Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

12 October 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 meeting held on 14 September 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 questions raised by Governors in relation to matters on the agenda *To be received by 1pm on 10 October 2023*	Chair	Verbal

Strategic Items (1.50 pm – 2.40 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

BREAK – 10 minutes

Goal 1: To co-create a great experience for our patients, carers and families (2.50 pm – 3.30 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)	*To follow*
13	The consider the Learning from Deaths report	MD	Report

Goal 2: To co-create a great experience for our colleagues (3.30 pm – 4.00 pm)

14	To consider the report from the Guardian of Safe Working	Dr Burke	Report
15	To approve the publication of the Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard submissions and associated action plans – as previously considered by People, Culture and Diversity Committee.	DfP&C	Report

Exclusion of the Public:

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

David Jennings
Chair
6 October 2023

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

Tees, Esk and Wear Valleys NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 13 JULY 2023 AT WEST PARK HOPSITAL, 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
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
J Haley, Non-Executive Director
P Hungin, Non-Executive Director
K Kale, Medical Director
J Maddison, Non-Executive Director
B Murphy, Chief Nurse
J Preston, Non-Executive Director and Senior Independent Director
L Romaniak, Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
A Bridges, Director of Corporate Affairs and Involvement (non-voting)
M Brierley, Assistant Chief Executive (non-voting)
H Crawford, Director of Therapies (non-voting)
S Dexter-Smith, Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary (minutes)

Observers/members of the public:
M Booth, Governor
A Grant, Corporate Governance Officer
M Williams, Governor
Member of the public

23-24/72 CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and noted that prior to the start of the meeting the board had the opportunity receive a powerful patient story, which had highlighted the impact of good support on recovery, and he welcomed the honesty and openness of those who had attended the meeting.

23-24/73 APOLOGIES FOR ABSENCE

Apologies for absence were received from C Carpenter, Non-Executive Director.

23-24/74 DECLARATIONS OF INTEREST

In the interests of transparency, the Chair noted that he had submitted an update to the Register of Interests to record that that a family member had been employed by a bank used by the trust.

During the meeting J Haley declared an interest in respect of a family member employed by Ward Hadaway.

23-24/75 MINUTES OF THE MEETING HELD ON 13 JULY 2023

The minutes of the meeting were agreed as an accurate record for signature by the Chair.

Hannah Crawford advised that the Memorandum of Understanding with Teesside University would be signed on 3 October 2023 [para 23-24/59 refers].

23-24/76 BOARD ACTION LOG

In discussion the following points were noted:

1) S Dexter-Smith outlined the range of support provided by the trust to internationally recruited nurses and it was noted that the trust had received a pastoral award from NHS England [23-24/40].

2) K Kale advised that the Learning from Deaths Report had been deferred to October due to constraints on the agenda and in order that the report would first be considered by Quality Assurance Committee (QuAC) [23-24/15].

3) It was noted that the report from the Guardian of Safe Working had been delayed due to staff absence and would be rescheduled as soon as possible [23-24/16].

4) B Murphy acknowledged a concern raised by B Reilly in respect of progress on feeling safe and undertook to provide an update at the next meeting of QuAC [23-24/28].

5) B Murphy noted the update provided previously in respect of the establishment review and advised that significant work was underway to assure on safer staffing, to meet external reporting requirements and to progress steps to meet the deadline of March 2024 [23-23/17].

6) P Scott advised that, at its next meeting, the Executive Risk Group would consider the escalation of risk related to the Right Care, Right Person Policy from the care groups onto the Corporate Risk Register [23-24/38].

7) In respect of Section 17 leave, P Scott noted that the first meeting of the Urgent Care Programme Board would be held in October, and he undertook to speak to K Kale to progress the action in the interim [23-24/66].

   B Murphy and K Kale advised that the policy had been reviewed with clinical leaders earlier in the year to ensure it was understood and the standards adhered to. An audit tool had been launched in August to ensure changes were embedded and the outcome of this would be reported to Executive Directors Group in November 2023.

8) Z Campbell advised that a meeting would be held with P Hungin on 22 September 2023 to consider what further action may be required in respect of memory assessment services [23-23/28]

9) J Maddison highlighted the potential for the board to discuss some matters in more detail in a board seminar prior to the board meeting and P Bellas confirmed that the schedule of board seminars would be confirmed over the next few weeks.

   The Chair proposed that Non-Executive Directors meet with lead Executive Directors to discuss key topics for development sessions and matters that required protected time for discussion. P Bellas also invited the board to consider topics linked to the top risks outlined of the Board Assurance Framework.

Action: Non-Executive Directors & Lead Executive Directors.

10) The Chair invited Executive Directors to ensure deadlines in the action log were realistic and had taken account of any prior consideration required. He also proposed that the report include narrative on the reasons for any delay and that actions be red/amber/green rated to allow the board to discuss actions by exception. **Action: Executive Directors, K Christon**

11) The Chair also proposed that the Company Secretary and Executive Directors consider how the structure of the board meeting would be modified to support the move to bi-monthly meetings, with additional developmental sessions. **Action: Executive Directors, P Bellas**

23-24/77 CHAIRS REPORT

The board received and noted the report.

23-24/78 MATTERS RAISED BY GOVERNORS

No matters had been raised.

23-24/79 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

The board received and noted the report which provided a reminder of the strategic risks for consideration during the meeting. In discussion, the following points were raised:

1) In respect of BAF Risk 9 [Regulatory Action] B Murphy advised that the trust had not received any regulatory notices following the CQC inspection. The final report was expected in September 2023, and the Board Assurance Framework would then be updated accordingly.

2) In response to a query from J Maddison, P Bellas confirmed that there would be a full review of the Board Assurance Framework, which would take account of learning over the last 18 months and be based on a greater understanding by the trust of risk and actions that would drive changes in risk scores.

23-24/80 CHIEF EXECUTIVE'S REPORT

B Kilmurray presented the report, which aimed to highlight topical issues that were of concern. He drew attention to the key themes of the report and in discussion the following points were raised:

1) P Hungin commented on how important it was for the trust to learn lessons from the outcome of the Lucy Letby trial and that it had shown how crucial it was to have arrangements in place to identify adverse events.

   B Kilmurray suggested that there was sufficient information at this point for the trust to reflect on its own quality, clinical and people journey's and he commented on a presentation by the National Director of Patient Safety on the importance of hearing through the noise of data, having clarity on the use of data to identify concerns, and how the culture of an organisation impacted on decision making.

   Responding to a query from J Maddison, B Kilmurray confirmed that a report would be presented to the next meeting to ensure that the board was briefed on arrangements in place to ensure that colleagues had unfettered opportunities to raise concerns, that concerns were

welcome and that whistle-blowers were treated well. The board would also have the opportunity to consider the outcome from the statutory inquiry once it had concluded.

B Reilly advised that Quality Assurance Committee would consider the report, prior to the board and it was also noted that the report would incorporate feedback from Executive People and Culture Group.

L Romaniak also noted the role of Audit and Risk Committee in relation to assurance on the overarching systems of control and B Murphy advised that a piece of work had been commissioned from internal audit in respect of the process around mortality.

J Preston suggested that the new Fit and Proper Person Test Framework would become intertwined with the outcome of the case. Ne noted the alleged behaviour of the board at the Countess of Chester Hospital NHS Foundation Trust and welcomed the opportunity for a further board discussion.

The Chair reflected on the ability of those who had raised a concern to be heard and he noted the body of work underway at TEWV in relation to culture. He proposed that he had an opportunity to build a closer relationship with senior medics in order to maintain ongoing dialogue. H Crawford also proposed dialogue with the broader clinical workforce and undertook to discuss this outside of the meeting.

2) In response to a query from J Preston, K Kale advised that some routine clinics in the community had been stood down during the period of industrial action. ECT had not been stood down during the last period of industrial action, however close contact had been maintained with anaesthetics in response to concerns about capacity for emergency procedures.

Z Campbell noted that there had been emphasis on cover for inpatient crisis and psychiatric liaison teams. Where clinics had been stood down, the impact on patients had been considered and the service was re-established as quickly and efficiently as possible. She advised that reported performance metrics had indicated no adverse impact.

In response to a query from the Chair, she confirmed that the trust was able to recognise where a service change had impacted on an individual.

B Kilmurray noted that the trust model was different to that of acute trusts and industrial action at TEWV would not lead to an increase in waiting lists.

He placed on record his thanks to staff who had provided additional support during each period of industrial action.

23-24/81 OUR JOURNEY TO CHANGE DELIVERY PLAN, UPDATE

The board received the report, which provided assurance on projects and workstreams pertaining to the current Our Journey to Change 2023/24 Delivery Plan. In presentation, M Brierley proposed that the report provided a sense of focus on ongoing delivery, while the trust moved into planning for 2024/25 and he highlighted the following additional points:

- It was expected that movement would be noted between this report and the quarter two report presented to the board in November 2023.

- The appendices of the report provided an overview of progress on projects from differing perspectives. He noted that information had been directly informed by data or was subjective, until the project had been delivered and the impact reviewed.
- Information was presented in a format that would allow Executive Directors Group and Strategy and Resources Committee to focus on areas rated as amber that, with support, may improve.
- Information from the report would be reflected in the Board Assurance Framework, Integrated Performance Report and monthly finance report.
- The quarter two report would include information on timescales in respect of the serious incident backlog recovery/local management of incidents [appendix 3].

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

1) Responding to a query from P Hungin on the use of RAG ratings and the rating of CITO, M Brierley advised that there had been a change in timeline following completion of the report and the development of a critical path provided certainty on final requirements.

2) B Reilly noted the proposed timescales for CITO and requested the board be kept abreast of progress.

3) B Reilly raised a concern about the Inpatient Flow DTVF MSHOP project due to the absence of a service manager and noted how essential patient flow was to patient safety.

   In response, P Scott commented on the scale of ongoing transformation work to improve patient flow across all specialities and proposed that consideration be given to how that would be captured in the report.

   Commenting further, B Murphy advised that Executive Directors Group had acknowledged the impact of delayed transfers on services users and the trust had the necessary information to broker an outcome with partners to ensure there was not an adverse impact on quality of care.

4) The Chair welcomed the first edition of the report and the insight it provided. He thanked M Brierley and his team for its preparation and noted the transition that was required in order that preparation of the report would become business.

   In response, M Brierley recognised the collective effort required to prepare the report and the impact of key individuals or roles on project delivery.

5) B Kilmurray proposed that the narrative be reviewed to highlight where risks had been identified and managed. He acknowledged the scale of project work that had been completed and the number of areas rated as green and reiterated that there would be a focus on projects rated as amber where delivery may be at risk.

6) J Maddison welcomed the progress that had been made and proposed that information be provided on implications and timescales where projects had deviated from plan.

   Action: M Brierley

7) In response to a query from the Chair, M Brierley advised that quarter two would report a shift in digital and data priorities. He noted that the Green Plan was subject to ongoing conversation at Executive Directors Group and L Romaniak advised that the plan was subject to challenges related to available expertise, with the trust not able to use agency

staff to backfill or commit to new expenditure. Management Group would discuss the opportunity to take a different approach.

J Haley noted the oversight provided by the report and welcomed the opportunity to understand the proposals that would be developed through the Green Plan.

23/24/82 INTEGRATED PERFORMANCE REPORT

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

In presentation, he drew the board's attention to five areas of concern, where there was limited performance assurance and negative controls assurance and he noted that the next board report would provide an assessment across all 11 performance improvement plans, albeit that the impact of some plans would not be seen until quarter 4. He then went on provide an overview of key changes from the previous report.

The Chair invited Care Group Managing Directors to provide an overview.

Z Campbell advised that, although there had been some successful recruitment in CAMHS and Perinatal services, staffing continued to remain an issue. She noted work that had commenced with partners in respect of patient flow and delayed transfers and that the trust had worked closely with the voluntary sector to improve crisis call response rates. The NHS 111 pilot would commence in October and further improvements would then be expected.

P Scott advised that the Integrated Care Board had confirmed its intention to invest to support co-location of the all age crisis access service with the North East Ambulance Service (NEAS) and that concerns expressed by NEAS had been resolved. He referred to work that would be undertaken on the alignment of the three crisis services and advised that pick up rates to the crisis line had increased to 80% in Tees Valley and 72% in Durham and Darlington due to a significant increase in capacity. He went on to draw attention to chapter 2 of the report and advised that there were no concerns to note in relation to child eating disorders, where access to services was due to service user or family choice, or in relation to the psychosis team, where leadership issues had now been resolved.

B Murphy provided an update on the reported position on the serious incident backlog and advised that all the 47 incidents in cohort 1 had been allocated or closed. She expressed confidence that by November 2023 incidents would be allocated within the month they occurred, and progress would continue to be reported to Quality Assurance Committee.

She went on to draw the board's attention to the improved position on restrictive intervention incidents, where a reduction in incidents of restraint that were the most restrictive had been noted.

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

1) P Hungin expressed concern about the current level of service users that had waited more than two weeks and in response P Scott advised that the percentage was affected by the small numbers involved and the position had now been resolved.

2) B Murphy expressed concern about the metrics within chapter 2 of the report, despite performance improvement plans in place and P Scott confirmed that the care group had acknowledged this and commissioned a detailed piece of work in response.

3) Responding to a query from B Reilly on the outcome of performance improvement plans, M Brierley confirmed that the next board report would provide an analysis of all plans and a high level view on impact and expected change in performance.

   J Maddison welcomed the proposed approach.

4) J Preston welcomed the allocation of serious incidents from cohort 1 and queried the status of the remaining incidents. In response, B Murphy advised that of all incidents open – as under investigation, subject to quality assurance or submitted to the Integrated Care System for closure – 36 had not been allocated. Six of these related to the period January to May 2023 and the remainder were from June 2023 onwards. The trust had met duty of candour and support was provided to the families involved. The position continued to be closely monitored and work was underway to ensure reports were available to the Coroner.

5) K Kale welcomed the reported improvement in the number of staff who had left the trust.

6) L Romaniak advised that Strategy and Resources Committee had agreed to undertake a deep dive into the unique caseloads indicator.

7) L Romaniak drew attention to the reported financial position at 31 July 2023 and noted there had been positive mitigation in relation to the nationally negotiated pay award for Agenda for Change staff and that the Integrated Care Board had agreed to abate the defunding of providers for national Microsoft Licensing arrangements.

   She went on describe the continued reduction in run rates for months 1 to 4, and indicatively month five, and suggested this provided assurance on the impact of financial recovery actions, albeit that the year to date position was a £4.7m deficit. She proposed to include the deficit/surplus run rate trend in future reports, with recovery trajectories to be agreed using month 6.

8) In response to a query from J Maddison on the understanding of agency costs above cap, K Kale advised that weekly and fortnightly meetings were held to review the locum list and those where the price cap had been breached.

The Chair brought the discussion to close and welcomed the opportunity to review the analysis of the performance improvement plans at the next meeting.

23-24/83 CORPORATE RISK REGISTER

B Murphy introduced the report, which aimed to ensure the board had oversight of organisational wide risks that were rated as high in the Corporate Risk Register.

She drew the board's attention to the inclusion of three new risks and the reduction in the risk rating for three risks, as agreed by Executive Risk Group. She also commented on risk 1487, where staff concerns had been raised about increased risk of an anchor point and advised that on subsequent investigation it was determined that there were technical issues with the door fitting. However, the doors did not present an increased risk, and she welcomed the swift action that had been taken by staff.

In response to a query on the reported inconsistency in timely risk and action review, B Murphy advised that there had been a dip in performance during the period of the CQC inspection, and the Head of Risk Management had provided assurance that the position had now improved.

23-24/84 WINTER EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

Z Campbell introduced the report, which provided assurance against the standards and suggested requirements set down in the 'Delivering operational resilience across the NHS this winter' report and appraised the board of the actions and potential mitigation in place where standards would not be met.

In presentation, she noted work that would conclude in October 2023 on scenario based continuity plans to understand staff pressures. Commenting further B Kilmurray noted the government announcement of £200m additional funding for the NHS to support NHS winter resilience.

Agreed: *the board confirms the level of assurance as reasonable.*

23-24/85 LEADERSHIP WALKABOUTS REPORT

The board received and noted the report, which provided high level feedback from the leadership walkabouts to services who had issues with staff recruitment, which had been triangulated with themes from PALS and complaints.

In presentation, A Bridges noted that a new 18 month schedule for future visits had been developed, which would provide clarity and advance notice for those involved and a structured approach to how actions would be captured and reported.

Responding to a query, she confirmed that there was significant Governor interest in the visits, including from new Governors, and all were able to participate, with attendance agreed on rotation.

J Preston commented on how important it was for teams to be provided with timely feedback.

23-24/86 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

P Hungin presented the report and drew the board's attention to the alerts and assurance provided. He noted that committee remained concerned about unanswered calls to the crisis line and progress in respect of outstanding CQC and Niche actions, where there was limited assurance that they would be responded to in a timely way.

Commenting further, B Murphy advised that the reported use of inappropriate restraint had been identified through proactive leadership and escalated in order that appropriate steps would be taken. The trust had met duty of candour by ensuring the next of kin were informed and they would be part of the subsequent review. She went on to note that she had been unable to attend the Quality Assurance Committee meeting but considered that there was good assurance in relation to a significant number of Niche recommendations and limited assurance where actions related to multiagency work, and this would be considered with regional colleagues. The Deputy Chief Nurse had undertaken to carry out a piece of work to ensure the trust was able to provide evidence against the assurance statements.

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

1) B Reilly welcomed the work that had been undertaken to respond to the serious incident backlog and noted that she was assured that the Chief Nurse would escalate matters to her, if required.

2) In respect of emerging concerns at West Park Hospital, B Murphy noted that a number of small issues had presented, and the trust had been curious in response. Care group leadership had provided support and the outcome would be reported to Executive Quality Assurance and Improvement Group in September 2023 and Quality Assurance Committee in October 2023.

3) B Kilmurray advised that Niche were expected to carry out a revisit at any time.

23-24/87 REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

P Hungin, Chair of Mental Health Legislation Committee, introduced the report and drew the board's attention to a concern raised by the committee about the increased number of people detained in a 136 Suite for over 24 hours due to lack of beds and the impact on staff, who had been drawn from other services.

He also noted a concern in respect of recorded data on detention rates, where the Business Intelligence Team were not able to correct the data for a period of three months due to capacity.

In response, K Kale agreed to review the position to understand if work could be progressed at an earlier point. **Action: K Kale**

23-24/88 REPORT OF THE CHAIR OF PEOPLE, CULTURE & DIVERSITY COMMITTEE

J Haley, Chair of People, Culture and Diversity Committee, presented the report and advised there was limited assurance in respect of timely risk and action review, which had dropped to 64% and that the committee had received reassurance on the introduction of the InPhase system.

She went on to note positive progress in respect of recruitment, retention and sickness absence; the conclusion of the review of the Freedom to Speak up Policy; and advised that committee was able to give good assurance in respect of the robust process to review staff data by protected group.

She noted that the review of the Duty Nurse Coordinator had commenced and proposed that the outcome be considered by Quality Assurance Committee.

23-24/89 APPRAISAL AND REVALIDATION OF DOCTORS

K Kale introduced the report, which provided good assurance to the board that doctors working in the trust remained up to date and fit to practice.

In presentation he drew attention to: the level of compliance with appraisals; the number of doctors receiving validation recommendations; the level of appraisers and arrangements in place to provide support and development; and the outcome of investigations following concerns that had been raised about doctors.

In discussion, K Kale agreed to review the level of data provided in the public report.

Action: K Kale

Agreed: *that –*

i. The board is satisfied that there is good assurance, as proposed within the report.

ii. The Statement of Compliance be signed by the Chair or Chairman and submitted to NHS England.

23-24/90 THE NEXT DIRECTOR SCHEME (FOR INFORMATION)

The Chair advised that the report provided a prompt for the board to consider succession planning for Non-Executive Directors. He noted that there were candidates who had expressed an interest in a board appointment and proposed that the board consider the appointment of two Associate Non-Executive Directors to support succession planning.

Agreed: *The trust to seek expressions of interest for the appointment of two Associate Non-Executive Directors.*

23-24/91 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 ended at 5.58pm.

Chair's Report: 14th September – 11th October.

Headlines:

External:

- Weekly Mental Health Chairs' Network : emerging national issues. Discussion with Richard Medding, NHSE Chair
- Meeting Yorkshire and Humberside Foundation Trust Chairs: issues of common interest.
- Meeting North & South Tees Acutes' Chair: regular dialogue over interface between acute and Mental health NHS bodies in Teesside and North Yorkshire.
- Changing Futures South Tees Summer Conference: showcasing work to support most vulnerable in Teesside with Housing, skills, mental health and drug & alcohol support
- Meeting potential associate Non-Executive Directors
- Annual General Meeting for Humber & North Yorkshire Integrated Care Board
- Teesside University Memorandum of Understanding signing.

Council of Governors (CoG)

- CoG Task & Finish Group: refocusing original Terms of Reference, with agreed focus on Behaviours & Language, and Communication & Information.
- CoG Development Session: discussion over 'why I became a Governor', how I do the role, and what help and support I need to do it.
- Thank you meeting with retiring Governor.

Internal

- Various Living The Values Awards (Research & Statistics Team, Matron LD SIS)
- Non-Executive Director appraisal.
- Non-Executive Director catch-up discussions.
- Meet & greet with our new NHS Graduate Management Trainee
- Meeting Chief Clinical Information Officer: CITO and Digital development in TEWV
- TEWV Nursing Conference
- Foss Park Celebration & formal opening
- Leadership Walkabout System House Community LD Team York.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 October 2023**
Title:	**Board Assurance Framework – Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Report Author:	**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.

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	Related Agenda Items/Reports
	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**	**Moderate** ↓	**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: -** **PCDC –** ▪ Good assurance that the Trust has followed a robust process in recruiting, training, and inducting volunteers ▪ Good assurance of progress in delivering the employment elements of Our Journey to Change **Negative: -**	Public Agenda Item 16 – PCDC Key Issues Report
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: -** **IPD –** Bed occupancy (AMH and MHSOP A&T Wards (Metric 8) – Improvement in performance **Negative**: -	Public Agenda Item 10 – Integrated Performance Dashboard
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: -**	
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	Complaints Policy Friends and Family Test/Patient Experience Survey Patient and carer engagement and involvement structures and processes	**Positive**: - **IPD** – Percentage of CYP showing measurable improvement following treatment – patient reported (Metric 4) – Improvement in performance and improved	Public Agenda Item 10 – Integrated Performance Dashboard Public Agenda Item 12 – "Winter Planning 2023/20/24" Public Agenda Item 14 – QuAC

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	Related Agenda Items/Reports
	1	2	3										
										Workers Patient Experience Team	Our Quality and Safety Strategic Journey	assurance **QuAC** - Assurance on the contents of Positive & Safe Improvement Plan **MHLC** – Substantial assurance from Internal Audit on the reporting of rights and discharge information **Negative**: Reasonable assurance on the operation of controls to maintain delivery of services due to winter pressures **QuAC** – NICHE: limited assurance with significant risk to delivery that children with autism receive care in line with NICE guidance, due to capacity and/or complex multi-agency approaches all of which are needed to fully address the issues	Key Issues Report
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	**Moderate** ↓	**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: -** **PCDC –** ▪ Good assurances that the Trust has followed a robust process in analysing its staff data by protected group and is meeting its NHS Standard Contract requirements and Equality Act duties ▪ Good assurance that the right actions are being taken during Quarter 1 of 2023-24, to maintain the Trust's Apprenticeship workforce **Internal Audit** – Good assurance from the IA Review of Whistleblowing/Freedom to Speak Up Guardian Follow Up Review **Responsible Officer** – Good assurance on compliance with the Framework of Quality Assurance for Responsible Officers and Revalidation (FQA) **Negative:** **IPD –** Percentage Staff Absence Rate (Metric 19) –	Public Agenda Item 10 – Integrated Performance Dashboard Public Agenda Item 16 – PCDC Key Issues Report Public Agenda Item 17 – Report on the Appraisal and Revalidation of Doctors

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	Related Agenda Items/Reports
	1	2	3									Reduced assurance **PCDC** – Reasonable assurance in relation to health and wellbeing actions	
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	**CN**	**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: -** **IPD-** ▪ The number of incidents of moderate harm and near misses (Metric 11) – Improvement in performance and improved assurance ▪ The number of Restrictive Intervention Incidents (Metric 12) – Positive Stabilising in performance **QuAC** - Good assurance that the organisation is underway with the key themes identified against the recommendations from the Safeguarding Adults Review on Whorlton Hall (commissioned by Durham Safeguarding Adults Partnership), published in May 2023 **MHLC** – ▪ Good assurance that the legislative requirements for patients held in the Trust on section 136 are being met ▪ Substantial assurance that the CQC have been notified of those patients who were absent without leave under the stipulated definition **Negative** **QuAC** – ▪ Reasonable assurance on the delivery of the Patient Safety Incident Response Plan (PSIRP) ▪ Partial assurance on compliance and the position against the recommendations described in the Rapid Review of Data into MH Inpatient settings DHSC June 2023	Public Agenda Item 10 – Integrated Performance Dashboard Public Agenda Item 14 – QuAC Key Issues Report Public Agenda Item 15 – MHLC Key Issues Report

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	Related Agenda Items/Reports
	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:** **CEO Report** - Surveys of the estate have found no use of Reinforced Aerated Autoclaved Concrete (RAAC) in Trust buildings and no concerns have been flagged by the landlords of leased properties **Negative:**	Public Agenda Item 9 – Chief Executive's Report
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: -** **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	Related Agenda Items/Reports
	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: -** **PCDC** - Good assurance that the BAF risks continue to be managed effectively **Negative**: **IPD** - Reasonable assurance regarding the oversight of the quality of services being delivered **PCDC** – Limited assurance in relation to the Corporate Risk Register due to a reduction in compliance on the timeliness of risk and action reviews **Commissioning Committee** - No assurance on the data for Adult Secure Services as it was unavailable	Public Agenda Item 10 – Integrated Performance Dashboard Public Agenda Item 16 – PCDC Key Issues Report Private Agenda Item 10 – Commissioning Committee Key Issues Report
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	Roseberry Park Rectification Programme External Technical Expert Support Capital Programme Legal Support External Audit	**Positive:** **Negative:**	Private Agenda Item 6 – Chief Executive's Report

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	Related Agenda Items/Reports
	1	2	3							Huddle Capital Project 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: -**	Private Agenda Item 3 – Update Briefing
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: -** Assurance that there is a robust plan in place for the CITO project which is on track **Negative**:	Private Agenda Item 4 – CITO Update Report
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 -** Assurance in relation to cash management **Negative**: **IPD –** ▪ Financial Plan: Agency expenditure compared to target – Reduced assurance ▪ Cash balances (actual compared to plan) – reduced assurance	Public Agenda Item 10 – Integrated Performance Dashboard Private Agenda Item 7 – SRC Key Issues Report Private Agenda Item 8 – Month 4 Finance Report

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 October 2023**
Title:	**Chief Executive's Public Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Brent Kilmurray**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
9	**Regulatory Action**	• A key part of the context we operate in is the ongoing legal cases the CQC has brought.

Executive Summary:

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

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

Overview: An update on CQC prosecutions, the NHS Sexual Safety Charter, Vision based monitoring systems, RAAC, Letby prosecution implications and industrial action.

Prior Consideration and Feedback n/a

Implications: No additional implications.

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

Care Quality Commission Prosecutions
The Board are aware that the Trust were required to attend a hearing at Teesside Magistrates Court on 26th September. Our legal team entered pleas. Two guilty and one not guilty. The Court set directions regarding the exchange of further documentation and reports and a date was set for the next hearing on 26th February 2024.

Sexual Safety Charter
The Trust has put its name to the national NHS sexual safety charter. The charter was published at the beginning of September and sets out ten core principles that commit to taking and enforcing a zero tolerance approach to any unwanted, inappropriate or harmful sexual behaviours in the workplace.

The principles are:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific, and clear training is in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.
9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

As part of this we have been asked to identify a lead Executive Director to be the designated Domestic Abuse and Sexual Violence Lead. I have asked Sarah Dexter-Smith to take on this role and duly notified NHSE of this.

Vision Based Monitoring systems
NHSE have written to all Trusts highlighting that service-users, their families and stakeholders have written an open letter to Mental Health Trusts and NHSE England, raising concern about the use of Oxevision. Concerns have specifically included blanket utilisation of Vision Based Monitoring (VBM) in in-patient mental health settings and the issue of informed consent. These concerns have also been acknowledged by sector stakeholders, including the Restraint Reduction Network and British Institute for Human Rights.

NHSE have encouraged trusts to review the information governance arrangements in place in organisations with a specific focus on what records are kept about the decision to use (and the use of) such systems, what information is provided to patients, their families and staff. There is also focus on the use of such systems, how informed consent is obtained, and how information gathered through VBMs is stored, accessed and utilised.

TEWV implemented Oxehealth in 2019, commencing with 5 in-patient wards. Following the successful implementation and benefits realisation on the impact of the service, the Trust contracted a further 10 wards in March 2021, 7 wards in December 2021 and the Board approved further roll-out to remaining in-patient wards in February 2023, which is currently underway.

It was anticipated that further roll-out supports the Trust to work towards its wider goals including reducing restrictive practice, improved physical health monitoring, zero in-patient suicide ambition, improving sexual safety and agency reduction. Furthermore, it has been found to support staff with managing risk, particularly in relation to self- harm and ligature reduction, enhancing quality and saving clinical time.

We are currently adapting our standard operating procedure (SOP)to incorporate our response to recent concerns. The amended SOP also responds to the views and themes from the independent evaluation which we commissioned in early 2023 to understand the patient and staff experience of Oxehealth. It is anticipated that the amended SOP this will be in place by the end of October 23.

As a part of our further roll our we have three workstreams one of which is a service-user Lived Experience Group. This group is established by the Lived Experience Directors to ensure all concerns and issues raised from patients, external bodies and ongoing scrutiny of Oxehealth SOPs, policies are addressed. The purpose is to embed Oxevision into clinical practice on the wards, in partnership with patients.

A priority for the Service user / lived experience group is to review the Oxehealth operational policy which has been drafted.

TEWV is also participating in a planned review of the National Mental Health and Learning Disability Nurse Directors Forum ‘Guidelines on the use VBM.

Reinforced Aerated Autoclaved Concrete (RAAC)
Last month I mentioned the requirement for the Trust to undertake review and assurance work regarding our estate following the identification of risks associated with RAAC in the education sector. Previous work has been done on this following identification of these risks within NHS premises (not specifically TEWV) in 2019.

Since last month we have undertaken a desk top exercise to review the historical submissions of our owned estate. We have also identified lease stock that required assurance from landlords or surveying. We prioritised the inpatient estate and then reviewed outpatients/community and corporate. The Estates team is carrying out the inspection and surveys using a third party structural engineers to carry out the work.

Fortunately, most of our own estates is modern and we have been able to very easily rule out RAAC. We do have a smaller number of buildings, mainly leased where we now require further expert review to reassure ourselves on this. This work is underway. There are 21 buildings in this category with results due over the coming weeks.

Implications from the Letby prosecution

At Board in September we updated on the immediate implications for the NHS of the Letby prosecution, particularly focusing on confirmation to the Board and national team about our speak up arrangements, both formal FTSU provision and wider approaches to listening and responding to concerns.

In the intervening month, work has progressed on the leadership elements of our response. Specific discussions have been held at the quarterly leadership and management sessions (for all staff at service management to executive levels) covering the initial findings, the new FPPT proposals, leadership competency framework which we will apply to everyone in trust board, care group board and corporate deputies, and the regulation of senior managers. Groups went through our progress on metrics of culture change as outlined within the people journey, speak up data and processes and the plans for further culture work in the coming year.

Immediate actions are:

- Changes to the way in which FTSU data is provided in formal reports to increase clarity on thread from initial categorisation of concern, through findings, action and learning, alongside clusters of concerns to make the themes more transparent.
- Work on co-creating future work on culture change with involvement members is underway
- The annual staff survey has begun and within our additional questions section are the three evidence based questions (developed with York University) based on the autonomy/belonging/competence model of wellbeing at work. This will enable us to map a broad organisational footprint of staff wellbeing from which we can then target support more carefully and also track change with more rigour on a more frequent basis.
- Specific time out held with colleagues in People and Culture outlining the role of all employment related teams in maintaining a strong focus on patient safety, given their roles in core governance processes

Industrial Action

Since the previous board meeting there has been further industrial action. As has been previously briefed the action has seen both consultants and post-graduate doctors out on co-ordinated strike action. We have a well honed planning process and have taken steps to ensure that there is minimal disruption to services. Some services have run at “Christmas Day levels”. In these cases planned activities have been stood down and emergency cover only provided. Patients have been booked to the next available clinic and we are monitoring patients that have been rebooked more than once.

Information will be tabled at the meeting following analysis of the impact of the latest action from 2nd to 4th October.

Communications Dashboard

September 2023

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

This month we...

- Created a new starter programme team to make positive changes for everyone as part of our journey to change.
- Shared more stories of our inspirational colleagues across the trust
- Reminded staff members to get their nominations in for the Star awards in November
- Announced that our InPhase Oversight training will be commencing from 2 October
- Opened our seasonal staff vaccination programme from 26 September
- Opened Brook House, a brand-new custom-built building on Durham Road which will bring some of our Stockton Community Mental Health services into one site.

Highlights

Staff at Kilton View donned fancy dress for a week of fairy-tale festivities

Ridgeway held their annual Soundwaves Music Festival with games, music, food, and ice-cream

Springwood Unit in Malto fried up a special breakfast for a patient

Staff from Ceddesfeld Ward raise over £1,000 for The Alzheimer's Society with a 5k charity walk

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

11
Media enquiries handled by the team

6
Media releases issued

50
Total pieces of coverage across online news, TV, and radio

News stories

- **Teesside NHS workers buy uniforms for 31 Middlesbrough school pupils in 'emotional' donation drive** - *Teesside Live*
- **Special event celebrates first year of York's Dementia Strategy** - *City of York Council*
- **'Blooming marvellous' NHS gardening project in town** - *The Press (York) online, YAHOO Sport (UK), Scarborough News, YAHOO! News UK & England*
- **CQC Prosecution Coverage** - *BBC Online, Northern Echo, ITV (online) Teesside Live, BBC Tees, ITV 1 TT N, BBC Radio 2, BBC Newcastle*

Our website

55,628
page views

Top three visited pages

1. Careers
2. Crisis
3. Services

Staff intranet

896,638
page views

Top staff intranet news stories

1. Eamonn McClurey volunteers as a magician in his spare time
2. Jade Jackson has been nominated for Nursing Times award
3. Mental health, pregnancy alcohol and me
4. Vaccination clinics open next week
5. InPhase incident training dates
6. Research into food insecurity

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

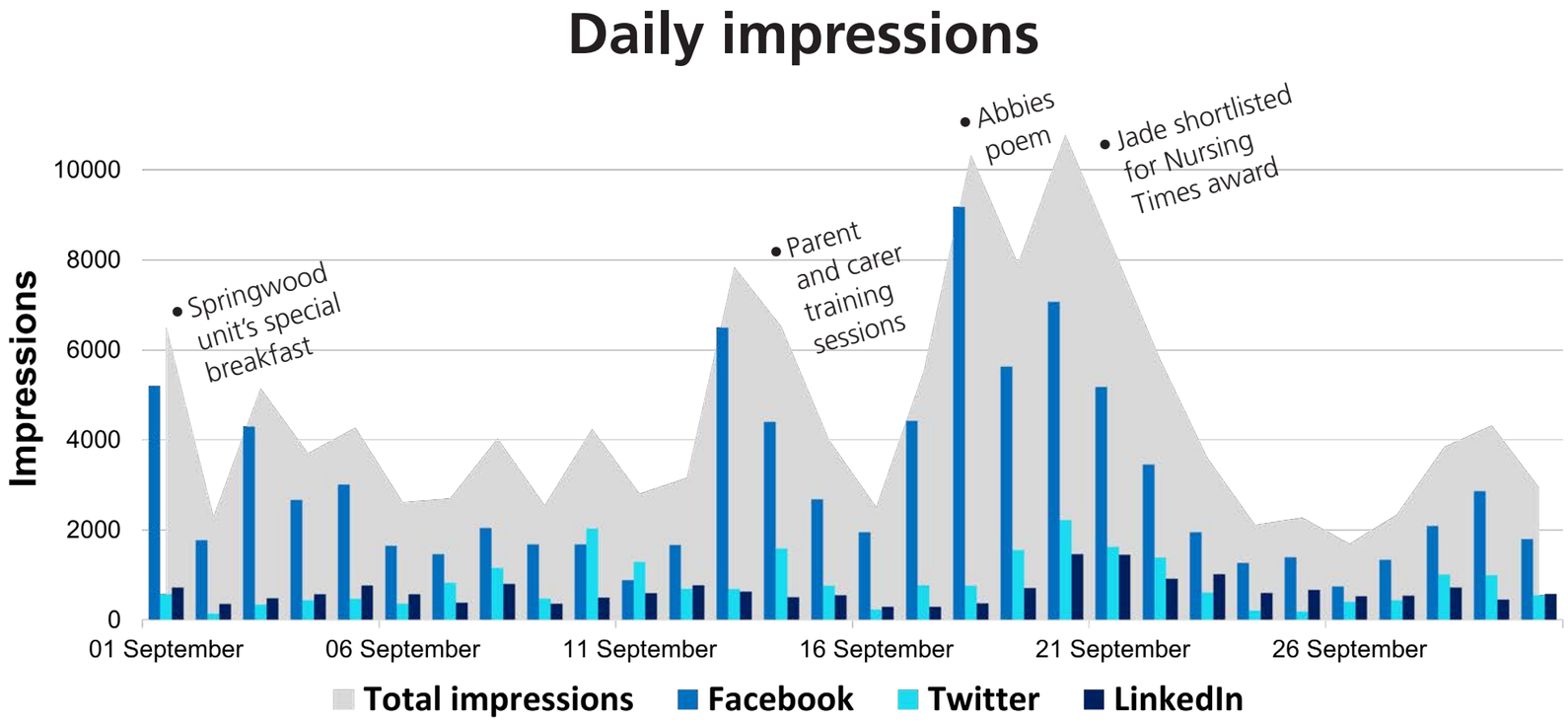
Our audience

25,553
Total followers

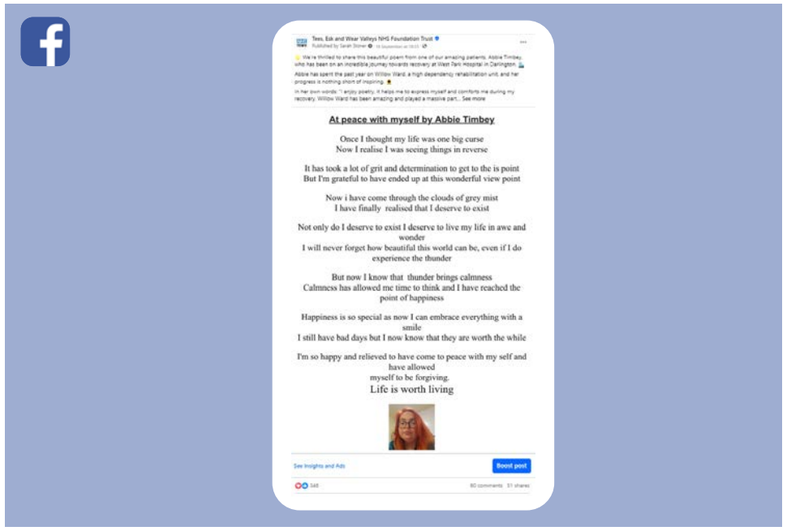
407
New followers

131,256
People who saw our content - impressions

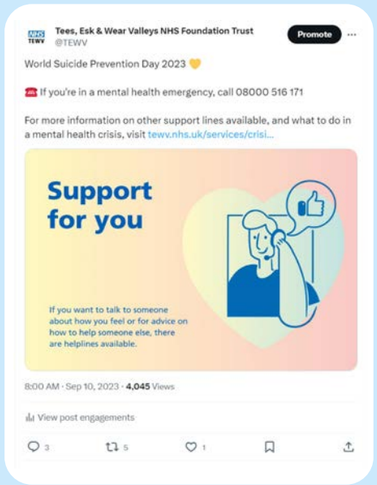
4,029
Engagements



Top posts



Impressions 12,085 - Engagement 726



Impressions 4,045 - Engagement 56

Impressions 2,357 - Engagement 96

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th October 2023**
Title:	**Board Integrated Performance Report as at 31st August 2023**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Ashleigh Lyons, Head of Performance**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

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

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

Overview: The overall **reasonable** level of assurance has been determined 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 expenditure compared to agency target
- Financial plan: Agency price cap compliance
- CRES Performance Recurrent

(*See Appendix A for detail*)

Performance Improvement Plans

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

- 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)

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 Quality, Workforce, Inpatient Pressures and Finance this month are:

- Ward Quality & Safety
- Serious Incidents
- Patient Outcomes
- Statutory & Mandatory Training
- Bed Occupancy

- People Measures
- Workpal Implementation
- Agenda for Change and other pay awards

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

Data Quality Assessment

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

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 is not where we would want it to be.
3. Confirm 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 Patients surveyed reporting their recent experience as very good or good	Improved assurance
Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	Deterioration in performance
Percentage of CYP showing measurable improvement following treatment - clinician reported	Improved assurance
Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	Improvement in performance Improved assurance
The number of Restrictive Intervention Incidents	Improvement in performance Improved assurance
The number of unexpected Inpatient unnatural deaths reported on STEIS	Improved assurance

IPD Areas of Concern

There are 5 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	As at 31st August 2023 the Trust has a deficit to plan of £4.58m compared to its planned deficit of £4.75m. Two national pressures fully account for the year-to-date variance: • Adverse recurrent financial impacts have been assumed following the nationally negotiated pay award for Agenda for Change staff (increase from 2.1% plan to 5% pay uplift). With underfunding of the increase through a 1.6% additional tariff uplift, this is contributing £0.66m to the deficit as at 31st August 2023 (£1.58m projected 2023/24). • Defunding of providers in relation to national Microsoft Licensing arrangements (with no equivalent opportunity to reduce locally contracted Microsoft licences) is contributing £0.19m to the year-to-date deficit (£0.46m projected 2023/24). However, there are indications from the ICB that this will be reviewed and restated. These two pressures are offset in part by the revised medical pay award (not yet paid but accounted for in M5 based on national guidance) which is contributing to a reduction to the deficit at M5 of (£0.52m). There continue to be three consistent key operational drivers of financial performance: elevated bed occupancy/delayed transfers of care, independent sector bed utilisation and elevated agency staffing pressures/premia. The Trust has recommenced the financial recovery measures introduced during 2022/23 and actions including vacancy control, task and finish activities for beds oversight, agency reduction and will tighten controls around discretionary spending to improve financial performance, and CRES delivery that is back end loaded in the plan.

Measure	Comments
Financial Plan: Agency expenditure compared to agency target	The Trust agency expenditure is £0.09m lower than planned costs up to 31st August 2023 (0.95% lower than plan, previous month 1.30% lower than plan), albeit that plan levels reflected elevated 2022/23 run rates. Monthly run rates for agency staff costs remain high, and the financial plan included additional stepped CRES targets in Q2 and beyond. There is limited assurance with elevated levels of agency expenditure being a cause of ongoing concern, both from a volume and a rate perspective. Key usage includes cover for increased medical vacancies, staffing needed for patient observations, backfill for sickness, and vacancies, most notably for inpatient rosters, as well as support for complex packages of care for Adults with a Learning Disability. High inpatient bed occupancy, including due to longer lengths of stay, is continuing to exacerbate impacts on safe staffing and therefore elevating temporary staffing requirements. There are modest positive signs of improvement, including from significant progress to eliminate off-framework agencies, expenditure reductions in Adult Learning Disability Services (and with future reductions forecast from planned discharge of individuals with a complex care package), and impacts anticipated following success of international recruitment of both nursing and medical staffing. Medical locum assignments rates are subject to review, with actions to pursue substantive recruitment status, and/or conversion to substantive and non-direct engagements. Agency Reduction and safe staffing subgroups of the Executive People and Culture Group have been established to deliver optimal e-rostering and target agency reductions. However, despite wider discussions, including through regional Quality Board, progress is slow to enact system plans for the discharge of a small number of individuals supported through complex Trust Care Packages.
Financial plan: Agency price cap compliance	Agency usage includes shifts fulfilled on hourly rates above the price cap or off framework (albeit minimal residual off-framework – digital only). 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 quarter 1 2023 and moving into quarter 2 2023, compliance at 86 shifts per day om August 2023 (previous month was 96 shifts per day). However, in August 2023 34% of shifts 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, level loading of Inpatient roster to reduce agency costs, review of surge posts and actions to reduce taxi/transport costs. As at 31st August 2023 £4.17m CRES has been achieved, £2.68m recurrently (£2.04m behind plan measure 27) and £1.49m non-recurrently (£1.14m ahead of plan measure 28). Planning of a trust wide CRES event is in train to take place during quarter 2. Composite CRES delivery of £4.17m is £0.91m behind plan.

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 experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	County Durham and 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	County Durham, North Yorkshire
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	North Yorkshire and Vale of York

Appendix B

Broader Key Issues/Work

Quality

Ward Quality & Safety
Improvement work has been undertaken on two of our West Park wards, Elm and Birch, to improve safety and quality of care. This has included the reallocation of modern matron time and the progressing of key vacancy recruitment on both wards. Away days are scheduled during September to develop further actions for Birch ward and an improvement plan for Elm Ward is currently being developed with support of the Urgent Care Supercell.

Serious Incidents
There is an ongoing recovery plan and a clear trajectory of improvement, which we continue to focus on whilst ensuring we deliver quality reviews and share and spread learning. The trajectory projects performance made on several assumptions: human factors such as reviewer capacity, average incidents per month (14), and the capacity to review incidents and progress through governance assurance panels. All serious incidents are reviewed to ensure we have met Duty of Candour, (which is line with the Patient Safety Incident Response Framework requirements) and ensures 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. An additional family liaison officer is now working within the patient safety team to ensure timely and compassionate links with families.

Patient Outcomes
There continues to be concern for our patient outcome measures, both patient-related and clinician-rated and we have recognised a need for a Trust-wide approach/focus on improvement. One of the priorities of the TEWV Outcomes Group is to ensure that outcome measurement is implemented meaningfully and enhances personalised care, outcomes and experience. It is imperative that staff understand how outcome tools can improve care and outcomes themselves. All future training will have this at its heart, providing a strong focus on why and how to implement outcome measurement in a manner that is aligned to this ambition.

Statutory & Mandatory Training
Access to face to face training remains an area of concern within both Care Groups and a Trust-wide Quality Improvement event is currently being planned, which will focus on the delivery of quality training and the timely releasing of staff to attend this training.

Inpatient Pressures

There is continued focus on reducing Out of Area Placements (OAP) to zero as quickly as possible through the various schemes that are in place and the immediate work being undertaken that has formed the performance improvement plan.

Over recent months there has been a significant reduction in Out of Area Placements to single figures, this position has continued through Q2: as of the 12th September, DTV 1, NYY 0.

The continuous and sustained reduction of Out of Area Placements over a number of months suggests that the plans in place are having an impact, however some of the schemes will need to embed and some are in their infancy. It should also be noted that there still remains a number of patients that are internally displaced across adult wards i.e. patients flow from DTV to NYY, this flow creates significant pressure within NYY to maintain a Nil out of area position.

It is important to note that whilst Out of Area Placements are currently nearing the target of zero, bed occupancy remains high (DTV ≥ 100%, NYY ≥ 95%). To ensure we can achieve zero Out of Area Placements and ensure patients are admitted to a local bed, bed occupancy will need to be reduced further, hence the continued efforts to implement plans and identify new areas of work.

Progress updates on key schemes being taken forward to address Out of Area Placements are below:

- Purposeful In-Patient Admission (PIPA): Action plans in place post PIPA events. All wards plan to meet to consolidate plans and review progress. Clinical Network to support with some focused work on report out agendas and handovers following observations.
- A workshop is being planned to undertake a review of the discharge policy and processes. This will incorporate the homeless / no fixed abode issue. Workshop undertaken and principles identified. Next steps are to undertake a review of national homeless guidelines.
- OPTICA pilot: Technical teams from CIVICA, NECS and TEWV are working together to put in place the necessary technical systems to enable a diagnostic / feasibility assessment.
- Plan to review the active support placed on wards showing highest level of patients with a length of stay over 60 days and feedback from observations to inform new actions for improvement plan.
- The Implementation of lead psychiatrists focused on patient flow is now complete and has been extended to October.
- Targeted work to be undertaken with the Darlington, Hambleton & Richmondshire community teams to explore why admission rates are higher than expected per weighted population. A meeting was due to take place in DTV but due to key stakeholder availability, the meeting has, had to be rescheduled. In NYY the issue lies with staff capacity hence recruitment to posts has commenced.
- A review of all medical vacancies has taken place and adverts out for substantive posts. Further review of establishment planned Sept 23.
- An independent peer review of the patient flow process has been undertaken in DTV to identify any areas for improvement. Feedback following the review to be received.

Preparations continue for the Urgent Care Programme workshop, which will enable the development of the programme purpose. It is still anticipated that new governance arrangements will be in place by October 2023. It is worthy of note that the National Mental Health Inpatient Quality programme is to be launched in October, which is likely to also inform plans.

Workforce

People Measures
New performance trajectories have been developed for the four key people metrics including Sickness Absence, Leavers Rates, the percentage of staff recommending TEWV as a great place to work and the percentage of staff feeling they are able to make improvements happen within their work. Based upon previous performance, national benchmarking and incorporating achievable yet challenging stretch targets, these will further support the Trust to continue the improving position with clear aspirational targets for the future years ahead. These were discussed at Executive People, Culture and Diversity Committee on 19th September and will go to People, Culture and Diversity Committee in November 23.

Workpal Implementation
The implementation of Workpal has reached the halfway point in the 12-month roll out period. A review was undertaken in September together with Workpal colleagues to provide feedback on implementation so far, understand the current position with those staff registered on the system and explore any technical issues experienced. Following staff changes within the People & Culture team, a new Programme Manager has been appointed to lead the next 6 months of implementation working together with a small project team from across the Trust. Their primary focus will be upon improving the compliance rates for appraisal across the Trust whilst implementing the new system, working closely with Workpal to ensure the transition for staff is as smooth as possible whilst providing assurance that a high-quality appraisal conversation is experienced by all.

Finance

Agenda for Change (AFC) and Other Pay Awards
The Trust has an existing accumulated funding shortfall up to 2023/24 plan 2022/23 relating to impacts of prior year and current year plan Agenda for Change pay awards of around £11.5m due to the disproportionate impacts from funding via national annual 'tariff' uplifts applied to provider contract values. A further impact of the outcome of the 2023/24 revised Agenda for Change Pay Review Body which awarded 5% uplift versus 2.1% included at plan is c.£1.5m full year (£1.7m recurrently) or £0.66m at 31st August 2023, resulting in a recurrent cumulative impact of £13.2m. Tariff inflation at a flat percentage uplift of 1.6% has generated an additional in-year pressure for the Trust due to our higher (than acute providers') pay cost weight. Both mental health providers in the North East & North Cumbria (NENC) Integrated Care Board (ICB) patch have requested a review of the tariff funding methodology, due to precedents established in 2022/23, where funding was allocated relative to actual cost. The AFC pay award pressures are offset in part by the revised medical pay award (not yet paid but accounted for in M5 based on national guidance) which is contributing to a reduction to the deficit at M5 of £0.52m (£1.24m full year). Without additional support the Trust would need to find further mitigations in order to deliver its financial plan.

Care Group Summaries

Durham Tees Valley and Forensic Care Group

The key areas of concern identified from the Integrated Performance Dashboard (IPD), with triangulation of any other relevant information
Pressures on our inpatient services are continuing; our bed occupancy remains high within our adult ward although we are starting to see increased discharges, reduced lengths of stay on some wards and a sustained reduction in the use of Independent Sector beds across July and into September, with 1 patient from our Care Group in an independent sector bed as at 12th September. Work continues on the OPTICA Pilot with Technical teams from CIVICA, North of England Commissioning Support and Tees, Esk and Wear Valleys NHS Foundation Trust currently working together to put in place the necessary technical systems to enable a diagnostic / feasibility assessment. A meeting of the Urgent Care Programme Board will take place early October to share the programme. In early November a workshop will take place to share the programme workstreams, deliverables and governance.

We are concerned about the Percentage of Adults and Older Persons showing measurable improvement following treatment for both patient and clinical reported outcomes. The Care Group have agreed to undertake a deep dive into each speciality to support us in setting some key actions to improve the outcomes for our patients.

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 are in place at Trust level. We are starting to see some improvements to our Appraisal compliance across all specialities with most now on or above the standard with the exception of Adult Mental Health. This remains a key focus. A Trust wide Performance Improvement Plan for both areas are included in this report. A Quality Improvement event to be developed jointly with People and Culture leads to look at the potential to transform the approach to face to face Mandatory and Statutory training modules.

Whilst we have seen an improvement in compliance with the standard for Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommenced package of care within our County Durham Sub ICB, following implementation of key actions, we have now seen a reduction in compliance in the Tees Valley sub ICB. This is as a result of staff shortages in one of the teams in that area. Staff have been realigned short term to cover and support that team.

Within our Talking Therapies service, we did not achieve the access standard in either sub ICB area in August, this was accompanied by a reduction in referrals compared to the previous month. Key

action ongoing within the Performance Improvement Plan is in relation to marketing of the service to increase referrals received. A deep dive is being undertaken across all Talking Therapies measures, supported by the Corporate Performance Team, in order to support further development of actions within the Performance Improvement Plan.

As at August 2023 the Care Group has reported a deficit to budget of £5.6m, this is an improvement on July primarily due to a number of contract income and budgets. The areas of concern for the care group are:

- Delivery of CRES for agency (current spend £5.2m - 5.4% of pay spend)
- Delivery of CRES for Independent sector bed use (current spend £1.5m)
- Over established clinical posts in community and BCP wards (£1.9m)

The Care group is developing a series of recovery actions to address overspending areas including improved reporting and oversight.

The areas of positive assurance identified within the IPD

We continue to see an increase in the Percentage of CYP showing measurable improvement following treatment, both patient and clinician reported measures. Whilst a Performance Improvement Plan is in place for patient reported outcomes, an increase in both can be seen as a result of increased training, awareness raising and discussion across the service.

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 as a result of focused work and key actions in all areas. At the end of July, the Care Group were invited to present at a national conference sharing the work undertaken in Adult Learning Disabilities to reduce the use of restrictive interventions, the positive impact for our service users and how we are now sharing this learning across our organisation.

Our staff leaver rate continues to reduce across the last 9 months and improvement is demonstrated in most specialities. This will continue to be monitored.

Within our Talking Therapies services we continue to achieve the standard for patients achieving recovery and 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 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 with particular attention focused on the North Durham area where an improvement plan is progressing alongside staff recruitment. Following agreement with the ICB regarding investment to support all age crisis access service that will be co-located with the North East Ambulance Service (NEAS), discussions have progressed and it has been agreed that due to us not having immediate access to NEAS clinical systems, “phase 1” would not include co-location with NEAS but this will be revisited 24/25. Clinical work is ongoing with working groups agreed with NEAS and Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

Within the Care Group, we have agreed to work at a stronger alignment of the screening function of the 3 crisis services (Adult Mental Health, Mental Health Services for Oder People and Children & Young People) to maximise the capacity of the call pick rate. This commenced in both areas during August and improvements are beginning to be seen.

The current answer rates (1st – 15th September) are 61% in Durham and Darlington team and 73% 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

Bed occupancy has increased for August, reporting 95.60%; Adult Mental Health is 98.49% and Mental Health Services for Older People is 92.40%,

Delayed Transfers of Care are improving within Adult Mental Health due to the pathway to recovery team with City of York helping with the discharge of patients, this is supported further through weekly meetings that have been set up with Local Authority to discuss cases and barriers to discharge. Within Cross Lane Hospital, Local Authority staff are co-located which aids quick discussions in relation to barriers / issues, along with weekly meetings.

A slight improvement has been seen in Mental Health Services for Older People. Ongoing complex needs and patients waiting for identified placements, due to the nature of their presentation, which is being monitored through patient flow via 30/60/90-day reviews, discharges and average Length of Stay. Discussions continue with Tees, Esk and Wear Valleys NHS Foundation Trust and the Head of Social Work regarding potential support with the Delayed Transfers of Care position and weekly partnership meetings to plan discharges are in place.

There were 0 independent sector beds at the end of August 23.

Appraisals remains an area of concern. Significant work continues with Workpal and those staff who aren't on Workpal are being advised to register and in the interim, continue with the paper based.

Memory waiting times demand and capacity exercise is ongoing and due for completion at the end of September to report to Commissioners on 3rd October.

The areas of positive assurance identified within the IPD

We are achieving an excellent standard on the following measures within both North Yorkshire and Vale of York Sub-ICB:

- Talking Therapies Recovery
- Children & Young People supported through NHS funded mental health 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 mental health services.
- Percentage of Service users under Adult Mental Health specialties who were followed up within 72 hours of discharge.
- Patients waiting less than 2 weeks for first episode of Psychosis.
- Talking therapies 6- & 18-week standards for accessing our services
- Adult Mental Health patients seen by crisis within 4 hours for Vale of York Sub-ICB
- Children & Young People patients seen by suitably trained practitioner within 4 hours for York Sub ICB.
- Children & Young People patients aged 17 years and 6 months with a transition plan.

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

Lack of medical workforce is impacting across all Service areas. Adult Mental Health & Mental Health Services for Older People have agency and mind the gap arrangements in place to ensure continuity. No permanent psychiatry cover identified for CAMHS Selby, and the non-medical prescriber cover ends at the end of August. Mitigation is in place with a covering rota to support teams and there are on-going efforts to recruit into the permanent post with support from People, Culture and Diversity. There have also been some successes - we have 1 new substantive consultant commencing with the Northallerton CRHT in November and in June we recruited 2 consultant Psychiatrists who will start in post with York Child & Adolescent Mental Health Services later in this calendar year.

Crisis - vacancy rates within Child & Adolescent Mental Health Services crisis continue to be of concern. Two more band 6 staff will be leaving soon to take up posts outside of the Trust. There are also on-going pressures caused by vacancy rates in Adult Mental Health crisis teams. Work continues within Adult Mental Health to develop and improve the all age mental health crisis line support. The

revised mental health first response model for the all age 0800/NHS 111 connection is going live on 13 September; aiming to increase the response rate to calls in both the Mental Health screening and crisis hub.

There is a significant lack of access to Learning Disability beds within the Trust and nationally. There are difficulties with appropriate social care placements for Learning Disability patients and clients are placed in high-cost packages in other areas. Due to no beds being available, this is putting clients who are requiring admission at risk as they are remaining in the community when the priority would be a period of time as an inpatient. Additional pressure is also placed on the community teams who have to cancel other appointments to ensure time can be released to offer increased care and to attend more frequent multi-disciplinary team/System meetings.

Service Improvement Delivery Group has recommended that the seclusion space in Cross Lane is closed from 1st November, to support staff training, match the approach of Foss Park Hospital regarding the call for police and discharge of people who assault staff and don't have an underlying mental illness greater use rapid tranquilisation. This change would remove the current use for people who can't be contained on the ward prior to a transfer to psychiatric intensive care unit.

Appendix C

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st August 2023

Report Produced by: Ashleigh Lyons, Head of Performance
Date the report was produced: 4th October 2023

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

CONTENTS

Chapter 1

Integrated Performance Dashboard (IPD)

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

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

Assurance: is the standard achievable?

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

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

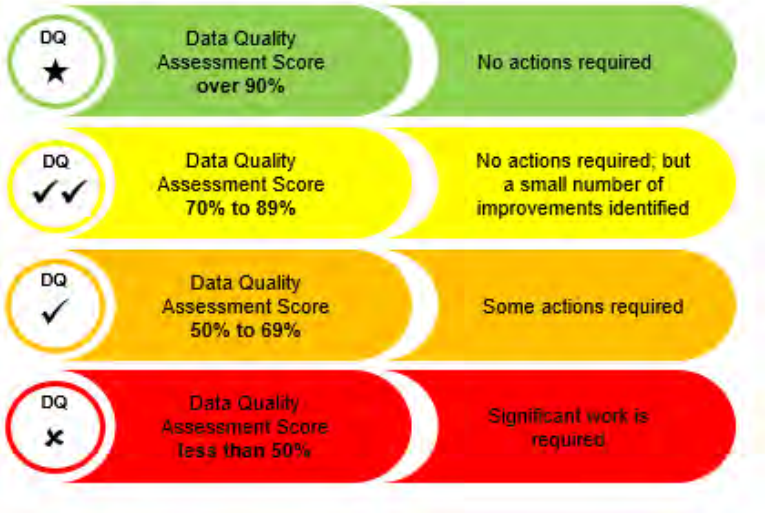
Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The latest assessment on all measures has been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

Tees, Esk and Wear Valleys NHS Foundation Trust

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive	***Patients surveyed reporting their recent experience as very good or good** ***Restrictive Intervention Incidents** *Medication Errors with a severity of moderate harm and above	*Incidents of moderate harm and near misses *Staff Leaver Rate *Staff in post with a current appraisal *CRES Performance – Non-Recurrent		
Neutral		*Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for *CYP showing measurable improvement following treatment - patient reported ***CYP showing measurable improvement following treatment - clinician reported** ***Inappropriate OAP bed days for adults that are 'external' to the sending provider** ***Unexpected Inpatient unnatural deaths reported on STEIS**	*Bed Occupancy (AMH & MHSOP A & T Wards) *Serious Incidents reported on STEIS *Uses of the Mental Health Act *Staff recommending the Trust as a place to work *Staff feeling they are able to make improvements happen in their area of work *Percentage Sickness Absence Rate *Compliance with ALL mandatory and statutory training *New unique patients referred *Use of Resources Rating - overall score *Capital Expenditure (Capital Allocation) *Cash balances (actual compared to plan)	
Negative			*Inpatients reporting that they feel safe whilst in our care ***Adults and Older Persons showing measurable improvement following treatment - patient reported** *Adults and Older Persons showing measurable improvement following treatment - clinician reported	*Unique Caseload (snapshot) *Financial Plan: SOCI - Final Accounts - Surplus/Deficit *Financial Plan: Agency expenditure compared to agency target *Agency price cap compliance *CRES Performance - Recurrent

***NOTE**: green and white text indicates changes in assurance to the previous month's report.*

Board Integrated Performance Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC	H	?	92.00%	92.14%
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%	75.02%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	54.03%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	24.50%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	46.69%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC		F	50.00%	44.15%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	19.76%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC				99.66%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC				773
10)	The number of Serious Incidents reported on STEIS	QAC				55
11)	The number of Incidents of moderate harm and near misses	QAC	L			762
12)	The number of Restrictive Intervention Incidents	QAC	L			2,639
13)	The number of Medication Errors with a severity of moderate harm and above	QAC	L			2
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				1
15)	The number of uses of the Mental Health Act	MHLC				1,871

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
16)	Percentage of staff recommending the Trust as a place to work	PC&D				54.48%
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				59.08%
18)	Staff Leaver Rate	PC&D	L			11.56%
19)	Percentage Sickness Absence Rate (month behind)	PC&D				5.54%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D		?	85.00%	86.94%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	?	85.00%	82.14%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				42,508
23)	Unique Caseload (snapshot)	S&RC	H			64,119

Rep Ref	Our Finance Measures	Committee Responsible for Assurance	Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	P	4,747,302	4,581,445
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	P	8,828,909	8,743,878
25b)	Agency price cap compliance	S&RC	F	100%	63%
26)	Use of Resources Rating - overall score	S&RC	P	3	3
27)	CRES Performance - Recurrent	S&RC	F	4,723,000	2,678,000
28)	CRES Performance - Non-Recurrent	S&RC	P	351,000	1,490,000
29)	Capital Expenditure (Capital Allocation)	S&RC	F	7,069,000	3,475,000
30)	Cash balances (actual compared to plan)	S&RC	F	67,055,000	65,635,000

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

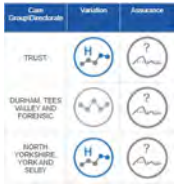
During August, **806** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **755 (93.67%)** scored "very good" or "good".

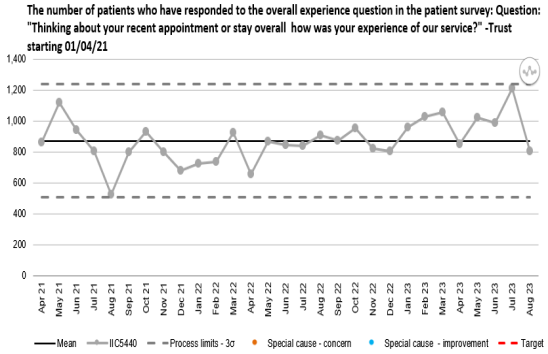
We're aiming to have high performance and we're moving in the right direction.

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

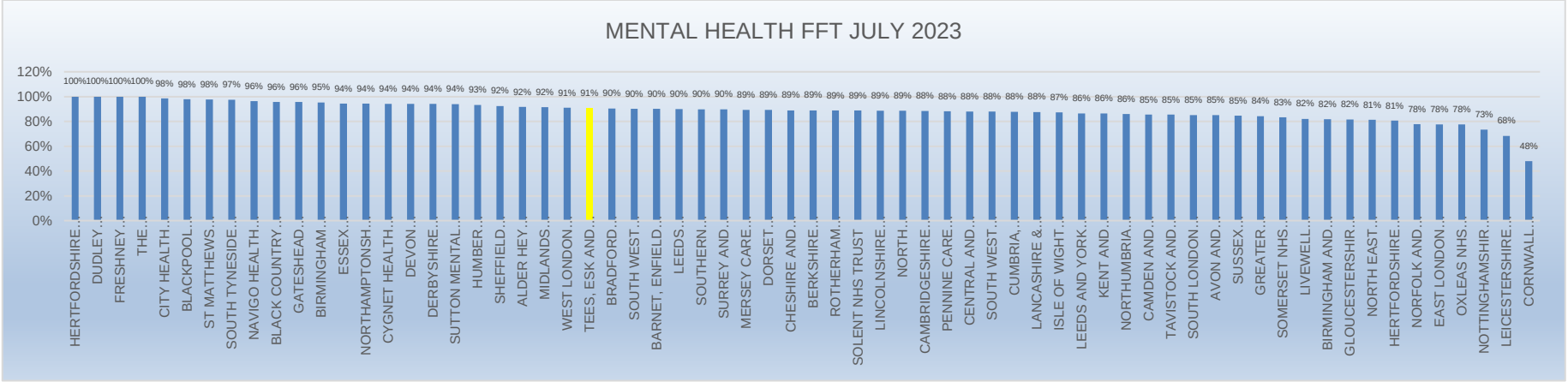
DQ ★ 93%

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





National Benchmarking - Mental Health Friends and Family Test (FFT) data - July 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 24 in the list of providers shown. The Trust was ranked highest for the total number of responses received.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Analysis at service level for August shows:

- Crisis Services **87.5%** reported their recent experience of our services as very good or good
- Learning Disability Services **100%** reported their recent experience of our services as very good or good
- Adult Mental Health Services **90.2%** reported their recent experience of our services as very good or good
- Younger People Services **94.5%** reported their recent experience of our services as very good or good
- Older Person Services **94.6%** reported their recent experience of our services as very good or good

Patients are encouraged to provide additional information when completing the survey. A total of 1,527 comments were received in August of which 1,129 (74%) were positive and 353 (23%) were negative; the highest number of negative comments were in relation to "Quality of care and treatment" followed by "Personalised care".

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:* The Trust-wide Patient & Carer Experience Group to undertake a deep dive of the Friends & Family Test data in order to develop actions to improve our response rates. This work will be completed by ~~September~~ October 2023.		

Page 9 of 11

Additional Intelligence in support of continuous improvement

In March we commenced a review of our Patient Advice & Liaison Service (Pals) and complaints handling service following the publication of the new NHS complaints standards, a year-on-year increase in concerns being raised in the Trust and in recognition of feedback received about our service. Since then, we have carried out a range of activities as part of our review process including a thorough scoping exercise, which included those that have used our services, staff and our partner organisations, as well as two quality improvement events. From September we will be piloting a new way of handling those concerns that are raised locally at ward/team level and if successful we hope to roll this out Trust-wide later in the year. A new approach to the Chief Executive final signatory process has started. We are starting to see a number of benefits from this review; compliance was up to 77% in July 2023 and caseload numbers are decreasing. Compliance is reporting at 67% In August, we anticipated a slight decrease due to peak holiday season.

Staff and patients within our North Yorkshire & York Child & Adolescent Mental Health Services, Adult Mental Health Services and Learning Disability Services have been completing First Impression Tours of entrance areas. This has resulted in the decoration being improved, more comfortable furniture being sourced, old style posters updated, and the purchase of modern wall art. Some areas have started planting outside areas to provide a more welcoming entrance and have improved the signage from roads to the centres.

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.

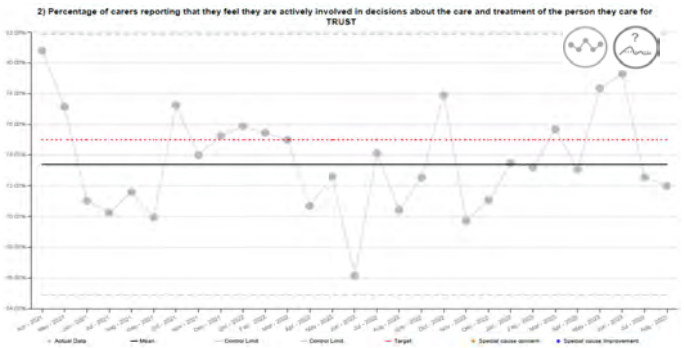
During August, **325** carers responded to the question in the carer survey: Question: “Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?”. Of those, **234 (72.00%)** scored “yes, always”.

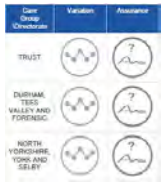
No significant change in the data during the reporting period shown

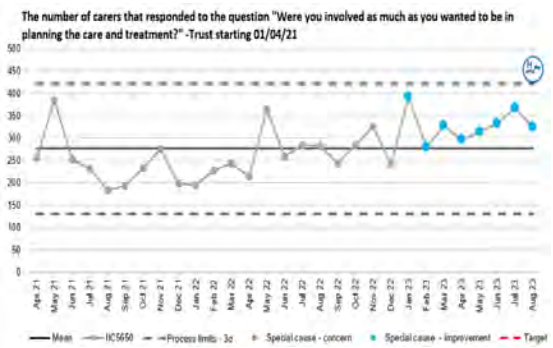
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ✓✓ **87%**

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







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 ~~August~~ September 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.	Work is underway and the deep dive will continue throughout September. Initial learning indicates that although there is a perceived shortage of required staff, carers consider our workforce to be pleasant, compassionate, professional and knowledgeable. 25% of complaints have been raised from Carers, relatives, or a family member, with concerns being related to a lack of communication, treatment of care, assessments, and care planning.	

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 Carers Trust, who awarded our Triangle of Care 2-star accreditation, have rebranded their Triangle of Care resources, including new guidance to support teams in completing the Triangle of Care self-assessment. This is being rolled out across the Trust to ensure that carers and staff have access to the most up-to-date information.

Re-procurement of the Meridian system which captures our patient and carer survey data is due to be undertaken next year. As part of this a prerequisite will be to revisit our patient and carer surveys.

A Carer Engagement Visual Control Board has been developed within our North Yorkshire, York & Selby Adult Mental Health services to monitor carer feedback and carer engagement activity in-month. This is monitored weekly by all wards and teams via performance huddles.

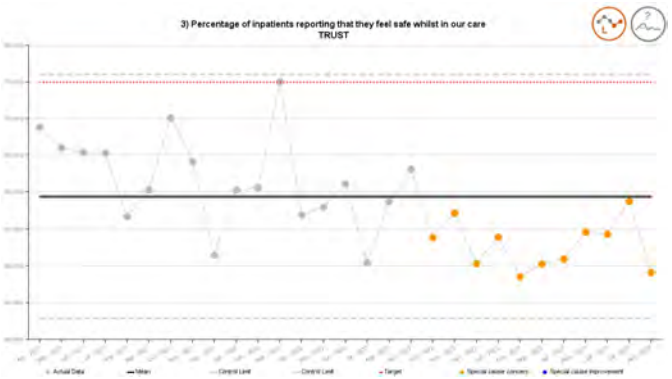
Involvement of carers has been identified as a key priority and is being addressed within the service improvement action plan framework. Specialty level plans are at various stages of development; however, actions incorporated in a number of the plans include self-assessments against the Triangle of Care standards and the development of carer information packs and leaflets.

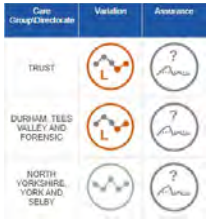
03) Percentage of inpatients reporting that they feel safe whilst in our care

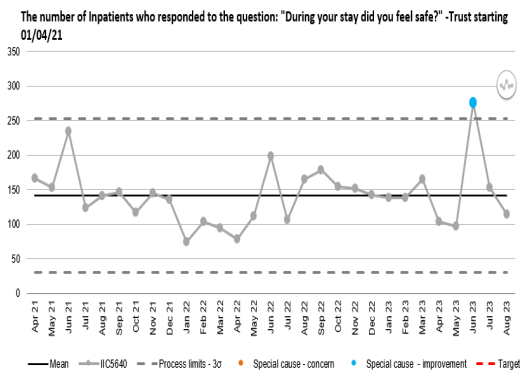
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

During August, **114** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **56 (49.12%)** scored “yes, always"







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:* The Patient Experience Team to revisit the focus groups in Adult Mental Health Services and Secure Inpatient Services by the end of ~~June~~ August 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.	The SIS focus groups have been completed and findings shared with services and Care Boards. Staffing levels continue to be the primary concern for both patients and staff and several actions have been undertaken to address this, including recruitment drives and the protection of roles such as activity coordinators (although this can be difficult due to staffing pressures). There were noted improvements from both patients and staff in terms of accessing the leave team. Ward cultures are to be continuously reviewed to ensure they encourage supportive engagement in positive interactions and activities, which could prevent situations that contribute to our patients feeling unsafe. Findings and learning should be included within all Service Improvement Plans. The AMH focus groups have been completed and will report out in September.	

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
A cohesive programme of work is required to improve our understanding of the experience our patients are having, improve survey response rates, identify key themes and hotspot areas, and develop a set of clearly defined improvement actions.	Director of Quality Governance to establish a Trust-wide Feeling Safe Group by the end of September 2023 to ensure the Trust has a cohesive and consistent approach to improving patient safety.	**Complete.** A Trust-wide focus group has been established, bringing together all Trust leads for the current strands of work focusing on patients feeling safe on our inpatient wards. Initial discussions identified a need for an overarching rationalised strategic workplan and reporting framework, and the establishment of a steering group to develop this; further discussions are underway to consider how this could be taken forward. Progress will be reported through the Executive Quality Assurance & Improvement Group.	
A Stirling Review has been completed on Wold View and identified a number of improvements to reduce the risk of falls on the ward and estate.	Modern Matron to submit a proposal to the September Quality Assurance & Improvement Group for approval , with a view to reducing falls and improving patient safety on the ward. Upon approval this will be submitted to the September Care Group Board.		
Self Harm in inpatient settings can cause emotional distress, an increase in the use of restrictive interventions and for patients to feel unsafe	Consultant Clinical Psychologist to lead a self harm review and to pilot work , including peer reviews and assurance processes, across all Trust Adult Mental Health wards including PICUs. This will be evaluated and reporting shared by the end of November 2023.		

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. There are 9 actions currently included within the plan. 7 actions had been due for completion by the end of September 2023, but all have been delayed; the first 5 actions are scheduled to be completed by the end of October 2023.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Additional Intelligence in support of continuous improvement

The Patient & Carer Experience (PACE) team have met with the Associate Director of Nursing for Planned Care and Mental Health Services for Older People to establish patient experience groups for both services. A meeting is arranged for September to discuss support for Adult Learning Disabilities and Children & Young People's Services. The groups will follow the same structure as the group in Adult Mental Health Urgent Care and will consist of:

- a review of patient experience response numbers and channels;
- support given to patient experience leads to access meridian;
- advice and guidance in writing patient experience reports that support evidence against the Patient Experience Service improvement Framework;
- support with the Triangle of Care
- information sharing

A safe ward shared learning event was held by Rowan Lea and Springwood at Cross Lane Hospital on 16th August. Ward staff supported colleagues to visit Rowan Lea to show them areas of good practice and Springwood demonstrated how they are using safe wards creatively to support patients with Dementia and how the clinical teams are working to reduce restrictive interventions.

The acute wards at Roseberry Park have undertaken two brief pilots of silencing alarms (vibrate alert) as part of their ward improvement plans. The primary aim is to reduce stimulation on wards that can trigger distress amongst patients. A third brief pilot is ongoing at the time of writing and whilst There have been no reported incidents associated with these pilots, a formal evaluation will taken to September's specialty governance meeting for consideration.

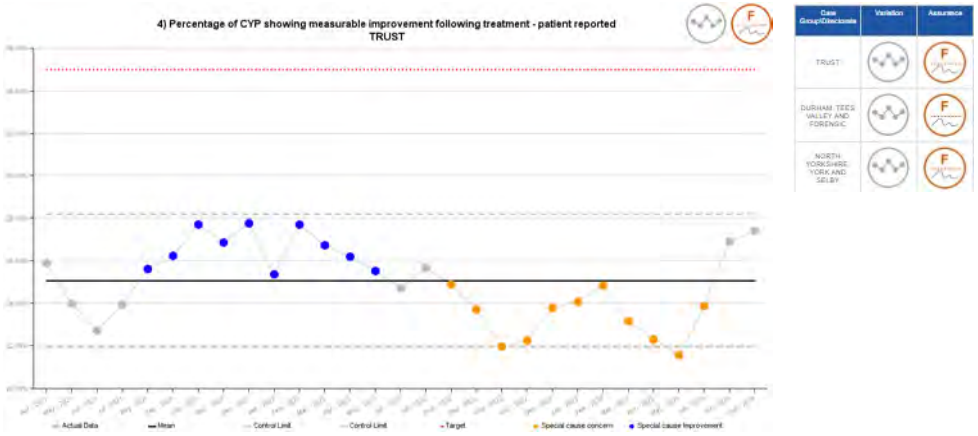
Page 55 of 55

04) Percentage of CYP showing measurable improvement following treatment - patient 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 patient perspective, is one way we will know our care is outstanding

For the 3 month rolling period ending August, **769** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 211 (27.44%)** made a measurable improvement compared to our standard of 35%.

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



No significant change in the data during the reporting period shown

Our system is expected to consistently fail the target/expectation

93%

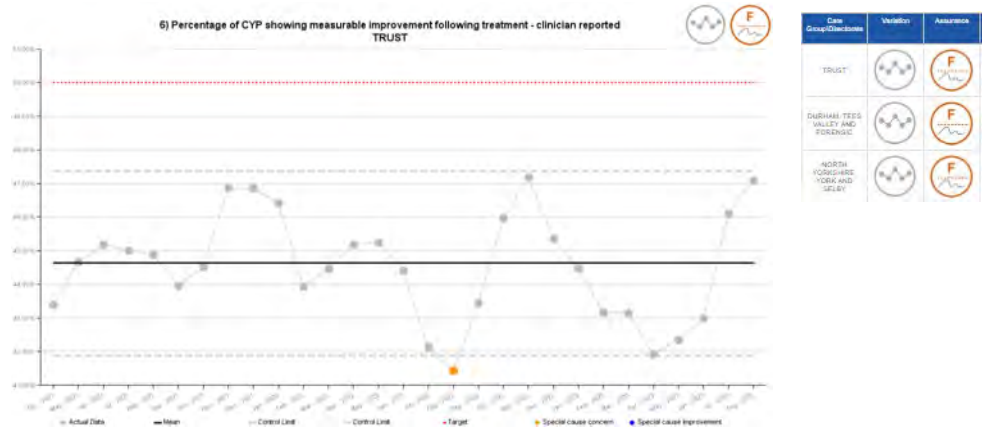
An Area of Concern
We are concerned with our performance in this area and action is required to improve

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 August, **843** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 397 (47.09%)** made a measurable improvement compared to our standard of 50%.

(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 August, 10 staff (out of 10) attended the monthly training sessions from Durham & Tees Valley and 1 (out of 1) for North Yorkshire, York & Selby. Team Managers are monitoring all new starters to ensure they are booked onto the next available training.	
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 in October 2023 and 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.		

Page 51

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 12 actions currently included within the plans; 3 were to be completed by the end of September 2023, of which 1 has been completed:

- The development of a Durham & Tees Valley service-wide register and training plan to ensure that all lead professionals and clinicians are trained to complete paired rated outcome measures.

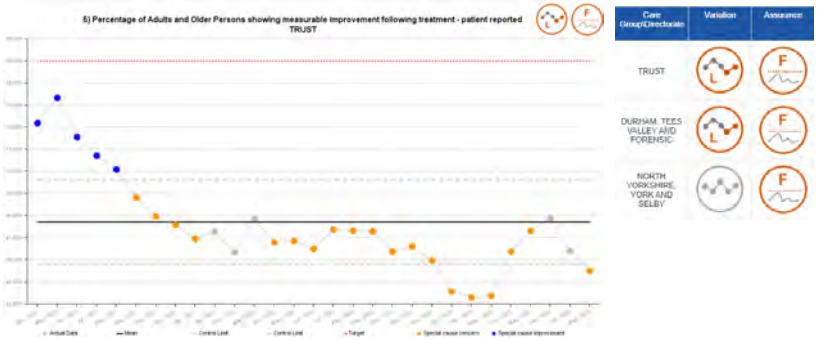
The remaining 2 have been delayed; one is now scheduled to be complete by the end of October 2023.

05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient 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 patient perspective, is one way we will know our care is outstanding

For the 3 month rolling period ending August, **2061** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 938 (45.51%)** made a measurable improvement compared to our standard of 55%.

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



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

Our system is expected to consistently fail the target/expectation

93%

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

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

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

For the 3 month rolling period ending August, **3101** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 626 (20.19%)** made a measurable improvement compared to our standard of 30%.

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

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

Our system is expected to consistently fail the target/expectation

93%

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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 3 actions currently included within the plan; 2 have been completed to date, both supporting enhanced monitoring of the use of outcomes measures in clinical practice through clinical supervision and caseload management supervision. The third action is dependent on the rollout of Cito.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

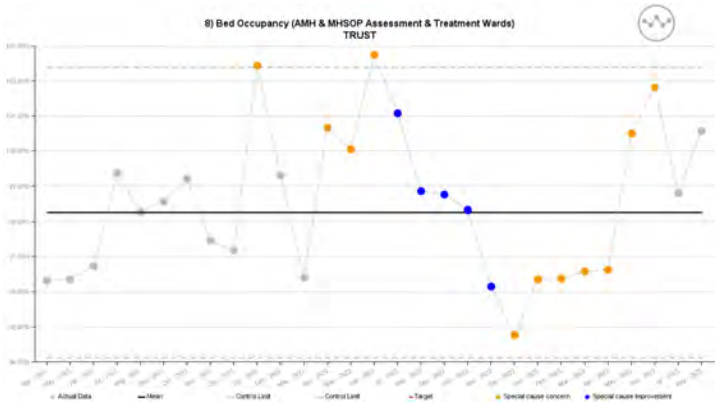
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important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

During August, **10,850** daily beds were available for patients; of those, **10,912 (100.57%)** 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 ✓✓ 87%



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

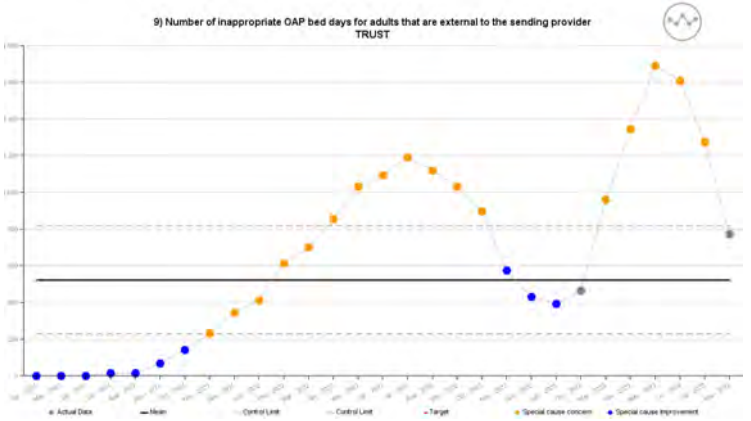
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending August, **773** days were spent by patients in beds away from their closest hospital.

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%



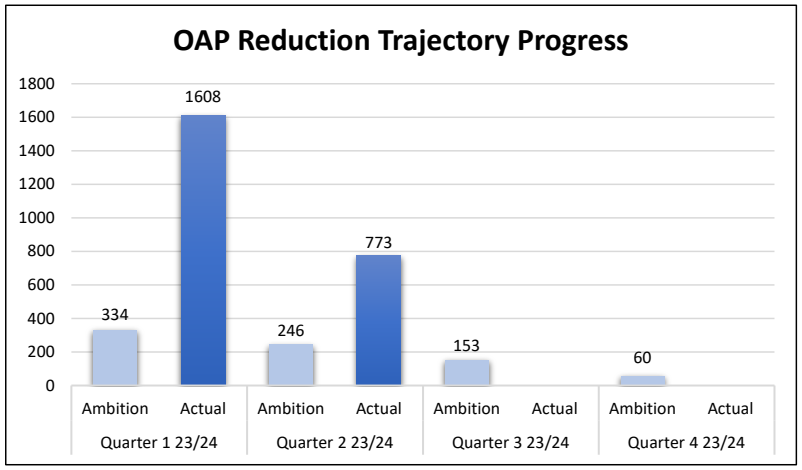
Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Measures

		2023 - 2024					
		Apr	May	Jun	Jul	Aug	FYTD
Overall Occupancy including Trust and independent sector bed usage	Number of occupied bed days	10,633	11,533	11,212	10,950	11,100	**55,428**
	Number of available bed days	10,740	10,866	10,500	10,850	10,850	**53,806**
	Percentage Bed Occupancy	**99.00%**	**106.14%**	**106.78%**	**100.92%**	**102.30%**	**103.01%**

Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider	Quarter 1 23/24		Quarter 2 23/24	
	Ambition	Actual	Ambition	Actual
Trust	334	1608	246	773
North East & North Cumbria ICB	334	1445	246	700
Humber & North Yorkshire ICB	0	163	0	73



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 **Performance Improvement Plans** for both Care Groups that define the actions being taken to support improvement and increased assurance. There are 13 actions currently included within the plan; 10 are due for completion by the end of September, of which 7 have been completed. Additional actions completed include:

- The establishment of place-based Purposeful Inpatient Admission action plans.
- Active support from Senior Super Cells to be implemented to those Durham & tees Valley wards where there are patients with a length of stay over 60 days.

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

Additional Intelligence in support of continuous improvement

An in-depth analysis and review of Trust inpatient activity is currently underway. Initial findings suggest that the increase in the use of independent sector beds across Spring/Summer 23 and associated delays in eliminating out of area placements are attributable to:

- a fluctuating demand for admissions;
- the scale of change in flow following the Purposeful Inpatient Admission (PIpA) events was not realised as quickly as we had hoped;
- the need to induct people to new processes and embed standard work; and
- time to embed our revised interface meetings with local authorities.

The themes relating to barriers to discharge are largely related to housing and specialist packages of care; with a view to reducing these weekly interface meetings are now in place and include housing leads and service manager representation for Local Authorities.

Recent performance indicates that we are seeing an improvement and as at the 15th September 2023 we had 3 patients placed in beds outside the Trust.

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

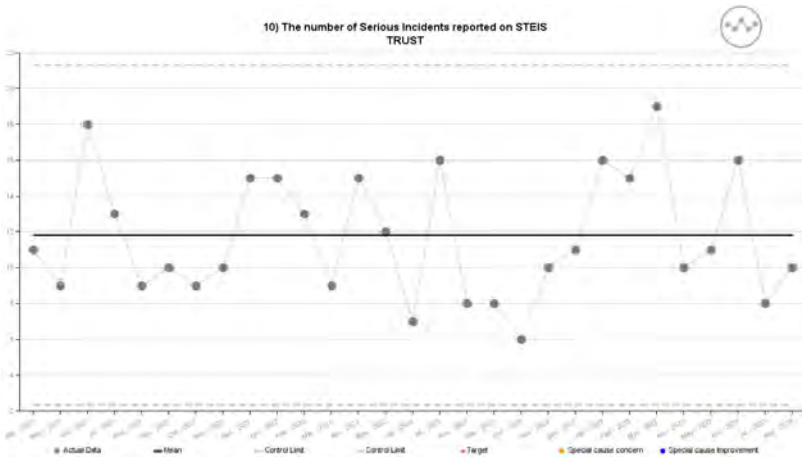
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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

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	

10 Serious Incidents are reported for August; however, there were 11 serious incidents reported on STEIS. The additional incident was approved on Datix after data had been extracted for the report; this is being addressed by the Patient Safety Senior Nurse with the relevant team.

Each incident has been subject to an early learning review within the patient safety huddle and there are no specific themes in relation to incident details or teams.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

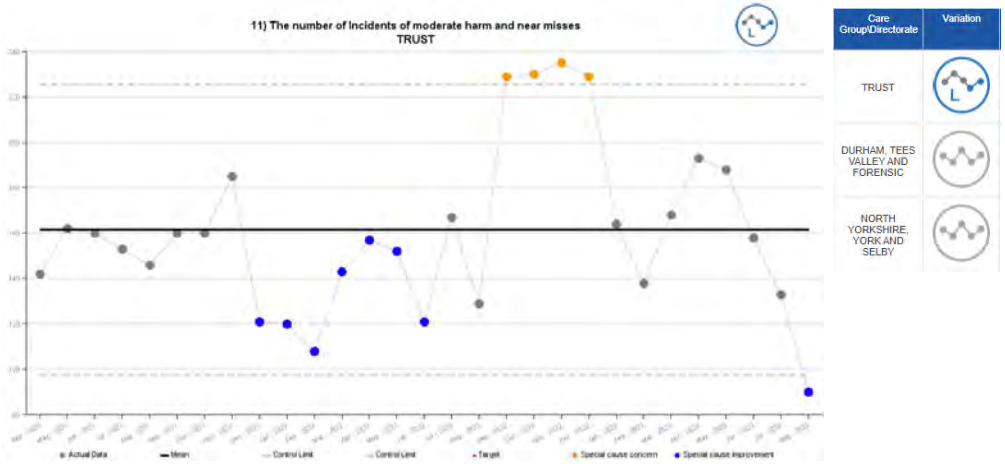
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

90 incidents of moderate harm or near misses were reported during August.

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

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

DQ ✓✓ **80%**



There are no new emerging themes within the 90 incidents of moderate harm or near miss reported in August. Where any early learning is identified immediate actions are agreed and monitored until completion.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
When incidents are centrally approved, the patient safety team request an Early Learning Review (ELR) be undertaken by the services; when services approve their own incidents, they initiate they ELR. Clinical services are not always undertaking a timely ELR due to confusion regarding the process.	*Enabling action:* Patient Safety Team to link in with the care groups by the end of August to ensure that where moderate harm incidents have occurred there is an ELR with appropriate oversight and approval, undertaken in a timely manner.	**Complete.** Associate Director for Patient Safety attended both Care Groups and met with all of the Fundamental Standards Group attendees in August. Matrons had helpful feedback on the process and flowcharts were revised and reissued. Further meetings to review the ELR process are planned for October.	Improvement and a decreasing trend is visible

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

Tees, Esk and Wear Valleys NHS Foundation Trust

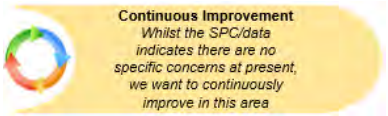
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
There is a concern that a number of incidents are being incorrectly recorded and approved as moderate harm within the clinical services when the severity should have been reduced at the review/approval stage.	*Enabling action*: Patient Safety Team to link in with the care groups by the end of August to ensure that reviewers and approvers correctly understand their responsibilities to ensure incident severity is being correctly coded.	**Complete.** Through the attendance at the Care Group and Fundamental Standards Group meetings, and the sharing of a number of 'moderate' incidents that services had approved, care groups are aware of process and importance of checking severity is accurately coded. The Associate Director for Patient Safety has added a summary of moderate and severe harm numbers of incidents to each monthly Care Group Board patient safety update.	Improvement and a decreasing trend is visible

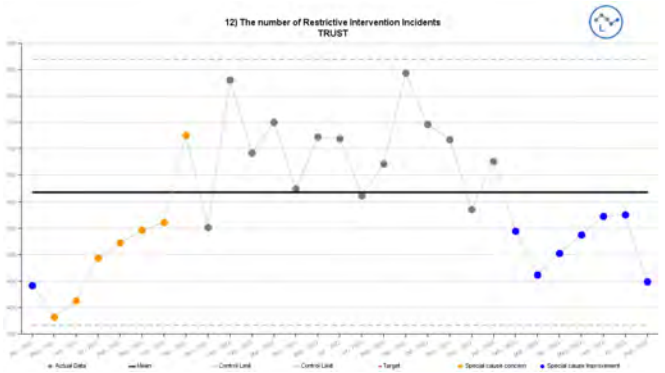
12) The number of Restrictive Intervention Incidents

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.

449 Restrictive Intervention Incidents took place during August.





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~~ 31st October 2023.	**Complete.** The Restraint Reduction Plan was agreed in July 2023 and was presented to the August Quality Assurance Committee.	Continuous improvement is visible
	Enabling action: The Nurse Consultant for Positive and Safe Care to lead the development of a Positive & Safe Care Policy. The proposed Policy will be completed by the ~~30th June~~ 31st October 2023 for pubic consultation.	Work is ongoing with the Lived Experience Directors and 2 task & finish groups have been established to progress the policy to ensure it is co-created with service users.	
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.	**Closed.** Current staffing provision is under review for Positive & Safe Care due to imminent additional vacancies.	

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS Foundation Trust

Additional Intelligence in support of continuous improvement

The Trust Positive & Safe Plan for 2023/24 has been agreed. Key priorities include:

- The use of the Safewards approach to identify Safewards champions for each ward area and to develop a community of practice to enable wards to support each other and share learning.
- Improved learning from incidents, ensuring that rapid reflection tools are utilised following the use of restrictive interventions and that in-depth reviews are undertaken following every use of severe forms of restrictive intervention.
- Ensuring our seclusion suites are safe and offer patients an environment that promotes quality of life and protects their human rights.
- A review of body worn cameras.

A Positive & Safe Conference is scheduled with our colleagues in Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust in November 2023 to share best practice.

A new group of students will be starting restraint reduction training at Cumbria University in September 2023.

A Quality Impact Assessment is currently being undertaken on the proposed closure of the seclusion unit at Cross Lane Hospital. Should this be approved, all seclusion facilities within the North Yorkshire, York & Selby area will be closed from the 1st November 2023.

At the end of July senior nurses from the Durham, Tees Valley & Forensic Care Group had the opportunity to be involved in a national event hosted by the Mental Health & Learning Disabilities Nurse Directors Forum. The co-produced event focused on how we work together to reduce restrictive practice and involved over 100 people from across the system with colleagues from mental health trusts, private providers and the Care Quality Commission in attendance. The team were chosen to present the work that has been undertaken by our Adult Learning Disabilities Services to reduce restrictive practice, a key focus of which was the positive impact for our service users and how we are now sharing this learning across the organisation to support further reduction in restrictive practices. The event provided an opportunity to explore how the new CQC Single Assessment Framework will impact the use of restrictive practice, to share our thoughts on the CQC inspectors' role in terms of their skills and knowledge to assess restrictive practice within provider organisations, and to consider how we can work together to share learning.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

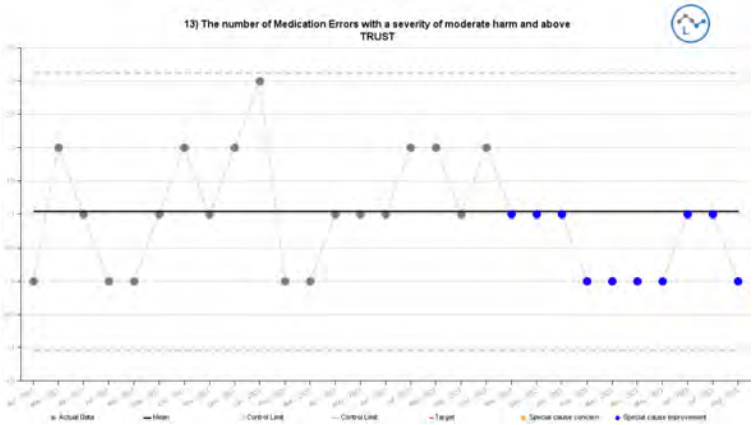
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When medication errors occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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

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

DQ 80%

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



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

Additional Intelligence in support of continuous improvement

The Trust successfully launched a pilot on Moor Croft Ward at Foss Park for electronic prescribing & medicines administration (EPMA) in June 2023. EPMA will enable more timely prescribing of medication to patients and will reduce the risk of errors. The pilot was well received by the ward team (prescribers and nursing staff) and therefore, we have set an ambitious aim to complete the roll out of EPMA for inpatients prior to the launch of our new patient administration system, Cito; rollout remains dynamic, however, and is adjustable to need.

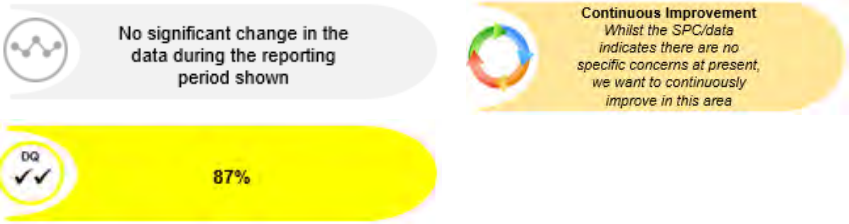
The ambition is the rollout to all inpatient wards within North Yorkshire, York & Selby will be completed by the end of September 2023. As at the 13th September, in addition to Moor Croft, we have successfully put EPMA in place on Esk Ward, Rowan Lea and Springwood. Following successful completion of the rollout in Cross Lane and Foss Park hospitals, plans will be developed to implement EPMA within our Durham, Tees Valley & Forensic services.

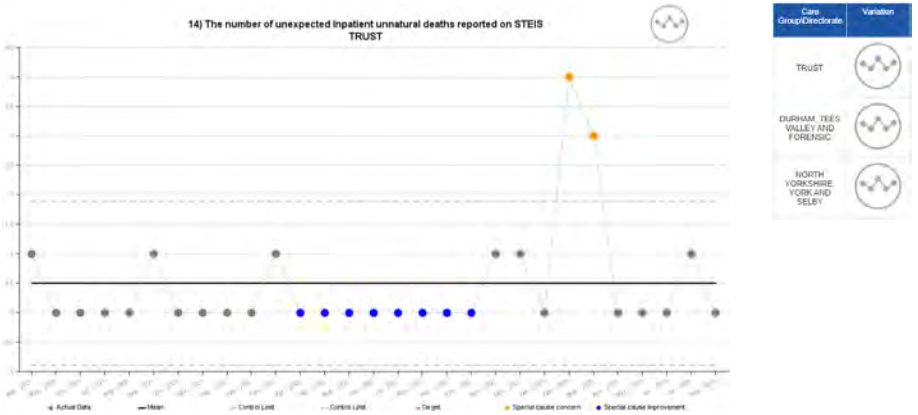
14) The number of unexpected Inpatient unnatural deaths reported on STEIS

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 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 August.





Additional Intelligence in support of continuous improvement

As part of our Advancing Our Journey to Change Programme *reducing suicide and self-harm in inpatient mental health services, the healthcare workforce and non-mental health acute settings* was identified as a priority. The programme prioritised the implementation of a Preventing Suicide Plan Framework that had been developed during 2022, following an engagement exercise on a Trust-wide plan for the prevention of suicide. The Framework contains a series of actions aligned to: Delivering safe care, Working in partnership, Providing support and Always learning.

As at August 2023, we have:

- Assigned a dedicated Suicide & Self-Harm Lead for the Durham, Tees Valley & Forensic Care Group, ensuring that we now have focussed support in both Care Groups.
- Implemented a post incident peer support model that is offered as a standard evidence-based approach to all staff that have been impacted by a critical incident at work, including exposure to suicide.

Work is currently underway to:

- Develop and roll out a “Being with Distress” training plan across all inpatient staff, including non-clinical staff.
- Develop a process for a framework for the delivery of diffusion and post incident peer support.

Our staff have recently teamed up with our colleagues in the South Tees Hospitals NHS Foundation Trust Safeguarding Team at James Cook University Hospital for World Suicide Prevention Day, to raise awareness of services, offer advice and promote positive wellbeing to patients, visitors and staff. A quiet, separate space was also used for those who needed to speak to anyone who needed support.

15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

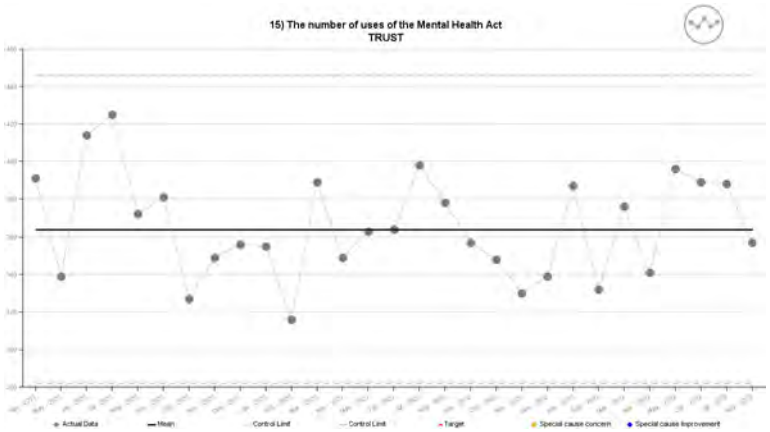
We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers,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

There were **357** uses of the Mental Health Act during August.

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~~ ~~August~~ September 2023 report.	The development of the measure has progressed; however, upon validation of the new logic, some queries were identified that require confirmation from the data owner before the work can be completed. The expectation is that we will complete the development and testing during September 2023.	

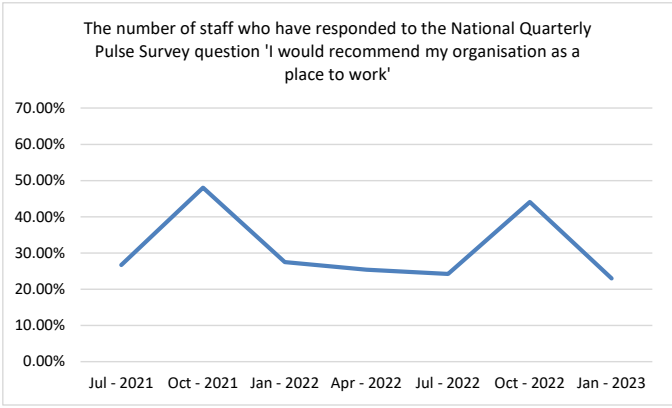
16) Percentage of staff recommending the Trust as a place to work

Tees, Esk and Wear Valleys NHS Foundation Trust

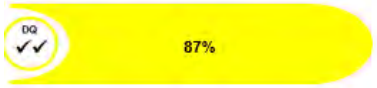
We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise staff recommending the Trust as a place to work is an indication of a high level of job satisfaction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

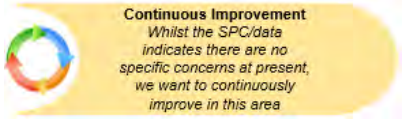
1988 staff responded to the January 2023 Pulse Survey question "I would recommend my organisation as a place to work" Of those, **1104 (55.53%)** responded either "Strongly Agree" or "Agree". ***Please note this is not "new" data as survey is only undertaken once a quarter***

	Jul - 2021	Oct - 2021	Jan - 2022	Apr - 2022	Jul - 2022	Oct - 2022	Jan - 2023
TRUST	54.23%	52.46%	52.54%	55.01%	53.60%	54.05%	55.53%
ASSISTANT CHIEF EXEC	69.23%	60.94%	51.61%	61.29%	47.83%	62.86%	56.00%
DIGITAL AND DATA SERVICES	68.09%	60.50%	70.13%	68.00%	57.65%	60.50%	57.50%
DURHAM, TEES VALLEY AND FORENSIC	51.50%	50.76%	50.72%	54.63%	54.64%	53.42%	55.92%
ESTATES AND FACILITIES MANAGEMENT	57.14%	52.43%	46.92%	50.38%	50.76%	41.95%	46.00%
FINANCE	61.54%	57.41%	62.22%	57.58%	61.54%	46.30%	47.37%
MEDICAL	67.44%	78.95%	68.42%	64.10%	65.71%	63.64%	61.36%
NORTH YORKSHIRE, YORK AND SELBY	50.19%	47.92%	50.48%	52.85%	49.89%	55.21%	55.60%
NURSING AND GOVERNANCE	61.90%	56.31%	53.42%	51.95%	35.14%	49.14%	43.53%
PEOPLE AND CULTURE	69.86%	68.00%	57.69%	56.99%	61.05%	61.34%	52.17%
THERAPIES	82.35%	61.54%	62.96%	54.17%	53.85%	47.06%	67.86%



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 **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%

87%

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

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

National Benchmarking – NHS Staff Survey 2022

The 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

TO NOTE: From April 2023 we have changed the provider that undertakes the Pulse surveys on behalf of the Trust; this has resulted in a delay to reporting the April data. Initial data has now been sourced and we are currently linking in with our data suppliers to review and validate it.

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.	A proposal to use the tool developed by colleagues at York University has been agreed at Executive People Culture & Diversity Group. Plans will now be developed to roll out usage of the tool.	
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.	We are currently awaiting feedback from the Integrated Care Board on the success of the Northumbria pilot approach.	

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

A proposal has been developed to recruit a number of staff survey champions within the Trust. This will presented to the October Healthcare Assistant Professional Council to seek volunteers to champion within Roseberry Park in the initial instance.

A Trust-wide flexible working pilot has been approved in principle and is due to start in October 2023. The proposal includes a number of options and would provide staff with the possibility of working a 5-day week condensed into 4 days or working a 9-day fortnight.

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 01.08.2023	
Enable **100%** of staff to access Foundation training	**15%**	(1162 out of 7603 members of staff)
To have trained **50%** of staff at Intermediate level	**11%**	(860 out of 7603 members of staff)
To have **15%** of staff trained at Leader level	**4%**	(320 out of 7603 members of staff)
To have **1%** of staff trained at Expert level	**0.51%**	(39 out of 7603 members of staff)

The Trust is currently exploring the option to add Foundation training to the mandatory training dashboard for all new applicants. This would ensure that all new starters within the Trust have a Foundation-level understanding of quality improvement and its importance, as they take up their roles.

18) Staff Leaver Rate

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

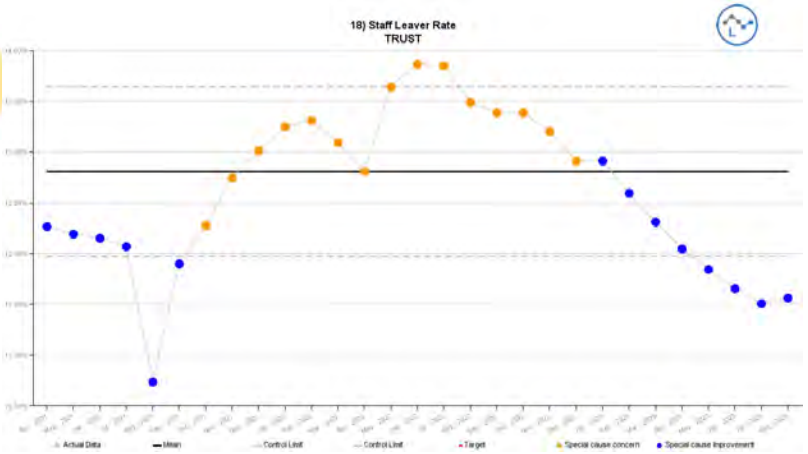
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

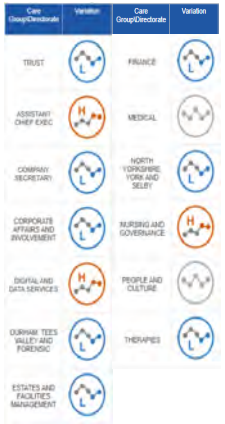
From a total of **6,661.78** staff in post, **770.37 (11.56%)** had left the Trust in the 12 month period ending August.

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

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

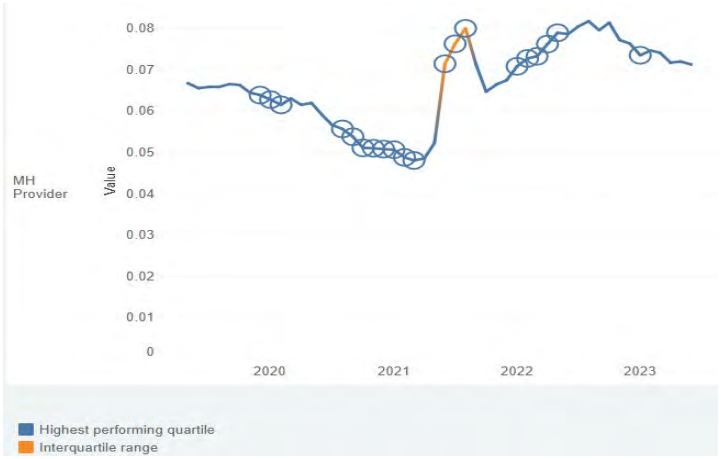
DQ
80%





National Benchmarking: NHS Staff Leaver Rate - England Mental Health and Learning Disability – May 2023 (latest published data)

The NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked 10 of 71 Trusts Mental Health & Learning Disability Trusts (1 being the best with the lowest leaver rate) and are placed in the highest performing quartile range.



18) Staff Leaver Rate

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 ~~July~~ Aug 2023, with a view to improving our staff retention.	**Closed.** This work has been superseded by incorporating Recruitment & Retention as a core focus within the Safer Staffing Group, which is co-chaired by the Deputy Director for People & Culture and the Deputy Chief Nurse. Task & Finish Groups will be established to oversee the work and progress will be monitored through the Trust governance process into the People, Culture & Diversity Committee.	

Additional Intelligence in support of continuous improvement

To improve medical workforce recruitment and retention the Trust has developed a Charter for the Medical Workforce; Trust Leadership will work to ensure the following for the medical workforce:

- effective and tailored job planning;
- a developmental and supportive appraisal process;
- appropriate and sufficient administrative support;
- timely access to personal workspace and suitable equipment;
- effective communication within the Trust, including clarification about professional roles;
- internal professional development programmes for medics;
- support for Trust medics to hold relevant roles in external organisations, example, the Royal College of Psychiatry; and
- sustained, specific efforts to fill vacant medical posts.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

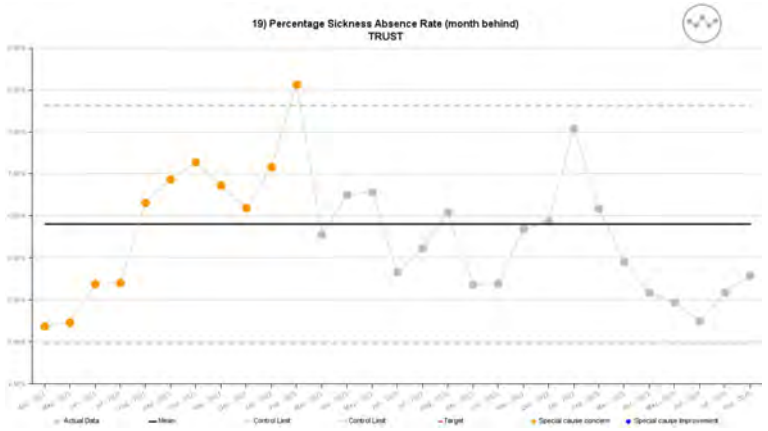
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

There were **226,678.31** working days available for all staff during July (reported month behind); of those, **13,126.36 (5.79%)** days were lost due to sickness.

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%



Page 7

National Benchmarking: NHS Sickness Absence Rates - England Mental Health and Learning Disability – April 2023.

NHS Sickness Absence Rates published 24th August 2023 (data ending April 2023 for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.69% compared to the Trust mean of 6.36%.

Update

As at the 11th September 2023, sickness absence is 5.79% for September 2023.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Additional Intelligence in support of continuous improvement

The Workforce team continue to provide the following with a view to reducing sickness absence, specifically short-term absence :

- Sickness clinics, including 3-month follow up appointments to discuss specific cases
- Training sessions, including refresher training for our band 6s and 7s
- Increased support for teams with staff that have 5 or more sickness episodes
- Focused discussions with managers for those top 5 teams in each specialty with the highest sickness, reviewing all staff with 3 or more episodes.

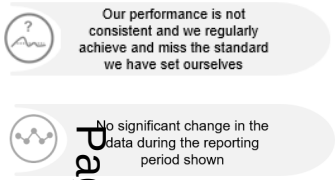
20) Percentage compliance with ALL mandatory and statutory training

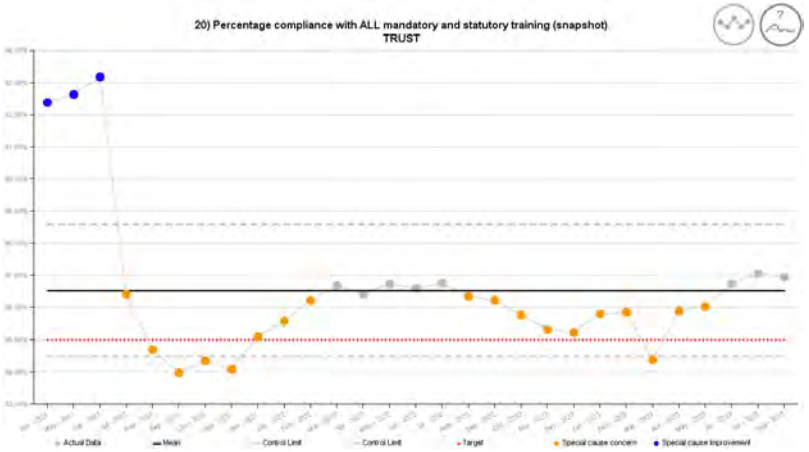
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

138,273 training courses were due to be completed for all staff in post by the end of August. Of those, **120,216** (**86.94%**) 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. An improvement plan is in place with NHS England and this includes an action to agree trajectories with Care Groups and Directorates for when the standard will be achieved. As at end of August, **7645** were due for completion, **6983 (91.44%)** were actually completed.





We recognise that the levels of compliance with our mandatory and statutory training may be impacting on our ability to provide high quality and safe services. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. There are 28 actions currently included within the plan; 13 are due to be completed by the end of September 2023, of which 5 have been completed. Those completed include:

- The recruitment of 2 additional Positive & Safe Care trainers; however, there remains concern that capacity is still insufficient to meet demand.
- The upskilling of 8 Positive & Safe Care trainers to be able to provide Basic Life Support (Resus) training.
- A capacity & demand exercise completed to provide assurance that we have sufficient capacity to deliver Moving & Handling training.

No additional actions were completed to those reported in July.

To Note: a request is currently being processed to expand the scope of the Information Governance training to encompass all staff. This has to date excluded students and volunteers.

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Additional Intelligence in support of continuous improvement

Starting in September 2023, all new starters are being given Information Governance training as part of their Corporate Welcome Days with a view to increasing our compliance.

The Corporate Systems Team have updated the e-learning portal on the Electronic Staff Record, to align the storage of the theory documentation and tests for all mandatory and statutory training. This improves user experience, by providing easier access to all training.

Supporting Information

As at the 11th September 2023, compliance for each of the Trust directorates is as follows:

Directorate	Mandatory & Statutory Training Compliance	
	Trajectory to achieve 85% compliance:	Data as at 11th Sept
Trust	Achieving	86.75%
Assistant Chief Executive	Achieving	94.20%
Capital Programme	Achieving	91.67%
Company Secretary	Achieving	86.84%
Corporate Affairs & Involvement	Achieving	89.46%
Digital & Data Services	Achieving	86.25%
Durham, Tees Valley & Forensic	Achieving	86.94%
Estates & Facilities Management	Achieving	91.47%
Finance	Achieving	92.17%
Medical	Achieving	85.71%
North Yorkshire, York & Selby	Achieving	85.45%
Nursing & Governance	Achieving	85.70%
People & Culture	Achieving	88.37%
Therapies	Achieving	86.38%
Trust-wide roles	Achieving	90.32%

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 **6595** eligible staff in post at the end of August; **5417** (**82.14%**) had an up to date appraisal

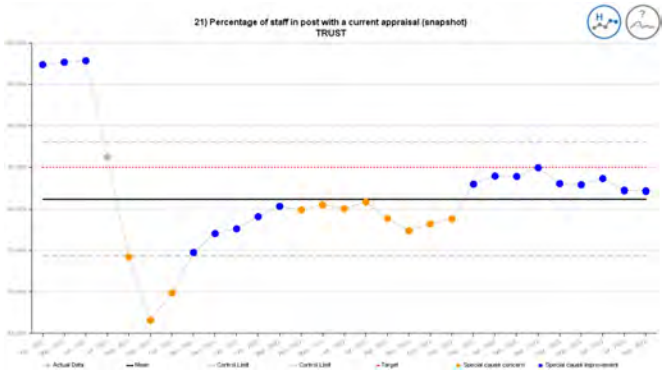
We're aiming to have high performance and we're moving in the right direction.

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

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

DQ

87%



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 13 actions currently included within the plan; 6 are due to be completed by the end of September 2023, of which 2 have been completed and will be continued monthly, these are:

- The running of twice-monthly coffee break sessions to raise awareness and understanding of Workpal.
- Monthly reviews within the Safer Staffing Group to ensure that the Care Groups are supported to release staff for their appraisals.

No additional actions were completed to those reported in July.

Additional Intelligence in support of continuous improvement

Bespoke WorkPal and appraisal training is being provided to Digital & Data Services and Estates & Facilities to improve compliance within those directorates.

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Information

As at the 11th September 2023, compliance for each of the Trust directorates is as follows:

Directorate	Appraisal Compliance	
	Trajectory to achieve 85% compliance:	Data as at 11th Sept
Trust	Not achieving	82.11%
Assistant Chief Executive	Achieving	91.43%
Capital Programme	Trajectory required	83.33%
Company Secretary	Trajectory required	33.33%
Corporate Affairs & Involvement	Trajectory required	67.65%
Digital & Data Services	Trajectory required	73.01%
Durham, Tees Valley & Forensic	Trajectory required	83.27%
Estates & Facilities Management	Trajectory required	83.87%
Finance	Achieving	95.12%
Medical	Achieving	85.94%
North Yorkshire, York & Selby	30 November 2023	79.06%
Nursing & Governance	Achieving	87.50%
People & Culture	31st September 2023	78.68%
Therapies	Trajectory required	83.78%
Trust-wide roles	Trajectory required	80.00%

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

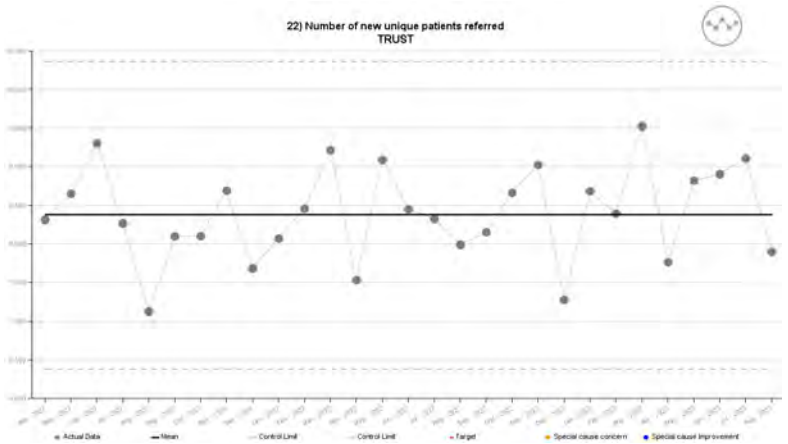
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

7902 patients referred in August 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

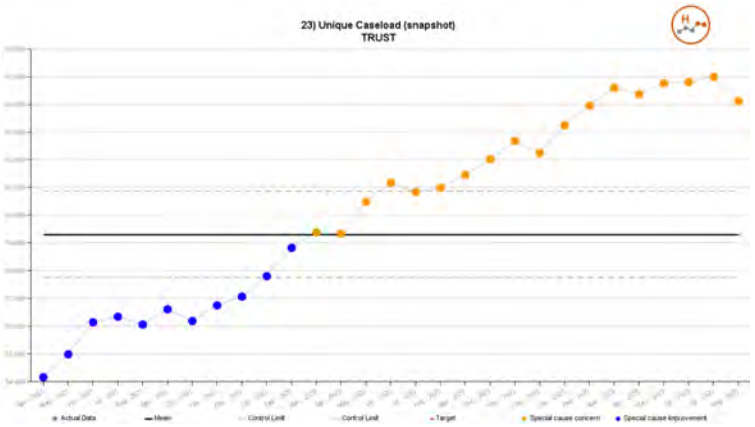
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

64,119 cases were open, including those waiting to be seen, as at the end of August 2023.

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

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

DQ 93%



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

This is a **key area of concern;** 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 34 actions currently included within the plans; 20 are to be completed by the end of September 2023, of which 11 have been completed. Those completed include:

- The recruitment of two additional assessment posts within Durham & Tees Valley Adult Mental Health Planned Care to support patients waiting for and Attention Deficit Hyperactivity Disorder assessment.
- The development of an automated patient tracker list to support the waiting list for patients with an Autism Spectrum Disorder; this is currently being validated.
- The increase of our medic complement within the Ripon Adult Community Team.
- The increase of nursing capacity within our York Memory Team.
- The undertaking of a caseload review within our Harrogate Vanguard Community Care Team.

No additional actions were completed to those reported in July; 2 actions were removed due to duplication within the plan.

Whilst the impact on the Trust measure may not be obvious at this time, we have observed a decreasing (improving) position in North Yorkshire, York & Selby, which is largely being driven by improvements in Adult Mental Health services.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

We delivered a **£4.58m deficit** (to break even) to 31st August 2023 against a planned year to date deficit of **£4.75m,** resulting in a (**£0.17m) favourable** plan variance.

Summary

This is a **key area of concern.**

The financial position at 31st August 2023 is an operational deficit of £4.58m against a planned year to date deficit of £4.75m, resulting in a (£0.17m) favourable plan variance. Two national pressures partly account for the year to date deficit i) underfunding of the nationally negotiated pay award for **Agenda for Change** staff is contributing £0.66m of the year to date position (£1.58m projected 2023/24), ii) defunding of providers for national **Microsoft Licensing** arrangements (with no equivalent compensating cost reduction) is contributing £0.19m to the year to date position (£0.46m projected 2023/24), however there are indications from the ICB that this will be reviewed and restated. These two pressures are offset in part by the revised medical pay award (not yet paid but accounted for in M5 based on national guidance) which is contributing to a reduction to the deficit at M5 of (£0.75m).

• **Agency expenditure** within August 2023 was £1.67m, which is in line with plan, and £8.74m to date, or £0.09m below plan to date. Usage includes material costs linked to inpatient occupancy and rosters, medical cover and reducing costs relating to complex specialist packages of care.

• **Independent sector beds** - the Trust required 190 bed days during August 2023 (232 in July, a 42-bed day reduction) at a cost of £0.22m (including estimates for unvalidated periods of occupancy and average observation levels pending billing). Year to date costs were £1.72m, or £0.99m more than the £0.73m year to date plan. This remains a key area of clinical and management focus including through the Beds Oversight Group including developing a range of forecast scenarios.

• **EFM Building & Engineering Contracts** cost £1.22m to date, or £0.70m more than planned. Costs relate to on-call and vacancy cover (pay surplus of £0.28m YTD as of August 2023). Revised roles, job descriptions / bandings are in recruitment to align pay with regional peers and mitigate these pressures recurrently with structures planned to be operational from Q2 onwards.

• **Taxis and Secure Patient Transport** YTD cost to August 2023 was £1.23m, which was £0.58m more than plan. A recent quality improvement event was held which included grip and control recommendations as well as alternative options. The results of this will be monitored over the coming months.

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 Foundation Trust

Summary

• **Planned CRES** are £1.75m behind plan to date. Key variances relate to independent sector bed pressures for Adult Mental Health, level loading of Inpatient roster to reduce agency costs, review of surge posts and actions to reduce taxi/transport costs. Under achievement of planned CRES is being partly off-set by unplanned CRES delivery of £0.85m to date (including interest receivable). Composite under-achievement of CRES is £0.91m to the end of August 2023.

To deliver the 2023/24 financial plan of breakeven the Trust needs to achieve planned CRES financial targets 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. Key new risks relate to pay award (including ongoing non-Agenda for Change impacts as well as Agenda for change funding gap) and defunding for Microsoft licenses, part offset by the benefit from the revised medical pay award.

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.* *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.*		
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~~ September 2023	Care Group Boards have had oversight and signed off QIA's for relevant CRES schemes with delivery plans in progress.	Greater understanding of differences between Care Group / directorate schemes and schemes from Trust plan.
2023/24 financial forecast to understand likely deliverability of plan	Financial forecasts are being developed in conjunction with Care Group / directorate leads so assess best, worst and likely case scenarios for 2023/24 outturn		

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 Foundation Trust

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.

There are 31 actions within the current Safer Staffing PIP; 3 actions are no longer being progressed. All 11 actions initially identified for completion by the end of September have been delayed, with completion dates distributed between October 2023 and January 2024.

There are 22 actions within the current Agency PIP; 14 are due for completion by September, of which 6 have been completed. Actions completed include:

- Active recruitment to vacant posts and an increase in substantive staff
- Off-framework agency for nursing posts has not been used since April 2023

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

YTD Agency expenditure of £8.74m is **£0.09m (0.95%) below plan**, however NHS planning guidance suggested that ICS agency expenditure should be no more than 3.7% of pay bill, as at M5 the Trust's agency expenditure represented 5.4% of pay bill.

Summary

This is a **key area of concern.**

Agency expenditure for the month of August 2023 was £1.67m, which is in line with plan, and £8.74m year to date, or £0.09m below year-to-date plan. NHS planning guidance suggested that ICS agency expenditure should be no more than 3.7% of their pay bill. As at Month 5 Trust agency expenditure represented 5.4% of pay bill. Planned agency costs for 2023/24 were relatively in line with 2022/23 outturn and remain slightly below plan for quarter 2 of 2023/24 but are 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.

Previous 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 (favourable reductions now being seen) 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.

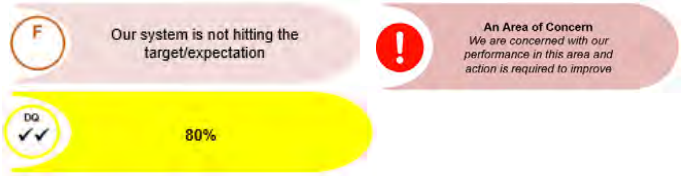
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

25b) Agency price cap compliance

Tees, Esk and Wear Valleys NHS 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 August 2023 there were 4,284 agency shifts worked, with **2,706 shifts compliant (63%).**



Summary

This is a **key area of concern.**

During August 2023 4,284 agency shifts were worked (232 fewer than July). This is equivalent to approximately 138 shifts per day, compared to 146 per day in July.

Of these, 2,706 or 63% shifts were compliant (2,977 compliant shifts or 66% compliance prior month). This is equivalent to approximately 87 compliant shifts per day in August, compared to 96 compliant shifts per day in July.

Of the non-compliant shifts 1,453 or 34% breached price caps (compared to 1,444 shifts and 32% prior month). This is equivalent to approximately 47 price cap breaches per day in August, compared to 47 price cap breaches per day in July.

125 or 3% breached framework and price cap compliance (compared to 95 shifts and 2% prior month). This is equivalent to approximately 4 framework breaches per day in August, compared to 3 framework breaches per day in July.

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. Other key areas of focus include actions to ensure optimal roster efficiency.

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.

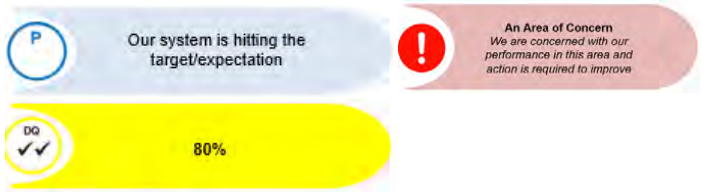
We recognise that agency expenditure is significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

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

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 August 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 0.00x, which is in line with plan and is **rated as a 4** (0.28x behind plan in July).
- 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 20.1 days; this is behind plan by 2.8 days and is **rated as a 1** (3.9 days behind plan in July).
- 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 -2.42%, this is better than plan by 0.10% and is **rated as 4** (0.33% behind plan in July)
- **The agency expenditure metric** assesses agency expenditure against a capped target for the Trust. Costs of £8.74m are £0.84m (0.95%) less than plan, and would be **rated as a 1.** (The agency metric assesses performance against plan) NHS planning guidance suggested that providers agency expenditure should be no more than 3.7% of their pay bill, as at M5 the agency expenditure was 5.4% of 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 August 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.

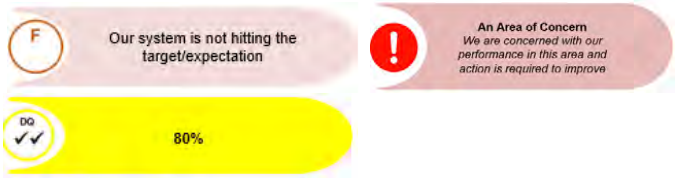
27) CRES Performance - Recurrent

Tees, Esk and Wear Valleys NHS 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 **£4.72m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£2.68m**.

£2.04m deficit to plan.



Summary

This is a **key area of concern.**

The Trust planned to deliver **£4.72m** recurrent Cash-Releasing Efficiency Savings (CRES) to August 2023 but delivered **£2.68m** resulting in **under performance of £2.04m**. 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.

Recurrent CRES delivery for the year is behind plan at Month 5 with specific performance noted as:

- £0.70m under-delivery of CRES for OAPs Reduction in AMH (Performance Improvement Plan in place)
- £0.84m under-delivery of CRES for Surge post review (Pay)
- £0.20m CRES for Agency (Inpatient level loading of rosters – actions in train via sub group of safer staffing group)
- £0.14m CRES for Taxi spend reduction (Improvement Event and associated actions being progressed)
- £0.31m CRES for other schemes
- Recurrent CRES unachieved £2.19m to date mitigated in part by:
- £0.10m CRES delivered (unplanned) Pay Review
- £0.05m CRES delivered (unplanned) EFM Capitalisation of combined heat & power
- Composite recurrent CRES **under delivery** to M5 of **£2.04m**.

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 Foundation Trust

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*	Performance Improvement Plans in place for Agency and OAPs cost reductions. Improvement event progressed for taxis expenditure. Non recurrent mitigations identified to mitigate in-year slippage.	OAPs reduced from 21 (peak) to 1 currently. £0.15m recurrent CRES mitigation Measure 27.

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

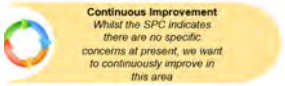
28) CRES Performance – Non-Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

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

We planned to deliver **£0.35m** of non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£1.49m**.

(£1.14m) surplus to plan.



Summary

The Trust planned to deliver **£0.35m** non-recurrent Cash-Releasing Efficiency Savings (CRES) to August 2023 but delivered **£1.49m** resulting in **over performance of (£1.14m)**. The Trust planned to deliver non-recurrent Cash-Releasing Efficiency Savings (CRES) of **£5.38m** for the year with key areas of focus being:

- Individual scheme baseline assessment by Care Group and Directorate, 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.

Non-Recurrent CRES delivery for the year is ahead of plan at Month 5 relating to:

- £0.69m Interest Receivable
- £0.79m Non Recurrent Grip & Control (Non Pay)
- £0.01m Income Contribution

Non-recurrent CRES delivery of (£1.49m) offset by under-delivery of non-recurrent CRES schemes:

- £0.35m Non Rec Grip & Control Trust wide Recovery Actions / budget rebasing (Non Pay)

Composite non-recurrent CRES **over delivery** to M5 of **(£1.14m).**

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

29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys NHS 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 August was **£3.48m** against an allocation of **£7.07m** resulting in a **£3.59m** underspend.

Summary

Capital expenditure at the end of August was £3.48m, and is **£3.59m below** allocated expenditure of £7.07m.

There are several favourable and adverse variances to allocation; however, year to date slippage of £3.59m is mainly linked to previously anticipated costs of 2023/24 schemes which completed in the 2022/23 financial year; and reprofiling of the implementation plan for additional assistive technologies. The Trust is forecasting to outturn in line with allocation at the end of the financial year.

Any delays to planned schemes are communicated to the Environmental Risk Group to manage any associated risks.

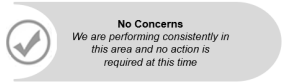
30) Cash balances (actual compared to plan)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

We have an actual cash balance of **£65.64m** against a planned year to date cash balance of **£67.01m.**

£1.42m lower than plan.



Summary

Cash balances were **£65.64m** at 31st August 2023, which is £1.42m lower than planned **£67.01m** balance**.** This is mainly due to accrued income being higher than planned, and unplanned SoFP benefits in the revenue position. These are offset by underspends on capital, and HEE income received in advance of the period it relates to.

The Trust narrowly 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, achieving a combined year to date BPPC of 94.9%. 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 August 2023 was £3.51m, with debts exceeding 90 days amounting to £0.63m (excluding amounts being paid via instalments and PIPS loan repayments).

Four whole government accounting organisations account for 72% of total debts greater than 90 days old (£0.45m), progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged.

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?

Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measures	1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Staff Retention	6. Safety	7. Infrastructure	8. Cyber Security	9. Regulatory Action	10. Influence	11. Governance & Assurance	12. Roseberry Park	13. West Lane	14. CITO	15. Financial Sustainability
BIPD_16	Percentage of staff recommending the Trust as a place to work	√		√	√	√	√			√	√	√				
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√	√	√	√			√	√	√				
BIPD_18	Staff Leaver Rate	√				√	√					√				√
BIPD_19	Percentage Sickness Absence Rate	√	√			√	√			√						√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√		√	√	√	√		√	√		√				√
BIPD_21	Percentage of staff in post with a current appraisal	√			√	√	√			√		√				
BIPD_22	Number of new unique patients referred		√				√					√				√
BIPD_23	Unique Caseload (snapshot)		√			√	√					√				√
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit									√		√				√
BIPD_25a	Financial Plan: Agency expenditure compared to agency target									√		√				√
BIPD_25b	Agency price cap compliance									√		√				√
BIPD_26	Use of Resources Rating - overall score									√		√				√
BIPD_27	CRES Performance - Recurrent									√		√				√
BIPD_28	CRES Performance - Non-Recurrent									√		√				√
BIPD_29	Capital Expenditure (CDEL)							√		√		√	√			√
BIPD_30	Cash balances (actual compared to plan)									√		√	√			√

Chapter 2

Mental Health Priorities including National Quality Standards

Mental Health Priorities including National Quality Standards

Tees, Esk and Wear Valleys NHS Foundation Trust

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

Mental Health Priorities

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

Mental Health Contract Trust Standards	Agreed Standard for 2023/24	Q1	Q2 (Jul - Aug)
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)	1608	773

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.

Mental Health Priorities including National Quality Standards

Tees, Esk and Wear Valleys NHS Foundation Trust

There are 23 actions currently included within the plan; of those 19 are due to be completed by the end of September 2023, of which 12 have been completed.

Additional actions completed to improve our National Quality Standards include:

- A review and subsequent rollout of the Paris guidance to ensure it supports the Durham & Tees Valley Child Eating Disorders services' patient tracker lists.

Additional actions completed to improve our Local Quality Priorities completed include:

- The restructuring of timetables within our Durham & Darlington Talking Therapies teams to ensure our Psychological Wellbeing Practitioners ptovide additional capacity for assessments.
- Targeted Talking Therapies marketing to local businesses within North Yorkshire & York to increase access rates within the area.

County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **3** national quality standards at risk of delivery for quarter 2 (**2** at risk for the financial year) and **3** local priorities at risk of delivery for quarter 2 and the financial year.

NATIONAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 (Jul-Aug)**	**FYTD**
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	60%	63.64%	55.32%	60.18%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	83.82%	83.33%	83.33%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	75.86%	69.23%	69.23%

LOCAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 (Jul-Aug)**	**FYTD**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 12448 Monthly 1037	2662	2060	4722
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	13.92%	11.20%	12.73%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	22.49%	25.61%	24.16%

County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Staff shortages and changes to patient assessors and administration staff within our North Durham Early Intervention in Psychosis (EIP) team have been experienced, which have impacted on the number of patients waiting less than 2 weeks to start a NICE-recommended package of care.	Team Manager to implement a plan to manage the assessment process, including timely monitoring of the patient tracker list, by the end of July 23 with a view to improving the timeliness of patients entering treatment.	**Complete.** Process in place to review the tracker 3 times weekly and a visual flow chart is being developed for staff as a prompt around completion timeframes.	The standard was achieved in August 2023 and we are currently on track to achieve standard in September.

Tees Valley Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **2** national quality standards and **2** local priorities at risk of delivery for quarter 2 and the financial year.

NATIONAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 (Jul-Aug)**	**FYTD**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	91.01%	93.90%	93.90%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	50.00%	50.00%	50.00%

LOCAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 (Jul-Aug)**	**FYTD**
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	19.76%	16.05%	18.18%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	28.57%	27.89%	28.21%

North Yorkshire Sub-ICB Location

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

There are **2** national quality standards and **4** local priorities at risk of delivery for quarter 2 and the financial year.

NATIONAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 (Jul-Aug)**	**FYTD**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	80.00%	80.00%	80.00%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	87.50%	85.71%	85.71%

LOCAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 (Jul-Aug)**	**FYTD**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 8627 Monthly 719	1723	1140	2863
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	17.57%	13.64%	15.83%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	38.24%	37.62%	37.89%
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 71 Q2 142 Q3 213 Q4 284	77	95	95

Vale of York Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **3** national quality standards at risk of delivery for quarter 2 (**2** at risk for the financial year) and **4** local priorities at risk of delivery for quarter 2 and the financial year.

NATIONAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 (Jul-Aug)**	**FYTD**
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	60%	73.33%	58.33%	69.05%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	79.66%	83.93%	83.93%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	71.43%	71.43%	71.43%

LOCAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 (Jul-Aug)**	**FYTD**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 7096 Monthly 591	1495	1077	2572
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	31.15%	26.67%	29.24%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	30.25%	26.40%	28.28%
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 60 Q2 120 Q3 180 Q4 240	37	52	52

Vale of York Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Reduced staffing capacity within the York & Selby EIP team due to vacancies and maternity leave has impacted the team's ability to undertake assessments in a timely manner, to enable a number of patients to commence a NICE approved care package within 14 days.	Service Manager to temporarily redeploy a member of staff from the Harrogate, Hambleton & Richmondshire team to the York & Selby EIP team from the end of September 2023 for a period of 3 months.		
	York and Selby EIP team manager to lead the recruitment for 5 Band 6 clinicians by the end of December 2023, to increase access capacity within the team.	One clinician has been recruited and is due to start in September 2023; the remaining 4 posts are being re-advertised as no suitable candidates applied. Recruitment of agency staff has been considered however, there have been no suitable candidates at this stage.	

For General Release

Meeting of:	**Board of Directors**
Date:	**12th October 2023**
Title:	**Board Integrated Performance Report: Performance Improvement Plan Assessment as at 31st August 2023**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Ashleigh Lyons, Head of Performance**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

Purpose: The Board Integrated Performance Report aims to provide oversight of the quality of services being delivered and to provide assurance to the Board of Directors on the actions being taken to improve performance in the required areas. 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 that we are focussed on the right things, in a timely manner. This report provides an assessment as to when we should see visible impact of these PIPs.

Proposal: It is proposed that the Board of Directors receives this report with **reasonable** assurance that a number of measures are likely to show improvement during quarters 2 and 3 2023/24, but that we have a number of metrics are not likely to show any demonstrable impact until late quarter 4.

Overview: The overall **reasonable** level of assurance has been determined by management and the PIP leads based on target achievement dates within the PIPs and current performance. (*See Appendix A)*

PIPs have been developed and shared with Executive Directors for approval for the following issues that are impacting on performance within

our Integrated Performance Report 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)

Those likely to show improvement during quarters 2 and 3 2023/24 are:

- Bed Pressures including OAPs
- Percentage compliance with ALL mandatory and statutory training
- Caseload
- Agency Expenditure

All other measure are not likely to show any demonstrable impact until late quarter 4.

In addition, Care Groups have developed PIPs for the following mental health priorities:

- Child Eating Disorders 4 week National Standard
- Child Eating Disorders 1 week National Standard
- Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy
- IAPT: Percentage of people who have waited more than 90 days between first and second appointments
- Number of women accessing specialist community PMH services (North Yorkshire & York Care Group only)

Most are likely to show improvement during quarters 2 and 3 2023/24 with the exception of IAPT: Percentage of people who have waited more than 90 days between first and second appointments within our Durham & Darlington services and Number of women accessing specialist community PMH services within our North Yorkshire & York services, where the impact is expected to be during quarter 4.

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 Performance Improvement Plans are updated monthly and 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. Confirm it is assured on the actions being taken to improve performance in the required areas.
3. Discuss whether they consider PIPs appropriate for those measures that are unlikely to show a short- or medium-term impact.

Appendix A

Performance Improvement Plan Impact Assessment

Integrated Performance Report/ Mantal Health Priority Measure	Assessment
01 DTVF Feeling Safe	**Longer term – end of March 2024** All work currently underway is investigative. Key enabling actions will be completed by the end of October; however, improvement actions will then need to be implemented
02 DTVF CYP PROMs	**Longer term – end of March 2024** The key improvement measure is a change to the construction of the measure. However, any change is dependent on the availability of resource due to Cito.
03 NYYS CYP CROMs	**Longer term –** cannot be confirmed at this stage The actions identified within the PIP will support completion of ROMs but that will not necessarily improve our patient outcomes.
04 NYYS Adult & OP Outcomes	**Longer term –** cannot be confirmed at this **stage** The actions identified will support completion of ROMs and the introduction of Cito will include a prompt to ensure that ROMs have been undertaken, but whilst these may increase the number of outcomes measured, they may not improve the outcomes of our patients.
05 DTVF Bed Pressures	**October 2023 – March 2024** Given the actions undertaken to date and those to be completed in the coming weeks, we should start to see an improving position established by October 2023, with continuing improvement as further work is completed with partner agencies.
05 NYYS Bed Pressures	**December 2023 – March 2024** Given the actions undertaken to date and those to be completed in the coming weeks, we should start to see an improving position established by October 2023, with continuing improvement as further work is completed with partner agencies.
06 Trust Training	**September 2023 onwards** With the appointment of additional Positive & Safe Care trainers and 8 Positive & Safe Care trainers now trained to deliver Basic Life Support, we could expect to see some initial improvements by the end of September as staff to come into post and new training is delivered. Improvements should start to become embedded as more actions are completed.
06 DTVF Training	**September 2023 – December 2023** If the actions are completed freeing up extra venues and ensuring staff are released, we should expect to see some initial improvements by the end of September, with these becoming embedded over the next couple of months.
06 NYYS Training	**Medium term** – cannot be confirmed at this stage No dates for completion have been included in the PIP so it is difficult to assess the timescale.
07 Trust Appraisals	**March 2024** Whilst this PIP predominantly increases awareness and promotion; however, given the actions detailed in their individual PIPs we could expect to see some level of improvement from December 2023. Most improvements will be visible from March 2024 as WorkPal becomes fully embedded.
07 DTVF Appraisals	**September 2023 onwards** We should expect to see some improvements from September with these increasing as more appraisals are due/undertaken.
07 NYYS Appraisals	**November 2023 onwards** Whilst no dates for completion are provided, the Care Group view is that we should expect to see some improvements from

	September with these increasing as more appraisals are due/undertaken.
08 DTVF Caseload	**January 2024 onwards** Most actions are due for completion within the next 3 months, but whilst we may see some improvements in quarter 3, it is likely that we will not see any significant improvement until quarter 4.
08 NYYS Caseload	**November 2023 onwards** A number of actions have been completed, particularly in Older Peoples services; however, most actions are due for completion after September. Whilst we may see some early improvements, these should become more evident from November.
09 Safer Staffing	**Medium to long term** – cannot be confirmed at this stage It is difficult to assess when we will start to see improvements as most actions will not be completed until December 2023 or after.
10 Agency Reduction	**October 2023 onwards** Should the actions be completed to schedule, we could expect to see some benefits from October as we reduce costs on agency and implement increased bank usage. It is likely that most benefits will be seen in the medium to long term.
11 DTVF CEDs	**Immediate** The 2 key actions have been completed so it can be expected that we see improvements going forward.
11 NYYS CEDs	**Short team** – cannot be confirmed at this stage The actions have not been completed but when effected, should have an immediate impact.
11 DTVF IAPT	**Access – October 2023 onwards** Whilst we should start to see some improvements within the coming weeks, the key action is marketing the service which is not due to be completed until September. **In-treatment - Medium Term –** cannot be confirmed at this stage The key action requires our trainee cohort to be in post but whilst the numbers have been approved, they are not in post yet. The training plan has been developed but that will take time to disseminate through the teams.
11 NYYS IAPT	**Access - October 2023 onwards** As the increased marketing is completed by the end of September 2023, we could expect to see improvements from October. **In-treatment – October 2023 onwards** With the use of the choose & book tool, we could expect to see some improvements visible from October with more improvements from February 2023 as the new trainees become fully embedded within the teams.
11 NYYS Perinatal	**February 2024 onwards** If all posts are appointed to be the end of December, allowing some time for staff to be trained up we could expect to see improvements from February.

Current Measure Performance

Integrated Performance Report Measure	Issue Level	Expected Improvement*	Trust Performance as at August 2023		
			Standard	Actual	Variation
Percentage of inpatients reporting that they feel safe whilst in our care	DTVF	Mar-24	75%	54.03%	
Percentage of CYP showing measurable improvement following treatment - patient reported	DTVF	Mar-24	35%	24.50%	
Percentage of CYP showing measurable improvement following treatment - clinician reported	NYYS	Long Term tbc	50%	44.15%	
Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	NYYS	Long Term tbc	55%	46.69%	
Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	NYYS	Long Term tbc	30%	19.76%	
Bed Pressures: Bed Occupancy (AMH & MHSOP A & T Wards) & Number of inappropriate OAP bed days for adults that	Trust	Oct-23	-	99.66%	
Percentage compliance with ALL mandatory and statutory training	Trust	Sep-23	85%	86.94%	
Percentage of staff in post with a current appraisal	Trust	Mar-24	85%	82.14%	
Unique Caseload	Trust	Nov-23	-	64,119	
Safe Staffing	Trust	Dec 2023 – Mar 2024	-	-	
Agency	Trust	Oct-23	-	-	

* month indicates when improvements should start to be seen; however, these may become more visible as the actions become embedded

Mental Health Priority Measure	Issue Level	Expected Improvement*	S-ICBL Performance as at August 2023		
			S-ICBL	Standard	Actual
Child Eating Disorders 4 week National Standard	DTVF	Sep-23	County Durham	95%	83.33%
Child Eating Disorders 4 week National Standard	DTVF	Sep-23	Tees Valley	95%	93.90%
Child Eating Disorders 4 week National Standard	NYYS	Short Term tbc	North Yorkshire	95%	80.00%
Child Eating Disorders 4 week National Standard	NYYS	Short Term tbc	Vale of York	95%	83.93%
Child Eating Disorders 1 week National Standard	DTVF	Sep-23	County Durham	95%	69.23%
Child Eating Disorders 1 week National Standard	DTVF	Sep-23	Tees Valley	95%	50.00%
Child Eating Disorders 1 week National Standard	NYYS	Short Term tbc	North Yorkshire	95%	85.71%
Child Eating Disorders 1 week National Standard	NYYS	Short Term tbc	Vale of York	95%	71.43%
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	DTVF	Oct-23	County Durham	5187 (FYTD)	4722
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy (FYTD)	DTVF	Oct-23	Tees Valley	942	965
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy (FYTD)	NYYS	Oct-23	North Yorkshire	3595	2863
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy (FYTD)	NYYS	Oct-23	Vale of York	2957	2572
IAPT: Percentage of people who have waited more than 90 days between first and second appointments	DTVF	Medium Term tbc	County Durham	<10%	11.35%
IAPT: Percentage of people who have waited more than 90 days between first and second appointments	DTVF	Medium Term tbc	Tees Valley	<10%	10.91%
IAPT: Percentage of people who have waited more than 90 days between first and second appointments	NYYS	Oct-23	North Yorkshire	<10%	9.24%
IAPT: Percentage of people who have waited more than 90 days between first and second appointments	NYYS	Oct-23	Vale of York	<10%	19.08%
Number of women accessing specialist community PMH services in the reporting period (cumulative)	NYYS	Feb-24	North Yorkshire	142 (Q2)	95
Number of women accessing specialist community PMH services in the reporting period (cumulative)	NYYS	Feb-24	Vale of York	120 (Q2)	52

* month indicates when improvements should start to be seen; however, these may become more visible as the actions become embedded

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 October 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 September 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 on Monday 25 September 2023 and focused on adult learning disability (ALD) community services and CAMHS extreme behaviours including:

- ALD Systems House, York
- ALD Community, South Tees, Middlesbrough
- ALD Eastfield Clinic, Scarborough
- ALD Alexander House, Knaresborough
- CAMHS Holly Unit, Darlington

3 **Key issues**

- Strengths:
  - Team dynamics: teams reported the strength of positive working relationships and support for each other, and the mix of professional skills, experience and knowledge, including MDT working and the benefits that brought.
  - Person-centred care and culture within teams, making them more responsive to the needs both their patients and family's needs, including physical health needs.
  - Being a great partner: good partnership working internally and externally including with a wide range of health, social services, care providers, voluntary and private providers, and discussions around new and innovative ways of working. Challenges reported in some localities.
- Challenges:
  - Staffing and recruitment highlighted as an area of concern, in different specialisms, including psychology and admin capacity and support (to clinicians).
  - Demand on services particularly following the growth of private care homes, green light admissions and working with care providers to avoid admissions.
  - Cocreation: participation and really involving patients and their loved ones in cocreating their care was raised as an issue, with support requested to help facilitate this.

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 A further strengthened approach to leadership walkabouts is being developed, including an 18-month forward plan, better cocreation with teams on addressing main challenges, and improved reporting and tracking is being implemented. Clarity will also be provided to governors on their role at these visits.

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 25 September 2023.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12 October 2023**
Title:	**Guardian of Safe Working for Postgraduate Medical Trainees**
Executive Sponsor(s):	**Dr Kedar Kale**
Author:	**Dr David Burke – Interim Guardian of Safe Working**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

It is the responsibility of the Guardian of Safe Working to provide quarterly reports and an annual update to the Trust Board for assurance. This report aims to provide assurance that postgraduate doctors are safely rostered and that their working hours are safe and in compliance with their terms and conditions of service.

It is noted that there was no report submitted at the last Board Meeting and this was because of a sudden illness to Dr Jim Boylan, Guardian of Safe Working. We can inform the Board that Dr David Burke has since been appointed as interim Guardian of Safe Working and will cover the role until at least the New Year. As such, Dr Burke is currently undertaking his induction and orientation to the role and so this report is shortened and written with the support of medical development.

The Trustwide Junior Doctor Forum which was scheduled for September was stood down, with postgraduate doctors invited to share feedback at the Postgraduate Training Forum that was held in each Care Group. There were no matters highlighted as concerns and later this week the medical staffing manager will meet with the postgraduate doctors' representatives from each locality, as per normal practice, and will check that this situation remains so.

A notable update since the last Guardian report was the feedback from the 2023 GMC training survey. The national survey gives an illustration of satisfaction levels of postgraduate doctors across all postgraduate grades and specialties, including a new domain that specifically focuses on rota design. The feedback from the GMC survey was excellent and indicated that the Trust was the best performing in the North East and second in the Yorkshire and the Humber area. The Trust sat 17th of all Trust's in the whole of the UK. Specifically in relation to rota design, the Trust scored 73.89, compared to a national average of 56.85, and was higher than both CNTW and LYPFT.

As can be seen in the appendices to this report, there continues to be some exception reports and these will be outlined later in the report.

Recommendations:

The Board are asked to read and note this Quarterly report from the Interim Guardian of Safe Working.

MEETING OF:	**Trust Board**
DATE:	**12th October 2023**
TITLE:	**Quarterly Report by Interim Guardian of Safe Working for Postgraduate Doctors**

1. INTRODUCTION & PURPOSE:

The Board receive Annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for Postgraduate Doctors. This report contains quarterly data in the appendices and includes aggregated data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern. This will provide assurance to the Board and, if needed, ask for approval for action to rectify a safety concern.

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for postgraduate doctors encourages stronger safeguards to prevent doctors working excessive hours and, during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.

The Guardian role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The Guardian is required to levy a fine against a department(s) if a Postgraduate Doctor:

- works on average over 48 hours/week
- works over 72 hours in 7 days
- misses more than 25% of required rest breaks
- when on non-residential on call (NROC) does not have a minimum of continuous rest for 5 hours between 22:00 and 07:00
- does not have the minimum 8 hours total rest per 24 hour NROC shift
- has more than the maximum 13 hour residential shift length
- does not have the minimum 11 hours rest between resident shifts

The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by NHS England.

3. KEY ISSUES:

- **Appendices 1 and 2** provide more details for North (Durham & Teesside) and South (York and North Yorkshire) sectors respectively for the quarter July to September (inclusive) 2023. Within these is a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendices are shared with the corresponding Health Education England body for the different sectors.

- There has been a slight increase in the total number of doctors in training, both in the North and South of the Trust, between Q1 and Q2. The total number of exception reports has remained approximately level in the North between the quarters.

- In the South, there has been an increase from 26 (Q1) to 39 (Q2) exception reports. However, the number for this quarter is similar to those of Q4 last year. Consistent with previous Guardian reports, these have been predominantly in Scarborough (22) where a NROC rota is in place and all exception reports there related to not achieving 5 hours of continuous rest between 10pm – 7am.

- I am satisfied that all exception reports submitted by doctors on the 2016 contract have been actioned. Some submitted at the end of the quarter may still be in the process of review. In terms of timescales, 11% in the North and 59% in the South were addressed within 7 days, with increased work in relation to industrial action being a factor. I have initiated discussions with Medical Staffing to review ways of improving this.

- Guardian fines have been levied to a sum of £4144.28 in the South and £0.00 in the North.

- The internal locum system appears to function well in that there is no reported use of Agency locums on Postgraduate Doctors' rotas. Industrial action has contributed to the number of locum requests across the Trust as indicated in the appendices. In the South there were a number of requests for middle-tier cover on the Scarborough rota (where there is only one LTFT Senior Registrar posted), and in the North there is a similar situation in Durham and Darlington where there is a shortage of participating middle-tier doctors.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour. This report gives evidence of maintenance of these standards.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that postgraduate doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board understands that extra costs will be incurred for additional anti-social hours work and breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to postgraduate doctors is necessary and appropriate.

4.3 Legal and Constitutional (including the NHS Constitution):

The Learning Agreement signed by the Trust with NHS England sets out the expectations on placement providers. The organisation must ensure that the work

schedules in the new contract allow postgraduate doctors to fulfil their curriculum needs within a sound learning environment.

4.4 **Equality and Diversity:**
The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity is therefore invited to the quarterly trustwide Postgraduate Doctor Forum. An Equality Impact Assessment has been completed and is updated within the forum.

The Champion of Less Than Full-time (LTFT) Working is a core member of the Postgraduate Doctor forum and holds an additional forum, network for less than full time doctors. The Medical Directorate is currently seeking to expand the role of the Champion to include LTFT career grade medical staff within its remit.

4.5 **Other implications:**
It is important that our postgraduate doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.

5. RISKS:

There was a concern expressed by a Postgraduate Doctor where they believed they were acting too independently and that this was compounded by career grade vacancies. The Associate Director Medical Education undertook a full review and supportive interventions and offers were made. The matter is now resolved with all parties happy.

Discussions are ongoing to identify an appropriate venue in DTV&F Care Group for postgraduate training and suitable base for doctors. There is a meeting to be held before the next report and a more detailed summary will be provided.

We continue to be mindful of the impact of Covid-19 and emerging variants. There is a risk of this impacting doctors and necessitating sick leave, but there may also be an indirect effect on the workload of doctors if other staff are sick.

6. CONCLUSIONS:
There continues to be a risk of breaches in the two non-residential rotas in the South of the Trust. Introduction of more residential rotas where possible may help to alleviate this. Postgraduate doctors are appropriately submitting exception reports but as mentioned above, we will continue to review how to maintain and improve the efficiency of this process and ensure medical staffing are actioning exception reports in an appropriate and fair way.

A more detailed analysis of the 2023 GMC survey relating to the satisfaction of our postgraduate doctors will be shared in the 2022/23 Medical Education Annual Report.

7. RECOMMENDATIONS:
The Board are asked to read and note this quarterly report from the Guardian of Safe Working.

Author: Dr David Burke
Title: Interim Guardian of Safe Working hours for Postgraduate Doctors

Background Papers:
Appendices 1 & 2: detailed information on numbers, exception reports and locum usage - North and South Care Groups respectively.

Appendix 1 DTV&F (North)

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

High level data

Number of doctors / dentists in training (total): 127
Number of doctors / dentists in training on 2016 TCS (total): 118
Amount of time available in job plan for guardian to do the role: 1 PAs
Admin support provided to the guardian (if any): 4 days per quarter
Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st July 2023 up to 30th September 2023

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

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	2	2	0
Teesside & Forensic Senior Registrars	0	1	1	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	3	3	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	1	1	0
Total	**0**	**7**	**7**	**0**

*F1 exceptions are not included as they do not participate in any out of hours rotas.

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	0	1	1	0
Teesside & Forensic Senior Registrars	0	0	1	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	0	5	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	1	0
Total	**0**	**1**	**8**	**0**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Specialty	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
	0	0	0	0	0

Work schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	0	5	0	0	36.5
	CT1	61	54	0	564.5	512
	CT2			0		
	GP			0		
	CT3	0	1	0	0	4
	Trust Doctor	0	0	0	0	0
	SAS/SR	13	9	0	264	176
North Durham	F2	0	0	0	0	0
	CT1	44	21	0	388.5	128.5
	CT2			0		
	GP			0		
	CT3	0	23	0	0	260
	Trust Doctor	0	0	0	0	0
	SAS/SR	53	48	0	984	888
South Durham	F2	0	0	0	0	0
	CT1	37	27	0	342.5	235.5
	CT2			0		
	GP			0		
	CT3	0	7	0	0	86.5
	Trust Doctor	0	0	0	1	12.5
	SAS/SR	54	53	0	1024	1008
Total		**262**	**248**	**0**	**3568.5**	**3347.5**

*Some SAS/SR shifts were not filled

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	81	74	0	1459	1329
Sickness	10	9	0	48	48
Compassionate / special leave	2	2	0	12	12
On call cover	169	163	0	2049.5	1974.5
Increase in workload	0	0	0	0	0
Total	**262**	**248**	**0**	**3568.5**	**3347.5**

*A number of the vacant shifts are on the middle tier rotas in Durham and Darlington due to lack of higher grade trainees/SAS doctors participating.
On call cover can refer to shifts from those who have come off the rota (due to mat leave/ pregnancy/OH restrictions) or to cover those taking industrial action (patchwork doesn't have a separate element yet)

Vacancies

Vacancies by month						
Locality	**Grade**	**Month 1**	**Month 2**	**Month 3**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	1	0	0	0.33	0
	F2	0	0	0	0	0
	CT1	2	0	0	0.66	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	1	1	0.66	0
	Trust Doctor	0	0	0	0	0
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
South Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0

	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**3**	**1**	**1**	**1.6**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	0	£00.00
North Durham	0	£00.00
South Durham	0	£00.00
Total	**0**	**£00.00**

*Due to NROC dates, some fines may not have been reported yet.

Appendix 2 NYY&S (South)

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

High level data

Number of doctors / dentists in training (total): 83
Number of doctors / dentists in training on 2016 TCS (total): 76
Amount of time available in job plan for guardian to do the role: 1 PAs
Admin support provided to the guardian (if any): 4 days per quarter
Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st July 2023 up to 30th September 2023

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

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Total	**0**	**39**	**39**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	4	4	0
Harrogate	0	1	1	0
Scarborough	0	22	22	0
York	0	12	12	0
Total	**0**	**39**	**39**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Northallerton	1	0	3	0
Harrogate	0	1	0	0
Scarborough	7	7	8	0
York	2	5	5	0

The last NROC monitoring period ended in late September and as yet the monitoring forms have not been checked. It is likely that there will be additional exception reports submitted in October to reflect the additional hours worked.

All of the exceptions raised by Scarborough junior doctors are due to not achieving 5 hours continuous rest between 10pm – 7am.

The majority of exceptions from the Northallerton, Harrogate and York Senior Registrars are due to not achieving 5 hours continuous rest during the night as a result of attending Mental Health Act Assessments.

Work Schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Northallerton/ Harrogate/ York	F2	19	19	0	276	276
	CT1/2/GP	40	40	0	429.75	429.75
	CT3	2	2	0	20	20
	Trust Doctor	1	1	0	12.5	12.5
	ST4-6/SAS	15	15	0	272	272
Scarborough	F2	7	7	0	128	128
	CT1/2/GP	22	22	0	356	356
	CT3	3	3	0	56	56
	Trust Doctor	0	0	0	0	0
	ST4-6/ SAS	88	87	0	1632	1616
Total		**197**	**196**	**0**	**3182.25**	**3166.25**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	77	76	0	1345	1329
Sickness	14	14	0	220	220
Increase in workload	0	0	0	0	0
Other	106	106	0	1617.25	1617.25
Total	**197**	**196**	**0**	**3182.25**	**3166.25**

A high number of the locum bookings in "Other" are as a result of the on-call doctor taking industrial action during this quarter. The majority of locum bookings in "Vacancy" are due to locum cover being provided each night on the Scarborough Senior Registrar rota – there is only one Senior Registrar on this rota (0.8 wte).

Vacancies

Vacancies by month						
Locality	**Grade**	**July 2023**	**August 2023**	**September 2023**	**Total gaps (average)**	**Number of shifts uncovered**
Northallerton/ Harrogate/ York	F1	1	0	0	0.33	0
	F2	0	0	0	0	0
	CT1/2/GP	2	3	3	2.66	0
	CT3	0	0	0	0	0
	ST4 -6	2	5	5	4	0
	Trust Doctor	0	0	0	0	0
Scarborough	F1	1	0	0	0.33	0
	F2	0	0	0	0	0
	CT1/2/GP	1	0	0	0.33	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**7**	**8**	**8**	**7.65**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Harrogate & Northallerton	0	£00.00
Scarborough	6	£1977.98
York & Selby	6	£2166.3
Total	**12**	**£4144.28**

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**12th October 2023**
Title:	**WRES WDES SOWES & Publication of Staff Equality Information**
Executive Sponsor(s):	**Sarah Dexter- Smith, Director of People and Culture**
Author(s):	**Lisa Cole, Voluntary Services and EDIHR Manager & Sarah Dallal, Equality, Diversity, Inclusion and Human Rights & Voluntary Services Lead.**

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	**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 experience of our staff who share one or more protected characteristics is an important indicator of the culture of our organisation, as well as reflecting the experience of each specific group. As well as being important ethically, these play a key part in our efforts to retain staff through ensuring they have a good experience whilst employed in TEWV.
4	**Experience**	

Executive Summary:

Purpose:

This paper provides assurance that the Trust adheres to the NHS Standard Contract, undertaking the WRES and WDES data collection and publishing the results and associated action plans. Publishing staff equality data also helps to meet the obligations under the Public Sector Equality Duty of the Equality Act 2010 to:

- Have due regard to the need to eliminate discrimination, harassment, and victimisation.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between those who share protected characteristics and those who do not.

The Trust is required to publish its latest WRES and WDES action plans by 31st October 2023 following ratification by the Board of Directors. The SOWES is not mandatory but helps the Trust to identify and address any inequalities experienced by LGB staff.

Information relating to service users is published separately.

The data and action plans in this paper supports the Trust's Journey to Change commitment.

The documents presented are:

- 2023 WRES (Workforce Race Equality Standard) data and action plan
- 2023 WDES (Workforce Disability Equality Standard) data and action plan
- 2023 SOWES (Sexual Orientation Workforce Equality Standard) data and action plan
- The 2023 Publication of Information (staff)
- The Model Employer trajectory update

A more detailed document is attached to this report including WRES, WDES and SOWES data and action plans and the publication of staff equality information data report – Appendix 2.

The Human Rights, Equality, Diversity, Inclusion Policy must be reviewed at board level each year in line with the MHA code of practice. This is also attached for the Boards consideration – Appendix 3.

Proposal:

The paper proposes that there is good assurance that the Trust has followed a robust process in analysing its staff data by protected group and that the actions provide a clear response to the concerns raised. In doing so it is meeting its NHS Standard Contract requirements, Equality Act duties and supports the Trust's Journey to change.

Overview:

The proposal for good assurance is based on the information in the appendix which demonstrates that a robust analysis has been carried out on WRES data, WDES data and equality data for staff from other protected characteristic groups.

It is important to recognise how the data and action plans supports Our People Journey to Change commitment. The Trust continues to create a compassionate and inclusive culture whereby all staff, including those from protected characteristic groups, can bring their whole self to work, feel safe at work, feel valued and share ideas and concerns and trust they will be listened to. The information in this paper ensure we are working towards having a workforce which represents the communities we serve.

Areas of progress

BAME staff and staff with disabilities are no more likely to enter the Trust's formal disciplinary and capability processes than their colleagues; this remains a positive continuation from previous year's data.

Staff are increasingly declaring their protected characteristics which is encouraging and suggests an increasing confidence in the organisation. BAME staff 5.9% compared to 5.1% last year, staff with disabilities 7.9% compared to 6.6% last year, LGB staff 4.2% compared to 3.9% last year.

Similarly, the Board's demographic data completeness has improved, 94.5% data complete. This is important both to understand the diversity of the board and to model the importance of sharing this information. It has also enabled us to have more transparent conversations with networks and other colleagues about the shared experiences of board members at a group level.

Ongoing work

The centralised reasonable adjustments team is now in place, supporting staff to access adjustments in a more timely manner as well as supporting the organisation to recoup some of the costs

The first long term health conditions reverse mentoring programme is being delivered, building on the success of the BAME reciprocal mentoring programmes.

The first mid-career programme, for staff from protected characteristic groups, was delivered. This has had a positive impact on participants from protected characteristic groups.

The staff networks continue to grow and members report feeling that these are a positive way to engage with the organisation.

Concerns

There are number of immediate concerns and actions to address these are in place and will be closely monitored - see Appendix 1.

- White people are 1.83 times more likely to be appointed from shortlisting compared to BAME people; this is higher than in previous years.
- We are meeting our trajectory targets for all bands 8a and above except for band 8c. this is likely to be linked in part to the restructure which removed a disproportionate number of 8c roles.
- BAME staff, staff with long term health conditions (LTHC) and Lesbian, Gay, and Bisexual (LGB) staff all report higher levels of bullying, harassment, abuse and discrimination compared to other colleagues.
  From patient's relatives or public: White 22.6%, BAME 35.6%, Long Term Health Condition 26.7%, without Long Term Health Condition 21.4%, Gay/Lesbian 27.8%, Bisexual 28.2%, Heterosexual 22.7%.
  From staff: White 17.1%, BAME 19.3%, Long Term Health Condition 18.8%, without Long Term Health Condition 11.2%, Gay/Lesbian 17.7%, Bisexual 12.7%, Heterosexual 13.1%.
  Discrimination from manager/colleagues: White 5.2%, BAME 9%, Long Term Health Condition 8.5%, without Long Term Health Condition 3.8%, Gay/Lesbian 9.3%, Bisexual 7%, Heterosexual 5.1%.
- The percentage of staff with a disability saying that their employer has made adequate adjustment(s) to enable them to carry out their work was 75.8%. This has increased from

last year's 72% but still shows that 24.2% of people who require workplace adjustments do not have these in place.

- Staff with long term health conditions report they are less likely than staff without long term health conditions to report having equal opportunities for career progression or promotion (LTHC 57.3%, without LTHC 65.3%), they are less satisfied with the extent that the organisation values their work (LTHC 41.5% without LTHC 49.1%), and they are less engaged than non-disabled staff (LTHC 6.5 engagement score, without LTHC 7 engagement score).
- LGB staff (1.65 times more likely than heterosexual staff), male staff (2.18 times more likely than women) and staff aged 16-24 (1.7 times more likely than other age groups) are more likely to enter disciplinary processes than other staff.
- This year 11 staff members responded to the staff survey identified as 'sex not the same as assigned at birth'. The data showed that staff who identified in this way experienced higher levels of abuse, harassment, or discrimination than the other protected characteristic groups.

Actions against all of these concerns are outlined in Appendix 1.

The full detail is presented in Appendix 2

Human Rights, Equality, Diversity, Inclusion Policy

The Human Rights, Equality, Diversity, Inclusion Policy is also due for annual review by board. This is presented in Appendix 3.

The Policy sets out how the Trust complies with applicable human rights and equality legislation. It outlines the roles and responsibilities of everyone in the Trust regarding the policy and how this policy will be implemented in practice.

There have been minor changes made to the policy, the changes consist of updating the Equality, Diversity and Human Rights team name to include "Inclusion" and adding "other gender identities" to the LGBTQ+ definition.

Prior Consideration and Feedback

The development of the data has been undertaken by the Trust's Business Analytics and Clinical Outcomes Information Department and the Equality, Diversity, Inclusion and Human Rights Team. Staff networks have been involved in the development of the WRES, WDES and SOWES actions plans, through consultation events.

A version of this report has been to the People, Culture and Diversity Committee, the Executive People, Culture and Diversity subgroup and JCC.

Implications:

Failure to undertake the WRES and WDES or understand the differences in outcomes and experiences of our staff from protected

groups in accordance with the Public Sector Equality Duties and the NHS Standard Contract may have regulatory and reputational consequences.

Failure to act to reduce differences in outcomes and experiences of our staff from protected groups may impact on the ability of the Trust to recruit and retain staff.

Recommendations: The Board is recommended to
1. confirm that it has good assurance that a robust process has been undertaken when developing the attached data and actions and that the actions are appropriate.
2. approve the data for publication.

Appendix 1
Areas of concern and actions

Indicator 2 on the WRES show that White people are 1.83 times more likely to be appointed from shortlisting compared to BAME people; this is higher than in previous years.
Actions:

- Pilot the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process. Measure the diversity of successful candidates, evaluate feedback from panel members and applicants.
- Develop action plan from the NHS England, Widening Access Programme, including actions to increase the diversity of staff.
- Advertise the Steps Towards Employment Programme (STEP) within the BAME communities.
- Develop Equality & Recruitment information for panel members.

The Model Employer Trajectory rates show that we are meeting our trajectory targets for all bands 8a and above except for band 8c.
Actions:

- Deliver a staff mid-career leadership programme for staff from protected characteristics.

BAME staff, staff with disabilities and LGB staff all report higher levels of bullying, harassment, abuse and discrimination compared to other colleagues. This is an area that remains a concern for the organisation.
Actions:

- Development of the violence reduction strategy.
- Promote and participate in the stand up to bullying campaign.
- Promote staff networks, continuing to develop safe spaces for staff.
- Work with Care Groups to develop localised action plans to address harassment, bullying and discrimination.
- Update EDI training to include upstanding and how to address discrimination.
- Piloting Kind Life (creating a kinder and safer culture).
- Work with Unison as part of their focus this year on supporting Black colleagues

The percentage of staff with a disability saying that their employer has made adequate adjustment(s) to enable them to carry out their work was 75.8%, this has increased from last year's 72%. However, this still shows that 24.2% of people who require workplace adjustments do not have these in place.
Actions:

- Reasonable adjustment centralised team pilot – ensuring staff are able to access adjustments in a timely manner.
- Managers training and resources on reasonable adjustments.
- Increase the number of staff with individual workplace adjustment plans and central recording of adjustments.

Staff with disabilities are reporting the are less likely than non-disabled staff to believe they have equal opportunities for career progression or promotion, they are less satisfied with the extent that the organisation values their work, and they are less engaged than non-disabled staff.
Actions:

- Deliver a staff mid-career leadership programme for staff from protected characteristics.
- Evaluate the Long-Term Health Conditions reverse mentoring programme.

- Reasonable adjustment centralised team pilot – ensuring staff can access adjustments in a timely manner.
- Managers training and resources on reasonable adjustments.

LGB staff, male staff and staff aged 16-20 are more likely to enter disciplinary processes than other staff.

Actions:

- To explore how the PAG process prior to disciplinary processes can be improved to ensure EDI input in relevant cases.

15% of staff have not declared if they have a disability or not and 10% of staff have not declared their sexual orientation, this has improved since last year however this still means the Trust does not have reliable data to fully understand the experiences of staff.

Action:

- Carry out targeted data completeness campaigns with specific protected characteristic groups, involving staff networks.

This year 11 staff members who responded to the staff survey identified as sex not the same as assigned at birth. The data showed that staff who identified in this way experienced higher levels of abuse, harassment, or discrimination than the other protected characteristic groups.

Action:

- Work with the rainbow network to further understand the experiences of staff who identify as sex not the same as assigned at birth.

Appendix 2

Detail of the measures - separate document

Appendix 3

Human Rights, Equality, Diversity, Inclusion Policy

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FOR GENERAL RELEASE/CONFIDENTIAL

Board of Directors: EDI item, October 2023

Appendix 2: 2023 WRES, WDES, SOWES & Publication of Staff Equality Information appendix

1. WRES data (including Model Employer trajectory update)
2. WRES action plan 2023/24
3. WDES data
4. WDES action plan 2023/24
5. SOWES data
6. SOWES action plan 2023/24
7. Publication of staff equality information 2023

Tees, Esk and Wear Valleys
NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD

2022/2023

	1. Background narrative a. Any issues of completeness of data
	The Pulse survey does not include a question about CPD and non-mandatory training as the staff FFT did therefore information from the staff survey has been used for indicator 4.
	b. Any matters relating to reliability of comparisons with previous years
	2. Total numbers of staff a. Employed within this organisation at the date of the report
	7927 (data from 31st March 2023)
	b. Proportion of BME staff employed within this organisation at the date of the report
	5.9%
	3. Self-reporting a. The proportion of total staff who have self-reported their ethnicity
	99%
	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity
	No
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity
	The level of self-reporting is very high.
	4. Workforce data a. What period does the organisation's workforce data refer to
	Data as of 31st March 2023
	5. Are there any other factors or data which should be taken into consideration in assessing progress?
	6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

KEY:

Green = Improvement from the previous year
Amber = Remains the same or similar to previous year
Red = Decline from previous year

WORKFORCE RACE EQUALITY STANDARD

	Indicator	Data 2023	Data for 2022	Data for 2021	Data for 2020, 2019, 2018, 2017	Narrative – the implications of the data and any additional background explanatory narrative
	For each of these four workforce indicators, compare the data for White and BME staff.					
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.	Please see appendix 1 for 2022/23 data.				There is an increase in the % of BAME staff within the trust from 5.1% (387 staff members) in 2022 to 5.9% (467 staff members) in 2023. The percentage of BAME staff in the trust is still affected by the large numbers of medical staff who are from BAME backgrounds. 2023 data shows that there were 20 BAME staff in bands 8a to VSM compared to 18 in 2022.

						In order to meet the Model Employer Trajectory rates (Appendix 2), we need an addition BAME staff member in band 8c. We are meeting or exceeding the trajectories in the other bands
2	Relative likelihood of staff being appointed from shortlisting across all posts.	White people are **1.83 times more likely** to be appointed from shortlisting compared to BAME people.	White people are **1.38 times more likely** to be appointed from shortlisting compared to BAME people.	White people are 1.71 times more likely to be appointed from shortlisting compared to BAME people.	White people are: 2020 = 1.56 2019 = 1.7 2018 = 1.6 2017 = 1.3 2016 = 1.4 more likely to be appointed from shortlisting compared to BAME people.	There has been an increase in the likelihood of white people being appointed for shortlisting compared to BAME people. This is the worse result since beginning to report in 2016.
3.	Relative likelihood of staff entering the formal disciplinary process, as	BAME staff are **1.03 times more likely** to enter the formal	BAME staff are **0.78 times more likely** to enter the formal	BAME staff are 0.76 times more likely to enter	BAME staff are 2020 = 0.81 2019 = 1.62 2018 = 2.59	BAME staff are similarly likely to enter disciplinary processes compared to white staff.

	measured by entry into a formal disciplinary investigation. This indicator will be based on data from last two year rolling average of the current year and the previous year.	disciplinary process than white staff	disciplinary process than white staff (this means they are less likely to enter disciplinary processes.)	the formal disciplinary process than white staff. (this means they are less likely to enter disciplinary processes.)	2017 = 2.08 2016 = 2.03 more likely to enter the formal disciplinary process than white staff.	
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	White staff are **less likely** (0.8) to report that they have access to the right learning and development opportunities when they need to.	White staff are **less likely** (0.9) to report that they have access to the right learning and development opportunities when they need to.	White staff are 1.1 more likely to access non-mandatory training and CPD compared to BAME staff.	White staff are 2020 = 1.1 2019 = 1.3 2018 = 1.2 2017 = 1.15 2016 = 0.86 more likely to access non-mandatory training and CPD compared to BAME staff.	This indicator has been taken from a response to the staff survey Q20e due to the new Pulse survey not including a relevant question.
	National NHS Staff Survey indicators (or equivalent). For each of the four staff survey indicators, <u>compare the outcomes of the responses for White and BAME staff</u>.					
5.	Percentage of staff experiencing	**White: 22.6%** **BAME: 35.6%**	**White: 24%**	White: 24%	2020 = White: 29%	There has been an increase in the % of BAME staff reporting

	harassment, bullying or abuse from patients, relatives or the public in last 12 months.		**BAME: 32%**	BAME: 29%	BAME: 32% 2019 = White: 27% BAME: 32% 2018 = White: 28% BAME: 34% 2017 = White: 28% BAME: 37% 2016 = White: 21% BAME: 27%	that they have experienced harassment, bullying, bullying or abuse from patients, relatives or the public. The gap between white staff and BAME has increased this year to 13%.
6.	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	**White: 17.1%** **BAME: 19.3%**	**White: 18%** **BAME: 21%**	White: 20% BAME: 25%	2020 = White: 21% BAME: 25% 2019 = White: 20% BAME: 24% 2018= White: 19% BAME: 29% 2017 = White: 17% BAME: 19% 2016 = White: 14% BAME: 36%	There has been a decrease in this indicator for both BAME and white staff. There continues to be a gap between BAME and white staff's experience of bullying, harassment and abuse from staff, with BAME staff being more likely to experience this.

7.	Percentage believing that Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?	**White: 62.7%** **BAME: 65.3%**	**White: 61%** **BAME: 60%**	2020 results White: 64% BAME: 53.9%	2019 = White: 59% BAME: 59% 2018 = White: 69% BAME: 53% 2017 = White: 68% BAME: 60% 2016 = no data	BAME staff a more likely to believe the trust provides equal opportunities for career progression or promotion.
8	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	**White: 5.2%** **BAME: 9%**	**White: 6%** **BAME: 10%**	White: 6% BAME: 15%	2020 = White: 5% BAME: 14% 2019 = White: 5% BAME: 7% 2018 = White: 6% BAME: 18% 2017 = White: 5% BAME: 3%	The % of staff reporting discrimination at work from managers/team leaders or other colleagues has decreased. However there is still between BAME staff and white staff's experiences, with BAME staff more likely to report this.

					2016 = no data	
9.	Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce	Percentage difference between organisations boards voting membership and its overall workforce is **+ 5.1%** Percentage difference between organisations boards voting membership and its overall workforce is **+ 8.4%** Percentage difference between organisations board executive membership and its overall workforce is **+ 4.1%**	Percentage difference between organisations boards voting membership and its overall workforce is **+ 4%** Percentage difference between organisations board executive membership and its overall workforce is **-5.1%**	Percentage difference between organisations boards voting membership and its overall workforce is + 12% Percentage difference between organisations board executive membership and its overall workforce is + 9%	Percentage difference between organisations boards voting membership and its overall workforce is 2020 = + 11% (voting) + 10% (exec) 2019 = + 4% 2018 = +8.5% 2017 = not available 2016 = not available Percentage difference between organisations board executive membership and its overall workforce is 2019 = + 8.5% 2018 = not available 2017 = not available 2016 = not available	This data shows that the trust board has some BAME representation.

APPENDIX 1

DETAILED STAFF BREAKDOWN RACE 31st March 2023

	Clinical Staff %		
Band	**White**	**BAME**	**Not Declared**
1-4	92% (1741)	7% (125)	2% (31)
5-7	94% (3169)	5% (160)	1% (34)
8ab	95% (336)	5% (16)	0% (0)
8cd	100% (108)	0% (0)	0% (0)
9	100% (5)	0% (0)	0% (0)
VSM	75% (3)	0% (0)	25% (1)
Medics	52% (137)	39% (102)	9% (24)
	Non-clinical staff %		
Band	**White**	**BAME**	**Not Declared**
1-4	96% (1351)	3% (37)	1% (14)
5-7	95% (364)	5% (20)	0% (1)
8ab	98% (101)	2% (2)	0% (0)
8cd	93% (28)	3% (1)	3% (1)
9	2 (100%)	0	0
VSM	94% (16)	6% (1)	0% (0)

DETAILED STAFF BREAKDOWN RACE 31st March 2022

	Clinical Staff %		
Band	**White**	**BAME**	**Not Declared**
1-4	96% (1708)	4% (80)	(15)
5-7	96% (3080)	4% (132)	(30)
8ab	96% (306)	4% (13)	(0)
8cd	99% (110)	1% (1)	(0)
9	100% (1)	0% (0)	(0)
VSM	0	0	0
Medics	53% (141)	41% (107)	6% (15)
	Non-clinical staff %		
Band	**White**	**BAME**	**Not Declared**
1-4	98% (1333)	2% (33)	(12)
5-7	95% (350)	5% (17)	(2)
8ab	97% (87)	3% (3)	(1)
8cd	96% (22)	4% (1)	(1)
9	0	0	0
VSM	100% (20)	0	0

APPENDIX 2

Model Employer 2023

The Model Employer trajectories set aspirational goals for each organisation to increase BAME representation at leadership levels.

	Proportion of BAME workforce (as 31st March 2018)	Proportion of BAME workforce (as 31st March 2019)	Proportion of BAME workforce (as 30th November 2020)	Proportion of BAME workforce (as 31st March 2021)	Proportion of BAME workforce (as 31st March 2022)	Proportion of BAME workforce (as 31st March 2023)	Trajectory for 2023	Additional recruitment over next 5 years	Total BAME staff by 2028 to reach equity
Band 8a	6	9	9	9	14	13	8	0	10
Band 8b	0	2	2	2	2	5	2	0	4
Band 8c	1	1	2	1	1	1	2	3	4
Band 8d	0	0	0	1	1	0	0	1	1
Band 9	0	0	0	0	0	0	0	0	0
VSM	0	0	1	1	0	1	0	0	1

Orange no change since 2022	Orange same as 2023 trajectory
Green increase since 2022	Green above 2023 trajectory
Red decrease since 2022	Red below 2023 trajectory

WRES Action Plan 2023

ACTIONS: Please specify which actions are different to current practice, and which are continuation	*Person who is responsible for overseeing the action*	*Please specify KPIs and timelines for monitoring the actions*	*How will actions be made sustainable*	*Governance*
1. New - Deliver a second mid-career programme, for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Promote this programme to the BAME staff network and using Trust communication channels. Evaluate programme.	Sarah Dallal	**Q4 2023/24** - WRES workforce data, evaluation from participants (post programme, 6 months, 1 year)	Integrated into the participants personal development plan, post evaluation, managers approve application to the programme.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
2. New - Undertake further analysis of data to understand the data on career progression in non-clinical roles (lower to middle levels). Understanding the current roles of these staff and the areas that they work. Work with the BAME staff network to understand if there are barriers for progression in these areas.	Lisa Cole	**Q3 2023/24 -** Analysis of the 45 BAME staff member that work in non clinical roles bands 2-5. Survey/feedback from these staff regarding barriers for progression. Recommendations developed to improve.	An action plan will be developed to address the career progression of non clinical staff in lower bands. The EDI team will work in conjunction with non clinical leadership teams.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

1. Continuation - Pilot the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process. Measure the diversity of successful candidates, evaluate feedback from panel members and applicants.	Sarah Dallal	**Q4 2023/24** - 650 Interviews to be involved in the pilot. Evaluation of the pilot. WRES recruitment and workforce data.	A full evaluation of the pilot and recommendations for the organisation. Working in conjunction with recruitment team and services.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
2. New - Develop an action plan from the NHS England, Widening Access Programme, including actions to increase the diversity of staff and hyperlocal recruitment.	Lisa Cole	**Q4 2023/24** - Action plan approved, actions allocated to appropriate team, WRES recruitment and workforce data.	Sponsorship from the Director of People & Culture.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
3. New - Promote the Steps Towards Employment Programme (STEP) within the local BAME communities.	Lisa Cole	**Q3 2023/24** - Increased attendance from BAME participants, Increased number of BAME volunteers, WRES recruitment and workforce data.	Links will be made with BAME communities and all future programmes will be promoted using this network.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
4. New - Hold a stall at Middlesbrough MELA (multi cultural event), including information about working in the organisation, STEP and current vacancies.	Lisa Cole & Abby Holder	**Q2 2023/24 -** WRES recruitment and workforce data.	The event will provide an opportunity to develop networks in the community. Attending future events.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

5. New - Develop Equality & Recruitment information for panel members	Lisa Cole	**Q3 2023/24 -** Information included in all recruitment packs**.** WRES recruitment and workforce data.	Explore with the recruitment team where this document would be most effective to ensure all panel members refresh their knowledge before the interview.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
1. Ongoing - Equality, Diversity & Inclusion and Human Rights Team to attend all PAG (preliminary assessment group) meetings involving BAME staff.	EDIHR Team	**Ongoing -** WRES disciplinary data, feedback from the BAME staff network.	This is an established practice that is embedded in the process.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
1. New - Deliver a second mid-career programme, for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Promote this programme to the BAME staff network and using Trust communication channels. Evaluate programme.	Sarah Dallal	**Q4 2023/24** - WRES workforce data, evaluation from participants (post programme, 6 months, 1 year)	Managers are informed about the expectation of the programme. There is post programme support in place. There is an evaluation process to measure the effectiveness, which supports future programmes.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
1. New - Development of a Trust's violence reduction strategy	Sarah Dexter-Smith	**Q4 2023/24** - WRES staff survey results, feedback from BAME staff network. Datix's, SUI data	Development of a policy/guidance	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC,

				Exec PCDC, JCC and is approved at Board
2. New - Promote and participate in the Stand up to Bullying campaign	Lisa Cole & Abby Holder	**Q4 2023/24** - WRES staff survey results, feedback from BAME staff network.	The campaign will link to ongoing work such as the BAME staff network, the verbal aggression procedure and the race training.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
3. New - Promote the BAME staff network, including holding a BAME staff network celebration event, celebrating diversity.	Lisa Cole & Sarah Dallal	**Q4 2023/24** - Attendance figures to the BAME staff network, WRES staff survey results.	Development of the network provides a safe space for BAME staff to seek support. The Trust is committed to the staff networks and have made a commitment to ensure all staff can attend a minimum number of meeting per year.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
4. New - Work with the Care Group's EDI subgroups to develop a localised action plan to address harassment, bullying and discrimination.	Lisa Cole & Helen Cook (DTVF Care Group), Sarah Dallal & Abby Holder (NYYS Care Group)	**Q3 2023/24 -** WRES staff survey results, feedback from BAME staff network.	Developing localised actions will ensure that clinical teams identify specific actions that address their relevant issues.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

1. Continuation - Deliver four Compassion, Respect, Responsibly and Race Training sessions – focus is empathy, understanding and upstanding.	Lisa Cole & Sarah Dallal	**Q4 2023/24** - Training evaluation, WRES staff survey results, feedback from BAME staff network.	This training is available for all staff but can also be delivered at team level and is recommended for individuals/teams following incidents.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
2. New - Hold a Schwartz Round on the experiences of BAME staff in Black History month	Lisa Cole	**Q3 2023/24** - WRES staff survey results, feedback from BAME staff network.	Sharing stories provides a powerful way to build understanding, empathy and positive action.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
3. New - Update EDI training to include upstanding, understanding biases, how to address discrimination.	Abby Holder	**Q3 2023/24** - Training evaluation, WRES staff survey results, feedback from BAME staff network.	This training is available for all staff but can also be delivered at team level and is recommended for individuals/teams following incidents.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
4. New - Piloting Kind Life (creating a kinder and safer culture programme)	Kathryn Atkinson	**Q4 2023/24** - WRES staff survey results, feedback from BAME staff network.	This training is intended to help the organisations culture regarding how we treat others and speaking up.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

5. New - Work with the Care Group's EDI subgroups to develop a localised action plan to address harassment, bullying and discrimination.	Lisa Cole & Helen Cook (DTVF Care Group), Sarah Dallal & Abby Holder (NYYS Care Group)	**Q3 2023/24** - WRES staff survey results, feedback from BAME staff network.	Developing localised actions will ensure that clinical teams identify specific actions that address their relevant issues.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
Ethnicity Pay Gap produced and published	Sarah Dallal	**Q4 2023/24 -** Ethnicity pay data	Annual publication of the data and monitoring.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
1. New - Undertake a survey to understand the experiences of staff and what discrimination has occurred.	Lisa Cole	**Q3 2023/24 -** Survey results, feedback from BAME staff network	Understanding the experiences discrimination of BAME staff will help us to develop specific actions to try and address them.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
2. New - Develop and deliver a Compassion, Respect, Responsibly and Race Training session designed for mangers.	Lisa Cole & Sarah Dallal	**Q4 2023/24** - Training evaluation, WRES staff survey results, feedback from BAME staff network	Managers have a significant impact on the experience of staff. The training will be aimed at developing understanding, compassion and empathy.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

3. New - Promote the EDI team – can offer independent advice to BAME staff and managers	Lisa Cole	**Q2 2023/24 -** Number of queries, Survey results, feedback from BAME staff network	Developing support networks for BAME staff to raise concerns.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
4. New - Explore identifying senior BAME leaders who would be willing to provide support to staff who feel they are experiencing discrimination at work	Lisa Cole & Sarah Dallal	**Q3 2023/24** - number of senior BAME staff agreed to be involved.	Developing support networks for BAME staff to raise concerns.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
5. New - Work with the Care Group's EDI subgroups to develop a localised action plan to address harassment, bullying and discrimination.	Lisa Cole & Helen Cook (DTVF Care Group), Sarah Dallal & Abby Holder (NYYS Care Group)	**Q3 2023/24** - WRES staff survey results, feedback from BAME staff network	Developing localised actions will ensure that clinical teams identify specific actions that address their relevant issues.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
6. New - Piloting Kind Life (creating a kinder and safer culture programme)	Kathryn Atkinson	**Q4 2023/24** - WRES staff survey results, feedback from BAME staff network.	This training is intended to help the organisations culture regarding how we treat others and speaking up.	EDHR Steering group monitor the WRES action plan quarterly. WRES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
No actions required				

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

WORKFORCE DISABILITY EQUALITY STANDARD

2022/2023

	1. Background narrative a. Any issues of completeness of data
	b. Any matters relating to reliability of comparisons with previous years
	2. Total numbers of staff a. Employed within this organisation at the date of the report
	7927 (data from 31st March 2023)
	b. Proportion of disabled staff employed within this organisation at the date of the report
	8%
	3. Self-reporting a. The proportion of total staff who have self-reported their disability status
	85%
	b. Have any steps been taken in the last reporting period to improve the level of self-reporting by disability
	We ran a campaign encouraging staff to complete their demographics on ESR during 2023.
	c. Are any steps planned during the current reporting period to improve the level of self-reporting by disability
	Yes
	4. Workforce data a. What period does the organisation's workforce data refer to
	Data as of 31st March 2023
	5. Are there any other factors or data which should be taken into consideration in assessing progress?
	6. Organisations should produce a detailed WRES Action Plan, agreed by its Board. Such a Plan would normally elaborate on the actions summarised in section 5, setting out the next steps with milestones for expected progress against the WRES indicators. It may also identify the links with other work streams agreed at Board level, such as EDS2. You are asked to attach the WRES Action Plan or provide a link to it.

KEY:

Green = Improvement from the previous year
Amber = Remains the same or similar to previous year
Red = Decline from previous year

WORKFORCE DISABILITY EQUALITY STANDARD

	Indicator	Data for 2023	Data for 2022	Data for 2021	Data for 2020, 2019, 2018, 2017	Narrative – the implications of the data and any additional background explanatory narrative
	For each of these four workforce indicators, compare the data for disabled and non-disabled staff.					
1	% of staff in each of the AfC pay bands or medical and dental subgroups and VSM (excluding executive board members) compared with the % of staff in the overall workforce.	Please see appendix 1 for 2022 and 2023 data				There has been an increase in staff recording if they have a disability this year, 15% not declare compared to 16.5% not declared in 2022. 8% of staff have declared having a disability on ESR.

2	Relative likelihood of staff being appointed from shortlisting across all posts.	1.12	Non-disabled staff are **1.14 times more likely** to be appointed from shortlisting compared to disabled staff.	Non-disabled staff are 1.29 times more likely to be appointed from shortlisting compared to disabled staff.	Non disabled people are: 2020 = 1.36 2019 = 1.27 more likely to be appointed from shortlisting compared to disabled people.	likelihood of a non-disabled staff member being appointed compared to a disabled staff member is similar to last years.
3.	Relative likelihood of staff entering the formal capability process, as measured by entry into a formal process. This indicator will be based on data from a two year rolling average of the current year and the previous year.	1.08	Disabled staff are 0.64 times more likely to enter capability than non-disabled staff (they are less likely)	Disabled staff are 0 times more likely to enter capability than non-disabled staff (they are less likely)	Disabled staff are 0.78 times more likely to enter capability than non-disabled staff (they are less likely)	This data shows that non disabled staff and disabled staff are almost equally as likely to enter capability processes.
4.	Percentage of staff experiencing harassment/bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers	2022 LTHC – 26.7% Without LTHC – 21.4% LTHC – 8.5% Without LTHC – 3.8% LTHC – 18.8%	2021 Disabled 28% Non-disabled 23% Disabled 13% Non-disabled 6% Disabled 20%	2020 Disabled 29% Non-disabled 22% Disabled 15% Non-disabled 8% Disabled 23%	2019 Disabled 34% Non-disabled 28% Disabled 14% Non-disabled 9% Disabled 22%	The results are similar to the previous years with staff with long term health conditions being more likely to experience harassment/bullying or abuse from patients/service users, their relatives or members of the public, managers and other colleagues. The results for both staff with long term health conditions and those without has improved this year.

	Other colleagues	Without LTHC – 11.2%	Non-disabled 11%	Non-disabled 13%	Non-disabled 13%	
5.	Percentage believing that Trust provides equal opportunities for career progression or promotion.	2022 LTHC – 57.3% Without LTHC – 65.3%	2021 Disabled 55% Non-disabled 64%	2020 Disabled 56% Non-disabled 66%	2019 Disabled 58% Non-disabled 64% 2018 Disabled 63% Non-disabled 70%	The results show that staff with long term health conditions are less likely than staff without long term health conditions to believe the Trust provides equal opportunities for career progression or promotion. The results for both staff with long term health conditions and those without has improved this year.
6.	Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	2022 LTHC – 20.9% Without LTHC – 12.5%	2021 Disabled 22% Non-disabled 15%	2020 Disabled 26% Non-disabled 19%	2019 Disabled 26% Non-disabled 17% 2018 Disabled 22.5% Non-disabled 17%	The percentage of staff with long term health conditions and staff without long term health conditions who have felt pressure to come to work despite not feeling well enough has reduced. There is still an 8% difference, with staff with long term health conditions being more likely to attend work.
7.	Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	2022 LTHC – 41.5% Without LTHC – 49.1%	2021 Disabled 36% Non-disabled 47%	2020 Disabled 45% Non-disabled 57%	2019 Disabled 44% Non-disabled 55% 2018 Disabled 46%	There has been an increase for both staff with and without long term health conditions There continues to be a difference of 7% with staff with long term health conditions reporting

					Non-disabled 57%	feeling less satisfied with the extent the organisation values their work.
8.	Percentage of staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	2022 75.8%	2021 72%	2020 81%	2019 76% 2018 89%	There has been an increase in disabled staff saying their employer has made adequate adjustments.
9.	a) The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. (out of 10) b) Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? Yes or No	LTHC – 6.5 Without LTHC – 7.0	Disabled 6.5 Non-disabled 6.9 Yes Via Staff networks	Disabled 6.8 Non-disabled 7.3	2019 Disabled 6.8 Non-disabled 7.2 2018 Disabled 6.9 Non-disabled 7.4	The scores are like last years. The Trust has a disability/long term health conditions staff network and a neurodivergent network which engages with disabled staff / those with LTHC.

10.	Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce	Overall + 8.72% Difference voting + 6.34% Difference exec + 2.05%	Percentage difference between organisations boards voting membership and its overall workforce = + 2.5% Percentage difference between organisations board executive membership and its overall workforce = - 6.6%	Percentage difference between organisations boards voting membership and its overall workforce = -6% Percentage difference between organisations board executive membership and its overall workforce = -6%	Percentage difference between organisations boards voting membership and its overall workforce = -5% Percentage difference between organisations board executive membership and its overall workforce = -5%	11% of the board has not declared if they have a disability, this is an improvement to last year when 31.25% of the board had not declared. The data shows that there is representation on the board.

APPENDIX 1

DETAILED STAFF BREAKDOWN DISABILITY 31st March 2023

	Clinical Staff %		
Band	**Disabled**	**Not Disabled**	**Not Declared**
1-4	8% (144)	72% (1362)	21% (391)
5-7	9% (302)	81% (2738)	10% (323)
8ab	6% (22)	84% (295)	10% (35)
8cd	6% (6)	71% (77)	23% (25)
9	0% (0)	80% (4)	20% (1)
VSM	25% (1)	50% (2)	25% (1)
Medics	3% (11)	82% (211)	15% (37)
	Non-clinical staff %		
Band	**Disabled**	**Not Disabled**	**Not Declared**
1-4	7% (104)	74% (1035)	19% (263)
5-7	7% (27)	81% (310)	12% (48)
8ab	10% (10)	77% (79)	14% (14)
8cd	7% (2)	60% (18)	33% (10)
9	0 (0%)	50% (1)	50% (1)
VSM	6% (1)	71% (12)	24% (4)

DETAILED STAFF DISABILITY 31st March 2022

	Clinical Staff %		
Band	**Disabled**	**Not Disabled**	**Not Declared**
1-4	7% (122)	71% (1275)	23% (406)
5-7	8% (247)	81% (2620)	12% (375)
8ab	5% (18)	83% (275)	11% (38)
8cd	4% (4)	73% (81)	23% (26)
9	0%	100% (1)	0%
VSM	5% (1)	75% (15)	20% (4)
Medics	3% (9)	81% (212)	16% (42)
	Non-clinical staff %		
Band	**Disabled**	**Not Disabled**	**Not Declared**
1-4	5% (75)	73% (1009)	21% (294)
5-7	7% (24)	81% (298)	13% (47)
8ab	7% (6)	71% (65)	22% (12)
8cd	4% (1)	50% (12)	46% (11)
9	0%	0%	0%
VSM	0%	0%	0%

WDES Action Plan

	ACTIONS: Please specify which actions are different to current practice, and which are continuation	*Person who is responsible for overseeing the action*	*Please specify KPIs and timelines for monitoring the actions*	*How will actions be made sustainable*	*Governance*
Actions around WDES Indicator 1: % of staff in each of the AfC pay bands or medical and dental subgroups and VSM (excluding executive board members) compared with the % of staff in the overall workforce.	No actions required				
Actions around WDES Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts.	1. Continuation - Pilot the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process. Measure the diversity of successful candidates, evaluate feedback from panel members and applicants.	Sarah Dallal	**Q4 2023/24** - 650 Interviews to be involved in the pilot. Evaluation of the pilot. WDES recruitment and workforce data.	A full evaluation of the pilot and recommendations for the organisation. Working in conjunction with recruitment team and services.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

	2. New - Deliver a second mid-career programme, for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Promote this programme to the LTHC and Neurodivergent staff networks using Trust communication channels. Evaluate programme.	Sarah Dallal	**Q4 2023/24** - WDES workforce data, evaluation from participants (post programme, 6 months, 1 year)	Managers are informed about the expectation of the programme. There is post programme support in place. There is an evaluation process to measure the effectiveness, which supports future programmes.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	3. New - Develop Equality & Recruitment information for panel members	Lisa Cole	**Q3 2023/24 -** Information included in all recruitment packs**.** WDES recruitment and workforce data.	Explore with the recruitment team where this document would be most effective to ensure all panel members refresh their knowledge before the interview.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	4. Continuation - Work with locality leads to utilise the quarterly recruitment information which shows information of the diversity of applicants and those appointed at locality/corporate directorate level	Helen Cooke	Established and ongoing each quarter.	Care Groups are provided with the quarterly data to review and identify and trends and actions.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC,

					JCC and is approved at Board
	5. New - Develop an action plan from the NHS England, Widening Access Programme, including actions to increase the diversity of staff and hyperlocal recruitment.	Abby Holder	**Q4 2023/24** - Action plan approved, actions allocated to appropriate team, WDES recruitment and workforce data.	Sponsorship from the Director of People & Culture.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
Action around WDES indicator 3: Relative likelihood of staff entering the formal capability process, as measured by entry into a formal process. This indicator will be based on data from a two year rolling average of the current year and the previous year.	***No actions required***				

Actions around WDES indicator 4: Percentage of staff experiencing harassment/bullying or abuse from: i. Patients/service users, their relatives or other members of the public; ii. Managers iii. Other colleagues	1. New - Development of a Trust's violence reduction strategy	Sarah Dexter-Smith	**Q4 2023/24 -** WDES staff survey results, feedback from LTHC's Neurodiverse staff networks. Datix's, SUI data	Development of a policy/guidance	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	2. New - Promote and participate in the Stand up to Bullying campaign	Lisa Cole & Abby Holder	**Q4 2023/24** - WRES staff survey results, feedback from BAME staff network.	The campaign will link to ongoing work such as the BAME staff network, the verbal aggression procedure and the race training.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	3. New - Promote the LTHC network and neurodivergent staff support network	Helen Cooke	**Q4 2023/24** - Attendance figures at the relevant Networks	Development of the network provides a safe space for staff with LTHC or who are neurodiverse to seek support. The Trust is committed to the staff networks	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is

				and have made a commitment to ensure all staff can attend a minimum number of meeting per year.	approved at Board
	4. New - Work with the Care Group's EDI subgroups to develop a localised action plan to address harassment, bullying and discrimination.	Lisa Cole & Helen Cooke (DTVF Care Group), Sarah Dallal & Abby Holder (NYYS Care Group)	**Q3 2023/24 -** WDES staff survey results, feedback from the relevant staff networks.	Developing localised actions will ensure that teams identify specific actions that address their relevant issues.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	5. New - Update EDI training to include upstanding, understanding biases, how to address discrimination.	Abby Holder	**Q3 2023/24** - Training evaluation, WDES staff survey results, feedback from the relevant staff networks.	This training is available for all staff but can also be delivered at team level and is recommended for individuals/teams following incidents.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

	6. New - Piloting Kind Life (creating a kinder and safer culture programme)	Kathryn Atkinson	**Q4 2023/24 -** WDES staff survey results, feedback from LTHC'S/Neurodiverse staff networks.	This training is intended to help the organisations culture regarding how we treat others and speaking up.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	7. Continuation - review and develop the training provided to staff and managers in respect of reasonable adjustments and supporting staff with LTHC	Helen Cooke & Nicky Robertson	**Q4 2023/24** - Training evaluation, WDES staff survey results, feedback from BAME staff network	Managers and colleagues have a significant impact on the experience of staff. The training will be aimed at developing empathy and understanding of expectations and associated processes.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	8. Continuation - review the existing workplace adjustments procedure and associated resources available for staff and managers in respect of reasonable adjustments	Helen Cooke & Nicky Robertson	**Q2 2023/24** - Procedure consultation feedback, feedback from networks and managers, WDES staff survey	Managers and colleagues have a significant impact on the experience of staff. The resources will be aimed at increasing understanding of	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is

				issues relating to reasonable adjustments and increase awareness of support for staff with LTHC / disabilities and associated processes.	approved at Board
	9. New - Promote the central reasonable adjustments team, where staff and managers can seek independent advice and support	Helen Cooke & Nicky Robertson	**Q2 2023/24 -** Number of contacts, WDES staff survey and feedback from networks and managers	Developing support networks and practices for staff or managers with staff who have LTHC / disabilities	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	10. New - Evaluate the learning from the LTHC Reverse mentoring programme and identify any actions relating to harassment and bullying	Sarah Dallal	**Q3 2023/24** - evaluation from reverse mentoring programme, WDES staff survey, feedback from networks	A full evaluation of the programme and recommendations for the organisation	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

Actions around WDES Indicator 5: Percentage believing that Trust provides equal opportunities for career progression or promotion.	1. New - Disability Pay Gap produced and published	Helen Cooke	**Q4 2023/24** - report produced and published	This will be first report produced by the Trust but will be produced annually to allow for comparisons.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	2. New - Deliver a second mid-career programme, for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Promote this programme to the LTHC and Neurodivergent staff networks using Trust communication channels. Evaluate programme.	Sarah Dallal	**Q4 2023/24** - WDES workforce data, evaluation from participants (post programme, 6 months, 1 year)	Managers are informed about the expectation of the programme. There is post programme support in place. There is an evaluation process to measure the effectiveness, which supports future programmes.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	3. New - Evaluate the learning from the LTHC Reverse mentoring programme and identify any actions relating to career progression / promotion	Sarah Dallal	**Q3 2023/24** - evaluation from reverse mentoring programme, WDES staff survey, feedback from networks	A full evaluation of the programme and recommendations for the organisation	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC,

					JCC and is approved at Board
Actions around WDES Indicator 6: Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	1. Continuation - review and develop the training provided to staff and managers in respect of reasonable adjustments and supporting staff with LTHC	Helen Cooke & Nicky Robertson	**Q4 2023/24** - Training evaluation, WDES staff survey results, feedback from BAME staff network	Managers and colleagues have a significant impact on the experience of staff. The training will be aimed at developing empathy and understanding of expectations and associated processes. To include disability leave and other options	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
Actions around WDES Indicator 7: Percentage of staff saying that they are satisfied with the extent to which their organisation values their work.	1. New - Centralised reasonable adjustments team to improve experience staff with LTHC / diabilities have, investing in reasonable adjustments	Nicky Robertson	**Q1 2024/25** - Evaluation of pilot. WDES, staff survey results, network feedback	Quarterly updates on progress and effectiveness of centralised pilot. Metrics relating to centralised pilot to be presented and reviewed	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

Actions around WDES Indicator 8: Percentage of staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	1. New - Centralised Reasonable Adjustments team pilot to lead on obtaining adjustments for staff and reclaiming monies from ATW where appropraite	Nicky Robertson	**Q1 2024/25 -** Evaluation of pilot, WDES, Staff survey results and network feedback	Quarterly updates on progress and effectiveness of centralised pilot. Metrics relating to centralised pilot to be presented and reviewed	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	2. Continuation - review and develop the training provided to staff and managers in respect of reasonable adjustments and supporting staff with LTHC	Helen Cooke & Nicky Robertson	**Q4 2023/24** - Training evaluation, WDES staff survey results, feedback from staff network	Managers and colleagues have a significant impact on the experience of staff. The training will be aimed at developing empathy and understanding of expectations and associated processes.	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	3. Continuation - review the existing workplace adjustments procedure and associated resources available for staff and managers in respect of reasonable adjustments	Helen Cooke & Nicky Robertson	**Q2 2023/24** - Procedure consultation feedback, feedback from networks and managers, WDES staff survey	Managers and colleagues have a significant impact on the experience of staff. The resources will be aimed at increasing understanding of	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is

				issues relating to reasonable adjustments and increase awareness of support for staff with LTHC / disabilities and associated processes.	approved at Board
	4. New - Promote the central reasonable adjustments team, where staff and managers can seek independent advice and support	Helen Cooke & Nicky Robertson	**Q2 2023/24 -** Number of contacts, WDES staff survey and feedback from networks and managers	Developing support networks and practices for staff or managers with staff who have LTHC / disabilities	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
Actions around WDES Indicator 9: Staff Engagement	1. Contination of staff networks, lunch and learns, Disability History month activities	Sarah Dallal	Ongoing	Quarterly updates to EDI Steering group and escalation of any concerns as appropraite	EDHR Steering group monitor the WDES action plan quarterly. WDES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
Actions around WDES Indicator 10:	***No action required***				

Board representation					

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

SEXUAL ORIENTATION WORKFORCE EQUALITY STANDARD

2022/2023

	1. Background narrative a. Any issues of completeness of data	
	The Pulse survey does not include a question about CPD and non-mandatory training as the staff FFT did therefore information from the staff survey has been used for indicator 4.	
	b. Any matters relating to reliability of comparisons with previous years	
	2. Total numbers of staff a. Employed within this organisation at the date of the report	
	7927 (data from 31st March 2023)	
	b. Proportion of LGB staff employed within this organisation at the date of the report	
	4%	
	3. Self-reporting a. The proportion of total staff who have self-reported their sexual orientation	
	90%	
	b. Have any steps been taken in the last reporting period to improve the level of self-reporting	
	Yes	
	c. Are any steps planned during the current reporting period to improve the level of self-reporting	
	Yes	
	4. Workforce data a. What period does the organisation's workforce data refer to	
	Data as of 31st March 2023	
	5. Are there any other factors or data which should be taken into consideration in assessing progress?	

KEY:

Green = Improvement from the previous year
Amber = Remains the same or similar to previous year
Red = Decline from previous year

SEXUAL ORIENTATION WORKFORCE EQUALITY STANDARD

	Indicator	Data for 2023	Data 2022	Data for 2021	Data for 2020, 2019, 2018, 2017	Narrative – the implications of the data and any additional background explanatory narrative
	For each of these four workforce indicators, compare the data for LGB staff and heterosexual staff.					
1	Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation	Please see appendix 1 at the end of the document				10% of staff have not declared their sexual orientation, this is the same as last years data.

	separately for non-clinical and for clinical staff.					
2.	Relative likelihood of staff being appointed from shortlisting across all posts.	1.14	Heterosexual people are 1.09 times more likely to be appointed compared to LGB people.	Heterosexual people and LGB people are equally likely to be appointed compared to LGB people.	2020 Heterosexual people and LGB people are equally likely to be appointed compared to LGB people. 2019 Heterosexual staff are 1.05 times more likely to be appointed from shortlisted posts than LGB staff.	The data shows a similar picture of the previous years. There is little difference in the likelihood of heterosexual people being appointed from shortlisting compared to LBG people.
3.	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This	1.65	LGB staff are **1.68** times more likely to enter disciplinary than heterosexual.	LGB staff are 1.11 times more likely to enter disciplinary than heterosexual.	2020 LGB staff are 1.49 times more likely to enter disciplinary than heterosexual	This indicator is similar to last years, with LGB staff being 1.65 times more likely to enter disciplinary processes.

	indicator will be based on data from last two year rolling average of the current year and the previous year.				2019 LGB staff are 2.5 times more likely to enter the formal disciplinary process than heterosexual staff.	
4.	Relative likelihood of staff accessing non-mandatory training and CPD.	LGB staff and heterosexual people are equally likely to report that they have access to the right learning and development opportunities when they need to.	LGB staff and heterosexual people are equally likely to report that they have access to the right learning and development opportunities when they need to.	LGB staff and heterosexual people are equally likely to respond positively on the staff FFT question on the question: I am able to access job relevant non-mandatory training and/or Continuing Professional Development opportunities	2020 LGB staff and heterosexual people are equally likely to respond positively on the staff FFT question on the question: I am able to access job relevant non-mandatory training and/or Continuing Professional Development opportunities	This indicator has been taken from a response to the staff survey Q20e due to the new Pulse survey not including a relevant question. The indicator continues to show that LGB report that they have the same results as heterosexual staff regarding having the right learning and developmental opportunities.

					2019 Heterosexual staff and LGB staff are equally likely to access non-mandatory training and CPD.	
5.	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	Gay Man or Gay Woman (Lesbian) **27.8%** Bisexual **28.2%** Heterosexual (straight) **22.7%** **Gender Identity** Same as assigned at birth **23.1%** Not the same as assigned at birth **54.4%** Prefer not to say **19.2%**	2021 Gay Man or Gay Woman (Lesbian) **33%** Bisexual **33.3%** Heterosexual (straight) **23.4%**	2020 Gay Man or Gay Woman (Lesbian) **32.4%** Bisexual **33.3%** Heterosexual (straight) **23.7%**	2019 Gay Man 38.2% Gay Woman (Lesbian) 33.3% Bisexual 26.7% Heterosexual (straight) 28.9% 2018 Gay Man 36% Gay Woman (Lesbian) 26% Bisexual 40% Heterosexual (straight) 26%	LGB staff continue to report higher levels of harassment and bullying from patients, relatives or the public compared to heterosexual staff. In the 2022 staff survey results we were able to gather data regarding staff who are not the same gender as assigned at birth as 11 people identified in this way. Those who identified as gender not the same as assigned at birth were more likely to report experiencing harassment and bullying from patients, relatives or the public

6.	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.	Gay Man or Gay Woman (Lesbian) **17.7%** Bisexual **12.7%** Heterosexual (straight) **13.1%** **Gender Identity** Same as assigned at birth **13.3%** Not the same as assigned at birth **36.4%** Prefer not to say **26.4%**	2021 Gay Man or Gay Woman (Lesbian) **16.2%** Bisexual **20.8%** Heterosexual (straight) **13.6%**	2020 Gay Man or Gay Woman (Lesbian) **17.6%** Bisexual **30%** Heterosexual (straight) **15.2%**	2019 Gay Man 23.5% Gay Woman (Lesbian) 20.9% Bisexual 20% Heterosexual (straight) 14.8% 2018 Gay Man 18% Gay Woman (Lesbian) 16% Bisexual 17% Heterosexual (straight) 15%	Gay men and gay women report higher levels of harassment, bullying or abuse from staff. There has been the biggest improvement for bisexual staff results. Those who identified as gender not the same as assigned at birth were more likely to report experiencing harassment and bullying from staff.
7.	KF 21. Percentage believing that Trust provides equal opportunities for career progression or promotion.	Gay Man or Gay Woman (Lesbian) **65.6%** Bisexual **67.1%** Heterosexual (straight**)** **64.1%** **Gender Identity**	Gay Man or Gay Woman (Lesbian) **66.4%** Bisexual **49.1%** Heterosexual (straight**)** **62.3%**	2020 Gay Man or Gay Woman (Lesbian) **62.2%** Bisexual **56.7%** Heterosexual (straight**)** **64.9%**	2019 Gay Man or Gay Woman (Lesbian) 67.5% Bisexual 56.7% Heterosexual (straight) 63.8% 2018	The percentage of gay men and gay women has worsened whist bisexual and heterosexual staff has improved. There has been the biggest improvement for bisexual staff results.

		Same as assigned at birth **63.4%** Not the same as assigned at birth **72.7%** Prefer not to say **23.6%**			Gay Man or Gay Woman (Lesbian) 80.9% Bisexual 66.7% Heterosexual (straight) 69.3%	People who selected prefer not to say (gender identity) have the lowest scores regarding feeling the Trust offers equal opportunities to career progression and promotion.
8.	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.	Gay Man or Gay Woman (Lesbian) **9.3%** Bisexual **7%** Heterosexual (straight) **5.1%** **Gender Identity** Same as assigned at birth **5.3%** Not the same as assigned at birth **27.3%** Prefer not to say **11%**	2021 Gay Man or Gay Woman (Lesbian) **6.8%** Bisexual **12.7%** Heterosexual (straight) **5.8%**	2020 Gay Man or Gay Woman (Lesbian) **5.4%** Bisexual **23.3%** Heterosexual (straight) **6%**	2019 Gay Man 8.8% Gay Woman (Lesbian) 11.6% Bisexual 6.9% Heterosexual (straight) 5.1% 2018 Gay Man 4% Gay Woman (Lesbian) 0% Bisexual 17% Heterosexual (straight) 5%	Gay men & women and bisexual staff continue to be more likely to report experiencing discrimination at work. There has been an improvement again this year for bisexual staff results. Those who identified as gender not the same as assigned at birth were much more likely to report experiencing discrimination from managers or other colleagues.
	Board representation indicator: <u>For this indicator, compare the difference for LGB</u>					

	staff and heterosexual staff					
9.	Percentage difference between (i) the organisations' Board voting membership and its overall workforce and (ii) the organisations' Board executive membership and its overall workforce	2023 Percentage difference between organisations boards voting membership and its overall workforce = -4.2% Percentage difference between organisations board executive membership and its overall workforce = -4.2%	2022 Percentage difference between organisations boards voting membership and its overall workforce = **-3.9%** Percentage difference between organisations board executive membership and its overall workforce = **-3.9%**	2021 Percentage difference between organisations boards voting membership and its overall workforce = +5% Percentage difference between organisations board executive membership and its overall workforce = +11%	2020 Percentage difference between organisations boards voting membership and its overall workforce = +5% Percentage difference between organisations board executive membership and its overall workforce = +11% 2019 Percentage difference between organisations boards voting membership and its overall workforce = +8% Percentage difference	There is no one on the board who has identified as LGB. All board members have declared their sexual orientation, which is an improvement from last year.

					between organisations board executive membership and its overall workforce = +12.5%	
10.	The staff engagement score on the National Staff Survey for LGB staff, compared to heterosexual staff and the overall engagement score for the organisation. (out of 10)	Gay Man or Gay Woman (Lesbian) **6.6** Bisexual **6.9** Heterosexual (straight) **6.9**	2021 Gay Man or Gay Woman (Lesbian) **6.5** Bisexual **6.4** Heterosexual (straight) **6.9**	2020 Gay Man or Gay Woman (Lesbian) **7** Bisexual **6.7** Heterosexual (straight) **7.2**	2019 Gay Man 7 Gay Woman (Lesbian) 7.2 Bisexual 7.5 Heterosexual (straight) 7.1 2018 Gay Man 7.3 Gay Woman (Lesbian) 7.7 Bisexual 7 Heterosexual (straight) 7.3	LG staff have lower engagement scores than heterosexual staff, engagement scores have decreased for LGB and heterosexual staff.

APPENDIX 1

STAFF BREAKDOWN SEXUAL ORIENTATION 31st March 2023

	Clinical Staff %		
Band	**Heterosexual**	**LGB**	**Not Declared**
1-4	83% (1569)	5% (99)	12% (224)
5-7	88% (2952)	5% (156)	7% (249)
8ab	88% (309)	5% (18)	7% (25)
8cd	85% (92)	3% (3)	12% (13)
9	100% (5)	0%	0%
VSM	75% (3)	0%	25% (1)
Medics	64% (166)	5% (12)	31% (81)
	Non-clinical staff %		
Band	**Heterosexual**	**LGB**	**Not Declared**
1-4	86% (1200)	2% (31)	12% (170)
5-7	90% (345)	3% (11)	8% (29)
8ab	90% (93)	2% (2)	8% (8)
8cd	90% (27)	0%	10% (3)
9	50% (1)	50% (1)	0
VSM	71% (12	6% (1)	24% (4)

STAFF BREAKDOWN SEXUAL ORIENTATION 31st March 2022

	Clinical Staff %		
Band	**Heterosexual**	**LGB**	**Not Declared**
1-4	84% (1516)	5% (86)	11% (193)
5-7	88% (2844)	4% (144)	8% (294)
8ab	85% (283)	5% (17)	9% (30)
8cd	86% (96)	5% (5)	9% (10)
9	100% (1)	0%	0%
VSM	75% (15)	0%	25% (5)
Medics	61% (161)	4% (10)	35% (91)
	Non-clinical staff %		
Band	**Heterosexual**	**LGB**	**Not Declared**
1-4	86% (1182)	2% (22)	12% (169)
5-7	91% (336)	2% (9)	7% (24)
8ab	90% (82)	1% (1)	8% (7)
8cd	75% (18)	0%	25% (6)
9	0	0	0
VSM	0	0	0

SOWES Action Plan

	ACTIONS: Please specify which actions are different to current practice, and which are continuation	Person who is responsible for overseeing the action	Please specify KPIs and timelines for monitoring the actions	How will actions be made sustainable	Governance
Actions around SOWES Indicator 1: Workforce Demographics	1. New - Carry out a targeted data completeness drive with support from the Rainbow network to promote the importance for staff to complete their SO demographic	Abby Holder	**Q4 2023/24 -** ESR data completeness figures.	This work will link with a wider data completeness drive which will be carried out on an annual basis. The importance of data completeness is covered in the EDI and LGBTQ+ Awareness Training.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	2. New - Members of the Rainbow Network to utilise Brents Blog to promote the improtance for staff to complete their SO demographic	Abby Holder	**Q4 2023/24 -** ESR data completeness figures.	This work will link with a wider data completeness drive which will be carried out on an annual basis. The importance of data completeness is covered in the EDI and LGBTQ+ Awareness Training.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

Actions around SOWES Indicator 2: Recruitment and promotion	1. New - Pilot the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process. Measure the diversity of successful candidates, evaluate feedback from panel members and applicants.	Sarah Dallal	**Q4 2023/24** - 650 Interviews to be involved in the pilot. Evaluation of the pilot. SOWES recruitment and workforce data.	A full evaluation of the pilot and recommendations for the organisation. Working in conjunction with recruitment team and services.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	2. New - Develop an action plan from the NHS England, Widening Access Programme, including actions to increase the diversity of staff and hyperlocal recruitment.	Abby Holder	**Q4 2023/24** - Action plan approved, actions allocated to appropriate team, SOWES recruitment and workforce data.	Sponsorship from the Director of People & Culture.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	3. New - Develop Equality & Recruitment information for panel members	Lisa Cole / Abby Holder	**Q3 2023/24 -** Information included in all recruitment packs**.** SOWES recruitment and workforce data.	Explore with the recruitment team where this document would be most effective to ensure all panel members refresh their knowledge before the interview.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

Actions around SOWES Indicator 3: Disciplinary	1. New - Equality, Diversity & Inclusion and Human Rights Team to work with HR to ensure that there is EDI representation on all PAG (preliminary assessment group) meetings involving staff who identify as LGBTQ+	Abby Holder	**Q3 2023/24 -** SOWES disciplinary data.Feedback from the Rainbow Network.	This is an established practice that is embedded in the process. This action will just reinforce the need for EDI representation at PAG meetings that involve staff who identify as LGBTQ+	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	2. New - Invite LGB staff to speak to EDI & HR staff confidentially about their experiences and provide possible context	Abby Holder	**Q3 2023/24 -** Feedback from the Rainbow Network.	This will help to provide possible context and insight in relation to the data and help to establsh a baseline of staffs experiences.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
Actions around SOWES Indicator 5: Bullying and Harassment From Public	1. New - Development of a Trust's violence reduction strategy	Sarah Dexter-Smith	**Q4 2023/24 -** SOWES staff survey results, feedback from Rainbow network. Datix's, SUI data	Development of a policy/guidance	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

	2. New - Promote and participate in the Stand up to Bullying campaign	Lisa Cole & Abby Holder	**Q4 2023/24** - SOWES staff survey results, feedback from the Rainbow staff network.	The campaign will link to ongoing work such as the Rainbow staff network, the verbal aggression procedure and the LGGBTQ+ Awareness training.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	3. New - Promote the Rainbow staff network	Abby Holder	**Q4 2023/24** - Attendance figures at the Rainbow Network	Development of the network provides a safe space for LGBTQ+ staff to seek support. The Trust is committed to the staff networks and have made a commitment to ensure all staff can attend a minimum number of meeting per year.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	4. New - Work with the Care Group's EDI subgroups to develop a localised action plan to address harassment, bullying and discrimination.	Lisa Cole & Helen Cook (DTVF Care Group), Sarah Dallal & Abby Holder (NYYS Care Group)	**Q3 2023/24 -** SOWES staff survey results, feedback from the Rainbow staff network.	Developing localised actions will ensure that clinical teams identify specific actions that address their relevant issues.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	5. New - Update EDI training to include upstanding, understanding biases, how to address discrimination.	Abby Holder	**Q3 2023/24** - Training evaluation, SOWES staff survey results, feedback from the	This training is available for all staff but can also be delivered at team level and is recommended for individuals/teams following incidents.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC

			Rainbow staff network.		and is approved at Board
	6. New - Piloting Kind Life (creating a kinder and safer culture programme)	Kathryn Atkinson	**Q4 2023/24 -** SOWES staff survey results, feedback from Rainbow network.	This training is intended to help the organisations culture regarding how we treat others and speaking up.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	7. New - Lunch and learn on LGBTQ+ experiences of working in TEWV	Abby Holder / Rainbow Network	**Q4 2023/24 -** Lunch and learn feedback, SOWES staff survey results, feedback from the Rainbow network.	These sessions will provide an insight into staff experiences and help the organisations culture regarding how we treat others and speaking up.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	8. New - Identify LGB staff who would be interested in becoming FTSU ambassadors / reviewers	Abby Holder / Dewi Williams	**Q4 2023/24 -** Numbers of FTSU reported from staff who identify as LGBTQ+	Having staff who identify as LGBTQ+ in the voluntary role of FTSU ambassador / reviewer could help remove barriers for LGBTQ+ staff to speak up.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

Actions around SOWES Indicator 6: Bullying and harassment from staff	1. New - Promote and participate in the Stand up to Bullying campaign	Lisa Cole & Abby Holder	**Q4 2023/24** - SOWES staff survey results, feedback from the Rainbow staff network.	The campaign will link to ongoing work such as the Rainbow staff network, the verbal aggression procedure and the LGBTQ+ Awareness training.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	2. New - Identify LGB staff who would be interested in becoming FTSU ambassadors / reviewers	Abby Holder / Dewi Williams	**Q4 2023/24** - Number of staff who identify as LGBTQ+ recruited as FTSU ambassadors / reviewers	Having staff who identify as LGBTQ+ in the voluntary role of FTSU ambassador / reviewer could help remove barriers for LGBTQ+ staff to speak up.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	3. New - Update EDI training to include upstanding, understanding biases, how to address discrimination.	Abby Holder	**Q3 2023/24** - Training evaluation, SOWES staff survey results, feedback from the Rainbow staff network.	This training is available for all staff but can also be delivered at team level and is recommended for individuals/teams following incidents.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	4. New - Piloting Kind Life (creating a kinder and safer culture programme)	Kathryn Atkinson	**Q4 2023/24** - SOWES staff survey results, feedback from Rainbow network.	This training is intended to help the organisations culture regarding how we treat others and speaking up.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC

					and is approved at Board
	5. New - Work with the Care Group's EDI subgroups to develop a localised action plan to address harassment, bullying and discrimination.	Lisa Cole & Helen Cook (DTVF Care Group), Sarah Dallal & Abby Holder (NYYS Care Group)	**Q3 2023/24** - SOWES staff survey results, feedback from Rainbow staff network.	Developing localised actions will ensure that clinical teams identify specific actions that address their relevant issues.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	6. New - Lunch and learn on LGBTQ+ experiences	Abby Holder / Rainbow Network	**Q4 2023/24 -** Lunch and learn feedback, SOWES staff survey results, feedback from the Rainbow network.	These sessions will provide an insight into staff experiences and help the organisations culture regarding how we treat others and speaking up.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	7. Update the LGBTQ+ Awareness Training to include staff / service users who identify as LGBTQ+	Abby Holder / Lisa Cole	**Q3 2023/24** - Training evaluation, SOWES staff survey results, feedback from the Rainbow staff network.	This training is available for all staff but can also be delivered at team level and is recommended for individuals/teams following incidents.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

	8. New - Identify LGB staff who would be interested in becoming FTSU ambassadors / reviewers	Abby Holder / Dewi Williams	**Q4 2023/24** - Number of staff who identify as LGBTQ+ recruited as FTSU ambassadors / reviewers	Having staff who identify as LGBTQ+ in the voluntary role of FTSU ambassador / reviewer could help remove barriers for LGBTQ+ staff to speak up.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
Actions around SOWES Indicator 8: Discrimination from manager	1. New - Work with the Care Group's EDI subgroups to develop a localised action plan to address harassment, bullying and discrimination.	Lisa Cole & Helen Cook (DTVF Care Group), Sarah Dallal & Abby Holder (NYYS Care Group)	**Q3 2023/24** - SOWES staff survey results, feedback from Rainbow staff network	Developing localised actions will ensure that clinical teams identify specific actions that address their relevant issues.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	2. New - Piloting Kind Life (creating a kinder and safer culture programme)	Kathryn Atkinson	**Q4 2023/24** - SOWES staff survey results, feedback from Rainbow network.	This training is intended to help the organisations culture regarding how we treat others and speaking up.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
	3. New - Identify LGB staff who would be interested in becoming FTSU ambassadors / reviewers	Abby Holder / Dewi Williams	**Q4 2023/24** - Number of staff who identify as LGBTQ+ recruited as FTSU ambassadors / reviewers	Having staff who identify as LGBTQ+ in the voluntary role of FTSU ambassador / reviewer could help remove barriers for LGBTQ+ staff to speak up.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC

					and is approved at Board
Actions around SOWES Indicator 9: Board representation	1. New - Rainbow network member(s) to carry out a presentation to The Board to provide insight from a lived experience perspective	Abby Holder / Rainbow Network	**Q4 2023/24** - feedback from BoD	These presentations will provide an insight into the experiences of staff who identify as LGBTQ+ to help The Board understand possible barriers and issues that staff can face in the workplace at TEWV.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board
Actions around SOWES Indicator 10: Engagement	2. New - Promote the Rainbow network and Pride planning group	Abby Holder	**Q4 2023/24** - Attendance numbers at monthly Rainbow network meetings. Attendance of staff at Pride events.	Development of the network provides a safe space for LGBTQ+ staff to seek support. The Trust is committed to the staff networks and have made a commitment to ensure all staff can attend a minimum number of meeting per year.	EDHR Steering group monitor the SOWES action plan quarterly. SOWES is shared with Care Boards, PCDC, Exec PCDC, JCC and is approved at Board

PUBLICATION OF STAFF EQUALITY DATA

Data up to 31st March 2023

Published June 2023

If you need this information summarised in another language or format such as Braille, talking tape or DVD please call the number below.

Polish:

Jeżeli potrzebujesz streszczenia tych informacji w innym języku lub formacie, np. w Braille'u lub w formie nagrania dźwiękowego, zadzwoń na poniższy numer.

Arabic:

إذا أردت منا تلخيص هذه المعلومات بلغة أخرى أو بصيغة مختلفة مثل لغة بريل أو شريط صوتي أو قرص DVD يرجى الاتصال برقم الهاتف التالي.

Bengali:

যদি আপনি অন্য একটি ভাষায় এই তথ্যের সংক্ষিপ্তসার চান অথবা ব্রেইল, কথা বলা টেপ অথবা ডি.ভি.ডি. ফরম্যাট-এ এই তথ্য চান, তাহলে অনুগ্রহ করে নিচের নম্বরে টেলিফোন করুন।

Farsi:

در صورتی که مایلید خلاصه این اطلاعات را به زبان یا فرمت دیگری مانند بریل، نوار یا دی وی دی دریافت کنید، لطفا با شماره زیر تماس بگیرید.

Hindi:

यदि आप इस सूचना का सारांश किसी अन्य भाषा या स्वरूप में, जैसे ब्रेल, टाकिंग टेप या DVD में चाहते हों, तो कृपया नीचे दिए गए नंबर पर फोन करें।

Kurdish (Kurmanji):

Heke hun vê agahîyê bi kurtî bi zimanekî din an formateke din a wek Braille (ji bo kêmasîya dîtinê), teypa axaftinê yan jî DVD dixwazin, ji kerema xwe telefonî hejmara jêrîn bikin.

Punjabi:

ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਦਾ ਸਾਰ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈਟ ਜਵਿੇਂ ਬ੍ਰੇਲ, ਟਾਕਿੰਗ ਟੇਪ ਜਾਂ DVD ਵਚਿ ਚਾਹੀਦਾ ਹੈ ਤਾਂ ਕਰਿਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦੱਤਿੇ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।

Simplified Chinese:

如果您需要该条信息用其他语言或格式概述，例如盲文，录**音磁**带或 DVD。请联系以下号码**：**

Urdu:

اگر آپ کو ان معلومات کے خلاصہ کی کسی دیگر زبان یا شکل مثلاً بریل، ٹاکنگ ٹیپ یا ڈی وی ڈی میں ضرورت ہو تو برائے مہربانی درج ذیل نمبر پر کال کریں۔

Telephone 0191 3336267

Introduction

The general equality duty of the Equality Act 2010 requires the Trust in the exercise of its functions to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to staff who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are sex, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity.

The Trust has published information to meet its public sector duties for the last eight years.

The information in this report as far as possible replicates the indicators of the Workforce Race Equality standard (WRES). The information in the disability section mirrors the indicators for the Workforce Disability Equality Standard (WDES) and the Sexual Orientation Workforce Equality Standard (SOWES).

Analysis of Trust data has been performed to identify any differences within protected characteristic groups across a number of measures deemed to be important. These measures included: distribution of staff within the Agenda for Change Pay Band structure, recruitment metrics (including shortlisting and subsequent recruitment patterns), capability and disciplinary data, Trust Board membership and staff survey details. Due to the nature of the data properties, the majority of reporting was limited to descriptive analytics. However, where possible, additional analyses were undertaken, and likelihood ratios were calculated. This report aims to track key elements of Trust process, with regard to staff, through a protected characteristic lens.

Recruitment

Relative likelihood of staff from one of the protected characteristic groups compared to the non-protected characteristic groups being appointed from shortlisting across all posts.

Data: Data was extracted from the trac website (the recruitment management system) and supplied by a HR colleague. The data looks at a 12-month period (April 2022 – March 2023), and analysis tracks protected characteristics amongst successful shortlisting and recruitment practices. Information was recorded for all staff in relation to the following protected characteristics: Disability, Ethnicity, Age, Gender and Sexual Orientation. For the purpose of this report, those who did not have a protected characteristic listed have been removed from the analysis (ie not stated, not disclosed etc).

Analysis: Descriptive statistics were utilised in order to assess the breakdown of the protected groups entering the process. Further to this, likelihood ratios were calculated to evaluate any disparity between protected groups. The ratios were broken down to show comparisons of the following reference groups:

- Disabled compared to non-disabled.
- BAME compared to White.
- Age categories compared to one another.
- Male compared to Female.
- Heterosexual compared to LGB

Understanding the likelihood calculation.

Likelihood ratios are calculated for both recruitment and disciplinary/capability metrics within this report.

For illustrative purposes, a worked example of fictitious data is provided below to aid understanding of likelihood ratio methodology and interpretation:

Disability Status	Shortlisted N	Appointed N	Ratio	Relative Likelihood
Non-Disabled	780	170	(170/780) = 0.22	(0.22/0.14) = 1.57
Disabled	210	30	(30/210) = 0.14	

If the relative likelihood figure is above 1, it indicates they are more likely to be appointed, if it is below 1 then it indicates that they are less likely to be appointed.

Interpretation of the example provided above would be: non-disabled applicants are 1.57 times more likely to be appointed than applicants with a disability.

Results

Disability

	Disability	Non-Disability
Disability		0.88
Non-Disability	1.13	

The above table demonstrates that applicants without a disability were 1.13 times more likely to be appointed from shortlisting than applicants without a disability.

BAME

	BAME	NON-BAME
BAME		0.55
NON-BAME	1.83	

White applicants are 1.83 times more likely to be appointed from shortlisting than BAME applicants.

Gender

	Female	Male
Female		1.16
Male	0.86	

It can be seen from the above table that Females are 1.16 more times to be appointed from shortlisting than Males are.

Sexual Orientation

	Heterosexual or Straight	Gay/Lesbian/Bi
Heterosexual or Straight		1.13
Gay/Lesbian/Bi	0.89	

Heterosexual applicants were 1.13 more likely to be appointed from shortlisting than Gay, Lesbian or Bi-sexual applicants.

Age categories

	16-20 yrs	21-30 yrs	31-40 yrs	41-50 yrs	51 – 65 yrs	66+
16-20 yrs		0.78	0.81	0.75	0.74	0.73
21-30 yrs	1.29		1.04	0.97	0.95	0.94
31-40 yrs	1.24	0.96		0.93	0.91	0.90
41-50 yrs	1.33	1.03	1.08		0.98	0.97
51 – 65 yrs	1.36	1.05	1.10	1.02		0.99
66+	1.38	1.07	1.12	1.03	1.01	

The above categories show the different age groups and the likelihood of someone from that age category being appointed from shortlisting compared to the other age groupings. It can be seen from the above table that those in the age group 66+ were consistently most likely to be appointed to a job from shortlisting when compared to the other groups. Those who were in the age category of 16-20 were least likely to be appointed from a shortlisting when compared to the other age categories.

Summary

It can be seen from all the tables above that there are still some small inequalities when comparing the protected characteristic groups against one another, however the likelihood figures have improved since last year. The likelihood of non-disabled applicants compared to disabled applicants being appointed has slightly improved, with last year's likelihood being non-disabled being 1.14 times more likely, this is now reduced to 1.13 times more likely. The likelihood of white applicants being appointed compared to BAME applicants has increased, last year white applicants were 1.38 times more likely to be appointed from shortlisting, this is now 1.83 times more likely.

Disciplinary and Capability

Relative likelihood of staff from one of the protected characteristic groups compared to the non-protected characteristic entering the disciplinary or the capability process.

Data: Data was extracted from a HR spreadsheet which is used to record the Capability and Disciplinary data, it was provided by Workforce and Information. The data covered a 24 month period from April 2021 to March 2023 and contained a list of all staff members who had entered the disciplinary or capability process within that time frame. Information was recorded for all staff in relation to the following protected characteristics: Disability, Ethnicity, Age, Gender and Sexual Orientation. For the

purpose of this report, those who did not have a protected characteristic listed have been removed from the analysis (ie not stated, not disclosed etc).

Analysis: Descriptive statistics were utilised in order to assess the breakdown of the protected groups entering the process. Further to this, likelihood ratios were calculated to evaluate any disparity between protected characteristics. The ratios were broken down to show comparisons of the following groups:

- Disabled compared to non-disabled.
- BAME compared to white.
- Age categories compared to one another.
- Male compared to Female.
- Heterosexual compared to LGB

Results:

Disability

Disciplinary

			Overall	
	Total Disciplinary	Total workforce	% likelihood for each grouping	Relative Likelihood
Disability	13	630	0.0206	1.1535
No Disability	110	6149	0.0179	
Not Declared	29	1157	0.0259	

The above table demonstrates that applicants with a disability were 1.15 times more likely to go through the disciplinary process than those without.

Capability

			Overall	
	Total Disciplinary	Total workforce	% likelihood for each grouping	Relative Likelihood
No Disability	11	6149	0.0018	1.1270
Disability	1	630	0.0016	

In this table, which looks at capability between disabled and non-disabled staff members, we can see that those without a disability are more likely than those with a disability to enter the capability process. However, it should also be noted there was

only 1 person with a disability who entered the capability process in the 2 years that this report was looking at.

Grievance

			Overall	
	Total Disciplinary	Total workforce	% likelihood for each grouping	Relative Likelihood
Disability	3	630	0.0048	1.9521
No Disability	15	6149	0.0024	

The above table demonstrates that applicants with a disability were twice as likely to go through the grievance process than those without a disability.

BAME

Disciplinary

				Overall	
	Total Disciplinary	Total Medical Disciplinary	Total workforce	% likelihood for each grouping	Relative Likelihood
Ethnic minority	9		466	0.0193	1.0081
White	140	1	7360	0.0192	

There was no notable difference between the likelihood of entering the disciplinary process between the different ethnicities.

Capability

No staff who are BAME went through the capability process and therefore likelihood was not calculated.

Grievance

No staff who are BAME went through the grievance process and therefore likelihood was not calculated.

Gender

Disciplinary

	Total Disciplinary	Total Medical Disciplinary	Total workforce	Overall % likelihood for each grouping	Overall Relative Likelihood
Male	54	1	1610	0.0342	2.1829
Female	99		6326	0.0156	

It can be seen from the above table that males are more likely to enter the disciplinary process than females are (2.18 times more likely)

Capability

	Total Disciplinary	Total workforce	Overall % likelihood for each grouping	Overall Relative Likelihood
Male	5	1610	0.0031	1.9646
Female	10	6326	0.0016	

Male staff are 1.96 times more likely that female staff to enter the capability process.

Grievance

	Total Disciplinary	Total workforce	Overall % likelihood for each grouping	Overall Relative Likelihood
Male	4	1610	0.0025	1.1226
Female	14	6326	0.0022	

In the above table, it can be seen that Male staff are 1.12 times more likely than female staff to enter the grievance process.

Sexual Orientation

Disciplinary

	Total Disciplinary	Total workforce	Overall % likelihood for each grouping	Overall Relative Likelihood
LGB	9	356	0.0253	1.4050
Heterosexual	122	6780	0.0180	

Gay, Lesbian and Bisexual staff members are 1.41 times more likely to enter the disciplinary process than what heterosexual staff members are.

Capability

No staff who identified as Lesbian/Gay or Bi-sexual went through the capability process and therefore likelihood was not calculated.

Grievance

No staff who identified as Lesbian/Gay or Bi-sexual went through the Grievance process and therefore likelihood was not calculated.

Age categories

Disciplinary

				Overall					
	Total Disciplinary	Total Medical Disciplinary	Total workforce	% likelihood for each grouping	16-24	25-34	35-44	45-54	55-64
16-24	12		383	0.0313		2.3699	1.3566	1.9072	1.2404
25-34	25		1891	0.0132	0.4220		0.5724	0.8047	0.5234
35-44	46	1	2035	0.0231	0.7371	1.7470		1.4059	0.9144
45-54	31		1887	0.0164	0.5243	1.2426	0.7113		0.6504
55-64	39		1544	0.0253	0.8062	1.9106	1.0937	1.5375	

We can see from the above table, that overall, staff members who fall in the age category 16-24 are more likely than any other age category to enter the disciplinary process. However, it is worth acknowledging that there are only 12 people in that age category who had a disciplinary, and that age 16-24 has the lowest total workforce figures out of all the age groupings.

Capability

			Overall						
	Total Disciplinary	Total workforce	% likelihood for each grouping	16-24	25-34	35-44	45-54	55-64	65+
16-24	2	383	0.0052		4.9373	10.6266	3.2846	1.3438	1.0235
25-34	2	1891	0.0011	0.2025		2.1523	0.6653	0.2722	0.2073
35-44	1	2035	0.0005	0.0941	0.4646		0.3091	0.1265	0.0963
45-54	3	1887	0.0016	0.3045	1.5032	3.2353		0.4091	0.3116
55-64	6	1544	0.0039	0.7442	3.6742	7.9080	2.4443		0.7617
65+	1	196	0.0051	0.9770	4.8240	10.3827	3.2092	1.3129	

We can see from the above table that those in the 16 – 24 age category and those in the 65+ age category are more likely than any of the other age categories to enter the capability process. The likelihoods are quite significant, with them both being about 10 times more likely than those in the age 35-44 age category.

Grievance

			Overall					
	Total Disciplinary	Total workforce	% likelihood for each grouping	25-34	35-44	45-54	55-64	65+
25-34	2	1891	0.0011		0.4305	0.6653	0.2333	0.2073
35-44	5	2035	0.0025	2.3231		1.5455	0.5419	0.4816
45-54	3	1887	0.0016	1.5032	0.6471		0.3507	0.3116
55-64	7	1544	0.0045	4.2866	1.8452	2.8517		0.8886
65+	1	196	0.0051	4.8240	2.0765	3.2092	1.1254	

We can see from the above table that those aged 55 and over are more likely than any of the other age categories to enter the grievance process.

Staff survey results 2022

Data: The national staff survey was sent to all staff, and they were asked to respond to questions and to freely declare their long-term health condition status, gender, age, ethnicity and sexual orientation. The data is measured by those that agree with a series of questions and offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling NHS England and NHS Improvement to explore staff experience across different parts of the NHS and work to bring about the necessary improvements. The data was published on 9th March 2023.

Analysis: The statistics from the staff survey were utilised in order to assess the breakdown of the protected groups completing the staff survey, and these were then compared with the scores provided for the previous year. This enabled a comparison to be made for the trust performance compared to the year before. The scores were broken down to show comparisons of the following groups:

- Disabled compared to non-disabled (with a LTHC compared to without a LTHC)
- BAME compared to white.
- Age categories compared to one another.
- Gender compared to one another
- Sexual orientation compared to one another.

Question guide

Question Number	Question
Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.
Q14c	Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months.
Q15	Percentage believing that Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?
Q16b	In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues.
Q11c	Percentage feeling unwell due to work related stress in the last 12 months.
Q11e	Percentage pressure from their manager to attend work in the last 3 months despite not feeling well enough to perform their duties
Q4b	Percentage of staff satisfied with the extent to which their organisation values their work

Q30b	Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry out their work
Q14d	Percentage of staff saying that the last time they experienced harassment, bullying, or abuse at work, they or a colleague reported it
Q22e	I am able to access the right learning and development opportunities when I need to
SE	Staff Engagement – score out of ten

When looking at the tables of scores a comparison has been made for the % Agree, with the scores in last year's staff survey. A colour and a directional arrow rating have been used i.e., where that has been an improvement in the score then the box is green and the arrow next to the percentage is pointing up (h), and if the score is worse the box is red, and the arrow is pointing down (i). If the score this year is the same as last year, then an amber colour and a horizontal arrow is used (1). Any percentage box that has no arrow has no comparable category/score in last year's survey. The logic of the question can sometimes be that a higher percentage is a worse score e.g., Q14a, Q14c, Q16b, Q11c and Q11e, and the direction of the arrow reflects this.

Disability Breakdown for Trust Staff and question responses

	Staff with a LTHC		Staff without a LTHC		LTHC Not Declared
Workforce	630		6149		1157
	Responses	% Agree	Responses	% Agree	
Q14a	1111	26.7% ↑	2193	21.4%↓	
Q14c	1093	18.8% ↑	2174	11.2%↑	
Q15	1103	57.3% ↑	2181	65.3%↑	
Q16b	1107	8.5% ↑	2186	3.8%↑	
Q11c	1113	57.1% ↓	2195	38.1%↑	
Q11e	761	20.9% ↑	1058	12.5%↑	
Q4b	1111	41.5% ↑	2196	49.1%↑	
Q30b	604	75.8%*↑	N/A	-	
Q14d	408	56.4% ↓	580	59.5%↑	
Q22e	1112	55.5%↑	2194	63.2%↑	
SE	1113	6.5↔	2198	7.0↑	

*This question was only for those staff who had a LTHC and only the percentage was supplied and not the number of responses.

Note: Within workforce information it is classed as Disability/Non-Disability and staff with a declared disability total 630. For the survey, Long Term Health Condition (LTHC) was used, and staff completing the survey were asked to self-declare their response to having a LTHC or not. This may offer an explanation into the disparity between the numbers.

Summary

- Staff with a LTHC experience a higher level of harassment, bullying and abuse from patients, relatives, or the public, and from colleagues than those without a LTHC. (Q14a & Q14c)
- Staff with a LTHC experienced more discrimination from managers/team leaders or other colleagues. (Q16b)
- Staff with a LTHC are more likely to have received pressure from their manager to attend work in the last 3 months despite not feeling well enough to perform their duties. (Q11e)
- Staff with a LTHC are more likely to have felt unwell due to work related stress in the last 12 months. (Q11c)
- Staff with a LTHC are less satisfied with the extent to which the organisation values their work. (Q4b)
- Staff with a LTHC are less convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)
- 72% of staff reported that reasonable adjustments had been made to enable them to carry out their work. (Q30b)
- Staff with a LTHC feel they are less able to access the right learning and development opportunities. (Q22e)
- Staff with a LTHC are less engaged than staff without a LTHC. (SE)

Age breakdown for Trust staff and question responses

	21-30		31-40		41-50		51-65		66+	
Workforce	1389		2084		1840		2472		125	
	Responses	% Agree	Responses	% Agree	Responses	% Agree	Responses	% Agree	Responses	% Agree
Q14a	414	22.9%↑	732	24.6%↓	869	24.5%↓	1220	21.6%↑	59	16.9%↓
Q14c	409	8.8%↑	727	14.2%↑	856	15.1%↑	1210	14.3%↓	57	12.3%↓
Q15	414	72.7%↑	724	63.1%↑	864	60.0%↑	1215	61.3%↑	57	56.1%↑
Q16b	414	4.1%↑	731	5.3%↓	864	5.6%↑	1216	5.3%↑	58	8.6%↓
Q11c	414	48.1%↑	732	49.5%↑	871	45.8%↑	1223	40.5%↑	59	20.3%↑
Q11e	221	19.5%↑	425	14.4%↑	509	14.1%↑	632	16.3%↑	24	20.8%
Q4b	414	49.5%↑	732	47.4%↑	871	45.5%↑	1222	45.7%↑	59	54.2%↑
Q30b	No Data	-	No Data	-	No Data	-	No Data	-	No Data	-
Q14d	105	70.5%↓	222	58.6%↓	281	56.9%↑	362	55.8%↔	13	53.8%
Q22e	414	71.5%↑	730	62.5%↑	872	55.6%↓	1223	59.6%↑	59	57.6%↓
SE	414	7.0↑	732	6.8↑	872	6.8↔	1225	6.9↑	59	6.9↓

Summary

- Staff aged 66+ experience a lower level of harassment, bullying and abuse from patients, relatives, or the public than all other age groups. (Q14a)

- Staff aged 21-30 experience a lower level of harassment, bullying or abuse from colleagues. (Q14c)
- Staff aged 66+ are less likely to have felt unwell due to work related stress in the last 12 months. (Q11c)
- Staff in age group 21-30 are more likely to report an incident of harassment, bullying or abuse if they experience it (Q14d)
- Staff aged 66+ are the least convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)
- Staff aged 21-30 are slightly more engaged than other staff age groups. (SE)

Gender breakdown for Trust staff and question responses

	Female		Male		Prefer not to say	
Workforce	6326		1610		-	
	Responses	% Agree	Responses	% Agree	Responses	% Agree
Q14a	2545	22.0%↑	652	27.6%↑	85	22.4%
Q14c	2523	13.8%↑	640	11.1%↑	84	31.0%↓
Q15	2530	65.1%↑	648	57.4%↑	84	26.2%↓
Q16b	2535	5.1%↑	652	5.7%↑	84	14.3%↑
Q11c	2548	44.0%↑	654	44.8%↓	85	58.8%↑
Q11e	1386	15.9%↑	359	14.8%↑	58	20.7%↑
Q4b	2549	48.7%↑	652	40.8%↓	85	27.1%↑
Q30b	No Data	-	No Data	-	No Data	-
Q14d	731	59.2%↓	217	57.6%↑	32	50.0%↓
Q22e	2546	61.7%↑	654	58.4↑	85	48.2%↑
SE	2551	7.0↑	654	6.5↓	85	5.5↓

Summary

- Male Staff experience a higher level of harassment, bullying and abuse from patients, relatives, or the public. (Q14a)
- Staff that prefer not to say what their gender is experience a higher level of harassment, bullying and abuse from colleagues. (Q14c)
- Staff that prefer not to say what their gender is experienced more discrimination from managers/team leaders or other colleagues. (Q16b)
- Staff that prefer not to say what their gender is are more likely to have received pressure from their manager to attend work in the last 3 months despite not feeling well enough to perform their duties. (Q11e)

- Staff that prefer not to say what their gender is are more likely to have felt unwell due to work related stress in the last 12 months. (Q11c)
- Staff that prefer not to say what their gender is are less satisfied with the extent to which the organisation values their work. (Q4b)
- Staff that prefer not to say what their gender is are the least convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)
- Staff that prefer not to say what their gender is are less engaged than other staff. (SE)

Ethnicity breakdown for Trust staff and question responses

	White		BAME		Ethnicity Unknown / Null
Workforce	7360		467		109
	Responses	**% Agree**	**Responses**	**% Agree**	
Q14a	3156	22.6%↑	146	35.6%↓	
Q14c	3121	17.1%↓	145	19.3%↓	
Q15	3138	62.7%↑	144	65.3%↑	
Q16b	3147	5.2%↑	144	9.0%↑	
Q11c	3161	44.9%↑	146	34.9%↑	
Q11e	1757	15.8%↑	61*	18.0%↓	
Q4b	3160	46.5%↑	146	50.7%↓	
Q30b	No Data	-	No Data	-	
Q14d	913	57.8%↓	55**	61.8%↑	
Q22e	3400	59.9%↑	138	74.7%↑	
SE	3164	6.8↔	146	7.3↓	

*Only Black/Black British: African/Caribbean and Mixed/Multiple background responded

**Only Asian/Asian British and Black/Black British: African/Caribbean responded

Summary

- More BAME staff experience a higher level of harassment, bullying and abuse from patients, relatives, or the public and Colleagues. (Q14a & Q14c)
- More BAME staff than white have experienced discrimination from managers/team leaders or other colleagues. (Q16b)
- More BAME staff have attended work in the last 3 months despite not feeling well enough to perform their duties. (Q11e)
- More White staff have felt unwell due to work related stress in the last 12 months. (Q11c)
- More BAME staff are satisfied with the extent to which the organisation values their work. (Q4b)

- BAME Staff are more convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)
- White staff are less engaged than other staff. (SE)

Sexual Orientation breakdown for Trust staff and question responses

	Bisexual		Gay / Lesbian		Heterosexual		Other		Prefer not to say	
Workforce	334				6780		810			
	Responses	% Agree	Responses	% Agree	Responses	% Agree	Responses	% Agree	Responses	% Agree
Q14a	71	28.2%↑	97	27.8%↓	2953	22.7%↑	18	27.8↑	160	24.7%↑
Q14c	71	12.7%↑	96	17.7%	2918	13.1%↑	18	27.8↓	161	23.0%↓
Q15	70	67.1%↑	96	65.6%↓	2938	64.1%↑	17	64.7↑	160	33.1%↓
Q16b	71	7.0%↑	97	9.3%↓	2944	5.1%↑	18	11.1%	161	6.8%↑
Q11c	71	69.0%↓	97	56.7%↓	2958	42.7%↑	28	27.8↑	162	59.9%↑
Q11e	47	14.9%↑	55	12.7%↑	1600	15.4%↑	No Data	-	101	26.7%↑
Q4b	71	53.5%↑	97	41.2%↑	2956	47.6%↑	18	50.0↑	162	27.8%↓
Q30b	No Data	-	No Data	-	No Data	-	No Data	-	No Data	-
Q14d	23	69.6%↑	31	54.8%↓	863	58.5%↓	No Data	-	60	55.0%↑
Q22e	71	73.2%↑	97	58.8%↓	2956	61.5%↑	18	38.9↓	161	41.6%↑
SE	71	6.9↑	No Data	-	2960	6.9↔	18	6.6↓	162	5.8↔

Workforce data has 4 categories; Hetro, LGB, Undecided and Not Declared which do not immediately align with the choices available when completing the staff survey. The 'other' and 'prefer not to say' choices have been aligned with 'Undecided' and 'Not Declared' purely to allow comparison of the data.

Summary

- Heterosexual staff are less likely to experience harassment, bullying and abuse from colleagues or from patients, relatives, or the public. (Q14a)
- Bisexual Staff experience a lower level of harassment, bullying or abuse from colleagues. (Q14c)
- Heterosexual staff experienced less discrimination from managers/team leaders or other colleagues. (Q16b)
- Staff that prefer not to say what their sexuality is are more likely to have received pressure from their manager to attend work in the last 3 months despite not feeling well enough to perform their duties. (Q11e)
- Bisexual staff are more likely to have felt unwell due to work related stress in the last 12 months. (Q11c)
- Bisexual staff are more satisfied with the extent to which the organisation values their work. (Q4b)

- Staff that prefer not to say what their sexuality is are less convinced that the Trust provides equal opportunities for career progression or promotion. (Q15)
- Staff that prefer not to say what their sexuality is are less engaged than other staff. (SE)

Analysis of individual questions compared with last years results

Q14a. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

In general, a slightly better score this year than last. Both genders and all Sexual Orientation characteristics improved.

The largest positive change was the prefer not to say sexuality category last year 34% this year 24.7%. White Irish changed from 23.5% last year to 37.5% this year and as such were the largest negative movement.

Q14c. Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months.

In general, a slightly better score this year than last. Both genders and all disabilities were improved on last year.

The largest changes were seen in: Asian / Asian British Pakistan which was 28.6% last year and 7.7% this year (21% improvement), Bisexual, 20.8% last year and 12.7% this year (8.1% improvement).

All other scores had seen a +/- of <=5.5%

Q15. Percentage believing that Trust acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?

Of all the staff surveyed, only 5 characteristics rated this as worse this year than last (Gender – prefer not to say, Asian/Asian British Pakistan, White Irish, Gay/Lesbian and prefer not to say sexuality).

The largest changes were seen in: Sexual orientation - other, which was 44% last year and 64.7% this year (20.7% better), Bisexual, 49.1% last year and 67.1% this year (18% better).

Q16b. In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues.

In general, a better score this year than last. Most characteristics in each of their groups saw improvements. There were two characteristics notably worse than last year (Asian/Asian British Pakistan and White Irish).

Q11c. Percentage feeling unwell due to work related stress in the last 12 months.

Most staff rated this better this year than last.

The largest changes were seen in: Staff without LTHC was 58.9% last year and 38.1% this year (20.8% better), Sexual Orientation – other, 32.2% better this year than last. Staff without a LTHC score worsened by 16.3% (57.1% against 40.8% last).

Q11e. Percentage pressure from their manager to attending work in the last 3 months despite not feeling well enough to perform their duties

Mostly all staff surveyed said that this had improved since last year.

The largest change was seen in White Irish which was 9.1% last year and 28.6% this year (19.5% worse).

All other scores had seen a +/ - of <=8%.

Q4b. Percentage of staff satisfied with the extent to which their organisation values their work

Again, generally scores were better than last year. Both staff with a LTHC and those without a LTHC scored this better than last year. All age groups scored this better than last year too.

Bisexual scored as 53.5% this year compared to 36.4% last year. The prefer not to say gender were the least satisfied at 27.1%, this was 18.5% last year so there has been an improvement. 64.7% of Black/Black British agreed with the statement.

Q30b. Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustments to enable them to carry out their work

The percentage in agreement with the question this year was 75.8%, last year 72.2% agreed.

Q14d. Percentage of staff saying that the last time they experienced harassment, bullying, or abuse at work, they or a colleague reported it

All responses were within 10% of the scores form last year. Six characteristics had higher scores this year than last (Male, 41-50 Age group, BAME, Staff without a LTHC, Bisexual and prefer not to say sexual orientation).

Q22e. I am able to access the right learning and development opportunities when I need to

Generally, all scores were better than last year for most of the characteristics. The only characteristics to score worse than last year were; Age groups 41-50 and 66+, White Irish and both Gay/Lesbian and other sexualities. The most improvement on last year's score was Asian/Asian British Indian (87.5% this year and 62.5% last) and Bisexual (73.2% this year and 50.9% last). White Irish score worsened the most by 22.3% from last year (76.5% to 54.2%)

Staff Engagement

For all staff (other than Male and gender prefer not to say, 66+, Black/Black British: African, White Irish, other sexual orientation) the engagement score was better or the same as last year. However, all scores were within +/- of <0.5 change.

The largest improvements were seen with Asian/Asian British Indian and Bisexual, both of which score 0.5 higher than last year.

Board Representation

Percentage difference between the organisations' Board membership and its overall workforce disaggregated.

Data: Data was provided from Workforce information. The data and analysis was carried out on the 18 board figures, in relation to the total workforce. Information was recorded for all staff in relation to the following protected characteristics: Disability, Ethnicity, Age, Gender and Sexual Orientation.

Analysis: Descriptive statistics were utilised in order to assess the breakdown of the protected groups in respect of Board membership. Further to this, differences between board numbers relative to the workforce were calculated to evaluate any disparity between protected characteristics. The following characteristics were explored.

- Disabled compared to non-disabled.
- BAME compared to white.
- Age categories compared to one another.
- Male compared to Female.
- Heterosexual compared to LGB

Percentage difference between the organisations' Board membership and its overall workforce calculation example:

Voting board members broken down by ethnicity: BAME = 2(11.11%)

Total workforce broken down by ethnicity: BAME = 467(5.88%)

Percentage difference between organisations boards voting membership and its overall workforce for BAME members = +5.23%

Results:

There are a total of 18 board figures.

	Total board figures =
Voting members	14
Non voting members	4
Executive members	10
Non Executive member	8
Total	18

BAME

	Ethnicity								
	BAME			WHITE			NOT DECLARED		
	N	%	% difference betweenboard members and workforce	N	%	% difference betweenboard members and workforce	N	%	% difference between board members and workforce
Total Workforce	467	5.88%		7360	92.47%		109	1.37%	
Voting members	2	14.29%	8.41%	12	85.7%	-6.76%	0	0.0%	-1.37%
Non voting members	0	0.00%	-5.88%	4	100.0%	7.53%	0	0.0%	-1.4%
Executive members	1	10.00%	4.12%	9	90.0%	-2.47%	0	0.0%	-1.4%
Non Executive member	1	12.50%	6.62%	0	0.0%	-92.47%	0	0.0%	-1.4%
Total Board	2	11.11%	5.23%	16	88.9%	-3.58%		0.0%	-1.4%

Percentage difference between organisations boards voting membership and its overall workforce for BAME members = +8.41%

Percentage difference between organisations board executive membership and its overall workforce for BAME members = +4.12%. This has improved since last year. Last year there were no BAME executive members.

Gender

	Gender					
	MALE			FEMALE		
	N	%	% difference between board members and workforce	N	%	% difference between board members and workforce
Total Workforce	1610	21.01%		6326	79.71%	
Voting members	7	50.0%	28.99%	7	50.0%	-29.71%
Non voting members	1	25.0%	3.99%	3	75.0%	-4.71%
Executive members	4	40.0%	18.99%	6	60.0%	-19.71%
Non Executive member	4	50.0%	28.99%	4	50.0%	-29.71%
Total Board	8	44.4%	23.43%	10	55.6%	-24.15%

Percentage difference between organisations boards voting membership and its overall workforce for Female members = -29.71%

Percentage difference between organisations board executive membership and its overall workforce for Female members = -19.71%.

Disability

	Disability								
	DISABLED			NON-DISABLED			NOT DECLARED		
	N	%	% difference between board members and workforce	N	%	% difference between board members and workforce	N	%	% difference between board members and workforce
Total Workforce	630	7.94%		6149	77.48%		1157	14.58%	
Voting members	2	14.29%	6.35%	10	71.43%	-6.05%	2	14.29%	-0.29%
Non voting members	1	25.00%	17.06%	3	75.00%	-2.48%	0	0.00%	-14.58%
Executive members	1	10.00%	2.06%	7	70.00%	-7.48%	2	20.00%	5.42%
Non Executive member	2	25.00%	17.06%	6	75.00%	-2.48%	0	0.00%	-14.58%
Total Board	3	16.67%	8.73%	13	72.22%	-5.26%	2	11.11%	-3.47%

Percentage difference between organisations boards voting membership and its overall workforce for Disabled members = +6.35%

Percentage difference between organisations board executive membership and its overall workforce for disabled members = +2.06%. This is an improvement on last year's figures.

Age

	Age groupings								
	41-50			51-65			66+		
	N	%	% difference between board members and workforce	N	%	% difference betweenboard members and workforce	N	%	% difference between board members and workforce
Total Workforce	1840	23.18%		2472	31.15%		125	1.57%	
Voting members	0	0.00%	-23.18%	12	85.71%	54.56%	2	14.29%	12.72%
Non voting members	1	25.00%	1.82%	3	75.00%	43.85%	0	0.00%	-1.57%
Executive members	1	10.00%	-13.18%	9	90.00%	58.85%	0	0.00%	-1.57%
Non Executive member	0	0.00%	-23.18%	6	75.00%	43.85%	2	25.00%	23.43%
Total Board	1	5.56%	-17.62%	15	83.33%	52.18%	2	11.11%	9.54%

Percentage difference between the organisations board voting membership and its overall workforce for the different age groups is highest for those aged 51-65. This finding is the same for executive members compared to the overall workforce.

Sexual Orientation

	Sexual Orientation								
	Heterosexual			LGB			NOT DECLARED		
	N	%	% difference between board members and workforce	N	%	% difference between board members and workforce	N	%	% difference between board members and workforce
Total Workforce	6780	85.43%		334	4.21%		810	10.21%	
Voting members	11	78.57%	-6.86%	0	0.00%	-4.21%	3	21.43%	11.22%
Non voting members	4	100.00%	14.57%	0	0.00%	-4.21%	0	0.00%	-10.21%
Executive members	7	70.00%	-15.43%	0	0.00%	-4.21%	3	30.00%	19.79%
Non Executive member	8	100.00%	14.57%	0	0.00%	-4.21%	0	0.00%	-10.21%
Total Board	15	83.33%	-2.10%	0	0.00%	-4.21%	3	16.67%	6.46%

There is currently no member of the trust board who identifies as Lesbian, Gay or Bi-sexual.

Summary:

Summary:

- BAME Staff have a higher voting membership on the board relative to the workforce population.
- Females are underrepresented on the board relative to the workforce populations for both voting membership and executive membership.
- Staff with a disability have a higher representation of voting members compared to the workforce population of disabled staff.

- Board membership is underrepresented in age ranges from 41-50 but over-represented in age brackets 51-65 and 66+.
- There are currently no board members represented by persons identifying as Lesbian, Gay or Bi-sexual.

Agenda for Change Banding Distribution

Data: The data was provided by workforce information and maps the protected characteristics against the agenda for change pay bandings. The information is provided for both the Non-Clinical and Clinical workforce as well as Medical & Dental.

Analysis: The data provided is very high-level count data, for this reason, only descriptive analytics were utilised to summarise the variation and patterns within the data.

Results

- **BAME**

Indicator		Data Item			WHITE		BME		ETHINICITY UNKNOWN/ NULL	
					Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1						
			2	Band 1	15	100%	0	0%	0	0%
			3	Band 2	447	96%	9	2%	9	2%
			4	Band 3	515	97%	14	2%	3	1%
			5	Band 4	374	96%	14	3%	2	1%
			6	Band 5	142	95%	8	5%	0	0%
			7	Band 6	107	93%	8	7%	0	0%
			8	Band 7	115	96%	4	3%	1	1%
			9	Band 8a	52	98%	1	2%	0	0%
			10	Band 8b	49	98%	1	2%	0	0%
			11	Band 8c	15	88%	1	6%	1	6%
			12	Band 8d	13	100%	0	0%	0	0%
			13	Band 9	2	100%	0	0%	0	0%
			14	VSM	16	94%	1	6%	0	0%
		1b) Clinical workforce of which Non Medical	15	Under Band 1						
			16	Band 1	1	100%	0	0%	0	0%
			17	Band 2	28	85%	5	15%	0	0%
			18	Band 3	1340	92%	86	6%	25	2%
			19	Band 4	372	90%	34	8%	6	2%
			20	Band 5	715	90%	67	8%	10	2%
			21	Band 6	1609	95%	66	4%	15	1%
			22	Band 7	845	96%	27	3%	9	1%
			23	Band 8a	251	95%	12	5%	0	0%
			24	Band 8b	85	96%	4	4%	0	0%
			25	Band 8c	95	100%	0	0%	0	0%
			26	Band 8d	13	100%	0	0%	0	0%
			27	Band 9	5	100%	0	0%	0	0%
			28	VSM	3	75%	0	0%	1	25%
		OR which Medical & Dental	29	Consultants	86	59%	55	37%	6	4%
			30	of which Senior medical manager	2	22%	3	33%	4	45%
			31	Non-consultant career grade	46	42%	47	43%	17	15%
			32	Trainee grades	2	100%	0	0%	0	0%
			33	Other	0	0%	0	0%	0	0%

The distribution of BAME staff compared to White staff across the banding structures indicates that significantly high proportions of BAME staff make-up the higher banding structures within the Medical and Dental professional roles. Staff of white ethnicity predominantly make up the figures across the clinical and non-clinical workforce

- **Disability**

Indicator		Data Item			DISABILITY		NON DISABLED		DISABILITY NOT DECLARED	
					Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1						
			2	Band 1	0	0%	6	40%	9	60%
			3	Band 2	24	5%	324	70%	117	25%
			4	Band 3	48	9%	418	79%	66	12%
			5	Band 4	32	8%	287	74%	71	18%
			6	Band 5	4	3%	126	84%	20	13%
			7	Band 6	13	11%	93	81%	9	8%
			8	Band 7	10	8%	91	76%	19	16%
			9	Band 8a	5	9%	40	76%	8	15%
			10	Band 8b	5	10%	39	78%	6	12%
			11	Band 8c	2	12%	9	53%	6	35%
			12	Band 8d	0	0%	9	69%	4	31%
			13	Band 9	0	0%	1	50%	1	50%
			14	VSM	1	6%	12	71%	4	23%
		1b) Clinical workforce of which Non Medical	15	Under Band 1						
			16	Band 1	0	0%	0	0%	1	100%
			17	Band 2	1	4%	16	48%	16	48%
			18	Band 3	102	7%	1035	71%	314	22%
			19	Band 4	41	10%	311	75%	60	15%
			20	Band 5	87	11%	613	77%	92	12%
			21	Band 6	145	8%	1395	83%	150	9%
			22	Band 7	70	8%	730	83%	81	9%
			23	Band 8a	16	6%	220	84%	27	10%
			24	Band 8b	6	7%	75	84%	8	9%
			25	Band 8c	4	4%	69	73%	22	23%
			26	Band 8d	2	15%	8	62%	3	23%
			27	Band 9	0	0%	4	80%	1	20%
			28	VSM	1	25%	2	50%	1	25%
		OR which Medical & Dental	29	Consultants	3	2%	118	80%	26	18%
			30	of which Senior medical manager	0	0%	5	56%	4	44%
			31	Non-consultant career grade	8	7%	91	83%	11	10%
			32	Trainee grades	0	0%	2	100%	0	0%
			33	Other	0	0%	0	0%	0	0%

Within non-clinical roles 7% of the workforce have a disability, this compares to 8% of staff in clinical roles. The leadership roles between staff with a disability and those without were 20% and 22% respectively. The figures considered for the medical and dental roles are relatively small, however 2% of staff with a disability are employed within these roles, compared to 4% of staff without a disability.

- **Age**

Indicator		Data Item			AGE 16-20		AGE 21-30		AGE 31-40		AGE 41-50		AGE 51-65		AGE 66+	
					Figure	%	Figure	%	Figure	%	Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1												
			2	Band 1	0	0%	0	0%	0	0%	3	20%	11	73%	1	7%
			3	Band 2	2	0%	38	8%	68	15%	82	18%	250	54%	25	5%
			4	Band 3	2	0%	80	15%	101	19%	111	21%	217	41%	21	4%
			5	Band 4	1	0%	45	11%	70	18%	88	23%	168	43%	18	5%
			6	Band 5	0	0%	25	17%	31	20%	37	25%	54	36%	3	2%
			7	Band 6	0	0%	10	9%	27	23%	33	29%	44	38%	1	1%
			8	Band 7	0	0%	5	4%	34	28%	44	37%	37	31%	0	0%
			9	Band 8a	0	0%	3	6%	16	30%	15	28%	19	36%	0	0%
			10	Band 8b	0	0%	2	4%	9	18%	23	46%	16	32%	0	0%
			11	Band 8c	0	0%	0	0%	3	18%	9	53%	5	29%	0	0%
			12	Band 8d	0	0%	0	0%	2	15%	6	46%	5	39%	0	0%
			13	Band 9	0	0%	0	0%	0	0%	0	0%	2	100%	0	0%
			14	VSM	0	0%	0	0%	1	6%	2	12%	14	82%	0	0%
		1b) Clinical workforce of which Non Medical	15	Under Band 1												
			16	Band 1	0	0%	0	0%	0	0%	0	0%	1	100%	0	0%
			17	Band 2	0	0%	1	3%	7	21%	6	18%	18	55%	1	3%
			18	Band 3	22	1%	294	20%	315	22%	300	21%	501	35%	19	1%
			19	Band 4	0	0%	165	40%	79	19%	73	18%	91	22%	4	1%
			20	Band 5	0	0%	286	36%	227	29%	141	18%	131	16%	7	1%
			21	Band 6	0	0%	311	18%	581	34%	340	20%	447	27%	11	1%
			22	Band 7	0	0%	90	10%	303	35%	257	29%	223	25%	8	1%
			23	Band 8a	0	0%	7	3%	113	43%	81	31%	61	23%	1	0%
			24	Band 8b	0	0%	0	0%	15	17%	40	45%	34	38%	0	0%
			25	Band 8c	0	0%	0	0%	17	18%	45	47%	32	34%	1	1%
			26	Band 8d	0	0%	0	0%	1	8%	6	46%	6	46%	0	0%
			27	Band 9	0	0%	0	0%	0	0%	1	20%	4	80%	0	0%
			28	VSM	0	0%	0	0%	0	0%	1	25%	3	75%	0	0%
		OR which Medical & Dental	29	Consultants	0	0%	0	0%	19	13%	70	48%	55	37%	3	2%
			30	of which Senior medical manager	0	0%	6	56%	1	11%	0	0%	3	33%	0	0%
			31	Non-consultant career grade	0	0%	20	18%	44	40%	25	23%	20	18%	1	1%
			32	Trainee grades	0	0%	1	50%	0	0%	1	50%	0	0%	0	0%
			33	Other	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%

No staff in the age group 16-20 are employed within leadership roles within the organisation. There are also no staff aged 66+ within non-clinical leadership roles. The age group 41- 50 occupy the most non-clinical leadership roles at approximately 22% of the workforce within that age category. Within clinical leadership roles, the age range of 31-40 and 41-50 occupy the highest number of leadership posts (27% and 34% respectively). This compares to only 8% within the age bracket 21-30. The figures across the medical and dental posts are relatively equal across age groups apart from age groups 21-30 and 66+ which are quite low numbers compared to the other age groups.

- **Gender**

Indicator		Data Item			MALE		FEMALE	
					Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1				
			2	Band 1	3	20%	12	80%
			3	Band 2	89	19%	376	81%
			4	Band 3	58	11%	474	89%
			5	Band 4	55	14%	335	86%
			6	Band 5	60	40%	90	60%
			7	Band 6	40	35%	75	65%
			8	Band 7	39	33%	81	68%
			9	Band 8a	9	17%	44	83%
			10	Band 8b	19	38%	31	62%
			11	Band 8c	6	35%	11	65%
			12	Band 8d	4	31%	9	69%
			13	Band 9	1	50%	1	50%
			14	VSM	8	47%	9	53%
		1b) Clinical workforce of which Non Medical	15	Under Band 1				
			16	Band 1	0	0%	1	100%
			17	Band 2	11	33%	22	67%
			18	Band 3	370	25%	1081	75%
			19	Band 4	63	15%	349	85%
			20	Band 5	124	16%	668	84%
			21	Band 6	271	16%	1419	84%
			22	Band 7	149	17%	732	83%
			23	Band 8a	47	18%	216	82%
			24	Band 8b	20	22%	69	78%
			25	Band 8c	31	33%	64	67%
			26	Band 8d	5	38%	8	62%
			27	Band 9	1	20%	4	80%
			28	VSM	0	0%	4	100%
		OR which Medical & Dental	29	Consultants	75	51%	72	49%
			30	of which Senior medical manager	2	33%	4	67%
			31	Non-consultant career grade	49	43%	64	57%
			32	Trainee grades	1	50%	1	50%
			33	Other	0	0%	0	0%

There are double the proportion of non-clinical male staff in non-clinical leadership roles compared to females (22% of male workforce compared to 12% female). There are also significant differences with medical and dental. Approximately 8% of the entire male workforce are appointed into medical/dental roles compared to 2% of the entire female workforce. No difference was found in relation to clinical leadership roles between genders.

- **Sexual Orientation**

Indicator		Data Item			SEXUAL ORIENTATION HETRO		SEXUAL ORIENTATION LGB		SEXUAL ORIENTATION UNDECIDED		SEXUAL ORIENTATION NOT DECLARED	
					Figure	%	Figure	%	Figure	%	Figure	%
1	Percentage of staff in each of the AfC bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in in the overall workforce	1a) Non Clinical workforce	1	Under Band 1								
			2	Band 1	12	80%	0	0%	0	0%	3	20%
			3	Band 2	370	80%	5	1%	0	0%	90	19%
			4	Band 3	477	90%	17	3%	1	0%	37	7%
			5	Band 4	341	88%	9	2%	0	0%	40	10%
			6	Band 5	135	90%	2	1%	0	0%	13	9%
			7	Band 6	104	90%	4	4%	0	0%	7	6%
			8	Band 7	106	88%	5	4%	0	0%	9	8%
			9	Band 8a	48	91%	2	4%	0	0%	3	5%
			10	Band 8b	45	90%	0	0%	0	0%	5	10%
			11	Band 8c	16	94%	0	0%	0	0%	1	6%
			12	Band 8d	11	85%	0	0%	0	0%	2	15%
			13	Band 9	1	50%	1	50%	0	0%	0	0%
			14	VSM	12	71%	1	6%	0	0%	4	23%
		1b) Clinical workforce of which Non Medical	15	Under Band 1								
			16	Band 1	0	0%	0	0%	0	0%	1	100%
			17	Band 2	26	79%	0	0%	0	0%	7	21%
			18	Band 3	1206	83%	67	5%	3	0%	175	12%
			19	Band 4	337	82%	32	8%	2	0%	41	10%
			20	Band 5	676	85%	45	6%	2	0%	69	9%
			21	Band 6	1501	89%	75	4%	3	0%	111	7%
			22	Band 7	775	88%	36	4%	1	0%	69	8%
			23	Band 8a	228	87%	14	5%	0	0%	21	8%
			24	Band 8b	81	92%	4	4%	0	0%	4	4%
			25	Band 8c	82	86%	2	2%	0	0%	11	12%
			26	Band 8d	10	77%	1	8%	0	0%	2	15%
			27	Band 9	5	100%	0	0%	0	0%	0	0%
			28	VSM	3	75%	0	0%	0	0%	1	25%
		OR which Medical & Dental	29	Consultants	84	57%	4	3%	0	0%	59	40%
			30	of which Senior medical manager	6	67%	0	0%	0	0%	3	33%
			31	Non-consultant career grade	82	75%	7	6%	0	0%	21	19%
			32	Trainee grades	0	0%	1	50%	0	0%	1	50%
			33	Other	0	0%	0	0%	0	0%	0	0%

There were no differences noted between leadership numbers across those who identified as LGB and those who are recorded as being heterosexual.

Census Comparison

Gender

	Gender	Trust		Census		Trust diff % +/-
		N	%	N	%	
DTV&F	Female	3847	81.30%	613200	51.00%	30.30%
	Male	885	18.70%	586200	49.00%	-30.30%
	DTV&F Total	**4732**		**1199200**		
NYYS	Female	1531	81.44%	419000	51.00%	30.44%
	Male	349	18.56%	399200	49.00%	-30.44%
	NYYS Total	**1880**		**818300**		

Compared to census figures TEWV's work force is disproportionately made up of female members of staff. Within the staff makeup of the trust, DTV&F workforce is made up of 81.30% of females, which is 30.30% higher than census figures. With only 18.70% of the workforce made up by males. This is similar for NYY&S, with 81.44% of their workforce being made up by females.

Age

0	Age Band	Trust		Census		Trust diff % +/-
		N	%	N	%	
DTV&F	15 to 19	11	0.23%	68,500	5.71%	-5.48%
	20 to 29	801	16.93%	140,900	11.75%	5.18%
	30 to 39	1335	28.21%	147,000	12.32%	15.89%
	40 to 49	1102	23.29%	140,100	11.68%	11.61%
	50 to 64	1393	29.44%	252,900	21.09%	8.35%
	Over 64	90	1.90%	245,000	20.43%	-18.53%
	DTV&F Total	**4732**		**995,100**		
NYYS	15 to 19	0	0%	47,300	5.78%	-5.78%
	20 to 29	308	16.38%	90,900	11.11%	5.27%
	30 to 39	510	27.13%	92,300	11.28%	15.85%
	40 to 49	412	21.91%	94,900	11.60%	10.31%
	50 to 64	601	31.97%	179,000	21.87%	10.10%
	Over 64	49	2.61%	192,600	23.54%	-20.93%
	NYYS Total	**1880**		**697,000**		

The age ranges which have the largest negative difference in staff make up compared to census figures is the over 64 category which is to be expected as well as the 15 to 19 age group. Both DTV&F and NYYS have the highest number of staff members within the 50 to 64 age group.

Ethnicity

		Trust		Census		Trust diff % +/-
		N	%	N	%	
DTV&F	White	4380	92.56%	1129136	94.15%	-1.59%
	Mixed	40	0.85%	14015	1.17%	-0.32%
	Asian	123	2.60%	37702	3.14%	-0.54%
	Black or Black British	117	2.47%	9170	0.76%	1.71%
	Other	23	0.49%	9223	0.77%	-0.28%

	Not Stated	49	1.04%			
	Total	**4732**		**1199246**		
NYYS	White	1725	91.76%	783322	95.72%	-3.96%
	Mixed	17	0.90%	10463	1.28%	-0.38%
	Asian	43	2.29%	15954	1.95%	0.34%
	Black or Black British	37	1.97%	3784	0.46%	1.51%
	Other	13	0.69%	4797	0.59%	0.10%
	Not Stated	45	2.39%			
	Total	**1880**		**818320**		

For both DTV&F and NYY&S both of their workforces are predominantly made up of staff who classify themselves as White, however the percentage difference compared to the census figures shows that we are below the census make up for the White group.

Sexual Orientation

		Trust		Census		Trust diff % +/-
		N	%	N	%	
DTV&F	Heterosexual or straight	4065	85.90%	894421	91.17%	-5.27%
	Gay or Lesbian	139	2.94%	14158	1.44%	1.50%
	Bisexual	68	1.44%	10779	1.10%	0.34%
	Other (not listed)	10	0.21%	2471	0.25%	-0.04%
	Undecided	5	0.11%			
	Not Stated	445	9.41%	59211	6.04%	3.37%
	Total	**4732**		**981040**		
NYYS	Heterosexual or straight	1598	85.00%	619782	90.05%	-5.05%
	Gay or Lesbian	48	2.55%	9280	1.35%	1.20%
	Bisexual	45	2.39%	9364	1.36%	1.03%
	Other (not listed)	10	0.53%	2190	0.32%	0.21%
	Undecided	5	0.27%			
	Not Stated	161	8.56%	47639	6.92%	1.64%
	Total	**1880**		**688255**		

DTV&F and NYY&S both have workforces which are predominantly made up of staff who classify themselves as Heterosexual or straight. 85% of NYY&S and 85.90% for DTV&F. When compared against the census both show under-representation by around 5%.

Disability

	Disability	Trust		Census		Trust diff % +/-
		N	%	N	%	
DTV&F	Yes	369	7.80%	255829	21.33%	-13.53%
	No	4363	92.20%	943371	78.67%	13.53%
	DTV&F Total	**4732**		**1199200**		

NYYS	Yes	164	8.72%	133178	16.28%	-7.56%
	No	1716	91.28%	685122	83.72%	7.56%
	NYYS Total	**1880**		**818300**		

The workforce for DTV&F is made up of 92.20% of people with no disability which is 13.53% higher than the census figures, NYYS is also made up of 91.28%, which is 7.56% higher than census figures.

Summary

Recruitment

Some inequalities were apparent when comparing protected characteristic groups across the shortlisting and recruitment process. These differences were as follows:

- Applicants without a disability were 1.13 times more likely to be appointed than applicants with a disability.
- White applicants were 1.83 times more likely to be appointed than BAME applicants.
- Females were 1.16 times more likely to appointed than males.
- Heterosexual applicants were 1.13 times more likely to be appointed than Gay, Lesbian or Bi-sexual applicants.
- Age category 66+appeared to be the most successful in being appointed, whilst the16-20 age group appeared the least likely to be appointed.

It is important to note that, although differences were found in the likelihood of being appointed, the ratios calculated for male and BAME applicants have improved since last year's report.

Disciplinary and Capability

The likelihood figures, compared to last years, have for the majority reduced, meaning that there is less disparity between the different groupings.

For those staff who identified as having a disability, the likelihood of them entering the disciplinary and capability process compared to those without a disability has reduced since last year.

There are also no notable differences to report for BAME compared to white staff for capability and disciplinary, which would indicate that there is less disparity this year compared to last year's numbers.

LGB staff are now 1.4 times more likely to enter formal disciplinary than heterosexual staff, last year this likelihood was 1.68, showing that this figuring is slowly decreasing.

For Gender, Males are more likely than females to enter the formal disciplinary, capability and grievances process, by quite a significant amount (2.18, 1.96 and 1.12 respectively).

This finding has stayed consistent with last year's findings, however the likelihood figure has reduced indicating that the gap between Males and Females is getting smaller.

Staff Survey

Inequalities across protected characteristics were found in relation to the staff survey results. These are summarised below:

Long-Term Health Conditions

- Staff with a long-term health condition (LTHC) experienced a higher level of:
    - harassment, bullying and abuse from patients, relatives, the public and colleagues
    - Discrimination from managers, team leaders and colleagues
    - Pressure to attend work despite not feeling well enough
    - Work related stress
    - Not feeling valued at work
    - Difficulty finding opportunities for career progression
    - Feeling unengaged with work

However, a high proportion felt that reasonable adjustments had been made to enable them to work effectively.

Age

Within the different age groups, the 66+ group generally experienced lower levels of harassment, bullying and abuse, feeling unwell due to work related stress and felt more

engaged with work than other age groups. However, they did feel they had less opportunities for promotion.

Gender

The survey results indicated that male staff experience higher levels of harassment, bullying and abuse. However, all other differences were noted only within the group of staff who preferred not to record their gender.

Ethnicity

In comparison to white staff, BAME staff reported experiencing higher levels of:

- Harassment, bullying and abuse
- Discrimination from managers and team leaders
- Unequal opportunities for career progression
- Feeling engaged
- Feeling valued

Sexual Orientation

In relation to sexual orientation, inequalities included:

- Higher levels of bullying and harassment in non-heterosexual staff
- Heterosexual staff experienced lower levels of discrimination by managers and team leaders.
- Bisexual staff are more likely to feel unwell due to work related stress
- Bisexual staff feel more valued by the organisation

Board Membership

- BAME Staff have a higher voting membership on the board relative to the workforce population, however, there is only one BAME executive member on the board.
- Females are underrepresented on the board relative to the workforce populations for both voting membership and executive membership.
- Staff with a disability have a higher voting member representation compared to the workforce population of disabled staff, and a slightly higher representation in executive membership. However, the number of disabled board members is only three in total.
- Board membership is underrepresented in age ranges from 41-50 but over-represented in age brackets 51-65 and 66+.

- There are currently no board members represented by persons identifying as Lesbian, Gay or Bi-sexual

Workforce

These findings echo what was reported last year.

- BAME staff are recruited into medical and dental posts at a significantly higher rate than White staff.
- Staff with a disability are appointed to leadership roles within clinical and non-clinical posts at a similar rate to staff without a disability. However 2% of staff with a disability are employed within medical/dental roles, compared to 4% of staff without a disability.
- No leadership roles are appointed to staff in the age range 16-20. No staff within the 66+ bracket are appointed to non-clinical leadership roles. Within clinical leadership roles, significantly more staff are appointed in the age brackets 31-40 and 41-50 compared to the other age categories.
- There are double the proportion of non-clinical male staff in non-clinical leadership roles compared to females (22% of male workforce compared to 12% female).

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Tees, Esk and Wear Valleys
NHS Foundation Trust

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Contents

1 Introduction

Our Journey to Change
The trust's core values of respect, compassion and responsibility are integral to equality, diversity inclusion and human rights. This policy is critical to the delivery of OJTC and our ambition to co create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism.

This policy supports the trust to co- create a great experience for all patients, carers and families from its diverse communities by:

- Outlining the trust's commitment to provide services that meet people's needs and are available and accessible to its diverse communities and that any barriers to accessing services are identified and removed (see paragraph 4)
- Detailing the measures the trust will take to ensure that its services meet the needs of its diverse communities (see paragraph 7.1, 7.2 and 7.7
- Outlining clear expectations of the behaviours expected from all staff to ensure that patients, carers and families from protected groups have the same outcomes and experiences as other patients, carers and families (see paragraph 4)

This policy supports the trust to co-create a great experience for all colleagues from its diverse communities by:

- Outlining the trust's commitment to ensuring that staff from protected groups have the same outcomes and experiences as other staff and outlines the measures to ensure this will happen in recruitment and selection, learning and development and performance management (See paragraphs 7.3, 7.4 and 7.5)
- Outlining clear expectations of the behaviours expected from all staff to ensure that staff from protected groups have the same outcomes and experiences as other staff see paragraph 4)

The NHS Constitution states that **'The NHS belongs to us all'**, it is with this principle in mind that this policy has been written.

The Trust is under increasing pressure to deliver high quality services, with limited resources to an increasingly diverse population whose needs and expectations are growing. At the heart of the Trust is a commitment to provide comprehensive and flexible services that meet people's needs and are available and accessible to all. In order for the Trust to be equipped to deliver its services in a respectful, fair and inclusive way, the Trust must become more innovative in how it can meet the different needs of service users and make best use of the resources it has, most notably its people.

In employment matters the Trust recognises that harassment, discrimination, bullying and victimisation are destructive behaviours that can happen within any team, in any organisation. Wherever they exist they contribute to and exacerbate poor mental health and wellbeing, add to workplace stress and lower team morale. This in turn can result in

increased sickness absence levels, high staff turnover and can ultimately result in mental ill health.

If bullying is allowed to thrive within an organisation it becomes a destructive force that can prohibit open challenge, whistleblowing or raising concerns. Staff may become fearful of reprisal (victimisation) from both managerial and non-managerial colleagues. Left unchecked this can have a direct impact on the safety and quality of patient care as was highlighted in the Francis Report into Mid Staffordshire Hospital. The Trust considers all the above mentioned abusive behaviours as ‘avoidable and unjustifiable harm’

Trust staff have a duty of care towards their colleagues, service users, their relatives and carers or anyone else they come into contact with whilst engaged in Trust business.

2 Why we need this policy

2.1 Purpose

This policy sets out how the organisation complies with applicable human rights and equality legislation (MHA CoP 2015, para.3.15). This policy is a key policy and as such should be read by all staff regardless of role, grade or position.

2.1.1 Legislation - The Human Rights Act 1998

The Human Rights Act is a foundation law, meaning that all other laws must be compatible with it. When there are abuses of Human Rights people have the right to challenge, speak up or to request an investigation. The Act has three duties which all staff and those acting on behalf of the Trust must abide by at all times. The three duties are;

- **Respect**; this means to **not** violate rights
- **Protect**; to take action to prevent a violation (by whistleblowing, raising concerns etc.)
- **Fulfil**; to provide investigation and review when violations occur (procedural duty)

The Human Rights Act is an enabling foundation law that aims to promote the rights of human beings, whatever their circumstances. It is not possible for a person not to have rights; a person always has human rights.
In particular circumstances Human Rights can be limited or restricted, but rights can never be taken away completely. Human Rights provide a set of minimum standards and are a vital safety net for the treatment we can all expect from our services, including;

- **Better services and outcomes**: can help drive up quality and improve outcomes
- **Not reinventing the wheel**: Not about completely changing what you do, human rights are a practical framework to help you improve how you do it
- **Familiar shared values**: dignity, respect, fairness, autonomy, equality and choice – upholding these values under challenging circumstances
- **Power not pity**: human rights provides a powerful language
- **Changing the day-to-day practice**: not theory

2.1.2 Key Human Rights for mental health and learning disability services

There are five key Human Rights for mental health and learning disability services, these are:

Article 2 - **The right to life** includes a duty not to take away anyone's life, a positive duty to take reasonable steps to protect life and a procedural duty to investigate deaths where public officials may be implicated / involved.

Article 3 - **The right to be free from torture, inhuman and degrading treatment**. This is an absolute right. It covers three types of treatment: Torture, Inhuman treatment, degrading treatment

It imposes three types of obligations on public officials:

- A negative duty **not** to torture or treat someone in an inhuman and degrading way
- A positive duty to take reasonable steps to protect people known to be at risk of such treatment
- A procedural duty to investigate where torture, inhuman or degrading treatment has occurred

Article 5 - **The right to liberty** is a non-absolute right. In specific circumstances liberty can be limited, e.g. detention under Mental Health Act or prison. The right to liberty is not a right to be free to do whatever you want. It is a right not to have extreme restrictions placed on a person's movement. It includes procedural safeguards such as review mechanisms and time limits.

Article 8 – **The right to respect for private and family life, home and correspondence**. This right protects four interests: private life, family life, home and correspondence

This right is non-absolute and can be restricted. It has to be balanced against the rights of others and the needs of society. This right involves three types of obligations on public officials:

- A negative duty **not** to interfere with people's family life, private life, home and correspondence
- A positive duty to take reasonable steps to protect people known to be at risk of having their rights violated, especially in relation to mental and physical well-being
- A procedural duty to ensure fair decision-making processes

Article 14 – **The right to non-discrimination**. This right can only be used in conjunction with another right or rights. The definition of discrimination is broader than that of the Equality Act and a person can bring a case of discrimination for any reason.

Human Rights belong to everyone. They are the basic rights that we all have simply because we are human, regardless of who we are, where we live or what we do. Human Rights represent all the things that are important to us as human beings, such as being able to choose how to live our lives whilst being treated with dignity and respect. We have Human Rights from the moment we are born until the moment we die. Putting Human Rights at the heart of the way Trust services are designed and delivered ensures better services for everyone.

2.1.3 Legislation - The Equality Act 2010

The Trust focuses on Equality, Diversity and Human Rights from two perspectives that are intertwined with each other.

- **Service Delivery** – Equality, Diversity and Human Rights in healthcare for service users and their carers

- **Employment** – Equality, Diversity and Human Rights for our staff

The Equality Act 2010 makes it unlawful to discriminate against someone because of one or more protected characteristics. The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Section 149(1) of the Equality Act 2010 states – A public authority must, in the exercise of its functions, have due regard (take seriously) to the need to –

- **Eliminate** unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- **Advance** equality of opportunity between people who share a protected characteristic and those who do not
- **Foster** good relations between people who share a protected characteristic and those who do not

These are more commonly known as the three aims of the Act.

The Act requires that the Trust demonstrates 'due regard' this means the Trust **MUST** demonstrate that it has reasonably considered its impact on equality. This is an ongoing requirement (continuous duty) and it is essential that this is done in a proactive and anticipatory way, rather than in a reactive way which is ineffective and does not evidence or demonstrate 'due regard' (reasonable consideration) of the requirements of the Act.

Section 149(2) of the Equality Act 2010 states
A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).
Section 149(2) relates to Trust staff and anyone else who provides or delivers services to the public such as council workers, the police, teachers etc. All NHS staff and anyone else who carries out a function or functions on, or on behalf of the Trust must take their responsibility seriously and in accordance with the Act, acting in compliance with section 149(1) of the Act at all times. Further information on how to access the Equality Act 2010 can be found on page 15.

2.2 Objectives

The objective of this policy is to provide a set of minimum standards that everyone who has dealings with the Trust must adhere to. We must ensure that all aspects of Trust business are non-discriminatory, carried out in a fair and consistent manner and in line with the Trust values; compassion, respect and responsibility . The Trust is committed to providing services and employment environments that promote Equality, Diversity, Inclusion and Human Rights and will make every effort not to discriminate against service users, relatives, carers, Trust staff, potential Trust staff, bank workers, agency workers, volunteers, students, contractors or anyone that deals with the Trust in any way. The Trust

has a duty to respect and promote people's Human Rights which improve experiences for all.

3 Scope

3.1 Who this policy applies to

This policy applies to the following groups of people. Expected standards of behaviour can be found in section 3.2 Roles and Responsibilities. The trust's values of respect, compassion and responsibility are key to ensuring that all those from its diverse populations who come into contact with the trust have the same high quality outcomes and experiences.

- The Chief Executive and The Trust Board of Directors including Non-Executive Directors
- All Trust Managers, regardless of role, grade or position
- All Trust staff regardless of role, grade or position
- Bank Workers and Agency Workers
- Service users, their carers, relatives and friends
- Trust Governors
- Trust experts by experience
- Trust Volunteers
- Hospital Managers
- Contractors

3.2 Roles and responsibilities

Role	Responsibility
Chief Executive and the Trust Board of Directors	• The Chief Executive is responsible for providing leadership to the Trust in the promotion of Equality, Diversity, Inclusion and Human Rights in both service delivery and employment matters • Members of the Trust Board collectively and individually are responsible for supporting the Chief Executive in this objective • The Trust must conform to current legislative requirements of the Human Rights Act 1998 and the Equality Act 2010. • The Trust seeks to ensure equitability of access in the provision of its services, which meets the needs of service users • As a provider of mental health, learning disability and substance misuse services, the Trust is committed to meaningful engagement with all parts of its communities and commissioners

	The Trust seeks to dismantle barriers that prevent equality of access to employment, promotion, training and development opportunities for all protected groups
Director of People and Culture	• The Director of People and Culture has operational responsibility for Equality, Diversity and Human Rights throughout the Trust in both Employment and Service Delivery
The Equality, Diversity, Inclusion and Human Rights Lead	• The Equality, Diversity, Inclusion and Human Rights Lead role is to support the Director of People and Culture to be able to make informed decisions in all matters relating to Equality, Diversity, Inclusion and Human Rights. The EDI & Human Rights Lead reports to the Director of People and Culture monthly and to the relevant board committee/s covering employment and clinical services three times a year, submitting an annual report of progress made as part of the reporting cycle. Further to this the EDI & Human Rights Lead reports to the Senior Leadership Group (SLG) and Workforce Development Group as and when necessary and in accordance with Trust requirements
Equality, Diversity, Inclusion and Human Rights Officer	• The Equality, Diversity, Inclusion and Human Rights Officer reports to the Equality, Diversity, Inclusion & Human Rights Lead and has an active role in supporting the Equality, Diversity, Inclusion and Human Rights Lead, supporting Trust staff to embed Equality, Diversity, Inclusion and Human Rights within employment and services
Managers and Leaders	• Managers and Leaders understand that unlawful discrimination, harassment, bullying and victimisation are unacceptable practices and have no place in Trust services, departments or teams. • Managers and Leaders are expected to foster positive working environments where mutual respect for Equality, Diversity, Inclusion and Human Rights are central to their role as manager, leading by example, and actively challenging abusive behaviour of any kind to maintain good staff morale, wellbeing and good patient care • Making staff aware of the Trust policy on Equality, Diversity, Inclusion and Human Rights and the supporting policies in relation to employment and service delivery • Promoting Equality, Diversity, Inclusion and Human Rights by their behaviour and actions • Ensuring that complaints are dealt with in a fair and consistent manner

	• Ensuring that contractors working within the Trust adhere to the principles of the Equality, Diversity, Inclusion and Human Rights Policy
Staff, including agency workers, bank workers and students	• Are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision • Must not discriminate e.g. This includes any person who is responsible for selection decisions in recruitment, promotion, transfer, training etc. or those responsible for the provision and delivery of services • Not acting, persuading, attempting to persuade or instructing other employees, unions or Management to practice unlawful discrimination, harassment, bullying, victimisation or any act that would result in a breach of the Human Rights Act 1998 • Not harassing, bullying or intimidating other employees, including their peers, subordinates or seniors. This includes amongst others: sexual, racial and homophobic harassment • Not victimising or attempting to victimise individuals on the grounds that they have made complaints or provided information on discriminatory practice. • Informing management if they suspect or are aware that an act or acts of discrimination or inhumane treatment of any kind is or have taken place
Contractors	• All contractors must comply with the requirements of the Equality Act 2010 and the Human Rights Act 1998 whilst providing or delivering goods, services and facilities to Trust staff, service users, their relatives, carers and anyone else who has links with the Trust. • Not complying with the above means that the contractor is in direct breach of the ‘Terms and Conditions of its contract with the Trust and the contract will be terminated.
Service users, their relatives and carers	• Service users, their relatives, friends and carers can expect to be treated with respect and courtesy whilst accessing or engaging with Trust services. We encourage service users, their carers and relatives to contact the Trust using the PALS service if they experience unfair or unequal treatment or feel that Trust services do not meet their needs. • Service users, their relatives, friends and carers are expected to treat Trust staff with respect and courtesy whilst receiving Trust services.

	• The Trust will not tolerate racist, sexist or homophobic abuse etc., towards its staff, other service users, their relatives or carers. The Trust will provide support and/or signposting to staff or anyone else who feels that they have been harassed, discriminated against or victimised whilst they have been delivering services or receiving care.
Trust Governors and Volunteers	• Trust Governors and Volunteers are expected to treat each other and anyone else they come into contact with whilst carrying out their duties with respect and courtesy • Trust Governors and Volunteers can expect to be treated with respect and courtesy whilst performing duties, with or on behalf of the Trust
Hospital Managers	• Hospital Managers have a statutory role under the Mental Health Act 1983 which requires them to attend review meetings to ensure the lawful criteria for detention under the Act is met. This role is also pivotal in that it addresses the Human Rights of service users. It is expected that they will be non-biased and that their decisions will be made without prejudice. It is expected that individuals who are selected to act on behalf of the Trust as Hospital Managers will uphold the principles of this policy, in that the Trust expects high standards in relation to Equality, Diversity, Inclusion and Human Rights from Hospital Managers. The Trust will take action to remove Hospital Managers who do not meet the Trusts expected standards.

4 Policy

1. The Trust will respect and protect the Human Rights of all service users, staff and anyone else who has a relationship to the Trust.
2. Any restriction/s placed on the rights of service users, for example a decision to detain a person under the Mental Health Act will be lawful, justifiable and proportionate, will have a legitimate aim and will be the least restrictive option in the circumstance
3. The Trust takes breaches of policy very seriously, particularly those that when breached have a harmful effect on other people. Victimisation, harassment, discrimination (or an attempt to do so) and bullying will not be tolerated and will, where substantiated lead to disciplinary action
4. Staff who identify with protected groups have the right to be treated fairly and with dignity and respect and without the fear of unlawful discrimination, harassment, victimisation or bullying
5. Service users who identify with protected groups, their relatives and their carers have the right to be treated in a fair, reasonable and consistent way with dignity, respect and compassion and without the fear of unlawful discrimination, harassment, victimisation or bullying
6. The Trust will work to reduce health inequalities for all service users
7. The Trust is committed to the ongoing development of staff awareness and knowledge of Equality, Diversity, Inclusion and Human Rights. Staff development begins on employment and continues throughout an individual's career until they leave the Trust
8. The Trust is committed to monitoring, evaluating and reporting on issues of Equality, Diversity, Inclusion and Human Rights in employment and service provision
9. The Trust will work towards best practice standards of Equality, Diversity, Inclusion and Human Rights and not merely comply with legislation
10. The Trust will promote equality, foster good relations and take an anti-discriminatory approach in all areas of employment and service delivery
11. The Trust will ensure that barriers to accessing services and employment are identified and removed so that no person is treated less favourably because they identify with a protected group/s
12. The Trust recognises the importance of this policy in the employment relationship it has with its staff and in provision of services for service users, and will reflect this commitment in all Trust policies, procedures and practices etc.
13. Anyone that deals with the Trust will receive equitable treatment whether they are receiving a service, providing a service, tendering for a contract or in any other relationship with the Trust
14. This policy extends outside the workplace and Trust staff should be aware that work place behaviour includes times when they are not physically at work but are participating in activities where work is a factor, e.g. team nights out, shopping trips with colleagues and if behaviours in these situations are deemed discriminatory and / or unethical, it could warrant disciplinary action or allegations of gross misconduct

15. Staff with a professional registration may also find that discriminatory and or unethical practices outside work may lead to complaints to their professional body and possible action by them

The Trust recognises the benefits which will arise from implementation of the Human Rights, Equality, Inclusion and Diversity Policy including:

1. Right respecting clinical practice provides the very best opportunity for recovery. Services take a positive and inclusive approach to minimising distress and harm
2. The provision of accessible, flexible and adaptable services that are delivered by highly capable staff that meet the needs of service users', resulting in equitable levels of patient satisfaction regardless of which protected group/s they identify with
3. Equality, Diversity, Inclusion and Human Rights enhance opportunity, inclusivity, creativity and innovation leading to better working and patient care environments
4. Employing staff from different protected groups and cultural backgrounds enables a better understanding of the needs of all service users, and results in a workforce with increased levels of empathy and compassion
5. A diverse workforce and inclusive working environments increase the reputation of the Trust in different communities. In turn this encourages people from these communities such as BAME and LGBTQ+ people, and people with disabilities and long-term health conditions to apply for positions within the Trusts as its reputation grows as an employer of choice
6. A diverse organisation has higher levels of emotional intelligence and empathy than less diverse organisations. Diversity also drives innovation and creativity which is a key element in developing inclusive working practices and service provision. Staff that share similar values on issues such as respect, compassion, equality and fairness are more likely to get on and more likely to be part of an effective and successful team

5 Definitions

Term	Definition
CQC	Care Quality Commission

Diversity (difference)	The Trust recognises that everyone has a unique contribution to make and that a person's personal attributes contribute significantly in achieving the Trusts goals. Diversity is a strength and it should be visible at all levels of the organisation. Valuing Diversity is integral to valuing people. When we value Diversity we promote a positive, supportive and innovative working environment. When we value the Diversity of our service users we are more likely to meet their needs and support them on their journey to recovery.
EHRC	Equality and Human Rights Commission
Equality	Equality in the UK is about fostering and promoting the right to be different, to be free from discrimination, and to have equal choices, opportunities being valued as an individual
Human Rights	The rights that we all have and share, simply because we are human that are protected by the Human Rights Act
BAME	Black, Asian and Minority Ethnic
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer, Questioning, other sexual orientations & gender identities

6 Related documents

To provide context the Trust has a number of closely associated policies, procedures, guidance and other documents that support the aims of this central policy, they include:

Managing Potential Concerns of Conduct (Disciplinary Procedure); Freedom to Speak Up Policy (Whistleblowing);Incident Reporting and Serious Incident Review Policy, Ridgeway Security Procedure, Equality Impact Assessment Guidance, Interpreting and Translation Policy and Guidance, Staff Development Policy, Dress Code Procedure; Flexible Working Procedure; Special Leave Procedure; Recruitment and Selection Procedure; Grievance Procedure , Bullying and Harassment Resolution Procedure, Job Evaluation Procedure, Organisational Change Procedure, Retirement and Long Service Recognition Procedure (including retire and return) ; Information Governance and Information Security and Risk Policy, Leavers Procedure; Staff Health, Wellbeing and Attendance Procedure; Workplace Adjustments Procedure and Managing Potential Concerns of Poor Performance (Capability) Procedure.

7 How this policy will be implemented

Equality, Diversity, Inclusion and Human Rights will be embedded into every aspect of Trust business. This section highlights some of the key areas and themes that have been identified in the Trust and how this policy will be implemented

7.1 Equality Impact Assessments

The Trust will use Equality Impact Assessment (EIA) to ensure that it reasonably considers its impact on equality. Equality Impact Assessment Policy and Guidance, defines the requirements of the Trust and its staff in more detail.

7.2 Interpreting and Translation

Trust staff will refer to the Interpreting and Translation Policy and Guidance when providing care for people who speak using a language other than English or who communicate using British Sign Language. Patient care cannot take place if the service user is unable to understand the clinician or any member of staff involved in their care and treatment.

7.3 Recruitment, Selection and Employment

- All recruitment processes, conditions of service, job requirements and learning and development opportunities, must fit with the needs of the service and those who work in it. The trust will comply with the legal requirements of the Equality Act 2010 and the Human Rights Act 1998
- The Trust will strive to provide a positive working environment in which people want to work and be a leader in good employment practices and effective communication
- All staff will have the opportunity to have talent management conversations
- Under representation, where it exists, will be identified and addressed by removing barriers. People will have equal access to career advancement and other opportunities within the organisation
- Taking positive action, where appropriate, to ensure applicants and employees can participate in, and have opportunity work for the Trust, further ensuring that Trust services meet the needs of its communities
- The Trust is also committed to enabling every member of staff to achieve their full potential in an environment characterised by opportunity, dignity and mutual respect

7.4 Learning and Development

- All staff must undertake Equality and Diversity training as they start working for the Trust. Additionally staff are required to undertake regular refresher training in accordance with the mandatory training needs analysis which is part of the staff development policy
- All employees should have an annual individual appraisal including a personal development plan. This should completed in accordance with the staff

development policy On an annual basis the Trust will produce a Training Needs Analysis to outline how the Trust priorities for development will be achieved

- Information on training and development opportunities is widely publicised and all employees will be encouraged to undertake appropriate training and development, which will enable them to meet the requirements of their role in meeting service needs

7.5 Performance Management

- Performance assessments should be based on employee's performance against their actual objectives and the Knowledge and Skills Framework profile linked to their job description
- All managers with responsibility for appraisal should be able to show evidence of competence in Appraisal and Equality and Diversity Awareness
- Concerns over discriminatory or inappropriate behaviour picked up through supervision, whether clinical, professional or managerial, should be dealt with promptly by the manager
- In relation to disability, the Trust will make every effort to make reasonable adjustments for Trust staff that have or develop a disability whilst employed by the Trust. This could include people who can continue to work but the reasonable adjustments can't be accommodated in that particular role. Under the Trusts capability or sickness procedures there would be opportunity for staff to enter redeployment to explore whether adjustments could be accommodated in another job in a different area
- If an individual is so unwell or the condition is so severe/life-threatening that they cannot continue working then Occupational Health advice would be sought and the Trust would follow the Staff Health, Wellbeing and Attendance Procedure.
- Reasonable adjustments and other support procedures will be put in place to support and enable staff with disabilities to meet the requirements of their role, but on very rare occasions it will be not be possible to make reasonable adjustments or redeploy staff. This may be because the nature of the person's disability will be such that it inhibits the person's ability to work at all. When this happens the Trust will follow the End of Employment Procedure.
- If you believe that you have been subjected to bullying, harassment, discrimination or victimisation, you can raise a grievance using the Trust's Grievance Procedure. The Trust will not tolerate harassment, discrimination, victimisation or bullying of staff because of a protected characteristic(s) or for any other reason. Any member of staff committing such actions will be subject to the Trusts Managing Concerns of Potential Conduct (Disciplinary) Procedure and it could result in dismissal
- **If you witness someone being subjected to bullying, harassment, discrimination or victimisation and don't feel you can raise it with your line manager then you should use the Trust's** Whistleblowing Procedure and Raising Serious Concerns Procedure **to raise the issue.**

7.6 Partnership Agreement

The Trust has an agreement with staff side representatives which reinforces the importance of partnership working with all parties sharing a commitment to the business and service needs of the Trust.
The agreement encourages managers to spread the benefits of partnership working by ensuring that staff and staff side representatives are systematically and routinely involved in shaping the service and involved in the decision making process. This reinforces an environment where the right balance is reached between the needs of the service and the needs of its employees, ultimately improving the working environment for staff which has a positive knock on effect which can be seen in the quality of patient care.

7.7 Trust Services

- The Trust will ensure that its priorities are informed by the health needs of the communities it serves. When health inequalities are recognised steps will be taken to remove them by engaging and seeking the views of the communities, including those represented by protected groups and by working with commissioners
- Equality, Diversity, Inclusion and Human Rights will be considered throughout the planning stages of all Trust services. This will include the completion of an equality impact assessment and/ or the use of demographic data
- Trust staff will take a positive and proactive approach to Equality, Diversity, Inclusion and Human Rights by raising their own awareness and knowledge levels to accomplish this aim. The Trust (the Equality, Diversity, Inclusion and Human Rights team) will support staff to do this.
- All Trust services will proactively endeavour to anticipate and meet the needs of people that identify with protected groups. When a protected group is underrepresented in a service the Trust will investigate the reasons for this and where necessary will take action to remove barriers that impact on services being accessed in an equitable way
- The Trust will ensure that its services are accessible to people with disabilities
- The Trust recognises the importance of data completeness and will continue to undertake work to ensure gaps in data are reduced and both staff and service users understand the importance of why the data is requested
- Trust services will be delivered in a respectful, dignified, compassionate and professional way with the needs of the service user taking priority
- Trust services and the staff involved in the delivery of services will maintain a flexible and adaptable approach to delivering care, if concerns or issues arise around working with protected groups or in how to meet the human rights of service users, staff will seek advice from the Equality, Diversity Inclusion and Human Rights Team in the first instance
- Trust services will ensure that patients are involved in discussions about their care and treatment and that their culture and ethnicity are respected and

supported. The Trust will gather feedback on patients' experiences at appropriate times.

The Trust expects that staff will actively challenge and report abusive behaviour of any kind. The Trust expects managers to take steps to support staff who experience challenging or abusive behaviour of any kind. If you are unsure what this is, you can seek further advice and guidance from the Equality, Diversity, Inclusion and Human Rights Team

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.
- Where additional training needs for staff are identified they will be taken forward using existing Trust processes by the Equality, Diversity, Inclusion and Human Rights Lead.

7.8 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All staff and volunteers	Mandatory Equality, Diversity and Human Rights training	On line	Every 3 years
All staff and volunteers	Other Equality, Diversity, Inclusion and Human Rights training	As necessary	As necessary

8 How the implementation of this policy will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Equality Impact Assessment (policies and procedures)	Policy Lead	Senior Leadership Group

2	Equality Impact Assessment (projects and programmes)	Policy Lead	Programme Management Team
3	Equality and Diversity Mandatory Training	Line Manager	ODDG or equivalent
4	Complaints relating to EDI & Human Rights	Complaints Manager	EDI & Human Rights steering group

9 References

Equality Act 2010
Human Rights Act 1998
Mental Health Act 1983
NHS Constitution

10 Document control (internal)

To be recorded on the policy register and removed by Policy Coordinator before publication

	Sarah Dallal
Members of working party	Abigail Holder, EDI and Human Rights Officer, Helen Cooke, EDI and Human Rights Officer, Sarah Dallal EDI and Human Rights Lead.
Equality analysis completed by	Abigail Holder, EDI and Human Rights Officer
Equality analysis approved by	Sarah Dallal EDI and Human Rights Lead
This document has been agreed and accepted by (Director)	Sarah Dexter- Smith, Director of People and Culture

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	17th August 2022
Next review date	16th August 2023
This document replaces	HR-0013-v8 Human Rights Equality and Diversity Policy
This document was approved by	Executive Management Group
This document was approved	17th August 2022
This document was ratified by	Executive Management Group
This document was ratified	[Day Month Year]

An equality analysis was completed on this policy on	[Day Month Year]
Document type	Public
FOI Clause (Private documents only)	

12 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval:	17th August 2022	
Next review date:	16th August 2023	
This document replaces:	HR-0013-v8 Human Rights Equality and Diversity Policy	
This document was approved by:	Name of committee/group	Date
	Executive Management Group	17th August 2023
This document was ratified by:	Name of committee/group	Date
	Executive Management Group	17th August 2023
An equality analysis was completed on this document on:	26th September 2022	
Document type	Public	
FOI Clause (Private documents only)	N/A	

Change record

Version	Date	Amendment details	Status
9	22 Sept 2021	Transferred to the new template and Our Journey to Change added. Minor changes to wording in the remainder of the document.	Ratified
10	26 Sept 2022	Added Journey to Change section. Minor changes to wording in the remainder of the document. Titles of relevant procedures updated	
11	April 2023	Minor changes to wording in the remainder of the document.	

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Equality Diversity Inclusion and Human Rights Team, People and Culture Directorate
Title	Human Rights, Equality and Diversity Policy Ref:HR-0013
Type	Policy
Geographical area covered	Trust wide
Aims and objectives	This policy lays down the Trusts expected standards in relation to Equality, Diversity, Inclusion and Human Rights in both employment and services. This policy is inclusive of all Trust staff, bank workers, service users, carers and volunteers etc. It is hoped that by taking a joined up and inclusive approach the Trust can promote a unified message for all. **The Equality Act 2010** is legislation aimed at eliminating unlawful discrimination, promoting equality of opportunity for different groups of people and fostering good relations between different groups of people. These are more commonly known as the three aims of the Act. The Trust focuses on Equality, Diversity, Inclusion and Human Rights from two perspectives that are intertwined with each other. • **Service Delivery** – Equality, Diversity, Inclusion and Human Rights in healthcare for service users and their carers • **Employment** – Equality, Diversity, Inclusion and Human Rights for our staff The policy applies to the following groups of people. • The Chief Executive and The Trust Board of Directors including Non-Executive Directors • All Trust Managers, regardless of role, grade or position • All Trust staff regardless of role, grade or position • Bank Workers and Agency Workers • Service users, their carers, relatives and friends • Trust Governors • Trust Volunteers • Hospital Managers • Contractors

Start date of Equality Analysis Screening	4.4.23
End date of Equality Analysis Screening	4.4.23

Section 2	**Impacts**
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All staff and Patients
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	
Describe any positive impacts	This Policy is very positive as it recognises the link between staff behaviour and service delivery. Many other groups of people are covered within it such as service users, carers, bank staff, volunteers and contractors. The policy is clear about what the Trust should expect from its employees and what its staff should expect from service users. The Policy is inclusive of all protected groups and ensures that there is no hierarchy of values in relation to discrimination and harassment. I.e., sexism is equally as negative as ageism, ageism is equally as negative as homophobia, homophobia is equally as negative as racism etc.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Human Rights Act 1998 Equality Act 2010
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	No specific protected groups were consulted, however all staff will be consulted on this policy before ratification. In the future it is envisaged that staff engagement groups will play an active part in the consultation process.

Section 4	Training needs
As part of this equality analysis have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Training is available to staff mandatory for Equality and Diversity training and optional for Human Rights however staff are encouraged to complete the programme where possible.
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Are training needs included in the document?	Yes	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

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