Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

9 November 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 staff story.

Standard Items (1.30 pm – 1.45 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 12 October 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 7 November 2023*	Chair	Verbal

Strategic Items (1.45 pm – 3.05 pm)

8	To receive the Board Assurance Framework summary report	Co Sec	Report *to follow*
9	To receive the Chief Executive's report	CEO	Report
10	To receive an update on the CQC Core Service and Well-led Inspection 2023 and development of the improvement plan	CN	Report

BREAK – 10 minutes

11	To consider the Integrated Performance Report	Asst CEO	Report
12	Our Journey to Change Delivery Plan, update	Asst CEO	Report

Goal 1: To co-create a great experience for our patients, carers and families (3.05 pm – 3.30 pm)

13	To consider the report of the Chair of Quality Assurance Committee	Committee Chair (BR)	Report *to follow*
14	To receive an update on the Patient Safety Incident Response Framework	Dep CN	Report

Matters for information:

15	To note the Annual Medical Education Board Report	MD	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
3 November 2023

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Tees, Esk and Wear Valleys NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 12 OCTOBER 2023 AT WEST PARK HOPSITAL, DARLINGTON AND VIA MS TEAMS, COMMENCING AT 1.30PM

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
C Carpenter, Non-Executive Director
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)
D Burke, Interim Guardian of Safe Working

Observers/members of the public:
S Double, public
R Farmer, public
H Flynn, public
S Paxton, Head of Communications
L Roberts, Admin Manager & PA, Health & Justice, HMP Hull and Humber
J Wardle, Governor

23-24/92 CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting, including D Burke, the Interim Guardian of Safe Working. He then went on to comment on the valuable patient story that the board had received prior to the meeting.

23-24/93 APOLOGIES FOR ABSENCE

None.

23-24/94 DECLARATIONS OF INTEREST

None.

23-24/95 MINUTES OF THE MEETING HELD ON 14 SEPTEMBER 2023

The minutes were agreed as an accurate record of the meeting, subject to the following amendments:

- Date of the minutes to be corrected.
- Reference to be included to the concern expressed by B Reilly about the number of metrics rated as red in Chapter 2 of the Integrated Performance Report [para 23-24/82 refers].
- Minutes to show that B Murphy had been unable to attend Quality Assurance Committee due to her attendance at Council of Governors [para 23-24/86 refers].

23-24/96 BOARD ACTION LOG

In discussion the following points were noted:

1) K Kale reminded the board about the review of detentions by MHLC in response to a concern that they had been double counted and he advised that the position had been rectified and a reduction of circa. 8-10% would be reflected in the next report [action 23-24/89].

2) K Kale advised that the content of the report to the board on the appraisal and revalidation of doctors would be reviewed prior to the next report to ensure no identifiable information was included but would still to provide visibility to the board that due process had been followed [action 23-24/89].

3) It was noted that a briefing on feeling safe had been circulated by the Chief Nurse, and it was proposed and agreed that the action related to assurance work underway by Durham Tees Valley and Forensics Care Group would be closed [23-24/39].

4) It was noted that the board would receive a report in November on the Patient Safety Incident Response Framework.

5) P Bellas advised that Executive Directors Group had discussed proposed risks for inclusion in the revised Board Assurance Framework and invited the board to identify topics for the 2024/25 board seminar programme.

23-24/97 CHAIRS REPORT

The Chair presented the report and commented on the recently held nursing conference, where he proposed there had a clear message from speakers about the importance of mental health and celebrating what the trust had achieved. He went on to welcome the official opening of Foss Park Hospital at York by the reception team and commented on the positive feedback he had received from staff and service users who had attended.

23-24/98 MATTERS RAISED BY GOVERNORS

None.

23-24/99 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 presentation, P Bellas noted that the summary report would be updated, and B Kilmurray confirmed that a full review of the Board Assurance Framework (BAF) had begun, which would

support its continued improvement. This would reflect that risks had changed over time and would take account of the revised business plan and trust priorities.

P Bellas outlined the process for development of the revised Board Assurance Framework and advised that consideration would be given to improved links with the Integrated Performance Report, which included assurance provided through key performance indicators and mitigation as outlined in performance improvement plans.

The Chair welcomed the focus on continued improvement and proposed alignment with Integrated Performance Report and suggested that the framework was increasingly used by the board to monitor overall changes.

J Maddison, Chair of Audit and Risk Committee, advised that the committee had also welcomed progress made in recent years on the development of the framework and Corporate Risk Register and he suggested that he was comfortable with the direction of travel proposed.

B Murphy noted the opportunity to demonstrate work undertaken in an updated Board Assurance Framework summary report and welcomed the discussion on risk at Quality Assurance Committee.

The Chair invited Executive Directors to comment on risks that they would wish to bring to the board's attention, and the following was noted:

1) M Brierley advised that a deep dive on cyber security would be completed by Strategy and Resources Committee, to consider controls the trust had in place, its reliance on third parties and how rigorous their controls were.

2) In respect of CITO, M Brierley noted that board had received a report the previous month and he expressed confidence about progress that had been made and the assurance this provided.

3) In respect of financial sustainability, L Romaniak noted that the board and Strategy and Resources Committee were well sighted on the challenging financial position and she commented on the underlying deficit that the trust was required to mitigate and the key drivers of this – the Agenda for Change funding gap, decommissioned services, learning development packages of care, medical recruitment and the premium for locum support, and the absence of an elective recovery fund for the mental health sector.

   She went on to note in-year financial mitigation in respect of the medical pay award and Microsoft software licence fee and advised that work would be undertaken to develop a financial strategy linked into wider medium term financial programme recovery work.

4) In respect of Roseberry Park Hospital, L Romaniak advised that the legal case had proceeded as planned and the trial would take place in April 2024. The nature of the risk had not deteriorated, albeit there had been a change in the risk score.

5) J Haley noted that reputational risk was an element in a number of existing BAF risks and proposed the inclusion of a separate risk in the new framework. In response, P Bellas confirmed that a new risk had been developed by the Director of Corporate Affairs and Involvement for further discussion.

6) In respect of involvement and engagement activity, A Bridges noted the appointment of L Corbally as Head of Cocreation and the establishment of Cocreation Boards by care groups. She went on to comment on the significant increase in the different types of meaningful cocreation activity offered to involvement members each month and work

undertaken with members in order that they would make best use of their experience and were provided with training and support, to ensure they were able to influence change.

7) In respect of PALs and complaints, A Bridges advised that progress had been reported to Quality Assurance Committee and interim improvements had been made during the review and work continued on a positive trajectory.

8) B Reilly queried the nominated lead on the demand risk, in the context of its impact across both care groups, and in response, P Scott advised that this was an historical arrangement, and the new framework would reflect its joint ownership. He went on to advise that there continued to be pressure in some services and the Urgent Care Programme Board would meet to seek to address demand issues in areas such as inpatient crisis and home treatment pathways.

   He welcomed the opportunity to present an update at the recent Tees Valley Joint Health Scrutiny Committee.

9) C Carpenter suggested that information in the Integrated Performance Report did not reconcile with that of the Board Assurance Framework and she noted the importance of demand in the context of impact on patient experience, and proposed a session be included on the board seminar programme. **Action: P Bellas**

   M Brierley noted that the integrated performance report provided high level information on demand to the board to provide an outline of the current position, with operational level detail provided to each of the care groups

23-24/100 CHIEF EXECUTIVE'S REPORT

B Kilmurray presented the report, which highlighted topical issues that were of concern. In addition to the information provided in the report, he noted that the trust had received the draft CQC final report, and this would be made available once the factual accuracy process had concluded.

In discussion the following points were raised:

1) K Kale advised that to date there had been 10 periods of industrial action, four involving Consultants and 6 involving junior doctors. This had resulted in a loss of 31 days in total for outpatient clinic appointments in community services. On average 419 consultant and 2751 junior doctor appointments had been lost – not booked or cancelled. There had been no cancellation of emergency procedures, but the position had been a challenge for anaesthetics in the acute sector.

   It was noted that, in order that service users were not inconvenienced by cancellation of clinics at short notice, clinics had been stood down where consultants or doctors had indicated they intended to participate in strike action. They were then reorganised as soon as possible. The trust was able to identify and respond where there may be a disproportionate impact on any one individual.

2) B Murphy reminded the board that the impetus for the Oxehealth pilot was the trust's desire to use every opportunity to improve patient safety and, in moving on from the pilot, the trust would work closely with service users and families to understand concerns raised and develop a policy that was fit for purpose and protected human rights. She noted that use of assistive technology had not led to a reduction in nursing or required skill levels.

   Responding to a query she advised that a revised policy would be in place by the end of the calendar year with an interim standard operating procedure agreed early November.

She went on to welcome national engagement in this area and noted that the trust had put itself forward to participate in national research commissioned by the National Mental Health and Learning Disability Nurse Directors Forum.

The Chair welcomed the opportunity for the board to receive an update at an appropriate point.

3) P Hungin queried what arrangements the trust had in place to ensure that staff were able to report safety concerns and to ensure they were quickly responded to.

In response, B Kilmurray confirmed that the freedom to speak up process supported staff to report a safety concern – and anonymously if required – and these would be reviewed and investigated quickly, and intelligence would be shared to identify any emerging cultural concerns.

He noted that the Freedom to Speak up Guardian reported independently to the board each quarter on emerging issues and any barriers he faced in undertaking this role, and the board were supported by R Barker as Freedom to Speak Up Champion. Staff also had the opportunity to raise concerns with the National Guardian's Office.

The Chair also noted the independent role of R Barker, should there be any suggestion that the Chair or the Chief Executive had not responded appropriately to a concern raised.

B Kilmurray went on to remind the board of the closed culture reviews undertaken in inpatient areas and proposed that this would be repeated in community and corporate services. The Chair noted that the trust had been an early adopter of the tool, which had been used to triangulate a range of information and subsequent follow up visits had been undertaken if required. B Murphy advised that the trust had continued this approach where any concern about culture had been identified.

S Dexter-Smith advised that the review of freedom to speak up arrangements would conclude in 2023 and she noted that under current arrangements she received a report on themes and action taken in response, which provided an opportunity to consider if issues had been dealt with appropriately.

P Hungin welcomed the process, as outlined.

J Maddison suggested that issues may be difficult to identify and proposed that the trust would need to use the range of controls and monitoring systems it had in place to triangulate all strands of freedom to speak up, in order to provide greater oversight. B Kilmurray noted that this would also need to include use of the trust's analytical information and J Maddison proposed that a related action be included on the board action log. **Action: DfP&C**

S Dexter-Smith noted that a discussion would be held on culture at the next quarterly leadership events in respect of listening and monitoring data. Commenting further, B Murphy proposed the trust had good level of quality data across the organisation and would support staff to triangulate that and be curious.

The Chair brought the discussion to a close and reflected that there were systems in place to support freedom to speak up, which included contact with the board champion if needed, and there was recognition that information needed to be triangulated - with a greater focus on risk and performance data.

23/24/101 INTEGRATED PERFORMANCE DASHBOARD

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. He noted that the report also included a performance improvement plan assessment and that as part of continuous improvement, additional measures had been developed for committee use.

In presentation, he provided an overview of key changes from the previous report and drew the board's attention to the proposed reasonable level of assurance regarding the quality of services delivered, and those areas highlighted in the report where there was limited performance assurance and negative controls assurance.

In discussion the following points were raised:

1) M Brierley advised that metrics that reported on a measurable improvement following treatment had been consistently below standard and would be reviewed through a performance improvement plan. He noted that, to support improved monitoring, CITO would provide the opportunity to complete a goal based assessment with service users, at the start of treatment.

   K Kale welcomed the initial assessment tool and noted that the metric for adults and older people included service users with dementia, where an improvement following treatment may not be expected.

   B Murphy expressed an interest in understanding the change in the positive position reported previously and in response it was noted that the scale of the sample would impact on performance. However, the position would be considered through the performance improvement plan.

2) In respect of an unnatural and unexpected death reported previously, B Murphy advised that there was no indication the death was unnatural at this point and the trust would wait for the coroner's final determination.

3) Commenting on Durham, Tees Valley and Forensics Care Group metrics, P Scott noted there was improvement in the inpatient position, but occupancy remained high and there were ongoing pressures in male pathways. Executive Directors Group would consider a proposal to step back up the ALD treatment unit.

   In respect of children eating disorders [chapter 2], the care group had commissioned a deep dive to review the quality of data on waiting times, where performance was affected by non-attendance at appointments.

   Whilst an improvement had been noted in relation to waiting times for service users experiencing a first episode of psychosis, it was suggested that the position was fragile, and further measures would be taken to ensure an improvement was achieved.

   He went on to welcome: the reduction in use of restrictive intervention, in the context of what this meant for traumatised patients who felt vulnerable; clinical recruitment and improvement in staff leaver rates; and the improvement in crisis line call pick-up rates.

4) Commenting on North Yorkshire, York and Selby Care Group metrics, Z Campbell welcomed a number of recent medical appointments and advised that there was an increased focus on stubborn issues affected by staff capacity to meet demand, where further consideration would be given to alternative approaches.

She went on to note that the trust was working closely with local authorities in relation to patient flow, where there were challenges due to the lack of appropriate care packages and there had been some improvement in the position.

5) M Brierley drew the board's attention to the performance improvement plan assessment and the proposal that the report provided reasonable assurance, with a number of measures that would show improvement during quarter 2 and 3 of 2023/24, with others due to show a demonstrable impact in quarter 4.

The Chair and J Maddison welcomed the inclusion of the report.

6) Responding to a query from J Maddison on cash releasing efficiency savings [CRES] targets and financial controls, L Romaniak noted a positive impact from the declining run rate, which had reduced the ongoing deficit to £0.5m at month five. This was additional to the forecast £4.5m deficit.

She noted that a CRES workshop had been held with staff to consider areas for improvement in the current year and over the longer term. She acknowledged that CRES plans required additional capacity and proposed to consider additional support for the development of performance improvement plans and savings proposals.

7) J Maddison sought assurance that the trust would make best use of capital funding to maximise the benefit for patient care and in response L Romaniak advised that trust had proposals which committed its full capital allocation, regardless of any in-year changes linked to Roseberry Hospital and CITO.

8) B Reilly noted the number of performance improvement plans where the impact would not be realised until March 2024 and sought assurance that plans would have the desired impact.

In response, B Murphy reflected on the scale and complexity of metrics and proposed that a change in how metrics were described would support better assessment of delivery. She noted that performance improvement plans provided a mechanism to track action taken and the information reported to the board was aggregated from detailed data, in order to provide a view on progress, albeit this was subjective.

9) B Reilly queried if there was adequate focus on all metrics rated as red in chapter 2 and proposed that data be provided from previous quarters in order for the board to be able to determine performance over a longer period.

In response, M Brierley noted that the metrics reported in chapter 2 were commissioned services and were reported to and scrutinised by commissioners. He suggested the position reflected the reality of demand versus capacity and noted that performance improvement plans provided assurance to commissioners on action that would be taken and when progress was expected to be realised.

Commenting further, Z Campbell advised that the care group was held to account for delivery of all targets and there was an acknowledgement that targets were often subject to wider system pressures.

10) B Reilly welcomed the work undertaken to improve the position in relation to out of area placements in the context on the impact on patients, carers and families and she sought assurance that the trust was doing all it could and there was no disparity between the care groups.

In response, P Scott acknowledged that service users would want to be placed as close to home as possible and confirmed that there was no difference between care groups, who worked closely on the bed position and in relation to the Urgent Care programme Board. A performance improvement plan was in place and changes would be strengthened, as work progressed, if that was required.

11) J Haley welcomed the positive trajectory on medication errors and sought assurance that there would be no impact from the roll out of electronic prescribing and medicines administration [EPMA] in North Yorkshire, York and Selby. In response, M Brierley confirmed that learning and training requirements had been captured from the pilot and there was good assurance on the roll out.

12) In response to a query from J Haley on the proposed review of the discharge policy, B Kilmurray advised that the policy would be amended to ensure that individuals who were homeless were discharged into suitable accommodation.

13) B Murphy commented on the prominence that would be given in Quality Assurance Committee to children and young people improvements and noted the risk to and impact on quality from high levels of vacancies in some teams. She also undertook to speak to M Brierley in relation to trends analysis on restrictive interventions, to provide clarity on improvements for the public and regulators and expressed confidence that further reductions would be achieved.

14) B Kilmurray welcomed the conversation held at the board meeting across a breadth of issues and suggested that performance improvement plans provided assurance on progress, whilst recognising that some were long term issues.

He confirmed there was a focus on out of area placements, from a quality perspective and noted that the trust committed to bringing service users back to their local area whenever that was possible.

He went on to note pressure across the health system and the creation of a North East and North Cumbria Executive Performance Group.

23-24/102 LEADERSHIP WALKABOUTS

The board received and noted the report, which provided high level feedback from the leadership walkabouts to adult learning disability community services and CAMHS extreme behaviours.

A Bridges provided an overview of the report and welcomed that, as a result of the visit to Holly Ward, a governor had offered time from a colleague to support development of the garden area.

She went on to advise that a strengthened approach to visits had been explored to ensure reports were cocreated with the teams visited and actions captured and tracked, and she proposed the board receive the monthly report a month following the visit allow for this information to be reported in a meaningful way.

[H Crawford left the meeting]

Responding to a query from J Preston, A Bridges confirmed that a member of the group would be expected to capture key points and actions on the visit, which would be agreed by the service and other attendees. Individuals would be assigned to progress any action points, and these would be tracked, and information fed into the monthly board report.

Agreed: *the leadership walkabouts report to be presented to the following month board meeting.*

23-24/103 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee presented the report and advised there were no specific concerns to draw to the attention of the board.

She noted the position in respect of the backlog of serious incidents where continued improvement had been made, with oversight provided by the Chief Nurse and commented on the assurance outlined in the report in respect of commissioner safety review visits and PALs, complaints and patient carer experience, where she acknowledged the work undertaken by A Bridges to improve the key performance indicators for complaint responses.

She went on to note that committee would receive a report from the Environmental Risk Group and had sought further assurance in respect of: work undertaken previously on self-harm; on the use of inappropriate restraint; and on the national shortage of ADHD medication.

Summing up she welcomed the attendance of care group representatives and suggested that the reports committee received were concise and clear, which contributed to a constructive meeting.

[H Crawford re-joined the meeting]

23-24/104 LEARNING FROM DEATHS

The board received the report, which aimed to provide assurance on the trust's approach, in line with national guidance on the collection and publication of information.

K Kale presented the report and advised that it had been considered in detail by Quality Assurance Committee and that the board was able to take assurance that reporting and learning was in line with national guidance.

In discussion, the following points were raised:

1) B Murphy drew attention to the themes arising from the actionable learning and noted that she had worked with the Better Tomorrow Programme at AQUA on the development of mental health specific dashboards. She also noted that from April 2024 all patient deaths would be reported through the lead medical examiner and related training would be provided to medics.

2) Commenting further B Murphy advised that learning and dissemination would be through clinical networks and specific professional groups if required, and that pharmacy and patient safety briefings and live learning webinars were regularly completed. Operational teams would also follow-up on individual cases. Oversight was provided by the Fundamental Standards Group or the Environmental Risk Group to ensure learning was embedded.

3) B Reilly advised that Quality Assurance Committee had considered there was good assurance that the trust operated in line with national guidance and that a structure was in place to support and embed learning, and that mortality reviews were completed in line with guidance from the Royal College of Psychiatrists. She noted that there was no opportunity for national benchmarking.

4) In response to a query on the potential to gain further insight into the themes identified, K Kale noted that appendix 3 of the report provided detail on actionable learning points.

Bringing the discussion to a close, the Chair commented on the reoccurring nature of the themes reported and noted the assurance that would be provided by Quality Assurance Committee that appropriate action had been taken to reduce to the themes or how consistently they arose.

23-24/105 GUARDIAN OF SAFE WORKING

The board received the report, which aimed to provide assurance that postgraduate doctors were safely rostered and that their working hours were safe and in compliance with their terms and conditions of service.

D Burke presented the report and drew attention to fines incurred in the south due to the increase in exception reports related to the continuous rest period, where a non-residential on call rota was in place. He noted the potential to introduce a residential on call rota, subject to the engagement of doctors. He also commented on work undertaken with medical staffing to improve the turnaround of exception reports.

In discussion, the following points were raised:

1) D Burke confirmed that the potential to introduce a residential on call rota in the south, would be subject to contractual discussion and any issues that may arise through the process.

2) In the context of the NHS Sexual Safety Charter and work undertaken by the Royal College of Surgeons, B Kilmurray queried if any concerns had been expressed by Junior Doctors. In response, D Burke advised he had received no intelligence, but would continue to remain alert to this.

3) P Hungin queried the reported concern raised by a junior doctor that they had been required to act too independently and in response, K Kale advised that a model had been implemented in response, and this had been welcomed by all parties.

4) J Maddison welcomed the positive feedback from the GMC survey related to the satisfaction of postgraduate doctors.

Bringing the discussion to a close, the Chair thanked D Burke for taking on the interim role of Guardian of Safe Working and he placed on record his thanks to junior doctors for all the work they did.

23-24/106 WORKFORCE RACE QUALITY STANDARD, WORKFORCE DISABILITY EQUALITY STANDARD [WDES], SEXUAL ORIENTATION WORKFORCE EQUALITY STANDARD [SOWES] SUBMISSIONS

The board received the report, which provided assurance that the trust had adhered to the NHS Standard Contract, and undertaken WRES and WDES data collection and published the results and associated action plans.

S Dexter-Smith presented the report and proposed that there was good assurance that the trust had followed robust processes in the analysis of staff data by protected group and that actions provided a clear response to concerns raised and commented on the immediate concerns and actions to address them.

J Haley, Chair of People, Culture and Diversity Committee, advised that the committee had considered the report prior to the board and was content with the direction of travel and noted that there was more to do in this area.

Agreed: *that –*

i. The board considered there was good assurance that a robust process had been undertaken when developing the data and actions and that the actions were appropriate.

ii. The data be approved for publication.

iii. The Human Rights, Equality, Diversity, Inclusion Policy be approved.

23-24/107 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 5.15pm.

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Board of Directors
Public Action Log

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

Updates since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
29/09/2022 22/10/2022 27/04/2023	22/144 22/174 23-24/06	Topics for board seminars	a) Mental Capacity Act b) Reported outcomes following treatment c) what transformation may mean for future services	MD CEO Co Sec	Jun-23		Apr-23: proposed board & committee dates circulated w/c 24 April for consultation May-23: the seminar programme will be developed to take account of topics identified by the board during the year. **Oct-23: BoD invited to submit proposals for Board Seminars. It is expected that the programme will also include topics that arise during preparation of the delivery plan**
26/01/2023	23/215 23-24/5	BAF	Format to be reviewed to consider potential for a table detailing the target level of risk, actual risk and gap	Co Sec	Sep-23		Apr-23: timescale changed to August 2023 to align with the outcome of the full review of the BAF due commence in May-23 Sept-23: BAF Review to conclude in Oct-23 **Nov-23: BAF review to be completed in January. Risk descriptions due to be considered by the board in November - see private agenda item 7**
26/01/2023	23/215		Risk tolerance - Executive Directors and committees to scrutinise the position to understand how long high risks had remained at their current level and what related action was proposed.	Exec Directors, Committee Chairs	Jun-23		Mar-23: Discussed by QuAC in March-23 Next cycle of committee meetings will be May 2023 Sept-23: BAF Review to conclude in Oct-23 **Nov-23: BAF review due to conclude in Jan-24**
27/04/2023	23-24/11		BAF report to reflect the impact of the financial position on delivery of priorities for 2023/24	Co Sec DoFI&E	Sep-23		May23: Linked to full review of the BAF due to commence in May-23 Sept-23: BAF Review to conclude in Oct-23 Oct-23: EDG BAF workshop on 4-Oct-23 agreed next steps for Executive review **Nov-23: BAF review due to conclude in Jan-24**
25/05/2023			Board discussion to be held on areas of the BAF where the IPR had reported there is limited performance assurance and negative controls assurance, and where the target date has passed.	Co Sec	Sep-23		Linked to the review of the BAF Sept-23: BAF Review to conclude in Oct-23 **Nov-23: BAF review due to conclude in Jan-24**
27/04/2023	23-24/17	Establishment Review	Format of the report to be revised, to include summarised actions proposed to mitigate risks highlighted and to outline the level of assurance provided to the board.	CN	Mar-24		Next report to the board due March 2024 Sept23: noted that a verbal update had been provided on the significant work underway to assure on safer staffing, to meet external reporting requirements and to progress steps to meet the deadline of March 2024
13/07/2023	23-24/63	IPR	Report to include narrative on the strategic context (commissioned services/demand) and the outcome of conversations with commissioners	ACEO	Nov-23		Sept-23: Will be included in the next Quarterly report due to the board in Nov-23 **Nov-23: Agenda item 11**
27/06/2023	23-24/47	Annual Report and Accounts	Chair to raise with COG T&F group, governor attendance at Audit & Risk Committee when committee consider the annual report and accounts and draft annual Quality Account Report	Chair	May-24		To be progressed at 2023/24 year end
13/07/23	23-24/62	National Investigation into MH inpatient care settings	CEO to provide further information once ToR are available	CEO	Autum 23		Sept-23: the HSIB website reports that the investigation will be launched in Autumn 2023. Oct-23: HSIB overview circulated to the board of Directors by email

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
13/07/23	23-24/62	Industrial Action	CEO to update retrospectively on management of industrial action and the trajectory for recovery	CEO	Nov-23		Sept-23: Further dates announced and an update is provided within the CEO report (item 9) Oct-23: Item 9 will be supplemented at the meeting with snapshot update of latest activity and impact
			Report to be provided to Council of Governors to outline the position and controls the trust had established	MD NYYS	Dec-23		Sept-23: next Council of Governors meeting is December 2023
13/07/23	23-24/66	Section 17 leave	Board to receive feedback from the Urgent Care Programme Boardin relation to variance in how the act is used.	MD DTVF MD	Nov-23		Sept-23: First meeting of the UCPB to be held in October - P Scott to progress the action with K Kale in the interim
14/09/23	23-24/76	Board meetings	Consideration to be given to the structure of board meetings to support the move to bi-monthly meetings with additional development sessions	Co Sec	Jan-24		
14/09/23	23-24/81	Our Journey to Change Delivery Plan	Information be provided on implications and timescales where projects have deviated from plan.	ACEO	Nov-24		**Nov-23: Agenda item 12**
12/10/23	**23-24/100**	**Responding to issues raised by freedom to speak up arrangements**	**Trust to consider greater use of analytical data, alongisde existing tools, to ensure all issues had arose through freedom to speak up arrangements had been captured and considered.**	**DfP&C**	**Jan-24**		

Chair's Report: 12th October – 14th November.

Headlines:

External:

- Weekly Mental Health Chairs' Network : emerging national issues. Discussion with Ian Trenholm CQC Chief Executive
- Meeting Yorkshire and Humberside Foundation Trust Chairs: issues of common interest.
- Central (County Durham & Sunderland) ICP
- IRIS Network Launch York
- CQC Briefing with Alex Cunningham MP

Council of Governors (CoG)

- CoG Task & Finish Group: role of Governor, and role of Non-Executive Directors, and role of Council of Governors, as distinct from Trust Board. Facilitated by Good Governance Institute.

Internal

- Various Living The Values Awards (Sam Blair Selby Community Team, Martin Turner & HMP Preston Team, Kyla Brown & GP assigned mental health team West Park)
- Non-Executive Director catch-up discussions :.
- Leadership Walkabout: Auckland Park Hospital : Sedgefield & Dales Community mental Health Team
- Ridgeway Star Awards
- Carnall Farrar : data & metrics for assessing mental health.
- Roseberry Park Sub-Committee.
- CQC Publication, and various meetings around communications on CQC and other associated matters. Meeting also with strategic Communications advisor (Alders).
- Liam Corbially : New Head of Co-Creation : introduction, background, and shared aims & values.
- Mark Allen : Head of Peer Support - regular catch-up

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**09 November 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**	• CQC Report publication • NICHE Independent Investigations Assurance Review
7	**Infrastructure**	• RAAC Update

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: CQC Report publication
Stakeholder Engagement
NICHE Independent Investigations Assurance Review
RAAC Update

Prior Consideration and Feedback n/a

Implications: No additional implications.

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

CQC Report publication

On 25th October the Care Quality Commission (CQC) published the results of our latest trustwide inspection on its website. There is a separate item on today's agenda covering the report and our response. I wanted to put on record my thanks to everyone who has been involved in our improvement journey and the delivery of Our Journey to Change so far. I am incredibly proud of what we have achieved so far and am looking forward to the next phase where we continue our work.

Stakeholder Engagement

On the back of the publication of the CQC report there has been the opportunity within the past two weeks to engage with a number of important partners and stakeholders.

We carried out briefing sessions with other NHS trust partners, our Integrated Care Boards and representatives from the local Voluntary and Community sector. This was a very positive session that led to an agreement to work together on the development of a physical health strategy (one of our actions) that could be shared between partners. There were other offers of ongoing support.

We also had contact with several of our MPs. We met with Andy McDonald MP and Alex Cunningham on 27th October, and will be meeting Rachael Maskell on 3rd November.

We have had further follow up for conversations from the NENC primary care mental health leads, lead members from City of York Council, our Health and Care partners in County Durham, an invitation to present at the board of the Humber North Yorkshire Integrated Care Board, executive team members from the University of York and the Chief Executive of North Yorkshire County Council.

NENC ICB Chief Executive, Sam Allen has offered to organise a Quality Summit meeting with a range of key partners for us to discuss the CQC report, providing us with an opportunity to highlight our progress, set out our further improvement plans, highlight specific system issues and any support requirements from the system.

Niche Independent Investigations Assurance Review

On 24th October the Chief Nurse and I attended a meeting with NHS England, representatives of Niche and a range of partner organisations to hear how they are planning to approach the assurance review of the recommendations associated with the four independent reports that were published.

It was always NHSE's intention to carry out a review of the status of actions across the 120 recommendations that were made across the reports. Some of these recommendations were repeated or duplicated across other agencies

Colleagues from Niche outlined that phase 1 of there plan will be the development and agreement of an Assurance Plan. They are keen to work with agencies to

understand existing sources of assurance against each recommendation. From this they can determine what further audit or other assurance work they will need to commission or request. They hope to have the plan developed before the end of December 2023.

Having set out the plan they will then engage in the assurance process, as mentioned, using as much existing information as possible. They have undertaken to do as much of this work as possible "on the ground" in the region. They will speak with individual organisations and may, for some of the recommendations, ask organisations to come together.

It is Niche's aim to have produced an interim report by Easter 2024, with the final report expect some time in the Summer 2024.

RAAC

A structural engineering consultant has now been engaged to undertake intrusive survey work at properties which our in-house team would like a second opinion on. This is merely to give assurance and confirmation on their assessment that the buildings do not contain RAAC. There are 13 owned and 2 leased properties (of which we are sole occupant). None of the buildings are inpatient facilities.
With regard to those properties we occupy which our legal representatives have written to, there have been 7 returns, 6 of which confirm no RAAC present and 1 stating 'unconfirmed', which suggests a second/expert opinion is required. A report is being provided to Management Group on Wednesday 15th November.
The NENC Provider Collaborative Estates Directors Group have commissioned a RAAC sub-group which will be chaired by TEWV Director of Estates, Facilities and Capital Development (Simon Adamson). The group's first meeting will take place on Wednesday 8th November.

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Communications Dashboard

October 2023

Tees, Esk and Wear Valleys
NHS Foundation Trust

This month we...

- Held over 200 nursing colleagues at the Nursing Conference to celebrate best practice
- A new network was launched to support hearing voices groups
- Star awards shortlisted nominees were announced
- We celebrated black history month
- Officially opened up Foss Park Hospital in York
- Announced our Annual General Meeting (AGM)

Highlights

Primrose Lodge held a Tea and Talk morning for World Mental Health Day

A patient donated artwork she created influenced by her recovery journey

Foss Park held an official opening ceremony

Cedar Ward decorated for Halloween with spooktacular patient drawings

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

17
Media enquiries handled by the team

5
Media releases issued

84
Total pieces of coverage across online news, TV, and radio

News stories

- **Outdoor therapy programme helping to improve mental health -** *North Yorkshire Council*
- **Vision to create Stockton 'innovation zone' gets green light** - *Tees Business*
- **Foss Park Hospital in Haxby Road, York, officially opens -** *The Press (York) online*
- **Acomb Garth centre receives painting donated as a thank you -** *The Press (York) online*
- **Tees Esk and Wear Valleys Trust improving but 'more work to be done'** - *CQC - ITV Online*

Our website

81,294
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

997,960
page views

Top staff intranet news stories

1. Foss Park officially opened
2. Star Awards shortlisted nominations
3. InPhase updates
4. New NYYS Co-Creation Board
5. CQC report shows progress
6. Cito 'Links' feeling confident after training to support teams when Cito goes live

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

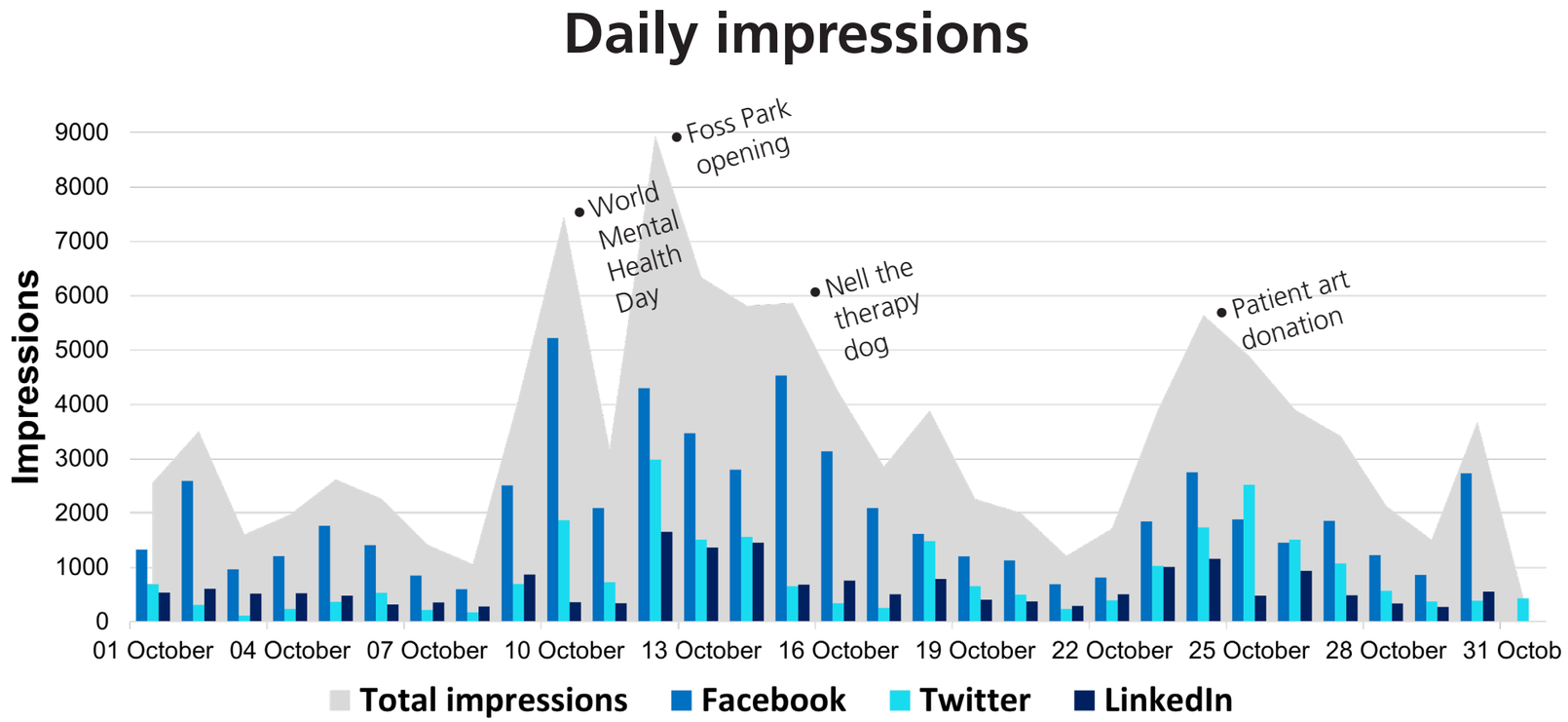
Our audience

25,555
Total followers

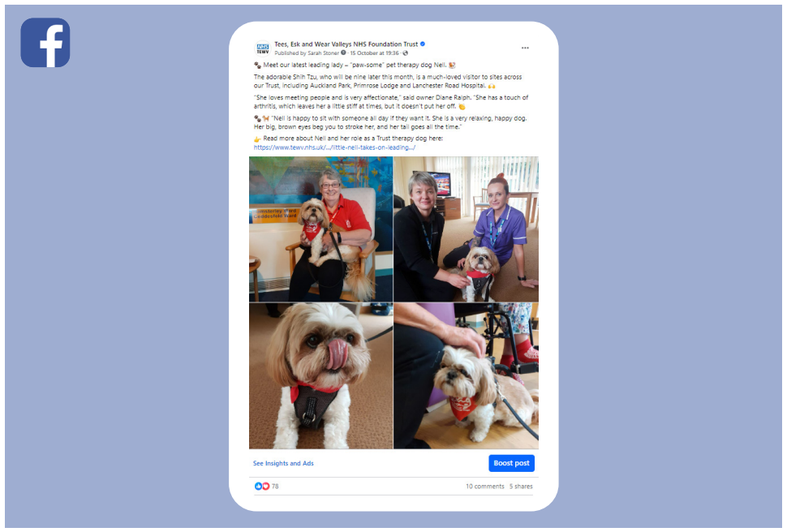
208
New followers

96,554
People who saw our content - impressions

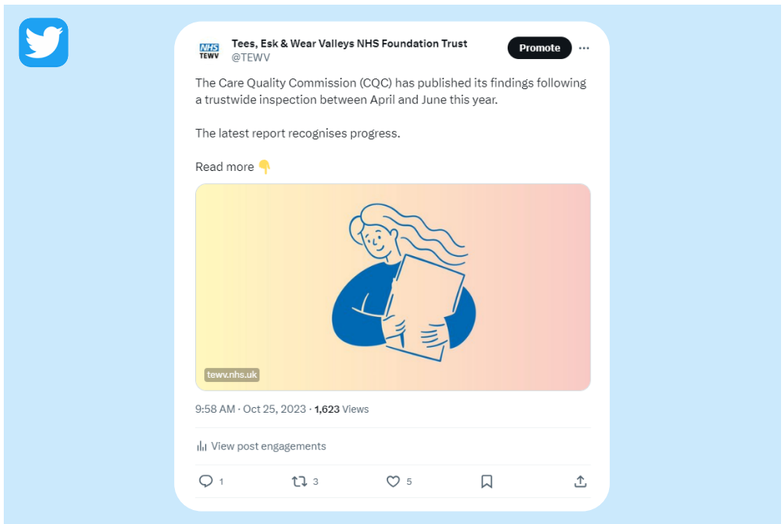
3,233
Engagements



Top posts



Impressions 5,156 - Engagement 534



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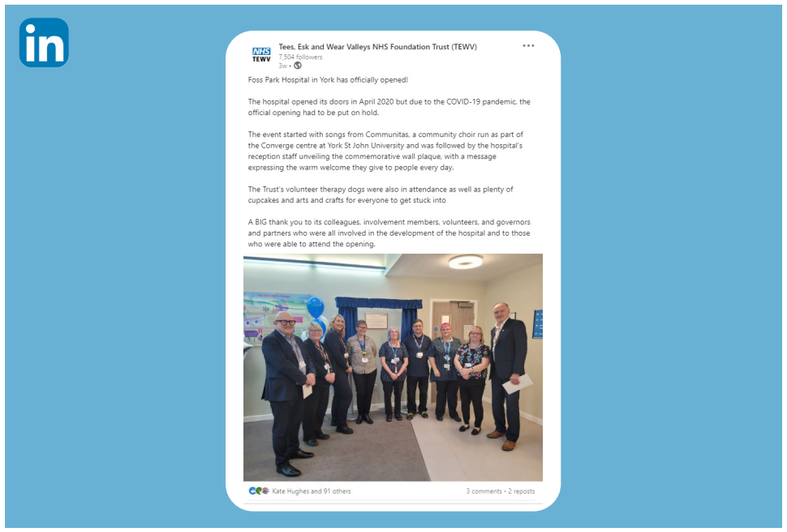

Impressions 2,215 - Engagement 228

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For General Release

Meeting of:	**Board of Directors**
Date:	**09 November 2023**
Title:	**CQC Core Service and Well-led Inspection 2023 update and development of Improvement Plan**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Leanne McCrindle, Associate Director of Quality Governance, Compliance and Quality Data**

Report for:

Assurance	✓	***Decision***	
Consultation		***Information***	

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
11	**Governance Assurance**	The delivery of the CQC action plan resulting from CQC inspections is related to multiple BAF risks, however the monitoring and oversight of the CQC action plan relates specifically to the BAF risk 11 (Governance Assurance): • **Governance Assurance** - The absence of a clear line of sight from ward to Board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risks to patients. The risk management approach detailed within the BAF risk 11 (Jan-23) is as follows: • The target risk score is above tolerance levels and the Trust has a minimal appetite for regulatory risks. • Urgent action to be taken to strengthen controls but a higher degree of exposure than acceptable will need to be tolerated. • Regular monitoring of the risk advisable. The report provides details of the ongoing actions in response to the previous CQC inspection and provides an update on the development of the Improvement Plan for this year's CQC Core Service and Well-led Inspection 2023.

Executive Summary:

Purpose: The purpose of this report is to present to the Board in public the outcome of the 2023 CQC Well Led and Core Inspection and to provide assurance of progress regarding the development of the Improvement Plan in response to the recommendations.

For completeness the current progress and assurance status of the open actions from the previous CQC Trust core service and well-led inspection 2021 and the Secure Inpatient Service re-inspections which took place in 2022 is also included.

Proposal: It is proposed that the Board receive the outcome of the CQC inspection public and take **good** assurance regarding the system oversight and delivery of the CQC improvement plan.

No new gaps in assurance or mitigating actions have been escalated or proposed by management within this report.

Overview:

The good overall assurance level has been determined by management based on the progress reported via the Integrated Oversight Plan and the associated assurance evidence reviewed. For existing actions, operational oversight is maintained via the responsible Lead Directors and Managers. Reporting is co-ordinated by the Quality Governance Team at a strategic level and presented to the EDG/ Management Group and the Quality Assurance Committee.

The CQC must do action plan status as at **02 October 2023** was as follows:

- There is a total of 3 Must Do actions (1 Trustwide and 2 Secure Inpatient Services) which are ongoing as part of the Integrated Oversight Plan. Appendix 1 of this report provides details of progress against these remaining actions.
- This action plan update was presented to the Quality Assurance Committee 05 October 2023 and was formally received with good assurance.

Core Service and Well-led Inspections 2023

The 2023 CQC Core Service and Well-led inspection report was published on **25 October 2023**. The outcome of the inspection is shown in the appended slide set.

Improvement Plan Development and Communication Plan

The Communication Strategy was implemented with good effect with partners and the media responding positively to the transparency of TEWV leaders.

The Quality Governance Team are coordinating the development of the improvement actions in response to identified Must and Should Do CQC recommendations in collaboration with Care Group colleagues and Specialty/Directorate leaders. This will form a single Improvement Plan alongside relevant recommendations from the Provider Collaborative Commissioner Safety Reviews (Specialist Services) and the ICB Commissioner Safety Reviews and the themes from serious incidents to avoid any duplication and optimising our focus on improvements that will impact the quality of care.

An outline of the timescales for the development of the Improvement Plan are as follows:

A range of face to face and virtual meetings will be used to develop the Improvement Plan. As part of the process for development, relevant Executive Directors and Operational Delivery Leads will be agreed alongside delivery timescales.

Once all actions are established and approved, these will be centrally monitored. Responsible operational action owners and accountable Directors will be required to maintain oversight and provide regular updates regarding the completion status and assurance levels for each improvement action.

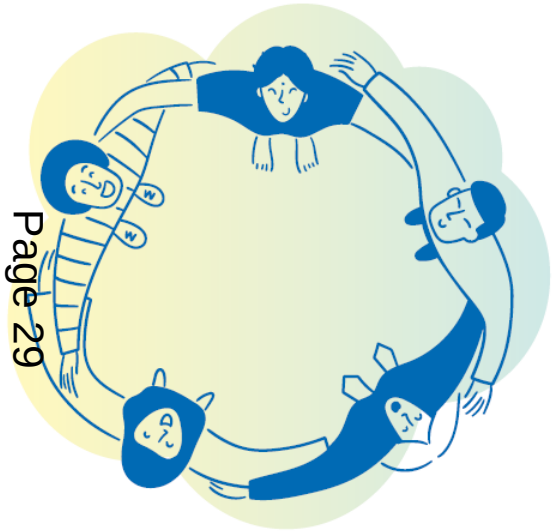
Prior Consideration and Feedback	The Quality Governance Team will continue to maintain the evidence repository to provide assurance of completion and implementation of actions. Delivery progress for the CQC Improvement Plan will continue to be formally reported to the Quality Assurance Committee. Monthly updates are provided to the Quality Assurance Committee. There are no new risks nor matters arising for escalation this month.
Implications:	The Group is requested to note that there may be risks if the Trust fails to deliver mitigating actions to identified risks associated with the outputs from CQC inspections and the need to effectively undertake actions in response to CQC Regulatory activity.
Recommendations:	The Board is asked to receive in public the outcome of the 2023 Core and Well Led CQC Inspection and to confirm the level of assurance that the improvement planning is progressing as required.

Appendix 1

Current status key:	Complete	On track/Little risk to delivery	Some risk to delivery	Not delivered/ significant risk to delivery
Level of assurance key:	Substantial	Good	Reasonable	Limited

Core Service	No.	Recommendation / Finding	Action	Action owner	Evidence of completion	Original target date for completion	Latest target date for completion	Current status	Level of assurance against evidence	Progress update
Core Service and Well-led 2021										
Trust wide	**1d**	The trust must ensure that it continues to deliver its board development programme to strengthen the scrutiny and challenge by boards members. (Regulation 17)	d) Commission a further external governance review.	Company Secretary	Board and Committee Minutes	30/03/2024	30/03/2024	On track/Little risk to delivery		External Governance Review commissioned and in progress. Deloittes are undertaking the review and this will be reported to the Trust Board.
SIS – Re-Inspection 2022										
Secure Inpatient Services	9c	The trust must ensure that seclusion reviews are carried out as outlined in the MHA code of practice and ensure that seclusion rooms contain a two-way intercom that is fit for purpose and a clock.	c) There will be a review of the TEWV Seclusion Procedure in line with the MHA Code of Practice, to ensure compliance	Positive and Safe Lead Nurse	Procedure review	30/11/2023	30/11/2023	On track/Little risk to delivery		• Two-way intercoms are in place and checked regularly to ensure in working order – reported immediately when errors. • Clocks have been ordered for all seclusion rooms within SIS Ridgeway • MHA code of practice statutory requirements. Current audit not suitable for SIS (due to length of time in seclusion and only to be completed at discharge). Therefore, daily audit assurance tool developed and will be agreed within governance structures (October 23) • Positive and Safe Associate Nurse Consultant is currently recording compliance with MHA code or practice. • Policy is currently under review led by the Nurse Consultant for Positive and Safe.
Secure Inpatient Services	9d	The trust must ensure that seclusion reviews are carried out as outlined in the MHA code of practice and ensure that seclusion rooms contain a two-way intercom that is fit for purpose and a clock.	d) A Trust wide Long-Term Segregation and Prolonged Seclusion Group will monitor and review the use of seclusion and compliance with the MHA Code of Practice.	Associate Nurse Director	Minutes of meetings and action logs from the Trust wide Long-Term Segregation and Prolonged Seclusion Group will evidence that seclusion reviews are undertaken as outlined within the MHA Code of Practice.	30/11/2023	30/11/2023	On track/Little risk to delivery		• All seclusion and segregation are reviewed in the positive and safe group (RRI group local and trust wide). • HOPEs are also providing support within SIS • Weekly MDT review of Seclusion and Segregation for any service users who are in LTS.

Tees, Esk and Wear Valleys
NHS Foundation Trust



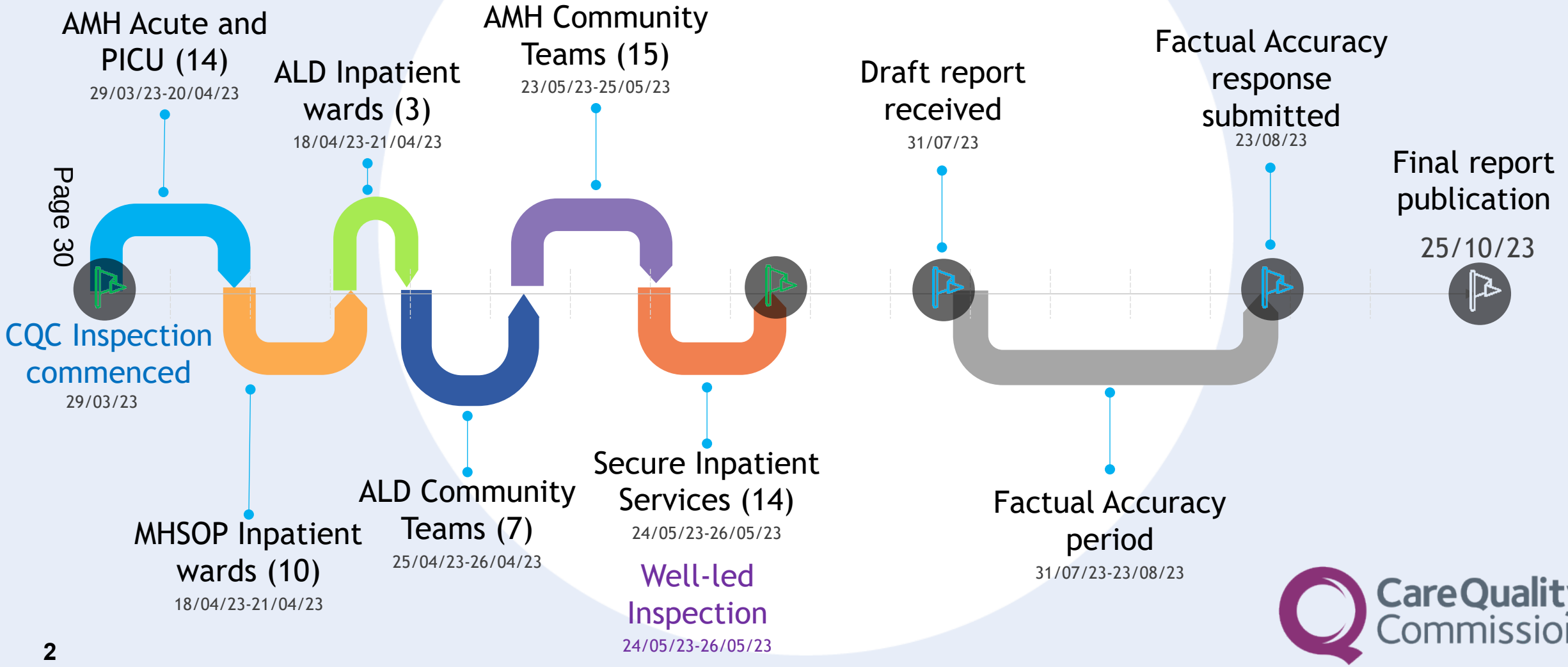
Tees, Esk and Wear Valleys NHS Foundation Trust

CQC Core Service and Well-led Inspection 2023

CareQuality Commission

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust



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CQC Core Services Inspected 2023

NHS
Tees, Esk and Wear Valleys

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

Previous CQC Ratings Table

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Overall rating

Inadequate | **Requires improvement** | Good | Outstanding

Last rated 28 October 2022

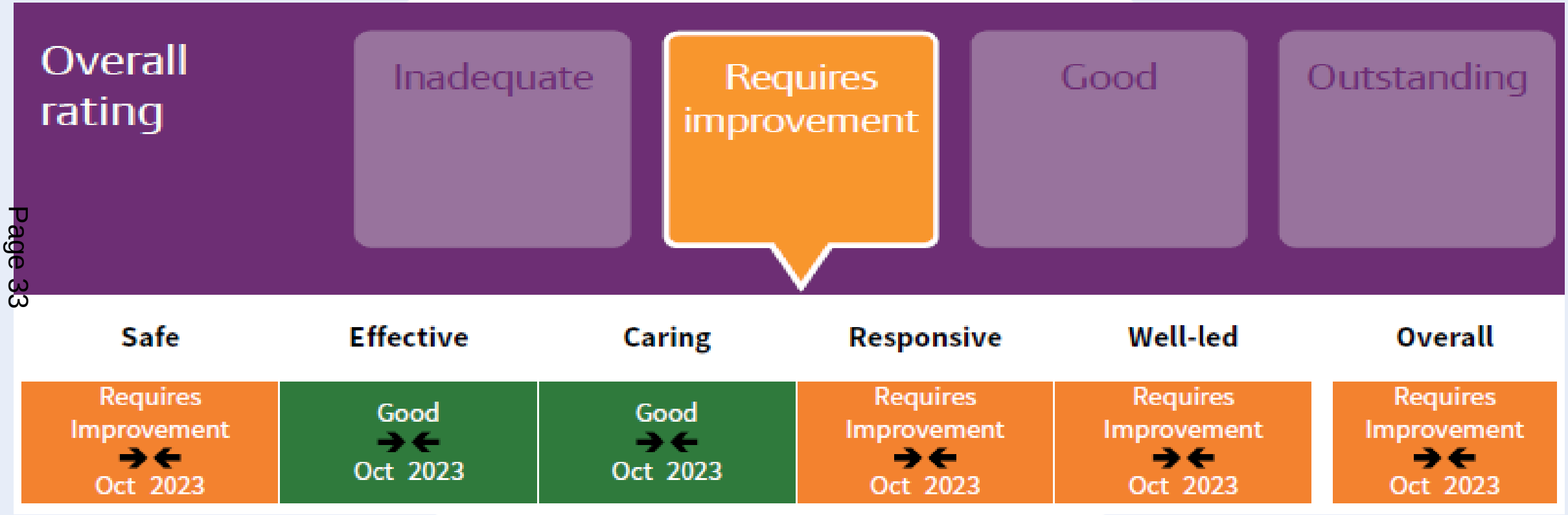
Age services

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Requires improvement
Well-led?	Requires improvement

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorders service	Requires Improvement	Outstanding ☆	Good	Good	Good	Good
Specialist community mental health services for children and young people	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community mental health services with learning disabilities or autism	Good	Requires Improvement	Outstanding ☆	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Wards for people with a learning disability or autism	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Forensic inpatient or secure wards	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community-based mental health services for adults of working age	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust



The overall Trust rating remains as: **Requires Improvement**

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement → ← Oct 2023
Community-based mental health services of adults of working age	Requires Improvement ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Requires Improvement → ← Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023
Wards for older people with mental health problems	Requires Improvement → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Community mental health services for people with a learning disability or autism	Requires Improvement ↓ Oct 2023	Good ↑ Oct 2023	Good ↓ Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023	Good → ← Oct 2023
Forensic inpatient or secure wards	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023	Good ↑ Oct 2023
Specialist community mental health services for children and young people	Requires improvement Sep 2022	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Sep 2022
Community-based mental health services for older people	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Wards for people with a learning disability or autism	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023	Good ↑ Oct 2023	Requires Improvement → ← Oct 2023	Requires Improvement ↑ Oct 2023	Requires Improvement ↑ Oct 2023
Specialist eating disorders service	Requires improvement Mar 2020	Outstanding Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020	Good Mar 2020
Mental health crisis services and health-based places of safety	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021	Good Dec 2021

Of the 6 Core Services inspected:

- **3** Overall Core Service ratings have improved (MHSOP, ALD Inpatient, and Secure Inpatient Services)
- **3** Overall Core Service ratings have remained the same (AMH Acute and PICU, AMH Community and ALD Community)
- There have been **12** CQC domains across the core services inspected that have improved, **15** which have remained the same, **3** where the rating has decreased.

CareQuality Commission

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust

Positives

- ✓ Cultural changes
- ✓ Innovative practice
- ✓ Person-centred care
- ✓ Multi-disciplinary working
- ✓ Environmental changes
- ✓ Medication Management
- ✓ Risk Management
- ✓ Governance
- ✓ Clear Vision and Strategic Direction

Areas for Improvement

- Staffing
- Mandatory/Statutory Training
- Complaints/PALs
- Supervision
- Waiting times
- Physical health monitoring
- Serious Incident processes (including Duty of Candour)

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust

Must and Should Do Actions

Core Service	Must Do	Should Do	Total
A&D Community	1	3	4
A&D Inpatient	6	7	13
AMH Acute and PICU	5	7	12
AMH Community	2	3	5
MHSOP Inpatient	1	6	7
Secure Inpatient Services	6	16	22
Trust wide	17	14	31
Total	**38**	**56**	**94**

CareQuality Commission

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust

Trust-wide Must and Should Do Actions:

Action No.	Must/ Should Do	CQC Action Required
1	Must Do	The trust must ensure that there is a reduction in the use of restraint and restrictive practices particularly prone restraint. The board must have improved oversight of the use and reduction of restrictive practices including mechanical restraint.
2	Must Do	The trust must ensure that people can access care which meets their needs by reducing waiting times.
3	Must Do	The trust must ensure that all staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion are trained in immediate life support as per national guidance and best practice.
4	Must Do	The trust must ensure that learning from incidents, deaths and complaints is effective and embedded and that the risk of repeat incidents is reduced.
5	Must Do	The trust must ensure that it continues with work, at pace to improve and make safe the inpatient estate including the continuation of the removal of ligature anchor points and door replacement programmes.
6	Must Do	The trust must ensure that engagement involves working with service users and their families to understand poor experiences and learn from episodes of harm.
7	Must Do	The trust must ensure that governance systems and processes are established, embedded and operated effectively to assess, monitor and improve the quality and safety of the services. Using accurate and clear information to make improvements to the safety and quality of services.
8	Must Do	The trust must improve governance systems and processes to identify and escalate risks including early warning signs in frontline services.
9	Must Do	The trust must ensure that feedback from audits, complaints, incidents and executive and CQC visits to services are utilised and tracked to improve quality.
10	Must Do	The trust must ensure that backlogs in the; serious incident review, mortality review, incident review and complaints are resolved with pace, and that actions are taken to prevent reoccurrence.
11	Must Do	The trust must ensure there is a specific, measurable action plan in place to implement internal and external report recommendations.
12	Must Do	The trust must ensure that all risks on the corporate risk register and board assurance framework are reviewed, mitigated and removed with enough pace to resolve key issues to patient safety, service quality and strategy in a timely manner.

CQC Core Service and Well-led Inspection 2023

Tees, Esk and Wear Valleys NHS Foundation Trust

Trust-wide Must and Should Do Actions:

Action No.	Must/ Should Do	CQC Action required
13	Must Do	The trust must ensure that there are safe levels of nursing and medical cover in place on all wards throughout the day and night to ensure that seclusion reviews are completed, and doctors can attend wards within 30 minutes of a psychiatric and in a medical emergency.
14	Must Do	The trust must ensure that staff receive and record appropriate support, training, professional development, supervision, and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
15	Must Do	The trust must ensure that it acts in accordance with the duty of candour regulation.
16	Must Do	The trust must ensure that it has a strategy for physical healthcare.
17	Must Do	The trust must ensure that it has a clear policy relating the use of technology to monitor patients on inpatient wards and that this policy is accessible to patients and staff to understand the reasons for its use.
1	Should Do	The trust should consider that the mental health legislation committee reviews data on the use of restraint and the use of force report.
2	Should Do	The trust should ensure that governors have clear lines of support and access to non-executive directors.
3	Should Do	The trust should ensure that disciplinary and grievances are completed within the trust's policy.
4	Should Do	The trust should ensure that data and intelligence provided to the board from the freedom to speak up guardian is utilised to its full extent including within its work on closed cultures.
5	Should Do	The trust should ensure that freedom to speak up guardian's report includes what action had been taken to resolve cases to assure the board and committee of the outcomes of speak up feedback.
6	Should Do	The trust should consider a review of the work and rest spaces for doctors.
7	Should Do	The trust should ensure that support offered to peer support workers is formally included in supervision policies.
8	Should Do	The trust should consider how actions and outcomes from executive visits to service is fed back to staff at service level.
9	Should Do	The trust should review how issues effecting more than one sub-committee of the board are reviewed and shared.
10	Should Do	The trust should review Mental Health Act policies to ensure that they are reviewed and in line with best practice and statutory frameworks.

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Tees, Esk and Wear Valleys NHS Foundation Trust

Trust-wide Must and Should Do Actions:

Action No.	Must/ Should Do	CQC Action required
11	**Should Do**	The trust should ensure that the quality of information provided in safeguarding referrals improves to ensure they wholly evidence 'think family' and always include information about what is in place to support management of immediate risk.
12	**Should Do**	The trust should ensure that the pharmacy workforce and succession plans are in place.
13	**Should Do**	The trust should ensure that the harm minimisation policy is fully embedded and reflected in staff practice.
14	**Should Do**	The trust should consider how audits include review and oversight of clinical decision making and clinical practice beyond the daily huddle structure.

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Secure Inpatient Services Must and Should Do Actions:

Action No.	Must/ Should Do	CQC Action required
18	Must Do	The trust must ensure that the seclusion facilities meet the needs of patients in the service and meet the requirements of the Mental Health Act Code of Practice.
19	Must Do	The trust must ensure there is a comprehensive handover for all patients which includes risk and how best to support patients. Information must be accessible for staff new to the ward, in a format that provides essential information in how best to support patients.
20	Must Do	The trust must ensure that patients' health is appropriately monitored, including the side effects of high dose antipsychotic treatment, blood glucose and where appropriate bowel monitoring.
21	Must Do	The trust must ensure that blind spots on the wards are mitigated.
22	Must Do	The trust must ensure that there is a comprehensive oversight of the use of mechanical restraint and that the necessary safeguards are in place with records to support this.
23	Must Do	The trust must ensure that there are sufficient staff to provide consistent care to patients.
15	Should Do	The service should ensure that staff receive supervision.
16	Should Do	The trust should ensure that search records are accurate and reflect the search process and findings.
17	Should Do	The trust should ensure that patients and staff are offered a debrief following incidents.
18	Should Do	The trust should ensure that the blanket restrictions on Kestrel and Kite wards are individually assessed.
19	Should Do	The trust should ensure that rooms and facilities are accessible for patients with mobility needs, including access to emergency call alarms.
20	Should Do	The trust should ensure that appropriate food options are available for patients and food is stored in line with food safety requirements.
21	Should Do	The trust should ensure that staff complete all required training including mandatory training.
22	Should Do	The trust should ensure that information is shared consistently with ward based staff who cannot attend the team meetings.
23	Should Do	The trust should ensure that actions from community meetings are actioned, and the outcome and update shared with patients.
24	Should Do	The trust should ensure that care records are person centred, including individual reasons for the care plan for example choking. There should be evidence of patients' involvement in care plans and that the patient voice is clear. Multidisciplinary meeting minutes should be person centred with thorough updates from members of the team recorded and rationale for decision recorded.
25	Should Do	The trust should ensure that staff consider how they access the ward spaces and not use wards as a cut through.
26	Should Do	The trust should ensure that all equipment that required calibration is calibrated, including auroscopes.
27	Should Do	The trust should ensure there is support available for staff to attend reflective practice and other wellbeing opportunities.
28	Should Do	The trust should review how they plan and conduct the ward visits to ensure staff visit unannounced at different times to ensure balanced feedback is gathered.
29	Should Do	The trust should ensure that all lockable safes for patient use are in working order.
30	Should Do	The trust should develop their governance processes to ensure information is easily accessible.

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MHSOP Inpatient Must and Should Do Actions:

Action No.	Must/ Should Do	CQC Action required
24	Must Do	The trust must ensure that there are cogent recorded reasons for the use of prone restraint and that the reason for its use is recorded with a suitable rationale to ensure patients are protected from abuse and improper treatment.
31	Should Do	The service should ensure that staff receive training and supervision.
32	Should Do	The trust should ensure that there is clear rationale for prescribing as required medicines including when multiple medicines are prescribed for the same indication and a direction is given for which is first or second line.
33	Should Do	The trust should ensure that the storage of gas cylinders is carried out in line with their own policy.
34	Should Do	The trust should ensure that each patient's identified risks are clearly mitigated within a risk management plan.
35	Should Do	The trust should continue to make improvements to ensure that the number of bathrooms is sufficient for the number of patients on each ward.
36	Should Do	The trust should continue to monitor and mitigate the risk of patient falls and take action to reduce the number of falls.

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ALD Inpatient Inpatient Must and Should Do actions:

Action No.	Must/ Should Do	CQC Action required
30	Must Do	The trust must ensure that care and treatment is provided in a safe way for service users by ensuring that staff carry out appropriate monitoring of patient's physical health.
31	Must Do	The trust must ensure that care and treatment is provided in a safe way for service users by ensuring that there is a continued reduction in the use of restraint particularly in the reduction of prone and supine restraint.
32	Must Do	The trust must ensure that seclusion reviews are undertaken in line with the Mental Health Code of Practice.
33	Must Do	The trust must ensure that care meets people's needs and reflects their preferences by ensuring all patients have a discharge plan and by continuing to make progress in supporting people to be safely discharged from the service into appropriate ongoing placements and reduces lengths of stay.
34	Must Do	The trust must ensure that governance processes are effective and embedded and ensure the service continues to improve.
35	Must Do	The trust must ensure that there are enough staff to provide safe and consistent care to people.
44	Should Do	The service should ensure that staff receive training.
45	Should Do	The service should ensure that the respite unit at Bankfields Court is well-maintained.
46	Should Do	The service should ensure that all of people's care records are holistic, thorough, and regularly updated.
47	Should Do	The service should ensure that governance processes are embedded to ensure audits are effective in making improvements to people's care records.
48	Should Do	The service should ensure that they continue to work within models of care that support people to leave long term segregation and seclusion.
49	Should Do	The service should ensure that the reasons for use of as required medication is consistently recorded.
1450	Should Do	The trust should ensure that people's living spaces are conducive to recovery and feel welcoming.

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ALD Community Inpatient Must and Should Do actions:

Action No.	Must/ Should Do	CQC Action required
38	**Must Do**	The trust must ensure that there are sufficient staff to provide safe and consistent care to people.
51	**Should Do**	The service should ensure that staff receive training and supervision.
52	**Should Do**	The trust should ensure staff have access to integrated online systems.
53	**Should Do**	The trust should ensure that supervision systems allow accurate recording.

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AMH Acute and PICU Must and Should Do Actions:

Action No.	Must/ Should Do	CQC Action required
25	Must Do	The trust must ensure that there is adequate medical cover on all wards which ensures that medical staff can undertake timely reviews and attend within 30 minutes of a psychiatric emergency and in medical emergencies..
26	Must Do	The trust must ensure that staff manage and mitigate the risks to service users when they are detained and are permitted to go on section 17 leave.
27	Must Do	The trust must ensure that leaders operate effective systems to improve the quality and safety of the service and to mitigate the risks to the health safety and welfare of service users.
28	Must Do	The trust must ensure that patients' health is effectively and safely monitored, following rapid tranquilisation, and physical health monitoring is completed in line with the regularity as stated in care plans where appropriate such as blood glucose and bowel monitoring.
29	Must Do	The trust must ensure that concerns about access and discharge to the service are managed appropriately including management of delayed discharges and the use of leave beds.
37	Should Do	The service should ensure that staff receive training and supervision.
38	Should Do	The trust should ensure that patients are afforded the necessary safeguards when they are secluded, including appropriate medical and nursing reviews. The trust should ensure that where it is not possible to meet the requirements for seclusion safeguards that cogent reasons are recorded for having to depart from national guidance.
39	Should Do	The trust should ensure there is clear rationale for prescribing as required medicines including when multiple medicines are prescribed for the same indication and a direction is given for which is first or second line.
40	Should Do	The trust should ensure that medicines authorisation paperwork is readily available at the time of prescribing and administering medicines.
41	Should Do	The trust should ensure that appropriate action is taken when medicine fridge temperatures are out of range and that oxygen is stored correctly.
42	Should Do	The trust should continue to maximise patients' privacy and dignity when patients on Cedar ward were required to be escorted to the seclusion room at the end of the male patients' bedroom corridor.
43	Should Do	The trust should ensure that where autistic patients are admitted to the acute wards, information about their individualised needs (positive behavioural support, communication, and sensory needs) are more clearly indicated in care planning and risk assessments records for all staff to see and consider.

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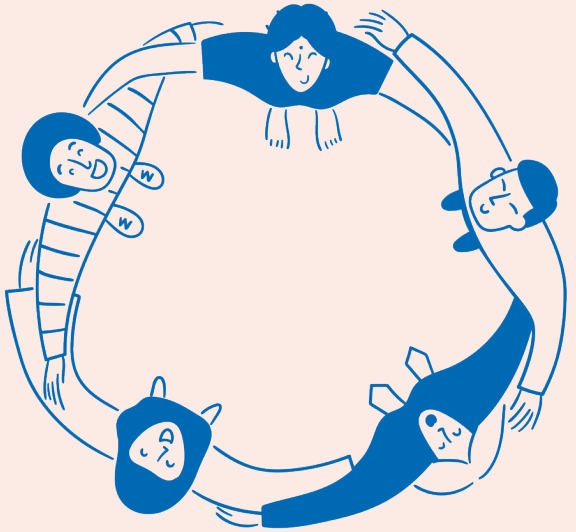
AMH Community Must and Should Do actions:

Action No.	Must/ Should Do	CQC Action required
36	**Must Do**	The trust must ensure that waiting lists are reduced to ensure that patients receive timely access to services and support.
37	**Must Do**	The trust must ensure that there are sufficient staff to provide timely, safe and consistent care.
54	**Should Do**	The service should ensure that staff receive training and supervision.
55	**Should Do**	The trust should ensure that patients are able to access services by telephone in York and Middlesborough.
56	**Should Do**	The trust should ensure that they continue to embed the harm minimisation policy.

Next Steps

- Development of the Trust's collaborative Improvement Plan
- Submission to the CQC 27.11.23



Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**9th November 2023**
Title:	**Board Integrated Performance Report as at 30th September 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.

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, and NHS Oversight Framework. (*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*)

Risks to Quality reviewed in Executive Review of Quality & Quality Assurance Committee are:

- Restrictive Practice – use of mechanical restraint on 2 occasions, use of Cross Lane seclusion room and continued use of prone restraint. A lapse in completing seclusion audits in one service line, now rectified.
- Delay in accessing beds – multiple issues impacting flow in Durham & Tees Valley services, some of which are beyond Tees, Esk & Wear Valleys leaders to address, eg people being admitted on a s.37/41.
- Physical healthcare – a lack of assurance that we are consistently meeting the needs of people who are diabetic and in one of our wards.
- Backlog of serious incident reviews – the work to resolve the backlog of reviews is having a short-term impact on the capacity of clinical and operational leaders.
- Adult Outcomes – there is a lack of a Performance Improvement Plan developed within Durham & Tees Valley services.

Performance Improvement Plans

Performance Improvement Plans (PIPs) have been established for the following issues that are impacting on performance to demonstrate to the Board, that we are focussed on the right things and in a timely manner:

- 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)

Whilst progress has continued on the Performance Improvement Plans (PIPs) for Safe Staffing, Mandatory & Statutory Training Compliance and Appraisals Compliance since the August Report, due to proposed changes in how the sub-groups will function going forward, in order to ensure clearer line of sight and recognising the interplay of each, the PIPS

themselves have not all been updated this month. These sub-groups are to become time limited workstreams each delivering on key elements of Safer Staffing with performance and progress managed within the Safer Staffing Group, reporting into Executive People, Culture & Diversity Group or the new joint Executive Resources and Workforce Sub-group. The Executive Director of People & Culture and the Chief Nurse are to submit a proposal to Executive Directors Management Group to merge these PIPs and subsume these actions as part of the broader business of the Safer Staffing Group.

Mental Health Priorities including National Quality Standards

There is 1 Trust priority and 8 commissioner priorities that have not been achieved for quarter 2 2023/24. (*See Appendix A*). PIPs have been established to drive improvements in these areas.

Broader Key Issues

Broader key issues/work in relation to Workforce and Inpatient Pressures this month are:

- Bed Occupancy
- Statutory and Mandatory Training Review
- Appraisals
- Occupational Health Tender

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

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	Deterioration in performance Reduced assurance
Percentage of CYP showing measurable improvement following treatment - clinician reported	Improvement in performance
Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	Reduced assurance
The number of Restrictive Intervention Incidents	Deterioration in performance Reduced assurance
Percentage Sickness Absence Rate	Improvement in performance Improved assurance
Percentage of staff in post with a current appraisal	Deterioration in performance Reduced 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 30th September 2023 the Trust reports a deficit of £4.43m compared to its planned deficit of £5.13m, being a favourable variance of (£0.7m). Two in-year national pressures are included within the year to date deficit, but with some expected mitigation: • 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 £0.79m to the deficit as at 30th September 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 £0.23m to the year to date deficit (£0.46m projected 2023/24). However, confirmation has been received from the ICB that our impact for 2023/24 is likely to reduce to £0.03m. These two pressures are offset in part by the revised medical pay award (paid in Month 6) which is contributing to a reduction to the deficit at Month 6 of (£0.62m). 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 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.
Financial Plan: Agency expenditure compared to agency target	The Trust agency expenditure is £0.32m lower than planned costs up to 30th September 2023 (3.05% lower than plan, previous month 0.95% lower than plan), albeit that plan levels reflect 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 (albeit these costs are reducing) and vacancies in Health and Justice. 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 has been slower than planned to enact the discharge of a small number of individuals supported through complex Trust Care Packages. A review of non-clinical agency assignments following recent national guidance is underway with eradication of these assignments required by October 2023, with the exception of assignments meeting specific criteria.
Financial plan: Agency price cap compliance	Agency usage includes shifts fulfilled on hourly rates above the price cap or off framework. There is limited assurance due to the pressures highlighted at measure 24 and 25a) above driving staffing pressures. However, the flexible staffing team have obtained reduced rates above cap and continue to challenge agency suppliers on meeting framework terms and conditions. There has been a consistent level of compliance (based on average per day) for quarter 1 2023 and moving into quarter 2 2023, compliance at 76 shifts per day in September 2023 (previous month was 87 shifts per day). However, in September 2023 36% 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 30th September 2023 £6.51m CRES has been achieved, £3.86m recurrently (£2.12m behind plan measure 27) and £2.65m non-recurrently (£2.12m ahead of plan measure 28). A trust wide CRES event took place during September, themes are emerging from the event which will need clear focus and work is on-going on next steps. Composite CRES delivery of £6.51m is in line with plan.

Mental Health Priorities including National Quality Standards

As at quarter 2 2023/24 we have not achieved 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	Vale of York
CED: Percentage of Service Users designated as routine cases who access NICE concordant treatment within 4 weeks	County Durham, North Yorkshire and Vale of York
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 and Vale of York
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 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	Vale of York
Number of women accessing specialist community PMH services	North Yorkshire and Vale of York

Appendix B

Broader Key Issues/Work

Inpatient Pressures

Bed Occupancy
In Quarter 2 there was a noticeable sustained reduction in Out of Area Placements (OAP) and associated OAP bed days, resulting in our ability to achieve our ambition of admitting zero patients to a bed outside the Trust for a period, despite bed occupancy still remaining high across the Trust (DTV ≥ 100%, NYY ≥ 95%). However, the current position shows that our Out of Area Placements have increased, and we are no longer achieving that ambition. As of the 13th October, there were 6 Out of Area Placements. This change in position at the start of Quarter 3 is attributed to a rise in admissions coupled with an already high bed occupancy rate. In August 2023 (Quarter 2) there had been a reduction in admissions which enabled the repatriation of Out of Area Placements, therefore stopping the use of Independent Sector Beds for a brief period. There has also been a slight increase in the number of patients with a Length of Stay over 60 days across all of Durham Tees Valley and the number of patients delayed and who are Clinically Ready for Discharge remains high in some areas across the Trust, impacting our ability to sustain a zero OAP position.

Ongoing work to help address high bed occupancy rates:

- Now that all actions have been undertaken to review and refresh the Purposeful In-Patient Admission (PIPA) process, services now continue to monitor progress and help embed the changes.
- OPTICA pilot: A critical path has been developed with associated timelines. Technical changes are being made to support connection and flow of data once all the necessary governance/due diligence checks have been completed and approved.
- Active support is still being provided to wards with the highest level of patients with a Length of Stay over 60 days.
- An independent peer review of the patient flow process has been undertaken in Durham & Tees Valley to identify any areas for improvement. Feedback is due to be received this month.
- Undertaking Multi agency events to understand the cause of higher admission, starting in Darlington. This and the North Tees Deep Dive to be reviewed with Integrated Care Board and Local Authority Leads to make recommendations across at place.

New governance arrangements will be in place as of the 20th October through the implementation of the new Urgent Care Programme Board. The Board will provide immediate oversight to several schemes that are in progress, these include some of the schemes mentioned above. The Board will also be responsible for the delivery of the programme and its benefits related to the Urgent Care Pathway, this will include Inpatients as an area of focus.

Workforce

Statutory and Mandatory Training Review
The review into how statutory and mandatory training is delivered across the Trust has commenced. Initial scoping has involved engagement with colleagues across services to inform the redesign of how, when and where training is delivered to ensure staff are trained in the most efficient and effective way meeting corporate standards and safe staffing requirements.

Appraisals
Additional programme management resource has been secured to support the continued implementation of Workpal across the Trust. Commencing at the end of October, this role will coordinate the technical, operational and strategic workstreams to provide oversight, identify issues/barriers to achieving compliance trajectories and the design and delivery of a programme of training and development for both managers and staff.

Occupational Health Tender
A comprehensive programme of work has been undertaken to develop the tender for the new Occupational Health Service, due to take effect from 1st April 2024. This has involved engagement

with a working group of colleagues across the Trust, gaining feedback on current provision to inform the development of the service specification going forward. The procurement period is due to commence early November 2023.

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

The key issues continuing within the Care Group are:

- Bed occupancy within our adult wards. Work continues on the OPTICA development; we are currently working to establish the necessary technical systems to enable a diagnostic / feasibility assessment.
- Percentage of Adults and Older Persons showing measurable improvement following treatment for both patient and clinical reported outcomes. A deep dive is currently underway to identify the key improvement actions required.
- Compliance with mandatory and statutory training. A Quality Improvement event is to be co-developed with People & Culture leads to look at the potential to transform the approach to face-to-face Mandatory and Statutory training modules.
- Talking Therapies. Access to our services continues below standard in County Durham Sub-ICB, although an increase in referrals was reported. Marketing of the service with a view to increasing referrals is being progressed.
- As at September 2023 the Care Group has reported an overspend to budget of £6.1m, a deterioration on August. The areas of concern for the care group are:
    - Delivery of CRES for agency (current spend £6m - 5.35% of pay spend)
    - Delivery of CRES for Independent sector bed use (current spend £1.6m)
    - Over established Adult Mental Health clinical posts in community and BCP wards (£2.3m)

This month we identify Appraisals, for which some areas have reported a slight decline in September.

The areas of positive assurance identified within the IPD

The key areas of positive assurance continuing within the Care Group are:

- Percentage of CYP showing measurable improvement following treatment, both patient and clinician reported measures.
- Restrictive Interventions, particularly within Adult Learning Disabilities and Secure Inpatient Services.
- Staff leaver rate.
- Talking Therapies standards for patients achieving recovery and waiting times.
- 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.
- Number of CYP aged under 18 supported through NHS-funded mental health with at least one contact.
- The follow up of patients discharged from our services within 72 hours.

This month we have achieved the standard in both Sub-ICB Locations 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.

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

The Crisis 4-hour measure continues to be monitored closely and discussions have progressed with the Integrated Care Board regarding investment to support an all age crisis access service co-located with the North East Ambulance Service (NEAS). As we do not have immediate access to NEAS clinical systems, “phase 1” will not include co-location with NEAS; this will be revisited in 2024/25. Clinical work is ongoing with weekly working groups agreed to implement the screening team during quarter 3. Current call answer rates (September) are 60% in Durham and Darlington team and 68% 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

The key issues continuing within the Care Group are:

- Bed occupancy. Delayed Transfers of Care continue to be a concern but are improving within Adult Mental Health following the establishment of the pathway to the recovery team with City of York. Mental Health Services for Older People has reported a slight improvement and discussions continue between the Trust and Head of Social Work regarding potential support. There was 1 independent sector bed at the end of September 23.
- Appraisals. A deep dive has taken place with teams who have expressed concerns.
- Memory Service waiting times. A demand and capacity exercise has been delayed until the end of October 2023 due to workforce pressures within Business Planning.

This month we identify Adult and Older Persons showing measurable improvement following treatment for both patient and clinician reported. Whilst many older adults have deteriorating illnesses that may not show improvement, this remains a key focus. MHSOP Hambleton & Richmondshire Team Managers are reviewing samples of patients to understand whether the Health of the Nation Outcome Scores have been completed at the right points in a patient journey; this is ongoing as part of the staff supervision structure. Outcome measures are covered in the induction of new staff.

The areas of positive assurance identified within the IPD

The key areas of positive assurance continuing within the Care Group are:

- Talking Therapies Recovery Rate.
- Number of CYP aged under 18 supported through NHS-funded mental health with at least one contact.
- 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.
- The follow up of patients discharged from our services within 72 hours.
- Patients waiting less than 2 weeks for first episode of Psychosis for North Yorkshire Sub ICB Location.
- Talking therapies 6- & 18-week standards for accessing our services.
- Adult Mental Health patients seen by crisis within 4 hours for North Yorkshire and York Sub ICB Location.
- Children & Young People seen by suitably trained practitioner within 4 hours for York Sub ICB Location.

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

Inpatient staffing is a concern due to a high level of vacancies within Adult Mental Health which is resulting in high temporary staffing use.

The Adult Learning Disabilities (ALD) Psychology Lead post will be vacant from mid-October with a gap until recruited into. The ALD administrative lead is retiring at the end of this year which will be a significant gap in service.

The revised mental health first response model for the all-age 0800/NHS 111 connection went live on 13 September, which aims to increase the response rates 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. This continues to put enormous time pressure on teams when a client needs an inpatient bed. Awaiting to see how the bed management process will support the service to locate beds when needed. There are currently 3 Adult Learning Disability patients placed externally.

Appendix C

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 30th September 2023

Report Produced by: Ashleigh Lyons, Head of Performance
Date the report was produced: 20th October 2023

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

journey to change

CONTENTS

Chapter 1

Integrated Performance Dashboard (IPD)

Our Guide To Our Statistical Process Control Charts

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

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

Action status

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

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

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

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

Performance & Controls Assurance Overview

Tees, Esk and Wear Valleys NHS Foundation Trust

Controls Assurance Rating	Performance Assurance Rating: Substantial	Good	Reasonable	Limited
Positive	*Medication Errors with a severity of moderate harm and above	***CYP showing measurable improvement following treatment - clinician reported** *Incidents of moderate harm and near misses *Staff Leaver Rate ***Percentage Sickness Absence Rate** *CRES Performance – Non-Recurrent		
Trend		***Patients surveyed reporting their recent experience as very good or good** *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 ***Restrictive Intervention Incidents** *Unexpected Inpatient unnatural deaths reported on STEIS	*Bed Occupancy (AMH & MHSOP A & T Wards) ***Inappropriate OAP bed days for adults that are 'external' to the sending provider** *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 *Compliance with ALL mandatory and statutory training ***Staff in post with a current appraisal** *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 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		?	92.00%	91.80%
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%	75.07%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	53.07%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	24.59%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	46.26%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	44.83%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	19.87%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC				99.83%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC				494
10)	The number of Serious Incidents reported on STEIS	QAC				67
11)	The number of Incidents of moderate harm and near misses	QAC	L			926
12)	The number of Restrictive Intervention Incidents	QAC				3,296
13)	The number of Medication Errors with a severity of moderate harm and above	QAC	L			3
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				52.51%
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				61.87%
18)	Staff Leaver Rate	PC&D	L			11.56%
19)	Percentage Sickness Absence Rate (month behind)	PC&D	L			5.62%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D		?	85.00%	86.48%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D		?	85.00%	81.11%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				50,852
23)	Unique Caseload (snapshot)	S&RC	H			64,120

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	5,129,833	**4,424,811**
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	10,575,000	10,171,178
25b)	Agency price cap compliance	S&RC	100.00%	63.40%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	5,976,000	3,858,000
28)	CRES Performance - Non-Recurrent	S&RC	528,000	2,645,000
29)	Capital Expenditure (CDEL)	S&RC	8,358,000	4,284,000
30)	Cash against plan	S&RC	63,854,000	62,738,558

* The number of uses of the Mental Health Act data as at August 2023

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.

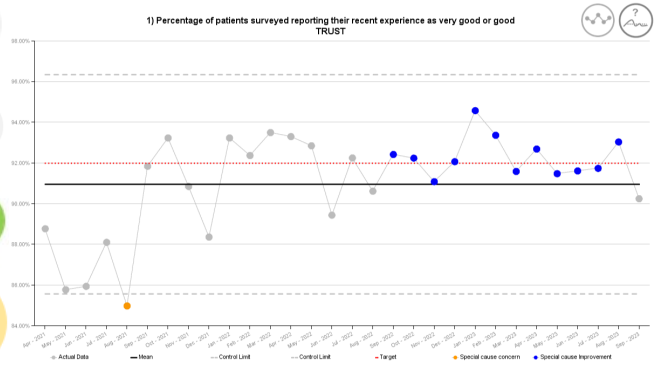
During September, **882** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **796 (90.25%)** scored "very good" or "good".

No significant change in the data during the reporting period shown

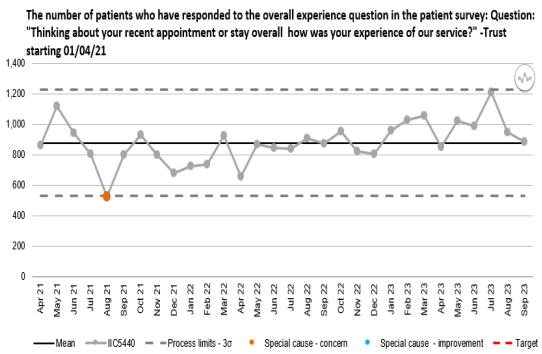
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ ★ 93%

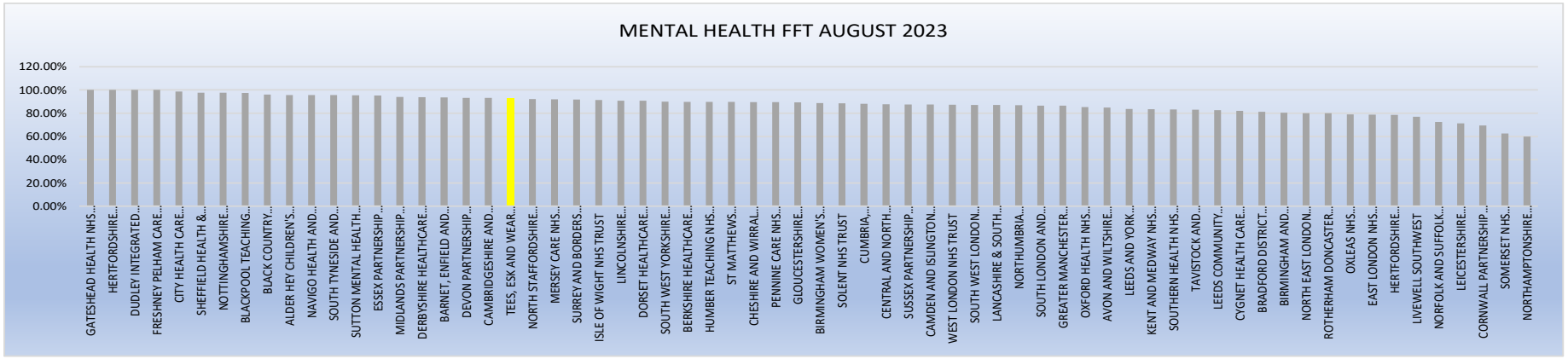
Continuous Improvement
Whilst the SPC/data indicates there are no specific concerns at present, we want to continuously improve in this area



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



National Benchmarking - Mental Health Friends and Family Test (FFT) data - August 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 20 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 September shows:

Learning Disability Services **86.67%** reported their recent experience of our services as very good or good
Adult Mental Health Services **87.53%** reported their recent experience of our services as very good or good
Younger People Services **90.64%** reported their recent experience of our services as very good or good
Older Person Services **95.54%** 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 1,480 comments were received in September of which 1,101 (74%) were positive and 367 (25%) 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.	The deep dive is completed, and the Patient & Carer Experience Team, Lived Experience Director and Senior Performance Manager are to review the findings and agree the actions to be taken.	

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Additional Intelligence in support of continuous improvement

The North Yorkshire, York and Selby Co-Creation Board has been created to work with patients, carers, families, partners and Trust colleagues to bring about positive change. This will ensure that people in our care have a voice and choice over their well-being and care plans. It will also expand the lived experience roles within the Care Group and develop lived experience leadership, so that everyone involved in the Trust can be heard.

In September we opened Brook House, a new custom-built building that will house some of our Stockton community adult mental health services, helping them work closely together and providing a modern and improved environment for our colleagues and the people we support.

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.

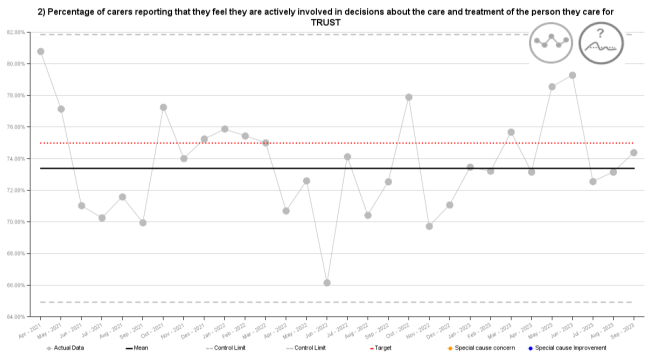
During September, **324** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **241 (74.38%)** scored "yes, always".

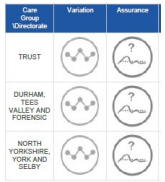
No significant change in the data during the reporting period shown

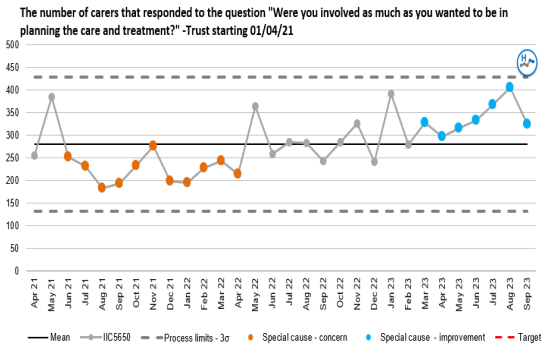
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

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.	**Complete**. Concerns related to a perceived shortage of required staff, a lack of communication, treatment of care, assessments, and care planning. The following actions have been identified.	
NEW There is a need to improve our engagement with carers and to ensure we have clear visibility of their concerns.	*Enabling action:* Patient & Carer Experience Team to investigate and identify the barriers to collecting feedback from our carers by the 30th November 2023, with a view to increasing response rates.		
	Patient Safety Team to review the carer awareness training by the 30th November 2023 to understand our offering and identify a more efficient way to deliver the training, to ensure our staff understand the importance of engaging with carers and feel confident to do so.		

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

Durham, Tees Valley & Forensic Care Group have reviewed their carer information packs and these are being trialled in a number of Adult Mental Health wards prior to sharing learning across all urgent care inpatient services.

The Care Groups are currently reviewing their Triangle of Care self-assessments and action plans are being developed to progress the required standards to ensure we are fully compliant with the requirements.

The Patient & Carer Experience Team has delivered a presentation to the North East & North Cumbria Triangle of Care inaugural meeting in October, presenting how we deliver the Triangle of Care standards in Mental Health to acute sector colleagues. This was well received, and the Patient & Carer Experience Officer has subsequently been asked to support other organisations in their implementation.

A new support group for carers of people in our services in Whitby has been established, facilitated by the Community Mental Health Team Carer Champion and a member of the local Carer Support Organisation, Carers Plus. Any carer of a service user can attend to talk freely about their experiences, feelings and discuss any difficulties, thereby increasing the level of emotional support carers receive.

North Yorkshire, York & Selby have held an event to prioritise carer support where teams who have engaged well with the visual control board process and Triangle of Care showcased their work and approach to share best practice with other teams in the Care Group.

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.

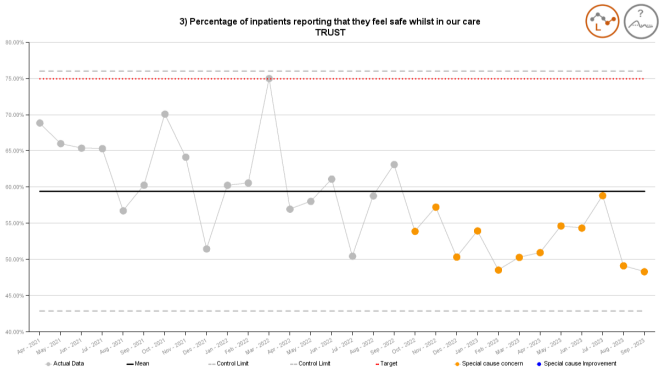
During September, **149** patients responded to the overall experience question in the patient survey: Question: "During your stay, did you feel safe?". Of those, **72 (48.32%)** scored "yes, always"

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

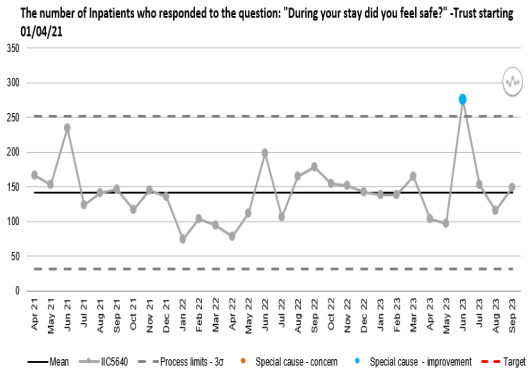
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

87%

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



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



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.	**Complete**. The SIS focus groups have been completed and a draft Service Improvement Plan has been developed. This is to be presented at the October Service Improvement Delivery Group for approval. The AMH focus groups have been completed and action plans have been drafted. All themes were consistent with those previously identified.	
	NEW *Enabling action:* The Patient & Carer Experience Team to revisit the focus groups in Mental Health Services for Older People and Learning Disability Services by the 31st December 2023, to revisit the findings and progress from previous groups, with a view to learning from successes and identifying any further improvement actions. Findings will be reported to the Executive Quality Assurance & Improvement Group.		

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
NEW We need to better understand how other providers monitor this measure with a view to sharing learning and improving the support we provide to our inpatients.	*Enabling action:* Patient & Carer Experience Team to revisit the benchmarking work previously undertaken by the 31st January 2024, to understand how we compare to other organisations and identify any key learning that can be taken forward within the Trust.		
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.	**Complete.** The proposal was submitted to Care Group Board and agreed. Work will be undertaken in a phased approach and a meeting has been arranged at the end of October to agree the scope of the project.	
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; 8 of these are actions are scheduled to be completed by the end of November 2023.

Additional Intelligence in support of continuous improvement

Within Ridgeway (Secure Inpatient Services) a visual one-page summary of patient experience feedback has been developed to be shared and discussed with service users on the wards to enable us to understand their feedback in more detail, support any actions to be developed and support patients to feel safe in their environment.

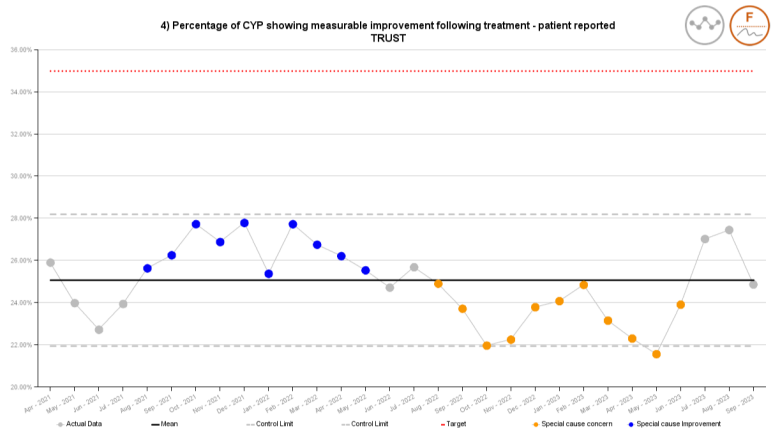
04) Percentage of CYP showing measurable improvement following treatment - patient reported

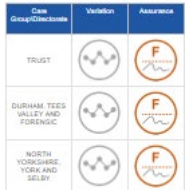
Tees, Esk and Wear Valleys NHS Foundation Trust

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

For the 3-month rolling period ending September **756** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 188 (24.87%)** 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%

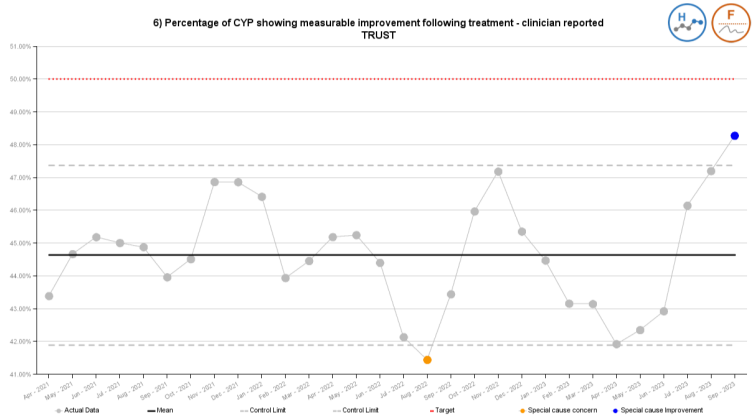
An Area of Concern
We are concerned with our performance in this area and action is required to improve

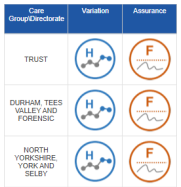
06) Percentage of CYP showing measurable improvement following treatment - clinician reported

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 September **812** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 392 (48.28%)** 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)





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

Our system is expected to consistently fail the target/expectation

93%

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

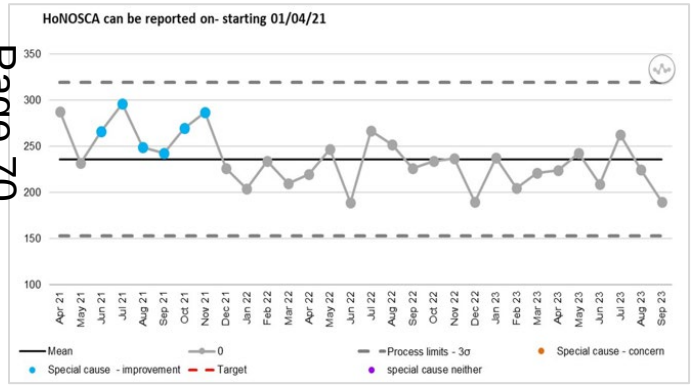
06) Percentage of CYP showing measurable improvement following treatment - clinician reported

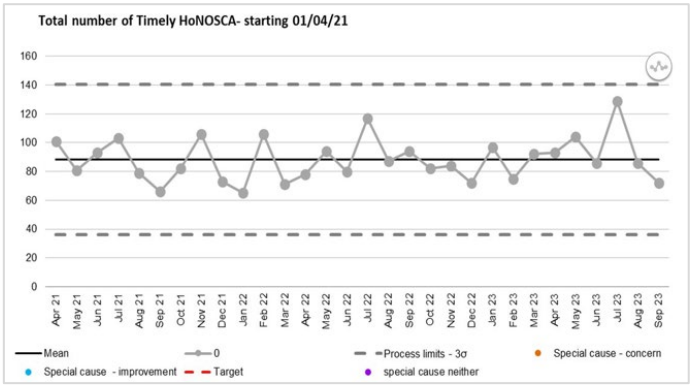
Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Measures

The number of patients that have a paired measure recorded over-time. The percentage of discharged patients that have a paired HoNOSCA tool where outcome can be reported has remained consistent since April 2022, showing there is still progress to be made. **Impact**: If less paired measures are recorded, the patient population captured by the IPD is significantly reduced. This means that a significant proportion of patients are being discharged that we cannot evaluate the impact of care for.

The number of patients who are discharged with 2 HoNOSCA recorded that are considered representative of their presentation at the start of care and at the end of care. The SPC chart indicates that the number of measures that are capturing the whole course of treatment is remaining consistent. A significant proportion of paired measures are not capturing two appropriate time points in the patient journey, and therefore we are unable to evaluate true and meaningful change.





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	No training sessions were delivered during September due to staff sickness. All booked training is now being rescheduled.	
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.	**ON HOLD.** Following discussion at the September Child & Adolescent Mental Health Steering Group, the training has been deferred due to staff sickness. This will be rearranged once support for the event has been identified.	

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 due to be completed by the end of September 2023, of which 1 has been completed. No additional actions have been completed this month.

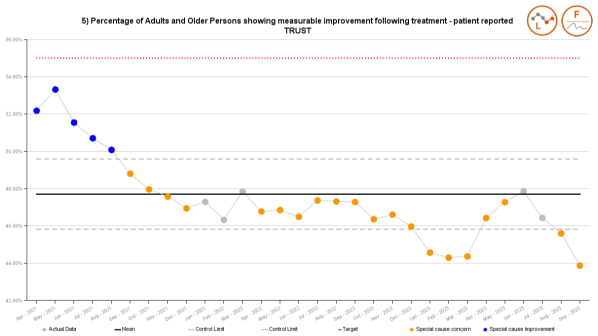
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

Tees, Esk and Wear Valleys NHS Foundation Trust

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

For the 3-month rolling period ending September **1953** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 857 (43.88%)** 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%

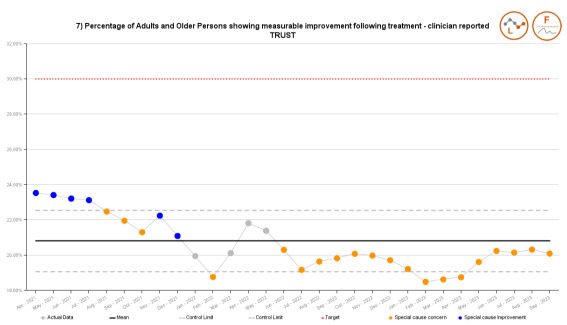
An Area of Concern
We are concerned with our performance in this area and action is required to improve

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 September **2966** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 596 (20.09%)** 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

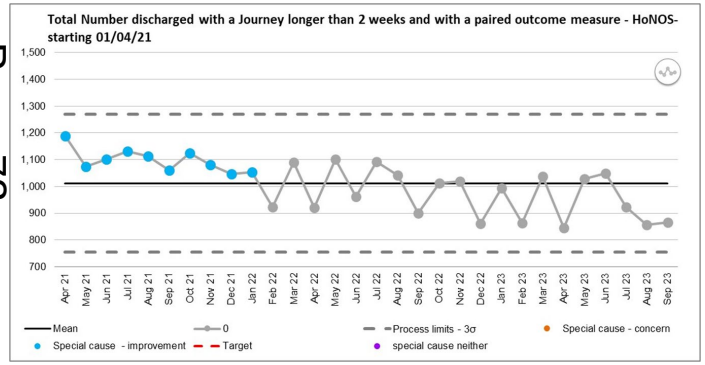
Outcomes: 05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported and 07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

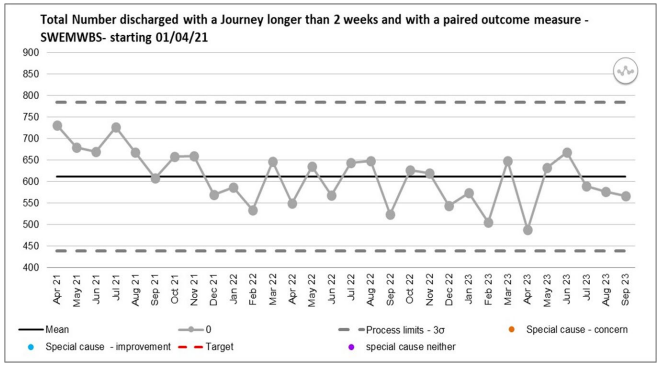
Tees, Esk and Wear Valleys NHS Foundation Trust

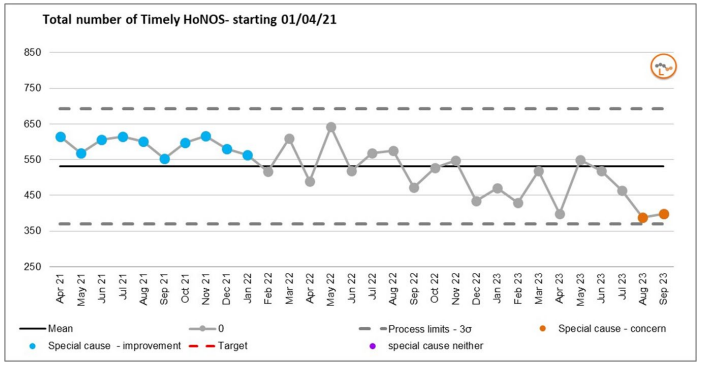
Supporting Measures

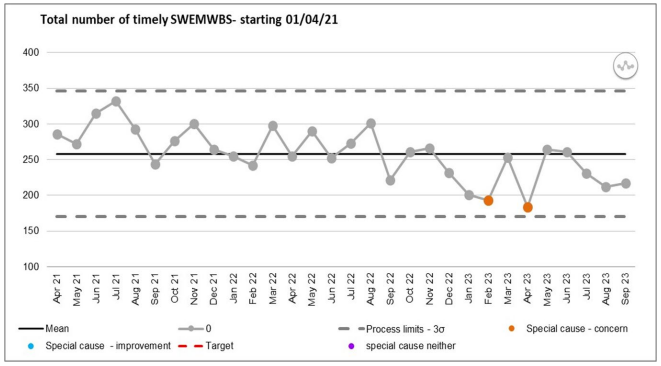
The number of patients who are discharged with 2 HoNOS recorded that are considered representative of their presentation at the start of care and at the end of care. The SPC charts indicate that improvements were made in capturing the tools in a timely manner between April 21 and June 22, however since June 22 these have steadily been decreasing. A significant proportion of paired measures are capturing two random time points in the patient journey. **Impact**: A high rate of untimely measures inhibits our ability to show meaningful change, even when it has happened. We are unable to evaluate the full impact of care if the measures do not capture patient presentation at the beginning and end of their journey.

The number of patients who are discharged with 2 SWEMWBS recorded that are considered representative of their presentation at the start of care and at the end of care. The SPC chart indicates that the number of measures that are capturing the whole course of treatment is remaining consistent. A significant proportion of paired measures are not capturing two appropriate time points in the patient journey, and therefore we are unable to evaluate true and meaningful change.









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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Focused work is required within Durham, Tees Valley & Forensic Care Group to understand why we are unable to improve outcomes for our patients in AMH and MHSOP	*Enabling action.* General Managers to lead a deep dive into the data by the 31st November 2023 to identify specific areas of concern and required improvement.		

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.

Whilst the actions within the PIP are predominantly longer term, we are starting to see increasing trends within our North Yorkshire Adult Mental Health Services for both measures and improvement is visible within Mental Health Services for Older People, in respect of clinician-reported outcome measures.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

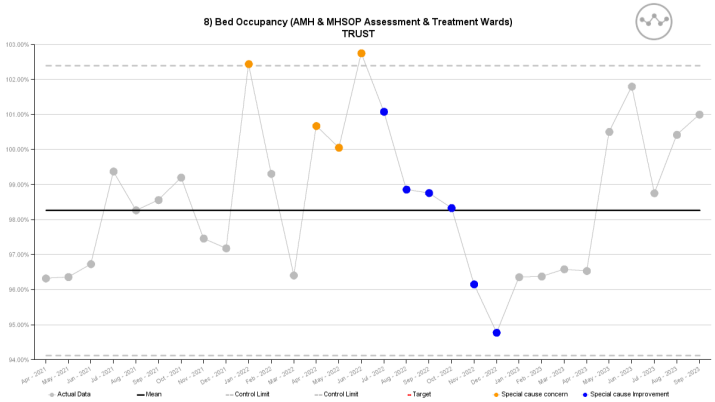
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important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

During September, **10,500** daily beds were available for patients; of those, **10,605 (101.00%)** 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

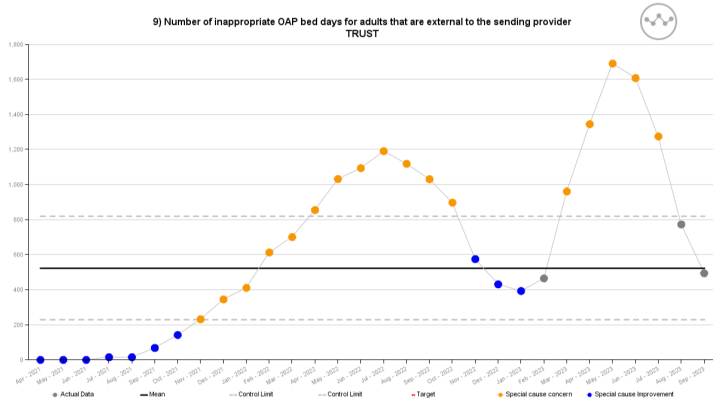
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

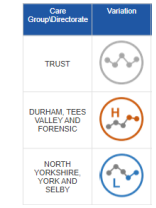
For the 3-month rolling period ending September **494** days were spent by patients in beds away from their closest hospital.

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%





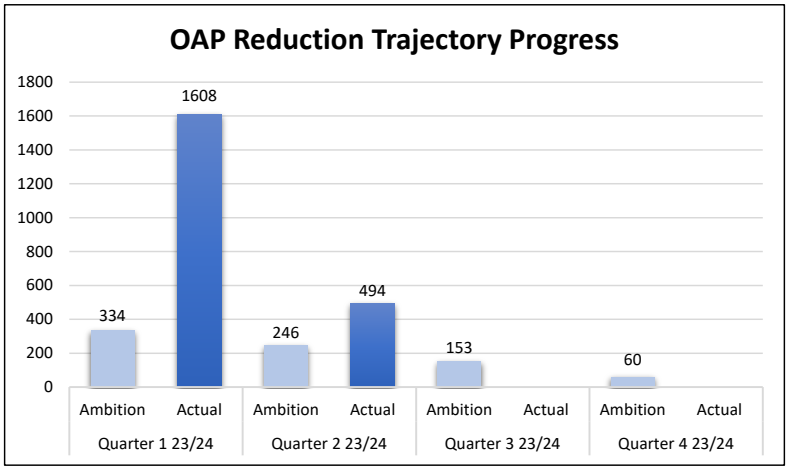
Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Measures

		2023 - 2024						
		Apr	May	Jun	Jul	Aug	Sep	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	10,687	**66,115**
	Number of available bed days	10,740	10,866	10,500	10,850	10,850	10,500	**64,306**
	Percentage Bed Occupancy	**99.00%**	**106.14%**	**106.78%**	**100.92%**	**102.30%**	**101.78%**	**102.81%**

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	494
North East & North Cumbria ICB	334	1445	246	436
Humber & North Yorkshire ICB	0	163	0	58



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 were due for completion by the end of September, of which 8 have been completed. No additional actions have been completed this month.

We are seeing no visible improvement from a Trust-wide perspective in respect of bed occupancy; however, this is offset by a visible reduction in our out of area placements. Whilst it is too early to say that a decreasing trend is visible for out of area placements, four consecutive months' reductions is positive and indicates the PIP is having a positive impact.

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

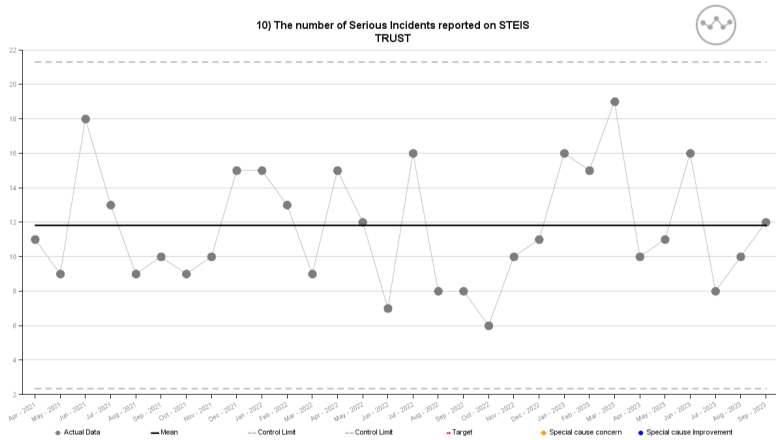
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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

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	

Whilst 12 serious incidents have been reported in the chart, there were 11 serious incidents reported in September. The additional incident is attributable to data quality and the Business Intelligence Team are actively investigating to correct this error.

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

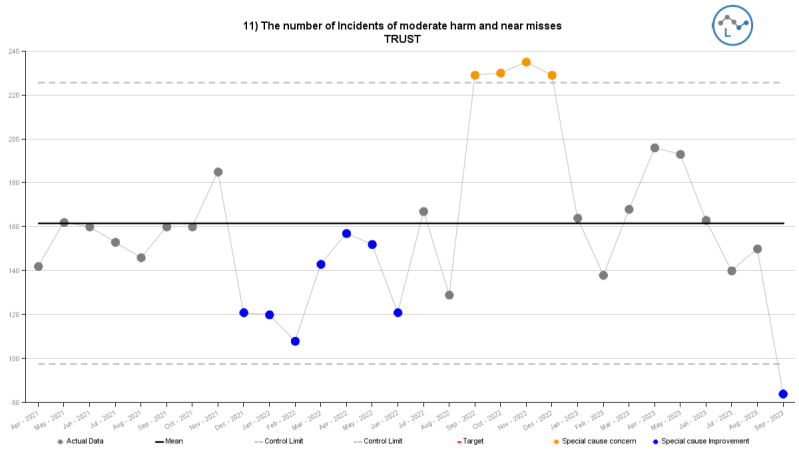
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

84 incidents of moderate harm or near misses were reported during September.

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%



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

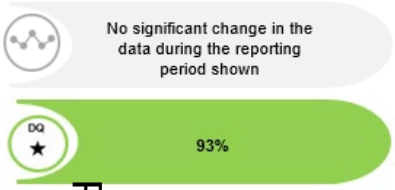
There are no new emerging themes within the 84 incidents of moderate harm or near miss reported in September. Where any early learning is identified immediate actions are agreed and monitored until completion.

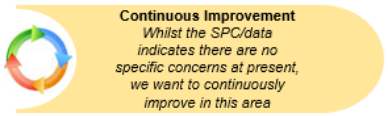
12) The number of Restrictive Intervention Incidents

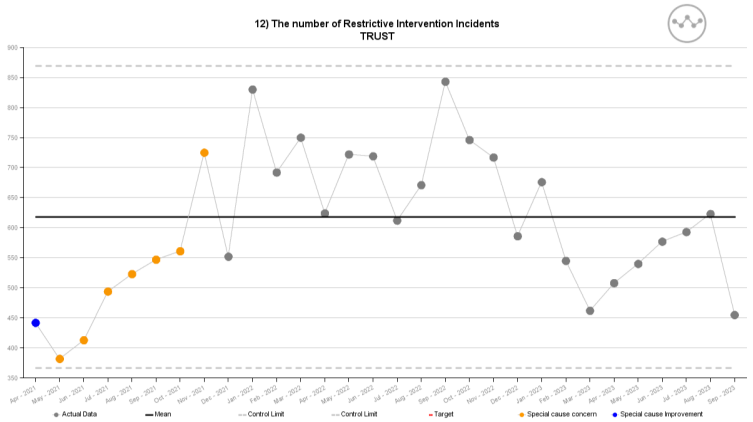
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

455 Restrictive Intervention Incidents took place during September. Looking forward, the intention is to report which incidents were prone restraint or supine restraint in order that we understand patient experience and safety in more detail.







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

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We require greater assurance locally from Care Boards on the implementation of the Restraint Reduction Plan	*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 December 2023 for public consultation.	The draft policy is complete, and two stakeholder workshops are being planned to enable the policy to be circulated for consultation in December 2023.	

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

Tees, Esk and Wear Valleys NHS Foundation Trust

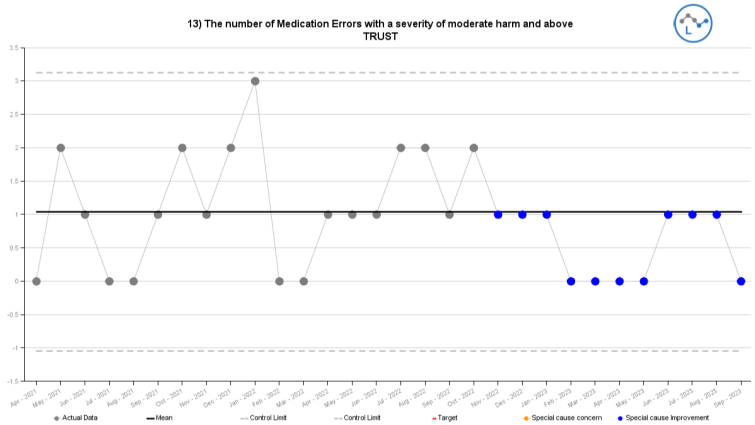
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When medication errors occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

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%



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.

As at the 29th September, we have successfully put EPMA in place on 8 inpatient wards within North Yorkshire, York & Selby; implementation on The Orchards is planned for a later date. Plans are now in place to implement EPMA on our Tees wards by the end of October 2023, prior to finalising the rollout to our Durham & Darlington wards and Secure Inpatient Services. The ambition is to have completed the inpatient roll-out by the end of January 2024.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

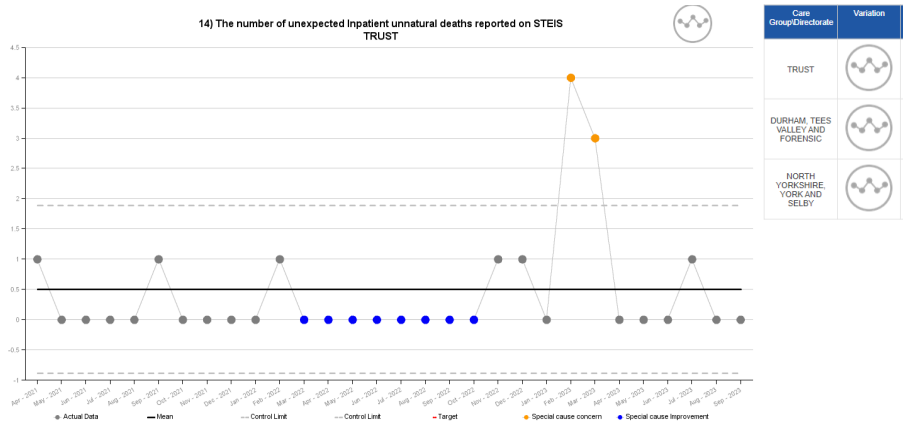
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety of our patients and to minimise the risk of any harm to them and distress to their carers and families.

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

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%



Additional Intelligence in support of continuous improvement

We are awaiting the cause of death regarding the July 2023 death reported above. There is no indication that this death was caused by self harm.

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. As at September 2023, we have 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, and Post Incident Peer Support (PIPS) as an evidence-based group intervention is currently available and being utilised by teams across care groups. Feedback is reviewed and is positive.

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.

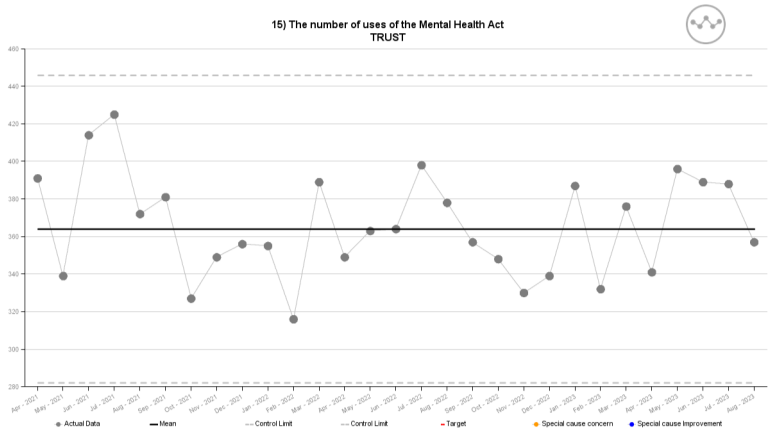
NOTE: Data as at August 2023

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 ~~September~~ November 2023 report.	Business Intelligence has worked closely with the Mental Health Act office to update the construction of this measure; however, following initial testing further issues have been identified. Work is now underway to resolve these.	

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.

716 staff responded to the April 2023 Pulse Survey question "I would recommend my organisation as a place to work" Of those, **376 (52.51%)** 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	Apr - 2023
TRUST	54.23%	52.46%	52.54%	55.01%	53.60%	54.05%	55.53%	52.51%
ASSISTANT CHIEF EXEC	69.23%	60.94%	51.61%	61.29%	47.83%	62.86%	56.00%	55.56%
CORPORATE AFFAIRS AND INVOLVEMENT								58.33%
DIGITAL AND DATA SERVICES	68.09%	60.50%	70.13%	68.00%	57.65%	60.50%	57.50%	73.33%
DURHAM, TEES VALLEY AND FORENSIC	51.50%	50.76%	50.72%	54.63%	54.64%	53.42%	55.92%	51.66%
ESTATES AND FACILITIES MANAGEMENT	57.14%	52.43%	46.92%	50.38%	50.76%	41.95%	46.00%	46.88%
FINANCE	61.54%	57.41%	62.22%	57.58%	61.54%	46.30%	47.37%	48.15%
MEDICAL	67.44%	78.95%	68.42%	64.10%	65.71%	63.64%	61.36%	61.36%
NORTH YORKSHIRE, YORK AND SELBY	50.19%	47.92%	50.48%	52.85%	49.89%	55.21%	55.60%	45.00%
NURSING AND GOVERNANCE	61.90%	56.31%	53.42%	51.95%	35.14%	49.14%	43.53%	57.89%
PEOPLE AND CULTURE	69.86%	68.00%	57.69%	56.99%	61.05%	61.34%	52.17%	53.70%
THERAPIES	82.35%	61.54%	62.96%	54.17%	53.85%	47.06%	67.86%	58.82%

DQ 87%

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

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

National Benchmarking – NHS Staff Survey 2022

The 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

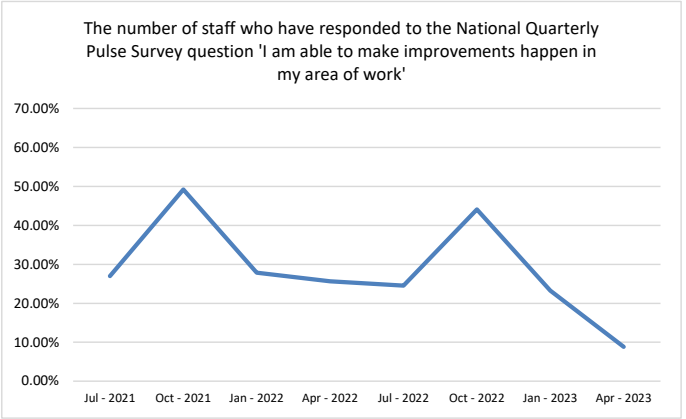
We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise that having the ability to suggest improvements and a high level of job satisfaction within our workforce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

716 staff responded to the April 2023 Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **443 (61.87%)** 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	Apr - 2023
TRUST	57.10%	57.11%	57.50%	58.76%	59.12%	58.53%	60.31%	61.87%
ASSISTANT CHIEF EXEC	76.92%	67.19%	67.74%	74.19%	65.22%	80.00%	88.00%	77.78%
CORPORATE AFFAIRS AND INVOLVEMENT								79.17%
DIGITAL AND DATA SERVICES	65.96%	72.27%	74.03%	72.00%	65.88%	66.39%	65.00%	60.00%
DURHAM, TEES VALLEY AND FORENSIC	56.23%	54.59%	57.00%	57.98%	58.94%	57.60%	57.35%	57.70%
ESTATES AND FACILITIES MANAGEMENT	55.24%	26.04%	53.08%	52.67%	51.52%	46.55%	61.00%	59.38%
FINANCE	65.38%	61.11%	64.44%	69.70%	71.79%	53.70%	57.89%	88.89%
MEDICAL	67.44%	73.68%	81.58%	79.49%	68.57%	65.45%	70.45%	72.73%
NORTH YORKSHIRE, YORK AND SELBY	54.44%	56.48%	54.35%	56.45%	55.77%	57.26%	59.12%	53.33%
NURSING AND GOVERNANCE	61.90%	66.99%	65.75%	63.64%	59.46%	59.48%	69.41%	63.16%
PEOPLE AND CULTURE	78.08%	77.60%	73.08%	73.12%	69.47%	77.31%	71.74%	64.81%
THERAPIES	94.12%	58.97%	81.48%	70.83%	69.23%	47.06%	67.86%	88.24%

DQ ✓✓ 87%

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



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

National Benchmarking – NHS Staff Survey 2022

The 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: There was a significant decrease in returns for the April 2023 survey; whilst this may have been impacted by the change in survey provider, there was a reduction in submissions nationally which may have been impacted by industrial actions being taken during that period.

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.	The plan has not been developed at this stage. The Organisational Development Lead has taken over this work and is currently linking in with York University to understand more about the initiative and research.	
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.	**Complete.** There has been a sharing of ideas across the North East & North Cumbria Collaborative, following which we have undertaken the development of an Organisational Development Catalogue, detailing the different interventions the service facilitates. The Collaborative will continue to meet regularly to share and spread good practice in areas including culture and staff engagement.	

Additional Intelligence in support of continuous improvement

The Trust has embarked on a 5-year stepped approach to Quality Improvement (QI) Training until November 2027 to support staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements.

Programme Aim	Position as at 01.08.2023	
Enable **100%** of staff to access Foundation training	**17%**	(1261 out of 7603 members of staff)
To have trained **50%** of staff at Intermediate level	**12%**	(917 out of 7603 members of staff)
To have **15%** of staff trained at Leader level	**5%**	(349 out of 7603 members of staff)
To have **1%** of staff trained at Expert level	**0.54%**	(41 out of 7603 members of staff)

18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

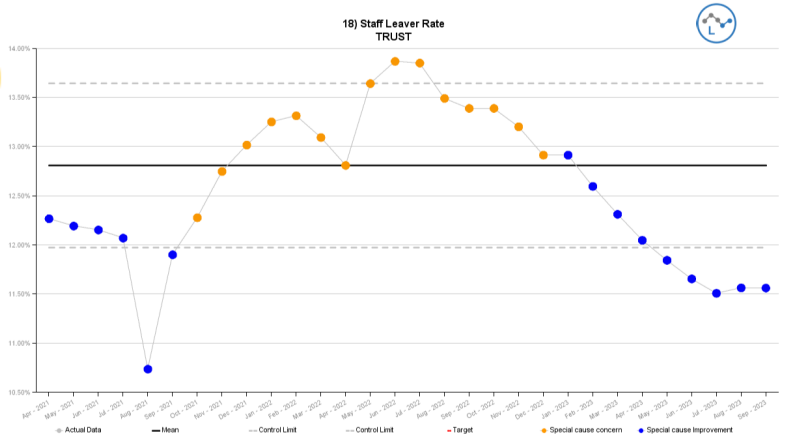
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

From a total of **6,662.69** staff in post, **770.37 (11.56%)** had left the Trust in the 12-month period ending September.

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

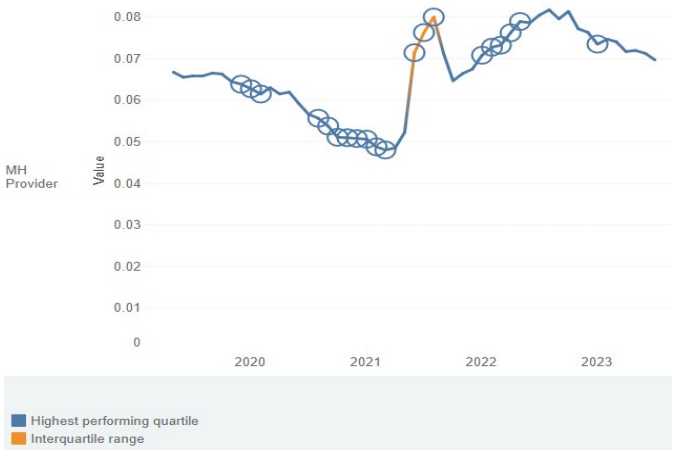
DQ 80%



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

National Benchmarking: NHS Staff Leaver Rate - England Mental Health and Learning Disability – June 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.



19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

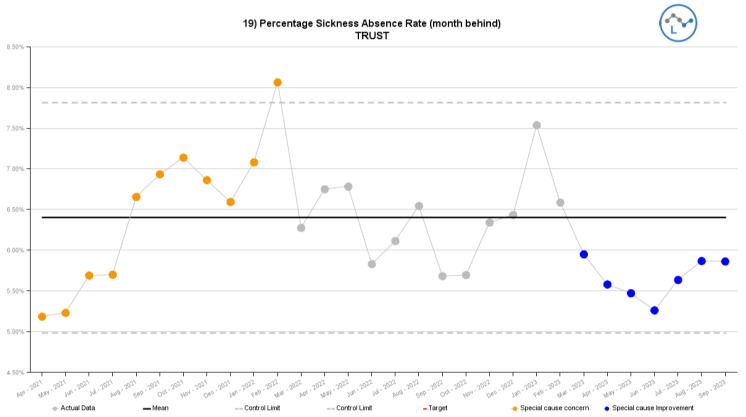
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

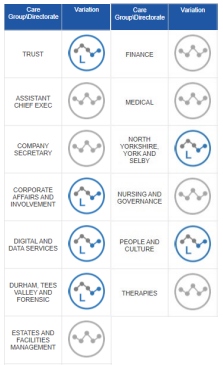
There were **226,547.63** working days available for all staff during August (reported month behind); of those, **13,286.51 (5.86%)** days were lost due to sickness.

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

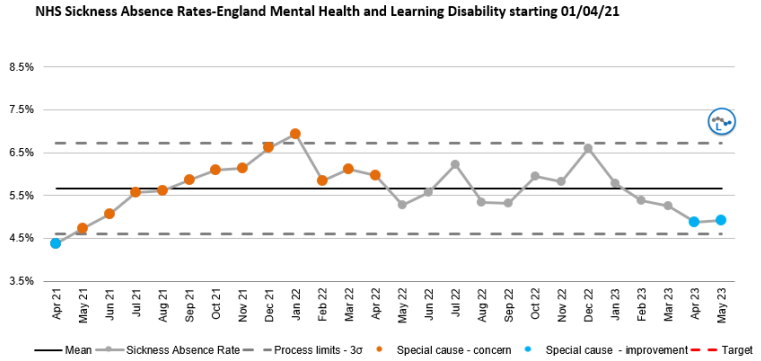
DQ ✓✓ 87%





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

NHS Sickness Absence Rates published 28th September 2023 (data ending May 2023 for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.66% compared to the Trust mean of 6.32%.



Update

As at the 11th October 2023, sickness absence is 5.88% for October 2023.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Additional Intelligence in support of continuous improvement

Our seasonal staff vaccination programme started on the 26th September 2023. Whilst there is a national focus on frontline health and social care staff, all colleagues are encouraged to get their flu vaccinations. With a view to encouraging wider participation, we have changed our clinic format this year and are hosting vaccine clinics at various times across our Trust over the next few months. With no requirement to book an appointment, staff can arrive at a time convenient to them and receive their vaccine. In addition to the flu vaccine, a Covid vaccine is also being offered to all front-line staff, our vulnerable colleagues and any staff members that support or care for people that are at high risk.

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.

136,579 training courses were due to be completed for all staff in post by the end of September. Of those, **118,115** (**86.48%**) courses were actually completed.

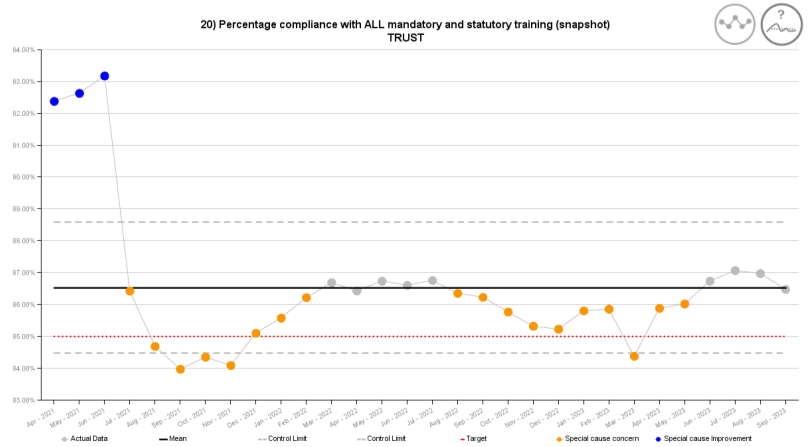
Percentage Compliance with Information Governance & Data Security Training. As required by the Information Governance Tool Kit the Trust must achieve 95% staff compliance. An improvement plan is in place with NHS England and this includes an action to agree trajectories with Care Groups and Directorates for when the standard will be achieved. As at end of September, **7612** were due for completion, **6813 (89.50%)** were actually completed.

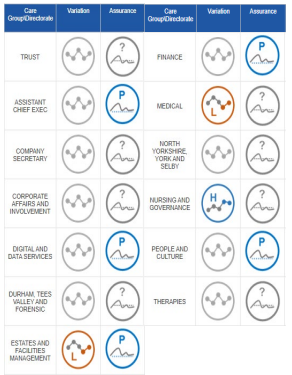
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

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

93%





We recognise that the levels of compliance with our mandatory and statutory training may be impacting on our ability to provide high quality and safe services. To address this, we developed a **Performance Improvement Plan** to define the actions being taken to support improvement and increased assurance. There are currently 26 actions included within the plan; 12 were due to be completed by the end of September 2023, of which 6 have been. One action has been completed this month; the revision of Moving & Handling training from annual to 2-yearly compliance, freeing up training capacity for delivery.

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

Supporting Information

As at the 10th October 2023, compliance for each of the Trust directorates is as follows:

Directorate	Mandatory & Statutory Training Compliance	
	Trajectory to achieve 85% compliance:	Data as at 10.10.2023
Trust	Achieving	86.75%
Assistant Chief Executive	Achieving	94.87%
Capital Programme	Achieving	91.57%
Company Secretary	Trajectory required	80.22%
Corporate Affairs & Involvement	Achieving	87.44%
Digital & Data Services	Achieving	85.65%
Durham, Tees Valley & Forensic	Achieving	86.41%
Estates & Facilities Management	Achieving	91.34%
Finance	Achieving	94.85%
Medical	Trajectory required	84.89%
North Yorkshire, York & Selby	Trajectory required	84.74%
Nursing & Governance	Trajectory required	81.22%
People & Culture	Achieving	85.43%
Therapies	Trajectory required	82.20%
Trust-wide roles	Achieving	90.28%

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 **6648** eligible staff in post at the end of September; **5392** (**81.11%**) had an up-to-date appraisal

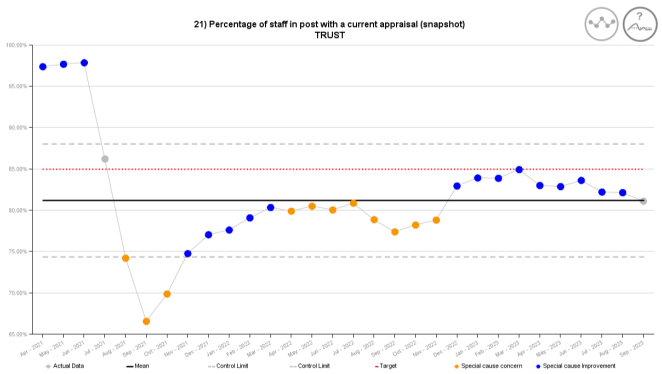
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

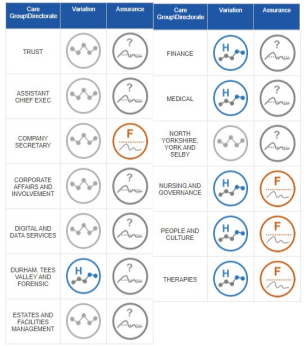
An Area of Concern
We are concerned with our performance in this area and action is required to improve

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 developed a Performance Improvement Plan to define the actions being taken to support improvement and increased assurance. As at August 2023, there were 13 actions included within the plan; 6 were due to be completed by the end of September 2023, of which 2 had been completed.

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Information

As at the 10th October 2023, compliance for each of the Trust directorates is as follows:

Directorate	Appraisal Compliance	
	Trajectory to achieve 85% compliance:	Data as at 10.10.2023
Trust	Not achieving	82.11%
Assistant Chief Executive	Achieving	85.29%
Capital Programme	Trajectory required	71.43%
Company Secretary	Trajectory required	42.86%
Corporate Affairs & Involvement	Trajectory required	75.68%
Digital & Data Services	Trajectory required	74.55%
Durham, Tees Valley & Forensic	Trajectory required	79.65%
Estates & Facilities Management	Trajectory required	82.00%
Finance	Achieving	97.62%
Medical	31 October 2023	82.63%
North Yorkshire, York & Selby	30 November 2023	79.37%
Nursing & Governance	Achieving	81.25%
People & Culture	31 October 2023	76.30%
Therapies	Trajectory required	73.68%
Trust-wide roles	Trajectory required	75.00%

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

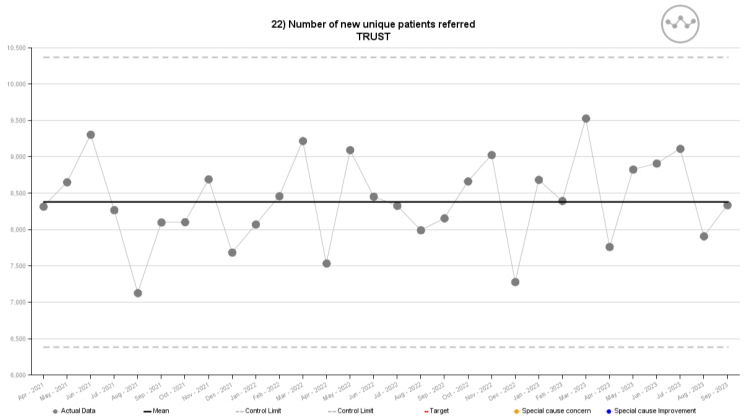
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

8336 patients referred in September 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

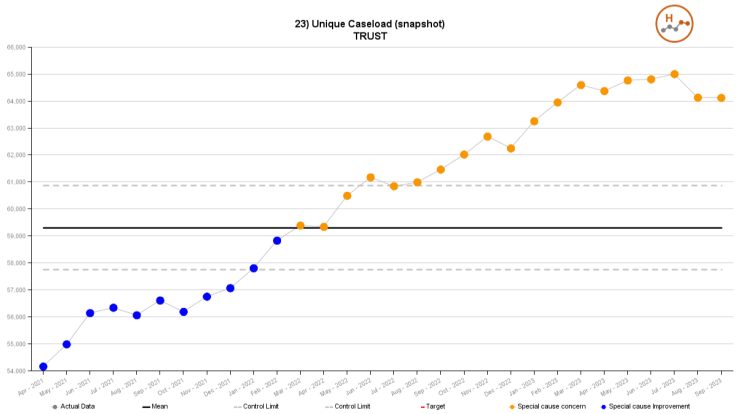
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

64,120 cases were open, including those waiting to be seen, as at the end of September 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	L

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 32 actions currently included within the plans; 20 were due to be completed by the end of September 2023, of which 16 have been completed. Those completed since the last report include:

- The Durham & Tees Valley Child & Adolescent Mental Health Services Manager has developed an options paper for an approach to increasing assessment capacity and address the backlogs. This has been shared with the Care Board and Quality Impact Assessments are currently underway.
- A caseload review to identify those cases that have not been seen for over 3 and 6 months to assess their status on caseload and planned exit, has been undertaken for the York East Intensive Care Team and a triage processed has been established from September, which is demonstrating positive impact.

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 reported a **£4.42m deficit** to 30th September 2023 against a planned year to date deficit of **£5.13m,** resulting in a **(£0.71m) favourable** plan variance.

Summary

The financial position at 30th September 2023 is an operational deficit of £4.42m against a planned year to date deficit of £5.13m, resulting in a (£0.71m) favourable plan variance.

• **Agency expenditure** in September 2023 was £1.43m, or £0.23m below plan in month, and £10.17m, or £0.32m below plan to date. Usage includes material costs linked to inpatient occupancy and rosters, medical cover, costs within Health and Justice, and reducing costs relating to complex specialist packages of care.

• **Independent sector beds** - the Trust required 85 bed days during September 2023 (190 in August, or a 105 bed day reduction) at a cost of £0.10m (including estimates for unvalidated periods of occupancy and average observation levels pending billing). Year to date costs were £1.82m, or £0.97m more than the £0.85m 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 £1.29m to date, or £0.66m more than planned. Costs relate to on-call and vacancy cover (pay surplus of £0.22m YTD as of September 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 September 2023 was £1.47m, which was £0.69m 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.

• **Planned CRES** are £1.85m 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. **Unplanned CRES of £1.85m** to date (including interest receivable) is fully mitigating adverse performance against planned schemes. Composite CRES achievement is therefore in line with plan to the end of September 2023.

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

To deliver the 2023/24 financial plan of breakeven the Trust needs to achieve planned CRES financial targets, or equivalent recovery actions, and recover the year to date £4.43m deficit. Variation from this will be monitored in year with any necessary recovery actions developed and implemented. Key in-year risks relate to the Agenda for Change pay award funding gap) and defunding for Microsoft licenses, partially mitigated by the benefit from the tariff uplift for the medical pay award, and with the expectation that contract income will be adjusted to almost fully reverse the Microsoft defund non-recurrently for 2023/24 only.

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 reporting	Care Group Boards have had oversight and signed off QIA's for relevant CRES schemes with delivery plans in progress. CRES workshop 28th September identified a number of additional short-term actions as well as themes with longer lead in times and requiring work up.	Greater understanding of differences between Care Group / directorate schemes and schemes from Trust plan. Non Recurrent mitigations identified and fully mitigating under performance against planned CRES at Month 6.
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	Financial forecasts based on intelligence at month 5 has been shared with Care Group / directorate leads and has been updated based on month 5 run rates. Further Care Group / directorate review required.	The financial forecast has informed the risks and mitigation (to deliverability of financial plan) assessment and a specific risk template to the ICB.

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. No actions were identified for completion by the end of September.

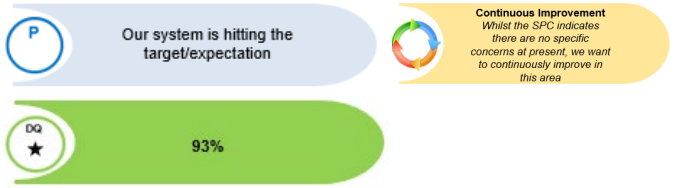
There are 23 actions within the current Agency PIP; 14 were due for completion by September, of which 8 have been completed or are ongoing pieces of work. Additional actions completed to those already reported include increased engagement with agency workers in hard to fill areas to encourage moving from agency to bank, including campaign stalls through August and the distribution of posters to all inpatient wards.

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 £10.17m is **£0.32m (3.05%) below plan**, however NHS planning guidance suggested that ICS agency expenditure should be no more than 3.7% of pay bill, as at M6 the Trust's agency expenditure represented 5.3% of pay bill.



Summary

Agency expenditure for the month of September 2023 was £1.43m, or £0.23m below plan, and £10.17m or £0.32m below plan to date.

NHS planning guidance introduced systems agency cost caps of 3.7% of pay bill. As at Month 6 Trust agency expenditure represented 5.3% 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, including recent guidance regarding eradication of non-clinical agency assignments.

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 (sustained favourable reductions now being seen) but equally to net new recruitment (including to medical, qualified nursing, inpatient health and justice hot spots) and securing alternative whole system models of care for specialist adult learning disability packages of care and high cost medical assignments.

We recognise that volume pressures and rate premia associated with agency expenditure are 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.

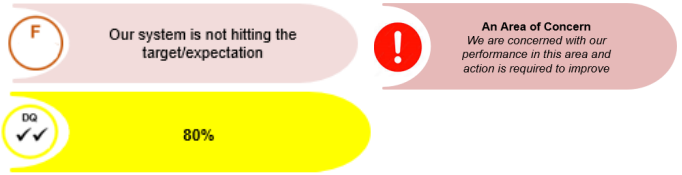
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

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 September 2023 there were 3,596 agency shifts worked, with **2,274 shifts compliant (63%).**



Summary

During September 2023 3,596 agency shifts were worked (688 fewer than August). This is equivalent to approximately 120 shifts per day, compared to 138 per day in August.

Of these, 2,274 or 63% shifts were compliant (2,706 compliant shifts or 63% compliance prior month). This is equivalent to approximately 76 compliant shifts per day in September, compared to 87 compliant shifts per day in August.

Of the non-compliant shifts 1,273 or 36% breached price caps (compared to 1,453 shifts and 34% prior month). This is equivalent to approximately 42 price cap breaches per day in September, compared to 47 price cap breaches per day in August.

49 or 1% breached framework and price cap compliance (compared to 125 shifts and 3% prior month). This is equivalent to approximately 2 framework breaches per day in September, compared to 4 framework breaches per day in August.

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 showing sustained reductions. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence but equally to net new recruitment recruitment (including to medical, qualified nursing, inpatient health and justice hot spots) 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 NHSE Temporary Staffing submission mid-month which may result in minor differences between reported data.

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

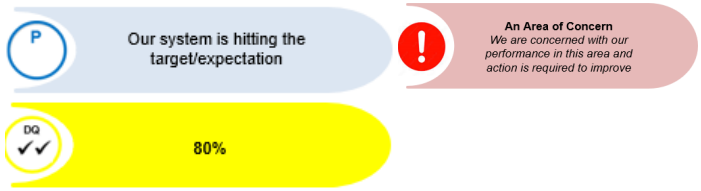
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys NHS Foundation Trust

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

The overall rating for the trust is a **3** for the period ending 30th September 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 0.30x, which is 0.15x better than plan and is **rated as a 4** (in line with plan in August).
- 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 18.1 days; this is behind plan by 3.5 days and is **rated as a 1** (2.8 days behind plan in August).
- 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 -1.96%, this is better than plan by 0.31% and is **rated as 4** (0.10% better than plan in August)
- **The agency expenditure metric** assesses agency expenditure against a capped target for the Trust. Costs of £10.17m are £0.32m (3.05%) 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 M6 the agency expenditure was 5.3% 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 30th September 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.

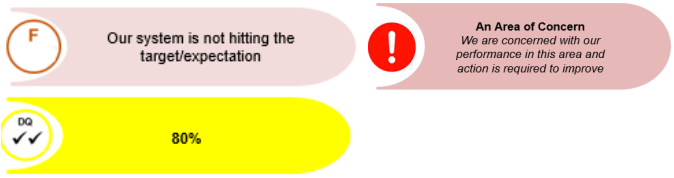
27) CRES Performance - Recurrent

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 **£5.98m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£3.86m recurrent CRES**.

£2.12m adverse variance against planned recurrent schemes.



Summary

The Trust planned to deliver **£5.98m** recurrent Cash-Releasing Efficiency Savings (CRES) to September 2023 but delivered **£3.86m** resulting in **under performance of £2.12m**. 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 6 with specific performance noted as:

- £1.68m under-delivery of CRES for OAPs Reduction in AMH (Performance Improvement Plan in place)
- £1.12m under-delivery of CRES for Surge post review (Pay)
- £0.25m CRES for Agency (Inpatient level loading of rosters – actions in train via sub group of safer staffing group)
- £0.16m CRES for Taxi spend reduction (Improvement Event and associated actions being progressed)
- £0.18m CRES for other schemes
- Recurrent CRES unachieved £2.39m to date mitigated in part by unplanned schemes:
- £0.12m CRES delivered (unplanned) Pay Review
- £0.06m CRES delivered (unplanned) EFM Capitalisation of combined heat & power
- £0.09m CRES for other schemes
- Composite recurrent CRES **under delivery** to M6 of **£2.12m**.

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 8 currently. £0.27m 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 **£0.53m** of non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£2.65m**.

(£2.12m) favourable variance against planned non-recurrent schemes.

Summary

The Trust planned to deliver **£0.53m** non-recurrent Cash-Releasing Efficiency Savings (CRES) to September 2023 but delivered **£2.65m** resulting in **overperformance of (£2.12m)**. 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 6 relating to:
Planned Schemes
- £0.66m Non Recurrent Grip & Control (Non Pay)
- £0.40m Non Recurrent Grip & Control Trust wide Recovery Actions / budget rebasing (Non Pay)

Unplanned Schemes
- £0.79m Interest Receivable
- £0.01m Income Contribution
- £0.79m LD, Medical and Long Covid contribution

Composite non-recurrent CRES **over delivery** to M6 of **(£2.12m).**

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 September was **£4.26m** against an allocation of **£8.36m** resulting in a **£4.10m** underspend.

Summary

Capital expenditure at the end of September was £4.26m and is **£4.10m below** allocated expenditure of £8.36m.

There are several favourable and adverse variances to allocation; however, year to date slippage of £4.10m 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, costs relating to which are expected to be £5.3m (£0.6m year to date). The Trust is forecasting to outturn in line with planned performance, but note 1) a likely upside in relation to the phase 1 Teesside works and 2) a request to reprofile national PDC funding for Frontline Digitisation following the replanning of EPR-related work, both of which may generate slippage against the Trust's £16.2m capital plan. Discussions with ICS partners are commencing following the month 6 re-forecast.

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

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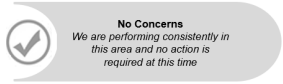
30) Cash balances (actual compared to plan)

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 **£62.74m** against a planned year to date cash balance of **£63.85m.**

£1.11m adverse variance compared to plan.



Summary

Cash balances were **£62.74m** at 30th September 2023, which was £1.11m lower than the planned **£63.85m** balance**.** This is mainly due to accrued income being higher than planned, increased creditor payments and unplanned non-recurrent flexibilities in the revenue position. These are offset by underspending on capital, and Health Education England income received in advance of the period it relates to.

The Trust has achieved the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment suppliers, achieving a combined year to date BPPC of 95%. We continue to support the use of Cardea to make processes as efficient as possible, and ensure suppliers are paid promptly.

The value of debt outstanding at 30th September 2023 was £2.49m, with debts exceeding 90 days amounting to £0.39m (excluding amounts being paid via instalments and PIPS loan repayments). This is the lowest aged debt has been all year and was an improvement of £1.0m in month.

Three whole government accounting organisations account for 64% of total debts greater than 90 days old (£0.25m), 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?

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

Chapter 2

Mental Health Priorities including National Quality Standards

Mental Health Priorities including National Quality Standards

Tees, Esk and Wear Valleys NHS Foundation Trust

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

Mental Health Priorities

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

Mental Health Contract Trust Standards	Agreed Standard for 2023/24	Q1	Q2
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	494

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 25 actions currently included within the plan; 20 were due to be completed by the end of September 2023, of which 13 have been completed.

No additional actions have been completed to improve our National Quality Standards since last month.

The additional action completed to improve our Local Quality Priorities is the undertaking of focused promotional work by our Durham & Darlington IAPT services with local GPs and via mental health awareness events, with a view to increasing access to our services.

County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **2** national quality standards and **3** local priorities that were not delivered at quarter 2 2023/24.

NATIONAL QUALITY REQUIREMENTS				
Measure	Agreed S-ICBL Ambition	Q1	Q2	FYTD
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	83.82%	83.61%	83.61%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	76.67%	67.74%	67.74%

LOCAL QUALITY REQUIREMENTS				
Measure	Agreed S-ICBL Ambition	Q1	Q2	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	2900	5562
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	13.92%	12.86%	13.35%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	22.49%	25.73%	24.49%

Tees Valley Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There is **1** national quality standard and **2** local priorities that were not delivered at quarter 2 2023/24.

NATIONAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2**	**FYTD**
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**	**FYTD**
Talking Therapies:Percentage of people who have waited more than 90 days between first and second appointments	<10%	19.76%	18.66%	19.19%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	28.57%	27.12%	27.66%

North Yorkshire Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **2** national quality standards and **4** local priorities that were not delivered at quarter 2 2023/24.

NATIONAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2**	**FYTD**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	80.00%	78.05%	78.05%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	87.50%	87.50%	87.50%

LOCAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2**	**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	1665	3388
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	17.57%	12.73%	15.01%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	38.24%	37.80%	37.96%
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 71 Q2 142 Q3 213 Q4 284	77	96	96

Vale of York Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **3** national quality standards and **5** local priorities that were not delivered at quarter 2 2023/24.

NATIONAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2**	**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%	50.00%	63.46%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	79.66%	84.48%	84.48%
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**	**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	1605	3100
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	31.15%	25.77%	28.33%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	30.25%	25.60%	27.54%
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.	3224	3340	3181	3181
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 60 Q2 120 Q3 180 Q4 240	37	64	64

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.	**Complete.** The member of staff started with the York & Selby EIP team in September and will remain in that position until December 2023.	No visible impact; low consistent performance remains visible.
	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.	
NEW We need to review the EIP referral criteria to ensure only suitable patients are accepted within North Yorkshire and York EIP services.	By 31st October 2023, NYYS EIP Service manager to work with the Associate Director of Therapies EIP Trust lead, to review the criteria and agree the pathway for patients who do not meet the EIP criteria and remain with the team on extended assessments to establish next steps.	It has been proposed that patients not meeting EIP criteria are to be returned to the care of their GP and not placed on an extended assessment, unless there is a clinical need to do so. The revised pathway and criteria is to be fully implemented by the end of October.	

Chapter 3

NHS Oversight Framework

NHS Oversight Framework

Tees, Esk and Wear Valleys NHS Foundation Trust

Introduction:

The NHS Oversight Framework is built around five national themes:

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

The 5 themes are underpinned by 29 key performance measures and sub-measures and Trust/ICB performance is monitored via an allocation to a top, inter- or bottom quartile. Those typically within the top quartile indicate the higher performing Trusts.

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

Summary:

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

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

- NHS Staff Survey compassionate culture people promise element sub score
- CQC well led rating
- Staff survey engagement theme score
- Sickness absence rate*
- Proportion of staff in a senior leadership role who are from a BME background
- Access rate for IAPT services (North East & North Cumbria)*
- Women accessing specialist community perinatal mental health services (Humber & North Yorkshire)*

**Please see the relevant sections within the Integrated Performance Report, Mental Health Priorities and Performance Improvement Plans*

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

NHS Oversight Framework

Tees, Esk and Wear Valleys NHS Foundation Trust

1) Quality, Access & Outcomes: Mental Health

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

Tees, Esk & Wear Valleys NHS Trust	Oversight Standard	Q1	Q2	Latest National Position
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	0	1608	494	Interquartile range as at June 2023 (1525) 39 out of 56 Trusts

Please see the Bed Pressures section within the Integrated Performance Dashboard from slide 17 and the Performance Improvement Plan.

North East & North Cumbria ICB	Oversight Standard	Q1	Q2	Latest National Position
IAPT access (total numbers accessing services)	100.00%	87.54%	95.24%	Lowest performing quartile (a position of concern) as at Q1 2022/23 (63.6%) 33 out of 42 ICBs
Children and young people (ages 0-17) mental health services access (number with 1+ contact)	100.00%	113.64%	114.69%	Interquartile range as at June 2023 (94%) 15 out of 42 ICBs
Overall Access to Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	100.00%	113.66%	115.24%	Interquartile range as at June 2023 (101%) 16 out of 42 ICBs
Women accessing specialist community perinatal mental health services	100.00%	195.13%	130.31%	Interquartile range as at June 2023 (132.4%) 26 out of 42 ICBs

Humber & North Yorkshire ICB	Oversight Standard	Q1	Q2	Latest National Position
Access rate for IAPT services	100.00%	81.87%	83.19%	Interquartile range as at Q1 2022/23 (68.1%) 26 out of 42 ICBs
Number of children and young people accessing mental health services as a % of population	100.00%	122.23%	118.87%	Interquartile range as at June 2023 (86%) 21 out of 42 ICBs
Access rates to community mental health services for adult and older adults with severe mental illness	100.00%	103.72%	101.26%	Interquartile range as at June 2023 (102%) 14 out of 42 ICBs
Women accessing specialist community perinatal mental health services	100.00%	87.02%	61.07%	Lowest performing quartile (a position of concern) as at June 2023 (55.8%) 39 out of 42 ICBs

Please see the relevant measures within the Performance Improvement Plans.

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

Quality of Care, access & outcomes; Safe, high-quality care	Oversight Standard	Q1	Q2	Latest National Position
National Patient Safety Alerts not completed by deadline	0	0	0	Highest performing quartile (a positive position) as at September 2022 (100%) 1 out of 71 Trusts
Consistency of reporting patient safety incidents	100%	100.00%	*	
Overall CQC rating	N/A	Requires Improvement		Interquartile range as at August 2023 51 out of 69 Trusts
NHS Staff Survey compassionate culture people promise element sub-score	As per staff survey benchmarking	6.8	6.8	Lowest performing quartile (a position of concern) as at 2022 survey (6.85) 65 out of 71 Trusts
NHS Staff Survey raising concerns people promise element sub-score	As per staff survey benchmarking	6.7	6.7	Interquartile range as at 2022 survey (6.71) 43 out of 71 Trusts
Adult Acute Length of Stay Over 60 Days	0%	13.80%	13.42%	Highest performing quartile (a positive position) as at June 2023 (14%) 9 out of 52 Trusts
Older Adult Acute Length of Stay Over 60 Days	0%	25.81%	33.58%	Highest performing quartile (a positive position) as at June 2023 (20%) 5 out of 52 Trusts

* National reporting paused pending the introduction of the new Learn from Patient Safety Events (LFPSE) service

Quality of care, access and outcomes; Compassionate and inclusive culture

Quality of care, access and outcomes; Compassionate and inclusive culture	Oversight Standard	Q1	Q2	Latest National Position
Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants	1.00	1.83	1.83	Interquartile range as at 2023 (1.8) 48 out of 69 Trusts
Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants	1.00	1.12	1.12	Interquartile range as at 2023 (1.1) 50 out of 69 Trusts

People; Looking after our people

People; Looking after our people	Oversight Standard	Q1	Q2	Latest National Position
Staff survey engagement theme score	As per staff survey benchmarking	6.80	6.80	Lowest performing quartile (a position of concern) as at 2022 survey (6.85) 65 out of 71 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	As per staff survey benchmarking	7.00%	7.00%	Interquartile range as at 2022 survey (7.32%) 24 out of 71 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	As per staff survey benchmarking	14.00%	14.00%	Interquartile range as at 2022 survey (13.7%) 34 out of 71 Trusts
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	As per staff survey benchmarking	23.00%	23.00%	Highest performing quartile (a positive position) as at 2022 survey (22.7%) 17 out of 71 Trusts
Staff Survey – We Are Compassionate and Inclusive People Promise element score	As per staff survey benchmarking	7.40	7.40	Interquartile range as at 2022 survey (7.44) 53 out of 71 Trusts
NHS Staff Leaver rate	None	11.66%	11.56%	Highest performing quartile (a positive position) as at June 2023 (6.97%) 10 out of 71 Trusts
Sickness absence rate (working days lost to sickness)	None	5.44%	5.79%	Lowest performing quartile (a position of concern) as at April 2023 (5.48%) 57 out of 71 Trusts

People; Belonging in the NHS

People; Belonging in the NHS	Oversight Standard	Q1	Q2	Latest National Position
Proportion of staff in senior leadership roles who a) are from a BME background b) are women c) disabled staff				
BME background	12%	1.37%	1.72%	Lowest performing quartile (a position of concern) as at 2022 calendar year (1.28%) 67 out of 69 Trusts
Women	62%	65.75%	64.22%	Interquartile range as at July 2023 (63.9%) 27 out of 45 Trusts
Disabled staff	3.20%	10.96%	11.64%	
Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	As per staff survey benchmarking	63.00%	63.00%	Interquartile range as at 2022 calendar year (62.4%) 20 out of 71 Trusts

Leadership and Capability; Leadership

Leadership and Capability; Leadership	Oversight Standard	Q1	Q2	Latest National Position
CQC well-led rating	N/A	Requires Improvement		Lowest performing quartile (a position of concern) as at August 2023 53 out of 69 Trusts

Finance & Use of Resources

Finance and use of resources	Oversight Standard	Q1	Q2	Latest National Position
Financial efficiency - variance from efficiency plan - Recurrent	N/A	£1,178,000	£3,858,000	Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.
Financial efficiency - variance from efficiency plan - Non-Recurrent	N/A	£363,000	£2,645,000	
Financial stability - variance from break-even	N/A	£3,881,456	£4,424,811	
Agency spending: Agency spend compared to the agency ceiling	100%	86.26%	99.96%	
Agency spending: Price cap compliance	100%	67%	63%	

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	9th November 2023
Title:	Trust OJTC Delivery Plan Q2 progress update
Executive Sponsor(s):	Mike Brierley, Assistant Chief Executive
Author(s):	Strategy Team

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

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

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

Strategic Risks relating to this report:
The *Our Journey to Change Delivery Plan 2023/24* is informed by an understanding of all of the BAF risks and the differential levels of risk appetite for each of the risks within it.

Executive Summary:

Purpose: This report has been produced to enable Board of Directors (BoD) to gain assurance on projects and workstreams pertaining to the current *OJTC* 23/24 Delivery Plan. The report aims to succinctly capture project/workstream progress against key milestones over the year, highlighting those that are completed, work that is on track, and work that is deemed at risk and/or facing significant issues. Where progress is not on track, the report gives BoD assurance on the mitigations being put in place or escalates issues/decisions that require attention.

Proposal: The current delivery plan was produced when the Trust's new governance systems were still maturing. Monitoring and escalation of the delivery plan is not fully embedded within the organisation due to this. While the planning framework for the new plan will resolve many of these issues for 2024/25, it is proposed that BoD take account of the variable levels of assurance that the Strategy team is able to give across the 17 priorities within this plan and identify where their own intelligence can improve the accuracy of the information in this report.

Overview: The updates to this report were provided from either:

- One to one discussion between priority leads and Strategy team members.
- Care Group governance meetings (by the Planning team).
- Intelligence gathered by the Planning and Strategy team from attendance of other meetings (e.g. Commissioning groups).
- Existing reports where information could be extracted.

As many of the plan priorities have several initiatives/projects contributing to their overall goal, the strategy team have RAG rated the main projects and initiatives contributing to each priority. Blue has been used for milestones completed, to differentiate from on-track, but yet to be completed (Green).

The legend outlining RAG categories is below.

Key	
	complete
	on track
	some targets missed, but overall end date is not at risk
	some targets missed & overall end date is at risk
	not started

This report includes:

- **Appendix One - Priority RAG status** for each of the 17 priorities.
- **Appendix Two - 23/24 Our Journey to Change delivery overview** summarising RAG ratings by project. Please note, **RED** text denotes a request for a change to timescales or an issue to escalate.
- **Appendix Three - Project RAG rating** summarising project RAG rating.
- **Appendix Four – Milestone Plan**

Prior Consideration and Feedback

Where appropriate, progress and issues have been discussed within Care Group or Executive Group meetings.

Implications:

There are a total of 61 projects within our 17 priorities. As at the end of quarter two - 8 are red, 22 amber, 19 green, 3 blue and 4 grey. 6 projects have requested changes in timescales or resources and are flagged in **RED** in Appendix 2. These requests were approved at Management Group on 18th October.

At the point of submission (10/10/23) there is 1 update missing, this has been rated as red.

Key updates for each priority and projects within can be found in Appendix 2. Table 1 shows projects which have some risk to delivery and table 2 shows projects which are on track or complete.

Recommendations:

Board of Directors are asked to:

a) Note the information and analysis provided in this report.

b) Provide comments/feedback where appropriate.

Appendix One - Priority RAG status

Clinical Journey priorities	Project RAG status					Total projects per priority
Community Transformation		2	7		1	10
CITO		1				1
Autism		3	4			7
						18

Q&S Journey priorities	Project RAG status					
Reducing In-patient pressures			3		1	4
Patient Safety		2	1			3
Harm Free Care		1	1	2		4
Personalising Care Planning				1		1
						12

Co-creation Journey priorities	Project RAG status					
Expand/develop Lived experience posts		1				1
Data collection & Learning		2				2
Diversify/expand Involvement		1				1
						4

People Journey priorities	Project RAG status					
More people		2	1			3
Inclusive & compassionate culture	1	1				2
Working differently			1		1	2
						7

Infrastructure Journey priorities	Project RAG status					
One Team TEWV	4					4
Digital & Data		1	4		1	6
Green Plan				5		5
Estates Masterplan	3	2				5
						20

Overall number	8	19	22	8	4	61

Appendix Two - 23/24 Our Journey to Change delivery plan project overview

	TABLE 1 - Projects potentially at risk
Clinical	**1. Community Mental Health Transformation** **Crisis DTV: (AMBER) Implementation of the agreed outputs following the Durham and Darlington crisis service improvement event:** After the re-design event in April 2023 it was agreed to formally separate the Crisis Service into two separate teams, one in Durham and one in Darlington, and for each of these teams to then be split into further teams for Triage, Assessment and Home-Based Treatment. Following the event, a task & finish group was established to commence the business proposal and move towards the safe implementation of the model. As part of this T&F Group an interim model has been proposed where the two teams will separate geographically but not split further into function for the time being. It is anticipated this will improve continuity of care and staff wellbeing and will support recruitment of staff. Staff all indicated they would prefer one permanent work base and preferences of staff could be achieved without any additional formal HR process. This change is due to go live in Q3 due to issues with Health Roster. **Therefore, it is requested to extend the end date of this priority from December 2023 to March 2024. This request was approved by Management Group on 18th October.** **2. Autism** **Adult Neurodevelopmental Service - DTV (AMBER)** An RPIW has been held for the ADHD service in September 2023, and new ways of working have been agreed. The RPIW has produced two pilot processes. 1) the specialist ADHD team still completing the assessment for the community teams, including diagnosis and initiation of medication where appropriate, 2) four Community Teams (Durham East and West, Chester-le-Street and Middlesbrough) completing their own ADHD assessments in their provision of 'business as usual'. The 30-day report-out is due on 13th October **Therefore, it is requested to extend the end date of this priority from September 2023 to December 2023. This request was approved by Management Group on 18th October.**
Q&S	**4. Reducing In-patient pressures** **Inpatient Flow – DTV AMH and MHSOP wards (AMBER):** Due to unforeseen circumstances a delay has been encountered in the ratification of the central bed management policy, it is expected that the policy will be reviewed by the Executive Clinical Leaders group in October with executive sign off middle of Q3, with implementation commencing thereafter. **Reducing pressure on inpatient beds programme: (AMBER):** Both care groups have a Performance Improvement Plan focused on reducing OAPs, outlining multiple schemes that are in progress. To aid the PIP, further data analysis is being undertaken to identify if further targeted work is required.

5. Patient Safety

Serious Incident backlog recovery/Local management of incidents: (AMBER): recovery plan now in place to ensure SI's are reviewed within set timescales. A range of mechanisms are ongoing to support delivery of the recovery plan and to sustain good performance. An additional family liaison officer is now working within the patient safety team to ensure timely and compassionate links with families.

6. Harm Free Care

Reducing the use of Restrictive Interventions (AMBER) A plan has been developed to take this work forward and this has been approved by QUAG. Reporting and assurance processes for the monitoring of this plan are in place. However, the key metric for this work (To reduce the use of restrictive interventions by 50% by 31 March 2024) needs to be reviewed and this will be carried out by the Positive & Safe Networks in each Care Group at their November meetings.

Reducing Sexual Safety Incidents- (no update received) At the point of report submission, this update had not been received and therefore this has been RAG rated as RED.

Reducing Suicide/misadventure: (RED) Staff are offered additional support following a critical incident at work. Staff who come into contact with Services users who have self-harmed will have received the being with distress training (IP wards). Service users who have a risk of suicide at discharge from a MH inpatient setting will receive a face to face follow up within 48 hours in line with the NICE quality standards. ***Given delays in governance approvals the timescales will require rescoping as they were based on full 12 months of delivery. Further support for this rescoping is being sought from Planning and PMO.*** **This request was approved by Management Group on 18th October.**

7. Personalised Care Planning (RED)

DIALOG+ full implementation through CITO: A lack of resource to take this piece of work forward is creating a challenge with developments. However some key progress to has been made;

- We have had two Trust-wide events to consider the implications of the CPA Position Statement and implications for local policy (pre-cursor to the drafting of a policy).
- After each event there has been a MS Teams-based TEWV update on developments to keep stakeholders informed of developments.
- There is an event on Monday 23rd October to consider governance/assurance & oversight of this workstream.

People	**11. More People** **Workforce Planning: (AMBER):** Workforce planner started in post 21/08/23. Processes (toolkit) for workforce planning created and suitable to be used therefore Sep 23 deadline met for that element. Meetings have been scheduled with key staff to socialise this (including SCDs and Clinical Networks). Pilot sites being sought for detailed work. Work was due to complete by September 2023 however, work will extend throughout remainder of year. However a revised date of end March 2024 is needed for pilot areas to have been engaged as evidenced by the production of workforce plans. **Therefore, it is requested to extend the end date of this priority from September 2023 to March 2024. This request was approved by Management Group on 18th October.** **13. Working Differently** **Workpal**: **(AMBER):** One out of 5 metrics complete, 2 on track and one paused. The paused metric relates to 'Scope and set up implementation plan for the transfer of supervision recording onto workpal' An options case is being developed as some issues have come to light which mean we are reviewing whether to bring other elements forward and implement this later. Revised timescales are not known at this stage. **Smarter working (GREY):** This piece of work is being subsumed into the new estates work and a revised timeline will be drafted following on from the Estates event at the end of September.
Infrastructure	**15. Digital and Data** 4 amber and 1 grey metrics relate to: **Improving Connectivity (AMBER):** - A change to plan has been submitted this month. Now we can commence work on all workstreams revised timescales for the milestone deliverables have been described below. Following approval of the change to plan we will report against the new timescales from October. **IIC re-procurement and migration - (AMBER):** The project has been on pause whilst we resolved the commercial arrangements between Advanced and TEWV as a result of the delay. A new contract variation has been signed which means the project has re-started with effect from 1st September 2023. The project management will now be under the control of Dot Group and it is expected that we will receive a detailed project plan by 15th September 2023, which will focus on delivery of the project by the end of January 2024. **It is therefore requested to extend the end date of this project from July 2023 to January 2024. This request was approved by Management Group on 18th October.** **Robotic Process Automation: (AMBER):** Confidence remains high that the original completion timescales will be achieved overall. **Enhancing collaboration: (AMBER):** There are 2 areas left to complete, the move from Pando (cease using this software application) and move from Modern Gov to teams alongside the transition to Bau activities. We are currently planning when this work can recommence due to the delay in CITO – an update should be provided to DPB on 11th October.

	Asset Management (GREY) - The new processes have been reviewed and KPI reports have been established. Asset management plan for stage 2 and 3 is still being worked on (delayed due to CITO precedence) – we are hoping to have a plan approved at DPB in October 2023. On Hold. **16. Green Plan: (RED)** Progress hindered by lack of resource and capacity. Job advert out for a Sustainability and Energy Officer (closing date 12/10/23) to take forward the actions associated with the Green plan. External specialist input will be required for issues such as Heat decarbonisation plan. This piece of work is wider than Estates and needs wider support. A review of delivery dates is required. This will be considered as part of the 24/25 delivery planning process. **17. Estates Master Plan** **One Public Estate participation & Strategic Estates Planning: (BLUE) these are strategic partnership meetings and business as usual not projects and therefore are requested to be removed from the delivery plan. This request was approved by Management Group on 18th October.**

	TABLE 2 - Projects on Track
Clinical	1. **Community Mental Health Transformation:** Currently 7 projects are showing as amber, two as green and one grey. Two amber projects have requested an extension (listed on projects at risk). The other 5 amber RAG rated projects have completion dates of March 2024. 2. **CITO** end date has been changed to July 24 and is currently on track. 3. **Autism** is currently showing 3 projects as green and 4 as amber (shown on table above where necessary).
Q&S	4. **Reducing inpatient pressures:** **Older adults pathway (NYYS) Ensure 7 day availability for Assessment & Treatment (GREY):** Options paper was produced at end Q1 as requested by Commissioners however due to no availability of funding the service is unable to progress this further. If funding does become available the service will progress as required. **Implement bed configuration in line with NE&NC SSs Provider Collaborative Review (AMBER)**: Following further discussions with CNTW it has been agreed to review the proposed future bed base as one of 4 workstreams. It is not anticipated this will impact upon the anticipated end date.

	5. Patient safety: **Learning from patient safety events; national system (LFPSE) (GREEN)** End moved to 30th October (from December) on track incident and reporting going live on 30th October, reviewer and reporter training occurring through October. **6. Harm free care:** **Safeguarding / Parental/Carer Mental Ill Health impact on children (PAMIC): (GREEN)** a working group established and holding regular meetings to progress actions.
Co-Creation	**8. Expand & develop Lived Experience Posts:** **Expand and develop lived experience roles and leadership, including peer support workers: (GREEN)** Substantial Development of Roles continues: peer work job description suite completed. Operational competencies mapped vs HEE organisational competencies. Peer training mapped against HEE essential competencies revealing that the Trust exceeds in many areas. progress is being made to expand lived experience roles. **9. Data collection and learning** **Improve & accurately capture patient experience data: (GREEN)** quality visit programme continues to progress well across the Trust. In August 2023 those that would recommend TEWV services to friends and family was 92.92% exceeding the national benchmark of 88%. **Review/transform PALS and complaints pathways with co-creation principles: (GREEN)** all scoping work has concluded which will be used to shape the remainder to the quality improvement work. Looking to replace the current Datix System with the InPhase Feedback Module, the anticipated go live date of this is mid-November 2023. This will allow for greater triangulation with other sources of intelligence e.g., incidents **10. Diversify & expand involvement** **Embed and grow co-creation across the organisation: (GREEN)** Continued progress has been made on this priority. New posts in the team include a I&E Facilitator for CAMHS trust-wide, a co-creation comms lead, and a new Head of Cocreation starts in early October. Co-creation Framework is set to be rolled out trust-wide in Q4.
People	**11. More People** **New starters and onboarding: (GREEN)** Phase 1 has delivered improvement to the new starter process. Phase 2 is being scoped. **12. Inclusive & compassionate culture**

	1 project complete and 1 green. **Health and Wellbeing council (complete):** We have been successful in getting the Funds from NHS Charities Together (Captain Tom) £165K so the staff-led Council has money to allocate.
Infrastructure	**14. One Team TEWV –** all projects complete **17. Estates Master Plan** **Oxehealth (GREEN)–** this project which is part of the Health, Safety and Assistive technology work is progressing. Following the successful implementation and benefits realisation on the impact of the service across 22 inpatient wards, wider installation of an inpatient digital monitoring system (Oxevision) is being planned. Inpatient wards with the system reported improved patient safety and quality of care, as well as better patient experience and staff experience. The PMO will complete a project plan with all milestones and formal reporting will commence in October. The project has a Steering Group that meets monthly overseeing the implementation of Oxehealth. Under this group are 2 workstream groups that meet fortnightly. The PMO will hold the overall project plan, receiving updates from Oxehealth, Capital, D&D, Nursing and Governance, and ward colleagues and provide reporting to enable close montoring and management of the delivery plan, risk and issues. Oxehealth have provided an account manager and delivery lead attending both subgroups and regional manager attending the subgroup and steering group. **New base for Stockton AMH services (BLUE/COMPLETE)** AMH services have moved into the new building in Stockton.

Appendix Three - Project RAG rating

Journey	Individual Projects	End Date & RAG
Clinical Journey Priorities		
Community Transformation	Adult / Older People's community mental health team transformation - DTV	Mar-24
	Crisis - DTV	Jun-23
	I-Thrive - DTV	Mar-24
	Adult LD - DTV	Sep-24
	Forensics – Establishing a Community	Sep-24
	Health and Justice – Reconnect, North Yorkshire	Jul-23
	Older People's community mental health team transformation – NYYS	Mar-24
	Adult community mental health team transformation – NYYS	Mar-24
	Crisis - NYY	Mar-24
	I-Thrive - NYY	Jun-24
Cito	CITO	Jun-24
Autism	Autism Training	Mar-24
	Autism Reasonable Adjustment support and coordination.	Mar-24
	Complex Autism case work	Mar-24
	Children and Young People Neurodevelopmental Assessment Service - DTV	Sep-23
	Adult Neurodevelopmental Service - DTV	Sep-23
	Children and Young People Neurodevelopmental Assessment Service - NYY	Sep-23
	Adult Neurodevelopmental Service - NYY	Sep-23
Q&S Journey Priorities		
Reducing in-patient pressures	Inpatient Flow – DTV AMH and MHSOP wards	Mar-24
	Older adults pathway (NYYS) Ensure 7 day availability for Assessment & Treatment	Mar-24
	Reducing pressure on inpatient beds programme	Mar-24
	Implement bed configuration in line with NE&NC SSs Provider Collaborative Review	Oct-25
Patient Safety	Patient Safety Incident Response Framework (PSIRF)	Apr-24
	Learning from patient safety events (national system) (LFPSE)	Dec-23
	Serious Incident backlog recovery/Local management of incidents	Dec-23

Harm Free Care	Reducing the Use of Restrictive Interventions	Mar-24
	Safeguarding / Parental/Carer Mental Ill Health impact on children (PAMIC)	Mar-24
	Reducing in Sexual Safety Incidents	Mar-24
	Reducing suicide / misadventure	Mar-24
Personalising Care Planning	DIALOG+ full implementation through CITO	Jul-23
Co-creation Journey Priorities		
Lived Experience Posts	Expand and develop lived experience roles and leadership, including peer support workers	Dec-23
Data Collection & Learning	Improve & accurately capture patient experience data	Ongoing
	Review/transform PALS and complaints pathways with co-creation principles	31/12/2023
Diversify & Expand Involvement	Embed and grow co-creation across the organisation	Oct-23
People Journey Priorities		
More people	New Starters and Onboarding	Nov 23/Mar 24
	International Recruitment	Dec-23
	Workforce Planning	Sep-23
Inclusive & compassionate culture	Leadership Development programme	ongoing
	Health and Wellbeing Council	Mar-23
Working Differently	Workpal	Feb-24
	Smarter Working	TBC
Infrastructure Journey Priorities		
One Team TEWV	Full review of Corp service staff lists & reconciliation of data on Oracle/ESR	Jun-23
	Develop digital and data service standards	Jan-24
	Set up a new Corporate Services Leadership Group	Jul-23
	Voluntary and Community Sector provider grants scheme	TBC
Digital & Data	Electronic Prescribing and Medicines Administration (EPMA)	Mar-25
	Improving Connectivity	Jul-23
	IIC re-procurement and migration	Jul-23
	Robotic Process Automation	Oct-23
	Enhancing collaboration	Jun-23

	Asset Management	Mar-24
Green Plan	Embedding the Green Plan and Carbon reduction	May-23
	Heat Decarbonisation Plan	Sep-23
	Installation of additional electric charging points at trust properties	Dec-23
	Trust Environmental Pledge - 'Pledge for Greener'	Dec-23
	Look to address the carbon footprint from supplier to door when procuring goods	Mar-24
Estates masterplan	Health, safety and assistive technology	Rolling
	New base for Stockton AMH services	Sep-23
	Medical Education Facilities	Mar-24
	One Public Estate participation	Ongoing
	Strategic Estates Planning	Mar-24

Appendix Four – Milestone plan

	Projects and Milestones								
	Individual Projects	**Milestone**	Q1	Q2	Q3	Q4	Q1	Q2
Clinical Journey Priorities								
Community Transformation	Adult/older people's community mental health team transformation - DTV	New Transformed models for adults & older adults in place across geography, in line with national roadmap				**Mar-24**		
	Crisis - DTV	New access model in place with NEAS & demonstrable improvement in call answer rate, responsiveness, signposting and assessment processes			**Dec-23**			
	Adult LD - DTV	Working with partners/ regulators on future respite service model						**Sep-24**
	Older People's community mental health team transformation - NYYS	Review memory serivce offer to support development of a consistent offer across the care group with medical and leadership provision		**Sep-23**				
	Adult community mental health team transformation - NYYS	Progress development of the community hubs across place-based settings				**Mar-24**		
	Crisis - NYY	Improve All Age Crisis Telephone service & addressing service response rates & call retention (LTP funding proposal submitted)				**Mar-24**		
CITO Implementation	Implementation of the CITO EPR	Phase 1 go live		**Jul-23**				
Autism	Adult neurodevelopmental service - DTV	Using improvement methodology and events to implement a single pathway to manage ADHD and ASD referrals		**Sep-23**				
Q&S Journey Priorities								
Reducing in-patient pressures	Impatient flow -DTV AMH and MHSOP wards	A central bed management policy implemented, supported by refreshed PIPA (Purposeful Inpatient Admission) processes	**Jun-23**					
	Implement bed configuration in line with NE & NC secure services provider collaborative review	Bed model agreed	**Jun-23**					
Patient Safety	Learning from patient safety events; national system (LFPSE)	Implementation of fit for purpose Risk & Quality management system			**Dec-23**			
Personalising care planning	DIALOG+ full implementation through Cito	CITO module goes live		**03-Jul-23**				
Co-Creation Journey Priorities								
Expand & develop Lived experience posts	Expand and develop lived experience roles and leadership, including peer support workers	Enhance and develop peer support operational and training infrastructure & agree banding for leads, training & development roles			**Dec-23**			
Data Collection and Learning	Improve & accurately capture patient experience data	Further QI work/refinement from consultation/proposals/policy development			**Nov-23**			
	Review/transform PALS and complaints pathways with co-creation principles	Policy refreshed/launched				**Jan-24**		
Diversify & expand involvement	Embed and grow co-creation across the organisation	Develop shadow governance mechanism to work interdependently with new TEWV governance structures		**Jul-23**				
People Journey Priorities								
More people	International recruitment	Delivery on cohorts of healthcare professionals, as per implementation plan			**Dec-23**	**Mar-24**		
	Workforce planning	Implement new workforce planning processes		**Sep-23**				
Inclusive & compassionate culture	Health and Wellbeing Council	Health and Wellbeing Council in place	**Apr-23**					
Working differently	Workpal	Scope and set up implementation plan for the transfer of supervision recording onto workpal	**Jun-23**					
Infrastructure Journey Priorities								
One Team TEWV	Voluntary and community sector provider grants scheme	New scheme in place and ready to be used by TEWV budget managers		**Jul-23**				
Digital & data journey	Electronic prescribing and medicines administration (EPMA)	Go live inpatient services		**Sep-23**				
	Improving connectivity	Wifi replacement of new controllers (all sites)		**Jul-23**				
	RPA (Robotics)	Delivery into live environment of six processes			**Oct-23**			
Green plan	Embedding the Green plan and carbon reduction	Establish green plan 'community of interest' to lead and scope workstreams and co-produce a phased implementation plan which will work towards NHS Net zero by 2040		**Sep-23**				
	Installation of additional electric charging points at trust properties	Carry out installations (three months lead time)			**Dec-23**			
Estates masterplan	Health, safety and assistive technology	Complete installation of next phase of assistive technology including sensor doors and Oxehealth installations				**Mar-24**		
	Medical Education Facilities	Business case completed. Complete interim scheme at Roseberry Park	**Jun-23**			**Mar-24**		

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For General Release

Meeting of:	**Board of Directors**
Date:	**9 November 2023**
Title:	**Patient Safety Incident Response Framework**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Dawn Jessop, Deputy Chief Nurse**

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***
6. 11.	Safety: Failure to effectively undertaken and embed learning could result in repeated serious incidents Governance: The absence of a clear process during implementation from ward to Board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risks to patients	PSIRF is a national NHS framework that sets out an approach to developing and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Executive Summary:

Purpose: To appraise the Board on the introduction of the Patient Safety Incident Response Framework.

PSIRF seeks to replace the previous Serious Incident framework 2015 with broader, risk-based approach, which moves away from reactive responses towards a proactive approach to learning:

- Includes the option to use proportionate and effective responses to incidents to address queries and concerns – not all incidents will require a full serious incident review

- Focuses on learning rather than performance management – A just culture
- Clear expectations for informing and involving ALL parties with families being treated as equal partners
- More robust governance and oversight
- Systems approach replaces root cause analysis and a lapse in care
- Systems approach to identify interconnected contributory, human and causal factors
- New standards and processes including new ways of working in patient safety team and care groups

Proposal: It is proposed that the Board receives this update for information and notes that **reasonable** assurance has been provided to Quality Assurance Committee on the delivery of the related PSIRF plan and in respect of any associated risks.

Prior Consideration and feedback: Quality Assurance Committee received an update on PSIRF and the related Patient Safety Incident Response Plan in September 2023, and agreed there was reasonable assurance on delivery of the plan.

Implications

- There may be a risk while transferring to a new system of thematic learning outcomes.
- Confidence in implementation of PSIRF regarding patient safety knowledge and learning, may hinder the ability to fully implement the intention of PSIRF.
- Limited capacity of the patient safety team to implement the new approach, whilst also focusing on the backlog of serious incidents.
- The new approach requires a shift in culture and thinking from staff and whilst some initial training has taken place, a whole system change is required.

Recommendations: The Board are invited to note the update and the reasonable assurance at this time.

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Patient Safety Incident Response Framework (PSIRF)

Dawn Jessop
Deputy Chief Nurse
09 November 2023

journey to change

PSIRF Incidents and Serious Incidents

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- The PSIRF provides the NHS with guidance on how to respond to patient safety incidents
- What is classed as a patient safety incident? "*An unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare*".
- There is no distinction between incidents and 'serious incidents' for the purpose of learning.

Key differences between PSIRF and the 2015 framework

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- Moves away from **reactive** and hard-to-define thresholds for serious incidents towards a **proactive** and proportionate approach to **learning** from patient safety incidents.
- Focuses on a systems approach to safety
- Option to use alternative, proportionate and effective responses to incidents such as case note reviews, timeline mapping, after action reviews and audit.

Principles of PSIRF

- Openness and transparency
- Just culture
- Continuous learning and improvement
- Family and patient Involvement

Continuous Learning and Improvement

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The findings from incident reviews, PSIIs or other related activities must be translated into effective and sustainable actions that reduces the risk to patients.

Apply science of patient safety and improvement to identify:

- Where improvements are needed - PSIRF offers a variety of tools to inform this
- What changes need to be made. How these changes will be implemented?
- How to determine if those changes have the desired impact and if not – how can they be made more robust (adapted)

An example of Horizon Scanning Tool

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The horizon scanning tool supports teams to have a forward look at potential or current safety themes and issues. These can be identified in several ways:

- From concerns raised during conversations with families, patients, staff or stakeholders
- Observing how care is delivered
- Triangulating other sources of information
- Insights from data, care group boards, locality panels for PSII's
- Reconfiguration of services
- Reviewing safety plans

TEWV – Where are we?

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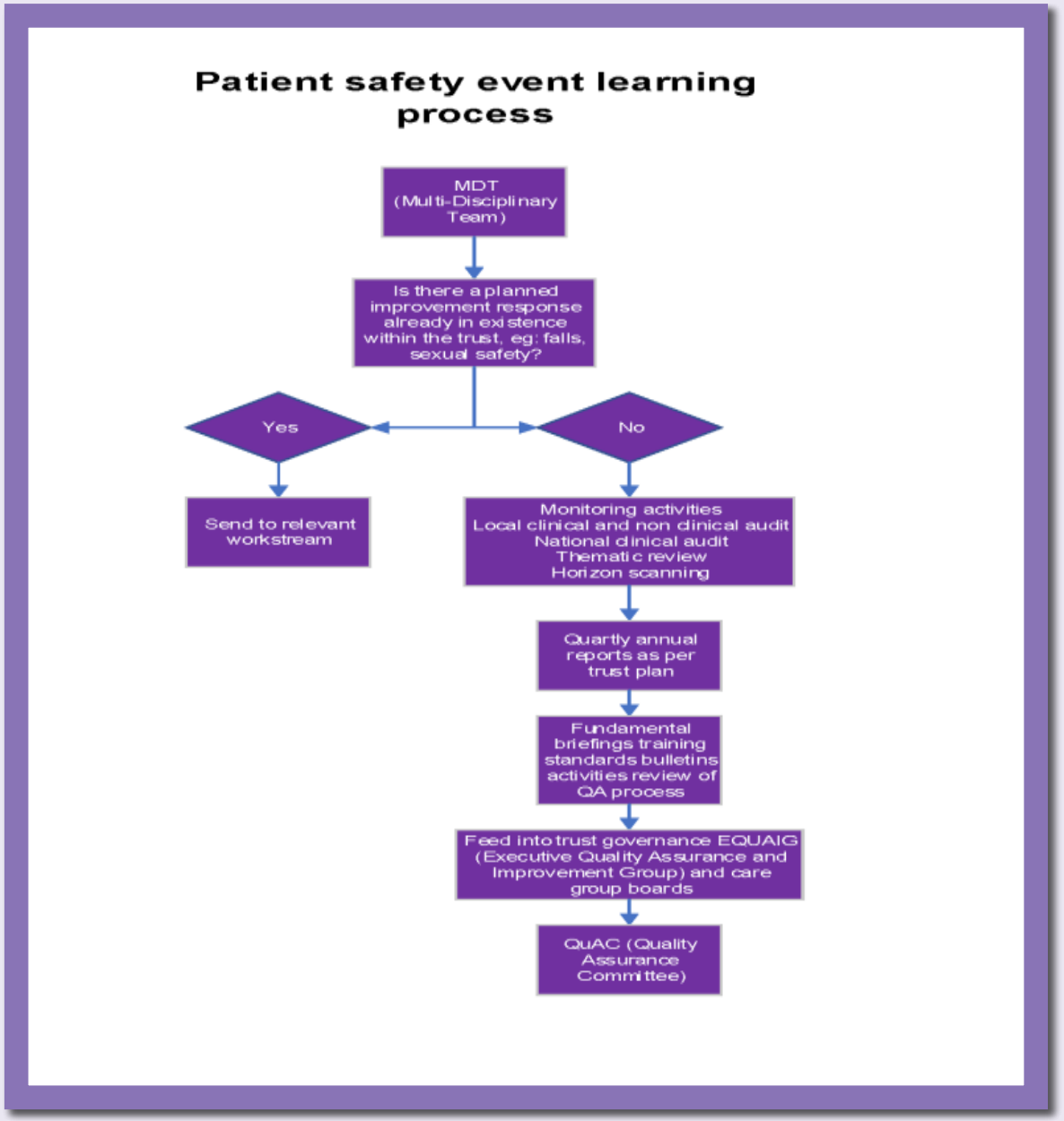
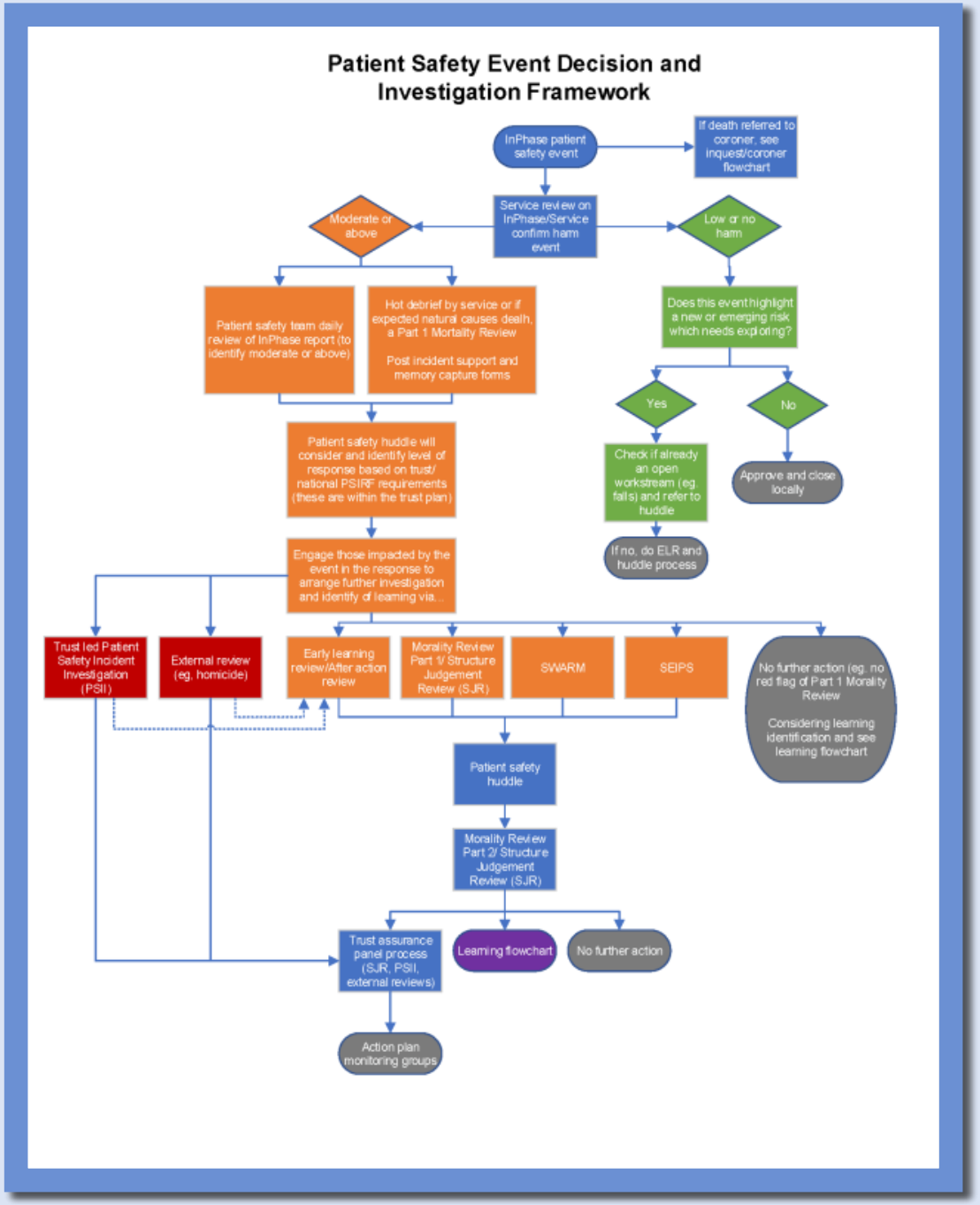
Good news!

- Families are already involved in working with reviewers, setting terms of reference.
- Two family liaison officers in place.
- ‘Patient safety partners’ plan in place.
- Incident forms and action plans transitioning already to new templates.
- InPhase reporting system is now live.
- MDT set up for reviewing and triangulating incident learning.
- Training on ESR for staff and some higher-level training already delivered.
- ICB sign off aiming for 16th November 23


Patient safety event learning process
MDT (Multi-Disciplinary Team)
Is there a planned improvement response already in existence within the trust, eg: falls, sexual safety?
Yes
No
Send to relevant workstream
Monitoring activities
Local clinical and non clinical audit
National clinical audit
Thematic review
Horizon scanning
Quartly annual reports as per trust plan
Fundamental briefings training standards bulletins activities review of QA process
Feed into trust governance EQUAIG (Executive Quality Assurance and Improvement Group) and care group boards
QuAC (Quality Assurance Committee)


Patient Safety Event Decision and Investigation Framework
InPhase patient safety event
If death referred to coroner, see inquest/coroner flowchart
Service review on InPhase/Service confirm harm event
Moderate or above
Low or no harm
Patient safety team daily review of InPhase report (to identify moderate or above)
Hot debrief by service or if expected natural causes death, a Part 1 Mortality Review
Post incident support and memory capture forms
Does this event highlight a new or emerging risk which needs exploring?
Yes
No
Patient safety huddle will consider and identify level of response based on trust/ national PSIRF requirements (these are within the trust plan)
Check if already an open workstream (eg. falls) and refer to huddle
Approve and close locally
If no, do ELR and huddle process
Engage those impacted by the event in the response to arrange further investigation and identify of learning via...
Trust led Patient Safety Incident Investigation (PSII)
External review (eg. homicide)
Early learning review/After action review
Morality Review Part 1/ Structure Judgement Review (SJR)
SWARM
SEIPS
No further action (eg. no red flag of Part 1 Morality Review
Considering learning identification and see learning flowchart
Patient safety huddle
Morality Review Part 2/ Structure Judgement Review (SJR)
Trust assurance panel process (SJR, PSII, external reviews)
Learning flowchart
No further action
Action plan monitoring groups

Thank You

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	November 2023
Title:	Medical Education Annual Board Report
Executive Sponsor(s):	Dr Kedar Kale, Executive Medical Director
Author(s):	Hayley Lonsdale, Medical Education Manager & Medical Education Leadership Team

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: Not appliable

Executive Summary:

Purpose: This annual report will provide an overview of medical education activity during the last twelve months and outline key priorities for the next academic year 2023/24.

Proposal: This report will provide assurance to board members regarding the provision of medical education in the Trust.

Overview: TEWV hosted 220 postgraduate doctor and 465 medical student placements from four medical schools, in addition to a further 47 Physician Associate (PA) student placements during the 2022-2023 academic year.

Last year the Trust received over £6.8 million from NHS England (NHSE) via the Education contract (EC) to support the salaries and educational infrastructure required to deliver medical education placements.

The Trust has a legal responsibility through the EC and the GMC (General Medical Council) to quality assure the delivery of medical education and this is undertaken through a cycle of quality control, namely the self-assessment report (SAR) and quality improvement plans (QIP) and this report will be shared with NHSE to demonstrate how it meets the GMC domains for training.

The GMC national training survey (NTS) provides an opportunity for postgraduate doctors and trainers to provide feedback, and this allows the Trust to benchmark the level of training provided against other similar organisations.

	This year the Trust has demonstrated an exceptionally high level of training across all programmes, despite the constant challenges the Faculty of Medical Education (FoME) face ensuring the provision of high quality training placements whilst dealing with an increasing shortage of consultant psychiatrists / accredited trainers due to the number of consultant vacancies.
Prior Consideration and Feedback	This annual update was requested by the Chief Executive.
Implications:	A detailed breakdown of implications and risks to the Trust are detailed in Appendix A.
Recommendations:	It is recommended that the Trust Board note the content of this paper and Appendix A which provides a comprehensive summary of medical education activity, key achievements, horizon scanning, action planning and conclusions.

Medical Education Annual Board Report

1 Proposal

- This report will provide board members with confidence regarding the quality of undergraduate and postgraduate medical placements provided in the Trust.

2 Prior Consideration and Feedback:

- This report has been produced as a requirement as part of the NHSE education contract.

3 Commentary:

- Detailed within Appendix A.

4 Risks and Mitigations:

- Detailed within Appendix A.

5 Conclusions:

- Detailed within Appendix A.

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Medical Education 2022-2023

Contents

1. INTRODUCTION & PURPOSE

This report will provide an overview of medical education activity in the last twelve months and outline key priorities for the next academic year.

2. BACKGROUND INFORMATION

2.1 The Trust currently hosts around 220 approved postgraduate doctor placements in Foundation, GP, core, and higher training. The configuration of these posts are outlined in the embedded spreadsheet below.

Medics Post Configuration Sprea

An illustration of the training pathway in psychiatry a visual created by the Royal College of Psychiatrists (RCPsych) is provided below.

During the 2022-2023 academic year the Trust hosted 465 medical student placements from four universities and 47 Physician Associate (PA) student placements. Appendix 1 provides an overview of medical student internal feedback for the last academic year. Detailed below is a breakdown of medical student and PA student numbers and their placement stage.

Medical Schools (medical students)	Stage	Number of students
Newcastle (Durham, Darlington & Teesside localities)	3	114
Newcastle (Durham, Darlington & Teesside localities)	5	119
Sunderland (Durham & Darlington & localities)	3	94
Leeds (Harrogate locality)	4	31
Hull & York (York locality)	3	62
Hull & York (Scarborough locality)	3	30
Hull & York (South Tees locality)	3	15

Universities (physician associates)	Stage	Number of students
Newcastle University (Durham, Darlington & Teesside localities)	2	11
Leeds University (Harrogate locality)	1	8
University of Bradford (York locality)	2	12
Hull & York Medical School (York & Scarborough locality)	1	16

2.2 Internal governance of postgraduate medical education is overseen through Postgraduate Doctor Training Forums (PDTF). These represent the two Care Groups in the Trust and oversee the delivery of postgraduate training. Similarly, there are local undergraduate groups in each Care Group, overseen by a Trustwide undergraduate forum. The Medical Education Committee (MEC) oversees all groups and sets out the strategic direction of the Faculty.

2.3 In 2021, NHS England (NHSE) (previously known as Health Education England – HEE) reviewed their quality framework. The framework makes clear the quality standards NHSE expects of clinical learning environments, safeguarded through the NHS Education Contract (EC) https://www.hee.nhs.uk/our-work/new-nhs-education-contract. Through these standards, placement providers are required to work with NHSE and other stakeholders to support learners in their career pathways and transition from healthcare education programmes to employment, while also working collaboratively with system partners to maintain and improve practice placement capacity and capability.

2.4 The ongoing cycle of quality control is undertaken through a self-assessment report (SAR) and quality improvement plans (QIP). These reports are shared with NHSE and set out how the Trust meets the General Medical Council (GMC) domains for training https://www.gmc-uk.org/education

2.5 The quality improvement schedule for medical education is set out in the 2022 / 2023 Quality Improvement Plan and Self-assessment Report.

Appendix 2: *2022 / 2023 Quality Improvement Plan (QIP)*

Appendix 3: *2022 Self-Assessment Report (SAR)*

2.6 The GMC national training survey (NTS) provides opportunity for postgraduate doctors and trainers to provide feedback to the Trust. It allows the Trust to benchmark the level of training provided against other similar organisations. ***This year the Trust demonstrated an exceptionally high level of training across all programmes***. The most significant of the highlights include TEWV being ranked 17th nationally within the 2023 trainee survey results (30th in 2022) and ranking 20th nationally within the 2023 trainer survey results (25th in 2022).

The Trust overall dashboard for the **trainee survey** confirmed sixteen of the eighteen indicators were above this year's national average. There were eight green outliers (areas of strength), with no overall red or pink outliers (areas of weakness). 2022 saw a total of eight green areas of strength across all programmes, whilst this year there were **fifty three green**

areas of strength. Eight green areas overall, a further twenty three strong areas when drilling down the data by site and a further twenty two by specialty.

The Trust overall dashboard data for the **trainer survey** showed nine of the thirteen indicators were above this year's national average. There was one green outlier and no overall red or pink outliers. Last year saw a total of one green area of strength overall and a further nine strong areas across all sites. This year, there is one green area of strength overall and a **further fifty one strong areas**.

Appendix 4: *2023 GMC Trainee Survey Report*

Appendix 5: *2023 GMC Trainer Survey Report*

2.7 In 2021 the Faculty introduced an Internal Educational Audit framework for postgraduate programmes to understand local detail better and raise standards. The framework provides an overview of the internal educational audit cycle to enhance quality monitoring and assurance for all postgraduate activity within the Trust. Following a review, the framework now includes undergraduate programmes.

Appendix 6: *TEWV Internal Educational Audit Framework v4*

2.8 The Medical Education Operating Framework (MEOF) was created to provide an overview of the function of the Faculty of Medical Education in TEWV. It summarises the governance framework that is used within the Trust to oversee all undergraduate and postgraduate activity. The MEOF is reviewed and updated on an annual basis.

Appendix 7: *Medical Education Operating Framework v10*

3. KEY ACHIEVEMENTS IN MEDICAL EDUCATION

3.1 Detailed below are the key achievements in the last 12 months.

3.2 **Review of the Faculty of Medical Education**

A comprehensive review into the structure and function of the Faculty was recently undertaken. A key driver was to create more opportunities for medical colleagues with enthusiasm and skills to be involved and that this support future succession planning and connect postgraduate doctors and medical students to role models.

There was a reduction in posts from four Associate Directors of Medical Education (ADME) to three enhanced roles. One overseeing postgraduate training in the North Care Group and one in the South. The third role oversees medical student placements and teaching. This was because more focus and rigor was required for the divergent medical school curriculums to ensure local strategies were developed.

In addition, historically tutors were responsible for both FP and GP agendas and this was because posts were fewer in number and generally GP posts required less input. Since the

last Faculty review, there has also been an expansion of foundation posts and it was necessary to separate the responsibility for these programmes.

In 2022 the Faculty recruited an International Medical Graduate (IMG) Tutor which was a new role. This role oversees the IMG support programme for doctors in TEWV, both training grade and career grade. Following the introduction of the IMG tutor role a dedicated IMG support page has now been created on the intranet https://intranet.tewv.nhs.uk/international-medical-graduates and this role works closely with the new Medical Equality Group.

A further new role was the creation of an addictions tutor role. The primary responsibility of this tutor was to enable core trainees to undertake two work placed based assessments (WPBAs) over their three years of core training.

The total number of PA's allocated to support the work of the Faculty now totals 31.5 SPA. A breakdown of the SPA currency is detailed in Appendix 8 alongside the Faculty structure (Appendix 9).

3.3 Workforce Planning

3.3.1 *Trust Doctor recruitment*

The trust doctor programme was developed several years ago and began on the basis of overseas recruitment. There is a tutor responsible for supporting this group of doctors and overseeing a programme of support that includes physical health training, communication, leadership, and clinical skills. The programme provides immediate clinical support to services where there are postgraduate doctor vacancies and acts as a feeder scheme for core training, so long as the experience and support they receive is good. Without this programme the Trust would face a significant shortfall in postgraduate doctors and higher agency costs.

Such is the success of the programme; the Trust no longer undertakes recruitment campaigns overseas as the scheme is well regarded and doctors apply because they have been informed about the good experience it offers. Over the last seven years, the Trust has appointed a total of 88 trust doctors. 27% of these appointments has led to trust doctors joining the core psychiatry training scheme and who now work within the Trust as a registrar. A further 4% now work in TEWV as a senior registrar following the completion of their core training and 8% work as specialty doctors within the Trust. Two doctors have even been appointed to substantive consultant posts.

3.3.2 *Clinical Teaching Fellows*

The Trust currently employs eight Clinical Teaching Fellows (CTF), four in the North Care Group and four in the South. CTF posts allow doctors to participate meaningfully in medical education with protected time. Doctors occupying these posts will usually be at transitional stages (pre-core or pre-higher training) and will work two days per week in medical education and clinically for the remainder of the week.

CTF's contribute to the development, planning, delivery and monitoring of teaching for relevant medical school undergraduate students, working with the Undergraduate Tutors, Nurse Leads and Medical Education Faculty. They act as a direct source of educational advice and expertise offering guidance to clinical and medical staff on all aspects of the medical student programme. CTF's agree and contribute to teaching programme design and are involved in the development and review of teaching material.

3.3.3 *Physician Associates*

Although the Physician Associate (PA) profession is still considered relatively 'new', certainly in MH, the first PA's were formally introduced in 2003. PA's are medically trained, generalist healthcare professionals, who work alongside doctors providing medical care. PA's work collaboratively with the multi-disciplinary team and play a key role in ensuring that the highest standards of patient care and treatment are provided. All PA's receive supervision from a Consultant Psychiatrist.

There are currently three PA's working in the Trust with a further three PA's due to commence in the near future. The Faculty has a Lead Tutor who focuses on supporting them in practice and ensuring they receive relevant CPD. Over the next year, colleagues in People & Culture, will support the workforce planning activity as the Trust will need to understand how this role will support clinical services in the future.

3.3.4 *Expansion of posts - Trustwide*

The recent expansion in medical school places has led to a national increase in postgraduate training placements. Following requests from NHSE, TEWV has increased postgraduate doctor placements across all programmes in the last twelve months with an additional 22 posts created.

Whilst additional placements are welcome, as this supplements doctors into higher training and ultimately to take up roles in the Trust, we have seen issues identifying appropriate clinical supervisors due to a lack of substantive consultants in the Trust. The Faculty has worked closely with medical management to identify suitable clinical supervisors and have utilised the "Mind the Gap" arrangements where necessary to ensure each postgraduate doctor has an accredited trainer to provide one hour protected weekly supervision session as mandated by the Royal College of Psychiatrists.

3.4 Engagement with Doctors

The best way to improve placements within the Trust is to obtain intelligence and feedback from postgraduate doctors so the Faculty has immediate knowledge of local service pressures that impact on the quality of placements. Open and honest dialog with the postgraduate doctor workforce is fundamental and we have established processes across programmes to ensure this is understood.

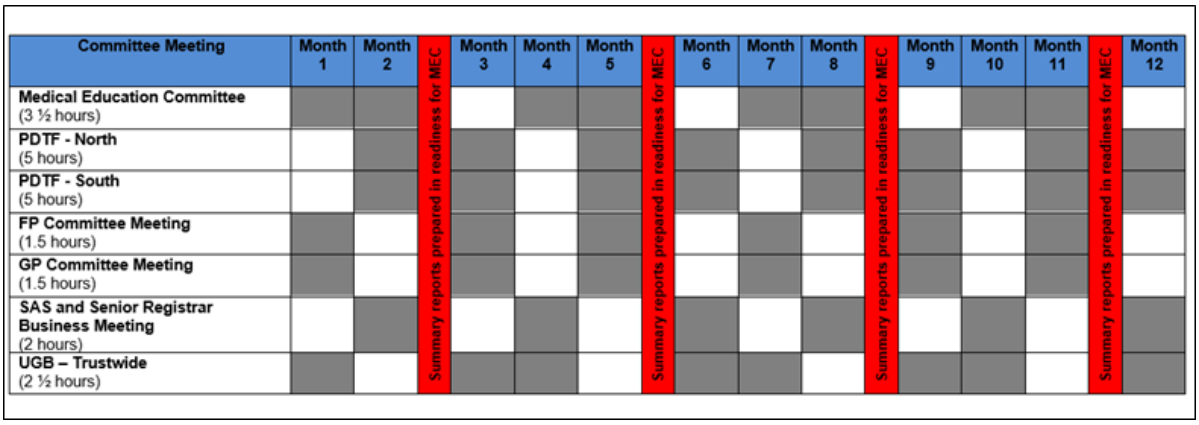
Relevant tutors and the Medical Education Manager host clinics and meet individually with core trainees, senior registrars and trust doctors at mid-term intervals to help understand local issues and provide pastoral support. Clinics are also arranged to meet GP registrars

and foundation doctors at mid-point in group format and at the end of each placement. Training clinics, mid-point and end of placement reviews are well attended and are a vital source of feedback.

3.5 Review of committee meeting structure

As mentioned earlier in the report, there was review of the committee structure that led to a better balanced governance framework. This is illustrated below.

In addition to this, there is a Medical Education Leadership Team (MELT), who meet on a weekly basis to oversee operational challenges and the strategic direction of medical education in the Trust.



3.6 Contributing to the medical recruitment and retention strategy

Due to the shortage of Consultant Psychiatrists, the Faculty has supported the development of medical recruitment and retention strategy. The strategy, to be shared very soon, has four high level priorities:

- Making TEWV an attractive place to train
- Creating TEWV as a centre of excellence
- Focussing on "attainment" with recognition for "competency based" versus typical "time served" training for all medics
- Training the future generation (Faculty led)

3.7 Sponsorship opportunities

The Faculty has created opportunities allowing senior registrars to develop formal skills during their higher training in leadership, psychotherapy and quality improvement. This can be supported by funding to undertake a year long Psychoanalytic psychotherapy or CBT taught course, or the postgraduate certificate in medical education. The funding is awarded via competitive application and interview.

Part of this sponsorship requires the senior registrar to support the current substantive Tutors with teaching / quality improvement activities and also to develop their observation

skills within supervision sessions. The leadership and management opportunity also allows for 50 hours teaching support for medical student teaching.

3.8 **Medical Workforce Equality Group**

This year the Trust has developed a group that meets on a quarterly basis to oversee equality for both postgraduate doctors and career grade colleagues. The overarching purpose of this group is to consider agendas from what you would describe as disadvantaged groups and / or those with protected characteristics and oversees postgraduate doctors and our career grade workforce. Sarah Dallal, Trust Strategic Lead EDI and Engagement, is also a member of the group. We will be formulating a plan to help tackle some of the issues highlighted in the work Katie is leading on and other agendas which include:

- Differential attainment
- Less than full time working (lots of interest in role)
- Sexism & Racism
- IMG agenda
- Wellbeing
- MWRES

4. IMPLICATIONS / RISKS

4.1 **Quality:**

4.1.1 The QIP outlines the quality objectives to be delivered in the next reporting period.

4.2 **Financial:**

4.2.1 The Trust received over ***£6.8 million*** in 2022/3 to support the salaries and educational infrastructure required to deliver medical education placements.

4.3 **Legal and Constitutional:**

4.3.1 The Trust has a legal responsibility through the EC to quality assure the delivery of medical education.

4.4 **Equality and Diversity:**

4.4.1 There are no implications to consider.

4.5 **Other Risks:**

4.5.1 ***Post expansion***

Further postgraduate doctor post expansion is planned for August 2024. Whilst exact numbers have yet to be confirmed by NSHE, it is highly likely that each training programme (Foundation, GP, core, and higher training) will see a request for further expansion which will ultimately lead to a request to create additional training posts.

The Trust will need to quickly understand the associated salary costs and difficulties in identifying suitable placements with appropriate levels of supervision. This will be costed and presented to Care Groups.

We understand that creating attractive posts for newly qualified medics is an ideal opportunity to showcase psychiatry as a specialty, both early in their career pathway and through core training, and this can lead to future applications for core psychiatry training.

4.5.2 *Trainer shortage*

Having sufficient substantive trainers to provide supervision remains a challenge. The Faculty will be outlining proposals for SAS doctors to become trainers for core training, now that the Schools of Psychiatry have relaxed their rules. Should we not seek a remedy, this may lead to a decrease in postgraduate doctor training posts and their associated funding which in turn increases agency locum costs.

Where concerns arise, NHSE uses its escalation processes Intensive Support Framework (ISF) to describe and monitor its concerns, based on the level at which it is having to work with an individual organisation, department, programme, or the wider system to ensure the appropriate steps are taken to clarify, improve and resolve the concerns raised. NHSE have applied an ISF Level 1 to “overall workforce” for TEWV and continue to keep this under close review.

Appendix 10: A guide to the HEE Intensive Support Framework

4.5.3 *Retaining senior registrars*

The Trust continues to face difficulties in attracting senior registrars to the Trust once they have gained their Certificate of Completion of Training (CCT). The Medical Pledge will go some way to reduce the risk of prioritising other Trusts over our own.

The Trust has a dedicated senior registrar tutor, and they take a lead role in setting quality improvement targets to improve the satisfaction rate of senior registrars. The tutor is a conduit with Trust management to highlight Consultant Psychiatrist opportunities available in the organisation and they strive to ensure that meaningful career discussions are held with senior registrars. The Faculty continues to provide dedicated teaching and events for senior registrars including the well established leadership and management programme, senior registrar away days which include a senior registrar business meeting, and the senior registrar development programme – “Roadmap for Aspiring Consultants”.

4.5.4 *Lack of dedicated Medical Education facilities*

The Trust does not have sufficient facilities to train medical students and junior doctors at all Trust sites. Whilst this has been highlighted to the Trust and conversations welcomed, there remains no definitive decision on a remedy for such. The NHSE Quality Interventions Review report produced following the 2022 joint quality visit from the Northern Foundation School and Newcastle University Medical School confirmed that the Trust is not currently meeting the GMC standards for training in relation to the standard of education facilities.

The lack of an education centre at each main hospital site where medical students and postgraduate doctors can be taught, have space to work and discuss patient encounters with their peers safely, leads to a sense of not belonging.

This is and will become a greater burden as the Trust risks not being able to participate in future student expansion, but even that it cannot offer placements at the scale it does now.

4.5.6 ***Saturation of clinical areas***

Over recent years there has appears to be an increase in the negative feedback received from medical students and postgraduate doctors regarding the training environment in TEWV and at times a lack of multi-disciplinary team working. The Faculty are further aware of the high levels of saturation of clinical students in most areas throughout the Trust.

In some areas, there does appear to be an increasing resistance from services to host medical student placements and this could be because of the number of other clinical placements it provides. The Faculty is keen to collaborate and understand this further and will seek again to meet with other clinical professional groups to discuss this.

4.5.8 ***Industrial action***

In a recent Guardian of Safe Working (GoSW) board paper, colleagues were informed about the significant number of consultant vacancies across the Trust and the increasing use of agency locums. This raised some concern about the adequacy and availability of senior supervision for trainees and the additional workload on substantive consultant supervisors.

This was exacerbated further over recent months with periods of industrial action. During this time, the Trust re-deployed some postgraduate doctors to inpatient units and also to support Out Of Hours (OOH) rotas. All those who worked outside of their normal location and / or a different specialty, were met by a lead psychiatrist and clinical supervision arrangements were made clear. The Trust also strengthened the support OOH with the introduction of the Vertical Advice and Support for Colleagues On-call (VASCO) guidance referred to in detail in Appendix 11.

The Trust will continue ongoing efforts with medical recruitment and a new strategy will be shared soon. Despite this work, we know that some of the shortages mean some consultants are having to provide additional one hour supervision to postgraduate doctors that are not placed with them. There is a system in place to allocate supervisors when this occurs, but we will be looking to strengthen this process and engagement between medical managers and the Faculty.

5. HORIZON SCANNING

To ensure the Faculty remains proactive in its approach to continual improvement, several initiatives are planned for the next academic year.

5.1 ***Implementing recommendations from "sharing good practice"***

Since 2022, the Medical Education Manager (MEM) has made contact with Directors of Medical Education (DME) and MEM's from other organisations at each of the top ten scoring trusts in the GMC NTS to discuss their outstanding survey results and to share good practice within medical education.

To date the meetings have been very productive and several recommendations have been agreed for implementation (Appendix 12 and Appendix 13). By proactively addressing the few negative outliers in the Trust GMC NTS though considering and in some cases implementing transferable areas of good practice from the top scoring Trust's, the Faculty hopes to continue to see an improvement in TEWV's national rankings in the GMC NTS over the coming years.

5.2 ***Faculty retreat***

In November 2023 the Faculty will host a one and a half day educational retreat which will run in tandem with the medical managers programme. During the retreat the Faculty will:

- Explore the NHSE Educator Workforce Strategy
- Receive an overview of the T-GROW coaching model
- Undertake group work to identify top 3 objectives for 2024
- "Focus on self" as a trainer or tutor
- Review the actions plans created to address the negative outliers received in the 2023 GMC NTS
- Scrutinise the areas of good practice gleaned from MEM meetings with DME / MEM's from the top ten scoring trusts in the 2023 GMC NTS

The retreat will allow networking between Faculty members and medical managers, and incorporated within the programme is a professional challenge to medical managers, who will in turn, receive a professional challenge from medical managers on key agenda areas.

5.3 ***Academic pathways development***

At present TEWV is deficient of Academic Clinical Fellowship (ACF) posts. Recent approval from NHSE Yorkshire and Humber will see the creation of an ACF post linked to Hull and York Medical School (HYMS) at CT1-3 level from August 2024. ACF posts are essentially 75% clinical and 25% academic and are planned for 3 years of core training. The academic educational supervision for the ACF will be provided via HYMS. The Faculty are also pursuing a parallel discussion with NHSE North East to replicate this arrangement in the north Care Group to offer parity for training. The hope is to achieve the holy grail of an entry level academic programme in TEWV, as we continue to be well behind many Trusts in this ambition. An ambition, that will eventually lead to interest from more senior colleagues to want to join the Trust.

6. ACTIONS

6.1 To address the risks outlined in this report, MELT have agreed a high level objective for each member to lead. These objectives are detailed in Appendix 14.

7. CONCLUSIONS

7.1 The Trust continues to have a pro-active and strong Faculty of medical education. Feedback demonstrates more than ever that despite ongoing challenges, the Trust continues to achieve high results in relation to the delivery of all medical education programmes.

8. RECOMMENDATIONS

8.1 It is recommended that the Trust Board note the content of this paper.

Authors: **Hayley Lonsdale, Medical Education Manager**
MELT

Appendices

Appendix 1: Medical Student Internal Feedback 2022/2023

Medical Student Internal Feedback 2

Appendix 2: 2022/2023 Quality Improvement Plan (QIP)

QiP - Full QiP - August 2022 to July

Appendix 3: 2022 Self-assessment Report (SAR)

Self-Assessment Report (SAR) 2022 TI

Appendix 4: 2023 GMC Trainee Survey Report

2023 GMC NTS Trainee Report.pdf

Appendix 5: 2023 GMC Trainer Survey Report

2023 GMC NTS Trainer Report.pdf

Appendix 6: TEWV Internal Educational Audit Framework v4

TEWV Internal Educational Audit F

Appendix 7: Medical Education Operating Framework v10.0

Medical Education Operating Framewo

Appendix 8: SPA currency within defined roles in Medical Education

SPA currency within defined roles in Me

Appendix 9: Faculty of Medical Education Structure Chart

Faculty Chart - November 2023.pdf

Appendix 10: A guide to the HEE Intensive Support Framework

Intensive-Support-Framework-Guide-Ju

Appendix 11: Vertical Advice and Support for Colleagues On-call

VASCO Guidance - September 2023.pdf

Appendix 12: 2022 Intelligence Gathering / Sharing Good Practice

Summary of GMC NTS 2022 Meetings.

Appendix 12: 2023 Intelligence Gathering / Sharing Good Practice

Summary of GMC NTS 2023 Meetings.

Appendix 14: 2024 MELT Objectives

MELT 2024 Objectives.pdf

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