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Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

8 June 2023

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

AGENDA

Standard Items (1.00 pm – 1.15 pm)

1	Chair's welcome and introduction	Chair	Verbal
2	Apologies for absence	Chair	-
3	Declarations of interest	-	Verbal
4	Board Action Log	-	Report
5	Chair's report	Chair	Report
6	To note any matters raised by Governors *Questions to be received by 1pm on Tuesday 6 June.*	Chair	Verbal

Strategic Items (1:15 pm – 1.40 pm)

7	To receive the Chief Executive's report	CEO	Verbal
8	To consider the Integrated Performance Dashboard	Asst CEO	Report

Goal 2: To co-create a great experience for our colleagues (1.40 pm – 1.45 pm)

9	To consider the report from the Chair of People, Culture & Diversity Committee	Cmt Chair (JH)	Report

Exclusion of the Public:

10	**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*	Chair	Verbal

	Annex 9 to the Constitution as explained below: *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.* *Information which, if published would, or be likely to, inhibit –* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*		

David Jennings
Chair
2 June 2023

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

Board of Directors
Public Action Log

ITEM NO. 4

RAG Ratings:

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Grey	Action superseded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

Updates since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
29/09/2022 22/10/2022 27/04/2023	22/144 22/174 23-24/06	Topics for board seminars	a) Mental Capacity Act b) Reported outcomes following treatment c) what transformation may mean for future services	MD CEO Co Sec	Ongoing		Apr-23: proposed board & committee dates circulated w/c 24 April for consultation May-23: the seminar programme will be developed to take account of topics identified by the board during the year.
26/01/2023	23/215 23-24/5	BAF	Format to be reviewed to consider potential for a table detailing the target level of risk, actual risk and gap	Co Sec	Aug-23		Apr-23: timescale changed to August 2023 to align with the outcome of the full review of the BAF due commence in May-23
26/01/2023	23/215		Risk tolerance - Executive Directors and committees to scrutinise the position to understand how long high risks had remained at their current level and what related action was proposed.	Exec Directors, Committee Chairs	Jun-23		Mar-23: Discussed by QuAC in March-23 Next cycle of committee meetings will be May 2023
27/04/2023	23-24/11		BAF report to reflect the impact of the financial position on delivery of priorities for 2023/24	Co Sec DoFI&E	Aug-23		May23: Linked to full review of the BAF due to commence in May-23
25/05/2023			**Board discussion to be held on areas of the BAF where the IPR had reported there is limited performance assurance and negative controls assurance, and where the target date has passed.**	**Co Sec**	**Aug-23**		**Linked to the review of the BAF**
26/01/2023	23/215	Lobbying	Stakeholder mapping being completed to inform conversations held by the board.	DoCA&I	Jul-23		Apr-23: board report will be available in June May-23: agreed to defer the report to July-23
23/02/2023	23/244	Freedom to Speak up	Board to receive a report on the proposal, linked to culture assessment work and which would respond to concerns raised that some of those who had spoken up had suffered detriment.	DfP&C	Jul-23		April-23: Report to be combined into a broader paper to the board in June. May-23: A report will be presented to the next meeting of PCDC. This includes the agreement, clarified with the NED Champion and P&C team, about how we will respond to concerns about detriment.
27/04/2023	23-24/11	Our Journey to Change Delivery Plan	Quarterly report to the board to include an assessment of the financial impact on delivery of proposals.	ACEO	Jul-23		**Report to be provided to the board in Sept-23, following S&RC in August.**
27/04/2023	23-24/11		Consideration to be given to how the quarterly report would be provided to S&RC and the board and how it would be reported to governors, as a means by which they would hold the board to account.	ACEO	Jun-23		**It is proposed that a report will be provided to S&RC prior to discussion by the board (will seek to avoid duplication). A progress report will then be provided to the following Council of Governors meeting**
27/04/2023	23-24/11	Autism T&F Group	Update to be provided from the T&F group discussion with the ICB on waiting times for the neuro-development assessment service.	J Preston	Jun-23		**T&F Group held on 26 May - verbal update to be provided to the BoD in Jun-23**
27/04/2023	23-24/13	Serious Incidents	Proposal to come to the board on how it can close the loop on reported incidents.	CN	Jul-23		

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Agenda Item 4

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
27/04/2023	23-24/15	Learning from Deaths	Report to provide narrative on what action had been taken since the previous report	CN	Jul-23		Next report to the board due July 2023
27/04/2023	23-24/16	Guardian of Safe Working	Next report to provide an update on the introduction of residential on call rotas and senior medical workforce staffing levels.	J Boylan	Jul-23		Next report to the board due July 2023
27/04/2023	23-24/17	Establishment Review	Format of the report to be revised, to include summarised actions proposed to mitigate risks highlighted and to outline the level of assurance provided to the board.	CN	Mar-24		Next report to the board due March 2024
25/05/2023	**23-24/22**	**Minutes**	**K Kale and J Haley to confirm in writing their proposed correction to the minutes of the April meeting.**	**MD** **J Haley**	**Jul-23**		**Jun23: Correction provided by J Haley**
25/05/2023	**23-24/27**	**Food Supplier**	**Report to S&RC on procurement options related to food supplies**	**DoFI&E**	**Aug-23**		**Next meeting of S&RC 8 August 23** **Proposed that the action to be moved to S&RC Action Log**
25/05/2023	**23-24/27**	**Third party risks**	**Executice Directors to ensure that risks related to the supply chain and third party delivery are considered.**	**CEO**	**Jul-23**		
25/05/2023	**23-24/28**	**IPR**	**Narrative to be included where a third party response is required, for delivery.**	**ACEO**	**Aug-23**		**To be incorporated into the next quarterly update in August 2023**
26/05/2023	**23-24/28**	**Advocacy for older people**	**MB to review what advocacy exists for older people**	**ACEO**	**Jul-23**		**Verbal update to be provided at BoD Jul-23**
26/05/2023	**23-24/28**		**AB to consider the issue once the new I&E facilitator is in post**	**DoCA&I**	**Sep-23**		

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Tees, Esk and Wear Valleys NHS Foundation Trust

Deputy Chair Public Board Report

May 2023

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

Core Business

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

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

Quality Assurance Committee Development Session

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

Our Admin Journey to Change

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

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

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

Visit to Lanchester Road Hospital

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

ITEM NO. 8

For General Release

Meeting of:	**Board of Directors**
Date:	**8th 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.	Recruitment & Retention	The Integrated Performance Report is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks.
2.	Demand	
3.	Involvement and Engagement	
4.	Experience	
5.	Staff Retention	
6.	Safety	
9.	Regulatory Action	
11.	Governance & Assurance	
15.	Financial Sustainability	

Executive Summary:

Purpose: The Board Integrated Performance Report aims to provide oversight of the quality of services being delivered and to provide assurance to the Board of Directors on the actions being taken to improve performance in the required areas.

Proposal: It is proposed that the Board of Directors receives this report with **reasonable** assurance regarding the oversight of the quality of services being delivered. Whilst there are a small number of areas with **limited** assurance, Performance Improvement Plans have been developed for some of the issues that are impacting on performance and are in the process of being developed for others.

Overview: The overall **reasonable** level of assurance has been determined 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 Board of Directors.
Recommendations:	The Board of Directors is invited to confirm the level of assurance identified; whether the level of oversight in this report is sufficient and if it is assured on the actions being taken to improve performance in the required areas.

Appendix A

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

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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
Contact Details: Ashleigh.lyons@nhs.net

journey to change

CONTENTS

Tees, Esk and Wear Valleys
NHS Foundation Trust

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.

<u>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.</u>

Our Approach to Data Quality and Action

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

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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

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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

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

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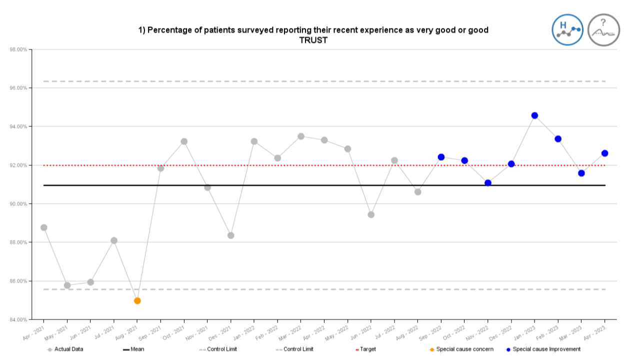
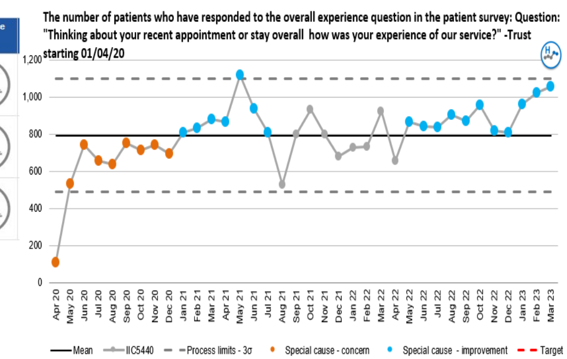
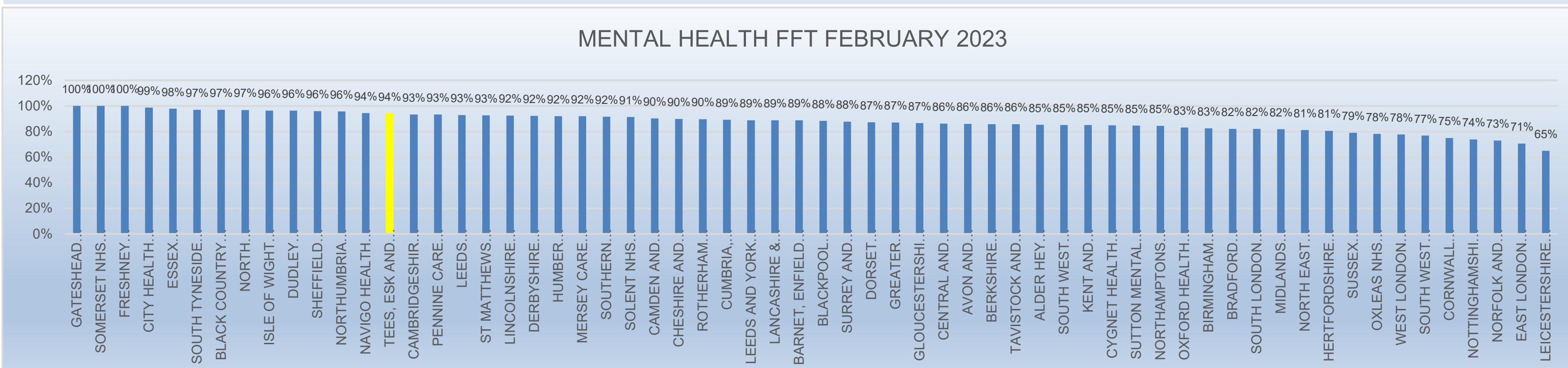


Care Group\Directorate	Variation	Assurance
TRUST		
DURHAM, TEES VALLEY AND FORENSIC		
NORTH YORKSHIRE, YORK AND SELBY		



National Benchmarking - Mental Health Friends and Family Test (FFT) data - 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

NHS
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

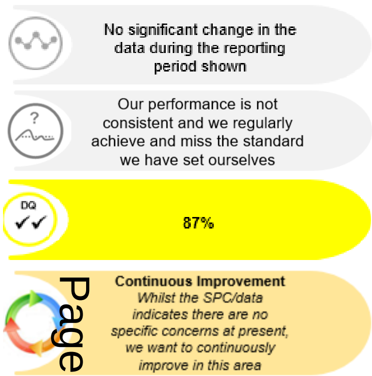
A patient newspaper has been launched within Secure Inpatient Services (Ridgeway). Developed by the patients and supported by staff, the newspaper outlines activities on the wards, staff updates and good news stories. The aim is to improve patient experience and sense of community within the service.

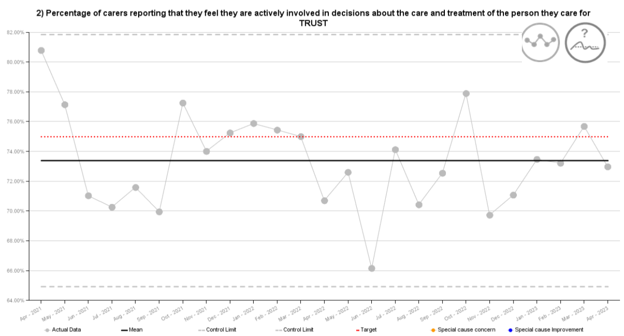
An action plan has been developed by the North Yorkshire, York & Selby Care Group Directors to address those areas where scores have decreased or not improved. This will be monitored on a monthly basis through the Quality Assurance & Improvement Group and reported to Care Board.

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

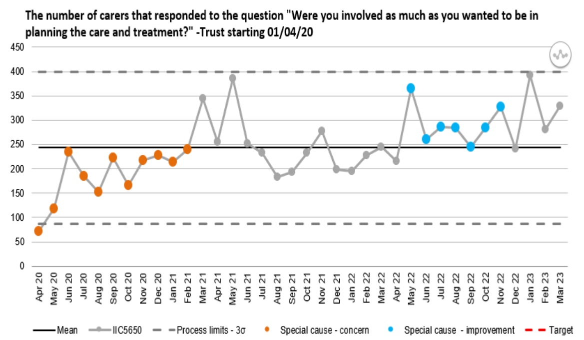
We are all committed to co creating a great experience for patients, carers and families by including carers in any decisions about the person they care for and working with them to provide quality care, and that carers will tell us this is the case from their experience.

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”.





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

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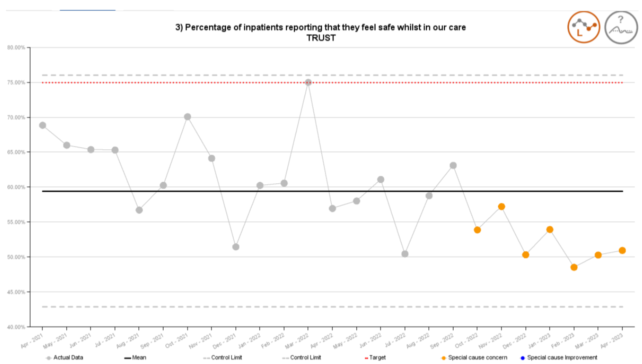
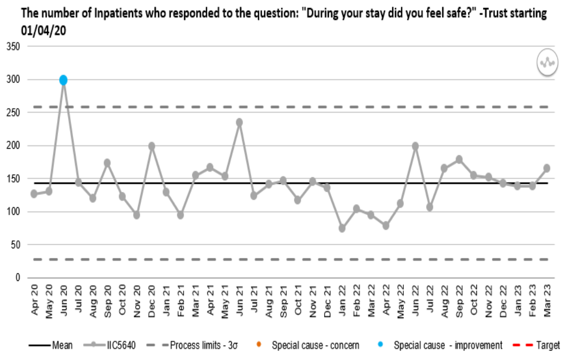


Care Group \Directorate	Variation	Assurance
TRUST		
DURHAM, TEES VALLEY AND FORENSIC		
NORTH YORKSHIRE, YORK AND SELBY		



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.

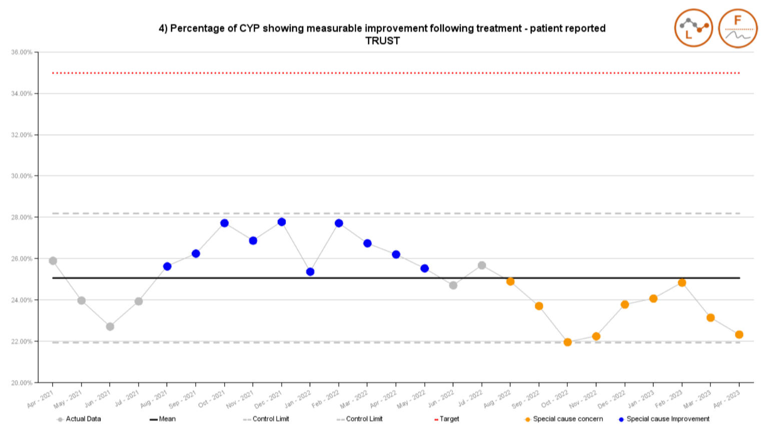
04) Percentage of CYP showing measurable improvement following treatment - patient reported

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.



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

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

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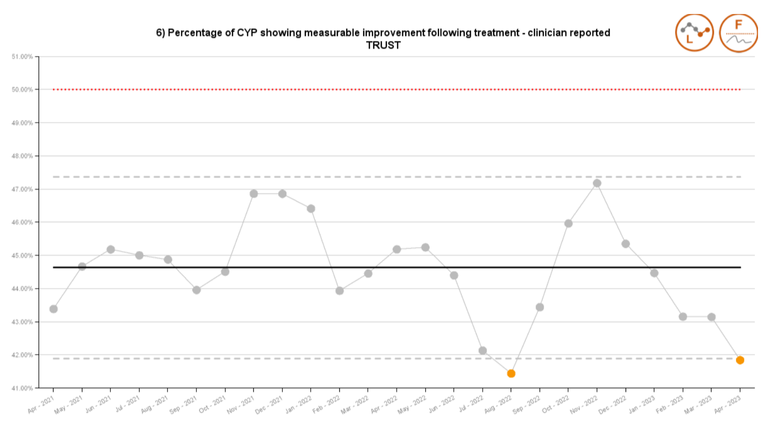
06) Percentage of CYP showing measurable improvement following treatment - clinician reported

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)



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

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

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

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.

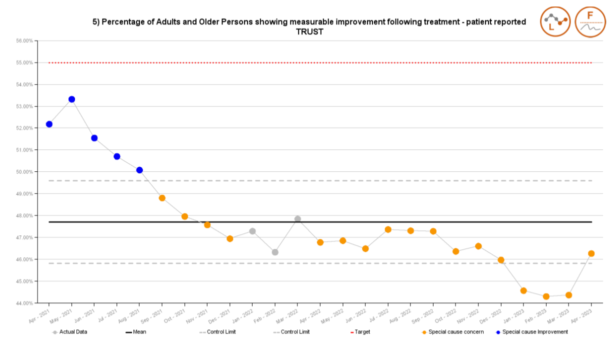
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

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

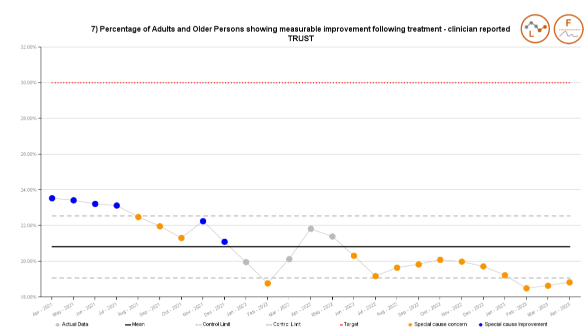
Page 31

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

NHS 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

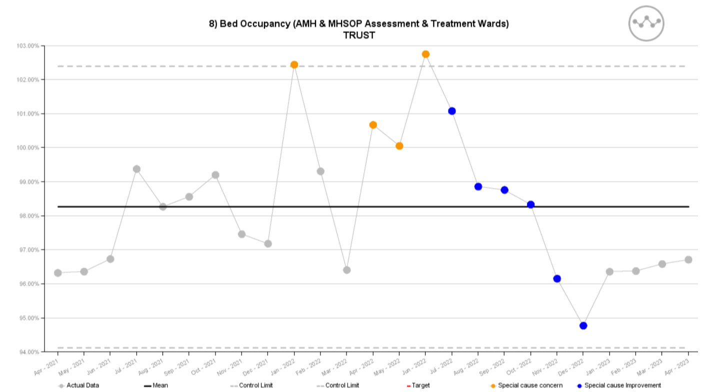
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important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



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

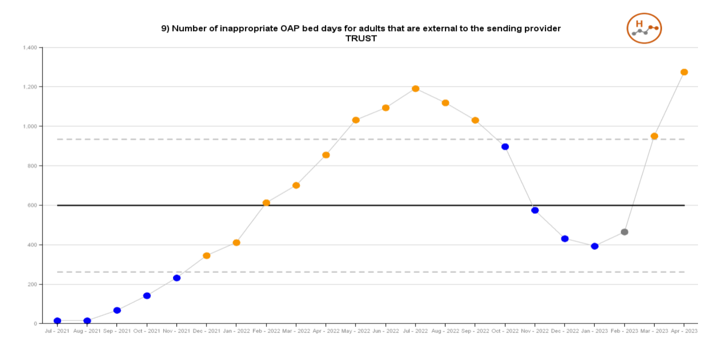
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending 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%



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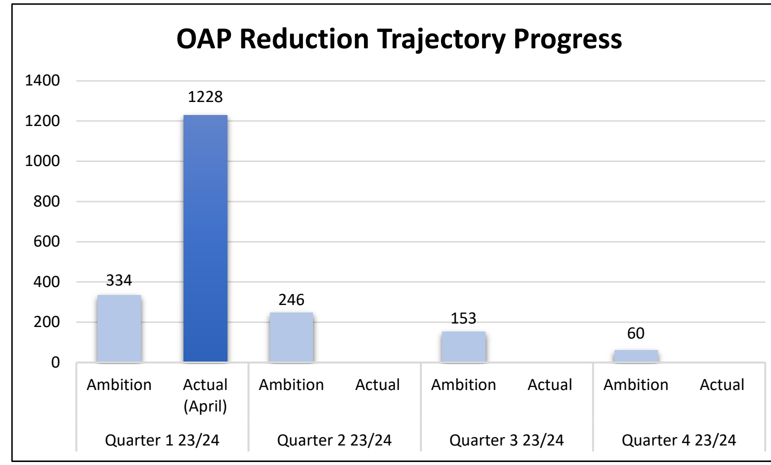
Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) <u>and</u> 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

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

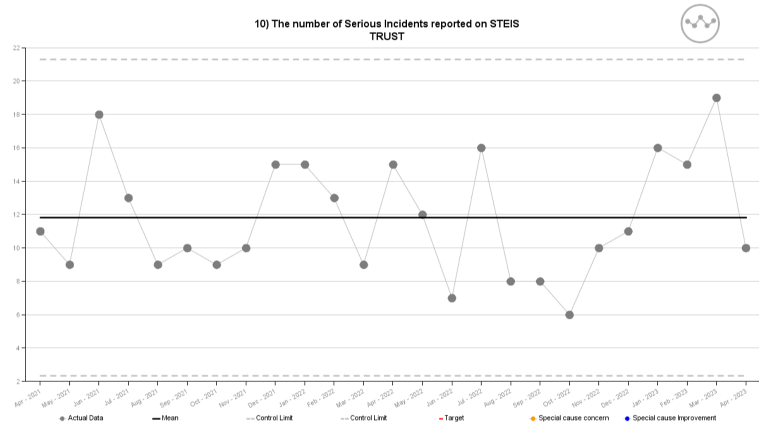
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

DQ ✓✓ 87%

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



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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.

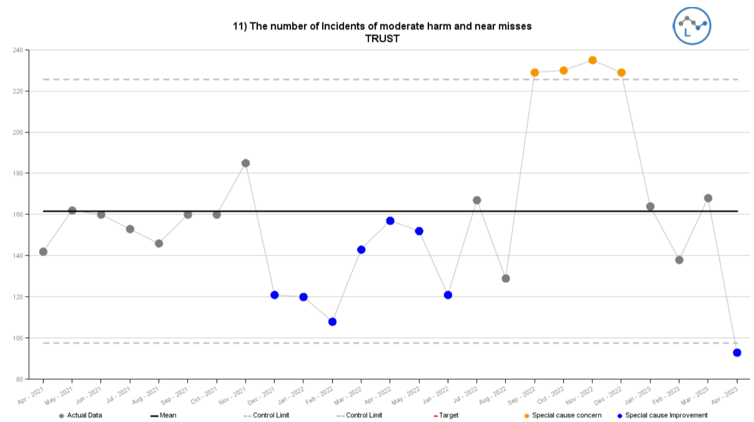
93 incidents of moderate harm or near misses were reported during April.

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



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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

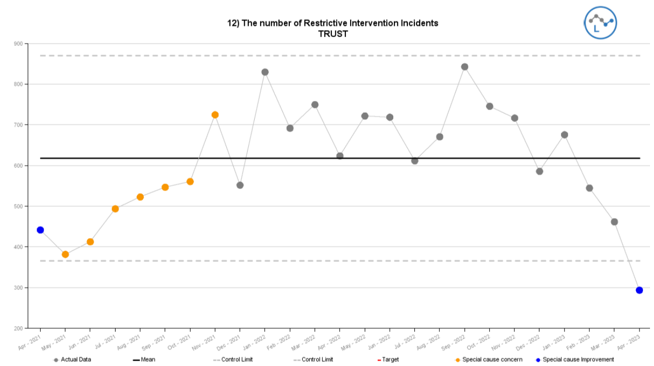
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When restrictive intervention incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented 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.

DQ 93%

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



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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

Tees, Esk and Wear Valleys
NHS Foundation Trust

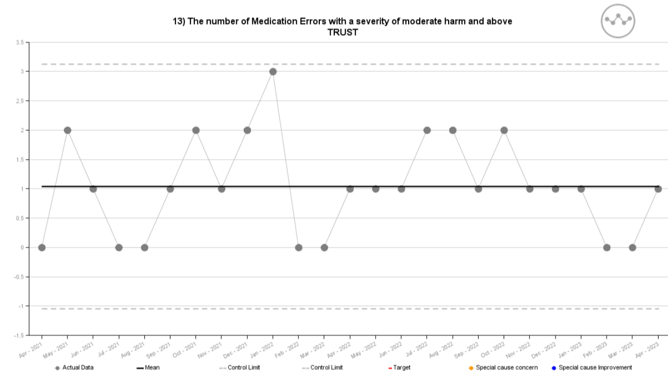
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When medication errors occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

No significant change in the data during the reporting period shown

DQ 93%

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



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

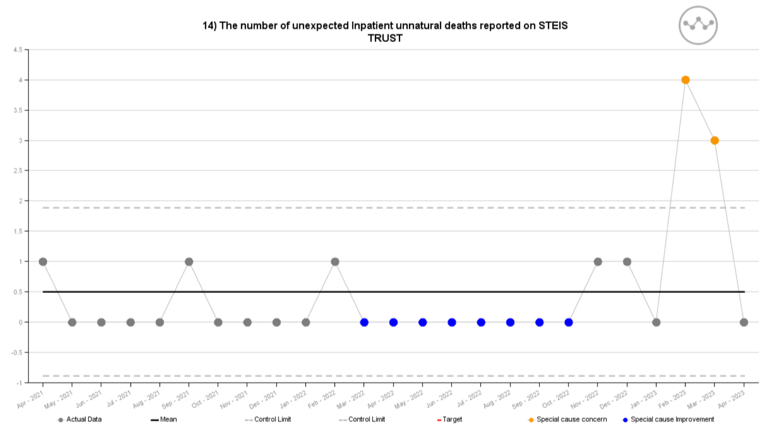
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements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



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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

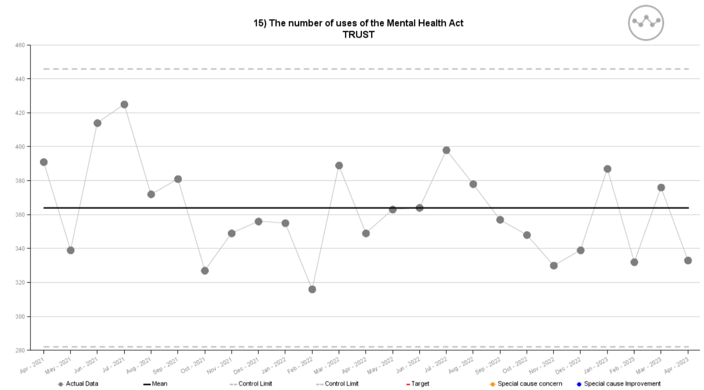
We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers,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



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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%

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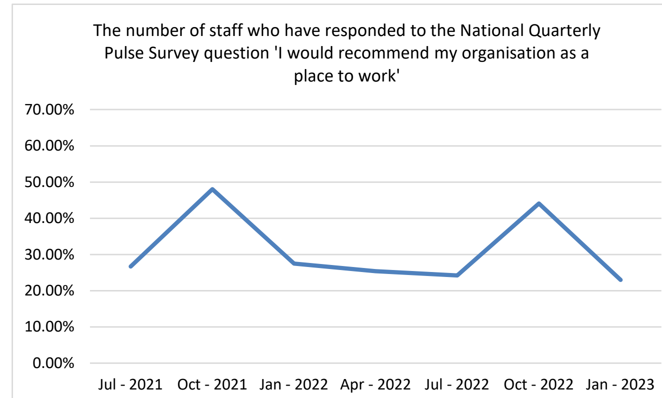

DQ ✓✓ 87%

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

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%

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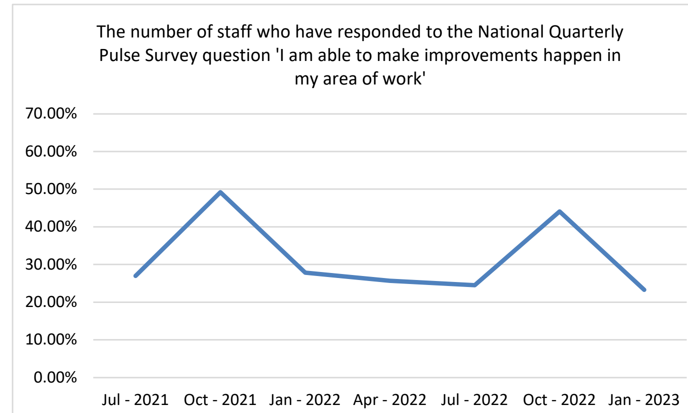
DQ ✓✓ 87%

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



Response rates for the Quarter 2 2223 NHS Pulse Survey ranged between 0.10% and 52.08%.
Note: October 2021 and October 2022 in the chart reflects the annual Staff Survey that is undertaken by Picker

National Benchmarking – NHS Staff Survey 2022

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

NB. *Picker carried out the NHS Staff Survey for 2022 on behalf of 25 Mental Health and Mental Health Community Trusts.

Staff Experience: 16) Percentage of staff recommending the Trust as a place to work <u>and</u> 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

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

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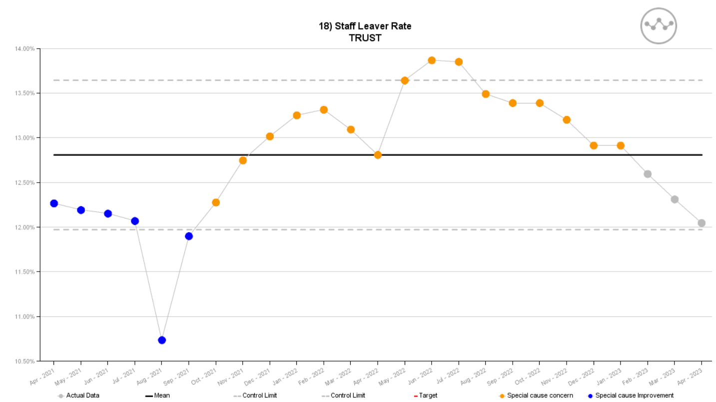

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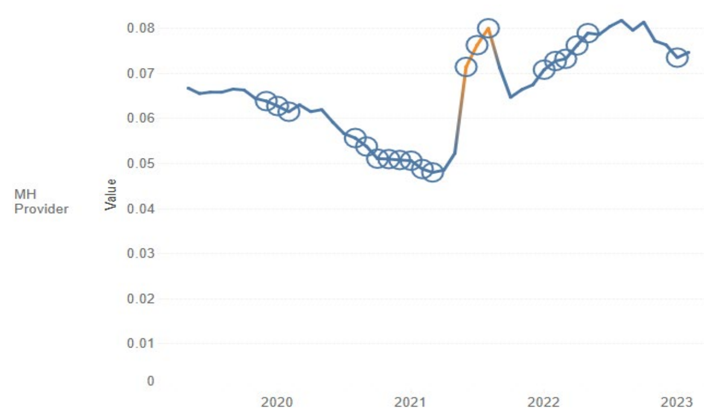
TRUST		FINANCE	
ASSISTANT CHIEF EXEC	H	MEDICAL	H
COMPANY SECRETARY	H	NORTH YORKSHIRE, YORK AND SELBY	L
CORPORATE AFFAIRS AND INVOLVEMENT	L	NURSING AND GOVERNANCE	
DIGITAL AND DATA SERVICES	H	PEOPLE AND CULTURE	
DURHAM, TEES VALLEY AND FORENSIC	L	THERAPIES	L
ESTATES AND FACILITIES MANAGEMENT	H		

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

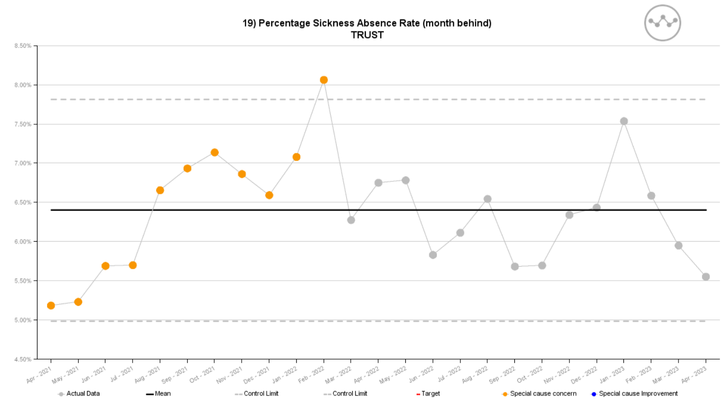
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

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			

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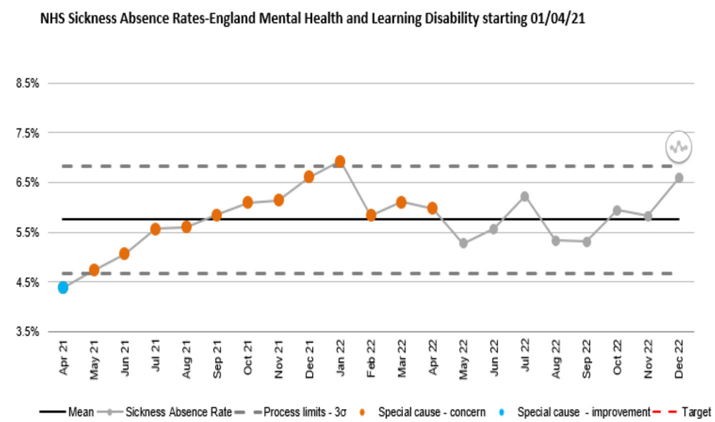
National Benchmarking: NHS Sickness Absence Rates - England Mental Health and Learning Disability – December 2022

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.

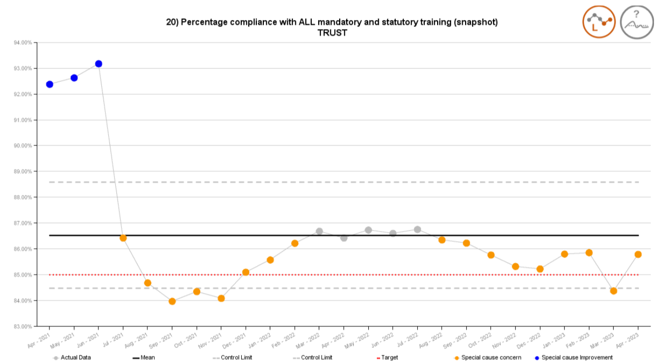
20) Percentage compliance with ALL mandatory and statutory training

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.



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

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

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

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

DQ
93%

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

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

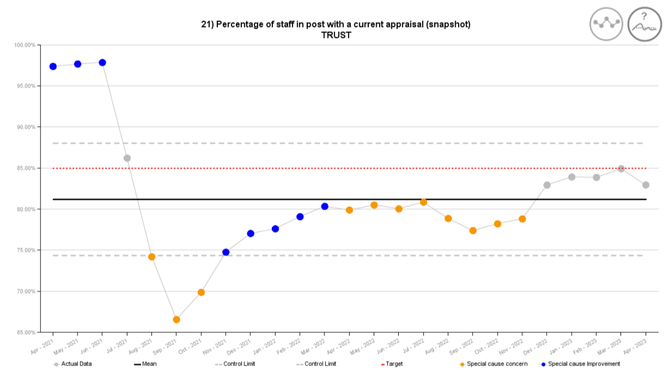
No significant change in the data during the reporting period shown

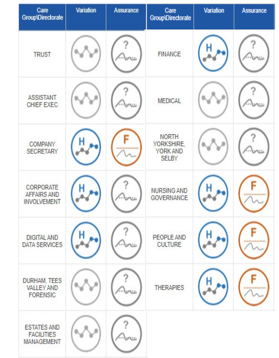
Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area

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

DQ

93%





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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

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

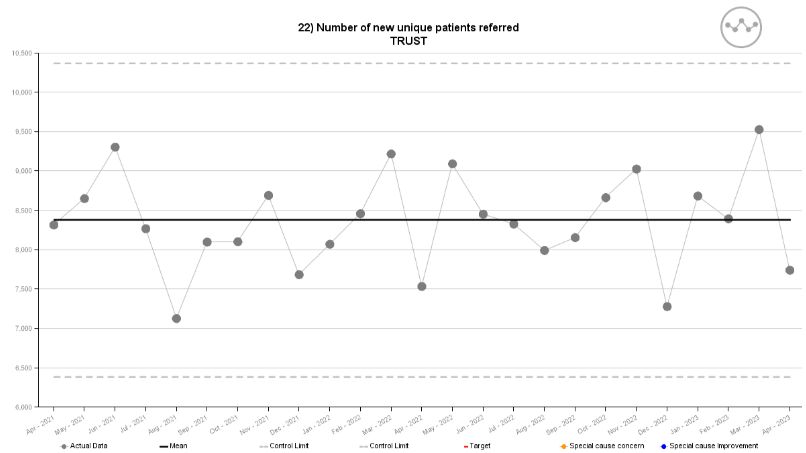
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

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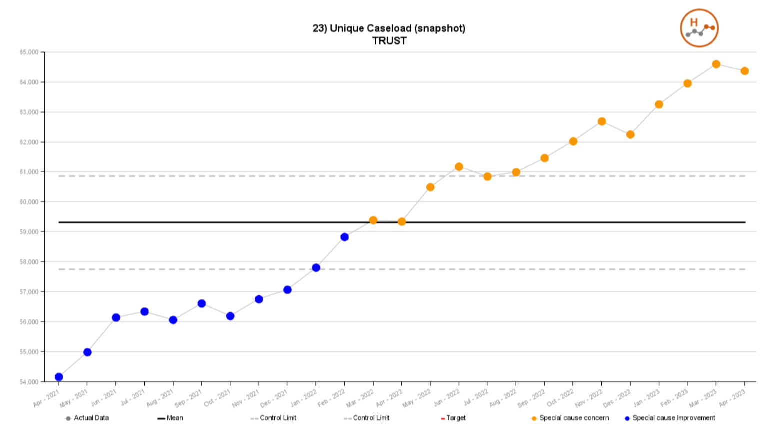

Care Group \Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

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.

F Our system is not hitting the target/expectation

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

DQ ★ 93%

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) <u>and</u> 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 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.

P Our system is hitting the target/expectation

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

DQ ★ 93%

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%).**

F Our system is not hitting the target/expectation

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

DQ ✓✓ 80%

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 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.

F Our system is not hitting the target/expectation

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

DQ 80%

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.

P Our system is hitting the target/expectation

DQ 80%

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

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.

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

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.

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30) Cash balances (actual compared to plan)

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

P Our system is hitting the target/expectation

DQ 93%

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

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?

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?

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?

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.

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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

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

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

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.

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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

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Tees, Esk and Wear Valleys NHS Foundation Trust

<table>
<tr><td colspan="2">People, Culture and Diversity Committee: Key Issues Report</td></tr>
<tr><td>Report Date:
8 June 2023</td><td>Report of: People, Culture and Diversity Committee</td></tr>
<tr><td>Date of last meeting:
12 May 2023</td><td>The meeting was quorate, there were apologies for absence from Roberta Barker, Non-Executive Director</td></tr>
</table>

1	**Agenda: The following agenda items were considered during the meeting:** • Colleague Story • PCD Business Cycles • Corporate Risk Register • Board Assurance Framework • Workforce Planning and Delivery Plan 2023/2024 • 'Deep Dive' into Staff who would recommend TEWV as a place to work • Executive Sub-Group People, Culture and Diversity – Feedback • Integrated Performance report • Staff Network update • Staff Equality Data Quarter 4 2022/2023 • Apprentice Data Quarter 4 • External assurance regarding workforce
2a	**Alert** None
2b	**Assurance** **The Committee assures members of the Board of the following:** **The Corporate Risk Register** The Committee notes that following the meeting on 6 February 2023, the Chair wrote to the Chair of Audit and Risk Committee, to highlight her concerns and to progress a discussion about what further refinements are needed to ensure the risk and assurance process work effectively in reporting PCDC assigned risks. As a result, a meeting took place between the Chair and Chair of ARC, DoPC, DoQG and Head of RM where a more succinct format was agreed for the report to Committees. Actions agreed include: an improved level of assurance on the Committee risks reported; identified risk owners to receive the required level of training to manage and mitigate risk effectively; risk owners to be aware of how to horizon scan to identify new and potential risks; and risk owners to promote a risk culture within their teams. It was also agreed that risk should be added as an item to every Agenda to ensure that risk discussion becomes part of the Trust culture from Ward to Board. The Committee notes the 6 aligned risks, an increase of 3 following 1 removal and 4 additions. A total of 4 of the 6 risks, also align to Quality Assurance Committee. A new risk (reference 1229) had been added due to the increase in score from 12 to 15 in view of limited assurance of the visibility of compliance with clinical supervision, one risk had reduced below 12 and was removed in accordance with policy by Executive Risk Group and two other new risks had been added. Of the risks on the Corporate Risk Register at 1 May 2023, 6 of the 20 have passed their review date, indicating that review compliance has reduced from 90% to 70%. Risk Management identified the visits and provision of information to CQC as an underlying reason for this reduction. The Committee notes compliance is expected to improve next month along with the visibility of supervision with 'Workpal' and 'PowerApp' becoming more widely used. Whilst it was acknowledged that progress had been made with the structure of the report, concern was expressed that the movement of risks between quarters was not easily tracked and that this remained an ongoing risk/matter for escalation.

Board Assurance Framework
The Committee considers that there is “good” assurance that the strategic risks continue to be managed effectively based on: (1) Positive assurance provided by the Internal Auditors and previous judgements made by the Board and the Audit and Risk Committee in regard to the processes supporting the management of the BAF; (2) All the risks having been recently reviewed by the Director of People and Culture (the Executive Lead); (3) Mitigations, generally, being delivered to plan. Where slippage has occurred, there is evidence of progress being made; (4) The present risk score of BAF risk 5 has reduced from 20 to 15, although it continues to be high. It is recognised that the present score of BAF risk 1 has not reduced in line with its trajectory due to there being only reasonable assurance on the operation of the majority of controls. The Indicative Controls Assurance Rating increased to 61% due to improvements in the control “Understanding why people choose to leave the trust or move roles” (April 2023). The Committee comments that the two risks are being managed appropriately (see item below in relation to BAF risk 5). A new postholder has been appointed to develop the work on People and Culture risks, focussing particularly on the retention risk and clinical pathways in the first instance.

‘Deep Dive’ into Staff who would recommend TEWV as a place to work
The Committee notes that work associated with the staff survey for 2023 will be incorporated into the Workforce Delivery Plan. For 2022, there is good assurance in that the Trust has received similar responses to other Trusts and to other consultation exercises undertaken such as the ‘Big Conversation’. This indicates that the direction of travel is appropriate, however, there are areas which have been brought to the Committee’s attention. Firstly, pay is identified as a major factor as to why staff do not feel sufficiently recognised and rewarded; and secondly, the quality of appraisals. Other issues relate to the number of unpaid hours worked/work-life balance and not having all the equipment needed on commencing employment with the Trust. Robust Action Plans are in place which will be further developed by the Workforce Planner who is about to commence in post. The Committee took comfort from the Trust being the most improved Mental Health Trust nationally, whilst recognising considerable work remains in relation to the metric for staff ‘not recommending’ the Trust as a place for care and treatment for friends/relatives which had reduced by 3% from the previous year (51%).

Integrated Performance Report
The Committee notes an overall reasonable level of assurance based on the Performance & Controls Assurance Framework for the Board Integrated Performance Dashboard (IPD), with the key changes in the IPD this month being a deterioration in performance in respect of the Staff Leaver Rate (measure 18). There were no people measures with limited performance assurance/negative controls assurance. However, staffing concerns are impacting on our financial measures, for example, in relation to Agency Expenditure (measure 25a) and Agency price cap compliance (measure 25b), with both measures identified as having Performance Improvement Plans in place.

Performance Improvement Plans are also in place for Safe Staffing, facilitated by the Safe Staffing Group and they are being developed to support improvement and increased assurance in relation to the following metrics:

- Percentage compliance with ALL mandatory and statutory training (measure 20) – to be facilitated by the Executive People, Culture & Diversity Sub-Group; and *[NB: for information - this PIP now reports into the Safer Staffing Group first]*
- Percentage of staff in post with a current appraisal (measure 21) – to be facilitated by the Executive People, Culture & Diversity Sub-Group.

The Committee notes that on 16 April 2023, sickness absence (measure 19) was 5.55% for April 2023 – an improved position. Work is progressing to gain a better understanding of persistent vacancies, the role of training in supporting retention and people working safely as temporary staff via the Bank. It was acknowledged that considerable effort was being made by Temporary Staffing to prioritising consistent staffing due to the quality and safety benefits and use of ‘Off Framework’ Agencies has been stopped.

Staff Networks
The Committee notes the positive contribution of the staff networks to the culture of the organisation as evidenced at the ‘Lunch and Learn’ celebrating Staff Networks earlier that week.

	Apprentice Data Quarter 4 2022/2023 The Committee confirms that it has good assurance that the Trust has followed a robust process in developing its Apprentice provision, is taking appropriate actions to maintain the Apprentice workforce, and is meeting the requirements of the Public Sector Target. It welcomes the very low attrition rate, with a total of 47 new starters during the quarter and only 2 non-completers. All those successfully finishing their Apprenticeship with the Trust are offered permanent employment. **External assurance regarding workforce (Intention to move or leave Audit and Capability and Disciplinary Processes Audit)** The Committee notes the assurance provided by four external sources in relation to: • Year 2 Training Accreditation secured from the accrediting body for training with regards to restrictive physical intervention from the British Institute for Learning Disabilities (BILD) • Better Health at Work Award. Next observations to take place in June 2023; • Intention to move or leave Audit by Audit One – baseline position of limited assurance due to ineffective communications. Most of the recommendations already in place with the option of leavers speaking with OD staff or coaches – new processes receiving positive feedback about feeling valued and being listened to. Monthly target of 20 interviews being consistently achieved; and • Capability & Disciplinary Processes Audit by Audit One - actions agreed and a wider review of daily processes in the HR operations team is planned.
2c	**Advise** **The Committee advises the Board that:** **Colleague Story** It is important for the Trust to create the conditions where Autistic strengths are embraced in the workplace and ensure colleagues have the optimum opportunities to work authentically and without their professionalism being questioned where they have a late diagnosis and are in people facing roles. The Committee understands how challenging change can be for Autistic people and how masking helps to operate within a world which is designed by and for Neuro-typical people. The benefits of the Neuro-divergent Staff Network as a place of both acceptance and a voice for those with lived experience shone through. The Committee acknowledges the role of the reasonable adjustments team and the importance of staff being aware of the ability to easily access reasonable adjustments in the form of a transferable 'passport'. It also highlights the significant contribution to the awareness of equality and diversity of the reverse mentoring scheme in supporting greater understanding of other people's 'maps of the world'. **Workforce Planning and Delivery Plan 2023/2024** The Committee accepts reasonable assurance that the workforce delivery plan and associated workforce return to the region is based on a good understanding of the patterns of workforce turnover in TEWV given the work on vacancies, recruitment patterns, leavers and movers and the knowledge of the roles that the clinical networks have outlined as core and optional for their service delivery. However, it identifies that further work is needed to understand the underlying reasons in relation to certain aspects eg retention in order to improve the level of assurance. The Committee welcomes the growth of 189 WTE posts and notes that a new Workforce Planner will be commencing in post soon. One of the key tasks will be to work on persistent vacancies, for example, Team Manager Job Descriptions. The theme for the Committee's Development Day will be Workforce Planning. A future area for development will be the co-creation elements of this work and the Committee looks forward to linking with the new Co-creation Board which will be established in June 2023. **Executive Sub-Group People, Culture and Diversity – Feedback** The Committee welcomes the approval of a Business Case for future international recruitment and notes the forthcoming interviews of 26 more nurses and additional medical staff (with these posts to be mapped against specific locum posts/vacancies as part of agency reduction spend initiatives). In addition, the Committee notes that over 5000 staff are already registered with Workpal.

	The Committee notes that a Health and Wellbeing governance group and staff-led Health and Wellbeing council, chaired by Ann Bridges, have been approved. The former is evaluating the impact of the Trust's health and wellbeing offers whilst the latter will provide a route for staff to decide how to spend charitable funds and raise further resources. The Committee welcomes the establishment of a Violence and Aggression Reduction Group focused on reducing violence and aggression towards staff, noting that a development session was held with staff from Broadmoor on introducing restorative practice, in addition to immediate responses to an incident. The verbal aggression policy has been updated to include physical violence and a review is now taking place with a view to producing one overarching policy on violence and aggression towards staff. The Committee informs that the Governance Review has concluded and changes are now being made both in Care Group and Executive Sub-Group information flows to ensure that resources and risks are considered in a more collective manner and free up significant amounts of staff time. **Staff Equality Data Quarter 4 2022/2023** The Committee notes there is little variation to the data and agrees to receive the report on a six-monthly basis in future with the inclusion of more visuals and a greater focus on action plans/impact.	
2d	**Risks**	No new risks identified. The Committee commented there was an ongoing risk in relation to the structure of the report on the Risk Register which inhibits understanding specifically of the risk movement between Committee meetings. Whilst other aspects of the report structure had been addressed for this meeting, this particular element which had been highlighted previously, had not been remedied. The Committee requested for future meetings that the report would provide oversight, at a glance, of any quarterly variance to risks.

Recommendation: The Board is asked to note the contents of this report.		
3	**Any Items to be Escalated to another Board Sub-Committee/Board of Directors**	The risk in relation to the structure of the report on the Risk Register inhibiting the monitoring of the quarterly variance of risks to be escalated to Audit and Risk Committee.
4	**Report compiled by:** Deborah Miller, ***Corporate Governance Manager*** Jillian Haley, ***Non-Executive Director/Interim Deputy Chair (Committee Chair)*** Sarah Dexter-Smith, **Director of People and Culture/**Kate North, **Deputy Director of People and Culture** Minutes are available from: Deborah Miller	

DM/3/06/2023