Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

8 February 2024

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

AGENDA

NOTE: there will be a confidential session at 1.00pm for the Board of Directors 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	-
3	Declarations of interest	All	Verbal
4	Minutes of the last meeting held on 11 January 2024	Chair	Draft Minutes
5	Board Action Log	Chair	Report
6	Chair's report	Chair	Report
7	Questions raised by Governors in relation to matters on the agenda *(to be received by 1pm on Tuesday 6 February)*	Board	Verbal

Strategic Items (1:45 pm – 2.55 pm)

8	Board Assurance Framework Summary Report	Co Sec	Report
9	Chief Executive's Report	CEO	Report
10	Integrated Performance Report	Asst CEO	Report
11	Our Journey to Change Delivery Plan, progress report	Asst CEO	Report

BREAK

Goal 1: To co-create a great experience for our patients, carers and families (3.10 pm – 3.20 pm)

12	Report of the Chair of Quality Assurance Committee	Committee Chair (BR)	Report

Goal 2: To co-create a great experience for our colleagues

13	Equality Delivery System 2022 (for information)	EDfPC&D	Report

Exclusion of the Public:

14	Exclusion of the public 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
2 February 2024

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 11 JANUARY 2024 AT WEST PARK HOPSITAL, DARLINGTON AND VIA MS TEAMS, COMMENCING AT 1.30PM

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

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

Observers:
S Double, Alder
Hazel Griffiths, Governor
M Norman, Deputy Director of Finance designate
K North, Deputy Director for People and Culture
Sarah Paxton, Head of Communications
S Theobald, Associate Director of Performance

23-24/127 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and noted the board had received a powerful story prior to the meeting from a young man and his mother in relation to his experience of autism and mental health, and the support provided by the trust. The Chair referenced the work of the Council of Governors' task and finish group on Autism and the clarity that had been provided on progress made and work still to do, and he noted the collective commitment of the board to step up the challenge set out by the young man.

On behalf of the board, the Chair congratulated P Hungin, who had been named a Knight Bachelor in the 2024 New Year Honours list.

The Chair went on to reflect on progress that had been made against priorities during 2023 and confirmation of that from the CQC, albeit the trust had been rated as requiring improvement. He proposed that the trust would continue to work with staff, external partners, service users and their families to continue its transformation work through Our Journey to Change and to end the year in a further improved position. There would be a focus on outcomes with appropriate processes, skills and culture to support that.

23-24/128 APOLOGIES FOR ABSENCE

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

23-24/129 MINUTES OF THE PREVIOUS MEETING ON 9 NOVEMBER 2023

Agreed as an accurate record of the meeting, subject to the inclusion of T Olusoga who had attended on behalf of Z Campbell.

23-24/130 MINUTES OF THE PREVIOUS MEETING ON 14 DECEMBER 2023

Agreed as an accurate record of the meeting.

23-24/131 ACTION LOG

The following points were noted:

1. P Bellas provided an update on development of the board seminar programme for 2024/25 and the Chair invited board members to contribute proposed topics.

2. P Bellas provided an update on the development of the revised Board Assurance Framework and noted that draft risk profiles would be prepared for the board to consider in February 2024. There would then be subsequent monitoring and reporting arrangements through board committees. It was agreed that the action rating would remain as red in the interim.

3. S Dexter-Smith advised that the board would receive a report on Freedom to Speak up arrangements at the board meeting in February 2024. **Action: S Dexter-Smith**

4. A Bridges welcomed the opportunity for Lived Experience Directors to attend the board meeting and proposed that they be invited to attend in March 2024. **Action: A Bridges**

   The Chair invited executive directors to consider how the board would take advantage of lived experience input at all board meetings. **Action: B Kilmurray**

5. It was agreed that Quality Assurance Committee or Mental Health Legislation Committee would receive a report on the implementation of Section 17 leave. **Action: K Kale**

6. L Romaniak noted the board had been invited to attend an extraordinary meeting of Strategy and Resources Committee to consider and approve submission of a reforecast financial position.

23-24/132 CHAIR'S REPORT

Noted.

23-24/133 QUESTIONS RAISED BY GOVERNORS IN RELATION TO MATTERS ON THE AGENDA

None.

23-24/134 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

P Bellas introduced the report, which outlined information on risks included in the Board Assurance Framework (BAF), to support discussion during the meeting.

In discussion the following points were raised:

1. Given its rating, it was proposed that consideration be given to experience [BAF risk 4] during the meeting.

2. The Chair welcomed the development of the BAF and proposed that the next iteration provide a short executive summary on changes since the previous report, gaps between actual and target scores, and timescales to achieve target scores.

   Action: P Bellas

   P Bellas advised at, in order to provide greater visibility, the revised report would provide clarity on when risk scores were expected to change and the drivers of that.

23-24/135 CHIEF EXECUTIVE'S REPORT

B Kilmurray introduced the report, which aimed to highlight topical issues that were of concern. In addition to the information provided, he noted:

- The extended period of industrial action by junior doctors, which had been well managed by the trust, and he placed on record his thanks to colleagues who had attended and had been flexible, to ensure services were safe.

  Commenting further, K Kale advised that a larger number of doctors had been redeployed across the trust to support inpatient services, compared to other periods of industrial action. He noted that the BMA had proposed a further period of industrial action in February 2024 and would ballot doctors on proposals to extend the period during which industrial action could be taken, by six months. He also noted that speciality doctors had voted to take strike action.

- A visit by Stockton Borough Council Cabinet to Roseberry Park Hospital and subsequent meeting, at which there had been agreement on a number of opportunities to work together.

Commenting further, P Scott noted agreed areas of common purpose, related to community infrastructure around adult learning disability and action to improve accessibility to and responsiveness of the crisis services.

It was noted that there had also been engagement with other local authorities and positive feedback received from this.

In discussion the following points were raised:

1. It was noted that the HSJ had reported on the development of an alliance between Newcastle, Northumbria, Gateshead and North Cumbria acute trusts. B Kilmurray confirmed that executives were mindful of any implications arising from the acute groupings, the ICB reorganisation and development of combined authorities and the trust would continue to position itself as an advocate for Durham, Tees Valley and North Yorkshire residents with mental health and learning disability needs.

2. B Kilmurray confirmed that the board would have visibility on all significant matters, with reports to the board or a board committee. He also noted there was a number of different provider collaborative models, some of which had included non-executive director involvement.

   L Romaniak commented on the potential to take learning from elsewhere and consider how the trust would with to engage, should it need to do so.

3. B Kilmurray noted that consideration would need to be given to responsibilities previously held by Commissioning Committee related to the provider collaborative.

   J Maddison, commented on the background to the decision to stand down Commissioning Committee and concerns expressed at Strategy and Resources Committee that it may not have capacity to undertake this work. The Chair proposed that executive directors consider the most appropriate governance arrangements for responsibilities previously held by Commissioning Committee. **Action: B Kilmurray**

4. B Reilly expressed a concern that the NENC Foundation Trust Collaborative had an acute focus and in response, B Kilmurray advised there would be other vehicles for the trust's work, including a nested collaborative. The Chair confirmed that this had been referenced at a meeting of Trust Chairs in December.

5. A query was raised about the number of provider collaboratives and their alignment with combined authorities and related funding streams. In response, B Kilmurray undertook to provide a briefing to the board on the background and direction of travel. The Chair also proposed a further discussion through the business planning process to understand how arrangements supported delivery of strategic objectives.
   Action: B Kilmurray

23-24/136 INTEGRATED PERFORMANCE DASHBOARD

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

In presentation, M Brierley drew attention to: changes that had been made to the report as part of continuous improvement work and to incorporate feedback from NSHEI and CQC; the review of performance improvement plans to ensure they included SMART objectives; and the proposed reasonable level of assurance regarding the quality of services delivered, and areas highlighted in the report where there was limited performance assurance and negative controls assurance. He went on to note that some reporting processes, which involved clinical staff, would be paused during Cito implementation, and provided assurance that performance oversight would still continue.

He noted a correction to page 44 of the report – where the Co Durham full year to date figure [8195] for 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, should be rated as green.

Z Campbell reported from North Yorkshire, York and Selby Care Group and noted that adult mental health and mental health services for older people patient recorded outcome measures and staff appraisal levels were areas of concern. She noted an improvement in relation to children and young people outcomes, patient and clinician reported and welcomed the improvement in staff leaver rates. In respect of national indicators and child eating disorder waiting times, she advised that data was reported over a 12 month rolling period and would be impacted by small changes due to the small cohort of service users.

P Scott reported from Durham, Tees Valley and Forensics Care Group and advised that deep dives had been undertaken into the measures for adults and older persons showing measurable improvement following treatment, patient and clinician reported. He noted intensive work by the senior leadership team at West Park Hospital and Roseberry Park Hospital to understand bed occupancy pressures and patient flow, which would be reported to Quality Assurance Committee. He also commented on: operational oversight of mandatory and statutory training and staff appraisal levels; a workshop that would be held by the Lived Experience Director in relation to feeling safe; work that would be undertaken to understand unique caseloads in adult services; and the recording of waiting times for children and young people eating disorder services, which did not reflect genuine waiting times due to how waits were recorded.

In discussion the following points were raised:

1. B Reilly, Chair of Quality Assurance Committee, confirmed that committee was sighted on issues raised in the report.

2. B Reilly queried the trust's capacity to deliver the number of actions outlined in performance improvement plans and noted a number had a quarter 4 deadline. In response, M Brierley confirmed that plans would focus on short term SMART actions to turn performance around and advised that the review would seek to identify plans that included longer term transformation work.

3. P Hungin raised a concern about the achievement of patient outcomes, particularly for vulnerable groups and in response, K Kale commented on the measurement of paired outcomes and factors that would impact on their assessment, and he noted a board seminar had been proposed to provide further clarity.

   The Chair expressed a concern that the trust was not able to report more clearly on achievement of patient outcomes and K Kale commented on the inclusion of DIALOG in Cito to support measurement and development of goal based outcomes based on individual care plans.

   L Romaniak provided assurance that Executive Directors Group had considered the matter and supported proposals to improve outcome measurement, with a view to identifying outcomes that would be measurable and specific for each individual, during their recovery.

   The Chair requested the board be appraised on timescales for this work, following the meeting. **Action: B Kilmurray**

4. B Murphy drew attention to the reported increased trend in incidents of moderate or severe harm and noted that the trust may expect a period of less stable reporting during transition to InPhase. She provided assurance that levels remained within acceptable parameters for an organisation of its size.

   Commenting further, P Scott advised that DTVF Care Group closely monitored the position in relation to children and young people to identify any themes or emerging areas of concerned. He acknowledged that one incident was too many and noted that there had been 18 reported incidents in November 2023, of which two were severe.

5. In respect of previously reported unexpected inpatient unnatural deaths reported on STEIS [chart 14], B Murphy advised there had been no signs of self-harm and the trust would wait for the outcome of any inquest.

6. B Murphy welcomed the inclusion of headline information in the report and suggested this also responded to a concern raised by the CQC on the level of detail provided to the board. She cautioned that whilst the board was able to review specific indicators the ability to highlight quality issues of concern, may have been lost.

   Commenting further, she noted that the performance team would work with board committees to develop use of committee dashboards and proposed that there was good floor to board reporting.

7. J Maddison welcomed the continued development of the report and proposed that a level of detail would be expected. He raised a query in relation to delivery of non-recurrent cash releasing efficiency savings (CRES) and the unplanned scheme referenced in the report as LD, medical and long covid contribution [page 38].

   In response, L Romaniak advised that the scheme was not recurrent and reflected that the cost pressure had not materialised to the extent projected. She noted challenges

to delivery of CRES proposals, which included use of medical locums and vacancy rates, despite significant work undertaken, and welcomed the reduction in agency use.

8. L Romaniak highlighted the receipt of additional national funding and the reforecast financial submission, approved by Strategy and Resources Committee in November 2023, which projected a breakeven position based on an assessment of a mid-case financial position. She noted that the IPR reported against the original plan and not the reforecast submission and commented on further work that would be undertaken to revisit best case scenario planning to consider if pressures identified at month 7 were able to be mitigated.

9. J Murray welcomed the opportunity for board committees to receive a performance dashboard and proposed that clarity be provided on what information was expected.

10. The Chair welcomed the work that had been undertaken to develop the IPR and the quality of data and analysis that it provided. He noted that its development would continue to be an iterative process and proposed that consideration be given to: consistent reporting on timescales to achieve target; how the board would have oversight of outcomes and traction through the PIP process; inclusion of narrative that would highlight the strategic thread, based on the KPI analysis; how care groups would provide assurance to the board, rather than reassurance.

    B Reilly, as Chair of Quality Assurance Committee, proposed that the committee was well sighted on matters, including those reported by care groups and she undertook to consider how she could report on this to the board.

    The Chair proposed that board reports provide clarity on matters considered by each committee and there be a consistent approach.

    J Maddison proposed that committee Chairs would work with lead executives to respond to that, whilst ensuring reports to the board provided an appropriate level of detail.

23-24/137 CORPORATE RISK REGISTER

B Murphy introduced the report, which aimed to ensure the board had oversight of organisational wide risks that were rated as high in the Corporate Risk Register. She noted an addendum had been provided to the report, in order to report across the full period since the last board meeting.

She noted the register would routinely be considered by Executive Risk Group and relevant board committees and drew the board's attention to changes in risk scores during the period.

In discussion the following points were raised:

1. J Murray welcomed the inclusion of narrative on the rationale for changes to risk scores and proposed an at a glance summary to show risk movement across the financial year, in order that the board could understand trends and track changes more

easily. B Murphy proposed to include this in the quarter 2 2024/25 report, to allow for implementation of InPhase and would bring that forward to quarter 1, if possible.
Action: B Murphy

2. B Reilly, as Chair of Quality Assurance Committee, indicated she was content with progress that had been made. She noted that risks reported to committee had dropped significantly and expressed caution about oversight of cross cutting committee risks.

3. J Maddison, as Chair of Audit and Risk Committee, welcomed the progress that had been made and proposed the inclusion of timescales to indicate when a target rating would be achieved. **Action: B Murphy**

4. The Chair acknowledged the refinement of the Corporate Risk Register and BAF and the triangulation of data between them. He also welcomed the inclusion of a heat map to indicate where risks scores had remained at the same level for some time.

5. B Kilmurray advised that all executive and care group board meetings considered risk and reported significant risks into Executive Risk Group, and B Murphy highlighted the opportunity for an annual review of risks, as part of the board development programme.

6. Noting reference in the IPR [page 18] to the implementation of InPhase, the Chair sought assurance that the trust remained sighted on patient safety incidents. In response, B Murphy confirmed the system was reliable and nuances between InPhase and the previous system in how data was captured would be reported to Quality Assurance Committee.

23-24/138 CHARITABLE TRUST FUND ANNUAL REPORT AND ACCOUNTS FOR 2022/23

The board received the report, which provided the annual report and accounts of the Charitable Trust Fund for 2022/23 for consideration, following independent review by Mazars.

L Romaniak presented the report and noted the following additional points:

- That, due to size, funds were subject to independent review rather than external audit and positive assurance had been received from Mazars.
- The reported balance of £524k, was a net reduction of £54k from the previous year, as a result of expenditure exceeding income.
- Strategy and Resources Committee continued to review items of expenditure and the overall position, on a quarterly basis.

In discussion, the following points were raised:

1. J Maddison, as Chair of Audit and Risk Committee, confirmed that the committee had approved the report for consideration by the board, subject to minor changes which had been completed.

2. J Preston noted the principle that trust funds would add value and be used to support activity over and above that, which was the responsibility of the trust and queried the role of Strategy and Resources Committee and any potential conflict of interest.

   In response, L Romaniak acknowledged the point raised and confirmed that standing financial instructions provided clarity on the purpose of trust funds and on arrangements to approve and review applications, which included a final review by herself and consideration by Strategy and Resources Committee. She also noted the assurance provided by the independent review, albeit that had been limited in scope, and agreed to consider how governance arrangements could reflect independent assurance provided by Non-Executive Directors.

   Action: L Romaniak

3. L Romaniak confirmed that restricted funds were funds created in legacy, where its use had a defined purpose.

4. J Preston expressed concern that the funds had not been reviewed by Internal Audit for a number of years and L Romaniak confirmed that the funds would be reviewed on a three year cycle and had been delayed to quarter 4 2023/24 or quarter 1 2024/25, due to staffing challenges.

5. A Bridges highlighted the potential to develop a trust wide strategy for use of un-restricted charitable funds and noted that other trusts employed a charitable fund officer to lead on this work and to support staff and families to raise funds.

6. The Chair queried the organisation title used on the front of the submission and L Romaniak undertook to confirm that this reflected the registered name of the charity.

   Action: L Romaniak

***Agreed**: that, subject to confirmation of the title name on the submission, the board:*

i. Approve the submission of the Annual Report and Accounts of the Charitable Trust Fund, to the Charities Commission.

ii. Authorise the Chair and Chief Executive to sign:
- *The statement of trustee responsibilities (Chair and Chief Executive)*
- *The balance sheet (Chief Executive)*

23-24/139 LEADERSHIP WALKABOUTS

A Bridges presented the report, which provided high-level feedback from leadership walkabouts that took place in October and November 2023 to Mental Health Services for Older People and Children and Adolescent Mental Health Services.

In discussion the following points were noted:

1. A Bridges confirmed that feedback from teams would be captured and actions agreed, and these would be centrally logged and progress monitored. She also noted triangulation of information with patient experience intelligence and performance indicators.

2. B Reilly noted the potential for teams to feel isolated due to their geography and the Chair proposed that the board would wish to be sighted on any related themes, and for issues raised to contribute to strategic planning.

23-24/140 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee, presented the report and noted the significant agenda and quality of papers considered at the meeting, and observation by Deloittes as part of the governance review.

She noted a correction to the report to include reference to 'We continue to keep the Durham and Darlington Coroner fully appraised...' [section 2b refers] and provided an overview of matters raised in the report. She highlighted the following additional points:

- The potential to develop an external focus, including engagement with HealthWatch and commissioner review visits, and she welcomed the outcome of the recent visit by North East and North Cumbria Mental Health, Learning Disability and Autism Partnership.
- Evaluation completed at the end of each meeting, to support committee learning and development.

In discussion the following points were raised:

1. B Reilly confirmed that committee was assured on issues related to a long-term seclusion in SIS. B Murphy also confirmed that the care group had reported confidently against the code of practice and, whilst there were no concerns, a position review would be completed, and advocacy had been sought.

2. B Murphy confirmed that committee had received a report on progress against NICHE recommendations and she had met with them as they prepared the scope of their assurance activity, prior to commencement in February 2024. She suggested there were no matters of concern related to the trust's delivery of recommendations.

   The Chair proposed that the board be sighted on the review, via Quality Assurance Committee. **Action: B Reilly/B Murphy**

Agreed: *Board approves the work plan for Quality Assurance Committee for 2024/25.*

23-24/141 REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

P Hungin, Chair of Mental Health Legislation Committee, presented the report and reflected on the remit of the committee and the range of associated work that would be undertaken, and he placed on record his thanks to the Mental Health Legislation Team for the work they had undertaken and progress they had made.

He noted that committee reminded itself that each number represented a service user and proposed that committee was assured the trust was fulfilling its legislative requirements. He provided an overview of matters raised in the report and welcomed the information provided by P Scott and Z Campbell on use of the section 136 suite.

In discussion the following points were raised:

1. P Scott confirmed that DTVF Care Group monitored use of the section 136 suite and escalation processes were in place, should a service be user be detained in a suite or to respond to capacity challenges. Where a service user was detained, standards had been established to ensure the environment and care they received was a close as possible to that provided on a ward.

   Z Campbell confirmed similar arrangements were in place in NYYS Care Group and were rarely used.

   B Murphy advised that the impact on experience of care had been explored at Executive Review of Quality.

2. P Hungin advised that the CQC had raised a query in respect of the trust's approach to monitoring of black and minority ethnic groups and noted the limited capacity to respond to this, due to implementation of Cito.

3. K Kale welcomed that, when benchmarked nationally against other trusts, the trust was in the lower quartile for discharges from detention.

23-24/142 REPORT OF THE CHAIR OF PEOPLE, CULTURE AND DIVERSITY COMMITTEE

J Murray, Chair of People, Culture and Diversity Committee, presented the report and provided an overview of matters raised, drawing attention to the outcome of the review of the role of the Duty Nurse Coordinator and noting that committee would hold a time out session later in the month.

In discussion the following points were raised:

1. S Dexter-Smith noted that the Equality Delivery System would be considered by the board in February and contained no matters of concern. **Action: S Dexter-Smith**

2. Board would be briefed on the outcome of the staff survey results when the data was able to be shared. **Action: S Dexter-Smith**

23-24/143 GUARDIAN OF SAFE WORKING, QUARTERLY REPORT

[M Brierley left the meeting]

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

In presentation, Dr Burke, Interim Guardian of Safe Working, drew attention to the reported level of exception reporting and fines and advised that he would continue to emphasise the importance of exception reporting in order for the trust to gain an understanding of working patterns.

B Kilmurray commented on the importance of reporting, to support trust visibility.

The Chair thanked Dr Burke for his work as Interim Guardian of Safe Working and placed on record his thanks to junior doctors.

23-24/144 EXCLUSION OF THE PUBLIC

Agreed.

Following conclusion of confidential matters, the meeting concluded at 5.40pm

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 **09/11/2023**	22/144 22/174 23-24/06 **23-24/111** **23-24/117** **23-24/119**	Topics for board seminars	a) Mental Capacity Act b) Reported outcomes following treatment c) what transformation may mean for future services **d) Baroness Hollins' report on those with a learning disability and/or autistic people** **e) strategic discussion on the trust's financial position** **f) impact of peer support workers**	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 **Jan-24: Board invited to propose topics**
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
11/01/2024	**23-24/134**		**Report to provide a short executive summary on changes since the last report, gaps between actual and target scores and timescales to achieve target scores**	**P Bellas Risk Leads**	**Feb-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 Jan24: data collection is complete, there are some issues with validity, currently been analysed. CN will discuss next steps with CEO and Chair in relation to data validity
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 - next CoG meeting 19 March 2024

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
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
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 Jan-23: Further strike action during December 23 and January 24 - update to be provided at the next board meeting via CEO report
13/07/23	23-24/66	Section 17 leave	Board to receive feedback from the Urgent Care Programme Board in relation to variance in how the act is used.	MD DTVF MD NYYS	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 Jan-24: Report provided to EDG to provide assurance on implementation of the policy and many management action required - agreed that a report would be provided to QAC or MHLC on implementation **Feb24: the group nurse/medical directors will bring an update to MHLC in February 2024.**
12/10/23	23-24/100	Responding to issues raised by freedom to speak up arrangements	Trust to consider greater use of analytical data, alongside existing tools, to ensure all issues that arose through freedom to speak up arrangements had been captured and considered.	DfP&C	**Feb-24**		**Deferred to March 2024 - to follow discussion with FTSU Guardian and at Quality Board.**
09/11/23	23-24/119	Lived Experience Directors	Lived Experience Directors to attend a future board meeting	EDoCA&I	Mar-24		
09/11/23	23-24/120	Use of restraint	Progress report to Council of Governors on action taken to reduce the use of restraint	CN	Mar-24		Next Council of Governors meeting is 9 March 2024
11/01/24	**23-24/131**	**Lived Experience**	**Lived Experience Directors be invited to attend the board in March 2024. Executive Directors to consider how the board could take advantage of lived experience input at all board meetings.**	**CEO**	**Apr-24**		**Lived Experience Directors to attend the Board in April 2024**
11/01/24	**23-24/135**	**ToR - Commissioning Committee**	**Executive Directors to consider most appropriate arrangements for responsibilities previously held by Commisioning Committee**	**CEO**	**Mar-24**		
11/01/24	**23-24/135**	**Provider Collaboratives**	**CEO to provide a briefing to the board on the background and direction of travael of provider collaborative arrangements.**	**CEO**			
11/01/24	**23-24/136**	**Patient outcomes**	**Timescales to be provided for completion of current work to improve the reporting of patient outcomes.**	**CEO**			
11/01/24	**23-24/137**	**Corporate Risk Register**	**Report to provide an 'at a glance' summary of risk movement across the year.**	**CN**	**Q2 2024/25**		
11/01/24	**23-24/137**	**Corporate Risk Register**	**Report to include timescales to indicate when a target rating would be achieved.**	**CN**	**Apr-24**		**Next report due April 2024**

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
11/01/24	**23-24/138**	**Charitablle Funds**	**LR to consider how governance arrangements could reflect independent assurance provided by Non-Executive Directors**	**EDoFI&E**	**Apr-24**		**Discussing establishment of a new Charitables Committee formed from ARC NED membership supplemented by other colleagues, e.g. potentially staff wellbeing council / Lived Experience with SRC and ARC chair / Trust secretariat. Propose might meet 6-monthly (for example for 30 minutes following ARC). Trust secretary considering alongside scheduling of 2024/25 Board and Committee Meetings**
11/01/24	**23-24/138**	**Charitablle Funds**	**LR to confirm the correct organisation title had been used on the front of the submission.**	**EDoFI&E**	**Feb-24**	**Completed**	**Title confirmed as consistent with registered charity name**
11/01/24	**23-24/140**	**NICHE review**	**Board to be sighted on process of the Niche Review, via Quality Assurance Committee**	**Chair QUAC CN**			**To be actioned through committee reports to the board.**
11/01/24	**23-24/144**	**Equality Delivery System**	**Report to be provided to the board in February 2024**	**EDfPC&D**	**Feb-24**	**See agenda item 12**	
11/01/24	**23-24/144**	**Staff Survey**	**Report to be provided on the results of the Staff Survey**	**EDfPC&D**	**Mar/Apr 24**		**Results shared at PCDC time out and people journey delivery plan reviewed and agreed in light of the results. Implications to be reported to the board in March/April 2024**

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Chair's Report: 6th January – 7th February 2024.

Headlines:

External:

- Weekly Mental Health Chairs' Network : emerging national issues – Out of Area Placements, LD & Autism
- Meeting Yorkshire and Humberside Foundation Trust Chairs: issues of common interest & also H&NY Provider Chairs meeting
- Board of Directors January 2024.
- Meeting NHSE Chair & NHSE Regional Director.
- Meeting Norfolk & Suffolk NHS FT Chair.
- Meeting North Yorkshire Police & Fire Commissioner's Director of Partnership
- Central ICP Meeting February 2024.

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.
- Regular meeting with Lead Governor.

Internal

- Various Living The Values Awards (Derwent Clinic).
- Non-Executive Director catch-up discussions.
- Meeting with Head of Peer Support.
- Meetings regarding TEWV Constitution review.
- Meeting on Comms Strategy.
- Meeting NHS Graduate.
- Meeting with potential NED.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**8 February 2024**
Title:	**Board Assurance Framework – Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

Report for:

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
10	Regulatory Compliance	Under its Provider Licence, the Trust must take all reasonable precautions against the risk of failure to comply with: a. The Conditions of the Licence, b. Any requirements imposed on it under the NHS Acts, and c. The requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

Executive Summary:

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

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

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

A summary of the BAF is attached which is based on the strategic risks as agreed by the Board under minute 23-24/C/73 (9/11/23). It seeks to provide information on related key controls and positive and negative assurances relating to them, which have been identified since the last board meeting.

The board will recognise that it receives a number of reports to each meeting that are pertinent to the BAF risks, including:

- Integrated Performance Report
- Chief Executive's Report
- Board Committee Reports
- Monthly Finance Report (confidential)
- Reportable Issues Log (confidential)

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

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

BAF Summary

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
1	✓	✓		**Safe Staffing** **There is a risk** that some teams are unable to safely and consistently staff their services **caused by** factors affecting both number and skill profile of the team. **This could result** in an unacceptable variance in the quality of the care we provide, a negative impact on the wellbeing and morale of staff, and potential regulatory action and a lack of confidence in the standard of care.	DoP&C	PCDC	High	**Moderate (Q3, 25/26) (-2L to achieve)**	**Q1, 25/25** Workforce plans in place for all services (-1L)	**Reasonable**		Knowing which staff we need and where Ensuring that staff are recruited to and safely deployed to the right places Staff are appropriately trained to support people using our services Staff are supported to maintain their wellbeing, feel they belong and choose to stay and work here. Ensuring that local leaders and managers are equipped to lead and maintain safe staffing Early understanding of when things go wrong	**Positive:** **IPR** - Staff Leaver Rate (metric 18) – good performance assurance/positive controls assurance **EDS 2022** - Assessment that there is good assurance that the Trust has followed a robust process in completing EDS 2022 and is meeting its obligations in regard EDS 2022. **Negative:** **IPR -** ▪ Staff recommending the Trust as a place to work (metric 16) – reasonable performance assurance/neutral controls assurance ▪ Staff feeling they are able to make improvements happen in their area of work (metric 17) – reasonable performance assurance/neutral controls assurance ▪ Percentage Sickness Absence Rate (metric 19) – reasonable performance assurance/neutral controls assurance (reduced performance and controls assurance) ▪ Compliance with ALL mandatory and statutory training (metric 20) – reasonable performance assurance/neutral controls assurance ▪ Staff in post with a current appraisal (metric 21) – reasonable performance assurance/negative controls assurance (reduced controls assurance)	**Public Agenda Item 10** – Integrated Performance Report **Public Agenda Item 11** – Our Journey to Change Delivery Plan, progress report **Public Agenda Item 13** – Equality Delivery System 2022, 23-24 submission

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
2	✓			**Demand** **There is a risk** that people will experience unacceptable waits to access services in the community and for an inpatient bed **caused by** increasing demand for services, commissioning issues and a lack of flow through services **resulting in** a poor experience and potential avoidable harm.	Mng Dir	QuAC	High	Moderate	31/3/24 (-1L)	Good		Partnership Arrangements Demand Modelling Operational Escalation Arrangements Integrated Performance Reporting Establishment Reviews Strengthen voice of Lived Experience	**Positive:** **IPR** - New unique patients referred (metric 22) - good performance assurance/neutral controls assurance (increased performance assurance) **Negative:** **IPR** - ▪ Bed Occupancy (AMH & MHSOP A & T Wards) (metric 8) - reasonable performance assurance/neutral controls assurance ▪ Inappropriate OAP bed days for adults that are 'external' to the sending provider (metric 9) - reasonable performance assurance/neutral controls assurance ▪ Unique Caseload (metric 23) - limited performance assurance/negative controls assurance	**Public Agenda Item 10** – Integrated Performance Report **Public Agenda Item 12 –** Report of the Chair of the Quality Assurance Committee
3	✓			**Co-creation** **There is a risk** that if we do not fully embed a shared co-creation framework **caused by** issues related to structure, time, approaches to co-creation and power **resulting in** fragmented approaches to involvement and a missed opportunity to fully achieve OJTC	DoCAI	QuAC	High	**Low** **(Q2/Q3 2024/25)** **(-2L to achieve)**	**Q2/Q3 2024/25** ▪ Co-creation Framework: final chapters to completed and rolled out trust-wide (-1L) ▪ Review to provide assurance on patient experience data (-1L)	Good		Further develop the co-creation infrastructure Friends and Family / Patient Experience Survey Complaints Policy	**Positive:** **QuAC** - Good assurance evidenced by the activities and workstreams for co-creation. **Negative:**	**Public Agenda Item 11** – Our Journey to Change Delivery Plan, progress report **Public Agenda Item 12 –** Report of the Chair of the Quality Assurance Committee
4	✓	✓	✓	**Quality of Care** **There is a risk** that we will be unable to embed improvements in the quality of care consistently and at the pace required across all services to comply with the fundamental standards of care; **caused** by short staffing, the unrelenting demands on clinical teams and the lead in time for significant estates actions **resulting** in a variance in experience and a risk of harm to people in our care and a breach in the Health and Social Care Act.	CN	QuAC	High	**Moderate** **(1/4/25)** **(-1C &-1L to achieve)**	A number of actions will cumulatively achieve target score: ▪ Achieve safer staffing across all services – to within tolerable levels (1/4/25) ▪ Reduce occupancy on inpatient wards to 85% (TBC)	Good		Friends and Family/Patient Experience Survey Patient and carer engagement and involvement structures and processes Our Quality and Safety Strategic Journey	**Positive:** **IPR** - ▪ Patients surveyed reporting their recent experience as very good or good (metric 1) - good performance assurance/neutral controls assurance ▪ Carers reporting that they feel they are actively involved in	**Public Agenda Item 10 –** Integrated Performance Report **Public Agenda Item 11** – Our Journey to Change Delivery Plan, progress report **Public Agenda**

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3						▪ Complete inpatient safety estates works (1/4/25) ▪ Transform community services and reduce waits for services (TBC) ▪ Achieve a minimum of 85% compliance across all services with mandatory training, supervision and appraisal (TBC) ▪ Demonstrate robust floor to board quality governance (1/9/25)			Incident management policies and procedures Governance arrangements at corporate, directorate and specialty levels Performance Management of Serious Incident Review	decisions about the care and treatment of the person they care for (metric 2) - good performance assurance/neutral controls assurance ▪ Serious Incidents reported on STEIS (metric 10) - good performance assurance/neutral controls assurance ▪ Incidents of moderate or severe harm (metric 11) - good performance assurance/neutral controls assurance (increased performance assurance) ▪ Medication Errors with a severity of moderate harm and above (metric 13) - good performance assurance/neutral controls assurance ▪ Unexpected Inpatient unnatural deaths reported on STEIS (metric 14) - good performance assurance/neutral controls assurance **QuAC** – Historical backlog of serious incidents continues to reduce **Negative:** **IPR** - Inpatients reporting that they feel safe whilst in our care (metric 3) - reasonable performance assurance/negative controls assurance	**Item 12 –** Report of the Chair of the Quality Assurance Committee
5	✓	✓	✓	**Digital** **There is a risk that** failure to implement appropriate, cost effective and innovative approaches to digital infrastructure, **caused by** lack of resources, infrastructure challenges and digital expertise **resulting in** limited delivery of OJTC goals today and for the	**ACE**	**SRC**	-	-	-	-		Initial EPR Rollout and stabilisation Phase Governance Robust Clinical Change Control	**Positive:** **Negative:**	**Public Agenda Item 11** – Our Journey to Change Delivery Plan, progress report

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3	future.								Digital Strategy linked to Our Journey to Change New Control - Replacement strategy for IT infrastructure and devices New Control - Incident response, back-up and recovery, business continuity and disaster recovery plans are in place and periodically exercised.		
6	✓	✓	✓	**Estate / Physical Infrastructure** **There is a risk** of delayed or reduced essential investment **caused by** constrained capital resources **resulting in** an inability to adequately maintain, enhance or transform our inpatient and community estate, adversely impacting patient and colleague outcomes/experience.	**DoFE**	**SRC**	**Medium**	**Low (2028/29) (-1C & -1L to achieve)**	**2028/29** Estates Master Plan delivery achieves proposed rationalisation of estate to reduce call for capital and revenue funding on non-core assets (-1C & -1L) *(Note: Two other actions have been identified which may reduce or increase likelihood score but this will not be clear until the outcomes are known:* ▪ *NENC ICB CDEL funding methodology – March 2025* ▪ *Confirmation of national capital allocations - 2025/26 to 2027/28)*	**Good**		NENC Infrastructure board Estates Master Plan CIG & CPSG Estates, Facilities & Capital Directorate Management Team Meeting ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring ERIC Green Plan submission and monitoring Environmental Risk Group	**Positive:** **QuAC** - Good assurance that there is a dynamic process for assessing, managing and addressing environmental risks **Negative:**	**Public Agenda Item 11** – Our Journey to Change Delivery Plan, progress report **Public Agenda Item 12 –** Report of the Chair of the Quality Assurance Committee
7	✓	✓	✓	**Cyber Security** **There is a risk** of a successful cyber-attack or breach, **caused by** global threats, digital and data security and literacy, **resulting in** compromised patient safety, business continuity, systems and information integrity and loss of confidence in the organisation.	**ACE**	**SRC**	**High**	**High (March 2024) (-1L to achieve)**	**March 2024** Approval of new investment (-1L)	-		Controls information not provided due to security concerns	**Positive:** **Negative:**	
8	✓	✓	✓	**Quality Governance** **There is a risk** that our floor to Board quality governance does not provide thorough insights into quality risks **caused by** the need to further develop	**CN**	**QuAC**	**High**	**Moderate (01/01/25) (-1C & -1L)**	A number of actions will cumulatively achieve target score: ▪ Implement the	**Good**		Open and transparent culture working to organisational values steered by Our Journey to Change	**Positive**: **QuAC** – • Good assurance that risks to quality are identified and	**Public Agenda Item 11** – Our Journey to Change Delivery Plan, progress report

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
				and embed our governance and reporting including triangulating a range of quality and performance information **resulting in** inconsistent understanding of key risks and mitigating actions, leading to variance in standards.					Quality Dashboard ▪ Embed the Executive Review of Quality and supporting forums as an enabler to identifying and managing risks to quality of care ▪ Develop the role of the Associate Director of Nursing and Quality to increase curiosity into the Fundamental Standards of Care ▪ Review and relaunch the Quality and Safety priorities within Our Journey o Change ▪ TEWV Leadership Academy will help all leaders enact their role to safegarud and improve quality			Executive and Operational Organisational Leadership and Governance Structure Quality Improvement Approach and Team Oversight / Insight / Foresight	reported • Good assurance linked to the Quality Assurance & Improvement Programme • Good assurance on our progress with mortality reviews **Negative:** **QuAC**- • Reasonable assurances provided from the Integrated Performance Report • Limited assurance linked to immediate life support training compliance	**Public Agenda Item 12 –** Report of the Chair of the Quality Assurance Committee
9			✓	**Partnerships and System Working** **There is a risk that** failure to take a proactive role and engage effectively with partners **caused by** capacity challenges including spanning 2 ICSs and multiple local authorities **limits** our ability to influence service transformation and improve the health of the communities we serve.	**ACE**	**SRC**							**Positive:** **Negative:**	**Confidential Agenda Item 4** – Chief Executive's Report
10			✓	**Regulatory compliance** **There is a risk** that failure to comply with our regulatory duties and obligations, at all times, could **result** in enforcement action and financial penalties and damage our reputation	**CEO**	**Board**	**Moderate**	**Moderate (31/03/25) (-1C)**	**31/3/25** Delivery of CQC Improvement Plan (-1C)	-		Statutory Reporting Provider Licence Environmental Sustainability Compliance with the CQCs Fundamental Standards of Quality and Safety Compliance with Mental Health Legislation (MHL) NHSE Financial Controls Financial Regulations (e.g. HMRC requirements) Equality, Diversity, Inclusion and Human Rights	**Positive:** **IPR** – Uses of the Mental Health Act (metric 15) – good performance assurance/neutral controls assurance **EDS 2022** - Assessment that there is good assurance that the Trust has followed a robust process in completing EDS 2022 and is meeting its obligations in regard EDS 2022. **Negative:**	**Public Agenda Item 10** – Integrated Performance Report **Public Agenda Item 13** – Equality Delivery System 2022, 23-24 submission **Confidential Agenda Item 3** – Reportable Issues Log

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
												Information Governance Risk Management Arrangements Health Safety and Security (HSS) Executive and Care Group Leadership, management and governance arrangements Inquests and Coroners		
11	✓	✓	✓	**Roseberry Park** **There is a risk that** the necessary Programme of rectification works at Roseberry Park, limited access to capital funding, and associated PFI termination legal case **could adversely affect** our service quality, safety, financial, and regulatory standing.	**DoFE**	**Board**	**High**	**Moderate (TBC) (-1C & -1L)**	TBC	**Good**		Controls ratings subject to legal privilege	**Positive:** **Negative:**	
12	✓	✓	✓	**Financial Sustainability** **There is a risk that** constraints in real terms funding growth **caused by** government budget constraints and underlying financial pressures **could adversely impact** on the sustainability of our services and/or our service quality/safety and financial, and regulatory standing	**DoFE**	**SRC**	**High**	**Moderate (2028/29) (-1C & -1L)**	TBC	**Good**		ICB Financial Governance including Mental Health LDA Sub Committee and CEO and DoF financial planning groups and sub groups Financial Sustainability Board Business Planning and Budget Setting Framework and in Year Financial Forecasting & Recovery Arrangements	**Positive:** **IPR** – CRES Performance – Non-Recurrent (metric 28) – good performance assurance/positive controls assurance **Negative:** **IPR** – ▪ Use of Resources Rating - overall score (metric 26) – reasonable performance assurance/neutral controls assurance ▪ Cash balances (actual compared to plan (metric 30) – reasonable performance assurance/neutral controls assurance ▪ Financial Plan: SOCI - Final Accounts - Surplus/Deficit (metric 24) – reasonable performance assurance/negative controls assurance ▪ Financial Plan: Agency expenditure compared to agency target (metric 25a) –	**Public Agenda Item 10** – Integrated Performance Report **Confidential Agenda Item 6** – Finance Report

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Material Reports for consideration at the meeting
	1	2	3										reasonable performance assurance/negative controls assurance ▪ Capital Expenditure (Capital Allocation) (metric 29) – reasonable performance assurance/negative controls assurance (reduced controls assurance) ▪ Agency price cap compliance (metric 25b) – limited performance assurance/negative controls assurance ▪ CRES Performance – Recurrent (metric 27) – limited performance assurance/negative controls assurance	
13	✓	✓	✓	**Public confidence** **There is a risk that** ongoing external scrutiny and adverse publicity **could lead to** low public and stakeholder perception and confidence in the services we provide	**DoCAI**	**Board**	**High**	**Moderate (-2L)**	**31/3/24** Refreshed trust-wide communications strategy (-1L)	Reasonable		Communications Strategy Stakeholder Communications and Engagement Strategy Social Media Policy	**Positive:** **Negative:**	**Confidential Agenda Item 3** – Reportable Issues Log **Confidential Agenda Item 4** – Chief Executive's Report

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**8 February 2024**
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*
10	**Influence**	• **Senior Intervenor and HNY provider collaborative**

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: North East North Cumbria Senior Intervenor System Report
Independent Review of Greater Manchester NHSFT (Edenfield)
Humber North Yorkshire MHLDA Provider Collaborative
Well Led Governance Review

Prior Consideration and Feedback n/a

Implications: No additional implications.

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

North East North Cumbria Senior Intervenor System Report

In January 2023, North East and North Cumbria ICB were offered the services of a Senior Intervenor to lead a programme of work, now known as the 'Senior Intervenor Project'. The national Senior Intervenor Programme was set up in response to Baroness Hollins recommendation to introduce an additional senior person to support local services to plan for discharge, guide where there are challenges and agree actions to facilitate a reduction in restriction. This is with a view to support arrangements enabling people to leave long term segregation and hospital.

The broad purpose of the programme was to progress discharge from hospital for individuals currently in inpatient services for whom there are significant barriers to this being achieved. The Senior Intervenor appointed by NHSE was Sir David Pearson, a senior social care leader and policy expert.

The key themes identified following conclusion of the panels was:

- Service gaps – staff changes/shortages; Transforming Care awareness; difficulty assessing need on mainstream ward.
- Discharge processes – pathway unclear; disjointed processes; referrals not made.
- Lack of consensus – person does not agree with needs assessment, family objections.
- Provider issues – providers declining referrals.
- Housing – lack of housing/ISLs; boundary crossing.
- Legal processes – lack of clarity on capacity and framework; concerns restrictions are too great.

A more detailed briefing is appended to this report. Jamie Todd, Director of Operations and Transformation will attend the meeting to present this and respond to questions.

Independent Review of Greater Manchester NHSFT (Edenfield)

NHSE asked Professor Oliver Shanley OBE (working for Niche) to undertake an independent review of Greater Manchester mental health trust following the Panorama that exposed examples of poor care and abuse at the Edenfields unit in Manchester. The report was published this week.

Quality Assurance Committee has undertaken to carry out a full assessment of the findings of the report and an assessment will be made of any learning points for this Trust.

Given our history as an organisation we appreciate that we can never be complacent and this report services as a useful reminder to us about why our unrelenting focus on quality and safety is essential and must be sustained. We can be very proud of our achievements on our quality journey, but we must seek learning from all sources and continue to improve.

The report has 11 recommendations for Manchester and other stakeholders covering:

- Ensuring patient, carer and family voices are heard at every level.
- Ensuring clinical voices are heard at every level.
- Creating a culture that is clearly focussed on quality and compassionate leadership from floor to board.
- Filling nursing workforce gaps and making sure its workforce is representative, culturally sensitive and competent.
- Managing the Trust's estate, safe environments
- Ensuring the governance structure supports timely escalation and good quality information.
- Specific issues for the Edenfields unit to focus on compassionate, high-quality care.
- Refocussing their ongoing improvement work to address these recommendations.
- Ensuring all services in the Trust consider the issues.
- Regulators are directed to consider how they can work to identify issues earlier and escalate them to prevent failures.
- Issues for the provider collaborative.

Humber North Yorkshire MHLDA Provider Collaborative

We have previously discussed the collective aspiration of collaborative members and the ICB to consider the future development of the provider collaborative. The existing arrangements have been in place for the past, at least, 5 years and have served us well.

The ICB asked Carnall Farrar to carry out a review of the arrangements and the strategy and make recommendations for the way forward. There were then, subsequently, discussions between the collaborative members and the ICB on the best way forward.

Since our last discussions on this matter there has been a further workshop. There was an agreement that further work will be done to work up two options for our future governance and arrangements. These are a possible Joint Committee and a Joint Venture. The ICB is commissioning further support with this work.

It was also agreed that we would identify a senior colleague to work with the CEO group to assist with some of the background developmental work associated with the emerging options, support the development of our strategy and the programme support required to deliver this long term.

CEO colleagues have asked me to remain as Senior Responsible Officer on this work but have committed to support me with this.

It is proposed that the Convenor role will be filled later this month, that the options will be appraised by the end of March and that work can begin on the strategy review and delivery plan and programme arrangement from April.

Well Led Governance Review

Thank you to members of the Board for participating in the governance review being conducted by Deloitte. They are approaching the end of the process and are at the stage where they will be shaping their recommendations. As such they are keen to meet with the board for a short seminar. We are taking steps to get this set up in February. I hope to be able to confirm the date at the Board meeting.

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ICB SENIOR INTERVENER PANELS – AUGUST 2023 – TEWV ACTION PLAN

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Issue	Action	Who	Update
Staffing instability in Local Authorities, CMHTs and ICB Case Management function.	a. Regular MDT meetings and shared ownership of a 12-point discharge plan will reduce the impact of staff turnover. b. Identification of a professional who is leading the discharge will reduce the impact of staff inconsistencies. Should this staff member leave the MDT, reassign the responsibility.	Inpatient teams / Local Authorities / ICB Case Managers / Place Commissioners / Community Teams	a. Regular MDTs take place and 12-point discharge plan agreed. b. Identification of a professional to lead the discharge – agreed on a case-by-case basis.
Staffing instability impacting completion of discharge-planning activities, such as Mental Capacity assessments.	Consider if Mental Capacity assessments could be completed by another professional, such as a Case Manager, if involved, rather than waiting on reallocation of cases to a new worker.	Inpatient teams / Local Authorities / ICB Case Managers / Place Commissioners / Community Teams	This is agreed on a case-by-case basis. We will compile a list of MCA trained professionals who could be drawn upon to support if there are issues, and review training with a view to increase capacity.
Patients requesting new workers due to difficulty building relationships, interrupting continuity.	Consider joint working of two professionals from a service where there is a risk of frequent requests for alternative staff. Oversight from Team Management should be provided in these cases, to ensure continuity, should new workers be requested.	Inpatient teams / Local Authorities / ICB Case Managers / Place Commissioners / Community Teams	This would be managed through supervision with oversight from Team Management.

Issue	Action	Who	Update
Knowledge gap within the Mental Health pathway of best practice when working with people with Autism under Transforming Care.	Establish levels of awareness and training requirements for CMHTs and MH inpatient teams around working with people with Autism.	TEWV Associate Directors	Oliver McGowan e-learning is now mandatory for all staff. We are working at Trust level to begin face to face workshops (Elspeth Webb).
Discharge planning was at times impeded by unclear processes and the need to identify clear leadership	a. Identify one professional to lead discharge. In complex situations, identify a senior colleague to chair regular meetings to review discharge progress. b. Use of 12-point discharge plans to ensure clarity of process and responsibility of respective actions. c. Specific and task-focused discharge planning meetings will support momentum and are a more appropriate forum than a ward round or other inpatient MDT.	ICB Place / ICB Programme Team / Local Authorities / Inpatient Teams	12-point discharge plan is in place for all patients. Updated Purposeful Inpatient Admissions (PIPA) process to allow inpatient team to work collaboratively with the one professional at point of discharge. The PIPA process includes daily reviews and formal discharge planning meetings to support momentum.
Lack of consensus between family and MDT on what is in the person's best interests.	Agree a key point of contact for the family for each part of the transition plan. Follow embedded tools, such as carer's contact plans.	Inpatient teams / Local Authority / Community teams	This would be identified as part of the 12-point discharge plan, including carer's contact plans. We would ensure that all patients have access to advocacy service. This includes advocacy for carers.

Issue	Action	Who	Update
Lack of consensus on appropriate pathway for the person and their needs in the community.	a. Identify a lead professional in the discharge planning process. b. Ensure MDT agrees a service specification informed by the needs and aspirations of the person and their key supporters. c. Set up specific discharge planning meetings which focus around 12-point discharge plan and communicate timescales clearly.	All partners	Lead professional and 12-point discharge plan is in place for all patients. Service specification is informed by the needs and aspirations of the person and their key supporters. Updated PIPA process to allow inpatient team to work collaboratively with the one professional at point of discharge.
Providers declining referrals on the basis of risk and complexity of need.	Ongoing development of a Regional Commissioning Framework.	Sean Cocking / ICB Programme Team / Local Authorities	Not TEWV
Providers declining referrals on the basis of risk and complexity of need.	Seek information from regional ICB, if needed, for advice on specialisms and track records of off-framework providers.	Sean Cocking / ICB Programme Team / Local Authorities	Not TEWV
Commissioning framework processes are followed despite professionals being aware that approaching providers on the framework will not return appropriate offers of support.	Ensure flexibility is built into commissioning processes to enable professionals to use the most appropriate process when the person's needs clearly warrant this, for example, progression directly to the complex commissioning framework.	Graham King / Directors of ASC	Not TEWV

Issue	Action	Who	Update
Service specifications not always developed.	Roll out of 'gold standard' service specifications individualised for housing and care.	ICB Programme team (Sean Cocking / Fred Grand) / Place / ASC	Not TEWV
Alternative models of care provision, such as Personal Health Budgets, are not being considered where these could be appropriate.	Development of Personal Health Budget process to increase ease of access and publicity.	ICB Programme team / ICB Place / ASC	Awareness is needed within the service of these options and able to signpost as needed.
Lack of properties which meet wide-ranging environmental needs	Targeted local support in delivery of Building the Right Support programme (BtRS).	Place / ADASS / ICB Programme team	Not TEWV
Lack of properties available at the point of clinical readiness for discharge	a. ICB / Local Authorities to support development of strategic housing needs assessments at place and target local support in delivery of BtRS. b. ICB and Local Authorities to use MHSDS data to improve development pipelines.	ICB Programme team / Local authorities / ICB Place / Data	Not TEWV but our staff need a mechanism to flag to Commissioners where properties are not appropriate and to be able to influence decisions.
Lack of housing options.	a. MDTs to produce a clear specification of housing needed to meet the person's needs. b. MDTs to pursue different housing models simultaneously, e.g. council housing stock, RSLs with capital, NHS capital funding bids. c. ICB to support development of strategic housing needs assessments at place and target local support of BtRS.	Inpatient teams/ Local Authorities / Place / ADASS / ICB Programme team	a. As above. b. MDTs can and do produce clear specifications of housing needs to meet individual needs. Specifications are published on a portal which links to different housing providers. c. not TEWV

Issue	Action	Who	Update
Delays in establishing Mental Capacity and Best Interest decisions on care and accommodation/tenancy.	Utilise local authority in-house expertise on complex issues around Mental Capacity and Best Interests, such as PSW and legal team instead of submitting a hypothetical 'welfare application' to CoP.	Local Authorities	Not TEWV
MDT concerns about level of restrictions proposed in community care plans.	a. Utilise in-house expertise on reducing restrictive practice, such as PSW and legal team. Appreciation needed that CoP will also provide advice during authorisation process if they believe the proposed plan is overly restrictive, based on the justification given. b. Ensure PBS plans are in place where indicated, to reduce behaviours that challenge through least restrictive means. Assurance of this should be through CTR process.	Local Authorities / Inpatient teams / Community teams / Place commissioners	Teams in-reach into providers and make recommendations re restrictive practices. If providers do not act on this advice, then a mechanism is needed to escalate concerns e.g. Intensive Support Group – multi agency group – meet to discuss same. PBS plans are in place and aim to reduce behaviours that challenge through least restrictive means. These should be reviewed as part of CTR process.

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Communications Dashboard

January 2024

NHS
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This month we...

- Launched our January wellbeing campaign
- Launched PSIRF (Patient safety incident review) on 29 January
- Changed the Durham Tees Valley (DTV) listening services contact number
- Opened the national quarterly pulse survey
- Asked colleagues across the trust to log onto CITO for testing

Highlights

The Dual Diagnosis service launched to support for patients who have both mental health and substance misuse problems.

Following treatment from our Talking Therapies service, Marc Blair started a support group for men

A County Durham carer has vowed to try and make sport safer in memory of her footballer husband – a former Trust patient

The Stockton Lived Experience Forum celebrated its first anniversary

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

7
Media enquiries handled by the team

4
Media releases issued

19
Total pieces of coverage across online news, TV, and radio

News stories

- **Talking therapies puts Yorkshire man Marcs life back on track -** *MSN Online*
- **Exciting new NHS service to support people with mental health problems into work -** *Chronicle Live online*
- **Scarborough hospital staff and patients release song -** *This is the coast online*
- **Pioneering medic knighted by King Charles III -** *Durham Uni online*
- **Scarborough, Whitby and Ryedale residents invited to event to showcase community mental and emotional wellbeing support -** *Scarborough News online*

Our website

87,458
page views

Top three visited pages

1. Careers
2. Services
3. Supporting someone with suicidal thoughts

Staff intranet

1,112,907
page views

Top staff intranet news stories

1. Wellbeing champion calls for specialist training after lifesaving intervention
2. Man whose life was transformed by trust now aims to help others
3. Carer vows to make sport safer in memory of former trust patient
4. Winter wellbeing launch
5. Cito connect log in reminder
6. Resuscitation policy update

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

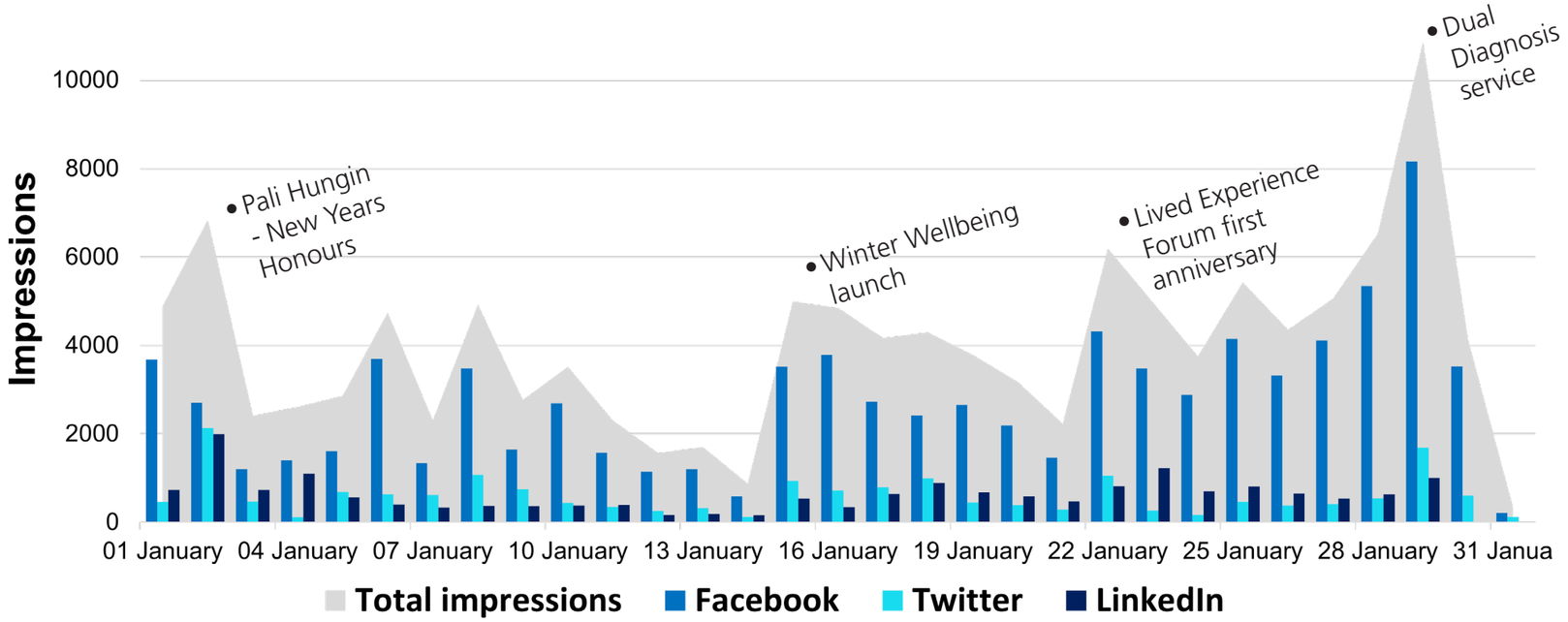
26,020
Total followers

313
New followers

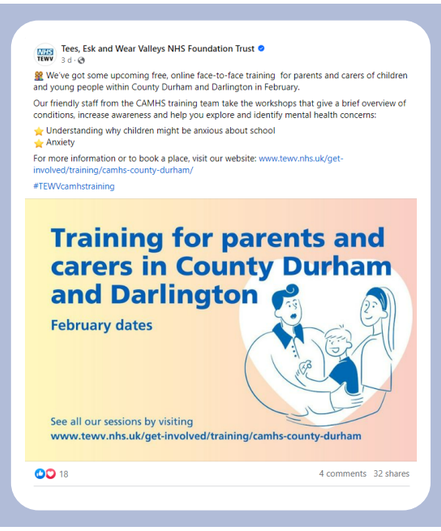
102,356
People who saw our content - impressions

3,922
Engagements

Daily impressions



Top posts



Impressions 6,239 - Engagement 159

Impressions 1,276 - Engagement 22

Impressions 4,294 - Engagement 140

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**8th February 2024**
Title:	**Board Integrated Performance Report as 31st December 2023**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Sarah Theobald, Associate Director 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 (IPR) 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. There continues to be three areas with **limited performance assurance** and **negative controls assurance**. Performance Improvement Plans (PIP) have been established for most of these areas; however, we are continuing to work on these to ensure they include SMART actions that support improvement.

Overview: This month's IPR includes the "Headlines" from each of the Care Group IPDs that was requested at the Board of Directors Meeting in January (see pages 6 and 7).

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 National Quality Standards/Mental Health Priorities.

The "Headlines" for the Integrated Performance Dashboard are shown at

page 5 and for the National Quality Standards/Mental Health Priorities at page 45. These headlines include mitigations which describe where we have PIPs developed or other actions in place to improve performance. PIPs have been established for several areas; however, we are continuing to work on these to ensure they include SMART actions that support improvement. Finally, the key changes for the IPD are shown in italics on page 8 within the Performance & Controls Assurance Overview.

We are recommending a new measure "The number of Restrictive Interventions used" replace the existing measure in the Board IPD (see page 21 for further details). This recommendation has been approved by the Chief Nurse and is pending Quality Assurance Committee approval at its next meeting, early February 2024.

The Integrated Performance Report (IPR) is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks (see page 44 alignment of measures to the Board Assurance Framework). The two key risks currently are:

- **(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.

- **(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.

Prior Consideration and Feedback

The Integrated Performance Report was discussed by Executive Directors Group and the Care Group individual IPRs by the Care Group Boards in in January 2024.

Implications:

There are no identified implications in relation to receipt of this report to the Executive Directors Group.

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.
4. Approve the new measure for Restrictive Interventions (pending QAC approval).

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st December 2023

Report produced by: Amy Walford, Performance Lead (Corporate) and Sarah Theobald, Associate Director of Performance
Date the report was produced: 25th January 2024

For any queries on the content of this report please contact: Sarah Theobald, Associate Director of Performance
Contact Details:: sarah.theobald@nhs.net

journey to change

CONTENTS

Our Guide To Our Statistical Process Control Charts

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

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

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

Assurance: is the standard achievable?

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

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

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS Foundation Trust

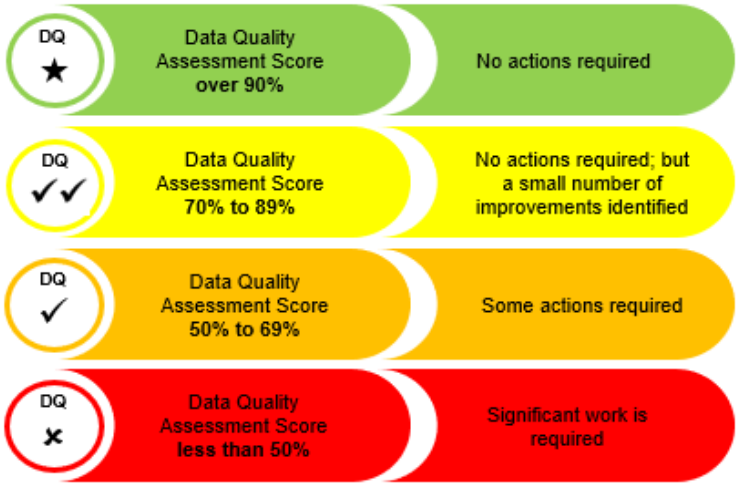
Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The latest assessment on all measures has been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

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

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

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

Data Quality Assessment status



Action status

Board Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience** no significant change, with patient experience just below standard and carer experience above standard
- **Inpatients Feeling Safe** special cause concern and below standard
- **CYP Outcomes** no significant change in PROM and below standard; special cause improvement for CROM and just below standard
- **AMH / MHSOP Outcomes** special cause concern and below standard for PROM and CROM
- **Bed Pressures** no significant change in bed occupancy and below the mean; however further increase in OAPs
- **Patient Safety / Incidents** no significant change across all measures
- **Staff** special cause improvement for leavers; however special cause concern for appraisal and a decreasing trend. No significant change in sickness or mandatory training however decreasing trend in sickness.
- **Demand** no significant change in referrals; however special cause concern in caseload
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues*

Of most concern:

- Caseload
- Financial Plan: Surplus/Deficit
- Financial Plan: Agency expenditure
- Agency price cap compliance
- CRES Performance – Recurrent

Of concern:

- Inpatients feeling safe
- AMH/MHSOP PROMS and CROMS
- Staff Appraisal
- Use of Resources Rating - overall score

Positive Assurance

Significant improvement seen in:

- CYP CROMS
- Staff Leaver Rate

Positive assurance for:

- CRES Performance – Non-Recurrent

Mitigations

We are continuing to work on the Performance Improvement Plans (PIP) in the following areas to ensure they include SMART actions that support improvement:

<u>Durham Tees Valley & Forensic Care Group</u>

- Inpatients Feeling Safe
- CYP PROM
- Bed Pressures
- Caseload

PIPs are also now being developed for the AMH/MHSOP PROM & CROM measures

<u>North Yorkshire, York & Selby</u>

- AMH/MHSOP PROMS and CROMS
- Bed Pressures
- Caseload (AMH)

<u>Trust-wide</u>

- Mandatory Training
- Appraisal
- Safer Staffing (Financial Plan)
- Agency Reduction (Financial Plan)

Finance – we have provided assurance to the ICB and NHSE that we project delivery of our 2023/24 breakeven plan, based on a mid-case scenario. Performance is being tracked against related 'control totals' by month to manage risk and provide mitigations, including assessing worst and best case assumptions.

Durham Tees Valley & Forensic Care Group Integrated Performance Dashboard (IPD) Headlines

Headlines

- **Patient and Carer Experience** no significant change, with patient experience below standard and carer experience just above standard
- **Inpatients Feeling Safe** special cause concern and below standard
- **CYP Outcomes** special cause concern in PROM and below standard; no significant change for CROM but below standard
- **AMH / MHSOP Outcomes** special cause concern and below standard for both areas for PROM. MHSOP showing no significant change and AMH special cause concern, both below the standard for CROM
- **Bed Pressures** no significant change in bed occupancy and special cause concern in OAPs
- **Patient Safety / Incidents** no significant change across all measures.
- **Staff** special cause improvement for leavers and sickness. No significant change in M&S training or appraisal.
- **Demand** no significant change in referrals; however special cause concern in caseload driven by AMH and CYPS.
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues*

Of most concern:
- Unique Caseload

Of concern:
- Inpatients feeling safe
- AMH/MHSOP PROMS
- CYP PROM
- AMH/MHSOP CROM
- OAPs

Positive Assurance

Significant improvement seen in:
- Staff leaver rate
- Sickness Absence

Mitigations

We are continuing to work on the Performance Improvement Plans (PIP) in the following areas to ensure they include SMART actions that support improvement:

- Inpatients Feeling Safe
- CYP PROM
- Bed Pressures
- Caseload

- New AMH/MHSOP PROM and CROM – to be developed February 24.

<u>Trust-wide</u>
- Mandatory Training
- Appraisal
- Safer Staffing (Financial Plan)
- Agency Reduction (Financial Plan)

Finance – we have provided assurance to the ICB that the financial plan will be delivered (breakeven) with control totals now set. The Trust will monitor adherence to control totals to manage risk and provide mitigations.

North Yorkshire, York & Selby Care Group Integrated Performance Dashboard (IPD) Headlines

Headlines

- **Patient and Carer Experience** no significant change, with patient and carer experience above standard and carer experience below standard
- **Inpatients Feeling Safe** special cause concern and below standard
- **CYP Outcomes** no significant change in PROM and below standard; special cause improvement for CROM and achieving standard
- **AMH / MHSOP Outcomes** special cause concern and below standard for PROM and special cause improvement for CROM
  Bed Pressures no significant change in bed occupancy and below the mean; OAPs special cause improvement
  Patient Safety / Incidents no significant change across all measures
- **Staff** special cause improvement for leavers. Sickness is no significant change with an increasing trend No significant change in M&S training or appraisal however decreasing trend
- **Demand** no significant change in referrals; common cause in caseload
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues*

Of most concern:

- AMH/MHSOP PROM
- Appraisals
- Financial Plan: Surplus/Deficit
- Financial Plan: Agency expenditure
- Agency price cap compliance
- CRES Performance – Recurrent

Positive Assurance

Improvement seen in:

- CYP PROM & CROM
- AMH/MHSOP CROM
- Bed Occupancy/Inappropriate OAP
- Incidents of moderate or severe harm
- Unexpected Inpatient unnatural deaths
- Staff Leaver Rate

Mitigations

We are continuing to work on the Performance Improvement Plans (PIP) in the following areas to ensure they include SMART actions that support improvement:

- AMH/MHSOP PROMS and CROMS
- Bed Pressures
- Caseload (AMH)

<u>Trust-wide</u>

- Mandatory Training
- Appraisal

Finance – we have provided assurance to the ICB that the financial plan will be delivered (breakeven) with control totals now set. The Trust will monitor adherence to control totals to manage risk and provide mitigations.

Performance & Controls Assurance Overview

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Controls Assurance Rating	Performance Assurance Rating				
		Substantial	Good	Reasonable	Limited
	Positive		• CYP showing measurable improvement following treatment - clinician reported **reduced performance assurance* • Staff Leaver Rate • CRES Performance – Non-Recurrent		
	Neutral		• 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 • Serious Incidents reported on STEIS • Incidents of moderate or severe harm **increased performance assurance* • Medication Errors with a severity of moderate harm and above • Unexpected Inpatient unnatural deaths reported on STEIS • Uses of the Mental Health Act • New unique patients referred **increased performance assurance*	• CYP showing measurable improvement following treatment - patient reported • Bed Occupancy (AMH & MHSOP A & T Wards) • Inappropriate OAP bed days for adults that are 'external' to the sending provider • Staff recommending the Trust as a place to work • Staff feeling they are able to make improvements happen in their area of work • Percentage Sickness Absence Rate **reduced performance and controls assurance* • Compliance with ALL mandatory and statutory training • Use of Resources Rating - overall score • 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 • Staff in post with a current appraisal **reduced controls assurance* • Financial Plan: SOCI - Final Accounts - Surplus/Deficit • Financial Plan: Agency expenditure compared to agency target • Capital Expenditure (Capital Allocation) **reduced controls assurance*	• Unique Caseload (snapshot) • Agency price cap compliance • CRES Performance - Recurrent

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)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC			92.00%	92.02%	92.00%
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%	75.62%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L		75.00%	53.96%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	24.18%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	45.14%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	46.46%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	19.71%	30.00%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC				98.96%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC				671	
10)	The number of Serious Incidents reported on STEIS	QAC				109	
11)	The number of Incidents of moderate or severe harm	QAC				540	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				14	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				3	
15)	The number of uses of the Mental Health Act	MHLC				3,044	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D				54.12% (Jul - 2023)	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				61.95% (Jul - 2023)	
18)	Staff Leaver Rate	PC&D	L			11.48%	
19)	Percentage Sickness Absence Rate (month behind)	PC&D				5.81%	
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D			85.00%	85.36%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	L		85.00%	77.68%	85.00%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				76,285
23)	Unique Caseload (snapshot)	S&RC	H			64,897

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	5,531,242	4,700,532
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	15,156,000	13,804,385
25b)	Agency price cap compliance	S&RC	100.00%	61.61%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	10,566,000	6,269,000
28)	CRES Performance - Non-Recurrent	S&RC	1,056,000	5,349,151
29)	Capital Expenditure (CDEL)	S&RC	11,914,000	8,469,989
30)	Cash against plan	S&RC	61,877,000	63,981,352

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

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Background / Standard description:
We are aiming for 92% of patients surveyed, reporting their recent experience as very good or good

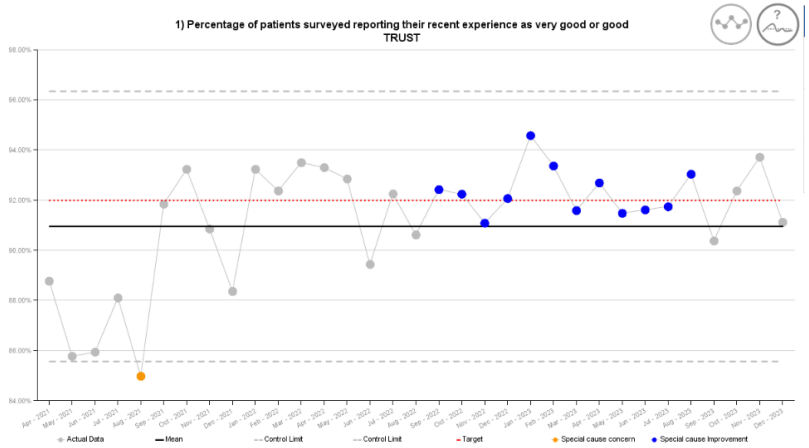
What does the chart show/context:
During December **1115** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **91.12% (1016)** scored "very good" or "good".

There is no significant change at Trust/Care Group level in the reporting period; however, we are showing special case improvement (an increase) in the number of patients who have responded to this question.

The latest National Benchmarking data (October 2023) shows the England average (including Independent Sector Providers) was 87% and we were ranked 16 in the list of providers. We were also ranked highest for the total number of responses received.

Underlying issues:
There are no underlying issues to report.

Actions:
- The Patient & Carer Experience Group are going to consider how a patient or carer could understand the performance of each individual team and what key 5 things they might look for (by end of April 2024)



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

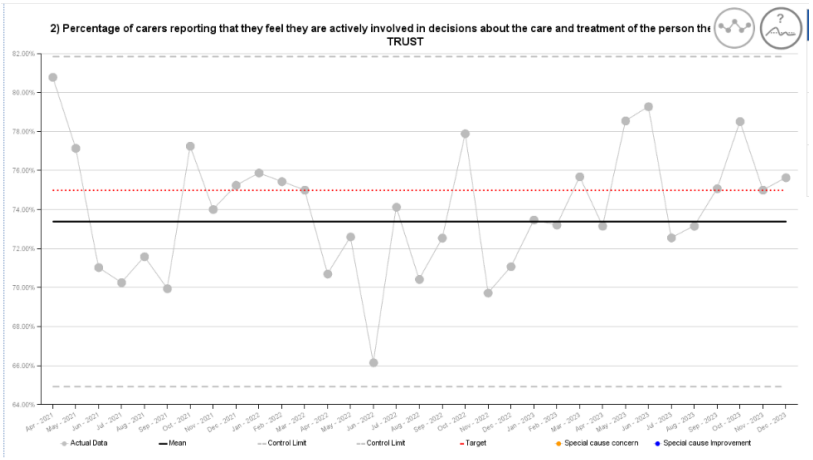
Background / standard description:
We are aiming for 75% of carers reporting, they feel they are actively involved in decisions about the care and treatment of the person they care for

What does the chart show/context:
During December, **353** 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, **267 (75.64%)** scored "yes, always".

There is no significant change at Trust/Care Group level in the reporting period; however, we are showing special cause improvement (an increase) in the number of carers who have responded to the question.

Underlying issues:
- Engagement with various patient groups (e.g. Secure Inpatient Services)
- Barriers to collecting feedback include:
  - Access to and up to date surveys through the various mechanisms
  - Up to date carer and team information
  - Lack of feedback including display of feedback

Actions:
- The barriers to collecting feedback have been shared with the General Managers and the Service Improvement and Delivery Groups to follow up
- The Patient & Carer Experience Team are working with the Recovery College to develop an e-learning package to deliver the Carer Awareness training and are continuing to deliver face to face training with an increased number of sessions



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 75% of inpatients reporting, they feel safe whilst in our care

What does the chart show/context:
During December, **144** patients responded to the overall experience question in the patient survey: Question: "During your stay, did you feel safe?". Of those, **85 (59.03%)** scored "yes, always".

There is special cause concern (low performance) at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period. There is also no significant change in the number of inpatient who have responded to the question.

Underlying issues:
- There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients, environment.
- Self Harm in inpatient settings can cause other patients to feel unsafe

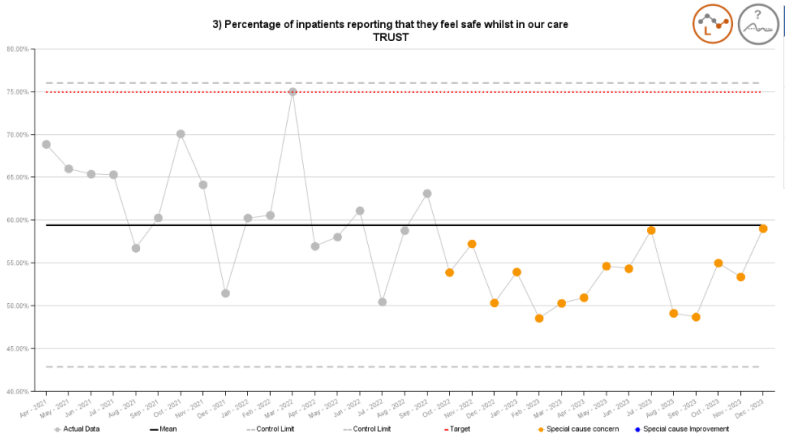
Actions:
- Durham Tees Valley & Forensic Care Group are continuing to work on their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement.
- The Consultant Clinical Psychologist for AMH services in Durham and Tees Valley is undertaking a self harm review/pilot work across all Trust Adult Mental Health wards including PICUs (January 2024).
- The Patient & Carer Experience Team are revisiting the benchmarking work previously undertaken to understand how we compare to other organisations and identify any key learning that can be taken forward within the Trust (by the end of January 2024).

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

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

DQ 87%

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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 35% of CYP showing measurable improvement following treatment - patient reported

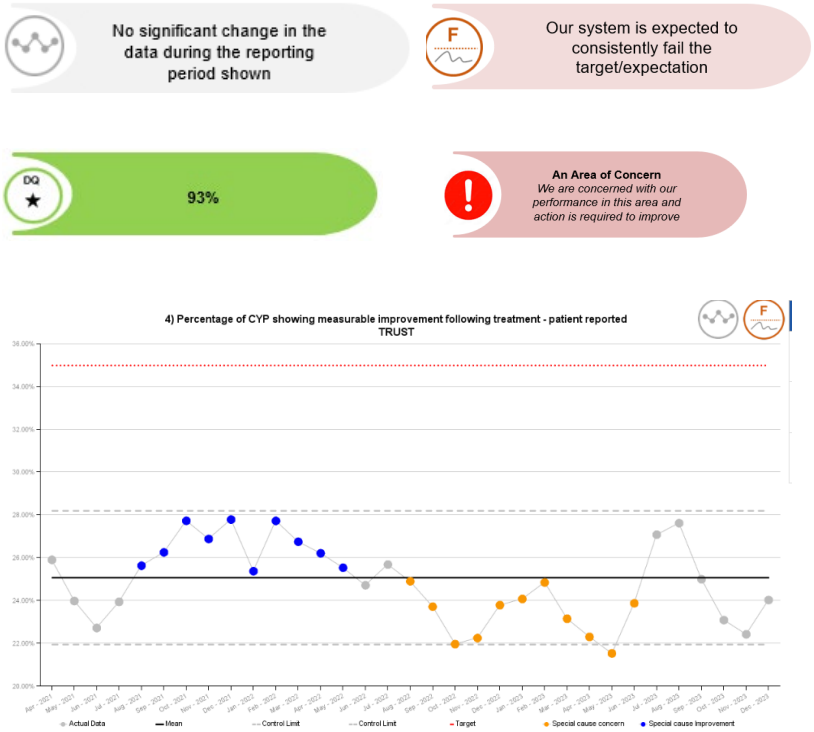
What does the chart show/context:
For the 3-month rolling period ending December **695** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 167 (24.03%)** made a measurable improvement.

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

There is no significant change at Trust level in the reporting period; however, there is special cause concern (low performance) within Durham Tees Valley and Forensic Care Group and special cause improvement (high performance) in North Yorkshire, York & Selby Care Group.

Underlying issues:
- This measure currently doesn't include Parent Rated outcomes (which is valid) or some of the newer assessment tools

Actions:
- Durham Tees Valley & Forensic Care Group are continuing to work on their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement.
- The CYP Speciality Development Manager has submitted a paper to update the measure to the CAMHS Clinical Network Group and the Clinical Outcomes Steering Group (both approved) which will now go to Management Group in January for final approval.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 55% of Adults and Older Persons showing measurable improvement following treatment - patient reported

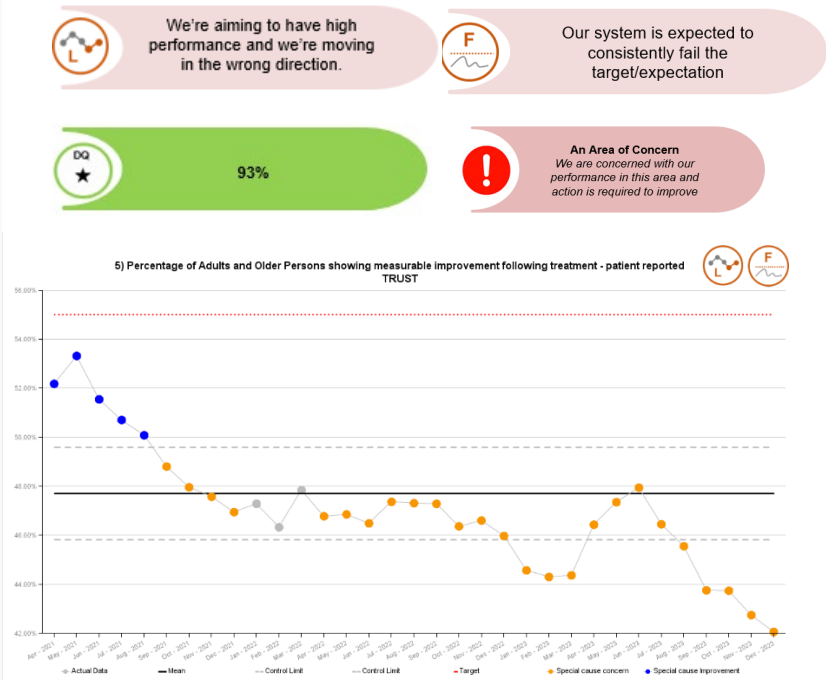
What does the chart show/context:
For the 3-month rolling period ending December **1928** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 811 (42.06%)** made a measurable improvement.

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

There is special cause concern (low performance) at Trust level and for both Care Groups in the reporting period. Special cause concern is in relation to AMH services in both Care Groups.

Underlying issues:
- Timeliness and frequency of completing outcomes is impacting

Actions:
- General Managers for Durham and Tees Valley Adults and Older Persons services to undertake a deep dive into the data by the 31st January 2024 to identify specific areas of concern and required improvement.
- North Yorkshire, York & Selby Care Group are continuing to work on their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement.
- Durham, Tees Valley & Forensic Care Group are developing a Performance Improvement Plan (PIP) to support improvement in this area which will be submitted to their Care Group Board in February 2024.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 50% of CYP showing measurable improvement following treatment - clinician reported

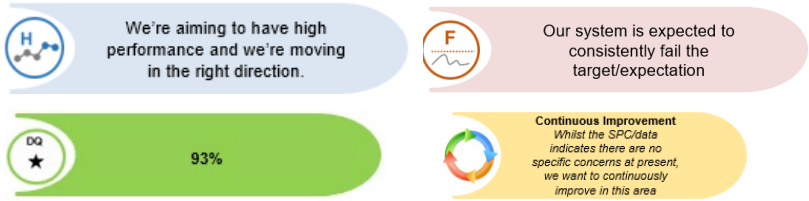
What does the chart show/context:
For the 3-month rolling period ending December **785** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 387 (49.30%)** made a measurable improvement.

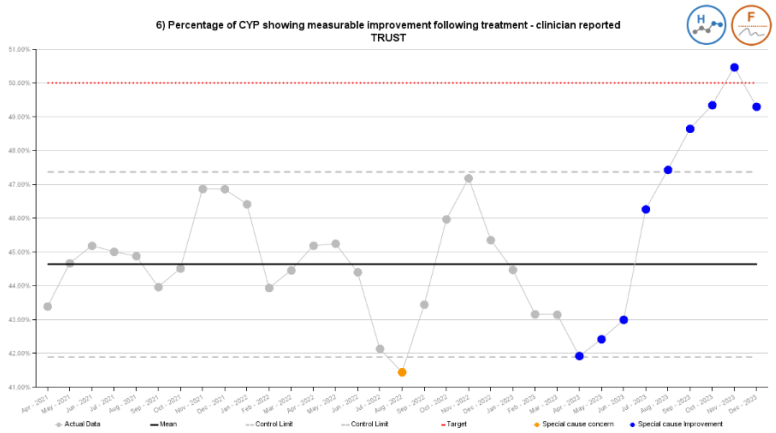
The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

There is special cause improvement (high performance) at Trust level and for North Yorkshire, York & Selby Care Group in the reporting period. There is no significant change in Durham, Tees Valley & Forensic Care Group.

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required





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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 30% of Adults and Older Persons showing measurable improvement following treatment - clinician reported

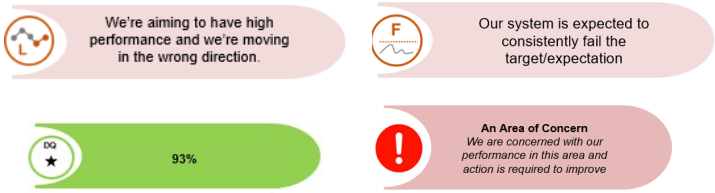
What does the chart show/context:
For the 3-month rolling period ending December **3256** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 621 (19.07%)** made a measurable improvement.

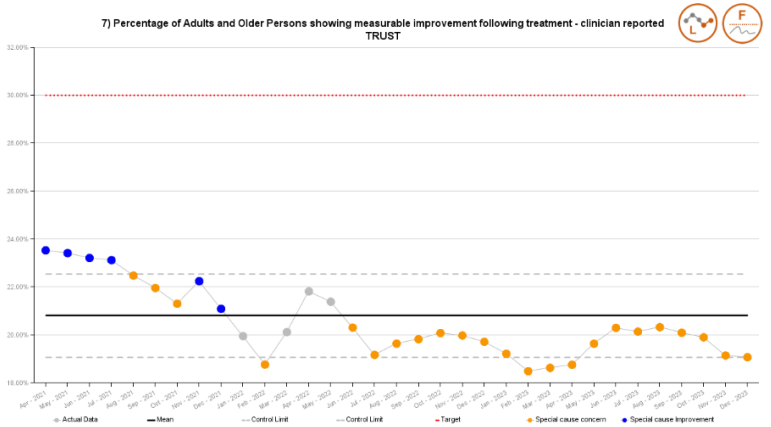
The accepted Patient Rated Outcome Measure is Health of the Nation Outcome Scales (HoNOS).

There is special cause concern (low performance) at Trust level and for Durham, Tees Valley & Forensic Care Group (AMH and MHSOP services) in the reporting period. However, it should be noted that that there is special cause improvement (high performance) for North Yorkshire, York & Selby Care Group.

Underlying issues:
- Timeliness and frequency of completing outcomes is impacting

Actions:
- General Managers for Durham and Tees Valley Adults and Older Persons services to undertake a deep dive into the data by the 31st January 2024 to identify specific areas of concern and required improvement.
- North Yorkshire, York & Selby Care Group are continuing to work on their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement.
- Durham, Tees Valley & Forensic Care Group are developing a Performance Improvement Plan (PIP) to support improvement in this area which will be submitted to their Care Group Board in February 2024.





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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
During December, **10,850** daily beds were available for patients; of those, **10,326 (95.17%)** were occupied. Overall occupancy <u>including</u> independent sector beds was **96.29%.**

There is no significant change at Trust level or for both Care Groups in the reporting period; however, there is special cause concern (poor performance) in AMH services within Durham, Tees Valley & Forensic Care Group. Special cause improvement (good performance) is noted in MHSOP within Durham, Tees Valley & Forensic Care Group

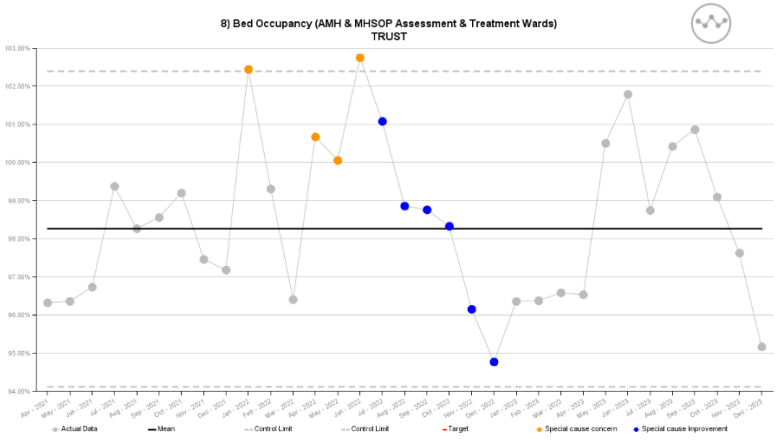
Underlying issues:
- Clinically Ready for Discharge – specifically around accommodation
- Patient flow and adherence to PIPA process
- Length of stay (linked to above issues)
- Greenlight admissions
- Ministry of Justice (MoJ) patients

Actions:
Both Care Groups are continuing to work on their Performance Improvement Plan (PIP) to ensure they include SMART actions that support improvement.

No significant change in the data during the reporting period shown

DQ 87%

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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming to have no more than 153 out of area bed days by 31st December 2023 and no more than 60 by the 31st March 2024. This is also the Mental Health Priority monitored at Trust level.

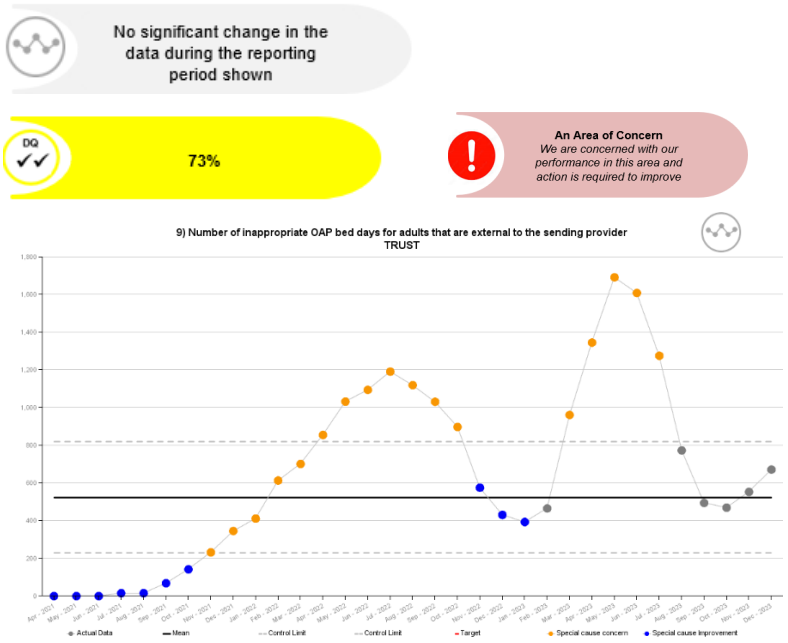
What does the chart show/context:
For the 3-month rolling period ending December **671** days were spent by patients in beds away from their closest hospital.

There is no significant change at Trust level in the reporting period; however, there is special cause concern (poor performance) for Durham, Tees Valley & Forensic Care Group (AMH services). This correlates with bed occupancy in AMH services for this Care Group. It should be noted, however that there is special cause improvement (good performance) in the North Yorkshire, York & Selby Care Group.

Performance against the trajectories agreed with the ICBs is shown in the **additional table below**. We are significantly exceeding the agreed number of OAP bed days.

Underlying issues:
Bed Occupancy is impacting on our ability to admit patients to our beds

Actions:
See measure 8) Bed Occupancy



ICB Trajectories versus actual performance

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		Quarter 3 23/24		Quarter 4 23/24	
	Ambition	Actual	Ambition	Actual	Ambition	Actual	Ambition	Actual
Trust	334	1608	246	494	153	671	60	
North East & North Cumbria ICB	334	1445	246	436	153	608	60	
Humber & North Yorkshire ICB	0	163	0	58	0	63	0	

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
8 serious incidents were reported on the Strategic Executive Information System (STEIS) during December; however, the chart is only showing 7 which is being investigated.

There is no significant change at Trust/Care Group in the reporting period.

Each incident has been subject to an after-action review/early learning by services and then reviewed within the Patient Safety huddle.

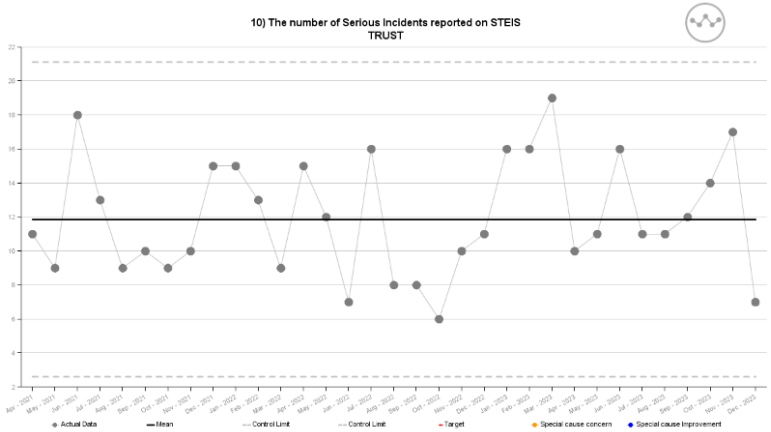
Underlying issues:
We have identified a specific team within AMH Services in North Yorkshire, York & Selby Care Group that have had several Serious Incidents. The Care Group are well sighted on the issues and have a robust action plan in place.

Actions:
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.

No significant change in the data during the reporting period shown

DQ 87%

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



To note:
Whilst we know the incident data recorded in InPhase is accurately reported through IIC, there are areas where data quality can be improved, which is to be expected following a transfer to a new recording system. With InPhase the visibility of some of the areas of poor quality in incident records has become more visible, therefore we have agreed several actions to support improvement in the quality of the incident data recorded:
- Additional communications have been sent via the weekly briefing and included in a weekly InPhase Weekly Newsletter circulated to key staff groups.
- We have set up a weekly group with key corporate stakeholders, who will identify through their reporting processes, any key areas of concerns and actions needed to improve the quality of data.
- The full roll-out of local incident review is now in place; however, as this process is new to some areas, additional support is being provided and we expect the quality of data to improve as the new processes are fully embedded. In addition, as part of the ongoing review of incidents, the relevant specialists and Central Team will continue to pick up areas of poor-quality reporting, and these will be addressed on an ongoing basis.

11) The number of Incidents of moderate or severe harm

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the chart show/context:
67 incidents of moderate or severe harm were reported during December.

There is no significant change at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period. It should be noted that there is special cause improvement (low) for the North Yorkshire, York & Selby Care Group.

Each incident has been subject to an after-action review/early learning by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

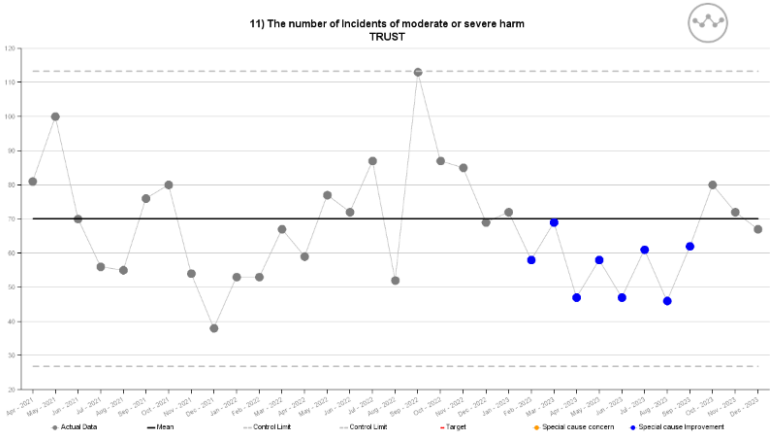
Underlying issues:
- As incidents are reviewed, the severity could be reduced or increased (early indications are that severity is usually reduced).
- We have identified a small number of females within Adult Mental Health Inpatient Services whose presentation during December has contributed to the increase in Durham Tees Valley & Forensic Care Group reported figures.

Actions:
- In line with Patient Safety Incident Response Framework (launch 29th January 2024) the Care Groups' process for completing after-action review/early learning reviews will be through a Multi-Disciplinary Team (MDT) approach.
- The learning from all incidents will be pulled together and themed by the Patient Safety Team and shared monthly with the Organisational learning Group
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.

No significant change in the data during the reporting period shown

DQ
80%

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



To note:
Whilst we know the incident data recorded in InPhase is accurately reported through IIC, there are areas where data quality can be improved, which is to be expected following a transfer to a new recording system. With InPhase the visibility of some of the areas of poor quality in incident records has become more visible, therefore we have agreed several actions to support improvement in the quality of the incident data recorded:
- Additional communications have been sent via the weekly briefing and included in a weekly InPhase Weekly Newsletter circulated to key staff groups.
- We have set up a weekly group with key corporate stakeholders, who will identify through their reporting processes, any key areas of concerns and actions needed to improve the quality of data.
- The full roll-out of local incident review is now in place; however, as this process is new to some areas, additional support is being provided and we expect the quality of data to improve as the new processes are fully embedded. In addition, as part of the ongoing review of incidents, the relevant specialists and Central Team will continue to pick up areas of poor-quality reporting, and these will be addressed on an ongoing basis.

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:
As reported previously, we moved to the national LFPSE reporting system in line with national requirements on 30th October 2023, which results in all patient safety incidents reported being directly reported into the national system and subsequent reporting. To do this we replaced our incident recording and management system with InPhase (replacing Datix)

To date, in the Board IPD, we have reported "The number of Restrictive Intervention Incidents"; however, following the change in national requirements, we have identified it is not possible to have a direct match across the two different systems. InPhase now records a "Patient Safety Event" in line with LFPSE requirements, which can have multiple patients and multiple types of Restrictive Interventions used whereas, DATIX recorded a Patient Safety Incident, where 1 incident equated to 1 patient however, it can also record where multiple types of Restrictive Interventions are used.

Following discussion with key staff, we are recommending a new measure "The number of Restrictive Interventions used" replace the existing measure in the Board IPD. We feel this is a key measure for Board to have oversight of and is also a measure CQC focus on.

This recommendation has been approved by the Chief Nurse and is pending Quality Assurance Committee approval at its next meeting, early February 2024.

To Note:
Oversight and assurance regarding restrictive practice and the various types used is managed through the Executive Review of Quality and into Quality Assurance Committee and this is reported by the chair to the Board through the Chair's report from the Committee.

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

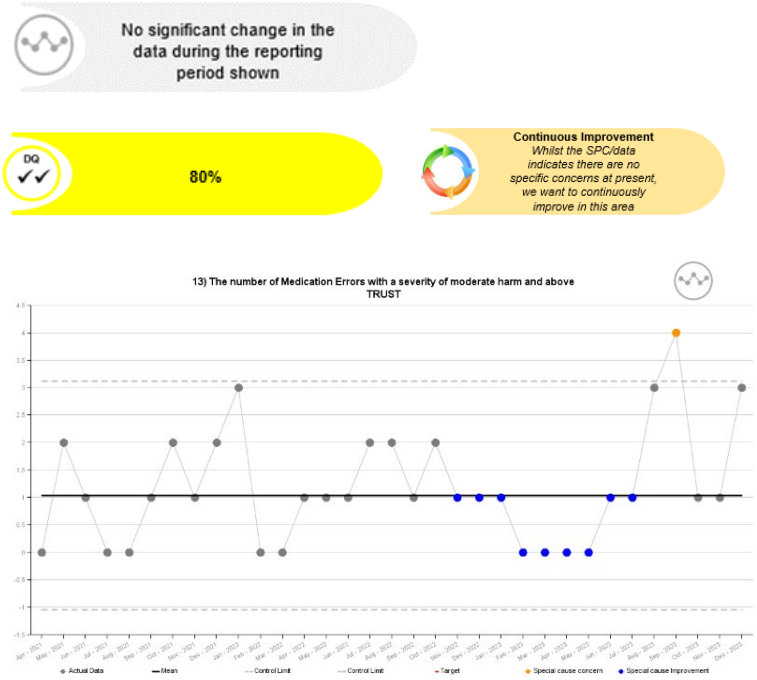
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
3 medication errors were recorded with a severity of moderate harm, severe or death during December.

There is no significant change at Trust/Care Group in the reporting period.

Underlying issues:
EPMA (electronic prescribing & medicines administration) will enable more timely prescribing and administration of medication to patients and will reduce the risk of errors once embedded.

Actions:
The roll out of EPMA for inpatients was completed on the 16th January 2024 with the final ward go live (NB. respite units are out of scope). During Q4 23/24 we will complete the Project Initiation Document for the community roll out which will begin early 24/25.



To note:
Whilst we know the incident data recorded in InPhase is accurately reported through IIC, there are areas where data quality can be improved, which is to be expected following a transfer to a new recording system. With InPhase the visibility of some of the areas of poor quality in incident records has become more visible, therefore we have agreed several actions to support improvement in the quality of the incident data recorded:

- Additional communications have been sent via the weekly briefing and included in a weekly InPhase Weekly Newsletter circulated to key staff groups.
- We have set up a weekly group with key corporate stakeholders, who will identify through their reporting processes, any key areas of concerns and actions needed to improve the quality of data.
- The full roll-out of local incident review is now in place; however, as this process is new to some areas, additional support is being provided and we expect the quality of data to improve as the new processes are fully embedded. In addition, as part of the ongoing review of incidents, the relevant specialists and Central Team will continue to pick up areas of poor-quality reporting, and these will be addressed on an ongoing basis.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
0 unexpected Inpatient unnatural deaths were reported on the Strategic Executive Information System (STEIS) during December.
**This has been confirmed by the Patient Safety Team based on a manual check.*

Since April 2023, there have been 3 unexpected Inpatient unnatural deaths however none of these have any signs of deliberate self-harm.

Update:
In October's IPR we noted there had been a third death which was expected to be attributed to natural causes (therefore was not included in the data), this has now been confirmed.

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required

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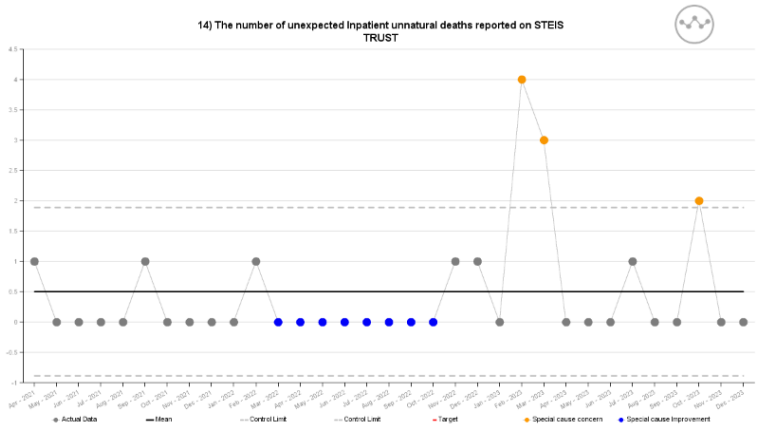
No significant change in the data during the reporting period shown

DQ 87%

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



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **326** uses of the Mental Health Act during December.

There is no significant change at Trust/Care Group in the reporting period. However, it should be noted that special cause improvement continues (a decrease) within Adult Learning Disability Services in both care groups and within Secure Inpatient Services.

Underlying issues:
There are no underlying issues to report

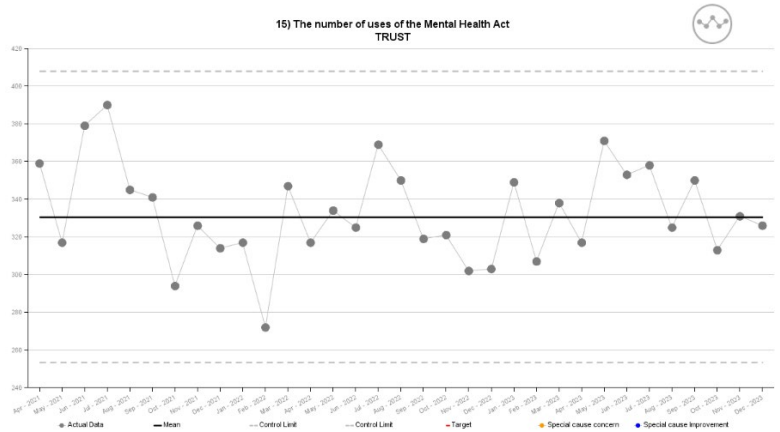
Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ

73%

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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
1276 staff responded to the July 2023 Pulse Survey question "I would recommend my organisation as a place to work" Of those, **702 (55.02%)** responded either "Strongly Agree" or "Agree".

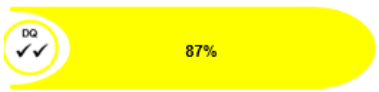
Whilst we have limited data in this area, the line chart demonstrates there is no significant change in the reporting period.

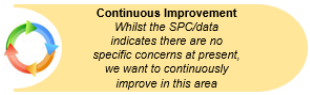
The latest survey (October 2023) was the annual National Staff Survey undertaken by Picker. Picker will provide us with our data in December 2023; however, these results will be under embargoed until March 2024.

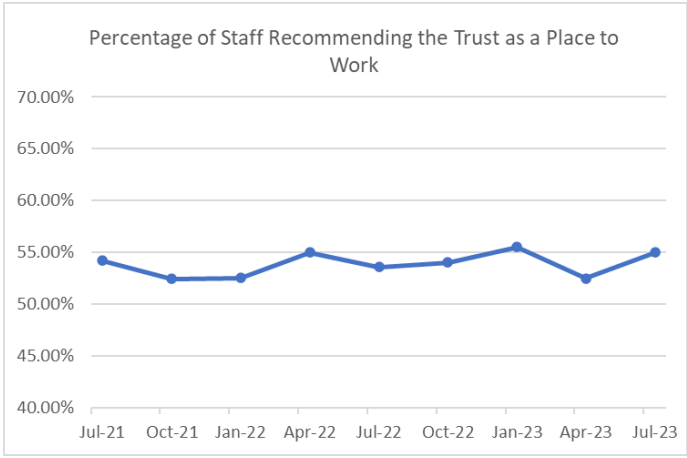
**Please note the survey is only undertaken once a quarter*

Underlying issues:
We currently have limited data on the percentage of staff recommending the Trust as a place to work.

Actions:
Whilst we don't have a specific improvement action; we do have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews/focus groups and a wide range of career development opportunities.







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

What does the chart show/context:
1276 staff responded to the July 2023 Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **791 (61.99%)** responded either "Strongly Agree" or "Agree".

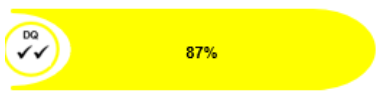
Whilst we have limited data in this area, the line chart demonstrates a slight improvement in the reporting period.

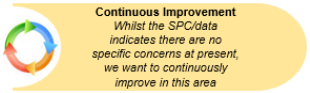
The latest survey (October 2023) was the annual National Staff Survey undertaken by Picker. Picker will provide us with our data in December 2023; however, these results will be under embargoed until March 2024.

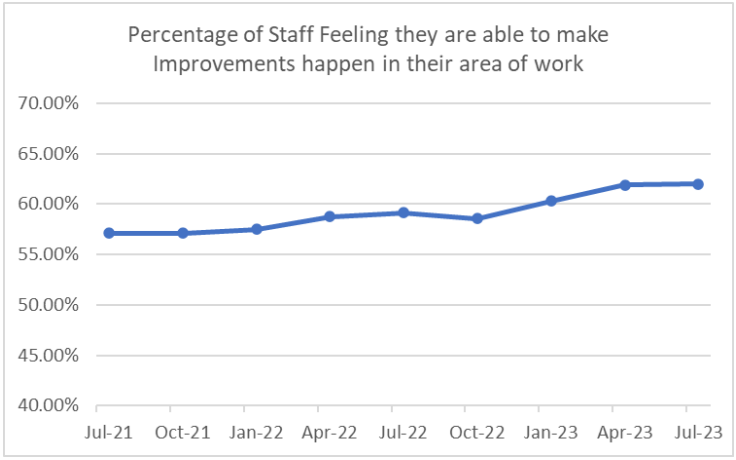
**Please note the survey is only undertaken once a quarter*

Underlying issues:
We currently have limited data on the percentage of staff feeling they are able to make improvements happen in their area of work.

Actions:
- The Trust has embarked on a 5-year (November 2027) stepped approach to Quality Improvement (QI) Training support staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements.
- Our Journey To Change focuses on our cultural development through a wide range of engagement, communication and learning opportunities to enable and empower our staff to make changes in their area of work.







18) Staff Leaver Rate

What does the chart show/context:
From a total of **6,564.71** staff in post, **753.96 (11.48%)** had left the Trust in the 12-month period ending December.

There is special cause improvement (low) at Trust level and for several areas in the reporting period. However, there are 4 areas (Assistant Chief Executive, Digital and Data Services, Nursing and Governance and People and Culture) are showing special cause concern (high) in the reporting period.

The latest (September 2023) National Benchmarking for NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked 10 (previously ranked 8 this financial year) 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.

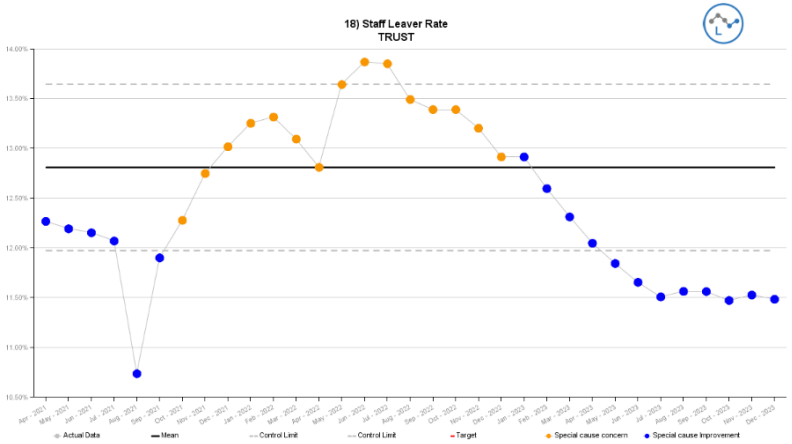
Underlying issues:
- Staff wanting a new challenge
- Role not being as expected
- Work-life balance

Actions:
- The Associate Director of Operational Delivery & Resourcing will facilitate the launch of the next Internal Transfer scheme by the end of January 2024, with a view to supporting internal transfers and reducing challenges in staff retention.
- We have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews and a wide range of career development opportunities.

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

DQ ✓✓ 80%

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



19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **222,237.69** working days available for all staff during October (reported month behind); of those, 14,314 **(6.44%)** days were lost due to sickness.

There is no significant change at Trust level and for 5 areas in the reporting period, with a further 5 areas showing special cause improvement (low). However, AMH Services in North Yorkshire, York & Selby, People & Culture and Therapies are all showing special cause concern (high) in the reporting period.

National Benchmarking for NHS Sickness Absence Rates published 4th January 2024 (data ending August 2023) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.46%** compared to the Trust mean of **5.89%.**

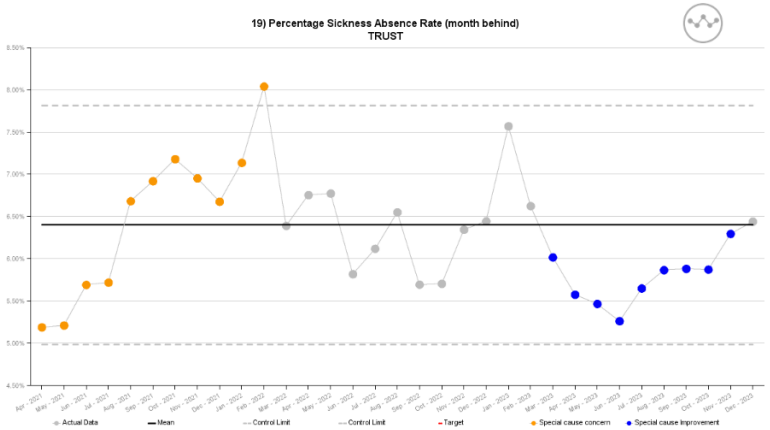
Underlying issues:
Anxiety/stress is the main reason of sickness absence

Actions:
People & Culture are focusing on the health, wellbeing and resilience of our staff. This includes flexible working opportunities, Employee Support Services, Employee Psychological services and Health & Wellbeing Champions. There is also an engagement programme including monthly health and wellbeing meetings, guest speakers and newsletters for staff.

No significant change in the data during the reporting period shown

DQ ✓✓ 87%

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



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20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 85% compliance with mandatory and statutory training

What does the chart show/context:
182,342 training courses were due to be completed for all staff in post by the end of December. Of those, **155,655** (**85.36%**) were completed.

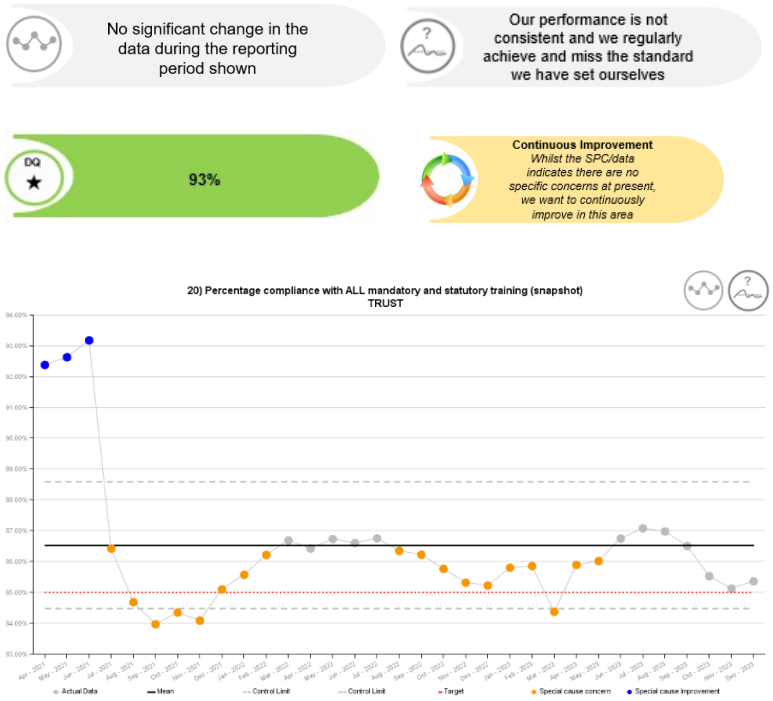
There is no significant change at Trust level and for most areas in the reporting period; however, 3 areas (Digital and Data, Estates and Facilities Management and Medical) are showing cause for concern (low performance) in their mandatory training levels. Cause for concern is also noted in AMH, CYP, Health & Justice and Management within Durham, Tees Valley & Forensic Care Group and AMH services in North Yorkshire, York & Selby Care Group.

As at the 9th January 2024 , by exception, **non-compliance** by area as follows:

- Nursing and Governance - 78.79%
- Corporate Affairs and Involvement- 82.44%
- Medical - 83.64%
- North Yorkshire, York and Selby - 84.15%
- Therapies- 84.53%

Underlying issues:
- Staff unable to be released to attend training (high DNA rate)
- Staff double booking courses which reduces availability
- Lack of capacity for Positive & Safe training courses
- Lack of suitable training rooms

Actions:
- People & Culture are continuing to work on their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement.
- Training Department are actively following up all staff who DNA and identifying and rectifying where staff double book on courses to increase availability
- Positive & Safe training Level 1 will change from 1st February 2024 with the requirement to be every 2 years
- The training portfolio for Positive & Safe is being reviewed currently with a potential implementation date of April 2024.
- We are constantly reviewing the availability of training rooms across trust premises.



20) Percentage compliance with ALL mandatory and statutory training – Supporting Information

Tees, Esk and Wear Valleys NHS Foundation Trust

Information Governance & Data Security Training

Background / standard description:
We are aiming for 95% compliance for Information Governance & Data Security Training (as required by the Data Security and Protection Tool Kit) by the end of March 2024

What does the data show/context:
7770 were due to be completed by the end of December. Of those, **6870 (88.42%)** were completed.

As at the 9th January 2024 , by exception, **non-compliance** as follows:

- Corporate Affairs And Involvement - 81.58%
- Medical - 86.10%
- North Yorkshire, York And Selby - 86.99%
- Durham, Tees Valley And Forensic - 88.04%
- Therapies - 88.11%
- Company Secretary - 90.91%
- Estates And Facilities Management- 92.31%
- Digital And Data Services - 92.53%
- Nursing And Governance - 93.69%
- People And Culture - 93.75%

Underlying issues:
- An improvement plan is in place with NHS England which includes a commitment to achieve the standard by the revised timescale of 31st March 2024.
- Our existing measure does not include all staff which is a requirement

Actions:
- All new starters are being contacted to ensure training is completed as part of the Trust Welcome/Induction
- The Business Intelligence Team will revise an existing measure to align it to NHS England's criteria by end of January 2024

All other mandatory and statutory training

As at the 9th January 2024 , by exception (below the 85% standard) are the following courses sorted by lowest performance:

1) Follow Up- 50.00%
2) Positive and Safe Care Level 1 Update*- 54.53%
3) Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year* - 62.93%
4) Rapid Tranquilisation 1 - 66.79%
5) Positive and Safe Care Level 2 Update* - 67.11%
6) Moving and Handling - Level 2 - 2 Years* - 67.83%
7) Face to Face Medication Assessment - 68.99%
8) Resuscitation - Level 1 - 1 Year* - 69.79%
9) Patient Safety Level 2 - 72.82%
10) Medicines Management Annual Module - 73.84%
11) Fire Safety - 2 Years** - 74.36%
12) Positive and Safe Care Level 1* - 75.90%
13) Resuscitation - Level 2 - Adult Basic Life Support - 1 Year* - 77.81%
14) MCA - MCA and Young People Aged 16/17 - 79.12%
15) Safeguarding Level 3** - 79.14%
16) Essentials for Patient Safety for Board L1 - 80.00%
17) Annual Medicines Optimisation Module- 80.08%
18) Rapid Tranquilisation 2 - 80.11%
19) Observation & Engagement - 81.10%
20) Infection Prevention and Control - Level 2 - 1 Year - 81.37%
21) LD & Autism Tier 1 E-Learning - 81.39%
22) Safe Prescribing - 81.61%
23) Controlled Drugs - Inpatient - 82.72%
24) Fire Safety - 1 Year - 84.02%
25) Mental Health Act Level 2 - 84.06%

*Indicates face to face learning ** face or face via MST

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 85% of staff in post with a current appraisal

What does the chart show/context:
Of the **6701** eligible staff in post at the end of December; **5205** (**77.68%)** had an up-to-date appraisal.

There is now special cause concern (low performance) at Trust level and for several areas in the reporting period; Estates and Facilities Management, Therapies, North Yorkshire, York & Selby Care Group (AMH Services) and AMH Services and CYP Services within Durham, Tees Valley & Forensic Care Group. However, there are several areas showing special cause improvement (high performance) which are Finance, Nursing & Governance and People & Culture and ALD Services within Durham Tees Valley & Forensic Care Group.

As at the 9th January 2024, by exception, **non-compliance** by area as follows:

- Therapies - 53.66%
- Company Secretary- 55.56%
- Capital Programme -62.50%
- Corporate Affairs & Involvement - 65.71%
- Trust-wide roles - 66.67%
- Medical- 68.21%
- Digital & Data Services - 69.14%
- Durham, Tees Valley & Forensic - 77.28%
- Nursing & Governance - 78.72%
- North Yorkshire, York & Selby -79.16%
- People & Culture - 82.22%
- Estates & Facilities Management - 82.50%
- Assistant Chief Executive - 84.38%

Underlying issues:
- Our new structured approach to high quality appraisal conversations through WorkPal is impacting
- WorkPal was down for 2 weeks in December 2023 which has impacted on the recording of some of our appraisal data (now available)

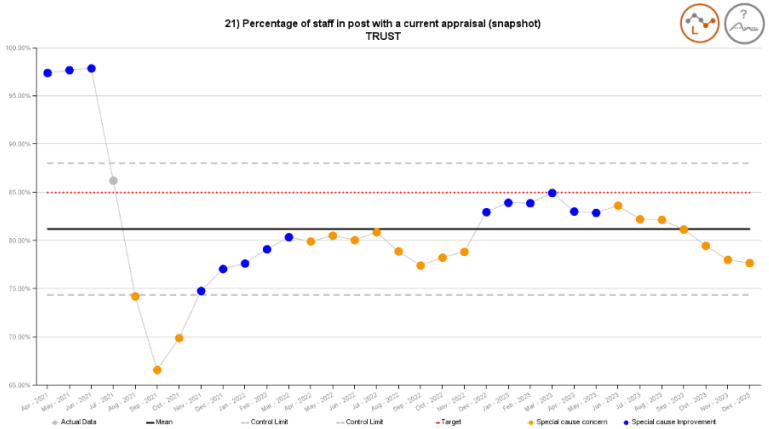
Actions:
- People & Culture are continuing to work on their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement.

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

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

DQ 87%

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



Actions continued:
- The new Programme Lead for WorkPal is undertaking a targeted piece of work in Estates and Facilities Management to support them using WorkPal.
- A plan on a page for completing appraisals is being developed (January 2024)
- Appraisal training is planned from March 2024 (post CITO) for both managers and staff (appraiser and appraisee)
- Ongoing communications brief to all staff not registered on WorkPal as a reminder

22) Number of new unique patients referred

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the chart show/context:
7364 patients referred in December that are not currently open to an existing Trust service.

There is no significant change at Trust/Care Group in the reporting period; however, there is special cause concern in AMH services within North Yorkshire, York & Selby Care Group(low referrals).

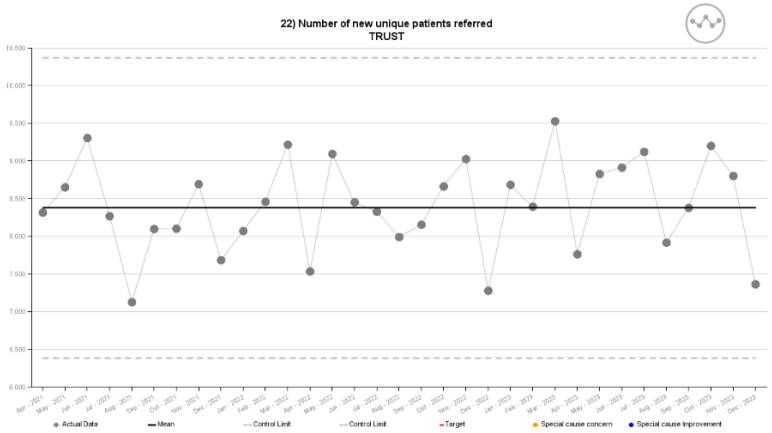
Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ ★ 93%

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



23) Unique Caseload (snapshot)

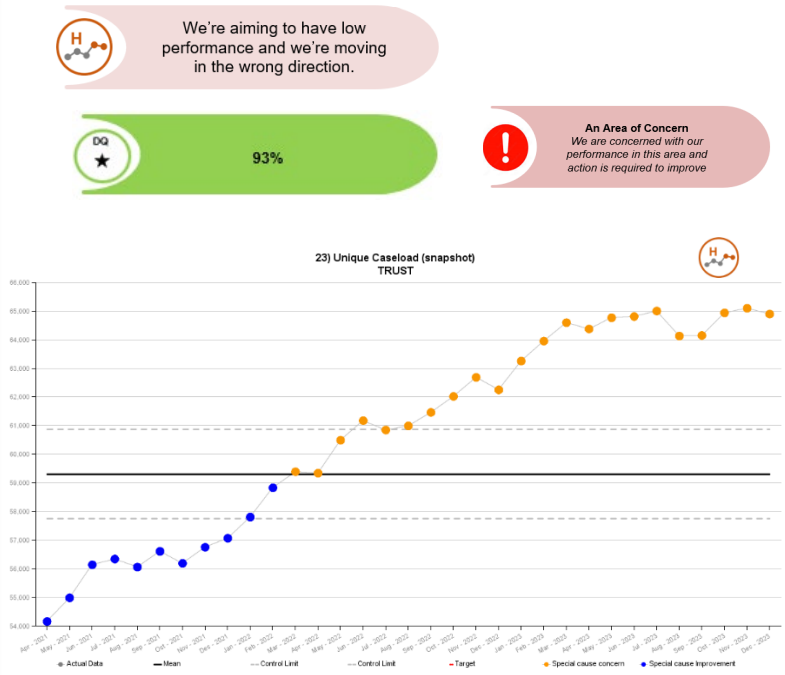
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
64,897 cases were open, including those waiting to be seen, as at the end of December 2023.

There is special cause concern (high) at Trust and for Durham Tees Valley and Forensic Care Group (CYP and AMH services) in the reporting period. There is also special cause concern in CYP and MHSOP services within North Yorkshire, York & Selby Care Group.

Underlying issues:
- An increase in referrals in CYP services for neuro diverse patients across both Care Groups
- An increase in referrals in AMH services within DTVF for neuro diverse patients
- Increase in referrals has led to a backlog of waiters, whilst referrals have levelled, they are higher than they used to be

Actions:
- Both Care Groups are continuing to work on their Performance Improvement Plan (PIP) to ensure they include SMART actions that support improvement.
- We have set up a Task & Finish Group within Corporate Services to triangulate key measures/data that relate to caseload so we can better understand the issues and how we support improvement. First meeting is late January 2024.



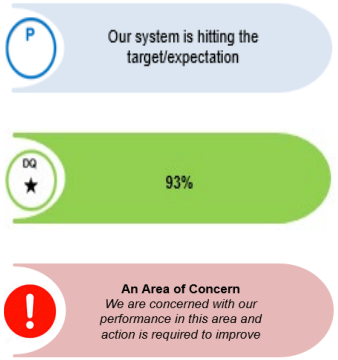
24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
The financial position to 31st December 2023 is an operational deficit of **£4.70m** against a planned year to date deficit of **£5.53m**, resulting in a **(£0.83m)** favourable plan variance. This includes £2.3m national funding for 2023/24 pressures reported in Month 8 and provided to support delivery of key operational priorities in the remaining months. The Trust reforecast the position at Month 7, using this as the basis to establish 'control totals' for Care Groups and Directorates for each month to year end. The control total for M9 was an in-month deficit of £1.20m compared to an actual deficit of £1.17m, or a (£0.03m) favourable variance to control total in month. The cumulative variance to control total at Month 9 is £0.23m adverse.

- **Agency expenditure** in December 2023 was £1.09m, or £0.43m below plan in month, and £13.81m, or £1.22m below plan to date, showing an improved favourable variance trend. This includes impacts from actions to exit non-clinical agency assignments and reducing costs relating to complex care packages. Ongoing usage includes material costs linked to inpatient occupancy and rosters, medical cover and costs within Health and Justice. The trust had **no off-framework agency assignments** in month.
- **Independent sector beds** - the Trust used 204 non-Trust bed days in month (286 in November, or an 82 bed day reduction) at a cost of £0.18m (including estimates for unvalidated periods of occupancy and average observation levels pending billing). Year to date costs were £2.45m (£2.27m prior month) and £1.39m more than the £1.06m year to date plan. This remains a key area of clinical and management focus including through the new Urgent Care Programme Board (chaired by the Managing Director for DTVF).
- **Taxis and Secure Patient Transport** cost £2.01m to December, or £0.80m more than plan. A quality improvement event identified grip and control recommendations as well as alternative options. The results, and need for additional Care Group action, are being closely monitored. The Chief Nurse is overseeing actions to ensure robust governance around Secure Transport and a recently approved procurement will reduce unit costs going forward, the benefit of this is being assessed.
- **Planned CRES** are £4.02m behind plan to date. Key adverse 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 £4.02m** to date (including interest receivable, with an interest rate at 5.2% for the past two months) are fully mitigating adverse performance against planned schemes. Composite CRES achievement is therefore in line with plan to the end of December but with a recurrent underlying risk to delivery.

The Trust provided assurance to NHSE at the end of December that the breakeven financial plan will be delivered, and established control totals for Care Groups / directorates based on this forecast with recovery actions modelled centrally. Care Groups and Directorates are monitoring compliance against control totals with the requirement to manage risk and variation to control totals.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Underlying issues:

- We need to reduce bed occupancy including through reduced lengths of stay to reduce reliance on independent sector beds.
- We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan.
- We need to deliver CRES schemes to achieve our financial plan and deliver recurrent programmes to address our underlying financial pressures.
- We need to continue to track delivery of our 2023/24 breakeven financial plan, including compared to the reforecast and control totals agreed in late November 2023.

Actions:

- Please see actions within measures - 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider.
- We are continuing to work on the Performance Improvement Plans (PIPs) for Agency and Safe Staffing to ensure they include SMART actions that support improvement.
- The CRES efficiency hub will be co-ordinated by a Programme Manager with recruitment underway. Terms of reference for the team / group are being established.
- Outputs from the CRES workshop will be co-ordinated by the CRES Support Team / efficiency hub once established and terms of reference agreed.
- Monthly variances to control totals will be monitored and an assessment made of the continued deliverability of our breakeven plan, including with reference to worst and best case, as well as the mid case scenario assumed.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
Agency expenditure for December 2023 was £1.09m, or £0.43m below plan, and £13.81m, or £1.22m below plan to date. This represents an improved favourable variance in month, including from actions to exit non-clinical agency and off-framework assignments.

NHS planning guidance introduced System agency cost caps of 3.7% of pay bill. As at Month 9 Trust agency expenditure represented 4.8% of pay bill (around 6% 2022/23. Planned agency costs for 2023/24 were relatively in line with 2022/23 outturn. Whilst levels have started to reduce from month 6 onwards, costs remain above the average percentage of pay bill system target. Reducing agency volume and premia is a key focus, including from actions to exit non-clinical assignments with a significant reduction observed from October onwards.

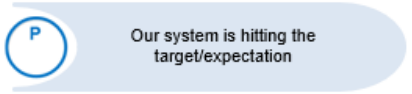
Previous regional reporting of sickness levels suggested peer mental health providers had experienced similar challenges. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence (sustained favourable reductions now being seen) but equally to net new recruitment (including to medical, qualified nursing, inpatient, and 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.

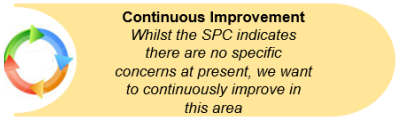
We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

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

Underlying issues:
We need to continue to ensure a sustainable permanent workforce, including in key shortage professions e.g. medical and nursing, and to use temporary staffing more optimally including through improved rostering.

Actions:
The Executive Workforce and Resources Group have the following actions to improve rostering:
- Outline clear governance flow in Care Groups related to how rosters are overseen, including specific information on roles and responsibilities (from January 2024)
- Look at central analysis of roster data to identify useful questions indicated by the data, with a view to providing areas of focus for discussion during live training (January 2024)
- Re-visit roster rules to ensure optimal rosters and equity for colleagues (December 2023) *Update expected at next meeting early February 2024*
- Develop roster training programme (from January 2024)





25b) Agency price cap compliance

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
2,782 agency shifts were worked in December 2023, with **1,714** shifts compliant **(62%)** and 1,068 non compliant (38%).

This is 93 fewer overall shifts than November which is equivalent to approximately 90 shifts per day (compared to 96 per day in November).

- Regional reporting of sickness levels suggested 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 (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.

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

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific additional improvement actions required, with actions from 25a) supporting delivery.

F — Our system is not hitting the target/expectation

DQ ✓✓ — 80%

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

26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:
The overall rating for the trust is a **3** for the period ending 31st December 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 0.69x, which is 0.13x better than plan and is **rated as a 4** (0.30x better than plan in November).
- 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 15.1 days; this is behind plan by 3.8 days but is **rated as a 1** (2 days behind plan in November).
- 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 -1.35%, this is better than plan by 0.28% and is **rated as 4** (0.52% better than plan in November).
- **The agency expenditure metric** assesses agency expenditure against planned costs for the Trust. Costs of £13.81m are £01.22m (8.12%) less than plan and would be **rated as a 1.** (The agency metric assesses performance against plan). NHS planning guidance suggested that providers' (and aggregate system level) agency expenditure should not exceed 3.7% of pay bill. As at Month 9 agency expenditure was 4.8% of pay.

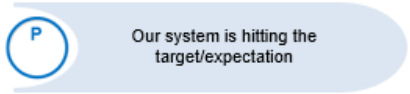
Specifically for agency please refer to **25a) Financial Plan: Agency expenditure compared to agency target & 25b) Agency price cap compliance.**

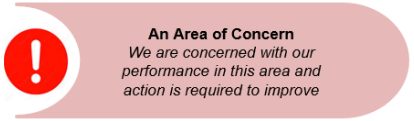
The Trust's financial performance results in an **overall UORR** of **3** for the period ending 31st December and **is in line with plan.**

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.





27) CRES Performance - Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
We planned to deliver **£10.57m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£6.27m recurrent CRES**. This is **£4.30m adverse variance** against planned recurrent schemes.

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 9 with specific performance noted as:
- £1.10m under-delivery of CRES for OAPs Reduction in AMH (Performance Improvement Plan in place)
- £1.47m under-delivery of CRES for Surge post review (Pay)
- £0.40m CRES for Agency (Inpatient level loading of rosters – actions in train via sub group of safer staffing group)
- £2.24m CRES for Taxi spend reduction (Improvement Event and associated actions being progressed)
- £.09m CRES for other schemes
- Recurrent CRES unachieved £4.30m to date

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

Underlying issues:
We need to deliver CRES schemes to achieve our financial plan.

Actions:
Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit.

F — Our system is not hitting the target/expectation

DQ — 80%

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

28) CRES Performance – Non-Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
We planned to deliver **£1.05m** of non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£5.35m**. **(£4.30m) favourable variance** against planned non-recurrent schemes.

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 9 relating to:

Planned Schemes
- (£1.14m) Non Recurrent Grip & Control (Non Pay)
- £0.46m Unachieved CRES Non Recurrent Grip & Control Trust wide Recovery Actions / budget rebasing (Non Pay)

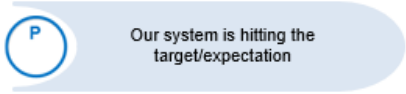
Unplanned Schemes
- (£1.17m) Interest Receivable (interest rate has been 5.2% for the last two months)
- (£0.01m) Income Contribution
- (£2.43m) LD, Medical and Long Covid contribution

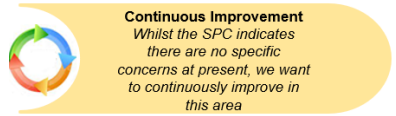
Composite year to date non-recurrent CRES **over delivery** of **(£4.30m).**

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

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required





29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
Capital expenditure at the end of December was **£8.47m** against an allocation of **£11.91m** resulting in a **£3.44m** underspend.

- Whilst several favourable and adverse variances contribute to the current position key areas include previously anticipated costs of 2023/24 schemes which completed in the 2022/23 financial year, slippage against start dates for lifecycle schemes and a change to plan for medical education centre development at Lanchester Road.

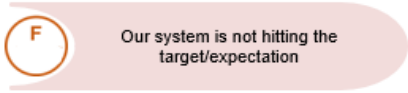
- The underspend reduced in month 9 by £1.75m mainly due to spend on assistive technologies in line with the revised implementation plan.

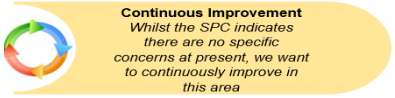
- The Trust is forecasting to outturn in line with planned performance in aggregate but notes an unplanned upside in relation to actual costs for phase 1 patient safety works Tees. Must do actions for 2024/25 financial year have been brought forward to ensure outturn spend in line with capital allocation.

- Any delays to planned inpatient environment schemes are communicated to the Environmental Risk Group to manage any associated risks. There is a delay in the start to Phase 3 sensor door works due to inability to secure escorts for contractors.

Underlying issues:
There are no underlying issues to report.

Actions:
Work is continuing into January 2024 to review progress against milestone plans for lifecycle works and to progress schemes that are being brought forward to utilise under spending, including from Phase 1 Teesside works.





30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
We have an actual cash balance of **£63.98m** against a planned year to date cash balance of **£61.88m** which is **(£2.10m) positive variance** to plan.

- This is mainly due to underspending on capital budgets and Health Education England income received in advance of the period it relates to, with partial offsets due to movements on working balances.
- The Trust has narrowly failed to achieved the 95.0% Better Payment Practice Code (BPPC) target compliance for the prompt payment suppliers, achieving a combined year to date BPPC of 94.9%. We continue to support the use of Cardea to make processes as efficient as possible, and ensure suppliers are paid promptly.
- The value of debt outstanding at 31st December 2023 was £3.09m, with debts exceeding 90 days amounting to £0.22m (excluding amounts being paid via instalments and PIPS loan repayments).
- Three whole government accounting organisations account for 84% of total debts greater than 90 days old (£0.18m), progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged

Underlying issues:
Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit

Actions:
As above

P — Our system is hitting the target/expectation

DQ ★ — 93%

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	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 or severe harm	√		
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	√		
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_25b	Financial Plan: Agency expenditure compared to agency target			
BIPD_25a	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

	Measure	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 and 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 or severe harm			√	√		√			√		√				
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		√	√	√	√	√			√		√				
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_25b	Financial Plan: Agency expenditure compared to agency target									√		√				√
BIPD_25a	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)									√		√	√			√

National Quality Standards and Mental Health Priorities Headlines

Headlines

- **72 hour follow up** achieving target in all areas except Vale of York (Q1 only)
- **EIP waiting times** achieving target in all areas except Vale of York
- **Talking Therapies waiting times** achieving target in all areas
- **Child Eating Disorders waiting times** consistently failing target across all areas for urgent and routine cases except Tees Valley (routine cases only)
- **Talking Therapies: Access -** consistently failing target across all areas except Tees Valley. **Recovery -** achieving financial year to date target across all areas; however, failed target for Q3 in County Durham and Tees Valley. **1st to 2nd treatment waits -** consistently failing target in all areas however, target achieved in North Yorkshire this quarter
- **CYP 1 contact** achieving target in all areas
- **Childrens Paired Outcomes** consistently failing target in all areas
- **AMH/MHSOP 2 contacts** achieving target in all areas except Vale of York
- **OAP (inappropriate)** consistently failing target **This is also the MH Priority monitored at Trust level – see IPD measure 9 for further details*
- **Specialist Community PMH services** consistently achieving target in Tees Valley; however, failing target in County Durham (*by 2), North Yorkshire and Vale of York

Risks / Issues

Of most concern:

- Child Eating Disorders Waiting Times (except for Tees Valley routine cases)
- Talking Therapies Access (except for Tees Valley)
- Talking Therapies 1st to 2nd treatment (except for North Yorkshire)
- Childrens Paired Outcomes
- OAP bed days (inappropriate)
- Specialist Community PMH services (except for Tees Valley)

Of concern:

- EIP Waiting Times Vale of York **National Quality Requirement*
- Adults/Older Persons 2 contacts Vale of York

Positive Assurance

Consistent achievement can be seen for:

- Talking Therapies waiting times (6 and 18 weeks)
- CYP 1 contact

Mitigations

We are continuing to work on the Performance Improvement Plans (PIP) in the following areas to ensure they include SMART actions that support improvement:

- Child Eating Disorders – both Care Groups
- OAP bed days (inappropriate) – Trust-wide
- Talking Therapies Access and Waiting Time – both Care Groups *North Yorkshire, York and Selby Access only*
- Perinatal Mental Health – North Yorkshire, York & Selby Care Group
- EIP waiting times - we are recruiting to 5 posts for the York and Selby EIP team
- Childrens Paired Outcomes – A business case has been developed for a dedicated outcomes team which will be shared with the Care Group in January
- Adult/Older Persons 2 contacts - Vale of York – a deep dive is underway to understand the issue(s)

Note *Talking Therapies previously known as IAPT*

National Quality Standards and Mental Health Priorities Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

National Quality Requirements																				
Measure	Agreed S-ICBL Ambition	County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	80%	88.99%	93.19%	89.03%		90.41%	86.40%	90.65%	84.98%		87.43%	87.30%	93.16%	84.40%		88.35%	79.38%	93.14%	89.02%		87.19%
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	60%	63.64%	63.77%	63.77%		63.73%	73.68%	69.05%	82.28%		74.90%	85.71%	88.24%	83.33%		85.71%	73.33%	50.00%	29.63%		51.90%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait six weeks or less from referral to entering a course of NHS Talking Therapies treatment	75%	99.47%	99.86%	99.57%		99.64%	99.46%	100.00%	99.65%		99.71%	99.54%	99.70%	99.52%		99.58%	99.20%	99.81%	99.62%		99.55%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait 18 weeks or less from referral to entering a course of NHS Talking Therapies treatment	95%	100.00%	99.97%	99.96%		99.98%	100.00%	100.00%	99.83%		99.94%	100.00%	100.00%	100.00%		100.00%	99.93%	100.00%	99.95%		99.96%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	83.82%	84.13%	81.94%		81.94%	91.01%	95.12%	96.34%		96.34%	80.00%	78.05%	83.33%		83.33%	78.33%	83.05%	83.02%		83.02%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	76.67%	67.74%	66.67%		66.67%	50.00%	50.00%	62.50%		62.50%	87.50%	87.50%	83.33%		83.33%	71.43%	71.43%	80.00%		80.00%

Local Quality Requirements																				
Measure	Agreed S-ICBL Ambition	County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	*	2662	2899	2781		8342	557	603	572		1732	1723	1672	1878		5273	1495	1607	1837		4939
IAPT: The proportion of people who are moving to recovery	50.00%	51.69%	51.01%	48.43%		50.34%	54.39%	56.75%	48.42%		53.13%	51.55%	53.67%	53.71%		53.01%	54.26%	58.34%	56.88%		56.55%
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	13.92%	12.91%	13.08%		13.28%	19.76%	18.56%	23.66%		20.72%	17.57%	12.63%	6.17%		12.10%	31.15%	26.61%	25.23%		27.58%
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact	*	9978	10236	10453		10453	11653	11598	11497		11497	4319	4098	4061		4061	4544	4528	4499		4499
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40.00%	22.46%	25.75%	21.99%		23.49%	28.53%	27.12%	26.76%		27.30%	38.24%	37.80%	33.17%		36.15%	30.38%	25.53%	27.35%		27.47%
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.	*	8193	8151	8235		8235	6825	7122	7527		7527	4162	4144	4102		4102	3341	3183	3073		3073
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	*	1445	436	608		608	1445	436	608		608	163	58	63		63	163	58	63		63
Number of women accessing specialist community PMH services in the reporting period (cumulative)	*	207	278	340		340	233	310	391		391	77	95	125		125	37	67	92		92

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NOTES ** Denotes individual plans agreed by area.*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

General Release

Meeting of:	Board of Directors
Date:	8th February 2024
Title:	Trust OJTC Delivery Plan quarter 3 (September – December 22023) 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 the 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 discussions 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 the 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

This report was previously discussed at Management Group on 17th January 2024. Where appropriate progress and issues have been discussed within Care Group or Executive Group meetings.

Implications:

There are several priorities which are at risk of not being delivered within agreed timescales. These have been flagged in **RED** within the OJTC delivery overview table in Appendix 2. Any requests for changes in timescales or requests for resources are also flagged in Appendix 2. These changes were approved by Management Group on 17th January 2024.

Recommendations:

BoD members are asked to:

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

b) Provide any comments as necessary.

Appendix One—Priority RAG status

Clinical Journey priorities	Project RAG status					Total projects per priority
Community Transformation		5	2	1	2	10
CITO		1				1
Autism		6		1		7
						18

Q&S Journey priorities	Project RAG status					
Reducing In-patient pressures		1	1	1	1	4
Patient Safety		2	1			3
Harm Free Care			4			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		1	2			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	2	3	1			6
Green Plan				5		5
Estates Masterplan	3		2			5
						20

Overall number	10	24	15	9	3	61

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

	Projects potentially at risk
Clinical	**1.Community Mental Health Transformation** **Crisis NYY (AMBER)** Implementation of agreed model for CAMHS will not take place in Q4 due to staffing/resource pressures meaning that there is no other operationally viable model to implement at this time. **I-Thrive – NYY (RED)** Q4 action to support I-Thrive event held by commissioners- TEWV attended the event however, this action will not be fully achieved by end Q4 and will be carried forward to 24/25, working with Commissioners and within their timescales. **Therefore an extension is requested to Q2 24/25 – this was approved at Management Group on 17th January 2024.** There is a risk that the Q1 24/25 action to review specifications with commissioners may be delayed. Meetings have been held with commissioners and currently this is on track however the delivery of this rests with the Commissioner timetable and the expectation is that this will move further into 24/25. **3. Autism Adult neurodevelopmental Service - DTV (RED)** due to issues in obtaining data from IIC a planned RPIW event has been pushed back to Q2 24/25. **Therefore an extension is requested to Q4 24/25 - this was approved at Management Group on 17th January 2024.**
Q&S	**4. Reducing In-patient pressures** **Reducing pressure on inpatient beds programme**: **(RED):** Care groups continue to focus on reducing Out of Area placements through the developed Performance Improvement Plans and QI activities. There has been a marked reduction in OAP and associated beds days since Q1, however we remain off trajectory in Q3. While work continues to focus on immediate actions that can be taken to reduce OAPs, there is likely to be a need for a system wide approach to address out of area placements longer term and ensure a sustainable change. **Older adults pathway (NYYS**) **Ensure 7 day availability for Assessment & Treatment (GREY):** Q4 actions remain unable to progress as per update at Q2 relating to availability of funding. **5. Patient Safety** **Learning from patient safety events; national system (LFPSE) (AMBER)** Project plan developed and agreed. Capacity to deliver is a current issue due to lack of resource allocated. Business case to be submitted to EDG in Jan 2024.

	6. Harm Free Care **Reducing the use of Restrictive Interventions (AMBER) A** 12 month work plan has been developed to take this work forward and this has been approved by QUAG. A lead for this work in each Care Group has been appointed to take this work forward. The plan and framework in place will move this work to green. **Safeguarding / Parental/Carer Mental Ill Health impact on children (PAMIC) (AMBER)** A working group has been established with clinical services and have representation from a range of services to take forward the actions. This group is meeting monthly to progress the actions. The priorities and objectives have been discussed in fundamental standards in DTVF and NYY. **Reducing Sexual Safety Incidents- (AMBER)** Monthly meetings are now in place and work is ongoing to collate data. Progress is being made in developing a workplan. **Reducing Suicide/misadventure: (AMBER) It** has been agreed that this work will move under the remit of the Patient Safety team. This will allow better alignment with patient safety learning and stronger governance for this work. **7. Personalised Care Planning** **Dialog+ full implementation through CITO (AMBER)** This work is being taken forward by the SDMs who are also working alongside Chris Morton as Lead Director for CPA. This work is in a stable position. There is a PMO lead and SROs in place for the wider care planning programme.
People	**11. More People** **New starters and onboarding (AMBER)** work is progressing well against this project. However due to some delays in phase 2 of the work **it is requested that the end date of this project be extended to Q3 24/25. This was approved at Management Group on 17th January 2024.** **Workforce Planning**: **(AMBER):** The Q2 update requested a change to end date to March 24 for pilot areas to have been engaged as evidenced by the production of initial workforce plans. The Trust workforce planning lead has engaged with Care Groups and Clinical Networks and the following areas have been identified for production of initial workforce plans: • DTVF – SIS, AMH, CYP, and LD • NYYS – MHSOP • Community Transformation • General plans – Nursing and Psychology

	The status of this item is being maintained as Amber due to potential resource availability constraints from operational areas during Q4 of 23/24. **13. Working Differently** **Workpal: (RED)** Rate of appraisals completed remains at an acceptable level and more staff registered after a follow up pre -Christmas. Some issues remain with the system which EDG are sighted on and mitigations developed and overseen by that group.
Infrastructure	**15. Digital and Data** **IIC re-procurement and migration - (AMBER):** The IIC project is reporting Amber as although a replan was agreed last month, this month a major issue has been identified which will likely cause further delay. The issue is that the proposed secure connection to extract data from the source systems into the IIC will not work as originally planned, the solution can be modified but will need further work. IBM specialists are reviewing the solution along with colleagues within the TEWV technical teams to work on agreeing an amendment as quickly as possible. **16. Green Plan: (RED)** All actions red. The Energy Sustainability Officer appointment was unsuccessful and the post has been re-advertised, with the interviews planned for the 19th Jan 2024. This project requires resource and capacity to progress and cannot be progressed until the Energy and Sustainability Officer post is filled. **17. Estates Master Plan** **Health, safety and assistive technology (AMBER)** Project on track in terms of scope and time but reporting amber in regards to resource. The Data Protection Impact Assessment (DPIA) was discussed at December's Information Governance Group (IGG) meeting. The group did not approve the DPIA. As a result, the recommendation is that wards included in the expansion project cannot go-live. Work is ongoing between the Nurse Consultant for Safe Nursing Workforce Staffing Standards and Information Compliance manager to address the DPIA issues. The install work is continuing in preparation of DPIA signoff, so no further delays are encountered. **Medical Education Facilities (AMBER)** There has been some slippage in plans due to dependencies on enabling works at Flatts Lane Centre to support an increase in training provision.

	Projects on Track
Clinical	**1. Community Mental Health Transformation:** Adult/Older people's community mental health team transformation - DTV **(GREEN)** Work is progressing well. **I-Thrive- DTV (GREEN)** The I Thrive transformation workshops continue to complete the core offer work. A draft document has been issued for comment internally with the aim to finalise and agree next steps and locality approach to implement in local systems. The clinical transformation workstreams are established with leads identified and draft priorities shared with the expectation that each workstream will meet and confirm plans by end February 2024. A**dult LD-DTV –(GREEN) Respite**: a further update paper to CGB was submitted to the December meeting, outlining next steps to develop a sustainable service model in collaboration with commissioners. This has been discussed with EDG and ICB and implications outlined. **Inpatients**: a plan to reopen to planned admissions at Bankfields in January has been developed. The dedicated programme manager has commenced to be able to provide leadership and support to this work. **Older People's community mental health team transformation – NYYS (GREY)** A review of the memory service offer has been completed and has led to internal quality improvement work taking place. Information has been shared with the commissioners alongside the previous capacity and demand work. Any future reviews will be commissioner led, system wide which the Trust will actively participate in when required. **Forensics – Establishing a Community (GREEN)** Physical health paper recommending GP led service agreed and will be implemented via formal procurement route. **Adult community mental health team transformation – NYYS (GREEN)** All actions on track. **2. CITO** **CITO (GREEN)** The Go Live date of the 5th of February 24 for the full release of Cito has been approved. Readiness Criteria for the project, for both project deliverables and to manage clinical readiness has been established and agreed by Care Groups. **3. Autism** **Children and Young People Neurodevelopmental Assessment Service – NYY (GREEN)** Business case has been developed and Commissioners will consider in early 2024.

Q&S	**4. Reducing inpatient pressures:** **Inpatient Flow -DTV AMH and MHSOP wards (GREEN)** As the patient flow work continues, further amendments are being made to the Central bed management policy which has delayed the ratification of the policy. It is anticipated that this will be complete by February. The PIPA refresh is now complete. All wards have completed their individual PIPA action plans and are being continually reviewed under a PDSA approach. Multi- Agency Discharge forums are in place. In addition, a deep dive into inpatient data within DTV Care Group has led to several QI activities being planned across the 3 main hospital sites with the aim of improving flow. **Implement bed configuration in line with NE&NC Secure Services Provider Collaborative Review (AMBER**) Meeting held with CNTW and new proposal for bed model developed. Timescales identified to progress through both provider and collaborative governance structures by end Q4. **5. Patient safety:** **PSIRF (GREEN) System** is live on 29th January and webinars and comms are currently underway. **Serious Incident backlog recover/Local management of incidents (GREEN)** The position is currently now sustainable with 30 SI's currently in review. Approvals are currently taking between 4-6 weeks and reducing.
Co-Creation	**8. Expand & develop Lived Experience Posts:** **Expand and develop lived experience roles and leadership, including peer support workers: (GREEN)** The I&E team are at the start of a period of exploring the need for lived experience roles within the team and the benefits this can bring to the overall I&E service. Funding is in place for 2 Band 5 roles which could be developed into lived experience roles. **9. Data collection and learning** **Improve & accurately capture patient experience data: (GREEN)** Increasing response rates continues to be a priority and forms part of the service improvement action plans for each of the Care Groups. In November 2023 those that would recommend TEWV services to friends and family was 92.75% exceeding the national benchmark of 88%. **Review/transform PALS and complaints pathways with co-creation principles**: **(GREEN)** All quality improvement activity has concluded and steps are been taken as we move towards full implementation (testing) of our new approach. Both Care Groups have gone live with the testing of the approval of complaints using MS Teams.

	10. Diversify & expand involvement **Embed and grow co-creation across the organisation: (GREEN)** The New Head of Co-Creation came into post on the 03.10.23, during this time they have met with over 200 staff and involvement members individually and in small groups to understand their experiences of co-creation across the organisation, themes from across these meetings from staff have been: the need for a clear offer of support around co-creation / reflective spaces / training and understanding who it can be applied in their part of the organisation.
People	**11. More People** **International Recruitment (GREEN)** Work continues with NHSE regarding OT and AHP recruitment. International recruitment for nursing is on target for 2023/24 with a refresh business case paper to be presented to EDG in Q4 (23/24) for a decision on the continuation of international nurse recruitment within 2024/25. IR for medics remains on track with 8 SAS level doctors currently working in the Trust and 5 more expected to join by June 2024. 15 further Doctors are expected to be recruited from the January recruitment drive. **12. Inclusive & compassionate culture** **Leadership Development Programme (GREEN)** Dates set for throughout 2024 for leadership development.
Infrastructure	**14. One Team TEWV –** all projects complete **15. Digital and Data** **EPMA (GREEN)** EPMA inpatient roll-out to the rest of the trust started after NYY&S, due to the delay in CITO go live. Full inpatient implementation on v3.1 will be complete by 19th January. **Improving Connectivity (GREEN)** On Plan to complete 31 Jan 2024. 956 access points have now been completed; the team continue to visit the remaining sites then will move to 'mopping' up any outstanding issues. **Asset Management (GREEN)** The Centralised Asset Management project is now fully re-initiated with Phase 2 concentrating on the existing provision of software, the instances of single software applications is more significant than expected and so extra resource from the End User Computing Team has been utilised. Phase 3 of the project is moving forward at pace with the contract documentation from Vodafone reviewed and now in the process of final sign off between Vodaphone and TEWV with completion expected imminently.

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	Dec-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	Mar-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	Jan-24
	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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NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 8 February 2024		
Date of last meeting: 1 February 2024		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda**	The Committee considered the following matters: • Summary of Executive Review of Quality Group • Integrated Performance Dashboard (IPD) • Proposed measures for new Quality Dashboard • Quality Assurance & Improvement Programme and NICE guidance information • Mortality Reviews • Physical Healthcare Report including Progress with End-of-Life Plan • Resuscitation • Co Creation • Safe Staffing Report – verbal • Serious Incident Improvement Plan • Waiting Time Reports from NYYS and DTVF Care Groups • Environmental Risk Group • National Safety Alerts • Quality Improvement Plan • Independent report reviewing the care at Edenfield Medium Secure Unit, GMMH The Committee held a confidential meeting on 1 February 2023 to: • Approve the minutes of the confidential meeting held on 7 December 2023 • Consider an early review (after action review), following a serious incident at Roseberry Park Hospital in early January.
2a	**Alert**	The Committee alerts the Board on the following matters: **From the NYYS and DTVF Care Groups:** • Improvements are required with the returns of inpatient quality review audits, which were less than 50% compliant on Elm, Mallard, Merlin and Northdale in December 2023. An improvement plan is in place and will be reported through Executive Review of Quality. • The Executive Review of Quality Group has requested a deep dive into practice that results in patients being detained in CAS whilst waiting for an inpatient bed to become available, patients who are transferred to other wards or other sites for seclusion and also the use of the Cross Lane seclusion facility. The outcome will be reported to the QAC • Inphase continues to cause issues and whilst the implementation of a new risk system was anticipated to take time to bed in the Care Groups are concerned that they are temporarily unable to access the same level of data. To mitigate the potential risks there are manual daily systems and processes in place for oversight and an additional post to support the development of InPhase is being recruited to. • Ripon community team continues to be managed under business continuity measures. The issues are understood and the Executive Review of Quality Group will monitor progress. • Staffing in some HMP services requires ongoing attention.

		Other business matters: • There is limited assurance linked to immediate life support training compliance, there is sufficient training capacity, the compliance rates are being impacted by people not attending for training. Although we have positive assurance about co creation and involvement generally of concern is the payments for involvement, which are significantly behind what is set out in national guidance.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** • The Executive Review of Quality group was able to give good assurance that risks to quality are identified and reported. The next step is to develop our insight and foresight. • All people who had a missed 72 hour follow up have been contacted to ensure they are safe. It is recognised that data quality issues and performance could be better than reported and that this data is reported externally. • All chronic disease reviews, physical health assessments and dental screening reviews are complete in secure inpatient services. • The use of restrictive interventions is beginning to see a downward trend in Secure Inpatient Services. • A young female patient transferred to a York inpatient ward after being in secure services for a prolonged period has now been on leave with her family and discharge plans are being developed. This is an excellent piece of care. • A proactive approach to pain management in Springwood ward has resulted in a reduction in restrictive practice for an older gentleman. The learning will be shared across the Trust. • There is good assurance on our progress with mortality reviews. The Trust Learning from Deaths policy is under review. There are no outstanding Structured Judgement Reviews (SJR's). Under the new PSIRF arrangements clinical services will hold the responsibility for mortality reviews and the Care Groups will be supported by the Patient Safety Team. **Other business matters:** • The historical backlog of serious incidents continues to reduce. • There is good assurance that there is a dynamic process for assessing, managing and addressing environmental risks. The Environmental Risk Group has met and determined an approach to looking at learning from the November 2023 national CQC guidance on the management of ligature risks in mental health and learning disability wards. • There is good assurance evidenced by the activities and workstreams for co-creation. The Committee are proud of the achievements that have been made with this hugely beneficial work, which is now impacting both at individual and system level. • A presentation setting out progress with the Quality Improvement Plan was noted. • The three resuscitation incidents in this period were conducted to good standards.

2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** • Continued focus will be given to reducing restrictive practice and specifically the use of mechanical restraint in non-secure settings where this may be part of a plan of care. **Other business matters:** • Reasonable assurance is provided from the Integrated Performance Report. • The QAC were advised that an assurance assessment of the requirements set out in the Mr. H homicide (2020) had taken place, the level of assurance is being reconsidered to ensure we are not being overly cautious about what we have delivered. • The plan to deliver improved physical health care across all services was presented. The paper was welcomed, there is a partnership focused planning event on 5 February 2024 after which time an implementation plan will be developed. • The proposed new quality dashboard measures were approved. The new measures will provide more granular detail on restrictive interventions broken down by teams and specialty. There is further development work necessary to ensure we have a data set for specialist services that indicates risks or assurances of the quality of care. • There is good assurance linked to the Quality Assurance & Improvement Programme. • A paper was received from the Care Groups on the people who are waiting for services. Factors considered included workforce, inequity of access for some, growing demand and the impact of commissioning. Work will centre around looking at those areas where the organisation can make an impact that are not related to commissioning. There is good assurance on the understanding of the risks. • Following a review into Edenfield medium secure unit, provided by Greater Manchester Mental Health FT a report has been published. The Chief Nurse, with clinical leaders, will facilitate reflection on what the report means for TEWV. This will be reported back to the QAC and onwards to the Board of Directors. • There was agreement of all executive, clinical and operational leaders that we need to ensure a good clinical pathway for people with autism in mental health services.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considered that risks are being managed effectively with more visibility of triangulating current and emerging risks linked to delivery of the quality and safety strategy. No changes were made to the BAF.
3	**Actions to be considered by the Board**	The Board is asked to note the report.
4	**Report compiled by**	Bev Reilly, Chair of the QAC, Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Chief Nurse and Donna Keeping, Corporate Governance Manager

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Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**8 February 2024**
Title:	**Equality Delivery System 2022, 23-24 submission**
Executive Sponsor(s):	**Sarah Dexter- Smith, Director of People and Culture**
Author(s):	**Abigail Holder, Equality, Diversity, Inclusion and Human Rights Officer& Sarah Dallal, Equality, Diversity, Inclusion and Human Rights & Voluntary Services Lead.**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
5	**Staff Retention**	The Trust has a minimal appetite for risks relating to quality. Although the present score is above tolerance, an acceptable level of exposure can be achieved. Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels
4	**Experience**	The Trust has a minimal appetite for risks relating to quality. Although the present score is above tolerance, an acceptable level of exposure can be achieved
11	**Governance and Assurance**	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

Executive Summary:

Purpose: This paper is presented to The Board to provide assurance that the Trust is meetings its obligations under the NHS contract to complete EDS 2022.

A more detailed document is attached to this report identifying the scores that have been agreed for the Trust and any areas of concern.

Proposal:

The Board is asked to confirm that it has good assurance that the Trust has followed a robust process in completing EDS 2022 and is meeting its obligations in regard EDS 2022.
The committee is asked to ratify the scores of EDS 2022 for 2023 and to agree to the publication of EDS 2022 on the Trust website as is required.

Overview:

EDS 2022 is a requirement of the NHS contract and must be completed annually using the evidence available for each of the outcomes. The proposal for good assurance is based on the information in the appendix which demonstrates that:

- Appropriate evidence has been gathered for each outcome.
- Consultation on the draft scoring has taken place as required by the technical guidance.
- EDS 2022 for 2023 has gone through the appropriate approval routes.

The Trust has scored 1(developing) for 3 criteria and further detail on this and plans to improve the scoring are contained in the Appendix. The Trust's overall score is 19 (developing).

Areas of Concern and Actions

The full rating scorecard and action plan is included at Appendix 1.

The Trust has scored 2 (achieving) for the majority of outcomes with the following exceptions:

Outcome 2 B (score 1) – When at work, staff are free from abuse, harassment, bullying and physical violence from any source. During the review / consultation process, it was recognised that a lot of work was going on in this area, there hasn't been a significant change from 2022 which would warrant an increase in the score for this domain. Further work on this will continue to be led by the Violence Reduction strategy.

Outcome 2D (score 1) – Staff recommend the organisation as a place to work and receive treatment. In the 2023 staff survey 54.4% of staff recommended TEWV as a place to work and 51.6% were happy for a friend or relative to be cared for by the Trust. To score a 2 over 70% of staff would

recommend the organisation as a place to work and receive treatment.

Outcome 3A (score 1)- Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities. Whilst the commitment of Board members to these issues was recognised – chairing EDI lunch and learn sessions, attending and sponsoring staff networks and including these issues in blogs to score a 2 the Leadership Framework for Health Inequalities Improvement would need to be implemented.

The Trust's overall score for EDS 2023 is 19 which is classed as developing. The action plan at the back of the attached score card details actions the Trust will take in the next year to improve its score.

Areas of Progress

Although there are no areas of progress with regards to an increase in scores in comparison to 2022/23, there have been areas of development in the following outcomes:

Outcome 2A (Score 2) - When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions.

Reasonable adjustments – Central Team

The Equality Act 2010 states that employers must make reasonable adjustments to make sure workers with disabilities, or physical or mental health conditions, are not substantially disadvantaged when doing their jobs.

Individuals' line managers have been responsible for implementing reasonable adjustments but it can be a complicated process so the team has been created as a pilot to see whether we can make it easier for managers and staff.

Outcome 2C (Score 2) - Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source.

Staff Networks

The Trust now has 8 active staff networks which focus on staff groups who have been traditionally underrepresented or who may experience discrimination in the workplace. Run by staff for staff, the networks facilitate peer support, sharing of experiences, and development of best practice within TEWV.

The number of staff networks have increased over the year and membership to them. Feedback from staff about their experiences of the networks continues to show the value and the contribution they make to our organisation's culture of inclusivity.

The list of the current staff networks are listed below:

- LTHC (for staff living and working with long term health conditions or disabilities)
- BAME (Black, Asian and minority ethnic)
- Rainbow (for staff who identify as lesbian, gay, bisexual, transgender, Questioning and "plus")
- Armed Forces (a member of staff who is no longer serving in the military)
- Neurodivergent staff
- Working Carers
- Menopause Café
- Ridgeway BAME Staff

Key Priorities

Outcome 2B - When at work, staff are free from abuse, harassment, bullying and physical violence from any source.

Objective - Ensure we support and respond to staff who experience verbal & physical aggression and proactively reduce the number of incidents of verbal and physical aggression from service users, carers, and members of the public towards staff.

Actions - To follow the actions detailed in the objective set in 2023 as one of the Trust's 2023-2026 Equality Objectives.

Continue to Promote Procedure for Addressing Verbal & Physical Aggression Towards Staff by Patients, Carers Relatives

Outcome 2D - Staff recommend the organisation as a place to work and receive treatment.

Objective - To improve the % of staff reporting that they would recommend the organisation to work or receive treatment.

Action - Continue to link this objective to The Great Place to Work workstream and actions.

Prior Consideration and Feedback The paper was considered by the Executive People and Culture group on 10TH November 2023 and the paper has been circulated to JCC as the meeting over ran on 14th November. The paper was also taken to QAIG Care Group on 14th December and has been circulated to network chairs.

Implications: Failure to complete EDS 2022 in accordance with the requirements of the NHS contract may have regulatory consequences.

Recommendations: The Board is asked to confirm that:

1. It has good assurance that a robust process has been undertaken when completing the proposed scoring and evidence for EDS 2022 for 2023.
2. To agree to the publication of EDS 2022 on the Trust website as is required.

Appendix 1

EDS 2022 for 2023

1. BACKGROUND INFORMATION AND CONTEXT.

1.1 EDS 2022 has been developed by NHS England and NHS Improvement and supported by the NHS Equality and Diversity Council as an improvement tool to support NHS organisations to review and develop their services, workforces, and leadership. The completed version must be published on the Trust's website by 28th February 2024 following approval at Board level. EDS 2022 should be carried out annually.

1.2 It comprises eleven outcomes spread across three Domains, which are:

1. Commissioned or provided services.
2. Workforce health and wellbeing
3. Inclusive leadership

1.3 Each outcome is evaluated, scored, and rated using available evidence and insight which assure or point to the need for improvement. The scoring system for each outcome is as follows:

- Undeveloped activity 0
- Developing activity 1
- Achieving activity 2
- Excelling activity 2

1.4 The scores are aggregated into an overall score for the organisation:

- Those scoring 8 or below are rated undeveloped.
- Those scoring between 8 and 21 are rated developing.
- Those scoring between 22 and 32 are rated achieving.
- Those who score 33 (the maximum score) are rated excelling.

1.5 For domain 1 the Trust had to choose 3 services. The categories of service and the services chosen are:

- One which where data indicates it is doing well Bedale.
- One where data indicates a service is not doing so well Scarborough CAMHS
- One where its performance is unknown Adult Kestrel Kite

1.6 The rating process is as follows:

- Domain 1 is rated by service users, the VCSE sector and NHS organisations.

- Domain 2 is rated by staff, staff networks, trade unions, and organisations.

- All scoring in Domain 3 must be independently tested, by a third party with no direct involvement in managing or working for the organisation. Chris Rowlands the EDI Lead for CNTW will undertake this role for the Trust in January 2024.

Author: - **Sarah Dexter- Smith, Director of People and Culture**
Abigail Holder, Equality, Diversity, Inclusion and Human Rights Officer
Sarah Dallal, Strategic Lead for Equality, Diversity, Inclusion and Human Rights and Volunteering.

Classification: Official

Publication approval reference:

NHS Equality Delivery System 2022

EDS Reporting Template

Third Version (test)

Version 0.8, 18 February 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS in accordance EDS guidance documents. The documents can be found at www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

The EDS is an improvement tool for patients, staff and leaders of the NHS. It supports NHS organisations in England - in active conversations with patients, public, staff, staff networks, community groups and trade unions - to review and develop their approach in addressing health inequalities through three domains: Services, Workforce and Leadership. It is driven by data, evidence, engagement and insight.

The EDS Report is a template which is designed to give an overview of the organisation's most recent EDS implementation and grade. Once completed, the report should be submitted via england.eandhi@nhs.net and published on the organisation's website.

NHS Equality Delivery System (EDS)

Name of Organisation		**Tees Esk and Wear Valleys NHS Foundation Trust**	**Organisation Board Sponsor/Lead**
			Sarah Dexter-Smith
Name of Integrated Care System		North East & North Cumbria ICB & Humber & North Yorkshire ICB	

EDS Lead	Sarah Dallal		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	Circulated to JCC and staff network chairs. People, Culture & Diversity Committee – 30.11.23 Exec PC&D – 10.11.23 QAIG Care Group – 14.12.23		**Individual organisation**	Tees Esk and Wear Valleys NHS Foundation Trust
			Partnership* (two or more organisations)	County Durham and Tees Valley Mental Health, Learning Disability and Autism Partnership
			Integrated Care System-wide*	Reviewed by Cumbria, Northumberland, Tyne and Wear Foundation Trust

Date completed	23.11.2023	**Month and year published**	February 2024

Date authorised		**Revision date**	

EDS Rating and Score Card

Please refer to the Rating and Score Card supporting guidance document before you start to score. The Rating and Score Card supporting guidance document has a full explanation of the new rating procedure, and can assist you and those you are engaging with to ensure rating is done correctly

Score each outcome. Add the scores of all outcomes together. This will provide you with your overall score, or your EDS Organisation Rating. Ratings in accordance with scores are below

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

Domain 1: Commissioned or provided services

Summary Domain 1 – Please see detailed ratings and evidence for the three services chosen

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Some of the Evidence Reviewed** **Kestrel Kite: Score 2** All patients are referred to a speech and language therapist upon admission. Easy read formats are available. Patients have option to have communication profiles and passports. Interpretation services are available when required. Sensory profiles are completed by occupational therapy. Some staff are trained to support service users with visual or auditory impairments. Multi-agency working to ensure good communication is maintained. **Scarborough CAMHS: Score 2** Protected characteristics are reported on Paris. Initial assessment explores needs related to protected characteristics. Sensory and communication needs are flagged as an alert in Paris.	2 2	Jody Buxton (Modern Matron) Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)

		Access to interpreter and translation services are available as required. Support is available for families with regards to referrals to other agencies Individual needs are assessed during admission assessment. Key workers are available to advocate if required. Flexible appointment times are available if required due to i.e., religious / cultural festivals. Reception / waiting areas displays information relating to local LGBTQ+ groups and the Pride Flag Promotion of local charitable services that help families in need. **Bedale: Score 2** Access to service is 24 hrs per day 7 days per week. Can take direct admissions from the community or other wards. Dedicated MDT to respond to individual needs of patients. Over establishment of HCA's to increase clinical capacity Access to support from MHSOP colleagues when supporting older patients. No age restrictions, admissions 18 years old upwards	2 **Average Score - 2**	Rebecca Stephenson (Modern Matron)

		Reasonable adjustments process in place with links to autism team.		
	1B: Individual patients (service users) health needs are met	**Some of the Evidence Reviewed** **Kestrel Kite: Score 3** Meeting needs of people from protected characteristic groups. Access to interpretation/translation services Accessible environment for wheelchair users OT and Physio support Access to support aids delivered within 24 hours. **Scarborough CAMHS: Score 2** Accessible building no steps, all rooms are on the ground floor, access to disabled toilets, lift available. Personal alarm system available where additional support is required. Environmental risk assessment is carried out at 3-month intervals. Concerns are highlighted in safety plans. Home visits can be provided for families who are unable to access the service. Referrals to perinatal services fare made where required.	3 2	Jody Buxton (Modern Matron) Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)

		Bedale: Score 2 Access to interpreter and translation service Accessible single-story building Bedrooms adapted and reasonable adjustments made where required. Daily meetings with patients about improving the environment. Comprehensive risk assessment are undertaken and maintained throughout the patient journey Documented PC's and individual requirements in safety plans Alerts relating to safety are recorded. Patients have access to independent MH Advocates	2 **Average score: 2**	Rebecca Stephenson (Modern Matron)

	1C: When patients (service users) use the service, they are free from harm	**Some of the Evidence Reviewed** **Kestrel Kite: Score 3** Early learning reviews completed with 72 hours for any incidents graded low to moderate. Safe wards framework used on ward. Individual risk documentation in place i.e., safety summary, safety plans 'Safe care system is embedded to review any daily risks with regards to staffing resources. Safeguarding alerts forms within Paris. Datix incidents are completed for all incidents. **Scarborough CAMHS: Score 2** Protected characteristics are reported when logging an incident. Incidents deemed to be 'medium to high' level of harm will be followed up with an early learning review report which provides an opportunity to consider individual needs and PC's. These reports are then reviewed by Patient Safety where further consideration around individual needs & PC's are considered Formal complaints are received vial PALS. Complaints received linked to PC's are specifically addressed. Complaints are used to improve clinical practice and service improvement.	3 2	Jody Buxton (Modern Matron) Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)

		Bedale: Score 2 Complaints received have not related to patients protected characteristics. Work taking place to look at reducing restrictive practices. Clear process in place to manage patient to patient discrimination on the ward. Mutual help meetings have been used, can include police liaison officer where incidents of discrimination have taken place. Incidents of discrimination are reported to the police.	2 **Average Score: 2**	Rebecca Stephenson (Modern Matron)
	1D: Patients (service users) report positive experiences of the service	**Some of the Evidence Reviewed** **Kestrel Kite: Score 2** Patient experience surveys offered 6 monthly. PREOMS surveys offered 6 monthly (alternate to pt experience to allow for quarterly surveys) Local issues resolution monitoring is being piloted on the ward. Friends and Family Test Freedom to speak guardian accessible.	2	Jody Buxton (Modern Matron)

		Advocates and IMHA offered to all service users. CQC, PALS & Complaints contact details / posters are visible on the ward. Timescales in place to resolve any complaints efficiently and effectively. **Scarborough CAMHS: Score 2** Act upon FFT feedback FFT Experience Sept 23 100% Scores are displayed for patients to review. Examples of compliment received: 'Very centred on the young person's needs. 'You said we did' board in reception – listing actions taking in response to feedback given. PALS, Complaints & CQC information is displayed in reception / waiting room area. **Bedale: Score 2** The patient experience information for the ward is provided below. This is reviewed monthly and also displayed for patients to review. Since January 2022, there have only been 3 complaints submitted for Bedale ward, none of which relate to a protected characteristic. PALS, complaints and CQC information is available on the ward and is available in different formats and languages. This is included in the ward welcome booklet.	2 2	Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager) Rebecca Stephenson (Modern Matron)

			Average Score: 2	
Domain 1: Commissioned or provided services overall rating			**8**	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

main 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Occupational Health Service Provision • Employee Support Service/Employee Psychology Service (including support groups such as Burnout group/Reliance) • VIVUP wellbeing platform (includes Counselling service for staff) • Long Term Health Conditions staff network and numerous other support network groups which meet regularly • Achieved Better Health at Work bronze level, in 2023 working towards Silver level (assessment October 2023 – campaigns have included financial wellbeing, better sleep, risky alcohol & substance use and workplace wellbeing environments/basic wellbeing needs (including nutrition and healthy eating). • Long term sickness absence team • Health and Wellbeing Strategic Group • Nutrition and weight management programmes • Over 300 Health & Wellbeing (H&W) champions • Staff led Health Council meets every two months • H&W pages on the staff Intranet • Smarter Working initiative • Reasonable adjustments – Central Team • Working carer support - network • Staff Mindfulness Programme • Bereavement Support	2	Sarah Dallal

		• Central staff Health and Wellbeing team (4 wte's) • Bi-monthly Strategic Health & Wellbeing Group which meets made up of MDT staff and Services. • H&W coordinator (Durham & Darlington Locations) • Health & Wellbeing Conversations training programme to be rolled out across the Trust from Autumn 2023		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Violence Reduction strategy development • Verbal & Physical Aggression procedure • Indicator 5 WRES – Staff experiencing harassment, bullying or abuse from patients, relatives, public. • Indicator 6 WRES - Staff experiencing harassment, bullying or abuse from staff. • Indicator 4 WDES • Indicator 5 SOWES • Indicator 6 SOWES • Publication of information Staff survey results (harassment, bullying & abuse) - Age and Gender • WRES/WDES/SOWES action plans • Equality objectives (include verbal & physical aggression actions) • Disciplinary data • Support offered after Datix. • Hate crime campaigns. • Staff Council • Staff Support – Speak Up Guardian, ESS, EPS • Training available including in leadership programmes • Domestic violence work	1	Sarah Dallal

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	• The Trust has a EDIHR Team • 8 active staff networks • Freedom to Speak Up Guardian embedded & increase in capacity for Freedom to Speak Up with the FTSU Officer • Employee Support Service, VIVUP platform (including Counselling service), Employee Psychology Service • Actively work with Unions • Work agreed in partnership with Unison as part of their 'Year of Black workers' to provide co developed training. • Equality Impact Assessments completed on all policies/procedures. • WRES/WDES/SOWES & Publication of Information data led to actions. • Chaplaincy Team • A relaunch of the Speaking Up Ambassadors • Speaking Up policy and includes information on how workers can access support for their wellbeing and Equality Impact Assessments these are also applied to other related policies. • Staff Survey Q21c & Q21d – Age, Ethnicity, Gender, LTHC, Sexual Orientation. • Overall recommend as a place to work: 54.4%	2	Sarah Dallal

		• Overall happy for friend or relative to be cared for: 51.6% • Reasons for leaving data broken down by demographics. • Disciplinary data broken down by demographics. • Recruitment data by demographics		
	2D: Staff recommend the organisation as a place to work and receive treatment	• Staff Survey Q21c & Q21d – Age, Ethnicity, Gender, LTHC, Sexual Orientation. • Overall recommend as a place to work – 54.4% • Overall happy for friend or relative to be cared for 51.6% • Reasons for leaving data broken down into demographics. • Disciplinary data broken down into demographics. • Recruitment data broken down into demographics	1	Sarah Dallal
Domain 2: Workforce health and well-being overall rating			**6**	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Brents/Senior staff Blogs/Vlogs include EDI. • BoD & committees – EDI & Health Inequalities discussed (minutes) • Board members & senior leaders sponsor & attend staff networks. • EDI Lunch & Learn sponsorship from BoD and Senior Leaders. • Significant increase in board declarations of EDI characteristics and over representation of some characteristics at board compared to community. • Commitment to review the new structure brought in April 2022 to check impact on protected characteristics. • All execs have EDI specific objective.	1	Sarah Dexter-Smith

	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• EDI & Health inequalities are discussed at BoD (minutes) • BAME staff risk assessments were completed during the pandemic. • EIA's are complete for policies & procedures and projects	2	Sarah Dexter-Smith
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• BoD and committees monitor Gender Pay Gap, WRES (including Model Employer), WDES & SOWES, EDS, leavers information. • Executive clinical lead identified to oversee EDI data related to patient care.	2	Sarah Dexter-Smith
Domain 3: Inclusive leadership overall rating			**5**	
Third-party involvement in Domain 3 rating and review				
Trade Union Rep(s): JCC approval		**Independent Evaluator(s)/Peer Reviewer(s): Chris Rowlands CNTW**		

EDS Organisation Rating (overall rating): 19
Organisation name(s): Tees, Esk and Wear Valleys NHS Foundation Trust

Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

EDS Action Plan	
EDS Lead	**Year(s) active**
Sarah Dallal	2024/25
EDS Sponsor	**Authorisation date**
Sarah Dexter-Smith	

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services.	1A: Patients (service users) have required levels of access to the service	Understand the demographics of people who access services at TEWV and their experiences	Design data reports for Care Groups to understand the needs of the population they serve.	
	1B: Individual patients (service users) health needs are met	Understand and improve the access and experiences of Trans people & the Gypsy Romany Traveller Community	As detailed in the Equality Objectives Continue to achieve our goal to co-create a great experience for our patients, carers and families	
	1C: When patients (service users) use the service, they are free from harm	Care is delivered in a way that minimises things going wrong, reduces risk and empowers and supports people to make safe choices.	Continue with the Journey to Change Quality & Clinical Journey Strategies to ensure we deliver safe and effective services	

	1D: Patients (service users) report positive experiences of the service	To offer all patients the opportunity to provide feedback about their experiences	Continue to review patient experience and FFT user surveys	

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	To promote and provide innovative initiatives for work-life balance, healthy lifestyles, encourages and provides opportunity to exercise.	The Health and Wellbeing Team will continue to run specific wellbeing campaigns on specific conditions such as COPD, Asthma and weight management, financial wellbeing, better sleep, risky alcohol & substance use and workplace wellbeing environments/basic wellbeing needs (including nutrition and healthy eating), (obesity) in the coming year (2024).	Ongoing
	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Ensure we support and respond to staff who experience verbal & physical aggression and proactively reduce the number of incidents of verbal & Physical aggression from service users, carers, and members of the public towards staff.	To follow the actions detailed in the objective set in 2023 as one of the Trust's 2023-2026 Equality Objectives. Continue to Promote Procedure for Addressing Verbal & Physical Aggression Towards Staff by Patients, Carers Relatives	Ongoing

	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	Ensure staff are aware of the protected time offered to them to attend 4 staff networks of their choice annually.	Launch & promote the Staff Networks documented Communications plan to target managers about the importance of staff networks and the Trusts commitment to support staff to attend.	March 24
	2D: Staff recommend the organisation as a place to work and receive treatment	To improve the % of staff reporting that they would recommend the organisation to work or receive treatment.	Continue to link this objective to The Great Place to Work workstream and actions.	Ongoing

Domain	Outcome	Objective	Action	Completion date
Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	To implement the trust approach to Health Inequalities	BoD to work with Health Inequalities Lead in the Trust approach to Health Inequalities	
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	To implement the NHS Oversight and Assessment Framework	BoD to implement the framework and use this to develop approaches and build strategies for equality and health inequalities related impacts.	
	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	For Board members and senior leaders to monitor the trusts approach to Health Inequalities.	BoD to implement the NHS Oversight and Assessment Framework. To review that all the following are monitored: WRES (including Model Employer), WDES, NHS Oversight and Assessment Framework, Impact Assessments, Gender Pay Gap reporting, staff risk assessments (for each relevant protected characteristic), SOM, end of employment exit interviews, (EDS	

			subject to approval), Accessible Information Standard, partnership working – Place Based Approaches.	

Domain 1 - detailed ratings & evidence

Kestrel Kite

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Patients are referred to the service when their learning disability and/or autism needs is impacting on risk. The ward abides by the Privacy and Dignity Policy. All patients referred to speech and language therapist upon admission to service. If a communication need is identified on referral form or during assessment for admission, then SLT can be involved from those initial stages. Easy read formats are available for MHA rights, medication for example with other easy read materials being available on an individual basis. For example, the ward has completed social stories, comic strip stories and have facilitated individual needs such as writing care documents in specific fonts, sizes or capitals and also pictorial forms. This is documented in care plans.	2	Jody Buxton (Modern Matron)

		Patients have the opportunity to have communication profiles and passports. There is also a statement of involvement from patients and carers included within care plans and risk documents. Interpretation services are available when required. Sensory profiles are completed by occupational therapy however sensory support is limited due to resource of sensory integration trained staff within the service / trust wide. The ward has staff in the process of completing this training with a view to complete in Summer 2024. The ward has a few staff trained to support service users with visual or auditory impairments where required. Information is shared with other agencies as and when required to ensure that communication is maintained at level appropriate for the service users' needs and wishes.		

	1B: Individual patients (service users) health needs are met	Ward is all on one level and accessible with wider doors if a service user had a physical disability and required use of a wheelchair. Accessible bedrooms and bathrooms are available where required. Occupational therapy and physio are available to assess, recommend and support with any physical health care needs and have provided equipment such as chair shower aids, walkers, chairs etc. There is also access to external services who can have equipment supplied to the ward within 24hours. Staff support with medical and health appointments to ensure that information is communicated. Impact of LD and autism is considered individually for all service users, with further consideration and adjustments to sensory needs, processing times, dietary requirements. Autism focussed formulations are provided to increase understanding of the impact of LD and / or autism for each service user. The staff team report this is a good opportunity to review the service users' holistic needs and inform care and treatment.	3	Jody Buxton (Modern Matron)

		Robust transition plans are developed. Historically the ward has provided training, formulations and worked alongside new providers to ensure smooth transition, with good outcomes. The ward has also been able to have input into environmental needs of services users to ensure sensory needs are considered when supporting service users to move on. In addition, the ward works alongside SOT (secure outreach and transition team) and also FOLs (forensic outreach and liaison service) to ensure a smooth transition into the community from secure care.		
	1C: When patients (service users) use the service, they are free from harm	Safeguarding training is completed for all staff. 1:1 support with safeguarding lead nurse for all RNs. Local authority awareness for all RNs. Trustwide safeguarding support from a designated team.	3	Jody Buxton (Modern Matron)

		Safeguarding alert forms within the electronic care record. HR processes available and followed for any staff related concerns. Complaints process in place with all complaints investigated. Local issues resolution monitoring is being piloted for all ward-based complaints monitoring along with more formal processes such as PALS and CQC Incident recording and monitoring is well embedded with oversight from senior leaders and discussed in governance meetings. Datix forms / incident reports are completed for all incidents. Early learning reviews completed with 72 hours for any incidents graded low to moderate severity. Serious incident investigations completed for any serious incidents. Positive and safe dashboard is in place and themes and learning are discussed at ward		

		level, as well as within service and trust wide governance meetings. Learning is shared. Ward safety drill and ward safety file which highlight and communicate risks and mitigations is well established on the ward. De-brief and safety bulletins are sent out to all staff. Safewards framework used on the ward. Individual risk documentation in place such as safety summary to highlight risk and safety plans to identify and evidence mitigation, which is reviewed as and when required, fortnight lightly by MDT, following significant change or review of care. Environmental ligature audit is kept up to date and reviewed as and when required with a minimum of yearly. Community meetings held fortnightly or minimum of monthly. “Safe care” system is embedded to review any daily risks with regards to staffing resources. Patient related issues including safeguarding are also discussed within his		

		meeting and resolution is sought before meeting can be concluded. Observation and engagement procedure in place and staff training compliance is monitored with regards to this Individual training to increase safety can be sourced / provided where required for example the positive and safe team have recently provided bespoke training upon request of the ward. Autism formulations are facilitated to understand the impact of the autism on each service user which provides greater insight into risk and mitigations. Equality diversity training is completed by staff on the ward. The Oliver McGowan training tier 1 is 100% compliant. Tony Attwood talk is 91% Face to face autism training compliance is 66% (due to new starters who are booked on this training)		

		The ward works closely with local authority safeguarding teams, MAPPA and other organisations / agencies to support the safety of service users and members of the public both during their hospital stay or when planning for discharge. Disclosures have been made to public institutions such as colleges to promote community participation, meaning activity etc for service users on discharge pathways. Local authorities are also consulted when looking for appropriate placements.		
	1D: Patients (service users) report positive experiences of the service	Patient experience surveys offered 6 monthly. PREOMS surveys offered 6 monthly (alternate to pt experience to allow for quarterly surveys) Local issues resolution monitoring is being piloted on the ward. PALS - contact details / posters are visible on the ward. Close links with PALS are maintained to resolve any complaints efficiently and effectively.	2	Jody Buxton (Modern Matron)

		CQC - contact details / posters are visible on the ward. Timescales are in place to resolve any complaints efficiently and effectively. Friends and Family Test Freedom to speak guardian accessible. Advocates and IMHA offered to all service users. ESSENCES is a psychology led short survey open to all stakeholders. It has a focus on safety and culture within a forensic setting. – offered to all service users, carers and staff. Quality improvement events for service users and staff on the ward to explore how to improve the therapeutic culture and environment and enhance the day-to-day organisation of the ward. Carers open days have taken place. Carer link staff identified for the ward. Pearls in the teacup video – the carers perspective of being a carer of someone detained in hospital portrayed by a theatre organisation was shown to staff, service users and families.		

		A video named Diamonds in the rough was also produced by the same theatre organisation to represent the being detained in hospital from a service users' perspective. These have been highly acclaimed by stakeholders. Contact with family was maintained during COVID when physical contact and visits was reduced. This included the increased use of digital support such as skype tablets. United voices group attendance and feedback – service user led group which feeds into governance structures. Community meetings 1:1 discussion with lead nurse and key workers Daily engagements with staff Collaborative working and involvement in all care and treatment plans where possible.		
Domain 1: Commissioned or provided services overall rating			**10**	

Bedale

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Access to the service is 24 hours per day, 7 days a week as is an inpatient ward. The ward can take either direct admissions from the community or transfers from other wards were felt necessary and has access to 10 beds and a seclusion suite. The service has expanded their staffing to provide a dedicated MDT to respond to the individual needs of each patient on the ward, this includes nurses, HCA's, medics, psychology, physical healthcare practitioner, SALT, OT, physio, STR worker, activity coordinator, gym instructor and access to many other services if required. This includes an over establishment of HCA posts to support greater levels of staffing on the ward and increase and maximise clinical capacity. Chaplaincy services are accessible on the ward. Voluntary workers are available on the ward.	2	Rebecca Stephenson (Modern Matron)

		Individual risk assessments are undertaken with patients to determine safe access to community services. There are no age restrictions on the ward, admissions are from 18 years. The access to PICU is based purely on risk and patient needs for their mental health at that time. Access to the service is determined via the PICU Pyramid and has no protected characteristic as an exclusion criterion. Any needs that need to be met following being accepted, would be done on an individual basis. The ward has access to support from MHSOP colleagues when caring for elderly patients, this includes support such as the falls team and moving and handling team. The service has developed closer relationships with inpatient and community ALD teams to support with training and guidance for greenlight admissions which has involved increased training on PBS by external trainers to the service and understanding of the CTR process. The PICU are currently working towards being a single sex environment in line with		

		the requirements of the privacy and dignity policy. Any individual needs would be assessed during admission assessment, and these would be recorded in the safety plans for the patient which is accessed by all individuals involved in their care. Complaints received since 2022 have not related to service users protected characteristics. Interpreter services are accessed when required. As part of the patient admission information, the ward document and record any identified disability, communication / language preferences. This is recorded in safety plans and where required the Dialog Plan for individual patients. The ward would also record this as an alert on the electronic care system. This information is used to inform plans of care and to use when discharge planning. The ward share safety plans which contain information about communication preferences with family, other NHS agencies		

		and any other care providers involved in a patients care. The trust has access to an Autism team and work is ongoing regarding Reasonable Adjustments on the ward. The ward use checklists to screen for these and can work without colleagues in the Specialist Health Team regarding solutions for identified issues including the environment. Communication passports are used and devised where needed with patients as well as being shared with other care providers. The trust intranet has access to information regarding legal status, medication, and diagnosis information in different languages. They also have access to sign language services in different languages and tactile writing systems. All patients are referred for an Independent Mental Health Advocate and Independent Capacity Advocate, this information is available on display in the ward and is in the welcome packs for the ward.		

	1B: Individual patients (service users) health needs are met	The organisation has an interpreter service which is accessed directly via the ward and works within the required policy. The ward is a single-story building with no access issues i.e., ramps required, and bedrooms would be adapted with hired beds if required for individual physical health needs. If a patient had additional needs identified, the supportive observations and engagement policy would be used to assess needs and how these would be supported. The bathroom has the ability for assisted grab rails to be fitted by estates as required. The ward has access to OT staff to assess for the need of aids in relation to mobility and personal care. The ward has access to hoists on site and manual handling training. The doorways on the ward are large enough to accommodate a wheelchair. The ward holds daily meetings with all patients that want to be involved on how they can improve the environment.	2	Rebecca Stephenson (Modern Matron)

		A comprehensive risk assessment is undertaken and maintained throughout the patient journey. The ward work closely with multiple agencies from across the system to ensure comprehensive care planning. As part of the patient admission information, the ward document and record any identified disability, communication / language preferences. This is recorded in safety plans and where required the Dialog Plan for individual patients. The ward would also record this as an alert on the electronic care system. The ward share safety plans which contain information about communication preferences with family, other NHS agencies and any other care providers involved in a patients care. The trust has access to an Autism team and work is ongoing regarding Reasonable Adjustments on the ward. The ward use checklists to screen for these and can work without colleagues in the Specialist Health Team in regard to solutions		

		for identified issues including the environment. Communication passports are used and devised where needed with patients as well as being shared with other care providers. Our trust intranet has access to information regarding legal status, medication, and diagnosis information in different languages. The ward also has access to sign language services in different languages and tactile writing systems. All patients are referred for an Independent Mental Health Advocate and Independent Capacity Advocate, this information is available on display in the ward and is in the welcome packs for the ward.		
	1C: When patients (service users) use the service, they are free from harm	Since January 2022, there have only been 3 complaints submitted for Bedale ward, none of which relate to a protected characteristic. The ward has been working to reduce their restrictive interventions on the ward and meet monthly to discuss initiatives and how these are personalised.		

		If a patient was to be subject to discrimination on the ward from a fellow patient, the ward would follow the appropriate VA policy. Mutual help meetings have been used to discuss where we have seen incidences of discrimination to discuss the impact of this on the patient's emotional wellbeing and to discuss criminality in relation to discrimination, Police liaison officer is available to attend these meetings. Discrimination is reported to the police. All patients are referred for an Independent Mental Health Advocate and Independent Capacity Advocate, this information is available on display in the ward and is in the welcome packs for the ward.		
	1D: Patients (service users) report positive experiences of the service	The patient experience information for the ward is provided below. This is reviewed monthly and also displayed for patients to review. This information is gathered monthly from the patients and carers. Since January 2022, there have only been 3 complaints submitted for Bedale ward, none of which relate to a protected characteristic. This is monitored by the complaints team. All	2	Rebecca Stephenson (Modern Matron)

		complaint responses are taken via our governance routes for discussion. PALS, complaints and CQC information is available on the ward and is available in different formats and languages. This is included in the ward welcome booklet. If a patient was to be subject to discrimination on the ward from a fellow patient, the ward would follow the appropriate VA policy. Mutual help meetings have been used to discuss where we have seen incidences of discrimination to discuss the impact of this on the patient's emotional wellbeing and to discuss criminality in relation to discrimination, Police liaison officer is available to attend these meetings. Discrimination is reported to the police.		
Domain 1: Commissioned or provided services overall rating			**8**	

Scarborough CAMHS

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	Most Children and Young People (CYP) access CAMHS through a referral to the Single Point of Access (SPA) Team. The SPA team document CYP protected characteristics on Paris. SPA complete a telephone assessment, in which they explore reason for referral. All CYP up until 18 years are able to be referred to CAMHS. Some CYP will access CAMHS through contact with CAMHS Crisis (24 hour service) or as a transfer from another NHS Trust; all CYP will have their protected characteristics recorded on Paris. Within the access call / initial assessment, CAMHS clinicians will explore if there are any additional needs related to protected characteristics. There are specific questions around sensory and communication needs, these are clearly documented within the assessment and are also flagged as an alert on Paris.	2	Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)

		CYP and families have access to a translator service if this is required. This will be booked by the access team to ensure the service is available for the assessment. Documents / Letters can be translated through this service also. CAMHS Clinical staff support CYP / Families in referrals to other agencies if it is identified they require additional support to meet their needs – for example, the service complete referrals for autism assessments – with the child and family. Any individual needs would be assessed during admission assessment, and these would be recorded in the safety plans for the patient which is accessed by all individuals involved in their care. Service users with an autism diagnosis and/or learning disability, the service can make referrals to the Dynamic Support Register (DSR), which is a multi-professional group that tried to ensure appropriate care and support is in place for CYP with additional needs. This service can also provide a key worker service, which advocates for CYP in multi-agency meetings.		

		The service is able to refer CYP to the National Youth Advocacy Service, who provide a range of services to support, safeguard and empower CYP Our trust has access to sign language services in different languages and tactile writing systems. Evidence to demonstrate adjustments the service makes with regards to race/religion/culture: - CAMHS have attended multi agency meetings with local MH and CSC services for asylum seeking families based in Scarborough; trying to improve access to services. - CAMHS can be flexible with appointments for CYP if they require this due to religious/cultural periods (e.g., fasting periods) Within reception / waiting room area there is information for local CYP LBTQI+ groups and celebration of Pride flags. Scarborough has a high level of deprivation, so as a team promotion of local charitable services that helps families in need takes		

		place. An example being the service created a poster that clearly shows all local food collection services. At Christmas the team also have a collection during which time we bring in toys / food and then take this to the local community support centre who distribute this to families. The service also have a CYP book collection in reception, with a sign that children are able to take a book home if they see one they would like to read.		
	1B: Individual patients (service users) health needs are met	Lake House is accessible – all rooms for children and young people are on the ground floor. There are no steps to access the building or on the ground floor. There is a lift to the first floor if visitors / staff are unable to use the stairs. There is access to a disabled toilet on the ground floor. There are emergency cords in all bathrooms if anyone needs support / assistance, as these are linked to a building-wide alarm and response system. An environmental risk assessment is conducted very three months.	2	Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)

		If any CYP have additional health needs that may require urgent response / additional support, staff have access to a personal alarm system which are taken into sessions – which will alert the team to attend the room if required. Any significant health issues would be highlighted as an alert in Paris. Concerns around risk are clearly highlighted within safety plans. CYP and families have access to a translator service if this is required. This will be booked by the access team to ensure the service is available for the assessment. Documents / Letters can be translated through this service also. CAMHS will provide home visits if CYP / families are unable to access Lake House – those with physical disabilities can struggle to attend if families do not drive as Lake House is on the outskirts of the town and is not on a bus / train route, and we recognise that some families cannot afford regular taxi fares. If CYP are pregnant and in service, we will liaise and refer to the perinatal mental health team if appropriate.		

	1C: When patients (service users) use the service, they are free from harm	When reporting an incident, information relating to protected characteristics is documented. If the incident is deemed to be 'medium to high' level of harm, then an early learning review report is completed, within which is specifically asks about their age and gender, and preferred pronouns. This report also provides opportunity to consider if there any additional needs linked to protected characteristics. The reports are reviewed by the Patient Safety Team, who would also have opportunity to consider if there are needs that have not been appropriately addressed and if any actions need to be taken in respect of the CYP protected characteristics. Formal complaints are received through the Patient Advice and Liaison Service (PALS); who are in place to support families to complain about the service. CAMHS have a statutory duty to respond to all complaints. If		Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)

		there are any concerns raised that are linked to CYP protected characteristics, these will need to be specifically addressed. If there are concerns regarding the provision of support from CAMHS, an apology would be provided (principle of Duty of Candour) and this would be opportunity for lessons learnt within the team. Complaints are used to help in the development of clinical practice and to understand areas which need to be improved.		
	1D: Patients (service users) report positive experiences of the service	The patient experience is reviewed monthly and also displayed for patients to review. This information is gathered monthly from the patients and carers. Examples of compliments from FFTs demonstrating good practice include: - Very centred on the young person's needs - I was made to feel very comfortable. - (Worker) is a knowledgeable, kind, patient and comes across as genuinely caring.	2	Keri Brearey (Service Manager) & Matthew Bower (Community Team Manager)

		There is a ‘you said we did’ board in reception that highlights comments made by CYP / families and what actions we have taken to evidence we are incorporating their views within changes to practice / environmental changes. An example of these are as follows: You Said- We did not have a choice of where our appointments were held. We did- A sign in reception informing that we can offer appointments in a variety of settings including children centres and within school and this can be discussed with the CYP clinician. There have been occasions CYP have struggled to attend Lake House – reasons have included poor physical health, feeling overwhelmed due to sensory issues. We have then offered alternative locations, including attending the home. PALS, complaints and CQC information is available in reception / waiting room in poster form and is available in different formats and languages.		

		Staff complete Equality and Diversity and Human Rights Training as part of their mandatory / statutory training requirements.		
Domain 1: Commissioned or provided services overall rating			**8**	

Patient Equality Team
NHS England and NHS Improvement
england.eandhi@nhs.net

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