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.

129,431 training courses were due to be completed for all staff in post by the end of April. Of those, **111,045** (**85.79%**) courses were actually completed.

Percentage Compliance with Information Governance & Data Security Training. As required by the Information Governance Tool Kit the Trust must achieve 95% staff compliance. As at end of April, **7253** were due for completion, **6727 (92.75%)** were actually completed.



We recognise that the levels of compliance with our mandatory and statutory training may be impacting on our ability to provide high quality and safe services. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

11 initial actions have been agreed, of which 5 are due to be delivered by the end of June 2023; no concerns have been raised regarding timely delivery. 4 actions are longer term projects that require the recruitment of additional trainers and sourcing of additional venues to deliver Positive & Safe Care training and the sourcing of additional training support to deliver Intermediate Life Support training.

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Information

As at the 30th May 2023, compliance for each of the Trust directorates is as follows:

Directorate	Mandatory & Statutory Training	
	Trajectory to achieve 85% compliance:	Data as at 30th May
Trust	Achieving	86.08%
Assistant Chief Executive	Achieving	90.42%
Capital Programme	Achieving	91.23%
Company Secretary	Achieving	90.62%
Corporate Affairs & Involvement	Achieving	95.44%
Digital & Data Services	Achieving	88.74%
Durham, Tees Valley & Forensic	Achieving	86.13%
Estates & Facilities Management	Achieving	93.22%
Finance	Achieving	94.05%
Medical	Achieving	87.69%
North Yorkshire, York & Selby	30th June 2023	84.10%
Nursing & Governance	Achieving	94.15%
People & Culture	Achieving	91.87%
Therapies	Achieving	85.39%
Trust-wide roles	Not Achieving	76.09%

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 **6478** eligible staff in post at the end of April; **5374** (**82.96%**) had an up to date appraisal

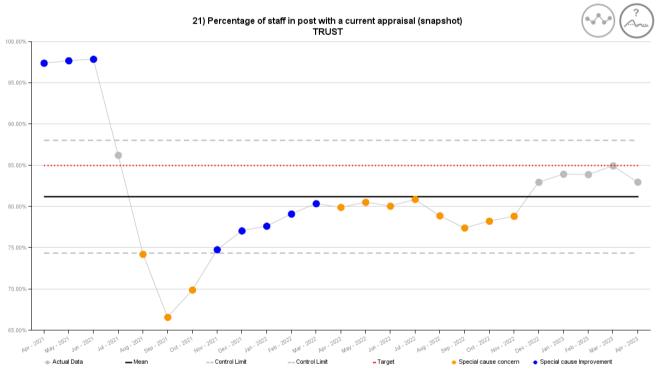
No significant change in the data during the reporting period shown

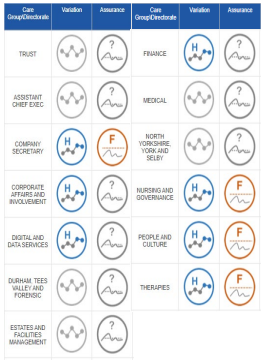
Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area

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

DQ

93%





We recognise that we have a significant number of staff within the Trust that have not received a timely appraisal and that this may be impacting on our ability to provide high quality and safe services. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

4 initial actions have been agreed, all of which are longer term pieces of work that require further training for staff and an increased understanding of specific service pressures.

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Information

As at the 30th May 2023, compliance for each of the Trust directorates is as follows:

Directorate	Appraisal	
	Trajectory to achieve 85% compliance:	Data as at 30th May
Trust	Not achieving	83.02%
Assistant Chief Executive	Achieving	88.24%
Capital Programme	Achieving	100.00%
Company Secretary	Achieving	100.00%
Corporate Affairs & Involvement	Achieving	90.00%
Digital & Data Services	30th June 2023	79.52%
Durham, Tees Valley & Forensic	Not achieving	83.72%
Estates & Facilities Management	Not achieving	79.70%
Finance	Achieving	85.37%
Medical	31st May 2023	83.51%
North Yorkshire, York & Selby	31st May 2023	80.77%
Nursing & Governance	Achieving	89.90%
People & Culture	Achieving	91.51%
Therapies	Achieving	90.48%
Trust-wide roles	Not achieving	66.67%

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

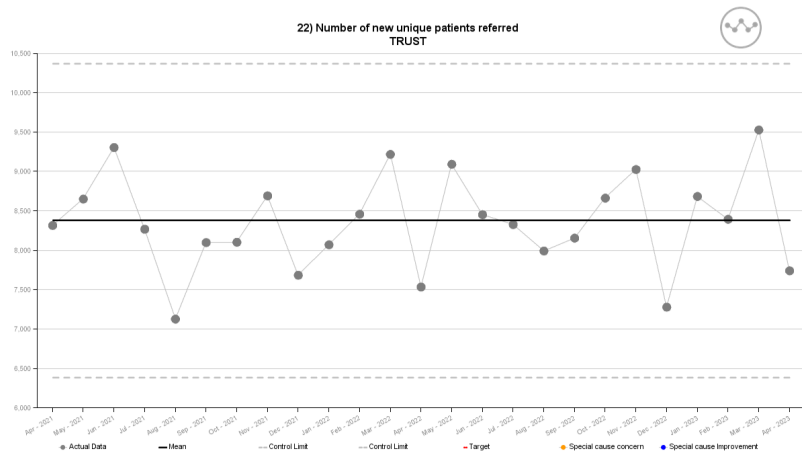
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

7741 patients referred in April that are not currently open to an existing Trust service

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 ★ 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

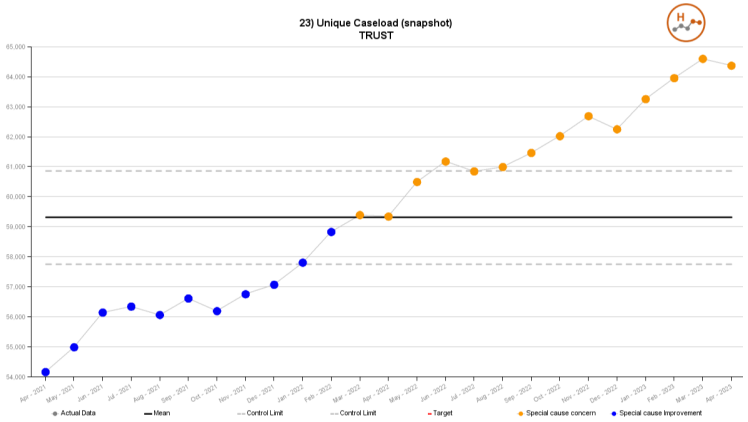
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

64,368 cases were open, including those waiting to be seen, as at the end of April 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

We recognise that the size of caseloads in a number of our services is an area of concern and may be impacting on the delivery of care and may affect our patients' recovery and staff wellbeing. To address this, our care groups have developed **Performance Improvement Plans** that define the actions that are being taken to support improvement and increased assurance.

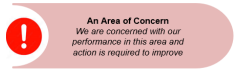
28 initial actions have been agreed across both care groups, of which 6 are due to be delivered by the end of June 2023; no concerns have been raised regarding timely delivery.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We delivered a **£1.49m deficit** (to break even) to 30th April 2023 against a planned year to date deficit outturn of **£1.32m,** resulting in a **£0.17m** deficit to plan.



Summary

The financial position at 30th April 2023 is an operational deficit of **£1.49m** against a planned year to date deficit of **£1.32m,** resulting in a **£0.17m** deficit to plan. Key observations for April were:

- **Agency expenditure** within April 2023 was £1.70m, which was £0.13m under plan. Usage includes material costs linked to inpatient occupancy and rosters, medical cover and complex specialist packages of care.
- **Independent sector beds** - the Trust required 507 bed days during April 2023 (560 for March 2023, 53 bed day decrease) at a cost of £0.46m (includes estimates for unvalidated periods of occupancy and average observation levels pending billing). Year to date expenditure was £0.31m above the plan of £0.15m. This remains a key area of clinical and management focus including CRES monitoring and operational overview through the Bed Oversight Group.
- **EFM Building & Engineering Contracts** for April 2023 was £0.27m, which was £0.17m more than plan. Costs relate to on-call and covering of vacancies, however a mitigation plan is currently being operationalised to reduce this expenditure.
- **Planned CRES performance** as at April 2023 is behind plan by £0.28m. Key variances relate to independent sector bed pressures for AMH and digital hardware with further analysis on-going to capitalise IT Hardware where relevant.

To deliver the 2023/24 financial plan of breakeven the Trust needs to achieve all planned CRES and operate within the planning assumptions contained within the submitted plan. Variation from this will be monitored in year with any necessary recovery actions developed and implemented.

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 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*		
We need to reduce Trust use of independent sector beds.	*A bed pressures **Performance Improvement Plan** that defines the actions that are being taken to support improvement has been developed and shared with Executive Directors for approval.*		
The cost of computer hardware is high and we need to mitigate overspend in this area.	The Digital and Data Team to establish a process by the end of June 2023 to ensure regular data is received into Finance to ensure robust and timely capitalisation of relevant assets		
We need to deliver CRES schemes to achieve our financial plan	Relevant Care Groups / Directorates to ensure that all CRES schemes have an appropriate QIA and delivery plan by the end of June 2023		
EFM building & engineering contracts are over planned expenditure levels	The EFM DMT to establish an expenditure reduction plan by the end of June 2023 to bring expenditure in line with planning assumptions		

We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan . To address this, we have developed **Performance Improvement Plans** that define the actions that are being taken to support improvement and increased assurance.

21 initial actions have been agreed in respect of agency expenditure, of which 12 are due to be delivered by the end of June 2023; no concerns have been raised regarding timely delivery.

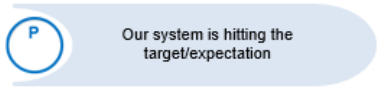
16 initial actions have been agreed in respect of safer staffing; all are due for delivery by or after the end of August 2023.

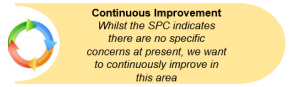
25a) Financial Plan: Agency expenditure compared to agency target

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 £1.70m is £0.13m **(7.4%)** lower than target.





Summary

Agency expenditure of £1.70m is £0.13m (7.4%) lower than target. The planned agency expenditure level for 2023/24 is relatively in line with 2022/23 outturn and has been communicated to ICB colleagues.

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.

We recognise that agency expenditure is significantly impacting our financial plan . To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. 21 initial actions have been agreed, of which 12 are due to be delivered by the end of June 2023; no concerns have been raised regarding timely delivery.

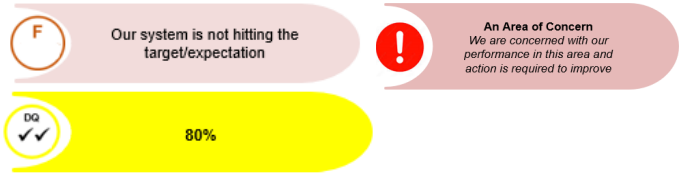
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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 April 2023 there were 4,383 agency shifts worked, with 3,056 shifts compliant **(70%).**



Summary

During April 2023 4,383 agency shifts were worked (101 fewer than March).

Of these, 3,056 or 70% shifts were compliant (63% compliance prior month).

Of the non-compliant shifts 1,237 or 28% breached price caps (compared to 1,565 shifts and 35% prior month) and 90 or 2% breached framework compliance (compared to 101 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.

We recognise that agency expenditure is significantly impacting our financial plan . To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. 21 initial actions have been agreed, of which 12 are due to be delivered by the end of June 2023; no concerns have been raised regarding timely delivery.

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.

Following the financial plan submission to the ICB and NHSI on 4th May 2023 work is ongoing to establish the relevant metrics to enable reporting of the Use of Resources Rating (UoRR). Although this is not yet available for M1 2023/24 reporting this will be included from M2 2023/24 onwards and will include the relevant metrics associated for M1 2023/24.

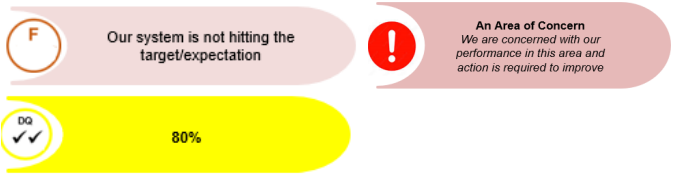
27) CRES Performance - Recurrent

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 **£0.62m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£0.34m**.

£0.28m deficit to plan.



Summary

The Trust has a plan to deliver **£0.62m** recurrent Cash-Releasing Efficiency Savings (CRES) in April 2023 but delivered **£0.34m** resulting in a deficit to plan of **£0.28m**. Following the submission of our financial plan, which includes **£15.5m** recurrent CRES, key areas of focus are:

- 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 behind plan at Month 1 with specific performance noted as:
- £0.24m under-delivery of CRES for OAPs Reduction in AMH, and Care Packages in Health & Justice and AMH rehab in Teesside
- £0.04m CRES for Digital hardware capitalisation
- £0.03m CRES for Taxi spend reduction
- £0.18m CRES for other schemes

CRES Unachieved £0.49m
Off set by:
- (£0.21m) CRES achieved for Travel reduction (hybrid working)

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to deliver CRES schemes to achieve our financial plan	*Please refer to progress for measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit*		

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

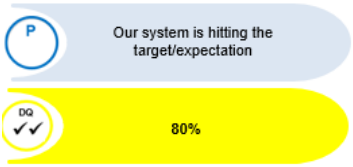
28) CRES Performance – Non-Recurrent

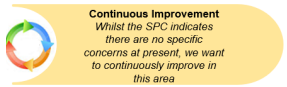
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 plan to deliver **£5.38m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year, however, the actions linked to these schemes are due to be phased in from Q2 onwards therefore the non-recurrent plan for month 1 is nil.

£0.00m variance to plan.





Summary

The Trust did not have a plan to deliver non-recurrent Cash-Releasing Efficiency Savings (CRES) in April 2023. Following the submission of our financial plan, which includes **£5.38m** non-recurrent CRES, key areas of focus are:

- 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.

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 April was **£1.0m** against planned expenditure of **£1.2m** resulting in a **£0.2m** underspend against plan.

Summary

Capital expenditure at the end of April was £1.0m, and is £0.2m lower than allocation of £1.2m.

Health and safety schemes identified after the plan was submitted amount to £0.4m, this is going to be managed within the capital allocation throughout the year.

Any delays to planned schemes will be communicated to the environmental risk group.

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

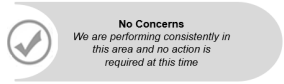
30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We have an actual cash balance of **£75.4m** against a planned year to date cash balance of **£75.4m.**

£0.0m variance from plan



Summary

Cash balances were **£75.4m** at 30th April 2023, which is in line with the planned **£75.4m.**

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 93%. We continue to support the use of Cardea to make processes as efficient as possible, and ensure suppliers are paid promptly.

The value of debt outstanding at 30th April 2023 was £3.3m of which the value of debt over 90 days is £0.3m (excluding amounts being paid via instalments and PIPS loan repayments). This is a reduction of £0.2m compared to debt over 90 days at 31st March 2023. Five government organisations account for 61% of total debts greater than 90 days old (£0.2m). 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			

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measures	Goal 1 - To co-create a great experience for our patients, carers and families	Goal 2 - To co-create a great experience for our colleagues	Goal 3 - To be a great partner
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	√	√	
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care	√	√	
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported	√		
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√		
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√	
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√	
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√	√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√		
BIPD_10	The number of Serious Incidents reported on STEIS	√	√	
BIPD_11	The number of incidents of moderate harm and near misses	√		
BIPD_12	The number of Restrictive Intervention Incidents	√	√	
BIPD_13	The number of Medication Errors with a severity of moderate harm and above	√		
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		
BIPD_15	The number of uses of the Mental Health Act	√		√

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Measures		Goal 1 - To co-create a great experience for our patients, carers and families	Goal 2 - To co-create a great experience for our colleagues	Goal 3 - To be a great partner
BIPD_16	Percentage of staff recommending the Trust as a place to work	√	√	√
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√
BIPD_18	Staff Leaver Rate	√	√	√
BIPD_19	Percentage Sickness Absence Rate	√	√	√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√	√	√
BIPD_21	Percentage of staff in post with a current appraisal	√	√	√
BIPD_22	Number of new unique patients referred	√	√	√
BIPD_23	Unique Caseload (snapshot)	√	√	
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit			
BIPD_25a	Financial Plan: Agency expenditure compared to agency target			
BIPD_25b	Agency price cap compliance			
BIPD_26	Use of Resources Rating - overall score			
BIPD_27	CRES Performance - Recurrent			
BIPD_28	CRES Performance - Non-Recurrent			
BIPD_29	Capital Expenditure (CDEL)			
BIPD_30	Cash balances (actual compared to plan)			

Which risk(s) within our Board Assurance Framework does this measure support/provide assurance towards?

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Measures		1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. 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

Mental Health Priorities including National Quality Standards

Mental Health Priorities including National Quality Standards

Tees, Esk and Wear Valleys NHS Foundation Trust

There are 6 National Quality Standards for 2023/24 and 4 Mental Health priorities for which we have agreed local plans for delivery. Of the Mental Health Priorities, one measure is monitored at Trust level with the remainder (3) monitored at ICB sub location.

Mental Health Priorities

Our performance against the Trust level plans are provided in the table below.

Mental Health Contract Trust Standards	Agreed Standard for 2023/24	Q1 (Apr)
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	Q1 334 Q2 246 Q3 153 Q4 60 (North East & North Cumbria only)	1228

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

The remaining 6 National Quality Standards and 3 Mental Health priorities are monitored at Sub-ICB Location (S-ICBLs) level. Whilst the National Quality Standards have nationally applied targets, the Trust has agreed trajectories for the Mental Health priorities with our commissioning S-ICBLs, agreeing to improved trajectories where there was either 2022/23 investment that had not fully worked through into improved performance or where quality improvement work held out the prospect of increased performance.

There are several areas that are at risk of achieving the national quality standards or local priority trajectories; these are outlined in the following pages. As part of the new Accountability Framework, we have developed **Performance Improvement Plans** for our commissioned services that define the actions that are being taken to support improvement and increased assurance.

25 initial actions have been agreed across the care groups, of which 8 are due to be delivered by the end of June 2023; no concerns have been raised regarding timely delivery.

County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **2** national quality standards and **1** local priority that are at risk for delivery for quarter 1.

NATIONAL QUALITY REQUIREMENTS		
Measure	**Agreed S-ICBL Ambition**	**Apr**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	87.30%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	80.00%

LOCAL QUALITY REQUIREMENTS		
Measure	**Agreed S-ICBL Ambition**	**Apr**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 12448 Monthly 1037	810

Tees Valley Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **2** national quality standards and **1** local priority that are at risk for delivery for quarter 1.

NATIONAL QUALITY REQUIREMENTS		
Measure	**Agreed S-ICBL Ambition**	**Apr**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	91.76%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	57.14%

LOCAL QUALITY REQUIREMENTS		
Measure	**Agreed S-ICBL Ambition**	**Apr**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 2260 Monthly 188	160

North Yorkshire Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **2** national quality standards and **2** local priorities that are at risk for delivery for quarter 1.

NATIONAL QUALITY REQUIREMENTS		
Measure	**Agreed S-ICBL Ambition**	**Apr**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	79.59%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	85.71%

LOCAL QUALITY REQUIREMENTS		
Measure	**Agreed S-ICBL Ambition**	**Apr**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 8627 Monthly 719	579
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 71 Q2 142 Q3 213 Q4 284	53

Vale of York Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **4** national quality standards and **2** local priorities that are at risk for delivery for quarter 1.

NATIONAL QUALITY REQUIREMENTS		
Measure	**Agreed S-ICBL Ambition**	**Apr**
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	80%	67.57%
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	60%	54.55%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	79.03%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	75.00%

LOCAL QUALITY REQUIREMENTS		
Measure	**Agreed S-ICBL Ambition**	**Apr**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 7096 Monthly 40	478
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 60 Q2 120 Q3 180 Q4 240	25

Tees, Esk and Wear Valleys
NHS Foundation Trust

Finance Update

Council of Governors – June 2023

2022/23 Financial Performance Summary

The Trust's draft annual accounts for 2022/23 report a composite deficit of £7.27m, which is £8.43m worse than planned. The accounts position includes £8.08m technical asset impairments and peppercorn lease depreciation £0.405m, both of which are excluded when assessing NHS providers' financial performance.

Excluding impairments and peppercorn lease depreciation the Trust reports an unaudited **operational surplus of £1.21m** which was **£0.05m better than the planned £1.16m surplus**.

The challenging 2022/23 Financial Plan targeted delivery of a stretching **£13.7m, or 3% Cash Releasing Efficiency Savings (CRES),** net CRES performance inclusive of non-recurrent recovery actions for the year was in line with plan however left an anticipated residual recurrent challenge, including on Out of Area Placement and Agency staffing costs.

2022/23 Revenue Position: The year-end deficit reflects higher than planned costs in several key areas, including:

- **Elevated bed occupancy,** driven by increased lengths of stay and driving higher than commissioned safer staffing levels (including agency staffing); and exacerbated by delayed transfers of care.

- **Elevated and increasing levels of agency expenditure**, including premium rates associated with cover for rising medical vacancies, support for a small number of complex care packages for Adults with a Learning Disability, and ongoing safe staffing, absence and vacancy cover for inpatient services.

- The ongoing need for **Independent Sector bed placements** due to rising bed pressures for Adult Mental Health Assessment and Treatment and PICU beds, with additional risk due to numbers of delayed transfers for Older Adults, and closure to ALD admissions.

Cash balances were £75.2m and £10.6m above plan as of 31st March 2023. This incorporates higher than planned working balances and additional commissioner funding for cost pressures.

2022/23 Capital Position: Capital expenditure was broadly on plan at **£9.7m, or £0.4m below plan** to 31st March 2023.

In-year slippage supported the Trust to replace £0.3m end of life defibrillators throughout the Trust. The Trust received £3.0m additional national capital funding for Crisis and Liaison services, of which £2.9m was spent during the financial year (balance to be spent 2023/24) and £1.7m capital funding to support IT frontline digitisation costs (fully expended).

2023/24 Financial Plan

The Trust met the national deadline for submitting final financial plans for 2023/24 to NHS England (NHSE) on 4th May 2023, following approval by the Board at the end of April 2023. This followed several discussions with regional Integrated Care Board (ICB) partners and feedback to them via NHS England.

2023/24 Revenue Plan: Plans reflect a breakeven revenue position (our income and expenditure will be the same) but **include a stretching £20.85m CRES requirement.** This is significantly greater than the national tariff efficiency assumption of 1.1% but is consistent with regional ICB and national NHSE expectations, with additional

Tees, Esk and Wear Valleys
NHS Foundation Trust

Finance Update

Council of Governors – June 2023

efficiencies being driven by the reduction of national Covid funding, excess non pay inflation, unfunded accumulated pay award pressures, unachieved prior year (recurrent) CRES, and other local cost pressures including relating to inpatient and medical staffing referenced above.

Plans assume an additional 1.3% vacancy factor (impact of staffing turnover) Trust wide.

Key concerns include management of local cost pressures, the differential underfunding of pay award costs for non-acute providers and industry inflationary indices.

Trust services are experiencing ongoing operational pressures, including through increased community caseloads and elevated inpatient lengths of stay, with over occupancy driving out of area placements and elevated safer staffing pressures compared to commissioned levels.

2023/24 Month One Reporting

Month One Revenue Position: revenue performance for the month ending 30th April 2023 is a **deficit of £1.49m, which is £0.16m worse than plan (a deficit of £1.32m).** Key issues are broadly consistent with those areas experiencing pressure during 2022/23:

- **Independent sector bed utilisation.** The plan anticipated 7 beds in use during April, but with average usage of 16 beds. Bed pressures are an ongoing challenge, with 21 Independent Sector assessment and treatment beds currently in use (11 female and 10 male).

- **Agency expenditure is £1.7m**, or 5.5% of pay spend, which is £0.1m lower than planned and includes material costs linked to inpatient rosters, medical cover, and complex adult Learning Disability specialist packages of care (for which 3 North Yorkshire discharges are forecast in quarters 2-3)

- **Estates Building & Engineering Contracts** for April 2023 were £0.3m, or £0.2m more than plan, off set in part by £0.06m pay underspending. Costs relate to on-call and covering of vacancies; however new roles are being operationalised following the approval of revised bandings and job descriptions to align pay with regional peers.

- **CRES performance is behind plan by £0.3m,** largely resulting from unachieved CRES in independent sector bed utilisation of £0.16m (referenced above) and an under-achievement of non-pay grip and control (IT and transport).

Month One Cash balances: were **£75.4m, or in line with plan** as of 30th April 2023, with the small adverse revenue and favourable capital plane variances offsetting.

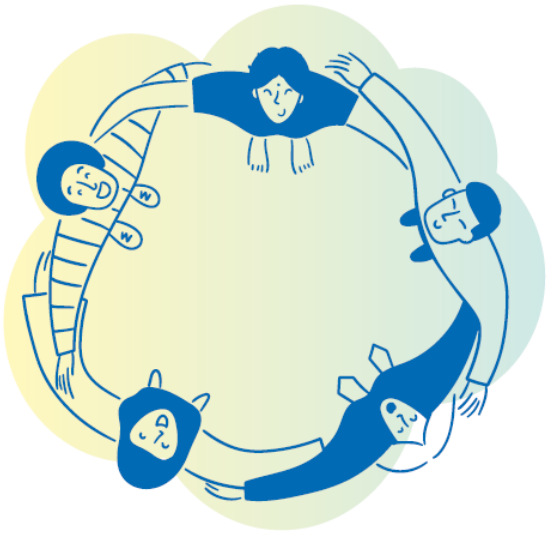
M1 Capital Position: The Trust agreed a **£16.2m capital plan for 2023/24** with £13.9m funded from our ICB capital allocation**.** The phased **capital plan for April was £1.25m**, with **expenditure of £1.03m,** resulting in **£0.22m slippage.**

Capital Forecast 2023/24 Outturn

The Trust projects fully committing the total regional capital allocation and is likely to need to re-prioritise the programme to incorporate:

i) £0.4m new health and safety related approvals and
ii) potential fast tracking of a door sensor programme (subject to business case).

These items will be included in a refreshed forecast to support management within the Trust's current regional capital allocation and/or agreement with NENC partners during 2023/24 to vary forecasts.



Tees, Esk and Wear Valleys
NHS Foundation Trust

2023/24 Financial Plan / Budget

Council of Governors

15th June 2023

Respect Compassion Responsibility

journey to change

What income will we receive in 2023/24 and how will it be expended?

Tees, Esk and Wear Valleys NHS Foundation Trust

	2023/24 £000's	Q1 £000's	Q2 £000's	Q3 £000's	Q4 £000's
Contracted Income:					
NENC ICB	**245,925**	61,481	61,481	61,481	61,481
HNY ICB	**111,017**	27,754	27,754	27,754	27,754
West Yorkshire ICB	**1,581**	395	395	395	395
Provider Collaboratives	**46,394**	11,599	11,599	11,599	11,599
NHS England - Specialist Services Contract	**8,759**	2,190	2,190	2,190	2,190
Health and Justice - inc. Spectrum contract	**8,497**	2,124	2,124	2,124	2,124
Non Contracted Actvity	**632**	158	158	158	158
Local Authorities	**2,820**	705	705	705	705
Other Clinical Income	**5,788**	1,257	1,364	1,578	1,590
Income from activities	**431,413**	**107,663**	**107,770**	**107,984**	**107,996**
R&D Income	**2,745**	686	686	686	686
Non patient care income	**1,376**	344	344	344	344
Education and Training income	**13,171**	3,264	3,264	3,264	3,381
Other operating income	**3,720**	930	930	930	930
Other operating income	**21,012**	**5,224**	**5,224**	**5,224**	**5,341**
Total Income	**452,425**	**112,887**	**112,994**	**113,208**	**113,337**
Pay Expenditure	**(363,338)**	(92,689)	(91,556)	(90,483)	(88,610)
Non Pay Expenditure	**(86,933)**	(23,008)	(22,426)	(22,400)	(19,099)
Operating surplus / (deficit)	**2,154**	**(2,810)**	**(988)**	**325**	**5,628**
Interest Receivable	**2,338**	610	576	576	576
Interest Payable	**(1,366)**	(342)	(342)	(342)	(342)
Public Dividend Capital Payable	**(3,126)**	(783)	(781)	(783)	(781)
FORECAST SURPLUS / (DEFICIT)	**0**	**(3,324)**	**(1,534)**	**(223)**	**5,082**
Surplus / (Deficit) as a percentage of turnover	***0.0%***	***-2.9%***	***-1.4%***	***-0.2%***	***4.5%***

Income

- We expect to receive £431.4m of from activities, of which £422.2m (97.9%) represents contracts with ICBs, NHS England, Health and Justice, and Foundation Trusts (as part of partnerships known as provider collaboratives).
- In addition we estimate £21m of other operating income (non-clinical activity which is largely training and education and research)

Pay

- Pay costs included pay award estimates of 2.1% (per NHS 2023/24 plan guidance). The final 5% Agenda for Change award will be partially mitigated by additional income in-year and as confirmed with ICBs.
- Efficiency schemes relating to pay are (£8.2m).

Non Pay

- Non pay budgets have been inflated by 5.5% (a weighted uplift across several categories), utilities receiving the highest increase at 29%.

General assumptions

- Assumptions underpinning the detailed workings have been taken from 2022/23 run rates adjusted for:
  - Non-recurrent income and expenditure e.g. covid funding
  - Full year effect of in-year contract changes & developments
  - Business planning priorities e.g. Autism training, Involvement and Engagement, Electronic Patient Record, Cyber Security

Financing Costs (Interest receivable and payable and PDC)

- Plans take account of cash balances, inflation and revenue and capital plan, and are consistent with NHS 2023/24 plan guidance.

£20.85m (4.6%) 2023/24 Efficiency Requirement – What areas are we targeting?

Tees, Esk and Wear Valleys NHS Foundation Trust

2023/24 Efficiency Schemes	Rec / N Rec	Low £000	Medium £000	High £000	Total £000
Agency Rate & Volume Reductions - Corp	Rec		580		580
Agency Rate Reductions - Medical (VAT)	Rec		215		215
Agency Volume Reductions - Medical/Nurse (International Recruit) - business plan	Rec		255		255
Agency Rate Reductions - Inpatient off framework / other rate reductions	Rec		290		290
Agency - Volume reductions - Inpatient level loading of rosters	Rec		600		600
Agency Usage Reduction - LD Packages (P2 Aug-23)	Rec		250		250
Agency Usage Reduction - LD Packages (P1 Dec-23)	Rec			211	211
BCU / LRH Site consolidation - staffing cost reductions	Rec			250	250
Other Identified Recurrent actions - Pay	Rec	1,212			1,212
Surge post establishment review - Pay	Rec			2,794	2,794
Non Recurrent Grip & Control Trustwide (Pay)	N Rec	1,500			1,500
OAPS Exceptional Care Packages (OAPs) Secure Inpatient	Rec		381		381
OAPS NY&Y OATs targeted planned discharges	Rec		400		400
OAPS Reduction in OAPs Rehab	Rec		840		840
OAPS Reduction in OAPs AMH	Rec			2,726	2,726
Prescribing reduction - Off Patent	Rec		400		400
Discretionary Spend CIP-Taxi spend reduction	Rec		326		326
Procurement (excl drugs) - non-clinical Procurement	Rec		500		500
Digital - IIC	Rec	353			353
Digital - Hardware	Rec	500			500
Digital - Microsoft Licenses	Rec	70			70
Travel Hybrid working	Rec	565			565
Recurrent Grip & Control Pressures (Non Pay)	Rec		350		350
Recurrent Grip & Control Trustwide Recovery Actions / budget rebasing (Non Pay)	Rec	1,000			1,000
Procurement - Target estates non-pay contract reduction	Rec		400		400
Non Rec Grip & Control Trustwide Recovery Actions / budget rebasing (Non Pay)	N Rec		1,580		1,580
Non Recurrent Grip & Control (Non Pay)	N Rec	2,300			2,300
Total 2023/24 Efficiency Schemes		**7,500**	**7,367**	**5,981**	**20,847**
		36%	*35%*	*29%*	100%

CRES:

- Required Efficiencies exceed national tariff levels (1.1%) but are in line with regional partner plans and national expectations.
- The excess is required to bridge the gap between income and local cost pressures – inc. accumulated unfunded pay award, excess non-pay inflation, reducing national Covid funding, medical, Adult LD care packages and inpatient agency cover and out of area placement pressures.
- Care Groups and Corporate Teams completing Project Initiation Documents (PIDs) for desktop or full Quality Impact Assessment

Statement of Financial Position 2023/24

Tees, Esk and Wear Valleys NHS Foundation Trust

	31/03/2023	31/03/2024	Notes	In Year Movement
	£000	£000		£000
ASSETS, NON-CURRENT				
Intangible Assets	16	0	1	(16)
Property, Plant and Equipment	163,423	172,778	2	9,355
Trade and Other Receivables	558	555		(3)
	163,997	**173,333**		**9,336**
ASSETS, CURRENT				
Inventories	856	856		0
Trade and Other Receivables	34,466	16,728	4	(17,738)
Cash and Cash Equivalents	75,171	62,932	3	(12,239)
	110,493	**80,516**		**(29,977)**
ASSETS TOTAL	**274,490**	**253,849**		**(20,641)**
LIABILITIES, CURRENT				
Trade and Other Payables: Capital	(6,037)	(6,092)		(55)
Trade and Other Payables: Non Capital	(61,939)	(43,819)	4	18,120
Borrowings	(3,034)	(2,776)		258
Provisions	(1,607)	(1,133)	5	474
	(72,617)	**(53,820)**		**18,797**
LIABILITIES, NON-CURRENT				
Borrowings	(25,398)	(22,992)		2,406
Provisions	(8,821)	(7,647)	5	1,174
	(34,219)	**(30,639)**		**3,580**
LIABILITIES TOTAL	**(106,836)**	**(84,459)**		**22,377**
TOTAL ASSETS EMPLOYED	**167,654**	**169,390**		**1,736**
Taxpayer's Equity				
Public dividend capital	160,212	161,948	6	1,736
Income and expenditure reserve	1,115	1,115	7	0
Other Reserves				
Revaluation reserve	6,327	6,327		0
TOTAL TAXPAYERS EQUITY	**167,654**	**169,390**		**1,736**

- The statement of financial position summarises the Trust's assets (what it owns), liabilities (what it owes), and equity (assets less liabilities).
- The positions as at the end of March 2023 and forecast to the end of March 2024 are shown, with notes to explain the larger expected in-year changes

Notes

1 The carrying value of intangible digital asset licences are reducing as they come to end of life.

2 Property Plant & Equipment (in addition to capital expenditure) and Borrowings reflect in-year impacts of International Reporting standards for leases (IFRS16).

3 Cash movements reflect the breakeven plan and internally funded capital costs offset by movements on working capital balances and PDC funding received for capital schemes.

4 Trade and Other Payables: Non Capital and Trade and other receivables at March 2023 include the NHS non-consolidated pay award, cash payable in 2023/24.

5 Provisions are reducing as used, or are deemed no longer required and are reversed.

6 Public dividend capital increased as the Trust will receive funding for capital schemes (e.g. Frontline Digitisation).

7 Income and expenditure reserve movements reflect the breakeven plan.

2023/24 Cashflow Forecast – What changes in cash do we expect in the next 12 months?

Tees, Esk and Wear Valleys NHS Foundation Trust

		£000
Closing Cash position 31 March 2023		75,171
Operating surplus / (deficit)		2,154
Add depreciation and peppercorn lease (non cash)		6,456
Interest Payable	(1,366)	
Interest Receivable	2,338	
PDC Payable	(3,126)	
Financing Cashflows		(2,154)
Movement in Working Capital		(1,567)
Expenditure on Capital Programme		(16,200)
PDC receivable		1,736
Repayment of borrowings (PFI leases)		(2,664)
Forecast Closing Cash 31 March 2024		**62,932**

- £2,154k operating surplus less (£2,154k) financing charges equates to breakeven revenue plan for 2022/23
- Cashflows exclude non-cash revenue transactions (depreciation & peppercorn leases)
- Depreciation charges contribute to Capital Programme expenditure (internally funded capital) – the balance of the Programme costs being a net reduction in Trust cash reserves.

2023/4 Capital Plan – what are our planned estate and infrastructure enhancements?

Tees, Esk and Wear Valleys NHS Foundation Trust

Capital Scheme	2023/24
	£000
Teesside health & safety	316
Sensor Door assistive technology	2,520
Oxehealth assistive technology	522
Anti-ligature windows (Farnham & Tunstall)	200
CCTV improvements	360
RPH - change in corridor lighting to controllable / dimmable	85
RPH, WPH and LRH Lifecycle works	3,482
Trust Lifecycle - essential	788
Combined heating & power solutions lifecycle	118
Digital Lifecycle	1,200
Patient reporting system (Frontline Digitalisation funded)	1,666
Capital team salaries	576
Stockton crisis modular build (continuation of 2022/23)	1,275
Ridgeway activity centre & bed confguration Block 10	195
Medical education suite - LRH	1,500
PLACE recommendations	360
Furniture & equipment general	200
H&S "must dos" inc. anti-ligature identified in-year	500
Other Low Value Schemes	337
Total 2023/24 Capital Expenditure Plan	**16,200**

2023/24 Capital	£000s
Capital Expenditure Plan	**16,200**
less PFI lifecycle (LRH)	(596)
less PDC funded developments	(1,736)
Capital Expenditure (regional allocation measurement)	**13,868**
add Residual interest on PFI scheme	330
add PDC funded developments	1,736
CDEL Expenditure	**15,934**

- Our regional capital allocation via NENC ICB is £13.9m
- In addition we will receive £1.7m national cash-backed capital and pat £0.3m interest chargeable against CDEL (capital departmental expenditure limit)

ITEM NO. 10d

For General Release

Meeting of: **Council of Governors**
Date: **15 June 2023**
Title: **CQC Compliance Update Report**
Executive Sponsor(s): **Beverley Murphy, Chief Nurse**
Avril Lowery, Director of Quality Governance
Author(s): **Leanne McCrindle, Associate Director of Quality Governance, Compliance and Quality Data**
Peter Hutchinson, Quality Governance Manager

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 delivery of the CQC action plan resulting from CQC inspections is related to multiple BAF risks, however the monitoring and oversight of the CQC action plan relates specifically to the BAF risk 11 (Governance Assurance): • **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. The risk management approach detailed within the BAF risk 11 (Jan-23) is as follows: • The target risk score is above tolerance levels and the Trust has a minimal appetite for regulatory risks. • Urgent action to be taken to strengthen controls but a higher degree of exposure than acceptable will need to be tolerated. • Regular monitoring of the risk advisable. The report provides details of CQC inspection activity as well as an update in relation to the actions undertaken in response to all CQC must do actions from the most recent CQC inspections. There is good oversight and delivery of the CQC action plan.

Executive Summary:

Purpose: The purpose of this report is to present to the Council of Governors the status of the actions arising from the CQC Trust core service and well-led inspection 2021, as well as the CAMHS, Secure Inpatient Service and Adult Learning Disability focused inspections which took place in 2022. In addition, to provide Governors with an update on the CQC inspection activity 29 March – 26 May 2023.

Proposal: It is proposed that the Council of Governors receive this update with **good** assurance regarding the oversight and delivery of the CQC action plan. It is further requested that the Council of Governors receive the recent CQC inspection activity update. No new gaps in assurance or mitigating actions have been escalated or proposed by management within this report.

Overview: The good overall assurance level has been determined by management based on the progress reported on the Trust's CQC Action Plan and the associated assurance evidence provided. Monitoring continues to be maintained by the corporate Quality Governance Team and by the responsible Lead Directors and operational Managers reporting to the Executive Directors Group.

CQC Must Do Action Plan:

An update on the Trust CQC Must Do action plans is presented as **Appendix 1** of this report. All actions scheduled for completion during the reporting period have been achieved within given timescales, with the exception of four (detailed below) for which an extension request was agreed by the Quality Assurance Committee to facilitate sustained delivery. Where actions are complete, the focus remains on embedding the changes in practice and sustaining these improvements.

The report provides good assurance regarding compliance with the respective CQC Fundamental Standards. It is envisaged that the focus on accelerating the Our Journey to Clinical, Quality and Safety Programme will support the embedding of high impact actions to address key quality, safety and regulatory concerns.

The CQC action plan status as at **25/05/2023** was as follows:

Core Service and Well-led 2021 actions:

- 69 (93%) actions are complete
- 5 (7%) actions are on track with little risk to delivery

CAMHS Community Re-inspection 2022 actions:

- 9 (100%) actions are complete

ALD Re-inspection 2022 actions:

- 4 (10%) actions are complete

SIS Re-inspection 2022 actions:

- 41 (87%) actions are complete
- 2 (4%) actions are on track with little risk to delivery
- 4 (9%) actions have some risk to delivery

CQC Inspection Activity:

The CQC Core Services inspections commenced 29 March 2023 and the CQC have visited 6 core services to date. Details of the wards/teams inspected by each core service can be viewed as Appendix 2 of this report.

The Trust Well-led Inspection took place 24 – 26 May 2023 where interviews were undertaken with Executive and Non-Executive Board Members and other Senior Leaders. The CQC also undertook Focus Groups, including with the Council of Governors, Staff Side representatives, Staff Network Groups and Trainee Doctors. In addition to onsite inspections, the CQC also submitted 251 information requests (as at 06.06.23). The Quality Governance Team have continued to work in collaboration with clinical and corporate services to coordinate responses to all CQC information requests.

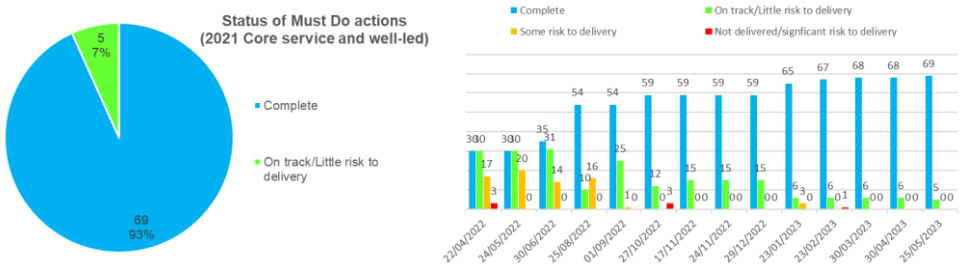
Twice daily oversight meetings were held with relevant senior leaders and executives throughout the inspection windows, to receive early feedback and take timely actions. No immediate quality or safety issues were escalated by the CQC to the Trust's Nominated Individual during the core service inspections.

The Trust have received two feedback letters from the CQC (05.06.22 and 02.06.23) about the services inspected. To communicate the findings to date with leaders and staff, a slide set has been developed. This is attached for information as Appendix 3.

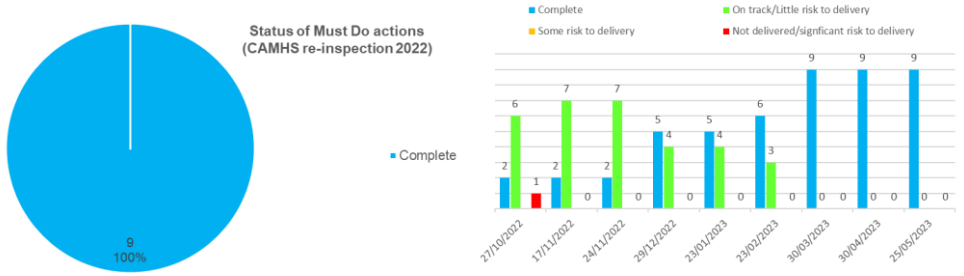
Prior Consideration and Feedback	Monthly updates are provided to the Executive Quality Assurance and Improvement Group and the Quality Assurance Committee in relation to delivery of the CQC Must Do action plan and CQC inspection activity.
Implications:	There are no identified implications in relation to receipt of this report by the Council of Governors.
Recommendations:	The Council of Governors is invited to note the CQC inspection activity and the CQC action plan progress update provided.

Appendix 1 – Assurance of CQC Must Do Action Delivery

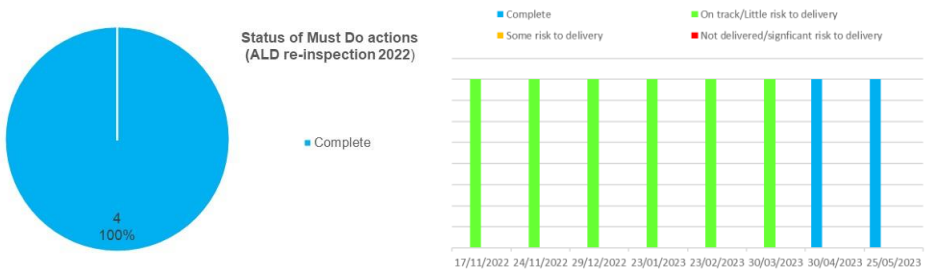
Core Service and Well-led 2021:



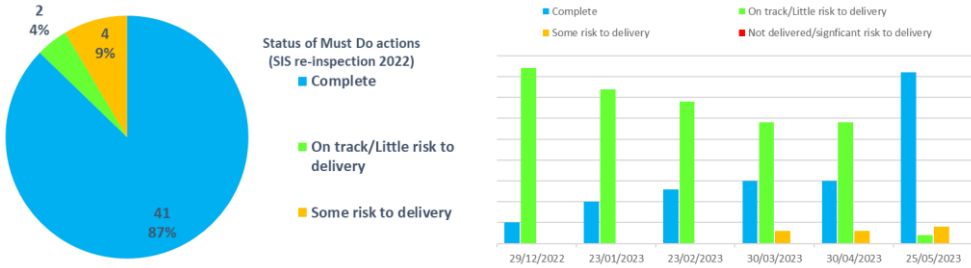
CAMHS Community Re-inspection 2022:



ALD Re-inspection 2022:



SIS Re-inspection 2022:



Appendix 2 – CQC inspection activity for Core service inspection commencing 29th March 2023

Core Service	Wards/ Teams			Dates of Inspections
Acute Adult Mental Health Wards and Psychiatric Intensive Care Wards	• Stockdale • Overdale • Farnham • Tunstall • Cedar PICU	• Bedale PICU • Bransdale Maple • Elm • Esk	• Danby • Bilsdale • Ebor • Minster	**29.03.23 – 20.04.23**
Mental Health Services for Older People Wards	• Rowan Lea • Ceddesfeld • Wold View • Moor Croft	• Westerdale North • Westerdale South • Springwood	• Hamsterley • Roseberry • Oak	**18.04.23 – 21.04.23**
Adult Learning Disability Wards/ Day Service	• Bankfields Court	• Talbot	• Aysgarth	**19.04.23 – 21.04.23**
Community Adult Learning Disability Teams	• LD York Community Team • LD Scarborough, Whitby, Ryedale • LD Harrogate and Craven	• Durham Integrated Learning Disabilities Team • The Orchard Day Service	• LD Darlington • North Tees LD Community	**25.04.23 – 27.04.23**
Community Adult Mental Health Teams	• AMH Central Community Team • AMH North Community Team • York and Selby Early Intervention in Psychosis • North Dales Community Mental Health Team • South Dales Community Mental Health Team	• Whitby and Ryedale Integrated Community Team • York Outreach Recovery Team • Easington South • Easington North • Whitby and Ryedale Early Intervention in Psychosis	• Scarborough Community Mental Health Team • West Community Mental Health Team • South Teesside Ryedale Early Intervention in Psychosis • Middlesbrough Access and Affective Disorders Team • Middlesbrough Psychosis	**23.05.23 – 26.05.23**
Secure Inpatient Services	• Brambling • Ivy/ Clover • Lark • Mallard • Mandarin	• Kestrel/ Kite • Linnet • Hawthorn/ Runswick • Merlin	• Newtondale • Swift • Sandpiper • Eagle/ Osprey	**24.05.23 – 26.05.23**

Appendix 3


NHS
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NHS Foundation Trust
CQC inspections early feedback
Beverley Murphy
Chief Nurse
6 June 2023
1

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NHS Foundation Trust

Core services inspection commenced on 18 April 2023, including:

- Acute Adult Mental Health wards
- Mental Health Services for Older People wards
- Adult Learning Disability wards
- Adult Learning Disability day service
- Community Adult Learning Disability teams

Well-led Inspection took place from 24-26 May 2023

To date, over 200 information requests have been received and most of these have been submitted to the CQC. Thank you for your help with this.

2

Acute wards and psychiatric intensive care units

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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 a ward at West Park Hospital. Two specific points were raised relating to safety and privacy and dignity.
- One ward at West Park Hospital , staff were not wearing uniforms which meant they were not identifiable to the inspection team and patients.

Acute wards and psychiatric intensive care units

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.

4

Inpatient mental health wards for older people

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.
- On one older adult ward 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.

Inpatient mental health wards for older people

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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 initiative 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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.

7

Wards for people with a learning disability or autism

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.

8

Community mental health services for people with a learning disability

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.

Community mental health services for people with a learning disability

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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.

10

Trustwideand well-led feedback

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- We received positive feedback about the diversity, culture and constructive challenge at our Board and the commitment to the trust's strategy and direction and our clear understanding of the organisation's direction, vision and values.
- The CQC found that leaders had a range of skills and were knowledgeable about risks and issues in the trust.
- We have seen clear examples of person centred care delivered by trust staff with kindness, respect and dignity.
- The improvements in our governance were recognised and we have been encouraged to look to make our systems less complex which is work we have underway.
- We have more to do to ensure that service user and carer experience is heard and embedded.

Trustwideand well-led feedback

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- We need to ensure that our reports to the Board make even more clear the things we are trying to improve such as restrictive practices, staffing issues and risks to safety for patient safety which would highlight risk including; restrictive interventions and numbers of incidents.
- We have work to do to improve our timeliness of incident and complaint reviews, to ensure we consistently meet and demonstrate duty of candour standards and to ensure we conduct mortality reviews to the standard we have set ourselves. All areas we are already focussed on.
- Mandatory training and supervision compliance have been emphasised as an area of improvement for us all.
- We need to explore if there is more we can do operationally and strategically to reduce waits in older adults memory services and in CAMHS neurodevelopmental assessments.
- We need to think about the services in business continuity and assure ourselves that recovery plans are in place and how these were monitored.

12

Trustwideand well-led feedback

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- Staffing challenges were cited as the most common reason impacting upon their morale. Staffing levels differ across the wards and service areas and some wards are managed with only one nurse per shift.
- Staff told the CQC that they were in receipt of basic life support training but not immediate life support training, which is 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).
- Our observation policy does not outline the manner in which staff should record observations of patients who are on enhanced levels of observation.

Next steps…..

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- The CQC will complete corroboration
- We will receive draft report for factual accuracy checking on or around 2 August 2023
- Report publication

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Thank you!

15

ITEM NO. 11

General Release

Meeting of: **Council of Governors**
Date: **15 June 2023**
Title: **Quality Account 2022/23**
Executive Sponsor(s): **Beverley Murphy, Chief Nurse**
Author(s): **Avril Lowery, Director of Quality Governance**

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

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

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

Contribution to the delivery of the Strategic Goal(s):
The Quality Account is a statutory document, with a prescribed format. It allows us to set out in detail the quality context (strengths and issues) facing the Trust. By setting out the progress and impact of 2022/23's quality improvement priorities and our plans for 2023/24 it allows our partners to understand and comment on what we intend to do. The actions set out for next year should also improve the quality and safety of our services.

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
NA	**NA**	***This is a statutory report and so its purpose is not to provide assurance on the BAF. However, the improvement actions set out in the document mitigate BAF risks 4, 6 and 9 (experience, safety and regulatory action)***

Executive Summary:

Purpose: The Council of Governors is presented with the Quality Account 2022/23.
It is essential that the Council of Governors have an opportunity to make their own comments on the draft Quality Account document (Appendix 1) prior to submission of the document to the Board of Directors'. Please note that there are still some minor additions to be included that are currently being validated.

Proposal: Comments will be considered and where possible appropriate changes made prior to the Board of Directors' consideration of the final document.

Overview: Every NHS provider must complete and publish a Quality Account by 30th June 2023. This must include statutory reports on the previous year's quality data and the updates

	in terms of the completion of quality improvement priorities for the previous year. It must also include between 3 and 5 quality priorities for the year ahead. The draft Quality Account is currently out for consultation with specified stakeholders with a deadline for return of 26 June 2023.
Prior Consideration and Feedback	This report has been considered and approved by the Quality Assurance Committee on 1st June 2023.
Implications:	The Quality Account is an important statutory document which the Trust is required to submit annually to the Department of Health and Parliament. It is a way for the Trust to report on quality and show improvements in the services they deliver to local communities and stakeholders.
Recommendations:	The Council of Governors are asked to discuss the Quality Account, including priorities for the coming year prior to consideration and approval by the Board of Directors.

Quality Account 2022/23

Part one

1.1 Welcome to the Quality Account and its purpose

What is a Quality Account?

A Quality Account is an annual report describing the quality of services provided by an NHS healthcare organisation. Quality accounts aim to increase public accountability and drive quality improvements in the NHS.

Our Quality Account looks back on how well we have done in the past year at achieving our quality goals.

It also looks forward to the year ahead and defines what our priorities for quality improvement will be and how we expect to achieve and monitor them.

The aims of the Quality Account

1. To help patients and carers make informed choices about healthcare providers
2. To empower people to hold providers to account for the quality of services
3. To engage leaders of an organisation in their quality improvement agenda

Who reads the Quality Account?

Lots of different people read the Quality Account. Some are people who we support through our services, their loved ones, colleagues, commissioners, partners and regulating bodies.

We produce our report for anyone who wants to know more about the quality of our services, and how we plan to maintain and improve them.

What information can be found in the Quality Account?

In this document, you will find information about how we measure and review the quality of services that we provide. You will also find our priorities for improvement for the year ahead. Like all NHS healthcare providers, we focus on three different aspects or domains of quality:

- Patient safety
- Clinical effectiveness
- Patient experience

Structure of the Quality Account

The structure of this Quality Account is in line with guidance published by the Department of Health and NHS England, and contains the following information:

- **Part 1** Introduction and context
- **Part 2:** Information on how we have improved in the areas of quality we identified as important for 2022/23, our priorities for improvement in 2023/24 and the required statements of assurance from the Board
- **Part 3:** Further information on how we have performed in 2022/23 against our key quality metrics and national targets and the national quality agenda

1.2 Chief Executive's statement on quality

Welcome to our Quality Account 2022/23. It sets out the quality of our services highlighting our achievements and where we must continue to make progress.

High quality patient care is the core of what we do every day and goes hand in hand with our unrelenting focus on patient safety and clinical excellence.

Our priorities are clear:

- improvements in patient safety supported by a positive culture
- safe, kind and compassionate care informed by evidence with outcomes that matter
- empowering patients and carers to be equal partners and help address barriers in care
- co-creating holistic, responsive and integrated models of care
- supporting people to be active members of their community
- being inclusive, trauma-informed and recovery-focused
- a skilled workforce supported to provide high quality care

You will read more about Our Quality Journey in this report and our commitment to a great experience for patients in our care and for patients and carers who want to work with us for better mental health in our region. Indeed, much of our focus now is working within communities, alongside our partners, to support people to get help early on and close to home – all part of the community mental health framework.

Nationally and regionally, organisational changes to the NHS mean we are closely linked with the two Integrated Care Boards that cover our patch. We'll continue to build these partnerships to benefit the health and wellbeing of people living in our areas.

While we are making progress, we continue to see unprecedented demand for services and recognise the impact that the pandemic continued to have last year on patients, carers and colleagues – a picture reflected nationally.

I must also acknowledge the publication of the independent reports into the tragic deaths of three young women in our care and the safety and quality of children and adolescent mental health inpatient provision at West Lane Hospital in Middlesbrough in 2019/20. They remind us we must remain fully committed to being a listening organisation and putting patient and carer experience at the heart of everything we do.

The reports make it clear that at the time of the tragedies there were shortfalls in care and leadership – both of which have changed significantly during the last three years. This includes our new governance structure, embracing patient and carer experience and using their insights to continually improve, as well as our unrelenting focus on patient safety – all underpinned by Our Journey to Change.

We welcomed the Care Quality Commission into our services with inspectors acknowledging that improvements are being made following inspections of our children and adolescent mental health community service and our secure inpatient services.

In October 2022 we acted quickly on concerns raised about our adult learning disability and autism wards to make the positive changes that were needed.

You will see in this report the awards that colleagues have won and been shortlisted for – it is testament to the hard work and commitment of individuals and teams who I am proud to work alongside. I witness people living our values of compassion, respect and responsibility every single day to deliver safe and kind care to those we support.

As we move into the new financial year, we will continue to put quality and safety above all else, working with patients and carers and our partners to support people in our region to live their best possible lives.

Brent Kilmurray
Chief Executive
30 June 2023

1.3 About our Trust

We are the mental health and learning disability NHS foundation trust for more than 2 million people living across County Durham and Darlington, Teesside, North Yorkshire, York and Selby. We provide a range of inpatient and community mental health, learning disability and eating disorders services.

We are also a catchment area for the largest concentration of armed forces personnel in the UK – Catterick Garrison – and our adult inpatient eating disorder services and adult secure (forensic) wards serve the whole of the North East and North Cumbria.

From education and prevention, to crisis and specialist care – our talented and compassionate teams work in partnership with patients, communities and partners to help the people of our region feel safe, understood, believed in and cared for.

We nurture the recovery journey of people in our care. Patients and carers have a say in how they are supported and treated because we know how important it is to listen and treat people as individuals. Our patients, their families and carers work together with us towards better mental health.

We also provide mental health care within prisons, and an immigration removal centre, located in the North East, Cumbria and parts of Lancashire.

Around 7,800 staff work across more than 90 sites, including Foss Park, a state of the art 72-bed hospital and research space in York which opened in 2020.

On 1 April 2022 our new leadership and governance structure came into effect with the creation of two Care Group Boards – one covering Durham, Tees Valley and Forensic services and one for North Yorkshire, York and Selby.

Our new organisational and governance structure:

- Simplifies governance processes – this gives nurses and other healthcare professionals more time to care, supports clinical teams to make decisions with the people they care for and makes it easier for everyone to understand their role and responsibilities.
- Strengthens reporting from teams through our two new care groups directly to our Trust Board.
- Embeds increased line of sight and oversight from ward to Board

We deliver care under six clinical directorates across our Care Group Boards:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

1.4 Our Journey to Change

Everything we do is guided by Our Journey to Change and our values. Our Journey to Change sets out where we want to be and how we'll get there. It includes our goals that we co-created with patients, carers, colleagues and partners:

- To co-create a great experience for our patients, carers and families.
- To co-create a great experience for our colleagues
- To be a great partner

"I've found that the staff members who I've worked with have been keen to hear our views and include us in decision making.

"I'm optimistic that TEWV's new way of co-creating services, which relies on developing trust, relationships and equalising power, can and will improve lives.

"It will take time and require much reflection but is an exciting journey to be on. Everyone needs to feel that their experiences are important and that they are valued."
Ros, carer

1.5 Co-creation

We're embracing patient and carer experience and using their insights to continually improve; working in close partnership with patients, families and carers to provide the best possible experience and outcomes. We also work in partnership with our partners and regulators to ensure we understand what good looks likes so we bring meaningful change to the care we provide.

We refer to this partnership-style of working as co-creation.

It is at the heart of Our Journey to Change and is fundamental to how we improve the care we provide to the communities we serve.

We want this to run through everything we do, so that it becomes the normal way of doing things from:

- Care plans written in partnership, where patients and families have choice about their care and make shared decisions with their clinician.
- A thriving and diverse involvement community that supports co-creation across all areas of our Trust from policy to research, recruitment to quality improvement.
- A growing and diverse peer workforce across all services, underpinned by peer values and driven by peer leadership.
- Innovative and diverse methods to really hear the experience of all patients and families and understand the relationship between patient experience, complaints and serious incidents.
- Lived experience leadership roles supporting transformation and culture change. By lived experience we mean people who have experience of mental illness as a patient or carer and who are using their experiences and insights to help others.

We are making progress. We recruited two lived experience directors into our leadership team in 2022 to make sure the patient voice is heard at the very highest level in the organisation.

A number of our trainers have experience of mental illness and are supporting staff to put themselves in the shoes of both patients and their families so that we show true empathy in the care we deliver.

We also employ peer support workers, who have lived experience of mental illness either themselves or as a carer.

"To me, being a peer is about being your authentic self; and that is enough. Having lived experience and using that experience to build meaningful relationships is making a difference to people's lives, to my own life too. The validation you stir up when someone knows you really get it is so rewarding and really helps to form mutual relationships with people which is the key to people feeling empowered. When someone is empowered – look out world!"
Rachel, peer worker

Examples of co-creation and lived experience in action

- CAMHS team in Northallerton are working on a newspaper with young people about mental wellbeing.
- The crisis team have co-produced information for young people who are accessing intensive home treatment.
- A Mental Health Older Peoples Service User and Carer Participation Group have been involved in many projects and service developments.
- Our Tees Valley Community Mental Health Transformation lived experience board members have guided the programme that is now working with partners to develop community hubs.
- We have worked with carers to develop a carers' hub – a one stop shop for people who have a loved one in our services, providing a range of support and information.
- The learning disability shadow quality assurance group in North Yorkshire continue to enhance governance in this area.
- Stockton Occupational Therapy Community Team have worked with patients and colleagues to design and grow the Ideal House allotment, transforming it into a calming green space.

1.6 Involvement member story

A veteran and one of our involvement members is using his skills to help develop our services and has also created paintings for patients and staff to enjoy.

Veteran Bob Etherton signed up to the army in 1959 and became a special operator in the Royal Corps of Signals as well as joining the regiment's band as a piper. Serving in Germany, Singapore, Borneo, Cyprus, Australia and the Falkland Islands, to name a few, he had many adventures and a rewarding and progressive career until his retirement in 1992.

When Bob spent time in our care, he was approached to become a Trust involvement member, and now works with us to help develop our services.

"I thought I'd give it a try," said Bob, "I knew it would be challenging, but I was able to draw on my army experience. I take part in workshops, focus groups, meetings, interview boards and much more that has all been positive experiences. My contributions are valued as are those of other service users and carers and working with the Trust has very much helped my recovery and personal development.

"I also found a talent for art, painting and drawing and it's something I find most therapeutic. I wanted to pay tribute to the wonderful life and 70 years of service of Queen Elizabeth II and create something that the patients and staff can enjoy."

Bob's paintings are on display at our mental health services for older people at Cross Lane Hospital in Scarborough and Foss Park Hospital in York.

1.7 The services we provide

We deliver care under six clinical directorates across our Care Group Boards:

- Adult mental health services
- Mental health services for older people
- Children and young people's mental health services
- Learning disabilities
- Health and justice
- Secure inpatient services

There is further detail about our Trust and the services we deliver in section 1.3.

1.8 Our CQC ratings

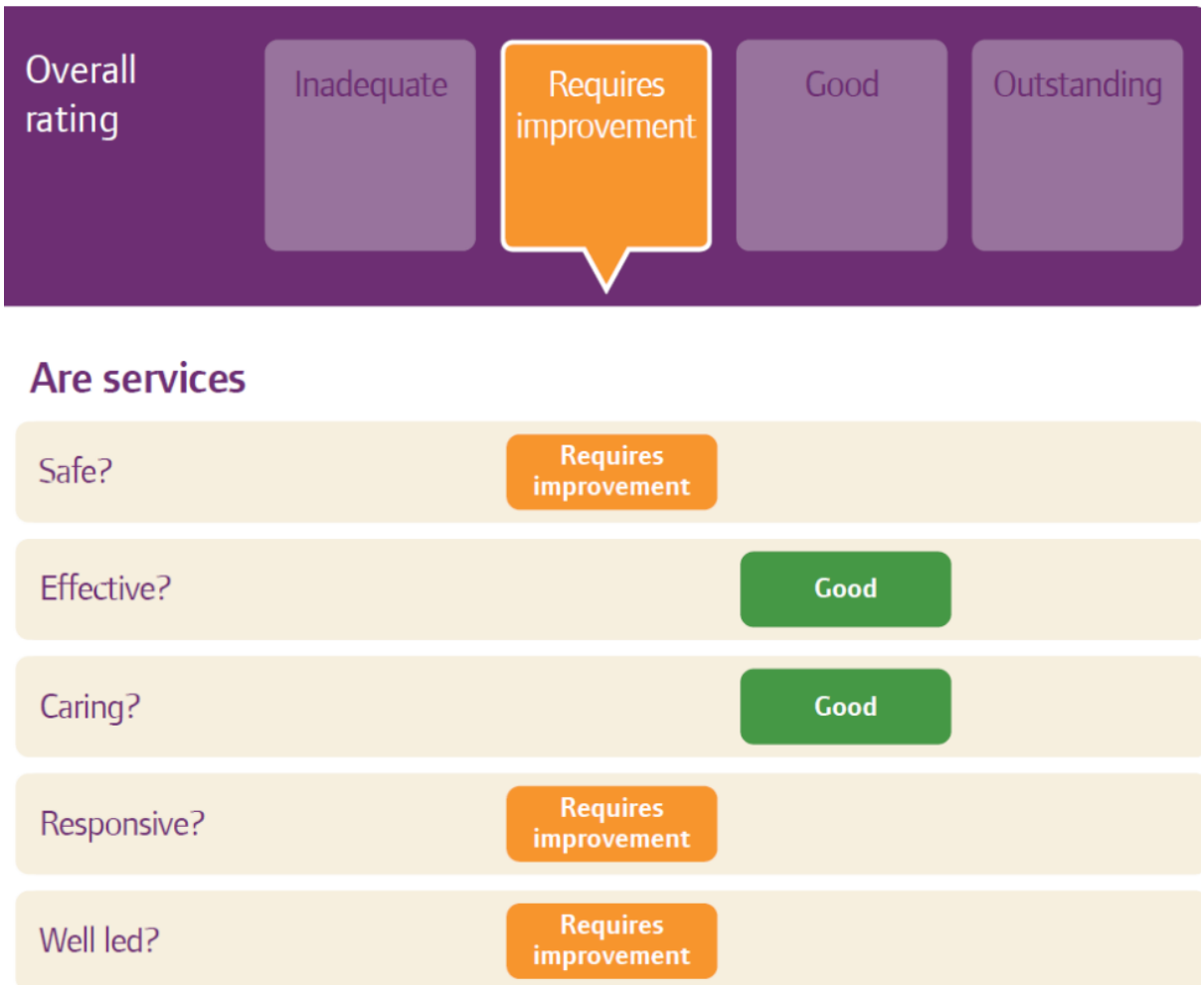
The CQC's current ratings for our Trust overall and for each key domain is as follows:

Overall rating: Requires improvement

For each key domain our Trust is rated:

- Safe: Requires improvement
- Effective: Good

- Caring: Good
- Responsive: Requires improvement
- Well-led: Requires improvement



Further information can be viewed within section 2.13, What the Care Quality Commission (CQC) says about us.

1.9 What we have achieved in 2022/23

We're making progress on our goals and working together to deliver a great experience for patients, carers and families, for colleagues and to be a great partner.

How we're co-creating a great experience for patients, carers and families

- £5m spent on making our wards safer since 2019, and almost £3m more planned in 2023.
- Waiting lists down by nearly 50% for children accessing mental health support.
- Carers Charter launched and being embedded in the Trust. It sets out our commitment to working with and supporting carers.

- Investing in our estates by opening a new community mental health hub in Northallerton and a new centre for young people in York.

- Installing innovative patient safety technology on some of our wards.

- Supporting members of the Armed Forces and showing our commitment to them by signing the Armed Forces Covenant.

- 46% more people helped to find work by our Individual Placement Service

- Putting patient experience at the heart of what we do.

- Peer support workers on our wards who are trained to use the knowledge and expertise that comes from their own lived experience of mental health services to support patients.

- Two lived experience directors bringing their own knowledge, understanding and compassion to the strategic leadership of our Trust.

"The team tried lots of different approaches and medications, and really listened to me."

"They were so helpful, so supportive, which helped me come out of myself a lot more."
James, patient, North Yorkshire

How we're co-creating a great experience for colleagues

- Recruiting 700 more staff since start of COVID in 2020.

- Introducing large scale recruitment events for healthcare assistants and nurses.

- We're on an international recruitment drive too.

- Streamlining our process making it quicker to recruit new people.

- Giving people a voice in our Trust by strengthening our staff networks.

- Investing in the health and wellbeing of our people.

- Introducing a staff awards and recognition scheme.

- Supporting teams to put patient experience at the heart of decision making.

"We have a really nice team. There is always somebody that you can check things with, that you can talk through issues with. It does feel like a big family really, where people look after each other and look out for each other."
Adele, Manager

How we're working with our partners

- More mental health nurses are working in GP surgeries across our region – supporting people to get the right help early on and close to home.

- 27 more schools are part of our mental health support programme helping young people and training teachers.

- Our innovative and world-class research team is part of a vital COVID-19 vaccine trial along with NHS partners and the University of York.

- Together with Hartlepool Borough Council we supported rough sleepers with their mental health.

- Our apprenticeship team has developed a strong partnership with Derwentside College to deliver a range of apprenticeship training to colleagues.

"They didn't need to take the partnership working approach they did but have chosen to. It's delivered a new and effective way of working."
Martin, Stockton Council

In addition to the achievements listed above, external bodies have recognised the work of individuals or teams through the award shortlisting, or award wins listed in the table below.

1.10 National awards – won and shortlisted

In addition to the Trust achievements listed above, external bodies have recognised the work of individuals or teams through the award shortlisting, or award wins listed in the table below.

Award body	Awarding status	Name / category of award	Team / individual
Health Watch Middlesbrough	Won	Leading Change Award	Tees Valley community mental health transformation lived experience members - Sophie Richardson, Michael Moorhouse and Sandra Bell
British Psychological Society's Division of Forensic Psychology	Won	Excellence in Forensic Psychology Practice Award	Alison Hodgson
Hull York Medical School Teaching Excellence	Shortlisted	Medicine Phase II and III Tutor of Excellence Award	Dr Meena Inasu, Dr Ioana Varvari and Dr Dan Whitney
Healthcare Financial Management Association (HFMA) - Northern Branch	Shortlisted	Accounting Technician of the Year	Emma Cruttenden and Laura Gittins
We Are NHS People	Won	NHS international HR Day	Michelle Lockwood

Hospitality Assured	Awarded	Covid Resilience Award - Premier Accreditation	Hotel services
British Institute of Learning disabilities (BILD)	Won	Positive Behavioural Support Coach of the Year	Steven Wilson
Nepacs' Ruth Cranfield Awards 2022	Won	Certificate of Excellence	Integrated Support Unit and PiPE team, HMP YOI Low Newton and TEWV
North of England Reserve Forces and Cadets Association	Awarded	Employer Recognition Scheme Silver Award 2022	Tees, Esk and Wear Valleys NHS Foundation Trust
Healthcare People Management Association	Shortlisted		Michelle Lockwood
LGBT Alliance	Awarded	Positive impact on LGBT Health	Roseberry Park
BBC Tees Making a Difference	Shortlisted	Together	Stephanie Addison
Northumbria in Bloom	Won	Best Grounds of a Hospital - Gold Award	Lanchester Road Hospital
Royal College of Nursing	Shortlisted	Commitment to Carers Award	Laura Blake
Positive Practise in Mental Health Awards	Won	Non-Clinical Team of the Year Mental health rehab and/or recovery Outstanding Leadership Forensic Mental Health Services (including Criminal Justice and Prisons)	Voluntary services team Recovery and outcomes support team Tom Hurst Cook healthy, eat, repeat ‘A recipe for a healthier lifestyle’
Positive Practise in Mental Health Awards	Highly commended	Complex Needs Mental Well-being of Workforce	Primrose Service - HMP & YOI Low Newton Employee support service

Royal Society for Public Health's prestigious Health and Wellbeing	Shortlisted	Arts and Health	York St John University - Converge
Nursing Times	Won	Nurse Leader of the Year	Judith-Marie Rose
Nursing Times	Shortlisted	Clinical Research Nursing	Nurses leading research
RC Psyche	Shortlisted	Psychiatric Team of the Year: Older-age adults	Mental health services for older people, inpatient organic service
Perinatal Quality Network (RC Psyche)	Awarded	Accreditation	Tees perinatal mental health team
Cavell Star	Won	Award	Suzanne Spence
Bright Ideas in Health Awards	Shortlisted	Cross-organisation Working to Deliver Research	Food Insecurity in Adults with Severe Mental Illness
Better Health at Work Awards	Awarded Awarded	Silver and Gold standard Bronze standard	Talking Changes IAPT service in Durham and Darlington Wellbeing team

Part 2: Quality priorities for 2022/23 and required statements of assurance from the Board

2.1 Introduction – purpose of this section

In part two of our Quality Account, we outline our planned quality improvement priorities for 2023/24 and provide a series of statements of assurance from the Board on mandated items, as outlined in the Detailed requirements for quality reports 2019/20 from NHSI.

In this section, we will also review the progress we have made in relation to the quality priorities we set ourselves in the 2022/23 Quality Account.

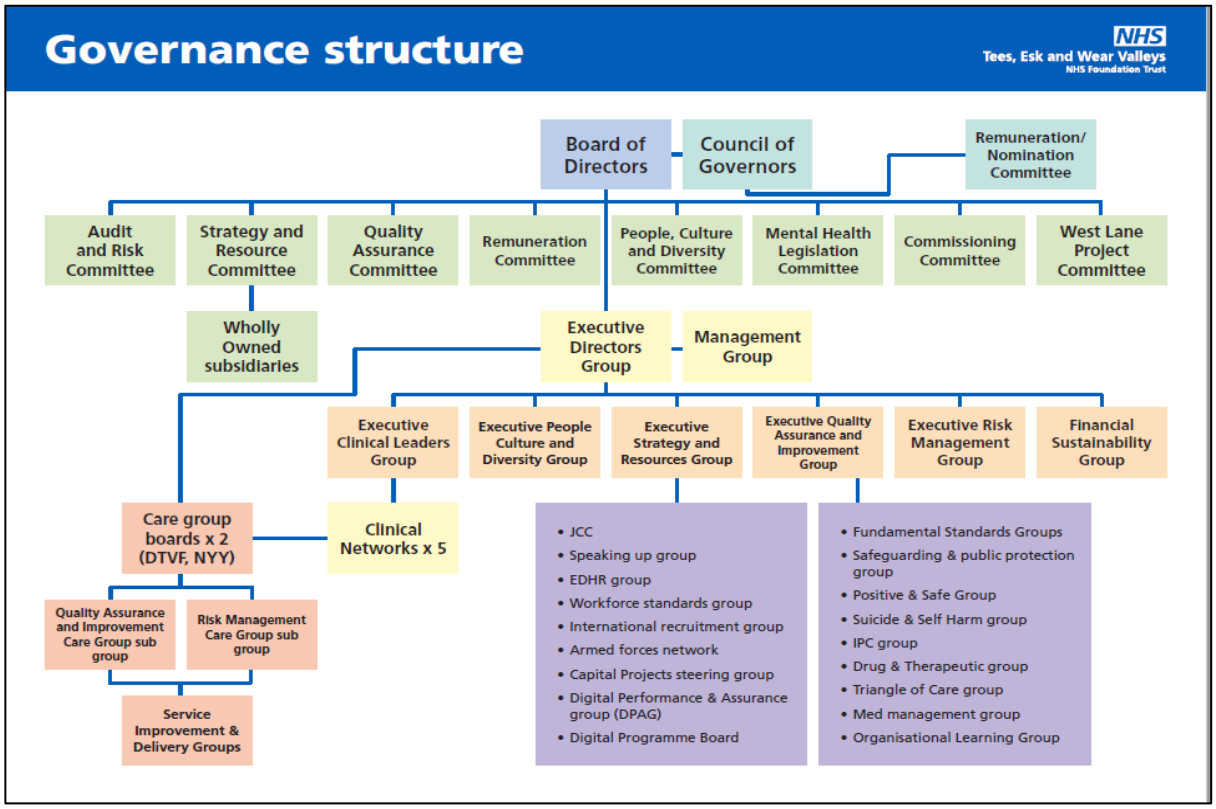
2.2 Our approach to quality governance and improvement

Our Trust has a robust governance infrastructure, with new arrangements put in place as part of the organisational restructure from 1 April 2022. The new governance structure is focused on enhanced oversight and accountability and is supported by the Trust's Accountability Framework.

Our new governance structure supports the delivery of Our Journey to Change by making sure we are:

- Clinically led and operationally enabled.
- Better able to align around the regional changes in the form of the two Integrated Care Systems in which we provide services.
- Able to deliver on individual and collective system wide accountability effectively and consistently, by making all roles clearer and manageable for post holders.
- Organised in a more simple, less complex way formally incorporating patient leadership into our structures.

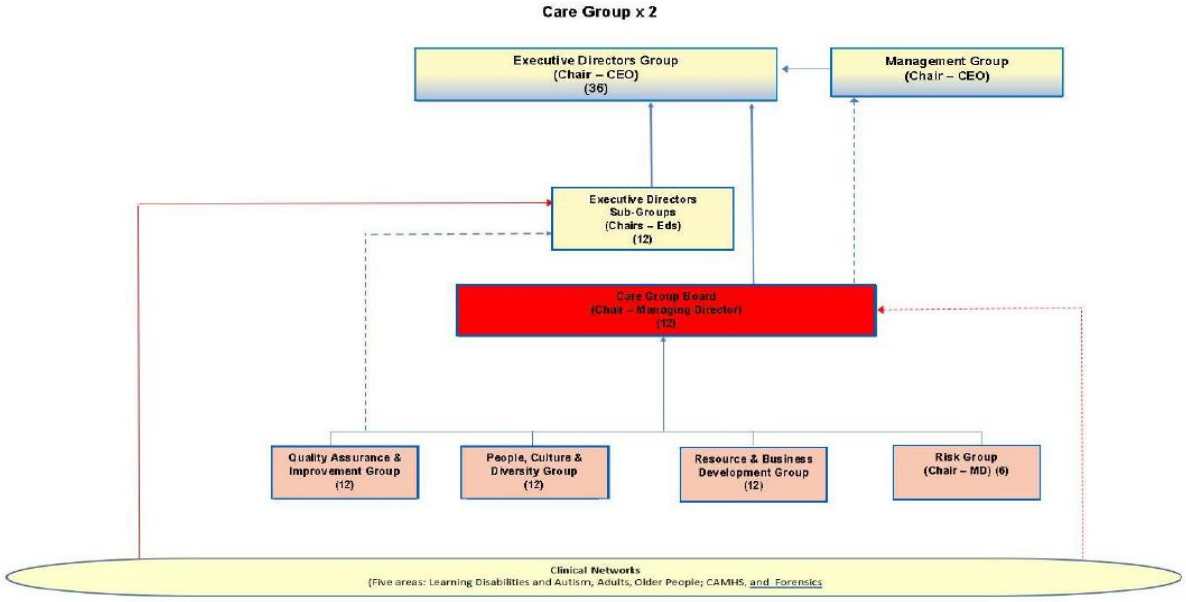
The new structures have been under review and evaluation to support us to provide safe, high quality, effective clinical services, and the best possible experience for people in our care, families and carers, our colleagues, and our partners. We continue to adapt and develop our governance process to achieve this aim. The structure in place during 2022/23 is shown in the figure below*.*



Our Trust Board ensures robust quality governance through the Quality Assurance Committee, a committee of the Board.

The Quality Assurance Committee is chaired by a non-executive director. Its strategic purpose is to provide assurance to the Board on the quality, safety and effectiveness of clinical and operational services through effective systems, structures and processes.

Each Care Group has quality governance arrangements to address the key elements of quality and safety. These are outlined in the figure below. Each Care Group reports directly to the Executive Quality Assurance and Improvement Group monthly, and to the Executive Directors Group weekly on quality performance issues that require executive oversight and/or escalation. Each Care Group is required to provide assurance to the Quality Committee against its quality improvement plans.



Quality Assurance and Improvement

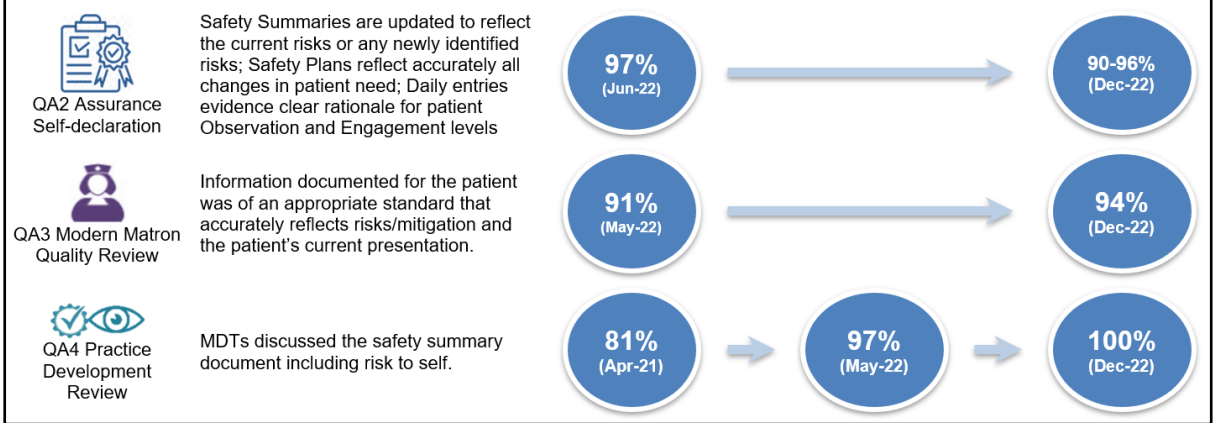
We have a well-established Quality Assurance and Improvement Programme which was first initiated in April 2021. This is focused partly on patient care documentation, recognising that high quality documentation is an enabler of high-quality patient care, as well as observation of practice and talking to teams in clinical areas.

The Programme comprises of a range of quality assurance tools that are used to gain a holistic assessment of the quality of patient care. These tools are subject to review to ensure they are informed by current areas of risks where further assurance is required.

- QA2: Assurance MDT self-declaration
- QA3: Modern matron quality review
- QA4: Practice development reviews
- QA5: Community Quality review
- QA6: Peer review
- QA7: MDT walkabout
- QA12: Directors visits

The Quality Assurance and Improvement Programme is an effective method of monitoring compliance against key standards of care related to patient safety, clinical effectiveness and patient experience. It has facilitated significant sustained practice improvements and provides the organisation with both quantitative and qualitative assurance evidence. Our Practice Development Practitioners continue to facilitate required practice improvements through supporting clinical staff via coaching, mentoring, education, and training.

Examples of Safety summary aspects indicating practice improvements from the QA programme – Quality Account



Key learning from incidents, patient surveys, complaints and other forms of intelligence helps to shape our Trust's quality improvement priorities and continues to be monitored using the Quality Assurance and Improvement Programme.

We have embedded an infrastructure and a range of approaches that support the delivery of high quality care and effective quality governance. Some examples are set out below:

- We have been using Quality Improvement (QI) since 2007 and, as a core element of Our Journey to Change, we will continue to use it in the future. Our QI approach gives people who access our services, who deliver our services and who partner with us to have a voice and to participate in QI activity to help make our Trust a great place to work and a great partner to work with, enabling people to live their best possible lives. Our dedicated Quality Improvement Team provides expertise and support across the Trust. To continue to build our capacity and capability QI training is provided at four different levels: foundation, intermediate, leader and expert.
- A wide range of staff training and development opportunities. We have implemented the National Patient Safety Syllabus at levels 1 and 2 as mandatory for all our staff.
- We have developed our training provision in relation to risk management and will be implementing a newly procured risk management system from July 2023 onwards. The system has a number of modules that provide digital solutions to incident reporting, risk registers, policies and procedures, complaints ad concerns, clinical audit and assurance and the CQC fundamental standards of care.
- Systems and structures that support organisation wide learning including rapid patient safety reviews, safety alerts, learning from serious incident bulletins and share and learn webinars.
- Working collaboratively with organisations on specific areas of practice and patient care e.g. sexual safety, implementing the HOPES model in adult learning disability services, suicide prevention and harm minimisation.

Co-creation is central to our overall approach. We work closely with patients, families and carers to identify and deliver our priorities. We are one of the first trusts nationally to create lived experience director roles for people with lived experience of mental illness and currently have two lived experience directors in post. These roles ensure that services continue to be developed and improved by working closely with our network of patients and carers, local communities, and colleagues in other lived experience roles.

2.3 Our Progress on implementing our 2022/2023 quality improvement priorities

In this first section of Part 2, we look backwards at the progress we made in implementing our quality priorities during 2022/23 and the impact this had for patients and their families/carers. Following this, we set out our quality improvement priorities for 2023/24.

Priority 1 – Improving Care Planning

Why it is important:

In any health and social care organisation, care planning is a vital component of safe and effective patient care and treatment. In July 2021, NHS England published a formal statement advising all mental health trusts to move away from the Care Programme Approach (CPA) in favour of a community mental health framework. DIALOG+ as part of a wider piece of work, is the tool to enable the move away from CPA while providing a clear co-created, care plan for patients.

The DIALOG+ process approach allows healthcare professionals to have supportive and meaningful conversations with patients about the aspects of their lives that are most important to them such as family, relationships, leisure activities and accommodation, in addition to their mental and physical health. It uses a person centred and patient rated scale that measures patient reported outcomes as well as a measure of patient experience. The output of the DIALOG+ assessment will be a care plan that the patient and health professional create together that is specific, co-created and clear. The care plan will be digital easy to change and updated regularly as agreed with the service user.

The benefits/outcomes we aim to deliver for our patients and their carers are:

- Personal circumstances, and what is most important to the person and those closest to them, are viewed as a priority when planning care and treatment.
- Accessible, understandable, and personalised care plan (including a crisis plan) containing contact details of those people and services that are best placed to help when the need arises.
- Discussions that lead to shared decision-making and co-creation of meaningful care plans.
- Agreed plans recorded in a way that can be understood by the patients and everybody else that needs to have this information.
- Information about support from people who have experience of the same mental health needs.

What we said we would do and what we did:

Record all care plans on our new Cito electronic patient record (EPR) system
Due to unforeseen circumstances, we have not been able to go live with the Cito system as anticipated and this has prevented us from achieving this action. However, we are pleased to report that Cito will go live on 1 July 2023 which will enable us to meet our ambition of recording all patient care plans in this system from this point onwards.

Ensure all clinical staff are trained in our new DIALOG+ care planning system
This action was aimed at adequately preparing and training our staff in the use of the digital care planning tool DIALOG+. However, due to the delays in launching Cito, we have had to adapt our approach to preparation. We have introduced a paper-based version of DIALOG+ and have taken an incremental approach to its introduction. We have successfully

implemented this in adult mental health services and mental health services for older people supported by staff education and training. Roll out of the paper-based version is continuing and this will converge toward the one plan approach embedded within Cito. However, now that Cito online training has commenced, DIALOG+ training will start at the end of May 2023.

Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework)
This action is linked to system wide changes and is dependent on working with system wide partners to agree on the future approach. There have been several meetings with our senior leaders about how best to move away from the Care Planning Approach (for most services) and how this links to the wider community transformation of mental health services. Following an initial scoping meeting, a series of multiagency engagement events workshops are being held, the first took place in March 2023.

Introduce improvements to care planning in Secure Inpatient Services
Work started in October 2022 to move away from My Shared Pathway to goal based plans, in line with DIALOG+. A three-phase work programme was developed. Phase one focused on decluttering and organisation of current intervention plans, with a view of removing any duplication and also to assess if information would sit more suitably elsewhere such as within Safety Summary/Safety Plans.

A range of staff workshops have been held, led by the CPA lead and Practice Development Practitioners to facilitate this work. Good progress has been made. Currently approximately 75% of plans have transitioned to the new goal-based approach, with work continuing to complete the remainder. An assessment of the quality of care plans is being undertaken by the Practice Development Practitioner. Work will continue over the coming year to transition to the Cito based DIALOG+.

Update all patient and carer information resources about care planning
This has not yet been done but will be part of the work to move toward personalising care/advancing the CPA in our Trust that has started as this information should be co-created. Ideally this will be completed in conjunction with the autism project - at an event in 2022 it was agreed that if we made all information autism/neuro-divergent friendly then it would prevent the need to produce separate resources. It is worth noting that during 2022 getting inpatient services up and running with DIALOG+ and changing the approach to care planning in Secure Inpatient Services were the priority issues. In addition, the information available now is not wrong it just needs to be updated to be in line with system and culture changes.

Have data collection and monitoring systems in place to assess the impact of our clinical interventions on the goals set out in patient care plans
This work is directly linked to the Cito development, outcomes, and caseload management work that is ongoing. Cito has much improved data collection capabilities and has been designed so that care plan goals are at the front and centre of the system. DIALOG+ (badged as shared decisions in Cito) ensures that the process used to agree these goals is a personalised experience and that the goals are realistic and achievable. The measurement of the impact of the interventions against the goals will be via the DIALOG+ rating system, in conjunction with other outcome measures such as ReQoL-10 and GBO (or others for non adult mental health or mental health for older people services). All of this is against the backdrop of increasing communication and emphasis on the move toward a more interventionist approach that is expected as part of the wider community transformation and CPA position statement.

What was the outcome/impact:

The following table shows how we have performed against the targets we set ourselves for this priority:

Indicator	Target 2021/22	Actual 2021/22	Actual 2022/23
Patients know who to contact outside of office hours in times of crisis	84%	80%	78%
Patients were involved as much as they wanted to be in what treatments or therapies, they received	85%	85%	75%
Patients were involved as much as they wanted to be in terms of what care they received	85%	73%	73%
Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	75.53%	83%

Question	May 2022	March 2023
Inpatient		
Were you involved as much as you wanted in the planning of your care?	78%	74%
Were your family/carers involved in your care as much as you wanted?	81%	72%
Community		
Were you involved as much as you wanted in the planning of your care?	91%	92%
Were your family/carers involved in your care as much as you wanted?	84%	80%
Carer Survey		
Have you been asked to provide your experiences and history of the person you care for?	83%	84%
Do you feel that you are actively involved in decisions about the person you care for?	90%	88%

Priority 2 – feeling safe

Why it was important:
Patient safety continues to be our key priority. Our Quality Journey (the quality strategy) identifies a number of patient safety priorities that we will continue to focus on going forward.

Patients feeling safe on our inpatient wards is a key area for improvement for us. It is acknowledged nationally that some patients report not feeling safe while in the care of mental health services. A survey, undertaken in 2020 by the Parliamentary and Health Ombudsman, examined people's experiences of NHS mental health care in England, reporting that one in five patients reported feeling unsafe.

On a monthly basis patients on our wards are asked: do you feel safe on the ward?

The data from our survey is telling us that on average 56% of patients feel safe within our inpatient areas against a target of 75% which is frequently not met, however there is a lack of data nationally to allow any benchmarking comparisons to be made.

The benefits/outcomes we aimed to deliver for our patients and their carers were:

- Improved patient safety and reduction of patient harm.
- An increase in the percentage of our patients feeling safe when they are in an impatient setting.
- Increased collaboration between patients, staff, and peers.
- A reduction in incidents e.g. violence and aggression, absence without leave, drug misuse.
- Improved understanding of ward environments and why patients feel unsafe
- Increased opportunity to use digital technology to support the delivery of care

What we said we would do and what we did:

Review the information we have available from patient surveys, incidents, and complaints from adult inpatient services to identify any new emerging themes that may help inform our programme of improvement work in this area

From the review undertaken we were able to identify the following themes:

- Environmental – missing bedroom keys, uncertainty around ward routine, doors banging, ward generally noisy, should feel homely.
- Staffing – patients value their relationships with staff, not enough staff around, staff are not always visible, lack of engagement from agency staff, staff don't feel safe due to low staffing, turnover of staff resulting in lack of consistent support, training of staff, lack of empathy, poor communication, staff sleeping whilst on duty, staff attitude.
- Ward based activities – should continue to be enhanced and there should be more productive use of courtyard areas.
- Patient safety – inadequate searches taking place on the ward, care planning, assessments not taking place in a timely manner, out of area admissions, medication reviews not being timely, sexual safety, assaults and patients being violent, dual diagnosis, timeliness of intervention and support, leave arrangements.
- Waiting times – for neurodevelopmental pathways, ADHD, ASD and autism assessments.
- Unsafe discharge – no care package in place, too early.
- Communication – patients not being able to get through to the team, calls not being returned, patients not being listened to, meeting the needs of the patient.
- Concerns being raised by MPs or via CQC rather than being reported directly to the Trust, repeated contacts from patients.

These themes have informed Our Quality Journey and further development of our Quality Assurance and Improvement Programme. In addition, the Patient and Carer Experience team (PaCE Team) have undertaken a series of focus groups between July 2022 and March 2023 across all inpatient wards. This was to understand what feeling safe means to our patients and staff and ask them what they feel would improve safety.

What did we ask patients and staff?

Patient questions

- What does feeling safe mean to you?
- During your stay on the ward have you felt safe?
- When you don't feel safe, what has caused this?
- What things help you when you don't feel safe?
- What does a safe day on the ward look like to you?
- When was the last time you felt safe?
- What was happening to make you feel like that?

Staff questions

- What does feeling safe mean to patients?
- During their stay on the ward have patients felt safe?
- When they don't feel safe what has caused this?
- What things help them when they don't feel safe?
- What does a safe day on the ward look like to you?

What patients said

- Peer support – talking to other patients on the ward.
- Staff support – getting reassurance from staff who listen and are adequately trained with the right skills and experience.
- Being able to easily identify staff members from patients.
- Being able to go to my bedroom when there are incidents on the ward.
- Accessing a place on the ward that is quiet.
- Listening to music, arts and crafts and access to the gym.
- Doing something productive, planting things looking after an allotment.
- PAT therapy animals on the ward.
- Doing activities, keeping myself occupied during the day.
- Being able to access leave, if I can't get out on my own having enough staff to escort me.

What staff said

- Access to patient alarms on the ward.
- Accessing one to one support and time with staff to offer them reassurance.
- Familiar faces and consistent staff on shift.
- Coping mechanisms and distraction techniques.
- Knowing the patients care plan, risks and offering debriefs when incidents happen.

Some of the things we have done in response to what our patients and staff have said:

Safe and visible staffing

- Introduced health care assistant and registered nurse councils to ensure that staff have a voice in our secure inpatient services.
- Introduced the SafeCare system (a nurse rostering system). This enables efficient allocation of staff and has inbuilt patient safety triggers to support patient safety.
- Improved the skill mix of staff on duty by investing in band 6 staff and recruiting advanced nurse practitioners and a positive and safe lead - this role focuses on adherence to best practice regarding restrictive interventions. There is also improved

clinical leadership through the introduction of practice development practitioners (PDPs) to support service improvement.
- Improved the continuity of care and safety on the wards by improving recruitment and retention within the service to provide consistent staffing.
- Invested in staff break areas to support wellbeing in the workplace.
- We are introducing an Agency Passport to improve competencies, training and induction of agency staff prior to them working on the wards.
- Supported block booking agency staff to ensure consistent staffing on the wards.
- Practice development practitioners are supporting improvements to the induction process for agency staff.

Patient leave
- Introduced a dedicated leave team to support patients to access leave.
- Patient access to leave is consistently discussed in the daily ward huddles

Patient activities
- An annual timetable of activities and health promotion activities has been produced and is offered across our secure impatient services.
- Recruited to a number of activity coordinators who work on our wards across a seven day week.
- Introduced pet therapy animals within some wards.
- Recruited gym instructors for both PICUs.
- Support from the arts at Foss Park Hospital and Cross Lane Hospital with projects, co-created with patients, that are creating a better environment.

Patient environment
- Improvements to Roseberry Park Hospital courtyard areas including decorating feature walls and installing new planters which are managed by activity coordinators on the wards.
- Allocated lifecycle funds to replace outside furniture.
- Improved the safety of the internal space by introducing heavy duty furniture onto wards. On some wards there is ongoing estates work to improve the ward environment with daily (ward managers) and weekly (matron) walkabouts to ensure issues are addressed.
- Installed anti-ligature doors within Tunstall ward.
- Continue to review the use of carpets in collaboration with the IPC team and acoustics have been considered as part of the Roseberry Park Hospital rectification works.
- A number of actions in place as part of the environmental ligature reduction work with regular reporting through estates and facilities management.

Each care group has developed a patient experience improvement plan that incorporates actions related to a range of patient feedback and includes those actions related to patients feeling safe on our wards. The plans are reported and monitored through the care group quality assurance meetings and reported for assurance to the Executive Quality Assurance and Improvement Group. This area of patient safety will continue as a priority over the coming year.

Increase the visibility of staff within adult inpatient areas

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Review of the ward clerk and administrative roles: The introduction of seven day a week administrative support to wards is supporting the provision of an increase in the clinical time available to clinical staff. The impact of these developments has increased the quality of care and patient safety within our Trust and also aims to improve staff wellbeing and retention.

Introduction of new roles: The introduction of peer support and activity workers on our wards increase engagement and improve meaningful and diversional activity on the wards.

Focus on reducing patient-on-patient violence through exploring further use of information technology solutions

A pilot of body worn cameras: Ten wards are testing the use of body worn cameras. The aim is to prevent violence on acute mental health wards by recording audio and video footage of interactions between staff and patients. This is based on evidence around the impact of their use on police and public behaviour. The aim of the initiative is to assess the impact on patient aggression.

As the pilot has progressed there has been a range of emerging challenges. These include IT issues and the need for additional training to further progress the pilot.

Wards and teams can then explore ways in which they can develop sustained local processes focused upon maintenance and reviewing footage. Although the prime expected benefit of this technology is a reduction in restraint, national studies have also suggested that incidents (which include patient-patient violence) should be reduced.

Oxevision: Oxevision is a tool that helps colleagues care for patients more safely and was developed in collaboration with patients. The system has been designed specifically for mental health care and includes a regulated medical device which operates with an infrared-sensitive camera. It helps staff visually confirm a patient is safe through measuring their pulse and breathing rate - without disturbing their sleep.

The evaluation of the Oxevision pilot has reported some positive outcome for patients to date as shown below. Our Trust has also supported a national review of the use of vision-based patient monitoring systems (VBPMS) in mental health wards and is disseminating the resulting guidance to relevant wards. Oxevision is being rolled out to further wards across our Trust following the success observed to date. This includes:

Improved safety on the wards

- Over 90% of staff reported Oxevision improves safety on the ward and helps them identify falls they may otherwise not have known about. 90% of staff reported the system enabled them to prevent potential incidents and 86% reported the system made it easier to monitor the physical health of patients.
- 83% of patients felt the system kept them safer and 88% felt that it allowed staff to respond to them more quickly.

Older adults (Rowan Lea ward)

- 16% relative reduction in falls in bedrooms when compared to the control ward
- 25 - 40% relative reduction in assaults across the bedroom and ward respectively when compared to the control ward.

Acute (Elm ward)

- 7% relative reduction in self-harm in bedrooms when compared to the control ward.
- Harmful self-harm in the bedroom had a relative reduction of 85% when compared to the control ward.
- Ligatures also had a relative decrease when compared to the control ward.

Psychiatric Intensive Care Units (Cedar ward)

- 25% reduction in self-harm in bedrooms compared to its baseline.

- 17% and 10% increase in assaults bedrooms and across the ward, respectively, compared to its baseline.

Improved patient experience

- 100% of patients felt the system reduced disturbance at night-time.
- 89% of patients felt that the system improved their wellbeing and 92% felt it enabled staff to care for them better.
- Patients felt the system helps them get better sleep (80%), gives them a greater sense of privacy (83%) and dignity (90%) and improved their relationship with staff (88%).

Positive impact on risk management and restrictive practice levels

- 90% staff reported that the system enables them to better manage patient risk.

Improved care quality

- 79% of staff reported that the system enables them to provide better care for patients.
- 72% of staff reported that the system provides them with more information to help make better care or clinical decisions.

Continue to implement the Safewards initiative (an evidence-based tool to reduce violence and support a safe ward environment)

Use of the Safewards model and its 10 core interventions remains a key part of our overall strategy for reducing restrictive interventions. Its implementation is documented within our policy for supporting behaviours that challenge and the annual Positive and Safe Report 22/23.

Each ward has identified champions for implementing the approach in their wards. Training on the Safewards model is included in our Restrain Reduction Network accredited courses and must be completed by all staff working across inpatient services.

All inpatient wards complete a Safewards self-assessment checklist each month. Compliance is shared and discussed via local Positive and Safe Groups each month.

Additional workshops for staff in champion or ward leadership roles are available each month for staff to focus upon specific ward implementation issues. We hold a Trustwide Safewards Sharing Practice Group every three months for ward staff to network and share good practice.

Wards can seek specific support regarding the Safewards model anytime through our Positive and Safe team.

What was the outcome / impact?

Indicator	Target	Actual 2021/22	Actual 2022/23
Percentage of inpatients who report feeling safe on our wards	75%	64.37%	56%
Percentage of inpatients who report that they were supported by staff to feel safe	66%	68.04	85%

Priority 3 - implementation of the new Patient Safety Incident Reporting Framework

Why it was important
The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers. This includes maternity and all specialised services.

What we said we would do and what we did

- **Roll out the two-part incident approval process across all areas of our Trust. This involves operational staff taking responsibility for reviewing and approving incidents that have occurred within their service before submitting centrally.** Roll-out of this programme continues and 150 clinical areas have adopted the two-part approval of incidents. Significant training and staff support have been required to reach this point and we are closely monitoring progress with the approval of incidents. To facilitate this, daily reports are provided to services to enable them to have oversight of incident occurrence, stage of review and approval. Twice weekly sit rep meetings take place to enable strategic oversight and performance and weekly reports are provided to the Executive Directors Group.

- **Introduce a triage process for incidents that have been categorised as moderate and serious harm to quickly determine the appropriate route for review.** We have successfully implemented the incident triage process implemented

- **Develop the daily patient safety huddle to include service staff and subject matter experts so we can effectively review reported incidents in a timely way and where rapid reviews can be undertaken, where appropriate, that lead to immediate actions and improve safety.** The Patient Safety Huddle is now embedded as routine practice and is operating effectively.

- **Improve our Serious Incident Review process so it is robust and uses evidence-based tools and involves families to the level of their satisfaction.** We have a continued focus on improving the quality of incident reporting, investigation, and identification of key learning. A strategic project manager, with additional support from the NHSE/I's System Improvement Team initially provided support for this workstream. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring that they are compliant with the requirements of the National NHS Patient Safety Strategy and the PSIRF. This improvement workstream forms part of our key quality priorities within the Quality Journey and our Quality Strategy, with formal governance reporting routes in place. The Incident Reporting and Serious Incident Policy has also been fully reviewed and consulted upon. Further review of the policy is planned as PSIRF implementation progresses. PSIRF is to be fully implemented by 30 September 2023

- **Provide updates for staff on the duty of candour to ensure all have a full understanding.** As part of the improvement work related to learning from deaths, several training needs for staff Trustwide have been identified. These include incident reporting, holding difficult conversations with bereaved relatives, duty of

candour/culture of candour, report writing and writing smart action plans. These have been fed into the Trustwide training needs analysis event.

An internal audit of the Duty of Candour Policy identified some areas for improvement. We have since reviewed the policy and updated it in line with current best practice to support staff understanding of the standards to be met. We have also held listening events to gain a better insight of staff understanding and application of the duty of candour. We will be using this to make improvement over 2023/24.

- **Improve the quality and oversight of action plans.** We continue to work on this improvement action. We have developed a standard action plan template for use across our Trust. However, the quality of some actions plans continue to be less than expected. We will continue to focus on this over the coming months.

- **Refresh the terms of reference for the Director Assurance Panels.** The Directors Assurance Panel terms of reference have now been revised and implemented. The function and performance of the review panel is under continual review to ensure continuous improvement.

2.4 Our Quality Journey

We focused on five areas to support Our Journey to Change. During 2022 we worked with patients, carers, partners and colleagues to create strategies – that we're calling journeys – to show what we will do and how each area will enable us to achieve Our Journey to Change.

The five journeys are:

- Clinical – how we will provide high quality, safe, kind, effective and personalised clinical care to the people we support
- Quality – how we will make our services safer and improve patient experience through evidence-based care
- Co-creation – how we will seek out and act upon the voices of the people we work with to improve care
- Infrastructure – how the places we work, such as our hospitals and offices, the equipment we use, the information we gather and the systems and processes we put in place will support excellent patient care
- People – how we will ensure everyone who works and volunteers with us has a great experience, whether they're permanent employees, people working as bank staff or through an agency, students or volunteers

The journeys set out specific ambitions and principles that support the mission, values and goals of Our Journey to Change and will drive both incremental and large-scale improvement initiatives. The journeys will be delivered through a series of programmes and workplans that make up our 2023/24 delivery plan.

The journeys create a strong framework and strategic vision that allow our Trust to prioritise key work. They will introduce rigour and support through a programme management approach and allow the Trust Board to receive assurance that we are making sufficient progress and achieving the outcomes and impact required.

Our Quality Journey sets out our quality ambitions for the next three to five years showing where we want our journey to take us. It sets out key principles and explains how our

objectives connect to the national NHS Patient Safety Strategy. It also outlines our key strategic quality objectives.

Our ambition is that by 2028, we will achieve the specific aims and measurable improvements set out in Our Quality Journey, through continuous learning and improvement using a range of tools and enablers. This Journey has been shaped by our other journeys; Clinical, Co-creation, People and Infrastructure.

We will continue to have an unrelenting focus on patient safety and are committed to:

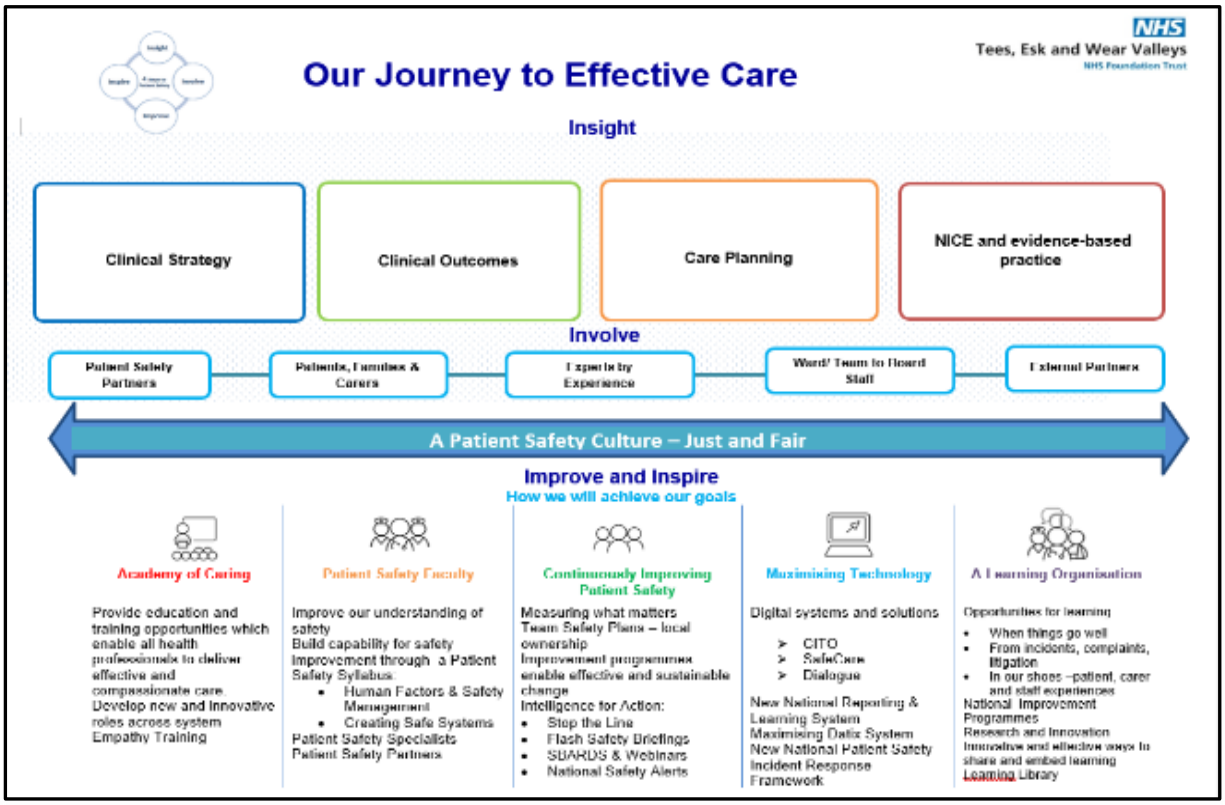
- Driving improvements in patient safety across our Trust, together with patients, carers and families, colleagues, and partners, and supported by a positive culture.
- Providing a great experience for patients in our care and for patients, carers and families who want to work with us for better mental health in our region.
- Providing safe and kind care that's based on evidence and has outcomes that matter to people

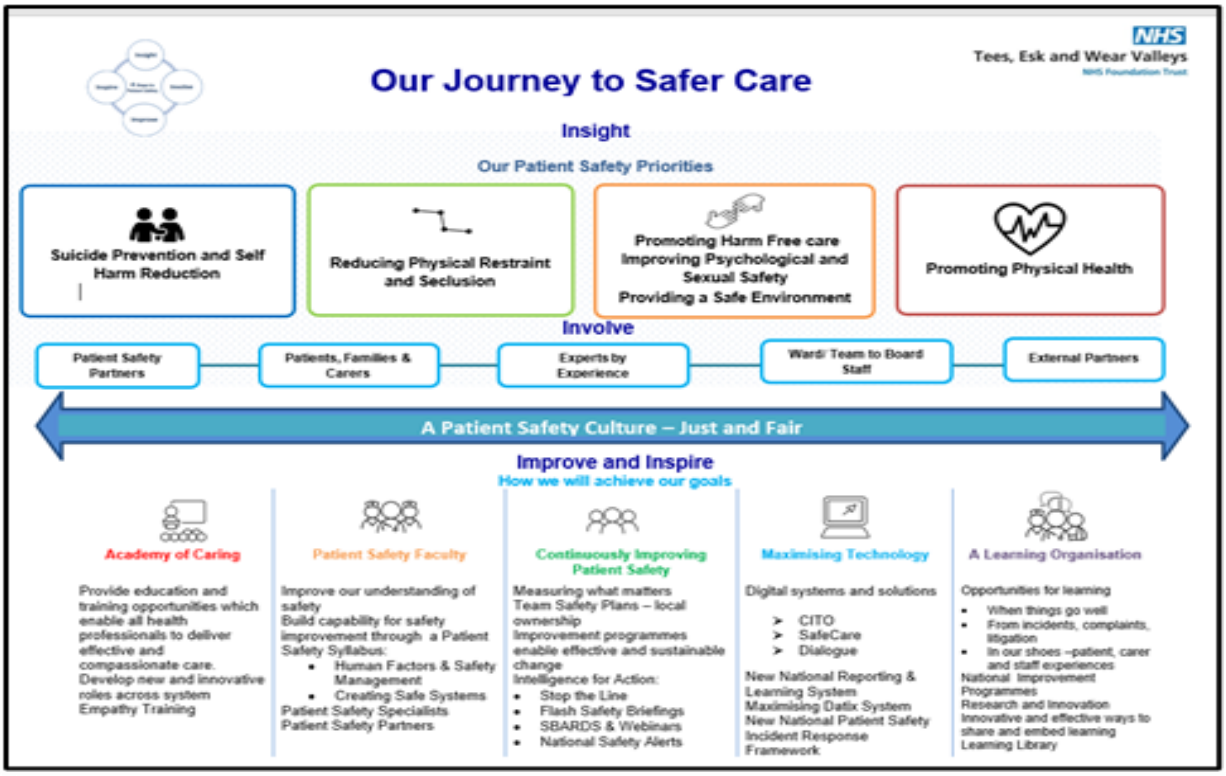
It is often important to make quick changes to tackle quality issues, and our governance system will promote a culture and processes where data is analysed holistically, and changes implemented swiftly. This means that not everything we need to improve will have a detailed, long-term plan around it.

However, there will be some potential changes which will require lengthy development and implementation periods. These will be governed as projects, grouped into programmes, and be backed by clear business cases which set out the benefits (improvements) that should be seen and when they should be expected to occur.

During 2023/24 the initial set of quality related programs will be:

- Personalised care planning, including implementing the DIALOG+ model. This is a shared ambition with the Co-creation Journey.
- Harm free care, including psychological safety, feeling safe on our wards, sexual safety, self-harm / suicide / misadventure reduction, safeguarding, environmental risk minimisation.
- Patient safety, including electronic risk management system procurement, patient safety incident reporting framework (PSIRF), rapid learning from serious incident investigations and sharing learning at every level.


Tees, Esk and Wear Valleys
NHS Foundation Trust
Our Journey to Effective Care
Insight
Clinical Strategy
Clinical Outcomes
Care Planning
NICE and evidence-based practice
Involve
Patient Safety Partners
Patients, Families & Carers
Experts by Experience
Ward/ Team to Board Staff
External Partners
A Patient Safety Culture – Just and Fair
Improve and Inspire
How we will achieve our goals
Academy of Caring
Provide education and training opportunities which enable all health professionals to deliver effective and compassionate care
Develop new and innovative roles across system
Empathy Training
Patient Safety Faculty
Improve our understanding of safety
Build capability for safety Improvement through a Patient Safety Syllabus
Human Factors & Safety Management
Creating Safe Systems
Patient Safety Specialists
Patient Safety Partners
Continuously Improving Patient Safety
Measuring what matters
Team Safety Plans – local ownership
Improvement programmes enable effective and sustainable change
Intelligence for Action:
Stop the Line
Flash Safety Briefings
SBARDS & Webinars
National Safety Alerts
Maximising Technology
Digital systems and solutions
CITO
SafeCare
Dialogue
New National Reporting & Learning System
Maximising Datix System
New National Patient Safety Incident Response Framework
A Learning Organisation
Opportunities for learning
When things go well
From incidents, complaints, litigation
In our shoes –patient, carer and staff experiences
National Improvement Programmes
Research and Innovation
Innovative and effective ways to share and embed learning
Learning Library


Tees, Esk and Wear Valleys
NHS Foundation Trust
Our Journey to Safer Care
Insight
Our Patient Safety Priorities
Suicide Prevention and Self Harm Reduction
Reducing Physical Restraint and Seclusion
Promoting Harm Free care
Improving Psychological and Sexual Safety
Providing a Safe Environment
Promoting Physical Health
Involve
Patient Safety Partners
Patients, Families & Carers
Experts by Experience
Ward/ Team to Board Staff
External Partners
A Patient Safety Culture – Just and Fair
Improve and Inspire
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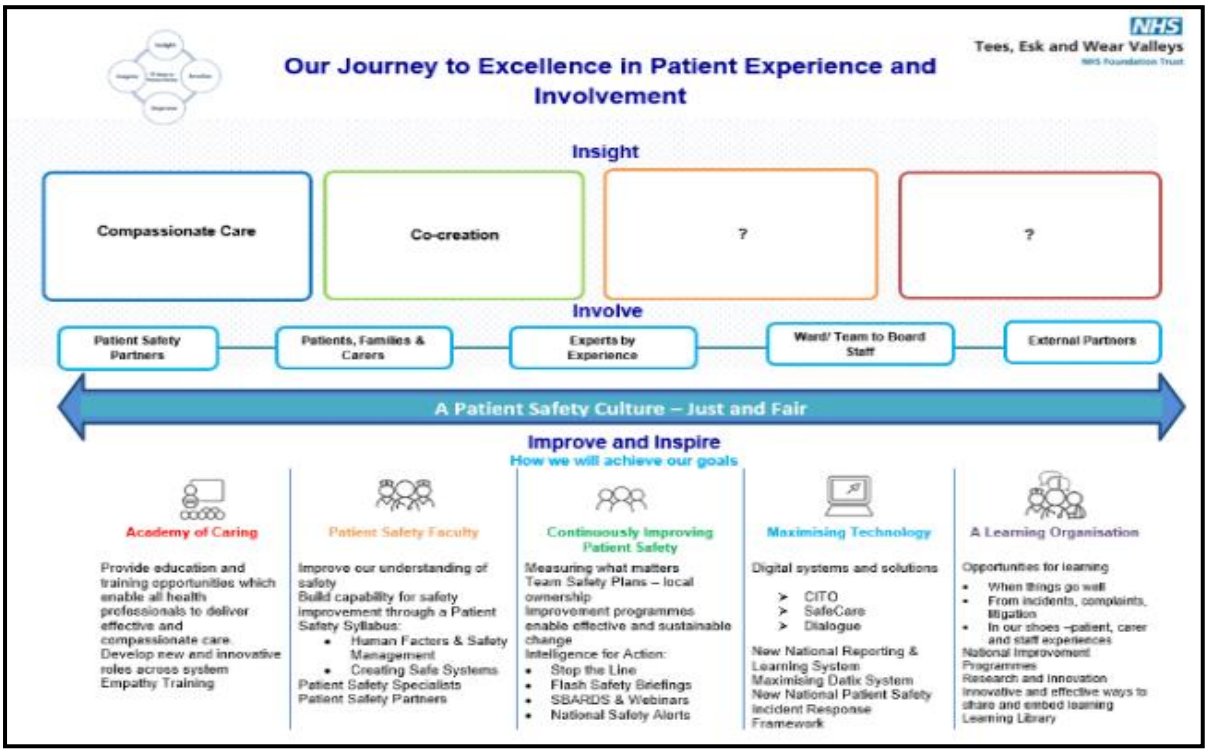
Tees, Esk and Wear Valleys
NHS Foundation Trust
Our Journey to Excellence in Patient Experience and Involvement
Insight
Compassionate Care
Co-creation
?
?
Involve
Patient Safety Partners
Patients, Families & Carers
Experts by Experience
Ward/ Team to Board Staff
External Partners
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2.5 Our priorities for 2023/24

Developing our priorities

Following initial discussion and a review of quality data, risks and future innovation, we have developed our priorities in collaboration with colleagues, patients, families and carers. Our priorities will support our Trust as we continue with our mission to make sure that safe, quality care is at the heart of all we do.

We did not hold our traditional quality account stakeholder workshops in 2022/23, however considerable engagement has been undertaken during the creation of our journeys and particularly Our Quality Journey. This together with consideration of a range of patient safety and experience data and information, and the level of progress made against priorities in 2022/23, has given a strong sense of where we need to improve.

Priority 1 – care planning

Information on why this is important and the benefits/outcomes that we aim to deliver for our patients and their carers can be found earlier in this document.

By 31 March 2024 we will:

a) Ensure all clinical staff are trained in our new DIALOG+ care planning system.
b) Record all care plans on our new Cito patient record system using DIALOG+.
c) Have measurable goals in all patient care plans.
c) Publish new policies and procedures in relation to care planning and new ways of working (linked to Community Mental Health Framework).
e) Have data collection and monitoring systems in place to assess the impact of our clinical interventions on the goals set out in patient care plans.

How will we know we have made a difference / made an impact

Indicator	Target 2021/22	Actual 2021/22	Actual 2022/23
Patients know who to contact outside of office hours in times of crisis	84%	80%	78%
Patients were involved as much as they wanted to be in what treatments or therapies, they received	85%	85%	75%
Patients were involved as much as they wanted to be in terms of what care they received	85%	73%	73%
Percentage of patients who were involved as much as they wanted to be in the planning of their care	70%	75.53%	83%

Priority 2 – feeling safe

Information on why this is important and the benefits/outcomes that we aim to deliver for our patients and their carers can be found earlier in this document on page xx

By 2023/24 Q4 we will:

a) Implement the range of actions identified from the Feeling Safe focus groups with patients and staff.
b) Continue to progress our body worn camera pilot work and evaluate its impact.
c) Continue to implement the Safewards initiative.

How will we know we are making things better?
To demonstrate that we are making progress against this priority we will measure and report on the following metrics:

Indicator	Actual 2021/22	Actual 2022/23	Target for end 2023/24
Percentage of inpatients who report feeling safe on our wards	64.37%	56%	75%
Percentage of inpatients who report that they were supported by staff to feel safe	69.04%	85%	75%

Priority 3 – embed the new Patient Safety Incident Reporting Framework (PSIRF)
Information on why this is important and the benefits/outcomes that we aim to deliver for our patients and their carers can be found earlier in this document on page xx.

By 2023/24 Q4 we will:
a) Be compliant with the national requirements regarding PSIRF.
c) Increase the number of staff completing level 1 and 2 training within the national Patient Safety Syllabus training.
d) Introduce an annual patient safety summit.
e) Introduce the role of patent safety partners.
f) Complete the focused work we have initiated on the Duty of Candour through the delivery of an improvement plan

How will we know we are making things better?
To demonstrate that we are making progress against this priority we will measure and report on the following indicators:

- Full implementation of PSIRF.
- Compliance with level 1 and 2 national patient safety training.
- Delivered our Duty of Candour Improvement Plan.

2.6 Statement of assurances from the Trust

In this section of the Quality Account, the Trust is required to provide statements of assurance in relation to a number of key performance indicators which are as follows:

- Review of services provided by or contracted our Trust
- Our 2023 Community Mental Health Survey results
- Our 2023 National NHS Staff Survey results
- Clinical Audit: Participation in clinical audits and national confidential inquiries
- Clinical Research
- Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework
- What the Care Quality Commission (CQC) says about us
- Information governance
- Freedom to Speak Up
- Reducing gaps in rotas
- Learning from deaths
- PALS and complaints

- Data quality
- Mandatory quality indicators

2.7 Review of services provided by or contracted by our Trust

During 2022/23 our Trust provided and/or subcontracted 20 relevant health services. Our Trust reviewed all the data available to us on the quality of care in 20 of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by our Trust for 2022/23.

2.8 Our 2022 Community Mental Health Survey Results

There were 253 completed surveys returned within our Trust for the 2022 Community Mental Health Survey, a response rate of 20.69%. This is the same as the national response rate and compares with a rate of 20.9% in 2021.

The following table shows how our Trust performed for each section of the survey in comparison to the national average (all scores are out of 10):

Section	2022 score	Band
1: Health and Social Care workers	7.4	
2: Organising Care	8.2	
3: Planning care	7.0	
4: Reviewing care	7.5	
5: Crisis care	7.1	Somewhat better
6: Medicines	7.5	
7: NHS Talking Therapies	7.2	
8: Support and Wellbeing	5.2	
9: Feedback	2.2	
10: Overall view of care and services	7.2	
11: Overall experience	6.9	
12: Responsive care	7.9	

Our Trust did not score significantly better or worse than comparable Trusts for any of the individual questions or sections as a whole, however, we did score better and somewhat better than expected as set out below:

Better

- Has the purpose of your medicines ever been discussed with you?
- Have the possible side effects of your medicines ever been discussed with you?

Somewhat better

- Were you given enough time to discuss your needs and treatment?
- Would you know who to contact out of office hours within the NHS if you had a crisis? This should be a person or a team within NHS mental health services.

Our top five scores against the national average were for the following questions:

Top five questions	Score
Q13. Do you know how to contact this person if you have a concern about your care?	96.0%
Q6. Have you received your care and treatment in the way you agreed?	85.8%
Q38. Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	83.6%
Q19. Did you feel that decisions were made together by you and the person you saw during this discussion?	83.2%
Q24. Has the purpose of your medicines ever been discussed with you?	82.7%

Our bottom five scores against the national average were for the following questions:

Bottom five questions	Score
Q39. Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	21.9%
Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	41.4%
Q35. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?	46.3%
Q33. In the last 12 months, did NHS mental health services support you with your physical health needs?	50.3%
Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?	60.1%

There are 13 areas where we are in the top 20% nationally and these are:

- Have you received your care and treatment in the way you agreed?
- Were you given enough time to discuss your needs and treatment?
- Did the person or people you saw understand how your mental health needs affect other areas of your life?
- Have you been told who is in charge of organising your care and services?
- Have you agreed with someone from NHS Mental Health Services what care you will receive?
- Did you feel that decisions were made together by you and the person you saw during this discussion?
- Do you know who to contact out of office hours if you have a crisis?
- Thinking about the last time you tried to contact this person or team, did you get the help needed?
- How do you feel about the length of time it took you to get through to this person or team?
- Has the purpose of your medicines ever been discussed with you
- Have the possible side effects of your medicines ever been discussed with you?

- In the last 12 months, did NHS Mental Health Services give you any help or advice with finding support for finding or keeping work?
- Have NHS Mental Health Services involved a member of your family or someone else close to you as much as you would like?

The areas where service user experience could improve are:

- Organising the care and services that individuals need
- Knowing who to contact when you have a concern about your care
- Receiving the help that they need
- NHS Talking Therapies explained in a way that is easily understood
- People are involved as much as you wanted to be in deciding what therapies to use

Full results of the survey for our Trust can be found at: https://nhssurveys.org/all-files/05-community-mental-health/05-benchmarks-reports/2022/

To take forward these results so we continue to improve our patient experience, we are:

Organising the care and services that individuals need.

- Included within the Service Improvement Plan for each Care Board

Ensuring patients know who to contact when they have a concern about their care.

- PALs and Complaints service is currently going through a whole service review. The team has introduced pop up clinics in hospital reception areas and are visiting wards to raise their profile and be more accessible.

Supporting people to receive the help that they need.

- An improvement event was held in June 2022 where the current Crisis line system and infrastructure were reviewed. This identified improvements that can be made.

Explaining NHS Talking Therapies in a way that is easily understood.

- Leaflets are available including easy read versions and translated into other languages.

Involving patients, as much as they want to be, in deciding what therapies to use.

- The IAPT team provide support in the way that feels best for the individual. For example, some people find guided self-help really suits them, others find counselling can help.

2.9 Our 2022 National NHS Staff Survey Results

All colleagues were invited to participate in the 2022 national NHS Staff Survey.

Guidance now states that colleagues have to be absent from work for at least 365 days before being considered as long term sick and not eligible for the survey. Previously this was 90 days. This meant that 304 people (3.5%) were unable to complete the survey.

The final response rate was 44% compared to 50% in 2021, 3330 participants in total.

We ranked 15th against the other 25 mental health trusts who commission Picker for the survey and first in overall positive score change.

Our overall staff engagement score remained seven out of 10.

The most improved results compared to 2021 are shown in the following table.

	2022	**2021**	**Increase**
Received appraisal in the past 12 months	84%	79%	5%
Feel organisation respects individual differences	74%	69%	5%
Organisation is committed to helping balance work and home life	51%	47%	4%
Feel supported to develop my potential	62%	57%	5%
Team members often meet to discuss the team's effectiveness	69%	65%	4%

The scores that declined the most between 2021 and 2022 are shown below.

	2022	**2021**	**Decrease**
Satisfied with level of pay	31%	38%	7%
Have adequate materials, supplies and equipment to do my work	62%	65%	3%
If friend/relative needed treatment would be happy with standard of care provided by organisation	51%	54%	3%
Don't work any additional unpaid hours per week for this organisation, over above contracted hours	40%	42%	2%
Organisation acts on concerns raised by patients/service users	74%	76%	2%

Areas where the Trust scored low compared to national average:

- If friend or relative needed treatment would be happy with standard of care
- Staff involved in a near miss or incident feel treated fairly
- Would recommend Trust as a place to work

Areas where the Trust scored better than the national average:

- Career progression

- Not experiencing musculoskeletal problems as a result of work
- Not experiencing discrimination from patients, carers and families

2.10 Clinical Audit: Participation in clinical audits and national confidential inquiries

A clinical audit is the process by which the quality of care and services provided are measured against agreed standards. Where services do not meet the agreed standard, the audit provides a framework where suggestions for improvements can be made. A third party conducts national audits. Participating in these audits gives organisations the opportunity to compare their results with other organisations. Local audits are conducted by the organisation itself. For local audits, the Trust evaluates aspects of care that the healthcare professionals themselves have selected as being important to their team. The statements on a clinical audit demonstrate the healthcare provider is concerned with monitoring the quality of their services and improving the healthcare provided.

- During 2022/23, four national clinical audits and one national confidential enquiry covered NHS services that Tees, Esk and Wear Valleys NHS Foundation Trust provides.

- During that period, Tees, Esk and Wear Valleys NHS Foundation Trust participated in 100% of national clinical audits and 100% of the national confidential enquiries which it was eligible to participate in.

- The national clinical audits and national confidential enquiries that Tees, Esk and Wear Valleys NHS Foundation Trust was eligible to participate in during 2022/23 are as follows:

    - National Audit of Inpatient Falls (NAIF) – continuous audit
    - National Clinical Audit of Psychosis (NCAP) EIP Re-audit
    - POMH Topic 21a: The use of Melatonin
    - POMH Topic 20b: Valproate Prescribing in Adult Mental Health Services
    - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

- The national clinical audits and national confidential enquires that Tees, Esk and Wear Valleys NHS Foundation Trust participated in, and for which data collection was completed during 2022/23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit Title	Cases Submitted	% of number of registered cases required
National Audit of Inpatient Falls (NAIF) – Continuous audit	3	100%
National Clinical Audit of Psychosis (NCAP) EIP re-audit	507 (and a further 7 contextual team level questionnaires)	100%
POMH Topic 21a: The use of Melatonin	Sample provided: 242	100%
POMH Topic 20b: Valproate Prescribing in Adult Mental Health Services	Sample provided: 197	100%
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	69 questionnaires sent to the Trust with 46 returned	67%

- The reports of six national clinical audits were reviewed by the provider in 2022/23 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

  - Existing procedures in relation to alcohol detoxification were re-circulated to all staff with a copy of the clinical audit report and the findings shared.
  - Our Deputy Chief Pharmacist and Cito Clinical Locality Lead collaborated to develop effective guidance and prompts which will be included as part of the Cito developments before this is launched.
  - As part of the depression medication pathway review, a checklist was added for annual reviews which cover assessment of medication adherence, side-effects (with example rating scales), alcohol and substance use and co-morbidities.
  - Barriers to performance in relation to the NCAP standards were explored and actioned within our EIP Steering Group. This included an identified plan and timeline for delivery of At Risk Mental State (ARMS) provision within the North Yorkshire, York and Selby Care Group.
  - A review was undertaken of the shared pathway between EIP and CAMHS.
  - The process and recording flowchart were disseminated to all teams via the adult mental health clinical network.
  - Key physical health Key Performance Indicators (KPIs) have been developed, led by our Physical Health Group, which facilitates the recommendations highlighted from the NCEPOD Physical Healthcare in Mental Health inpatient settings audit.

- The reports of 129 local clinical audits were reviewed by the provider in 2022/23 and Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

  - Indication was added as a necessary field for antibiotics on the Electronic Prescribing and Medicines Administration (EPMA) system which is being piloted during 2023. Options were explored including using protocols for antibiotic regimens, mandating stop/review dates and having links to guidelines within the new prescribing system.
  - Training was provided for delivering Performance Development Reviews (PDR) to mental health team managers and assistant team managers and facilitated sessions included the appraisal process and how to identify measurable outcomes included throughout supervision sessions with staff.

- Briefings were shared (developed with the Practice Development Practitioner Group) including key areas requiring improvement highlighted from the NEWS2 clinical audit report.
- Amendments were made to the Quality Assurance and Improvement Programme QA tools following recommendations highlighted from clinical audit findings to facilitate regular monitoring and oversight.
- Educational videos were shared in relation to diabetes management.
- Assurance was gathered that mattress checklists were in place across the Trust and following the clinical audit, the Trust Infection Prevention and Control (IPC) Team developed and shared an educational video to demonstrate the correct full mattress checking process required.
- A clinical audit summary briefing was developed by the Safeguarding and Public Protection Team illustrating key findings from the Safeguarding Children's Policy audit. This was shared with teams and the Care Group Fundamental Standards Groups as well as being published within our Trust's weekly bulletin.
- Amendments were identified following clinical audit results in relation to our Trust's emergency equipment annual audit. This included the requirement that locations have clear signage to the emergency response bag/AED and oxygen, updates made in relation to items within three month of expiry requiring replacement, updates made to the checklists used for teams and explicit guidance as to which spare oxygen should be available for areas.
- The reporting of staff allegations, Making Safeguarding Personal (MSP), record keeping, and safeguarding supervision have been incorporated into the Safeguarding Level 3 Training for staff following the clinical audit results.
- All Infection Prevention and Control audits are continuously monitored by the IPC Team and any required actions are rectified collaboratively by the IPC Team and ward staff. Assurance of implementation of actions is monitored by the Clinical Audit and Effectiveness Team via the clinical audit action monitoring database. A total of 110 IPC clinical audits were conducted during 2022/23 across inpatient areas, prison teams, and applicable community teams where there are clinic facilities. 71% (78/110) of clinical areas achieved standards between 90-100% compliance. Local clinical audit action plans were implemented in collaboration with the IPC Team and the clinical team members to mitigate any areas of non-compliance.

In addition to those local clinical audits reviewed (i.e., those that were reviewed by our Quality Assurance Committee and Quality Assurance and Improvement Group), we undertook a further 52 clinical audits in 2022/23 including clinical effectiveness projects by trainee doctors, consultants and other professionals, in addition to those by directorates/specialty groups. These clinical audits were led by the services and individual members of staff to support service improvement and professional development and were reviewed by specialties.

Over the next year, our Trust intends to use an electronic clinical audit application to make clinical audits more efficient and easier for teams to review their clinical quality information in a live format and to make any changes needed to improve practice and ultimately the quality of care and the experience of our patients and their families.

We continued to implement an extensive Quality Assurance and Improvement Programme during 2022/23. This provides ongoing assurance that key quality and risk issues identified are addressed. Significant improvements in practice and patient safety have been facilitated through this programme.

2.11 Participation in Clinical Research

The Trust participates in research activity to help provide new knowledge that has the potential to be valuable in improving care for patients. It is important that such research is open to critical examination and open to all that would benefit from it.

The number of patients receiving relevant health service provided or sub-contracted by our Trust in 2022/2023 that were recruited during that period to participate in research approved by a Research Ethics Committee was 975. Of the 975 participants, 827 were recruited to 36 National Institute for Health Research (NIHR) portfolio studies. This compares with 806 patients involved as participants in 27 NIHR research studies during 2021/22.

As well as acting as a research site and participant identification centre, our Trust sponsors research including three major NIHR grant-funded multi-centre studies (COMBAT, MODS WP3&4 and CASCADE). As part of this role our research and development team are actively engaged in governance activities such as site set-up and performance tracking. As sponsor, during 2022/2023, our Trust oversaw the completion of the BASIL pilot study which showed the acceptability of behavioural activation intervention amongst older adults (https://bmjopen.bmj.com/content/13/3/e064694).

Other examples of how we have continued our participation in clinical research include:

- We continue to work closely with the NIHR Clinical Research Network North East and North Cumbria to support large scale national portfolio research studies, and to measure patient research experience when taking part in studies with feedback and any actions reported to our Research Governance Group.
- 23 different staff members took on the role of Principal Investigator for NIHR supported studies.
- We continue to collaborate with a wide range of universities and other NHS providers to deliver large multi-site research studies for the benefit of our service users, carers, and staff. Through these collaborations we have been awarded a further two NIHR research grants this year.

2.12 Use of the Commissioning for Quality and Innovation (CQUIN) Payment Framework

A proportion of our Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between Tees, Esk and Wear Valleys NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2022/23 and for the following 12 month period are available on request from Ashleigh Lyons, Head of Performance, email Ashleigh.lyons@nhs.net.

2.13 What the Care Quality Commission (CQC) says about us

The CQC is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Tees, Esk and Wear Valleys NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions for services being delivered by the Trust. The Trust is therefore licensed to provide services.

The CQC took enforcement action against Tees, Esk and Wear Valleys NHS Foundation Trust during 2022/23. We have not participated in a special review/investigation by the CQC during the reporting period.

We are subject to periodic reviews by the CQC and a number of reviews have taken place this year. A comprehensive inspection of adult inpatient learning disability wards took place between 29 May to June 22.

A further focused inspection of community child and adolescent mental health services and secure inpatient services took place in July 2022. This considered review of the actions and improvements taken by these services in response to the Section 29a notification issued in August 2021.

The CQC's assessment of our Trust following these reviews remained requires Improvement. Changes to the core service areas inspected did however change, and the overall rating for adult inpatient learning disability wards moved from good to inadequate.

The outcome of the community child and adolescent mental health services inspection remained as requires improvement, with the safe domain improving from inadequate to requires improvement.

The outcome of the secure inpatient service inspection improved overall ratings, increasing from inadequate to requires improvement.

Inspections of the adult inpatient learning disability wards demonstrated that people's care and support was provided in a clean, well-equipped, well-furnished and well-maintained environment which mostly met people's sensory and physical needs. Some people made choices and took part in activities which were part of their planned care and staff supported them to achieve their goals.

However, some issues with care delivery were noted. The service did not meet all of the principles of Right Support, Right Care, Right Culture. Inspections of the service observed some issues with staffing levels, training, restrictive practices and safeguarding processes. Some people experienced delayed discharges due to there not being sufficient appropriate community provision.

Inspections of community child and adolescent mental health services were undertaken by the CQC to see if improvements had been made following the section 29a notification issued in June 2021. The CQC found that the senior management team had responded promptly to address issues identified at the previous inspection. Inspections demonstrated that the service was achieving its targets of maintaining contact with children and young people on waiting lists. It also observed that premises were clean, well maintained and well furnished.

Some issues were noted regarding a high number of vacancies and high caseloads in some teams. Improvements were also required in completion of mandatory training for some staff.

Inspections of the secure inpatient service were undertaken by the CQC to see if improvements had been made following the CQC section 29a notification issued in June 2021. The CQC found that the culture within the service had improved since the previous inspection, staff felt more supported by managers and there were mechanisms in place to

allow staff to escalate any staffing concerns. Staff actively involved patients, families and carers in care decisions and staff supported patients well to live healthier lives. The ward teams had access to a range of specialists required to meet the needs of patients and staff worked well together as a multi-disciplinary team.

Some issues were noted regarding staffing, safeguarding and restrictive practices and improvements were required in facilitating holistic activities for patients.

Tees, Esk and Wear Valleys NHS Foundation Trust intends to take the following action to address the points made in the CQC's assessment: Immediate action was taken in response to the inspection findings and a comprehensive action plan was developed to ensure that areas of risk were being adequately addressed. Implementation of the action plan has been well progressed with routine reporting and oversight through the Trust's Quality Improvement Board.

Tees, Esk and Wear Valleys NHS Foundation Trust has made the following progress by 31 March 2023 in taking such action: 68 of 74 actions (92%) must do actions within the action plan have now been completed. The remaining six actions were on track with little risk to delivery.

Actions have included:

- Implemented a programme that will increase the knowledge and skills of staff in relation to patient safety, improve incident reporting and enable learning from patient safety incidents.
- Undertaken a caseload deep dive in community child and adolescent mental health services to improve caseload management and reduce team's overall caseload size and to allow for more timely appointments.
- Developed Keeping In Touch processes for patients waiting for community child and adolescent mental health services.
- Improved recruitment to vacant posts.
- Implemented recruitment and retention programmes to attract new staff.
- Undertaken a staffing establishment review.
- Undertaken a review of the clinical model in adult learning disability services.
- Improving the staffing skill mix in adult learning disability wards.
- Increased leadership capacity and visibility.
- Improved staffing escalation processes in secure inpatient services and adult learning disability services.
- Developed and implemented adult learning disability specific post incident rapid review guidance to support rapid reflection and learning.
- Implemented Reducing Restrictive Practice Assurance Panels.
- Improving mandatory and statutory training compliance.
- Embedding the new governance structure.
- Implemented the revised Board Assurance Framework.
- Developed systems for learning from incidents and complaints.
- Developed and enhanced the Trust's corporate risk register.
- Review of the Safeguarding Policy.
- Reviewing the Speak Up and Whistle Blowing Policy.

In addition to clearly evidencing delivery of the required actions, we continue to implement a wider programme of change and improvement. During 2022/23 this has included, strengthening governance arrangements, increasing leadership visibility and oversight, improving staffing establishments and improving mandatory training and the quality of clinical supervision. Work has also been achieved to enhance organisational learning from a

range of internal and external sources. This has included strengthening and further developing mechanisms for capturing and communicating learning. In addition, significant progress has been made in implementing learning from the Quality Assurance and Improvement Programme to improve practice and gain assurance of the impact of our actions to improve care for patients, their families and carers.

This work continues to nurture a positive culture of patient safety and continuous quality improvement.

During 2022/23 we reported to and have been supported by an external Quality Board jointly chaired by the North East North Cumbria Integrated Care Board Lead Officer and the Regional Chief Nurse.

Tees, Esk and Wear Valleys NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

We are confident that we will continue to improve services and will work with staff, patients, carers, volunteers, governors, commissioners and partners to address the areas where standards were not as expected.

Further information can be found at: https://www.cqc.org.uk/provider/RX3

2.14 Information governance

The reporting deadline for the toolkit is now 30 June, so our position is as for our 2021/22 position which is 'approaching standards'.

We are currently at 91% completion of our information governance mandatory and statutory training.

Our Trust currently has a sickness rate of higher than 5% so our ability to achieve the 95% target has been impacted. Many other healthcare organisations are in the same situation, and NHS E have taken this on board for future iterations of the toolkit.

2.15 Freedom to Speak Up

There are a number of routes through which staff can raise concerns:

- Through their own management or professional structures.

- Through the Freedom to Speak Up team. This is as confidential as the person asks for it to be. Concerns are shared with the Director of People and Culture where possible to provide oversight of any ongoing or widespread themes, but where the person does not want this to happen, the Freedom to Speak Up team will support any investigation independently. Depending on the concern this may lead to a review commissioned by someone independent of the service or support given to the individual eg. through the Employee Support Service. Feedback is given to the person on a regular basis, in line with our revised process. As much feedback is given as appropriate although, by the nature of some concerns and investigations, full feedback is not always possible.

- Through the online raising concerns form which people can complete anonymously. Where the person leaves their name we respond directly to them. Where it is anonymous, the relevant director provides a written response to go on the staff intranet.

- Through our safeguarding team or directly to the CQC.

- Through our formal HR processes, the timescales of which vary and are laid out in the relevant policy.

- Through the Employee Support Service who will signpost and provide guidance on how to make best use of the options available.

- Through any trade union of which they are a member.

Any concerns of detriment are, in line with national guidance, dealt with through our normal HR processes. We have recently agreed that concerns will be passed to our Associate Director for Operations and Resourcing, with indication of who should not be involved in any review. They will provide the names of three people who could potentially look into it, so the person raising the concern has the opportunity to identify any conflicts of interest.

The Non-Executive Director Freedom to Speak Up lead has agreed that they will receive quarterly reports on these concerns and raise any issues with the Director of People and Culture and include their feedback in the Freedom to Speak Up reports to our Board.

2.16 Reducing gaps in rotas

Please note we are awaiting information on progress in bolstering staffing in adult and older adult community mental health services, following additional investment from local CCGs' baseline funding.

The role of Guardian of Safe Working for Postgraduate Doctors within our Trust sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

The Guardian is required to levy a fine against a department(s) if a postgraduate doctor:

- Works on average over 48 hours/week
- Works over 72 hours in seven days
- Misses more than 25% of required rest breaks
- On non-residential on call (NROC) does not have a minimum of continuous rest for five hours between 10pm and 7am
- Does not have the minimum eight hours total rest per 24-hour NROC shift
- Has more than the maximum 13-hour residential shift length
- Does not have the minimum 11 hours rest between resident shifts

The Guardian of Safe Working for Postgraduate Doctors within our Trust produces quarterly and annual reports to the Board that focus on gaps in medical rotas and safety issues.

The Board received the Guardian's annual report for 2022/23 at its meeting of 27 April 2023. During the year, the most common reasons for needing short-term/locum cover was due to vacancies on the rotas and staff sickness (short/long term).

Exception reports received related mostly to claiming additional hours whilst on NROC, having to stay later than normal working hours or shift end time or missing teaching/training due to staff shortages. Discussions on these issues have taken place at the relevant forums and additional staffing put in place where possible.

2.17 Learning from deaths

1. During 2022/23, 2329 Tees Esk and Wear Valley patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 577 in the first quarter, 552 in the second quarter, 661 in the third quarter and 539 in the fourth quarter.

2. By the end of 2022/23, 167 case record reviews and 62 investigations were carried out in relation to 2339 of the deaths included in item 1.

NB: case review record reviews have been defined as those cases falling under the Trust's mortality review process and investigations as cases that have been reported on the Strategic Executive Information System (StEIS) and investigated under the Serious Incident Investigation Framework. In Mental Health and Learning Disability Services we have a number of older people who are cared for in the community and their needs are such they only require minimal contact with us. Many of these people, who die, do so through natural causes as happens in the wider population. This explains the difference between the total number of deaths (from all causes including natural causes) and the numbers we go on to investigate further. To support staff in their decision making regarding the investigation of deaths, staff have clear policy guidance, setting out criteria for categories and types of review.

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 73 in the first quarter; 72 in the second quarter; 30 in the third quarter; 54 in the fourth quarter.

3. During 2022/2023 in keeping with our Journey to Change and whilst preparing for the new Patient Safety Incident Response Framework both of which focus on just culture and learning, we began categorising **all** learning from case reviews and investigations as actionable learning. This replaced terminology such as contributory findings/factors and root causes. 156 learning points were identified over 2022/2023. During each quarter the number of learning points identified from case record reviews and investigations were as follows. First Quarter 12, second Quarter 42, Third Quarter 45, and Fourth Quarter 57.

4. Significant work was undertaken during 2022/2023 to identify learning and themes from both case record reviews, and serious incidents investigations as identified in point 3 above.

The top 7 themes from serious incidents were identified as:

- Risk assessment and management (Safety Summary/Plan/contingency planning)
- Care planning
- Safeguarding (including use of PAMIC tool)
- Family involvement
- Record keeping
- Multi-agency working
- Records management

Themes from case record reviews were identified as:

- Risk assessment/risk management
- Communication between Trust teams
- Poor multi-agency working
- Poor consideration and management of risks related to medication and obesity
- Need to have a greater focus on review of service users mental state at depot clinics
- Poor physical health monitoring
- Poor record keeping

All learning in our Trust is now referred to as actionable learning which replaces previous categories of learning including root and contributory causes. This language supports our approach towards a just and learning culture in line with Our Journey to Change and a systems-based approach to learning.

Learning from all types of reviews is triangulated to identify emerging themes.

5. Learning from serious incidents, once reviewed, continues to be monitored against the themes identified in point 4 above. Our Quality Assurance Programme is regularly updated to reflect learning from patient safety incidents. It provides assurance that improvements are being made in relation to risk assessment, risk management, and contingency planning, care plans and carer involvement and that these improvements are being sustained in both inpatient and community settings.

Work around care planning and safeguarding forms part of our quality strategy in keeping with our Journey to Change.

Practice Development Practitioners (PDPs) are addressing areas of learning within their teams through compliance audits, coaching and supervision of staff. PDPs are integrated into the Fundamental Standards group where wider learning is shared to inform improvements in other areas.

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

Previous learning from case record reviews and early learning reviews has suggested that a community frailty pathway to help staff in recognising the deteriorating patient in community settings should be actioned. Training has commenced in recognition of the physically deteriorating patient in community settings. Work is underway with key stakeholders including the primary care networks to create a pathway and guidance document.

Our Trust continues to strengthen arrangements for organisational learning via the Organisational Learning Group. The group's role is to gain assurance that: a) we identify areas of learning b) we are implementing change to address areas of learning c) the actions we are taking are having the desired impact. Agenda items have included analysis of the Quality Assurance and Improvement report to determine the effectiveness of the assurance tools used, identification of emerging themes, effectiveness of associated actions and the learning from deaths improvement work with the Better Tomorrow Programme.

Forty patient safety briefings have been circulated trust wide during 2022/23 as a result of learning.

Examples of these briefings include:

- Accurate documentation of observations and general observations/care rounds for all inpatient, respite, and residential settings.
- Ensuring all staff are aware of how to access anti-barricade doors especially if there may be pressure behind the door.
- The importance of bowel monitoring when patients are on high dose anti-psychotic therapy (HDAT), or any medications where constipation could cause significant issues such as Clozapine.
- Delivering compassionate care and the importance of raising concerns.
- Raising awareness of the importance of seamless transfers of care and service delivery when patients move between services/trusts.
- Door handles - potential ligature risks.
- Shower drain – potential ligature risk.
- Emergency rescue of a collapsed person.
- Observation and engagement/care rounds.
- Guidance to support the identification and management of safeguarding (adult/child) cases.
- Patient leave - sharing of relevant information and keeping in touch plans.

The briefings circulated are specific about any assurance required from services. On receipt of completed actions these are documented in the local safety alert and learning database.

Learning from Serious Incidents Bulletins are also regularly distributed across our Trust. The bulletins have shared key learning and good practice highlighted in serious incident reviews considered at the Directors Assurance Panels. All briefings and bulletins are stored in the learning library on our staff intranet and are accessible to all employees.

The Environmental Risk Group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated trust wide via Patient Safety Briefings. Environmental surveys with a multi professional input from estates, health and safety and clinical services were recommenced.

In relation to safeguarding, the Quality Assurance tool for practice development reviews has demonstrated improvements in relation to identification of risk to others and from others within the safety summaries being discussed within Multi-disciplinary Team. Peer reviews (Quality Assurance tool 6) have evidenced good examples of safeguarding procedures and staff knowledge. Training figures indicated that over 90% of staff are compliant with mandatory safeguarding training in both Care Groups.

Connecting for people, suicide awareness training, continues, and our mandatory harm minimisation training was revised. The harm minimisation training continues to include updated headlines from serious incidents in relation to learning from deaths. Training dates are available up to 2024. Training has been adapted for relevant specialties, for example CAMHS. The training considers completion of documentation/record keeping, patient/carer involvement and the importance of multi-agency working. Bespoke training sessions in hot spot areas are available on request. For example, in front line teams such as Crisis.

As part of the improvement work around the serious incident process and learning from deaths, several training needs for staff trust wide were identified. These include incident reporting, holding difficult conversations with bereaved relatives, duty of candour/culture of candour, report writing and writing smart action plans. These were fed into the trust wide training needs analysis event.

The Incident Reporting and Serious Incident Review policy was reviewed to incorporate improvement work which was co-produced with clinical services and bereaved families/carers. It also includes the Patient Safety Incident Response standards. A designated programme manager continues to work with the project team to implement the Patient Safety Incident Response Framework (PSIRF) which will gradually be introduced in line with national requirements during Autumn 2023.

The Learning from Deaths policy was also reviewed. Both policies are aligned to Our Journey to Change in that we will ensure carers and families receive compassionate care following the loss of a loved one. We will continue to work closely with families and carers of patients who have died to ensure meaningful support and engagement with them at all stages, from the notification of death through to actions taken following an investigation/review.

We continue to work collaboratively as part of the Better Tomorrow Programme to facilitate shared learning/good practice and valid comparisons with other trusts.

A replacement risk management system has been procured that will bring additional benefits in terms of triangulation of learning and oversight of serious incident action plans.

Deaths of people with a dual diagnosis are increasing. Community transformation work has facilitated collaborative pathways across the system it operates within. It aims to create a core mental health service which is aligned with primary care networks and voluntary sector organisations to ensure that services are accessible to the community it serves and inclusive of population need.

7 Statement: [Number] case record reviews and [number] investigations completed after [date] which related to deaths which took place before the start of the reporting period.

8 Statement: [Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period] % of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the [name, and brief explanation of the methods used in the case record review or investigation].

9 Statement: [Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period] % of the patient deaths during [the previous reporting period] are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.18 PALS and complaints

Complaints are managed following national guidance and we endeavour to respond to all our formal complaints within 60 days. We have a complaints manager aligned to each Care Group of our Trust who works with operational colleagues, patients and/or carers to resolve the issue that has been raised.

Our policy and procedure for the Management of Compliments, Comments, Concerns and Complaints outlines our approach to receiving valuable feedback and information from patients and their carers about the services we provide.

When people raise concerns, they are given options by the Patient Advice and Liaison Service (PALS)/Complaints Team for taking their concerns forward. They may opt to have their concerns addressed by PALS staff liaising on their behalf with clinical staff or through meetings with the clinicians.

People may also choose at any point to have their concerns registered under the NHS Complaints Regulations (2009) with a more formal investigation and a written response letter from the Chief Executive.

During 2022/23 PALS dealt with 2,438 concerns or issues from patients and carers, an increase of 157 when compared to 2021/22.

1,008 (41%) of the concerns raised were around adult mental health services.

1,950 of the PALS concerns (80%) were closed within 15 working days (although no formal target is set for this). Non-compliance was largely in relation to obtaining timely feedback from operational services.

338 formal complaints were received and registered during 2022/23 compared to 300 for the same period last year.

Complaints across services:

- 230 in adult mental health services
- 69 in children and young people services
- 1 in crisis
- 13 in mental health services for older people
- 8 in secure inpatient services
- 0 in Health and Justice
- 1 in adult learning disability services and
- 16 in corporate services

2.19 Data quality

The latest published Data Quality Maturity Index (DQMI) score is 97.4. This is for December 2022.

Our Trust did not submit records during 2022/23 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Our Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

We did have a clinical coding audit for the Information Governance Toolkit. The results were 99% correct for primary diagnosis and 90.8% correct for secondary diagnosis.

We stopped making Commissioning Data Sets submissions that go to Secondary Uses Service and Hospital Episode Statistics about four years ago as the data was duplicated with the Mental Health Services Data Set. The Mental Health Services Data Set data quality for NHS Number and GP practice from the Data Quality Maturity Index publication for December 2022 were both 100%

2.20 Mandatory Quality Indicators
Since 2012/13, all NHS Foundation Trusts have been required to report performance against a core set of indicators:

Inpatients that are discharged are followed up within 72 hours.

341 people were not followed up within 72 hours during 2022/23.

The 72 hour measure is the percentage of people discharged from a CCG-commissioned adult mental health inpatient setting, that were followed up within 72 hours. This includes all people over the age of 18years.

Of our commissioned services, 2940 patients were discharged between 1st April 2022 and 31st March 2023; of those:

- 2599 were followed up
- 341 were not

Crisis Resolution Home Treatment team acted as gatekeeper
This measure was removed from the oversight framework in 2018/19. This is no longer a national access standard for Mental Health Trusts.

Patients' experience of contact with a health or social care worker

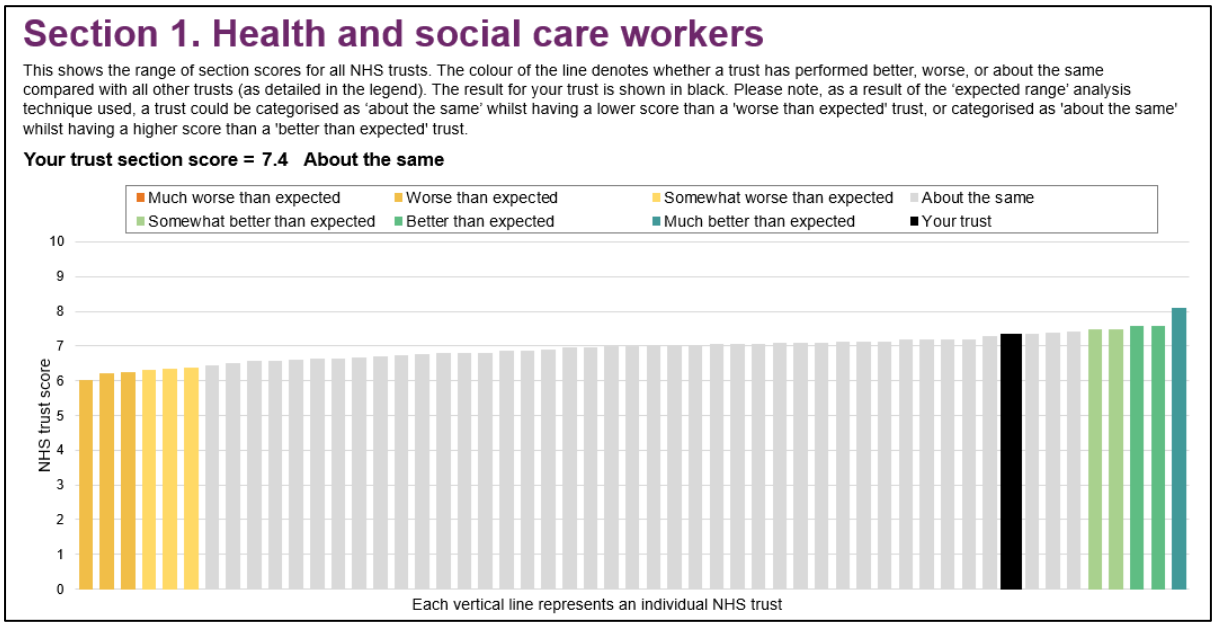
For 2022, we have reported the Health and Social Care Workers section score of the NHS Community Mental Health Survey Benchmark. This demonstrates improvements when compared to last year's section score.

TEWV Actual 2022	National Benchmarks in 2022	TEWV Actual 2021	TEWV Actual 2020	TEWV Actual 2019	TEWV Actual 2018
Overall section Score: 7.4 (sample size 251)	Highest/ best Mental Health Trust: 8.09. Lowest/ worst Mental Health Trust: 6.03	Overall Section Score: 7.3	Overall Section Score: 7.34	Overall Section Score: 7.3	Overall Section Score: 7.3

The section score is compiled from the results of the 3 survey questions below.

Question	TEWV Mean Score 2022	National Average 2022	TEWV Mean Score 2021
Were you given enough time to discuss your needs and treatment?	**7.7**	7.1	7.5
Did the person or people you saw understand how your mental health needs affect other areas of your life? (This includes contact in person, via video call and telephone).	**7.3**	6.8	7.2
Did the person or people you saw appear to be aware of your treatment history? (This includes contact in person, via video call and telephone).	**7.0**	6.9	7.0

The graph below shows the Trusts ranking against all Mental Health NHS Trusts nationally which is positive to note.



Patient Safety incidents including incidents resulting in severe harm or death

The data made available by NHS Digital with regard to the number of patient safety incidents, and percentage resulting in severe harm or death, reported within the Trust during the reporting period. **TEWV Actual Q3 22/23**	**National Benchmark in Q1 & Q2 22/23**	**TEWV Actual Q1 & Q2 22/23**	**TEWV Actual Q3 22/23**
Trust reported to NRLS: xx incidents reported of which xx (xx%) resulted in severe harm or death*	Not available	Trust reported to NRLS: xxxx incidents reported of which xx (x%) resulted in severe harm or death*	Trust reported to NRLS: xxxxx incidents reported of which xx (xx%) resulted in severe harm or death

PART 3 – Further Information on how we have performed in 2022/23

3.1 Introduction to part 3

Part 3 of this document contains further information which the legal guidance requires us to include. This includes statutory statements. As with Part 2, this helps to develop an overall picture of quality at our Trust.

3.2 Our performance against our quality metrics

The Quality Account has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report. The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

Quality metrics	Target	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark (where available)	
Patient safety indicators						
Percentage of patients who report 'yes, always' to the question 'do you feel safe on the ward?'	75.00%	55.57%	65.30%	64.66%	Not measured nationally	Please refer to section on Feeling safe. We are unable to benchmark with other mental health trusts as this is not universally collected. Intelligence gathered via the focus groups has informed the patient experience improvement plan and the work is being implemented. Delivery against the actions is being closely monitored via the care group and strategic governance routes. We also recognise that the feeling of safety is affected by some of an inherent aspect of some of our patient's mental health conditions. We will continue to focus on this important area of patient safety in 2023/24.
Number of incidents of falls (level 3 and above) per 1000 occupied bed days (OBDs) – for inpatients	0.35	0.28	0.17	0.13	The Royal College of Physicians discourage any benchmarking or comparisons due to the high number variables that exist that makes comparison unreliable.	Analysis of information suggests the slight increase in the rate of falls is associated with the increase in the acuity of patients accessing our services.

The number of incidents of physical intervention/ restraint per 1000 occupied bed days	19.25	33.27	28.84	20.9	Please refer to further benchmarking data in section below.
The number of medication errors with a severity of moderate harm and above	2.5	13	12	7	Not available
The number of serious incidents reported on STEIS	-	144	141	142	
Clinical Effectiveness Indicators	**Target**	**Whole Trust 22/23**	**Whole Trust 21/22**	**Whole Trust 20/21**	**National Benchmark**
Percentage of adults discharged from CCG-commissioned mental health inpatient services receive a follow-up within 72 hours	85%	88%	Previously reported indicator: (Existing percentage of patients on Care Programme Approach who were followed up within 72 hours after discharge from psychiatric inpatient care)		
Adults with a long length of stay over 60 for adult admissions	N/A	12%	N/A	N/A	According to the NHS Oversight Framework System Benchmarking as at February 2023, national rank 9 out of 52 mental health providers and are performing within the highest performing quartile.
Older adults with a long length of stay over 90 days for older adult admissions	N/A	35%	N/A	N/A	According to the NHS Oversight Framework System Benchmarking as at February 2023, national rank 10 out of 52 mental health providers and are performing within the highest performing quartile.

Patient experience indicators	Target	Whole Trust 22/23	Whole Trust 21/22	Whole Trust 20/21	National benchmark
Percentage of patients who reported their overall experience as very good or good	92.00%*	92.16%	94.34%	93.21%	87%
Percentage of patients that report that staff treated them with dignity and respect	94.00%	86.69%	84.72%	86.77%	95%
Number of complaints raised	-	338	257	533	-

* *Previous target was 94% changed Dec 2023 to 92%*

Comments on areas for improvement

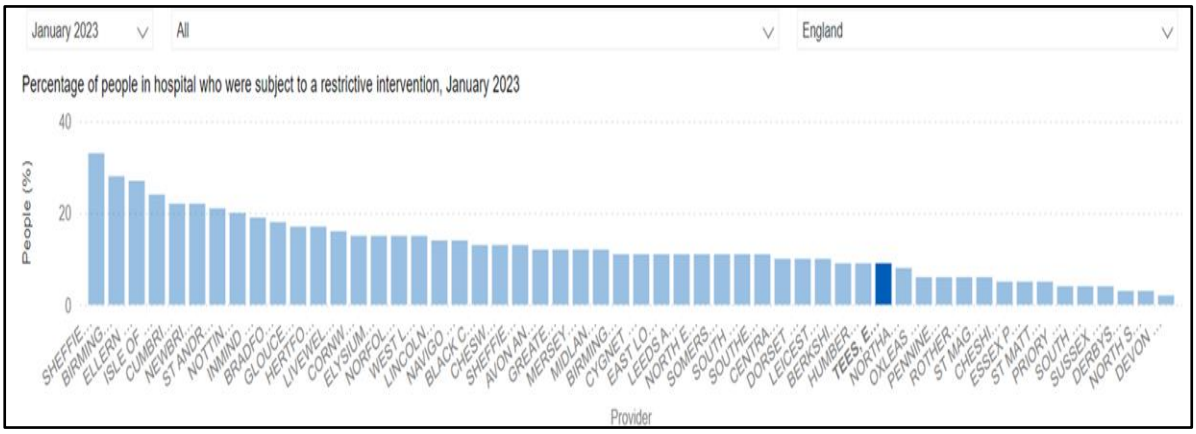
Percentage of patients reported 'yes always' to the question 'do you feel safe on the ward'?
The end of 2022/23 position was 55.57% which relates to 962 out of 1731 surveyed. This is 19.43% below our target of 75.00%. Both Care Groups have underperformed this year. Durham, Tees Valley and Forensics with 54.72% and North Yorkshire, York and Selby with 58.94%. This area continues to be a priority for 2023/24.

Number of incidents of physical intervention/ restraint per 1000 occupied bed days (OBDs) – for inpatients
The end of 2022/23 position was 33.27 which relates to 7873 incidents and 236,605 OBDs. This is 14.02 above our target of 19.25

North Yorkshire, York and Selby were the only Care Group achieving the target with a rate of **12.78**. Within Durham, Tees Valley and Forensics Care Group the actual rate was **38.23.** This higher rate is due to a large proportion of the restrictive intervention usage in a small number of wards in adult learning disabilities where this is more likely to occur in a small group of patients with complex needs.

We have been working with Mersey Care NHS Foundation Trust implementing the HOPES model, a care approach that reduces the use of long-term segregation sometimes experienced by autistic adults, adults with a learning disability and children and young people. We now have a dedicated HOPE(S) practitioner, to work in partnership with the national team and Mersey Care NHS Foundation Trust.

The graph below illustrates the Trusts positive position against other mental health trusts nationally. We continue to work towards the long-term reduction of all forms of restrictive intervention. A range of actions are in progress via our Restrictive Intervention Reduction Plan.



	Total mean 22/23	Total mean 22/23 (ALD inpatient services excluded)
Incidents involving restrictive interventions	578.56	321.20
Total number of restrictive interventions used	897.73	504.82
Use of prone restraint	10.08	8.04
Use of supine restraint	208.68	88.64
Use of rapid tranquilisation	107.32	91.12
Use of seclusion	82.82	14.64
Use of tearproof clothing	7.64	7.64
Use of mechanical restraint	2.48	2.48

Percentage of patients that report that staff treated them with dignity and respect
The end of **2022/23** position was **86.69%** which relates to **8718** out of **10057** surveyed. This is **7.31%** below our target of **94.00%.**

Broken down by Care Groups, we are pleased that the majority of our patients are treated with dignity and respect. North Yorkshire, York and Selby are closest to the target with **91.03%** with Durham, Tees Valley and Forensics **85.06%**.

We continue to focus on this important area of patient experience. Our patients tell us that treating people with dignity and respect includes staff treating people in a caring and compassionate way which will be strengthened by the work we are doing on our Trust values and empathy training for staff. It is also about involving people in decisions around their care which will be supported by the ongoing quality priority around personalised care planning and our goal of co-creation. Having an environment that respects privacy and dignity is

important, and we are proud that we have eliminated all dormitory accommodation and all patient bedrooms are now single, many with ensuite facilities.

The number of medication errors with a severity of moderate harm and above
The end of **2022/23** position was **13** which is **10.5** above our target of **2.5.**

These 13 were split across the Care Groups. North Yorkshire, York and Selby had five and Durham, Tees Valley and Forensics had eight medication errors with a severity of moderate harm and above.

A review of incidents (moderate harm and above) identified medication errors occurring mainly in relation to medications such as Clozapine, Lithium and Depot Medication. In response to this, the Pharmacy Team has led workstreams focused on making practice improvements to reduce the number of incidents reported. The Safe Medication Practice Group has co-created action plans to address key issues. Actions delivered during 2022/23 have included changes to procedures, development of e-learning training packages for staff and the production of posters focused on patients to raise their awareness of the key side effects of medication.

These incidents occur in low numbers and are routinely reported to the Trust's Board through the Integrated Performance report to ensure robust monitoring and oversight.

3.3 Our Performance against the System Oversight Framework Targets and Indicators

The NHS Oversight Framework is built around five national themes:

- Quality of care, access and outcomes
- Leadership and capability
- People
- Preventing ill health and reducing inequalities
- Finance and use of resources

A sixth theme focusses on local strategic priorities.

The five themes are underpinned by 23 key performance measures and sub-measures and Trust and Integrated Care Board (ICB) performance is monitored via an allocation to a top, inter or bottom quartile. Typically, those 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).

Our Trust is currently placed within segment 3; 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 and 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 are below:

1) Quality, access and outcomes: Mental health
There are four 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.

TEWV	**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 ranges as at December 2022 (500) 23 out of 56 Trusts.

North East and North Cumbria ICB	**Oversight standard**	**Q1**	**Q2**	**Q3**	**Q4**	**Latest national position**
Access rate for IAPT services	100%	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%	114.52%	113.38%	113.65%	112.47%	
Access rates to community mental health services for adult and older adults with	100%	211.2%	211.49%	214.24%	217.97%	

severe mental illness						

Humber and North Yorkshire ICB	Oversight standard	Q1	Q2	Q3	Q4	Latest national position
Access rate for IAPT services	100%	85.67 %	85.53%	97.43%	96.39%	Interquartile ranges as at December 2022 21 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100%	148.9 %	153.31 %	153.10 %	154.21 %	
Access rates to community mental health services for adult and older adults with severe mental illness	100%	239.47 %	231.06 %	227.55 %	218.56 %	

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 group results	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 group results	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 group results	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 group results	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	As per staff survey benchmarking group results	25.00%	25.00%	25.00%	23.00%	Interquartile range as at 2021 survey (24%) 20 out of 70 Trusts

members of the public						
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%	

3.4 Learning from West Lane Hospital

On 2 November 2022, three NHS England independent investigation reports were published following the deaths of three young people in our care between 2019 and 2020.

The reports looked at the care and treatment of Christie Harnett, Nadia Sharif and Emily Moore at West Lane Hospital in Middlesbrough, and in addition for Emily, at Lanchester Road Hospital in Durham, as well as the actions for partner organisations. The investigation was commissioned by NHS England and carried out by Niche Health and Social Care Consulting.

In response to the findings of the three reports our Chief executive said:

“On behalf of the trust, I would like to apologise unreservedly for the unacceptable failings in the care of Christie, Nadia and Emily which these reports have clearly identified.

“The girls and their families deserved better while under our care. I know everyone at the trust offers their heartfelt sympathies and condolences to the girls’ family and friends for their tragic loss.

“We must do everything in our power to ensure these failings can never be repeated.

“However, we know that our actions must match our words. We accept in full the recommendations made in the reports – in fact the overwhelming majority of them have already been addressed by us where applicable to our services.

“It is clear from the reports that no single individual or group of individuals were solely to blame – it was a failure of our systems with tragic consequences.

“We have since undergone a thorough change in our senior leadership team and our structure and, as importantly, changed the way we care and treat our patients. However, the transformation needed is not complete. We need to get better and ensure that respect, compassion, and responsibility is at the centre of everything we do.”

The reports and our response to the identified recommendations is available as follows:

Report and our response to the recommendations: Christie Harnett
Report and our response to the recommendations: Nadia Sharif
Report and our response to the recommendations: Emily Moore

In addition to the three reports published, a further system-wide independent investigation report was published on 21 March 2023 looking into the concerns and issues raised relating to the safety and quality of CAMHS provision at West Lane Hospital.

The report included recommendations for our Trust as well as other organisations. The assurance statement is our response to the recommendations, and this was published at the same time.

The report and our response is available as follows:

Report and response to the recommendations: System-wide independent investigation

We stopped delivering inpatient CAMHS provision in September 2019 at West Lane Hospital.

Our Trust accepted in full the recommendations made in the reports and we reiterated how deeply sorry we are for the events that contributed to the deaths of Christie, Nadia and Emily.

In the three years since these tragedies, we've made significant improvements in our environments, how we organise staff and services and most importantly how we more closely involve families and loved ones themselves.

These improvements are being delivered through our five year change programme, Our Journey to Change, in line with our three big goals to co-create a great experience for our patients, carers and their families, for our staff and our partners. This includes an unrelenting focus on patient safety, supported by a robust quality assurance schedule.

3.5 Learning from Okenden- the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust

The consideration of learning from organisations across the health and social care system is essential to continuous improvement and the provision of high quality care. All trust boards have a duty to prevent failings found in the wider NHS from happening within their organisations and the local system. Our Trust is committed to applying such learning and to take action to mitigate any risks identified.

The independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt MP when he was Secretary of State for Health and Social Care, and commissioned by NHS Improvement, to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the Trust in 2009 and 2016 respectively.

The independent review examined the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. The review found that consistently lessons were not learned, mistakes in care were repeated, and the safety of mothers and babies was unnecessarily compromised as a result.

There were a number of reviews carried out by external bodies, including local clinical commissioning groups and the Care Quality Commission, during the last decade. The review team was concerned that some of the findings from these reviews gave false reassurance about maternity services at the Trust, despite repeated concerns being raised by families, and therefore opportunities for improvement were lost.

The Ockenden report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022 and is available as follows:

Ockenden review: summary of findings, conclusions and essential actions

NHSE/I wrote to all trusts to ask that the Ockenden report and its recommendations be considered at public board meetings and shared with all relevant staff. Trusts were expected

to take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

In April 2022 a paper presenting the key learning from the Ockenden review was presented to our Trust Board. It recognised the wider implications for learning and improvement across our organisation in relation to the four key pillars.

Key learning from the four pillars has helped inform continuous improvement workstreams in our Trust, for example the ongoing work on safer staffing, implementation of the national Patient Safety Incident Review Framework, developing mechanisms for recognising and sharing learning from incidents, patient safety events, complaints and patient, family and carer feedback and involving families in the serious incident review process.

The Trust's Organisational Learning Group has reviewed the report further and agreed additional actions to mitigate any risks identified with specific reference to the four key pillars

3.6 Identifying closed cultures

Following findings of patient abuse at the Edenfield Centre at Greater Manchester Mental Health Foundation Trust, the National Director for Mental Health wrote to all NHS trusts to request specific areas of care were reviewed by trust boards. In addition to this, the Humber and North Yorkshire Integrated Care Board requested that providers within the Mental Health, Learning Disability and Autism Provider Collaborative review the mitigations in place to prevent closed cultures like that at the Edenfield Centre from developing.

The CQC has undertaken some significant work on defining and identifying closed cultures. They describe a closed culture as, "a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches. The development of closed cultures can be deliberate or unintentional – either way it can cause unacceptable harm to a person and their loved ones."

Our Trust recognises that many of our services are at inherent risk of developing a closed culture because of the services provided, where some people are not free to leave and have multiple vulnerabilities. This includes all our inpatient services where people may be treated under the Mental Health Act.

In response to learning from the Edenfield Centre and the need to provide assurance both internally and to the ICB, the Nursing and Governance Directorate developed a cultural assessment tool or 'trigger tool'. This tool was informed by the characteristics of a closed culture identified through the project work of the CQC.

The first stage of our review involved a tabletop review of all inpatient wards using the cultural assessment tool. This allowed us to identify wards with the highest risk of developing a closed culture. Following this the 48 inpatient wards were independently visited.

We used the 'see, hear and feel' approach to test out, at patient care level, the factors that impact on patient and staff safety and experience and therefore impact on culture. Findings were reviewed for positive and negative themes. Any immediate concerns identified were escalated and remedial action was taken.

The exercise gave us improved visibility and there was positive feedback received from the Trust's Care Groups and visiting teams about this approach.

It should be acknowledged that quantitative, qualitative data and ward reviews alone will not inform the Trust of closed cultures, however they support the identification of early warning signs of poor cultures and therefore are effective at mitigating risks in conjunction with a wider quality assurance approach.

The majority of feedback from both staff and patients and from observations of practice suggested many aspects of good practice from compassionate and caring staff.

While teams and reviewers found this work to be worthwhile, no closed cultures were identified. We recognise that closed cultures are very difficult to spot, therefore this exercise has been seen as part of a need for wider and ongoing surveillance to identify risks and address poor cultures emerging at an early stage.

3.7 Reading the Signals - Maternity and Neonatal Services in East Kent

Following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHS E/I) commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust.

The final report Reading the Signals - Maternity and Neonatal Services in East Kent was published in October 2022.

It reviewed 202 cases of families who received care in East Kent between 2009 to 2020.

The review found a clear pattern. Over that period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.

The individual and collective behaviours of people providing the services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020 and lay at the root of the pattern of recurring harm. The report identified eight clear separate missed opportunities, both internally and externally, when these problems could and should have been acknowledged and tackled effectively.

It found that the Trust treated problems as limited one-off issues, rather than acknowledging the systemic nature of the challenges and confronting the issues head on. When issues were brought into public focus, it found the Trust focussed on reputation management, reducing liability through litigation and a 'them and us approach'. This got in the way of patient safety and learning.

A copy of the full report is available as follows:

Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation

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

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

A paper was presented to our Trust Board in February 2023 that set out the key issues and learning from the national report, recognising that they are not unique to East Kent Trust or only trusts delivering maternity services. The paper provided details on how learning from the report has been taken forward to mitigate risks to quality and safety and included an overview of assurance against the recommendations and potential delivery risks.

Our response reinforced the importance of culture and the need for patient safety to be a priority for the Board. The paper detailed the assurance mechanisms in place across our Trust including the recent use of team cultural assessments across all inpatient wards, the development of quality and safety dashboards to highlight hot-spots and track changes in quality and safety including safe staffing over time and improved systems for organisational learning.

In relation to culture and behaviours, the establishment of two lived experience directors as core members of the Care Group Boards as well as the continued recruitment of peer workers into our Trust seeks to positively influence culture and achieve our goals of co-creation in everything we do.

Work also includes improvements to risk management systems and the more effective use of the risk register to support enhanced oversight, assurance and management of risks. In addition, our dedicated Quality Assurance and Improvement Programme focuses on key quality and safety issues and is informed and regularly refreshed to take account of new learning.

We have also set out actions we will take to further triangulate workforce and quality information and to continuously improve teamwork with a common purpose. Due to the importance of the learning, an interactive discussion and presentation on the Kirkup review has continued to be delivered at multiple clinical and managerial leadership sessions across our Trust.

3.8 External audit

Under guidance from NHS England, the Quality Account 2022/23 is not subject to review by external audit.

3.9 Our stakeholders' views

Summary of stakeholders' views to be included

Appendix 1: 2023/24 Statement of directors' responsibilities in respect of the Quality Account

Please note we are awaiting some dates in this section.

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Accounts/Reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the Quality Account/Report.

In preparing the Quality Account/Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Account/Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2022/23 and supporting guidance
- The content of the Quality Account is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2022 to May 2023
  - Papers relating to quality reported to the Board over the period April 2022 to May 2023
  - Feedback from the integrated Care Boards *dated xx* and *dated xx*
  - Feedback from Healthwatch *dated xx*
  - Feedback from Overview and Scrutiny Committees *dated xx*
  - Feedback from Health and Wellbeing Boards *dated xx*
  - The Trust's complaints information reported to its Quality Assurance Committee of the Board of Directors, which will be published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - The latest national patient survey *published xx*
  - The latest national staff survey *published xx*
  - CQC inspection report *dated xx*
  - The Quality Account/Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
  - The performance information reported in the Quality Account/Report is reliable and accurate
  - There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account/Report, and these controls are subject to review to confirm that they are working effectively in practice
  - The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Account regulations) as well as the standards to support data quality for the preparation of the Quality Report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account/Report

By order of the Board.

Appendix 2: Glossary

Adult Mental Health (AMH) Services: Services provided for people aged between 18 and 64 – known in some other parts of the country as 'working-age services. These services include inpatient and community mental health services. In practice, some patients younger than 64 may be treated in older people's services if they are physically frail or have Early Onset Dementia. Early Intervention in Psychosis (EIP) teams may treat patients less than 18 years of age as well as patients aged 18-64.

Audit: An official inspection of records; this can be conducted either by an independent body or an internal audit department.

Autism: This describes a range of conditions typically characterised by social deficits, communication difficulties, stereotyped or repetitive behaviours and interests, and in some cases cognitive delays. People with autism are sometimes known as neuro-diverse. Autism cannot be cured, but the mental illnesses which are more common for people with autism can be treated.

Board/Board of Directors: Our Trust is run by a Board of Directors made up of the Chairman, Chief Executive, Executive and Non-Executive Directors. The Board is responsible for ensuring accountability to the public for the services in manages. It is overseen by a Council of Governors and monitored by NHS England. It also:

- Ensure effective dialogue between our Trust and the communities we serve
- Monitors and ensures high quality services
- Is responsible for our financial viability
- Appoints and appraises our executive management team

Business plan: A document produced once a year to outline what we intend to do over the next three years in relation to the services that we provide.

Child and Adolescent Mental Health Services (CAMHS): See Children and Young People's Services (CYPS).

Care Planning: See Care Programme Approach (CPA).

Care Programme Approach: describes the approach used in specialist mental health care to assess, plan, review and coordinate the range of treatment options and support needs for people in contact with secondary mental health services who have complex characteristics. It is called 'an approach' rather than a system because of the way these elements are carried out, which is as important as the tasks themselves. The approach is routinely audited.

Care Quality Commission (CQC): The independent regulator of health and social care in England. They regulate the quality of care provided in hospitals, care homes and people's own homes by the NHS, Local Authorities, private companies, and voluntary organisations, including protecting the interests of people whose rights are restricted under the Mental Health Act.

Children and Young People's Services (CYPS): Mental Health Services for children and young people under the age of 18 years old. This includes community mental health services, inpatient services and learning disability services.

Cito: An information technology system which overlays the Trust's patient record system (PARIS) which makes it easier to record and view the patient's records.

Clinical Commissioning Groups (CCGs): NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. CCGs are clinically led groups that include all GP practices in their geographical area. The aim of this is to give GPs and other clinicians the power to influence commissioning decisions for their patients. CCGs are overseen by NHS England.

Clinical Supervision: a supportive mechanism which involves clinicians meeting regularly to reflect on practice, with the intention of learning, developing practice and providing high quality, safe care to patients.

Commissioners: The organisations that have responsibility for purchasing health services on behalf of the population in the area they work for.

Commissioning for Quality and Innovation (CQUIN): A payment framework where a proportion of NHS providers' income is conditional on quality and innovation.

Community Mental Health Survey: a survey conducted every year by the CQC. It represents the experiences of people who have received specialist care or treatment for a mental health condition in 55 NHS Trusts in England over a specific period during the year.

Confidential Inquiry: A national scheme that interviews clinicians anonymously to find out ways of improving care by gathering information about factors which contributed to the inability of the NHS to prevent each suicide of a patient within its care. National reports and recommendations are then produced.

Co-production/Co-creation: This is an approach where a policy or other initiative/action is designed jointly between our staff and patients, carers, and families.

Council of Governors: Made up of elected public and staff members and includes non-elected members such as the prison service, voluntary sector, acute trusts, universities and local authorities. The Council has an advisory, guardianship and strategic role including developing our Trust's membership, appointments and remuneration of the non-executive directors including Chairman and Deputy Chairman, responding to matters of consultation from the Trust Board, and appointing the Trust's auditors.

Crisis Resolution & Home Treatment (CRHT) Team: Provide intensive support at home for individuals experiencing an acute mental health crisis. They aim to reduce both

the number and length of hospital admissions and to ease the pressure on inpatient units.

Dashboard: A report that uses data on a number of measures to help managers build up a picture of operational (day-to-day) performance or long-term strategic outcomes.

Data Protection and Security Toolkit: A national approach that provides a framework and assessment for assuring information quality against national definitions for all information that is entered onto computerised systems whether centrally or locally maintained.

Data Quality Strategy: A strategy which sets out clear direction and outlines what the Trust expects from its staff to work towards our vision of providing excellent quality data. It helps TEWV continue to improve the quality and value of our work, whilst making sure that it remains clinically and financially sustainable.

Department of Health: The government department responsible for health policy.

DIALOG+: A clinical tool that allows for assessment, planning, intervention, and evaluation in one procedure and allows more personalised care planning.

Forensic Adult and Mental Health and Learning Disability Services: Work mainly with people who are mentally unwell or who have a learning disability and have been through the criminal justice system. The majority of people are transferred to a secure hospital from a prison or court, where their needs can be assessed and treated.

Formulation: When clinicians use information obtained from their assessment of a patient to provide an explanation or hypothesis about the cause and nature of the presenting problems. This helps in developing the most suitable treatment approach.

Freedom to Speak Up Guardian: Provides guidance and support to staff to enable them to speak up safely within their own workplace.

Friends and Family Test (FFT): A survey put to service users, carers and staff that asks whether or not they would recommend a hospital/community service to a friend or family member if they need treatment.

Gatekeeper/gatekeeping: Assessing the service user before admission to hospital to consider whether there are alternatives to admission and the involvement in the decision-making processes that result in admission.

General Medical Practice Code: The organisation code of the GP Practice that the patient is registered with. This is used to make sure a patient's GP code is recorded correctly.

Guardian of Safe Working: Provides assurance that rotas and working conditions are safe for doctors and patients.

Harm minimisation: Our way of working to minimise the risks of sometimes multiple and conflicting harm to both service users and other people.

Health and wellbeing boards: The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and care system (i.e., local authorities and the NHS) would work together to improve the health and wellbeing of their local population and to reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities, and encourage commissioners to work in a more joined-up way.

HealthWatch: Local bodies made up of individuals and community groups, such as faith groups and resident's organisations associations, working together to improve health and social care services. They aim to ensure that each community has services that reflect the needs and wishes of local people.

Home Treatment Accreditation Scheme (HTAS): Works with teams to assure and improve the quality of crisis resolution and home treatment services for people with acute mental illness and their carers.

Hospital Episode Statistics (HES): The national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organisations and individuals.

Improving Access to Psychological Therapies (IAPT): An NHS initiative to increase the provision of evidence-based treatments for common mental health conditions such as depression and anxiety by primary care organisations.

Integrated Information Centre (IIC): Our system for taking data from the patient record (PARIS) and enabling it to be analysed to aid operational decision making and business planning.

Intranet: This is our Trust's internal website used for staff to access relevant information about the organisation, such as Trustwide policies and procedures.

Learning Disability Services: Services for people with a learning disability and/or mental health needs. We have an Adult Learning Disability (ALD) service in each Care Group and also specific wards for Forensic LD patients. We provide child LD services in Durham, Darlington, Teesside, and York but not in North Yorkshire.

LeDeR: The learning from deaths of people with a Learning Disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a Learning Disability and reduce health inequalities.

Local authority Overview and Scrutiny Committee (OSC): Statutory committees of each local authority which scrutinise the development and progress of strategic and operational plans of multiple agencies within the local authority area. All local authorities have an OSC that focusses on health, although Darlington, Middlesbrough, Stockton, Hartlepool and Redcar and Cleveland councils have a joint Tees Valley Health OSC that performs this function.

Mental Health Act (1983): The main piece of legislation that covers the assessment, treatment, and rights of people with a mental health disorder. In most cases when people are treated in hospital or in another mental health facility they have agreed or

volunteered to be there. However, there are cases when a person can be detained (also known as sectioned) under the Mental Health Act and treated without their agreement. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Mental Health Services for Older People (MHSOP): Services provided for people over 65 years old with a mental health problem. They can be treated for functional illness, such as depression, psychosis, or anxiety, or for organic mental illness (conditions usually associated with memory loss and cognitive impairment) such as dementia. The MHSOP Service sometimes treats people less than 65 years of age with organic conditions such as early-onset dementia.

Mortality Review Process: A process to review deaths, ensuring a consistent and coordinated approach, and promoting the identification of improvements and the sharing of learning.

Multi-Disciplinary: This means that more than one type of professional is involved, for example, psychiatrists, psychologists, occupational therapists, behavioural therapists, nurses, pharmacists all working together in a Multi-Disciplinary Team (MDT).

National Institute for Clinical Excellence (NICE): NHS body that provides guidance sets quality standards and manages a national database to improve people's health and to prevent and treat ill health. NICE works with experts from the NHS, local authorities, and others in the public, private, voluntary and community sectors – as well as patients and carers – to make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties.

National Institute for Health Research (NIHR): An NHS research body aimed at supporting outstanding individuals working in world class facilities to conduct leading edge research focused on the needs of the patients and the public.

National Reporting and Learning System (NRLS): A central (national) database of patient safety incident reports. All information submitted is analysed to identify hazards, risks, and opportunities to continuously improve the safety of patient care.

NHS England (NHSE): leads the National Health Service in England.

NHS Long-Term Plan (2019): A new plan for the NHS to improve the quality of patient care and health outcomes. It sets out how the £20.5 billion budget settlement for the NHS, announced by the Prime Minister in summer 2018, will be spent over the next five years.

NHS Staff Survey: Annual survey of staff experience of working within NHS trusts.

Non-executive directors (NEDs): Members of the Trust Board who act as a critical friend to hold the Board to account by challenging its decisions and outcomes to ensure they act in the best interests of patients and the public.

North Cumbria and North East Integrated Care System: Consists of four Integrated Care Partnerships – North, South, East, and West (see Integrated Care Partnerships).

PARIS: Our electronic care record, designed with mental health professionals to ensure that the right information is available to those who need it at all times.

Patient Advice and Liaison Service (PALS): A service within our Trust that offers confidential advice, support, and information on health-related matters. The team provides a point of contact for patients, their families, and their carers.
Peer worker: Someone who is trained and recruited as a paid employee within the Trust in a specifically designed job, to actively use their lived experience (as a patient or carer) to support other patients, in line with the recovery approach.

Prescribing Observatory in Mental Health (POMH): A national agency led by the Royal College of Psychiatrists, which aims to help specialist mental health services improve prescribing practice via clinical audit and quality improvement interventions.

Programme: A coordinated group of projects and/or change management activities designed to achieve outputs and/or changes that will benefit the organisation.

Project: A one-off, time limited piece of work that produces a product (such as a new building, a change in service or a new strategy/policy) that will bring benefits to relevant stakeholders. Within our Trust, projects will go through a scoping phase, and then a business case phase before they are implemented, evaluated, and closed down. All projects will have a project plan and a project manager.

Psychiatric Intensive Care Unit (PICU): A unit (or ward) that is designed to look after people who cannot be managed on an open (unlocked) psychiatric ward due to the level of risk they pose to themselves or others.

Quality Account: A report about the quality of services provided by an NHS healthcare provider, the report is published annually by each provider.

Quality Assurance Committee (QuAC): Sub-committee of the Trust Board responsible for quality and assurance.

Quality Assurance Groups (QuAG): Locality/divisional groups within the Trust responsible for quality and assurance.

Quarter one/quarter two/quarter three/quarter four: Specific time points within the financial year (1 April to 31 March). Quarter one is from April to June, quarter two is from July to September, quarter three is October to December and quarter four is January to March.

Reasonable adjustments: A change or adjustment unique to a person's needs that will support them in their daily lives, e.g., at work, attending medical appointments, etc.

Research Ethics Committee: An independent committee of the Health Research Authority, whose task it is to consider the ethics of proposed research projects which will involve human participants, and which will take place, generally, within the NHS.

Royal College of Psychiatrists: The professional body responsible for education and training and setting and raising standards in psychiatry.

Safeguarding: Protecting vulnerable adults or children from abuse or neglect, including ensuring such people are supported to get good access to healthcare and stay well.

Secondary Uses Service: The single, comprehensive repository for healthcare data in England which enables a range of reporting and analysis to support the NHS in the delivery of healthcare services.

Section 29a Notice: This is a warning notice served by the CQC where concerns are identified across either the whole or part of an NHS trust and where it is decided that there is a need for significant improvements in the quality of healthcare.

Serious incident (SI): An incident that occurred in relation to NHS-funded services and care, to either patient, staff, or member of the public, resulting in one of the following – unexpected/avoidable death, serious/prolonged/permanent harm, abuse, threat to the continuation of delivery of services, absconding from secure care.

Single Oversight Framework: sets out how NHS trusts and NHS foundation trusts are overseen.

Staff Friends and Family Test: A feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It helps us identify what is working well, what can be improved and how.

Statistical Process Control (SPC) charts: a graph used to show how a process changes over time and to see whether a situation is improving or deteriorating, whether the system is likely to be capable to meet the standard and whether the process is reliable or variable.

Steering group: Made up of experts who oversee key pieces of work to ensure that protocol is followed and provide advice/troubleshoot where necessary.

Strategic framework: primarily intended as a framework for thinking about the future and a guide to inform the investment and disinvestment decisions by those tasked with future planning.

Substance Misuse Services: Clinical services who work with people who abuse alcohol, illegal drugs or over the counter or prescription medications in a way that they are not meant to be used.

TEWV: Tees, Esk and Wear Valleys NHS Foundation Trust.
Thematic review: A piece of work to identify and evaluate Trustwide practice in relation to a particular theme. This may be to identify where there are problems/concerns or to identify areas of best practice that could be shared Trustwide.

The Trust: Tees, Esk and Wear Valleys NHS Foundation Trust.

Trust Board: See Board/Board of Directors above

Trustwide: The whole geographical area served by our Trust.

Unexpected Death: A death that is not expected due to a terminal medical condition or physical illness.

Urgent Care Services: Crisis, Acute Liaison and Street Triage services across our Trust.

Whistleblowing: this is a term used when a worker highlights a concern about their organisation and/or services to the Freedom to Speak Up Guardian or NHS Regulators. This will normally be regarding something they have witnessed at work.

Year (e.g., 2022/23): These are financial years, which start on the 1 April in the first year and end on the 31 March in the second year.

Appendix 3: Stakeholders' views

Feedback to be included

Tees, Esk and Wear Valleys
NHS Foundation Trust

Council of Governors
15th June 2023

Patrick Scott

Managing Director - DTVF

Operational Update

journey to change

Updates from DTVF Care Group

Tees, Esk and Wear Valleys NHS Foundation Trust

- New appointments into the Care Group – Welcome to;

❖ Jamie Todd, Director of Operations and Transformation for CAMHS and LD.

❖ John Savage, General Manager, LD.

❖ Ranjeet Shah, Care Group Medical Director.

- Successful and well attended 5-day RPIW to review our Governance took place in March 2023. Evidence in time saving across senior managers within the Care Group. New meeting structures are being implemented from 5th June.
- Financial Recovery – CRES targets
- Monthly Co Creation Board commencing 15th June.
- In June, Lived Experience Advisory Group met at Chester Le Street Cricket Club and co produced work with CNTW colleagues
- Feeling safe – From Feb to May there has been a 10% improvement in patients reporting they feel safe within inpatient wards

QI Update

Tees, Esk and Wear Valleys
NHS Foundation Trust

- RPIW Durham and Darlington Crisis Team Redesign
- RPIW to improve governance processes
- PIPA Refresh and local implementation events
- SIS provider collaborative referral admissions and discharge
- RPIW to make improvements in relation to taxi contract
- RPIW in relation to processes for handling of patient monies and valuables
- September - ADHD

Current key pressures

Tees, Esk and Wear Valleys NHS Foundation Trust

Workforce

- Continues to be the biggest risk and challenge for us
- Particular concern across Adult Mental Health/Secure Inpatient/Adult Learning Disability inpatient services, but also challenges within IAPT, crisis and some community services (adults and children's services), Health & Justice
- Daily staffing oversight and escalation in place across all services up to care group level.

Demand

- Across our inpatient estate and many of our community services, including ASD & ADHD for adults and children.
- Crisis Call Answer Rate anticipated to increase in Aug/Sep when the proposed all age screening team is introduced.

System pressures - Social Care & Providers

- Transitions for complex ALD patients and failures/closures of community placements with independent providers – the impact of this on the capacity of case management and delayed discharges

Teams in Business Continuity Plan

- Daily monitoring continues to be in place across services in BCP to monitor safe staffing levels with senior clinical and operational oversight of improvement planning and temporary reallocation of resource to maintain core service function, when needed. We are reviewing our processes around Business Continuity.
- Teams in BCP currently include: Roseberry Park Adult Mental Health inpatient services, Adult Mental Health Community Easington South, Durham and Darlington Adult Mental Health Crisis Services, Adult Learning Disability inpatient service, Stanley Community Team.

Spotlight on…

Tees, Esk and Wear Valleys NHS Foundation Trust

OJTC BIG GOALS	KEY WORK
To co-create a great experience for our patients, carers and families	• Trust-wide All Age Crisis Project – embedding learning from crisis line RPIW. • Bed Management work – to address barriers and ensure patients are in most suitable clinical setting. • Adult Learning Disability inpatient services – positive feedback from recent CQC inspection and follow-up Mersey Care visit and Challenging Behaviour Foundation – noted significant reduction in use of restrictive practices, increased S17 leave and increased staff morale. • Embedding learning from pilot in North Durham children and young people's service to focus on giving quality advice and improve quality of initial decision-making at point of referral - right support from the right place. • Team Manager development day in Health and Justice in June where the new model of care document will be shared. • Closed culture – the Associate Director of Nursing in Health and Justice has drafted the Trust Culture Review assessments to reflect the nuances of the service.

Spotlight on…

OJTC BIG GOALS	KEY WORK
To co-create a great experience for our colleagues	• Workforce transformation continues within community and inpatients across all services. • Appointed a recruitment lead for Health and Justice to assist with new appointments. • Bespoke HCA recruitment event at Bankfields Court with over 200 attendees and 90 candidates offered an interview during June. • Work to improve caseload management supervision processes for staff. • Staff Wellbeing – wide range of activities to support staff wellbeing, including reviewing rostering, weekly staff support sessions and comms, refreshing staff wellbeing (wobble) rooms and rest rooms, bespoke staff induction, clinical leadership and breaks. • The Trust were awarded Bronze for Better Health at Work Award in May 2023 • New governance processes to reduce time spent in meetings and create space in diaries. • New process for email and meeting etiquette to be rolled out. • The Trust's Rainbow Network joined the longest Pride March in the UK at York Pride 

Spotlight on…

Tees, Esk and Wear Valleys NHS Foundation Trust

OJTC BIG GOALS	KEY WORK
To be a great partner	• Community Mental Health Transformation across Adult Mental Health and Mental Health Services for Older People. • Quarterly Strategy Development days in diaries for senior leaders across all Care Group specialties and professional groups to focus on delivering our Journey to Change. • Neurodevelopmental pathway – draft option appraisal in progress with system partners. • Close working with CNTW paediatric service for children and young people with eating disorders – joint MDT workplan and decision making process. • Caseload management will move across to ICB from end of July. • Effective system working with Adult Learning Disability service which has effectively progressed a number of patient onward transitions. • CQC visit to Holme House Prison – excellent feedback. • Outreach work with communities to improve Secure Inpatient Service patients' integration into community.

Update from our DTVF Governance Time Out

Introduction:
DTVF held a week-long event to review governance arrangements within DTVF Care Group as part of the wider Trust governance review. We thought it was important to feedback to you some of things we did and what to look out for over the coming weeks.

What was our key focus of the event:

How information flows through our governance structure.

Ensuring the right conversations are taking place in the right place.

To make sure we make the best decisions.

How we standardise a consistent reporting format to allow shared learning.

How we communicate better.

Some of the things we agreed in the week-long event are:

- We have developed an information flow process from teams to care group board and back again each month.
- We agreed daily, weekly, monthly meeting process that ensures and monitors access, effectiveness safety and staffing.
- We agreed we need clearer agendas, shorter more purposeful meetings to focus on the real things that make a difference for our patients. It may not be perfect!

What is to come in the coming weeks

- The next few weeks more details shared.
- Briefings/webinars to be held next week.

Co-Creation Journey to Change

Introduction to Co-Creation

We value lived experience of people with life changing mental illness, living with a Learning Disability and/or neuro divergent, and the wisdom it can bring to our organisation. We want close partnership working with patients, families, and carers to provide best possible experience and outcomes. We define this as Co-creation. It is fundamental that the service we provide is co-created with the community we serve so we can deliver the best possible outcomes for people.

The Co-Creation Journey Goals

We want co-creation to run through everything we do, some of the things we are doing to embed co-creation in our everyday business are:

Supporting staff to create care plans that are written in partnership with patients and their families, so they have choice about their care and make shared decisions with their clinician.

We are building an involvement community that supports our trust business from policy to research, recruitment to quality improvement.

Create a growing and diverse peer workforce across all services, underpinned by peer values and driven by peer leadership.

Look at different ways we can hear the experience of all patients and families and understand the relationship between patient experience, complaints, and serious incidents.

Lived experience leadership roles supporting transformation and culture change

Co-Creation Challenges and Opportunities

There are both challenges and opportunities that we need to consider when we are embedding our co-creation strategy, these include:

Challenges:

We need to rebuild trust with our service users, carers, and partners.

We need to improve our communication, how we capture experience, information sharing and create a trauma informed, safe service.

We need to make sure that where co-creation happens people feel psychologically safe when giving their experiences.

We know that Co-creation can be difficult, take time and be uncertain.

Opportunities:

The foundations exist, as an organisation we have some great examples of co-created groups for example shadow groups for governance and participation groups.

We serve a large community with motivated and passionate members who are willing to work with us to create better services.

The Peer Support Worker training and workforce is strong and getting established across the trust.

The is a robust volunteer service bringing a range of experience and perspectives.

Co-Creation, where are we now?

We are finalising the co-creation journey and framework. Working closely with our involvement members, peers and growing our networks. Some highlights of the progress we have made so far are:

We are embedding the Community transformation programme. This is the vanguard of co-creation/co-production. Involvement in Hartlepool is award winning.

Lived experience roles are growing. Lived Experience directors, Transformation leads and Peer Support workers.

We are in the process of reviewing our PALs and Complaints services so we can respond quickly and incorporate learning into our day-to-day work.

Growing our involvement and engagement team. Dedicated CAMHS and Learning Disabilities leads.

Focusing on increasing diversity and the seldom listened too voices. One of the ways we will d this is through our Community Development Works.

Establish our co-creation/lived experience boards and networks.

Our People

Workforce and Staff Wellbeing

Introduction

We are aware that there are significant staffing pressures across our services and we wanted to let you know of some of the work that is going on to try and improve the situation. We recognise the extent that everyone does to ensure that we can provide **safe** and **effective** services every day.

Our purpose is to improve our recruitment and retention of people so we can ensure that our services are **safe**, we also want to be an attractive and enjoyable place to work. Our aim is to improve staff experience and positively impact people, families and partners we work with, these are some of the ways we have done this:

Our People

One of our key focuses is how we recruit and retain staff, these are some of the ways we are supporting this:

- **We have a dedicated Recruitment officer due to start in** DTVF and H&J to help get people into posts quickly.
- Many of you may be involved in the **DTVF Daily Staffing Call** and Roster work.
- We are recruiting **more staff** to ensure we maintain **safe staffing levels** with a focus on retention of staff for our **inpatient areas.**
- **Improving our knowledge around why people leave** through exit interviews.
- We are continuing to support **International recruitment.**
- Supporting services to fill our **current staff vacancies,** Support retention and centralised recruitment to ensure we know who we have and who we need.
- A focus on the majority of newly qualified nurses working in **inpatient services** and supporting where we have significant staffing pressures.
- Developing role specific recruitment videos.

Changing the Way That We Work

Following the pandemic, we recognised that staff work best in different ways, these are some of the things we are doing to support working differently:

- **We have introduced a Workforce coordinator role** to support Health Education England training places and improve access to psychological therapy.
- Facilitating the Trust **Leadership Programme**.
- Supporting the **Community Transformation Programme** in the Development of Mental Health Hubs.
- **DTVF Workforce Delivery plan** ideas and actions to support recruitment, retention and transformation including developmental posts.
- **We are undertaking a Job Description review** trust wide to ensure similarity in advertised roles.
- **DTVF Equality, Diversity and Human Rights** group set up to improve equality for people that use our Staff and Service Users.

Examples of some of new roles in the Trust

- Lived Experience Directors, peer support workers.
- Health and Wellbeing Coordinator
- Multi professional approved clinicians.
- Workforce Support roles.
- Childrens'/Mental Health Wellbeing Practitioners. Healthy Living Advisors

Embedding a Compassionate and Inclusive Culture

As a service we want to embed a culture that is compassionate and inclusive, these are some of the ways we will do this:

- Measure the **Experience of our staff** to find out what working at TEWV is like we will do this by Leadership walkabouts, Culture review & Staff surveys
- We have employed a **Health and Wellbeing coordinator** and wellbeing champions to support colleagues & teams.
- **Team sharing initiatives** – sharing good practice, to support staff wellbeing as well as working with local partners.
- Learning from **Freedom to Speak Up**
- **Celebrating success** and learning when things don't go to well, providing opportunities to share.
- We achieved the bronze **Better Health at Work Award** this year and working for the silver award.
- **Compassionate leadership**. Workforce delivery plan to further develop collective leadership and management styles.

And finally…….

- “It was abundantly clear the team demonstrated compassion and a strong commitment to improving outcomes”.
- Mersey Care (April 2023)

- Any Questions ?

ITEM NO. 12

For General Release

Meeting of:	Council of Governors Public Meeting
Date:	15th June 2023
Title:	North Yorkshire, York & Selby Care Group report June 2023
Executive Sponsor(s):	Zoe Campbell, Managing Director North Yorkshire, York & Selby Care Group
Author(s):	

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:

This reports relates to *all* risks in the BAF *other than*:

8: Cyber Security. A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage

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.

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

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Executive summary:

Purpose: The aim of this report is to provide information to and update the Council of Governors (CoG) on behalf of the North Yorkshire, York & Selby (NYYS) Care Group (CG).

Proposal: CoG receive the report as an update from the NYYS CG.

Overview: The key pressures, highlights and areas of focus for NYYS are set out below.

Training & supervision
There is an upward trajectory for mandatory and statutory training and supervision, with some areas, such as Learning Disability, hitting 90+% for training. In the main however, there is further work to be done to increase rates.

Finance
Financial risk remains, associated with out of area bed use (OAP) and use of agency staff. Recovery action plans have been partially successful. Targets and actions have been set for reductions and QIAs completed. Delayed transfers of care (DTOCs) are impacting on our OAP situation – DTOCs have been sitting at around 18 across NYYS. We continue to work closely with our partners in the broader system to alleviate these.

We have seen acute financial pressures within the system, however we have been advised of new funding for learning disability pathway/services across NYYS.

All age crisis line
Response rates have improved and currently sit at around 40%, however further improvement is required. Capacity continues to impact on ability to increase the pick-up rate.

A new delivery model has been agreed with commissioners that will increase the response rate but this will not be established until Jan – April 2024.

Staffing
Staffing remains a challenge. There are particular pressures for AMH in the Harrogate community team and consultant posts in Scarborough. The CG is working closely with colleagues in People and Culture and has established a focussed workstream. Recent success with international will be of benefit.

Co-creation
The NYYS Lived Experience Director continues to support the Trust's co-creation journey. The most recent CGB report highlighted the following:

- There will be a soft launch of a co-creation board in June 2023. This board will align with current care group structure, linking into core business aspects of the care group.

- Reporting mechanisms that would support the board such as Cocreation metrics are being explored. This will require support and input from colleagues from Digital and Data Services, Business Intelligence, Quality Governance, and Patient Experience.

- In line with the recent NHS complaints standards, a project team has been established to review the current PALS and Complaints handling service.
- Our first step is reviewing the approvals process.

- Trauma informed care (TIC) steering group established to take TIC work forward in a way which supports and values all the different strands of the work and develop a

structure within the Trust to support consistency, sustainability and integration. The TIC steering group is planning a day session to develop key workstreams, timelines and key deliverables.

Community mental health transformation
Work in this area continues to be a priority. We are currently, actively engaging partners to firm up and improve the offer in the York Community Hub.

Performance
The NYYS CGB has a continued focus on areas of concern within the integrated performance report. Performance improvement plans have been produced on all areas where performance is below target which will be monitored and tracked.

Governance
The recent governance review has resulted in a streamlined, more efficient governance process. The merging of 3 sub-groups into 1 overall quality, safety and improvement group will increase assurance to the CGB.

General

Item	Assurance level – *how?* Mitigations & actions	Risk reg.	Attention of exec sub group:
• Quality assurance: *Positive & safe* – Embedded care	• Assurance level: ***good*** • Assurance of safety and quality gained from 'go and see' approach of senior leaders, monitoring of key metrics: for		QAIG

group meeting to achieve reducing rates of restrictive interventions and embedding SafeWards program	patient experience, low levels of restrictive interventions **Actions:** • Evaluate attendance and meaningful value of the meeting with a view to aligning more closely with Fundamental Stds		
• Quality assurance: *Fundamental standards* - progressing towards a vibrant, interactive and live action & learning plans to enable the next step towards development of local accreditations.	• Assurance level: ***good*** • Assurance of safety and quality gained from 'go and see' approach of senior leaders, monitoring of key metrics & quality assurance audit tools **Actions:** • Dedicated Associate Director of Nursing to support Fundamental Standards • Evaluate attendance and meaningful value of the meeting with a view to aligning more closely with Positive and Safe • Director of Nursing to enable close working with corporate colleagues to progress the review of current QA tools • Launch pilot of care group governance assurance support program (Appendix III)		QAIG
• Patient experience & co creation - risk of silo working, missing key risks and losing cocreation aspect	• Assurance level: ***reasonable*** • Assurance to date sought from variety of sources and report productions **Actions:** • Finalise robust triangulated report into QAIG of patient experience and co creation based on service user feedback, complaints data etc • Ensure corporate patient experience kin attends service levels meetings update care group reflective of trust key people headings and objectives • Cocreation updates to be provide at QAIG		PCD QAIG
• Statutory and mandatory training	• Statutory and mandatory training Assurance level: ***limited*** • BLS showing upward trajectory overall but accessing courses issues remain. **Actions:** • Analysis underway for manual handling compliance in MHSOP. • QI work to continue		PCD
• Finance financial risk remains at end of year, associated with out of area bed	• Finance financial risk remains at end of year, associated with out of area bed use and use of agency staff.Assurance level: ***reasonable*** • Recovery action plans have in part		R&B

use and use of agency staff.	reduced this deficit to £3.5m which is 0.2m above the £3.3m recovery target **Actions:** • Targets and actions set for reductions and QIAs completed – impact on quality to be monitored via care group QAIG		
• Workforce planning – risk of silo working, missing key risks and losing cocreation aspect	• Assurance level: ***reasonable*** • Assurance to date sought from variety of sources and report productions **Actions:** • Finalise robust overarching People plan in care group reflective of trust key people headings and objectives • Finalise format of care group people report		PCD

AMH

Item	Assurance level Assurance- *how?* Mitigations & actions	Risk reg.	Attention of exec sub group:
• Vacancy – all professions &impact on service delivery in HHR CMHT & Crisis teams, Cross Lane & Foss Park Hospitals. From mid-May there will be no substantive Consultant Psychiatrists on Esk, Danby or SWR Community.	• Assurance level: ***reasonable*** • Assurance of safety and quality gained from 'go and see' approach of senior leaders, weekly oversight meetings for community and crisis services and monitoring of key metrics: for example good RN fill rates, patient experience, low levels of restrictive interventions **Actions:** • Locum solution for Cross Lane & Scarborough community until August 2023 • Recruitmnet plans in place with new recruits identified for September 2023 • Harrogate crisis team collapse into Northallerton out of hours • Agency usage	970 1261 1380 1416 1022 1033 1001 1287	QAIG & PCD
• All age crisis line team response remains low due to capacity, plus delay in procurement for the new model – moving launch 1-Jan-24 to 1-Apr-24.	• All age crisis line team response remains low due to capacity, plus delay in procurement for the new model – moving launch 1-Jan-24 to 1-Apr-24. Assurance level: ***reasonable*** • Assurance of safety and quality gained from 'go and see' approach of senior leaders, weekly oversight meetings for crisis services and monitoring of key metrics: patient experience **Actions** • QAIG confirmed support for option to extend existing VCS provider, contract variation to be drawn up. • Implications for NHS 111 to be worked through.	1131 1453	QAIG R&B

	• New risk being added to Risk Register.		
• LD admissions into AMH beds – inappropriate with potential of distress to patient, carers and staff	• Assurance level: ***reasonable*** • Assurance of safety and quality gained from 'go and see' approach of senior leaders, of key metrics: patient experience, restrictive interventions **Actions:** • Proactive in reach of LD link nurse • Deep dive into proactiveness of admission (non green light) and length of stay led by trust medical director • Enabling CTRs	1362 (ALD risk)	
Areas of good practice and substantial assurance			
• Low incidence of complaints and PALS • Low incidence of restrictive intervention inpatient settings			

MHSOP

Item	Assurance level – *how?* Mitigations & actions	Risk reg.	Attention of exec sub group:
• Delayed transfers of care (N=7): Issues in City of York due to no longer funding placements without prejudice plus lack of funding from CoY local authority	• Assurance level: ***reasonable*** • Assurance of safety and quality gained from 'go and see' approach of senior leaders, weekly DToC review meetings and monitoring of key metrics: for example physical health, patient experience **Actions:** • Intensive input from led nurses for transfers of care/S117 • Discussions between local authority and ICB continue. To be added to TEWV risk register, already included on ICB risk register.	Will be added	QAIG R&B
• High falls rate – Wold View (organic)	• Assurance level: ***reasonable*** • Assurance of proactive improvement planning by 'go and see' approach of senior leaders, multi disciplinary improvement plan monitored via QAIG **Actions:** • Recruitment of physical health matron & PDP • Peer review and action learning with Westerdale Ward	N/A	QAIG
• Acute liaison: Harrogate lack of security York team premises -	**Actions:** • Acute trust are bringing in external security services and training porters in control and restraint • Introductory meeting with care group DoN and acute DoN • No solution agreed, Chief Exec is involved	1269 1462	QAIG

inappropriate SWR team dynamic issues with impact on partner agency relationships	• Service Manager/Lead Psychiatrist/Modern Matron supporting huddle structure and discussions with Emergency Dept. • Team Manager post out to advert. • OD team available to support, regular review in place and this will be requested if seen as something that would help resolve any remaining issue		
Ares of good practice or substantial assurance			
• Lessons learned (from deaths) review has been shared at Trust level and will be presented at NYY Fundamental Standards Group and wider • Low incidence of complaint and PALs. 97% positive FFT feedback (numerical data unknown) • Low incidence of restrictive interventions • Positive CQC feedback regarding falls improvement work			

LD

Item	Assurance level – *how?* Mitigations & actions	Risk reg.	Attention of exec sub group:
No LD in patient facility – risk of out of areas admission	• Assurance level: ***good*** • Assurance of safety and quality gained from 'go and see' approach of senior leaders, demonstrable & effective admission avoidance work **Actions:** • Follow up on QI intensive support event – revised to enhanced service, launch date TBC • Transformation work has highlighted lack of understanding of core offer -four sub groups to be established including service model and governance	1362	QAIG
Areas of good practice or substantial assurance			
• Mand & Stat: overall compliance 90%+ • Excellent patient and carer feedback			

CAMHS

Item	Assurance level – *how?* Mitigations & actions	Risk reg.	Attention of exec sub group:
• Referrals of 17.5 year olds for autism assessments remains high (due to waiting lists they won't be assessed	• Assurance level: ***limited*** • Assurance of safety and quality gained from 'go and see' approach of senior leaders, key metrics such as patient experience and ongoing QI initiatives **Actions:**	1456	QAIG

before 18th birthday)	• GMs AMH and CAMHS to meet and agree on joint approach to discuss with commissioners		
• 16-25 years work	• Assurance level: ***limited*** • Assurance of safety and quality gained from 'go and see' approach of senior leaders, key metrics such as patient experience **Actions:** • Trust workstream to continue rather than be a time limited task & finish relating to transition in the NICHE report. This sits alongside NYY willingness to progress system wide discussions. • Priority to complete transition panels information gathering	N/A	QAIG

Item	Gap	Assurance level - current state	CGB or exec sub group:
New supervision and appraisal electronic capture tools	Ability to see early supervision/appraisal data to mitigate local concerns/highlight issues to be addressed. Still reliant on local records	Limited	PCD
Recruitment; multiple oversees applicants submitting identically worded applications. potentially agency providing narrative	Review process to identify identical applications and have a consistent approach to reduce impact on shortlisting administrative time	N/A	PCD
Recruitment of newly qualified nurses (NGN)	Process glitches around centralised recruitment system which risks losing NQNs	Limited	PCD
Recruitment & retention premia	Update required increase the likelihood of recruitment and reduce agency usage and cost	Reasonable	CGB
Permanent versus fixed term contracts	Request to form a vacancy control panel to review new posts and requests for conversion to fixed term to permanent in hard to recruit posts	Reasonable	CGB
New governance structure	Agreed terms of reference and report detail required	Reasonable	QAIG

Prior Consideration and Feedback Clinical Specialties each submitted and presented summaries by exception of detailed reports which were informed from specialty improvement an development meetings, IPR, local intelligence and associated data.

Corporate services also submitted papers and reported by exception.

Implications: Nil

Recommendations: N/A

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ITEM NO. 13

For General Release

Meeting of:	Council of Governors
Date:	15 June 2023
Title:	Involvement and Engagement Committee Update
Executive Sponsor(s):	Ann Bridges, Director of Corporate Affairs and Involvement
Author(s):	Angela Grant, Corporate Governance Officer

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All		The report provides assurance on involvement and engagement activities in relation delivering on our strategic goals on cocreation. The Cocreation Journey was approved by Board in March 2023, with four chapters that are all linked and contribute to service user and carer involvement and experience, including: 1. Ensuring cocreation in care planning. 2. Growing, diversify, and embedding service user and carer involvement across the Trust. 3. Expanding and developing lived experience roles and leadership, including peers. 4. Capturing accurate patient, carer and partner experience data including friends and family test, surveys, Patient Advice and Liaison (PALS) and complaints, and triangulating this with other intelligence eg serious incidents and using this to improve our services. These will be delivered and KPIs set as part of the business planning cycle and OJTC Delivery Plan. These are reported monthly through EQAIG and EDG, and to the Involvement and Engagement (I&E) Committee and Board quarterly.

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Executive Summary: This report provides an overview of the discussion at the most recent meeting of the Involvement and Engagement (I&E) Committee. The report also highlights proposed changes to the Terms of Reference of the committee, for agreement.

Purpose:	This report aims to keep the Council of Governors abreast of the discussions held at the Involvement and Engagement Committee.
Proposal:	Council of Governors are invited to note the update and agree changes to the terms of reference of the committee.
Overview:	In respect of the proposed changes to the Terms of Reference of the committee, to Cocreation Committee, in line with the Trust's ambition around cocreation and describes how we work together with others.
Prior Consideration and Feedback	Proposed changes to the terms of reference were agreed by the committee at its last meeting and reflect that the Our Cocreation Journey to Change has now been agreed.
Implications:	The proposed changes to the terms of reference provide an opportunity for the Council of Governors, through the committee, to align it's remit to that of Trust's strategy outlined in the Cocreation Journey.
Recommendations:	The Council of Governors is invited to consider and agree the revised Terms of Reference.

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Council of Governors' Involvement and Engagement Committee Update

The Committee last met on the 18 May 2023. In the absence of the Vice Chair, Keith Marsden, Mary Booth was appointed by the committee as Acting Chair for the meeting. The following was discussed:

TEWV Cocreation Journey and Draft Cocreation Framework

It was noted that:

- The Cocreation Journey outlined where the Trust aspired to be in relation to co-creation and the issues and challenges it faced.
- The Cocreation Framework was almost finalised, and now being rolled out within the Trust.
- The Trust's ambition was to seek out the voices of service users and carers and for their voices to be listened to and acted upon at every level.
- There were four strategic objectives of the Trust's Cocreation Journey:
    - Ensure cocreation in care planning.
    - Grow, diversify and embed service user and carer involvement across the Trust.
    - Expand and develop lived experience roles and leadership, including peers.
    - Capture accurate patient experience data including friends and family test, surveys, compliments, PALS and complaints and use to inform.
- The Trust's Lived Experience Directors would be invited to the next meeting of the Committee to provide an update on ongoing work regarding cocreation in care planning.
- The Trust had a structured approach to cocreation and recognised the importance of embedding learning.
- Our Journey to Change had enabled the Involvement and Engagement (I&E) Team to raise the profile of involving and engaging with service users and carers. This has also been made possible flowing an increase in the team's capacity.
- The Head of Patient Experience in the Trust had been working with the Lived Experience Directors to undertake a review of the Patient Advice and Liaison Service (PALS) and Complaints process.
- There were levels of engagement regarding cocreation, and these are outlined in the Cocreation Framework. For transparency, fairness and to manage the expectations of those involved, it was important to identify and assign a level of involvement for every involvement opportunity.
- Workshops had been held in the Durham, Tees Valley and Forensics (DTV&F) Care Group and the North Yorkshire, York and Selby (NY,Y&S) Care Group to understand cocreation, its governance and structure and to consider the establishment of a Cocreation Boards across the two care groups (previously referred to as a Lived Experience Board).

Revised Terms of Reference (ToR)

At the meeting held on 19 January 2023, the Committee agreed to postpone its decision on changing its ToR until committee members had gained a better understanding of what 'cocreation' meant in the Trust, and how it linked into the Committee's priorities. Following a briefing on the Trust's Cocreation Journey and Draft Cocreation Framework, committee

members were able to agree a revised ToR for the Committee, which included changing its name to the Cocreation Committee (see Appendix 1 attached).

The Council of Governors is asked to consider and approve the new ToR.

Trust Membership

Committee members considered a report on the Trust's public and staff membership at year end, 31 March 2023. The report provided details on the number of staff and public members recruited and lost during 2022/23 and demographic information showing that the Trust's membership was broadly representative of the communities it serves.

It was noted that:

- The number of public members on 1 April 2022 had been 9,206 and the number on 21 March 2023 had been 8,863.
- The number of new public members recruited (including four who had joined and left during 2022/23) had been 60.
- The number of public members leaving had been 403, resulting in a total loss of 343 members in 2022/23.
- The total number of staff members as at 31 March 2023 had been 7,774.
- The Governor election for 2023 was underway and a number of candidates had been confirmed as being elected without contest, whilst others would be taking part in a ballot. New and re-appointed Governors would be starting their term of office on 1st July.

Involvement and Engagement Update

The Committee considered a report on the position relating to involvement and engagement in the Trust as at 31 March 2023.

It was noted that:

- As at 31 March 2023, 449 people were on the Involvement register. An increase of 90 people during 2022/23.
- A further 76 people had been recruited by the I&E team and were awaiting an induction.
- There had been a significant increase in the number of requests for involvement / cocreation activity from the I&E Team, and this was expected to continue – an increase of 357% which reflected the historical activity mostly around recruitment, to a significant increase in cocreation activities.
- A total of £72,955 had been paid in involvement payments for 2022/23, an increase of £9,015 on payments in 2021/22. £400 in vouchers had also been paid to young people under 16 years old in 2022/23, an increase of £245 from 2021/22.
- Mapping work was needed, to understand what people were involved in and how to increase the amount of involvement activities available in the Trust.

The Annual General and Members' Meeting 2022 and future engagement events.

The Committee noted the following in relation to the AGM 2023 and future engagement events:

- Following his appointment to the newly created role of Stakeholder and Engagement Lead, James Burman would be organising the Trust's Annual General and Members' Meeting for 2023, and responsible for organising engagement events for the Trust.
- Proposed date and time for the AGM 2023 - 21 September (pm).
- Consideration would need to be given to whether the AGM for 2023 should be held online or face to face.
- Advantages for holding it online included convenience and accessibility for speakers and attendees, a low carbon footprint, reduced costs in comparison to face to face events and reduced health risks. It was noted that Governors with limited or no access to IT equipment or internet could perhaps join the meeting from one of the Trust's premises.
- Advantages for holding it face to face included providing opportunities to network and engage with others, giving staff the opportunity to showcase their services and network with other colleagues and enabling those with limited or no access to IT equipment and internet, to attend the event.
- Committee members welcomed the suggestion of holding the formal AGM online, on the proviso that additional face to face engagement events would be held across the Trust. It was also suggested that Governors could help to support those events.
- Suggested themes for the AGM in 2023 had included:

    - Cocreation
    - Community Mental Health Transformation Programme
    - Patient Safety
    - Change Management
    - Medical Education

- As the next meeting of the Committee was expected to be held after the AGM 2023, a Task and Finish Group consisting of members of the Committee would be established to help plan the event. James Burman would circulate details of the scope of the group as soon as possible.

Future Priorities

The Committee future priorities are:

- Planning the Trust's Annual General and Members' Meeting 2023.
- Planning other engagement events and roadshows Trust-wide, incorporating member recruitment and involving local services both internally and externally.
- Periodically reviewing and refreshing the Committee's Terms of Reference.
- Overseeing public member recruitment in the Trust.
- Monitoring the delivery and implementation of the Trust's Cocreation Framework.
- To consider the future approach to member and Governor communications.

Tees, Esk and Wear Valleys
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Membership of the Committee and Appointment of Chair

If you would be interested in becoming a member of this Committee, please let Angela Grant know. We will also be seeking new members at the Council of Governors' meeting on Thursday 27 July 2023, by which time newly appointed Governors will have started their term of office. It is hoped that a new Chair for the Committee will be appointed at its next meeting, later this year.

The Committee wishes to thank Audrey Lax and Keith Marsden, whose terms of office will be coming to an end on 30 June, for their contribution as members of the Committee. Additional thanks are extended to Keith for his support as Vice Chair.

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Appendix 1

CO-CREATION COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1. The Council hereby resolves to establish a formal Committee of the Council of Governors to be known as the Co-creation Committee.

2. Key Objectives

2.1. To oversee and monitor the implementation of the Co-creation Framework.

2.2 Ensure that the Trust's membership reflects the demographics of each constituency.

2.3 To ensure that the public, members, service users and carers are involved in the planning, design and delivery of efficient, joined up, co-ordinated services that are responsive to the needs of the community

3. Membership

- Up to 20 Governors
- Chairman / Vice-Chairman to be chosen by members of the Committee
- The Director of Corporate Affairs and Involvement and Head of Co-creation
- A representative of the Company Secretary's Department

The Committee's quorum is one third of the Committee's Governor membership.

4. Attendance

4.1. If the Chairman or (if appointed) the Vice-Chairman of the Committee is unable to attend the meeting will be chaired by a volunteer Governor of the Committee.

4.2. Involvement and Engagement team representatives may attend, as well as Lived Experience Directors where appropriate / required.

4.3. The Committee may also invite other attendees or external advisors as required and deemed appropriate.

5. Frequency

5.1. Meetings will be held a minimum of four times a year or more frequently as determined by the Committee.

6. Authority

6.1. The Committee is authorised by the Council of Governors to investigate any activity within its Terms of Reference.

7. Duties of the Committee

The duties of the Committee can be categorised as follows:

7.1. To support and monitor the delivery of the Co-creation Framework.

7.2 To review the Trust's progress on embedding co-creation in the organisation, as outlined in two strategic goals in co-creating a great experience for our patients, carers and families, and our colleagues

7.3 To engage members of the public, service users and carers and staff in contributing to the development of the Trust's membership.

7.4 Ensure the Council of Governors is briefed on membership, public, service user and carer involvement and engagement issues.

7.4 To provide regular updates to the Council of Governors in relation to the Trust's membership and involvement activities within the Trust.

7.5 To plan the delivery of the Annual General and Members' meeting of the Trust.

8. Date of Review

8.1. 12 month review following approval by the Council of Governors.

Item 14

For General Release

Meeting of: Council of Governors
Date: 15th June 2023
Title: Report on Progress of Autism Task & Finish Group
Non-Executive Sponsor: Jules Preston
Author: Jules Preston

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** We might not always provide a good enough experience for those who use our services, their carers and their families, in all places and all of the time (see also BAF refs 1 (recruitment and retention), 2 (Demand) and 6 (Learning))	All members of the Group have experience as service users or carers or staff or a combination of more than one. Consensus reached re priorities based on their experiences. Assurance in itself that the work will progress as proves necessary. Actions and recommendations will flow from the Group deliberations

Executive Summary:

Purpose: The purpose of the report is to provide re-assurance to the Council of Governors (CoG) that progress is being made as they intended when establishing the Task & Finish Group.

Proposal: That the CoG accept the report as demonstrating progress in determining a Governor view as to what the Trust needs to achieve in order to be an 'exemplar provider of autism services'. This will culminate in a number of recommendations against which the Trust (the Board) can be held to account.

The 'wish list' suggested by members of the Group as described below goes beyond the suggestions in the scoping document initially agreed by Governors but all will be considered should timescales allow.

Overview:

The Group all have experience of autism either as service users, carers, family members or staff colleagues. Some have more than one type of experience.

The group agreed to meet using TEAMS on the first Friday of every month. Membership of the Group comprises Christine Hodgson, Heather Leeming, Alicia Painter, Graham Robinson, Roger Tuckett* and Jill Wardle. It is chaired by Jules Preston, NED, as confirmed by the group at its first meeting. The group is also assisted by Dr Kedar Kale (Medical Director), or a deputy, being in attendance.
**not attending at the moment*

List of issues (abbreviated) to be considered: The wish list

1. *There is a need to improve communications. Staff need to have greater awareness realising that everyone is different.*
2. *Involve autistic people, carers, families and friends to identify their priorities and map the good, the bad and ugly.*
3. *Understand the current scale and spread.*
4. *Invest (time not necessarily money) in clinical leadership setting explicit standards of behaviour and linked to the journey for change.*
5. *Map out the key actions from SUI's, complaints, CQC reports etc. that link to autistic people and establish the current position and further work to be undertaken.*
6. *To be evidence based and a leading Autism provider.*
7. *Ensure Autism training and service development remains a priority and the team have a forward plan.*
8. *A full understanding and appreciation of Autistic Burnout.*
9. *Start to be a true partner in working with all other system players.*
10. *Read and implement this list of six ideas for addressing the Autism mental health crisis, written by Prof Will Mandy*
11. *Review the Trust position on atypical Autism presentations e.g. PDA (Pathological Demand Avoidance) and establish a clear position on the diagnosis of Personality Disorder and Autism.*

Following the style of the first report it is worth continuing the same theme as each meeting has added to the richness of information and understanding within the group, especially the Chair.

4th Meeting:

Following contact with the Lead Governor the Chair got in touch with mum D and her son. They were invited to meet with members of the group and tell of their experiences. It was an occasion for many emotions but also a huge opportunity for mum, and her son, to know that they were not alone. It was also good for them to know that Governors were acutely aware of the difficulties.

Several action points came from the meeting:

- Training in autism is critical
- Reasonable adjustments need to be considered at all stages of treatment, recovery and transition back into the community.
- The use of 'hospital passport' should be standard e.g. in the interface between locations and between acute care, particularly A&E, and MH hospitals.
- Our visit to the Northdale Centre, Roseberry Park, highlighted the need for more structured activities and for the swift replacement of equipment needed by patients because it is effectively their home for several years (UPDATE: All repairs & replacement now complete)
- There is a need for TEWV to consider the introduction of electronic prescribing. People with autism may not find it easy to go to a pharmacy on a high street. It can be a significant challenge.

5th Meeting

This meeting was attended by the MD for Durham, Tees Valley & Forensic services, Patrick Scott, and Martin Liebenberg: Director of Therapies, North Yorkshire, York & Selby Care Group. Patrick is the lead MD for autism services across the whole of the Trust and he updated the Group as to his view on future development.

A concern was expressed by one of the Governors about the introduction of diagnostic/assessment pilot in the NY, York and Selby area which proposes that someone has to be in crisis before they will be assessed. It is going to lead to people dying. She was very concerned that it had not been discussed by the Trust Board suggesting that the Board should be protecting services. Whilst understanding that the Trust and the Board were not aware of Commissioner intentions, and that the statement on the website inaccurately suggested that the idea was TEWV's, it is inevitably a big concern given that it is family, carers and patients who will suffer. TEWV will have to deal with any consequence to such action.
(The inaccuracy on the web site has been taken down and from comments made by ICB at our 6th meeting it would appear that a change of mind by commissioners may not be far off.)

6th Meeting:

Two quotes from the meeting sum up the discussion.

‘It seems that people who are autistic with a learning disability, there is quite a wide range of services available. For those autistic persons without a learning disability, there's very, very little. However, being pigeon holed into learning disability services is quite inappropriate for most people. Unless we close that circle of support and we have people in the right supported environment for their needs, they're always going to get into crisis and they're always going to be coming back as an inpatient admission as the right people are not there to support them. Jill felt that it's such a huge issue that it needs to be addressed.’

‘As part of Community mental health transformation, we need to ensure that it's built in within that when we're looking at how services are developing their plans, how services are planning any changes in that model of service delivery. What we have been discussing has to be built within what we do. And Brian suggested that what we've seen is that there's an expectation from Commissioners now when we're looking at additional investments, how does that link to supporting people with autism? There's real challenge coming back from Commissioners now as well, which is welcome in terms of how our services supporting people with autism and not excluding them and in ensuring that they receive the same good quality care as everybody else. That challenge comes from a recently published national framework to deliver improved outcomes in all-age autism assessment pathways describing the expectations now placed on ICBs.

The report to Governors dated 9th March 2023 has already been taken over by events. The Trust has published the Clinical Strategy for 2023 – 24, training of staff, numbering 150 – 200 per month in autism awareness, continues at pace. The specialist team in Stockton is merged with the Autism Project Team and recurring funding has been agreed. This ‘new’ team is to operate across the whole footprint of the Trust reporting to the Managing Director for Durham, Tees Valley & Forensics Care Group. And the Integrated Care Boards, as stated above’ have recently received national guidance on how they should commission for autism services. All of these steps see progress being made in how services are delivered for those with autism. BUT…..

Copies of any of the meeting notes are available should governors wish to see a fuller description of the considerations.

Prior Consideration and Feedback

Hopefully this report compares favourably with the Terms of Reference agreed by the Council of Governors. It is clear that improvements are underway and the change in commissioning considerations is critical. But community transformation is key.

Implications: The Health System must get this right otherwise patients with autism will go from crisis to crisis often in the wrong environment given the lack of suitable placements.

Recommendations: **The Council of Governors is asked to note the progress of the Task & Finish Group to date and to offer any comment or direction that Governors feel appropriate.**