MEETING OF THE BOARD OF DIRECTORS

13 July 2023

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

AGENDA

Note: there will be a confidential session at 1.00 pm for the board to receive a patient story.

Standard Items (1.30 pm – 1.50 pm)

1	Chair's welcome and introduction	Chair	Verbal
2	Apologies for absence	Chair	Verbal
3	Declarations of interest	All	Verbal
4	To approve the minutes of the meetings held on: a) 25 May 2023 b) 8 June 2023 c) 27 June 2023	Chair	Draft Minutes
5	To receive the Board Action Log	Chair	Report
6	To receive the Chair's report	Chair	Report
7	To note any matters raised by Governors in relation to matters on the agenda *To be received by 1pm on 11 July 2023*	Chair	Verbal

Strategic Items (1.50 pm – 2.30 pm)

8	To receive the Board Assurance Framework summary report	Co Sec	Report
9	To receive the Chief Executive's report	CEO	Report
10	To consider the Integrated Performance Dashboard	Asst CEO	Report

Goal 1: To co-create a great experience for our patients, carers and families (2.30 pm – 2.50 pm)

11	To consider the Leadership Walkabouts report	DoCA&I	Report
12	To consider the report of the Chair of Quality Assurance Committee	Committee Chair (BR)	Report
13	To consider the report of the Chair of Mental Health Legislation Committee	Committee Chair (PH)	Report

BREAK – 10 minutes

Goal 2: To co-create a great experience for our colleagues (3.00 pm – 3.20 pm)

14	To consider the report from the Freedom to Speak up Guardian	V Brinsley	Report
15	To receive a report on the trust's response to the staff survey	DfP&C	Report

Goal 3: To be a great partner (3.20 pm – 3.25 pm)

16	To receive an update on the Stakeholder Communications and Engagement Strategy	DoCA&I	Report

Governance (3.25 pm – 3.30 pm)

17	To receive the annual review of the Board of Directors Register of Interests	Co Sec	Report

Exclusion of the Public:

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

	(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
7 July 2023

Contact: Karen Christon, Deputy Company Secretary
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Tees, Esk and Wear Valleys NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 25 MAY 2023 AT WEST PARK HOSPITAL, EDWARD PEASE WAY, DARLINGTON AND VIA MS TEAMS, COMMENCING AT 1.30 PM

Present:
B Reilly, Non-Executive Director and Deputy Chair (in the Chair)
B Kilmurray, Chief Executive
R Barker, Non-Executive Director
C Carpenter, Non-Executive Director
J Haley, Non-Executive Director
P Hungin, Non-Executive Director
J Maddison, Non-Executive Director
J Preston, Non-Executive Director and Senior Independent Director
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
K Kale, Medical Director
B Murphy, Chief Nurse
P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
A Bridges, Director of Corporate Affairs and Involvement (non-voting)
M Brierley, Assistant Chief Executive (non-voting)
H Crawford, Director of Therapies (non-voting)
S Dexter-Smith, Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary

Observers/members of the public:
J Green, Governor
H Griffiths, Governor
M Ovens, Governor
T Pinder, Specialty Registrar, Malton Community Mental Health Team
S Double, member of the public

23-24/19 WELCOME AND INTRODUCTIONS

The Chair opened the meeting and welcomed the attendance of Dr Pinder from Malton Community Mental Health Team. She noted that the CQC Well-led inspection was underway and would impact on board member attendance during the meeting.

23-24/20 APOLOGIES FOR ABSENCE

Apologies for absence were received from D Jennings, Trust Chair and L Romaniak, Director of Finance, Information and Estates

23-24/21 DECLARATIONS OF INTEREST

None.

23-24/22 MINUTES OF THE MEETING HELD ON 30 MARCH 2023

It was noted that:

- The briefing on basic life support training had been provided [page 8, para (2) refers].

- B Murphy would provide a proposal to a future board meeting on closing the loop from serious incidents [page 12, para (3) refers].
- Workforce reports to People, Culture and Diversity Committee and Strategy and Resources Committee on assumptions or mitigation required to achieve the financial plan, would be responded to outside of the board action log [page 15, para (4) refers].

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

- *Correction: J Boylan [in attendance]*
- *Amendment: 'C Carpenter proposed that prior to the BAF review in August, narrative be included in the BAF on speed of progress towards the target level of risk' [board action log, 23-24/5]*
- *Proposed amendments from J Haley and K Kale, which would be provided following the meeting.*

  [the minutes were subsequently varied to read:

  - K Kale suggested that a preferred approach would be the measurement of goal based outcomes and recovery focussed quality of life outcomes, rather than improvement noted by a reduction or change in symptoms only, and he noted the intention to hold a board session on outcome and assessment measures [page 7, para (1) refers].

  - J Haley, Chair of People, Culture and Diversity Committee (PCDC) drew attention to the increase in red flags in respect of staffing levels, which included less registered nurses on shift than that required and sought assurance that this related to the quality of care and support provided to service users and did not imply that the trust was not always safely staffed.

    She went on to indicate that through reports provided to PCDC she had noted evidence of increased staffing levels via less sickness absence and less agency staffing, and through a positive recruitment trajectory, which indicated the trust was moving in the right direction [Page 8, para (3) refers]].

23-24/23 BOARD ACTION LOG

The Chair welcomed the clarity provided in the updated action log.

Agreed: *that the target date for action 23/215 [stakeholder mapping] be moved to July 2023.*

23-24/24 DEPUTY CHAIR'S REPORT

The Chair introduced the report and commented on: the Quality Assurance Committee development session; a recent related visit and progress in respect of Our Admin Journey to Change; and the positive feedback that had been received from the visit of two councillors from Durham County Council to Lanchester Road Hospital.

23-24/25 QUESTIONS RAISED BY GOVERNORS

No questions had been received.

The Chair placed on record her thanks to governors who had taken part in the focus group session, held as part of the CQC well-led inspection.

23-24/26 BOARD ASSURANCE FRAMEWORK

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

C Carpenter noted that there was negative assurance in respect of risks 4 [experience] and 6 [safety] and they had exceeded the March target date. She proposed that the board discuss these further in the confidential session.

The Chair drew attention to narrative within the Integrated Performance Report (IPR) in respect of BAF risks 4 and 5 [staff retention].

23-24/27 CHIEF EXECUTIVE'S REPORT

B Kilmurray introduced the Chief Executive's report, which aimed to highlight topical issues that were of concern, and he provided the following additional information:

1) In respect of the change in inpatient food supplier, he noted there had been no disruption to services and suggested that the change provided an opportunity to reconsider food distribution across the estate and understand inflationary cost pressures. He proposed to report to a future meeting of Strategy & Resources Committee on procurement options. **Action: B Kilmurray**

   Responding to a proposal from C Carpenter, B Kilmurray agreed that executive directors would review risks related to supply chain and third party delivery. **Action: B Kilmurray**

2) The trust was not aware of any staff that had been recruited via the Nigerian CBT test centre, where anomalies had been reported by the Nursing and Midwifery Council. Commenting further, S Dexter-Smith advised that should any issues subsequently arise, the trust would work directly with the staff member to resolve them.

3) Staff would receive the pay award at the end of June and had been given the option to receive the non-consolidated award in staged payments, to negate any adverse financial impact.

4) The trust would revisit continuity plans should there be further industrial action. K Kale advised that there would be strike action by junior doctors from 14 to 16 June and the ballot of consultants would close on 27 June.

   J Maddison queried the impact of strike action on services and in response K Kale advised that doctors, and in one instance a consultant, had been redeployed to ensure there was appropriate cover. Where there had been cancellations, those appointments had been prioritised.

5) The CQC well-led inspection had included a focus group with governors and interviews with individual board members, and positive initial feedback had been received. It was noted that the main themes identified for improvement were already highlighted in the BAF and Corporate Risk Register (CRR).

In respect of the reported low battery charge on a defibrillator, B Kilmurry advised that this had been misread and was not expected to be included in the final CQC report, which would be published in September.

He proposed to circulate a briefing to the board on conclusion of the inspection and following receipt of final feedback. **Action: B Kilmurray**

23-24/28 INTEGRATED PERFORMANCE REPORT

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

[P Hungin joined the meeting]

The Chair referred to links between the BAF, IPR and CRR and suggested that the information reported in the IPR triangulated well with that received from recent leadership walkabouts and initial feedback from the CQC.

B Kilmurray introduced the report and advised that the development of performance improvement plans (PIPs) had been well received and would provide assurance to executive directors on mitigation.

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

1) J Maddison welcomed the management focus on PIPs and future reports to the board on delivery of outputs, in due course. He noted there had been some improvement in agency expenditure and referenced the financial challenge and themes that would continue into 2023/24.

2) C Carpenter welcomed the development of the IPR and board visibility of key challenges. She expressed concern about areas where there continued to be limited performance assurance and negative controls assurance or where the target date for improvement had passed and the board was not sighted on proposed mitigation.

   B Kilmurray indicated that work was underway by executive subgroups, which would provide clarity on mitigation and confirmation of realistic timescales.

   C Carpenter acknowledged there had been a related discussion by board committees.

3) P Scott advised that the PIPs process had been welcomed by DTVF Care Group, as a means by which areas of concern would be drawn out, and he noted that the process had been positively received by the CQC.

4) In respect of feeling safe, B Murphy suggested that it was a challenge to understand the various elements to this, and to build appropriate trajectories, but that good progress had been made to gain a clearer understanding and this could be shared with the board.
   Action: B Murphy

5) K Kale noted that experience would be affected by a number of factors including out of area placements. In respect of bed occupancy, he advised that the target had not be achieved for a number of reasons and he had visited the crisis and planning teams to understand the

position and patient flow. He noted an increase in voluntary admissions and advised that he was in discussion with partners on all aspects of this and improvements that could be made.

6) In respect of out of area placements, J Maddison proposed that the IPR include narrative to outline why the slippage had occurred. **Action: M Brierley**

7) Responding to a query from the Chair, B Kilmurray advised that PIPs would be considered by the Executive Directors Group and the board would receive summary information on impact and outputs.

8) J Preston expressed a concern about high waiting lists for memory assessment services in North Yorkshire, York and Selby Care Group area, due to demand and service capacity and he queried if the issue related to lack of investment by the ICB.

   In response, Z Campbell acknowledged that the trust was underfunded and did not have the capacity to respond to the current waiting list. A significant amount of work had taken place to improve waiting times and the trust had sought to work collaboratively with partners, including GPs and primary care, but wholescale change was required.

   She went on to suggested that the board may wish to have a conversation on those issues where the trust had done all it could and where a system or national response was required.

   B Kimurray advised that dementia care was not part of the mental health investment standard and the trust relied on the ICB to prioritise resources. He noted delays in respect of scanning capacity at acute trusts and access to results and confirmed that the trust had introduced a number of waiting time initiatives to resolve the position and senior staff had provided additional clinics. Responding to a query, he confirmed that discussions would continue to be held with partners, but this may not result in investment in the current year.

   P Hungin welcomed further information regarding the delays in scanning and the impact of this. **Action: Z Campbell**

9) B Kilmurray noted that there were few complaints about memory assessment services and suggested that the trust may wish to consider how it engaged with older people who were waiting to access the service.

   Z Campbell suggested that the level of complaints would be lower from older people, as they may not have a network to advocate for them and she commented on the potential to review the availability of advocacy services.

   A Bridges confirmed that waiting times for memory assessment services were not a theme through the complaints service and proposed that the new Involvement and Engagement Facilitator coordinate a piece of work to consider advocacy for older people
   Action: A Bridges

10) J Maddison proposed that the IPR provide clarity where an external agency or external factor impacted on delivery. **Action: M Brierley**

    C Carpenter supported the proposal and noted that Strategy and Resources Committee had acknowledged that there were a number of external factors that would impact on the cyber risk score.

[J Preston left the meeting]

Agreed:

a) There was a reasonable level of assurance.

b) The level of oversight provided by the report was sufficient, and in future would include reporting of outcomes from the PIPs.

c) The board was assured on the actions being taken to improve performance.

23-24/29 CORPORATE RISK REGISTER

B Murphy introduced the report, which aimed to ensure the board was sighted on organisational wide risks rated as high. She drew the board's attention to risks added and removed from the report and invited the board to consider the report and level of assurance provided.

Commenting further, B Kilmurray advised that Executive Risk Group (ERG) considered the BAF and CRR prior to the board and would also seek to review emerging issues arising from the delivery plan during the year.

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

1) In respect of the graph on committee alignment of risks and the percentage of risks related to the Durham, Tees Valley and Forensics Care Group, P Hungin proposed that narrative be included to indicate the scope and range of services that were provided by the DTVF care group. **Action: B Murphy**

2) J Maddison commented on the progress that had been made in respect of risk management, which included integration between the IPR, BAF and CRR, assurance to committees from the Executive Risk Group where risks had changed, and the meeting of committee chairs to ensure oversight on shared risks. He went on to note there had been some slippage on risk reviews.

3) B Murphy advised that Executive Risk Group had met since publication of the report and the further work would take place to build on the existing report to capture action and mitigation.

4) J Maddison proposed that the board would take good assurance based on progress made, subject to completion of risk reviews.

5) P Hungin suggested the trust was aware of its risks and able to manage those to the best of its ability, given resource challenges.

Agreed*: there was a good level of assurance, regarding risk management processes.*

23-24/30 LEADERSHIP WALKABOUTS

A Bridges presented the report, which provided high level feedback from recent leadership walkabouts to the recruitment team and teams who had challenges related to recruitment.

S Dexter-Smith indicated that the recruitment team had welcomed the visit and opportunity to discuss new ideas.

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

1) P Hungin suggested that, whilst the board had been reassured previously that concerns raised were responded to, there was a need to manage expectations where there were complex challenges that could not be easily resolved.

   B Kilmurray acknowledged the point raised and also suggested that some concerns were within the gift of the line manager to resolve and did not require board level intervention.

2) M Brierley welcomed the visits and the insight they provided, and he noted the enthusiasm of staff to improve services, despite the challenges faced.

3) B Kilmurray acknowledged the impact that concerns raised would have on staff experience, and he noted that the proposed recruitment videos would respond to concerns that new staff had not been clear on their role prior to joining the trust.

   He discussed the importance of clinical supervision, provision of quality training and staff feeling valued and suggested that, whilst pressures on services were understood, the leadership team would reflect that they understood those. He also noted the longer term impact of transformational work.

23-24/31 VERBAL UPDATE FROM THE CHAIR OF PEOPLE, CULTURE & DIVERSITY COMMITTEE

J Haley, Chair of the Committee, provided an introduction as a Non-Executive Director. She welcomed the leadership in place and commented on her working relationship with the Director for People and Culture and the committee focus on risks related to recruitment, retention and culture change. She suggested there was evidence of improvement and proposed that the agreed workforce plan would allow the trust to build on improvements to date and achieve the vision to create a great experience for colleagues, patients, families and carers.

Commenting further, S Dexter-Smith advised that CQC had attended the last committee meeting and provided positive feedback on the Chair, agenda content and contribution of attendees.

23-24/32 EXCLUSION OF THE PUBLIC

Agreed *– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*

Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

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

Following transaction of the confidential business, the meeting concluded at 4.50 pm

Tees, Esk and Wear Valleys NHS Foundation Trust

Prior to the start of the meeting the Chair agreed to vary the agenda in order that the board had the opportunity to hear a patient story. The formal meeting then commenced at 1.30pm.

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 8 JUNE 2023 AT WEST PARK HOSPITAL, EDWARD PEASE WAY, DARLINGTON AND VIA MS TEAMS, COMMENCING AT 1.30 PM

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
B Reilly, Non-Executive Director and Deputy Chair
R Barker, Non-Executive Director
P Hungin, Non-Executive Director
J Preston, Non-Executive Director and Senior Independent Director
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
K Kale, Medical Director
B Murphy, Chief Nurse
L Romaniak, Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
A Bridges, Director of Corporate Affairs and Involvement (non-voting)
M Brierley, Assistant Chief Executive (non-voting)
H Crawford, Director of Therapies (non-voting)
S Dexter-Smith, Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary

Observers:
H Griffiths, Governor
C Lee-Gowan, Governor
J Wardle, Governor
S Double, member of the public

23-24/33 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and noted that board meetings would now be held on the second Thursday of the month in order that the board could receive performance information at the earliest opportunity. He also noted a special board meeting in June in relation to the Annual Report and Accounts and the Quality Account.

23-24/34 APOLOGIES FOR ABSENCE

Apologies for absence were received from C Carpenter, Non-Executive Director, J Haley, Non-Executive Director and J Maddison, Non-Executive Director.

23-24/35 DECLARATIONS OF INTEREST

None.

23-24/36 BOARD ACTION LOG

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

1) P Hungin noted potential changes to the Mental Health Act and welcomed the proposed board seminar, as an opportunity for board members to be aware of any impact [ref 22/144].

2) J Preston advised that the Autism Task and Finish Group had met with Humber and North Yorkshire ICB and expressed concern about the position in relation to dementia diagnosis and assessment where, he suggested, individuals needed to reach crisis before support was provided. He noted that national guidance had been published within the last few weeks and based on this and feedback from the group, the ICB had agreed to review the position [ref 23-24/11].

[P Scott left the meeting]

3) In respect of serious incidents, B Murphy advised that the proposed timeline would be achieved [23-24/13].

4) S Dexter-Smith advised that a report on Freedom to Speak up arrangements would be provided to the next board meeting [23/244].

5) L Romaniak advised that work was underway with the interim food supplier to expand menu choices and positive feedback had been received from service users. The Chair welcomed the progress made and thanked the team for their efforts to date.

23-24/37 CHAIR'S REPORT

The Chair advised that, following a period of leave, he had attended an interview with the CQC and had received some initial feedback, which would be discussed during the meeting.

23-24/38 QUESTIONS RAISED BY GOVERNORS

No questions had been received.

23-24/39 CHIEF EXECUTIVE'S REPORT

B Kilmurray provided a verbal report and highlighted the following:

1) The introduction of the Right Care, Right Person model, which would result in a change to the way emergency services responded to calls that involved concerns about mental health. He suggested that the trust and police worked well together, and the trust would seek early engagement to ensure the model was implemented locally in a considered way.

[P Scott re-joined the meeting]

P Hungin welcomed early engagement with the police. He noted the number of times the police used Section 136 of the Mental Health Act and expressed concern about the impact of the model on trust capacity.

B Kilmurray suggested there were some aspects of the model, where the trust would need to take responsibility, and he provided assurance that the trust would work closely with the police and that concerns about capacity would be raised with the ICB.

The Chair noted that the matter had been discussed at the national Mental Health Chairs' Network and he echoed the view of B Kilmurray that the quality of existing local relationships would support positive implementation. He acknowledged the concern about trust capacity and indicated that there was an expectation nationally that changes would be delivered through the local integrated care system, although it was not clear how that would be resourced.

K Kale advised that similar discussions had also been held at the national Mental Health Directors Forum.

P Scott noted that there would also be a risk to acute providers and advised that work had taken place to prepare a submission to the ICB on the preparation and timeline needed. He suggested that if implemented successfully, it provided an opportunity to strengthen the current offer but needed to be well managed.

The Chair invited executive directors to consider if the position was reflected in the Corporate Risk Register and Board Assurance Framework and suggested an update be provided to board at an appropriate point, via the Mental Health Legislation Committee.

Action: B Kilmurray, P Bellas

B Kilmurray confirmed that there was no need to convene a meeting of the Mental Health Legislation Committee at that point.

2) The 75th anniversary of the NHS on 5 July.

A Bridges provided an overview of proposed events and noted that the trust would attend a service at Westminster Abbey and participate in a media campaign with the North East North Cumbria ICB and regional partners across the week and month of July.

The Chair reflected on how mental health services had changed since the NHS had been established and the investment there had been in services. A Bridges proposed that this be a feature of the media campaign.

3) The CQC well-led inspection, which had followed an inspection of a number of core services. Initial feedback indicated that they had noted a positive change in the culture and openness of the organisation and the unity of the board.

Commenting further, B Murphy advised that the CQC had noted how welcomed they had felt, and initial feedback had been provided in relation to:

- The diversity and skills of the board and its good level of knowledge of risks related to quality and delivery of strategy.
- Improvements in relation to the trust's governance arrangements, which had included risk management, the BAF and IPR. They had suggested there remained some complexity in the system and highlighted the opportunity to consider improvements to the consistency of board papers, the flow of information and understanding of patient safety issues.
- Witnessed examples of person centred care and care delivered with flexibility, kindness, respect and dignity.

- Patient safety and risk issues, that the board was already sighted on, which included the serious incident backlog, the mortality review process, duty of candour and complaints.
- The waiting list for community services, about which the trust was invited to consider interim support. B Murphy provided assurance to the board that work was underway.
- Staffing levels, about which B Murphy advised that the position was considered by services on a daily basis and regularly discussed by the board.

B Murphy went on to note that feedback had been circulated to trust leaders and would be provided at the next Council of Governors meeting. A draft report was expected in August and in the meantime the trust would respond positively to the points raised.

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

1) B Reilly placed on record her thanks to governors who had taken part in the CQC focus group. She went on to express disappointment that the inspectors had not attended a Quality Assurance Committee meeting, as committee had discussed the position in relation to serious incidents, duty of candour and positive and safe interventions.

2) Responding to a query on the nature of duty of candour concerns, B Murphy advised that there was good practice in place and the trust needed to ensure there was a consistent understanding at all levels on the action that would be taken when a service user experienced harm.

   In respect of the evaluation of duty of candour by the CQC, B Murphy suggested that they may conclude from the serious incident backlog that a consistent approach was not in place, and she advised that the trust would provide a response in respect of duty of candour processes and the external reviews completed.

3) B Kilmurray suggested that areas for improvement would always be highlighted by a CQC inspection, and the trust would respond positively to them and provide assurance on work underway.

B Kilmurray and the Chair placed on record their thanks to the CQC team and to colleagues and staff for their involvement and effort to support the inspection process.

23-24/40 INTEGRATED PERFORMANCE DASHBOARD

M Brierley presented the Integrated Performance Dashboard, which aimed to provide oversight of the quality of services delivered and assurance to the board on action taken to improve performance in required areas.

He cautioned on the interpretation of data where performance measures had improved due to the change in the reported performance period and provided assurance that measures continued to be monitored.

In presentation, he drew the board's attention to areas where performance improvement plans (PIPs) had been developed and the current position in respect of out of area placements, mandatory and statutory training and staff in post with a current appraisal.

Commenting further, B Murphy advised that work had taken place to ensure that data on quality was reported into care group boards and the Executive Quality Assurance Group, to ensure there was a clear understanding of risk to quality, prior to discussion at Quality Assurance Committee. She also noted the intention to provide narrative in the board report on the impact of performance

on quality of care, and the proposal to re-establish the trust wide carers group and to develop a strategy on how the trust would work with carers.

The Chair welcomed the ongoing development of the report and the understanding and feedback it provided, and he noted that the board would seek assurance on progress but would not wish to view the operational detail of proposals.

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

1) B Reilly welcomed the development of the report and the proposals outlined and noted the positive feedback provided by the CQC. She drew attention to the reported performance in respect of mental health priorities including national quality standards and queried if the trust received a level of funding that would support achievement of the agreed measures.

   In response, M Brierley confirmed that the measures had been based on funding provided and he highlighted the additional measures proposed through the last planning round.

2) B Reilly expressed concern in relation to the level of patients who reported that they felt safe and noted that assurance work was underway by DTVF care group, and she welcomed a future update on this. **Action: P Scott**

   P Scott confirmed that work was underway and noted that the DTVF Care Group Board would meet with the Co-creation Board, who had been asked to facilitate this work. He suggested that a culture change was required, which would take time to achieve, and the safety summit would provide a springboard for this.

   B Murphy commented on the safety summit on 23 June and the agenda that had been developed in consultation with L Durrant, service users, carers, lived experience directors and involvement staff, to ensure there would be a high quality conversation on where the trust would place its effort, in order to make the most difference.

   Commenting further, K Kale advised that the summit would consider feedback on improvements made in relation to issues raised at the last summit in 2020 and next steps, and he indicated there would be future summits to monitor progress against goals identified.

   H Campbell noted that targets would be aligned with the Our Clinical Journey to Change.

   The Chair welcomed a future summary of the summit and input from the event into the trust's strategic plan. **Action: B Murphy/K Kale**

3) B Reilly noted the positive position in respect of restrictive intervention and the narrative included in the report on continuous improvement and suggested that additional capacity was required to support the Lead Nurse.

4) P Hungin drew attention to the areas of concern referenced in the cover report and queried how that linked to narrative within the main report. M Brierley undertook to review the narrative of the performance and controls assurance overview section within the main report, to provide additional clarity. **Action: M Brierley**

5) The Chair welcomed the progress that had been made on the IPR and proposed that the board receive a progress update on PIPs and related timelines. **Action: M Brierley**

6) The Chair invited P Scott and Z Campbell to comment on the performance report from a care group perspective.

   P Scott advised that DTVF was sighted on concerns in respect of inpatient pressures. He noted that the care groups had held a board to board meeting to discuss and align their understanding of key issues and to develop a shared narrative.

   The Chair welcomed this approach and the opportunity for the board to understand differences between the care groups, traction that had been achieved and assurance on PIPs that would be dealt with at care group and organisational level.

   In respect of the crisis line, Z Campbell advised that an improvement had been noted in NYYS and response rates were now 43%, with the support line at 93%. A remodelled service would be implemented early 2024 and the trust was in discussion with the ICB on the impact of changes to the NHS 111 service.

   P Scott went on to note that performance was 50 to 75%, but varied across the DTVF care group area, and reflected spikes in activity and demand on the urgent care pathway. A business case had been developed to take forward further improvement work.

   K Kale highlighted that the number of calls to the crisis line had increased to the extent that current performance was still higher than that of two years ago. The Chair proposed that this context be provided at the next Council of Governors meeting.

   Action: Z Campbell/P Scott

7) B Reilly noted that, as Chair of Quality Assurance Committee, she had been advised of two recent incidents of mechanical restraint by TEWV staff which were not captured by the report as they had occurred within an acute setting. She noted that she had been provided with assurance that a clinical led meeting had been held in both instances to review the circumstances and outcome for the service user, and that the CQC and ICB and been notified.

8) L Romaniak commented on financial risks in relation to: future contract arrangements for Microsoft licences, about which further work would take place to determine if they would be nationally or locally funded; and the NHS pay award, where the trust would wish to lobby in respect of the funding allocation.

23-24/41 REPORT FROM THE CHAIR OF PEOPLE, CULTURE & DIVERSITY COMMITTEE

In the absence of the committee Chair, S Dexter-Smith presented the report and drew attention to work that had taken place in relation to persistent vacancies, international recruitment, the reduction in BAF risk 5 score, the deep dive into staff who would recommend the trust has a place to work and the establishment of an executive sub-group to oversee compliance with mandatory and statutory training. She also expressed confidence about the management of risks.

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

1) The Chair sought assurance that policies and procedures were in place to support international recruitment and subsequent retention. In response, S Dexter-Smith advised that medical colleagues would be well supported, and discussions had taken place with the BME network on what further support would be provided.

The Chair welcomed an update at a future meeting. **Action: S Dexter-Smith**

2) In response to a query on the percentage of staff with a current appraisal, S Dexter-Smith acknowledged that levels were not where the trust wished to be and noted that Workpal had been implemented to response, and that staff would need time to adapt to the new system. She also noted that WorkPal would provide training needs analysis information and indicated that an update on its impact would be provided to the committee.

3) The Chair welcomed an update at the next board meeting on how the trust intended to respond to the level of staff who would recommend the trust as a place to work, and the timeline for this. **Action: S Dexter-Smith**

23-24/42 EXCLUSION OF THE PUBLIC

Agreed *– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*

Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

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

Following the conclusion of an informal board session and transaction of confidential business, the meeting concluded at 4.35pm.

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Tees, Esk and Wear Valleys NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 27 JUNE 2023 VIA MS TEAMS, COMMENCING AT 1.00 PM

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
B Reilly, Non-Executive Director and Deputy Chair
R Barker, Non-Executive Director
P Hungin, Non-Executive Director
J Preston, Non-Executive Director and Senior Independent Director
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
B Murphy, Chief Nurse
L Romaniak, Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
M Brierley, Assistant Chief Executive (non-voting)
H Crawford, Director of Therapies (non-voting)
S Dexter-Smith, Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary

Observers/members of the public:
J Wardle, Governor

23-24/43 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the special meeting, noting the purpose to consider the trust's Annual Report and Accounts and related documents, and the draft Quality Account.

23-24/44 APOLOGIES FOR ABSENCE

Apologies from absence were received from C Carpenter, Non-Executive Director, A Bridges, Director of Corporate Affairs and Involvement and K Kale, Medical Director

23-24/45 DECLARATIONS OF INTEREST

None.

23-24/46 CHIEF EXECUTIVE'S REPORT

The Chief Executive advised that no briefing was required prior to the next board meeting in July.

23-24/47 REPORT OF THE CHAIR OF AUDIT AND RISK COMMITTEE

J Maddison, Chair of Audit and Risk Committee provided a verbal update from the last meeting held on 19 May 2023 and advised that committee had:

- Considered the Head of Internal Audit's Opinion for 2022/23, which gave reasonable assurance that there was a sound system of internal control, governance and risk management, and that controls were not applied in a consistent manner. The opinion was based on two reasonable assurance reports in relation to record keeping and capability and disciplinary processes, and

three limited assurance reports in respect of digital and data project management, intention to move or leave interviews and duty of candour.

Committee considered the opinion was fair as the audit had focused on areas where there had been known risks, but members challenged the view that controls had not been consistently applied and it was agreed that the Annual Governance Statement would reflect that this applied to a limited number of areas.

- Considered and approved the 2023-24 audit plan, subject to final review by executive directors and the Director of Finance, Information and Estates. Assurance had been provided that the plan would be achieved within the agreed number of audit days with some scope to mitigate day rate increases by a reduction in planned days and it was agreed that there would need to be phased audits matched to resource across the year, to ensure completion.

- Reviewed the draft Quality Account and recommended its approval, subject to the inclusion of statements from stakeholders and partner organisations.

- Considered the draft Annual Report and Accounts for 2022-23 and noted:
  - A proposed correction from the Director of Finance, Information and Estates in respect of the valuation of asset replacement costs on a modern equivalent asset basis, which did not result in a change to the bottom-line revenue position in the accounts, but which would improve 2023/24 revenue.
  - Three recommendations from external audit, which included two on the introduction of IFRS 16, with one related to the application of liability measurement principles to PFI and other service concession arrangements. External Audits had commented that it was usual to have recommendations on implementation of new standards. The trust team had already engaged with External Auditors to ensure requirements were met for 2023/24.

  Committee recommended the Annual Report and Accounts be approved by the Board of Directors, subject to changes as a result of the ongoing external audit.

- Considered the draft External Audit Completion Report and noted there remained a number of areas for completion, which were in part due to the short timescales that the trust had to prepare the draft accounts. Committee acknowledged the challenges faced by the finance team and the late guidance received and had thanked the team for their efforts in preparing the accounts.

  Committee had welcomed the report and the improved content in relation to value for money and governance arrangements. However, it was noted that the external auditor was statutorily required to report in a way which did not recognise improvements that had been made since the section 29a warning notice and it was agreed that this would be reflected in the audit annual report.

Responding to a query, J Maddison advised that no governor had been able to attend the committee meeting on this occasion and the Chair undertook to raise this at the Council of Governors' Task and Finish Group. **Action: Chair**

23-24/48 ANNUAL REPORT AND ACCOUNTS 2022

L Romaniak presented the report and advised that the Annual Report and Accounts had been prepared on a going concern basis and in line with the FT annual reporting manual published by NHS England. She invited the board to consider if the report was a true reflection of the trust, if there was additional information that had not been disclosed to the external auditor and to review the statement on modern slavery.

It was noted that there had been a number of material changes to the draft report and Annual Governance Statement, which had been circulated to the board following Audit and Risk Committee and work undertaken by the external auditor, and that work by the external auditor would conclude on 29 June 2023.

B Kilmurray placed on record his thanks to colleagues, Audit and Risk Committee, and staff from the finance and company secretary teams for their efforts in preparing and reviewing the papers.

In discussion, it was proposed that reference to 'OAPs' in the document to be amended to 'out of area placements' and that the Chair's full name be included on the foreword to the accounts.

Action: P Bellas

Agreed: *that -*

a) The Annual Report and Annual Accounts 2022/23 be approved, subject to final changes required as a result of the external audit.
b) The Letter of Representation be approved.
c) The Chair, Chief Executive and Director of Finance, Information/Facilities Management be authorised to sign off the relevant parts of the Annual Report, the Accounts, any certificates relating to them and the Letter of Representation.
d) The submission of the signed Annual Report and Accounts, and related documentation, to NHS England and Parliament, be authorised.

23-24/49 DRAFT QUALITY ACCOUNT 2022/23

B Murphy presented the draft Quality Account and noted that this was a statutory document, presented in a prescribed format, that was subject to consultation with specified external stakeholders. She advised that Quality Assurance Committee had considered the report and recommended it for approval.

Commenting on the content of the report, she advised that the quality priorities reflected the cocreated journey to change, and the document was a backward look at priorities for 2022/23, which would remain in place for 2023/24. She drew attention to section 1.10 of the report which highlighted the work of individuals or teams through awards that had been won or staff who had been shortlisted.

Agreed: *That the Quality Account, including the statutory declarations within it, be approved and published on the trust's website by 30 June 2023.*

23-24/50 BOARD ANNUAL CERTIFICATES

P Bellas introduced the report, which sought agreement from the board on the proposed responses to the annual certificates required by NHS England. He noted that the certificates had been considered and recommended for approval by Audit and Risk Committee (ARC) and that Council of Governors', had supported ARC's proposal.

It was noted that this would be the final time that board certificates were required in this format.

Agreed: *that the following certificates be approved -*

a) The Certificate on Systems for Compliance with Licence Conditions
b) The Certificate on the Training of Governors
c) The Corporate Governance Statement
d) The Certificate on the Availability of Resources

23-24/51 EXCLUSION OF THE PUBLIC

Agreed *– that representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:*

Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

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

Following the conclusion of confidential business, the meeting finished at 2.00pm

Board of Directors
Public Action Log

RAG Ratings:	
	Action completed/Approval of documentation
	Action due/Matter due for consideration at the meeting.
	Action outstanding but no timescale set by the Board.
	Action outstanding and the timescale set by the Board having passed.
	Action superseded
	Date for completion of action not yet reached

Updates since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
29/09/2022 22/10/2022 27/04/2023	22/144 22/174 23-24/06	Topics for board seminars	a) Mental Capacity Act b) Reported outcomes following treatment c) what transformation may mean for future services	MD CEO Co Sec	Jun-23		Apr-23: proposed board & committee dates circulated w/c 24 April for consultation May-23: the seminar programme will be developed to take account of topics identified by the board during the year.
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 **Jul-23: See agenda item 15**
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. **Jul-23: See confidential agenda item 8**
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	Sep-23		Jun-23: Report to be provided to the board in Sept-23, following S&RC in August.
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		CN to discuss with QuAC chair to agree content of the learning report to QuAC within a revised work plan. Change to reporting anticipated July 23. **Jul-23: CN is working on a review of incidents to report to the Q Board in August the themes of learning, the proposal is that we move to an integrated improvement plan based on themes. The themes will relate to our QA process in order that we continually monitor delivery of actions, the QA review is underway.** **The outcome of this work will be reported to QuAC and onto the Board.**

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		**Jul-23: Item deferred to Sept-23**
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		**Jul-23: Request from JB to defer the report to September**
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	23-24/27	Third party risks	Executive Directors to ensure that risks related to the supply chain and third party delivery are considered.	CEO	Jul-23		Jul-23: BK to provide verbal updat at the meeting
25/05/2023	23-24/28	Feeling safe	Briefing to be circulated in repsect of the various elements that contribute to feeling safe	**CN**	**Oct-23**		**Jul-23: An MDT has been brought together across care groups to develop a trustwide approach to this. To be reported back to QuAC.**
08/06/2023	**23-24/39**		**Update to be provided from assurance work underway by DTVF Care Group.**	**MD DTVF**	**Aug-23**		
25/05/2023	23-24/28	IPR	Out of area placements - narrative to be included in the IPR on why the slippage had occurred	ACEO	Aug-23		To be incorporated into the next quarterly update in August 2023
			Narrative in the IPR to provide clarity on where an external agency or factor has impacted on delivery.	ACEO	Aug-23		To be incorporated into the next quarterly update in August 2023
08/06/2023	**23-24/39**		**Report narrative to be reviewed to ensure that the areas of concern outlined in the cover report are appropriately reflected in the IPR.**	**ACEO**	**Aug-23**		**Jul-23: To be incorporated into the next quarterly update in August 2023**
			Board to receive an update on progress on PIPs and related timelines.	**ACEO**	**Aug-23**		**Jul-23: To be incorporated into the next quarterly update in August 2023**
25/05/2023	**23-24/28**	**Memory assessment services - NYYS**	**Memory assessment services - Information and data on delays in scans and access to results to be provided to P Hungin**	**MD NYYS**	**14-Jul-23**		**Jul-23: Information is currently being collected and will be shared with PH by the due date. A decision will then be taken as to whether any further action is required or not and if so, what form the action will take.**
26/05/2023	**23-24/28**	**Advocacy for older people**	**The issue of advocacy for older people to be considered once the new I&E facilitator is in post**	**DoCA&I**	**Sep-23**		**Jul-23: action amended to join up previous two related actions related to a) review of advocacy services for older people and b) the issue of advocacy for older people be considered once the new I&E Facilitator was in post**
25/05/2023	23-24/29	Corporate Risk Register (CRR)	In resepct to the graph on committee alignment of risks - narrative be included to indcate the scope and range of services provided by the NYYS care group.	CN	Aug-23		Next CRR report due August 2023 **Jul-23: the issue was considered at Quac on 6-Jul and the MD confirmed confidence about risk management and that the DTVF resource is sufficient.**
08/06/2023	**23-24/38**	**Right Care, Right Person model**	**Executive Directors to consider if the position is appropriately reflected in the CRR and BAF and a report to be provided to MHLC.**	**CEO**	**Aug-23**		**Jul-23: update provided with CEO report (agenda item 6). Next meeting of MHLC on 31 August 2023**
08/06/2023	**23-24/39**	**Safety Summit**	**Sumary from the event to be circulated.**	**CN/MD**	**Aug-23**		
08/06/2023	**23-24/39**	**Crisis Line**	**Context in relation to the level of calls answered historically, to be provided at the next Council of Governors meeting.**	**MD NYYS MD DTVF**	**Jun-23**		**Jul-23: Completed - update provided at CoG on 15 June 2023**
08/06/2023	**23-24/40**	**International Recruitment**	**Update to be provided on the policies and procedures in place to support international recruitment and subsequent retention.**	**DfP&C**	**Sep-23**		
08/06/2023	**23-24/40**	**Staff survey**	**Update to be provided at the next meeting on how the trust intends to respond to the level of staff who would recommend the trust as a place to work and the timeline for this.**	**DfP&C**	**Jul-23**		**See agenda item 15**

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
27/06/2023	**23-24/47**	**Annual Report and Accounts**	**Chair to raise with COG T&F group, governor attendance at ARC when committee consider the annual report and accounts and draft Quality Report**	**Chair**	**Aug-23**		
27/06/2023			**Proposed amendments to be actioned prior to publication of the final report**	**Co Sec**	**Aug-23**		

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Chair's Report: 22nd May – 12th July.

Headlines:

External:

- Weekly MH Chairs' Network, including TEWV leading a session on the 2023/24 Planning Round, and how to make it better in future.
- Meeting NHS FT Chair North & South Tees NHSFT: areas of common interest and role of our organisations as anchor institutions in Tees Valley.
- Meeting Chair County Durham & Darlington NHS FT Chair: areas of common interest
- Meeting North East & North Cumbria ICS Chair, Executive and FT Chairs
- Meeting Yorkshire and Humberside FT Chairs
- Meeting Humber & North Yorkshire Provider Chairs
- Meeting NHS NEDs
- Mentor meeting for DJ
- Part of CNTW Chair Recruitment Stakeholder Panel
- North Yorkshire Police & Fire Commissioner meeting and discussion: mental health, blue light services, and joint working
- TEWV / Teesside University Memorandum of Understanding signing ceremony
- Meeting South Tees Director of Public Health, and Public Health Consultant on Drug & Alcohol Strategy and joint working.

Council of Governors (CoG)

- CoG Task & Finish Group x 2 on the role of Governors
- Various ongoing issues from Governors
- Governor Development session
- New Governor induction
- CoG Remuneration Committee relating to reappointment of a Non-Executive Director, and the Chair's Appraisal.
- Formal Public & Private CoG.

Internal

- Various Living The Values Awards (Cedar Ward, Foss Park Reception, HMYOI Deerbolt, HMP Durham)
- Board of Directors June & July 2023
- Leadership Walkabouts Willow Ward, and Orca House CAMHs
- CQC Well-led interview and CQC initial feedback
- 'Pearls in a Teacup' film showing Roseberry Park Hospital / Ridgeway
- Feedback and conclusion meeting with IST Lead.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: Board of Directors
Date: 13 July 2023 (BAF summary report as of May 2023)
Title: Board Assurance Framework – Summary Report
Executive Sponsor(s): Brent Kilmurray, Chief Executive
Author(s): Phil Bellas, Company Secretary

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

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

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

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

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

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

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

BAF Summary

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

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

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

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 July 2023**
Title:	**Chief Executive's Public Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Brent Kilmurray**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1	**Recruitment**	**The workforce plan.**
5	**Staff Retention**	**The workforce plan**
6	**Safety**	**Rapid Review & Industrial Action**
10	**Influence**	**Public Inquiry & Right Person, Right Care**

Executive Summary:

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

Proposal: To receive and note the contents of this report.

Overview: The report covers the recently announced decision regarding a public inquiry in Essex, the outcome of the rapid review into inpatients, a summary of the Workforce plan, an update on industrial action and further information on Right Care, Right Person.

Prior Consideration and Feedback n/a

Implications: No additional implications.

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

Public Inquiry decision

On 28th June the Secretary of State made a statement to the House of Commons confirming that the independent inquiry into deaths at Essex Partnership University NHSFT would be moved to a statutory public inquiry status. This decision had been awaited for some time. It had been suggested that the Government was considering including other Trusts within the scope of the public inquiry, including TEWV. The statement confirms that the public inquiry will focus on Essex.

Mr Barclay also announced that there would be a wider review undertaken by the Healthcare Safety Investigation Branch (HSIB). This would have a remit on learning from deaths, how young people in mental health are cared for in inpatient services, how out of area placements are handled and how a safe therapeutic staffing model can be developed.

The HSIB review will commence on 1st October. Further details on the scope and methodology for the review will be published before then. It is understood that Dr Geraldine Strathdee will lead this work.

Rapid Review into Inpatient Care published

We sent to members of the Board a copy of the rapid review findings published by the Government on 28th June. This review was chaired by Dr Geraldine Strathdee. The focus of the review was on how data and information is used in patient safety within mental health inpatient settings.

The findings are divided into five headings:

1. Measuring what matters
2. Patient, carer and staff voice
3. Freeing up time to care
4. Getting the most out of what we have
5. Data on its own is not enough

There were thirteen recommendations. Some of which are for NHS England, some for ICBs and some for Trusts. The CQC and Royal College also pick up recommendations.

The recommendations range from NHS England pulling together a programme of work to support delivery of the range of recommendations, through access to digital platforms and data infrastructure, showcasing of best practice, a review of mortality data, increasing the lived experience voice at Board level across the system, improving data skills, quality improvement expertise, spending time on wards, re-mapping of inpatient pathways, capital planning and assurance regarding building notices, ward visiting policy, systematically reviewing carer feedback, focussing on compassionate provision of services. The report gives all parties 12 months to implement the findings.

ICB sub-committees and the provider collaboratives are considering the report. The Trust will be pulling together a formal response over the summer on the basis of a gap analysis, given many of the aspects are covered in Advancing our Clinical and Quality Journey.

NHS Long Term Workforce Plan

The NHS workforce plan has been released this month. It is set out under 'train, retain, reform' sections.

- Train: significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, including new roles to meet the changing needs of patients and support transformation of care.

- Retain: ensuring that we keep more of the staff we have within the health service through support, flexibility, culture and leadership.

- Reform: working and training in different ways, building broader teams with flexible skills, changing education and training ensuring staff have the right skills and are available in the services that need them, making the most of new technology.

It offers some welcome stability and certainty for us to continue to implement our People Journey and it is clear that the underlying principles of the national workforce plan align well with our own strategic direction of More People, Working Differently, In a Compassionate and Inclusive Culture.

For us, the 'train' element of the plan is the most significant as it gives us an indication of the increased numbers of colleagues who will be being trained in the professions that we and the wider NHS are struggling to fill posts in. Until this point it has been difficult to plan our future workforce with confidence as we are reliant on national training plans for these core clinical posts. With this national strategy we will be able to plan with more confidence beyond the next 18 months.

The retain and reform sections build on the work we have been doing since our people journey began two years ago and which will continue to have a significant focus for the remainder of our own People Plan and beyond.

The People and Culture Committee will review the plan in more depth and provide advice to the Board on any next steps. As stated there is significant resonance with our own People Plan, however there some aspects that may cause us to revisit our plan, internally and with partners.

Industrial Action

A brief update on where we are up to with industrial action and engagement with medical staff so far. Strike action is confirmed for post graduate doctors, this will take place between 13th July and 18th July. The BMA has confirmed that Consultants will strike for 48 hours from 20th July.

We wrote individually to all career grade doctors about those plans, outlining that dispute is not with the Trust. We also stated that any leave from this point would not be approved. We asked them to step down any planned activity for Thursday and Friday. We convened a Local Negotiating Committee meeting and agreed an allocation process to cover daytime emergencies as per Christmas Day cover. The Trust Contingency Planning Group also met

this week and we have highlighted the operational risks in relation to the consultant industrial action and how this differs significantly from the postgraduate doctor action.

Postgraduate Doctor Industrial Action
We follow a similar process and start by identifying the vacant slots out of hours across all sites and then try to fill those with locum shifts. We ask postgraduate doctors who will be available for work during the day and allocate them to our hospital sites. We are well on the way with this work and nearly all out of hours shifts are covered, with a few evening and night shifts remaining across the Trust. We will allocate doctors for daytime support at meetings with medical management from each care group today. We aim to keep disruption to a minimum.

Consultant Industrial Action
The first task was to ensure we had emergency consultant cover for daytime services on Thursday 20th and Friday 21st. Doctors have since been allocated to rotas across the Trust and we have explained to them why we have done this and what their role will be. They were generally supportive with the ask but we did have to explain to a few that it was part of the BMA agreement and really there was no choice. We have been contacting remaining consultants to determine who is not taking part in action and will be available for work and will discuss numbers with medical leads by 7th July and where to deploy those.

There are remaining tasks and issues to consider and we will be working with Care Groups and the Trust Contingency Planning Group about such. We will be operating a full control room approach during the strike period.

We are currently reviewing the cancelled activity and are anxious to confirm that any patients cancelled in previous strikes are not cancelled again.

Right Care, Right Person
Further to previous discussions about this Home Office led policy, I attach briefing notes prepared by each of the Care Groups. There has been a good amount of progress on this issue of the past few weeks following senior level, tactical and operational engagement with our three Police forces. Discussions have been constructive and there has been a clear sense of wanting to work in partnership and to work in the best interests of vulnerable people and to manage risks.

Further to the work each of the Care Groups have been doing we have also recently hosted a visit by Navigo CIC, who provide NHS mental health services in North East Lincolnshire. They have been part of the first deployment of this policy with Humberside Police, and have been giving us some useful advice and guidance.

The briefing notes are at appendix 1 and 2.

Right Care, Right Person and interface with TEWV

DTV services currently work alongside two police constabularies, Cleveland and Durham, although we also work with North Yorkshire police constabulary to facilitate Section 136 MHA (Hambleton and Richmondshire) when required.

Current DTV service provision:

Durham and Darlington Urgent care crisis services	Teesside Urgent care crisis services
Crisis team - Triage, assessment and treatment team, separated between to bases, one in the north and one in the south 24 hr service, 7 days a week	Crisis Team - Triage and assessment team - South Intensive Home treatment team - North Intensive home treatment team 24 hr service, 7 days a week
Street triage Team The team work alongside Durham police and are based within the Force control room. Currently the practitioners have limited face to face contact with people presenting to the police due to current staffing establishment and recruitment of new staff members. Staff are currently being inducted and staff are working with senior police to develop the service to allow the team to support the police and carry out assessments and triage within the community. Shift pattern - 12 noon to 12 midnight Familiar Faces The team work across D&D area alongside internal trust teams and external stakeholders including Police, NEAS and the local authority. The team supports patients and services to develop interventions and safety plans to support patients within the community using a trauma informed approach.	Street triage team The team work alongside Cleveland police in the force control department, responding to urgent mental health calls, completing triage and assessments within the community alongside the police. The STT hold regular high intensity user meeting with the police on a monthly basis to support the police and to provide early mental health intervention for vulnerable members of the public. Shift pattern - 12 noon to 12 midnight
DTV listening service A confidential emotional support line, that can be accessed via the free crisis telephone line.	

Current meetings:

- Urgent care interface meetings held monthly in DTV (one in D&D and another held within tees) involving external stakeholders including police, local authority and NEAS.
- High intensity user meeting held monthly with Cleveland Police.
- Familiar faces meeting held monthly with Durham Constabulary and external stakeholders including NEAS and Local authority.

Progress on RCRP:

- Cleveland Police and Teesside crisis urgent care service have held an initial tactical RCRP meeting, during this meeting it was agreed that RCRP will be added to the Urgent care interface meeting and if we identify issues or concerns, then a task and finish group will be set up to address these.
  Cleveland Police have commenced Phase 1 work, this is Control room demand and diversion to appropriate services.
- Durham Constabulary have initially discussed the RCRP agenda within the Urgent care meeting however we are awaiting the RCRP toolkit before setting up a tactical meeting.
- Executive Level meeting has taken place with Cleveland police and verbal agreement reached to work in partnership to ensure we implement this new policy in a way that supports the safe transition from historical ways of working to a position where people in our communities are getting the best possible responses from our respective teams.as such we will be jointly engaging a wider group of stakeholders to start to progress

North Yorkshire Police
Right Care-Right Person

'Right Care, Right Person' (RC,RP) is a model designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond. This usually does not fall within the role and powers of a police officer

In some cases, police may need to deploy alongside medical or mental health workers - where those agencies need to take primacy but there is still a risk to those involved.

What's the threshold for police to attend?

The threshold for police intervention will be:

- There is an immediate risk to life or serious harm to an identified person
- Immediate harm – it is obvious to the police that there is a risk to life presently, at this moment or in the immediate future, or has already occurred
- Serious harm – there is a risk of significant harm to the person concerned, this can be physical harm, serious neglect issues, significant mental health symptoms, all of which would amount to the suffering of potential significant injuries or psychological harm

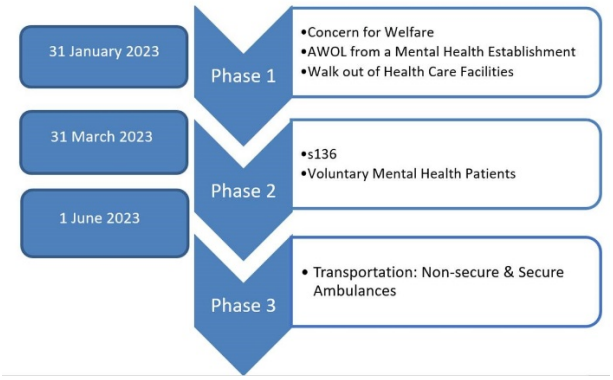
The focus of this policy is upon concerns for welfare from organisations/partner agencies. There is a distinction between concerns raised by partners and those made my members of the public and those involving the safeguarding of juveniles. The FCR will carry out a risk assessment of all requests.

Humberside police first implemented the policy, in response to their findings of increasing demand: "The force analysed its mental health and concern for welfare incidents and found that they were increasing. This was having a significant impact on the force's ability to respond to other calls for service. The force was receiving a substantial number of calls from health or care settings, including 25,000 concerns for welfare calls per year. This accounted for 11 percent of overall demand and an increase of 27 percent over two years." (Humberside police 2022).

Implementing the model

Phase 1 focuses on ‘Concern for Welfare’ and ‘Concern for Safety’ reports from Health Care providers, begins on 31 January 2023.

Phase 2, covering ‘Concern for Welfare’ and ‘Concern for Safety’ reports from Social Care providers, will get underway on 31 March 2023.



Escalation and oversight

Escalation of live incidents with NYP can be through the duty Force Incident Manager (FIM - police inspector rank) via telephone 101.

If a resolution cannot be agreed the FIM can escalate to NYP duty superintendent.

Operational support and intervention/mediation into incidents can be aided by the TEWV FCR mental health team (manager gary.matfin@nhs.net) and NYP RC,RP operational lead, inspector Dave.Barf@northyorkshire.police.uk

There is regular contact between the police and trust services and where appropriate reflective learning sessions are and have been put in place to explore scenarios where there have been challenges and any learning that can taken back into organisations.

Oversight

The implementation of RC,RP, in North Yorkshire is supported by a multi-agency meeting (titled ‘Working together, supporting the RC,RP initiative’), with senior representatives from Local Authorities (CYC and NYCC), NHS (TEWV, YAS, and YH), NYP and VCSO partners.

It is a forum to ensure that RC, RP is being safely implemented. The aim is for the group to work together to resolve issues and share learning with important interface incidents and issues, such as: Delayed Mental Health Act assessments; calls for police assistance; use of Section 136; and monitoring escalated incidents. The meeting is attended by the lead service manager and the general managers and Care Group Director of Operations and Transformation are also invited to attend and receive minutes / actions from the meeting.

It commenced on 6th June 2023 and is a monthly meeting, co-chaired by NYP and TEWV (currently inspector Dave Barf, NYP and Gary Matfin, TEWV).

As well as our Health and Justice colleagues our key relationship with the police is through our North Yorkshire Police Force Control Room Mental Health Team, Team manager: Gary Matfin, gary.matfin@nhs.net.

Examples of Ooperational and Tactical Interactions

In response to the above, our work with the police is multi-faceted.

The request for police assistance occurs in a number of scenarios

1) A detained patient who is current away without leave (AWOL) or who had gone on leave and subsequently refused to return to the ward. This would usually trigger a request for support from the police to facilitate returning the patient to the ward where they are refusing. Staff are unable to return the patient if they are refusing hence rely on the police to facilitate return sometimes with significant restraint.

2) Another scenario is in the context of a mental health act assessment where health staff have significant concerns of violence from the patient in their home, staff would often request police presence.

3) Scenarios where a patient leaves the emergency department prior to be assessed or prior to a final decision being made or refuses to return and there are concerns about patient safety, the police would usually be contacted.

4) Scenarios where a patient engages in significant levels of aggression to ward staff, other patients or property on the ward, the police are usually contacted to assist where the levels of aggression is great and support is required to reduce risk to patients and staff.

5) The police would be expected to contact the crisis team where they have put a patient on a section 136 to jointly agree where the nearest available place of safety is and what would be required at the place of safety to address the patient concerns. This does not always happen.

6) Scenarios where an individual has engaged in a serious criminal offence (serious assault, murder and may have a significant past history of such) and may have had previous imprisonment for such, the police would usually request a mental health act assessment though the pathway would expect the individual to go via liaison and diversion.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13th July 2023**
Title:	**Board Integrated Performance Report as at 31st May 2023**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Ashleigh Lyons, Head of Performance**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1. 2. 3. 4. 5. 6. 9. 11. 15.	Recruitment & Retention Demand Involvement and Engagement Experience Staff Retention Safety Regulatory Action Governance & Assurance Financial Sustainability	The Integrated Performance Report is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks.

Executive Summary:

Purpose: The Board Integrated Performance Report aims to provide oversight of the quality of services being delivered and to provide assurance to 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.)*

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: SOCI - Final Accounts - Surplus/Deficit
- 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:

- Percentage of inpatients reporting they feel safe whilst in our care (Durham, Tees Valley & Forensic)
- 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)
- Bed Pressures including OAPs (Trust-wide)
- Percentage compliance with ALL mandatory and statutory training (Trust-wide)
- Percentage of staff in post with a current appraisal (Trust-wide)
- Caseload (Care Groups)
- Agency Expenditure (Trust-wide)
- Safe Staffing (Trust-wide)

Performance Clinics are being established to review the content of the PIPs to ensure all actions are robust and that they provide full assurance to Board of Directors.

Mental Health Priorities including National Quality Standards

There are 1 Trust and 7 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
- Serious Incident Backlog

- Timely completion of Datix
- Safe Staffing Levels including Responsible Clinician vacancies
- Staff Training
- Crisis Lines
- Medical Devices
- Bed Occupancy
- Improvement in Retention and Absence
- 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 asked to:

1. Note the information contained within the report
2. Note the actions in place to manage any areas where performance isn't where we would want it to be
3. Confirm 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 CYP showing measurable improvement following treatment - clinician reported (measure 6)	Improvement in performance
The number of Incidents of moderate harm and near misses (measure 11)	Deterioration in performance
The number of Restrictive Intervention Incidents (measure 12)	Deterioration in performance
The number of Medication Errors with a severity of moderate harm and above (measure 13)	Improvement in performance Improved assurance
Staff Leaver Rate (measure 18)	Improvement in performance Improved assurance
Financial Plan: SOCI - Final Accounts - Surplus/Deficit (measure 24)	Reduced assurance
Financial Plan: Agency expenditure compared to agency target (measure 25a)	Improvement in performance

IPD Areas of Concern

There are 3 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 have been developed by both Care Groups; however, there is currently limited assurance pending the actions within those plans being progressed.
Financial Plan: SOCI - Final Accounts - Surplus/Deficit	The Trust reported a deficit of £3.04m for the two months to 31st March, an adverse variance of £0.35m compared to the planned deficit of £2.70m for the period. Three key operational drivers continue to challenge financial performance: elevated bed occupancy/delayed transfers of care, independent sector bed utilisation and elevated agency staffing pressures (including from medical vacancy, inpatient staffing and adult LD care packages). Adverse financial impacts are also included in the position in respect of the nationally negotiated pay review body outcomes (5% pay uplift) which is contributing a pressure (net of tariff uplift) of £0.21m to date. It is expected that National licencing arrangements for Microsoft will result in a clawback of related ICB allocations and Provider contracts generating a pressure compared to plan. Both result in adverse recurrent pressures compared to plan. The Trust is focused on financial recovery measures including vacancy control, task and finish activities for beds oversight and agency reduction, discretionary expenditure controls, and the delivery/mitigation of back-end loaded CRES plans.
Financial plan: Agency price cap compliance	Agency usage includes shifts fulfilled on hourly rates above the price cap or off framework. 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. There has been a consistent level of compliance (based on average per day) for April 2023 and May 2023, compliance at 102 shifts per day. However, in May 2023 three were 71% of shifts that were non-compliant with price cap or framework rules.
CRES Performance Recurrent	The Trust is not achieving its recurrent CRES savings target. Non-delivery of cost reductions predominantly relates to Independent Sector bed placements. The achievement as of 31st May 2023 was £0.65m behind plan. Planning of a trust wide CRES event is in train to take place during quarter 2. There is no planned CRES Performance Non-recurrent (measure 28) as of 31st May 2023.

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
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
IAPT: Percentage of people who have waited more than 90 days between first and second appointments	all Sub-ICB Location areas
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scored within the reporting period	all Sub-ICB Location areas
Number of women accessing specialist community PMH services	Vale of York

Appendix B

Broader Key Issues/Work

Quality

The key issues in relation to quality this month are:

Duty of Candour
Feedback both within and external to the Trust has indicated there is a lack of understanding of the compliance requirements for Duty of Candour amongst Trust staff. This has identified a need to develop robust monitoring processes Trust-wide, to ensure that we are open and transparent with our service used and carers.

Serious Incident Backlog
As at 22/06/2023 there are 175 open Serious Incidents. Of the 47 incidents in Cohort 1, 25 are currently being investigated and are at different stages in the governance process; 22 remain unallocated. Of the remaining 128 open incidents, 103 are in progress and 25 remain unallocated. We are concerned that the delays in completing incident reviews are not only impacting on the service users, carers and families directly involved within those incidents, but that there is also a potential risk that by not sharing timely learning from these incidents, we are impacting on the quality of the services we are currently delivering. The Chief Nurse has taken direct oversight to ensure that we have the capacity and skill to review historic incidents and address the current reviews. We have reviewed all incidents to ensure we have met Duty of Candour, that families have received notification of a review and have a named contact person and that we have clear terms of reference for each review. Letters of apology have been written to all cohort 1 families.

Timely completion of Datix
Although we have made improvements, we are concerned that there is a backlog of incidents to be recorded on Datix in a number of areas across the Trust, accompanied by a lack of agreed reporting and oversight of incidents. This is being given increased focus within the Care Groups and a new cross-Care Group review has been introduced with the aim of standardising processes across the Trust.

Safe Staffing Levels including Responsible Clinician vacancies
A shortage of substantive and regular staff continues to affect the delivery of care, impacting the flow of patients through our services and patient acuity. This is particularly impacting our inpatient services within North Yorkshire, York & Selby Care Group and mitigating processes are currently being implemented to support Danby Ward to manage the risk from the consultant psychiatrist vacancy.

Staff Training
Access to face to face Positive & Safe, Moving & Handling and Intermediate Life Support training continues to impact on the compliance of our staff with manual & statutory training requirements, and potentially the safety of our staff and people in our care.

Crisis Lines
Work is continuing within the Care Groups to support the answer rates for our crisis lines; however, there is concern, that we do not have sufficient oversight of the impact that the failure to answer these calls is having on our service users. We know that we have received complaints about this. Processes are to be established to share learning from any complaints and Patient Advice & Liaison issues raised.

Bed Occupancy
High bed occupancy continues to impact on the quality of the services we provide, particularly within our Durham, Tees Valley &Forensic Care Group. (*See below section on Inpatient Pressures*)

Medical Devices
We do not have sufficient oversight of all medical devices we have within the Trust, and this is being raised as an alert to the Quality Assurance Committee as we do not have full assurance that all

devices are fit for purpose and / or serviced appropriately. This is a risk that Executive Directors have full oversight of.

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, this includes the development of a Performance Improvement Plan (PIP).

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.

Progress to date with key schemes that are in implementation:

- Care groups continue to discuss cases with Local Authorities at a scheduled weekly meeting and / or use existing mechanisms to escalate issues via the Integrated Care Intensive Support Team. These are now established routes of escalation and embedded within service processes. Senior managers continue to ensure that the outcomes of the meetings are meaningful and purposeful.
- Work is commencing to explore how we approach the discharge process with patients who have no fixed abode / homeless to ensure a standard process across the Trust.
- Following the refresh of the PIPA process, an event was held in Roseberry Park Hospital to help develop a roll out plan to embed the process and documentation. Service managers and modern matrons are now overseeing the implementation plan across Roseberry Park (phase 1) with plans in place to hold events across Durham & Darlington (phase 2) the end of June. For the North Yorkshire, York & Selby care Group, the focus is upon the transition and implementation of the new PIPA documentation. Currently the Quality Improvement Team are scoping the work to produce a plan and timescales for completion.

New schemes:

- The OPTICA pilot continues to be progressed. A paper outlining the implementation plan and governance of the project has been developed and is currently being reviewed by the Care Groups before submission to Executive Directors Group. Work is also being undertaken in the background to commence the mapping of the admission to discharge pathway (PIPA) in collaboration with the operational teams, identifying key actions and data / information points that will feed into OPTICA.
- Through the PIPA work, Durham Tees Valley are to identify one ward where a Red to Green day approach can be piloted.
- Work is commencing to explore how we approach the discharge process with patients who have no fixed abode / homeless to ensure a standard process across the Trust.
- Targeted work to be undertaken with the Darlington, Hambleton & Richmondshire community teams to explore why admission rates are higher than expected per weighted population.

With many of these scheme's work is being undertaken to understand their impact (forecasted) to ensure correct alignment and prioritisation of schemes in 23/24 that will achieve the agreed targets: zero out of area placements by Q4 23/24, zero patients with a length of stay over 60 days by Q4 23/24, efficiency saving of £2.7million (through reduction in use of Independent Sector beds). Impact upon out of area placements, length of stay, delayed transfer of care and efficiency savings will be monitored monthly through the developed Scorecard which comprises a suite of primary / secondary metrics, targets, and trajectories.

People & Culture

Improvement in Retention and Absence
The year-to-date retention data shows an increasingly marked difference in care groups with DTVF losing 15 more than recruited and NYYS recruiting 16 more than have left.
Nursing has shown an overall small loss last month which is a shift, but an increase of 27% in numbers of graduates planning to join us compared to last year. The continuation of issues within medical staffing is being monitored, and there is an additional year to date increase of 20 for Psychological professions.

Sickness absence rates have continued to drop across the Trust and are now at 4.39%. The DTVF overall figure has decreased from 5.34% to 4.79% with the NYYS overall figure slightly decreasing from 4.21% to 4.11% and all areas remain under target. There are still some spikes in sickness levels, but these are now at individual team and ward level rather than across a service. The data, including the staff survey, indicates that we are on track to be able to reduce the retention risk in Q3 as projected.

Overall our leavers rate has fallen month on month for the last 10 months and we are now approaching the midline on the SPC chart. That combined with the significant reduction in absence rates indicates the potential for a more stable workforce developing.

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 have written to the ICB to request a review of funding methodology and explore alternate mechanisms that better reflect actual provider costs. Without additional support the Trust would need to find further mitigations to deliver its financial plan.

Care Group Summaries

Durham Tees Valley and Forensic Care Group

The key areas of concern identified from the Integrated Performance Dashboard (IPD), with triangulation of any other relevant information

- Several Performance Improvement Plans have been developed and approved within the Care group relating to 5 areas of focus, encompassing SMART actions and the expected impact, to support improvement and provide increased and assurance. The 5 areas are: -
    - Percentage of inpatients reporting that they feel safe whilst in our care
    - Percentage of CYP showing measurable improvement following treatment - patient reported
    - Unique caseload
    - Local Quality Standard –Number of people who first receive INHS Talking Therapies recognised advice and signposting or start a course of NHS Talking Therapies psychological therapy and Percentage of people who have waited more than 90 days between first and second appointments (INHS Talking Therapies)
    - National Quality Standard - Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks and Urgent cases within one week
    - Access to IPS services is also an area of concern however, we are requesting via Executives that the Performance Improvement Plan be stood down for this area due to levels of funding within the service. We will continue to monitor performance in this area.

- Pressures on our inpatient services are continuing; our bed occupancy remains high within our adult ward although we are starting to see increased discharges and reduced lengths of stay on some wards. Discussions have commenced with partners in Tees around supporting us to improve patient flow and with the implementation the Optica bed management system. We are attending an event in July, led by the ICB which will focus on improvements to the discharge process for Mental Health. Work continues to align the work of the care group and the Trustwide 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 and continue our weekly oversight of compliance trajectories. 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 and a Trust wide Performance Improvement Plan is included in this report.
- We note a deterioration in staff recommending the Trust as a place to work and 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.

The areas of positive assurance identified within the IPD

- We continue to see a reduction in the number of Restrictive Interventions used across the Care Group in all specialities but particularly in relation to Adult Learning Disabilities and Secure Inpatient Services. This is because of focused work and key actions in all areas.
- 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 from our services, followed up within 72 hours.

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

- Within our Crisis services, the 4-hour measure continues to be monitored closely to understand any areas of underperformance. A Durham and Darlington Team, 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 3 call screening roles is progressing. In addition to this work, we have a paper with ICB requesting investment to support all age crisis access service that will be co-located with the North East Ambulance Service. If agreed, the earliest we would be able to live is October 23. The current answer rates (1st – 15th June) are 50% in Durham and Darlington team and 58% in Tees team.

North Yorkshire, York & Selby Care Group

The key areas of concern identified from the Integrated Performance Dashboard (IPD), with triangulation of any other relevant information

- Pressures on our inpatient services continue; our bed occupancy remains high within our adult, older people and adult learning disability wards. As at end of May 23, we had 2 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.
- CAMHS Selby has seen a further reduction in WTE due to leavers and lack of medical cover in Scarborough.
- Reduced staffing capacity due to vacancies within the CYP North Yorkshire & York Crisis team has impacted their ability to achieve crisis 4 hours.
- 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 & AMH services are both achieving the standard for May position. The Director of Lived Experience has agreed to arrange a monthly Trustwide group focused on Mandatory and statutory Training and Appraisals. A covering paper is being written by the Business Manager to take to Care Board in June. The meeting will feed into the safer staffing group and oversee the Performance Improvement Plans for both measures.
- Memory waiting times demand and capacity exercise continues to progress with the aim for completion at the end of June 2023 which will scope out further requirements.
- The measure for AMH patients receiving follow up within 72 hours of discharge has a number of data quality issues which are being addressed. To ensure correct recording is embedded, this is being monitored by the General & Service Managers throughout June 23 as part of the weekly performance huddle

The areas of positive assurance identified within the IPD

- Patients surveyed reporting their recent experience as good or very good has moved from common cause to special cause improvement.
- We are achieving an excellent standard on the following measures within both NY and York Sub-ICB.
    - Patients waiting less than 2 weeks for first episode of Psychosis
    - Talking therapies 6 & 18 week standards for accessing our services
    - Talking Therapies Recovery
    - CYP supported through NHS funded MH with at least one contact
    - Adults and Older Adults with severe mental illness who receive 2 or more contacts from NHS or NHS commissioned community MH Services
    - AMH patients seen by crisis within 4 hours
    - CYP patients seen by suitably trained practitioner within 4 hours for VoY Sub ICB

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

- 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.
- Recruitment for a permanent consultant on Danby ward, Cross Lane Hospital is on-going. Alternative provision has been put place to ensure support for the MPAC trainees. The current arrangements secure the viability of the ward and will be kept under constant review.
- Previous pressures that exist within MHSOP Therapies continue to have an adverse impact on service delivery. In particular, recruitment into Psychology positions remains a challenge.

Appendix C

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st May 2023

Report Produced by: Ashleigh Lyons, Head of Performance
Date the report was produced: 23 June 2023

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

journey to change

CONTENTS

Chapter 1

Integrated Performance Dashboard (IPD)

Our Guide To Our Statistical Process Control Charts

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Within our Board Integrated Performance Dashboard we use Statistical Process Control Charts to determine whether we have any underlying causes for concern. SPC is an analytical tool that plots data over time; it helps understand variation in data and in doing so guides when and where it is appropriate to take action.

Variation: natural (common cause) or real change (special cause)?

Special Cause Improvement Low is good	We're aiming to have low performance and we're moving in the right direction.
Special Cause Improvement High is good	We're aiming to have high performance and we're moving in the right direction.
Common Cause – no significant change	No significant change in the data during the reporting period shown
Special Cause Concern Low is good	We're aiming to have low performance and we're moving in the wrong direction.
Special Cause Concern High is good	We're aiming to have high performance and we're moving in the wrong direction.

Assurance: is the standard achievable?

Target Pass	We will consistently achieve the target/standard
Target Pass / Fail	Our performance is not consistent and we regularly achieve or miss the target/standard
Target Fail	We will consistently fail the target/standard

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

Please note assurance on whether the standard/plan is achievable is now included for a number of measures. Standards for the remaining ones will be progressed this year.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS Foundation Trust

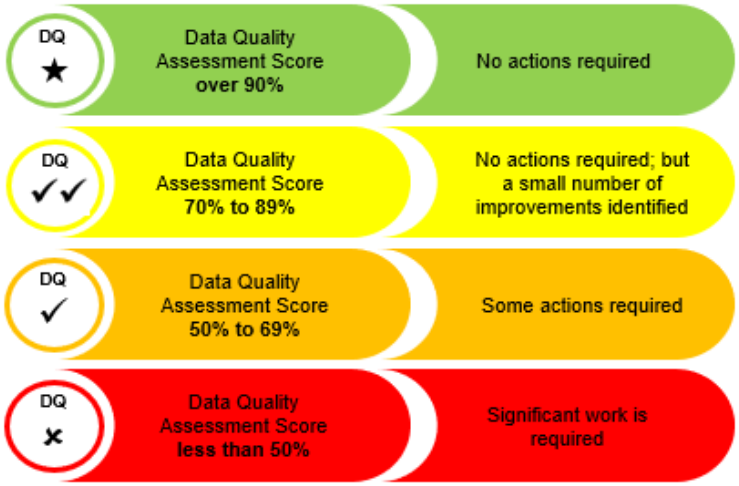
Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The latest assessment on all measures has been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

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

Action Status
Our action status is informed by a combination of current performance, performance over time (including trends) and general intelligence.

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

Data Quality Assessment status



Action status

Performance & Controls Assurance Overview

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive	***Medication Errors with a severity of moderate harm and above**	*Patients surveyed reporting their recent experience as very good or good ***Staff Leaver Rate**		
Neutral	*Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for ***Incidents of moderate harm and near misses** ***Restrictive Intervention Incidents** *CRES Performance – Non-Recurrent *Capital Expenditure (Capital Allocation) *Cash balances (actual compared to plan)	***CYP showing measurable improvement following treatment - clinician reported** *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 *Percentage Sickness Absence Rate *Staff in post with a current appraisal *New unique patients referred ***Use of Resources Rating - overall score**	***Financial Plan: Agency expenditure compared to agency target**
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 *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	*Unique Caseload (snapshot) ***Financial Plan: SOCI - Final Accounts - Surplus/Deficit** *Agency price cap compliance *CRES Performance - Recurrent

***NOTE**: green or white text indicates changes in assurance. Use of Resources Rating has been added as this was unavailable for April reporting*

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%	91.95%
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%	75.29%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	52.50%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC	L	F	35.00%	21.95%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	46.86%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC		F	50.00%	42.20%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	19.18%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC				98.73%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			1,691
10)	The number of Serious Incidents reported on STEIS	QAC				21
11)	The number of Incidents of moderate harm and near misses	QAC				268
12)	The number of Restrictive Intervention Incidents	QAC				829
13)	The number of Medication Errors with a severity of moderate harm and above	QAC	L			0
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0
15)	The number of uses of the Mental Health Act	MHLC				711

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				55.01%
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				58.76%
18)	Staff Leaver Rate	PC&D	L			11.84%
19)	Percentage Sickness Absence Rate (month behind)	PC&D				5.52%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L	?	85.00%	85.95%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D		?	85.00%	82.89%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				16,561
23)	Unique Caseload (snapshot)	S&RC	H			64,750

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	2,697,000	3,042,591
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	P	3,668,000	3,342,374
25b)	Agency price cap compliance	S&RC	F	100%	68%
26)	Use of Resources Rating - overall score	S&RC	P	3	3
27)	CRES Performance - Recurrent	S&RC	F	1,242,167	588,900
28)	CRES Performance - Non-Recurrent	S&RC	P	0	0
29)	Capital Expenditure (Capital Allocation)	S&RC	F	2,869,000	1,560,000
30)	Cash balances (actual compared to plan)	S&RC	P	72,428,000	75,444,836

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

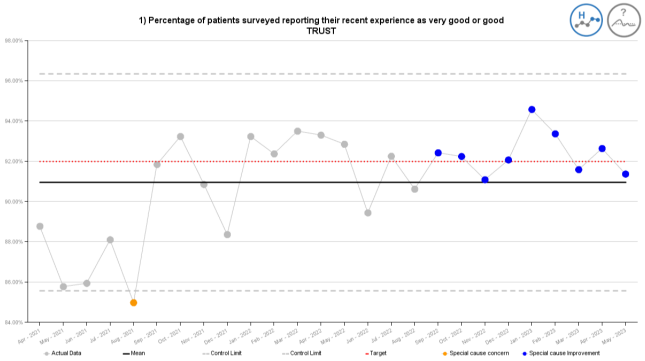
During May, **1008** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **921 (91.37%)** scored "very good" or "good".

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

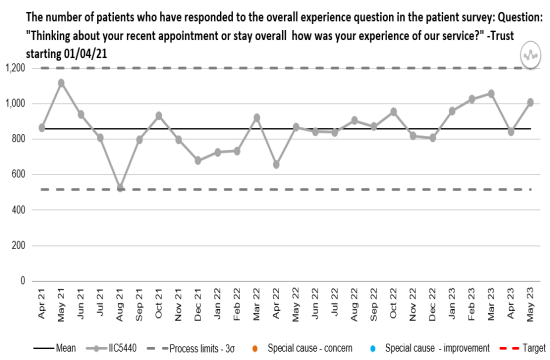
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

93%

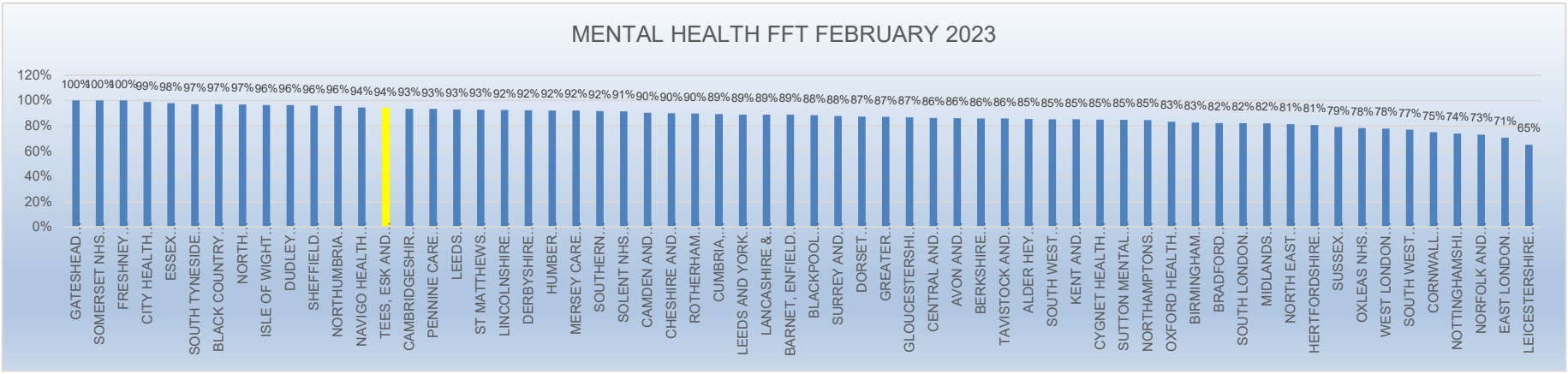
Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



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



National Benchmarking - Mental Health Friends and Family Test (FFT) data - February 2023 (latest data available)**.** The Mental Health FFT dataset includes FFT responses for the latest month from providers of NHS funded mental health services. The England average (including Independent Sector Providers) percentage positive responses about their overall experience was **87%**, our Trust is identified by the yellow bar in the chart below. We are ranked 14 in the list of providers shown.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
A cohesive programme of work is required to improve our understanding of the experience our patients are having, improve survey response rates, identify key themes and hotspot areas, and develop a set of clearly defined improvement actions.	*Enabling action:* Executive Director of Corporate Affairs to establish a Trust-wide Patient & Carer Experience Group by the end of ~~May~~ July 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.	

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

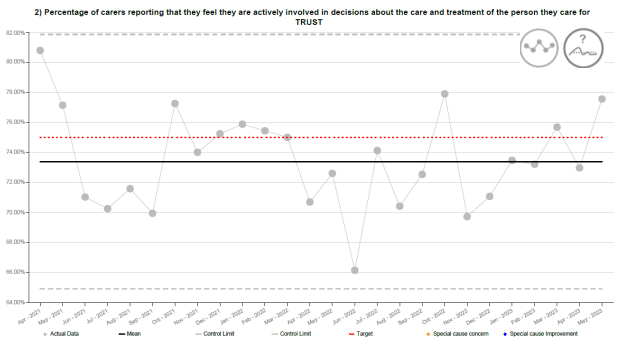
During May, **303** carers responded to the question in the carer survey: Question: “Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?”. Of those, **235 (77.56%)** scored “yes, always”.

No significant change in the data during the reporting period shown

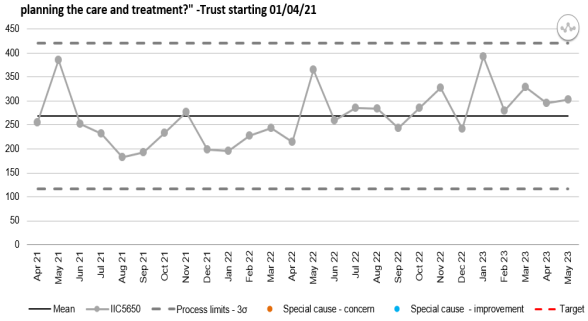
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ✓✓ **87%**

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



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



Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
An emerging theme is that staff are not engaging with carers on the grounds of patient confidentiality.	*Enabling action:* Patient & Carer Experience Group to conduct a deep dive into the involvement of carers by the end of ~~June~~ July 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.		
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 agreed at the April Service Delivery & Improvement meeting. The plan contains 8 actions, 4 of which are complete to timescale, including the establishment of a carers lead on each ward. The remaining 4 are on track to be completed by end of June 23.	

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

Additional Intelligence in support of continuous improvement

The Trust held its annual Carers Week during the week of the 5th June 2023. We understand how challenging and overwhelming it can be to care for someone with a mental illness or learning disability and these informal gatherings are hosted by fellow carers to enable our carers to connect with others who are going through the same experiences. Four events were held in different locations over the week providing an opportunity to discuss and share experiences, challenges and triumphs. They also provided carers with information about involvement opportunities within the Trust, to ensure that they have a say in how services are developed and delivered.

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.

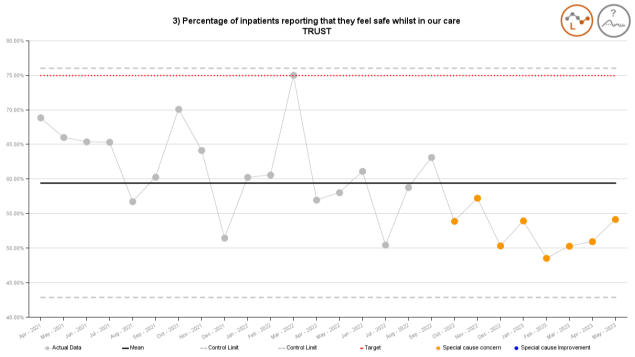
During May, **96** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **52 (54.17%)** scored “yes, always"

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

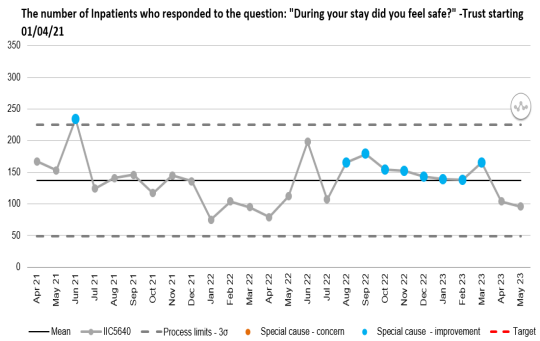
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ 87%

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



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



Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
‘Feeling safe’ has been identified as a priority within our 2022/23 Quality Account.	In order to improve Ward safety, 4 actions have been identified, which are being monitored on a quarterly basis by the Executive Quality Assurance & Improvement Group.	**Complete.** Of the 4 actions, all were progressed to plan throughout 2022/23 and work will now 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

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Patients within our North Yorkshire, York & Selby Care Group have told us that their sense of feeling safe is impacted by staffing numbers and the lack on consistent staff on wards.	Care Group Associate Directors of Nursing and Assistant Locality Manager to develop a robust workforce plan, which will include recruitment and retention, by the end of June 2023, with a view to increasing the number of inpatient staff available and to ensure consistency on rosters.		
Patients within our North Yorkshire, York & Selby Care Group have told us that their sense of feeling safe is impacted by incidents involving other patients.	Care Group Director of Nursing to develop a workplan focusing on the 'Safe Wards' programme by the end of June 2023, with a view to increasing the safety of our inpatient wards. This will be progressed through the Positive & Safe Care Groups and Fundamental Standards.		

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.

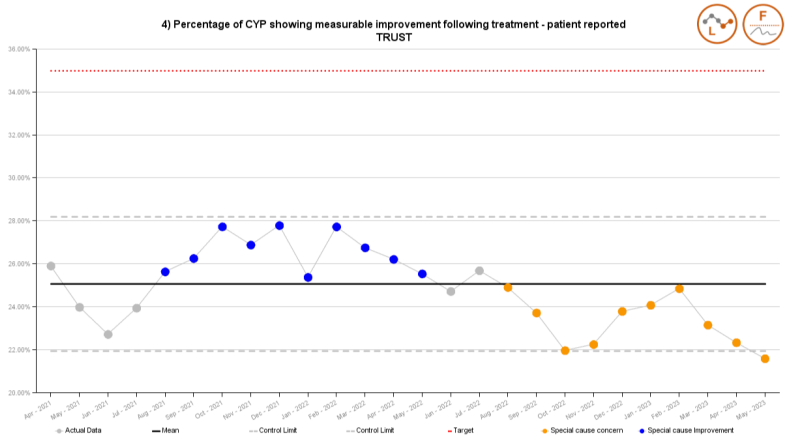
04) Percentage of CYP showing measurable improvement following treatment - patient reported

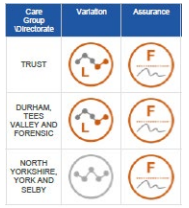
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

For the 3 month rolling period ending May, **741** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 160 (21.59%)** made a measurable improvement.

The accepted Patient Rated Outcome Measures are CORS / ORS / GBO (goal based outcomes) / RCADS / SDQ / SCORE-15 / PHQ-9 / GAD-7 / CORE-10.





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

Our system is expected to consistently fail the target/expectation

93%

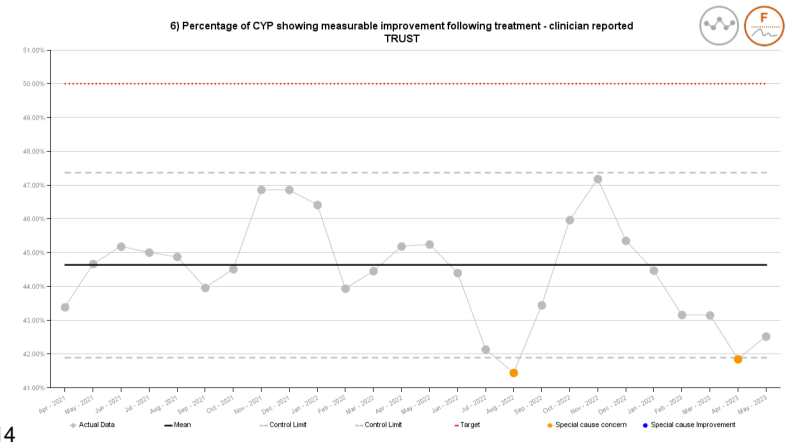
An Area of Concern
We are concerned with our performance in this area and action is required to improve

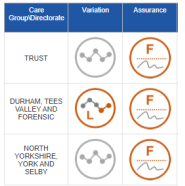
06) Percentage of CYP showing measurable improvement following treatment - clinician reported

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

For the 3 month rolling period ending May, **849** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 361 (42.52%)** 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)





No significant change in the data during the reporting period shown

Our system is expected to consistently fail the target/expectation

93%

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

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 May, 8 staff attended the monthly training sessions 6 (out of 6) from Durham & Tees Valley and 2 (out of 2) for 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.	**Complete**. Findings were discussed and it was agreed the information would inform actions within the Performance Improvement Plans being developed by the Care Boards.	
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.		

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. There are 6 actions currently included within the plan; 3 are to be completed by the end of June 2023.

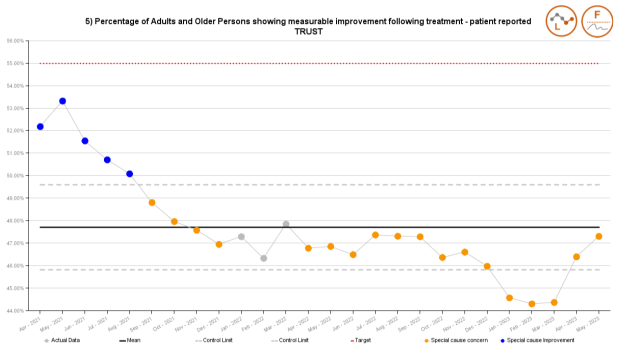
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

Tees, Esk and Wear Valleys NHS Foundation Trust

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

For the 3 month rolling period ending May, **1987** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 940 (47.31%)** made a measurable improvement.

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



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

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

Our system is expected to consistently fail the target/expectation

DQ ★ 93%

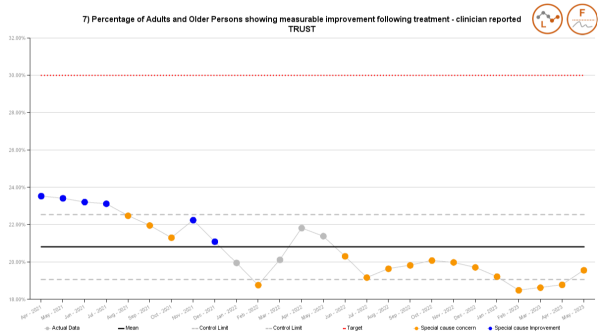
An Area of Concern
We are concerned with our performance in this area and action is required to improve

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

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

For the 3 month rolling period ending May, **3144** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 615 (19.56%)** made a measurable improvement.

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



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

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

Our system is expected to consistently fail the target/expectation

DQ ★ 93%

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Staff require training and support to better understand when and how to monitor the aspects of outcomes	*Enabling action*: The Section Head of Research & Statistics to work with the Digital Training Team to create a training video based on the content of the outcomes webinars. This work will be completed by the ~~17th March~~ 31st May 2023.	The Outcomes Steering Group Chair has requested the video be refreshed and linked to the suite of training on outcomes tools, including how to use them and record data. This will be discussed at the June Outcomes Group.	
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.	**Complete.** Investigations have concluded this issue does not impact on the measures.	

Page 105

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. There are 2 actions currently included within the plan; both are due for completion by the end of July

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

Tees, Esk and Wear Valleys NHS Foundation Trust

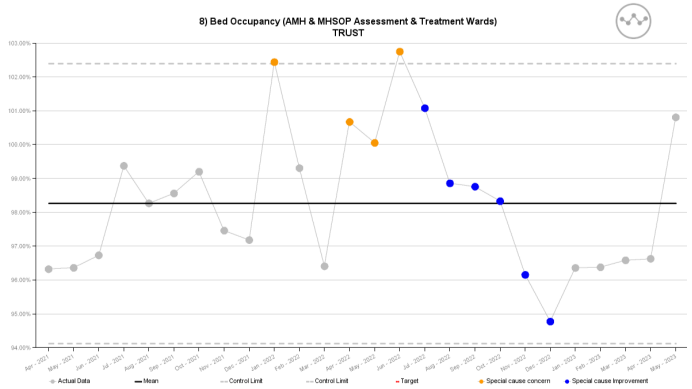
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important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

During May, **10,866** daily beds were available for patients; of those, **10,954 (100.81%)** were occupied.

No significant change in the data during the reporting period shown

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

DQ 73%



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

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

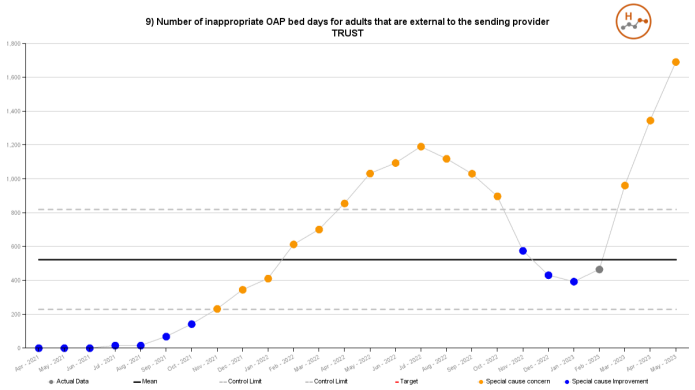
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending May, **1691** days were spent by patients in beds away from their closest hospital.

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

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

DQ 73%



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

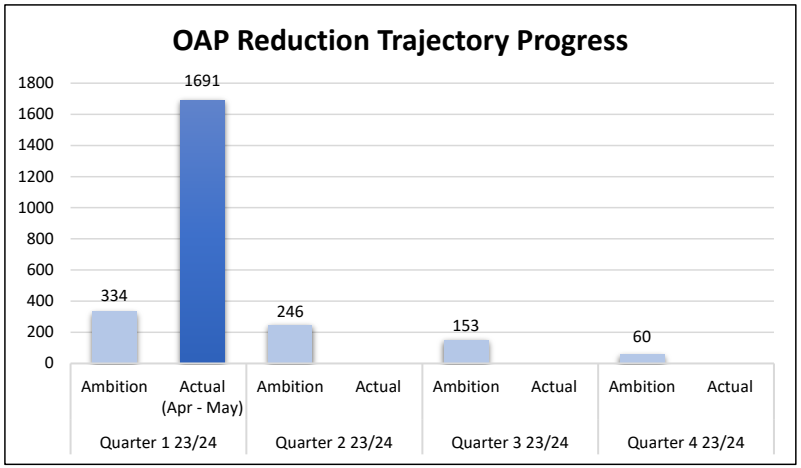
Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Measures

		2023 - 2024		
		Apr	May	FYTD
Overall Occupancy including Trust, block booked (Priory) and independent sector bed usage	Number of occupied bed days	10,914	11,657	**22,571**
	Number of available bed days	10,740	10,866	**21,606**
	Percentage Bed Occupancy	**101.62%**	**107.28%**	**104.47%**

Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider	Quarter 1 23/24	
	Ambition	Actual (Apr - May)
Trust	334	1691
North East & North Cumbria ICB	334	1431
Humber & North Yorkshire ICB	0	260



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. There are 11 actions currently included within the plan; 5 are to be completed by the end of June 2023.

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

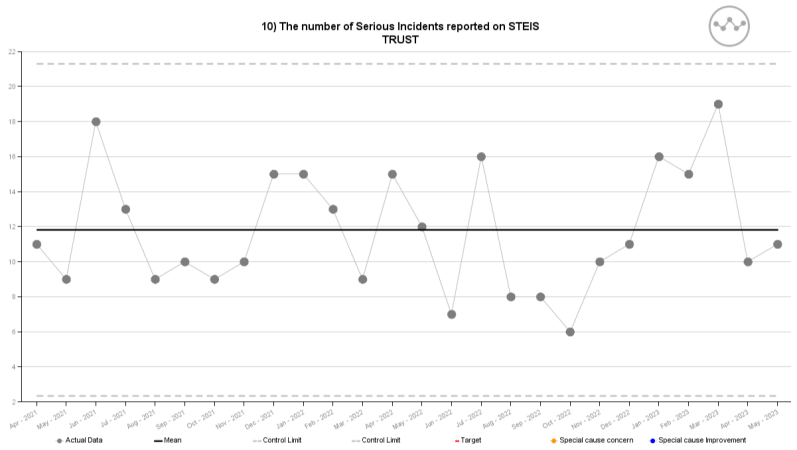
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

11 serious incidents were reported on the Strategic Executive Information System (STEIS) during May.

No significant change in the data during the reporting period shown

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

DQ
87%



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

11 Serious Incidents were reported in May. Each incident has been subject to an early learning review within the patient safety huddle and no new themes are emerging.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

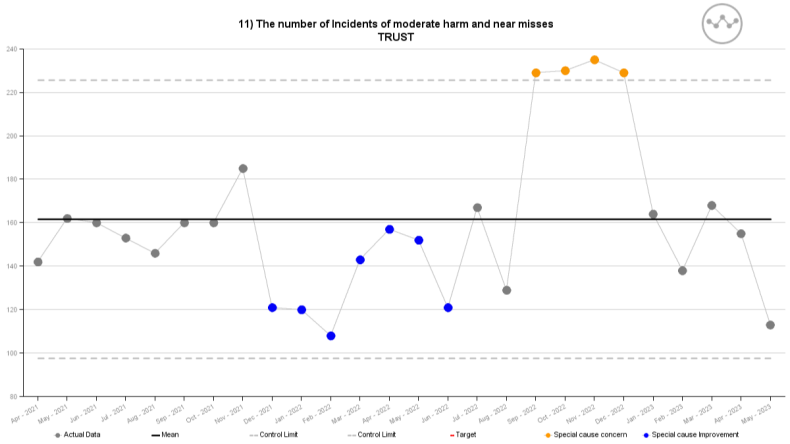
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

113 incidents of moderate harm or near misses were reported during May.

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
80%



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

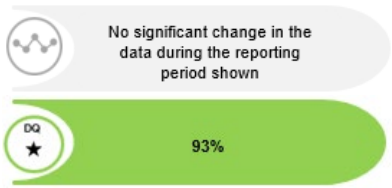
From a review of the 113 incidents we have identified a number of key areas of good practice and potential areas of learning, including Multi-Disciplinary Team discussions and liaison with other agencies.

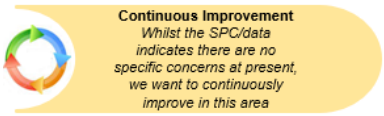
12) The number of Restrictive Intervention Incidents

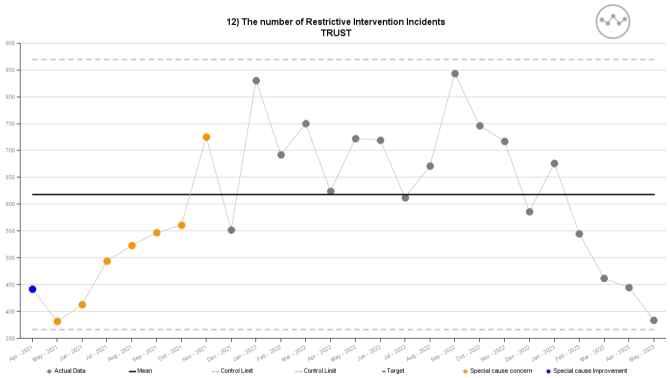
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

384 Restrictive Intervention Incidents took place during May.







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 is expected to be discharged mid-June • 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 has been undertaken, this patient now has a placement identified but their property needs to be built. A timescale has yet to be agreed. The service continue to receive bespoke support from an independent provider on a weekly basis 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~~ 30th June 2023.	The plan has been drafted and shared with the June Quality Assurance Committee. The planned away day to consult on the new Policy was delayed and will now take place on the 27th June 2023 at which we will agree the final Trust-wide Plan.	
	Enabling action: The Nurse Consultant for Positive and Safe Care to lead the development of a Positive & Safe Policy. The Policy will be completed by the 30th June 2023 for pubic consultation at that point.		
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.	

Page 76

Additional Intelligence in support of continuous improvement

- The HOPE(S) model is a human rights-based approach to working with people in long term segregation developed from research and clinical practice. HOPE(s) training has now been rolled out across Secure Inpatient Services and this has resulted in a reduction in the use of prone restraint and tear proof clothing.
- All inpatient services within our Durham & Tees Valley Care Group are using a live dashboard to support senior clinical oversight of restrictive interventions and clinical care.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

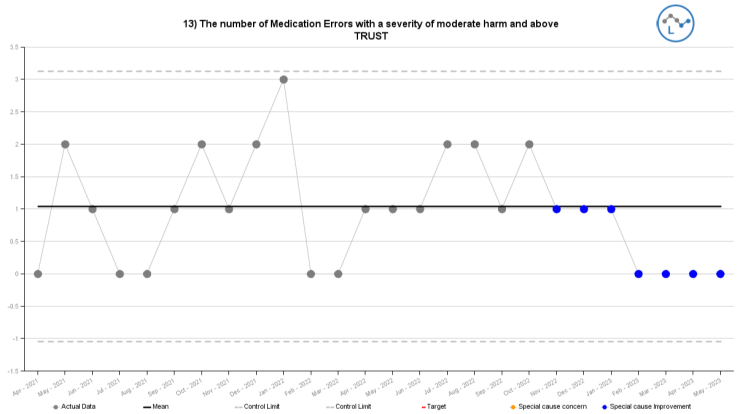
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When medication errors occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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

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



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

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Clozapine is a "high-risk" medication and was being taken in 6 of the incidents reported between April 2020 and August 2022. 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 included the development of e-learning, provision of patient information and 5 quality standards that will be audited. All actions are due to be completed by July 2023.	There were 27 overall improvement actions identified; 24 of which have been completed, including the production of a clozapine webinar video which is now being cascaded through the Trust. 1 action is currently under review and the remaining 2 are on track for delivery by the end of July.	
Depot antipsychotic injections are linked to 3 of the incidents reported between April 2020 and November 2022.	The Safe Medication Practice Group has co-created a set of depot-focused improvement actions, which are due for completion by the end of July 2023.	There are 8 improvement actions identified. Of these, 6 have been completed and the remaining 2 remain on track for completion. Bespoke depot prescription and administration charts have been developed for each drug and quotes are now being sourced to progress printing.	

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Additional Intelligence in support of continuous improvement

The Trust has successfully launched a pilot on Moorcroft Ward at Foss Park for electronic prescribing & administration on 6th June 2023. This pilot will enable more timely prescribing of medication to patients and reduce the risk of errors. Evaluation of the pilot scheme is scheduled for September 2023, after which we anticipate a wider rollout to all Trust inpatient services.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

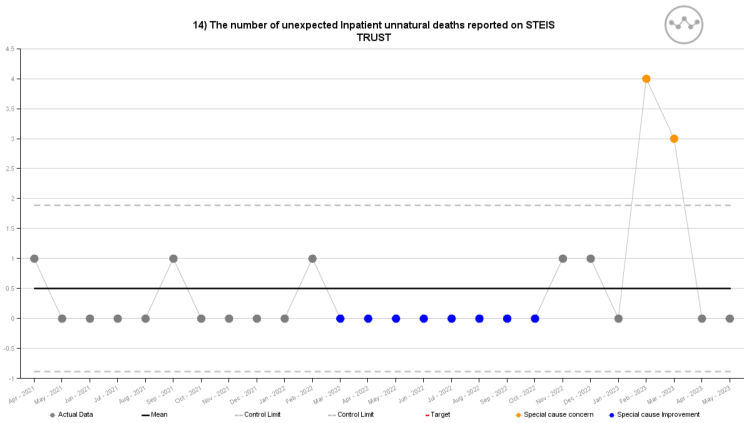
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements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

No significant change in the data during the reporting period shown

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

DQ ★ 93%



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

There have been no unexpected inpatient unnatural deaths during May.

Additional Intelligence in support of continuous improvement

Durham, Tees Valley & Forensic Care Group has undertaken a number of responsive safety audits across Adult Mental Health assessment & treatment wards and Mental Health Services for Older People functional inpatient wards, focusing on compliance with safety summaries and plans, leave arrangements, observation and engagement standards. This has included the undertaking of environmental surveys and a review of processes to share findings and actions from the surveys across ward staff of all disciplines. Senior members of the Care Group Board have been nominated to support these areas as a named mentor in completing improvement plans.

Monthly meetings have been established by the Care Group Director of Nursing to maintain oversight of progress and repeat audits have demonstrated improved compliance within a number of wards.

15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

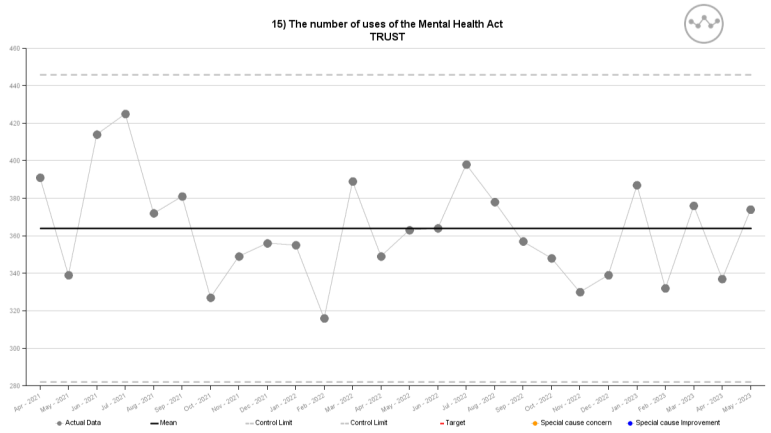
We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers,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

There were **374** uses of the Mental Health Act during May.

No significant change in the data during the reporting period shown

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

DQ 73%



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

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
As a result of monitoring and analysing this measure, we have identified through the IPA process, that some refinement is required.	The Head of Performance to work with the Business Intelligence Operational Manager – PLICS & MHMDS to develop a KPI change by the end of March 2023, with a view to amending the measure for the April 2023 report.	**On hold.** The number of uses of the Mental Health Act" measure is within the scope of being paused to facilitate the implementation of Cito (the Trust's new Electronic Patient Record system). The paper outlining these changes has been to Executive Directors Group for approval.	

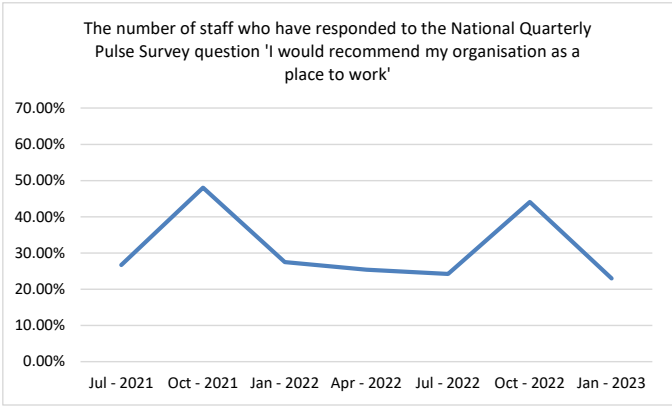
16) Percentage of staff recommending the Trust as a place to work

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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%



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

DQ 87%

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

National Benchmarking – NHS Staff Survey 2022

The national overall response rate for the 2022 Staff Survey was 46; TEWV was 44% and were the most improved Mental Health & Learning Disabilities trust nationally; ranked 1 out of 25 in overall positive change score.

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

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

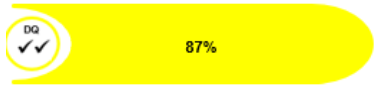
17) Percentage of staff feeling they are able to make improvements happen in their area of work

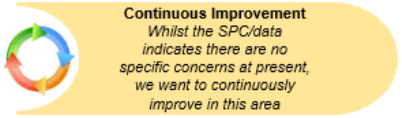
Tees, Esk and Wear Valleys NHS Foundation Trust

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

2013 staff responded to the January 2023 Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **1214 (60.31%)** responded either "Strongly Agree" or "Agree". ***Please note this is not "new" data as survey is only undertaken once a quarter***

	Jul - 2021	Oct - 2021	Jan - 2022	Apr - 2022	Jul - 2022	Oct - 2022	Jan - 2023
TRUST	57.10%	57.11%	57.50%	58.76%	59.12%	58.53%	60.31%
ASSISTANT CHIEF EXEC	76.92%	67.19%	67.74%	74.19%	65.22%	80.00%	88.00%
DIGITAL AND DATA SERVICES	65.96%	72.27%	74.03%	72.00%	65.88%	66.39%	65.00%
DURHAM, TEES VALLEY AND FORENSIC	56.23%	54.59%	57.00%	57.98%	58.94%	57.60%	57.35%
ESTATES AND FACILITIES MANAGEMENT	55.24%	26.04%	53.08%	52.67%	51.52%	46.55%	61.00%
FINANCE	65.38%	61.11%	64.44%	69.70%	71.79%	53.70%	57.89%
MEDICAL	67.44%	73.68%	81.58%	79.49%	68.57%	65.45%	70.45%
NORTH YORKSHIRE, YORK AND SELBY	54.44%	56.48%	54.35%	56.45%	55.77%	57.26%	59.12%
NURSING AND GOVERNANCE	61.90%	66.99%	65.75%	63.64%	59.46%	59.48%	69.41%
PEOPLE AND CULTURE	78.08%	77.60%	73.08%	73.12%	69.47%	77.31%	71.74%
THERAPIES	94.12%	58.97%	81.48%	70.83%	69.23%	47.06%	67.86%





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

National Benchmarking – NHS Staff Survey 2022

The national overall response rate for the 2022 Staff Survey was 46; TEWV was 44% and were the most improved Mental Health & Learning Disabilities trust nationally; ranked 1 out of 25 in overall positive change score.

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

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

Staff Experience: 16) Percentage of staff recommending the Trust as a place to work and 17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We currently have limited data on the percentage of staff recommending the Trust as a place to work and for staff feeling they are able to make improvements happen in their area of work.	*Enabling action*: 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.	**Complete.** The Workforce Delivery Plan is agreed and signed off and is now being progressed. Trust-wide priorities will focus on an increase in the quality of the appraisals we provide, an increase in the flexibility of employment, an improvement in how we co-create workforce priorities with staff and partners with lived experience and an evaluation of our health and wellbeing offers.	
We need to increase participation within the Staff Survey to ensure our results reflect a wider number of our staff.	*Enabling action:* Organisational Development to explore ideas shared by the North East Ambulance Service, North Tees & Hartlepool NHS Foundation Trust, South Tyneside & Sunderland NHS Foundation Trust and North East & North Cumbria Integrated Care Board for progressing within the Trust. This work will be completed by the 31st August 2023.		

Staff Experience: 16) Percentage of staff recommending the Trust as a place to work and 17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS Foundation Trust

Additional Intelligence in support of continuous improvement

The Trust has embarked on a 5-year stepped approach to Quality Improvement (QI) Training 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 01.06.2023	
Enable **100%** of staff to access Foundation training	**13%**	(1015 out of 7603 members of staff)
To have trained **50%** of staff at Intermediate level	**11%**	(845 out of 7603 members of staff)
To have **15%** of staff trained at Leader level	**4%**	(330 out of 7603 members of staff)
To have **1%** of staff trained at Expert level	**0.58%**	(44 out of 7603 members of staff)

It should be noted that the rollout of CITO is expected to have an impact on the training numbers as staff prioritise CITO training between June and August 2023.

18) Staff Leaver Rate

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

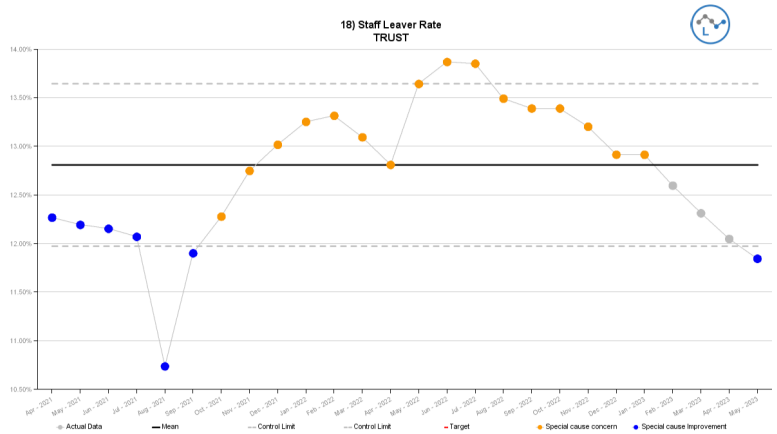
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

From a total of **6,903.24** staff in post, **817.67 (11.84%)** had left the Trust in the 12 month period ending May.

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

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

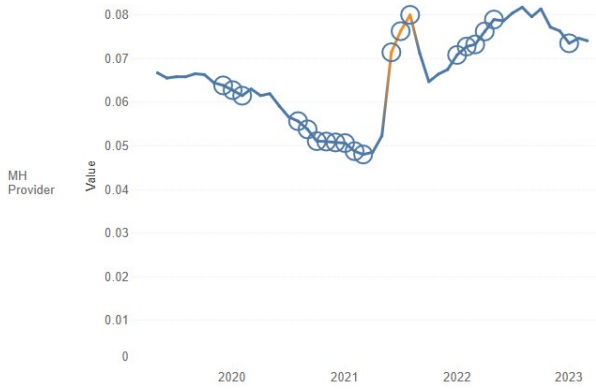
DQ
80%



Care Group/Directorate	Variation	Care Group/Directorate	Variation
TRUST	L	FINANCE	
ASSISTANT CHIEF EXEC	H	MEDICAL	
COMPANY SECRETARY	L	NORTH YORKSHIRE, YORK AND SELBY	L
CORPORATE AFFAIRS AND INVOLVEMENT	L	NURSING AND GOVERNANCE	
DIGITAL AND DATA SERVICES	H	PEOPLE AND CULTURE	H
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 – February 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.	**Closed.** This will now be incorporated as a specific action within the Safer Staffing Performance Improvement Plan.	

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

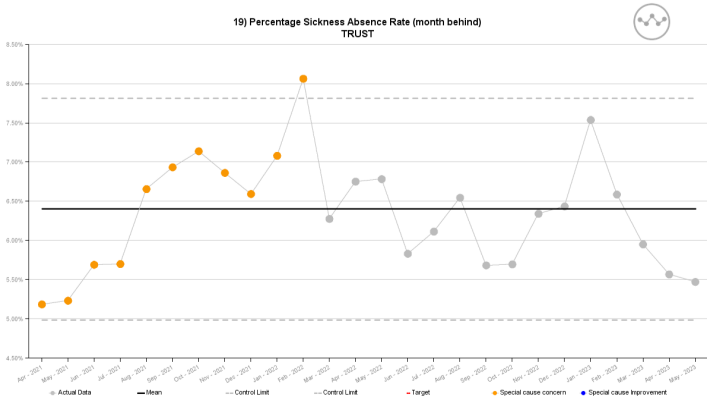
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

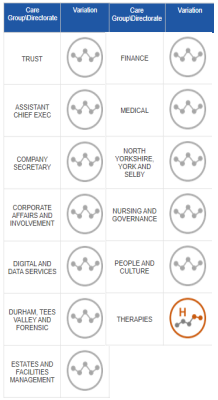
There were **219,498** working days available for all staff during May (reported month behind); of those, **12,012.48 (5.47%)** days were lost due to sickness.

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%

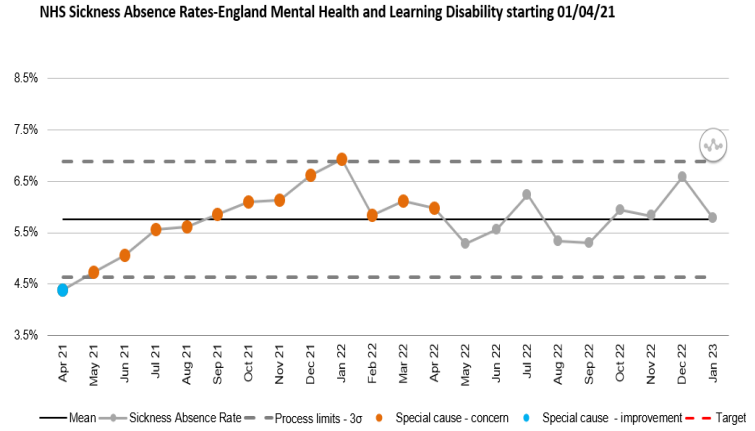




Page 207

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

NHS Sickness Absence Rates published 25th May 2023 (data ending January 223 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%.



Update

As at the 22nd June 2023, sickness absence is 5.22% for June 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 Partner 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.	The Corporate People Partner is now in post and establishment of the process is on track for completion.	

Additional Intelligence in support of continuous improvement

Sickness management training for managers is continuing to be progressed, with refresher sessions being provided for existing managers and focused training being provided to new managers, ensuring that the Trust policy is applied consistently across the Trust.

The People Partners have implemented 3-monthly follow-up reviews for services in which they have undertaken deep-dives. These reviews will ensure that any locally agreed actions are being progressed to plan and will enable any new issues to be identified and support and/or improvement actions established.

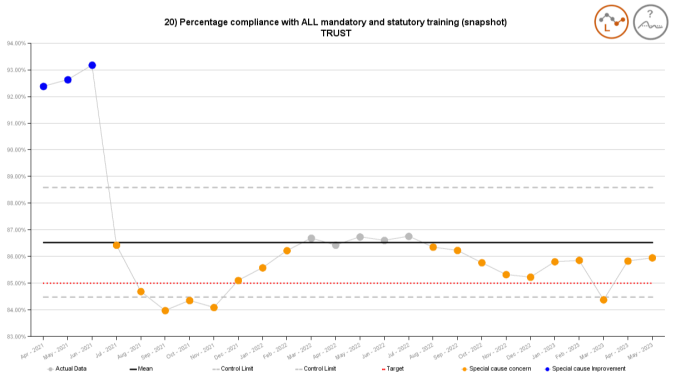
20) Percentage compliance with ALL mandatory and statutory training

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.

139,183 training courses were due to be completed for all staff in post by the end of May. Of those, **119,634** (**85.95%**) 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 May, **7695** were due for completion, **7077 (91.97%)** were actually completed.



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

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

Our 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. There are 28 actions currently included within the plan; 6 are to be completed by the end of June 2023.

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Information

As at the 23rd June 2023, compliance for each of the Trust directorates is as follows:

Directorate	Mandatory & Statutory Training Compliance	
	Trajectory to achieve 85% compliance:	Data as at 23 June 2023
Trust	Achieving	86.48%
Assistant Chief Executive	Achieving	91.94%
Capital Programme	Achieving	89.71%
Company Secretary	Achieving	88.16%
Corporate Affairs & Involvement	Achieving	93.87%
Digital & Data Services	Achieving	87.68%
Durham, Tees Valley & Forensic	Achieving	86.54%
Estates & Facilities Management	Achieving	92.72%
Finance	Achieving	90.96%
Medical	Achieving	85.53%
North Yorkshire, York & Selby	30th June 2023	84.98%
Nursing & Governance	Achieving	91.52%
People & Culture	Achieving	91.18%
Therapies	Achieving	85.34%
Trust-wide roles	Not Achieving	72.73%

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

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

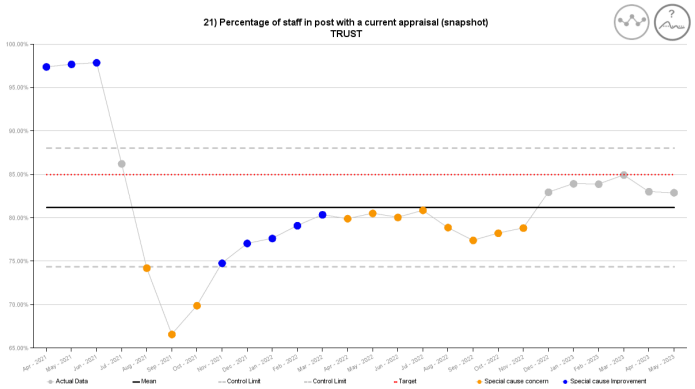
Of the **6499** eligible staff in post at the end of May; **5387** (**82.89%**) had an up to date appraisal

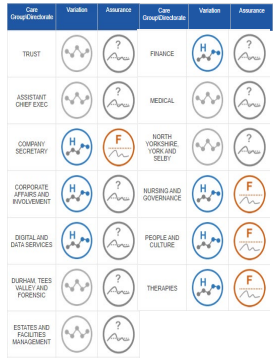
No significant change in the data during the reporting period shown

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

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

DQ ★ **93%**





We recognise that we have a significant number of staff within the Trust that have not received a timely appraisal and that this may be impacting on our ability to provide high quality and safe services. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. There are 9 actions currently included within the plan; 3 are to be completed by the end of June 2023.

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Information

As at the 23rd June 2023, compliance for each of the Trust directorates is as follows:

Directorate	Appraisal Compliance	
	Trajectory to achieve 85% compliance:	Data as at 23 June 2023
Trust	Not achieving	83.61%
Assistant Chief Executive	Achieving	87.50%
Capital Programme	Achieving	100.00%
Company Secretary	Achieving	100.00%
Corporate Affairs & Involvement	Achieving	100.00%
Digital & Data Services	30th June 2023	79.27%
Durham, Tees Valley & Forensic	31st March 2023	84.48%
Estates & Facilities Management	Trajectory requested	80.99%
Finance	31st July 2023	82.93%
Medical	31st May 2023	84.74%
North Yorkshire, York & Selby	31st May 2023	80.98%
Nursing & Governance	Achieving	91.67%
People & Culture	Achieving	89.31%
Therapies	Achieving	91.67%
Trust-wide roles	Trajectory requested	71.43%

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

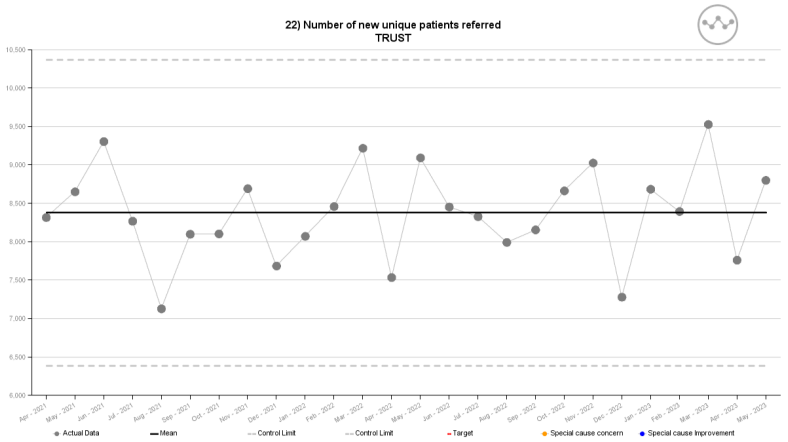
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

8800 patients referred in May that are not currently open to an existing Trust service

No significant change in the data during the reporting period shown

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

DQ ★ 93%



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

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

23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

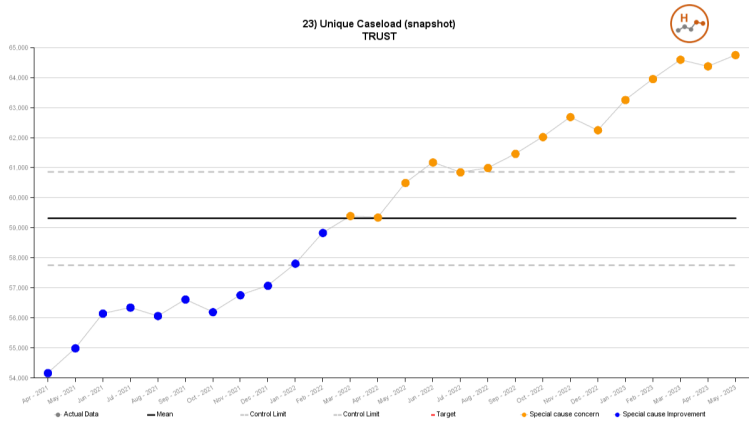
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

64,750 cases were open, including those waiting to be seen, as at the end of May 2023.

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

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

DQ ★ 100%



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

We recognise that the size of caseloads in a number of our services is an area of concern and may be impacting on the delivery of care and may affect our patients' recovery and staff wellbeing. To address this, our care groups have developed **Performance Improvement Plans** that define the actions that are being taken to support improvement and increased assurance. There are 27 actions currently included within the plans; 7 are to be completed by the end of June 2023.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We delivered a **£3.05m deficit** (to break even) to 31st May 2023 against a planned year to date deficit outturn of **£2.70m,** resulting in a **£0.35m** deficit to plan.

Summary

The financial position at 31st May 2023 is an operational deficit of £3.05m against a planned year to date deficit of £2.70m, resulting in a £0.35m deficit to plan. Key observations for May were:

• **Agency expenditure** within May 2023 was £1.65m, which was £0.19m under plan, or £3.34m YTD, which is £0.33m under plan YTD. Usage includes material costs linked to inpatient occupancy and rosters, medical cover and complex specialist packages of care.

• **Independent sector beds** - the Trust required 579 bed days during May 2023 (591 for April 2023, 12 bed day decrease) at a cost of £0.43m (includes estimates for unvalidated periods of occupancy and average observation levels pending billing). Year to date expenditure was £0.89m, which is above the YTD plan of £0.33m by £0.56m. 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 May 2023 was £0.46m, which was £0.25m 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 May 2023 is behind plan by £0.65m. Key variances relate to independent sector bed pressures for AMH, reduction on agency in Inpatients where rosters have been level loaded, and taxi spend reduction. Subsequent to reporting month 2, further savings of £0.17m were confirmed and will be adjusted in month 3 reports.

• **Pay Award** Since April 2023 Trusts have accounted for the nationally negotiated pay awards, which have differed since plan. Costs are partly offset by an inflationary tariff uplift of 1.6%, or £1.07m to month 2, resulting in a net pay award pressure above plan of **£0.21m YTD.**

• **Interest Receivable** to May 2023 was £0.62m which is **£0.21m higher than plan YTD**, and linked to higher than anticipated interest rates.

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

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to reduce Trust use of independent sector beds.	*Please refer to progress for measures - 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider*		
We need to reduce Trust use of independent sector beds.	*A bed pressures **Performance Improvement Plan** that defines the actions that are being taken to support improvement has been developed and shared with Executive Directors for approval.*		
The cost of computer hardware is high and we need to mitigate overspend in this area.	The Digital and Data Team to establish a process by the end of June 2023 to ensure regular data is received into Finance to ensure robust and timely capitalisation of relevant assets	The Digital and Data Team have advised that current stock levels have resulted in no new expenditure that requires capitalisation.	We have confirmed that £67k costs for year to date will be capitalised in month 3
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	CRES schemes will be discussed at relevant Care Group Boards / other committees throughout June.	
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	The expenditure reduction plan has been agreed, and is being implemented.	New roles advertised and in the process of recruitment. Reduction in non-pay costs being validated for month 3.

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.

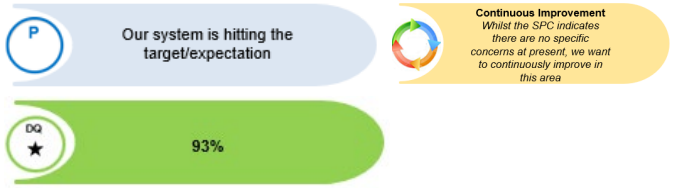
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

Agency expenditure of £3.34m is £0.33m **(8.8%)** lower than plan.



Summary

Agency expenditure for May 2023 was £1.65m, which was £0.19m under plan, or £3.34m YTD, which is £0.33m under plan YTD. Whilst the planned agency expenditure level for 2023/24 is relatively in line with 2022/23 outturn and plan, it remains high as a percentage of overall pay and higher than the average percentage target for integrated care systems in aggregate. Reducing agency volume and rates is a key focus.

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.

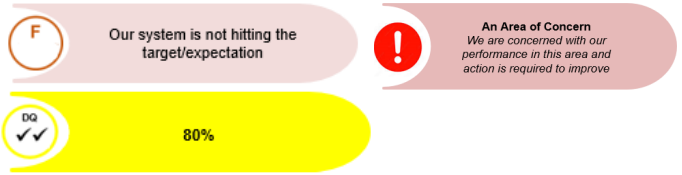
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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 May 2023 there were 4,610 agency shifts worked, with 3,151 shifts compliant **(68%).**



Summary

During May 2023 4,610 agency shifts were worked (227 more than April). This is equivalent to approximately 149 shifts per day, compared to 146 per day in April.

Of these, 3,151 or 68% shifts were compliant (3,056 compliant shifts or 70% compliance prior month). This is equivalent to approximately 102 compliant shifts per day in May and April.

Of the non-compliant shifts 1,363 or 29% breached price caps (compared to 1,237 shifts and 28% prior month). This is equivalent to approximately 44 price cap breaches per day in May, compared to 41 per day in April.

96 or 2% breached framework compliance (compared to 90 shifts and 2% prior month). This is equivalent to approximately 3 framework breaches per day in May and April.

Regional reporting of sickness levels suggests peer mental health providers have experienced similar challenges, albeit that the most recent absence reports for Durham, Tees Valley and North Yorkshire, York & Selby are reducing. 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.

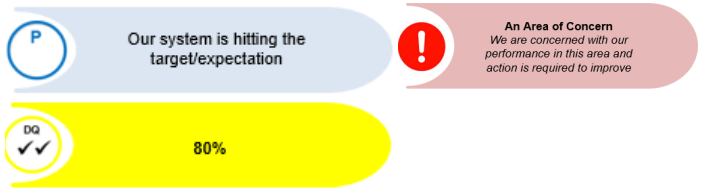
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

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



The **Use of Resources Rating** (UoRR) was impacted by Covid-19 with national monitoring suspended. The Trust has continued to assess the UoRR based on plan submissions compared to actual performance.

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity of -0.97x, which is 0.30x or £0.35m worse plan and is **rated as a 4** (£0.17m worse than plan in April).
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 23 days; this is behind plan by 4.3 days and is **rated as a 1** (4.8 days behind plan in April).
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust has an I&E margin of -3.92%, this is worse than plan by £0.26m and is **rated as 4** (£0.15m behind plan in April)
- **The agency expenditure metric** assesses agency expenditure against a capped target for the Trust. Costs of £3.34m are £0.35m (9.58%) less than plan, and would be **rated as a 1.** (The agency metric assesses performance against plan. It should be noted that planned costs were in excess of the 3.7% integrated care system target as a percentage of Trust pay.)

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

The Trust's financial performance results in an **overall UORR** of **3** for the period ending 31st May and **is in line with plan.**

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

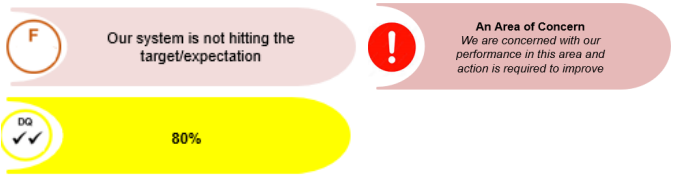
27) CRES Performance - Recurrent

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We planned to deliver **£1.24m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£0.59m**.

£0.65m deficit to plan.



Summary

The Trust has a plan to deliver **£1.24m** recurrent Cash-Releasing Efficiency Savings (CRES) in May 2023 but delivered **£0.59m** resulting in a deficit to plan of **£0.65m**. 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 2 with specific performance noted as:

- £0.33m under-delivery of CRES for OAPs Reduction in AMH
- £0.10m CRES for Agency (Inpatient level loading of rosters)
- £0.05m CRES for Taxi spend reduction
- £0.17m CRES for other schemes

CRES Unachieved £0.65m

Subsequent to reporting month 2, further savings of £0.17m on other schemes were confirmed and will be adjusted in month 3 reports. This would have reduced unachieved CRES to £0.48m

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.

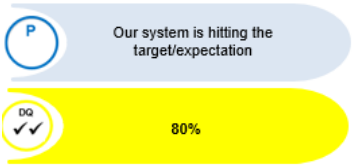
28) CRES Performance – Non-Recurrent

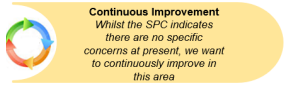
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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 2 is nil.

£0.00m variance to plan.





Summary

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

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

Additional non-recurrent mitigations are being considered through financial recovery work.

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

Page 101

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 May was **£1.6m** against planned expenditure of **£2.9m** resulting in a **£1.3m** underspend against plan.

Summary

Capital expenditure at the end of May was £1.6m, and is £1.3m lower than allocation of £2.9m.

There are a number of relatively small favourable and adverse variances to plan; however, year to date slippage of £1.3m relates to previously anticipated costs of 2022/23 schemes, which completed in year. The Trust is forecasting to outturn in line with plan at the end of the financial year.

Any delays to planned schemes are communicated to the environmental risk group to manage any associated risks.

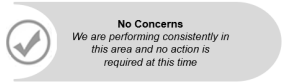
30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We have an actual cash balance of **£75.4m** against a planned year to date cash balance of **£72.4m.**

£3.0m higher than plan.



Summary

Cash balances were **£75.4m** at 31st May 2023, which ahead of the planned **£72.4m.** This is mainly due to slippage against the capital programme and payments received in advance of the period they relate to.

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 31st May 2023 was £3.7m of which the value of debt over 90 days is £0.4m (excluding amounts being paid via instalments and PIPS loan repayments). Four NHS organisations account for 63% of total debts greater than 90 days old (£0.3m), progress continues to be made to receive payment for older debts.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Please refer to progress for measure – 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit			

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Measures		1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Staff Retention	6. Safety	7. Infrastructure	8. Cyber Security	9. Regulatory Action	10. Influence	11. Governance & Assurance	12. Roseberry Park	13. West Lane	14. CITO	15. Financial Sustainability
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good			√	√	√	√			√						
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for			√	√	√	√									
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care			√	√	√	√			√						
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported			√	√		√					√				
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported			√	√		√					√				
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√		√	√	√					√				√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider		√		√							√				√
BIPD_10	The number of Serious Incidents reported on STEIS			√	√		√			√						
BIPD_11	The number of Incidents of moderate harm and near misses			√	√		√			√		√				
BIPD_12	The number of Restrictive Intervention Incidents			√	√	√	√			√						
BIPD_13	The number of Medication Errors with a severity of moderate harm and above				√		√			√						
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS			√	√	√	√									
BIPD_15	The number of uses of the Mental Health Act		√	√	√	√	√			√		√				

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

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 - May)
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)	1691

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, with accompanying narrative by exception. As part of the new Accountability Framework, we have developed **Performance Improvement Plans** for a number of measures that have consistently failed to achieve the national standard or commissioning plan. These plans define the actions that are being taken to support improvement and increased assurance. There are 24 actions currently included within the plan; 8 are to be completed by the end of June 2023.

County Durham Sub-ICB Location

There are **2** national quality standards and **3** local priorities that are at risk for delivery for quarter 1.

NATIONAL QUALITY REQUIREMENTS			
Measure	**Agreed S-ICBL Ambition**	**Q1 (Apr - May)**	**FYTD**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	86.96%	86.96%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	78.57%	78.57%

LOCAL QUALITY REQUIREMENTS			
Measure	**Agreed S-ICBL Ambition**	**Q1 (Apr - May)**	**FYTD**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 2260 Monthly 188	334	334
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	20.09%	20.09%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	25.48%	25.48%

Tees Valley Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **2** national quality standards and **3** local priorities that are at risk for delivery for quarter 1.

NATIONAL QUALITY REQUIREMENTS			
Measure	**Agreed S-ICBL Ambition**	**Q1**	**FYTD**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	90.36%	90.36%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	57.14%	57.14%

LOCAL QUALITY REQUIREMENTS			
Measure	**Agreed S-ICBL Ambition**	**Q1 (Apr - May)**	**FYTD**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 8627 Monthly 719	1142	1142
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	15.52%	15.52%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	36.30%	36.30%

There are **2** national quality standards and **3** local priorities that are at risk for delivery for quarter 1.

NATIONAL QUALITY REQUIREMENTS			
Measure	**Agreed S-ICBL Ambition**	**Q1 (Apr - May)**	**FYTD**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	81.82%	81.82%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	85.71%	85.71%

LOCAL QUALITY REQUIREMENTS			
Measure	**Agreed S-ICBL Ambition**	**Q1 (Apr - May)**	**FYTD**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 8627 Monthly 719	1142	1142
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	15.52%	15.52%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	36.30%	36.30%

Vale of York Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **3** national quality standards and **4** local priorities that are at risk for delivery for quarter 1.

NATIONAL QUALITY REQUIREMENTS			
Measure	**Agreed S-ICBL Ambition**	**Q1 (Apr - May)**	**FYTD**
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	80%	72.73%	72.73%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	80.00%	80.00%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	71.43%	71.43%

LOCAL QUALITY REQUIREMENTS			
Measure	**Agreed S-ICBL Ambition**	**Q1 (Apr - May)**	**FYTD**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 7096 Monthly 591	971	971
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	24.75%	24.75%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	33.88%	33.88%
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 60 Q2 120 Q3 180 Q4 240	29	29

Vale of York Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
New Follow up contacts undertaken by our Adult Mental Health Services are not being recorded correctly on Paris. Of the 7 patients that did not achieve the standard in May 23, 3 are attributable to data quality and were followed up within 72 hours.	AMH Service Managers and Community Modern Matron to ensure their teams/wards are aware of the criteria for 72 hour follow ups and understand how these contacts should be recorded correctly on Paris, with a view to reducing data quality issues.	**Complete:** The 72 hour criteria have been shared with all wards and teams and adherence to the requirements is being monitored by the General Manager& Service Managers as part of the weekly performance huddle.	
	General Manager to ensure that all data quality issues are corrected by the end of June 2023 to ensure correct reporting of this standard.		

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 July 2023**
Title:	**Feedback from Leadership Walkabouts**
Executive Sponsor(s):	**A Bridges, Director of Corporate Affairs & Involvement**
Author(s):	**A Bridges**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All	1 – Recruitment 2 – Demand 5 – Staff retention 6 - Safety	The report highlights summarised feedback from the June leadership walkabouts, which can contribute to the Board's understanding of strategic risks and the operation of key controls.

Executive Summary:

Purpose: The purpose of this report is to enable the Board to consider high-level feedback from the June 2023 leadership walkabouts.

Overview:

1 **Background**

1.1 The Trust undertakes a monthly programme of regular leadership walkabouts to services. These visits are not inspections but enable teams to hold conversations directly with Board Members and Governors to raise any matters of importance.

1.2 From a Board perspective, the walkabouts provide an opportunity to meet with team members to really understand the strengths of the service and consider the more challenging areas and how we can collectively work together to resolve these.

2 **Speciality areas visited**

2.1 The Leadership Walkabouts took place face-to-face on Monday 5 June 2023 and were themed visits to target teams who have had issues recruiting staff, and also those we have information on via PALS and complaints, and included:

- Willow Ward / Rehab, West Park Hospital
- Maple Ward/ AMH, West Park Hospital
- Overdale Ward / AMH, Roseberry Park Hospital
- Stockdale / AMH, Roseberry Park Hospital
- Estates / Facilities Management Teams at Roseberry Park Hospital and Cross Lane Hospital

3 Key issues

3.1 Operational services:

- Patient experience feedback was starting to feel more positive, with patients saying they 'feel listened to and heard', backed up by positive recorded feedback from patients and their carers.
- Some services reported that MDT working had made a positive difference – however, others said that they didn't have the whole MDT skills mix, so some discrepancies between teams. Medical staff cover also raised as an issue.
- Recent recruitment campaigns now starting to come to fruition, albeit work still to be done to ensure right skills mix (above) – teams thinking creatively about solutions.
- Visible and strengthened leadership across teams, and team resilience and mutual support really important, particularly around patient acuity.
- CITO was seen as a positive, training level good, and team readiness apparent, albeit some anxiety around transition and bedding in of new system.
- Some environmental issues highlighted re rehab unit next to PICU, example of unsuitability of alarms particularly in relation to neurodiverse patients.

Estates / Facilities Management Teams

- Strong team dynamic and teams committed to each other and hospital staff and patients: we heard how proud of staff the team felt, and outlined had good positive relationship with patients, carers and staff, which was really important
- Teamwork, being creative with ideas and being inclusive so the whole team participate in the running of the Estates department: team referenced this in action when they hosted a recruitment open day at Bankfields Court with over 400 people attending
- Recruitment: recruiting and retaining staff is a huge challenge, with better pay and conditions offered elsewhere in the same market. Team thinking about how they can attract younger people, and really sell the long-term benefits of working in the NHS. Also spoken to IPS team about possibility of offering patients training and skills to get back into employment.

3.2 For assurance, lead Directors have followed up on feedback

received to escalate issues and areas of concern where relevant and agree next steps.

Prior Consideration and Feedback n/a

Implications: No additional implications.

Recommendations: The Board is asked to:

1. Receive and note the summary of feedback as outlined.
2. Consider any key issues, risks or matters of concern arising from the visits held on 5 June 2023.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 13 July 2023		
Date of last meeting: 1 June 2023		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda**	The Committee considered the following matters: • The management of relevant risks included in the BAF • Corporate Risk Register • QUAC and EQAIG Development • Executive Quality, Assurance & Improvement Group (EQAIG) • Duty of Candour • Progress on delivery of the CQC Action Plans • Trust Level Quality & Learning Report • Internal Audit Update • Positive & Safe Annual Report • Adult Learning Disability Services (ALD) • Integrated Performance Dashboard • Quality Account 2022/23
2a	**Alert**	The Committee alerts the Board on the following matters: **1. Executive Quality, Assurance & Improvement Group (EQAIG)** One of the top areas of concern coming out of the EQAIG meeting on 25 April 2023 is the ongoing challenges relating to the Serious incident backlog and local ownership of Datix. A new report has been requested by the Chief Nurse that will demonstrate improvement over time with set trajectories and this will report to the July 2023 QuAC meeting. The ongoing issues with low response times to calls to the Crisis lines is another priority concern and it was suggested that an update be provided to the June 2023 Council of Governor meeting. In the meantime, there is a Positive Improvement Plan in place, however a clearer demonstration of the potential impact on individual patient care is needed and this will be reported to the July 2023 QuAC meeting. The Care Groups will be looking at the data relating to PALS and complaints to unpick hot spots and any practice issues and a report will be presented to the July 2023 QuAC meeting with a position statement and plans for improvements. **2 Duty of Candour** The overall awareness and understanding in the organisation about Duty of Candour is good, however limited regarding the statutory and contractual arrangements. EQAIG are monitoring progress with the Improvement plan. The Committee: • Approved the eleven medium/high set of corrective actions in response to the recommendations from the Duty of Candour audit. Immediate actions will be taken to complete and approve the policy, standard letters and templates are being revised, there will be representation in STEIS (serious incident reporting portal) and Duty of Candour will be reported at service, Care Group and corporate levels. • Confirmed that the level of assurance is good on delivery of the improvement plan. • Will receive an update to the September 2023 QuAC meeting. **3. Adult Learning Disabilities**

		The Committee received one final update on ALD services, who have made tremendous strides in making overall improvements to the services. Recent feedback from a further visit from Merseycare Health Trust was also very positive. The Committee congratulated teams and thanked them for all their hard work and commitment. Local ownership and monitoring will now resume. **4. Quality Account 2022/23 (QA)** The Committee approved the Quality Account and recommended that it be considered by the Council of Governors at its meeting to be held on 15 June 2023.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **1. Board Assurance Framework (BAF)** The Committee focused on the assurances and delivery of mitigations to reduce risks to acceptable levels, since there had been a recent review of the BAF by the Board on 25 May 2023, where good assurance was determined on the processes supporting the management of the strategic risks. From reflecting on the strategic risks discussed during the meeting, the Committee considers there is a need to be more sighted on PALS and Complaints, particularly the response times, which is impacting on those individuals or families who are seeking support and answers and a report will feature on the 6 July 2023 QuAC agenda. Safety was again an area of concern that members reflected on at the end of the meeting and is not following the set trajectory for improvement in the BAF, however a strategic review of the serious incident review process and Duty of Candour feedback to the Committee will seek to hear about assurances on the mitigations in place for improvements. There are no new risks considered to be added to the BAF. **2. Corporate Risk Register (CRR)** From the 20 risks currently on the CRR, 14 are aligned to this Committee. Questions were raised relating to the reduction of risk 1289: linked to the provision of MH services in HMP Hull and HMP Humber, however the Trust does have the ability to respond to any urgent needs of individuals and the average waiting time is four days to be seen for assessment. Risk review compliance has dropped - there are six risks where review dates have elapsed and the Committee, whilst recognising the tremendous efforts of staff and teams to prepare for the CQC inspection have urged that all risks are fully reviewed and up to date in the next month. Further refinement of aligning risks to Committees is taking place with the relevant Chairs who are undertaking some work to look at where risks should be primarily owned and managed with oversight across areas where the risk has multiple impact. **3. Delivery of the CQC Action Plan 2021 and CQC Inspection 2022** There continues to be good assurance relating to progress with all actions, with the exception of four actions where the *Committee approved extensions to the deadlines.* These actions relate to 3b) statutory and mandatory training, 9b) seclusion rooms not being fit for purpose, 10a) the secure inpatient service physical healthcare team supporting wards to do physical health checks and 12b) to increase access to Paris for all staff including bank and agency. **4. Trust Quality & Learning Report** Reasonable overall assurance can be provided regarding the operational and strategic oversight of key quality and safety areas of patient care with no significant matters to escalate. Discussion focused on Falls, restrictive interventions, serious incident review strategy and medication errors. Consideration will be given to hearing a more detailed update from Drug and Therapeutics at the September 2023 QuAC meeting. In relation to the backlog of SI reviews it is recognised that even with the additional capacity already in place and

		further help coming to fruition, assurance cannot be given that all risks associated with the backlog can be cleared. The priority must be to ensure learning is not delayed following a serious incident, but more importantly that families are supported as quickly as possible whilst waiting for a review to start. This is paramount to the reputation of the Trust. Colleagues in operational services have come forward who are willing to undertake reviews with relevant support. There are 174 incidents currently. A report will be presented to the July 2023 QuAC meeting, setting out a clear formula and understanding of the issues and how they will be addressed to a timeline with marked trajectories. **5. Internal Audit Update** A reasonable level of assurance is provided on progress with the current position since the first report to QuAC in February 2023 on the status of open actions identified through the Trust's internal audit program. There are two outstanding actions from the audit on National Safety Alerts, which include ensuring there is sufficient narrative in the database that can provide assurance that the data and information confirms that they are closed and complete. Also, that there will be quarterly updates on safety alerts reported to the Care Group Boards Members requested to see quarterly reports on all audits that relate to quality and that the Committee shall make the final decision on whether an action plan can be closed. EQAIG should also be seeing assurances and progress relating to audits feed up from the Care Groups month on month. **6. Positive & Safe Annual Report** The Committee took assurance from the positive trend towards less restrictive approaches for services and less standing restraint. Some of the more complex patients have been discharged, however this has taken six to eight months of work. Over the next year the focus will be given to the balance of continuing to reduce restrictive interventions with full clinical support and engagement. The first Positive & Safe conference was held since the pandemic which was really positive with over 400 staff in attendance from TEWV and CNTW.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **1. Quality Assurance Committee Development and Executive Quality Assurance Group** The Developmental session held on 5 May 2023 gave members time to agree precedence on the expectations for the Committee over the next twelve months, which include enhancing the role and purpose of meetings, review of membership, focus to be given on consistent metrics aligned to the quality goals and priorities to 'set the scene' and underpinning structures. The Committee needs to be demonstrably patient centric and outcomes orientated and individual patient testimonies will come through to meetings from September 2023. Pre-meetings have now been arranged directly before going into Committee for the Non-Executive Directors to hone their questions and challenge, which will enable smarter discussions and timely debates, amalgamation of reports and removal of some items from the agenda will help to eliminate duplication. Other housekeeping matters under review include whether the meeting should continue to be in public and whether attendance of a nominated member of the Council of Governors should be re-visited, considering the issue of any conflicts of interest. (The public Governor for NYYS has continued to observe QuAC over the last year). A review of the forward work plan will be led by the Chief Nurse – this will include providing clarity on mandatory reporting requirements. **2. The EQAIG will be re-named the Executive Review of Quality Group (ERQ)**

		A workplan is being devised to give focus to the areas that require priority attention, the risks that are escalating, duplication will be erased and robust discussions will be enabled by the Care Groups who will review the Integrated Performance Dashboard quality indicators. The key question will be, “where is our assurance on quality from the Care Groups and what are the cross-cutting themes?”. Assurances and concerns will be reported from the Care Groups up to the ERG and then a report will be provided for QuAC with Managing Directors providing accountability in the Quality Assurance Committee meetings. **3. Integrated Performance Dashboard** There were no comments raised about the IPD as members had covered the key business matters during the meeting. The new suite of quality indicators for the Committee will be finalised by September 2023.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considered that there were no material changes to be made to the strategic risks of the Trust. However, there are new risks emerging related to concerns over clinical supervision and the system to support this which will be taken to Executive Directors for further discussion to ensure that staff experience is fully understood. This will be then monitored through People & Culture.
3	**Actions to be considered by the Board**	There are no specific actions to be considered by the Board. However, the Board is asked to consider the report and where applicable, seek clarity and assurance.
4	**Report compiled by**	Bev Reilly, Non-Executive Director, Deputy Chair of the Trust, Chair of the Committee, Beverley Murphy, Chief Nurse, Donna Keeping, Corporate Governance Manager

Committee Key Issues Report		
Report Date to Board of Directors – 13 July 2023		
Date of last meeting: 6 July 2023		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda**	The Committee considered the following matters: • The management of relevant risks included in the BAF • Corporate Risk Register • Outcome of EQAIG and scrutiny of Integrated Performance Dashboard (IPD), including NYYS and DTVF QAIGs • Internal Audit Recommendations • Delivery of the CQC Action Plan • Quality Assurance & Learning • PALS and Complaints Review • Serious Incident Improvement Plan • Review of Mortality Process • Revised Terms of Reference and Committee Annual Work Plan
2a	**Alert**	The Committee alerts the Board on the following matters: **1. Serious Incident Improvement Plan** Following ongoing concerns raised by the Committee about the backlog of serious incidents awaiting review, the improvement actions and processes in place to address this were considered. The Chief Nurse also advises that a letter has been received from the Coroner in Durham and Darlington expressing concerns about the backlog, this has been responded to and is included in the reportable issues log. The Committee supports the recovery plan, which includes a clear trajectory of improvement going forward, based on assumptions that there will be on average 14 incidents reviewed per month. 32 staff have come forward from the Care Groups to help support this, with the aim that by October 2023 the backlog will be addressed, this is noted to be an aggressive improvement trajectory. Assurance can be provided to the Board that early learning reviews are carried out on any serious incidents with any immediate learning cascaded and there is a degree of confidence from the Care Groups that the trajectories can be met. There will be close monitoring of progress by the Chief Nurse. The Committee, therefore, based on the plans proposed can provide reasonable assurance to the Board. **2. Executive Quality, Assurance & Improvement Group (EQAIG), including DTVF and NYYS QAIGs** The top areas of risk reporting up from the DTVF and NYYS Quality Assurance and Improvement Groups are the backlog of serious incidents, staffing, access to statutory and mandatory training, which could lead to unsafe care (positive & safe, immediate life support and manual handling), access to the crisis line, capacity to track medical devices and continued bed occupancy at or above 100%. The Director of PCDC will be presenting to the Quality Board on 17 July 2023 setting out some proposed trajectories to bring the statutory and mandatory training back online and QuAC will be sighted on this. The Executive QAIG met on 23 June 2023 to gain assurance, advice and risks to quality of care from ward to Board. Good assurance can be evidenced that restrictive practice is decreasing in autism/LD, SIS and a four-month reduction trend is noted in the DTVF Care

		Group. There were no people moved to seclusion on other wards (guesting). NYYS has made great progress with closing incident reports on Datix and the roll out of the new AED's has commenced. All risks and concerns have been considered by the Care Group Boards and reported into the Executive Directors group on 27 June 2023. The MDs of the Care Groups stated that they had confident on the way risks are being managed. One risk that requires attention is the need to set up a Trust asset register for medical devices and some funding is being pursued to support the Medical Devices Officer, the Committee requires confirmation that this risk has been addressed. **3. Integrated Performance Report, as at 31 May 2023** Following consideration at QuAC, the IPR was then reported to the July 2023 Board of Directors, with overall reasonable assurance relating to the oversight of the quality of services being delivered. **4. PALS and Complaints Review** Following a request by the Committee at its meeting held on 1 June 2023, due to concerns over the lack of compliance with the 60-day response rate for answering complaints, a report outlining the rationale for the review of complaints and PALS was considered. The key areas to address for improvement of the complaints process include enhanced service collaboration, stronger operational ownership, effective modelling of capacity and demand, caseload management for the complaints team and to address the cultural aspect of responding compassionately with a positive approach to learning from complaints. Whilst pressing for some pace on this review, the Committee accepts that due to the national changes for the dissolution of the difference between PALS and complaints that this is going to be a huge piece of work that requires adequate time for quality improvement work, using the right tools to take this forward. The Committee sought further assurance on progress moving forward by requesting quarterly reports that include the numbers of complaints, by specialty and location and any hot spots. Also, to check that the risk score is reflected appropriately in the Corporate Risk Register/BAF. The Board can be assured that the complaints team are adequately resourced with the appropriately skilled staff in place. **5. Mortality Process** The Committee can provide the Board with reasonable assurance on the mortality review process and proposals for change to enhance more timely identification of learning. There have been challenges with completing mortality reviews over recent months due to capacity issues within the patient safety team, which has resulted in a backlog. To address this the plan is that the relevant clinical teams will review the Structured Judgement Reviews (SJR) – there are 43 outstanding from 53 open cases. These will be completed by the end of July 2023 and have been themed for focused MDT reviews. This will come with some risks if there is lack of buy in and capacity within clinical teams and within the patient safety team. It could also lead to failure to capture learning and actions centrally and being unable to triangulate learning and inform strategic improvements. To mitigate these risks there will be a robust communications strategy, staff training and support provided with professional accountability to establish a process for capturing the learning. The Committee supports the proposed mortality process plan.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **1. Board Assurance Framework (BAF)** Reflecting on the strategic risks during the discussions at the meeting, there are no new risks considered that should be added to the BAF, however the risks relating to serious incidents, complaints, mandatory and statutory training and the crisis service will be reviewed to ensure they adequately reflect the current position.

		2. Corporate Risk Register (CRR) From the 19 risks currently on the CRR, 13 are aligned to this Committee, with a reduction of one risk, which relates to DTVF and service delivery in HMP Hull and HMP Humber, where a reduction in waiting times has been demonstrated. Following the drop in risk review compliance over the last two months, it is positive to be able to inform the Board that as of 1 June 2023 all risks on the CRR are within their review dates, with compliance jumping from 70% to 100%. The Committee can assure the Board that there are effective controls in place to manage the corporate risks. **3. Delivery of the CQC Action Plans** There continues to be good assurance relating to progress with the system oversight and delivery of the CQC action plan. The actions relating to the CAMHS Community and ALD focused inspections in 2022 are now all completed. 95% of the Core service and Well-led 2021 actions are complete with 5% on track, with little risk to delivery. From the SIS re-inspection 2022 actions, 87% are complete with 13% on track with little risk to delivery. A mapping exercise will be undertaken by the Fundamental Standards Group to look at the key themes coming out of the feedback from CQC inspections and this will be reported to QuAC. The Committee is therefore satisfied to confirm to the Board the level of good assurance identified in the report. **4. Trust Quality & Learning Report** Reasonable overall assurance can be provided regarding the operational and strategic oversight of key quality and safety areas of patient care with no significant matters to escalate or new gaps in assurance. The Committee sought further assurance on medication errors detailed in the report. Hearing about the completion of all of the recommendations following the care of Viktor, the Committee's has delivered on its promise to his parents that we would have assurance oversight of the improvement plan. This has been delivered and we absolutely acknowledge Viktor's legacy. **5. Internal Audit Recommendations** Following review of the current status of the recommendations from eight internal audits, there are seven actions which remain in progress and on track for delivery within timescales for the Duty of Candour Audit. The risks to failing to take appropriate action to address and mitigate the issues relate to professional, contractual and statutory aspects of Duty of Candour and QuAC will continue to monitor with a progress report expected at the August 2023 meeting.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **Revised Terms of Reference for QuAC** The terms of reference have been reviewed with the principal changes being the proposal that the meeting will no longer be public and will held in private, membership will include the Director of Therapies as a non-voting member, a Governor representative shall be invited to be a consistent attender (non-voting) and a service user and carer representative role will be advertised, selected and remunerated to attend regularly. The clinical directors of the care groups are positioned as important attendees as are the care group directors of lived experience. There will be no change to reporting, except that the Committee will provide the Board with a summary of risks to quality, as an outcome of considering the Integrated Performance Dashboard. The revised ToR will be commended to the Board for its review.

		Annual Quality Assurance Committee Work Plan By concentrating on the Trust's strategic goals and in adhering to its terms of reference that the Committee "provides assurance to the Board on Compliance with (b) "Standards of quality and safety as set out in the Fundamental Standards prescribed in the Health and Social Care Act (Regulated Activities) Regulations 2014", the annual work plan now sets out a condensed set of report, looking at the information from the IPD, the Care Group Boards and EQAIG set against the themed priority areas, such as Trust wide themes of learning, CQC – Improvement plans, Performance Improvement Plans, positive and safe and mortality reviews. There will also be deep dive reports on escalated risks and concerns. The Committee will also see reports from the Drug & Therapeutic Committee, which had previously been stood down during the pandemic. The condensed cycle of reporting will provide oversight and assurance to QuAC on behalf of the Board that effective structures, systems and processes are in place and are being maintained and continually improved.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considered that there should be a review of the risks relating to serious incidents, complaints, mandatory and statutory training and the crisis service. An emerging risk for the Board to note is that staff are being asked from time to time to provide support to help restrain people in Acute hospitals. This has been Liaison staff which is not appropriate who are not trained, it is not within the legal framework and it takes them away from their jobs in the community. The Chief Nurse is pursuing a consistent position with the Acute hospitals.
3	**Actions to be considered by the Board**	There are no specific actions to be considered by the Board.
4	**Report compiled by**	Bev Reilly, Non-Executive Director, Deputy Chair of the Trust, Chair of the Committee, Beverley Murphy, Chief Nurse and Donna Keeping, Corporate Governance Manager

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report		
Report Date: 13 July 2023	**Report of the Mental Health Legislation Committee (MHLC)**	
Date of last meeting: 22 May 2023	Full quoracy was met	
1	**Agenda: The Committee considered the following agenda items during the meeting** • Revised Terms of Reference for the Committee • MHLC Annual Business Cycle • Data Integrity and Interpretation • Risks aligned to Mental Health Legislation Committee • Integrated Performance Dashboard, (31 December 2022 position) • CQC Mental Health Act Monitoring Activity • Discharges from Detention • Section 136 • Section 132b – Information to detained patients (Section 132 Mental Health Act 1983) • Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) • Section 17 Leave • Equality Data on Detention Rates	
2a	**Alert: The Committee alerts members of the Board on the following:** **CQC Mental Health Act Monitoring Activity** In seeking further assurance relating to system oversight and delivery of the actions arising from MHA inspections, the Committee has requested narrative to support the actions being progressed in future reports. All action plans are reviewed at Care Group level and signed off by Executive Directors. There is still some work to be done in terms of closing the loop on completed actions to identify the achievements made and lessons learned and shared. The Committee will continue to monitor progress against compliance with the legislation. **Data Integrity and Interpretation and Equality Data on Detention Rates.** Following a request by the Committee in February 2023 to check data accuracy of the recorded number of detentions, advice was sought from NHS Digital on the definition and recording of detentions. The Trust will now stop recording both new and renewals of detentions, to only record new detentions. It will take a few months for the data amendments to be made in IIC. This will change the Trust's position, which was previously reporting as being the second highest MH Trust nationally for the numbers of detentions. There is good assurance that the requirements of the Mental Health Act Code of Practice to monitor equality data is being met. The Committee's focus, now that the data is being cleansed will be on the details behind the individuals detained based on their ethnicity.	
2b	**Assurance: The Committee assures members of the Board on the following:** **Integrated Performance Report (IPR)** The IPR for the MHL Committee continues to contain one measure: "The number of uses of the Mental Health Act". This continues to report "reasonable performance assurance and neutral controls assurance". There were 376 uses of the Mental Health Act during March 2023, closely reflecting previous quarters' numbers. **Discharge from Detention** There are no exceptions in the data during Quarter 4. There is a low level of variation (2.9%) for first tier tribunals – three patients discharged and (0.9%) for Hospital Managers meetings – one patient out of 111, which demonstrates good assurance that the discharges have stood up to external scrutiny.	

	Section 136 Further refinement to reporting on Section 136 now includes those aged under 18 years old and the number of people detained in relation to bed availability, which is becoming a growing challenge. Since 30 January 2023 there have been 17 instances where no bed could be found for an individual. This high priority issue is being discussed at Care Group Board level and some imminent actions will be taken to improve the provisions for those waiting up to 24 hours in a section 136 suite, including the availability of food and access to medications. An updated escalation process has been developed in collaboration with Urgent Care Services and a briefing has been shared with Executive Directors which has been cascaded to wards and teams to ensure that the doctor on call is aware of the need for an assessment in the 136 suite and to ensure that individuals are seen by two doctors before the 24-hour compliance timeframe has elapsed. **Section 132b** There have been significant improvements made over the last year with patients being given their rights. From 696 new detentions in Q4, the escalation process was used for 8% of patients (10% in Q3) and there were three patients (0.4%) discharged with no evidence of being given their rights. The escalation process continues to ensure that Ward Managers are contacted for those ward areas that continue to have high numbers of escalations. The NYYS Care Group Board has introduced a "rights lead" to attend the regular huddle meetings to ensure a timely response to any escalations.
2c	**Advise: The Committee advises the Board on the following:** **Terms of Reference and Committee Business Cycle** The Committee has considered its terms of refence and made some minor changes, which include extending the meeting invitation to the Managing Directors of the Care Group Boards and the Lived Experience Directors. These amendments will be recommended to the Board of Directors at the September 2023 meeting. The annual Business Cycle for the Committee was reviewed and approved. **Moderate Risks relating to MH Legislation** There has been no change in the last quarter to the risks relating to mental health legislation - risk of failing to comply with the Mental Capacity Act (Ref. 1300), unlawful deprivation of a patient's liberty (Ref. 1299) and unlawfully depriving a patient of their liberty when Liberty Protection Safeguards come into place (Ref. 1298). All will continue to report to the Risk Subgroups of the Care Group Boards for discussion and shared ownership. Following the Executive Risk Group meeting, Risk 1304 on the Corporate Risk Register will be aligned to the MHLC, which relates to mitigations to help reduce pressure on A&E and an update will be reported to the MHL Committee in May 2023. **Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)** There is reasonable assurance that the Trust is meeting its requirements under the MCA and reasonable assurance that the use of and reporting of DoLS is being carried out as required. A monthly audit is being completed in inpatient areas to provide additional oversight to the recording of the MCA and an associated action plan is being developed. The challenges relating to the Mental Capacity Act have been reflected in the Care Group risk registers. From a national perspective, on 5 April 2023, the plans for implementing Liberty Protection Safeguards were placed on hold by the Department of Health and Social Care. **Honorarium Pay for Hospital Managers** Following consideration by Executive Directors, a formal agreement was made to make a small uplift to the recompense for panel members and the Chair at Hospital Managers meetings.

	Section 17 Leave The MHL team has introduced a standard operating procedure for checking that section 17 leave forms are being completed in clinical areas. There are around 10,000 forms received by the MHL team annually and the Officers in the team have been instrumental in providing scrutiny and oversight, including going back to wards and making the necessary checks and arrangements to ensure forms are signed and completed.	
2d	**Review of Risks**	There are no new risks to be highlighted to the Board. The Committee continues to drive forward the pursuit of data accuracy and evidence to demonstrate that progress is being made, through the operational links with the Care Groups on compliance with legislation. We recognise that each number represents a person for whom we are responsible.
Recommendation: The Committee proposes that the Board: *i) Note the positive levels of assurance confirmed by the Committee.* *ii) Note the change to the recording of detentions, following advice from NHS Digital.* *iii) Note the continued direction of travel to improve the oversight and monitoring of compliance with Mental Health Act legislation, through links to the Care Groups.* *iv) Approve the revised Terms of Reference at its September 2023 meeting.*		
3	**Actions to be considered by the Board:** There are no actions for the Board to consider.	
4	Report prepared by*:* ***Pali Hungin, Chair of the Committee/Non-Executive Director, Kedar Kale, Medical Director, Donna Keeping, Corporate Governance Manager***	

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For General Release

Meeting of: **Board of Directors**
Date: **13/07/2023**
Title: **REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN Executive**
Sponsor(s): **Sarah Dexter-Smith**
Author(s): **Dewi Williams**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
5	**Staff Retention**	The Freedom to Speak Up Guardian is part of the key control on ensuring staff are able to raise concerns in a safe and constructive way. At present it is considered that there is good assurance that this control is operating effectively.
6	**Safety**	Failure to effectively undertake and embed learning could result in repeated serious incidents and adversely affect worker experience. Recommendations within this report highlight learning and improvements that have been identified from those who have chosen to speak up.

Executive Summary:

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

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

Overview: The role of the FTSU Guardian (FTSUG) was created in response to the recommendations made in Sir Robert Francis QC's report "The Freedom to Speak Up" (2015).

The FTSUG supports staff who have raised concerns, as well as

delivering mandatory training to managers. He is supported by a FTSU Officer – this is a fixed term post which was put in to ensure that there was cover during leave, meet the increasing demand, and to address some of the issues that had been flagged about timely responses. The role reports independently to the CEO and NED FTSU champion but is managed within People and Culture. The FTSUG works alongside the Trust board to help develop more ways to empower and encourage staff to raise their concerns.

Information on the activities of the FTSUG service is attached.

This shows that:

- Over the last 2 quarters, the number of people speaking up continues to steadily increase.
- The highest proportion of staff choosing to speak up within Quarter 4 were from an additional clinical services profession, such as a health care assistant role for example and accounted for 26% of the cases received. In Quarter 1, the highest profession were from a Nursing and Midwifery profession accounting for 26% of the cases received.
- Detriment: Since our last report we have changed the way we support staff who say they have experienced detriment. We now refer all cases to the Associate Director for Operations and Resourcing within People and Culture. The handover includes people or parts of the service who would not be appropriate to ask to review. The ADO&R will then provide three names of suggested reviewers to look into the potential detriment within our existing HR operations frameworks the person experiencing detriment will then be asked to either choose/ veto as appropriate from that list. Quarterly summaries of the cases of detriment, outcomes and themes will then be provided to the NED FTSU champion and to the Director of People and Culture for review.
- Training: Compliance with speak up training is at 92%, and Listen up is at 75%. Follow up is available to Senior leaders and is strongly recommended for all board members
- The development of training and support for our speak up champions is continuing, but has been hampered as we have been developing jointly with the Bullying and Harassment role. We may need to revisit how we roll out this initiative.
- The monthly speak up forums continue to be held and the soft intelligence shared enables the service to provide a proactive approach by supporting staff in services where challenges have been noticed. There have been two notable situations where this has enabled us to work with

teams to explore difficulties much more quickly than needing to wait for a formal concern to be raised.
- The service can demonstrate it has had a positive impact particularly in relation to the Trust responding to concerns raised by staff working in prisons.

Work also continues to be undertaken on the development of the service. An options appraisal paper has been considered on future provision by the Director for People and Culture and was presented to the People and Culture committee on the 4th July.

The Board of Directors are asked to note the following lessons which have been learnt during the last 6 months

- People who speak up to us regularly tell us they came to us because they originally spoke to their management but heard nothing back. This lack of communication has led some to conclude the organisation does not value their contribution and in some cases, this has led to them leaving the organisation.
- Lessons learned are shared through our monthly forum and are shared with services through the people and culture committee.
- The 'closed culture audits' recently undertaken were informative and we hope that they will be rolled out to our prison services.

Prior Consideration and Feedback

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

Implications:

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

Further information

Report Title: Report of the Freedom to Speak Up Guardian

(1) Caseload

The steady increase in numbers of people speaking up through the service with 46 cases received by the Guardian (compared to 42 cases during Quarter 2).

The table below displays the figures for ongoing cases over the last 6 months. And shows the previous 6 month for comparison

	Quarter 2 2022	Quarter 3 2022	Quarter 4 2022	Quarter 1 2023
Total Cases Received	33	38	42	46
Bullying and Harassment	7	4	10	10
Worker Wellbeing	6	6	13	20
Patient Safety/Quality	8	12	8	22
Inappropriate Behaviours	10	8	12	18
Other	9	9	18	18
Demeaning Treatment	2	4	2	2

(individual cases received often include multiple themes)

(a) Assessment of Cases

The highest proportion of staff choosing to speak up within Quarter 1 were from a Nursing and Midwifery profession and accounted for 26% of the cases received. Additional Professional Services accounted for 1% which was the lowest representative profession choosing to speak up.

5 cases were received anonymously during this period.

(2) Impact on those Speaking Up

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

70% of those who spoke up said they would speak up again.

(3) Service Development

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

As well as the upcoming service review we recently underwent an audit through Audit one and expect the results shortly

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

(4) Training

It is mandatory for all staff to complete the Speak up, and Listen up eLearning modules developed by the NGO and NHSE. Speak up compliance is at 92%, and Listen up is at 75%.The final module Follow up aimed at senior leaders is available on ESR. It is hoped that board members would be encouraged to complete.

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

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

(5) Support networks

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

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

(6) Outcomes

Over the last 2 board reports we discussed Frankland prison, and concerns related to the culture. We have now received a final report and action plan form the care group director of operations and transformation which collates evidence from a number of sources, and details the proposed interventions for the team. There is also going to be ongoing OD support. Unfortunately, none of the original people who spoke up still work within the service.

We continue to collect lessons learned and feed these through our monthly speaking up forum and the PCD

Managing fear of speaking up and managing detriment remain significant challenges. Through the staff survey we know that up to a third of staff would not feel able to speak up. The National Guardians Office has just published it's document 'Fear and Futility' which looked at the staff survey results and concluded that staff confidence in speaking up had deteriorated over the last two years.

The survey questions are:-

The four questions used as an indicator of speaking up culture from the 2022 survey are:

- Q19a - I would feel secure raising concerns about unsafe clinical practice
- Q19b - I am confident that my organisation would address my (clinical practice) concern
- Q23e - I feel safe to speak up about anything that concerns me in this organisation
- Q23f - If I spoke up about something that concerned me I am confident my organisation would address my concern

../Downloads/Fear-and-Futility-NHS-Staff-Survey-1.pdf

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Confidential/For General Release

Meeting of: **Board of Directors**
Date: **13th July 2023**
Title: **Trust response to the Staff Survey**
Executive Sponsor(s): **Sarah Dexter Smith, Director of People & Culture**
Author(s): Sarah Dexter-Smith

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

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

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

Strategic Risks relating to this report

BAF ref no.	*Risk Title*	*Context*
5	**Staff Retention**	The Trust has a minimal appetite for risks relating to quality Although the present score is above tolerance, an acceptable level of exposure can be achieved. Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels
1	**Recruitment**	The Trust is prepared to accept some workforce risks where they provide the potential for improved recruitment and developmental opportunities for staff. Although present score is significantly above tolerance, it is considered that an acceptable level of exposure can be achieved. There is scope to strengthen controls. This is required at pace, through the delivery of mitigations, to reduce risk to tolerance

Executive Summary

Purpose: This report addresses the query about why the score for recommending the trust as a place to work had not increased despite us being the most improved mental health/ learning disability trust.

Proposal: It is proposed that the committee take a good level of assurance from this report that the seeming anomaly between the 'most improved' position and the lack of similar improvement in percentage of staff recommending the trust as a place to work is explicable once the detail is considered.

Overview: The NHS National Staff Survey is one of the largest workforce surveys in the world and has been conducted every year since 2003. Participation is mandatory for Trusts. While the staff survey is central to our evaluation of the impact of the People Journey, the

survey is only undertaken once a year and these metrics reflect responses provided by staff in September 2022 (which we then received in early 2023).

The data tells a necessarily complicated picture as it compares the trust to itself in previous years, to comparable trusts (MH/LD), the region and the national picture

Our response rate remained in line with regional and national levels and our engagement score remained at 7/10. We were the most improved MH/LD trust nationally – ranked 1 out of 25 in overall positive change score.

Compared to other trusts we were strong on:

- recognised and rewarded, at a time when most other trusts declined and at a time of national disquiet about pay rates.
- staff not experiencing discrimination from patients, relatives, the public
- not experiencing MSK problems as a result of work activities

organisation acting fairly with career progression

Compared to our own scores last year, we improved in all categories. Our most improved scores were as follows and all reflect focused work undertaken in the year prior to the survey.

- Receiving an appraisal in the last 12 months
- The organisation respecting individual differences
- Team members meeting to discuss team effectiveness
- Feeling supported to develop potential

However, we did decline in some areas, notably satisfaction with level of pay (down 7% to 31%), the only deterioration over 3%. This reflects a national picture and also some work we have since undertaken around mileage and bank pay.

Concerns about workload were also notable in the staff survey despite not being a significant deterioration. The deterioration in these factors are seen in the morale score and the overall recommendation score.

A significantly improving trajectory was encouraging but at that point was not enough to translate into the overall recommendation about the Trust as an employer and this could be seen in the leavers' and sickness rates which in September 2022 were still high. Although significant improvement is encouraging, this was in the context of scores that were lower than we wanted for our colleagues in the previous two years.

Whether to recommend the trust as a place to work is a complex interplay of factors, and our scores clearly reflect national issues of pay, workload (coming out of covid and with inspections and improvement work still having a significant impact), and changes in perception of clinical provision not at that point being evident across all parts of the organisation.

Trust response to results

Specific action plans for each directors' service area have been through committee but broad areas of focus are:

Workload - caseload reviews, clarity on objectives, and the governance review.

Transparency of development opportunities (top three compared to national scores but still at 63%), underpinned by our new appraisal and performance tool, Workpal.

A focus on quality of appraisals following previous work on raising compliance rates, face to face supervision/ appraisals where possible, increased time together as a team.

Improving the experience of joining the trust and continuing work on understanding why people leave/ supporting them to stay.

And ongoing and significant work under the clinical journey, out with the remit of this report.

Impact

Since the staff survey our leavers' rate has fallen month on month to the extent that it is now in common cause variation, and sickness has fallen steadily.

This has had an impact on both the recruitment and retention risks (recruitment risk decrease was signed off by board last month and the retention risk is proposed to reduce in the next iteration).

It is encouraging to note that at the end of week one of this quarter's pulse survey our response rate is already 3% higher than the whole of the last quarter.

Prior Consideration and Feedback:

The staff survey has been to the executive people culture and diversity group, the care group boards, each directorate leadership team, the quarterly leadership and management sessions, executive directors' group and People culture and diversity committee.

The detailed results were covered in a previous paper to the board and a detailed report on the actions being undertaken by each service has been to the People Culture and Diversity Committee.

Implications:

The survey results in September 2022 indicated a step change in the experience of colleagues. That improvement has continued and is now evident in reduced leavers and sickness rates trustwide.

Recommendations:

The committee is recommended to take good assurance that the staff survey results and actions provide a good level of assurance in support of delivery of the People Journey.

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Tees, Esk and Wear Valleys NHS Foundation Trust

Confidential/For General Release

Meeting of:	**Board of directors (public session)**
Date:	**13 July 2023**
Title:	**Draft stakeholder communications and engagement strategy**
Executive Sponsor(s):	**Ann Bridges, Executive Director of Corporate Affairs and Involvement**
Author(s):	**Sarah Paxton, Head of Communications**

Report for:				
	Assurance	**x**	***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	**x**

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
9 & 10	**Regulatory action**	• **Further regulatory action could result in loss of confidence and affect our reputation among services users, staff and other key stakeholder.** • **Changes in the external environment, and insufficient capacity to respond or to align our objectives with those of partners, might lead to loss of strategic influence and reputation.** The report impacts confidence and reputation among key stakeholders, with a focus on providing a clear, compelling and consistent narrative, demonstrating change, and showing the positive impact of these changes. This will support us to continue to develop meaningful relationships across our sector and support us to proactively build confidence and reputation.

Executive Summary:

Purpose: To present the Board with an overview of the proposed draft stakeholder communications and engagement strategy. The draft strategy is presented in response to a request for stakeholder mapping at the Board meeting held in January 2023.

Proposal: A draft stakeholder communications and engagement strategy has been developed predominantly aimed at partner organisations.

It is proposed that the Board considers and receives an overview of the draft strategy. Board members will be an opportunity to have a more detailed discussion, with a recommendation for approval, within the private Board meeting.

Overview: It's vital that our stakeholder approach underpins the strategic direction of our Trust.

As we continue Our Journey to Change, we need to provide a clear, consistent and compelling narrative, demonstrate change, and show the positive impact of these changes.

The draft stakeholder communications and engagement strategy includes the approach we'll take, supported by a range of tactics and actions, to achieve the following objectives over the next 12 months:

- Communicate the continued improvement work across our trust through Our Journey to Change and demonstrate the positive impact of these improvements.
- Build on the partnership working and open style of the leadership team.
- Provide continued assurance that we provide safe and kind care.
- Proactively tell our story on an ongoing basis - ensuring beliefs are based on accurate information.
- Be open, honest, and accountable when things go wrong – and demonstrate learning and improvements.
- Increase advocacy for our Trust.

The strategy will be monitored and continually evaluated to measure success against the objectives.

Prior Consideration and Feedback

We were able to gain insight and benchmarking through a targeted stakeholder audit. The audit included detailed findings and recommendations.

There has been ongoing dialogue with the Chair, Executive Directors Group and other colleagues – all of whom have provided considerations and feedback throughout the development of the draft strategy.

Industry best practice has also been considered throughout the development of the draft strategy.

Implications:

Board Assurance Framework (BAF) 9 and 10, as well as our goal to be a great partner rely heavily on meaningful stakeholder relationships. The implications of not having a stakeholder communications and engagement strategy would mean we are unable to mitigate the BAF risks and that we don't achieve our goal.

Recommendations:

The Board is invited to confirm that they are assured with the development of the draft stakeholder communications and engagement strategy and to provide any feedback.

The full strategy will be shared with Board members in the private session, where there will be an opportunity for further discussion and a recommendation for approval.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Draft stakeholder communications and engagement strategy

Forging meaningful relationships

Ann Bridges
Executive Director for Corporate Affairs & Involvement
July 2023

Introduction

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- Within our Trust, and more widely across health and social care, there continues to be rapid change. It's therefore vital that we continue to build and develop meaningful relationships across our sector.

- And as we continue Our Journey To Change, we need to ensure we encourage others along with us on our journey. We need to provide a clear and consistent narrative, demonstrate change, and show the positive impact of these changes.

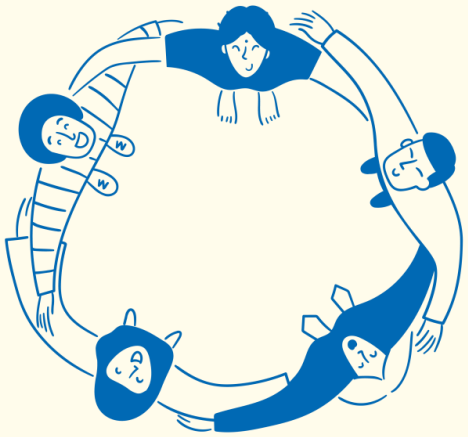
- Every organisation functions better if the people and groups around it are supportive. It's not always possible to achieve this, but it's possible to influence this by having a clear, strategic stakeholder communications and engagement strategy. This will also help us in achieving one of our three big goals – to be a great partner.

- All of our stakeholders play an important role. However, this stakeholder strategy is predominantly aimed at partner organisations that have a stake in our success. Our communications strategy addresses other audiences including people in our care, families and carers, our colleagues and the communities we serve.

What does the strategy include?

As with our wider communications strategy, this strategy has been developed using SOSTAC, a widely used model for marketing, communications and business planning. Essentially this approach includes:

- Situation – where we are now.
- Objectives – where we want to be.
- Strategy – how we'll get there.
- Tactics – specific tactics to fulfil the strategy.
- Action – detailed actions needed for each tactic.
- Control – measuring success.



Consideration and feedback

Tees, Esk and Wear Valleys NHS Foundation Trust

What we currently do

We currently deliver a range of stakeholder communications and engagement. However, we know there is more we can do to make our stakeholder engagement more strategic, more meaningful and impactful. We have reviewed what we do, where there are gaps and considered what approach and actions are needed.

Stakeholder insight

In 2022, research was commissioned via Ethical Healthcare Consulting to gain an understanding of what our stakeholders believed. It included an online survey as well as in-depth interviews with a range of external stakeholders. A number of recommendations were included in the report, and have been considered and addressed within our draft stakeholder communications and engagement strategy.

Feedback from colleagues

There have been meetings and ongoing conversations the Chair, the Executive Directors Group and other colleagues – all of whom have provided considerations and feedback throughout the development of the draft strategy.

Best practice

Industry best practice has also been considered throughout the development of the draft strategy.

Objectives

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NHS Foundation Trust

This plan reflects a three-year strategic vision, aligned with Our Journey to Change. We've developed the following stakeholder objectives which we'll review after 12 months:

- Communicate the continued improvement work across our trust through Our Journey to Change and demonstrate the positive impact of these improvements.
- Build on the partnership working and open style of the leadership team.
- Provide continued assurance that we provide safe and kind care.
- Proactively tell our story - ensuring beliefs are based on accurate information.
- Be open, honest, and accountable when things go wrong – and demonstrate learning and improvements.
- Increase advocacy for our Trust – our story is strengthened when it's told by others.

Strategy

Tees, Esk and Wear Valleys
NHS Foundation Trust

Stakeholder mapping

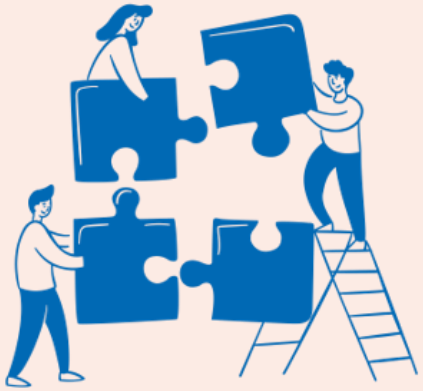
Stakeholders can massively influence our success. Whilst all of our stakeholders play an important role, we need to identify and prioritise our stakeholders through structured mapping. It's important to note that this is at an organisational level, primarily focused on stakeholder engagement with our Board and our senior leadership colleagues.

Communications principles

As part of our communications strategy, we have a set of communications principles which will support our stakeholder engagement.

Roles and responsibilities

Everyone in our organisation has a role to play in supporting the delivery of our stakeholder communications and engagement strategy, to ensure impactful communications and engagement takes place with our partners.



Tactics, actions & measuring success

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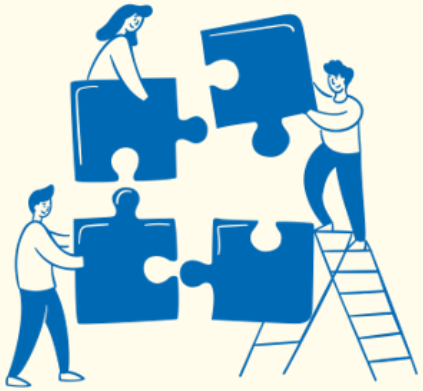
We have suggested a range of tactics that will support us to achieve our objectives. They are:

- Telling our story.
- Building meaningful relationships.
- Reputation management.
- Planning.
- Internal engagement.

A delivery plan has also been developed which includes key tactics and actions linked to objectives, milestones and action owners. This will be continually monitored.

The draft strategy outlines how we will measure the success of our strategy and how we'll know we've achieved our objectives. These will be continually monitored and reported.



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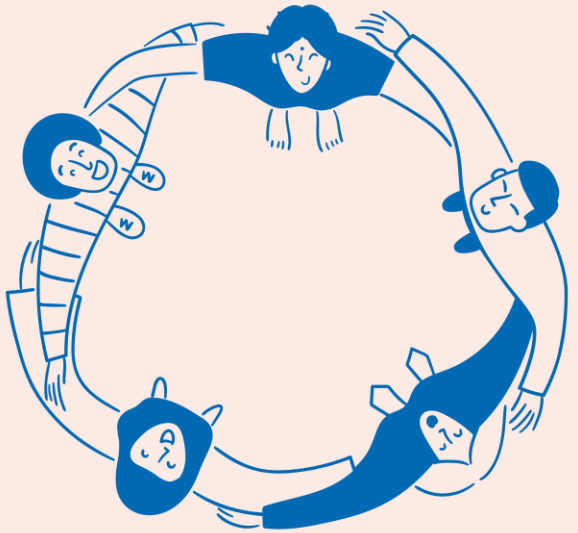
Thank you –

any questions?



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NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13th July 2023**
Title:	**Register of Interests of the Board of Directors**
Executive Sponsor(s):	**-**
Author(s):	**Phil Bellas, Company Secretary**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
11	Governance & Assurance	The Trust has a minimal appetite for regulatory risks and has recognised that, whilst exposure will remain above tolerance, urgent action needs to be taken to strengthen controls.

Executive Summary:

Purpose: The purpose of this report is to present the updated Register of Interests of the Board of Directors.

Proposal: To receive and note the updated Register of Interests of the Board of Directors as attached to this report.

Overview: The Trust is required to publish a register of the interests of the members of the Board of Directors under paragraph 20(1)(e) of schedule 7 of the NHS Act 2006.

The interests included in the register are specified in the Constitution and the Trust's Conflicts of Interests Policy.

The Register is published on the Trust's website to meet the requirements for allowing public access and inspection of the document.

Prior Consideration and Feedback None.

Implications: Failure to register a material interest could result in a breach of the Code of Conduct.

Recommendations: The Board is asked to receive and note the revised Register of Interest of Members of the Board of Directors.

Tees, Esk and Wear Valleys NHS Foundation Trust

Register of Interests of Members of the Board of Directors

Date: June 2023

Note: 1 - This Register has been established in accordance with the National Health Service Act 2006 (as amended) and the Consitution
Note: 2 - Descriptions of the types of interests are provided in NHS England Guidance "Managing Conflicts of Interests in the NHS" (Publications Gateway Number 06419) and the Trust's Conflicts of Interest Policy
Note: 3 - Changes of interest should be recorded as notified
Note: 4 - The Register should be refreshed annually

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
David Jennings	Chair	**None** *(Shares only with pension funds. No visibility of investment portfolios for local government/audit commission pension funds)*	**None**	**None** *(For completeness, Independent Non-Commissioner Member of Church Commissioners Audit and Risk Committee)*	**None**
Brent Kilmurray	Chief Executive	**None**	**None**	**None**	**Yes** Spouse is a member of clinical staff at Cumbria, Northumberland Tyne and Wear NHSFT
Roberta Barker	Non-Executive Director	**None**	**None**	**None**	**None**
Charlotte Carpenter	Non-Executive Director	**Yes** Executive Director at Karbon Homes which as a provider/landlord of supported housing has an overlapping business interest with the NHS	**None**	**None**	**None**
Jill Haley	Non-Executive Director	**None**	**None**	**None**	**Yes** Fiancé works for Ward Hadaway where he is a partner and the firm provides some legal services to the Trust. He is not personally engaged in this work however.
Prof. Pali Hungin	Non-Executive Director	**Yes** Advisor to Reckitt Benckiser, consumer products company Advisor to Tillots Pharma on pharma products Advisor to Oxford PharmaGenesis, an academic writing company	**Yes** The Chair of the Changing Face of Medicine a Commission of the Academy of Medical Royal Colleges A member of Genomics England's Access Review Committee, a Government funded body.	**None**	**None**
John Maddison	Non-Executive Director	**None**	**None**	**None**	**None**
Jules Preston	Non-Executive Director and Senior Independent Director	**None**	**None**	**Yes** Chairman of Boroughbridge and District Commuity Care which provides services to (elderly) people in the District e.g. transport to hospital and doctors appointments, shopping, gardening, marshalling vaccine sites, etc.	**None**

Name	Position	Financial Interests	Non-financial Professional Interests	Non-financial Personal Interests	Indirect Interests
Bev Reilly	Non-Executive Director & Deputy Chair	**None**	**None**	**None**	**None**
Ann Bridges	Executive Director of Corporate Affairs and Involvement	**None**	**None**	**None**	**None**
Mike Brierley	Assistant Chief Executive	**None**	**None**	**None**	**None**
Zoe Campbell	Managing Director (NYYS)	**None**	**None**	**None**	**None**
Hannah Crawford	Director of Therapies	**None**	**None**	**None**	**Yes** A close family member wrolks for DAC Beechcroft in the Leeds office. No work in undertaken for the Trust by this member of staff.
Sarah Dexter-Smith	Director of People and Culture	**None**	**None**	**None**	**None**
Dr Kadar Kale	Medical Director	**Yes** Company Director in a small business established by spouse to undertake private medical practice	**Yes** Member of BMA, RCPsych, GMC, BNPA, BAPIO	**None**	**None**
Beverley Murphy	Chief Nurse	**None**	**None**	**None**	**None**
Liz Romaniak	Director of Finance, Information and Estates/Facilities Management	**None**	**None**	**None**	**None**
Patrick Scott	Managing Director (DTVF)	**None**	**None**	**None**	**Yes** Spouse is a Non-Medical Accountable Clinician for Humber NHSFT

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