Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS
Thursday 10 October 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 patient/staff story.

Standard Items

1	Chair's welcome and introduction (verbal)	Chair	1.30pm
2	Apologies for absence (verbal)	Chair	
3	Declarations of interest (verbal)	All	
4	Minutes of the last meeting held on 8 August 2024	Chair	
5	Board Action Log	Chair	
6	Chair's report	Chair	
7	Questions raised by Governors in relation to matters on the agenda (verbal) *(to be received by 1pm on Tuesday 8 October 2024)*	Board	

Strategic Items

8	Board Assurance Framework - Summary Report	Co Sec	1.45pm
9	Chief Executive's Public Report	CEO	1.55pm
10	Integrated Performance Report	DCEO	2.10pm

BREAK (2.50pm – 3.00pm)

BAF RISK 1: Safe Staffing

11	Report of the Chair of People, Culture and Diversity Committee	Cmt Chair	3.00pm
12	Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard and publication of staff equality information	EDfP&C	3.10pm

13	Appraisal and revalidation of doctors 2023-24	EMD	3.20pm

BAF RISK 2: Demand
BAF RISK 3: Cocreation
BAF RISK 4: Quality of Care
BAF RISK 8: Quality Governance

14	Report of the Chair of Quality Assurance Committee	Cmt Chair	3.30pm
15	Teesside Adult Learning Disabilities Respite Care	MD DTVF	3.40pm

BAF RISK 10: Regulatory Compliance

16	Report of the Chair of Mental Health Legislation Committee	Cmt Chair	3.55pm

Governance

17	Board Assurance Framework (verbal)	Chair	4.05pm

Matters for information

18	Leadership Walkabouts	EDoCA&I	-
19	Register of Sealing	Co Sec	-

Exclusion of the Public:

20	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*	Chair	-

	(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.		

BREAK (4.15pm - 4.25pm)

Standard Items

21	Confidential minutes of the last meeting held on 8 August 2024	Chair	4.25pm
22	Confidential Action Log	Chair	

Strategic Items

23	Chief Executive's Confidential report	CEO	4.30pm
24	Reportable Issues Log	CN	4.55pm
25	Development of the Risk Management Strategy and Policy	CN	5.05pm
26	Integrated Performance Report: Waiting Times	DCEO	5.15pm
27	Our Big Conversation & Our Journey to Change	ADSP&P C Lanigan	5.30pm

BAF RISK 10: Regulatory Compliance

28	Confidential report of the Chair of Mental Health Legislation Committee	Cmt Chair	5.45pm

BAF Risk 5: Digital
BAF Risk 6: Estate/Physical Infrastructure
BAF Risk 7: Cyber Security
BAF Risk 9: Partnerships and System Working
BAF Risk 12: Financial Sustainability

29	Report of the Chair of Resources & Planning Committee	Cmt Chair	5.55pm
30	2024-25 Month 5 Finance Report	EDoFE&F	6.05pm
31	Report of the Chair of Roseberry Park Hospital Sub-Group	Cmt Chair	6.20pm

Governance

32	Deloitte Report Action plan	DCEO	6.30pm
33	Board Assurance Framework	Co Sec	6.45pm

Evaluation

34	Meeting evaluation *In particular, have we, as a board of directors:* • *Via the agenda, papers and our discussions, fulfilled our objectives of supporting our communities, staff and stakeholders?* • *Fulfilled our statutory roles?* • *Held the organisation to account for the delivery of the strategy and services we provide?*	Chair	7.00pm

Matters for information

35	Report of the Chair of the Board of Directors Nomination and Remuneration Committee (verbal update provided August 2024)	Chair	-
36	Minutes of meetings of board committees: a. Mental Health Legislation Committee 13 May 2024 b. Audit & Risk Committee 23 May 2024 c. People, Culture & Diversity Committee 30 May 2024 d. Quality Assurance Committee 4 July 2024 e. Quality Assurance Committee 5 September 2024	Co Sec	-

David Jennings
Chair
4 October 2024

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

Board of Directors
Public Action Log

RAG Ratings:

	Action completed
	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

Changes since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
11/01/24	23-24/136	Patient outcomes	Timescales to be provided for completion of current work to improve the reporting of patient outcomes.	K Kale	Jul-24		Board seminar held 11 July 2024
11/04/24	24-25/11	Corporate Risk Register	Committees to consider corporate risks that had remained static for 12 months and review target dates	Committee Chairs			
13/06/24	24-25/36	Board Assurance Framework	Risk leads to red/amber/green rate the assurance they had that actions would mitigate the risk	Executive Leads	Oct-24		Discussion on the BAF to be held at Executive Directors Group on 13/08/24
13/06/24	24-25/47	Emergency prepardeness, resilience and response	Board update to be provided on progress against the NHS core standards, following discussion at Audit & Risk Committee in September.	Z Campbell	~~Oct-24~~ Dec-24		**Audit & Risk Committee meeting to be held 14 October - feedback to be provided to the Board in December 2024**
08/08/24	**24-25/83**	**IPR - 72 hour follow up**	**Progress update to the next board meeting on progress to achieve the 72 hour follow-up target**	**N Lonergan, Z Campbell**	**Oct-24**		
08/08/24	**24-25/83**	**IPR - themes**	**IPR executive summary to include narrative on themes that arose consistently**	**P Scott**	**Oct-24**		**IPR agenda item 10**
08/08/24	**24-25/83**	**Staff Pulse survey**	**SDS to circulate the results of the last quarterly staff survey**	**S Dexter-Smith/ K North**	**Oct-24**		**Completed**
08/08/24	**24-25/83**	**Long term plan and Workforce metrics**	**Summary to be provided at the next meeting on the LT plan and workforce metrics, to provide assurance that where metrics have been static for a period of time, the position was understood and actions proposed would support progress.**	**S Dexter-Smith/ K North**	**Oct-24**		

Agenda Item 5

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Chair's Report: 9th August 2024 – 9th October 2024.

Headlines:

External:

- Recruitment for new NEDs – informal meetings with candidates, long and shortlisting, and special Nomination & Remuneration Governor Committee, plus interviews
- Meeting University Hospitals Tees Chair
- Meeting North East North Cumbria Integrated Care System Chief Executive
- Mental Health Chairs NHS Confederation network weekly calls : with NHSE Chair, with NHSE Mental Health policy lead, and with CQC Lead Inspector.
- Mental Health in Schools Team visit Darlington, with Darlington Councillor.
- NHS Providers Board meeting
- North East & North Cumbria Chairs & ICS meeting
- Humber & North Yorkshire ICS Chairs meeting
- Good Governance Institute catch-up

Council of Governors (CoG)

- Governor Development Day, including Upstander / Bystander training
- Locality meetings across both Care Group geographies
- 121 with Lead Governor.

Internal

- Directors & Peer Support Workers Forum
- Various 121 meetings with a number of Executive Directors (Finance, People, Therapies), and Head of Peer Support
- Meeting with Public Health Consultant on our work around Health Inequalities, with partners
- Roseberry Park Sub-Group
- Board Meeting and Board Seminar (on our Future over the next 5 years)
- STAR Awards judging
- Mandatory & Statutory training
- Visit to Foss Park Hospital to see our Research Team and understand their work
- Chairs Appraisal by the Senior Independent Director
- Attend Executive Directors Group to discuss our Business Assurance Framework

Key themes for me:

1) Future direction & strategy as a Trust, with partners, and a new Government
2) The skills we have as a Board to lead the organisation
3) Challenging & improving further our current performance across all our domains.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**10 October 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. It seeks to provide information on the strategic risks together with positive and negative assurances relating to key controls 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)

The board is asked to note that:

- RAG ratings for the controls for BAF ref 7 (Data Security and Protection) are not provided as this is a public report. The ratings can be found in the confidential BAF report under agenda item 32.
- A new column has been included in the table to highlight any new, emerging or increasing risks identified by the board's committees.

Prior Consideration and Feedback	None relating to this report.
Implications:	None relating to this report.
Recommendations:	The Board is asked to take the strategic risks into account during its discussions at the meeting.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Next Planned Change to Risk Score	Indicative Controls Assurance Rating	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
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 20** (C5 xL4)	**Moderate 10** (C5 x L2) **Q3, 25/26**	**Q1, 25/26** Workforce plans in place for all services (-1L)	**Good**	Knowing which staff we need and where	▪ Daily operational processes in care groups ▪ Monthly e-roster reviews re fill rates etc ▪ Safe staffing reports re shifts over 13 hours, missing RN, missed breaks	**Positive** ▪ **IPR:** Staff in post with a current appraisal (metric 21) - *improved performance assurance* ▪ **Internal Audit: Data quality:** KPI: Staff leaver rate – *good assurance* ▪ **PCDC (16/9/24)**: Good assurance on the progress of the People Journey Delivery Plan **Negative** **PCDC (16/9/24)**: ▪ Reasonable assurance that the plans for health and wellbeing activity in the Trust through providing strong support for colleagues will continue to meet colleagues' needs and contribute significantly to the increased retention rate ▪ Reasonable assurance that employee relation matters are being managed effectively and the areas which require further improvement are well understood		**Public Agenda Item 10 –** Integrated Performance Report **Public Agenda Item 11 –** Report of the Chair of the PCDC **Public Agenda Item 12** - Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard - submissions and associated action plans **Public Agenda Item 13** - Appraisal and revalidation of doctors – report and statement of compliance 2023-24
											Ensuring that staff are recruited to and safely deployed to the right places	▪ Rosters for inpatient services ▪ Daily management huddles/ staffing calls ▪ Daily safety huddles on wards			
											Staff are appropriately trained to support people using our services	▪ Daily safety huddles on wards ▪ Increasing number of development JDs in place to ensure people are safely developed into more senior roles ▪ Individual and manager compliance reports available weekly			
											Staff are supported to maintain their wellbeing, feel they belong and choose to stay and work here.	▪ Quarterly reviews and annual appraisals support staff ▪ Supervision – managerial and clinical ▪ OH provision ▪ Multiple H&W interventions including comprehensive support and psychological services – all with outcome measures			
											Ensuring that local leaders and managers are equipped to lead and maintain safe staffing	▪ Recruitment processes inc LE panel members ▪ 3 year leadership programme and quarterly leadership events for service management level and above			
											Early understanding of when things go wrong	▪ Operational escalation processes ▪ Links from services to ePCD increasingly strengthening ▪ Thinking about leaving interviews ▪ 'Working in TEWV' monthly online meetings			
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	**Mng Dir**	**QuAC**	**High 16** (C4 xL4)	**Moderate 12** (C4 xL3) Q4 25/26 ↑	**Q4 25/26** Implement transformational developments (-1L)	**Good**	Partnership Arrangements	▪ Weekly operational interface meetings with Local Authority partners to support flow within inpatient services	**Positive** ▪ **Internal Audit:** Integrated performance reporting (*substantial assurance)*	**QuAC (5/9/24) –** The Committee to start to look at bed flow as an escalated risk.	**Public Agenda Item 10 –** Integrated Performance Report **Private Agenda Item**
											Demand Modelling	▪ Associate Director of Strategic Planning and Programmes – Lead for demand modelling in the Trust			

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	1	2	3	and potential avoidable harm.							Operational Escalation Arrangements	▪ Inpatient wards – Management of admissions through PIPA process and the operational daily escalation calls ▪ Bed Management Team – Responsible for the oversight and management of the use of beds ▪ On-call arrangements – Agreement of actions in response escalation ▪ Freedom to Speak Up Guardian – Point of contact for staff with concerns about quality e.g. the impact of demand ▪ Daily Lean Management Processes – to understand and escalate risks associated with operational delivery are in place across inpatient and community services	**Negative** ▪ **IPR:** Bed Occupancy (AMH & MHSOP A & T Wards) (metric 8) *- reduced controls assurance*		**26 –** Waiting times
											Integrated Performance Reporting	▪ Operational delivery of performance standards by wards and teams ▪ Performance Department – Management of the IPR including validation of data, oversight of data quality and reporting to the various tiers of the governance structure			
											Establishment Reviews	▪ Safe Nursing Workforce Staffing Standards Team – Responsible for managing and delivering the establishment review process. This is based on: ▪ Acuity dependency assessments for each ward using the MHOST tool and professional judgements ▪ General Management reviews, including discussions with Matrons, on the ward assessments ▪ Assessments of a range of data including benchmarking, patient outcomes, staffing information e.g. use of temp staff and overtime ▪ Care Group Boards – Review the outcomes of the establishment reviews and development of proposals (included in the Establishment Review reports to the BoD) ▪ Finance Department – Reviews of affordability of the outcome of establishment reviews *(Reports to the FSB/EDG)*			
											Strengthen voice of Lived Experience	▪ Role of peer workers. ▪ Expanding opportunities of lived experience roles, including lived experience facilitators and senior lived experience roles/peers ▪ Service level service user and carer user groups ▪ Triangle of care ▪ Patient Experience			

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	1	2	3									reporting ▪ Understanding our complaints themes and impact on services ▪ Patient Safety Partners - PSIRF ▪ Partnership with clinicals networks – cocreation of clinical care initiatives and models ▪ Commissioning VCS lived in core services to meet identified needs			
3	✓			**Co-creation** **There is a risk** that if we do not fully embed co-creation **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	**Moderate 12** **(C4xL3)**	**Low 4** **(C4 x L1) Q2/Q3 2024/25**	**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	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team ▪ Peer Support team ▪ Clinical Leaders ▪ Service Managers	**Positive** ▪ **QuAC (5/9/24) –** Good assurance following the PALS and Complaints review ▪ **PCDC (16/9/24)**: Good assurance that the Trust has followed a robust process in recruiting, training, and inducting volunteers **Negative**		
											Friends and Family / Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)			
											Complaints Policy	▪ Chief Executive – Overall accountability for ensuring that the Complaints Policy meets the statutory requirements ▪ Director of Corporate Affairs and Involvement – Responsible for the development, implementation and monitoring of the complaints policy ▪ Head of Patient Experience - Responsible for facilitating the effective reporting, investigation, and communication of all complaint activity ▪ Complaints Team Manager – Responsible for managing the complaints' function including the central database for complaints and producing statistical data ▪ Trust Organisational Learning Group – triangulation between all sources of intelligence to			

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	1	2	3									identify and act on service improvements. ▪ General Managers/Service Managers ▪ Ward/Team Managers/Modern Matrons ▪ Complaints Team			
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 16** (C4 x L4)	**Moderate 9** (C3 x L3) **1/4/25**	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) ▪ 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)	**Good**	Friends and Family/Patient Experience Survey	▪ Director of Corporate Affairs and Involvement – Overall accountability for ensuring that the patient experience data and reporting of such, meets the statutory requirements ▪ Head of Patient Experience ▪ Patient and Carer Experience Team – Responsible for the organisation of patient experience activities including the Patient Experience Survey ▪ Performance Team – Responsible for the delivery of the Integrated Performance Approach including the patient experience metric (based on FFT data)	**Positive** ▪ **IPR:** ▪ PSII reported on STEIS (metric 10) - *improved performance and controls assurance* ▪ Medication errors with a severity of moderate harm and above (metric 13) - *improved performance assurance* ▪ Restrictive intervention Incidents used (metric 12) - *improved controls assurance* ▪ Adults and older persons showing measurable improvement following treatment - patient reported (metric 5) - *improved performance assurance* ▪ **Internal Audit:** Key performance indicator (KPI): the number of incidents of moderate and severe harm *(substantial assurance)* ▪ **QuAC (5/9/24):** Good assurance of reporting and learning in line with national guidance for learning from deaths. ▪ Good assurance from	New national waiting standards for Mental Health	**Public Agenda Item 10 –** Integrated Performance Report **Public Agenda Item 14 -** Report of the Chair of the Quality Assurance Committee **Public Agenda Item 15 –**Tees Valley Respite Review **Public Agenda Item 16 -** Report of the Chair of the Mental Health Legislation Committee **Private Agenda Item 26 –** Waiting times
											Further develop the co-creation infrastructure	▪ Director of Corporate Affairs and Involvement – Responsible for the delivery of the Cocreation priorities set out in Our Journey to Change (OTJC), and associated Delivery Plan ▪ Head of Co-creation ▪ Lived Experience Directors ▪ Involvement & Engagement (I&E) team ▪ Patient Experience team ▪ Peer Support team ▪ Clinical Leaders ▪ Service Managers			
											Our Quality and Safety Strategic Journey	▪ Chief Nurse – Responsible for the development of Our Quality and Safety Journey ▪ Workstreams and key performance indicators have been developed for each of the Journey's four priorities ▪ The professional structure with the care groups have day to day oversight of the quality and safety of care ▪ Integrated Performance Dashboard is utilised to identify variance in care delivery ▪ Learning from serious incidents and near misses			
											Incident management policies and procedures	▪ Chief Nurse ▪ Responsible for ensuring the systems for incident reporting, identification of patient safety issues and reporting appropriate incidents through correct procedures is in place ▪ Clinical and operational Managers medical Staff, modern matrons responsible for the operational implementation of the policy and associated guidelines. ▪ MDT in teams ensure effective after action reviews.			

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	1	2	3								Governance arrangements at corporate, directorate and specialty levels	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolios including: ▪ ERQ (CN) – Responsibilities include oversight of Serious Untoward Incident/Never Event management processes and receive lessons learnt for sharing across the Trust as appropriate ▪ CGBs (Mgt Dirs) – Responsibilities include Oversight of the day to day management of an effective system of integrated governance, risk management and internal control across the whole Care Group's activities	quarterly reports including: Environmental Risk Group; Pharmacy & Medicines Optimisation; and Safeguarding and progress with PSIRF. **Negative** ▪ **Internal Audit:** Duty of Candour *(reasonable assurance*)		
											Performance Management of Serious Incident Review	▪ Patient Safety Team - ▪ Responsible for ensuring all reportable serious incidents are reviewed within the agreed timescales following an internal governance process ▪ Daily patient safety huddles to review incidents of moderate harm and above to identify areas of immediate action and learning and support timely dissemination of information to mitigate risks ▪ Implementation of PSIRF Jan 24			
											Organisational Learning Group	▪ PSIRF Policy ▪ PSIRF Implementation plan			
5	✓	✓	✓	**Digital – Supporting Change** There is a risk of failure to deliver OJTC goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems	**CEO (CIO)**	**RPC**	**High 20** (C5xL4)	**Moderate 10** (C5 x L2) **2025/26 Q4**	**30/6/2025** EPR deployment and optimisation programme control moves to substantial assurance (-1L)	**Good**	Embedded Digital Strategy and Delivery Plan	▪ Digital Management Meeting ▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (DPAG)	**Positive** **Negative**		
											EPR deployment and optimisation programme:	▪ Executive Strategy & Resources Group (ESRG) ▪ Cito Improvement Group (CIG) ▪ Clinical Advisory Group (CAG) ▪ Transformation & Strategy Board			

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	1	2	3								Integrated Information Centre optimisation programme:	▪ Digital Programme Board (DPB) ▪ Digital Programme Assurance Group (DPAG)			
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**	**RPC**	**Medium 12** (C4 x L3)	**Low 6** (C3 x L2) **2028/29**	**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	▪ Executive Director of Finance and Estates/Facilities and Director of Estates, Facilities & Capital (or their deputies) represent the Trust at NENC meetings	**Positive** ▪ **Internal Audit:** Capital projects (*good assurance)* ▪ **QuAC (5/9/24):** Good assurance from quarterly report from the Environmental Risk Group ▪ **RPC (18/9/24)** NENC Infrastructure Plan submitted to NHSE in July commended by them as exemplar / Good assurance NENC understands challenges **Negative**		**Private Agenda Item 28** - Report of the Chair of Resources & Planning Committee
											Estates Master Plan	▪ EFM Directorate – Responsible for the preparation / delivery of the EMP in conjunction with the Care Groups based on an established prioritisation framework ▪ Finance Department – Responsible for the preparation of the annual capital and revenue financial plans for Board approval			
											CIG & CPSG	▪ Estates, Facilities, Capital and Finance teams work closely to ensure engagement across the Trust to collate capital investment priorities, risk / impact assess these and support agreement of final annual capital plan and medium term capital requirements			
											Estates, Facilities & Capital Directorate Management Team Meeting	▪ All of the directorate's functions provide monthly assurance reports to this meeting which is chaired by the Director of Estates, Facilities and Capital			
											ERIC, PLACE and PAM national annual reporting / benchmarks submission and monitoring	▪ EFM Directorate responsible for: ▪ **PLACE** ▪ Organising (with CA&I) the PLACE assessment visits ▪ Compiling the information ▪ Submission of the information to NHSE ▪ Preparation of the Action Plan ▪ **ERIC** Compiling and submitting ERIC submission to NHSE ▪ **PAM** Self-assessment against the questions included in the PAM and on the delivery of resultant action plans, processes in train to ensure timely submission			
											Green Plan submission and monitoring	▪ EFM Directorate responsible for compiling and submitting Green Plan submission to NHSE / ensuring progress to deliver milestones			
											Environmental Risk Group	▪ Director of Estates, Facilities and Capital ensures aligned CPSG and			

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	1	2	3												
												ERG agendas, including close collaboration with Chief Nurse / MD DTVF joint chairs ▪ Directors of Operations / Operational teams support identification of environmental issues ▪ Service desk tracks levels of maintenance issues			
7	✓	✓	✓	**Data Security and Protection** There is a risk of data breach or loss of access to systems, caused by successful cyber-attack, inadequate data management, specialist resource gaps, and low levels of digital literacy resulting in compromised patient safety, impacts on business continuity, systems and information integrity, reputational damage and loss of confidence in the organisation.	**CEO (CIO)**	**RPC**	**High 20** (C5 x L4)	**Moderate 10** (C5xL2) **2025/26 Q3**	**30/6/2025** Internal Audit assurance on 2024/25 DSPT with submission of Meets Standards; and control moves to substantial assurance (-1 L)	**Good**	Digital, Data & Technology (DDAT) Skills and Knowledge	▪ Digital and Data Management Meeting (DDMM) ▪ Digital Programme Assurance Group (DPAG) ▪ Digital Programme Board (DPB)	**Positive** DSPT submission secured 'standards met' (fully compliant) rating. **Negative**		
											Secure IT infrastructure and asset management.	▪ DPAG			
											Cyber Security and Incident Management	▪ DPAG			
											Data Security and Protection Toolkit (DSPT) and Information Risk Management fully operational	▪ DPAG			
											Robust Clinical Safety and Change Control	▪ DPAG ▪ DPB ▪ Digital Change Assurance Board			
											Digital service delivery monitoring	▪ Digital Programme Assurance Group (DPAG)			
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 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.	**CN**	**QuAC**	**Moderate12** (C4 x L3)	**Moderate 9** (C3 x L3) **01/01/25**	A number of actions will cumulatively achieve target score: ▪ Implement the 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	**Good**	Open and transparent culture working to organisational values steered by Our Journey to Change	▪ Cohesive Board ▪ Engaged and visible Executive ▪ High Quality Care Group Directors ▪ Substantive recruitment of service leadership and clinical teams	**Positive** ▪ **QuAC (5/9/24):** Good engagement with NICHE assurance review process **Negative**		**Public Agenda Item 14 -** Report of the Chair of the Quality Assurance Committee **Public Agenda Item 16 -** Report of the Chair of the Mental Health Legislation Committee
											Executive and Operational Organisational Leadership and Governance Structure	▪ Chief Executive – Responsible for the Operational Leadership and Governance Structure ▪ Executive Directors – Responsible for the delivery of key elements of the Leadership and Governance Structure within their portfolios ▪ Co Sec – Responsible for the provision of secretariat services within the governance structure ▪ Care group clinical leaders responsible for the oversight of care delivery			

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	Key Controls and Assurance Ratings	First Line of Defence	Material Positive/ Negative Assurances identified since last ordinary meeting	New, Emerging or Increasing Risks	Material Reports for consideration at the meeting
	1	2	3												
									Nursing and Quality to increase curiosity into the Fundamental Standards of Care ▪ Review and relaunch the Quality and Safety priorities within Our Journey to Change ▪ TEWV Leadership Academy will help all leaders enact their role to safeguard and improve quality		Quality Management System	▪ The QI team is well established and embedded into services. ▪ There is an operational, clinical and professional leadership structure. ▪ There are Improvement plans for incidents, complaints and inspections. ▪ The IPD tracks performance monthly. ▪ The Care Group Board oversees delivery of services.			
											Oversight / Insight / Foresight	▪ Performance team are responsible for measuring and reporting performance ▪ Chief Nurse leads the nursing and quality directorate who have responsibility to measure and report out on - patient safety - quality governance -audit - infection, prevention and control - safeguarding - risk -Use of Force ▪ Chief Nurse lead the executive review of quality reporting to QuAC ▪ Medical Director leads on a number of patient safety priorities including Mortality review and Sexual Safety ▪ Care groups have dedicated clinical leaders at director delivery levels with a role to assess delivery of care standards			
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.	**DCEO**	**RPC**	**Medium 12** (C4 x L3)	**Low 6** (C3 x L2) **Q3 – 31st Sept 2024**	-	**Good**	Place-based commissioning and partnership leads working for TEWV	▪ Engagement in a wide range of partnership functions and committees/ groups across each place, in line with individual place governance structures ▪ Joint work / operational processes with local authorities and other partners including PCNs ▪ Development of alliances and partnerships with other organisations, including the voluntary sector, to deliver services into the future	**Positive** ▪ **RPC (18/9/24):** Good assurance that information linked to external intelligence from partners, lived experience planning reference group and wider environmental issues and changes are received by the Committee to influence Executive members in discussions across the systems to be able to advance the strategic goal ▪ **Board Strategic Seminar (12/9/24):** Refresh of the		**Private Agenda Item 27 -** Our Big Conversation & Our Journey to Change **Private Agenda Item 28** - Report of the Chair of Resources & Planning Committee
											Supporting North East and North Cumbria Mental Health and Learning Disabilities Specialised Services Partnership	▪ Operational service leads from DTVF Care Group are members of the different groups in the Partnership			
											Supporting Humber North Yorkshire Provider Collaboratives	▪ Attendance at specialist provider collaborative governance groups			
											Placing AD Strategy into NENC ICB MHLDA Transformation Team	▪ AD Strategic Planning and Programs placed into NENC ICB MHLDA Transformation Team for one day per week. Asked to lead on Inpatient Quality Transformation (including bed census)			

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	1	2	3								Attending HNY ICB Operations Group	▪ AD Strategic Planning and Programs and Finance Business Partner attend	Strategy including alignment with objectives of system partners. Further discussions held at the Executive Director event on 1/10/24 ▪ Work being undertaken with CNTW on the refresh of the leadership and governance arrangements of the provider collaborative **Negative**		
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 12** (C4 x L3)	**Moderate 8** (C4 x L2) **31/03/25**	**31/3/25** Delivery of CQC Improvement Plan (-1L)	**Good**	Statutory Reporting	▪ Reporting requirements and timetables developed by the Company Secretary ▪ Information provided by designated leads ▪ Reports produced by Corporate Affairs and Communications based on submissions received. ▪ Annual Accounts timetable drafted by Head of Accounting and Governance ▪ Annual Accounts (and related TAC submissions) undertaken by the Finance Staff ▪ Head of Financial Accounting and Governance considers and coordinates annual training needs for annual accounts team ▪ Accounting ledger and accounts payable entries reviewed including to ensure accurate coding to support reporting as well as VAT recovery	**Positive** ▪ **QuAC (5/9/24):** Good assurance re: responding to HMC Regulation 28 notices ▪ **RPC (18/9/24):** Good assurance that the strategic (BAF) risks assigned to the Committee are being managed effectively ▪ **PCDC (16/9/24)**: ▪ Good assurance on the Board Assurance Framework as the controls have been strengthened and confirms that further work is to take place with People and Culture leads following a recent workshop on the trajectories ▪ Good assurance that the Trust has followed a	New national waiting standards for Mental Health	**Public Agenda Item 12** - Workforce Race Equality Standard, Workforce Disability Equality Standard, Sexual Orientation Workforce Equality Standard - submissions and associated action plans **Public Agenda Item 13** - Appraisal and revalidation of doctors – report and statement of compliance 2023-24 **Public Agenda Item 14 -** Report of the Chair of the Quality Assurance Committee
											Provider Licence	▪ Board certification processes undertaken by the Company Secretary ▪ Delivery of related by policies by operational and corporate departments ▪ Commissioning of external governance reviews, preparation of evidence for and support by the ACE and Co Sec ▪ Delivery of improvement plans by designated leads			
											Environmental Sustainability	▪ The Estates, Facilities and Capital Team are maintaining day to day BAU ▪ Estates & Facilities DMT maintain routine operational oversight			

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	1	2	3								Statutory Financial Duties	▪ Processes overseen by the Head of Financial Management including annual budget holder sign off of budgets / establishments following agreement of annual budget setting processes ▪ Annual budget prepared by DoFEF ▪ Monthly financial reports and refreshed forecast outturn positions prepared by Finance Department to support agreement with Care Groups / Directorates and returns for submission to NHSE ▪ Budget holder management of individual budgets ▪ Accountability Framework sets out responsibilities for financial management	robust process in analysing its staff data by protected group and that in doing so it is meeting its NHS Standard Contract requirements and Equality Act duties ▪ **MHLC (2/9/24)** ▪ Good assurance regarding the oversight of inspection activity and completion of actions. ▪ Substantial assurance that the number of times detained patients are discharged by the tribunal or hospital mangers is within normal range ▪ Good level of assurance that the legislative requirements for patients held in the Trust on a s136 are being met in all areas ▪ Good assurance that there is a robust escalation process in place for any patients who have not had their rights within three days of detention ▪ Good assurance on the use of holding powers (when a nurse may		**Public Agenda Item 16 -** Report of the Chair of the Mental Health Legislation Committee **Private Agenda Item 25** - Development of the Risk Management Strategy and Policy **Private Agenda Item 31** - Deloitte Report Action Plan
											Compliance with the CQCs Fundamental Standards of Quality and Safety	▪ Day to day delivery of the fundamental standards by ward and team staff ▪ Responsibility for delivery of each element of the CQC Action Plan designated to lead Directors ▪ Chief Nurse is the lead Executive for relationship management with the CQC			
											Compliance with Mental Health Legislation (MHL)	▪ Delivery of the requirements of MHL by ward and team staff			
											Equality, Diversity, Inclusion and Human Rights	▪ The Director of People and Culture has operational responsibility for Equality, Diversity, Inclusion and Human Rights throughout the Trust in both Employment and Service Delivery ▪ EDIHR Lead and officers: ▪ Provision of support for inclusion networks ▪ Compilation of Equality Act 2010 data ▪ Compilation of evidence and consultation on the EDS ▪ Support for the development of the Trust's equality objectives ▪ Designated managers/leads: ▪ Completion of equality analyses ▪ Delivery of actions under the EDS ▪ All staff are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision ▪ Public Health Consultant engaged to develop the Trust's approach to tackling health inequalities			
											Risk Management	▪ Care Group Managing Directors, General			

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	1	2	3								Arrangements	Management Tier and Service Management Tier – ▪ Consider capture and maintain risks raised by staff in local risk registers ▪ Develop and implement action plans to ensure risks identified are appropriately treated ▪ Ensure that appropriate and effective risk management processes are in place and that all staff are made aware of the risks within their work environment ▪ Other Executive Directors - Responsible for ensuring effective systems for risk management, are in place within their directorate ▪ Head of Risk Management – Day to day management of the Trust Risk Register	prevent a patient from leaving hospital if they consider it is necessary for their health or safety for a period of up to 72 hours) ▪ Substantial assurance that the CQC have been notified of all AWOL's that meet the statutory reporting criteria ▪ Good level of assurance linked to the process followed when notification of discharge by nearest relative is received by the MHL department ▪ Substantial assurance that the MHL Committee met its obligations set out in the terms of reference and the Scheme of Delegation **Negative** ▪ **RPC (18/9/24):** Reasonable assurance relating to the management of risks in the CRR ▪ **MHLC (2/9/24)** ▪ Reasonable assurance on the implementation of the Positive and Safe Improvement Plan ▪ Reasonable		
											Health Safety and Security (HSS)	▪ The Trust has a Health, Safety and Security Team who manage the day-to-day Health and Safety requirements in line with all relevant parliamentary acts ▪ Reporting system is in place for the reporting of incidents which fall under the requirements of Reporting of Incidents of Disease and Dangerous Occurrences regulation (RIDDOR) ▪ Provision of HSS information for new employees at Trust induction. ▪ HSS awareness training forming part of all staff mandatory package. ▪ HSS online tool kit available for all services, wards and departments across the trust. ▪ Regular workplace audits undertaken by the HSS team. ▪ Incidents recorded on 'InPhase' are shared with relevant service leads, including HSS. This enables investigation of incidents to identify trends and flag any remedial actions			
											Executive and Care Group Leadership, management and governance arrangements	▪ Individual Executive Directors – Responsible for the implementation and delivery of governance arrangements relating to their portfolio ▪ Individual staff compliance with the range of policies relating to regulatory compliance e.g. health and safety			
											Inquests and Coroners	▪ Inquest Team - Management of the Inquest process from a Trust perspective including: ▪ Arranging and			

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	1	2	3									compiling witness statements and submission to Coroner ▪ Instruction of Solicitors ▪ Co-ordination and compilation of information ▪ Provision of support for staff ▪ Preparation of responses to Regulation 28 Reports by staff nominated by the CEO	assurance that the trust is meeting its requirements under the Mental Capacity Act and a reasonable level of assurance that the use and reporting of DoLS is being carried out as required		
11	✓	✓	✓	**Roseberry Park** **There is a risk that** the necessary Programme of rectification works at Roseberry Park and impacted by limited access to capital funding **could adversely affect** our service quality, safety, financial, and regulatory standing.	**DoFE**	**Board**	**High 16 (C4xL4)**	**Moderate (12) (-1L)**	Two actions have been identified to support achievement of the risk score; however, delivery dates are uncertain: ▪ Roseberry Park Rectification Works complete ▪ Medium Term NHS and ICB Capital allocations confirmed nationally	**Good**	Roseberry Park Rectification Programme Capital Programme External Audit	▪ Programme Director and Programme Manager – Responsible for managing the RPRP including key risks and issues log (Assurance to weekly huddle) ▪ Trust CPSG overseeing agreement of priorities for capital investment / impact assessment ▪ DMT overseeing detailed milestone capital project planning ▪ NENC Infrastructure Board (ICS Estates & Finance Directors)	**Positive** **Negative**		**Private Agenda Item 30 –** Report of the Chair of the Roseberry Park Sub-Group
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**	**RPC**	**High 20** (C5 x L4)	**High 20** (C5 x L4) **2028/29**	**2028/29** A number of actions have been identified which might cumulatively reduce the risk score; however, the target score is being maintained at the present level given national and regional uncertainty	**Good**	ICB Financial Governance including Mental Health LDA Sub Committee and CEO and DoF financial planning groups and sub groups Financial Sustainability Board	▪ DoFE member of ICS DoF/CFO group ▪ DoFE member of ICS Resource Allocation Steering Group ▪ CEO member of NENC CEO provider collaborative group ▪ CEO leading HNY provider collaborative work for MHLDA ▪ COOs leading Provider collaborative work to assess implications for beds / pathways and clinical models ▪ Financial reporting using intelligence from Care Groups, Directorates and costing transformation programme to inform management of underlying financial position	**Positive** • **RPC (18/9/2):** Revenue Performance ahead of plan year to date Reducing agency and related premia costs Work in train to refresh Trust drivers of deficit and to submit NENC refreshed	**RPC (18/9/24) –** Potential in year and recurrent revenue risk relating to tariff mechanism for funding the initial estimates of recent government pay award offers	**Private Agenda Item 28** - Report of the Chair of Resources & Planning Committee

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	1	2	3												
											Business Planning and Budget Setting Framework and in Year Financial Forecasting & Recovery Arrangements	▪ ACE -Responsible for the delivery of the Business Planning Framework ▪ DoFE and ESRG – Responsible for arrangements to develop the Financial Plan including tracking the recurrent and non-recurrent implications and underlying financial position and cost drivers ▪ Managing Directors (for Care Groups) and other Execs (for their Directorates) responsible for management of costs with budgets and/or agreed forecasts and informing assumptions to underpin financial planning using business planning processes. *(Reporting into FSB and ESRG into EDG with assurances into S&RC and Board)*	Medium Term Financial Plan **Negative** ▪ **IPR:** Capital Expenditure (Capital Allocation) (metric 20) - *reduced 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 20** (C5 x L4)	**Moderate 10** (C5 x L2) **June 24**	**Q1 2024/25** (-2L) Refreshed trust-wide communications strategy	Reasonable	Communications Strategy	▪ Director of Corporate Affairs and Involvement ▪ Head of Communications ▪ Communications team	**Positive** **Negative**	New national waiting standards for Mental Health	
											Stakeholder Communications and Engagement Strategy	▪ Trust Board ▪ Director of Corporate Affairs and Involvement ▪ Care Group Board Directors ▪ Head of communications ▪ Corporate Affairs and Stakeholder Engagement Lead ▪ Communications team			
											Social Media Policy	▪ Director of Corporate Affairs and Involvement – responsible for the development, implementation and monitoring of the social media policy ▪ Head of communications ▪ Comms team – responsible for ongoing monitoring of social media ▪ General Managers/Service Managers – ▪ Ward/Team Managers/Modern Matrons – as above ▪ Complaints team ▪ Patient experience team ▪ Clinical leaders ▪ Service managers ▪ People and Culture			

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**
Date: **10 October 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***
1	Safe staffing	Covid / Flu / Winter planning - There is a risk that some teams are unable to safely and consistently staff their services.
2	Demand	Gender Identity Distress Services – there is a risk that changes to the national service will result in increased demand on services.
4	Quality of Care	Adult learning disability respite service in Teesside – there is a risk that changes will impact on the quality of care. Assertive Outreach – Nottingham assurance and the Lampard Inquiry – there is a risk that failure to respond to learning will impact on quality of care. NHS England - Workforce, Training and Education (WTE) Directorate Annual Quality Report 2024 – there is a risk that failure to provide a satisfactory level of training across all professional groups will impact on quality of care.

Executive Summary:

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

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

Overview:	A Range of topics to update the board
Prior Consideration and Feedback	n/a
Implications:	No additional implications.
Recommendations:	The Board is invited to receive and note the contents of this report.

Our Big Conversation & Our Journey To Change

As Board members will know, when we agreed Our Journey to Change as our new strategy in January 2021 we always expected to refresh it in 3 to 5 years. As a Board we are committed to completing that refresh by the end of March 2025. To inform that work we carried out another online" Our Big Conversation" during July. That data is still being analysed, and Clever Together who ran the conversation are going to go through it in depth with our Executive on 15th October.

But the initial findings tell us what I think we all already knew. The Trust has made progress over the last 4 years, but we still don't always provide good experiences to everyone who uses our services or their families and carers. We don't always create a good experience for colleagues and our work with partners – although improved – still has some way to go so that we influence and support system partners effectively. There's lots more work to do, including finalising our clinical models and identifying what TEWV and others need to do in the long run to make them a reality. I envisage being able to engage internal and external stakeholders throughout this winter so that we have an agreed revised and updated version of Our Journey to Change 2 ready for Board of Directors sign off in March.

To support this the Board had a useful workshop in September. We considered the Darzi report and its findings (a briefing was circulated as the report was published). We were able to consider its implications for our work on our strategy refresh.

A further, more detailed report will be presented at the December board.

Update on adult learning disability respite service in Teesside

There are planned changes to the future of adult learning disability respite care in Teesside, set to take place over the next year. The change is necessary to make sure:

- The service provides the highest quality of care for people, both now and in the future
- That we comply with regulations set out by the Care Quality Commission (CQC). For example, the current buildings need significant updates as they no longer provide the best environment for people in our care.
- There is enough staff to provide safe and kind care
- The service offers value for money.

To make the necessary changes we recently gave notice to the North East North Cumbria Integrated Care Board (ICB), who commission the service. The ICB can now start looking at

the best option for future respite care. We're committed to supporting families and patients already receiving respite care from our trust over the next 12 months, until the ICB develops a service that supports their needs.

We are already working closely with colleagues at the ICB who will lead the work on what happens next. They will make sure patient and carer voices are heard and continue to involve our partners to inform any decisions made about the future of the service. Our colleagues, who work in the respite service, will also be part of this important work.

Assertive Outreach – Nottingham Assurance

Following the conviction of Valdo Calocane in January 2024 for the killings of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of Nottinghamshire Healthcare NHS Foundation Trust (NHFT) under section 48 of the Health and Social Care Act 2008. The review looked at 3 specific areas:

1. A rapid review of the available evidence related to the care of Valdo Calocane
2. An assessment of patient safety and quality of care provided by NHFT
3. An assessment of progress made at Rampton Hospital since the most recent CQC inspection activity.

The first report, Part 1, detailed the findings of areas 2 and 3 in August 2024 Part 2 of the special review was published, focusing on area 1.

Learning for TEWV so far:

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TEWV carefully considered a summary of Part 1 and Part 2 at a range of senior clinical and operational meetings. During August the two Care groups considered the operational model and clinical pathways of our local community mental health services and completion of the Community Mental Health Service Review ICB Maturity Index Self [1] Assessment Tools commenced. On completion both were submitted to the relevant ICBs.

Both Care Group maturity index self-assessments and review outcome templates identified some process gaps which will require work to address, the care pathways were found to be in line with expectations. The maturity index also indicated caseload size as an area for consideration and the organisation is already cognisant of this. Thus, whilst there is ongoing work to embed the caseload management supervision policy it is recognised that as a Trust, we need to ensure our information systems can assist the teams to easily identify and highlight this cohort of people which includes the ability to stratify caseloads.

Our operational policies and pathways will require review and revision to ensure that they include criteria for the assertive outreach/intensive case management function in community service provision and we will need to review capacity and resourcing in each community team. In addition, we are reviewing our rehabilitation models which will include consideration as to how the model with supporting this cohort of people.

Using the outcomes of the reviews ICBs are to develop longer term action plans to address gaps and present these at their next local public board meetings after the 30th September. Regional NHS England teams will lead the review of the returns and continue to work with ICBs where gaps in provision have been identified to ensure alignment with national guidance. NHS England is also developing additional guidance to provide greater clarity and

steer on key elements of care for people with severe mental health problems. This will include:

• Delivering high quality care planning and care coordination
• Stepping up and down care
• Managing seamless care across inpatient and their mental health services
• Ensuring the availability of recommended treatments and interventions.

TEWV Community transformation programmes are the platform to address any actions required and we aim to create consistent operational models across our community services that are able to flex according to local needs. The work that has commenced within TEWV that will mean we are in a good position to flex and align to the plans that are developed through the work of the regional NHS England teams. For example: On 24th July Durham Tees Valley Adult Mental Health Planned Care held a 'consolidation day' with the aim of renewing familiarity with the AMH Clinical Model, the community combined pathway and community mental health framework, in the context of the aims of community transformation. There are seven workstreams in place as a result of this day.

The AMH clinical network is having a focussed discussion regarding the Nottingham review submission 3rd October which will include planning for the next steps/actions across both care groups based on the review process so far.

The Quality Assurance Committee received a full report 03/10/24 including the submissions made to the ICBs and were assured that we have complied with the system requirements and that we have a mechanism to ensure the learning from this tragic case is taken forward into our own community services.

Covid / Flu / Winter planning

FLU campaign 2024 – 25

Flu -campaign starts 3rd October , this is a later start than in previous years , evidence suggests this is the best time for optimal protection through the winter months. We are going with a mixed model , local ward/team vaccinators as well as pre publicised clinics and roving vaccinators.
The Infection Prevention and Control nursing team are supporting wards teams and also doing some clinics in community , hard to reach areas alongside attending conferences and any meetings likely to have clinical staff. We have a good communication plan and have more local vaccinators than in previous campaigns.

COVID vaccination

We and several Trusts are not directly offering Covid vaccines in consideration of the following:

1) Spikevax vaccination – staff are not trained to use this specific vaccine preparation and there may be significant competency issues.
2) National COVID vaccination training was made available in the last week of September and it is, too late to train staff for the campaign .However staff who are trained vaccinators in MHSOP, LD services and Eating disorders will undertake the training so they can offer this to patients in higher risk groups.
3) Wastage , we wasted a lot of vaccine last year as the vaccines are prepared in vials of multiple doses and we have seen nationally an increased hesitance for the Covid vaccines.

For Covid vaccinations staff are being directed to the national booking system , there are clinics spread over the Country where they can get vaccinated with COVID , alongside the GP who will offer to those staff who are risk groups.

Winter plan

The Infection Prevention and Control team will monitor and respond to national guidance as it is available for the prevention of outbreaks across the winter. To date there is no specific guidance or trend, we will respond to outbreaks and national learning dynamically.

We are ensuring that all wards have a stock of PPE which is ordered through the usual process, there is no longer a central store of PPE.

NHS England - Workforce, Training and Education (WTE) Directorate Annual Quality Report 2024

Each year NHSE Workforce Training Education Department visit the Trust for a Quality Management Visit to discuss our end of Year Report. The report is produced by the Trust and summarises what we see as our strengths, weaknesses, and challenges for the forthcoming year and how we meet the relevant governing bodies training standards. This provides assurance to NHSE of the quality of multi-professional clinical training in TEWV. In addition to that report, training data, Self-Assessment Report (SAR) and Quality Improvement Plans (QiP) are submitted.

Following the inspection visit, NHSE produce a 'board level' view as to how the Trust has delivered its training responsibility, with its purpose being to promote a board level overview of the training related strengths and weaknesses. This includes both the educational governance and the associated financial governance of monies it has been provided through the Education Contract to ensure that we meet the required training and education standards and actively addresses areas where we may struggle.

The visit concluded that they were very satisfied with the level of training provided across all professional groups in the Trust. They said “The GMC National Training Surveys covering the 2023-24 training cycle has once again shown that our Postgraduate Doctors in Training and their Trainers rate the regional provision of training and the support to those providing it as some of the best in the UK. Your organisation and your staff have had a huge part to play in this success and we thank both you and them for the ongoing commitment.”

Of note, since the visit, the 2024 GMC survey results (postgraduate doctors in training) have been announced and this confirmed that the Trust has climbed to 9th nationally (out of 226 active Trusts) in the trainee survey rankings and is also placed 30th nationally in the trainer survey, which puts the Trust in the Top 20% of all organisations.

Federated Data Platforms

What is the NHS Federated Data Platform (FDP)?

The NHS Federated Data Platform (FDP) is software that will sit across NHS trusts and integrated care systems enabling NHS organisations to bring together operational data – currently stored in separate systems – to support staff to access the information they need in one safe and secure environment.

What does it cost?

A consortium led by Palantir, which include Accenture, PWC, Carnall Farrar and NECS, was awarded the contract to deliver the NHS Federated Data Platform in November 2023.

The contract is valued at £330m for over a seven year period and this will provide funding for up to 240 NHS organisations (trusts and integrated care systems).

It should be noted that FDP is an underlying infrastructure, and organisations must then implement products on top of the platform. These may be readily available products with limited/no up-front cost (e.g. OPTICA) but can still require significant resource to implement e.g. network connectivity, data flow, Information Governance, operational training/rollout, system support. Alternatively, products can be locally developed to sit on top of the FDP at cost. The currently available products on the FDP are:

- Referral to treatment validation (RTT) – facilitates RTT pathway accuracy and progression with comprehensive validation and list management
- Inpatients care coordination solution – streamlines elective care with data insights to improve theatre utilisation and support planning, improve data quality oversight and waiting list validation
- Outpatients care coordination solution – enhances clinic operations with waiting list validation, data quality tools, and forthcoming cohorting features
- Discharge planning (OPTICA) – is real-time tracking and task management for efficient patient discharge processes

Products in development:

- Cancer360 – will streamline and integrate multiple data sources to control pathway management for cancer patient lists

What are the current use cases for the FDP?

NHS Priority	Problem	How the FDP can help
Elective recovery	Long waiting times for elective care, and not fully maximising capacity.	Local teams will be better able to prioritise waiting lists, manage theatre capacity and identify staffing needs. It will help local teams make more effective use of their resources such as theatres, ensuring that all available slots are used to treat patients and reduce the elective backlog.
Care coordination	Example: A patient is well enough to be discharged from hospital, but it is a manual task for the hospital to call care	The FDP can provide live visibility of care home beds or spaces on virtual wards, facilitating a quicker discharge.

	homes to find an available bed.	
Vaccination and immunisation	Need to manage national/regional vaccine (e.g. COVID-19, Influenza) supply alongside uptake by geography, gender, ethnicity, disability and deprivation to identify any barriers to vaccine uptake.	The FDP can provide visibility of stock levels and help local teams to identify communities who aren't accessing vaccines and trends of vaccine uptake.
Population Health Management	Availablity of data to support planning of NHS Services.	The NHS Federated Data Platform will help to help local Trusts, Integrated Care Boards (on behalf of the integrated care systems) and NHS England proactively plan services that meet the needs of their population
Supply Chain Management	Need better oversight of critical supplies to better manage availability, time and money.	It will make it easier to see where critical supplies (such as protective masks, medication and equipment) are, how much is available, and where there are shortages. This means that items can be moved between hospitals or allocated to areas that need them the most. It also means the NHS can track how much needs to be purchased overall and buy in bulk, which will save everyone time and money.

Where is TEWV on its FDP Journey?

As a Trust, we can report that we are utilising the FDP via OPTICA to support "Discharge Planning", one of the four "Product" areas highlighted in NHS England's August 2024 letter to all Trusts.

Does the FDP replace the IIC?

The scope of FDP is different to the IIC, so it is expected that these systems will co-exist.

The FDP is primarily for bringing together live operational data to facilitate care across organisations. The IIC is a data collation and analysis platform for the purpose of undertaking analysis and gaining insights from data on the organisation's past, present and future via data mining, predictive analytics, applied analytics and statistics. There will be some overlap between the two systems regarding Population Health Management.

Under the current scope of FDP, it is likely it will be a data source for the IIC and the two products will complement each other.

Where can I read more?

Further information on the FDP can be found on the NHS England website: NHS England » NHS Federated Data Platform (FDP)

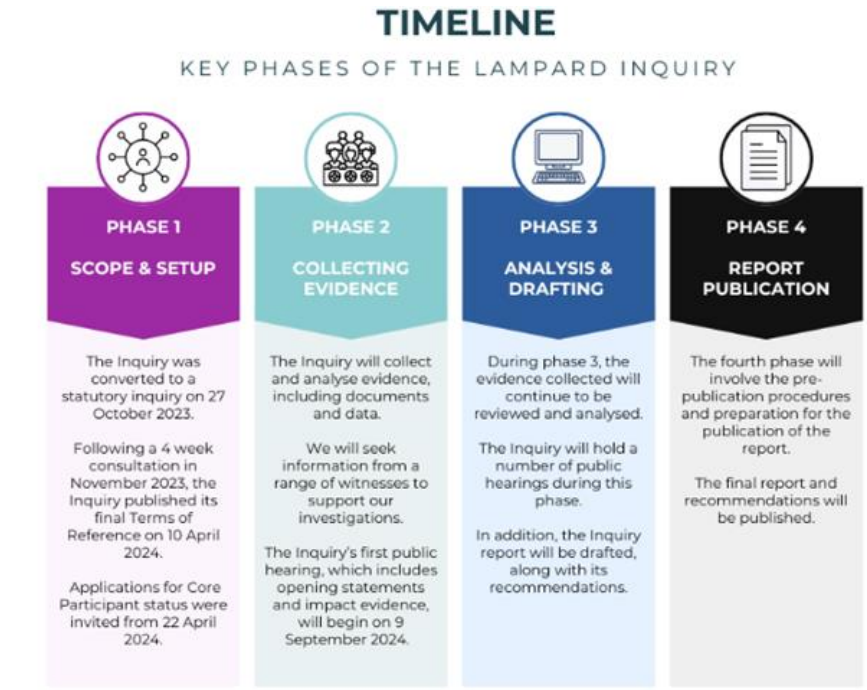
Lampard Inquiry

On 9 September 2024, the Lampard Inquiry's public consultation commenced to understand what happened to patients who died at children and adult inpatient units in Essex between the years of 2000 and the end of 2023, which claimed to be in the region of 2,000 deaths over this period. Public inquiries are funded by the government and are led by an independent chairperson. No one is found guilty or innocent however the inquiry will publish recommendations, which are likely to impact mental health trusts across the country.

Chaired by Baroness Kate Lampard CBE, it's the first of its kind specifically looking at inpatient mental health deaths in the Essex Partnership University Foundation NHS Trust (EPUT) and North East London Foundation Trust (NELFT). It will not look at community deaths unless they occurred within three months of discharge, the patient had been assessed and refused a bed, or they were on the waiting list for a bed.

This followed calls for an public inquiry from bereaved families over a number of years, as well as multiple concerns raised by the CQC from 2014-2018, a failed Essex Police corporate manslaughter investigation in 2018, a PHSO report in 2019 into the deaths of two young men, and an online petition set up in 2019 by the families which received 105,000 signatures thereby forcing a parliamentary debate (a petition must reach a 100,000 threshold to be considered for debate, 10,000 for a government response). In 2021, former health minister Nadine Dorries said a robust, independent inquiry would be held, and in the same year, HSE fined EPUT £1.5m following the deaths of 11 patients. In 2023, Channel 4's Dispatches published and broadcast an undercover report, which prompted CQC inspection and subsequent rating of two female wards as inadequate.

The inquiry will be split into specific themes included in the terms of reference, and from mid-September to November, bereaved families are invited to read their impact statements. In 2025, the first evidence sessions will take place, with barristers questioning the trusts and other participants on their experiences. Initial hearings are taking place at the Civic Centre in Chelmsford, Essex before the inquiry moves to London in 2025 and will continue to hear evidence until July 2026, which will be livestreamed on YouTube. 10 organisations and 56 relatives, patients and staff will initially give evidence in person, although more may be called to participate as the inquiry progresses. It is hoped the report will be published before the end of 2026. A phased timeline is detailed below.



Gender Identity Distress Services

Following the closure of Tavistock Gender Identification Distress Services (GIDS), national work has been undertaken to move toward a new Gender Identify service to move to more localised provision. The first being two regional services currently identified and operating in Liverpool and London with six more to be announced; however, these have not been announced as yet.

As part of the development, an instruction was given nationally to all NHS CAMHS services to offer a mental health assessment to young people who were on the waiting list for an assessment in the current GIDS services (Cohort A) and those young people who were currently in treatment within GIDS (Cohort B). The GIDS services wrote to all young people seeking their consent to undergo the requested assessment within a CAMHS team with national expectation that assessment completed for Cohort B by end of June 2024 and all young people within Cohort A by end of March 2025.

TEWV did not receive any referrals for Cohort B and to date with regard to Cohort A, North Yorkshire have received 2 referrals and a further 2 for Durham Tees Valley. The Trust has received appropriate income to put in place both clinical and non-clinical support to these children and families.

Additionally, a new referral process for young people with gender distress was also identified, to be called CYP Gender Services. This change means all referrals must now be made by NHS paediatric or NHS mental health services for children and young people. Referrals will not be accepted from any other source including primary care. The rationale being that the new referral pathway will ensure that young people's wider health and care needs will also be considered as part of their assessment for readiness to engage with the specialist gender service. The new arrangement came into effect from 01.09.24.

Our response to these new requirements has been led through our Children and Young People's Clinical Network and our role as a mental health provider is to assess these young people's needs within the iThrive framework, address and / or provide appropriate treatment for any mental health concern and if indicated support any referral on the new pathway to the national Gender Service. As part of this new role, we will be asked to review the GES (Gender Experience Summary) with the young person and parent / carer to determine any co-existing mental health or wider needs and coordinate onward care. This includes whether a referral is needed for neuro-diversity services.

As yet it is unknown the extent to which future demand will be placed on services and this will be picked up with commissioners as part of the upcoming planning round and in the interim our clinical teams continue to work closely with the national and regional NHSE colleagues to support children and families throughout the period of change.

Health Inequalities

In response to our local population need, TEWV have adopted a Trust approach to Health inequalities, and instigated a number of actions in delivering against this. Our approach has been co-created with staff and lived experience engagement members. It is based around 5 key commitments. It aims to identify the systematic ways in which we are uniquely well placed to act as a specialist NHS Trust. It supports our responsibilities against a number of national requirements.

Progress has been made in a number of areas over the last 12 months including on;

- Our approach to data and segmentation
- The delivery of a cocreated patient safety summit and launch of The TEWV "Health inequality team challenge"
- A lived experience led participatory arts project on the impact of inequalities in accessing care
- Research and workforce education on Gypsy, Roma and Traveller Communities and mental health
- Embedding inequalities' considerations in planning and inclusion in the annual plan as a cross cutting priority
- Research partnerships in areas including food insecurity, work and health and dementia diagnosis in BAME communities
- Delivery of British Institute for Human Rights (BIHR) training
- Development of Physical health plan
- Drafting of a strategic approach to dual diagnosis building on several areas of good practice across the Trust
- Poverty Proofing our service pathways led by CAMHS n South Tees
- Establishment of Equality Diversity and Human Rights groups at Care Group level.

A full board briefing paper including detail on areas of progress, challenges and areas for development will be circulated next week

Communications Dashboard

August - September 2024

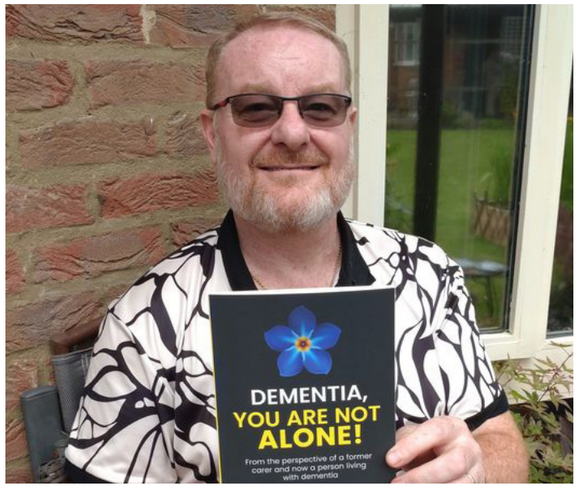
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

These months we...

- Announced the shortlisted nominations for the 2024 Star Awards.
- Celebrated our very own colleagues who took part in this years Great North Run.
- Announced our Annual General Meeting (AGM)
- Announced a unique lived in experience network for trust staff.
- Launched a new patient and carer experience survey for staff and service users.
- Announced the arrival of our upcoming flu vaccination campaign.

Highlights

The Voyage to Recovery team finished their journey to Ipswich



Michael Booth, an involvement member, has published a book about his experience with dementia

Kelly Conway, a volunteer service coordinator, won a BBC Make a Difference award for her work with therapy dogs

One of our volunteers, Pat, was recognised for 18 years of service

Our Wellbeing in Mind team was featured by BBC Yorkshire to highlight the work they do in schools

Roseberry Park hosted their annual summer Fayre

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

16
Media enquiries handled by the team

16
Media releases issued

97
Total pieces of coverage across online news, TV, and radio

News stories

- **Dementia diagnosis 'not the end' for Hartlepool author** – *BBC Online*
- **Callum's full circle story from dark place to helping other mental health sufferers** – *Teesside Live*
- **12 young psychosis sufferers to crew sailing boat on adventure of lifetime** – *Yahoo! News UK & Ireland*
- **York mental health partnership wins £2.44m for new mental health hub** – *City of York Council*
- **Nearly 1,000 older residents benefit from mental health partnership** – *Northern Echo (online)*
- **'One in a million' NHS trainee works extra shifts to help hundreds of Teessiders in need –** *Teesside Live*
- **York teachers welcome mental health scheme from Wear Valleys NHS Trust –** *BBC1 Yorkshire & North Midlands*
- **'Bubbly' Middlesbrough mum-of-three found dead seven days after last contact with** *Roseberry Park – Teesside Live*
- **Medical negligence claims land troubled mental health trust with 2.5m damages bill –** *Greatest Hits Radio*

Our website

120,633
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

2,370,596
page views

Top staff intranet news stories

1. Changes to senior roles
2. Jude's Journey
3. Hybrid working from September
4. Trainee works extra shifts to help others
5. Star Awards shortlisted nominations
6. Manager retires after 46 years

Social Media

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

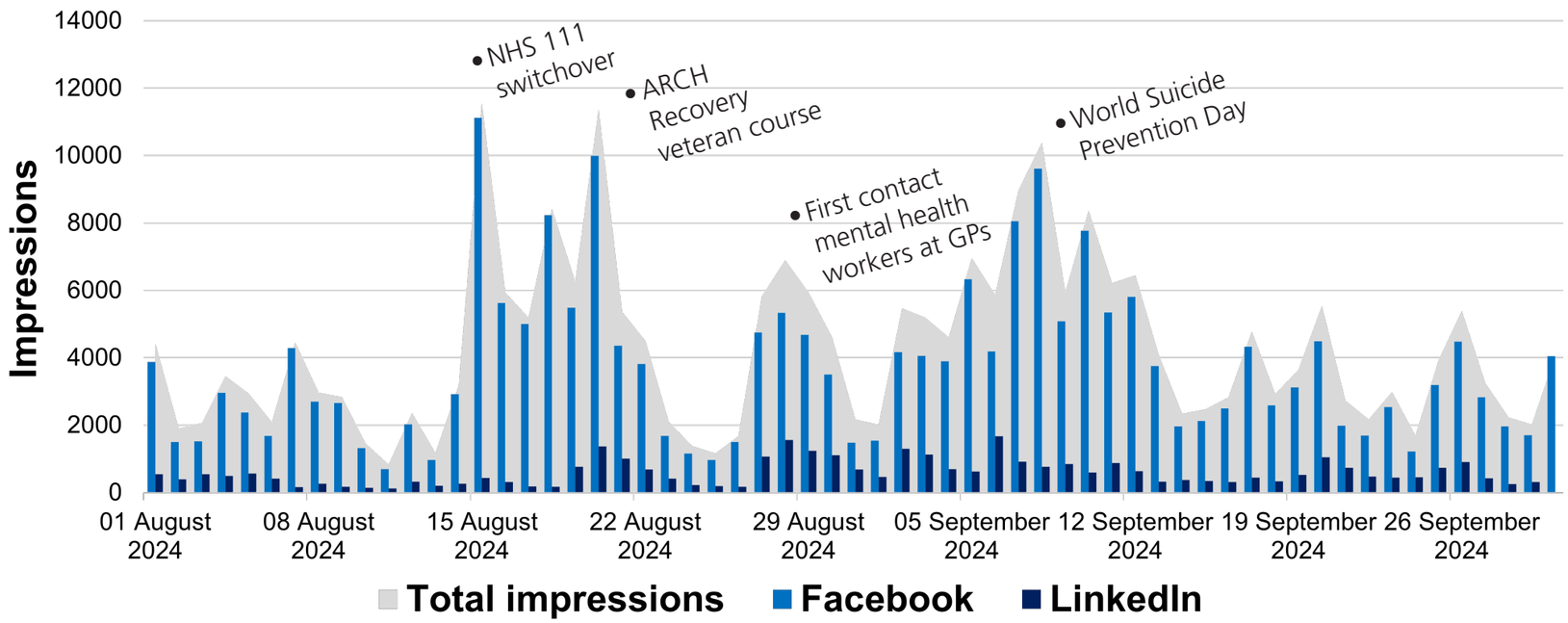
27,328
Total followers

355
New followers

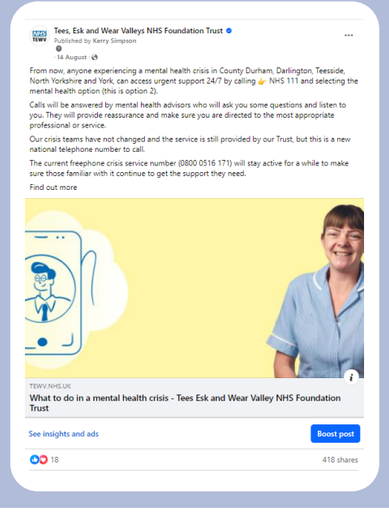
282,272
People who saw our content - impressions

162
Total posts

Daily impressions



Top posts



Impressions 38,647 - Engagement 1,484

Impressions 618 - Engagement 12

Impressions 4,260 - Engagement 326

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: Board of Directors
Date: 10th October 2024
Title: Board Integrated Performance Report as 31st August 2024
Executive Sponsor(s): Patrick Scott, Deputy Chief Executive
Author(s): Ashleigh Lyons, Head of Performance

Report for:

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1	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.
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.
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.
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 Our Journey To Change goals today and for the future.
6	Estates & 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.
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 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.
9	Partnerships & 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 Integrated Care Systems and multiple local authorities **limits** our ability to influence service transformation and improve the health of the communities we serve.
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
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
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.

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:

The Executive Directors Group is proposing that Board of Directors receives this report with:

- **Substantial controls assurance** regarding the oversight of the quality of services being delivered and the corrective actions/mitigations in place to address any gaps or negative assurances.
- **Good performance assurance** regarding the Integrated Performance Dashboard (IPD)
- **Reasonable performance assurance** regarding the National and Local Quality Requirements

Overview:

Controls Assurance

The overall **substantial** level of **controls assurance** has been determined based on the Performance Management Framework we have in place and the internal audit findings of the IPR by Audit One.

Performance Assurance

The overall **good** level of **performance assurance** for the IPD has been determined based on the following information which is underpinned by the Performance and Controls Assurance Framework. Of the 31 measures:

- There are now 3 (previously 4) measures within the Integrated Performance Dashboard (IPD) with **limited performance assurance** and **negative controls assurance.**
- There remain 5 measures within the IPD demonstrating **improved performance and/or controls assurance.** However, the improvement noted for the number of Patient Safety Incident Investigations reported on STEIS is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF).
- There are corrective actions/mitigations in place to address the risks and issues identified which have been reviewed; there are no new areas for escalation to EDG at this time.

The overall **reasonable** level of **performance assurance** for the National and Local Quality Requirements has been determined based on the following information:

- There are 6 National Quality Requirements within the IPR at sub ICB level and we are now failing 13 (previously 15) individual targets (from a total of 24). Of those failing, there is improvement for 6, no significant change for 5 and special cause concern for 2.
- There are 8 Local Quality Requirements within the IPR at sub ICB level and we are now failing 18 (previously 19) individual targets (from a total of 32). Of those failing, there is improvement for 1, no significant change for 8 and special cause concern for 9.
- There are corrective actions/mitigations in place to address the risks and issues which have been reviewed; there are no new areas for escalation to EDG at this time. A number of these risks and issues are pending the development of Performance Improvement Plans or have clear actions to take forward.

Positive Assurances

We have positive assurances in the following:

- ✓ Outcomes: CYP and Adults/Older Persons showing measurable improvement following treatment (clinician reported)
- ✓ Inappropriate OAP bed days and Inappropriate Active OAPs
- ✓ Talking Therapies: Wait Times 6 & 18 weeks
- ✓ Incidents of moderate or severe harm
- ✓ Staff Leaver Rate, Mandatory & statutory training compliance and Staff in post with a current appraisal
- ✓ Finance: CRES Performance – Non Recurrent
- ✓ Children and Young People Eating Disorder services – we have no CYP waiting more than the 1-week standard

Other Information

- **Proposed Standard -** Following approval at Strategy & Resources Committee, we are recommending that Board of Directors approves the application of an 85% **Bed Occupancy** standard from the 1st April 2024.

- **Trust-wide PIP (Financial Plan)** – Executive Directors Group have approved an extension to the timescale from the end of August to the end of September 2024 for the *cessation of accommodation costs for 6 agency workers* within the Agency Reduction PIP.

Prior Consideration and Feedback

The individual Care Group IPRs have been discussed and approved by the Care Group Boards and Executive Directors Group have approved the Trust IPR prior to Board of Directors.

Implications:

The Integrated Performance Report (IPR) is a fundamental component of our Board Assurance Framework. The implications of those measures with limited performance assurance and negative controls assurance and those where we are failing to achieve National and Local Quality Requirements impact on:

- Safe Staffing
- Demand
- Quality of Care
- Digital
- Estates & Infrastructure
- Quality Governance**
- Partnerships & System Working
- Regulatory Compliance
- Financial Sustainability
- Public Confidence

***The introduction of any new Electronic Patient Record can have a negative impact on Data Quality. Following the introduction of Cito in February 2024, data quality issues have impacted several patient-based measures across the organisation. To address this, data quality will be a key workstream in the Cito Improvement Project which is due to start Q3 2024/25. In addition, a newly formed Cito Improvement Group will own, and be responsible for the prioritisation of, Cito data quality issues and will be supported by the Data Quality Working Group. Data Quality workstream progress will be monitored via the standard Digital and Data Services project framework and will be formally reported via Digital Programme Board to Transformation and Strategy Board.*

They could also affect the Trust's ability to manage relevant risks to target level in accordance with agreed trajectories.

Recommendations: Board of Directors is asked to:

- note the substantial controls assurance on the operation of the Performance Management Framework; good performance assurance on the IPD and reasonable performance assurance on the National and Local Quality requirements,
- note the corrective actions/mitigations that have been/are being put in place to address the risks and issues identified and confirms it is assured on the actions being taken to improve performance in the required areas, and
- approve the application of the 85% standard for the *Bed Occupancy* measure from the 1st April 2024.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st August 2024

Report produced by: Amy Walford, Performance Lead (Corporate) and Ashleigh Lyons, Head of Performance
Date the report was produced: 25th September 2024

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

journey to change

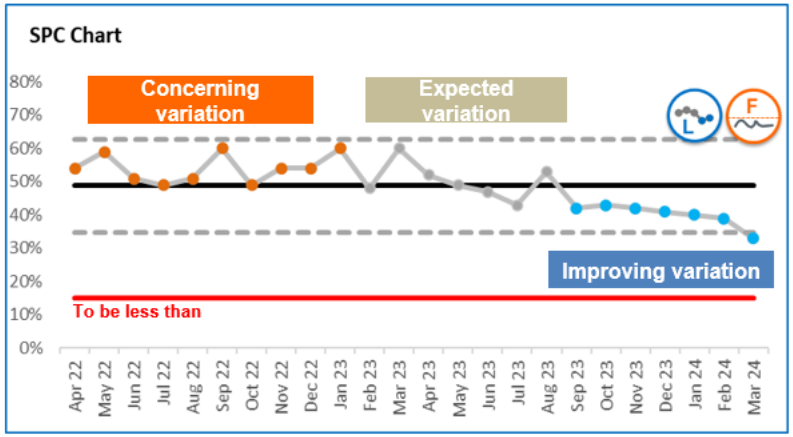
CONTENTS

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys
NHS Foundation Trust

Within our Board Integrated Performance Dashboard we use Statistical Process Control Charts to determine whether we have any underlying causes for concern. A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly). The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented;
Blue – there is a pattern of improvement which should be learnt from;
Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable.



The thick **black** line on an SPC chart is the average.

The dotted (- - - -) lines are the upper (top line) and lower (bottom line) process limits, which describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

Our Guide To Our Statistical Process Control Charts: Interpreting summary icons

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These icons provide a summary view of the important messages from SPC charts.

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

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 last assessment was completed in quarter 1 2024/25 and the next assessment will be completed in quarter 3 (reported to Board in quarter 4 2024/25).

	Data Quality Assessment		
Icon	***Description***	***What does this mean?***	***What should we do?***
	SUBSTANTIAL assurance; a data quality score of **93% or over**	The measure is reliable.	There is no specific action to take.
	GOOD assurance; a data quality score of **73% - 92%**	The measure is largely reliable; however, there are a small number of improvement actions that need to be undertaken.	**Review** what improvements were identified as part of the assessment and, if possible, take the appropriate action.
	REASONABLE assurance; a data quality score of **47% - 72%**	The measure is reasonably reliable; however, actions are required to improve its construction, data source and/or data.	**Identify** what improvements were identified as part of the assessment and take the appropriate action.
	LIMITED assurance; a data quality score of **46% or under**	The measure is unreliable and there are significant actions required to improve its construction, data source and/or data.	**Investigate** whether the measure is appropriate to be included in the Integrated Performance Report. **Remove** the measure from the Integrated Performance Report to enable improvement actions to be undertaken.

Action Status

Our action status is informed by a combination of current performance and performance over time (including trends).

	Action Status		
Icon	***Description***	***What does this mean?***	***What should we do?***
	POSITIVE ASSURANCE	Performance is EXCELLENT. There is special cause improvement or sustained high performance achieving standard. There are no deteriorating trends, and no underlying areas of concern.	There is no specific action to take.
	NO CONCERNS	Performance is GOOD or CONSISTENT. There is common cause (no significant change) with sustained acceptable level of performance, no deteriorating trends, and no underlying areas of concern.	There is no specific action to take.
	CONTINUOUS IMPROVEMENT	Performance is GOOD or CONSISTENT. There is a sustained level of performance with no deteriorating trends and no/minimum underlying areas of concern.	**Review** what improvement actions are being undertaken and **identify** what further actions could possibly be undertaken.
	AN AREA OF CONCERN	Performance is POOR. There is special cause concern or sustained low level of performance. There are deteriorating trends, and/or underlying areas of concern.	**Investigate** to better understand what is happening/has happened. **Undertake** a deep dive to identify any underlying services and **establish** SMART improvement actions.

Glossary of Terms

A&T	Assessment & Treatment
ACE	Assistant Chief Executive Directorate
ADHD	Attention deficit hyperactivity disorder
ALD	Adult Learning Disabilities
AMH	Adult Mental Health
ASD	Autistic Spectrum Disorder
CA&I	Corporate Affairs & Involvement
CNTW	Cumbria, Northumberland and Tyne & Wear NHS Foundation Trust
CRES	Cash Release Efficiency Savings
CROM	Clinician Reported Outcome Measure
CYP	Children & Young People
CYPS	Children and Young People Services
DTOC	Delayed transfers of care
DTVFCG	Durham Tees Valley and Forensic Care Group
EDG	Executive Directors Group
EIP	Early Intervention in Psychosis
ICB	Integrated Care Board
IPD	Integrated Performance Dashboard
MHSOP	Mental Health Services for Older People
MDT	Multi Disciplinary Team
MoJ	Ministry of Justice
NENC	North East & North Cumbria Integrated Care Board
NYYSCG	North Yorkshire, York & Selby Care Group
Neuro	Neurodevelopmental services
OAP	Out of Area Placement
PIP	Performance Improvement Plan
PIpA	Purposeful Inpatient Admission
PMH	Specialist Community Perinatal Mental Health
PROM	Patient Reported Outcome Measure
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Framework
RI	Restrictive Intervention
ROM	Routine Outcome Measures
SMART	Specific, measurable, achievable, relevant, time-bound
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STEIS	Strategic Executive Information System
TEWV	Tees, Esk & Wear Valleys NHS Foundation Trust
UoRR	Use of Resources Rating

Board Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience:** no significant change for all three patient and carer experience measures; all are achieving standard in August. There is no significant change in the responses received for the patient experience and carer experience questions, but there is special cause improvement for the inpatients feeling safe question.
- **Outcomes:** CYP no significant change and below standard for the PROM; however, special cause improvement for the CROM and above standard. AMH/MHSOP special cause concern and below standard for the PROM; however, special cause improvement but below standard for the CROM. There is special cause concern in the number of timely paired outcomes recorded for all measures, with the exception of the CYP PROM for which there is no significant change.
- **Bed Pressures:** special cause concern in bed occupancy; however, special cause improvement for the inappropriate out of area bed days.
- **Patient Safety:** special cause improvement for patient safety incident investigations; however, this is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). Special cause improvement for incidents of moderate of severe harm and no significant change for restrictive interventions and medication errors. There were 2 unexpected Inpatient unnatural deaths whilst on leave from the ward reported on STEIS during August.
- **Uses of Mental Health Act** no significant change.
- **Staff:** special cause improvement for leaver rate, mandatory training and appraisal; no significant change for sickness. We are achieving the standards in August for mandatory training and appraisals.
- **Demand** no significant change in referrals however, special cause concern continues for caseload.
- **Finance** The Trust's 2024/25 financial plan targets delivery of a break-even position. The year-to-date plan at Month 5 reflected a £1.967m deficit. When adjusted to remove technical items that are excluded from assessment of Trusts' financial performance the position is a deficit of £0.961m; or £1.006m favourable variance to plan. Whilst financial performance is ahead of plan, the year-to-date deficit needs to be recovered in-year, including through CRES targets that are more heavily weighted to deliver reduced costs in the second half of the year. There is uncertainty about the extent to which funding for nationally negotiated pay awards will cover anticipated costs. The position therefore requires ongoing focus, grip and control.

Risks / Issues

Of most concern:

- Unique Caseload
- Agency price cap compliance
- CRES Performance – Recurrent

Of concern:

- Adults and Older Persons PROM
- Bed Occupancy (AMH & MHSOP A&T Wards)

Positive Assurance

Significant improvement seen in:

- Children and Young Persons CROM
- Adults and Older Persons CROM
- Inappropriate OAP bed days
- Incidents of moderate or severe harm
- Staff Leaver Rate
- Mandatory & statutory training compliance
- Staff in post with a current appraisal

Positive assurance for:

- CRES Performance – Non-Recurrent

Board Integrated Performance Dashboard Headlines

Mitigations

AMH/MHSOP PROM

As part of their PIP, DTVFCG AMH Team and Service managers have implemented the use of the caseload report for monitoring completion of patient outcomes; it is expected that this should increase the number of patients discharged with paired outcome measures. DTVFCG MHSOP have met with the Section Head of Research & Statistics and a new action to use the caseload report to support oversight of completion of PROMs will be implemented by the end of September 2024; It is expected that this should increase the number of patients discharged with paired outcome measures. NYYSCG AMH services have reviewed their PIP. Actions are for professional leads to refresh the focus on ROMs in supervisions by the end of November 2024 and to ensure caseload reports to support oversight of completion of PROMs are used weekly by the end of December 2024. It is anticipated that both actions will provide a month on month increase in the number of paired PROMs completed. NYYSCG MHSOP are reviewing completion of outcomes in weekly performance huddles and using them as part of multi-disciplinary team discussions; however, the desired impact has not yet been achieved. A request has been submitted to EDG to extend the deadline to review a sample of patients to identify any specific issues and improvement actions to the end of September 2024, and a new action has been added to embed use of the caseload report by the end of October 2024; it is expected that this should increase the number of patients discharged with paired outcome measures. An Outcomes Event/Safety Summit is planned for the 6th November 2024 and quarterly webinars are anticipated to commence in quarter 3 2024/25 to support understanding and importance of outcome measures. Care Group Clinical Quads will present their outcomes and improvement actions to the November EDG meeting for focused discussion.

Bed Occupancy

As part of their PIP, DTVFCG have reviewed their discharge policy. The policy will be shared at a Care Group event in September 2024, with final approval expected November 2024. The Care Group Managing Directors briefed EDG in September, that the Care Groups will work together to develop a Trust-wide clinical model for the MHSOP organic bed base by the end of Q4 2024/25 and Trust-wide groups will be established to progress workstreams for Transforming Patient Flow and Transforming Mental Health Discharge within AMH services as part of the Urgent Care Programme Board.

Caseload

DTVFCG CYPS have developed a Recovery Plan to address the long waiting times within CYPS Neurodevelopmental teams. Actions include the implementation of a telephone line for professionals in Durham and Darlington for referrals; the revision and implementation of the neuro assessment protocol; the prioritisation of completion of ASD/ADHD assessment for children on the Getting More Help teams' waiting lists; a potential waiting list initiative and additional capacity; a refresh of the patient tracker list meetings to focus on capacity over the next 4 weeks; and a validation of the waiting list including writing to all patients to opt out if they feel they no longer require an assessment. The focused deep dive into the DTVFCG AMH active caseload to inform further PIP actions is progressing; however, completion has been delayed and a revised timescale will be confirmed by the end of September 2024. Following the full day event in July 2024 NYYSCG CYPS will develop a set of SMART improvement actionsby the end of October 2024. Outputs from the HNY ICB led a Memory Re-Design Event in April 2024 have been delayed and it is currently unclear when these will be shared. Corporately, a series of focused deep dives is being undertaken to better understand any other areas of concern. The first deep dive, focusing on CYP services, will be completed in September 2024 and findings will be with EDG.

Finance To support improved compliance, the Executive Workforce and Resources Group is overseeing a Performance Improvement Plan to ensure optimal rosters. The Efficiency Hub is now established to oversee delivery of CRES, to support early interventions should any schemes fall off track and to support the identification of mitigating schemes and/or new schemes to develop, with recent approval of a finance post to support delivery. Recruitment will be key to next steps. In addition to CRES, ongoing grip and control measures are required to deliver the 2023/24 exit run-rates based 2024/25 plan.

NOTE: See individual pages for full details of the improvement actions and expected impact/timescales

Durham Tees Valley & Forensic Care Group IPD Headlines

Headlines

- **Patient and Carer Experience:** no significant change for patients rating their recent experience as good or very good, carer involvement or for inpatients feeling safe. Achieving the standard for patients rating their recent experience as good or very good and for inpatients feeling safe. There is no significant change in the responses received for any of the measures.
- **Outcomes:** CYP special cause concern and below standard for the PROM; however, special cause improvement for the CROM and above standard. AMH/MHSOP no significant change in the PROM and special cause improvement in the CROM. Below standard for the PROM and CROM.
- **Bed Pressures –**no significant change in bed occupancy; however, special cause improvement for the inappropriate out of area bed days.
- **Patient Safety**. Special cause Improvement for patient safety incident investigations and incidents of moderate of severe harm No significant change for medication errors and unexpected inpatient unnatural deaths. There was 1 unexpected Inpatient unnatural death reported on STEIS during July. Special Cause Concern for Restrictive interventions.
- **Uses of Mental Health Act** no significant change.
- **Staff.** For recommending the Trust as a place to work we achieved 51.91 % and for staff feeling able to make improvements we achieved 62.57%. Special cause Improvement in appraisal and in mandatory and statutory training. No significant change in sickness.
- **Demand** special cause variation of a decreasing nature in referrals; however special cause concern in caseload driven by Adult Mental Health and Children and Young Peoples services.
- **Finance The Care Group**, planned to spend £108.8m as at August, and actual spend was £108.5m, which is £0.289m less than planned. The improvement is as a result of reduced levels of Independent sectors beds. As at M5 CRES delivery was £483k behind plan.

Risks / Issues*

Of most concern:

- Unique Caseload
- Financial Plan: Surplus/Deficit

Of concern:

- Children and Young Peoples PROM
- The Number of Restrictive Interventions used
- Agency price cap compliance
- Agency Spend

Positive Assurance

Significant improvement seen in:

- Children and Young Peoples CROM
- Adult Mental Health/Older Peoples CROM
- Inappropriate OAP bed days
- The number of Patient Safety Incidents investigations reported on STEIS
- Incidents of moderate or severe harm
- Staff Leaver Rate.
- Appraisal
- Compliance with ALL mandatory and statutory training

Durham Tees Valley & Forensic Care Group IPD Headlines

Mitigations

CYP PROM

The Care Group revised their Performance Improvement Plan (PIP) as the original actions did not have the desired impact. The service have undertaken a patient level deep dive into patients discharged with a paired outcome measure that are not demonstrating an improvement to understand the reason(s) why Findings were concluded but were then revisited by the service with the Head of Research and Statistics and Associate Director of Performance. These findings are being revisited and will be documented and shared in October 24 in order to inform additional actions.

AMH/MHSOP PROM and CROM

Within AMH Caseload reports produced by the Business Intelligence team will now be used by team and ward managers to monitor and improve the recording of timely paired outcomes. Within MHSOP, a meeting took place between Service leads, the Head of Research and Statistics and the Performance Team to discuss current issues and agreed further actions for the PIP. A further action has been added which is to use the caseload report to monitor timely outcome recording. This will be fully implemented by the end of September 24.

Caseload

CYPS have developed a Recovery Plan to address the long waiting times within CYPS Neurodevelopmental teams (this will replace the original PIP); which will need system-wide support. This plan was shared with Care Group Board in August. A PIP for AMH services includes pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues It is anticipated this action will increase assessment and reduce 80% of referrals coming into intervention teams by June 2024 (July report). This action has not yet had the desired impact and is now expected by the end of Quarter 2. In addition, a focused deep dive on active caseload is to be completed by end of August 24, which will inform further PIP actions.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience:** No significant change in either of the measures or in the number of carer responses, with the exception of patient who have responded to their experience which is showing special cause improvement.
- **Inpatients Feeling Safe:** No significant change and in the number of responses to this measure.
- **Outcomes:** CYP PROM and CROM are reporting special cause improvement. AMH/MHSOP PROM are reporting special cause concern, AMH/MHSOP CROM are reporting no significant change with further improvement in both specialties with MHSOP reporting special cause improvement, although remains low
- **Bed Pressures:** Bed Occupancy is reporting special cause concern at Care Group and AMH, MHSOP is above the mean; Inappropriate out of area beds days continues to report special cause improvement
- **Patient Safety:** Special cause improvement across all measures
- **Uses of Mental Health Act:** no significant change
- **Staff:** For recommending the Trust as a place to work we achieved 47.62% and for staff feeling able to make improvements we achieved 58.57%. **Staff leaver** is special cause improvement. **Sickness** no significant change**, Mandatory Training and Appraisals** is special cause improvement.
- **Demand:** no significant change in referrals and caseload is reporting special cause improvement
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues

Of most concern:

- Adults and Older Persons Patient reported Outcome Measure
- Bed Occupancy
- Unexpected deaths
- Financial Plan: Agency expenditure

Of concern:

- Financial Plan: Surplus/Deficit
- Agency price cap compliance

Positive Assurance

Improvement seen in:

- Children and Young Persons Clinician and Patient Reported Outcome Measures
- Inappropriate OAP
- Patient Safety Incident Investigations
- Number of Incidents of moderate or severe harm
- Staff Leaver Rate
- Mandatory & Statutory Training
- Appraisals

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Mitigations

AMH/MHSOP PROM and CROM

- A number of actions are in place as a wider Trustwide piece of work which are included within the outcome's slides.
- AMH have revised their PIP in line with the wider work, new actions include; Professional leads will refresh focus on ROMs with staff and request to be included and reviewed in clinical and caseload supervision and Team/professional leadership staff to familiarise themselves with the categorical change and caseload reports and to ensure these are used on a weekly basis during huddles/supervision. Both actions will see an increase will be seen month on month in the denominator of the outcome measure.
- MHSOP to review completed outcomes within weekly performance huddles using outcomes as part of multi-disciplinary team discussions to ensure staff complete the agreed outcome measures at the start and the end of the patient's journey to ensure they are timely and paired, this has not had the desired impact but has resulted in a small increase in patients discharged with a paired outcome, further actions are included in the relevant slides.
- To review a sample of patients who are not achieving measurable improvement to understand the reasons why which will allow for specific issues to be identified and align new actions with a timescale of 31st August 2024, however, due to service system pressures, a request for an extension is being sought from EDG in September, for the new timescale to be end of October 24
- All staff to use the new categorical change report and caseload reports to be used on a weekly basis during huddles/supervision is to be fully implemented by the end of October 2024

Caseload

- CYPS have further work required on their demand and capacity, which has been delayed due to capacity in the planning team, which is expected to be completed by the end of October and presented within the November QAIG, however, it must be noted, this has continued to reduce and is now reporting as no significant change and at the lower process limit.
- The HNY ICB Memory Re-Design Event outputs have been delayed and at this stage it is unclear when these will be shared.

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Finance

Improved performance relative to control totals set in year to support financial recovery provide increased assurance that the Trust will deliver our 2024/25 breakeven plan, based on a mid-case scenario. A small number of external factors have potential to impact the financial outturn however these are currently projected as being manageable within the overall position.

NOTE: See individual pages for full details of the improvement actions and expected impact/timescales

Performance & Controls Assurance Overview

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

Please note *this is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF).*

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%	93.05%	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%	73.56%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	80.04%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	23.71%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	43.37%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	51.30%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	H	F	30.00%	23.41%	30.00%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H			100.83%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L			113	
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC	L			15	
11)	The number of Incidents of moderate or severe harm	QAC	L			214	
12)	The number of Restrictive Interventions Used	QAC				5,102	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				3	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				3	
15)	The number of uses of the Mental Health Act	MHLC				1,749	

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				51.61% (Jul - 2024)	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				60.51% (Jul - 2024)	
18)	Staff Leaver Rate	PC&D	L	F	11.00%	11.29%	11.00%
19)	Percentage Sickness Absence Rate (month behind)	PC&D		?	5.50%	5.91%	5.50%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	?	85.00%	88.19%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	F	85.00%	87.53%	85.00%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				39,201	
23)	Unique Caseload (snapshot)	S&RC	H			63,655	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	1,967,000	961,079
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	5,437,266	4,804,857
25b)	Agency price cap compliance	S&RC	67.00%	66.99%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	6,877,750	6,309,000
28)	CRES Performance - Non-Recurrent	S&RC	666,667	1,037,000
29)	Capital Expenditure (CDEL)	S&RC	3,818,000	2,802,703
30)	Cash against plan	S&RC	55,927,000	56,457,916

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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 August **1008** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **942 (93.45%)** scored "very good" or "good".

There is no significant change at Trust, Care Group and Service level in the reporting period and no significant change in the number of patients who have responded to this question.

There is no updated National Benchmarking data available.

Underlying issues:
- Not all wards and teams are routinely facilitating completion of the surveys.

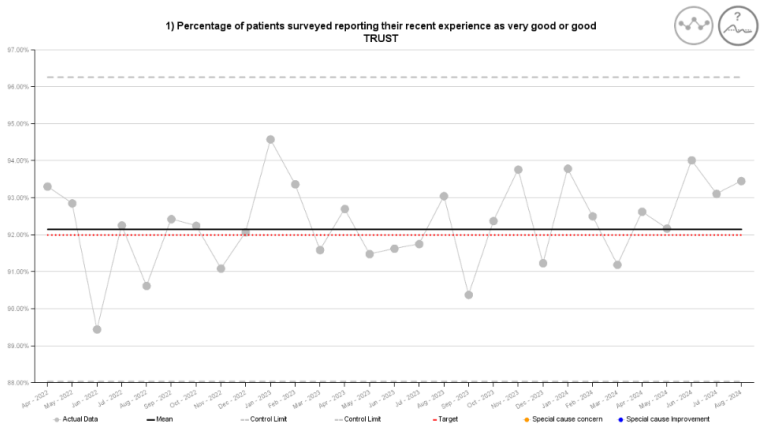
Actions:
- The Patient & Carer Experience Reference Group is establishing a task and finish group with service user and carer membership to understand the performance of each individual team and what key 5 things they might look for. The key 5 priorities will be agreed by the end of September 2024.
- Quality Improvement Team to undertake some focused work with the top 10 and bottom 10 teams regarding response rates, to learn from and share best practice. This work was to be completed by the end August 2024 but has been delayed to the end of September 2024. (**Completed)** Feedback is currently being reviewed.
- The Patient & Carer Experience team have implemented a rolling programme of Quality Visits targeting teams with zero response rates.

No significant change in the data during the reporting period shown

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

DQ ★ 93%

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



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

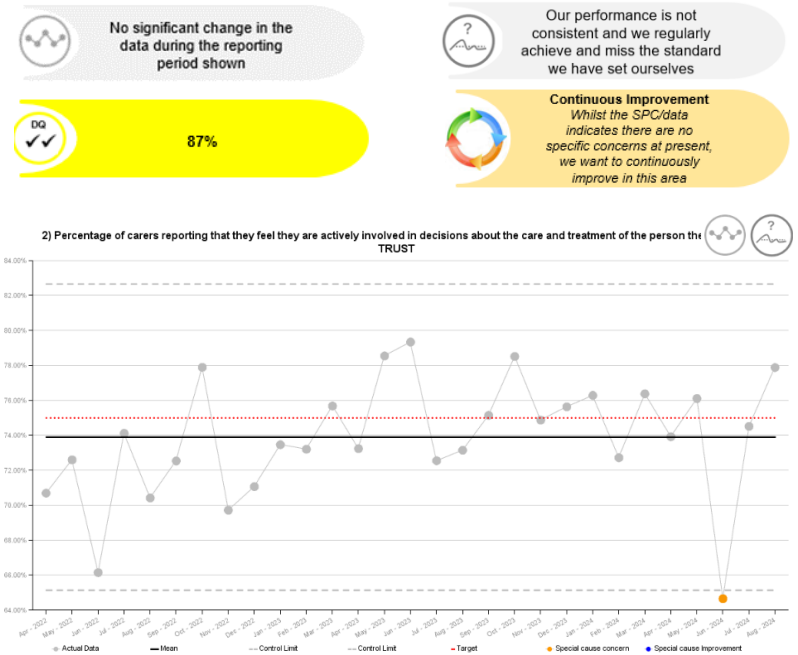
Background / standard description:
We are aiming for 75% of carers reporting they feel they are actively involved in decisions about the care and treatment of the person they care for.

What does the chart show/context:
During August, **416** 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, **324 (77.88%)** scored "yes, always".

There is no significant change at Trust and Care Group level in the reporting period and no significant change in the number of patients who have responded to this question. There is special cause for concern for Adult Learning Disabilities within North Yorkshire, York & Selby Care Group; however, the Care Group has confirmed there are no underlying issues to report.

Underlying issues:
- Engagement with various carer groups
- 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 Patient & Carer Experience Team are continuing to work with the Recovery College to develop an e-learning package to deliver the Carer Awareness training. The draft proposal was to be presented to the Carers Group for approval by the end of August 2024 (**Not completed);** however, will now be presented in September.
- Quality Improvement Team are to undertake some focused work with the top 10 and bottom 10 teams regarding response rates, to understand whether these barriers remain a concern and whether there are any new and emerging themes. This work was delayed to the end of September 2024. (**Completed)** Feedback is currently being reviewed.



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 August **182** patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **146 (80.22%)** scored “yes, always“ and “quite a lot”.

There is no significant change at Trust and Care Group level in the reporting period; however, there is special cause improvement in the number of patients who have responded to this question. There is special cause improvement for Adult Learning Disabilities in Durham, Tees Valley & Forensic Care Group.

There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients (including self-harm), environment, the acuity of other patients and violence & aggression and the use of restrictive interventions on wards.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions identified; however:

- All inpatient wards continue to implement the Safewards components to ensure our wards are safe at all times for patients. Application is monitored through the Fundamental Standards groups in both Care Groups.
- The Safe Staffing Group is working to ensure that we have a consistent and appropriately staffed workforce in all our wards.

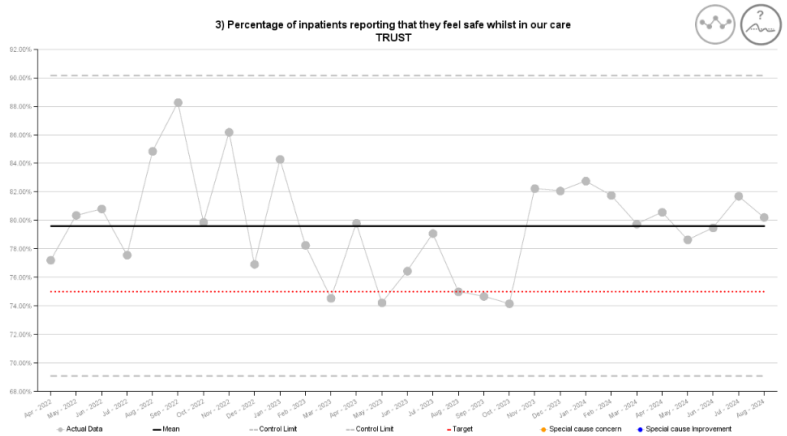
No significant change in the data during the reporting period shown

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

DQ

87%

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



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

NHS
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 August **693** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 172 (24.82%)** made a measurable improvement.

There is no significant change at Trust level in the reporting period. There is special cause concern for Durham Tees Valley & Forensic Care Group and special cause improvement for North Yorkshire, York & Selby Care Group. There is no significant change at Trust level in the number of patients discharged with a paired outcome measure.

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

Underlying issues:
There are a range of issues currently impacting this measure.
- This measure currently does not report the full suite of patient-related outcomes as a number of measures do not have a reliable change index.
- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture. One contributory factor is the length of time taken to record an outcome measure on Cito.
- We do not fully understand the reasons why our children and young people are not demonstrating measurable improvement.
- The measure is currently including patients that have died due to natural causes.

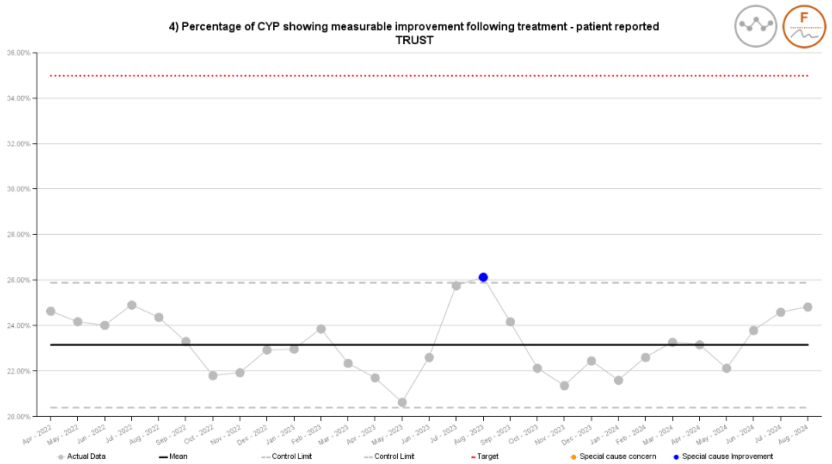
Actions:
- The Business Intelligence Team and Specialty Development Manager are working together to establish if there is a reliable change index for the 3 outstanding outcome measures. (**Completed**)
- The Business Intelligence Team will work with the Child Outcome Research Consortium (CORC) to establish a national reliable change index in collaboration with other member organisations. Timescale to be confirmed.

No significant change in the data during the reporting period shown

DQ 87%

F Our system is expected to consistently fail the target/expectation

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



Actions continued:
- The DTVFCG revised PIP was to go to Care Group Board and EDG for approval in September 2024 **(Not completed);** however, the findings from the deep dive, which were to inform new actions, need to be revisited following a review with Business Intelligence. The findings and new actions will be shared with the Care Group Board and EDG in October.
- An Outcomes Event/Safety Summit is planned for the 6th November 2024.
- Quarterly webinars are being arranged to support understanding and importance of outcome measures. It is anticipated these will commence from quarter 3 2024/25 onwards.
- Head of Performance to complete a change request for the measure to exclude patients that have died by the end of September 2024.

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

NHS
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 August **1586** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 705 (44.45%)** made a measurable improvement.

There is special cause concern at Trust level, for North Yorkshire, York & Selby Care Group and Adult Mental Health Services within that Care Group in the reporting period. There is no significant change for Durham, Tees Valley & Forensic Care Group. There is special cause concern at Trust level in the number of patients discharged with a paired outcome measure.

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

Underlying issues:
- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture.
- We do not fully understand the reasons why our adult and older persons patients are not demonstrating measurable improvement.
- The measure is currently including patients that have died due to natural causes.

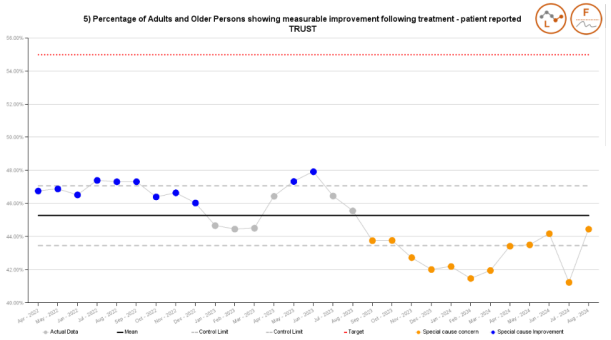
Actions:
- DTVFCG AMH have a PIP; the remaining action is to implement the use of the caseload report, which will be completed by the end of August 2024. **(Completed)**. It is expected that this should increase the number of patients discharged with paired outcome measures.
- DTVFCG MHSOP have met with the Section Head of Research & Statistics during August 2024 to discuss potential new actions for their PIP. **(Completed)** The new action is for Team Managers to use the caseload report to support oversight of completion of PROMs by the end of September 24. It is expected this should increase the number of patients discharged with paired outcomes.
- NYYSCG AMH services are reviewing their PIP as the original actions did not have the desired impact and will take into account the wider programme of work. **(Completed)** Actions are for professional leads to refresh the focus on ROMs in supervisions by the end of November 2024 and ensure caseload reports are used weekly by the end of December 2024. It is anticipated that both actions will provide a month on month increase in the number of paired PROMs completed.

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

Our system is expected to consistently fail the target/expectation

87%

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



Actions continued:
- NYYSCG MHSOP have a PIP. Actions include to: review completion of outcomes in weekly performance huddles and use them as part of MDT discussions. (**Completed),** however the desired impact has not yet been achieved; and to review a sample of patients to identify any specific issues and improvement actions by the end of August 2024 **(Not Completed)**; the service has requested an extension. A new action has been added to embed use of the caseload report by the end of October 2024. It is expected this should increase the number of patients discharged with paired outcome measures.
- An Outcomes Event/Safety Summit is planned for the 6th November 2024.
- Quarterly webinars are being arranged to support understanding and importance of outcome measures. It is anticipated these will commence from quarter 3 2024/25 onwards.
- Head of Performance to complete a change request for the measure to exclude patients that have died by the end of September 2024.
- Care Group Clinical Quads to present their outcomes and actions to the November EDG meeting for focused discussion.

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

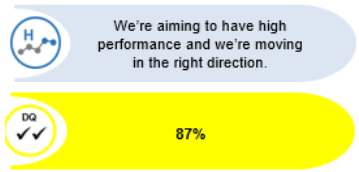
What does the chart show/context:
For the 3-month rolling period ending August **691** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 366 (52.97%)** made a measurable improvement.

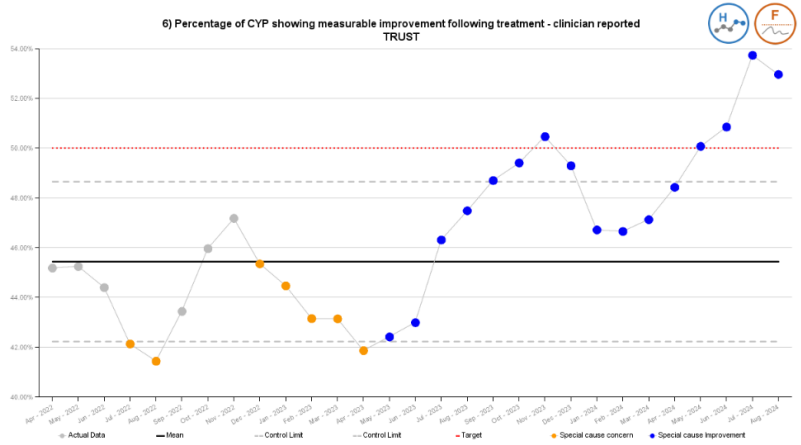
There is special cause improvement at Trust level and Care Group level in the reporting period, and performance is above standard at all levels. However, there is special cause concern at Trust level in the number of patients discharged with a paired outcome measure.

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)

Underlying issues:
- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture.
- The measure is currently including patients that have died due to natural causes.

Actions:
- Chief Information Officer to explore mandating CROMS on Cito by the end of October 2024.
- An Outcomes Event/Safety Summit is planned for the 6th November 2024.
- Quarterly webinars are being arranged to support understanding and importance of outcome measures. It is anticipated these will commence from quarter 3 2024/25 onwards.
- Head of Performance to complete a change request for the measure to exclude patients that have died by the end of September 2024.





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 August **2440** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 596 (24.43%)** made a measurable improvement.

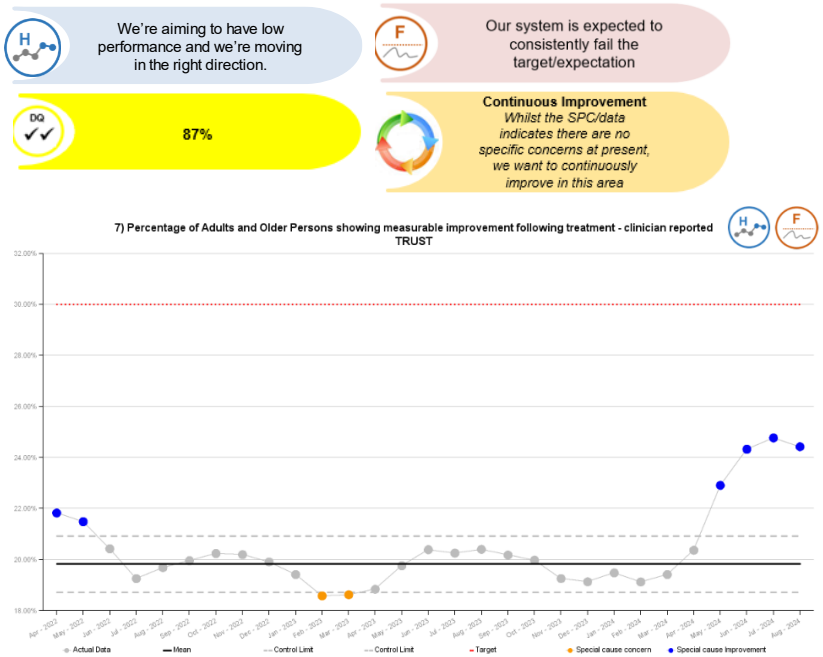
There is special cause improvement at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period, with both underlying specialties reporting special cause improvement. There is no significant change for North Yorkshire, York & Selby Care Group, but there is special cause improvement for Mental Health Services for Older People. However, MHSOP in both Care Groups continues to be a concern.

There is special cause concern at Trust level in the number of patients discharged with a paired outcome measure.

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

Underlying issues:
- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture.
- We do not fully understand the reasons why our adult and older persons patients are not demonstrating measurable improvement.
- The measure is currently including patients that have died due to natural causes.

Actions:
- Chief Information Officer to explore mandating CROMS on Cito by the end of October 2024.
- *The Trust-wide and Care Group specific actions described in measure 5, Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported, are also applicable for this measure.*



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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
During August, **10,850** daily beds were available for patients; of those, **11,119 (102.48%)** were occupied. Overall occupancy <u>including</u> independent sector beds was **102.65%**

There is special cause concern at Trust level and for North Yorkshire, York & Selby Care Group in the reporting period and no significant change for Durham, Tees Valley & Forensic Care Group. There is special cause concern for Adult Mental Health Services in both Care Groups, and whilst there is no significant Mental Health Services for Older People, an increasing position is seen.

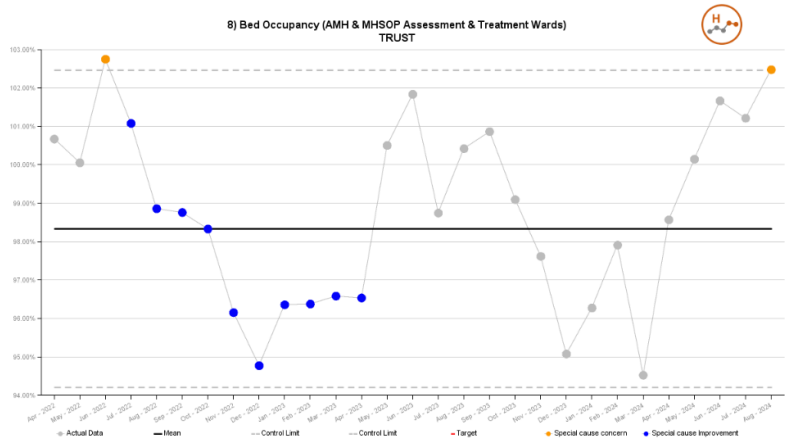
Underlying issues:
- Delayed transfers of care – specifically in Mental Health Services for Older People Services in DTVFCG.
- At Trust level (both Care Groups) patients classified as clinically ready for discharge equated to an average of 23.2 Adult and 17.9 Older Adult beds in August 2024, with an associated direct cost of c.£2.368m (including £463k independent sector bed costs). Of the cost, c.£1.489m relates to Adult and c.£0.878m relates to Older Adult.
- Patient flow and adherence to PIpA process
- Length of stay (linked to above issues)
- Greenlight admissions
- Ministry of Justice (MoJ) patients

Actions:
- Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP). Remaining actions are to:
  - Identify best practice across other NHS trusts to support the review of our discharge policy. The policy was expected to be implemented by end of April 2024. It is anticipated that the impact of this action should be a reduction in length of stay to an average of 30 days. The Care Group requested a further extension to the PIP with a revised date of the end of July 2024. **(Not yet completed)** The policy has been drafted for review at a Care Group event in September 2024; final approval expected November 2024.
- Care Groups to work together to develop a Trust-wide clinical model for the MHSOP organic bed base by the end of Q4 2024/25.
- Trust-wide groups to be established to progress workstreams for Transforming Patient Flow and Transforming Mental Health Discharge within AMH services as part of the Urgent Care Programme Board.

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

80%

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 out of area bed days by the end of March 2025.

What does the chart show/context:
For the 3-month rolling period ending August **113 days** were spent by patients in beds away from their closest hospital.

There is special cause improvement at Trust and Care Group level in the reporting period.

There was 1 active OAP placement as at 31st August 2024 (Tees Valley SICBL).

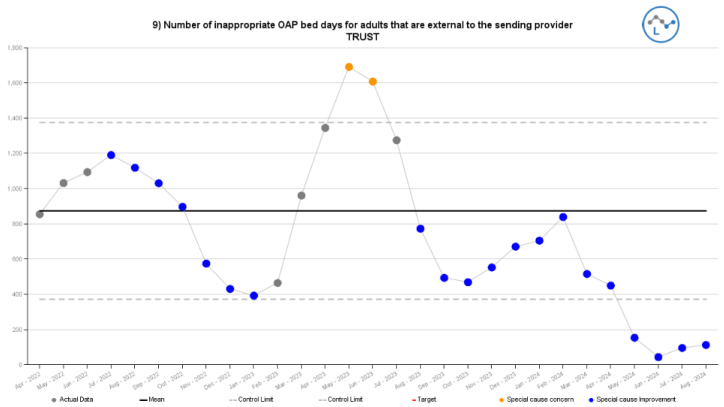
Underlying issues:
Bed Occupancy is impacting on our ability to admit patients to our beds

Actions:
See measure 8) Bed Occupancy

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

DQ 73%

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



ICB Trajectories versus actual performance for Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)

Active inappropriate adult acute mental health out of areas placements (OAPs)		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust	**Plan**	**10**	**10**	**8**	**7**	**7**	**4**	**4**	**4**	**2**	**2**	**1**	**0**
	Actual	**0**	**0**	**0**	**0**	**1**							
North East & North Cumbria ICB	**Plan**	7	7	6	5	4	3	3	3	2	2	1	0
	Actual	**0**	**0**	**0**	**0**	**1**							
Humber & North Yorkshire ICB	**Plan**	3	3	2	2	2	1	1	1	0	0	0	0
	Actual	**0**	**0**	**0**	**0**	**0**							

10) The number of Patient Safety Incident Investigations reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
3 patient Safety Incident Investigations (PSII) were reported on the Strategic Executive Information System (STEIS) during August.

There is special cause improvement at Trust and Care Group level in the reporting period and for most services. *This is not necessarily an actual improvement, as there was a change in process late January 2024, when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations.*

Each incident is subject to a multi-disciplinary after-action review by services and then reviewed within the Patient Safety huddle.

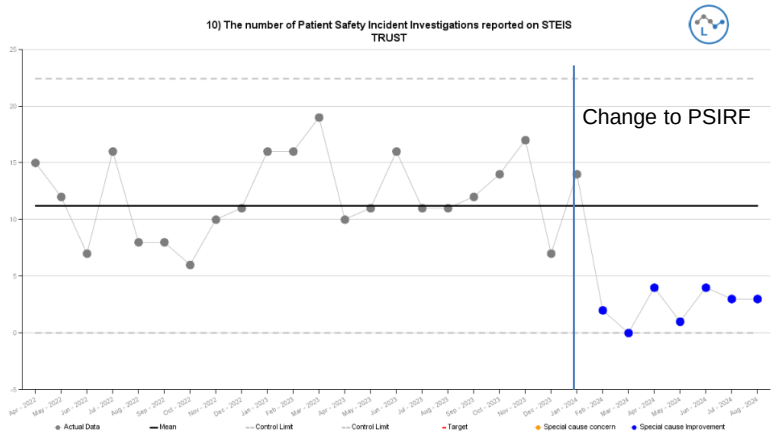
Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

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

DQ 93%

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



11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is special cause improvement at Trust and Care Group level in the reporting period. There is special cause improvement for Adult Learning Disabilities, Adult Mental Health and Children & Young Peoples Services within Durham, Tees Valley & Forensic Care Group and Adult Learning Disabilities within North Yorkshire, York & Selby Care Group.

Each incident is subject to a multi-disciplinary after-action review by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

As incidents are reviewed, the severity could be reduced or increased (severity is usually reduced).

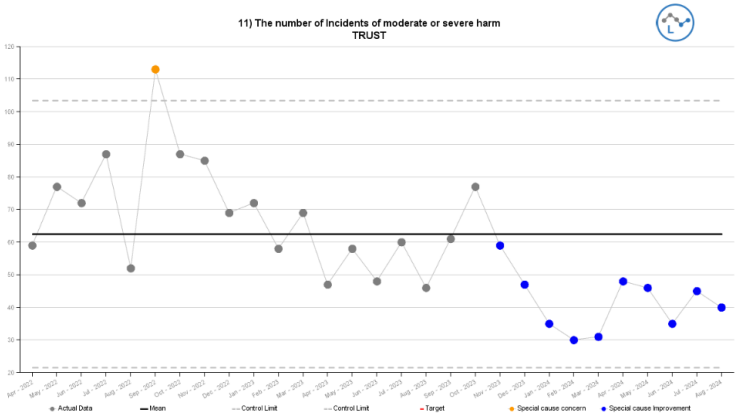
Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

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

DQ 93%

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



12) The number of Restrictive Intervention Used

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
876 types of Restrictive Interventions were used during August.

There is no significant change at Trust and Care Group in the reporting period. There is special cause concern in Adult Mental Health Services within Durham, Tees Valley & Forensic Care Group. There is special cause improvement for Adult Learning Disabilities in both Care Groups and Children & Young Peoples Services and Health & Justice in Durham, Tees Valley & Forensic Care Group.

Update:
Following identification of an issue that resulted in a number of duplicate interventions being counted, work has been undertaken to correct historic data.

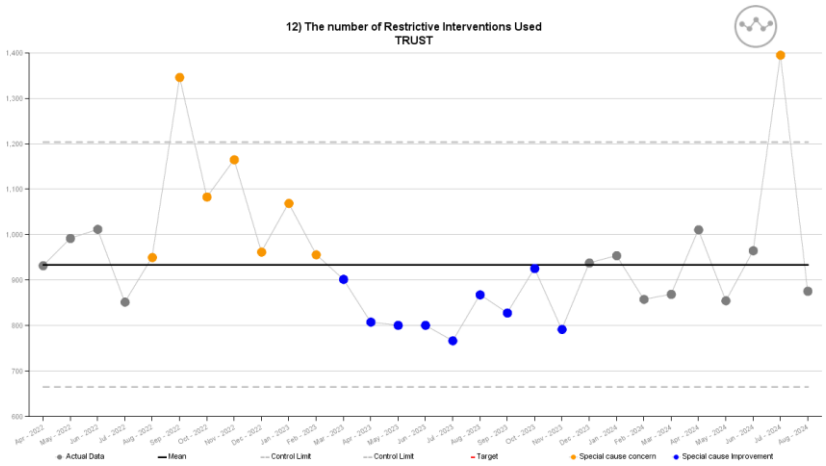
Underlying issues:
- Concerns remain on Cedar (PICU) and on Overdale (Assessment & Treatment) within AMH services in Durham Tees Valley & Forensic Care Group. However, the number of RIs used are significantly reducing on Overdale.
- Whilst special cause improvement is shown for DTVFCG ALD, there are significant concerns noted in that service due to the complexity of the patients.

Actions
- There are several actions to support improvement in AMH services, which include:
  - the Inpatient Lead Psychologist and additional leadership supporting Cedar Ward as part of a wider action plan, which includes clinically appropriate discharge.
  - due to the nature of the patient group, the Trust-wide Autism Team providing additional support into Cedar ward.
  - Specialist Practitioner for Positive & Safe working with the service, to review the use of restrictive interventions and to provide education.
- Additional training is being provided to the DTVFCG ALD services and increased support is being provided by the leadership team, SIS and AMH services. **(Completed)**
- DTVFCG ALD services continue to monitor the use of restrictive interventions, seeking support from the Specialist Practitioner for Positive & Safe where appropriate.

No significant change in the data during the reporting period shown

DQ ★ 93%

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



Note: The high use noted in July relates to one patient within Adult Eating Disorders Inpatients.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

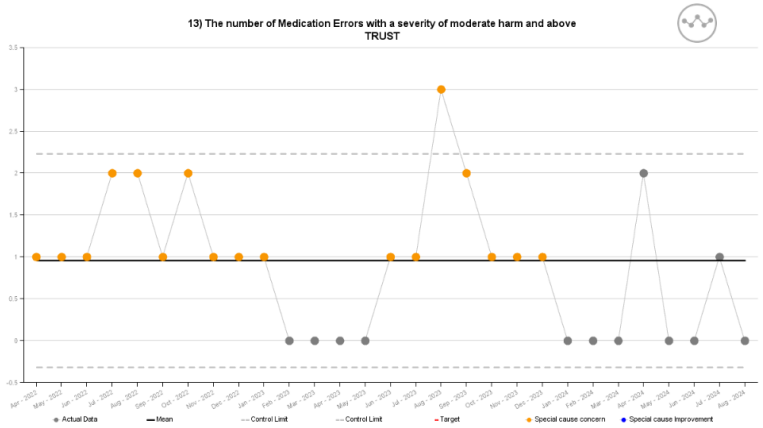
What does the chart show/context:
0 medication errors were recorded with a severity of moderate harm, severe or death during August.

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

As incidents are reviewed, the severity could be reduced or increased (usually reduced).

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

Actions:
The rollout of EPMA to community services has been impacted by a delay in the software release from our system suppliers. The rollout to clozapine and depot clinics will be completed by March 2025; further completion dates are to be confirmed at a later stage.



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:
2 unexpected inpatient unnatural deaths whilst on leave from the ward were reported on the Strategic Executive Information System (STEIS) during August.

All unexpected and unnatural deaths in inpatient wards are immediately reported in this data. Once the cause of death is confirmed, where necessary the data is refreshed. Therefore, on occasion we might be over reporting the number of unexpected, unnatural deaths.

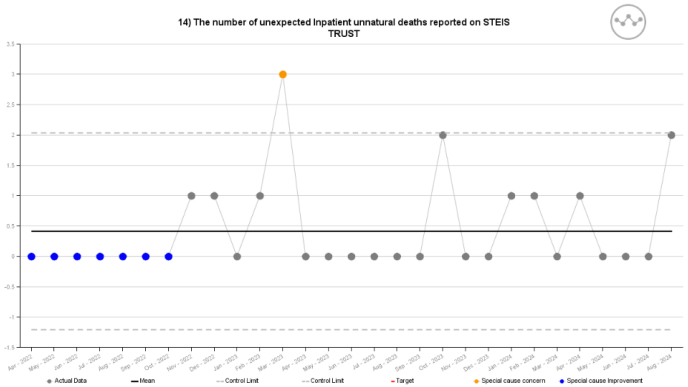
Underlying issues:
There are no underlying issues to report

Actions:
A comprehensive multi-disciplinary after-action review has been completed and in line with the National Patient Safety Incident Framework, a full Patient Safety Incident Investigation will be completed.

No significant change in the data during the reporting period shown

DQ

87%



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 **332** uses of the Mental Health Act during June .

There is no significant change at Trust and Care Group level in the reporting period. There is special cause concern for Secure Inpatient Services in Durham, Tees Valley & Forensic Care Group; however, the Care Group has confirmed there are no underlying issues to report. There is special cause improvement for Adult Mental Health Services in North Yorkshire, York & Selby Care Group.

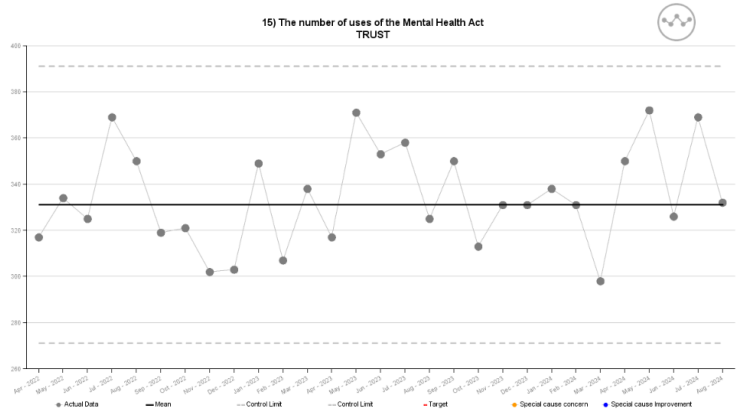
Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

No significant change in the data during the reporting period shown

DQ 87%

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

Background / standard description:
We are aiming for 60% of staff to recommend the Trust as a place to work (agreed March 2024)

What does the chart show/context:
We previously identified that the number of responses being used in the calculation was not consistent. Historic data has been provided for the quarterly Pulse Survey and is reflected in this month's report; however, we are still progressing the Annual Staff Survey data.

1,244 staff responded to the July 2024 Pulse Survey. In relation to the question "I would recommend my organisation as a place to work", **655 (52.65%)** responded either "Strongly Agree" or "Agree".

The NHS Staff Survey Benchmarking report 2023, shows the "best result" was 75.43% and the "average result" was 65.59% for similar organisations.

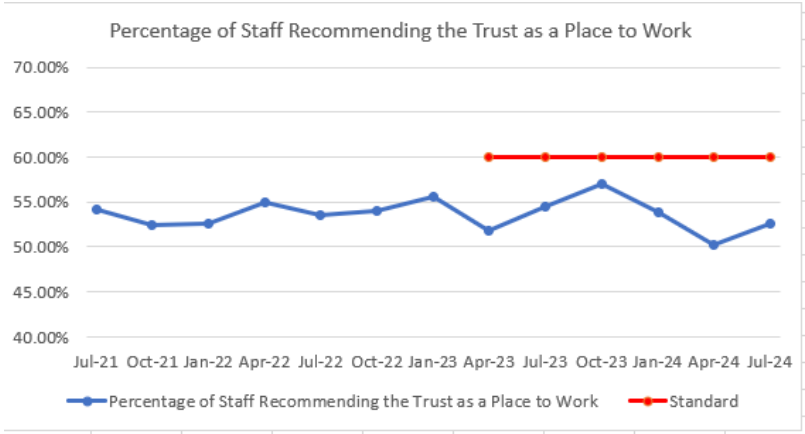
Underlying issues:
We are not capturing the views of all our staff (approximately 15% in July); therefore, this is not a comprehensive picture.

Actions:
The Organisational Development Team and People Partners to provide advice and guidance to support the Services to develop targeted action plans over the next 6 months and report into Executive People Culture and Diversity and People Culture & Diversity Committee. Originally to be completed by the end of September 2024, action plans will now be completed by the end of October 2024.

DQ

80%

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



** Please note the survey is only undertaken once a quarter . The National Staff Survey (annual) is October each year; the National Quarterly Pulse Survey is the months of January, April and July*

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

Background / standard description:
We are aiming for 65% of staff to feel they are able to make improvements happen in their area of work (agreed March 2024)

What does the chart show/context:
We previously identified that the number of responses being used in the calculation was not consistent. Historic data has been provided for the quarterly Pulse Survey and is reflected in this month's report; however, we are still progressing the Annual Staff Survey data.

1,244 staff responded to the July 2024 Pulse Survey. In relation to the question "I am able to make improvements happen in my area of work", **780 (62.70%)** responded either "Strongly Agree" or "Agree".

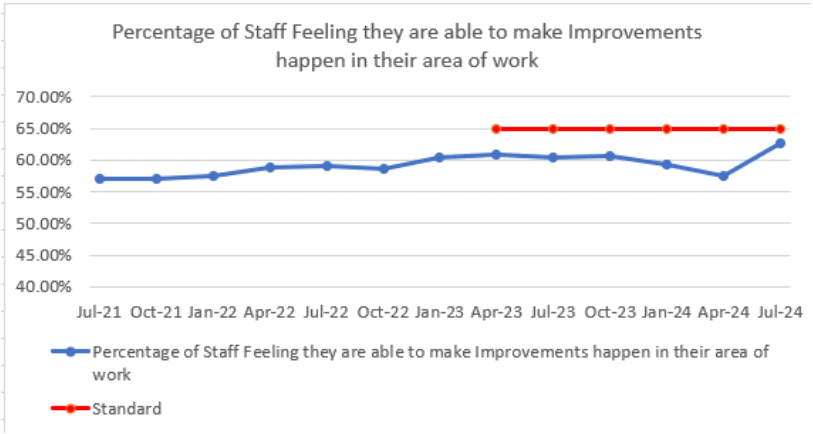
The NHS Staff Survey Benchmarking report 2023, shows the "best result" as 67.81% and the "average result" as 61.37% for similar organisations.

Underlying issues:
We are not capturing the views of all our staff (approximately 15% in July); therefore, this is not a comprehensive picture.

Actions:
The Organisational Development Team and People Partners to provide advice and guidance to support the Services to develop targeted action plans over the next 6 months and report into Executive People Culture and Diversity and People Culture & Diversity Committee. Originally to be completed by the end of September 2024, action plans will now be completed by the end of October 2024.

DQ ✓✓ 80%

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



** Please note the survey is only undertaken once a quarter . The National Staff Survey (annual) is October each year; the National Quarterly Pulse Survey is the months of January, April and July*

18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for our staff leaver rate to be no more than 11% (agreed June 2024).

What does the chart show/context:
From a total of **7,242.41** staff in post, **809.53 (11.18%)** had left the Trust in the 12-month period ending August 2024.

There is special cause improvement at Trust level and for Company Secretary, Corporate Affairs and Involvement, Durham Tees Valley & Forensic Care Group, Medical, North Yorkshire, York & Selby Care Group and Therapies in the reporting period. However, there is special cause concern for the Assistant Chief Executive Directorate, Nursing & Governance (the directorates have confirmed there are no underlying issues), and Health & Justice and Mental Health Services for Older People within Durham Tees Valley & Forensic Care Group. An increasing position (above standard) is noted in Adult Learning Disabilities in North Yorkshire, York & Selby Care Group.

The latest (May 2024) National Benchmarking for NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked 23 (previously ranked 20) 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 (*for those who do leave and tell us why):
- Staff wanting a new challenge
- Promotion
- Role not being as expected
- Work-life balance/wellbeing
- Management/team relationships

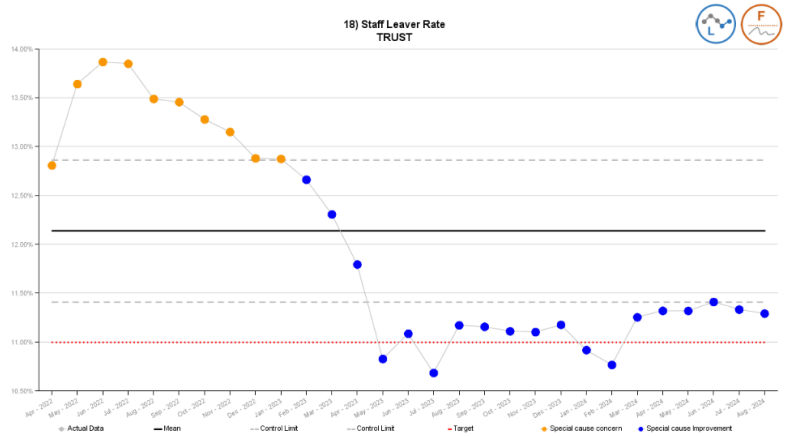
Actions:
- The revised PIP for e-Roster effectiveness focused on having 80% of rotas published in line with the Trust target and 80% of teams achieving target for annual leave level loading by the 1st July 2024. We have achieved 83% of rotas published, better than Trust target; however, the action on annual leave level loading has been extended to the 31st October 2024.
- Trust-wide “Should I Stay or Should I Go” sessions for staff will be launched from September 2024.

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

DQ 87%

Our system is expected to consistently fail the target/expectation

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

Background / standard description:
We are aiming for sickness absence to be no more than 5.5% (agreed March 2024)

What does the chart show/context:
There were 228,966.75 working days available for all staff during July (reported month behind); of those, **13,862.69 (6.05%)** days were lost due to sickness.

There is no significant change at Trust and for most directorates in the reporting period; however, there is special cause concern for Assistant Chief Executive, Corporate Affairs & Involvement and Management within North Yorkshire, York & Selby Care Group and an increasing position is seen for Adult Mental Health in Durham, Tees Valley & Forensic Care Group. There is special cause improvement for Nursing & Governance.

National Benchmarking for NHS Sickness Absence Rates published 29th August 2024 (data ending April 2024) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.55**%** compared to the Trust mean of **6.11%**, with the Trust ranked 37 of 48 Mental Health Trusts (1 being the best with the lowest sickness rate).

Underlying issues:
- Anxiety/stress/depression is the main reason of sickness absence
- Impact of organisational processes on sickness (eg disciplinary process)

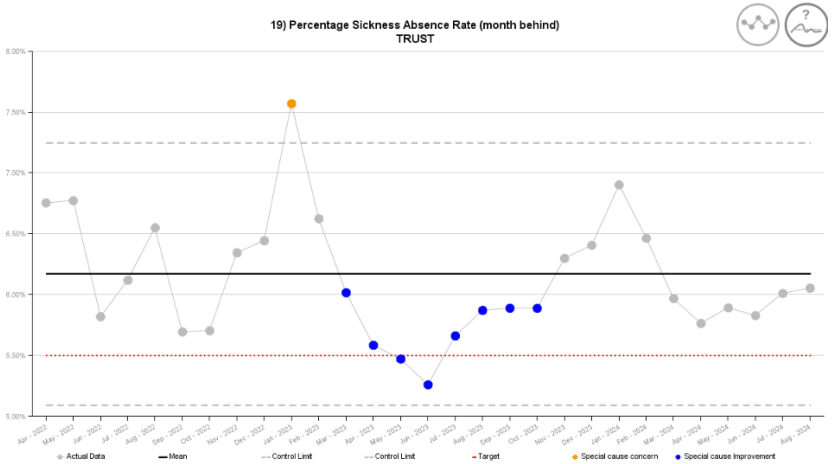
Actions:
- ACE and CA&I Directorate sickness is being managed through appropriate processes, with mitigating actions established. Most sickness is non-work related. In CA&I staff are returning to work; in ACE it is envisaged an improvement will be visible in September (October report) when staff return to work.
- DTVF People Partners to work with the services in each of their areas to develop sickness support plans. Originally planned for completion by the end of June 2024, work was extended to the 31st August 2024. **(Completed)**
- DTVFCG People Partners to link in with all services rated poor or very poor in the sickness audits by the end of October 2024 to share the outcome of the audit and the actions required.

No significant change in the data during the reporting period shown

DQ 93%

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

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



Actions continued:
- NYYSCG Principal People Partner to present a report on the findings of the sickness audits, including recommendations, to the North Yorkshire York & Selby Care Group by the end of December 2024.
- Principle People Partners to monitor causes of long-term sickness to identify the impact of organisational processes. Initially delayed to August 2024, a draft report will be completed by the end of October 2024.

20) Percentage compliance with ALL mandatory and statutory training

NHS
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:
179,367 training courses were due to be completed for all staff in post by the end of June. Of those, **158,180 (88.19%)** were completed.

There is special cause improvement at Trust level and for most areas in the reporting period.

As at the 31st August 2024, by exception compliance levels below 85% are shown in the bottom right-hand table. We are currently focusing on the lowest 5 compliance levels, plus the lowest core compliance.

Underlying issues *(specific to lowest 5)*:
- Staff unable to be released to attend training (high DNA rate)
- Reduced capacity for Positive & Safe training courses to manage the backlog
- Lack of suitable training rooms within Durham and North Yorkshire

Actions *(specific to lowest 5)*:
- Training Department are actively following up all staff who DNA.
- The training portfolio for Positive & Safe needs to be reviewed in line with the addition of courses for Trust Welcome. Originally planned for the end of September 2024 this will be implemented from January 2025.
- Care Groups to develop trajectories for achieving compliance for the lowest 5 training courses and Fire Safety 2 training, and to present these to the September EDG for a focused discussion.
- A trajectory has been agreed for Resuscitation – Level 3 – Adult Immediate Life Support – 1 Year, which will see 85% compliance by the end of December 2024. This is currently on track as per trajectory.

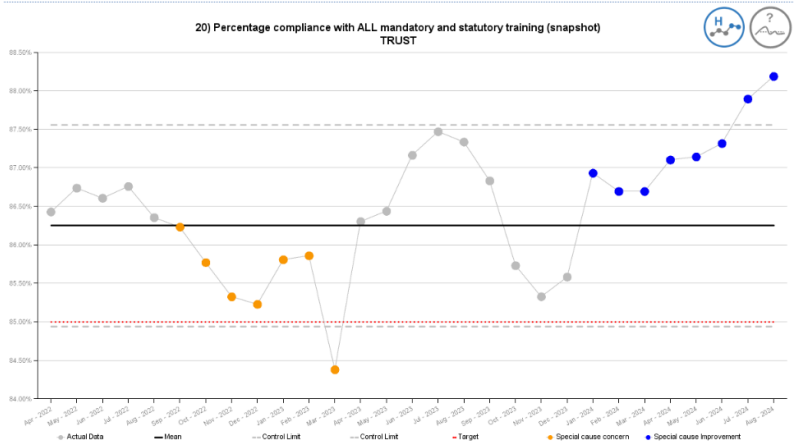
Workstreams have been agreed following the Quality Improvement Event to review all Mandatory Training requirements. Originally planned for the end of September 2024, action plans will now be completed by the end of October 2024.

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

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

93%

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



	Number Compliant	Total Number	% Compliant
1) Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	426	863	49.36%
2) Positive and Safe Care Level 2 Update*	1034	1666	62.06%
3) Rapid Tranquilisation 1	187	287	65.16%
4) Resuscitation - Level 1 - 1 Year*	1687	2570	65.64%
5) Medicines Management Annual Module	430	624	68.91%
6) Positive & Safe Care Level 1*	2988	4336	68.91%
7) Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1411	2018	69.92%
8) Face to Face Medication Assessment	1677	2291	73.20%
9) Moving and Handling - Level 2 - 2 Years*	732	940	77.87%
10) Safe Prescribing	209	253	82.61%
11) Mental Health Act Level 2	3181	3843	82.77%
12) Patient Safety Level 2	4777	5771	82.78%
13) Annual Medicines Optimisation Module	1820	2187	83.22%
14) Infection Prevention and Control - Level 2 - 1 Year	5068	6051	83.75%
15) Rapid Tranquilisation 2	493	587	83.99%
16) MCA - MCA and Young People Aged 16/17	740	881	84.00%
17) MCA - Relationship Between MCA and MHA	3423	4073	84.04%
18) Fire Safety - 2 Years**	6588	7814	84.31%
19) MCA - Restraint	3438	4073	84.41%
20) MCA - Deprivation of Liberty	3449	4066	84.83%

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

21) Percentage of staff in post with a current appraisal

NHS
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 **6759** eligible staff in post at the end of August; 5916 (87.53%)had an up-to-date appraisal.

There is special cause improvement at Trust level and for most areas in the reporting period.

As at the 31st August 2024, by exception compliance levels below 85% are as follows:

	Number Compliant	Total Number	% Compliant
1) COMPANY SECRETARY	9	13	69.23%
2) FINANCE	36	51	70.59%
3) PEOPLE AND CULTURE	114	141	80.85%
4) MEDICAL	162	193	83.94%

Underlying issues:
We have a small number of directorates not achieving standard (*see above*).

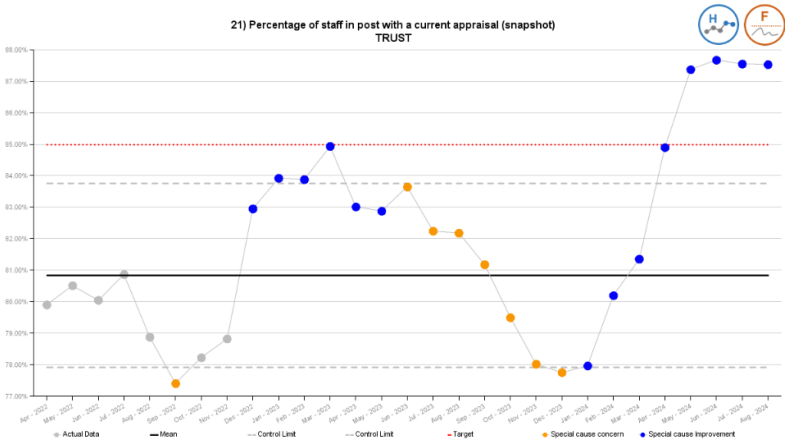
Actions:
- The directorates not achieving standard are developing trajectories to ensure that all outstanding appraisals are completed.

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

93%

Our system is expected to consistently fail the target/expectation

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



22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
6847 patients referred in August that are not currently open to an existing Trust service.

There is no significant change at Trust level and for North Yorkshire, York & Selby Care Group in the reporting period; however, there are a number of unexpected shifts of low referrals for Durham, Tees Valley & Forensic Care Group and for Children & Young Peoples Services and Health & Justice within that Care Group, and also for Adult Learning Disabilities and Mental Health Services for Older People within North Yorkshire, York & Selby Care Group; the Care Groups have confirmed there are no underlying issues.

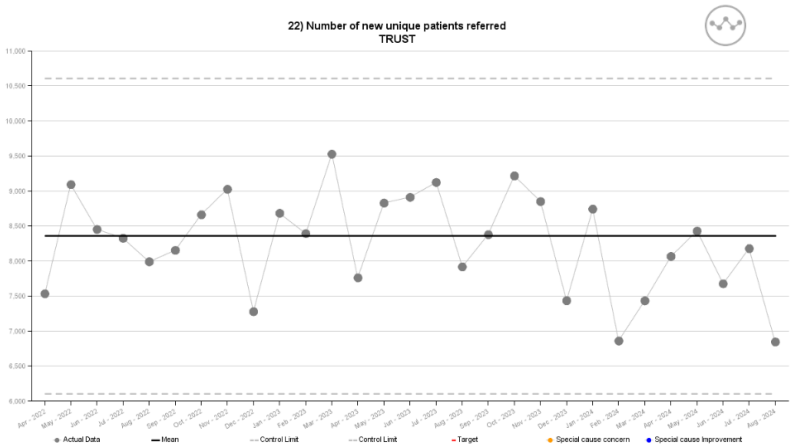
Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ ★ 93%

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



23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
63,655 cases were open, including those waiting to be seen, as at the end of August 2024.

There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period (including in ALD, AMH, CYP and H&J and in MHSOP within North Yorkshire, York & Selby Care Group). There is special cause improvement for North Yorkshire, York & Selby Care Group (including ALD and AMH, and MHSOP within Durham, Tees Valley & Forensic Care Group).

However, we know from the detailed analysis previously undertaken unique caseload is impacted by the increase in patients **waiting** for a first contact.

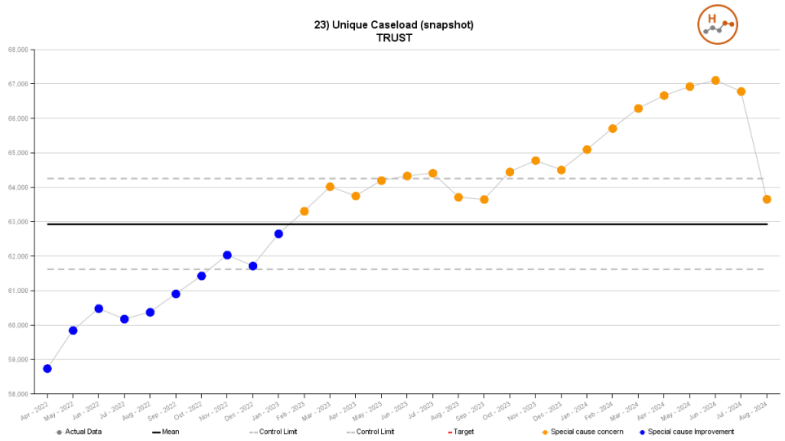
Underlying issues:
- Concern remains for the significant number of neuro-diverse patients waiting for assessment (approximately 20k patients which equates to **32**% of the caseload). We have had an 89% increase in the number of children and young people waiting for neurodevelopmental assessment between May 2022 and August 2024. There has also been an increase in AMH services within DDTVFCG.

Actions:
- DTVFCG CYPS have developed a Recovery Plan to address the long waiting times within CYPS Neurodevelopmental teams. Actions include the implementation of a telephone line for professionals in Durham and Darlington for referrals; the revision and implementation of the neuro assessment protocol; the prioritisation of completion of ASD/ADHD assessment for children on the Getting More Help teams' waiting lists; a potential waiting list initiative and additional capacity; a refresh of the patient tracker list meetings to focus on capacity over the next 4 weeks; and a validation of the waiting list including writing to all patients to opt out if they feel they no longer require an assessment. There is also a dedicated workstream within NENC ICB which will focus on CAMHS neuro, and we are working with CNTW to review the neuro diagnostic pathways for CAMHS across both Trusts.
- A focused deep dive on DTVFCG AMH active caseload will be completed by end of August 24, which will inform further PIP actions. (**Not completed)** A revised timescale is to be confirmed by the end of September 2024.
- NYYSCG CYPS held a full day event in July 2024 to agree SMART actions, but no actions were agreed.This has been escalated within the Care Group and will now be completed by the end of October 2024.

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

93%

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



Actions:
- The HNY ICB led a Memory Re-Design Event in April 2024. Outputs from this event have been delayed and it is currently unclear when these will be shared.
- Corporately, a series of focused deep dives will be undertaken to better understand any other areas of concern. The first deep dive will focus on CYP services and will be completed by the end of August 2024. Findings will be shared with EDG in September 2024.

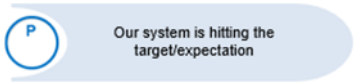
24) Financial Plan: SOCI – Financial Performance – (Surplus)/Deficit

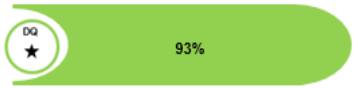
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

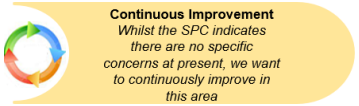
What does the data show/context:

The financial position to 31st August 2024 against which Trust performance is assessed is a deficit of **£0.96m which amounts to a £1.01m favourable variance against plan**. The Trust submitted a breakeven plan for 2024/25 which assumes delivery of challenging 4.5% or £21.78m Cash Releasing Efficiency Scheme (CRES) Plans.

- **Agency expenditure** for the year to date was £4.80m, which is £0.63m below plan. Costs for August were £0.91m and slightly above the previous month's, but in line with year to date average, run rates. Plans for 2024/25 assume agency costs are below the national cap of 3.2% of paybill, performance in-month was 2.60% and 2.96% year to date. A reducing WTE and expenditure run rate trend since April 2023 (save a minor increase in June 2024) reflects sustained impacts from actions to exit non-clinical agency assignments, reducing costs relating to complex care packages for a small number of adults with a learning disability, and reduced inpatient agency headcount. Ongoing usage includes high premia rate locum costs for cover of medical vacancies, residual inpatient agency headcount including linked to high bed occupancy and acuity, and costs within Health and Justice. The trust continues to have **no off-framework agency assignments** in month.
- **Independent sector beds** - the Trust used 62 non-Trust bed days in month (121 in July) which represented a decrease of 59 bed days from the previous month. Year to date costs were £0.46m, which includes estimates for unvalidated periods of occupancy and average observation levels pending billing. This remains a key area of volatility, and consequently clinical and management focus including through the Urgent Care Programme Board (chaired by the Managing Director for DTVF) is required. Bed pressures, including from elevated numbers of those who are clinically ready for discharge, mean that sustaining low (and delivering nil targeted) independent sector bed utilisation remains very challenging.
- **Taxis and Secure Patient Transport** costs were £1.05m (£210k average run rate) in the 5-months ending 31st August compared to a plan run rate, based on exit run rates, of £178k per month (£0.891m to date), and a £159k adverse variance to plan. Annual costs for 2023/24 were £2.675m, which was £1.0m higher than plan, and equated to a monthly average run rate of £223k. A quality improvement event was held in 2023 which recommended grip and control actions and development of a new policy. Results remain subject to review and oversight due to limited sustained impact**.** Additional rapid Care Group actions were requested at the September Financial Sustainability Board. The Chief Nurse is overseeing actions to ensure robust governance around Secure Transport and a procurement is expected to reduce unit costs in 2024/25.
- 2024/25 plans assume delivery of 4.5% £21.78m **Cash Releasing Efficiency Savings (CRES)** for the year, with £15.7m planned schemes being recurrent and £6.055m non–recurrent. Currently £1.760m of £2.055m non-recurrent target remains unidentified, although progress has been made to identify opportunities in Corporate and Estates/Facilities with a target date to fully transact opportunities by October 2024. Year to date CRES are £0.198m behind plan, but with recurrent schemes delivering £0.568m behind plan and non-recurrent schemes delivering £0.370m ahead of plan.







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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

Year to date agency costs of £4.80m at Month 5 are £0.63m below plan. In-month expenditure of £0.91m is £0.17m below plan and 2.6% paybill.

NHS planning guidance for 2023/24 introduced system agency cost caps of 3.70% pay bill, reducing to 3.2% pay bill for the 2024/25 financial year. Year to date agency costs are 2.92% of pay bill, having reduced from around 4.5% on average through 2023/24 and 6% on average through 2022/23.

Reducing agency shifts and premia paid above national price caps remains a key focus. The Trust has achieved agency reductions equivalent to 139 worked Whole Time Equivalent (WTE) from April 2023 (240 worked WTE) to August 2024 (101 worked WTE), and the related annualised premia has reduced from £4.9m in March 2023 to £2.8m in August 2024 (£2.1m reduction), demonstrating a positive impact from actions taken to date and the benefit from sustained focus, including through framework compliance, reduced numbers of shifts breaching price caps and WTE reduced reliance.

The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sustained management of sickness absence, but equally to net new recruitment (including to medical, qualified nursing, inpatient, and health and justice hot spots), securing alternative whole system models of care for specialist adult learning disability packages of care and reducing occupancy linked to increasing levels of patients who are clinically ready for discharge and require support to effect discharge.

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

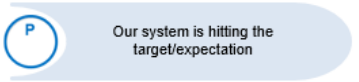
Underlying issues:

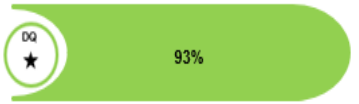
We need to continue to ensure a sustainable permanent workforce, including in key shortage professions including medical and nursing (notably to tackle price cap breaches in Health and Justice), to tackle high occupancy levels including driven by delayed transfers in inpatient wards (including with system collaboration) and to use temporary staffing more optimally including through improved rostering and regularly reviewing our safer staffing levels relative to clinical need.

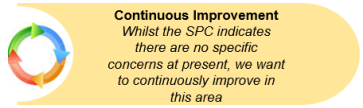
Actions:

The Executive Workforce and Resources Group are overseeing the following actions to improve rostering:

- Re-visit roster rules to ensure optimal rosters and equity for colleagues: This work is ongoing and is reviewed in the monthly safe staffing meeting. Training is being provided for teams in order to optimise their use of the roster. Care Groups are being asked to hold monthly governance meetings reviewing the roster KPIs such as timely publications of rotas.
- Develop roster training programme (ran 3 x weekly January to March 2024) – Planned Programme Completed and extended on an ongoing basis.







25b) Agency price cap compliance

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

2,042 agency shifts were worked in August 2024, with **1,368 shifts compliant** (67%) and **674 non-compliant** (33%) (prior month 1,327 shifts compliant or 64% and 758 non-compliant or 36%) **with national price caps**.

The vast majority of price cap breaches during 2024/25 have related to medical locum or prison mental health nursing assignments, covering hard to fill vacancies.

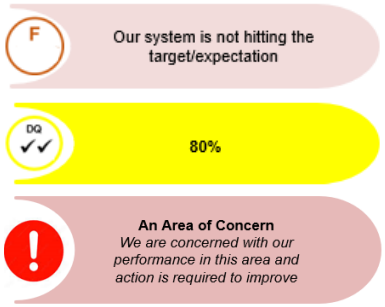
There were **43 fewer overall shifts worked this month** compared to last, with shifts worked being equivalent to **approximately 66 shifts per day** (67 in July and 69 in Jun).

This reflects a reduction in total shifts worked of 2,242 over the 12 months from 4,284 shifts worked in August 2023 and **a reduction of 54% or 779 shifts breaching price cap since August 2023** (1,453 shifts breached).

- The Trust's ability to reduce price cap breaches now almost entirely stems from recruitment challenges for medical and health and justice vacancies.
- Further refinement of shift data relating to the above takes place up to the point that NHSE Temporary Staffing data is submitted mid-month, which may result in minor differences between reported data.
- We recognise that volume pressures and particularly price cap breaches and rate premia associated with agency expenditure significantly impact 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 (Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit).

Underlying issues:
Particular persistent challenges relate to levels of medical staffing and prison mental health nursing vacancies requiring cover from premia rate locum assignments which have consistently breached price caps during 2024/25.

Actions:
In addition to actions from 25a) supporting improved compliance, the Trust has approved a business case for a second phase of International Recruitment to aim to recruit a more sustainable medical workforce (nursing business case approved previously) and reduce reliance on higher rate agency assignments, targeting SAS locum medical assignments initially. Medical assignments attract the highest value and percentage premia rates. Social media and other targeted recruitment activities are seeking to attract new colleagues to Health and Justice (prison) vacancies.



24) Financial Plan: SOCI – Financial Performance – (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. This will require support from local authority system partners, including due to rising and sustained high levels of patients who are clinically ready for discharge.
- We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan due to numbers of staffing above funded levels and including agency premia rates (including 36% of agency shifts being above price cap), and in part reflecting over occupancy linked to the above.
- We need to deliver CRES schemes to achieve our financial plan and deliver recurrent programmes to address our underlying financial pressures.

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.
- The revised PIP for e-Roster effectiveness focuses on having 80% of rotas published in line with the Trust target and 80% of teams achieving target for annual leave level loading by the 1st July 2024. We achieved 83% of rotas published which is marginally better than the Trust target of 80%. However, the action on annual leave level loading was not completed and EDG have approved an extension to the end of October 2024.
- The Agency Reduction PIP is progressing. The outsourcing timeframes have been reviewed and aligned for all DTVFCG areas. The cessation of accommodation costs was not achieved at the end of August 2024 and an extension to the end of September has been requested. Actions to identify and stop agency usage within DTVFCG services using fewer than 10 shifts per 6-week period and to implement targeted international recruitment for both Care Groups are to be completed by the 30th September 2024. An additional action to re-negotiate rates of pay with framework agencies for Health & Justice registered nurses and all new Health & Justice registered nurses to be within price caps will be completed in a phased approached, by the 31st January 2025.
- An Efficiency Hub has been set up to oversee delivery of CRES and provide support to Care Groups / Directorates.
- In addition to delivery of identified in year CRES, the Efficiency Hub will provide support to enable focus on key strategic financial recovery actions including to manage and reduce over-establishments, track benefits from International Recruitment, ensure the efficient rostering of inpatient staffing and linked to inpatient occupancy, flow and Out of Area Placements. It will also support the transformation programmes to identify and realise associated benefit. Progress will be supported by recruitment to a recently approved additional Finance post.
- Information on workforce spend (both financial and WTE) has been enhanced and will be available for all relevant managers to view and analyse in terms of driving efficiency.

26) Use of Resources Rating - overall score

NHS
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 August.
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.

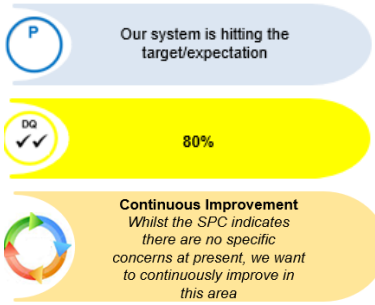
- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity rating of **4**.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is rated as **1.**
- 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 -0.47% which is a **rating of 3**.
- The Income and Expenditure **(I&E)** margin distance from plan is 0.74% which is a **rating of 1.**
- **The agency expenditure metric** assesses agency expenditure against a 3.2% cap (set by NHSE) on agency spend as a proportion of pay. Costs of £4.80m are below plan and would therefore be **rated as a 1.** The Trust's year to date agency costs were 2.92% of pay bill.

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 is an **overall UoRR** of **3** for the period ending 31st August compared to a planned UoRR of 3.

Underlying issues:
The Trust's forward liquidity position is of concern, including as cash balances are deployed to progress capital programmes. As recovery actions are identified to support delivery of the Trust's planned breakeven position and improved agency compliance are targeted and progressed these will support achievement of the associated individual UoRR metrics and overall UoRR rating.

Actions:
There are no specific improvement actions required albeit that the Trust's wider financial strategy and medium term financial plan are subject to continued review.



27) Cash Releasing Efficiency Savings (CRES) Performance - Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:

Recurrent CRES performance for the period ending 31st August was £6.31m which was below plan by £0.57m. 2024/25 financial plans assume delivery of 4.5% £21.78m Cash Releasing Efficiency Savings for the year. We planned to deliver **£15.7m or 3.2% recurrent** Cash-Releasing Efficiency Savings (CRES) for the year.

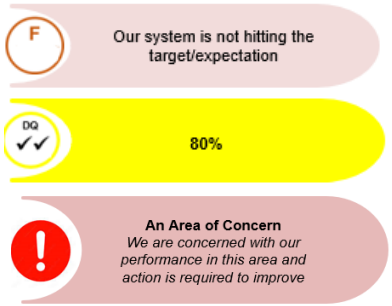
Following the submission of our financial plan, confirmed key recurrent CRES plans include:

- **Pay schemes** include actions to sustain Agency reductions in Inpatient and other clinical areas including from improved rostering, recruitment (including International), to aim to reduce Medical Locum (high premia rate) usage and to address over spending due to over establishments in both Care Groups.
- **Non Pay schemes** including actions to eliminate Independent Sector bed reliance by Quarter 4 as well as savings from LED Light installation, IT licences, mobile phones, printing, the appraisal system and Taxi usage.

- The Over Establishment Target has overperformed year to date by £0.21m. However this is being offset by schemes that are underperforming such as International Nurse recruitment (behind by £0.43m) and LED lighting (behind by £0.15m).

Underlying issues:
We need to deliver recurrent CRES schemes to achieve our in-year financial plan and improve our underlying financial sustainability. Delivery of CRES non-recurrently increases the CRES requirement the following the year.

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



28) Cash Releasing Efficiency Savings (CRES) Performance – Non-Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:
Non Recurrent CRES performance was reported as being ahead of plan by £0.37m for the period ending 31st August, with £1.04m being achieved.

2024/25 plans assume delivery of 4.5% £21.78m Cash Releasing Efficiency Savings for the year.

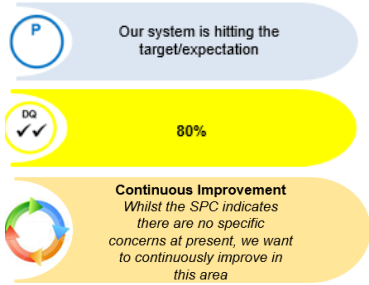
We plan to deliver **£6.06m or 1.25% of non-recurrent** Cash-Releasing Efficiency Savings (CRES) for the year.

£4.0m of non-recurrent CRES had been identified in the plan, which left £2.06m to be identified. As at 31st August £0.30m of this has been identified, with the remaining £1.76m still to be found. Opportunities have been identified in Corporate and Estates / Facilities but remain subject to validation - a small number may be confirmed as recurrent schemes, offering some mitigation to recurrent under performance.

The £0.37m overachievement year to date largely reflects Older Adult pay slippage in North Yorkshire and York which is mitigating under delivery on the recurrent agency CRES scheme.

Underlying issues:
It has been essential to target non-recurrent CRES to aim to target a broadly break even plan, however reliance on non-recurrent schemes leave an underlying unmitigated financial challenge moving ahead beyond 2024/25.

Actions:
Financial Planning activities will confirm the extent to which the same actions can be delivered recurrently (or non-recurrently) and any other scope to deliver new non-recurrent CRES in 2025/26 to mitigate underlying financial pressures.



29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

Capital expenditure was **£2.80m** at the end of August and **less than allocated by £1.02m**.

£8.51m 2024/25 capital schemes have been approved for funding from nationally allocated capital delegated via North East and North Cumbria Integrated Care Board (ICB). An additional allocation of £0.42m was approved by the ICB in July, resulting in a total capital allocation of £8.93m for 2024/25.

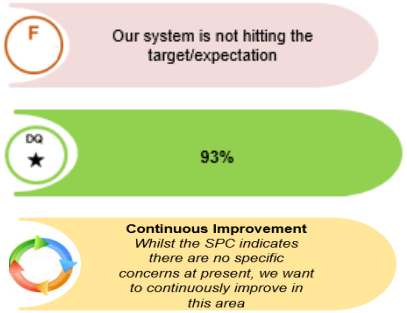
The Trust has secured £1.83m of additional cash-backed central funding in 2024/25 to improve Information systems and assist creating our Mental Health hub in North Yorkshire. This is not included in performance measurement against the £8.93m capital allocated to the Trust through North East and North Cumbria ICB.

This means the Trust's **aggregate capital programme for 2024/25 is £11.12m** (including £0.37m PFI life-cycle).

The underspend for the year to date is linked to slippage against schemes and will be managed within this financial year. The Trust is working to accelerate schemes planned for next year to offset any slippage.

Underlying issues:
There are no underlying issues to report in year, however reducing liquidity and the availability of Trust cash and increasingly constrained national and regional capital allocations relative to need are of concern going forward.

Actions:
A key focus is on the milestone tracking of Programmes, including for sensor door installation and the final design of works to be completed at Jesmond House. Any anticipated delays to planned inpatient environment schemes are communicated to the Environmental Risk Group to manage any associated risks.



30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:

The Trust had cash balances of **£56.45m** at the end of August 2024 which exceeded planned cash balances of **£55.93m** by **£0.53m** (favourable variance).

- This was mainly linked to the slippage in the capital programme and the positive variance to plan in the SoCI, offset by central funding not yet received for capital projects. Cash is expected outturn in line with plan for 2024/25.
- The Trust has achieved the 95.0% Better Payment Practice Code (BPPC) target compliance for the prompt payment suppliers, achieving a combined year to date BPPC of 95.0%. We continue to support the use of Cardea to make processes as efficient as possible, and to ensure suppliers are paid promptly.
- The value of debt outstanding as at 31st August 2024 was £1.46m, with debts exceeding 90 days amounting to £0.28m if adjusted to exclude amounts being paid via instalments and PIPS loan repayments. Three public sector organisations account for £0.21m of debt exceeding 90 days overdue. Progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged.

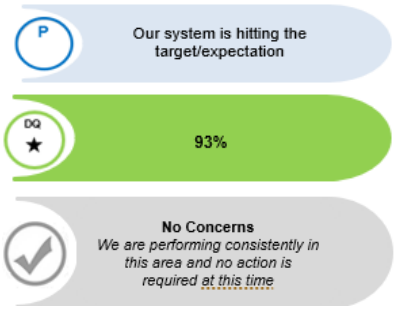
Underlying issues:

In additional to information at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit, the Trust needs to expend significantly more via its annual capital programme budget than is generated internally from depreciation, meaning the Trust's annual cash reserves are gradually reducing.

Cash has decreased linked to the year to date deficit position on revenue budgets, and because capital payments exceed cash generated internally from depreciation charged in year.

Actions:

See actions at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit.



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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	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
1	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	
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	√	√	
3	Percentage of inpatients reporting that they feel safe whilst in our care	√	√	
4	Percentage of CYP showing measurable improvement following treatment - patient reported	√		
5	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√		
6	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√	
7	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√	
8	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√	√
9	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√		
10	The number of Patient Safety Incident Investigations reported on STEIS	√	√	
11	The number of Incidents of moderate or severe harm	√		
12	The number of Restrictive Intervention Used	√	√	
13	The number of Medication Errors with a severity of moderate harm and above	√		
14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		√
15	The number of uses of the Mental Health Act	√		
16	Percentage of staff recommending the Trust as a place to work	√	√	√
17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√
18	Staff Leaver Rate	√	√	√
19	Percentage Sickness Absence Rate	√	√	√
20	Percentage compliance with ALL mandatory and statutory training	√	√	√
21	Percentage of staff in post with a current appraisal	√	√	√
22	Number of new unique patients referred	√	√	√
23	Unique Caseload (snapshot)	√	√	
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit			
25	Financial Plan: Agency expenditure compared to agency target			
26	Agency price cap compliance			
27	Use of Resources Rating - overall score			
28	CRES Performance - Recurrent			
29	CRES Performance - Non-Recurrent			
30	Capital Expenditure (CDEL)			
31	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. Safe Staffing	2. Demand	3. Co-Creation	4. Quality of Care	5. Digital	6. Estate / Physical	7. Cyber Security	8. Quality Governance	9. Partnerships and System	10.Regulatory compliance	11. Roseberry Park	12. Financial Sustainability	13. Public confidence
1	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	√	√									√
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	√		√	√									√
3	Percentage of inpatients reporting that they feel safe whilst in our care	√		√	√									√
4	Percentage of CYP showing measurable improvement following treatment - patient reported	√	√		√	√			√	√			√	√
5	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√	√		√	√			√	√			√	√
6	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√		√	√			√	√			√	√
7	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√		√	√			√	√			√	√
8	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√		√				√				√	√
9	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√	√		√				√				√	√
10	The number of Patient Safety Incident Investigations reported on STEIS	√		√	√		√				√			√
11	The number of Incidents of moderate or severe harm	√		√	√				√		√			√
12	The number of Restrictive Intervention Used	√		√	√		√				√			√
13	The number of Medication Errors with a severity of moderate harm and above	√			√	√			√		√			√
14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		√	√		√			√	√			√
15	The number of uses of the Mental Health Act	√	√						√	√	√			
16	Percentage of staff recommending the Trust as a place to work	√	√				√		√	√	√			√
17	Percentage of staff feeling they are able to make improvements happen in their area of work	√		√					√	√	√			√
18	Staff Leaver Rate	√							√		√		√	√
19	Percentage Sickness Absence Rate	√	√								√		√	√
20	Percentage compliance with ALL mandatory and statutory training	√			√			√	√	√	√		√	√
21	Percentage of staff in post with a current appraisal	√			√				√		√			√
22	Number of new unique patients referred		√		√				√	√	√		√	√
23	Unique Caseload (snapshot)	√	√		√				√	√	√		√	√
24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit					√		√	√		√	√	√	
25	Financial Plan: Agency expenditure compared to agency target	√	√		√				√		√		√	
26	Agency price cap compliance	√							√		√		√	
27	Use of Resources Rating - overall score	√	√		√				√		√		√	
28	CRES Performance - Recurrent	√	√				√		√		√		√	
29	CRES Performance - Non-Recurrent								√		√		√	
30	Capital Expenditure (CDEL)					√	√		√		√	√	√	
31	Cash balances (actual compared to plan)					√	√				√	√	√	

National Quality Standards and Mental Health Priorities Headlines

Headlines

- **72 hour follow up** failed target in all areas with the exception of Vale of York and there is no significant change in all areas.
- **EIP waiting times** failed target in County Durham and Vale of York and there is no significant change in all areas.
- **Talking Therapies waiting times (6 and 18 weeks)** achieved target in all areas.
- **Child Eating Disorders waiting times:** Failed target in all areas for **routine** referrals but special cause improvement. Failed target in all areas for **urgent** referrals and cause for concern in County Durham and Vale of York.
- **Talking Therapies: 1st to 2nd treatment waits** – failed target in all areas except for North Yorkshire. There is no significant change for Vale of York and cause for concern in County Durham and Tees Valley. **Reliable Recovery** and **Reliable Improvement –** failed targets in County Durham and Tees Valley and there is no significant change in all areas.
- **Children: 1 contact –** failed target in all areas and there is special cause concern. **Paired Outcomes –** failed target in all areas. There is no significant change in all areas with the exception of County Durham, which shows special cause concern.
- **Access to transformed community services** failed target in Vale of York and there is special cause concern in this area.
- **Active OAP (inappropriate)** achieved plan in both ICB areas.
- **Specialist Community Perinatal Mental Health (PMH) services** failed target in North Yorkshire and Vale of York and special cause concern for North Yorkshire.

Risks / Issues

Of most concern:

- 72 hour follow up* (except Vale of York)
- EIP Waiting Times (County Durham & Vale of York)
- Child Eating Disorders Waiting Times Urgent (County Durham & Vale of York)
- Talking Therapies 1st to 2nd treatment (except North Yorkshire)
- Talking Therapies Reliable Recovery (County Durham & Tees Valley)
- Talking Therapies Reliable Improvement (County Durham & Tees Valley)
- CYP 1 contact
- Childrens Paired Outcomes
- Access to transformed community services (Vale of York)
- Specialist Community PMH services (North Yorkshire)

Of concern:

- Child Eating Disorders Waiting Times Routine
- Child Eating Disorders Waiting Times Urgent (Tees Valley & North Yorkshire)
- Specialist Community PMH services (Vale of York)

This measure has been impacted following the implementation of Cito. A comprehensive validation of July data confirmed achievement of standard; a validation of August data is currently underway.

Positive Assurance

- Talking Therapies waiting times (6 and 18 weeks)
- Active OAPs (inappropriate)

Mitigations

EIP waiting times - NYYSCG have a recovery plan in place and have recruited to all 4 posts, two of which are preceptorship roles. Staff will start in September 2024; however, it will be December before the anticipated impact is seen. DTVFCG has achieved standard in August for County Durham following successful recruitment.

Child Eating Disorders waiting times – In DTVFCG, whilst there is special cause concern in the SPC, this is not an area of concern as the reasons were patient choice, patients required hospital admission, data quality and CITO issues; the latter of which has been addressed. There was one outstanding PIP action to ensure data quality is corrected in a timely manner; this has been completed and no data quality issues have been recorded for 3 consecutive months; therefore, approval has been requested to stand down the PIP. In NYYSCG, whilst there is special cause concern in the SPC, this is not an area of concern as the reasons were patient choice and a CITO issue; the latter of which has been addressed.

Talking Therapies 1st to 2nd treatment waits - DTVFCG had one outstanding PIP action to review the suitability criteria with GPs and secondary care services to ensure patients are referred to the correct service for their needs; as anticipated as at September 2024 there are no patients on caseloads that are not appropriate for service. Following a service review and options appraisal, a paper including recommendations will go to the Care Group Board in October. NYYSCG have a PIP with an action to temporarily increase capacity through overtime; it is anticipated that the full impact will be visible by the end of November (December report). Professional development training to prevent patients being mis-diagnosed with social phobia has been completed and has had the desired impact.

Talking Therapies Reliable Recovery - County Durham and Tees Valley have achieved standard for two consecutive months in County Durham and one month in Tees Valley; therefore, we are not recommending a PIP at this stage. The Service's suitability guidance has been reviewed to promote the importance of this with secondary care colleagues and other stakeholders.

Talking Therapies Reliable Improvement - A PIP was to be developed by the end of August 2024; however, this was not completed. The inclusion of patients receiving Step 1 care is impacting achievement of the standard. Further discussions are planned in early October between the Clinical Leads, Corporate Performance Team and Business Intelligence team to review the national measure and agree next steps.

CYP 1 contact - The deep dive in County Durham has identified issues relating to data quality and recording on Cito, sickness and vacancies. A PIP was to be developed by the end of August 2024; however, this was not completed. The September Care Group Board have agreed this will now be brought to the October meeting. The deep dive in North Yorkshire & York has identified access is being impacted by the operation of our Single Point of Access Team, which currently has a recovery plan in place.

Childrens Paired Outcomes - The deep dive in County Durham & Tees Valley has identified a lack of understanding of the points on a pathway at which outcomes must be undertaken. A PIP was to be developed by the end of August 2024; however, this was not completed. The September Care Group Board have agreed this will now be brought to the October meeting. A deep dive in North Yorkshire & York has identified concerns in the community, autism and ADHD teams and a PIP is recommended at this stage.

Access to transformed community services – The deep dive into County Durham was completed; however, further work is required to understand what the data is telling us. This will be completed by the end of September 2024. Following identification of an issue that resulted in a number of North Yorkshire & York Primary Care Networks not being included, work has been undertaken to correct historic data. As a result, the deep dive will be completed by the end of September 2024. It should be noted that at September the target has been achieved in County Durham and North Yorkshire.

Specialist Perinatal Mental Health - NYYSCG have developed a PIP and the actions are to recruit to the vacant posts and to develop standardised triage criteria to ensure all appropriate woman are accepted onto caseload. It is anticipated the impact of these actions will increase the number of women accessing services and achievement of standard by end of January 2025. A demand and capacity deep dive to identify further actions has been delayed due to capacity issues.

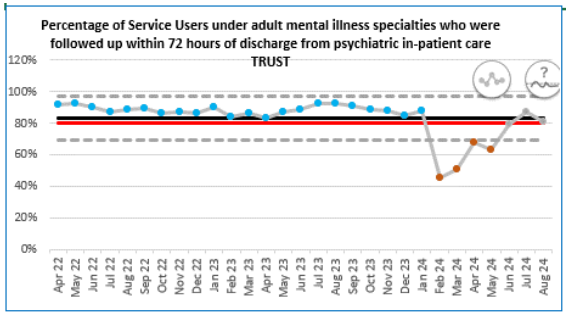
National Quality Standards and Mental Health Priorities Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

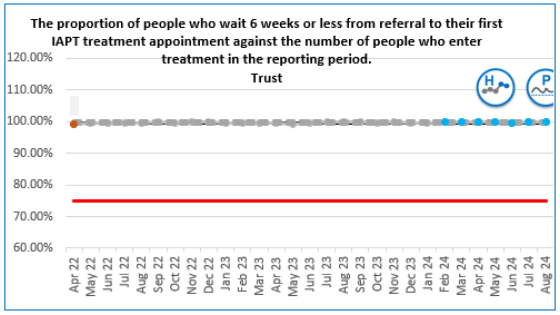
National Quality Requirements	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care		?	80%	76.11%	80%
Percentage of Service Users experiencing 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%	57.29%	60%
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	H	P	75%	99.78%	75%
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		P	95%	100%	95%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks (rolling 12 months)	H	F	95%	90.79%	95%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week (rolling 12 months)		F	95%	75.44%	95%
Local Quality Requirements	**Variation**	**Assurance**	**Standard (FYTD)**	**Actual (FYTD)**	**Annual Standard**
Talking Therapies:Percentage of people who have waited more than 90 days between first and second appointments	H	?	<10%	27.98%	<10%
Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness		?	48%	48.62%	48%
Talking Therapies: Reliable improvement rate for those completing a course of treatment		?	67%	67.10%	67%
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months)	L	?	29797	28757	29797
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	L	F	40%	21.10%	40%
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12 months)	H	?	11353	12367	22955
Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)		P	4	1	0
Number of women accessing specialist community PMH services in the reporting period (rolling 12 months)	H	F	1467	1399	1427

National Quality Requirements

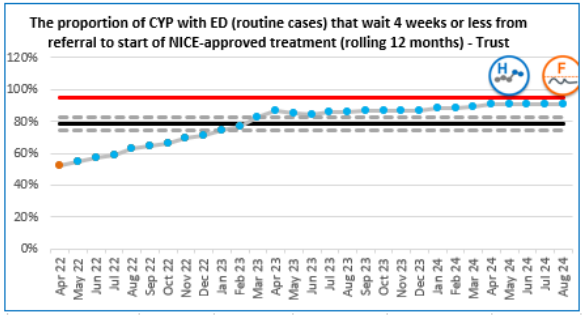
Tees, Esk and Wear Valleys NHS Foundation Trust



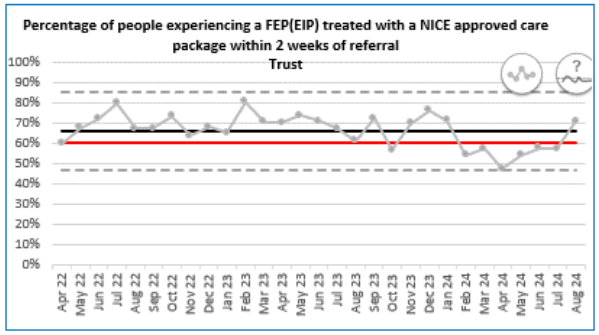
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	80%	76.11%			
County Durham	80%	73.32%			
Tees Valley	80%	76.23%			
North Yorkshire	80%	77.59%			
Vale of York	80%	81.29%			



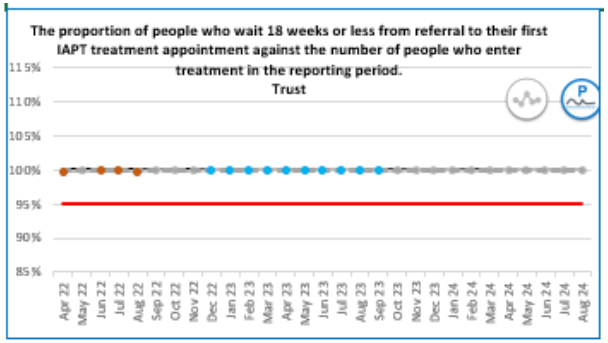
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	75%	99.78%			
County Durham	75%	99.89%			
Tees Valley	75%	99.70%			
North Yorkshire	75%	99.57%			
Vale of York	75%	99.82%			



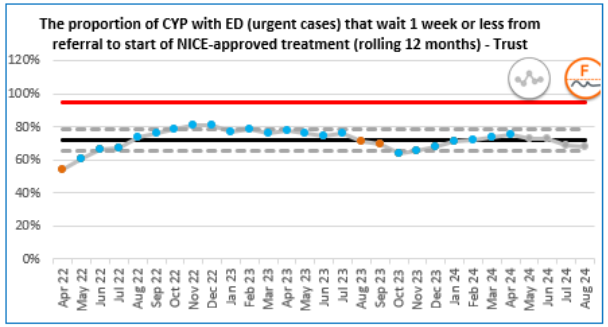
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	90.79%			
County Durham	95%	86.49%			
Tees Valley	95%	94.12%			
North Yorkshire	95%	91.89%			
Vale of York	95%	91.30%			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	60%	57.29%			
County Durham	60%	53.15%			
Tees Valley	60%	62.24%			
North Yorkshire	60%	80.56%			
Vale of York	60%	37.21%			



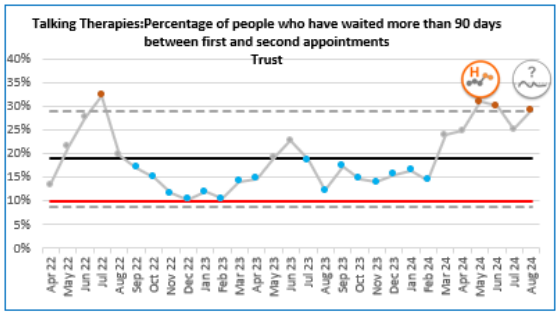
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	100%			
County Durham	95%	100%			
Tees Valley	95%	100%			
North Yorkshire	95%	100%			
Vale of York	95%	99.96%			



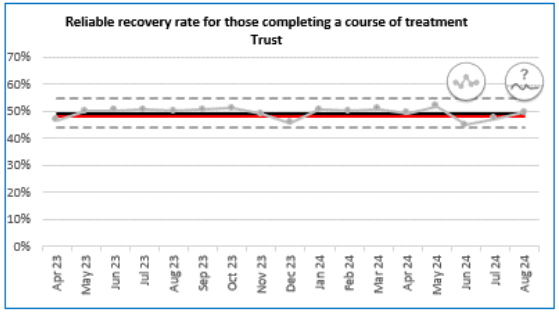
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	75.44%			
County Durham	95%	66.67%			
Tees Valley	95%	80.00%			
North Yorkshire	95%	80.00%			
Vale of York	95%	50.00%			

Local Quality Requirements

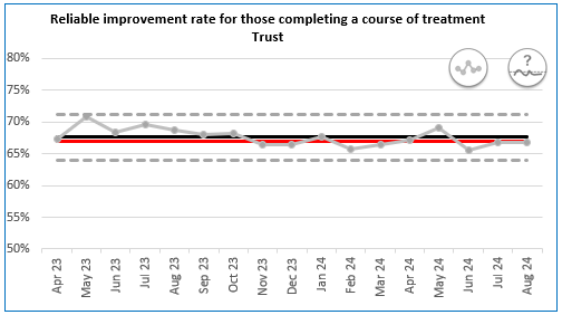
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	<10%	27.98%			
County Durham	<10%	36.69%			
Tees Valley	<10%	46.59%			
North Yorkshire	<10%	3.61%			
Vale of York	<10%	36.34%			



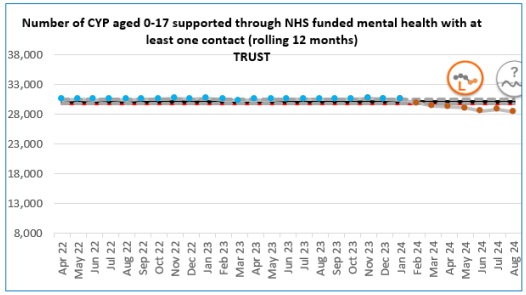
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	48%	48.62%			
County Durham	48%	46.46%			
Tees Valley	48%	46.70%			
North Yorkshire	48%	50.02%			
Vale of York	48%	51.34%			



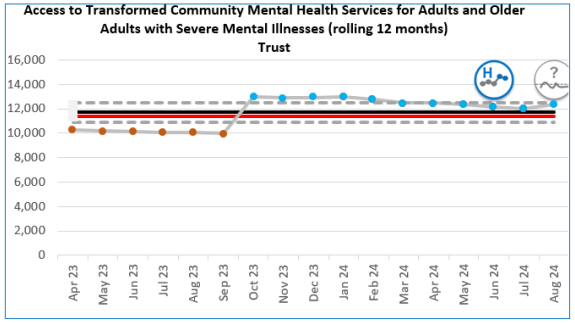
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	67%	67.10%			
County Durham	67%	64.33%			
Tees Valley	67%	62.58%			
North Yorkshire	67%	68.63%			
Vale of York	67%	71.62%			

Local Quality Requirements

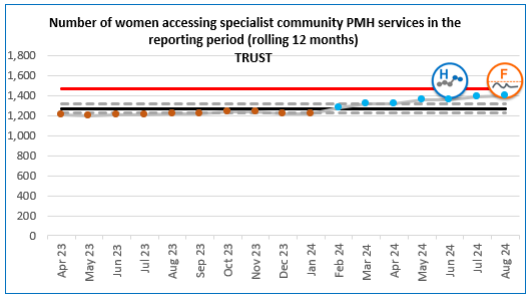
Tees, Esk and Wear Valleys NHS Foundation Trust



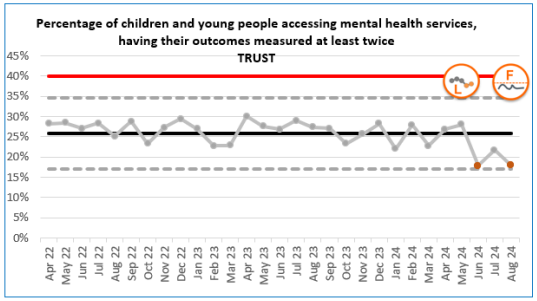
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	29797	28757			
County Durham	10012	9630			
Tees Valley	11218	11121			
North Yorkshire	4062	3466			
Vale of York	4505	4208			



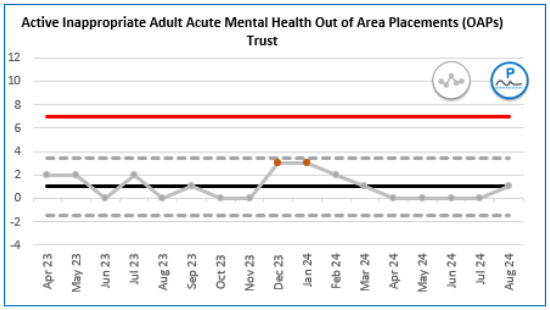
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	11353	12367			
County Durham	5768	5768			
Tees Valley	0	0			
North Yorkshire	2518	4483			
Vale of York	3067	2116			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	1427	1399			
County Durham	456	537			
Tees Valley	447	482			
North Yorkshire	284	198			
Vale of York	240	182			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	40%	21.10%			
County Durham	40%	16.39%			
Tees Valley	40%	25.98%			
North Yorkshire	40%	27.74%			
Vale of York	40%	15.56%			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	7	1			
County Durham	3	0			
Tees Valley		1			
North Yorkshire	1	0			
Vale of York		0			

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Tees, Esk and Wear Valleys
NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 10 October 2024		**Report of: People, Culture and Diversity Committee**
Date of last meeting: 16 September 2024		The meeting was quorate.
1	**Agenda: The following agenda items were considered during the meeting:** • Colleague Story/Experience • Minutes of the meeting and confidential meeting held on 30 May 2024 • Key Issues Report 30 May 2024 • Corporate Risk Register • Board Assurance Framework • Voluntary Services' Annual Update • WRES WDES SOWES & Publication of Staff Equality Information • Update following the recent Community unrest • Feedback from 'Time Out' event – 12 August 2024 • Freedom to Speak Up Guardian Update Report • People Journey Delivery Report • Health and Wellbeing Update Report • Employee Relations	
2a	**Alert: The Committee wishes to alert the Board on the following matters:** -	
2b	**Assurance: The Committee can confirm assurance on the following matters:** **Corporate Risk Register** The Committee notes that there are processes in place to work with Risk Owners and Risk Managers to look at the controls for each risk and that work was being progressed in relation to static risks. The Committee notes that the future plan is for updates for the Board Assurance Framework to be input via a module on InPhase and that the Digital and Data Department Performance and Assurance Group was reviewing all CITO risks. **Board Assurance Framework** The Committee notes that there is good assurance on the Board Assurance Framework as the controls have been strengthened and confirms that further work is to take place with People and Culture leads following a recent workshop on the trajectories. It is understood that controls are improving and that assurance levels will further increase by the next meeting of the Committee. **Voluntary Services' Annual Update** The Committee confirms that it has good assurance that the Trust has followed a robust process in recruiting, training, and inducting volunteers. The work of the Team and the Volunteers support the Trust's 'Journey to Change' through improving patient experience and staff wellbeing in addition to promoting the future supply of recruits joining the Trust. In addition, the NHS Long Term Workforce Plan 2023 is supported as volunteering improves people's mental and physical health and gives them the opportunity to acquire skills that enhance their ability to gain employment. There are a total of 237 active volunteers in the Trust, with 63% from DTVF and 37% from NYY which compares to 84% and 16% respectively the previous year. There has been a 24% increase in active volunteers from 2022/2023, with 74% of the increase being in NYY and 26% in DTVF. The demographics for volunteers indicates that they are far more diverse than the paid workforce, for example: Volunteers are 69% Female and 31% Male compared with a staff workforce 80% female and 20% Male; 86% heterosexual, 14% LGB/other compared with a staff workforce 85% heterosexual, 5% LGB, 10% not declared; 89% White, 11% BAME compared with a staff workforce 91% White, 8% BAME, 1% unknown; and 78% non-disability, 22% with a disability compared with a staff workforce comprising 77% non-disability, 9% with a disability, 14% not declared.	

The Committee notes that the Step Toward Employment Programme (STEP) programme for volunteers enables them to overcome barriers, such as not having a laptop to complete application forms, and access paid work in the Trust. An evaluation sent to participants 3 months after the programme resulted in 13 responses, over half of whom (n=7) had secured paid employment. In addition, the Committee welcomes the first cohort for the Routes to Recruit pathway which commences in September 2024 and the fourth Community Project, to commence this year with Creative Minds, a charity working with Refugees and Asylum Seekers. The Committee suggests producing a 'heat map' to show supply and demand for volunteers.

WRES WDES SOWES and Publication of Staff Equality Information

The Committee confirms that there is good assurance that the Trust has followed a robust process in analysing its staff data by protected group and that in doing so it is meeting its NHS Standard Contract requirements and Equality Act duties. The Committee notes that BAME staff are 2.57 times more likely to enter the Trust's formal disciplinary processes than their white colleagues with men 1.8 times more likely than women and Muslim and Buddhist staff having a higher likelihood than other religions. In relation to Career progression and promotion, the Trust is seen to act fairly, the overall Trust score was 63.83%, however, this contrasts with the score for BAME staff of 51.45%. In terms of pressure from Manager to attend work despite not feeling well enough, the overall Trust score was 11.4%, whereas for staff with Long Term Health Conditions (LTHC), the score was 21.59%. With regard to the percentage of staff satisfied with the extent they are valued at work, the overall Trust score was 48.77%, whereas for those with a LTHC this was 42.04% and those with a gender not the same as assigned at birth 33.77%. The Committee notes that 32.6% of staff live in the 3 areas of the highest deprivation. In DTVF this was 38.4%, whereas in NYY, this was 13.91% of staff.

A number of actions were proposed including: promoting the centralised reasonable adjustments team and the Reasonable Adjustments Passport; delivering the third mid-career programme including a focus on participants from protected characteristic groups; embedding 'being an upstander' in all Equality Diversity and Inclusion (EDI) training, including this in the EDI champion role; developing a reduction of violence and aggression strategy, including a Campaign to raise awareness of the verbal and physical aggression procedure; delivering the Kind Life programme to create a kinder and safer culture; adopting the Show Racism The Red Card (SRTRC) overarching education/training programme and an Anti-racist pledge; including additional information in the LGBTQ+ Awareness Training relating to Trans inclusion in the workplace; and further work analysing the disciplinary data to understand the recent increase and any patterns.

People Journey Delivery Update

The Committee notes that good assurance can be taken on the progress of the Delivery Plan. Workforce planning will feature heavily in NENC Regional work over the forthcoming six months, where the Trust is well represented by the Joint Executive Directors of People and Culture. Compliance with appraisals continues to increase steadily across the Trust following the introduction of TEWVision and more frameworks have been signed off for different professional groups. The standards are now an annual appraisal and one 6 monthly review (previously an annual appraisal and 3 quarterly reviews).

From 7 October 2024 the Trust Welcome will occur twice a month as a single face-to-face welcome day at Flatts Lane Centre representing Day 1 of an individual's employment with TEWV (occurring on the 1st and 3rd Mondays of month). From January 2025 it is intended to link the welcome day to the face-to-face training needed for each role so that everyone ends their first fortnight, having completed all the mandatory, statutory and essential training they need for their role, including ILS, Moving and Handling, CPR and Positive and Safe Care Level 2. There will also be a variety of stalls showing new colleagues the breadth of support and opportunities available.

The Committee notes the reasonable level of assurance in respect of the two audit reports (AuditOne), relating to the Leavers' and Recruitment processes respectively. The Committee informs that in the previous two months, the Recruitment team has cleared 170 candidates.

Health and Wellbeing Update

The Committee agrees there is reasonable assurance that the plans for health and wellbeing activity in the Trust through providing strong support for colleagues will continue to meet colleagues' needs and contribute significantly to the increased retention rate. The Trust has achieved the Silver Better Health at Work Award and is concluding its submission for the Gold award in October 2024. An element of the submission includes the identification of campaign topics: Domestic Abuse/Sexual Violence, including stalking behaviours; Alcohol and substance (safe) use; Active Travel and Move More; Wellbeing for harder to reach staff groups such as EFM/Housekeeping staff, shift workers, night-time/out of hours workers, geographically distant staff, Health and Justice staff; and Men's Health and Mental Health (Stress). This is a milestone in the development of the Health and Wellbeing Strategy which in turn contributes to the Trust's 'People Promise: We are Safe and Healthy'. When compared with other Trusts, the overall score of 6.37 for TEWV is slightly below the average of 6.39. However, the Trust's trajectory is an improving one for 'Safe and Healthy', given that the scores were 6.16 and 6.21 in the two preceding years.

The Committee notes several positive metrics from the Staff Survey, under the Health and Wellbeing category, including firstly, staff having not experienced musculoskeletal (MSK) problems in last 12 months as a result of work activities, with the average being 77% and the Trust results at 82%; and, secondly, staff not working any additional unpaid hours per week over and above contracted hours, where the Trust has increased from 40% to 44%, with the national average being 41%. In relation to staff sickness absence, sickness absence levels are remaining relatively static at 6.12% but above the national mean of 5.57%, with the Trust ranked at 37 of 48 Mental Health Trusts. Anxiety/stress/depression remains the main reason of sickness absence.

The Committee welcomes the Trust becoming a signatory to the first NHS England Sexual Safety Charter and the commitment to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. From 1 July 2024, Executive and Operational leads have been identified to take forward this work which includes the development and launch of Domestic Abuse and Sexual Safety in the Workplace toolkits, implementation of training programmes and guidance. The Committee notes that this work has already shown early impact on some cases referred to People and Culture.

The Committee notes that significant work on violence and aggression reduction is continuing with the following initiatives: piloting of a new multi-disciplinary review, approval and senior oversight process in PICUs and Bankfields for RIDDOR reportable incidents; completion of a survey by over 500 staff indicating a sense of disconnect between the reporting and oversight which takes place and the experience of teams in clinical areas. Further analysis will take place of the results during the next quarter; and a review of options for providing care when a patient is being abusive to our staff led by clinical executives and the clinical leaders group and sponsored in part by Unison and co-developed with the BAME staff network due to the links with the Show Racism the Red Card work.

A total of £48,500 was released for funding health and wellbeing initiatives to be approved by the Staff Led Health and Wellbeing Council.

The Committee notes that the HNY Resilience hub is in the process of closing down and the staff are being redeployed, with some staff joining the Trust's Employee Psychology Service. The NENC hub will continue to operate on a more limited model than previously, with referrals approved on a fee-paying case-by-case basis, where people do not meet the criteria for our internal services or cannot access them for a specific reason – these will be approved either by the Joint Directors of People and Culture or the Chief Psychological Professions Officer.

Employee Relations

The Committee notes a reasonable level of assurance that employee relation matters are being managed effectively and the areas which require further improvement are well understood. A six-monthly update (cases from January to June 2024) showed there were 39 disciplinary cases (72% DTVF; 21% NYY; 5% EFM and 1% Corporate). There were 15 grievances submitted in total within the reporting period (73% DTVF; 20% NYY; and 7% EFM). There were 7 formal capability cases (29%

	DTVF and 71% NYY). The Trust has recently held a workshop on its processes and a final meeting is to be held at the end of September. In addition, it has recruited a further investigating officer to support our commitment to conclude disciplinary cases in a timely and compassionate way.
2c	**Advise: The Committee would like to advise the Board on the following matters:** **Colleague Story/Experience** Two members of the Estates, Facilities Management Service informed the Committee about their respective roles in supporting the care of patients. Firstly, in relation to Facilities Site Management, for example, overseeing the cleanliness, food standards, portering, delivery standards, collecting post and undertaking vehicle checks several sites including Roseberry Park Hospital, Bankfields Court, Durham Road, Aysgarth, Adult Respite, Brook House. The Committee notes that Supervisors are responsible for staff training, appraisals, working collaboratively with Estates to ensure repairs/defects were addressed and day to day operational cleanliness and maintaining compliance with the 'star' rating. The Trust aims for 95% compliance (5 star), however, at the current time is mostly achieving 4 stars due to factors such as annual leave or sickness absence. Whilst there is a 7-day period to rectify non-compliant elements, should the rating drop to 3-star, the timescale for rectification is 24 hours. Secondly, the role as a Housekeeper at a Trust site was outlined as involving overseeing the deep cleaning of rooms on the Wards on a daily schedule of 4 rooms using the steam cleaner and scrubber on alternate weeks, high dusting all touch points, making beds, abiding by COSHH guidelines and interacting with patients. There was also food preparation in regard to cold breakfasts and lunches using the chilled food service. It was noted that there was a 3-weekly menu cycle every 12 weeks with Bank Holiday specials, Xmas buffets and Quarterly theme nights usually selected by Facilities Management. Facilities Site Management also attended a monthly menu meeting, where updates were discussed regarding allergens, for example, in relation to Natasha's Law. Both team members were thanked for the level of positive interaction they had with patients and carers and how they helped service users feel safe through this contact. The Committee suggests that Housekeeping staff are included in future Leadership visits and notes the difference Housekeepers make in relation to nutrition for patients. **Update following the recent Community unrest** The Committee notes the anti-racist work which has been undertaken and the Show Racism the Red Card training sessions with Unison and the BAME Staff Network which commenced on 2 September 2024. It acknowledges that this is the start of becoming an anti-racist organisation. The Committee particularly appreciates the work which the BAME Network has done to support the International Recruits during the race riots. **Feedback from 'Time Out' event – 12 August 2024** The Committee notes that future developments will be concerned with the culture of the organisation, including reducing discrimination, how the Trust can do more to support people's basic needs, linked to deprivation and staff's own mental health and how the Leadership Academy can support staff throughout their careers. **Freedom to Speak Up Guardian Report (FTSU)** The Committee notes the total number of cases received in Q4 2023/24 was 55 and for Q1 for 2024/25 was 52, indicating that numbers appear to have stabilized, although remaining high, given that one person has left the team. The Committee welcomes the additional support from a Specialty Clinical Director on a part-time basis into the team. The highest proportion of staff choosing to speak up within Quarter 4 and Quarter 1 were from a Nursing Profession and accounted for 36% and 58% of the cases respectively. For comparison they make up 26% of the Trust. The majority of staff speaking up were from a White British ethnicity, although more recently there had been some engagement from people with a BAME background. A total of 3 cases of detriment were referred to the Associate Director for Operational Delivery and Resourcing within People and Culture, all of which cited victimisation as the cause of the demeaning treatment received. With regard to training compliance, 'Speak Up' training is at 87%, 'Listen Up' is at 89% and 'Follow up' at 92%. Board members are encouraged to ensure their training is up to date.

2d	**Risks**	No new risks identified for inclusion in the BAF. Noted the work which was progressing on static risks in the Corporate Risk Register.

Recommendation: The Board is asked to note the contents of the report.

3	**Any Items to be escalated to another Board Sub-Committee/Board of Directors**	None
4	**Report compiled by:** Deborah Miller, Corporate Governance Manager, Jules Preston, Non-Executive Director (Interim Committee Chair), Sarah Dexter-Smith and Kate North, Joint Executive Director of People and Culture	

DM/27/09/2024

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**10th October 2024**
Title:	**WRES WDES SOWES & Publication of Staff Equality Information**
Executive Sponsor(s):	**Sarah Dexter- Smith, Director of People and Culture**
Author(s):	**Sarah Dallal, Equality, Diversity, Inclusion and Human Rights & Voluntary Services Lead and Lisa Cole, inclusive Community Engagement Lead**

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	**Safe Staffing**	The experience of our staff from protected groups is not always positive and can contribute to these staff feeling unsupported and not valued. The feedback from the WRES, WDES, SOWES and publication of information allows the Trust to better understand the experiences and outcomes for staff from protected groups, to act where necessary and in doing so to improve employee experience and retention.

Executive Summary:

Purpose:

The Trust recognises the need and benefits for championing a diverse workforce; recognising the impact of discrimination on staff wellbeing and commits to challenge discrimination wherever it arises in relation to the organisation.

This paper is presented to the Board to provide assurance that the Trust is meeting the requirements of the NHS Standard Contract by gathering data for the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) and publishing the results and associated action plans on its website by 31st October 2024 following ratification by the Board of Directors.

The Trust also undertakes and publishes a Sexual Orientation Workforce Equality Standard (SOWES). Publishing staff equality data also helps to meet the obligations under the Public Sector Equality Duty of the Equality Act 2010 to:

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

The documents presented are:

- 2024 WRES (Workforce Race Equality Standard) data and action plan
- 2024 WDES (Workforce Disability Equality Standard) data and action plan
- 2024 SOWES (Sexual Orientation Workforce Equality Standard) data and action plan
- The 2023 Publication of Information (staff)
- The Model Employer trajectory update

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

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

A version of this report and information has been to the Equality, Diversity, Inclusion and Human Rights group. This report went to People, Culture and Diversity Committee on 16th September and the Committee recommended that Board approve its publication on the Trust website

Proposal:

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

Overview:

The Trust is obliged to meet its NHS Standard Contract requirements and Public Sector Equality Duties as outlined above.

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

The NHS EI Model Employer trajectories sets aspirational goals for each organisation to increase BAME representation at leadership levels (8a and above).

Each year the Human Rights Equality Diversity Inclusion Policy must be reviewed each year in line with the MHA code of practice.

Areas of progress

The percentage of staff from a BAME background, those declaring having a disability and LGB staff has increased this year. BAME staff 7.89% compared to 5.9% last year, staff with disabilities 9.23% compared to 7.9% last year, LGB staff 4.8% compared to 4.2% last year.

The centralised reasonable adjustments team pilot has been running for 15 months and has been very positively received by both staff and managers. The original year's pilot has been extended until May 2025.

The Trust has produced data on staff's religion for the first time.

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

The Board's demographic data completeness has improved.

Concerns

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

Data completeness
There are issues with data completeness for ethnicity (1.58% not stated), sexual orientation (10.1% not stated), disability (13.49% not stated) and religion (16.86% not stated)

In the following sections an up arrow (↑) indicates that the score has improved since last year and a down arrow (↓) indicates the score has deteriorated since last year

Harassment, bullying or abuse.

From patients, relatives, or the public – overall trust score 21.4%
BAME staff 31.67% (↑), Gay or lesbian 27.39% (↑), gender not the same as assigned at birth 46.42% (↑), Muslim staff 34.52% (↓)
From colleagues – Overall trust score 13.53%
BAME 18.51% (↓), Staff with LTHC 19.06% (↓), Buddhist staff 21.74% (↓), Hindu staff 20.64% (↑).

Discrimination

From manager/team leader or other colleague - Overall trust score 5.3%
BAME 14.05% (↓), Bisexual staff 11.49% (↓), gender not the same as assigned at birth 15.38% (↑), Buddhist staff 12.5% (↓), Muslim staff 13.89% (↓).

Likelihood of entering the disciplinary process

BAME staff are 2.57 times more likely (↓) compared to white staff. This is a significant increase as since 2020 BAME staff have been less likely or no more likely than white staff to enter the disciplinary process. In previous years the Trust was required to report on the average number of disciplinaries over a 2-year rolling period however this year the calculation has been changed to disciplinaries over a 1-year period. Using the previous calculation the likelihood of BAME staff entering the disciplinary process

compared to white staff would be 1.9 which is still considerably higher than previous years. The EDI team attend pre assessment group meetings for cases involving BAME staff and have done so since 2020. 10 of the disciplinaries related to non- medical BAME staff. Of those 10% (1) resulted in a recommendation of counselling. Of the 77 cases involving white staff 4% resulted in a recommendation of counselling or no case to answer
Men are 1.8 times more likely (↑) compared to women. (2.18 times more likely in 2023). Research last year found that there are gender differences in the types of behaviour which lead to disciplinaries for men and women and that men aged 55-64 are over- represented in disciplinaries and received more significant sanctions which appear to correspond to the nature of the issues. Based on a comparison to an equivalent Trust there does not appear to be a bias against men in the Trust's disciplinary processes.
Muslim and Buddhist staff have higher likelihoods than other religions.

Believing the Trust acts fairly in relation to career progression and promotion

Overall trust score 63.83%
BAME 51.45% (↓)

Feeling pressure from manger to come to work despite not feeling well enough.

Overall trust score 11.4%
Staff with LTHC 21.59% (↑)

Staff engagement score

Staff engagement score - Overall trust score 6.94
Gender not the same as assigned at birth 5.75 (↓), non-binary staff 5.39 (↓)

Satisfied with the extent to which they are valued at work.

Overall trust score 48.77%
Staff with LTHC 42.04% (↑), gender not the same as assigned at birth 33.77% (↓).

Staff living in the 3 areas of highest deprivation.

In the Trust overall 32.6% of staff live in the 3 areas of highest deprivation. In the Durham, Tees valley and Forensic care group this is 38.4% of staff. In the North Yorkshire, York and Selby care group 13.91% of staff live in the 3 areas of highest deprivation.
.
Actions against all these concerns are outlined in Appendix 1.

The full detail is presented in Appendix 2

Human Rights, Equality, Diversity, Inclusion Policy

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

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

Minor changes have been made to the policy, correcting spelling, and typing errors.

Prior Consideration and Feedback

The development of the data has been undertaken by the Trust's Business Analytics and Clinical Outcomes Information Department and the Equality, Diversity, Inclusion and Human Rights Team. Staff networks have been involved in the development of the WRES, WDES and SOWES actions plans, through consultation events.
A version of this report and information has been to the Equality, Diversity, Inclusion and Human Rights steering group in July.
The report was reviewed by People, Culture and Diversity Committee on 16th September. It recommended that Board approve the paper for publication.

Implications:

Failure to undertake the WRES and WDES or understand the differences in outcomes and experiences of our staff from protected groups in accordance with the Public Sector Equality Duties and the NHS Standard Contract may have regulatory and reputational consequences. Failure to act to reduce differences in outcomes and experiences of our staff from protected groups may impact on the ability of the Trust to recruit and retain staff.

Recommendations:

The Board is asked to:
1. Confirm that it has good assurance that a robust process has been undertaken when developing the attached data and actions.
2. Agree that the attached report and data are published on the Trust website

Appendix 1

Areas of concern and actions.

Harassment, bullying or abuse from patients, relatives, or the public**.**

BAME staff, gay or lesbian staff, staff whose gender is not the same as assigned at birth and Muslim staff all report higher levels of harassment, bullying or abuse from patients, relatives, or the public.

Actions

- Develop and implement a violence reduction strategy.
- Campaign to raise awareness of the verbal and physical aggression procedure.
- DTVF care group have a specific focus on verbal, physical and racial aggression in inpatient settings.

Harassment, bullying or abuse from colleagues and discrimination from manager, team leader or other colleagues.

BAME staff, staff with disabilities, Buddhist staff and Hindu staff all report higher levels of bullying, harassment, or abuse from colleagues. BAME staff, bisexual staff, staff whose gender is not the same as assigned at birth, Buddhist staff and Muslim staff all report higher levels of discriminations from their manager/ team leader or other colleagues.

Actions

- Embed the Trust's 'Be an Upstander not a Bystander' in all EDI training and encourage more staff to become EDI champions for whom upstanding is a key role.
- Deliver a Kind life training (creating a kinder and safer culture programme)
- Show Racism the Red Card education and training programme.
- TEWV to become an anti- racist organisation.
- Explore whether different people with different disabilities are more likely to be bulled and harassed.
- Both care groups are rolling out Upstander training and working with BAME staff network members and staff to reduce bullying/ harassment over the next 12 months

Likelihood of entering disciplinary process

BAME staff and men are more likely to enter the disciplinary process compared to white staff and women.

Actions

- Analyse the disciplinary data to understand the rise for BAME staff and identify any patterns.
- EDI team to continue to sit on pre assessment groups for cases involving men.

Believing the Trust acts fairly in relation to career progression and promotion

BAME staff are 13% less likely to believe the Trust acts fairly in relation to career progression and promotion compared to other staff.

Actions

- Deliver 3rd mid -career development course for staff from protected groups.
- Promote career information sessions to networks.

Feeling pressure to attend work despite not feeling well enough.

Staff with disabilities feel more pressure to come to work despite not feeling well.

Actions

- Promote the reasonable adjustment team.
- Reasonable Adjustments Passport – review, reminder on TEWV Vision
- Explore and implement putting in place reasonable adjustments for new started within the first 6 weeks of their employment.
- Continue to provide training for staff on disabilities. Deliver Bitesize training for managers on this and lunch and learn sessions on specific conditions.

- Both care groups are to support awareness raising around reasonable adjustments for their staff
- Care groups to consider a celebration/ statement of intent for disability history month 2024.

Staff engagement and feeling valued at work.
Staff whose gender is not the same as assigned at birth and non- binary staff have lower levels of engagement compared to the Trust overall score. Staff with disabilities and staff whose gender is not the same as assigned at birth feel less satisfied with the extent to which they are valued at work compared to the Trust overall.

Actions

- Include additional information in the LGBTQ+ awareness training relating to Trans inclusion in the workplace.
- Develop a campaign to promote the importance of pronouns on staff ID badges, pronoun pins where appropriate, email signatures and on Teams.

Staff living in 3 highest areas of deprivation.
32.6% of staff live in the 3 areas of highest deprivation. In DTVF this is 38.4%. In NYYS this is 13.91%

Actions

- DTVF care group Health and Wellbeing coordinator and wellbeing champions are to include cost of living and useful resources in team presentations.
- Inclusion of cost of living, resources, and opening conversations in management bite size training.
- DTVF to hold an event/ survey to hear from staff what would make the most difference in the next 6 months especially targeting bands 2 – 5.

Appendix 2
Detail of the measures - separate document

Appendix 3
Human Rights, Equality, Diversity, Inclusion Policy

APPENDIX 2

EDIHR Department

Tees, Esk and Wear Valleys
NHS Foundation Trust

Workforce Race Equality Standard (WRES) 2024

2024

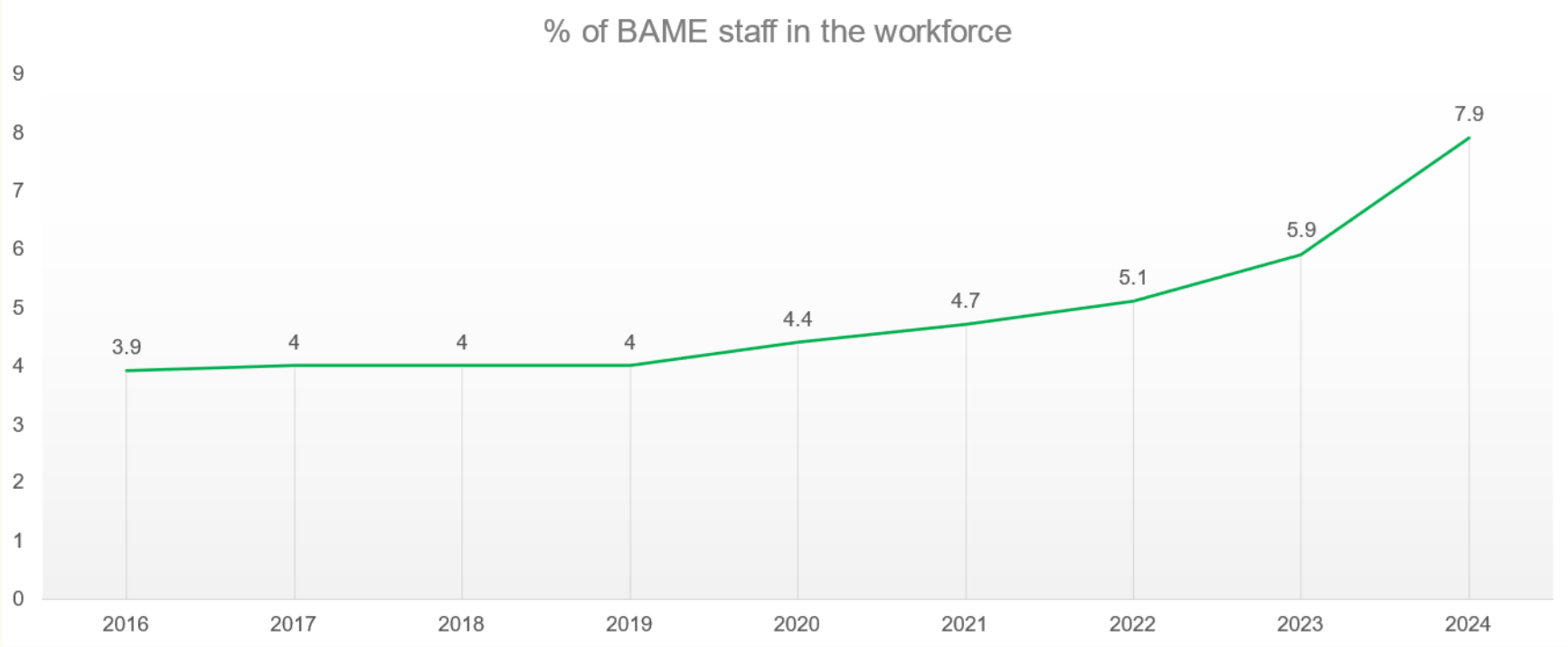
WRES

Tees, Esk and Wear Valleys NHS Foundation Trust

- Mandated as part of the NHS standard contract
- 9 indicators
- Been collecting data since 2015
- Submit data into a national system
- Develop and publish annual action plans
- Governance - Board
- Annual detailed report from the WRES team
- 7.9% of the workforce identify as BAME (664)
- Census data – Local population identify as BAME 5.2%
- Consultation event held with staff networks

Indicator 1 – Workforce ethnicity

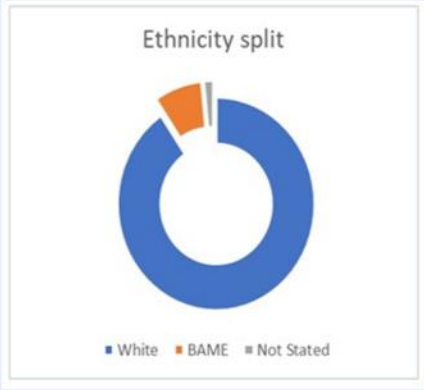
Tees, Esk and Wear Valleys NHS Foundation Trust

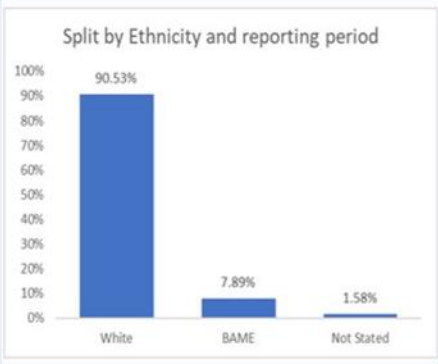


Indicator 1 – Workforce ethnicity

Tees, Esk and Wear Valleys NHS Foundation Trust

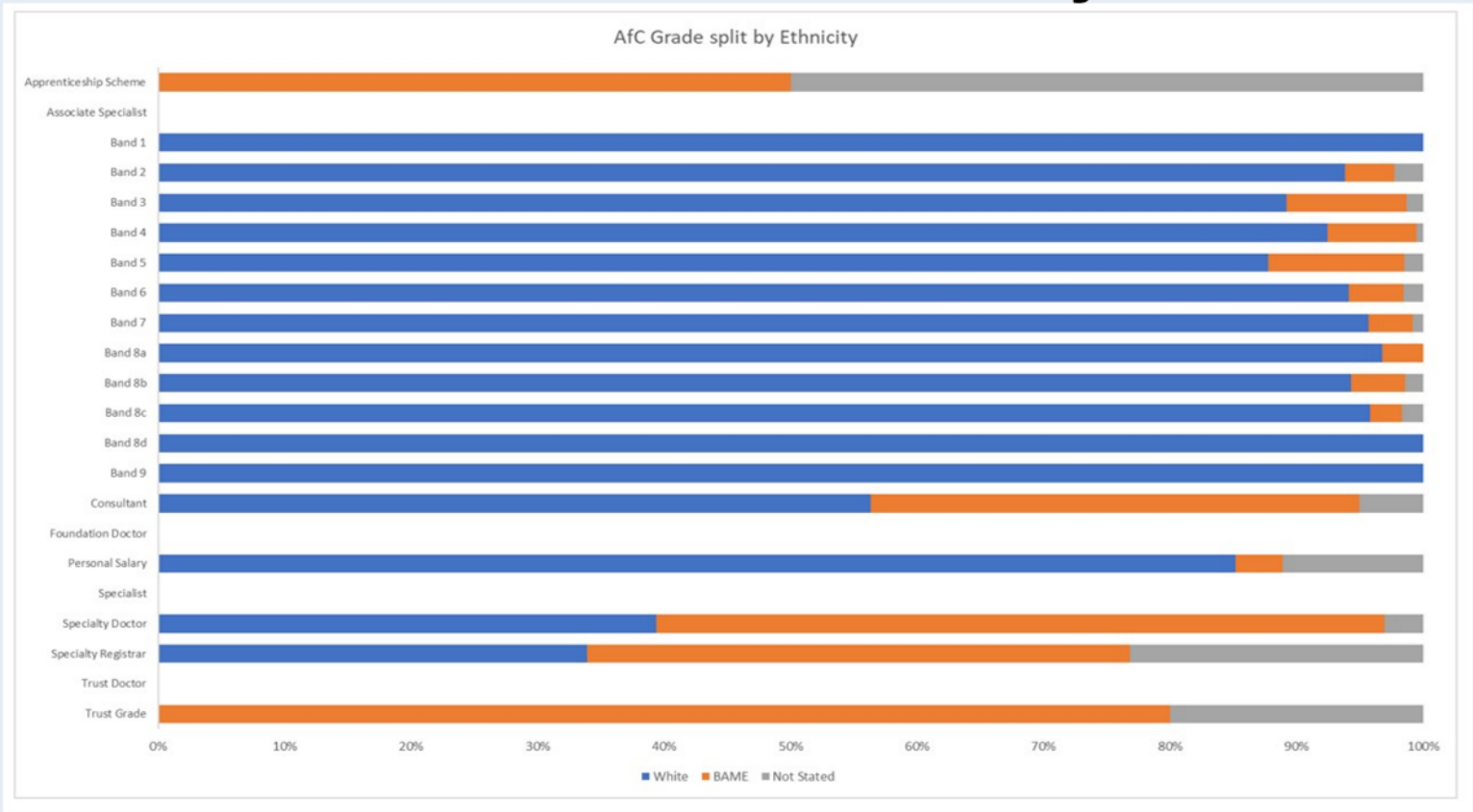
Data Item			Measure	WHITE		BME		ETHINICITY UNKNOWN / NULL	
				Figure	%	Figure	%	Figure	%
1a) Non Clinical workforce	1	Under Band 1	Headcount						
	2	Band 1-4		1327	95%	52	4%	16	1%
	3								
	4								
	5								
	6	Band 5-7		404	94%	25	6%	2	0%
	7								
	8								
	9	Band 8a-b		101	97%	2	2%	1	1%
	10								
	11	Band 8c-d		26	93%	1	4%	1	4%
	12								
	13	Band 9		5	100%	0	0%	0	0%
	14	VSM		24	92%	1	4%	1	4%
1b) Clinical workforce of which Non Medical	15	Under Band 1							
	16	Band 1-4		1657	87%	215	11%	23	1%
	17								
	18								
	19								
	20	Band 5-7		3434	93%	215	6%	52	1%
	21								
	22								
	23	Band 8a-b		348	95%	16	4%	1	0%
	24								
	25	Band 8c-d		118	98%	2	2%	1	1%
	26								
	27	Band 9		7	100%	0	0%	0	0%
	28	VSM		1	50%	50%	0%	0	0%
OR which Medical & Dental	29	Consultants		88	56%	60	38%	8	5%
	31	Non-consultant career grade		52	37%	74	52%	15	11%
	33	Other		0	0%	0	0%	0	0%





Indicator 1 – Workforce ethnicity

Tees, Esk and Wear Valleys
NHS Foundation Trust



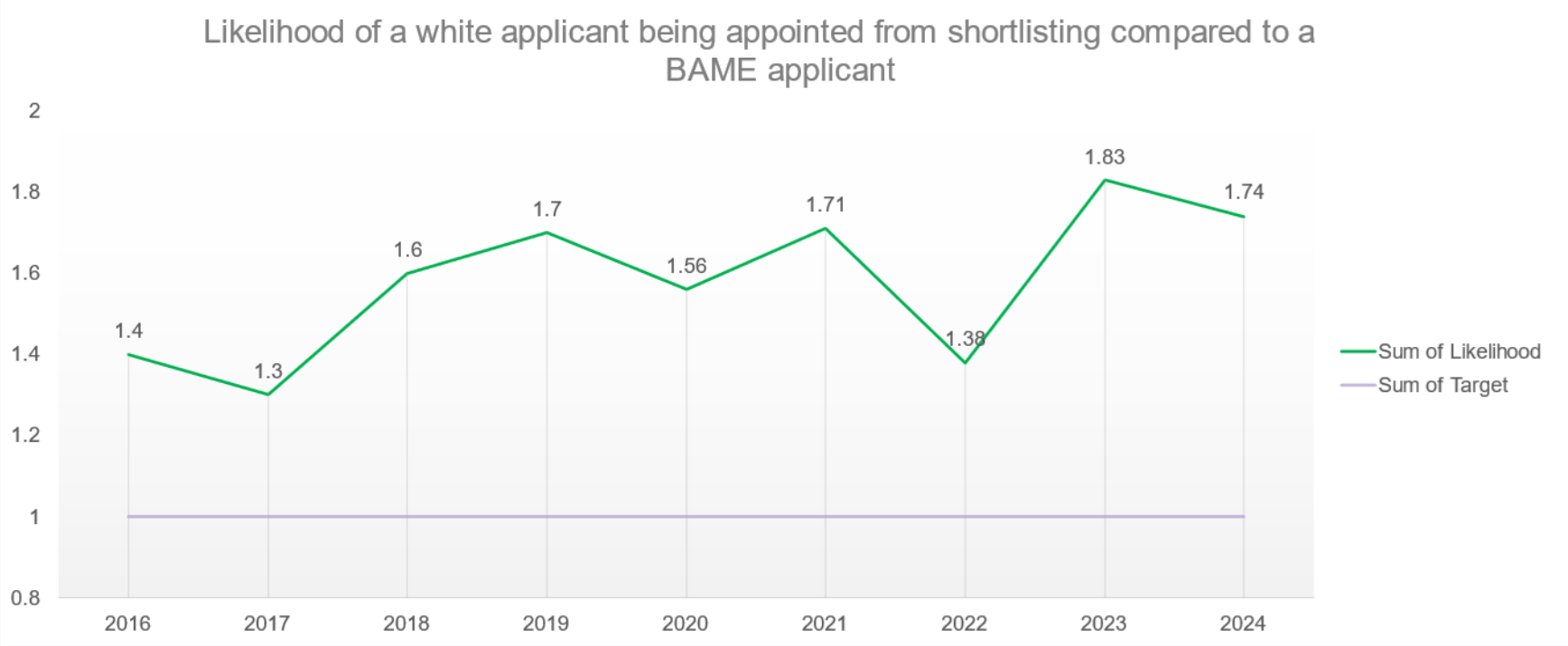
Indicator 1 – Workforce Model Employer

Tees, Esk and Wear Valleys NHS Foundation Trust

	Proportion of BAME workforce (as 31st March 2018)	Proportion of BAME workforce (as 31st March 2019)	Proportion of BAME workforce (as 30th November 2020)	Proportion of BAME workforce (as 31st March 2021)	Proportion of BAME workforce (as 31st March 2022)	Proportion of BAME workforce (as 31st March 2023)	**Proportion of BAME workforce (as 31st March 2024)**	**Trajectory for 2024**	Additional recruitment over next 4 years	Total BAME staff by 2028 to reach equity
Band 8a	6	9	9	9	14	13	11	9	0	10
Band 8b	0	2	2	2	2	5	7	3	0	4
Band 8c	1	1	2	1	1	1	3	3	1	4
Band 8d	0	0	0	1	1	0	0	0	1	1
Band 9	0	0	0	0	0	0	0	0	0	0
VSM	0	0	1	1	0	1	2	0	0	1

Indicator 2 - Recruitment

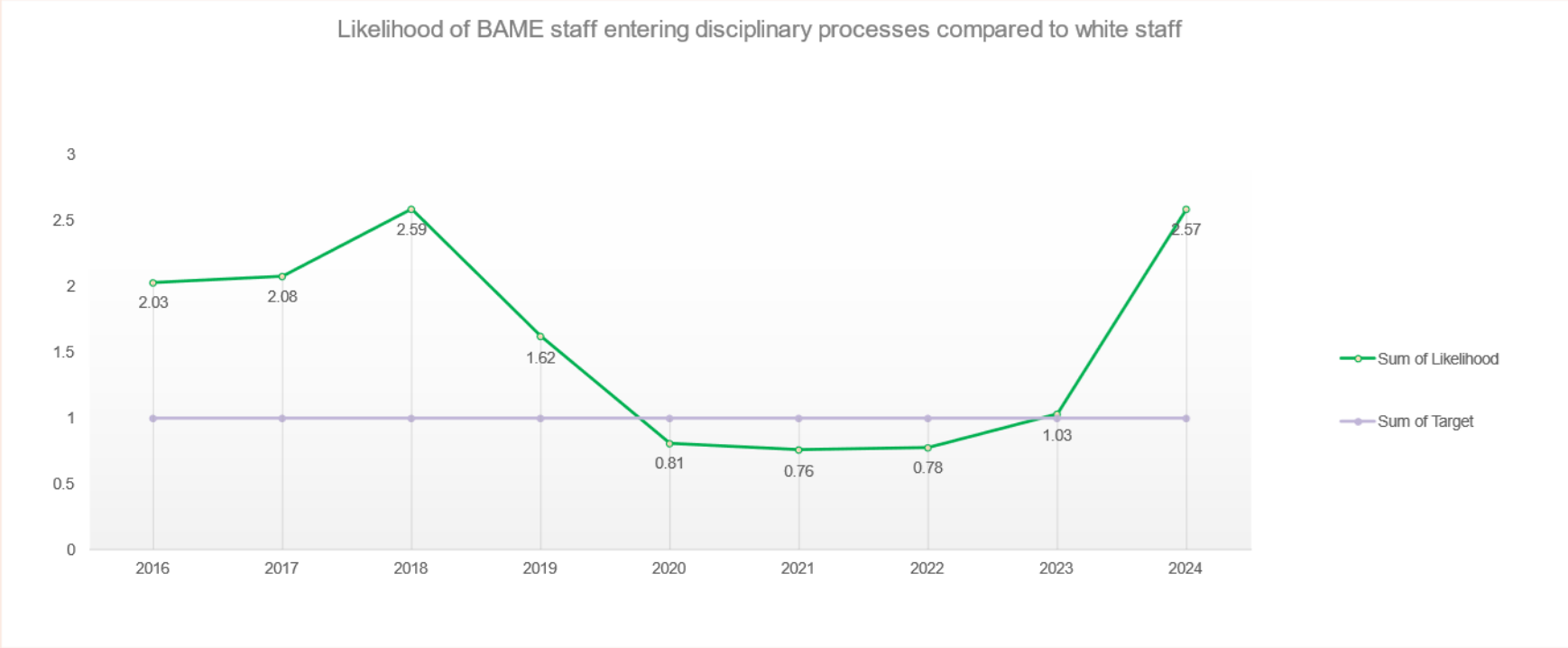
Tees, Esk and Wear Valleys NHS Foundation Trust



1400 BAME applicants shortlisted; 249 BAME applicants offered posts
3823 White applicants shortlisted; 1185 White applicants offered posts

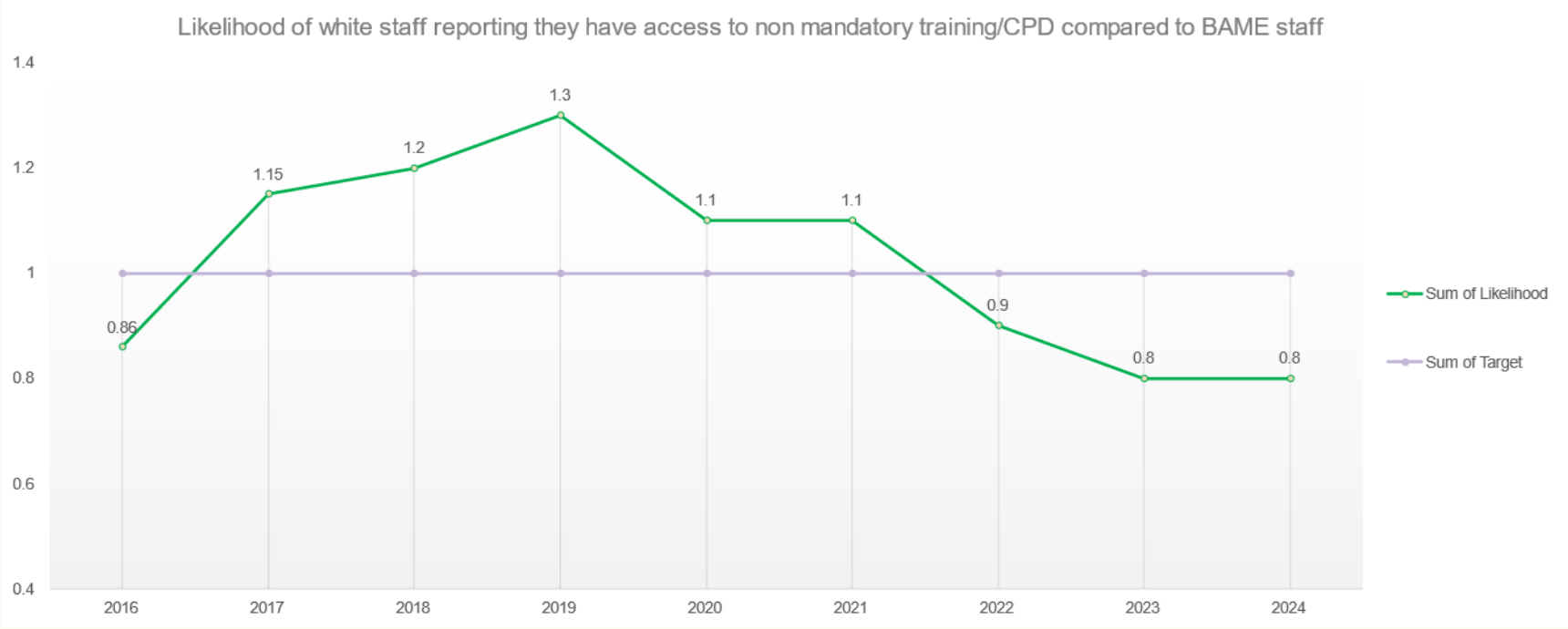
Indicator 3 – Disciplinary

Tees, Esk and Wear Valleys NHS Foundation Trust



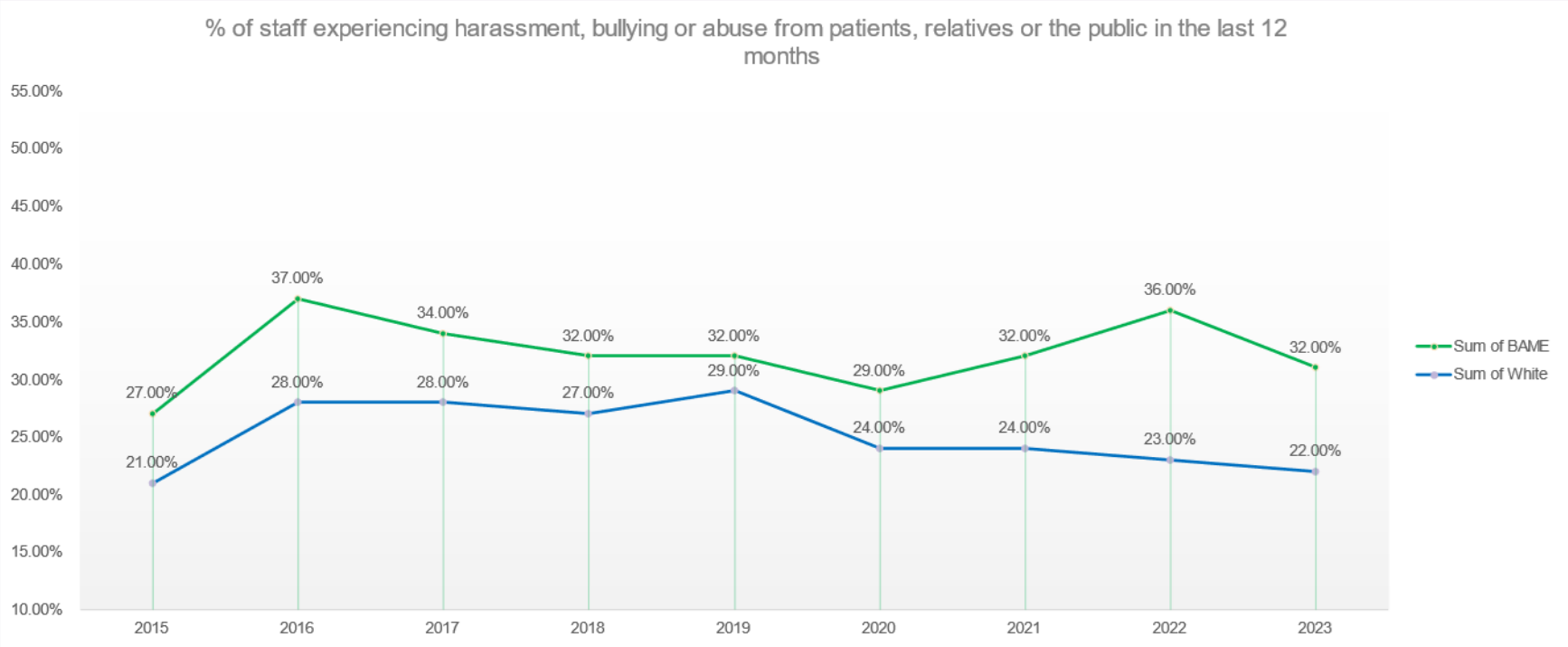
Indicator 4 – Non-mandatory training & CPD

Tees, Esk and Wear Valleys NHS Foundation Trust



Indicator 5 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

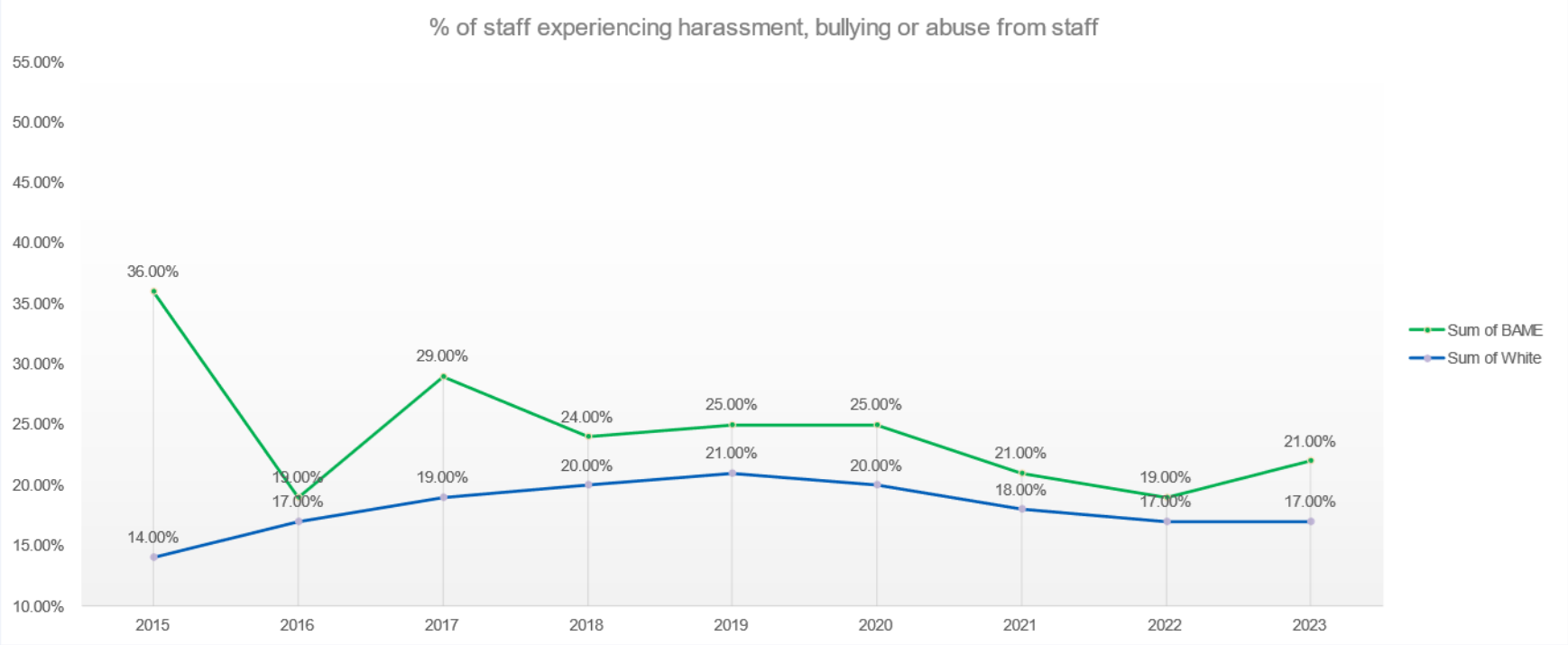
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey response rates: BAME 238, White 3418

Indicator 6 - % of staff experiencing harassment, bullying or abuse from staff in the last 12 months

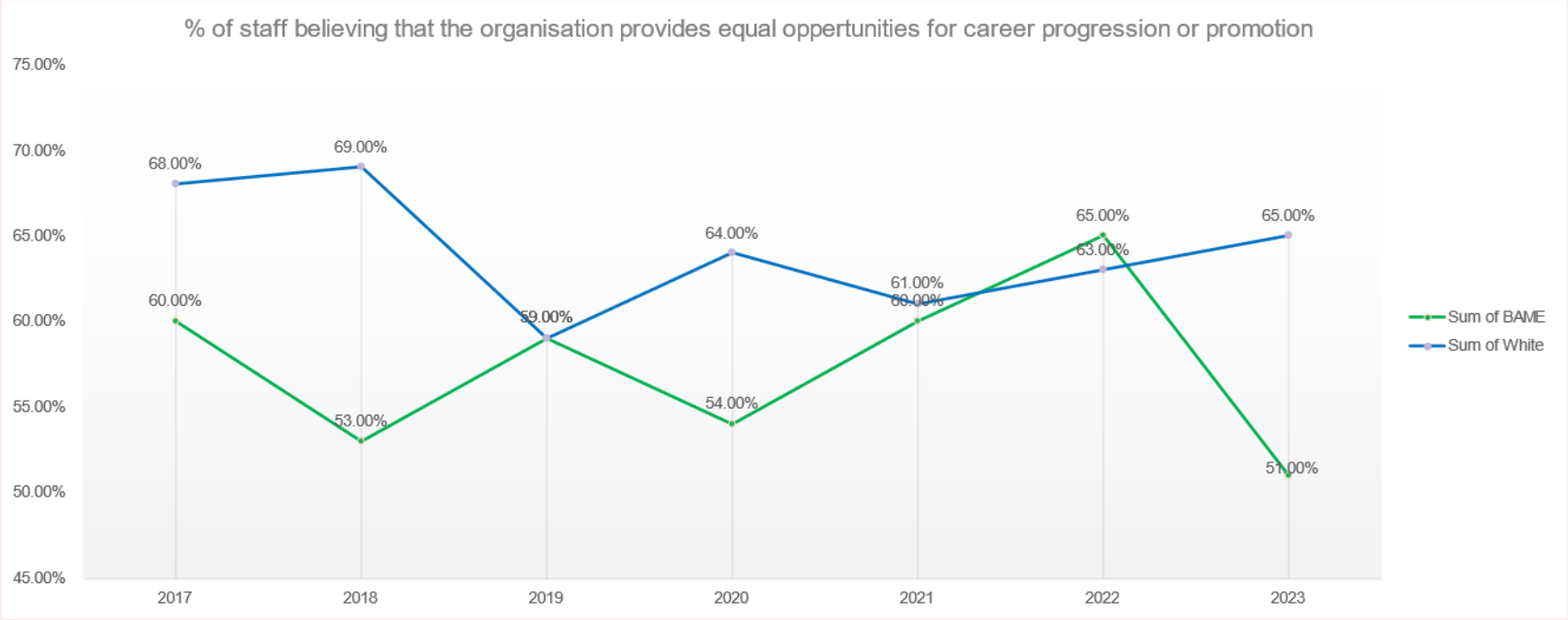
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey response rates: BAME 239, White 3422

Indicator 7 - % of staff the believe the Trust acts fairly with regards to career progression and promotion

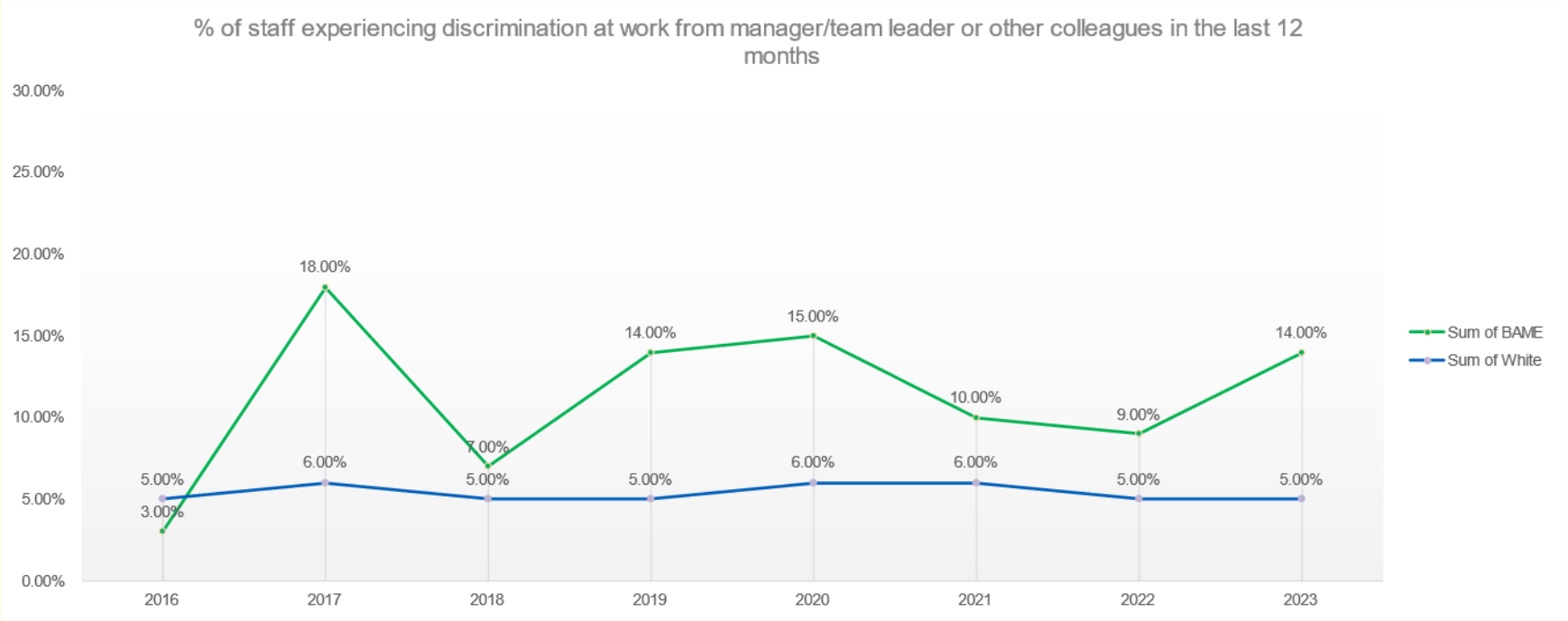
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey response rates: BAME 241, White 3484

Indicator 8 - % have personally experienced discrimination at work from manager/team leader or other colleagues In the last 12 months

Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey response rates: BAME 242, White 3476

Indicator 9 - Board diversity

Tees, Esk and Wear Valleys NHS Foundation Trust

Percentage difference between organisations boards membership and its overall workforce is

-2%

Percentage difference between organisations boards voting membership and its overall workforce is

0%

Percentage difference between organisations board executive membership and its overall workforce is

+ 2%

WRES ACTION PLAN

ACTIONS: Please specify which actions are different to current practice, and which are continuation	*Person who is responsible for overseeing the action*	*Please specify KPIs and timelines for monitoring the actions*
1. Continuation - Deliver a third mid-career programme, for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Promote this programme to the staff networks and using Trust communication channels. Evaluate programme.	Sarah Dallal	**Q4 2024/25** - WRES workforce data, evaluation from participants (post programme, 6 months, 1 year)
2. New- Embed being an upstander in all EDI training, including this in the EDI champion role	Abby Holder/Sarah Dallal/Lisa Cole	**Q3 2024/25 -** Training evaluation
3. Continuation - Promote the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process. Measure the diversity of successful candidates, evaluate feedback from panel members and applicants.	Sarah Dallal	**Q1 2025/26** - Increase in the number of interviews being carried out using the platform. WRES recruitment and workforce data.

4. New – Work to develop a reduction of violence and aggression strategy	Kate North	**Q4 2024/25** - Staff survey results
5. Continuation – begin the roll out and embedding of Kind Life (creating a kinder and safer culture programme)	Susan Coulson	**Q4 2024/25** - Staff survey results, Pulse survey results, attendance to training, evaluation of training
6. New - Promote career information sessions (Routes to Recruit pilot) to staff networks	Lisa Cole	**Q3 2024/25** - attendance to sessions, feedback from networks
7. New - Campaign to raise awareness of the verbal and physical aggression procedure	Abby Holder	**Q4 2023/24 -** number of Inphase incidents reported
8. New - Intersectionality of staff with Long-term Health Conditions, BAME staff, LGBTQ+ staff, explore whether it is possible to look at whether the data can tell us about staff members who identify as more than one or all 3 protected characteristics.	Lisa Cole	**Q4 2023/24 -** staff survey results
9. Continuation - Hold a stall at Middlesbrough MELA (multi cultural event), including information about working in the organisation, STEP and current vacancies.	Lisa Cole & Abby Holder	**Q2 2023/24 -** WRES recruitment and workforce data.
10. New - Analyse the disciplinary data, understand the rise and any patterns	Lisa Cole	**Q3 2023/24 -** Analysis of data report

11. New -Show Racism The Red Card (SRTRC) overarching education/training programme	Kate North	**Q4 2023/24 -** Training evaluation, staff survey results, feedback in network
12. New - TEWV becoming an Anti-Racist organisation	Kate North	**Q4 2023/24** - Staff survey results, feedback from network
13. Continuation - Celebration campaign for Black History Month	Lisa Cole	**Q3 2023/24** - communications plan
14. New - Hold a 2nd BAME staff network event	Lisa Cole & Sarah Dallal	**Q3 2023/24** - feedback from network, engagement scores on staff survey
15. New - Evaluate the Race training being delivered in SIS for the leadership team, this includes exploring cultural differences	Lisa Cole & Sarah Dallal	**Q4 2023/24** - training evaluation, SIS staff survey results
16. Continuation - Complete the routes to recruit programme for BAME community group	Lisa Cole	**Q3 2023/24 -** feedback from participants, number of people going into paid employment

EDIHR Department

Tees, Esk and Wear Valleys
NHS Foundation Trust

Workforce Disability Standard (WDES)

2024

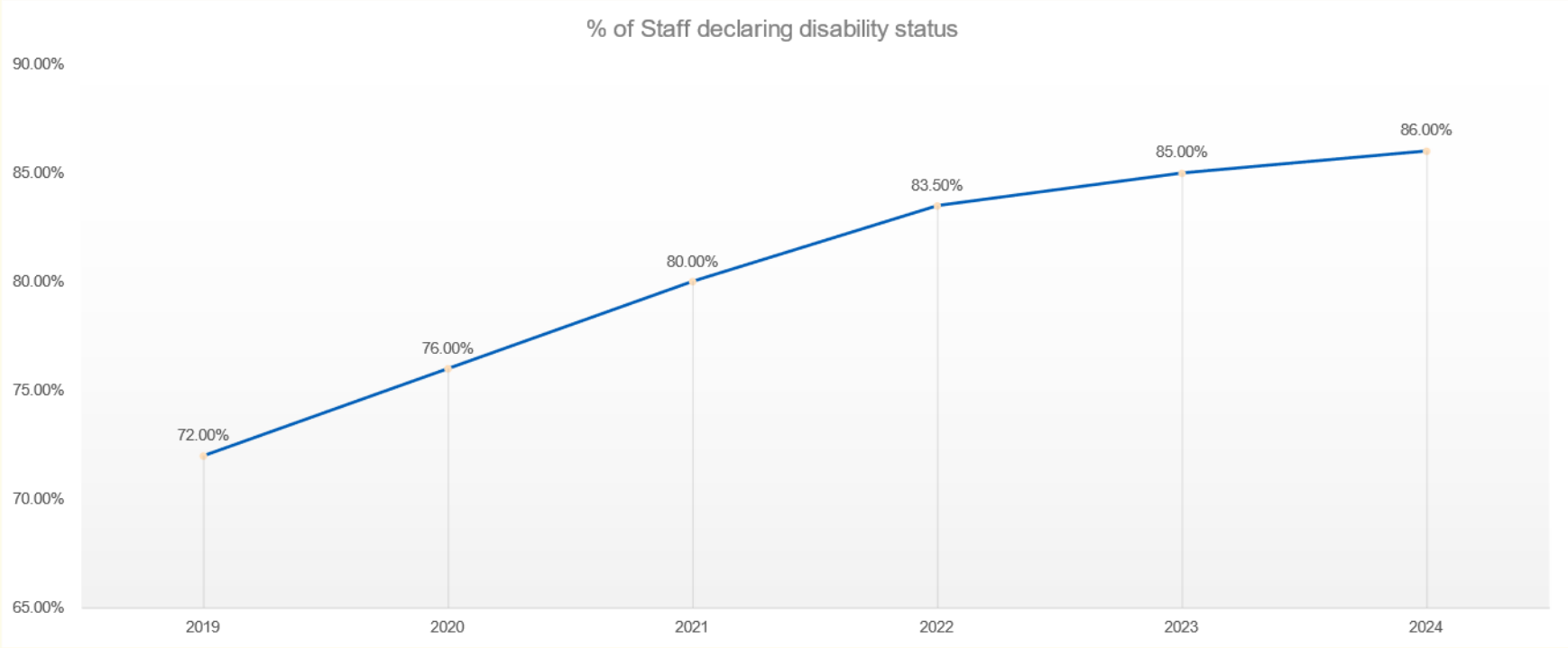
WDES

Tees, Esk and Wear Valleys
NHS Foundation Trust

- Mandated as part of the NHS standard contract
- Been collecting data since 2019 (5 years)
- Submit data into a national system
- Develop and publish annual action plans
- Governance - Board
- 9% of the workforce identify as having a disability on ESR (781)
- Census data – 7.94% Local population have a disability
- Consultation event held with staff networks

Indicator 1 – Workforce disability status

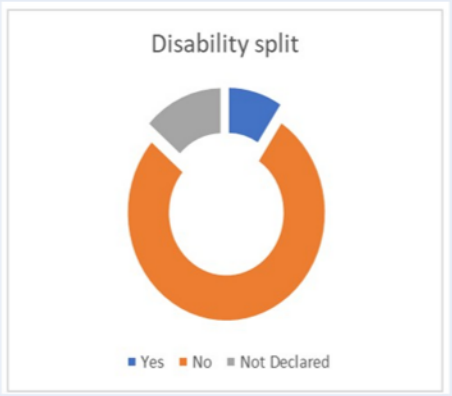
Tees, Esk and Wear Valleys NHS Foundation Trust

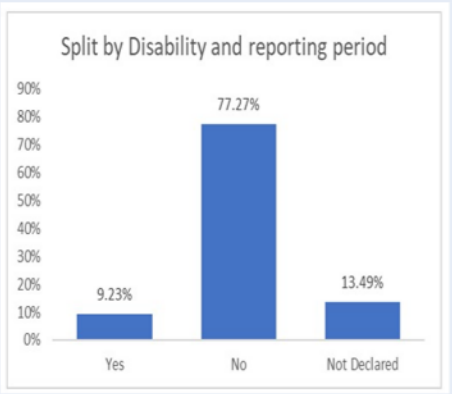


Indicator 1 – Workforce disability status

Tees, Esk and Wear Valleys NHS Foundation Trust

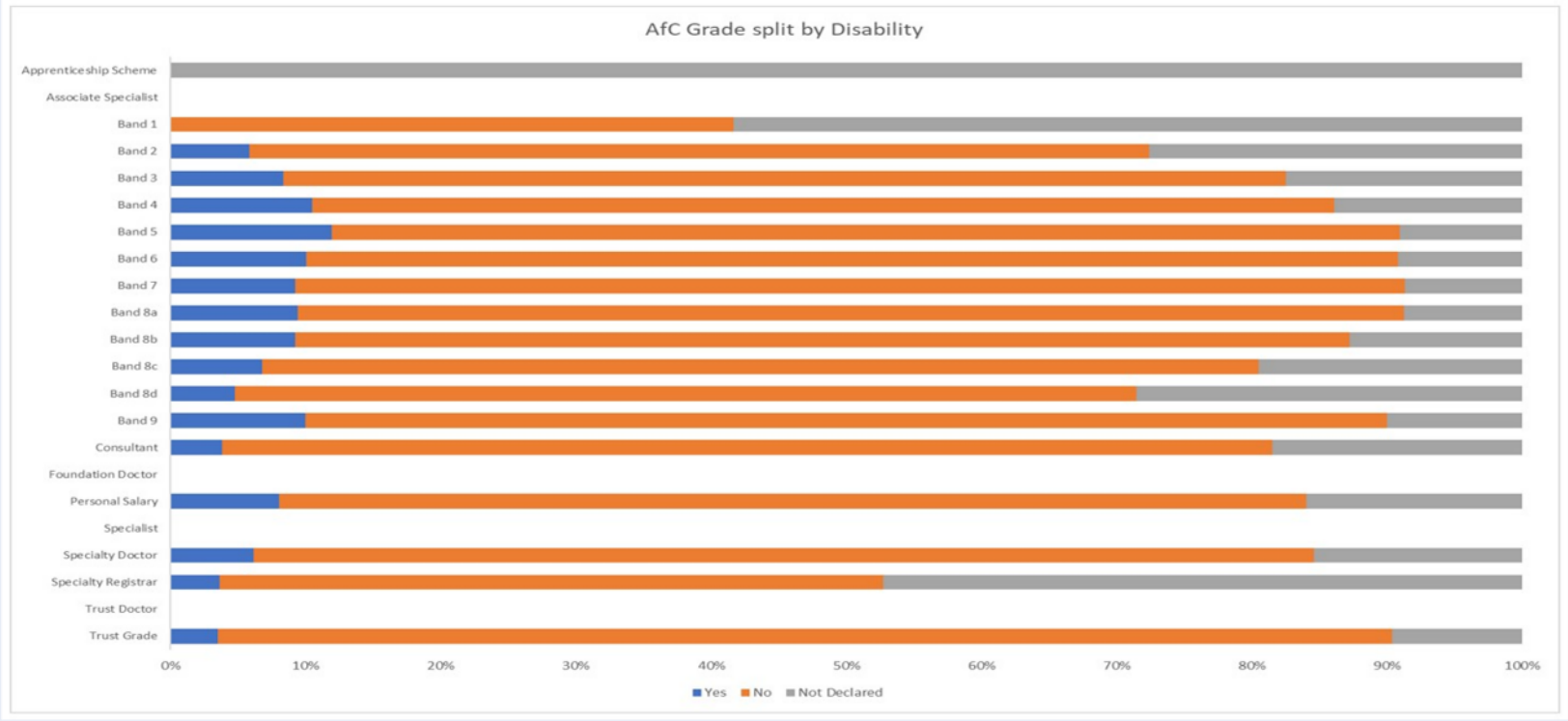
Data Item			DISABILITY		NON DISABLED		DISABILITY NOT DECLARED	
			Figure	%	Figure	%	Figure	%
1a) Non Clinical workforce	1	Under Band 1						
	2	Band 1-4	113	8%	1016	73%	266	19%
	3							
	4							
	5							
	6	Band 5-7	50	12%	331	77%	50	12%
	7							
	8							
	9	Band 8a-b	13	13%	78	75%	13	13%
	10							
	11	Band 8c-d	2	7%	19	68%	7	25%
	12							
	13	Band 9	0	0%	4	80%	1	20%
	14	VSM	3	12%	19	73%	4	15%
1b) Clinical workforce of which Non Medical	15	Under Band 1						
	16	Band 1-4	167	9%	1377	73%	351	19%
	17							
	18							
	19							
	20	Band 5-7	380	10%	2985	81%	336	9%
	21							
	22							
	23	Band 8a-b	30	8%	301	82%	34	9%
	24							
	25	Band 8c-d	8	7%	87	72%	26	21%
	26							
	27	Band 9	2	29%	4	57%	1	14%
	28	VSM	0	0%	1	50%	1	50%
OR which Medical & Dental	29	Consultants	7	4%	121	78%	28	18%
	31	Non-consultant career grade	6	4%	89	63%	46	33%
	33	Other	0	0%	0	0%	0	0%





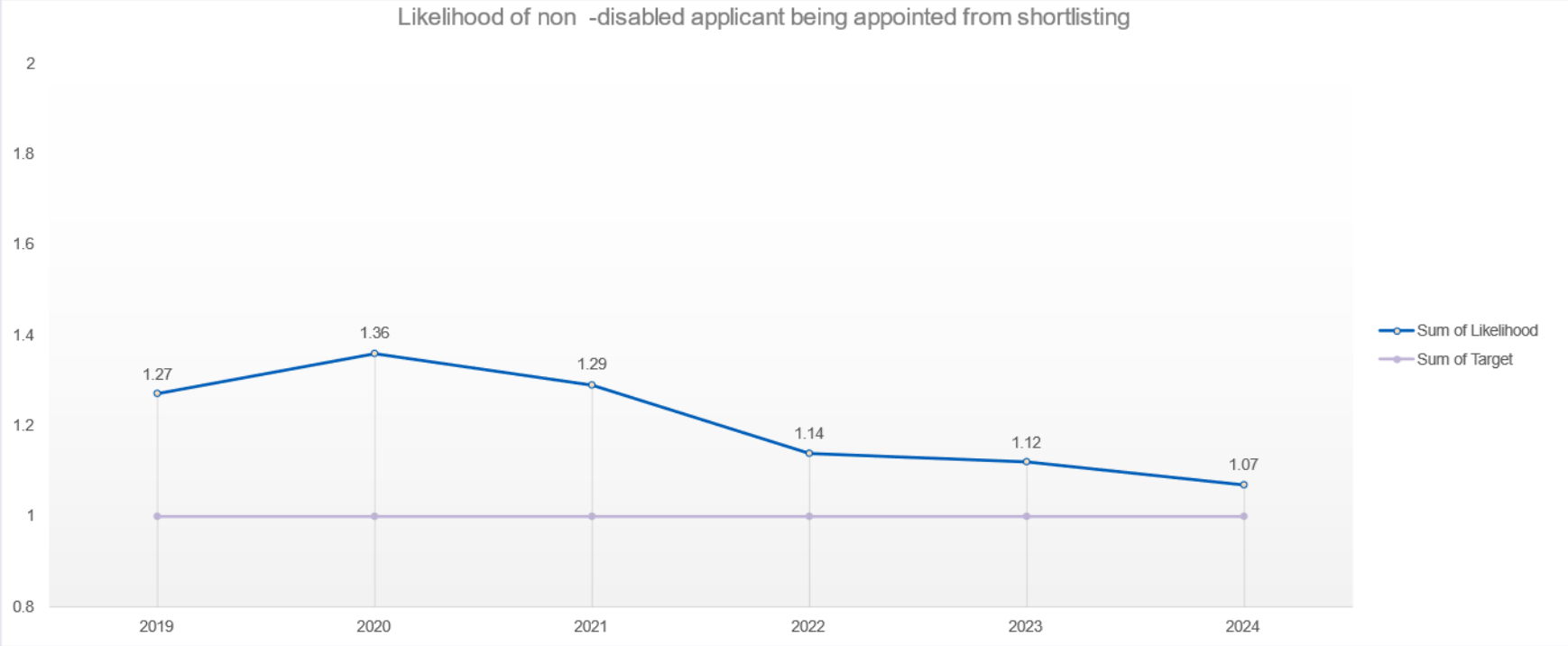
Indicator 1 – Workforce disability status

Tees, Esk and Wear Valleys NHS Foundation Trust



Indicator 2 - Recruitment

Tees, Esk and Wear Valleys NHS Foundation Trust

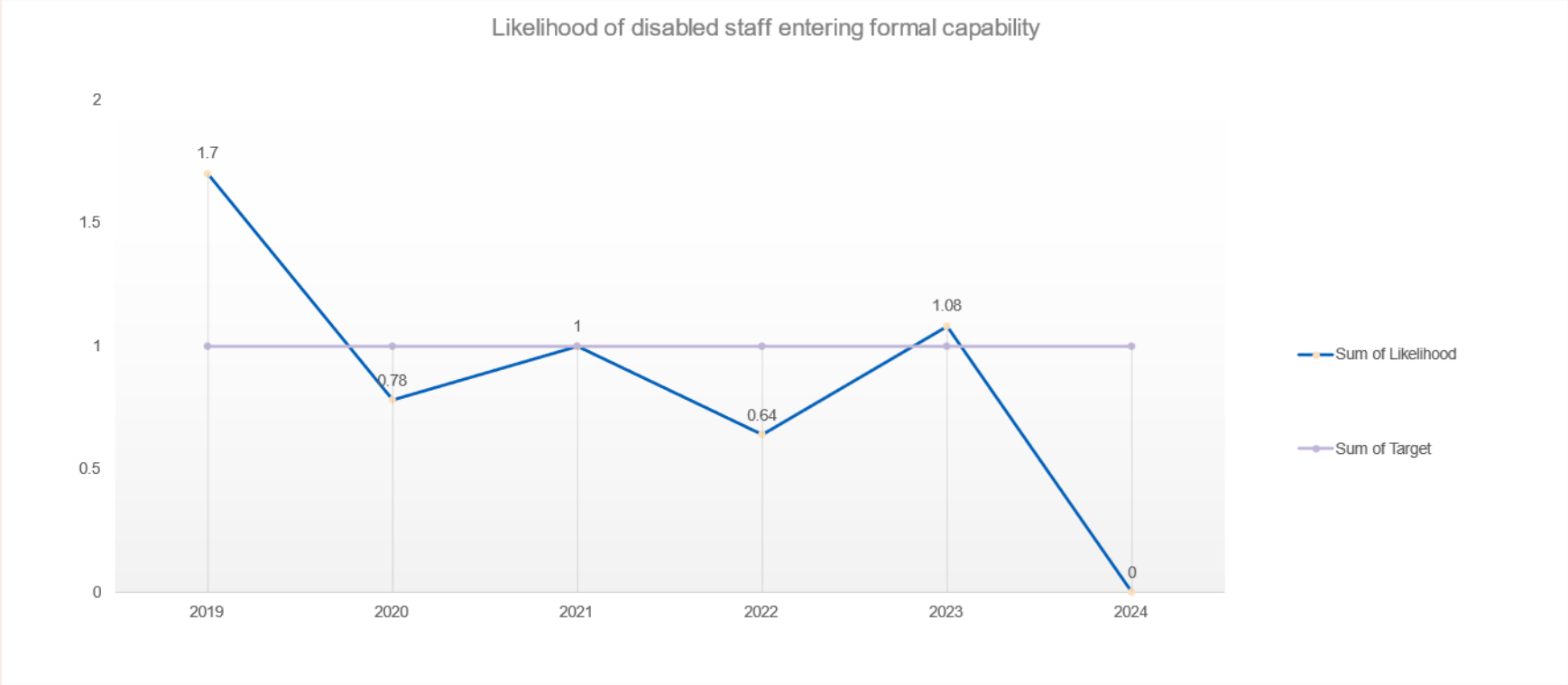


649 applicants with disabilities shortlisted; 169 applicants with disabilities offered posts

4503 applicants without disabilities shortlisted;1249 applicants without disabilities offered posts

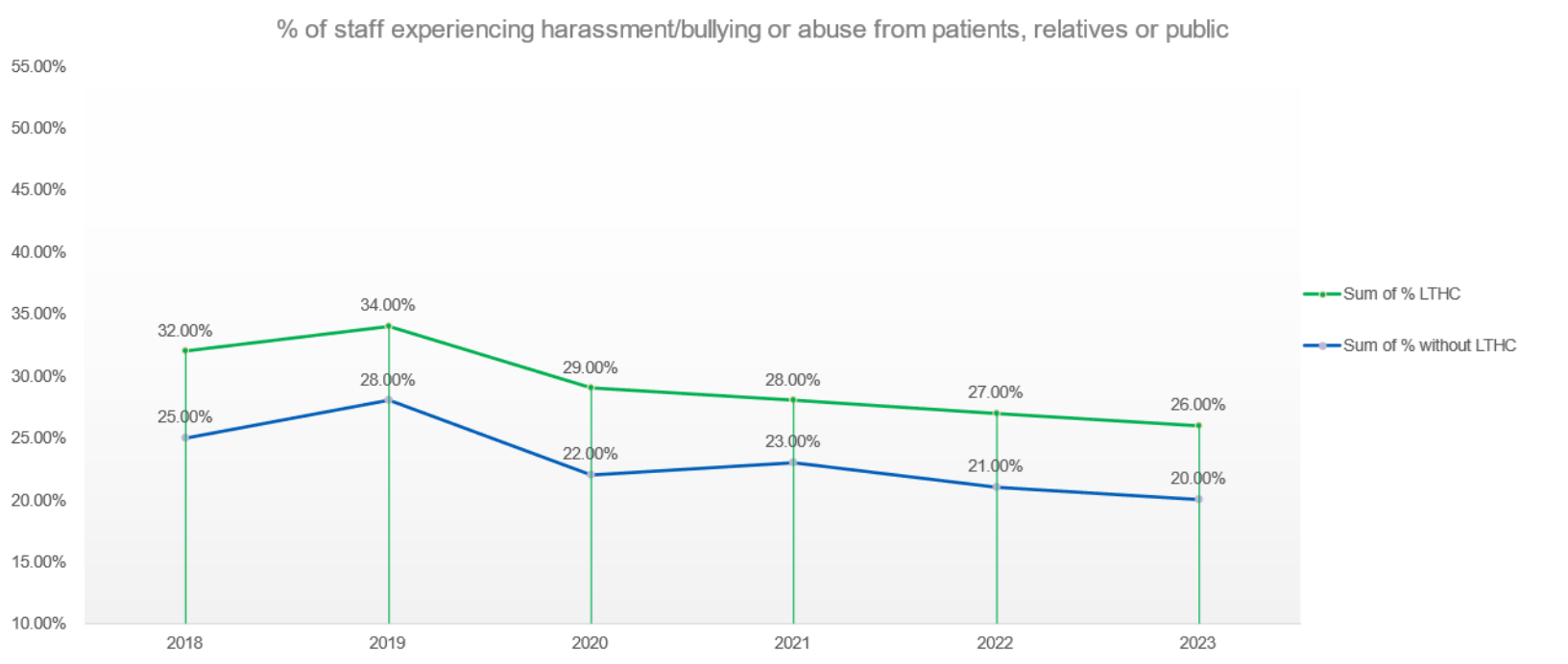
Indicator 3 – Capability

Tees, Esk and Wear Valleys NHS Foundation Trust



Indicator 4 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

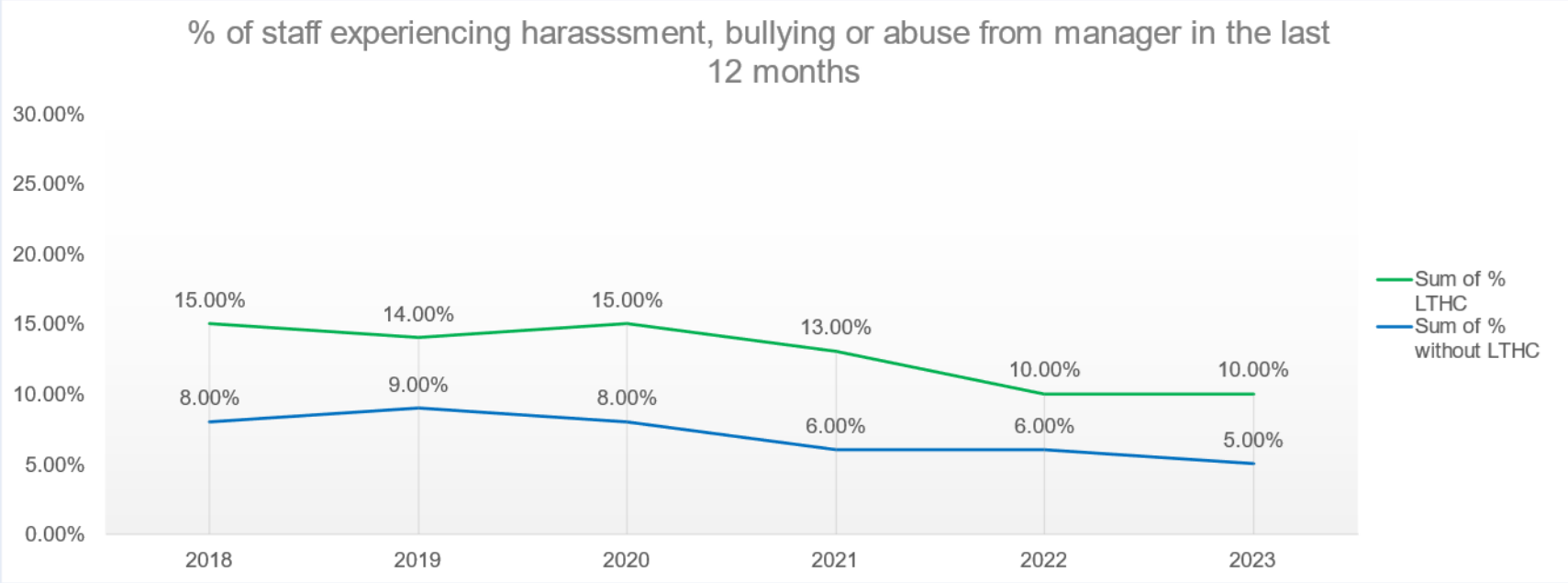
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses – Staff without a LTHC 2334, staff with LTHC 1258

Indicator 4 - % of staff experiencing harassment, bullying or abuse from manager In the last 12 months

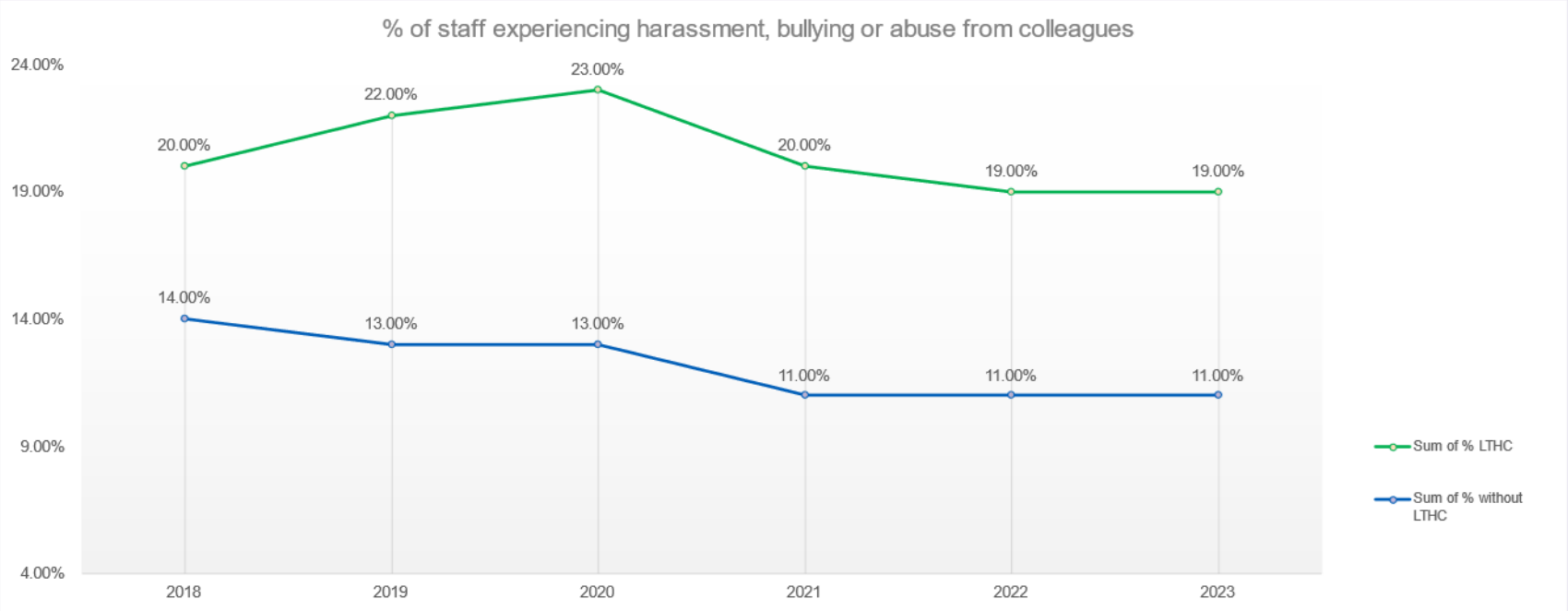
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses – Staff without a LTHC 2325, staff with LTHC 1252

Indicator 4 - % of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months

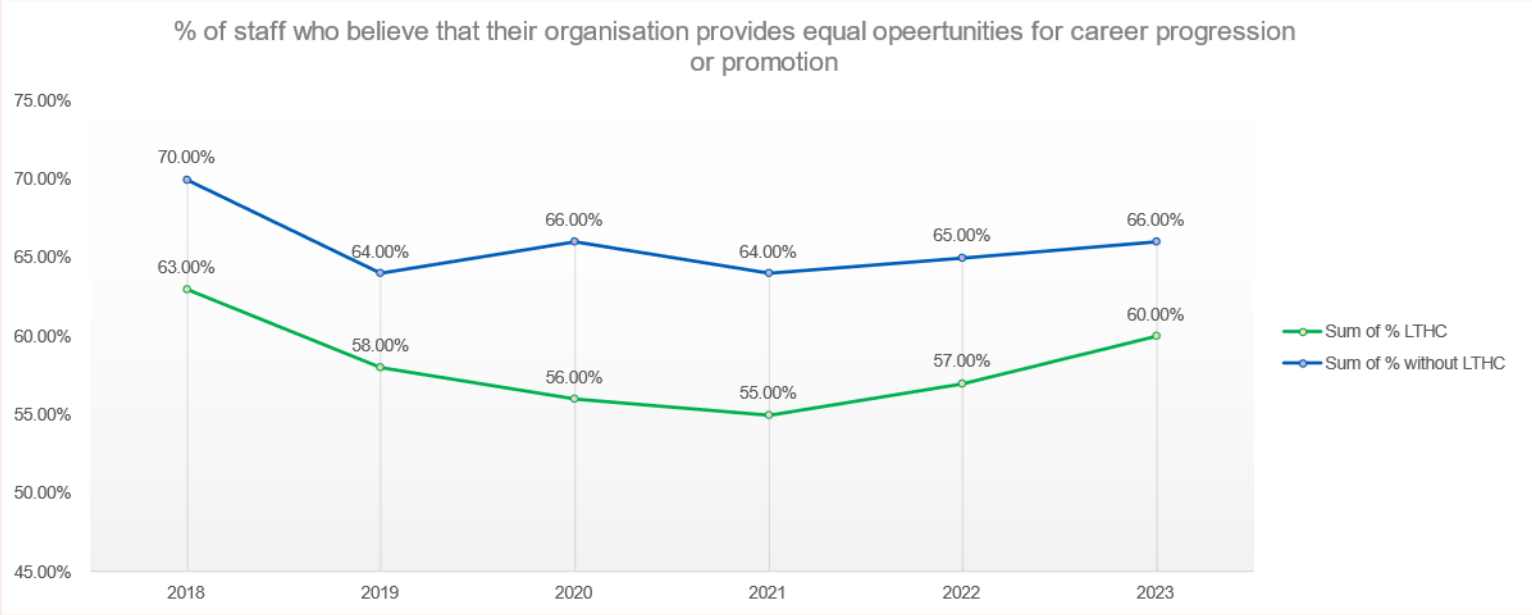
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses – Staff without a LTHC 2296, staff with LTHC 1240

Indicator 5 - % of staff the believe the Trust acts fairly with regards to career progression and promotion

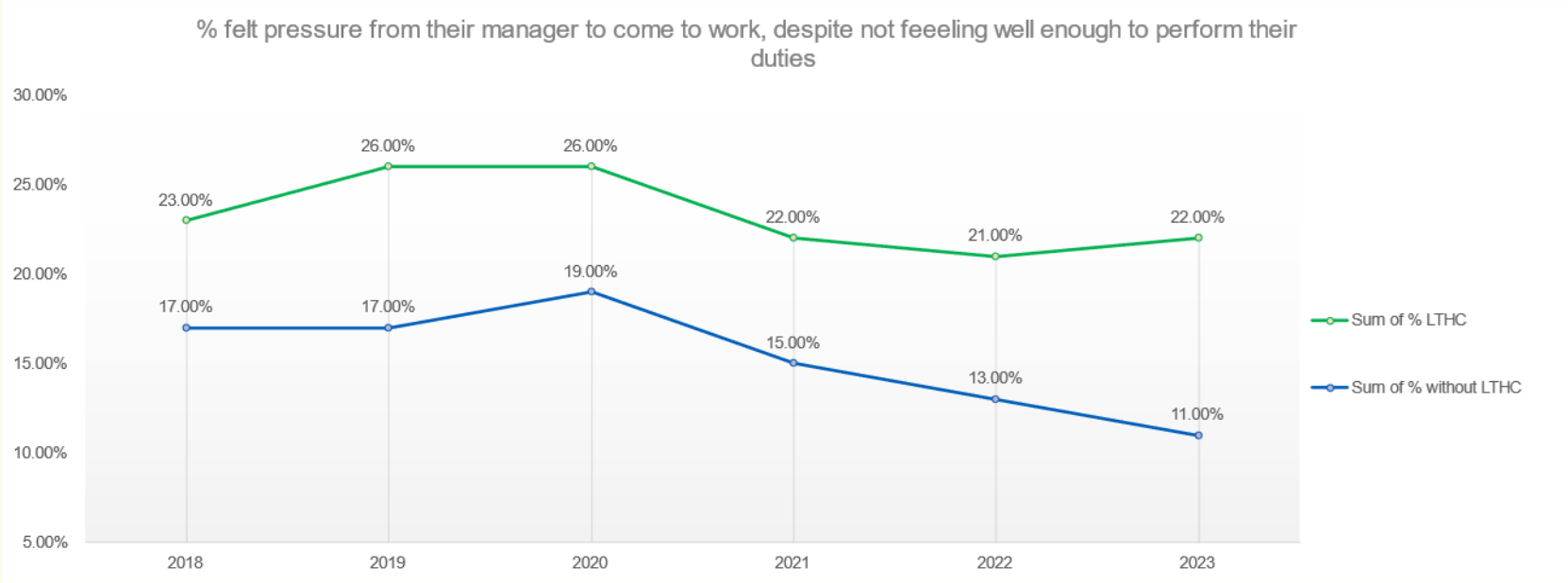
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses – Staff without a LTHC 2382, staff with LTHC 1283

Indicator 6 – % felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses – Staff without a LTHC 1105, staff with LTHC 886

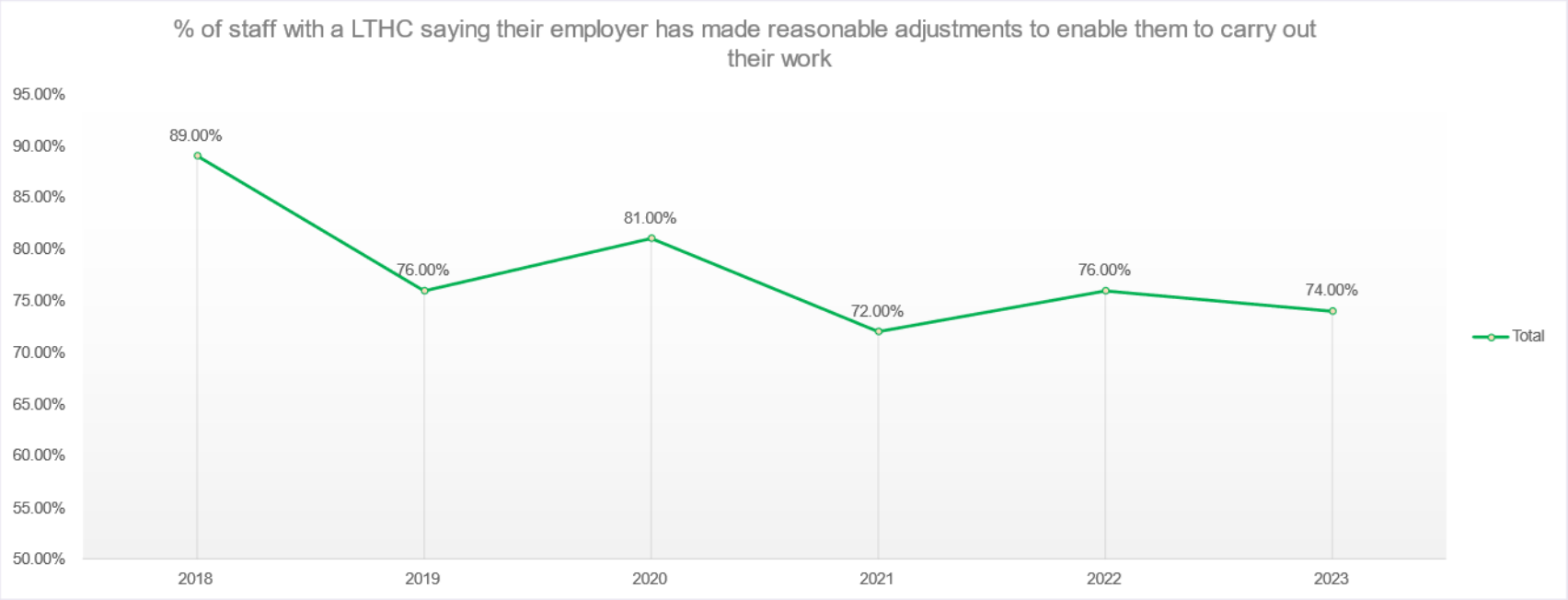
Indicator 7 - % satisfied with the extent to which their organisation values their work

Tees, Esk and Wear Valleys NHS Foundation Trust

Staff Survey Responses – Staff without a LTHC 2391, staff with LTHC 1294

Indicator 8 - % employer has made adequate adjustment(s) to enable them to carry out their work

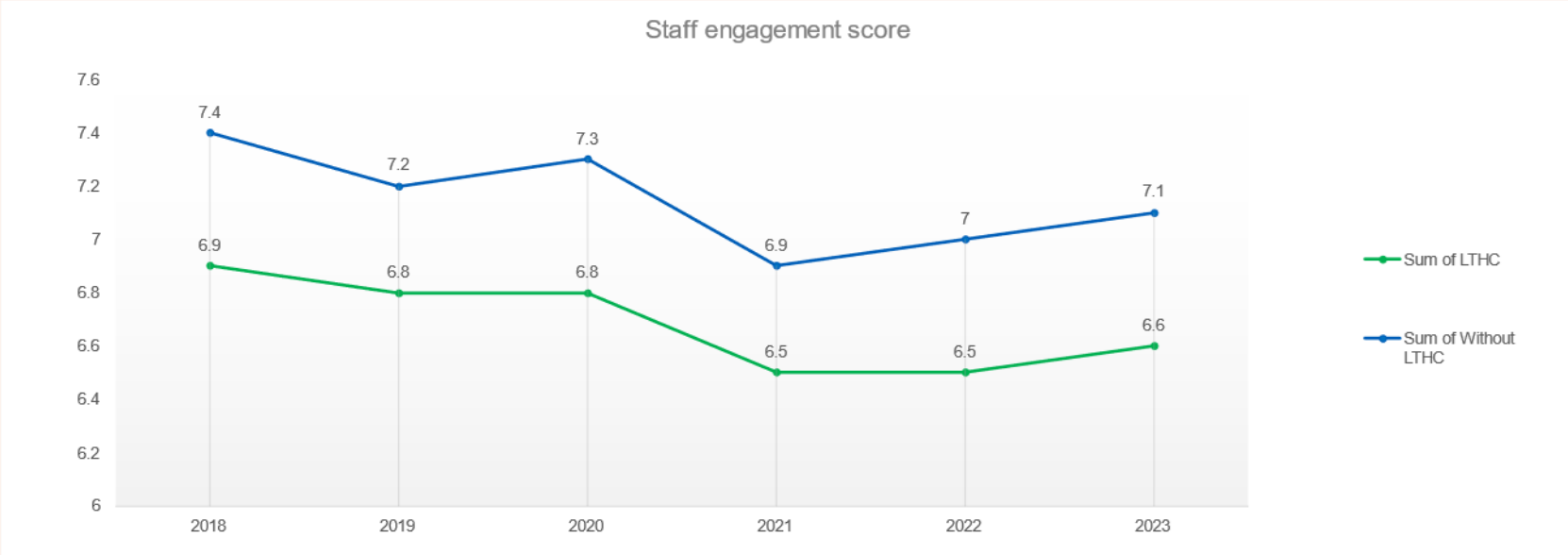
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses –staff with LTHC 758

Indicator 9 – Engagement Scores

Tees, Esk and Wear Valleys NHS Foundation Trust



The score for the staff engagement theme is derived from the nine questions, grouped into three themes: motivation; involvement; and advocacy.
Staff Survey Responses – Staff without a LTHC 2395, staff with LTHC 1297

Indicator 10 – Board Diversity

Tees, Esk and Wear Valleys NHS Foundation Trust

Members of the Board have identified as having a LTHC

Overall + 2.44%

Voting membership – 1.63%

Executive membership + 0.68%

WDES ACTION PLAN

ACTIONS: Please specify which actions are different to current practice, and which are continuation	*Person who is responsible for overseeing the action*	*Please specify KPIs and timelines for monitoring the actions*
1. Continuation - Deliver a third mid-career programme, for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Promote this programme to the staff networks and using Trust communication channels. Evaluate programme.	Sarah Dallal	**Q4 2024/25** - WDES workforce data, evaluation from participants (post programme, 6 months, 1 year)
2. New -Embed being an upstander in all EDI training, including this in the EDI champion role	Abby Holder/Sarah Dallal/Lisa Cole	**Q3 2024/25 -** Training evaluation
3. Continuation - Promote the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process. Measure the diversity of successful candidates, evaluate feedback from panel members and applicants.	Sarah Dallal	**Q1 2025/26** - Increase in the number of interviews being carried out using the platform. WRES recruitment and workforce data.

4. New - Work to develop a reduction of violence and aggression strategy	Kate North	**Q4 2024/25 -** Staff survey results
5. Continuation - begin the roll out and embedding of Kind Life (creating a kinder and safer culture programme)	Susan Coulson	**Q4 2024/25** - Staff survey results, Pulse survey results, attendance to training, evaluation of training
6. New - Promote career information sessions (Routes to Recruit pilot) to staff networks	Lisa Cole	**Q3 2024/25** - attendance to sessions, feedback from networks
7. New - Campaign to raise awareness of the verbal and physical aggression procedure	Abby Holder	**Q4 2023/24 -** number of Inphase incidents reported
8. New - Intersectionality of staff with Long-term Health Conditions, BAME staff, LGBTQ+ staff, explore whether it is possible to look at whether the data can tell us about staff members who identify as more than one or all 3 protected characteristics.	Lisa Cole	**Q4 2023/24 -** staff survey results
9. Continuation - Pilot a central team to ensure that, where agreed, staff who require a reasonable adjustment have these put in place in a timely manner and that there is consistency of approach across the Trust - increased awareness of the team Trust wide and improve/embed existing processes with the help of the new dedicated administrator	Nicky Robertson	**Q4 2024/25 -** Formal PILOT review by Executive Workforce and Resourcing Group

10. Continuation - Continue to provide training for staff to raise awareness on issues faced by staff with LTHCs and disabilities. - Bitesize Training for Managers monthly; Lunch & Learn sessions on specific conditions to improve staff and manager knowledge on disabilities / LTHCs.	Nicky Robertson	**Q1 2025/26 -** Monitor number of training sessions, number of attendees and feedback - quarterly feedback to EDI & HR Steering Group
11. New - Explore and implement putting in place reasonable adjustments for new starters within the first 6 weeks of their employment.	Nicky Robertson	**Q1 2025/26 -** Number of new starters asking for Reasonable Adjustments - quarterly feedback to EDI & HR Steering Group
12. New - Plan and implement encouraging recruitment applicants to declare disability on application forms - undertake working groups with staff networks to develop representative categories of disability.	Nicky Robertson	**Q4 2024/25 -** Number of people declaring on ESR

13. New - Explore whether different types of disabilities make a difference to experience of bullying & harassment (ND, visible vs non-visible)	Nicky Robertson	**Q3 2024/25 -** Survey results and analysis

EDI & HR Team

Tees, Esk and Wear Valleys
NHS Foundation Trust

Sexual Orientation Workforce Equality Standard (SOWES)

2024

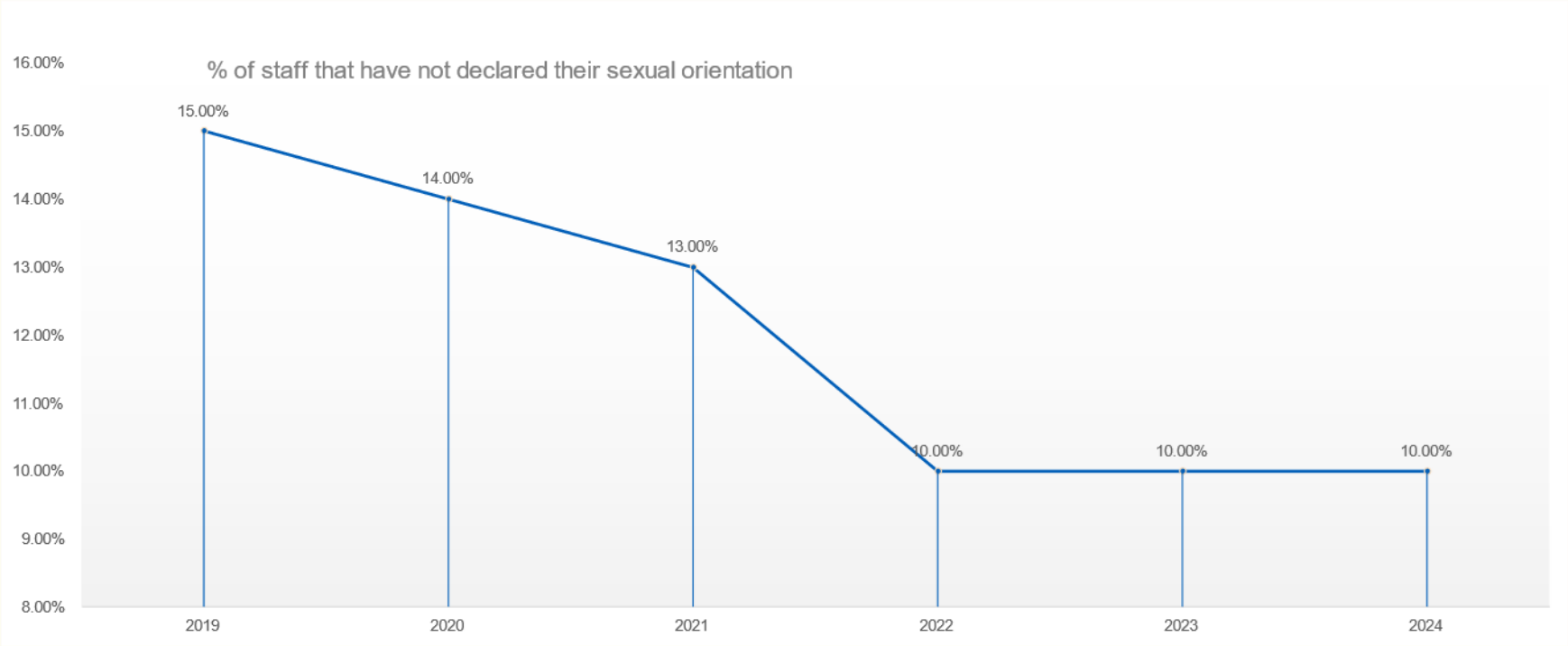
SOWES

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- The Trust developed the SOWES in 2019 to ensure we were measuring the experience of LGB staff in the organisation
- The Indicators mirror the WRES and WDES, which are mandated standards in the NHS contract
- 2022 staff survey result have provided some data on the experience of staff that identify as sex not the same as assigned by birth, this has continued in the 2023 results with 13 staff identifying as not the same sex as assigned at birth
- 5% of staff identify as LGB (402 staff members)
- Trust locality Census comparison – Heterosexual: 90.71%, Gay/Lesbian: 1.4%, Bisexual: 1.21%, not stated: 6.4%, other(not listed): 0.55%,

Sexual orientation declaration rates

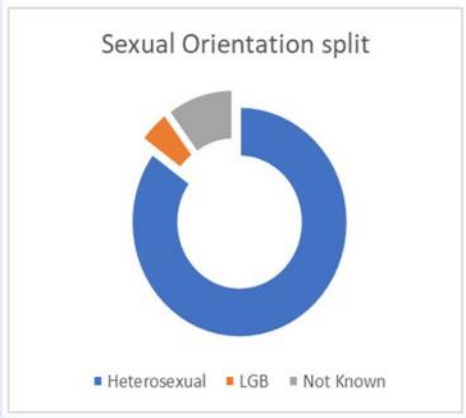
Tees, Esk and Wear Valleys NHS Foundation Trust

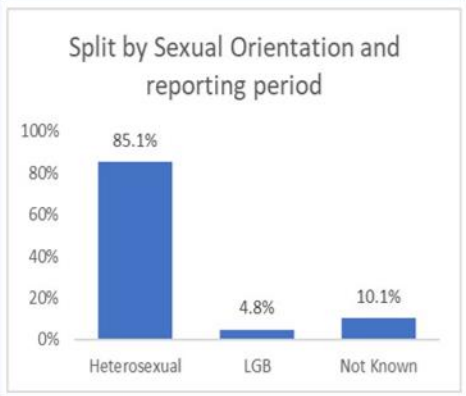


Indicator 1 – Workforce sexual orientation

Tees, Esk and Wear Valleys NHS Foundation Trust

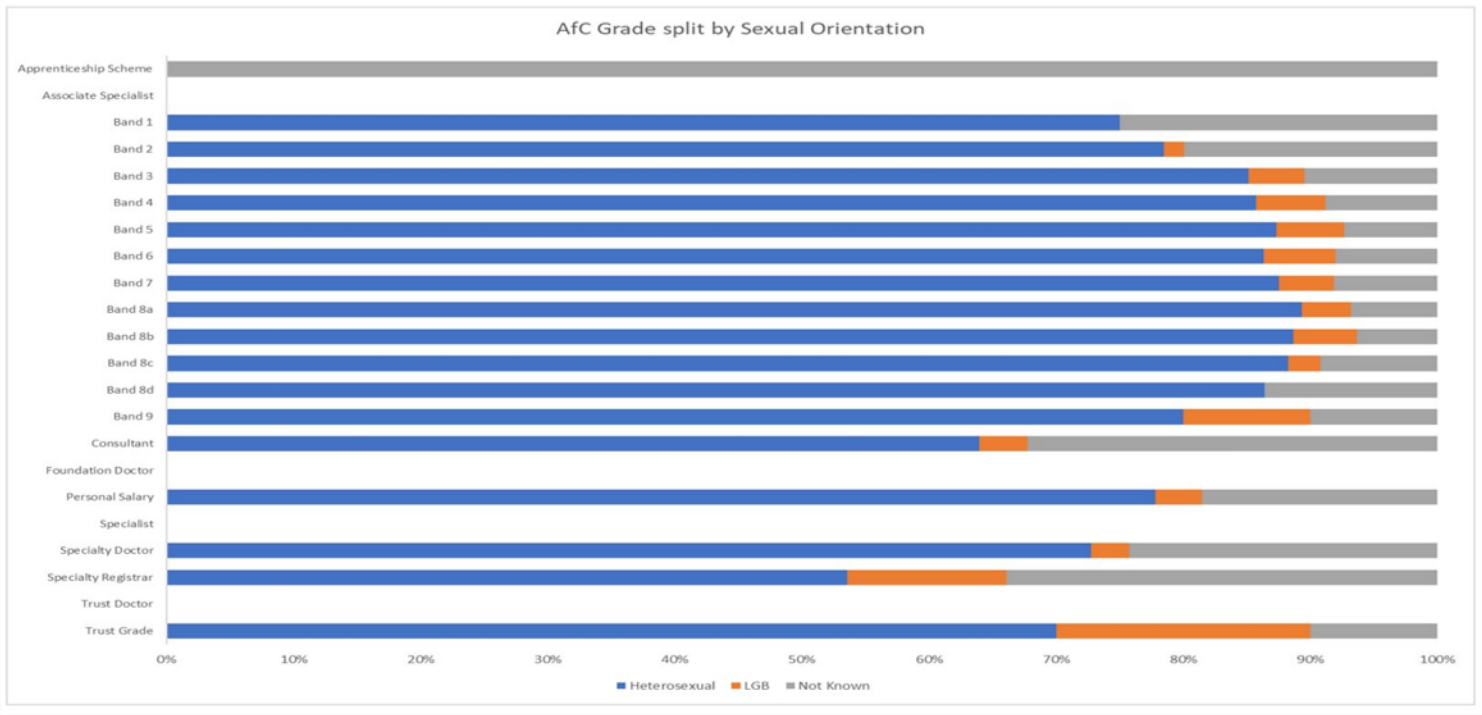
Data Item			SEXUAL ORIENTATION HETRO		SEXUAL ORIENTATION LGB		SEXUAL ORIENTATION UNDECIDED		SEXUAL ORIENTATION NOT DECLARED	
			Figure	%	Figure	%	Figure	%	Figure	%
1a) Non Clinical workforce	1	Under Band 1								
	2	Band 1-4	1198	86%	30	2%	2	0%	165	12%
	3									
	4									
	5									
	6	Band 5-7	385	89%	16	4%	0	0%	30	7%
	7									
	8									
	9	Band 8a-b	93	89%	3	3%	0	0%	8	8%
	10									
	11	Band 8c-d	27	96%	0	0%	0	0%	1	4%
	12									
	13	Band 9	4	80%	1	20%	0	0%	0	0%
	14	VSM	22	85%	1	4%	0	0%	3	12%
1b) Clinical workforce of which Non Medical	15	Under Band 1								
	16	Band 1-4	1576	83%	110	6%	5	0%	204	11%
	17									
	18									
	19									
	20	Band 5-7	3207	87%	203	5%	9	0%	282	8%
	21									
	22									
	23	Band 8a-b	324	89%	17	5%	0	0%	24	7%
	24									
	25	Band 8c-d	104	86%	4	3%	0	0%	13	11%
	26									
	27	Band 9	5	71%	0	0%	0	0%	2	29%
	28	VSM	1	50%	0	0%	0	0%	1	50%
OR which Medical & Dental	29	Consultants	99	63%	6	4%	0	0%	51	33%
	30	of which Senior medical manager	0	0%	0	0%	0	0%	1	100%
	31	Non-consultant career grade	87	62%	11	8%	0	0%	43	30%
	32	Trainee grades	0	0%	0	0%	0	0%	2	100%
	33	Other	0	0%	0	0%	0	0%	0	0%
			7132	85%	402	5%	16	0%	830	10%





Indicator 1 – Workforce sexual orientation

Tees, Esk and Wear Valleys NHS Foundation Trust



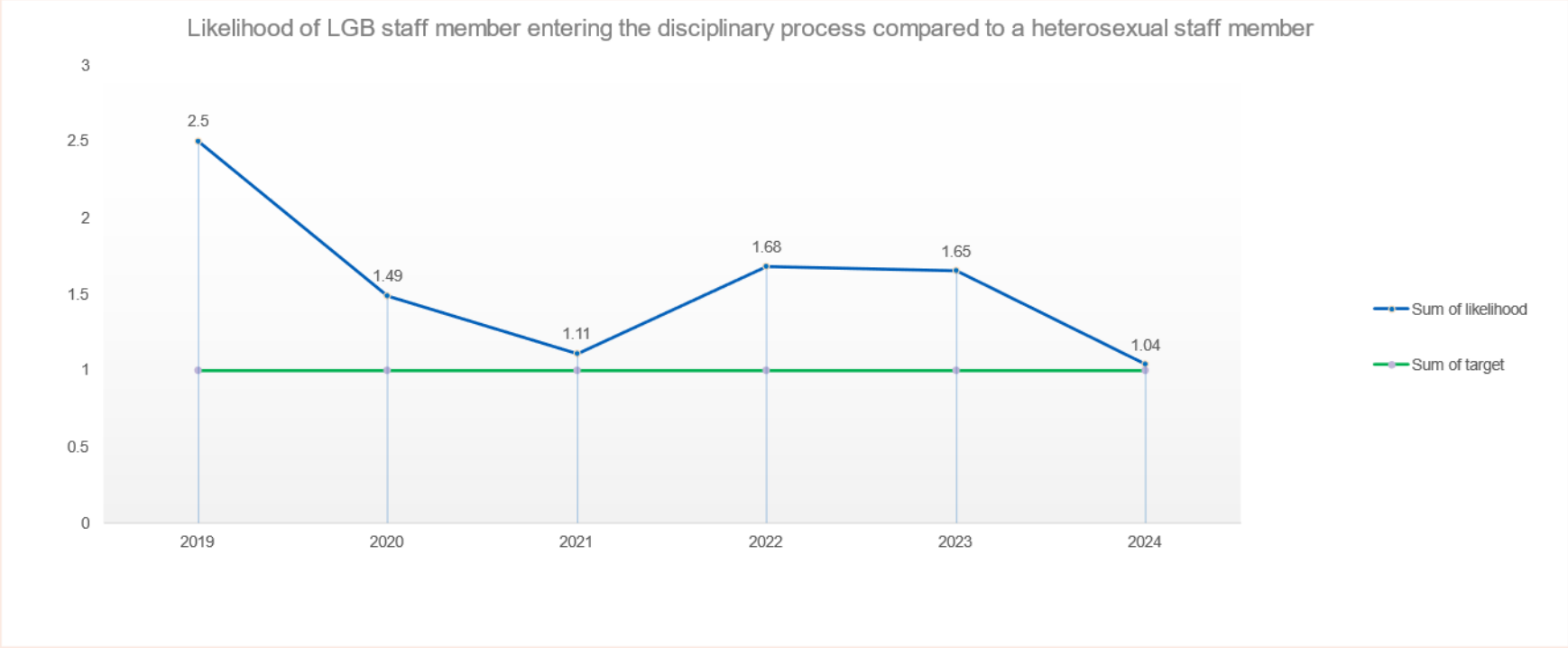
Recruitment

Tees, Esk and Wear Valleys NHS Foundation Trust

418 LGB applicants shortlisted; 102 LGB applicants offered posts
4633 Heterosexual applicants shortlisted; 1290 Heterosexual applicants offered posts

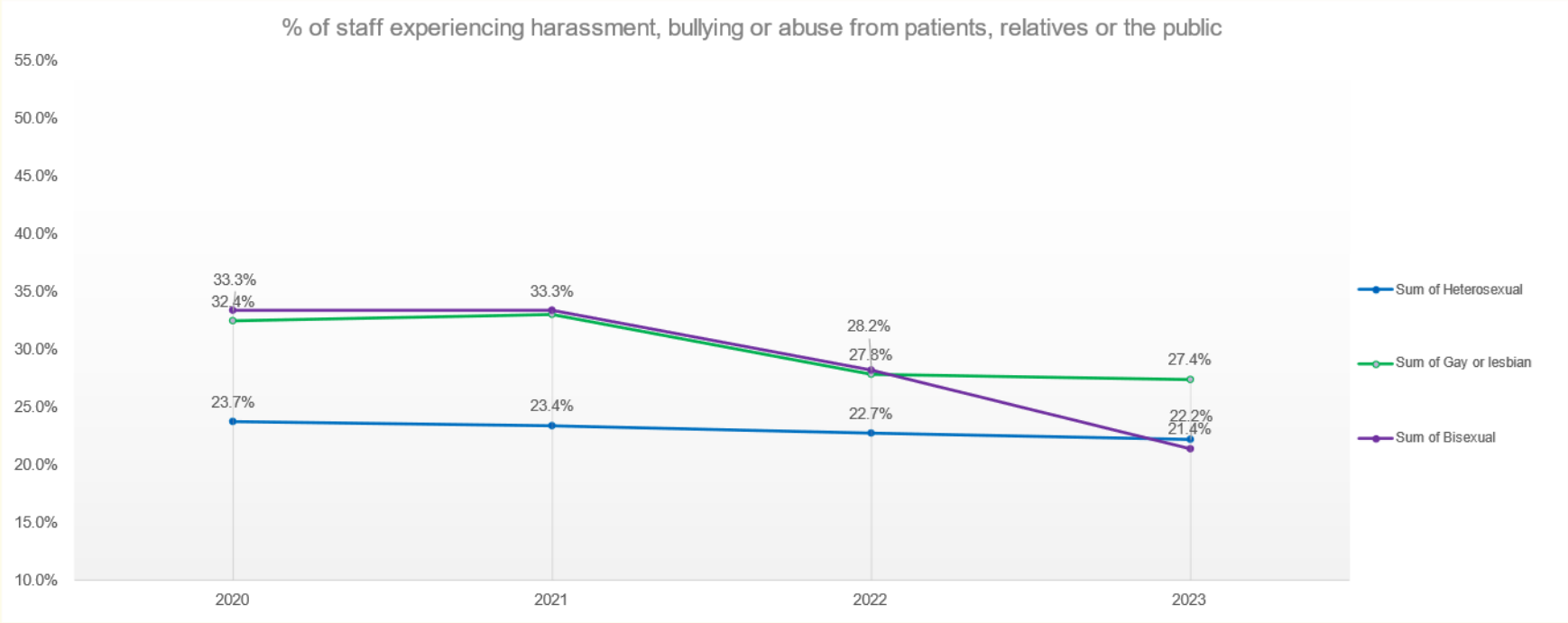
Disciplinary

Tees, Esk and Wear Valleys NHS Foundation Trust



Indicator 5 - % of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

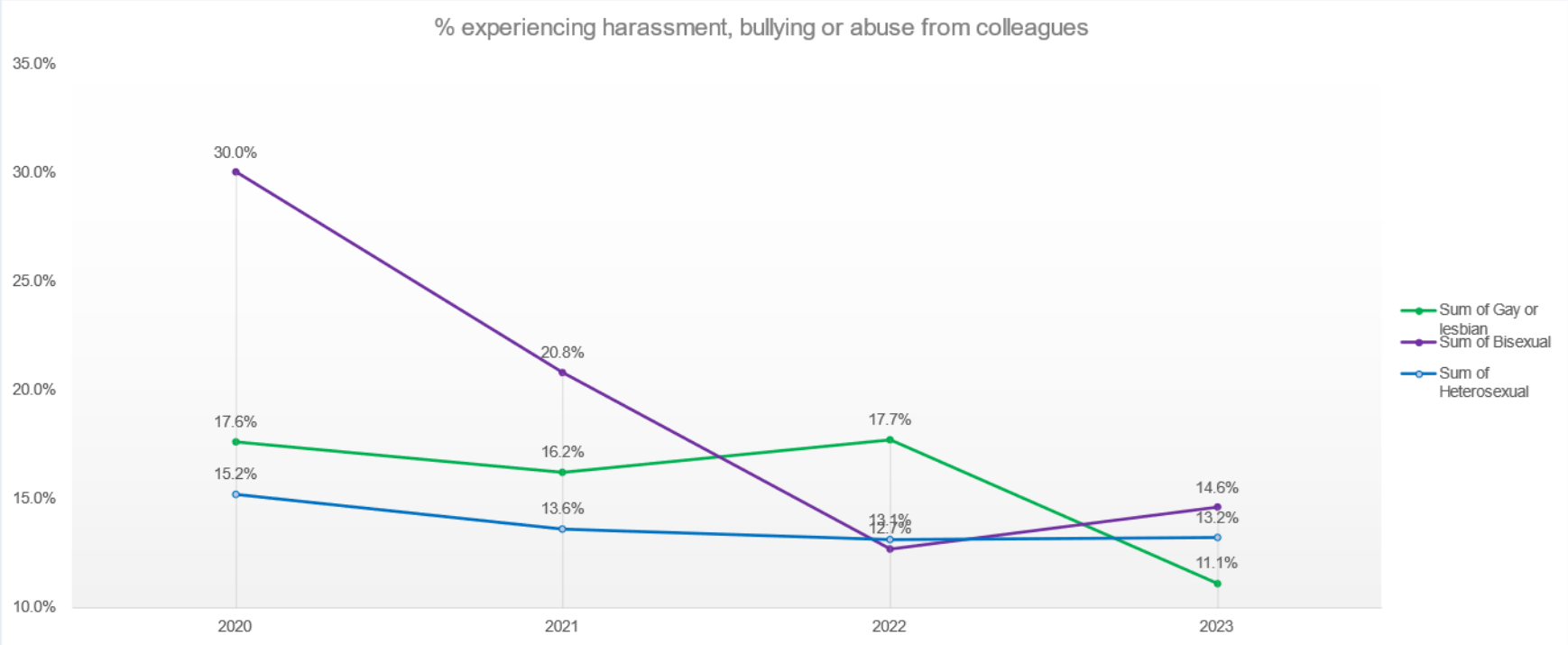
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses: heterosexual – 3254, gay or lesbian 110, bisexual 85

% of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months

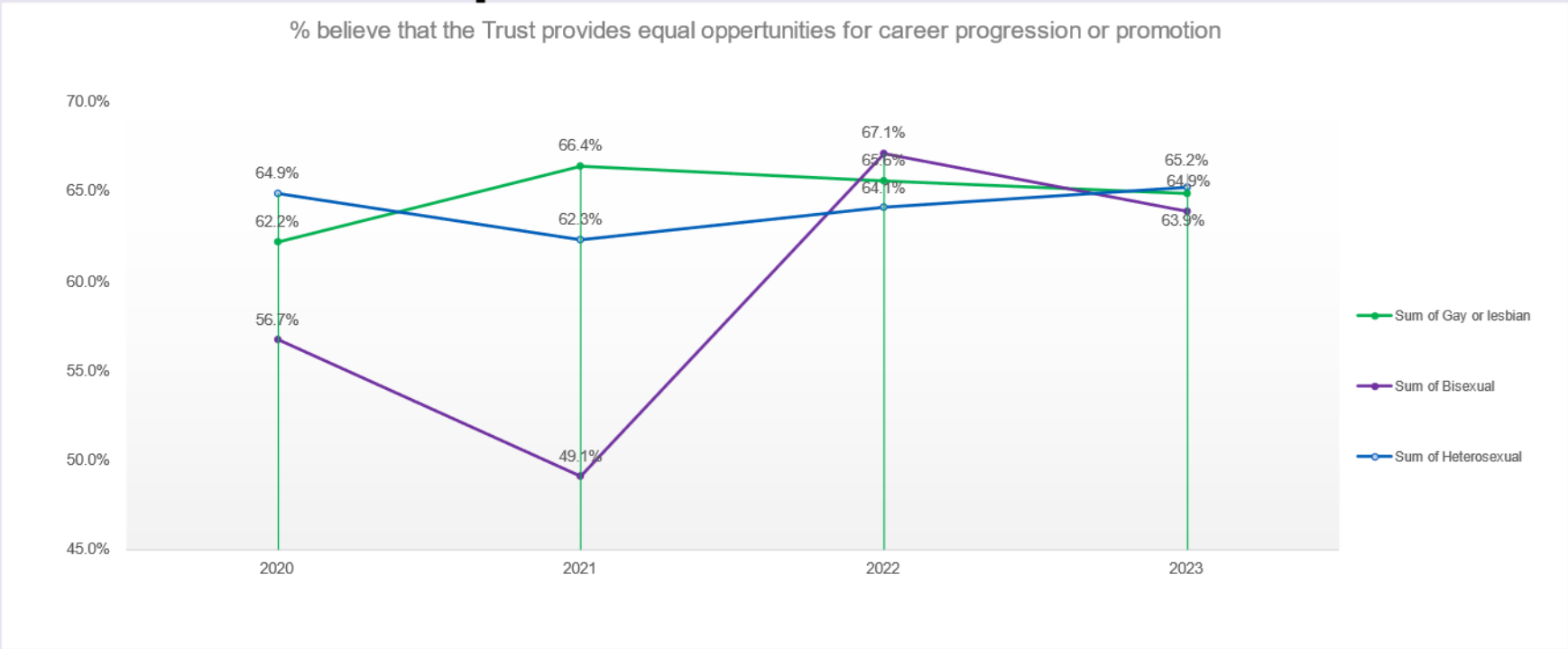
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses: heterosexual – 3200, gay or lesbian 108, bisexual 82

% of staff the believe the Trust acts fairly with regards to career progression and promotion

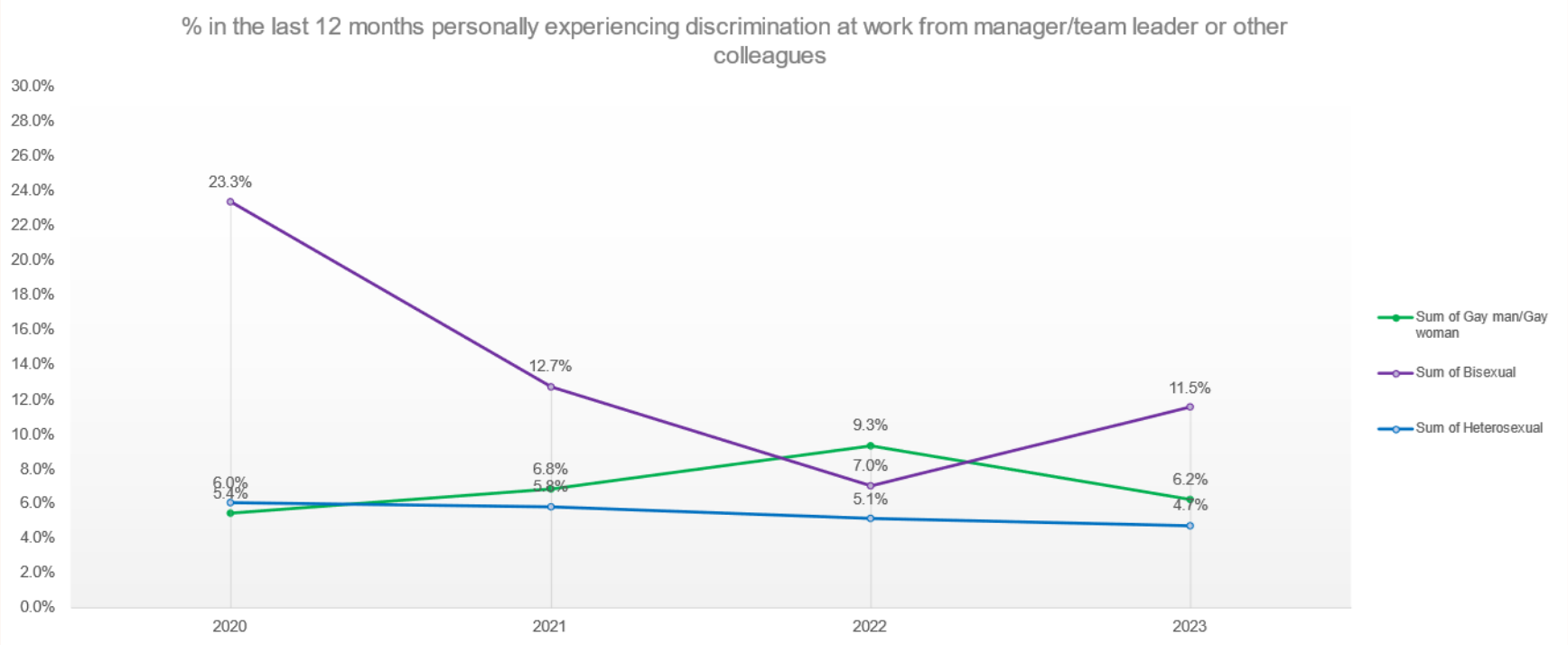
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses: heterosexual – 3311, gay or lesbian 114, bisexual 86

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

Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses: heterosexual – 3306, gay or lesbian 113, bisexual 87

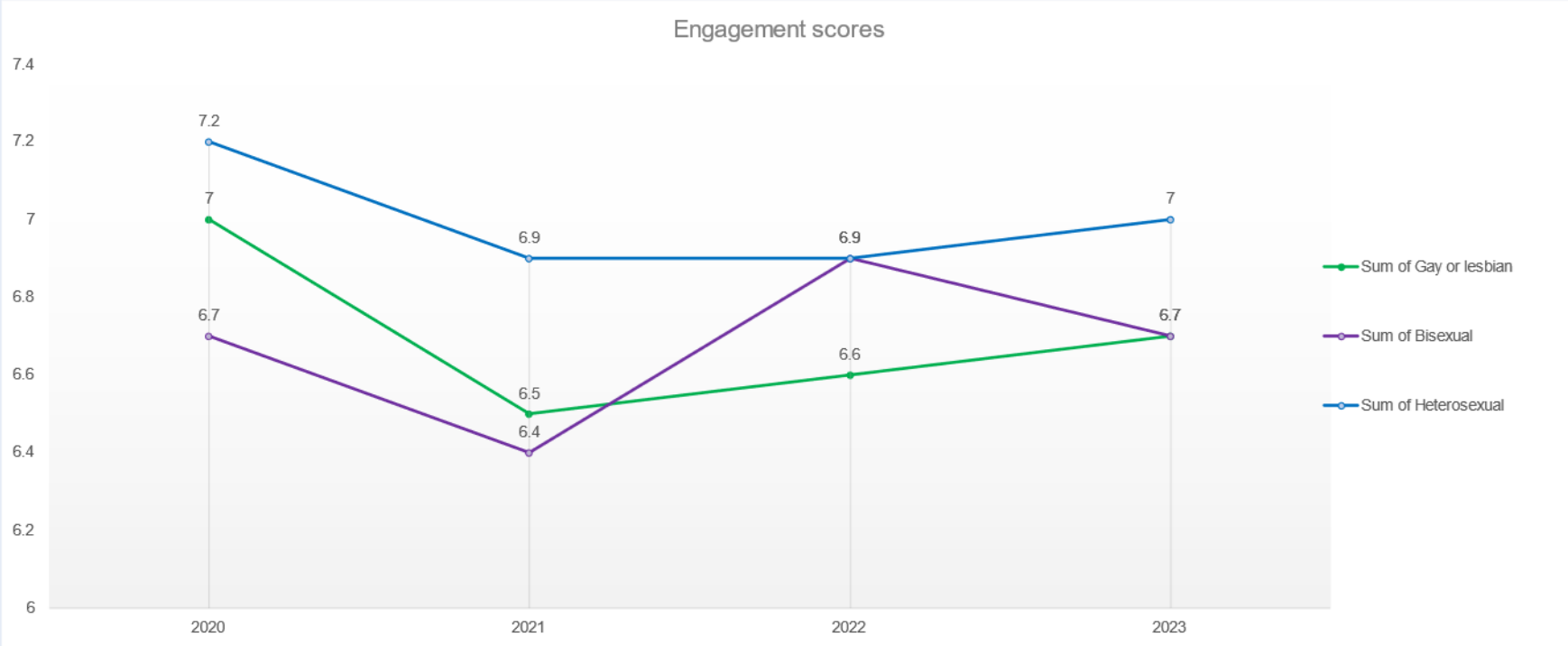
Board

Tees, Esk and Wear Valleys
NHS Foundation Trust

- No one on the Board identifies as LGB
- - 5% Overall difference

Engagement

Tees, Esk and Wear Valleys NHS Foundation Trust



Staff Survey Responses: heterosexual – 3337, gay or lesbian 115, bisexual 87

The score for the staff engagement theme is derived from the nine questions, grouped into three themes: motivation; involvement; and advocacy.

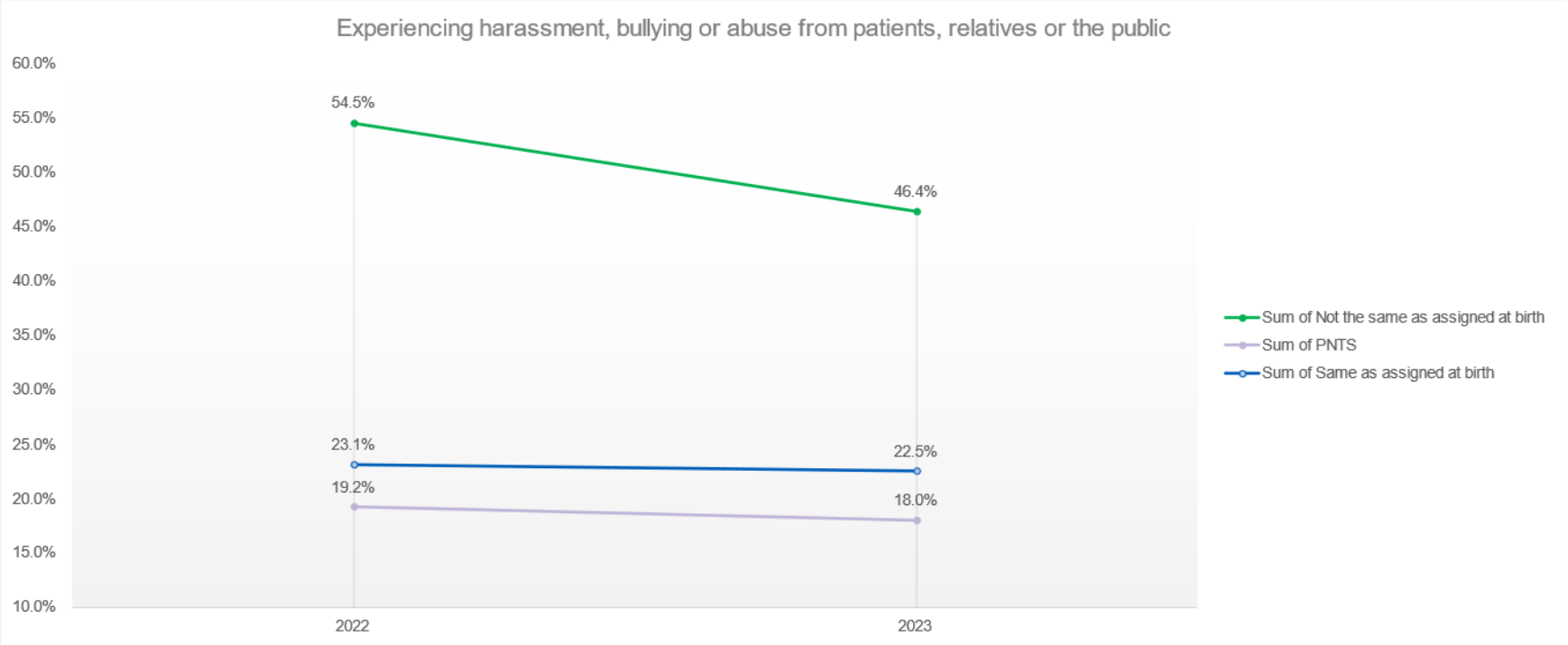
Gender Identity

Tees, Esk and Wear Valleys NHS Foundation Trust

- 13 staff identifying as not the same sex as assigned at birth

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

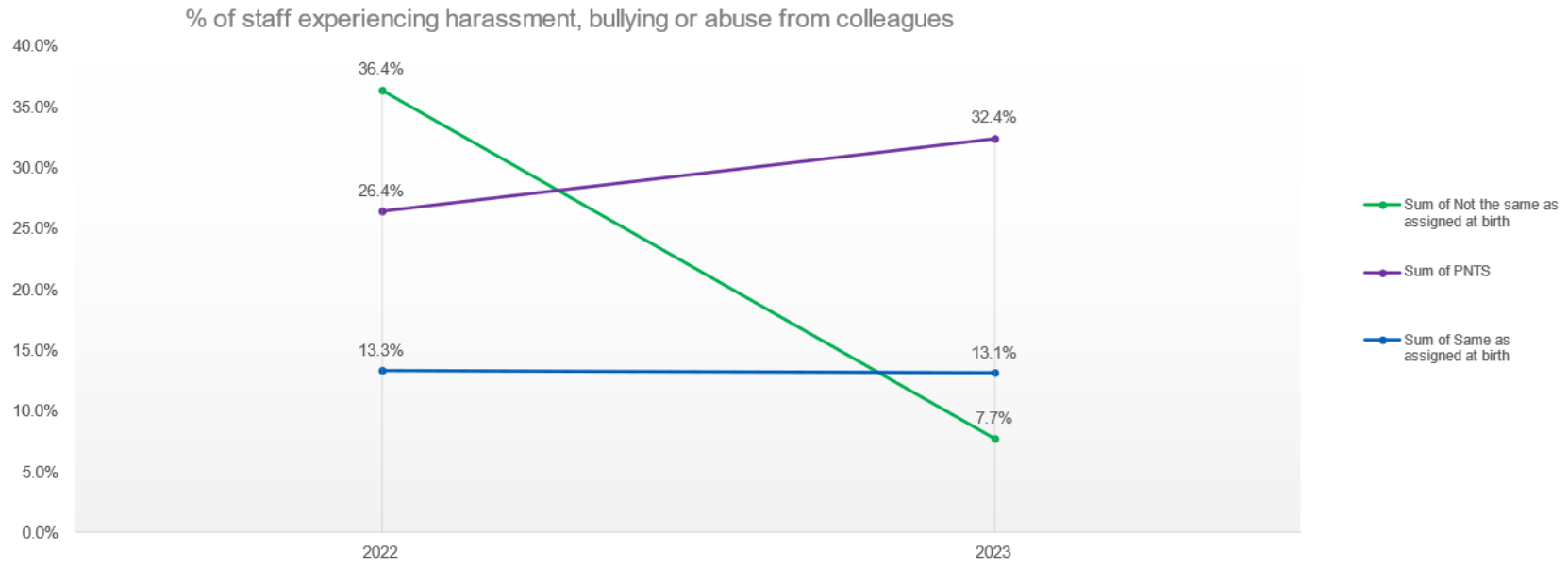
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff survey responses -Not the same as assigned at birth 13, prefer not to say (PNTS) 100, same as assigned at birth 3497

% of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months

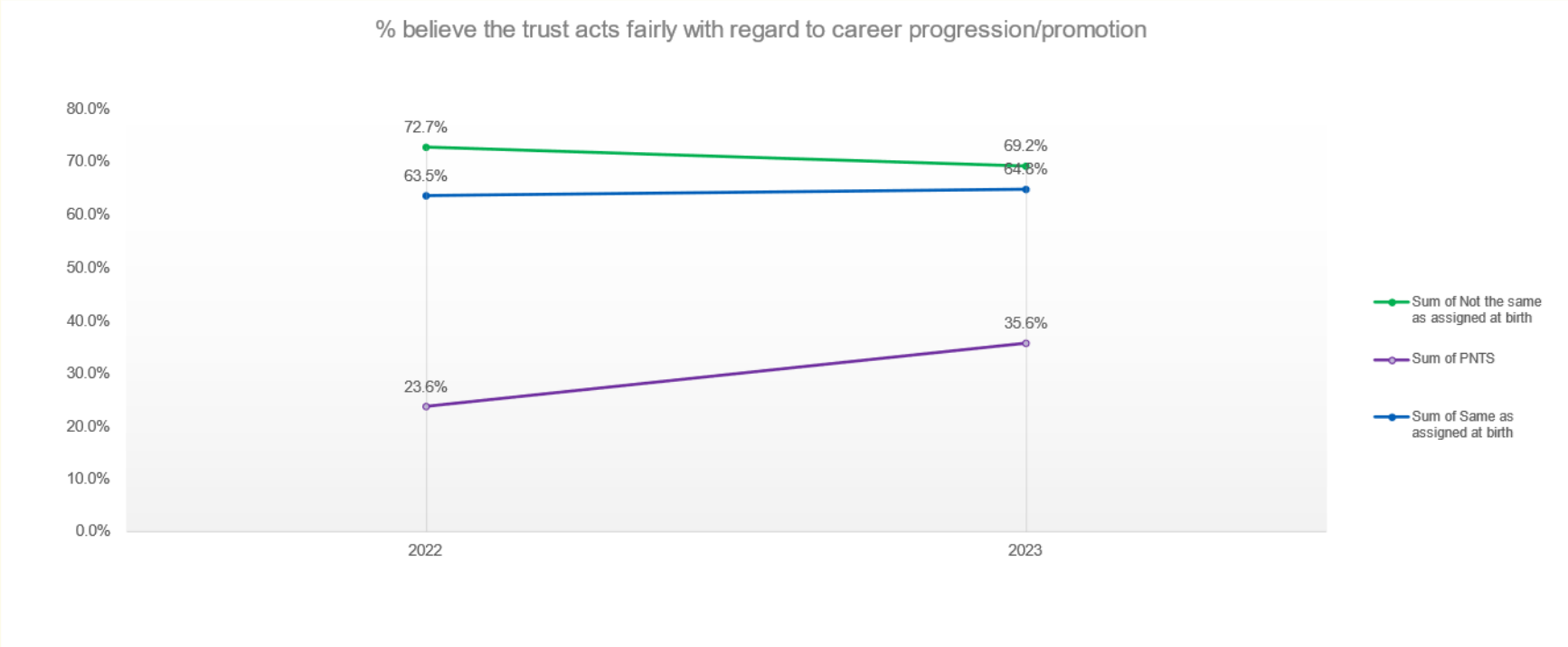
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff survey responses -Not the same as assigned at birth 13, prefer not to say (PNTS) 99, same as assigned at birth 3438

% of staff the believe the Trust acts fairly with regards to career progression and promotion

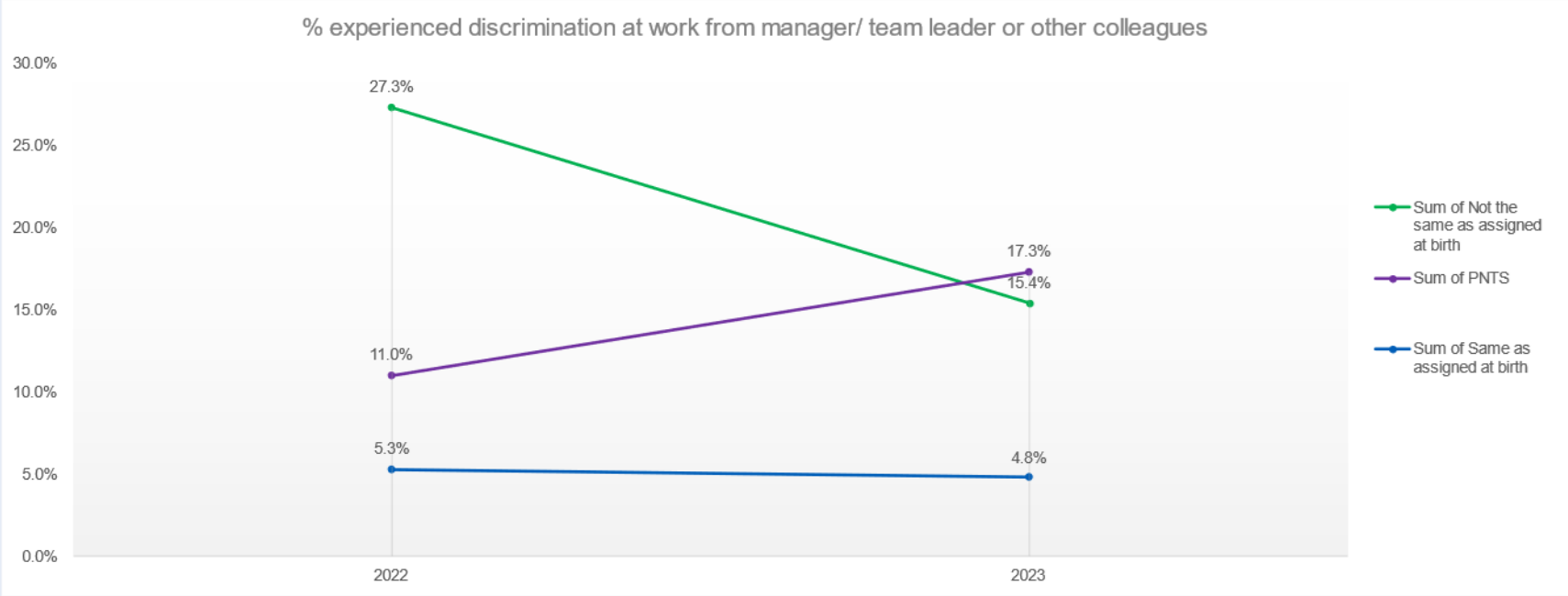
Tees, Esk and Wear Valleys NHS Foundation Trust



Staff survey responses -Not the same as assigned at birth 13, prefer not to say (PNTS) 104, same as assigned at birth 3566

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

Tees, Esk and Wear Valleys NHS Foundation Trust



Staff survey responses -Not the same as assigned at birth 13, prefer not to say (PNTS) 104, same as assigned at birth 3556

SOWES ACTION PLAN

ACTIONS: Please specify which actions are different to current practice, and which are continuation	***Person who is responsible for overseeing the action***	***Please specify KPIs and timelines for monitoring the actions***
1. Continuation - Deliver a third mid-career programme, for staff from protected characteristics which will include stretch/shadowing/developmental opportunities. Promote this programme to the staff networks and using Trust communication channels. Evaluate programme.	Sarah Dallal	**Q4 2024/25** - SOWES workforce data, evaluation from participants (post programme, 6 months, 1 year)
2. New - Embed being an upstander in all EDI training, including this in the EDI champion role	Abby Holder/Sarah Dallal/Lisa Cole	**Q3 2024/25 -** Training evaluation
3. Continuation - Promote the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process. Measure the diversity of successful candidates, evaluate feedback from panel members and applicants.	Sarah Dallal	**Q1 2025/26** - Increase in the number of interviews being carried out using the platform. SOWES recruitment and workforce data.

4. New - Work to develop a reduction of violence and aggression strategy	Kate North	**Q4 2024/25** - Staff survey results - Staff survey results
5. Continuation - begin the roll out and embedding of Kind Life (creating a kinder and safer culture programme)	Susan Coulson	**Q4 2024/25** - Staff survey results - Staff survey results, Pulse survey results, attendance to training, evaluation of training
6. New - Promote career information sessions (Routes to Recruit pilot) to staff networks	Lisa Cole	**Q3 2024/25** - attendance to sessions, feedback from networks
7. New - Campaign to raise awareness of the verbal and physical aggression procedure	Abby Holder	**Q4 2023/24 -** number of Inphase incidents reported
8. New - Intersectionality of staff with Long-term Health Conditions, BAME staff, LGBTQ+ staff, explore whether it is possible to look at whether the data can tell us about staff members who identify as more than one or all 3 protected characteristics.	Lisa Cole	**Q4 2023/24 -** staff survey results
9. Develop a communication plan which contains monthly campaigns, themes and messages in relation to LGBTQ+ people to ensure that there is continual learning for staff not just during Pride month.	Abby Holder	**Q4 2023/24 -** EDI & HR Comms Planner

10. Develop a campaign to promote the importance of pronouns on staff ID badges, pronoun pins where appropriate, email signatures and on Teams.	Abby Holder	**Q4 2023/24** - EDI & HR Comms Planner
11. Review Staff Survey data 2024 to compare the experiences of non-binary staff and Trans staff from 2023 to see if there has been an improvement in reported experience.	Abby Holder	**Q4 2023/24** - staff survey results
11. Develop a session for EDI Champions to include Trans lived experience.	Abby Holder	**Q4 2023/24** - staff survey results
12. To develop and review the LGBTQ+ Awareness training to include lived experience.	Abby Holder	**Q2 2023/24 -** training evaluation
13. Carry out a poster campaign to promote the Pride poster and other posters that promote inclusivity are displayed all year round not just during Pride month.	Abby Holder	**Q1 2025/26 -** EDI & HR Comms Planner
14. Purchase and distribute rainbow lanyards to Rainbow Network Members and EDI Champions to make upstanders more visible.	Abby Holder	**Q1 2025/26 -** staff survey results

15. Provide training to the board via staff / trainer(s) with lived experience.	Abby Holder	**Q3 2025/26 -** staff survey results
16. To include additional information in the LGBTQ+ Awareness Training relating to Trans inclusion in the workplace.	Abby Holder	**Q1 2025/26 -** staff survey results
17.Invite bisexual staff to speak to the EDI & HR Team regarding the possible reasons why there continues to be a difference in experience when compared to lesbian and gay staff.	Abby Holder	**Q1 2025/26 -** staff survey results

STAFF PUBLICATION OF INFORMATION DATA:

Staff Publication of Information for public

APPENDIX 3 - The Human Rights, Equality, Diversity, Inclusion Policy

Public – To be published on the Trust external website

Title: Human Rights, Equality Diversity and Inclusion Policy Ref: HR-0013-v9.2

Status: Ratified
Document type: Policy

Contents

Introduction

Our Journey to Change

The Trust's core values of respect, compassion and responsibility are integral to equality, diversity, inclusion and human rights. This policy is critical to the delivery of Our Journey to Change (OJTC) and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism.

This policy supports the Trust to co-create a great experience for all patients, carers and families from its diverse communities by:

- Outlining the Trust's commitment to provide services that meet people's needs and are available and accessible to its diverse communities and that any barriers to accessing services are identified and removed (see section 4)
- Detailing the measures the Trust will take to ensure that its services meet the needs of its diverse communities (see sections 7.1, 7.2 and 7.7
- Outlining clear expectations of the behaviours expected from all staff to ensure that patients, carers and families from protected groups have the same outcomes and experiences as other patients, carers and families (see section 4)

This policy supports the Trust to co-create a great experience for all colleagues from its diverse communities by:

- Outlining the Trust's commitment to ensuring that staff from protected groups have the same outcomes and experiences as other staff and outlines the measures to ensure this will happen in recruitment and selection, learning and development and performance management (See sections 7.3, 7.4 and 7.5)
- Outlining clear expectations of the behaviours expected from all staff to ensure that staff from protected groups have the same outcomes and experiences as other staff see paragraph 4)

The NHS Constitution states that **'The NHS belongs to us all'**, it is with this principle in mind that this policy has been written.

The Trust is under increasing pressure to deliver high quality services, with limited resources to an increasingly diverse population whose needs and expectations are growing. At the heart of the Trust is a commitment to provide comprehensive and flexible services that meet people's needs and are available and accessible to all. In order for the Trust to be equipped to deliver its services in a respectful, fair and inclusive way, the Trust must become more innovative in how it can meet the different needs of service users and make best use of the resources it has, most notably its people.

In employment matters, the Trust recognises that harassment, discrimination, bullying and victimisation are destructive behaviours that can happen within any team, in any

organisation. Wherever they exist they contribute to and exacerbate poor mental health and wellbeing, add to workplace stress and lower team morale. This in turn can result in increased sickness absence levels, high staff turnover and can ultimately result in mental ill health.

If bullying is allowed to thrive within an organisation it becomes a destructive force that can prohibit open challenge, whistleblowing or raising concerns. Staff may become fearful of reprisal (victimisation) from both managerial and non-managerial colleagues. Left unchecked this can have a direct impact on the safety and quality of patient care as was highlighted in the Francis Report into Mid Staffordshire Hospital. The Trust considers all the above mentioned abusive behaviours as 'avoidable and unjustifiable harm'.

Trust staff have a duty of care towards their colleagues, service users, their relatives and carers or anyone else they come into contact with whilst engaged in Trust business.

Why we need this policy

Purpose

This policy sets out how the organisation complies with applicable human rights and equality legislation (MHA CoP 2015, para.3.15). This policy is a key policy and as such should be read by all staff regardless of role, grade or position.

Legislation - The Human Rights Act 1998

The Human Rights Act is a foundation law, meaning that all other laws must be compatible with it. When there are abuses of Human Rights people have the right to challenge, speak up or to request an investigation. The Act has three duties which all staff and those acting on behalf of the Trust must abide by at all times. The three duties are;

- **Respect**; this means to **not** violate rights
- **Protect**; to take action to prevent a violation (by whistleblowing, raising concerns etc.)
- **Fulfil**; to provide investigation and review when violations occur (procedural duty)

The Human Rights Act is an enabling foundation law that aims to promote the rights of human beings, whatever their circumstances. It is not possible for a person not to have rights; a person always has human rights.
In particular circumstances Human Rights can be limited or restricted, but rights can never be taken away completely. Human Rights provide a set of minimum standards and are a vital safety net for the treatment we can all expect from our services, including;

- **Better services and outcomes**: can help drive up quality and improve outcomes
- **Not reinventing the wheel**: Not about completely changing what you do, human rights are a practical framework to help you improve how you do it

- **Familiar shared values**: dignity, respect, fairness, autonomy, equality and choice – upholding these values under challenging circumstances
- **Power not pity**: human rights provides a powerful language
- **Changing the day-to-day practice**: not theory

Key Human Rights for mental health and learning disability services

There are five key Human Rights for mental health and learning disability services, these are:

Article 2 - **The right to life** This is an absolute right which includes a duty not to take away anyone's life, a positive duty to take reasonable steps to protect life and a procedural duty to investigate deaths where public officials may be implicated / involved.

Article 3 - **The right to be free from torture, inhuman and degrading treatment**. This is also an absolute right. It covers three types of treatment: Torture, Inhuman treatment, degrading treatment

It imposes three types of obligations on public officials:

- A negative duty **not** to torture or treat someone in an inhuman and degrading way
- A positive duty to take reasonable steps to protect people known to be at risk of such treatment
- A procedural duty to investigate where torture, inhuman or degrading treatment has occurred

Article 5 - **The right to liberty** is a non-absolute right. In specific circumstances liberty can be limited, e.g. detention under Mental Health Act or prison. The right to liberty is not a right to be free to do whatever you want. It is a right not to have extreme restrictions placed on a person's movement. It includes procedural safeguards such as review mechanisms and time limits.

Article 8 – **The right to respect for private and family life, home and correspondence**. This right protects four interests: private life, family life, home and correspondence

This right is non-absolute and can be restricted. It has to be balanced against the rights of others and the needs of society. This right involves three types of obligations on public officials:

- A negative duty **not** to interfere with people's family life, private life, home and correspondence
- A positive duty to take reasonable steps to protect people known to be at risk of having their rights violated, especially in relation to mental and physical well-being
- A procedural duty to ensure fair decision-making processes

Article 14 – **The right to non-discrimination**. This right can only be used in conjunction with another right or rights. The definition of discrimination is broader than that of the Equality Act and a person can bring a case of discrimination for any reason.

Human Rights belong to everyone. They are the basic rights that we all have simply because we are human, regardless of who we are, where we live or what we do. Human Rights represent all the things that are important to us as human beings, such as being able to choose how to live our lives whilst being treated with dignity and respect. We have Human Rights from the moment we are born until the moment we die. Putting Human Rights at the heart of the way Trust services are designed and delivered ensures better services for everyone.

Legislation - The Equality Act 2010

The Trust focuses on Equality, Diversity, Inclusion and Human Rights from two perspectives that are intertwined with each other:

- **Service Delivery** – Equality, Diversity, Inclusion and Human Rights in healthcare for service users and their carers
- **Employment** – Equality, Diversity, Inclusion and Human Rights for our staff

The Equality Act 2010 makes it unlawful to discriminate against someone because of one or more protected characteristics. The protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Section 149(1) of the Equality Act 2010 states – A public authority must, in the exercise of its functions, have due regard (take seriously) to the need to:

- **Eliminate** unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- **Advance** equality of opportunity between people who share a protected characteristic and those who do not
- **Foster** good relations between people who share a protected characteristic and those who do not

These are more commonly known as the three aims of the Act.

The Act requires that the Trust demonstrates ‘due regard’ this means the Trust **MUST** demonstrate that it has reasonably considered its impact on equality. This is an ongoing requirement (continuous duty) and it is essential that this is done in a proactive and anticipatory way, rather than in a reactive way which is ineffective and does not evidence or demonstrate ‘due regard’ (reasonable consideration) of the requirements of the Act.

Section 149(2) of the Equality Act 2010 states:

A person who is not a public authority but who exercises public functions must, in the exercise of those functions, have due regard to the matters mentioned in subsection (1).

Section 149(2) relates to Trust staff and anyone else who provides or delivers services to the public such as council workers, the police, teachers etc. All NHS staff and anyone else who carries out a function or functions on, or on behalf of the Trust must take their responsibility seriously and in accordance with the Act, acting in compliance with section 149(1) of the Act at all times. Further information on how to access the Equality Act 2010 can be found on page 15.

Objectives

The objective of this policy is to provide a set of minimum standards that everyone who has dealings with the Trust must adhere to. We must ensure that all aspects of Trust business are non-discriminatory, carried out in a fair and consistent manner and in line with the Trust values; compassion, respect and responsibility . The Trust is committed to providing services and employment environments that promote Equality, Diversity, Inclusion and Human Rights and will make every effort not to discriminate against service users, relatives, carers, Trust staff, potential Trust staff, bank workers, agency workers, volunteers, students, contractors or anyone that deals with the Trust in any way. The Trust has a duty to respect and promote people's Human Rights which improve experiences for all.

Scope

Who this policy applies to

This policy applies to the following groups of people:

- The Chief Executive and The Trust Board of Directors including Non-Executive Directors
- All Trust Managers, regardless of role, grade or position
- All Trust staff regardless of role, grade or position
- Bank Workers and Agency Workers
- Service users, their carers, relatives and friends
- Trust Governors
- Trust experts by experience
- Trust Volunteers
- Hospital Managers
- Contractors

Expected standards of behaviour can be found in section 3.2 Roles and Responsibilities.

The Trust's values of respect, compassion and responsibility are key to ensuring that all those from its diverse populations who come into contact with the Trust have the same high-quality outcomes and experiences.

Roles and responsibilities

Role	Responsibility
Chief Executive and the Trust Board of Directors	• The Chief Executive is responsible for providing leadership to the Trust in the promotion of Equality, Diversity, Inclusion and Human Rights in both service delivery and employment matters • Members of the Trust Board collectively and individually are responsible for supporting the Chief Executive in this objective • The Trust must conform to current legislative requirements of the Human Rights Act 1998 and the Equality Act 2010. • The Trust seeks to ensure equitability of access in the provision of its services, which meets the needs of service users • As a provider of mental health, learning disability and substance misuse services, the Trust is committed to meaningful engagement with all parts of its communities and commissioners • The Trust seeks to dismantle barriers that prevent equality of access to employment, promotion, training and development opportunities for all protected groups
Director of People and Culture	• The Director of People and Culture has operational responsibility for Equality, Diversity, Inclusion and Human Rights throughout the Trust in both Employment and Service Delivery
The Equality, Diversity, Inclusion and Human Rights Lead	• The Equality, Diversity, Inclusion and Human Rights Lead role is to support the Director of People and Culture to be able to make informed decisions in all matters relating to Equality, Diversity, Inclusion and Human Rights. The EDIHR Lead reports to the Director of People and Culture monthly and to the relevant board Board/s covering employment and clinical services three times a year, submitting an annual report of progress made as part of the reporting cycle. Further to this the EDIHR Lead reports to the People, Culture and Diversity Board for people issues and QAC for matters relating to service user when necessary and in accordance with Trust requirements

Equality, Diversity, Inclusion and Human Rights Officer	• The Equality, Diversity, Inclusion and Human Rights Officer reports to the Equality, Diversity, Inclusion & Human Rights Lead and has an active role in supporting the Equality, Diversity, Inclusion and Human Rights Lead, supporting Trust staff to embed Equality, Diversity, Inclusion and Human Rights within employment and services
Managers and Leaders	• Managers and Leaders understand that unlawful discrimination, harassment, bullying and victimisation are unacceptable practices and have no place in Trust services, departments or teams. • Managers and Leaders are expected to foster positive working environments where mutual respect for Equality, Diversity, Inclusion and Human Rights are central to their role as manager, leading by example, and actively challenging abusive behaviour of any kind to maintain good staff morale, wellbeing and good patient care • Making staff aware of the Trust policy on Equality, Diversity, Inclusion and Human Rights and the supporting policies in relation to employment and service delivery • Promoting Equality, Diversity, Inclusion and Human Rights by their behaviour and actions • Ensuring that complaints are dealt with in a fair and consistent manner • Ensuring that contractors working within the Trust adhere to the principles of the Equality, Diversity, Inclusion and Human Rights Policy
Staff, including agency workers, bank workers and students	• Are responsible for co-operating with measures introduced by management to ensure equality of opportunity and non-discriminatory practices, including making sure that people have equality of access to service provision • Must not discriminate e.g., this includes any person who is responsible for selection decisions in recruitment, promotion, transfer, training etc. or those responsible for the provision and delivery of services • Not acting, persuading, attempting to persuade or instructing other employees, unions or Management to practice unlawful discrimination, harassment, bullying, victimisation or any act that would result in a breach of the Human Rights Act 1998 • Not harassing, bullying or intimidating other employees, including their peers, subordinates or seniors. This includes amongst others: sexual, racial and homophobic harassment • Not victimising or attempting to victimise individuals on the grounds that they have made complaints or provided

	information on discriminatory practice. • Informing management if they suspect or are aware that an act or acts of discrimination or inhumane treatment of any kind is or have taken place
Contractors	• All contractors must comply with the requirements of the Equality Act 2010 and the Human Rights Act 1998 whilst providing or delivering goods, services and facilities to Trust staff, service users, their relatives, carers and anyone else who has links with the Trust. • Not complying with the above means that the contractor is in direct breach of the 'Terms and Conditions of its contract with the Trust and the contract will be terminated.
Service users, their relatives and carers	• Service users, their relatives, friends and carers can expect to be treated with respect and courtesy whilst accessing or engaging with Trust services. We encourage service users, their carers and relatives to contact the Trust using the PALS service if they experience unfair or unequal treatment or feel that Trust services do not meet their needs. • Service users, their relatives, friends and carers are expected to treat Trust staff with respect and courtesy whilst receiving Trust services. • The Trust will not tolerate racist, sexist or homophobic abuse etc., towards its staff, other service users, their relatives or carers. The Trust will provide support and/or signposting to staff or anyone else who feels that they have been harassed, discriminated against or victimised whilst they have been delivering services or receiving care.
Trust Governors and Volunteers	• Trust Governors and Volunteers are expected to treat each other and anyone else they come into contact with whilst carrying out their duties with respect and courtesy • Trust Governors and Volunteers can expect to be treated with respect and courtesy whilst performing duties, with or on behalf of the Trust
Hospital Managers	• Hospital Managers have a statutory role under the Mental Health Act 1983 which requires them to attend review meetings to ensure the lawful criteria for detention under the Act is met. This role is also pivotal in that it addresses the Human Rights of service users. It is expected that they will be non-biased and that their decisions will be made without prejudice. It is expected that individuals who are selected to act on behalf of the Trust as Hospital Managers will uphold the principles of this policy, in that the Trust expects high standards in relation to Equality, Diversity, Inclusion and Human Rights from Hospital Managers. The Trust will take action to remove Hospital

	Managers who do not meet the Trusts expected standards.

Policy

1. The Trust will respect and protect the Human Rights of all service users, staff and anyone else who has a relationship to the Trust.
2. Any restriction/s placed on the rights of service users, for example a decision to detain a person under the Mental Health Act will be lawful, justifiable and proportionate, will have a legitimate aim and will be the least restrictive option in the circumstance
3. The Trust takes breaches of policy very seriously, particularly those that when breached have a harmful effect on other people. Victimisation, harassment, discrimination (or an attempt to do so) and bullying will not be tolerated and will, where substantiated, lead to disciplinary action
4. Staff who identify with protected groups have the right to be treated fairly and with dignity and respect and without the fear of unlawful discrimination, harassment, victimisation or bullying
5. Service users who identify with protected groups, their relatives and their carers have the right to be treated in a fair, reasonable and consistent way with dignity, respect and compassion and without the fear of unlawful discrimination, harassment, victimisation or bullying
6. The Trust will work to reduce health inequalities for all service users
7. The Trust is committed to the ongoing development of staff awareness and knowledge of Equality, Diversity, Inclusion and Human Rights. Staff development begins from employment and continues throughout an individual's career until they leave the Trust
8. The Trust is committed to monitoring, evaluating and reporting on issues of Equality, Diversity, Inclusion and Human Rights in employment and service provision
9. The Trust will work towards best practice standards of Equality, Diversity, Inclusion and Human Rights and not merely comply with legislation
10. The Trust will promote equality, foster good relations and take an anti-discriminatory approach in all areas of employment and service delivery
11. The Trust will ensure that barriers to accessing services and employment are identified and removed so that no person is treated less favourably because they identify with a protected group/s
12. The Trust recognises the importance of this policy in the employment relationship it has with its staff and in provision of services for service users, and will reflect this commitment in all Trust policies, procedures and practices etc.

13. Anyone that deals with the Trust will receive equitable treatment whether they are receiving a service, providing a service, tendering for a contract or in any other relationship with the Trust

14. This policy extends outside the workplace and Trust staff should be aware that work place behaviour includes times when they are not physically at work but are participating in activities where work is a factor, e.g. team nights out, shopping trips with colleagues and if behaviours in these situations are deemed discriminatory and / or unethical, it could warrant disciplinary action or allegations of gross misconduct

15. Staff with a professional registration may also find that discriminatory and or unethical practices outside work may lead to complaints to their professional body and possible action by them

The Trust recognises the benefits which will arise from implementation of the Human Rights, Equality Diversity and Inclusion Policy including:

1. Right respecting clinical practice provides the very best opportunity for recovery. Services take a positive and inclusive approach to minimising distress and harm
2. The provision of accessible, flexible and adaptable services that are delivered by highly capable staff that meet the needs of service users', resulting in equitable levels of patient satisfaction regardless of which protected group/s they identify with
3. Equality, Diversity, Inclusion and Human Rights enhance opportunity, inclusivity, creativity and innovation leading to better working and patient care environments
4. Employing staff from different protected groups and cultural backgrounds enables a better understanding of the needs of all service users, and results in a workforce with increased levels of empathy and compassion
5. A diverse workforce and inclusive working environments increase the reputation of the Trust in different communities. In turn this encourages people from these communities such as BAME and LGBTQ+ people, and people with disabilities and long-term health conditions to apply for positions within the Trusts as its reputation grows as an employer of choice
6. A diverse organisation has higher levels of emotional intelligence and empathy than less diverse organisations. Diversity also drives innovation and creativity which is a key element in developing inclusive working practices and service provision. Staff that share similar values on issues such as respect, compassion, equality and fairness are more likely to get on and more likely to be part of an effective and successful team

Definitions

Term	Definition
CQC	Care Quality Commission
Diversity (difference)	The Trust recognises that everyone has a unique contribution to make and that a person's personal attributes contribute significantly in achieving the Trusts goals. Diversity is a strength and it should be visible at all levels of the organisation. Valuing Diversity is integral to valuing people. When we value Diversity we promote a positive, supportive and innovative working environment. When we value the Diversity of our service users we are more likely to meet their needs and support them on their journey to recovery.
EHRC	Equality and Human Rights Commission
Equality	Equality in the UK is about fostering and promoting the right to be different, to be free from discrimination, and to have equal choices, opportunities being valued as an individual
Human Rights	The rights that we all have and share, simply because we are human that are protected by the Human Rights Act
BAME	Black, Asian and Minority Ethnic
LGBTQ+	Lesbian, Gay, Bisexual, Trans, Queer, Questioning and other sexual orientation/ gender identity

Related documents

To provide context the Trust has a number of closely associated policies, procedures, guidance and other documents that support the aims of this central policy, they include:

- Managing concerns of potential conduct (Disciplinary) Procedure, Dealing with concerns affecting Medical Staff, Freedom to Speak Up (Whistle Blowing) Policy, Incident Reporting and Investigating Policy, Security Procedure, Equality Impact Assessment Guidance, Interpreting and Translation Policy and Guidance, Staff Development Policy, Dress Code Procedure, Special Leave Procedure, Recruitment & Selection Procedure, Leavers Procedure, Grievance Procedure, Bullying and harassment resolution procedure, Job Evaluation Procedure, Organisational Change Procedure, Retirement and Long Service Recognition

Procedure, Information Governance Policy, Information Security and Risk Policy, and Managing Concerns of Potential Poor Performance (Capability) Procedure.

How this policy will be implemented

Equality, Diversity, Inclusion and Human Rights will be embedded into every aspect of Trust business. This section highlights some of the key areas and themes that have been identified in the Trust and how this policy will be implemented

Equality Impact Assessment

The Trust will use Equality Impact Assessments (EIA) to ensure that it reasonably considers its impact on equality. Equality Impact Assessment Policy and Guidance, defines the requirements of the Trust and its staff in more detail.

Interpreting and Translation

Trust staff will refer to the Interpreting and Translation Policy and Guidance when providing care for people who speak using a language other than English or who communicate using British Sign Language. Patient care cannot take place if the service user is unable to understand the clinician or any member of staff involved in their care and treatment.

Recruitment, Selection and Employment

- All recruitment processes, conditions of service, job requirements and learning and development opportunities, must fit with the needs of the service and those who work in it. The Trust will comply with the legal requirements of the Equality Act 2010 and the Human Rights Act 1998
- The Trust will strive to provide a positive working environment in which people want to work and be a leader in good employment practices and effective communication
- All staff will have the opportunity to have talent management conversations
- Under representation, where it exists, will be identified and addressed by removing barriers. People will have equal access to career advancement and other opportunities within the organisation
- Taking positive action, where appropriate, to ensure applicants and employees can participate in, and have opportunity work for the Trust, further ensuring that Trust

services meet the needs of its communities

- The Trust is also committed to enabling every member of staff to achieve their full potential in an environment characterised by opportunity, dignity and mutual respect

Learning and Development

- All staff must undertake Equality and Diversity training as they start working for the Trust. Additionally staff are required to undertake regular refresher training in accordance with the mandatory training needs analysis which is part of the staff development policy
- All employees should have an annual individual appraisal including a personal development plan. This should completed in accordance with the staff development policy On an annual basis the Trust will produce a Training Needs Analysis to outline how the Trust priorities for development will be achieved
- Information on training and development opportunities is widely publicised and all employees will be encouraged to undertake appropriate training and development, which will enable them to meet the requirements of their role in meeting service needs

Performance Management

- Performance assessments should be based on employee's performance against their actual objectives and the Knowledge and Skills Framework profile linked to their job description
- All managers with responsibility for appraisal should be able to show evidence of competence in Appraisal and Equality and Diversity Awareness
- Concerns over discriminatory or inappropriate behaviour picked up through supervision, whether clinical, professional or managerial, should be dealt with promptly by the manager
- In relation to disability, the Trust will make every effort to make reasonable adjustments for Trust staff that have or develop a disability whilst employed by the Trust. This could include people who can continue to work but the reasonable adjustments can't be accommodated in that particular role. Under the Trusts capability or sickness procedures there would be opportunity for staff to enter redeployment to explore whether adjustments could be accommodated in another

job in a different area

- If an individual is so unwell or the condition is so severe/life-threatening that they cannot continue working then Occupational Health advice would be sought and the Trust would follow the Staff Health, Wellbeing and Attendance Procedure (Maintaining Attendance at Work) Stage 4.

- Reasonable adjustments and other support procedures will be put in place to support and enable staff with disabilities to meet the requirements of their role, but on very rare occasions it will be not be possible to make reasonable adjustments or redeploy staff. This may be because the nature of the person's disability will be such that it inhibits the person's ability to work at all. When this happens the Trust will follow the End of Employment Procedure.

- If you believe that you have been subjected to bullying, harassment, discrimination or victimisation, you can raise a grievance using the Trust's Grievance Procedure. The Trust will not tolerate harassment, discrimination, victimisation or bullying of staff because of a protected characteristic(s) or for any other reason. Any member of staff committing such actions will be subject to the Trusts Managing Concerns of Potential Conduct (Disciplinary) Procedure (or for medical staff Dealing with concerns affecting Medical Staff) and it could result in dismissal

- **If you witness someone being subjected to bullying, harassment, discrimination or victimisation and don't feel you can raise it with your line manager then you should use the Trust's** Whistleblowing Procedure and Raising Serious Concerns Procedure **to raise the issue.**

Partnership Agreement

The Trust has an agreement with staff side representatives which reinforces the importance of partnership working with all parties sharing a commitment to the business and service needs of the Trust.
The agreement encourages managers to spread the benefits of partnership working by ensuring that staff and staff side representatives are systematically and routinely involved in shaping the service and involved in the decision making process. This reinforces an environment where the right balance is reached between the needs of the service and the needs of its employees, ultimately improving the working environment for staff which has a positive knock on effect which can be seen in the quality of patient care.

Trust Services

- The Trust will ensure that its priorities are informed by the health needs of the communities it serves. When health inequalities are recognised steps will be taken to remove them by engaging and seeking the views of the communities, including those represented by protected groups and by working with commissioners

- Equality, Diversity, Inclusion and Human Rights will be considered throughout the planning stages of all Trust services. This will include the completion of an equality impact assessment and/ or the use of demographic data

- Trust staff will take a positive and proactive approach to Equality, Diversity, Inclusion and Human Rights by raising their own awareness and knowledge levels to accomplish this aim. The Trust (the Equality, Diversity, Inclusion and Human Rights team) will support staff to do this.

- All Trust services will proactively endeavour to anticipate and meet the needs of people that identify with protected groups. When a protected group is underrepresented in a service the Trust will investigate the reasons for this and where necessary will take action to remove barriers that impact on services being accessed in an equitable way

- The Trust will ensure that its services are accessible to people with disabilities

- The Trust recognises the importance of data completeness and will continue to undertake work to ensure gaps in data are reduced and both staff and service users understand the importance of why the data is requested

- Trust services will be delivered in a respectful, dignified, compassionate and professional way with the needs of the service user taking priority

- Trust services and the staff involved in the delivery of services will maintain a flexible and adaptable approach to delivering care, if concerns or issues arise around working with protected groups or in how to meet the human rights of service users, staff will seek advice from the Equality, Diversity Inclusion and Human Rights Team in the first instance

- Trust services will ensure that patients are involved in discussions about their care and treatment and that their culture and ethnicity are respected and supported. The Trust will gather feedback on patients' experiences at appropriate times.

The Trust expects that staff will actively challenge and report abusive behaviour of any kind. The Trust expects managers to take steps to support staff who experience challenging or abusive behaviour of any kind. If you are unsure what this is, you can seek further advice and guidance from the Equality, Diversity, Inclusion and Human Rights Team

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.
- Where additional training needs for staff are identified they will be taken forward using existing Trust processes by the Equality, Diversity, Inclusion and Human Rights Lead.

Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All staff and volunteers	Mandatory Equality, Diversity, Inclusion and Human Rights training	On line	Every 3 years
All staff and volunteers	Other Equality, Diversity, Inclusion and Human Rights training	As necessary	As necessary

How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Equality Impact Assessment (policies and procedures)	Policy Lead	Management Group
2	Equality Impact Assessment (projects and programmes)	Policy Lead	Programme Management Team
3	Equality and Diversity Mandatory Training	Line Manager	ODDG or equivalent
4	Complaints relating to EDIHR	Complaints Manager	EDIHR steering group

References

Equality Act 2010
Human Rights Act 1998
Mental Health Act 1983

Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	18 October 2023
Next review date	18 October 2026
This document replaces	HR-0013-v9.1 Human Rights Equality and Diversity, Inclusion Policy
This document was approved by	Exec P&C Board
This document was approved	30 August 2023
This document was ratified by	Management Group
This document was ratified	18 October 2023
An equality impact assessment was completed on this policy on	30 August 2023
Document type	Public
FOI Clause (Private documents only)	n/a

Change record.

Version	Date	Amendment details	Status
9	22 Sept 2021	Transferred to the new template and Our Journey To Change added. Minor changes to wording in the remainder of the document.	Withdrawn
9.1	26 Aug 2022	Added Journey to Change section. Minor changes to wording in the remainder of the document. Titles of relevant procedures updated	Withdrawn
9.2	18 Oct 2023	Full review with minor changes including:- Updates to related documents titles and links; and minor formatting and wording changes throughout.	Ratified

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Equality Diversity Inclusion and Human Rights Team, People and Culture Directorate
Title	Human Rights, Equality Diversity and Inclusion Policy Ref:HR-0013-9.2
Type	Policy
Geographical area covered	Trust wide
Aims and objectives	This policy lays down the Trusts expected standards in relation to Equality, Diversity, Inclusion and Human Rights in both employment and services. This policy is inclusive of all Trust staff, bank workers, service users, carers and volunteers etc. It is hoped that by taking a joined up and inclusive approach the Trust can promote a unified message for all. **The Equality Act 2010** is legislation aimed at eliminating unlawful discrimination, promoting equality of opportunity for different groups of people and fostering good relations between different groups of people. These are more commonly known as the three aims of the Act. The Trust focuses on Equality, Diversity, Inclusion and Human Rights from two perspectives that are intertwined with each other. • **Service Delivery** – Equality, Diversity, Inclusion and Human Rights in healthcare for service users and their carers • **Employment** – Equality, Diversity, Inclusion and Human Rights for our staff The policy applies to the following groups of people. • The Chief Executive and The Trust Board of Directors including Non-Executive Directors • All Trust Managers, regardless of role, grade or position • All Trust staff regardless of role, grade or position • Bank Workers and Agency Workers • Service users, their carers, relatives and friends • Trust Governors • Trust Volunteers • Hospital Managers • Contractors

Start date of Equality Impact Assessment	17 July 2024
End date of Equality Impact Assessment	18 July 2024

Section 2	**Impacts**
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	All staff and Patients
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	
Describe any positive impacts	This Policy is very positive as it recognises the link between staff behaviour and service delivery. Many other groups of people are covered within it such as service users, carers, bank staff, volunteers and contractors. The policy is clear about what the Trust should expect from its employees and what its staff should expect from service users. The Policy is inclusive of all protected groups and ensures that there is no hierarchy of values in relation

	to discrimination and harassment. I.e., sexism is equally as negative as ageism, ageism is equally as negative as homophobia, homophobia is equally as negative as racism etc.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Human Rights Act 1998 Equality Act 2010
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	No specific protected groups were consulted, however all staff will be consulted on this policy before ratification. In the future it is envisaged that staff engagement groups will play an active part in the consultation process.

Section 4	**Training needs**
As part of this equality impact assessment have any training needs/service needs been identified?	Yes
Describe any training needs for Trust staff	Training is available to staff mandatory for Equality and Diversity training and optional for Human Rights however staff are encouraged to complete the programme where possible.
Describe any training needs for patients	N/A
Describe any training needs for contractors or other outside agencies	N/A

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate Board/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	
7.	**Implementation and monitoring**		
	Does the document identify how it will be	Yes	

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	implemented and monitored?		
8.	**Equality impact assessment**		
	Has an equality impact assessment been completed for the document?	Yes	
	Have Equality Diversity Inclusion and Human Rights reviewed and approved the equality impact assessment?	Yes	
9.	**Approval**		
	Does the document identify which Board/group will approve it?	Yes	
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**October 2024**
Title:	**Revalidation/Appraisal Annual Report**
Author(s):	**Kedar Kale, Lenny Cornwall, Elaine Corbyn, Jenny Miller**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
11	Governance & Assurance	*The absence of a clear line of sight from ward to board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risk to patients.*

Executive Summary:

The Framework of Quality Assurance for Responsible Officers and Revalidation (FQA) is requested by NHS England each year and has been designed to assist responsible officers in providing assurance to their organisations Board that the doctors working in their organisations remain up to date and fit to practice.

It highlights compliance rates for appraisal and revalidation amongst our doctors for the previous appraisal year (2023-24) and the supporting narrative explains the processes we have in place. The report also shows the number of doctors who were managed under 'Responding to Concerns' and demographic information relating to such concerns during the reporting period.

Proposal:

All Responsible Officers are asked to present an annual report to their Board or equivalent management team along with the statement of compliance (Annex A) in order to provide a substantial level of assurance that our doctors are fit to practice. The statement of compliance should be signed off by the Chief Executive or Chairman of the Designated Body's Board or management team and submitted to NHS England by 31st October 2024.

Overview:

The purpose of revalidation is to provide **assurance** to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise. This aim will be achieved through annual appraisal and processes supporting revalidation. By presenting our appraisal and revalidation data within this report which shows we have

strong compliance in these areas, it is hoped this will give **good assurance** that we uphold a strong system for appraising and revalidating our doctors.

Implications:
Failure to submit a signed version of the Board report and Statement of Compliance to NHS England by the required date means our appraisal and revalidation data will not be recognised and compared to that of other NHS organisations.

Recommendations:
The Board are required to confirm a level of assurance as proposed within the report. If assurance is met, the Statement of Compliance should be signed off by the Chief Executive or Chairman of the designated body's Board or management team and then the report can be submitted to NHS England.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

REVALIDATION / APPRAISAL ANNUAL REPORT
1st April 2023 – 31st March 2024

Management of Appraisal and Revalidation

Responsible Officer:	Dr Kedar Kale
Associate Responsible Officer:	Dr Lenny Cornwall
Medical Development and	Mr Bryan O'Leary
Medical Management:	Mrs Elaine Corbyn
	Mrs Chloe Casson/Miss Jenny Miller
	Dr Tolu Olusoga (GMD – NYY Care Group)
	Dr Ranjeet Shah (GMD – DTVF Care Group)
	Dr Hany El Sayeh (Director of Medical Education)

Activity Levels

Number of doctors that TEWV are responsible body	Consultant		SAS		Trust Doctors/IFD	
	2022–23	2023–24	2022-23	2023–24	2022-23	2023–24
Adult Mental Health	62	62	28	30	5	19
Mental Health Services for Older People	30	34	19	19	4	6
Child and Young Person's Services	33	33	8	8	0	1
Learning Disabilities	12	12	3	3	0	0
Forensic Services	15	14	2	2	1	4
Total:	**152**	**155**	**60**	**62**	**10**	**30**

Comments:
A total of 247 doctors had a prescribed connection with TEWV as at 31st March 2024.

Number of doctors who were due for an appraisal	Consultant		SAS		Trust Doctors/IFD	
	2022-23	2023–24	2022-23	2023–24	2022-23	2023–24
Adult Mental Health	59	59	20	22	4	15
Mental Health Services for Older People	28	29	15	16	3	6
Child and Young Person's Services	32	31	6	7	0	1
Learning Disabilities	12	12	3	2	0	0
Forensic Services	15	14	1	2	1	4
Total	**146**	**145**	**45**	**49**	**8**	**26**

Comments:
The table above illustrates the number of doctors that were due an appraisal in the last appraisal year between 1st April 2023-31st March 2024.

The reason colleagues were not due an appraisal was because they had already undertaken an appraisal with a previous organisation before joining TEWV, or not worked with the Trust for the minimum time period that is required to have an appraisal.

These account for the difference of 10 in the consultant figure as there were 10 new consultants who commenced employment with the Trust during the last year and therefore were not due an appraisal as of 31st March 2024.

In addition, there were 13 new SAS doctors who were not due an appraisal at this time. There were also 3 IFD (International Fellowship Doctors, previously known as MTI's) and 1 Trust doctor who were not due a 'priming appraisal' at 31st March 2024.

Number of doctors who have had an appraisal in the appraisal year	Consultant		SAS		Trust Doctors/IFD	
	2022-23	2023–24	2022-23	2023–24	2022-23	2023–24
Adult Mental Health	58	57	19	20	4	15
Mental Health Services for Older People	28	28	13	16	2	6
Child and Young Person's Services	29	30	4	6	0	1
Learning Disabilities	12	12	3	2	0	0
Forensic Services	15	12	1	2	1	4
Total	**142 (97%)**	**139 (96%)**	**40 (89%)**	**46 (94%)**	**7 (88%)**	**26 (100%)**

Comments:
The figures in the table above show the number of doctors that have had an appraisal between 1st April 2023 - 31st March 2024.

The reasons that a doctor may have missed their annual appraisal is detailed in the next section under exceptions.

Exceptions

The table below illustrates the 'approved missed or incomplete appraisals'. This cohort are doctors that could not complete their appraisal in the appraisal year for a reason that was accepted and signed off by the Associate Responsible Officer on behalf of the Responsible Officer.

For an appraisal to be an 'approved missed or incomplete', the Trust needs to produce documentation to demonstrate that they have agreed the postponement as reasonable. These requirements are set out by NHS England.

Number of 'approved missed or incomplete appraisals'	Consultant	SAS	Trust Doctors/IFD
Adult Mental Health	2	1	0
Mental Health Services for Older People	1	0	0
Child and Young Person's Services	1	1	0
Learning Disabilities	0	0	0
Forensic Services	2	0	0
Total	**6**	**2**	**0**

Comment:
The consultant exceptions are due to:

- 4 consultants being on long term sick
- 1 consultant on maternity leave
- 1 Consultant on a Career Break

This resulted in the doctors not being able to do an appraisal before 31st March 2023.
The SAS doctor exception was due to long term sickness and one doctor had requested a deferral due to appraiser sick leave and annual leave.

The table below illustrates the 'unapproved missed or incomplete appraisals'. This group of doctors have not completed their appraisal in the appraisal year, neither have they sought any agreement of this from the Associate Responsible Officer.

Number of 'unapproved missed or incomplete appraisals'	Consultant	SAS	Trust Doctors/IFD
Adult Mental Health	0	1	0
Mental Health Services for Older People	0	0	0
Child and Young Person's Services	0	0	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	**0**	**1**	**0**
Comments: There are ongoing communications with the Doctor concerned to deal with this matter. The Associate RO has written to the individual concerned to understand the situation and this will be monitored and documented accordingly.			

Revalidation

Number of doctors completing revalidation cycle	Consultant		SAS		Trust Doctors	
	2022-23	2023–24	2022-23	2023–24	2022-23	2023–24
Adult Mental Health	12	14	3	3	1	0
Mental Health Services for Older People	2	8	4	10	0	0
Child and Young Person's Services	4	6	1	2	0	0
Learning Disabilities	2	2	2	0	0	0
Forensic Services	1	5	1	2	0	1
Other	0	0	0	0	0	0
Total	**21**	**35**	**11**	**16**	**1**	**1**

Number of doctors receiving revalidation recommendations	Consultant		SAS		Trust Doctors	
	2022-23	2023–24	2022-23	2023–24	2022-23	2023–24
Adult Mental Health	12	14	2	3	0	0
Mental Health Services for Older People	2	8	3	9	0	0
Child and Young Person's Services	4	6	1	2	0	0
Learning Disabilities	2	2	2	0	0	0
Forensic Services	1	5	1	2	0	1
Other	0	0	0	0	0	0
Total	**21**	**35**	**9**	**16**	**0**	**1**
Comments: Between 1 April 2023 – 31 March 2024, there were 52 doctors who were due to be revalidated during this period. All 52 doctors were revalidated during the timescales allowed. Five of the 52 doctors above, were initially deferred due to them being either on sick leave or being unable to complete their final appraisal in the cycle due to lack of evidence and one of the five doctors was at that time involved in an ongoing investigation into a complaint.						

Performance Review, Support and Development of Appraisers

Training of Appraisers

	Consultant		SAS	
	2022-23	2023-24	2022-23	2023-24
Number of enhanced appraisers	48	45	7	5
Number of enhanced appraisers carrying out appraisals in appraisal year	48	44	7	5
One Consultant appraiser is on long term sick leave. The Trust trained 4 new appraisers in February 2023. They were ready to start the role in April 2023.				

Support and Development of Appraisers

Update/Support Sessions	Update/Support Sessions
17th May 2023	22nd November 2023
13th September 2023	7th February 2024
Comment: There are two different training sessions held each year and these are both repeated once, providing greater opportunity for colleagues to attend. The sessions in May and November are face to face, whilst September and February are operated on MS Teams virtually. This provides appraisers with options of how they wish to attend. As part of the session, the Trust provides appraisers with an opportunity to share feedback and/or issues that they may have experienced.	

Performance Review of Appraisers

Each appraiser's performance is reviewed by their appraisee after every appraisal that they complete. A set of standardised questions are sent to each appraisee of which they answer them on a scale from 'strongly agree' to 'strongly disagree'. On a yearly basis the feedback is anonymised, collated and fed back to the appraisers in a report. Part of this report allows the appraiser to reflect on the information fed back to them and include it in their own appraisal to contribute to any development discussions and/or PDP objectives.

If any trends are identified from the feedback received, this is then discussed with the Associate Responsible Officer who then incorporates this into the quarterly Appraiser Update Sessions and the Annual Trustwide Appraisal Session, which is held each year before the start of the new appraisal year.

Quality Assurance of Appraisals

The Trust took 27 appraisal summaries from doctors who were revalidated in the previous year 2022/23. These summaries were anonymised, and 8 volunteer appraisers were selected to rate 7 or 8 summaries each as part of a quality improvement exercise.

Each summary was rated by two different appraisers, with a feedback report provided to the appraisers in November 2023. This will be repeated in Summer 2024 for the doctors who were revalidated throughout 2023/24.

Responding to Concerns about doctors in TEWV

Total Number of All doctors who were managed under 'Responding to Concerns' (includes 'Low Level' and 'Investigations')	Consultant				SAS				Trust Doctors/IFD			
	2022/23		2023/24		2022/23		2023/24		2022/23		2023/24	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	0	0	1	0	0	0	0
Durham & Darlington	0	0	0	1	0	0	0	0	0	0	1	0
North Yorkshire & York	1	0	0	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	1	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	1	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	1	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2**	**0**	**1**	**1**	**0**	**0**	**0**	**2**	**0**	**0**	**1**	**0**

The total issues dealt with in Medical Development in terms of investigations and low level concerns this year was five.

In addition to the details documented in this report, Medical Development also deal with other issues and concerns in relation to our doctors, but do not specifically fall into the categories stated. For information purposes, we have dealt with three cases where we liaise with safeguarding over cases brought to our attention, however, the reason they are not documented in this report are due to the fact that the doctors concerned are employed by other employers, such as the LET or Locum agency or training schools.

Total Number of doctors spoken to under 'Low Level Concerns'	Consultant				SAS				Trust Doctors/IFD			
	2022/23		2023/24		2022/23		2023/24		2022/23		2023/24	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	1	0	0	0	0	0	0	0	0
North Yorkshire & York	1	0	0	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	1	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	1	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**0**	**1**	**1**	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**0**

Comments:

Low level concerns are dealt with by a medical manager or a relevant manager. They will organise a meeting with the individual to discuss the issues that have been raised or that might be causing some concern and which they would like to address before those issues become more serious. We have a low level concern form that managers complete and a copy is given to the doctor and Medical Development for recording purposes.

The purpose of the low level concern form is to allow concerns to be documented and monitored so that should there be any future concerns raised there are records to show that actions had already been taken before making the matter more formal. An example of concerns raised may be comments made by colleagues in relation to a doctor's behaviour or how they communicate with others etc.

This year there has been three low level concerns raised. Medical Development work closely with managers at a very early stage to try and prevent the need to formally document an issue or concern.

Total Number of doctors where investigation was necessary 'More Serious Concerns'	Consultant				SAS				Trust Doctors/IFD			
	2022/23		2023/24		2022/23		2023/24		2022/23		2023/24	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	0	0	1	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	1	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	1	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**1**	**0**

Comments:
In 2023/24 there was one investigation which has now completed and there is one ongoing investigation currently. The outcome of the concluded investigation was a reflection for their appraisal, to re-take mandatory and statutory training and redo IG training. Trust policies to be read and digested again in relation to Information Governance. I can confirm that all actions were adhered too. In terms of the ongoing investigation, this is yet to be finalised and reported upon.

Ongoing Actions

Responding to Concerns – Remediation/Disciplinary

Our Responsible Officer, Associate Responsible Officer and Associate Director of Medical Development attend regular sessions with the GMC representative throughout the year. These sessions allow for any concerns to be raised and advice to be given from a GMC perspective – additional to these sessions the representative from the GMC is always available to be contacted with queries throughout the year.

The Policy followed in relation to Career Grade Medical Staff doctors is called 'Dealing with concerns affecting medical staff policy'.

Electronic IT System

SARD JV continues to be used as the electronic system for appraisals and revalidation.
The Associate Responsible Officer continues to deliver training sessions to support the use of SARD for the purpose of appraisal and job planning for all new Consultant and SAS doctors that join TEWV, with sessions ran every 4 months.

The Trust continues to use a streamlined appraisal process for Trust doctor Grade appraisals, whereby they are given access to HORUS training E-portfolio on joining the Trust and then encouraged to attach this portfolio to SARD for their appraisal. This is because HORUS is more focused at foundation grade doctors. Trust doctors have a priming appraisal in the first three months of joining the Trust, where they agree a PDP with their appraiser for the year ahead. They have a full appraisal around month 10 if they remain in post.

The Trust continues to use the 360 MSF module on SARD JV for the production of patient and colleague feedback for medics in AMH & MHSOP services. The format of the feedback forms mirrors the structure of questionnaires in use by the GMC. Medics in CYPS, LD and Forensic services may use the ACP 360 as this has a slightly different patient questionnaire which is more 'user friendly'.

New for 2023/24 was the introduction of e-leave, which now allows our doctors to request annual leave via SARD and to have that signed off by managers in a more streamlined process. We continue to provide training and advice where needed and we will be looking to gain feedback on how this has been going over the next 12 months.

Furthermore, the Trust continues to use SARD e-job planning for medical staff to complete an annual job plan. The form aims to consider job planning as a process, taking stock of commitments in each year and their appropriateness, alongside developing continuity between years ensuring amendments to work practices and financial impact are accurately captured and can be reviewed when needed. The system will have a key role in ensuring all quality improvement requirements of NHSE&I can be achieved for job planning.

The Trust held five job plan consistency panels for each specialty which began in May 2023 and these meetings helped to identify areas where further training was required. This was subsequently delivered in December 2023 before the 2024 job planning round began.

The contract with SARD JV is due to expire in October 2024, however, we are working with IT colleagues to extend this contract for a further 12 months with an option to extend for a further 12 months if needed. The reason we are doing this is because we are going to explore other electronic systems to see if there are any better systems on the market and to ensure SARD is cost effective and can continue to meet our needs going forward.

Learning from Revalidation

The Trust continues to have a robust electronic system and team in place to help manage revalidation and this ensures the process runs efficiently.

Other Information:

Our medical Appraisal Policy and Procedure was updated and published in December 2022 and our Job Planning Policy was updated and published in March 2023.

SARD Guidance has been updated to reflect new system layout following the implementation of the e- job planning form. The Associate Responsible Officer has developed local guidance for doctors to help them when using the new system for the first time which helps with adapting to the new layout.

Presentations have been delivered to medical colleagues at the TEWV Senior Medical Staff Committee with further sessions to be held with specific groups at similar local events and departmental meetings with specific targeted teams.

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

The content of this template is updated periodically so it is important to review the current version online at NHS England » Quality assurance *before completing.*

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

While some of the statements in this section lend themselves to yes/no answers, the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to use concise narrative responses in preference to replying yes/no.

1A – General

The board/executive management team of Tees, Esk and Wear Valleys NHS Foundation Trust can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	No change expected
Comments:	Yes, Dr Kedar Kale, Executive Medical Director was appointed Responsible Officer on 27th June 2022 and remains in post to date.
Action for next year:	No change expected.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes / No:	Yes
Action from last year:	No change was expected.
Comments:	The Trust ensures we have the funds and staffing to support the role of Responsible Officer. TEWV as the designated body hosts the Medical Development team with dedicated members of admin and an Associate Responsible Officer to support the Responsible Officer.
Action for next year:	No change expected.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Action from last year:	We continue to use our current process of maintaining a prescribed connection with GMC Connect.
Comments:	Medical Development Team under the management of Dr Kedar Kale ensures that all our medical practitioners have a prescribed connection to GMC Connect, this is also linked to our electronic system SARD.
Action for next year:	The process will remain in place as described above.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	N/A
Comments:	Policies and Procedures are reviewed every 3 years, they were last updated in August 2022.
Action for next year:	Policies and Procedures to be reviewed in August 2025.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Action from last year:	To continue to undertake a peer review of a selection of appraisal summaries to review their quality.
Comments:	This exercise is currently in its sixth year of being carried out and last took place between July-September 2023. We use the appraisal summaries for those doctors who were revalidated in the last year. We have seen an improvement in the quality of our appraisal summaries in the previous years. We provide feedback of the results of this exercise at our appraiser networks which we run 4 times a year. This is an internal peer review process, and we are currently liaising with another organisation to explore Trust to Trust peer review.
Action for next year:	To continue to undertake a peer review of a selection of appraisal summaries to review their quality and improve our processes.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Action from last year:	Continued with the process below.
Comments:	We provide exit reports for agency locum doctors that have worked with us for a minimum of 3 months upon leaving the Trust, which states details of any leave / sickness / complaints / investigations and comments from line managers. Longer term locums are provided with time to complete the CPD. We provide supporting info to all our doctors (including those not prescribed to us) to enable them to input into their appraisal. For TEWV employed locums they are provided with software to access appraisals, coaching, CPD etc.
Action for next year	Continue with the process above.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	We continued using our own process (Appraisal 2016 model) for collecting evidence for appraisal.
Comments:	We are currently looking at using the Appraisal 2022 model template and this will be implemented in due course.
Action for next year:	Implementation of Appraisal 2022 model template.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year	No Action.
Comments:	We have an appraisal policy and procedure in place which is followed in this instance.
Action for next year:	No action identified.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	No action is required, Policy Review due in 2025.
Comments:	Yes. Our Trust appraisal policy and procedure were last updated in August 2022 and were approved at the Medical Directorate management meeting. The policy and procedure follows national guidance.
Action for next year:	Policy Review due in 2025.

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	To continue to monitor the number of appraisers to ensure we always have enough to cover the appraisal cycle.
Comments:	There were 49 appraisers for 247 Doctors in 2023 – 2024. Unfortunately, due to a variety of factors we have seen a reduction in our appraisers this year. These include retirement, long term sickness and work pressures.
Action for next year:	Currently trying to identify new appraisers due to the increase in IMG and Trust Doctors.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Action from last year:	Training Sessions continued to be held for Appraisers.
Comments:	Yes, we normally hold four training sessions a year, of which appraisers must attend at least two. These are held in June, September, November and February. We also provide feedback to appraisers from appraises and these are discussed at the appraiser's own appraisal.
Action for next year:	To continue providing training sessions.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	To continue with the process below.
Comments:	We follow a process whereby a group of appraisers undertake a peer review of appraisal summaries from the previous revalidation year, the findings are then fed back to the medical directorate management group and our appraiser group. Our appraisal process is quality assured through the use of feedback questionnaires following appraisal and then a report is collated for each appraiser at the end of the appraisal year.
Action for next year:	To continue with the process above.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Action from last year:	N/A

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	We ensure that all fitness to practice recommendations are undertaken in a timely manner and where this is not possible we record the reasons and actions taken. Good communications exist with no concerns raised from either side. In addition regular meetings occur between the Responsible Officer and the GMC's ELA which are minuted – these allow for ongoing concerns and low level concerns to be regularly reviewed.
Action for next year:	To continue with the process above

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Action from last year:	N/A
Comments:	Doctors are informed following the Revalidation Meeting of the recommendation, this is confirmed in a letter from Dr Kale. In terms of any deferrals or non-engagement these would have been discussed in advance of a revalidation meeting.
Action for next year:	To continue with the process above.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	N/A
Comments:	There are effective and well established processes in place for pre-employment checks, medical appraisal and revalidation, and responding to concerns. Within this, roles and responsibilities are clearly defined. The medical directorate has dedicated expertise and is adequately resourced to carry out its function.
Action for next year:	Above process to continue.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Action from last year:	N/A
Comments:	There is a disciplinary policy for maintaining high professional standards. Issues around conduct and performance can be identified from multiple sources, including formal complaints, SUIs, Guardian of Safe Working, and the Freedom to Speak up Guardian, Monitoring of any conduct and performance issue is undertaken within the medical development team. Processes are in place to allow this to be done under a variety of different formats, depending on the seriousness of the concern e.g. low level concerns and disciplinary investigations. The department receives Complaints (when available) and SUI reports each month and this is documented on the supporting information which is sent to doctors ahead of their appraisal. All doctors have a line manager who monitors performance.
Action for next year:	To continue with the above process.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Action from last year:	N/A
Comments:	Supporting Information template is populated 1-2 months in advance of the appraisal and uploaded into the SARD Portfolio. Supporting Information includes; Sickness, SUI's,& Complaints, Educational Events attended, Appraiser Details where appropriate.
Action for next year:	We continue to update the Supporting Information template as and when necessary.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	N/A
Comments:	We have a Dealing with concerns affecting Medical Staff Policy which deals with Low Level Concerns and more serious investigations.
Action for next year:	To continue to use the above policy and if necessary, update accordingly.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Action from last year:	N/A
Comments:	In our annual report to the Board, we include an analysis of the number of disciplinary cases/low level concerns, type, outcome as well as an analysis of the protected characteristics of the doctors concerned. We now have a quality assurance process in place, though no concerns have been raised and no appeals have been made regarding either process of outcome when we have responded to concerns
Action for next year:	To continue to follow the above.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Action from last year:	N/A
Comments:	We complete an MPIT form for doctors who work for us and are connected to us to pass to a doctor's new organisation. The medical development team inform the RO of any concerns, who would then directly contact the doctor's new Designated Body. If there are issues concerning agency doctors, we would contact the agency and ask that our concerns are discussed with their RO. If they wanted to discuss with our RO we would arrange this.

Action for next year:	To continue to follow the above.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	N/A
Comments:	All doctors have clinical manager supervision, annual appraisal and annual job planning. Quality assurance systems are in place checking our processes. The medical revalidation team are part of the medical directorate which meets weekly for huddles and quarterly to discuss and agree issues in relation to appraisals and revalidation. All doctors are treated equally and any issues would be dealt with following our procedures. We have a complaints team and a dedicated medical development team that deal with all issues/concerns as they arise.
Action for next year:	To follow the above.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Action from last year:	N/A
Comments:	Our governance arrangements and assurance processes for doctors employed by TEWV remain robust and fit for purpose.
Action for next year:	We will continue to ensure our processes remain fit for purpose.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	N/A
Comments:	Our appraisals are now more nuanced to reflect each profession's standards and development needs. Professional input is requested for disciplinary processes where professional standards are being queried.
Action for next year:	To continue with the above

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	N/A
Comments:	Yes, we ensure that all six NHS pre-employment check standards are completed. This is done by medical staffing.
Action for next year:	To ensure all pre-employment check standards are completed.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Action from last year:	N/A
Comments:	Yes, there is quarterly Leadership Timeout Sessions which explore quality, safety, learning from other organisations, Freedom to Speak Up. The Trust has undertaken a Culture Audit. Weekly bulletin and monthly Medical Directors Webinar support this agenda. The Trust has launched Show Racism the Red Card from September 2024. The restructure set up a formal expectation that our decision making would be clinically led, with clinical networks for each specialty to support. Our nursing and governance team developed and led the culture of care tool which is peer led by clinicians across our services. This links to our culture on a page oversight and our speak up group where representatives from teams come together to highlight any low level concerns they have about any teams. We engage with clinical leaders and managers in the same way that we engage with operational leaders – through quarterly events (recently covering organisational learning, quality, safety, learning from other organisations), and a core three year leadership and management development programme. The Freedom to Speak Up Guardian speaks at Senior Medical Staff Committee as well as Trust Board and our People Committee.
Action for next year:	To continue with the above. All new clinical leaders will now take part in the new managers programme to ensure that all senior staff have the same understanding of how the 'national expectations of senior managers' resources can support all our development.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Action from last year:	N/A
Comments:	All staff undertake necessary mandatory training and follow Trust Values and Behaviours as part of Our Journey to Change. We launched work with Show Racism the Red Card from September 2024, and invited clinical leaders from our BAME staff network to introduce this work and speak to board. We report all our statutory data but add extra monitoring to ensure we track all the experiences of our staff including through our employee relations processes which are reported to board. Staff networks are discussed at trust welcome session so that all staff know the opportunities for being part of the networks. Anti discriminatory training, upstander training and EDI champions are a key part of our work this year, with involvement in developing that work with clinicians from our staff networks. Staff and patients share stories of the organisation at committees and board on a regular basis.

	All staff networks have an exec sponsor and chairs meet with the director of people and culture every other month. The mandatory leadership and management programme includes work on understanding our impact on others, who we in/exclude, the way we behave in line with values and any access to wider development programmes requires evidence of paying it forward to colleagues and doing something to tackle health and social inequality,
Action for next year:	To continue with the above. Work is underway to look into why some groups are over-represented in our disciplinary processes.

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Action from last year:	N/A
Comments:	In addition to comments above, we have a transparent process in place including the deputy director of People and Culture and the NED champion for any individual who believes they have experienced detriment as a result of speaking up. All senior staff undertake a values and a knowing yourself workshop. The organisational learning group is chaired by one of our clinical executives. The clinical executive triumvirate lead on multiple forums to ensure clinical and professional standards are consistent and embedded.
Action for next year:	To continue with the above.

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Action from last year:	N/A
Comments:	Yes. Connected Doctors are able to provide feedback directly about their individual appraisal and also the general process for appraisals. In relation to Job Plans, doctors are able to escalate issues to the Job Planning Lead / Associate RO. All doctors can make complaints through the formal process or raise concerns through their team structures. The deputy director of people and culture and the associate director of medical development meet regularly to ensure our processes are consistent. The associate director of medical development is a member of the speak up group and the executive people and culture sub group to ensure that professional work is joined up across the organisation.
Action for next year:	To continue with the above.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Action from last year:	N/A
Comments:	We monitor information on all our Doctors involved in any concerns and quality information is provided as part of our MWRES return.
Action for next year:	To continue with process above.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Action from last year:	N/A
Comments:	Attendance at Regional Appraiser Networks and RO meetings, contacts made with other Trust colleagues to share information and best practice.
Action for next year:	To continue to attend Regional Appraiser Network meetings and RO meetings and continue to share best practice.

Section 2 – metrics

Year covered by this report and statement: 1 April 2023 – 31 March 2024 .

All data points are in reference to this period unless stated otherwise.

2A General

The number of doctors with a prescribed connection to the designated body on the last day of the year under review. This figure provides the denominator for the subsequent data points in this report.

Total number of doctors with a prescribed connection on 31 March	247

2B – Appraisal

The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions is as recorded in the table below.

Total number of appraisals completed	187 and 23 Priming Appraisals
Total number of appraisals approved missed	7
Total number of unapproved missed	1

2C – Recommendations

Number of recommendations and deferrals in the reporting period.

Total number of recommendations made	57
Total number of late recommendations	4 (contact made with the GMC to advise in advance).
Total number of positive recommendations	52
Total number of deferrals made	5
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0

2D – Governance

Total number of trained case investigators	Relatively few investigations each year. Individual training is provided to case investigators as they are appointed
Total number of trained case managers	Relatively few investigations each year. Individual training is provided to case investigators as they are appointed
Total number of new concerns registered	5 (2 Investigations & 3 Low Level Concerns)
Total number of concerns processes completed	4
Longest duration of concerns process of those open on 31 March	2 months
Median duration of concerns processes closed	5 months
Total number of doctors excluded/suspended	0
Total number of doctors referred to GMC	0

2E – Employment checks

Number of new doctors employed by the organisation and the number whose employment checks are completed before commencement of employment.

Total number of new doctors joining the organisation	128
Number of new employment checks completed before commencement of employment	104 (24 of these came directly from overseas and started without a DBS)

2F Organisational culture

Total number claims made to employment tribunals by doctors	1
Number of these claims upheld	Ongoing
Total number of appeals against the designated body's professional standards processes made by doctors	0
Number of these appeals upheld	N/A

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
SARD is due for renewal in October 2024, and it has been agreed to extend the contract to October 2025 during which time discussions will be taking place in relation to looking at what other electronic systems are available. Any future changes will require input from medical colleagues and senior managers as to what would be the most appropriate way forward. We are currently working with SARD to implement the changes from the Good Medical Practice 2024 update.
Actions still outstanding
• None
Current issues
• We have had issues in trying to recruit new appraisers, despite promoting and seeking support from medical colleagues, this is an ongoing issue that needs to be resolved.
Actions for next year (replicate list of 'Actions for next year' identified in Section 1):
• Medical Revalidation Policies and Procedures to be reviewed in August 2025. • To continue to undertake an internal peer review of a selection of appraisal summaries to review their quality and improve our processes. • To liaise with another organisation to consider external peer review. • Currently trying to identify new appraisers due to the increase in IMG and Trust Doctors.
Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):
• Our governance arrangements and assurance processes for doctors employed within TEWV remain robust and fit for purpose.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Tees, Esk and Wear Valleys NHS Foundation Trust

Name:	Brent Kilmurray
Role:	Chief Executive
Signed:	
Date:	

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Tees, Esk and Wear Valleys NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 10 October 2024		
Date of last meeting: 5 September 2024	**Report of: The Quality Assurance Committee**	
	Quoracy was achieved.	
1	**Agenda -** The Committee considered the following matters: • Summary of the Executive Review of Quality Group meetings: 25 July and 29 August 2024 • Integrated Performance Report (IPR) • CQC Activity and delivery of the CQC Improvement Plan • Quality Assurance and Improvement Programme and NICE Guidance Implementation Update (May – July 2024) • Trust Quality and Learning Report • Trust Position against the NICHE Independent Reports and update on NICHE Quality Assurance Review – Phase II Commercial Offer Process • North Yorkshire & York Clinical Outcomes • Feeling Safe Measures • Learning from Nottingham HealthCare NHS FT • Assurance Report on Access to Services/waiting times in North Yorkshire & York • Learning from Deaths Quarterly Reports: For Information: • *Quarterly Physical Healthcare Progress Report* • *Quarterly Environmental Risk Group Report* • *Quarterly Pharmacy and Medicines Optimisation Update Report* • *Quarterly Safeguarding and Public Protection Report* • *Quarterly PSIRF Progress Report* • Complaints Benefits Realisation Work • Regulation 28 Report • Corporate Risk Register • Board Assurance Framework • Organisational Learning Group Terms of Reference • Review of the Committee Workplan	
2a	**Alert**	The Committee alerts the Board on the following matters: **From the DTVF Care Group:** • Trustwide bed occupancy at 103% in July, with AMH occupancy over 108%. QAC will start to look at bed flow as an escalated risk. • Reported breaches with 72 hour follow ups continue to be mostly data quality issues which are manually checked. All patients known to be safe and more attention will be put on understanding the cause of the data quality issues. • DTVF not always getting necessary response from Police when there are incidents of violence and aggression. • Seven episodes of mechanical restraint in June, due to Ministry of Justice orders during escort to acute Trust. • Acuity remains high on Cedar with incidents of violence and aggression. Staff feel supported by the organisation, however don't feel listened to by the Police. **From NYY Care Group:** • Three breaches of mixed sex accommodation. One for a transgender person, which was very much a person-centered decision, two on Moorcroft due to technicality of using the female corridor for a male patient. (could be described as over reporting). Further focus needed to understand if this is a reportable breach. • One brief incident of prone restraint due to person positioning themselves in prone. **Other business matters:** • Level loading of annual leave allocation to prevent avoidable peaks in unavailability to work requires increased focus, in addition to parity allocation of weekend and night shifts between substantive and temporary staffing. • The committee has agreed to a full review of the impact of the CQC improvement actions to consider if we are bringing about the intended improvement.

		• Although improvements have been made in sharing leave plans with families there is room for improvement and there is inconsistency across teams. Improvement work is being monitored. • There is a need to better understand the impacts on care when teams are in business continuity, this will be an area of focus for the QAC.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** DTVF: • Significant improvements for call answer rates for 111(2), which improved in July to 91%. D&D crisis call answer rate 72% and Tees 75%. • One patient who was nurses in long term segregation in SIS has now transferred to Rampton Hospital. • No mixed sex breaches. • One patient being nursed in a SIS seclusion room with the ALD team from Bankfields has now been transferred to a medium secure service. NYY: • Compliance with mandatory/statutory training 86.69%. **Other business matters:** • Good engagement with NICHE assurance review process. • 100% compliance achieved for review of risks in the Corporate Risk Register. • There is good assurance of reporting and learning in line with national guidance for learning from deaths. • Quarterly reports received for information with good assurance included: Environmental Risk Group, Pharmacy & Medicines Optimisation, Safeguarding and progress with PSIRF. • There is good assurance following the PALS and Complaints review. There is a 42% reduction in the volume of formal concerns raised and overdue formal complaints have reduced by 16%. • Good assurance that we are responding to HMC Regulation 28 notices, the one open Regulation 28 received in August is due for response by 11 October. • The CRR was reviewed. Four risks assigned to the QAC have remained static for a year. Risk owners asked to review and update in October. • QAC has asked the Organisational Learning Group to review the assurance on learning.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** **NYY:** **DTVF:** • Tear proof clothing used on two occasions, one in SIS and one on Cedar ward following a patient known to conceal weapons in the seams of their clothes. **Other business matters:** • The Care groups are continuing the work to establish a small set of metrics to interrogate to enable a more nuanced understanding of the 'are you feeling safe' question. • A detailed paper was taken to articulate the waiting times for children and young people in NYY. Board are sighted on this this via IPR however, it is a cause for concern. • The workplan for the Quality Assurance Committee is under review taking advice from Deloitte's and the outcome of discussions at the QAC developmental day in May with implementation in October. The workplan will focus on fundamental standards of care and safety, escalated risks, gaps in assurance, quarterly/six monthly reports for information with Executives raising any risks. • In response to the special review of MH services at Nottinghamshire Healthcare NHS FT and the recommendations, TEWV is completing a non-mandatory

		assessment framework to take stock and understand if there are any gaps/risks in services. QAC will have oversight. • A Trust response will be prepared following a safety alert from NENC ICB linked to the treatment of people with learning difficulties. This will report to next month's meeting.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that risks to quality are understood and are being managed appropriately. Committee considers that bed flow, high bed occupancy (uncommissioned), high acuity and long waiting lists is a concern and directly impacting on quality care.
3	**Actions to be considered by the Board**	That the Board: i) Note the report. ii) Note the concerns linked to bed flow, high occupancy levels and the direct impact on quality of care.
4	**Report compiled by**	Bev Reilly, Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Executive Chief Nurse and Donna Keeping, Corporate Governance Manager

Committee Key Issues Report		
Report Date to Board of Directors – 10th October 2024		
Date of last meeting: 4 October 2024		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda -** The Committee considered the following matters: • Summary of the Executive Review of Quality Group meeting: 26 September 2024 • Integrated Performance Report (IPR) • Organisational Learning Group – theme of learning • Research and Development • Plans to reduce restrictive practice – Three Year Strategy • Community Transformation • Safer Staffing • Access to services (DTVF) • Learning from Nottinghamshire MH FT • Response to NENC Safety Alert – patients with a learning disability/care on intensive care units • Board Assurance Framework • Internal Audit Recommendations Progress • Annual Committee Evaluation Tool 2023/24 • Committee Workplan	
2a	**Alert**	The Committee alerts the Board on the following matters: **From the DTVF Care Group:** • Bed occupancy is in adult mental health is consistently above 100% and is potentially impacting on patient experience and staff. • Safety summaries are not consistently being saved in the right place (proactively identified by QA schedule), some of this relates to CiTo. • There were 13 occasions with 72 hour follow up was not completed. All have been contacted and are safe. One person did not receive a 72 hour follow up and we have been unable to contact them, this is a recognised pattern. There was significant consideration given to understanding the data quality issues. • Two prone restraints occurred and have been considered closely to ensure safety of the service users and learning. • The prevalence of deliberate self-harm including multiple uses of ligatures on PICU and female wards has significantly increased. Staff are being supported with practice and the psychological impact of the work. **From NYY Care Group:** • There were two episodes of seclusion in a non-designated area, which were clinically appropriate decisions. • Additional focus on a recruitment campaign for C&A community posts is necessary. • Tear proof clothing was used to preserve personal privacy and dignity. **Other business matters:** • Focussed discussion on waiting times for people to access treatment and assessments. Need to be clear about what is within the gift of the Trust and where additional commissioning conversations are necessary. The importance of community transformation to address some of the issues was discussed.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** DTVF: • No mixed sex accommodation breaches. • Strong assurance of improvements made on Birch ward. Provider collaborative has agreed to reduce oversight and increase the bed base. NYY:

		• There have been no mixed sex accommodation breaches. • Compliance with mandatory/statutory training 86.98%. • No prone restraint. • No use of agency staff on Esk and Danby ward for any registered nurses and the adult mental health wards in NYY are almost fully staffed with registered nurses. **Other business matters:** • The Positive and Safe three-year strategy was approved. The level of assurance is substantial, with leaders committed to making continuous improvements to eliminate the use of restrictive practices. Committee will monitor progress with the aims. • A clear six-monthly progress report from Research and Development provided good assurance that the Trust is compliant with the UK policy framework for health and social care research (2017), is meeting the required quality and governance standards and is promoting research across the Trust's geographies and specialties. • There is good assurance with the DTVF Community Transformation and reasonable assurance that NYYS care group are making progress. • There is good assurance evidenced that TEWV is complying with the system requirements and has a mechanism for implementing learning following the CQC Specialist Review of mental health services in Nottinghamshire NHS FT. • Although not applicable to TEWV services, the NENC System Safety Alert (NENCSSA1) the first of its kind by an ICB nationally which focuses on the care of people with a learning disability on intensive care units has been considered and the five requirements for Boards are met. (TEWV does not have a physical health emergency department or intensive care unit). • Internal Audit summary reports were considered. Substantial assurance was awarded for the audits Key Performance Indicator (KPI): the number of incidents of moderate or severe harm incidents, with no actions and for the NICHE Complaints review with one action now completed. • Good assurance awarded for the NICHE Action plan embeddedness. Two overdue actions are being targeted. • The Duty of Candour audit has been awarded reasonable assurance, with six recommendations to be taken forward. This is an improvement on the 2023 audit with more focus in the Care Groups needed. • The committee annual review suggested good assurance that the committee is meeting its obligations under the terms of reference and that governance is effective. Some areas for further improvement, in terms of using data more effectively and having the resources available to provide analysis will be considered over the coming months. A further Developmental day will be held in May 2025.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** **NYY:** • The level of progress with the Ripon ICT in BCP is not progressing as expected. There is oversight on the delays to access services and 'keeping in touch' gives us a trigger point for people who might need more timely support. • Following a death of an inpatient on leave from the NYY acute services, the leadership team are providing assurances of safety back to Exec Directors. **DTVF:** • A paper from DTVF outlined the challenges with access to services. The impact on quality is a matter for the Board to consider with specific reference to neurodevelopmental waiting times. **Other business matters:** • The Organisational Learning Group is developing momentum and supports our implementation of PSIRF. • Following the meeting, the first iteration of the new Quality Dashboard has been shared with Committee members. This iteration includes nine existing quality measures from the Trust IPD* and **nine new measures**. The three *remaining existing quality measure will be added.*

		• Committee noted an overview of the National Mental Health Inpatient Quality programme and the focused work being done within TEWV in response to this agenda. Central to this programme is the acceleration of new models of care that enable systems to harness the potential of people and communities within a citizenship model that promotes inclusion and respects human rights.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considers that good assurance can be provided that the risks to quality are understood and are being managed appropriately. Committee considers that the risks caused by high bed occupancy in the acute care pathway needs to be adequately narrated in the Board Assurance Framework.
3	**Actions to be considered by the Board**	That the Board: i) Note the report. ii) Note the concerns linked to the continued high bed occupancy levels over 100% and the impact on quality and safety. iii) Take good assurance that we understand the risks to quality and have plans in place to address this. iv) Should further consider our position in relation to patients waiting to access our care and treatment. v) Notes that the Committee have considered the static strategic risks in the BAF and action owners will be reviewing and refreshing progress.
4	**Report compiled by**	Bev Reilly, Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Executive Chief Nurse and Donna Keeping, Corporate Governance Manager

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	Board of Directors
Date:	10th October 2024
Title:	Teesside Adult Learning Disabilities Respite Care implications post notice period
Executive Sponsor(s):	Naomi Lonergan, Interim Managing Director, DTVF Care Group
Author(s):	Jamie Todd, Director of Operations and Transformation, DTVF CAMHS and ALD John Savage, DTVF ALD General Manager Phillip Darvill, DTVF ALD Programme Manager Jane Marron-Shepherd, DTVF ALD and CAMHS Business Manager

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*
4	**Quality of Care**	The Trust needs to ensure that the service continues to provide the highest quality of care for people.
9	**Partnerships & System working**	The ICB will lead on next steps and the Trust will work proactively with them to ensure there is no gap in provision.
13	**Public confidence**	There is a risk that ongoing/adverse scrutiny could lead to a reduction in public confidence in the service.

Executive Summary:

Purpose:	The purpose of this report is to provide an update to the Trust Board on the plans in place to support families and staff through the transition of the current Teesside Respite service into the future model.
Proposal:	This paper sets out some of the key next steps and timeline alongside ongoing support to families and staff throughout development of and transition to new arrangements across the

Tees Valley for Adult Learning Disability Respite provision.

Overview:

Following significant discussion and agreement, on the 20th September the Trust formally shared a letter with the Integrated Care Board (ICB) serving notice on the Teesside adult learning disability respite services provided out of Aysgarth in Stockton and Unit 2 at Bankfields Court in Middlesbrough. As has been briefed previously, this is in order for the ICB and wider system to engage in a full review of current provision and support the development of new models of care that can improve the quality of service provision by addressing the growing difficulties the trust has faced with regard to sustainability, access and environment. Confirmation of receipt and acceptance of this letter has been received from the ICB.

As a result of the submission of the notice letter, the ICB have commenced engaging with families to determine the most appropriate future model that will meet the needs of each family. Whilst the ICB are developing the new model, the Trust will continue to provide the current respite service to families.

Prior to the submission of the notice letter, the Trust and ICB invited families to attend an information engagement event on the 6th September in order to share and engage in the development of the service and the subsequent process. The engagement also allowed for families to discuss and share any concerns and for the Trust and ICB to give reassurances regarding continuing delivery of respite. Subsequently the ICB have held additional information engagement sessions during the week commencing the 9th September. As part of the formal engagement families will have the opportunity to discuss their own individual needs with the ICB so that future provision can best be developed to meet need and enhance choice. This will continue over the coming months enabling the ICB to develop a model that meets these needs. Families will also receive regularly updated question and answer fact sheets.

Staff were also updated at separate information engagement events on the 6th and 9th September, hosted by the Trust. A regular update meeting has been scheduled for the 4th Friday of each month to provide information to staff. Any urgent information will be shared if needed.

Prior Consideration and Feedback

The decision to serve notice has been considered through EDG, the DTVF Care Group Board, LCC and JCC. Additionally further scrutiny has been applied to plans in September via the Tees Valley Joint Health OSC with an aim to provide a further update in January 2025.

Implications:

Upon serving notice, the trust has a contractual requirement to continue providing the service for the next 12 months with the formal date of expiry of notice being the 19th September 2025. However the Trust has maintained a commitment with both the ICB and families that, where it remains safe to do so, the Trust will extend the notice period beyond 12 months in support of a safe and effective transition.

There is a commitment from the ICB to develop and deliver a specification for future provision that is co-created and in line with needs described by families. Therefore, at this time, there remains a number of unknown factors relating to the future service model and provision which will be informed by continuous engagement. Assurance can be given that as the model emerges the Trust will work actively with the ICB and families to ensure a safe and effective transition of care and provide necessary support to our staff.

From an internal perspective our key next steps involve:

- Continuous engagement with families, staff and ICB colleagues through the steering group.
- Further development of the quality impact assessment to ensure any quality risks are identified and mitigated.
- Ongoing monitoring of business continuity metrics to highlight reductions in key performance indicators that will impact service delivery.
- Engagement to commence with Estates department regarding the de-commissioning of ALD use for respite of Aysgarth and Unit 2
- Prepare an exit strategy once model of care is known

Recommendations:

Trust Board are requested to note the update and key steps within this report and take assurance regarding the process outlined as a roadmap to support effective exit and transition from current service arrangements.

Tees, Esk and Wear Valleys
NHS Foundation Trust

An update on respite care

Board of Directors Oct 24

Respect Compassion Responsibility

journey to change

Introduction

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- The Trust currently provides respite provision and support to people with a learning disability with complex needs from Bankfields Unit 2 in Middlesbrough and Aysgarth in Stockton.

- These services Currently support 70 families across the four Local authority areas and offers up to 33 days overnight respite provision per year.

- Ongoing challenges have been experienced in the ongoing delivery and improvement of services over time, some of which identified through inspection activity, with particular concerns relating to the environment and increasing complexity of meeting service user needs flexibility and sustainably (I.e. mixed sex accommodation) and our ability to invest in the changes required alone.

Why do things need to change?

Tees, Esk and Wear Valleys NHS Foundation Trust

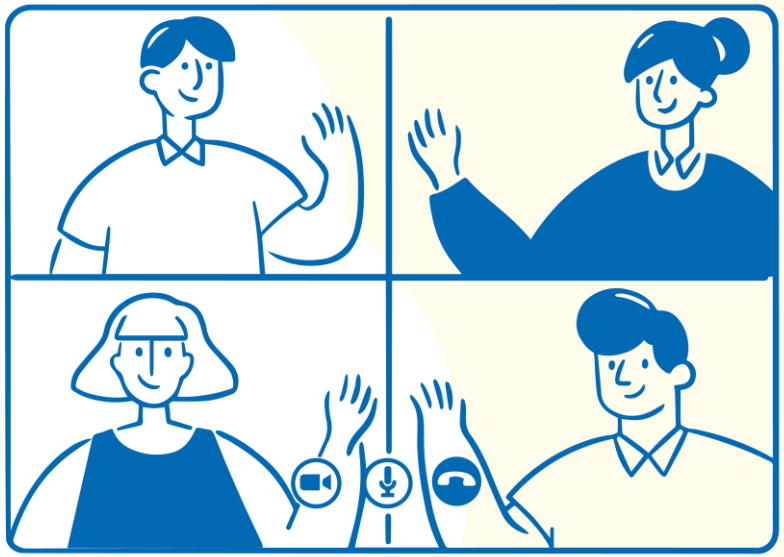
Most importantly, we need to ensure that the service continues to provide the highest quality of care for people.

We also need to make sure:

- Our buildings are providing the best environment to care.
- We comply with regulations set out by the Care Quality Commission (CQC).
- There is enough staff to provide safe and kind care.
- The service offers value for money so we can support more families that need this service.

What's already happened?

- A project group was established and looked at options on the potential future for the respite service.
- Unfortunately, none of these options were considered viable.
- We are not able to make changes on our own, the ambition is to create something better working together with our partners.
- An engagement event took place on the 6th of September with families, ourselves and the ICB to describe the planned changes, to listen to any concerns from families and describe the next steps of the process



- Staff were also updated at separate information engagement events on the 6th and 9th September, hosted by the Trust. Further, regular update meetings for staff have been scheduled for the 4th Friday of each month.

Ongoing Engagement

NHS
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NHS Foundation Trust

- Our trust submitted notice of current Tees Valley respite provision as planned on the **20th September 2024** and this was acknowledged by the ICB formally. Contractually this requires a minimum of 12 months notice.

- **September 24** – Trust and ICB leads attended the Tees Valley Joint Health Overview and Scrutiny Committee to describe planned changes and the process that would be undertaken to support families and conclude the review and service re-provision

- **October 24** – CEO, Trust and ICB leads held positive engagement meeting with Andy McDonald MP and a small number of service user / carer representatives to discuss the changes and to discuss any concern and next steps.

Next Steps…Planned Timeline

NHS
North East and North Cumbria

September 2024

- Meet the Commissioning Team Events
- Survey launched by Inclusion North (IN) and Skills for People (SfP)

October 2024

- Listening starts by SfP and IN – Commissioners present and available

November 2024

- Data collated
- Draft report to be shared

December 2024

- Feedback to people/ families
- Final report to be produced

January 2025

- Finalised report to ICB from IN and SfP
- Development sessions to start
- Co-production of future provision

February 2025

- Possible market engagement

April 2025

- Possible procurement

Introduction meeting with the ICB team

Meet the ICB Commissioning Team events held

- Face to Face: 11th Sept - Stockton, 12th Sept - Middlesbrough, 13th Sept - Redcar and Cleveland
- Online Event 16th Sept
- We have also offered 1:1 sessions with families who can't make the sessions either by phone or face to face
- Email and Telephone numbers of commissioners provided to all families

Informal Sessions in the community held to:

- Introduce the ICB commissioning Team
- Provide an overview of the ICB role and responsibilities
- Find out how families want to be part of developing future respite plans, communicated with and updated
- Introduce the Independent Listeners Skills for People and Inclusion North and their role
- Leaflet about IN and SfP shared in letter and at events
- Set out timelines for families and what happens next
- Questions and Answers – Recorded and FAQ to be developed from this to share with people who didn't attend

Listening Engagement Events
Independent providers facilitating the events

- **Inclusion North (IN) and Skills for People (SfP) have been commissioned to jointly carry out an independent listening exercise**
  - IN and SfP are 2 not for profit organisations, whose work includes providing information, guidance, advocacy, awareness raising, support people to influence health and care services.

- **IN and SfP are planning**
  - 6 events all face to face 3 hrs each, 2 in each area Stockton, Middlesbrough and Redcar and Cleveland
  - 3 Online sessions to be held in the evenings

- **Content will include:**
  - Brief information sharing
  - Group discussion
  - Face to face - Chance to speak to ICB commissioning team or IN/SfP rep on a 1:1 basis
  - Online – Opportunity to ask questions and discuss as a group

- **A survey both online and paper**

- **An opportunity to speak 1:1 to a member of staff from SfP or IN by phone or by zoom**

Development session in the New year

- Feedback from the listening engagement report
- Set out how we will co-produce respite support
- Service user representatives in project group to support design and specification of any service we may need to procure
- Consider the need for market engagement for future support dependent on feedback

On-going engagement with commissioning team via a Project Group

- **Set up a service users, families and carers project group to enable a collaborative approach to developing future respite provision**

- **The families project group will meet regularly (minimum once a month)**

- **We will feedback to families via their preferred route**

- **Joint Tees Valley Health Scrutiny Committee (All TBC)**
  - January following engagement to update on the findings
  - April with identified solutions and possible Market Engagement outcomes
  - July with potential procurement scenarios

What happens next …

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

- We will keep working with families and our partners to provide the highest quality of care.

- Committed to provide respite over the next 12 months and work with the ICB and families to ensure there is no gap in provision, even where this may take longer than 12 months and is safe to continue to do so.

- Our ICB colleagues will lead on the next steps. They will work with families to develop a service that understands and supports needs and addresses key challenges. We will work in partnership to agree an appropriate exit strategy and timeline for this as the outcome from the engagement process emerges.

- We will continue to communicate with families, staff, people in the health and social care sector and MPs.

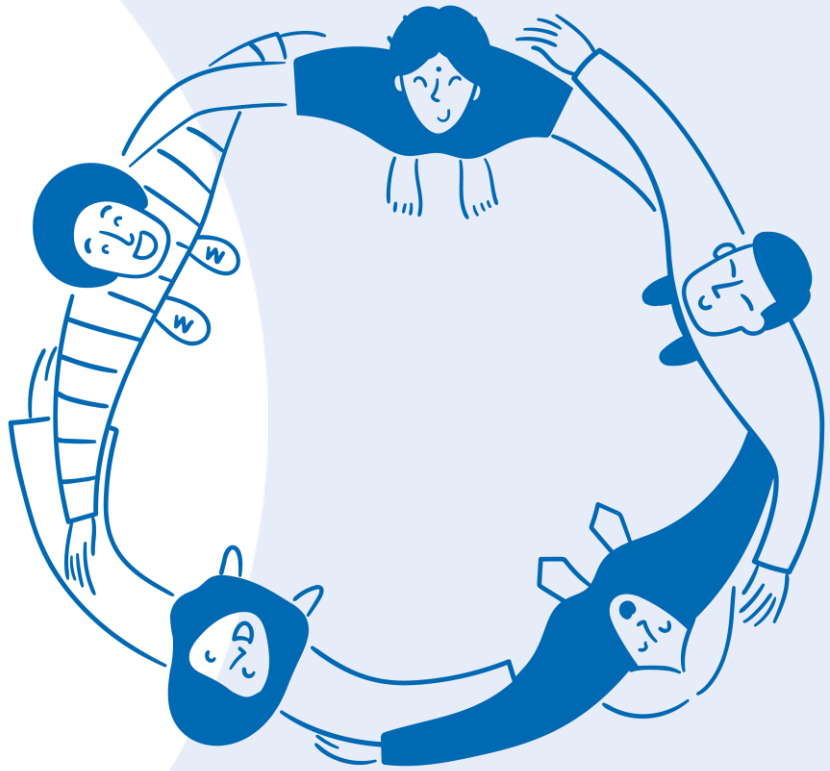
In summary

- These changes are about making sure that the service continues to provide the highest quality of care for people.

- TEWV is committed to providing respite over the next 12 months and support a transition to the new provision.

- Developing a future service that provides families with the highest quality of care needs a system-wide approach – involving families, colleagues and partners.

- Continue to support staff through any necessary organisation change



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Tees, Esk and Wear Valleys
NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report	
Report Date:	10 October 2024
Date of last meeting:	2 September 2024 – committee was quorate

1 **Agenda: The Committee considered the following agenda items during the meeting**

- CQC Mental Health Act Monitoring Activity
- Discharges from Detention
- Section 136 - Police emergency powers to take a patient to a place of safety
- Section 132b – Information to detained patients including reading of rights
- Section 5 MHA 1983 (Holding Powers) Report
- Section 18 Absent without Leave (AWOL)
- Notification of Discharge by nearest relative
- Quarterly Positive and safe Improvement Plan
- NYYS and DTVF Multi Agency Mental Health Legislation Operational Group Reports
- Summary Report from the Internal Mental Health Legislation Operational Groups
- Case Study
- Mental Capacity Act/Deprivation of Liberty Safeguards
- Revised policies: 136 Policy, 135(2) Procedure: Advance Decisions and Statement and Section 17
- Revised Workplan 2024/25
- MHLC Annual Report 2023/24
- Scheme of Delegation – for approval
- Annual Committee Performance Evaluation 2023/24
- Workplan 2024/25

2a **Alert: The Committee alerts members of the Board to the following:**
(See confidential board agenda)

2b **Assurance: The Committee assures members of the Board on the following:**

- The number of uses of the Mental Health Act has remained within common cause variation during the reporting period.

- The first couple of meetings have taken place for the newly established interagency MH Operational groups, led by the two care groups. The purpose of the groups is to take a proactive role and actively engage with partners, including the two ICBs and various local authorities to help influence service transformation and improve the health of the communities we serve. The terms of reference have been produced for both groups.

- **CQC MHA monitoring Annual Report and quarterly report** – there is good assurance regarding the oversight of inspection activity and completion of actions. In August, there were 9 actions outstanding over 31 days from the MHA inspections involving five inpatient wards in DTVF. Committee were given reassurance that the monitoring and oversight of these actions is through the care groups and up to the Quality Assurance Committee.

- **Discharge from detention -** There is substantial assurance that the number of times detained patients are discharged by the tribunal or hospital mangers is within normal range. During April to July there was one discharge by the Hospital Managers and ten by the Tribunal, with only one patient re-detained under the MHA following a change in presentation. Work is ongoing to try and centralise this reporting to give access to the care groups, however there are no hotspots or concerns.

- **Section 136 –** There is a good level of assurance that the legislative requirements for patients held in the Trust on a s136 are being met in all areas. There were five patients where there was no evidence recorded of rights being read.

	Data cleansing is underway as there was a discrepancy with the numbers of S136 recorded by the mental health legislation team as an additional ten had been reported in IIC. An app was launched in June for the crisis services to start recording the use of S136 with ownership by advanced practitioners and op managers in urgent care services. During the reported period there had been 47 admissions to the S136 suites across the Trust. Potentially, there are differences in what has been recorded as an informal admission as there are high numbers of informal admissions (23). A task and finish group will review the process and recording of S136 and this will be reported through the Internal Mental Health Operational Group and considered before it reaches Committee. The Committee is keen to explore the impact of processes in following legislation that tells us that quality of care is improving. • **Section 132b –** there is good assurance that there is a robust escalation process in place for any patients who have not had their rights within three days of detention. In 973 detentions (760 in the last period), during this period the escalation process was used 128 times – 13% (16% last quarter). Twelve patients were discharged with no evidence of rights being read. (eight last quarter). Work continues with modern matrons to ensure process is being followed. The Internal Operational Group will be given access to the information going forward. To note: that due to changes in the MHL Committee schedule, the current report period covered an additional month, which accounts for the higher numbers compared to the previous report. • **Section 5 MHA 1983 (holding powers) –** there is good assurance on the use of holding powers (when a nurse may prevent a patient from leaving hospital if they consider it is necessary for their health or safety for a period of up to 72 hours). The Internal MH Operational Groups are focusing on understanding variation across services. There is a much higher use of Section 5 with female patients and this needs to be understood. Work is underway with the IIC developers to help refine this data to make it more meaningful and break down the use of section 5(2) and section 5(4) and to show how many section 5's were attached to each patient admission. • Absence without Leave (AWOL) – there is substantial assurance that the QCQ have been notified of all AWOL's that meet the statutory reporting criteria. One patient was AWOL for 34 hours after returning from authorised leave and was taken back into Police custody. • Notification of discharge by nearest relative – there is good level of assurance linked to the process followed when notification of discharge by nearest relative is received by the MHL department. Between 1 August to 31 July 2024 there were 11 notifications of discharge by nearest relative. Committee has sought further assurance on the details for the reasons behind the notifications. • Reasonable assurance on the implementation of the **Positive and Safe Improvement Plan** • **Mental Health Act/Deprivation of Liberty Standards (DoLS) –** there is reasonable assurance that the trust is meeting its requirements under the Mental Capacity Act and a reasonable level of assurance that the use and reporting of DoLS is being carried out as required. Overall compliance for MCA training throughout the Trust is at 86%. • The Committees Annual Report for 2023/24 was received with substantial assurance that the MHL Committee met its obligations set out in the terms of reference and the Scheme of Delegation.
2c	**Advise: The Committee advises the Board on the following:** • The **DTVF Multi-agency Legislation Operational Group** met for the second time in July 2024, with good representation from key stakeholders, including the Police and Ambulance service where issues/concerns are being raised to agree appropriate mitigating actions. The Group will share new guidance, best practice and changes in case law and provide assurance to the Mental Health Legislation Committee on compliance with statutory legislation. Good assurance can be seen through the identification of workstreams to look at the issue of delay in detained patients being allowed on ward and allocation of beds through the bed management review.

	Issues of Police not being able to access CAMHS Crisis team, update on the replacement of section 12 solutions and acute Trust colleagues to share MH strategy and DoLs or MHA guidance. • NYYS have not had quite the same level of take up from stakeholders at their MHL Operational Group and therefore there is reasonable assurance on trying to improve links with partners to understand the multi-agency operational issues. • Internal Mental Health Legislation Operational Groups – these new quarterly meetings, led by the Mental Health Legislation team, will include representation from clinical teams – including service development managers, practice development practitioners, modern matrons and clinical leads. Terms of reference have been agreed and initial workstreams include focus on multiple uses of Section 5. Both groups have requested further training on the Mental Health Act and the Mental Capacity Act Legislation, which will be targeted at PDFs and clinical leads. These groups will then provide assurance to the MH Legislation Committee on operational matters linked to legislation. • **The Scheme of Delegation** 2024 was approved, with no changes made since the last review in August 2024. It is recommended that the Board ratify the Scheme of Delegation. • The outcome of the **annual Committee performance evaluation 2023/24** was considered. Results were in the majority positive with some areas highlighted for future focus which include review of membership, the forward workplan, ensuring reporting is holding to account, rather than being operational and timing of meetings to fit the annual cycles of reporting. These points will be picked up at the Committee's Developmental Session. • The **Committee's workplan** was received. This will be considered at the Developmental Session in January 2025. • A **case study** was received. Committee would like visibility at meetings from the Lived Experience Directors who are invited and is considering hearing the views of patients at future meetings. • The 135 (2) procedure, Advance Decisions and Statement and Section 17 leave policy were approved. The Section 136 policy required further review and was deferred.
2d	**Review of Risks**	No additional risks were identified.
Recommendation: The Committee proposes that the Board of Directors: *i) Note the report and confirms the levels of assurance provided across reporting.* ii) *Ratify the Scheme of Delegation*		
3	**Actions to be considered by the Board:** There are no actions for the Board to consider.	
4	**Report prepared by***: Roberta Barker, Chair of Committee/Non-Executive Director, Kedar Kale, Executive Medical Director and Donna Keeping, Corporate Governance Manager*	

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**
Date: **10 October 2024**
Title: **Feedback from Leadership Walkabouts – July 2024**
Executive Sponsor(s): **A Bridges, Director of Corporate Affairs & Involvement**
Author(s): **A Bridges**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All		The report highlights summarised feedback from leadership walkabouts in July 2024, which can contribute to the Board's understanding of strategic risks, quality of services and the operation of key controls.

Executive Summary:

Purpose: The purpose of this report is to provide the Board with high-level feedback from leadership walkabouts that took place in June 2024.

Overview:

1 **Background**

1.1 The Trust undertakes a monthly programme of regular leadership walkabouts to services. These visits are not inspections however offer an opportunity for teams to have conversations directly with Board members and Governors to raise any matters of importance.

1.2 Walkabouts provide an opportunity for Board to meet with teams to really understand the strengths of the service and consider the more challenging areas, and how we can work together to resolve these and co-create any potential solutions. Full feedback reports and actions are reported and monitored via Management Group.

2 Speciality areas visited

2.1 Leadership walkabouts took place on 29 July 2024 in across community services including perinatal, as well as rehabilitation wards and secure inpatient services including:

- Middlesbrough Adult Mental Health Community Hub, Parkside, Middlesbrough
- Princess Road Clinic, Malton, North Yorkshire
- Perinatal Services, Huntington House, York
- Willow Ward (rehab), West Park Hospital, Darlington
- Langley Ward (secure rehab), Health and Justice Services, Lanchester Road Hospital, Durham
- Nightingale Ward, Ridgeway, Roseberry Park Hospital, Middlesbrough

3 Key issues

- Strengths:
    - Our people: teams reported caring, compassionate and committed staff groups with strong multi-disciplinary approach offering good skills mix across most teams. Adaptable to change and open to developing and upskilling to support their patients and their carer's. Staff wellbeing was expressed as a priority.
    - Collaboration: working across different (eg inpatient/community) TEWV teams and wider partner organisations in voluntary and community sector for example in participating in community events, and primary care to support step down and packages of care. Good examples of where this is working well through various collaborative initiatives including pilot scheme to tackle drug/alcohol challenges and rough sleepers.
    - Dynamic environments: activities were really important to patients particularly in inpatient and rehab settings, and the flexibility and presence of activity coordinators were a real asset to support recovery, as well as responding to their individual needs.

- Challenges:
    - Staffing: vacancies, recruitment processes (delays) and in some teams staff sickness was a concern. Some of the latter related to caseloads and demand for services, and/or delays in discharge.
    - Training and development: some teams reported they would like better and more accessible to training and development for their staff (big geographical patch, different from one place). Felt that investing in our staff in this way would lift morale and feeling valued.

- Caseloads and discharge: related issues around caseload volume and sickness absence, as well as delays in discharge and domino effect on patient flow, and different approaches from others eg urgent care / acute and link with community transformation. Increased demand and support for neurodiverse referrals and treatment also challenging.

Recommendations: The Board is asked to:

- Receive and note the summary of feedback as outlined.
- Consider any key issues, risks or matters of concern arising from the visits held in July 2024.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**

Date: **10 October 2024**

Title: **Register of Sealing**

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: To advise the Board of the use of the Trust's seal in accordance with Standing Order 15.2.

Proposal: The Board is asked to receive and note this report.

Overview: The Trust's seal has been used as follows:

Ref	Document	Sealing Officers
435	Deed of surrender relating to Hartlepool Centre for Independent Living, Burbank Street, Hartlepool	Naomi Lonergan Managing Director – DTVF Care Group Phil Bellas, Company Secretary
436	Appointment of architect (CDM regulations) and principal designer (building regulations) relating to phase 2 remedial works at Roseberry Park Hospital	Naomi Lonergan Managing Director – DTVF Care Group Phil Bellas, Company Secretary

437	Appointment of structural and civil engineer relating to phase 2 remedial works at Block 1 and Block 9 Roseberry Park Hospital	Naomi Lonergan Managing Director – DTVF Care Group Phil Bellas, Company Secretary
438	Appointment of mechanical and electrical engineer relating to phase 2 remedial works at Roseberry Park Hospital	Naomi Lonergan Managing Director – DTVF Care Group Phil Bellas, Company Secretary
439	Appointment of fire engineer relating to phase 2 remedial works at Roseberry Park Hospital	Patrick Scott, Deputy Chief Executive Phil Bellas, Company Secretary

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

Recommendations: The Board is asked to note this report.