Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS
13 February 2025
1.30pm

Education Suite, Roseberry Park Hospital, Middlesbrough, TS4 3AF and via MS Teams

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 12 December 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 11 February 2025)*	Board	

Strategic Items

8	Board Assurance Framework Summary Report	Co Sec	1.45pm
9	Chief Executive's Report	CEO	1.50pm
10	Integrated Performance Report	DCEO	2.05pm

BREAK 2.35pm – 2.45pm

BAF Risk 1: Safe Staffing

11	Report of the Chair of People, Culture and Diversity Committee	Cmt Chair	2.45pm
12	Report of the Guardian of Safe Working	GoSW	2.55pm
13	Pay Gap Reports	EDfP&C	3.05pm
14	Equality Delivery System 2022	EDfP&C	3.10pm

BAF Risk 2: Demand
BAF Risk 3: Co-creation
BAF Risk 4: Quality of Care
BAF Risk 8: Quality Governance

15	Report of the Chair of the Quality Assurance Committee a. Niche Independent Assurance Review (for information)	Cmt Chair CN	3.15pm -
16	Learning from Deaths Report Quarter 3 2024/25	EMD	3.30pm
17	Patient Carer Race Equality Framework	EDoT	3.40pm

BAF Risk 10: Regulatory Compliance

18	Report of the Chair of Mental Health Legislation Committee	Cmt Chair	3.50pm

Governance

19	Board Assurance Framework (verbal)	Chair	4.00pm

Matters for Information

20	Register of Sealings	Co Sec	-

Exclusion of the Public

21	**Exclusion of the public:** The Chair to move: *"That representatives of the press and other members of the public be excluded from the remainder of this meeting on the grounds that the nature of the business to be transacted may involve the likely disclosure of confidential information as defined in Annex 9 to the Constitution as explained below:* *Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office holder or applicant to become an office-holder under, the Trust.* *Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.* *Information which, if published would, or be likely to, inhibit –* *(a) the free and frank provision of advice, or* *(b) the free and frank exchange of views for the purposes of deliberation, or* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*	Chair	4.10pm

BREAK 4.10pm – 4.20pm

CONFIDENTIAL SESSION

Standard Items

22	Minutes of the last confidential meeting held on 12 December 2024	Chair	4.20pm
23	Board Confidential Action Log	Chair	

Strategic Items

24	Chief Executive's Confidential report	CEO	4.25pm
25	Reportable Issues Log	CN	4.45pm

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

26	Finance update: a. 2024/25 Month 9 Finance Report b. 2025/26 Financial Planning update	EDoFE&F	4.55pm
27	Electronic Patient Record	CIO	5.10pm

BAF Risk 11: Roseberry Park

28	Report of the Chair of the Roseberry Park Hospital Sub-Group (for information)	Chair	-

BAF Risk 13: Public Confidence

29	Communications update	EDoCA&I	5.20pm

Governance

30	Report of the Chair of the Board of Director's Nomination and Remuneration Committee (for information)	Chair	-
31	Board Assurance Framework	Co Sec	5.30pm

Matters for information:

32	To receive and note the minutes of the meetings of the following committees: a. Quality Assurance Committee on 7 November 2024 b. Quality Assurance Committee on 25 November 2024 c. Quality Assurance Committee on 5 December 2024	Co Sec	-

Evaluation

33	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	-

David Jennings
Chair
7 February 2025

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

For information: Controls Assurance Definitions	
Substantial Assurance	Compliance with the control framework taking place. The control is being consistently applied. No remedial action required.
Good Assurance	A high level of compliance with the control framework taking place. The control is generally being applied consistently. Limited remedial action is required.
Reasonable Assurance	Compliance with the control framework taking place. The control is not being applied in a consistent manner. Some moderate remedial action is required.
Limited Assurance	Compliance with the control framework not taking place. The control is not being applied. Immediate and fundamental remedial action required.

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Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS HELD ON 12 DECEMBER 2024 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MSTEAMS

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
R Barker, Non-Executive Director
Z Campbell, Executive Managing Director, North Yorkshire, York & Selby Care Group
C Carpenter, Non-Executive Director
N Lonergan, Interim Managing Director, Durham Tees Valley and Forensic Care Group
J Maddison, Non-Executive Director
B Murphy, Chief Nurse
J Preston, Non-Executive Director and Senior Independent Director
B Reilly, Non-Executive Director and Deputy Chair
L Romaniak, Executive Director of Finance, Estates and Facilities
C Wood, Non-Executive Director
A Bridges, Executive Director of Corporate Affairs and Involvement (non-voting)
H Crawford, Executive Director of Therapies (non-voting)
S Dexter-Smith, Joint Executive Director for People and Culture (non-voting)
P Scott, Deputy Chief Executive (non-voting)

In attendance:
R Shah, DTVF Care Group Medical Director (on behalf of K Kale, Executive Medical Director)
P Bellas, Company Secretary
N Black, Chief Information Officer
K Christon, Deputy Company Secretary (minutes)
D Williams, Freedom to Speak Up Guardian (agenda item 15)
S Akowuah, Senior GP Education and Liaison Consultant (agenda item 18)
J Carlton, Senior GP Education and Liaison Consultant (agenda item 18)
H El-Sayeh, Director of Medical Education (agenda item 19)
H Lonsdale, Head of Medical Education (agenda item 19)
C Lanigan, Associate Director of Strategic Planning & Programmes (agenda item 28)

Observers:
S Adamson, Director of Estates, Facilities and Capital
K Evenden-Prest, Staff Governor
D Greenhalgh, Senior Director of Governance, Essex Partnership University NHS FT
H Griffiths, Governor
E Ross, Trainee Psychologist
S Theobald, Associate Director of Performance
D Katalenac Zovko, Registrar

24/25-140 CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed C Wood to the meeting following her appointment as Non-Executive Director and noted the attendance of R Shah, S Adamson and C Lanigan.

24/25-141 APOLOGIES FOR ABSENCE

Apologies for absence were received from K Kale, Executive Medical Director, K North, Joint Executive Director for People and Culture (non-voting) and J Robinson, Non-Executive Director; and from H Crawford, Executive Director of Therapies (non-voting) who needed to leave the meeting early.

24/25-142 DECLARATIONS OF INTEREST

None.

24/25-143 MINUTES OF THE LAST MEETING HELD ON 10 OCTOBER 2024

Agreed*: the minutes were an accurate record of the meeting.*

24/25-144 BOARD ACTION LOG

In discussion the following points were raised:

1. Z Campbell noted an improved position in relation to the 72 hour follow-up target, with progress reported to Quality Assurance Committee, and proposed that the action be closed. The Chair invited executive directors to confirm the position [action 83].
2. R Shah noted that a Trust wide outcomes improvement plan had been approved by Executive Directors Group and progress would be reported each month [action 136, patient outcomes].
3. S Dexter-Smith advised that People, Culture and Diversity Committee had reviewed the Board Assurance Framework and static risks and movement expected by March 2025. She also noted the Trust had access to North East North Cumbria dashboard data, which outlined how the workforce had changed in comparison to other organisations across the area [action 83].
4. It was proposed that the action log be updated to include: a glossary of terms, where abbreviations were included; progress against each action in the status column; completed actions, prior to removal; and timescales.

Action: K Christon/executive directors

24/25-145 CHAIR'S REPORT

The Chair presented the report, which outlined areas of focus for the previous two month period.

24/25-146 QUESTIONS RAISED BY GOVERNORS IN RELATION TO MATTERS ON THE AGENDA

None.

24/25-147 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

P Bellas presented the report, which provided information on risks included in the Board Assurance Framework to support discussion at the meeting. He noted an amendment to the target score for risk 6 [estate/physical infrastructure], which had increased to 12 due to the uncertain national financial position, as reported to and agreed by Resources and Planning Committee.

In response to questions from the Chair, P Bellas noted:

- The framework identified first, second and third lines of defence and aimed to provide assurance on the health of risks controls both individually and collectively. At present, it did not provide assurance on the appropriateness of each line of defence.
- Risks with the largest gap between actual and target risk score included safe staffing, digital – supporting change, data security and protection, and public confidence. Scores were proposed by the lead director, reviewed by Executive Directors Group and moderated via a board committee and could be accepted as realistic.

- Target scores for demand and financial sustainability had increased to recognise the ability of the Trust to influence the risk.
- There was a concern in relation to risks where the target score was above tolerance and it was not considered possible to reduce exposure via mitigation to an acceptable level. This included regulatory compliance and financial sustainability risks.
- As strategic risks, scores may be expected to remain high and would require significant work to change the score. Each risk had a trajectory for reduction in score, which had been reviewed by a board committee. At present all were on trajectory and scores for cocreation and public confidence were expected to reduce soon.

In discussion the following points were raised:

1. The Chair welcomed the summary provided of the current position and progress and noted that there were several risks that involved the wider system.
2. B Reilly, Chair of Quality Assurance Committee, welcomed that the report included a timely reflection of the discussion held by the committee the previous week.
3. It was proposed that points raised by the Chair be considered by committees.

24/25-148 CHIEF EXECUTIVE'S REPORT

B Kilmurray spoke to the report, which provided a briefing on topical issues of concern to the Chief Executive.

In discussion the following points were raised:

1. B Kilmurray commented on progress the Trust had made to satisfy the criteria to move from segment 3 of the oversight framework and it was noted that by doing so the Trust would be subject to scrutiny via the Integrated Care Board instead.
2. B Kilmurray confirmed that a gap analysis would be undertaken against the NHS England Insightful Board guides.
3. The Board noted the prescriptive nature of Integrated Care Board meetings and powers related to the operation of organisations that moved away from plan.
4. S Dexter-Smith provided assurance that the Trust was linked into changes related to the regulation of managers through North East North Cumbria Workforce Board and national programmes, and would seek to influence where possible.
5. L Romaniak commented on how important it was to demonstrate robust governance in a period of financial challenge and understandable scrutiny and advised the Trust had received an excellent outcome from the grip and control review, which had placed the Trust in a positive position in relation to its peers.

   S Dexter-Smith noted that, due to assurance the Trust had through its grip and control, it was more easily able to complete strategic workforce returns.
6. A Bridges noted an improvement in media coverage of the Trust and the placement of good news.

24/25-149 INTEGRATED PERFORMANCE REPORT

P Scott spoke to the report, which provided oversight on the quality of services delivered and proposed there was: good controls assurance on the operation of the performance management framework; good performance assurance on the Integrated Performance Dashboard and reasonable performance assurance on the national and local quality requirements and waiting times and that strategic risks were managed effectively.

N Lonergan reported from Durham, Tees Valley and Forensic Care group and drew attention to: work underway in respect of patient flow and length of stay; challenges in relation to the

metric for Talking Therapies first and second appointments; special cause for concern in relation to restrictive interventions; and the development of an all-age neurodiversity steering group with the Integrated Care Board.

Z Campbell reported from North Yorkshire, York and Selby Care Group and drew attention to: positive assurance in relation to workforce metrics and inappropriate area placements; financial challenges; challenges in relation to children and young people caseloads and waiting times; and actions in place in relation to waiting times for child eating disorders, Early Intervention in Psychosis Services and Talking Therapies.

In discussion the following points were raised:

1. B Murphy noted that Quality Assurance Committee continued to review the potential impact of high bed occupancy on quality. She reminded the board of NHS England concerns about corridor care and noted that, the Trust would re-run a piece of work to consider the Trust's position in relation to the mental health equivalent and findings would be reported to Quality Assurance Committee.

   Commenting further, L Romaniak noted that in November 2024 13.8% of adult beds and 14.2% of older adult beds were occupied by delayed transfers of care.

   In response to a query, L Romaniak confirmed that reported costs of £2.53m for adult mental health services and £1.33mm for mental health services for older people were cumulative direct costs for 2024/25.

   B Reilly queried the ability of the Trust to achieve the agreed target for maximum bed occupancy of 85% by April 2025. She went on to confirm that Quality Assurance Committee was sighted on high bed occupancy and its impact on staff, patient and carer experience, which included where patients were placed within the Trust area but away from their local community.
2. S Dexter-Smith provided assurance that the trajectory for face to face mandatory and statutory training indicated the Trust would be compliant by the end of March 2025.

   B Murphy reflected on the impact of statutory and mandatory training compliance on the quality of care and noted, for example, a band 5 member of staff in their first year would undertake 153 hours of training.
3. N Black noted that Board Assurance Framework Risk 5 [digital – supporting change] focused on how to make best use of systems and tools in order that team mangers were able to understand and monitor performance.
4. In relation to children and young people services, the Chair drew attention to the longest reported wait time for assessment at 955 days and the longest wait for treatment at 2223 days, and he requested further information following the meeting.

   Action: Z Campbell/N Lonergan

   B Murphy confirmed that waiting times were considered by Quality Assurance Committee.
5. The Chair welcomed the detail provided in the report, noting that it had won a national award, and proposed that, in its further development, information be included on the Trust's response to areas of challenge and timescales.
6. B Kilmurray reflected on the quality and purpose of the report and proposed that consideration be given to how it would be aligned to the next phase of the Trust's strategic journey and used to support discussion of key challenges.

   He noted there would be limitations to a performance improvement plan approach and suggested there was an opportunity to consider a different framework.

Commenting further, P Scott noted that the Trust would undertake a stocktake of all current content and concurred that the report should be aligned to Our Journey to Change objectives. He commented on the importance of tools and skills of managers to understand performance, to deliver Our Journey to Change and to strengthen assurance in the Integrated Performance Report.

7. J Maddison acknowledged the two fold purpose of the report and commented on the potential to review the order of the report, consider the impact on the Trust's strategy and to recognise those areas that required system support.
8. The Chair proposed that, whilst the report would be developed further, it provided assurance that the Trust had grip and control and mitigation was in place where performance was not as expected. He welcomed the verbal updates provided at the board meeting, which had added further richness to the report and proposed that this information be included in the report.
9. C Carpenter cautioned on the categorisation of assurance, where the report acknowledged there were data issues and she proposed, for example, that there be a focus on increasing the sample size in relation to patient outcomes and colleague engagement.

   S Dexter-Smith welcomed the point raised and undertook to reflect on narrative in the report to outline other metrics which would contribute to the level of assurance reported.

   Commenting further, R Barker noted that People, Culture and Diversity Committee had proposed that the annual staff survey, which had a larger response rate, be used as the baseline position.

The Chair drew the discussion to a close, welcoming the discussion on grip and control of current performance and future development of the report. Reflecting on comments raised, he invited executive directors to consider if the report was able to provide an overall assurance rating for performance, in the context of the Trust as a complicated and nuanced organisation.

Agreed: *there is good controls assurance on the operational of the performance management framework; good performance assurance on the integrated performance dashboard; and reasonable performance assurance on the national and local quality requirements and waiting times, and that the strategic risks are managed effectively.*

24/25-149 CORPORATE RISK REGISTER

B Murphy presented the report, which provided assurance on the management of risk and oversight of organisational wide risks that were rated as high in the Corporate Risk Register. She drew attention to risks removed from the register the inclusion of a new risk in respect of delayed discharges from adult mental health acute wards.

In discussion the following points were raised:

1. B Murphy confirmed that a green light admission, related to a patient admitted with a learning disability, where reasonable adjustments would be made to ensure they were able to access care and to ensure their admission was safe and appropriate.
2. B Kilmurray noted a challenge raised at the Executive Risk Group in relation to the number of risks on the Corporate Risk Register and alignment to the Board Assurance Framework.
3. The Chair welcomed the opportunity to align the report to the Integrated Performance Report and develop commentary that would address the question of ' and so what'.

Agreed: *there is reasonable assurance over the risk management processes in place, the consideration of risks for addition to the Corporate Risk Register and the ongoing management of these risks.*

24/25-150 OUR JOURNEY TO CHANGE QUARTER 2 2024/25

P Scott presented the report, which provided an update on delivery of priorities that made up Our Journey to Change Delivery Plan over the second quarter of 2024/25. He commented on requested extensions to timescales, future development of the report, and consideration of capacity in the development of the 2025/26 plan.

In discussion the following points were raised:

1. L Romaniak noted a correction to the report and advised that confirmation had been provided to Resources and Planning Committee that works related to freezer installations had been completed.
2. It was agreed that it would be important to reflect on delivery of the 2024/25 plan to inform development of the 2025/26 delivery plan and the next phase of Our Journey to Change.
3. In response to a query, Z Campbell undertook to confirm the progress made on two transforming community services deliverables that had previously been agreed and if their progress would impact on the extension sought in the report.

   Action: Z Campbell
4. Z Campbell suggested that in some areas the Trust had been optimistic about the time taken for delivery, particularly when working with partners on transformation proposals.
5. B Kilmurray advised that proposals were considered, challenged and monitored by Management Group.
6. R Barker noted that the position in relation to the occupational health contract had been considered by People, Culture and Diversity Committee.

Agreed:

i. North Yorkshire and York implementation of Children and Young People all age crisis hub – completion date extended to June 2025.
ii. Procurement of a new Occupational Health Service – completion extended to June 2025.
iii. Catering infrastructure (phased approach) – completion extended to November 2024.
iv. Harrogate Community Hub – completion extended to September 2025.

24/25-151 CHARITABLE FUNDS ACCOUNTS AND ANNUAL REPORT 2024/25

L Romaniak presented the report, which provided the Charitable Trust Fund accounts and annual report for consideration, in line with Charities Commission deadlines.

The Chair placed on record thanks to the team for work that had been undertaken in preparation of the accounts and annual report.

Agreed:

i. The submission of the Annual Report and Accounts of the Charitable Trust Fund be approved.
ii. The statement of trustee responsibilities to be signed by the Chair and Chief Executive.
iii. The balance sheet to be signed by the Chief Executive.

24/25-152 REPORT OF THE CHAIR OF PEOPLE, CULTURE AND DIVERSITY COMMITTEE

R Barker, Chair of People, Culture and Diversity Committee, provided a verbal update from the last meeting and noted committee had:

- Received an inspirational staff story provided by colleagues from the Positive Approaches Team who had spoken about their role and experience of the Trust.
- Agreed to consider the life cycle of a risk and levels of assurance it required at a future time out session.
- Considered the Board Assurance Framework and noted the potential for improvement in quarter 1 2025/26 in relation to statutory and mandatory training and recruitment.
- Discussed development of the people journey delivery report and how it would be used in different areas of the Trust to respond to workforce challenges.
- Been impressed by participation in equality, diversity and inclusion networks to share learning and good practice and build community spirit.
- Agreed the Equality Delivery System for publication.
- Received an update on work in relation to violence prevention and the role of the Duty Nurse Co-Ordinator, where there was now clarity and interest in the role.
- Considered the report of the Freedom to Speak up Guardian.
- Received a quarterly update on apprenticeships, which included use of the levy to support the development of new talent and to respond to organisational needs and workforce shortages.

24/25-153 FREEDOM TO SPEAK UP REPORT

D Williams, Freedom to Speak up Guardian, presented the report, which provided an overview of freedom to speak up activity over the previous six months. He welcomed the role of staff networks to support staff with protected characteristics to raise concerns where they felt they had been treated differently or where concerns had been minimised.

In discussion the following points were raised:

1. S Dexter-Smith advised that, although the guardian's report was independent, supporting information had been provided on building a speak up culture and triangulating areas of concern.
2. It was noted that People, Culture and Diversity Committee had queried the impact of outsourcing on the team's proactive role and had received assurance that the Trust would design the contract accordingly, with potential for a 50/50 reactive/proactive split.

   D Williams confirmed that a 50/50 split was highlighted in NGO guidance as a basic requirement, and he proposed the Trust needed to seek to continue to triangulate information with other sources of speaking up in the organisation.

   S Dexter-Smith confirmed the procurement process was underway.
3. B Kilmurray confirmed the Trust would continue to promote opportunities to speak up and he indicated that Executive Directors Group would discuss the reported disparity between care groups.
4. Responding to a query on how the Trust reflected on its freedom to speak up culture and external learning, S Dexter-Smith confirmed that Executive Directors Group discussed culture each quarter and reported into People, Culture and Diversity Committee.

Agreed: *there is good assurance from the process in place that the organisation is able to hear and respond to concerns.*

24/25-154 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee, presented the report, which outlined matters arising from committee meetings held on 7 November 2024 and 5 December 2024. She provided assurance that committee was sighted on concerns raised during discussion of the Integrated Performance Report and had reviewed and agreed updates to the Board Assurance Framework.

In discussion the following points were raised:

1. B Murphy confirmed the Trust had received the final draft of the NICHE Quality Assurance Review, which would be published mid-January 2025. The report matched the Trust's internal audit report, which provided a good level of assurance on progress that had been made.
2. In respect of section 17 leave, B Murphy noted whilst improvement actions had been put in place, this had not led to a consistent improvement in quality standards. Staff training had been provided and data from November suggested there had been an improvement. Until the Trust was able to confirm this was consistent, daily oversight arrangements were in place and progress would be reported to committee in February 2025.

   R Shah confirmed there was an improving trend and noted that nursing leads and a consultant had been identified to provide further support.

   The Chair welcomed the assurance provided on short term measures until the long term trajectory was confirmed.
3. In respect of data quality, N Black noted there was a focus on technology, support for staff to ensure they were trained and confident in use of the system, and revalidation of processes to ensure the system matched how the Trust wished to work to support clinical care.

24/25-155 LEARNING FROM DEATHS REPORT

R Shah presented the report, which provided information from the learning from deaths dashboard and proposed there was good assurance on reporting and learning in line with national guidance.

Responding to a query, R Shah agreed to confirm if medication management and multi-agency working were new themes in the report. H Crawford noted that the trust had identified 12 learning themes and proposed that these themes may have arisen as a result.

Action: R Shah/K Kale

24/25-156 SENIOR GP AND EDUCATION LIAISON CONSULTANTS, INTRODUCTION AND PRESENTATION

Dr S Akowuah and Dr J Carlton spoke to a presentation on the objectives of GP education and liaison, results of the GP learning needs survey, education headlines and 2025 objectives.

In discussion the following points were raised:

1. B Kilmurray welcomed the progress made over the first six months and reflected on pressures on primary care, challenges in relation to access to mental health and the importance of system working to support transformation and proposed this would be an area of focus.

J Carlton confirmed there was capacity to look further ahead to support transformation and noted links had been made with clinical networks and clinical directors.

2. It was noted that the Trust's approach, as outlined in the physical health care plan, was to support service users to access physical care in the same way as non-service users, with some resource available in the Trust for inpatients.

   S Akowuah welcomed the opportunity for a further discussion following the meeting on how they would support that approach.

3. Responding to a query, J Carlton suggested that it was not common for GPs to have a special interest in mental health or to have extended skills in that area and S Akowuah noted the potential to establish a group of primary care mental health champions.
4. L Romaniak queried whether the liaison might be utilised to develop a community of GPs with a special interest in mental health and welcomed the opportunity to consider and learn from case studies from interaction with GPs to better understand where people may have fallen between gaps in services, including from variation in provision. She also highlighted the potential to undertake a comparison of provision across both integrated care board areas, and to understand areas of good practice.
5. A query was raised about training provided in the acute sector to support the quality of care provided to patients with a mental health need.

   In response, R Shah noted that educational work was undertaken via liaison teams in acute hospitals to ensure they understood the mental health needs of patients who attended emergency care. The Trust also attended monthly meetings with consultants and local interface meetings would be held from January 2025 to support the early resolution of local issues.

   S Akowuah highlighted the potential to consider out of hours care and also advised that training for midwives had been constrained by capacity within the midwifery programme.

   B Murphy proposed the Trust's Associate Director of Nursing for Education and Practice Excellence would facilitate a discussion on midwifery training.

6. N Black commented on the opportunity to improve the flow of data with primary care.
7. A Bridges welcomed the opportunity to join up communications and attend protected learning events to help build relationships.
8. H Crawford outlined her portfolio as Executive Director of Therapies and welcomed the opportunity to discuss interdisciplinary learning.

The Chair drew the discussion to a close and proposed that S Akowuah and J Carlton return in six months' time to provide a progress update.

24/25-157 ANNUAL MEDICAL EDUCATION REPORT

H El-Sayeh and H Lonsdale presented the report, which provided an overview of medical education activity over the previous year and outlined priorities for the academic year 2024/2025.

In discussion the following points were raised:

1. Responding to a query on medical education facilities, H El-Sayeh commented on the importance of parity of esteem between investment in service provision and investment in educational provision, recognising that students were the Trust's future doctors and consultants.
2. B Kilmurray placed on record his thanks to the team for work they had undertaken during the year. He confirmed the Trust had agreed to take a hybrid approach, which

included some investment at Lanchester Road Hospital, until there was clarity on student numbers, local medical school expansion proposals and changes to models of delivery.

He noted there was a willingness of new consultants to be involved in education, as part of their career development, and the Trust would consider how headroom would be provided to support that.

He highlighted that, despite the period of industrial action, the Trust had maintained its position in the national student survey, which reflected the positive work undertaken by the team.

24/25-158 BOARD ASSURANCE FRAMEWORK

The Chair invited the board to consider if there had been any matters arising from the discussion at the meeting that changed the position outlined in the Board Assurance Framework.

No matters were highlighted.

P Scott noted the potential to involve the Senior GP and Education Liaison Consultants in future system and partnership working.

24/25-159 LEADERSHIP WALKABOUTS (FOR INFORMATION)

Noted.

24/25-160 USE OF THE TRUST'S SEAL (FOR INFORMATION)

Noted.

24/25-161 EXCLUSION OF THE PUBLIC

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

On conclusion of confidential business, the meeting closed at 6.35pm

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
	Action in progress & date for completion of action not yet reached

Changes since the last board meeting are provided in bold

Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
11/01/24	136	Patient outcomes	Timescales to be provided for completion of current work to improve the reporting of patient outcomes.	K Kale	Jul-24	**Completed**	Board seminar held 11 July 2024. Outcomes summit held on 6/11/24. An Improvement plan is in place and a number of updates from Cito are required to progress further. Care group representation on outcomes steering group is now in place and quaterly events are planned for the next year led by care groups for clinicians. Dec24: R Shah noted that a Trust wide outcomes improvement plan had been approved by Executive Directors Group and progress would be reported each month **Feb25: Improvement work is ongoing via the outcomes steering group and care groups and monthly updates are now provided to Executive Directors Group. The last update was provided 28-Jan and Executive Directors Group has requested that work be undertaken to review the improvement plan and identify high impact actions that need to be completed early. Some of the key actions are linked to Cito. Work is currently underway with clinicians Trust wide via webinars to help improve their understanding of outcomes and how they are very much part of quality clinical care.**
11/04/24	11	Corporate Risk Register	Committees to consider corporate risks that had remained static for 12 months and review target dates	Committee Chairs		**Completed**	Oct24 update: Confirmed that Quality Assurance Committee had reviewed static risks and People, Culture and Diversity Committee would do so at its next meeting. Dec24 update: S Dexter-Smith advised that People, Culture and Diversity Committee had reviewed the Board Assurance Framework and static risks and movement expected by March **Feb25: In November 2024, Resources and Planning Committee completed a detailed baseline review of digital and cyber. Two of the static risks linked to Board Assurance Framework risks are also subject to regular detailed discussions in relation to risk trajectory.**
13/06/24	36	Board Assurance Framework	Risk leads to red/amber/green rate the actions would mitigate the risk	Executive Leads	Oct-24	**Completed**	Discussion on the Board Assurance Framework held at Executive Directors Group on 13/08/24 **Feb25: implemented a more standarised approach to the RAG rating of mitigations**
13/06/24	47	Emergency prepardness, 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	**Completed**	Audit & Risk Committee meeting to be held 14 October - feedback to be provided to the Board in December 2024 **Dec24 update: Action complete - updated provided through Audit & Risk Committee Report**

Agenda Item 5

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
	Action in progress & date for completion of action not yet reached

Changes since the last board meeting are provided in bold

Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
08/08/24	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	**Completed**	Oct24 update, N Lonergan: 72 hour follow up post validation - 13 occasions where follow up was not completed within 72hours. Confirmation received of patient safety received for all patients with the exception of 1 person where contact has yet to be made. Actions to improve data quality are in place and improvements are now being seen. Dec-24: Z Campbell noted an improved position in relation to the 72 hour follow-up target, with progress reported to Quality Assurance Committee, and proposed that the action be closed. The Chair invited executive directors to confirm the position. **Feb25: Progress on the 72 hour follow up metric is reported into Care Group Boards and Quality Assurance Committee, who will continue to maintain oversight and escalate where needed.**
08/08/24	83	Integrated Performance Report - themes	Integrated Performance Report executive summary to include narrative on themes that arose consistently	P Scott		**Closed**	Oct24 update: Report to be prepared for Quality Assurance Committee on how the Trust intended to make substantial improvements in those areas of concern - Action moved to QAC Action Log
08/08/24	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	**Completed**	Dec24 update: verbal update at the board meeting following the PCDC meeting on 11Dec24 **Feb25: further updates to be provided to the board via People, Culture and Diversity Committee Report**
10/10/24	116	Workforce Race Equality Standard (WRES)	Feedback to be provided to the Board on how the Trust will respond to the lack of improvement in WRES data	S Dexter-Smith/ K North	Apr-25	in progress	Dec24 update: EDI discussions to be held at December and February committee meetings and January time out. The April board report will update the board on strategic plans in relation to areas of EDI static progress. **Feb25: formal WRES, Workforce Disability Equality Standard (WDES) and Sexual Orientation Workforce Equality Standard (SOWES) reports discussed by committee in January, discussions underway about future leadership of equality, diversity and inclusion work to support accelerated progress (across patient and staff domains)**
10/10/24	118	Transformation Programme	Summary to be provided to Quality Assurance Committee on each theme of the transformation programme, linked to the Integrated Performance Report/Board Assurance Report Risk and an overview to be provided to the Board.	P Scott	May-25	in progress	Dec24 update: TSB reported to Resources and Planning Committee in Dec24. **Feb25: Report to be provided to Quality Assurance Committee in March 2025. Overview to be provided to the Board via the committee report.**
12/12/24	**144**	**Action Log**	**Action log to be updated to include: Glossary of Terms (if needed), progress against actions; completed actions prior to removal; and timescales**	**K Christon**	**Feb-25**	**Completed**	**Feb25: Updates provided across all actions and acronyms removed.**
12/12/24	**149**	**Integrated Performance Report**	**Further information to be provided to the Chair on the longest waiting times.**	**Z Campbell, N Lonergan**	**Feb-25**	**Completed**	**Action completed**

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
	Action in progress & date for completion of action not yet reached

Changes since the last board meeting are provided in bold

Date	Minute Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
12/12/24	**150**	**Our Journey to Change Quarter 2 2024/25**	**Z Campbell to confirm following the meeting the progress made on two transforming community services deliverables that had previously been agreed and if their progress would impact on the extension sought in the report.**	**Z Campbell**	**Feb-25**	**Completed**	**Feb25: the action to assess if progress of the two deliverables was likely to impact on the extension, has been completed. A) the review of single Point of has completed - no impact on the extension sought. B) Implementation of children and young people all age crisis hub - recruitment is still an issue. The extension request to June is being reviewed.**
12/12/24	**155**	**Learning from Deaths Report**	**R Shah to confirm whether medication management and multi-agency working were new themes.**	**R Shah/K Kale**	**Feb-25**	**Completed**	**Feb25: Medicines management and multi-agency working have already been recognised as themes in the Organisational Learning Group and are not new themes.**

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Chair's Report: 14th December 2024 – 7th February 2025.

Headlines:

External:

- Meeting Cleveland Police Police & Crime Commissioner
- Safe Haven Launch Newcastle : Cumbria, Northumberland, Tyne & Wear Foundation Trust/Everyturn Mental Health / Road to Recovery
- University Hospitals Tees Chair catch-up
- Meeting North-East North Cumbria (NENC) Board Meeting : TEWV progress and improvement journey briefing (Chair & Chief Executive).
- Mental Health Chairs NHS Confederation network weekly calls.
- NHS Providers (NHSP) Board Meeting and monthly check-ins.
- Discussions with NHS Executive (NHSE), over the New Operating Model, Improvement Framework, and Planning Guidance.

Council of Governors (CoG)

- TEWV Council of Governors meeting
- Governor Development Day.

Internal

- Visit to Scarborough Cross Lane Hospital : Rowan Lea ward, Danby and Esk Wards, Community Team and the Crisis Team.
- Various 121 meetings with a number of Executive Directors (Finance, People, Therapies, Corporate Affairs, Legal), Head of Co-Creation.
- Roseberry Park Sub-Group
- Board Seminar (on our Future over the next 5 years, and developing the updated version of Our Journey to Change)
- ARCH Recovery College 10th Anniversary celebration event
- Freedom to Speak Up Guardian quarterly meeting with Chair & Chief Executive
- Health Service Safety Investigation Branch : Senior Decision Makers Course : initial discussions to set this up.

Key themes for me:

1) Impact of the emerging 10 Year Plan priorities on Mental Health and TEWV
2) Impact of new performance management and segmentation proposals
3) Senior Leadership changes.

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 February 2025**
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***

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.

CQC Inspection of Adult Mental Health (AMH) Crisis, Acute Liaison and Health Based Places of Safety

The CQC commenced a targeted inspection of the Trust's AMH Crisis, Acute Liaison and Health Based Places of Safety (Section 136 Suites) Services, 11 June 2024. The inspection included on-site inspections with clinical teams, discussions with people who use services and their carers and online Focus Groups with Trust Partners (including Commissioners, Local Authorities, GPs and the British Transport Police). A total of 132 information requests were also collated and submitted during the inspection.

Initial feedback was received during the inspection and was acted upon to make timely improvements in service delivery.

The draft report was received by the Trust 05 November 2024 and went through a process of factual accuracy checks, with comments submitted back to the CQC 06 December 2024. Follow up queries and points of clarification were also shared during January 2025. The report publication is anticipated 07 February 2025 and will be subject to the new CQC Single Assessment Framework (SAF) Scoring System. The CQC have apologised for the delay to publication of this report. A formal Briefing on the final report will be issued by the Trust 10 February 2025.

Upon publication of the final report, any required improvement actions resulting from the inspection will be agreed and formal oversight and monitoring of the resulting improvement plan will be undertaken by the Executive Directors Group and the Trust's Quality Assurance Committee.

HSSIB

A series of investigations were announced by the Secretary of State for Health and Social Care in June 2023, launched in January 2024 and completed in January 2025. The reports examined the delivery of safe and therapeutic care in mental health settings, the impact of out of area admission, transitions from child and adolescent services to adult servicers and learning from deaths in mental health inpatient services.

Links to the reports can be found below:

- Creating conditions for the delivery of safe and therapeutic care to adults in mental health inpatient settings.
- Out of area placements.
- Supporting safe care during transition from inpatient children and young people's mental health services to adult mental health services.
- Creating conditions for learning from deaths in mental health inpatient services and when patients die within 30 days of discharge.

HSSIB investigators spoke to care providers, regulators, professional bodies, voluntary and charitable organisations that represent patient and family groups and members of Parliament.

The aim of the reports was to identify and address the most serious risks to mental health inpatients, the individual investigation reports identify recommendations and other learning. The HSSIB state this is to lead to changes in the safety culture and how safety is managed within mental health services. The final report was published January 2025.

Recommendations have been made for The Shelford Group, NHS England, the Department of Health and Social care, Care Quality Commission and providers.

The safety observations and areas of improvement are in line with our transformation agenda including the Culture of Care Programme and the implementation of PSIRF. A formal review of the reports is underway and the learning across all reports will be triangulated with the work of the Organisational Learning Group and will be reported to the Quality Assurance Committee and to the Board.

Independent mental health homicide report into the treatment of Valdo Calocane
ON the 5th of February NHS England published the full independent investigation into the care and treatment of Valdo Calocane.

The full report can be found here:

Independent investigation into the care and treatment provided to VC

There were 21 findings for the Trust who provided Valdo's care. The findings included issues with management of risk, medication concordance, the family voice, us of the MHA and specifically this use of Community Treatment Order, diagnosis and insight, assessing patient capacity, multidisciplinary decision making, community assertive outreach , out of area placements, efficacy of discharge processes , non-engagement with treatment, communication with primary care, caseloads n the community, ward to Board visibility of key information, organisational stability and oversight of organisational risks, organisational risk management, and the use of temporary workforce and understanding the impact at Board. There were also findings for the ICB and for wider system oversight.

The report findings will be considered carefully by the Executive Team as a whole. We will also engage clinical and operational leaders to consider the findings and conduct a thorough review of what the findings may mean for TEWV, we need to consider where there is resonance, we need to understand any gaps and also look for assurances, we will be able to identify areas of good practice. We will build on the work already completed when we considered the learning from the Special review of mental health services at Nottinghamshire NHS Foundation Trust published March 24 and updated August 24, this report was a rapid review that was conducted ahead of the full independent investigation. Clinical Leaders conducted a full review of the recommendations and reported our position against them to the Quality Assurance Committee in September 2023 and the Board in October 2023. We were also required to send a formal return to both ICBs and there was an in-person assurance sessions with each ICB to challenge and confirm our position.

We anticipate a report back to the Quality Assurance Committee April 2025.

2025/26 Planning Guidance

On 30th January the national priorities and operational planning guidance was published. There are some really clear messages regarding the expectations on the financial outlook, the priority quality and safety should play, the need to transform services linked to the Government's mission shifts and a number of national deliverables/priorities. Alongside this document, there are a number of other financial, productivity packs, policy documents, contracting guides and links to other relevant programmes and initiatives.

The main national priorities are:

- Reduce the time people wait for elective care.
- Improve A&E waiting times and ambulance response times.
- Improve patients' access to general practice and urgent dental care.
- Improve flow through mental health crisis and acute pathways.
- Improve access to children and young people's mental health services.

It makes clear that we must:

- Drive the reform that will support delivery of priorities and ensure NHS is fit for the future.
- Live within the budget allocated, reducing waste and improving productivity.
- Maintain collective focus on the quality and safety of the service.

For mental health and learning disability care the guidance requires us to:

- Reduce average length of stay in adult acute mental health beds.
- Increase the number of children and young people accessing services compared to 2019.
- Reducing the reliance on mental health inpatient care for people with a learning disability and autistic people – delivering a 10% reduction

Like all NHS providers we are required to:

- Work toward delivering a balanced net system financial position in 2025/26.
- Reduce agency spend as far as possible. Working at system level to achieve a minimum of 30% across the system.
- Close the activity/whole time equivalent gap against pre covid levels.

There are also requirements around reducing inequalities.

There are deadlines for plan submissions on 27th February and 27th March. Liz Romaniak is leading us through this.

There has been a good deal of planning activity going on across the Trust to date.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13th February 2025**
Title:	**Board Integrated Performance Report as 31st December 2024**
Executive Sponsor(s):	**Patrick Scott, Deputy Chief Executive** **Naomi Lonergan, Interim Managing Director, Durham, Tees Valley & Forensic Care Group** **Zoe Campbell, Managing Director, North Yorkshire, York & Selby Care Group**
Author(s):	**Sarah Theobald, Associate Director of Performance** **Brian Cranna, Director of Operations, North Yorkshire, York & Selby Care Group** **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 – supporting change	There is a risk of failure to delivery Our Journey To Change goals, organisational and clinical safety improvements, caused by the inability to fully deploy, utilise, and adopt digital and data systems.
6	Estates/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.
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.
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 ICSs 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 Executive Directors Group (and subsequently the Board of Directors) on the actions being taken to improve performance in the required areas.

Proposal:

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

- **Good controls assurance** regarding the oversight of the quality of services being delivered
- **Good performance assurance** regarding the Integrated Performance Dashboard (IPD)
- **Reasonable performance assurance** regarding the National and Local Quality Requirements
- **Reasonable performance assurance** regarding Waiting Times

Overview:

Controls Assurance

The overall **good** level of **controls assurance** has been determined based on the Performance Management Framework we have in place and the recent internal audit report by AuditOne, which provided substantial assurance on the integrated approach to performance. Whilst we have robust controls in place, there is some slippage in timescales for a small number of measures and some further improvement actions have been identified that require timescales will be included in next month's report.

Performance Assurance

The overall **good** level of **performance assurance** for the IPD has been underpinned by the Performance and Controls Assurance Framework, which demonstrates 71% of measures with good or substantial assurance. Whilst we recognise that 6 measures (4 outcome and 2 staff survey) are known to have some inconsistencies in completeness, the overall data quality scores still provide good assurance.

We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

We have positive assurance in relation to Inappropriate Out of Area Placements (OAPs), our People measures for Staff Leaver Rate and Staff in post with a current appraisal. There is special cause improvement, and we are achieving standard in all measures. We also have positive assurance in relation to Cash Releasing Efficiency Savings (CRES) Performance – Non-Recurrent as we are ahead of plan by £0.72m.

The actual areas of concern are as follows:

1. **Outcomes** – whilst three of the measures indicate improvement; we remain concerned about the low number of timely paired outcomes which impacts the reliability of what the measures are representing. The Trust-wide Outcomes Improvement Plan is being monitored monthly by EDG. The first update was presented to EDG at the end of January, and it was agreed that the steering group would be asked to prioritise areas with the biggest impact and bring this back next month.

2. **Bed Occupancy** – whilst there remains special cause concern, we do have a sustained improved position with out of area occupied bed days. There are several mitigating actions in place to support the increased need for inpatient beds, in addition to the work of the Urgent Care Programme Board, including:

- Daily and weekly operational and executive level oversight.
- The Bed Management Team who are helping maximise the use of beds and minimising the use of out of area beds
- The introduction of the Mental Health OPEL framework has focused the aim of internal meetings and clear escalation actions from these, alongside supporting discussions within the wider urgent and emergency care system.
- The pilot of Optica (a digital tool to support flow for inpatient wards) across a number of inpatient wards in both care groups which is now due to conclude in March 2025 (previously December 2024) prior to wider roll-out
- Sustained improvement in our crisis line call pick-up rates. We are also developing a process to respond to patients who abandon calls to improve their experience.
- We have agreed investment for Safe Havens in Durham & Tees Valley Care Group for 2025/26 as part of our admission avoidance work.
- Agreed joint work with the NENC ICB, HNY ICB and local authority partners to have oversight of patients clinically ready for discharged who are delayed and improve processes aiming to have a positive impact on patient care through the provision of appropriate support.

3. **Mandatory & Statutory Training –** Whilst we are achieving the standard, we remain concerned about the face-to-face training compliance below the 85% standard. A review of the process for adding new courses or a change to an existing course concluded in December 2024 and a session with lead Directors and subject experts took place on the 6th of January 2025 with a view to Optimise, Rationalise and Reduce the training portfolio. A systematic review of various courses is to be undertaken; this started with a review of Immediate Life support (ILS) at the beginning of January 2025. Work across the Trust has been undertaken in relation to ILS which has improved by 28% across the last 6 months. Daily reviews of staffing are in place across the Care Groups to ensure that the right staff with the right training are in place to respond to any issues that arise, and staff will be moved to ensure we have the right skill mix available on our wards.

4. **Agency Price Cap Compliance** – Most price cap breaches during 2024/25 have related to medical locum or prison mental health nursing cover for hard to fill vacancies. To address this, we have developed a Performance Improvement Plan and with small exceptions are seeing a reduction in breaches.

5. **CRES Recurrent** - The Efficiency Hub oversees the delivery of CRES, supporting early interventions should any schemes fall off track and identifying mitigating schemes and/or new schemes for development. The Hub will co-ordinate and collate trackers for each scheme, receive exception reports, signpost/support on those schemes at risk, and in turn report into Financial Sustainability Board. Following the 2025/26 CRES Planning Event in October 2024; plans from Care Groups and Corporate Services are being worked up to support plans, with a further event planned on 31 Jan.

The overall **reasonable** level of **performance assurance** for the National and Local Quality Requirements has been underpinned by Statistical Process Control Charts, which demonstrates 52% of measures are achieving standard. We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

EDG discussed in detail, all the areas not achieving target and the associated actions. A small number of new actions were recommended and where agreed, these are detailed in the relevant pages of the IPR.

We have positive assurance for 72-hour follow up, Talking Therapies waiting times (6 and 18 weeks) and Active OAPs (Inappropriate), where we are achieving targets in all areas.

The actual areas of concern are as follows:

1. **EIP Waiting Times** (Vale of York) – Originally anticipated for December, it is now anticipated the backlog of patients waiting will be addressed and new patients will start treatment within 2 weeks by the end of January 2025.

2. **Talking Therapies 1st to 2nd treatment** (County Durham, Tees Valley and Vale of York)**, Reliable Recovery (**County Durham**) and Reliable Improvement** (County Durham and Tees Valley) – A Task & Finish Group has been established to oversee a Trust-wide deep dive. Data is currently being sourced to provide a triangulated understanding of the service from a staffing, finance, activity and clinical outcomes perspective. This will be completed by the end of February 2025 to inform the development of a Trust-wide action plan by the end of March 2025. In addition, the Care Groups are still progressing their individual performance improvement plans in relation to these services.

3. **CYP 1 contact** – The plans for this measure were based on activity in 2023/24 which included short-term realignment of staff and overtime in Durham and Tees Valley and several surge/other posts in North Yorkshire and York which have now been removed. Analysis is being undertaken, with Finance, to provide assurance that any reduction is directly attributable to the removal of these posts and the cessation of overtime. This will be completed by the end of January 2025 for Durham and Tees Valley and the timescale for North Yorkshire and York will be confirmed by the end of January 2025.

4. **Childrens Paired Outcomes** – The Trust-wide Outcomes Improvement Plan is being monitored monthly by EDG. The first update was presented to EDG at the end of January, and it was agreed that the steering group would be asked to prioritise areas with the biggest impact and bring this back next month.

5. **Access to transformed community services** (County Durham, North Yorkshire & Vale of York) - In County Durham the remaining three PCNs will be transformed by the end of March 2025; however, the chart shows that were all PCNs transformed, the target would still not be achieved. Further work has been agreed to restructure the Durham Adult Mental Health Community Teams which should help to improve access. In North Yorkshire & York, the Ripon and Scarborough Community team are in business continuity with recovery plans in place. Recruitment of staff is underway and in the interim, some posts have been back filled through agency staff and overtime is being offered. Data is currently being sourced to provide a triangulated understanding of the access to our adult and older adult services. This will be completed by the end of January 2025 to inform the identification and development of any required improvement actions.

6. **Specialist Community Perinatal Mental Health Services** (North Yorkshire & Vale of York) – The Perinatal teams are continuing to be supported with a service recovery plan in line with business continuity

processes. There are several key mitigating actions in place to support improvement which are the completion of a capacity and demand exercise (first draft will be produced by the end of January 2025). A Rapid Process Improvement Workshop was held in January, with a more efficient referral, screening and allocation process being implemented across the service. Local leadership has been strengthened with interim cover put in place for vacancy whilst recruitment continues. The output from these mitigating actions will inform the longer term structural and capacity requirements and any inefficiencies in process and structure. There have been two patient safety incidents that relate to these services which has resulted in further review of service delivery.

The overall **reasonable** level of **performance assurance** for Waiting Times has been underpinned by Statistical Process Control Charts; however, we recognise we have limited assurance about the impact on quality for those patients waiting to access our services. We have then analysed each measure in more detail to determine the areas of positive assurance and actual areas of concern.

The actual areas of concern are:

1. **Waiting for neurodevelopmental assessments (Children & Young People and Adults)** – The newly established all-age neurodiversity group across the NENC ICB have both providers reviewing their current processes, levels of demand and activity, financial positions and clinical thresholds. A specification is being finalised to facilitate partnership-working with alternative, accredited private providers, with a view to reducing the backlogs in the NENC area and two prospective providers have been identified.

   DTVFCG CYPS - In Tees the new clinical protocol has been applied to the single assessment pathway and has freed up clinical time for psychologists and speech and language therapy. The additional psychology capacity is being used to lead on diagnostic decision making, which is anticipated to release medic time to lead on ADHD diagnostic decision-making meetings. Phase 2 testing on dual assessments will be undertaken in Darlington from February 2025 and the full Evaluation of the clinical protocol work is due to be completed by the end of March 2025. Additional funding has been agreed with the NENC ICB for 3 posts in Tees Valley to support the development of a needs-led profiling too and to support the provision of additional assessments. The team have also recruited a psychologist; commencing in March/April 2025 which will also be used to support and increase diagnostic decision-making capacity. The Care Group Board have agreed to establish an all-age ADHD and Autism Clinical Transformation Group and Terms of Reference will be developed in the coming month.

   The North Yorkshire & York service continues to engage with commissioners, Humber & North Yorkshire ICB and the Provider Collaborative regarding capacity within our CYP services versus demand and the subsequent impact on waiting times, and the ICB is reviewing the process around “Right to Choose”, developing system wide guidance that will be shared with providers. Within the Humber and North Yorkshire provider collaborative there is ongoing discussion around aligning assessment pathways across providers in the area to support best use of resources across the HNY ICB area, at present there is no timescale around this work

   A review of operational and clinical working within the Selby and York teams has been completed and it has been agreed that the teams will

explore sharing resources to manage neuro waiters. A Task and Finish group are reviewing the existing model for the assessment and treatment of neurodevelopmental conditions to see if there are more efficient ways to deliver services which improve the patient's journey. The clinical network has considered possible changes to neuro pathways across the Trust to support best use of clinical time and increase the number of assessments available; however, most areas have already been implemented in North Yorkshire and York in previous improvement work or are limited by current resource and that this is unlikely to have a significant impact. The Scarborough ADHD team has been placed in business continuity and has a recovery plan in place. Whilst some improvement can be made, it is clear that the demand outstrips the capacity of the service, and this has been raised with commissioners and will be subject to ongoing discussion.

2. **Adults waiting for their second contact with Talking Therapies** – *please see Talking Therapies narrative (2 & 3) in the National and Local Quality Requirements section on page 5.*

Other Information

- **Trust-wide PIPs (Financial Plan)** – The revised PIP for e-Roster effectiveness did not achieve 80% of teams for annual leave level loading by the extended date of the 31st October 2024. Approval was given BY EDG to extend this date to the end of March 2025.

  The revised PIP for Agency Reduction did not achieve the cessation of accommodation costs for agency workers by the extended date of the 30th November 2024 (accommodation costs continue for 1 worker) and will not achieve the reduction of pay rates to the NHS cap within Health & Justice by the end of January 2025. Approval was requested to extend these dates to the 30th September 2025; however EDG requested further discussions take place with the PIP owner.

- The latest Data Quality Assessment has been undertaken in November; all changes are noted on the relevant slides.

Prior Consideration and Feedback

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

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 – supporting change
- Estates/Physical Infrastructure
- Quality Governance**
- Partnerships & System Working
- Regulatory Compliance
- Financial Sustainability
- Public Confidence

***The introduction of any new Electronic Patient Record has 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. The Cito Improvement workstream will be the main driver to address data quality issues that are user related. Cito*

Support and Optimisation Practitioners are being recruited to help clinical teams adopt and confidently use Cito, ensuring consistent improvements across specialties. In addition, Cito user confidence workshops are due to start in January which are tailored to meet the needs of inpatient, community, and specialist services, as well as medics, pharmacy and administrative staff. The sessions will give people an insight into the rationale for the changes as well as how-to guidance which focuses on using the system to its full potential.

It was agreed in January's EDG to have a focused discussion in February to understand the range of data quality issues, the actions identified and timescales.

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

Recommendations:

The Board of Directors are asked to:

- either confirm that there is good 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 and Waiting Times and that the strategic risks are being managed effectively; or
- identify the levels of assurance it considers to be appropriate; the reasons for this; and any corrective measures/improvements it considers should be put in place.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st December 2024

Report produced by: Amy Walford, Performance Lead (Corporate) and Ashleigh Lyons, Head of Performance
Date the report was produced: 24th January 2025

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

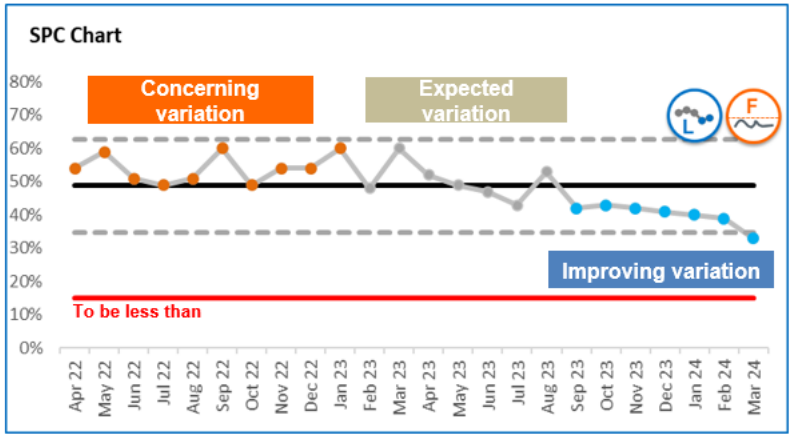
CONTENTS

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The latest assessment has been completed in November 2024 and results have been incorporated in this report.

	Data Quality Assessment		
Icon	***Description***	***What does this mean?***	***What should we do?***
DQ ★	SUBSTANTIAL assurance; a data quality score of **93% or over**	The measure is reliable.	There is no specific action to take.
DQ ✓✓	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.
DQ ✓	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.
DQ ✖	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.

Our Approach to Performance and Controls Assurance

Tees, Esk and Wear Valleys NHS Foundation Trust

Our Performance Assurance

Performance Assurance Rating takes into consideration the Controls Assurance Rating (as per table below), whether we are achieving standard (where appropriate) and any underlying areas of performance.

	Substantial	Good	Reasonable	Limited
	The control is operating effectively in meeting its objective (and managing the associated risk). It is being applied consistently. No remedial action required.	The control is operating effectively in meeting its objective. It is generally being applied consistently. Minor remedial action is required.	The effectiveness of the control in meeting its objective is uncertain. Compliance is variable/inconsistent. Some moderate remedial action is required.	The control is not operatively effectively in meeting its objective. There are low levels of/wide variation in compliance. Immediate and fundamental remedial action is required
Positive	We have Positive Assurance **AND** we are achieving the standard agreed (where relevant)	We have Positive Assurance; **HOWEVER,** we have 1 (or more) underlying areas of concern **OR** we are not achieving standard		
Neutral	We are achieving standard (where relevant); **AND** We have no underlying areas of concern	We are achieving the standard (where relevant) with only 1 area of concern; **OR** There is consistent performance	We have more than 1 underlying area of concern **OR** there is consistent underperformance below the standard	
Negative		We have no underlying areas of concern **AND** there is an improving position visible in the data	We have a small number of areas of underlying concern **OR** there is a deteriorating position visible in the data **OR** performance continues below the mean	We have the Trust and both Care Group/several directorates are all showing a concern **OR** there is a clear deterioration visible in the data **AND** outside the control limits

Our Controls Assurance

Our Controls Assurance is determined based on SPC variance or, where this is not appropriate, using forecast position or national benchmarking data.

Positive	Neutral	Negative
Positive assurance when SPC chart indicates Special Cause Improvement OR • Forecast position is positive • National benchmarking data indicates we are in the lowest (most positive) quartile	Neutral assurance when SPC indicates Common Cause	Negative assurance when SPC indicates Cause for Concern OR • Forecast position is negative • National benchmarking data indicates we are in the highest (least positive) quartile

Glossary of Terms

Tees, Esk and Wear Valleys NHS Foundation Trust

AAR	After Action Review
ADHD	Attention deficit hyperactivity disorder
ALD	Adult Learning Disabilities
AMH	Adult Mental Health
ASD	Autistic Spectrum Disorder
cCBT	Computerised Cognitive Behaviour Therapy
CRES	Cash Release Efficiency Savings
CROM	Clinician Reported Outcome Measure
CYP	Children & Young People
CYPS	Children and Young People Services
DTVFCG	Durham Tees Valley and Forensic Care Group
EDG	Executive Directors Group
EIP	Early Intervention in Psychosis
ESR	Electronic Staff Record
ICB	Integrated Care Board
ILS	Immediate Life Support
IPD	Integrated Performance Dashboard
MDT	Multi-Disciplinary Team
MHSOP	Mental Health Services for Older People
MoJ	Ministry of Justice
NENC	North East & North Cumbria Integrated Care Board
Neuro	Neurodevelopmental services
NYYSCG	North Yorkshire, York & Selby Care Group
OAP	Out of Area Placement
PACE	Patient and Carer Experience
PCN	Primary Care Network
PIP	Performance Improvement Plan
PMH	Specialist Community Perinatal Mental Health
PROM	Patient Reported Outcome Measure
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Framework
PWP	Psychological Wellbeing Practitioner
QI	Quality Improvement
ROM	Routine Outcome Measures
SIS	Secure Inpatient Services
SOCI	Statement of comprehensive income
SPC	Statistical Process Control
STEIS	Strategic Executive Information System
UoRR	Use of Resources Rating

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** there is no significant change for all patient and carer experience measures; carer experience and inpatients feeling safe are achieving standard. There is no significant change in the responses received for the patient and carer experience questions; there is improvement for inpatients feeling safe.

- **Outcomes:** in CYP there is no significant change and we are below standard for the PROM; however, there is special cause improvement for the CROM and we are above standard. In AMH/MHSOP there is special cause improvement for both the PROM and the CROM; however, we are below standard for both. Whilst some of the SPC charts indicate special cause improvement, this remains an area of concern as there is special cause concern in the number of timely paired outcomes recorded for all measures.

- **Bed Pressures:** there is special cause concern for bed occupancy. Whilst there is special cause improvement for the inappropriate out of area bed days, there were no active OAPs as at the end of December.

- **Patient Safety:** there is special cause improvement in the number of 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). There is a reduction (indicated as special cause improvement in the SPC chart) for incidents of moderate of severe harm and no significant change for restrictive interventions and medication errors. There were no unexpected Inpatient unnatural deaths reported on STEIS during December.

- **Uses of Mental Health Act:** there is no significant change.

- **People:** There is special cause improvement and we are achieving standard for leaver rate, mandatory training and appraisals; however, there is no significant change for sickness and we are exceeding standard. Whilst we are achieving the standard for mandatory training, we are concerned about the face-to-face training compliance below the 85% standard.

- **Demand:** There is no significant change in referrals. Whilst the SPC chart indicates there is special cause concern for unique caseload, this is not necessarily an actual concern as we know from the new active caseload measure there is no significant change. Unique caseload is impacted by the increase in patients waiting for a first contact which is an area of concern as highlighted in the waiting times section of this report.

- **Finance** The Trust's 2024/25 financial plan targets delivery of a break-even position. The year-to-date plan at Month 9 reflected a £3.033m deficit. When adjusted to remove technical items that are excluded from assessment of Trusts' financial performance the actual position is a deficit of £2.128m; or £0.905m favourable variance to plan. The position has deteriorated in month, including a one off depreciation adjustment (£0.3m) and the monthly impacts of pay awards. Whilst financial performance remains better than planned, the year-to-date deficit needs to be recovered in the remaining 3 months of 2024/25, including through Cash Releasing Efficiency Scheme (CRES) targets that are more heavily weighted in the second half of the year and through ongoing focus, grip and control.

Board Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Inappropriate OAPs
- People (leaver rate, appraisals)
- CRES Performance – Non-Recurrent

Risks & Issues

- Outcomes
- Bed occupancy
- Mandatory & Statutory Training
- Finance (Agency Price Cap Compliance & CRES Performance Recurrent)

Mitigations

Outcomes

The Trust-wide Outcomes Improvement Plan is being monitored on a monthly basis by EDG. The first update on progress is going to EDG on 28th January 2025.

Bed Occupancy

There are several mitigating actions in place to support the increased need for inpatient beds, in addition to the work of the Urgent Care Programme Board, including: daily and weekly operational and executive level oversight; the Bed Management Team who are helping maximise the use of beds and minimising the use of out of area beds; the pilot of Optica (a digital tool to support flow for inpatient wards) across a number of inpatient wards in both care groups which is now due to conclude in March 2025 (previously December 2024) prior to wider roll-out; sustained improvement in our crisis line call pick up rates and the development of a process to respond to patients who abandon calls to improve their experience; the introduction of the Mental Health OPEL framework; and agreed joint work with the NENC ICB to have oversight of patients clinically ready for discharged who are delayed. The Quality Assurance Committee are continuing to review the potential impact on quality of over-occupancy.

Mandatory & Statutory Training

We are continuing to focus on all face-to-face training below the 85% standard and there are several actions to support improvement. A review of the process for adding new courses or a change to an existing course concluded in December 2024 and a session with lead Directors and subject experts took place on the 6th January 2025 with a view to Optimise, Rationalise and Reduce the training portfolio. A systematic review of various courses is to be undertaken; this started with a review of Immediate Life Support (ILS) at the beginning of January 2025. Daily reviews of staffing are in place across the Care Groups to ensure that the right staff with the right training are in place to respond to any issues that arise, and staff will be moved to ensure we have the right skill mix available on our wards.

Finance – Agency Price Cap Compliance & CRES Performance Recurrent

Most agency price cap breaches have (consistently) been to provide cover for medical, and Mental Health nurse in prisons, vacancies. Actions to focus on medic recruitment and retention, including through international recruitment, have helped to reduce the number and value of breaches and related annualised premia costs. Actions to raise the profile of recruitment into vacancies in prisons have similarly helped to reduce the number breaches from shifts covered by agency. The annualised premia, based on in-month breaches, has reduced from £3.59m in March 2024 to £2.37m in December 2024. With PMO support, the efficiency hub has co-ordinated and collated trackers for each CRES scheme, and will receive exception reports, signpost/support on schemes at risk, and in turn report into Financial Sustainability Board. Under performance recurrently has continued to require non-recurrent mitigation.

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

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** no significant change for patients rating their recent experience as good or very good and carer involvement and 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 no significant change 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 both.
- **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 in the number of patient safety incident investigations and incidents of moderate of severe harm and medication errors. No significant change for the number of restrictive interventions used and for unexpected inpatient unnatural deaths
- **Uses of Mental Health Act** special cause concern
- **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 appraisals, mandatory and statutory training and staff leaver rate. No significant change in sickness.
- **Demand** No significant change 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 £202.791m as at December, and actual spend was £203.721m, which is £0.929m more than planned. As at M9 CRES delivery was £1m above plan.

Durham Tees Valley & Forensic Care Group IPD Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

•Inappropriate OAP bed days
•People (leaver rate, sickness, appraisals)

Risks / Issues*

- Outcomes
- Bed Occupancy
- Financial Plan

Mitigations

Outcomes
The Trust-wide Outcomes Improvement Plan, which incorporates all existing PIP actions, was approved by EDG in December, with agreement that the individual service-level PIPs be stood down with immediate effect. Monthly progress reports will be submitted from January 25.

Bed Occupancy
There are several mitigating actions in place to support the increased need for inpatient beds, in addition to the work of the Urgent Care Programme Board, including: daily and weekly operational and executive level oversight; the Bed Management Team who are helping maximise the use of beds and minimising the use of out of area beds; sustained improvement in our crisis line call pick up rates; and agreed joint work with the NENC ICB to have oversight of patients clinically ready for discharged who are delayed. Following Trust-wide for consultation, the care group revised discharge policy will be presented to the January Executive Clinical Leaders Subgroup prior to being presented to Management Group for final approval in February 2025.

Finance - Financial plan
Actions in place include, the Care Group General Managers are preparing recovery roadmaps for unfunded posts to address hot spot areas. These roadmaps will be reported via the finance and resource and business development sub groups of the Care Group Board. 25/26 Financial Planning, budget setting and contracting has commenced and will be ongoing to identify pressures and priority areas, which will be updated and reviewed now the planning guidance has been issued.

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

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

- **Patient and Carer Experience:** there is no significant change for all patient and carer experience measures; patient experience and inpatients feeling safe are achieving standard. We are achieving standard for percentage of Patients surveyed reporting their recent experience as very good or good.

- **Outcomes:** in CYP there is no significant change, and we are below standard for the PROM. There is special cause improvement for the CROM, and we are above standard. Whilst we are below standard in AMH/MHSOP for both the PROM and the CROM; we are seeing special cause improvement. Overall, there remains concern in the number of timely paired outcomes recorded for all measures. Slides 14-17 highlight the issues that are impacting these measure. Actions to improve performance are in place.

- **Bed Pressures:** there is special cause concern for bed occupancy. There is concern reported for patients delayed transfers of care in the reporting period for AMH and MHSOP. We are experiencing longer stays within a number of wards, including MoJ restricted patients and pressures resulting from clinically ready for discharge – specifically around accommodation, with a noticeable rise in delayed discharge in the North Yorkshire area.

- **Patient Safety:** there is special cause improvement in the number of patient safety incident investigations; (it should be noted that this is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when the Trust transitioned to the National Patient Safety Incident Framework (PSIRF)). There is a reduction (indicated as special cause improvement in the SPC chart) for incidents of moderate of severe harm and no significant change for restrictive interventions and medication errors. There were no unexpected Inpatient unnatural deaths reported on STEIS during December.

- **Uses of Mental Health Act:** no significant change is reported at Care Group and ALD is reporting special cause improvement in the reporting period.

- **Staff:** There is special cause improvement for leaver rate, and we are above standard. There is no significant change for sickness absence, and we are below standard except within Management which is reporting deterioration (special cause concern in the SPC chart) and above the standard. There is special cause improvement for mandatory training, and we are just below the standard; however, we are aware the face-to-face training compliance below the 85% standard and understand the reasons for this. Actions are in place. There is special cause improvement for appraisals; however, we are below standard within MHSOP and within management line which is driven by an anomaly rather than missed appraisals and actions are in place to resolve this.

- **Demand:** There is no significant change in referrals and caseload. We know from the detailed analysis previously undertaken, unique caseload is impacted by the increases in demand and patients waiting for a first contact.

- **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 by the end of the year, 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.

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- Inappropriate OAPs
- Use of the Mental Health Act
- Staff Leaver Rate
- Appraisals

Risks / Issues

- Outcomes
- Bed occupancy
- Mandatory & Statutory Training
- Financial Plan: Agency expenditure
- Financial Plan: Surplus/Deficit
- Agency price cap compliance

Mitigations

Outcomes

The Trust-wide Outcomes Improvement Plan, which incorporates all existing PIP actions, was approved by EDG in December, with agreement that the individual service-level PIPs be stood down with immediate effect. Monthly progress reports will be submitted from January 2025.

Bed Occupancy

The service is being impacted by longer patient stays, including MoJ restricted patients, patients clinically ready for discharge and consultant cover and gaps in leadership posts within inpatient areas. Work is progressing with the leadership team to reduce lengths of stay and delayed transfers of care. Recruitment into leadership posts is ongoing; support is being provided from the senior leadership team. Local Authorities Mental Health Team provision (York) - Ongoing support is being provided by the Local Authority. Following an external meeting end of last year, between ICB and Local Authority, conversations have begun about wider transformation journey across the whole system. To progress this work, a number of workshops are being planned in early 2025.

Mandatory & Statutory Training

Compliance continues to be impacted by the misalignment of competencies and staff on ESR; work to correct this is being supported by Finance and People & Culture. All staff in Management have not completed their fire safety level 2 training and are unable to book sessions prior to December 2024. There is reduced capacity for Positive & Safe training courses and Incident Reporting Level 1 is currently not available on ESR to complete and there are not enough face-to-face courses available. Extra dates have been added to support Incident Level 1 training and whilst E-Learning was expected to be available by the end of November 2024 this has been delayed, and a completion date is yet to be confirmed. The training portfolio for Positive and Safe is being reviewed, this will be completed by end of January 25. The Education & Training Team continue to work with the Managing Director and Directors of Operations to support issues with training room availability as they arise. The trajectory for Resuscitation – Level 3 – Adult Immediate Life Support – 1 Year has not been achieved and we are now expecting to achieve 81% compliance by the end of March 2025, pending the release of new training dates in April.

Finance

The Care Group financial position is forecast to be £512k above plan, with the key factor being out of area patients, which are impacted by delayed discharges.

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 • Incidents of moderate or severe harm • Staff in post with a current appraisal **improved performance assurance**	• Adults and Older Persons showing measurable improvement following treatment - patient reported • Adults and Older Persons showing measurable improvement following treatment - clinician reported • Staff Leaver Rate • Compliance with ALL mandatory and statutory training • CRES Performance – Non-Recurrent		
Neutral	• Inpatients reporting that they feel safe whilst in our care ***improved performance assurance*** • Medication Errors with a severity of moderate harm and above • Unexpected Inpatient unnatural deaths reported on STEIS	• Patients surveyed reporting their recent experience as very good or good ***reduced performance assurance*** • Carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for • Restrictive Intervention Incidents Used • Uses of the Mental Health Act • New unique patients referred	• CYP showing measurable improvement following treatment - patient reported ***improved performance and controls assurance*** • 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 • Financial Plan: Agency expenditure compared to agency • Use of Resources Rating - overall score • Cash balances (actual compared to plan)	• Capital Expenditure (Capital Allocation)	• Bed Occupancy (AMH & MHSOP A & T Wards) • Unique Caseload • Agency price cap compliance • CRES Performance - Recurrent

Board Integrated Performance Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	93.01%	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%	74.38%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC		?	75.00%	80.66%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	22.39%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	H	F	55.00%	45.09%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	52.80%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	H	F	30.00%	23.74%	30.00%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H	F	85.00%	100.86%	85.00%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	L			194	
10)	The number of Patient Safety Incident Investigations reported on STEIS	QAC	L			21	
11)	The number of Incidents of moderate or severe harm	QAC	L			300	
12)	The number of Restrictive Interventions Used	QAC				8,495	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				4	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				7	
15)	The number of uses of the Mental Health Act	MHLC				3,123	

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%	10.82%	11.00%
19)	Percentage Sickness Absence Rate (month behind)	PC&D		?	5.50%	5.99%	5.50%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	H	?	85.00%	86.71%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	F	85.00%	87.56%	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				73,344	
23)	Unique Caseload (snapshot)	S&RC	H			63,600	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	3,035,000	2,128,406
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	9,441,429	7,871,416
25b)	Agency price cap compliance	S&RC	67.00%	61.60%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	11,770,884	11,286,209
28)	CRES Performance - Non-Recurrent	S&RC	2,227,500	2,948,039
29)	Capital Expenditure (CDEL)	S&RC	5,652,000	3,955,760
30)	Cash against plan	S&RC	48,872,000	51,313,155

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

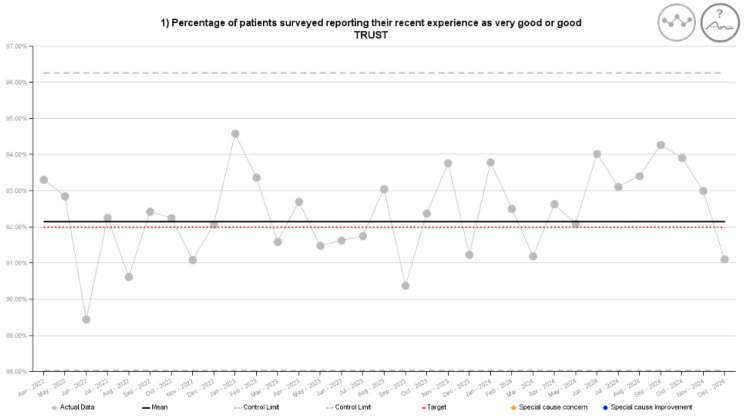
What does the chart show/context:
During December **1158** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **1055 (91.11%)** scored "very good" or "good".

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 improvement for Secure Inpatient Services.

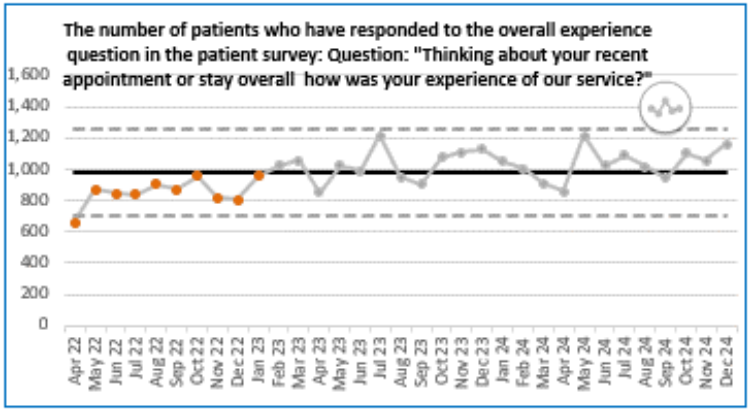
The latest National Benchmarking data (October 2024) shows the England average (including Independent Sector Providers) was **89**% and we were ranked **11 out of 61 trusts** (1 being the best with the highest ratings).

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

Actions:
- Each month, the Patient and Carer Experience (PACE) team share with the care group leadership teams a list of those wards/teams who have not provided feedback in the month. This is also reflected in the current Quality Assurance and Improvement Group reports to both Care Groups. In addition, the PACE Team use this intelligence to focus on who we see and when, as part of the quality visit programme. *NB. This is standard work for the PACE Team*
- The Patient & Carer Experience Team to procure a new patient experience system, which will increase the methods by which patients can provide survey feedback with a view to increasing response rates. The "I Want Great Care" system has been approved at the January Digital Programme Board and will be procured by the end August 2025.



The below chart represents the number of patients who have responded to the overall experience question.



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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

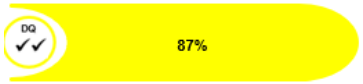
Background / standard description:
We are aiming for 75% of carers reporting they feel they are actively involved in decisions about the care and treatment of the person they care for.

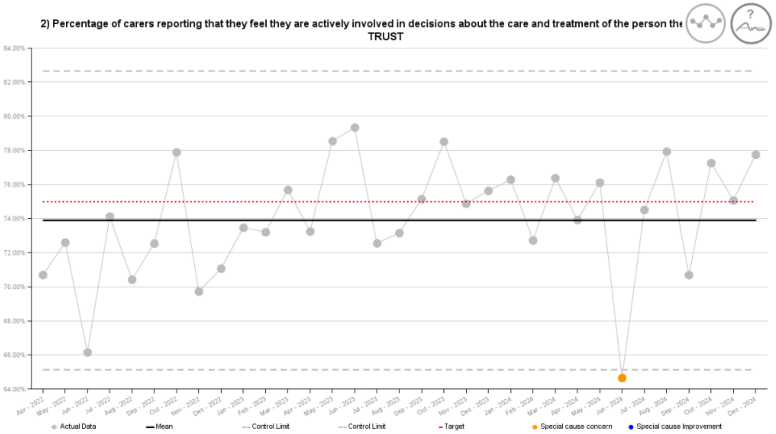
What does the chart show/context:
During December, **409** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **318 (77.75%)** scored "yes, always".

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 concern for Adult Mental Health Services in Durham, Tees Valley & Forensic Care Group; however, at this stage this is not an actual concern.

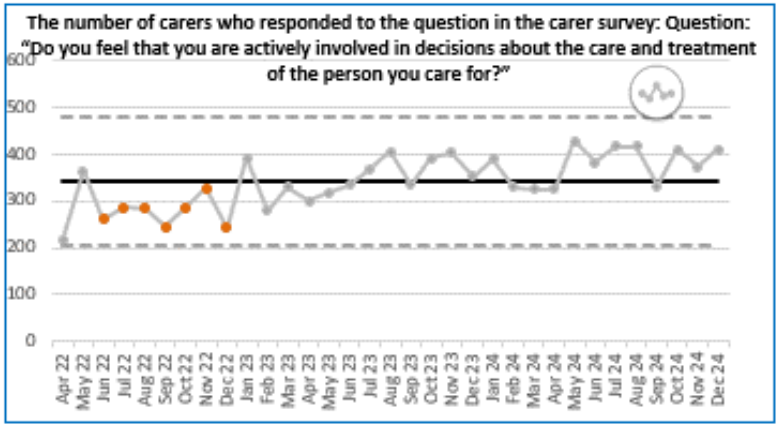
Underlying issues:
- Engagement with various carer groups
- Barriers to collecting feedback include:
    - Access to and up to date surveys through the various mechanisms
    - Up to date carer and team information
    - Lack of feedback including display of feedback
- A lack of awareness of the Triangle of Care within Trust Services

Actions:
- The Patient & Carer Experience Team have reviewed the output from the recent Quality Improvement focused work and will develop a work plan by the end of January 2025.
- The Patient & Carer Experience Team to meet with the Lived Experience Directors in December 2024 to discuss the Triangle of Care with a view to raise awareness through the Care Groups. (**Not Completed**). The meeting with DTVFCG has taken place; however, that with NYYSCG is to be rescheduled. Timescale to be confirmed.





The below chart represents the number of carers that responded to the involvement question.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
During December **264** patients responded to the overall experience question in the patient survey: “During your stay, did you feel safe?”. Of those, **211 (79.92%)** scored “yes, always“ and “quite a lot”.

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

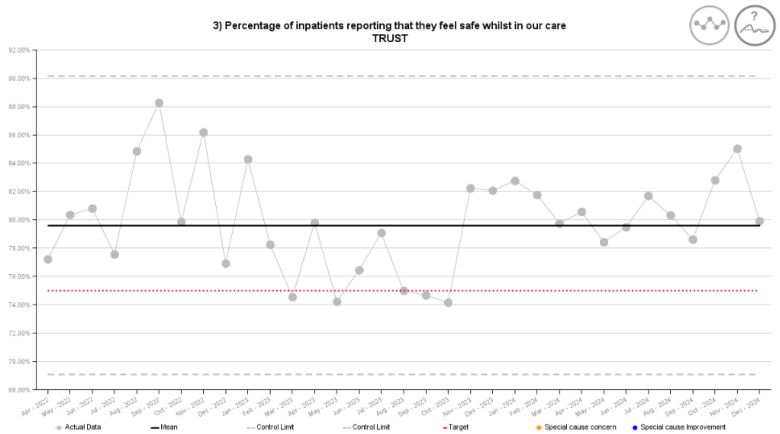
There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients (including self-harm), environment, the acuity of other patients and violence & aggression and the use of restrictive interventions on wards.

Underlying issues:
There are no underlying issues to report.

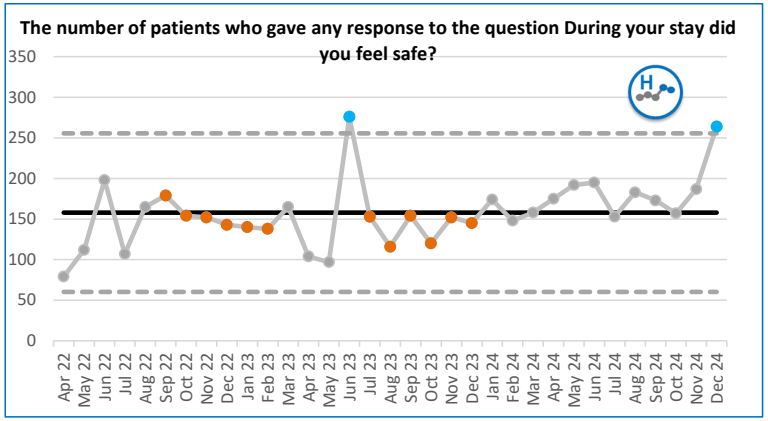
Actions:
Whilst there are no specific improvement actions to note, feeling safe on our inpatient wards is one of the core standards of the Culture of Care Programme which we are rolling out as part of the National Inpatient Transformation Programme.

DQ

87%



The below chart represents the number of patients that responded to the safety question.



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 December **648** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 140 (21.60%)** made a measurable improvement.

There is no significant change at Trust and Care Group level. There is special cause concern at Trust level in the number of patients discharged with a paired outcome measure; there is no significant change at Care Group level.

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

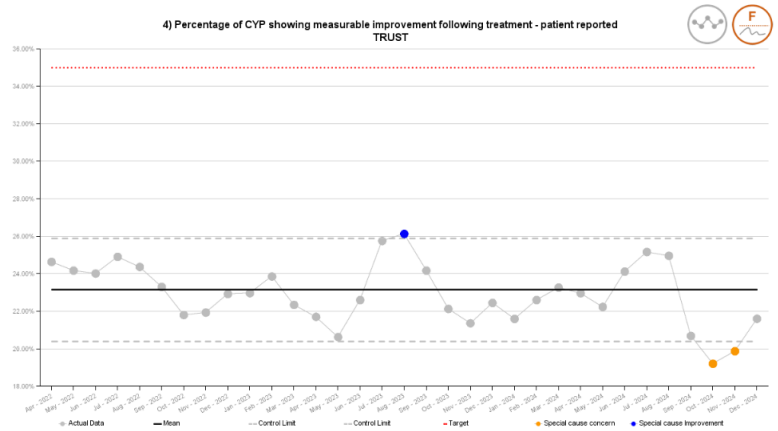
Underlying issues:
There are a range of issues currently impacting this measure.

- 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.
- 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.

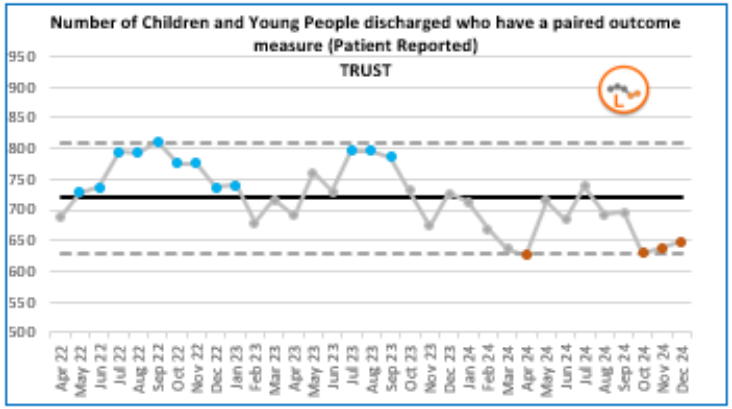
Actions:

- The Trust-wide Outcomes Improvement Plan is being monitored monthly by EDG. The first update was presented to EDG at the end of January, and it was agreed that the steering group would be asked to prioritise areas with the biggest impact and bring this back next month.
- The Business Intelligence Team are working with the Child Outcome Research Consortium (CORC) to establish a national reliable change index for EDE-Q in collaboration with other member organisations. Research & Development leads from all participating organisations are to meet in February 2025 to talk through the research/data governance controls for the project and will jointly complete the research application; TEWV will be the lead organisation.

DQ ✓✓ 87%



The below chart represents the number of discharges with paired outcome measures.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
For the 3-month rolling period ending December **1439** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 684 (47.53%)** made a measurable improvement.

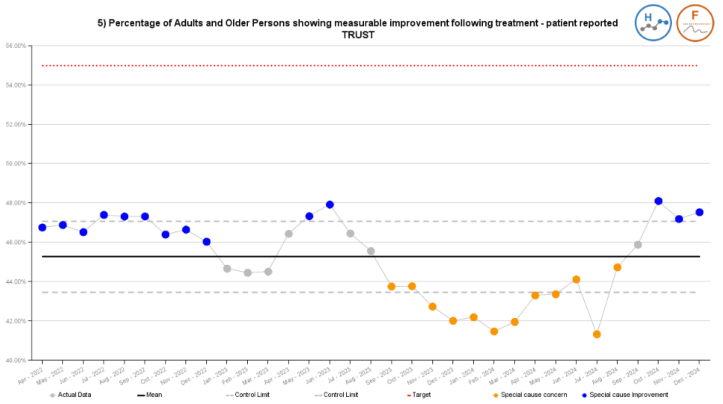
There is special cause improvement at Trust level and for North Yorkshire, York & Selby Care Group and Mental Health Services for Older People within that Care Group in the reporting period. There is no significant change for Durham, Tees Valley & Forensic Care Group. There is special cause concern at Trust and Care Group 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).

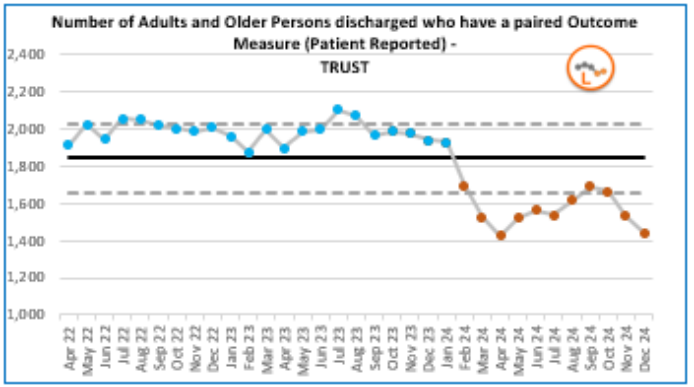
Underlying issues:
- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture.
- We do not fully understand the reasons why our adult and older persons patients are not demonstrating measurable improvement.
- The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

Actions:
- The Trust-wide Outcomes Improvement Plan is being monitored monthly by EDG. The first update was presented to EDG at the end of January, and it was agreed that the steering group would be asked to prioritise areas with the biggest impact and bring this back next month.
- Business Intelligence to implement the change to exclude patients that have died by the end of January 2025.

DQ ✓✓ 87%



The below chart represents the number of discharges with paired outcome measures.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
For the 3-month rolling period ending December **667** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 376 (56.37%)** made a measurable improvement.

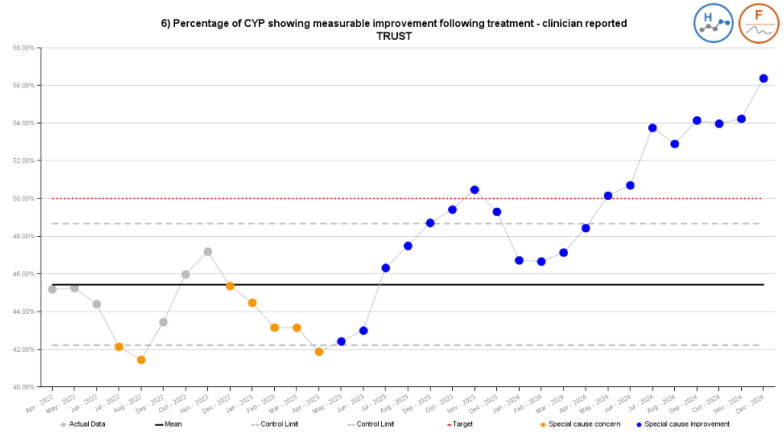
There is special cause improvement at Trust and Care Group level in the reporting period, and performance is above standard at all levels. There is special cause concern at Trust and Care Group level in the number of patients discharged with a paired outcome measure.

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)

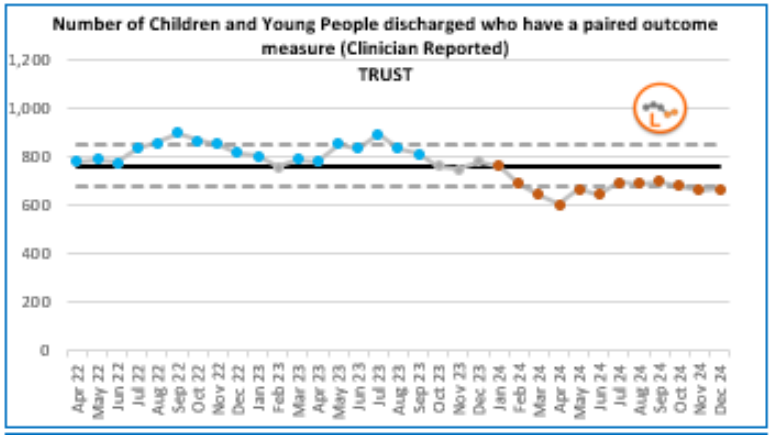
Underlying issues:
- We are not capturing timely, paired outcome measures for all of our patients that are discharged; therefore, this is not a comprehensive picture.

Actions:
- The Trust-wide Outcomes Improvement Plan is being monitored monthly by EDG. The first update was presented to EDG at the end of January, and it was agreed that the steering group would be asked to prioritise areas with the biggest impact and bring this back next month.

DQ ✓✓ 87%



The below chart represents the number of discharges with paired outcome measures.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

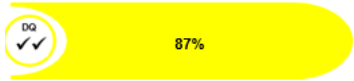
What does the chart show/context:
For the 3-month rolling period ending December **2314** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 585 (25.28%)** made a measurable improvement.

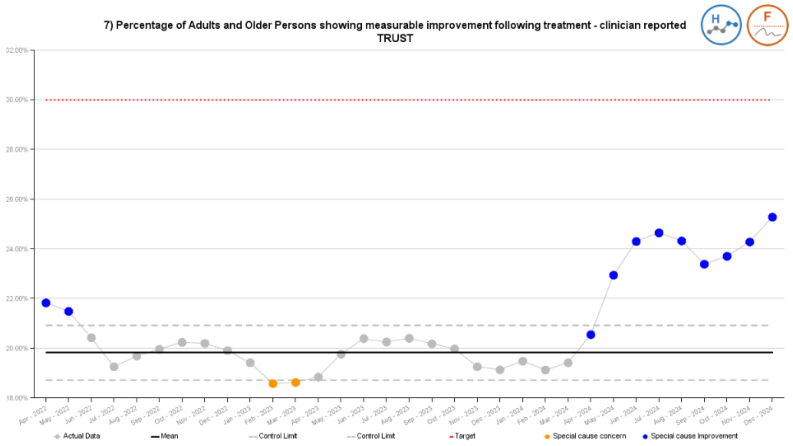
There is special cause improvement at Trust and Care Group level in the reporting period, with all underlying specialties reporting special cause improvement. Whilst there is improvement for MHSOP in both Care Groups, the low activity continues to be a concern. There is special cause concern at Trust and Care Group 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).

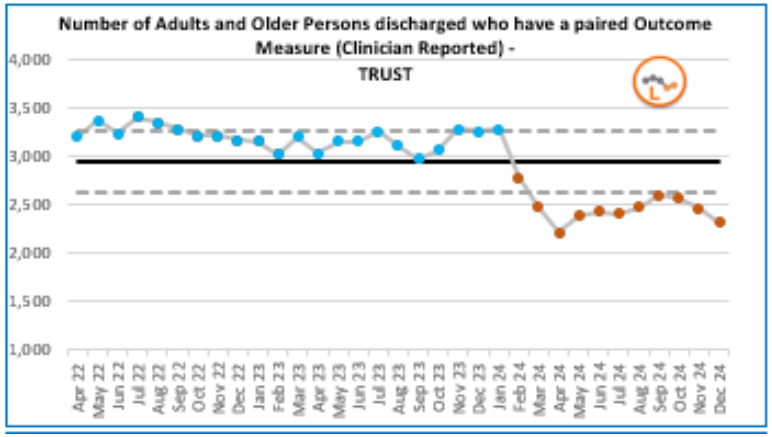
Underlying issues:
See measure 5, Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported.

Actions:
See measure 5, Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported.





The below chart represents the number of discharges with paired outcome measures.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming to have a maximum bed occupancy of 85%. (Agreed October 2024)

What does the chart show/context:
During December, **10,850** daily beds were available for patients; of those, **10,769 (99.25%)** were occupied. Overall occupancy including independent sector beds was **99.66%**.

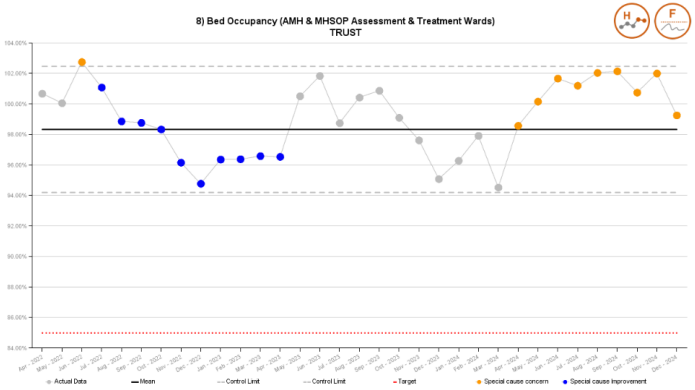
There is special cause concern at Trust and Care Group level in the reporting period.
There is special cause concern for Adult Mental Health Services in DTVFCG and in Mental Health Services for Older People in NYYSCG.

Quality Assurance Committee are fully sighted on bed occupancy and focussed on the potential impact on quality.

Underlying issues:
- Delayed transfers of care – specifically the length of time that patients are delayed in Adult Mental Health Services in DTVFCG.
- At Trust level (both Care Groups) patients classified as clinically ready for discharge equated to an average of 29.8 Adult and 32.9 Older Adult beds in December 2024, with an associated direct cost YTD of c.£6.38m (including £869k independent sector bed costs). Of the cost, c.£3.32m relates to Adult and c.£3.06m relates to Older Adult. Patient flow
- Length of stay (linked to above issues)
- Ministry of Justice (MoJ) patients

Actions:
- DTVFCG have one outstanding action on their PIP, to implement a revised discharge policy. Following Trust-wide for consultation, the policy will be presented to the January Executive Clinical Leaders Subgroup prior to being presented to Management Group for final approval in February 2025.
- 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.
- A Trust-wide Adult Mental Health patient flow workforce model is being developed to create a clearer escalation structure for operational staff both in and out of hours and is currently in the approval process. An implementation date will be confirmed in February 2025.

DQ ✓✓ 80%



Costings attached to patients clinically ready for discharge:

	Average Beds for Patients Classified as Clinically Ready for Discharge		Associated Cost for Patients Classified as Clinically Ready for Discharge	
FYTD	AMH	MHSOP	AMH	MHSOP
2023/24	25.8	16.5	£4.7m (*inc £3.34 IS bed costs*)	£1.96m
2024/25 *(as at December 2024)*	29.8	32.9	£3.32m (inc £869k IS bed costs)	£3.06m

Actions continued:
- A Trust-wide process is being developed to respond to patients who abandon calls to our crisis lines, to support the improvement of pick-up rates and patient experience. Timescales are to be confirmed.
- Durham & Tees Valley Care Group has agreed investment for Safe Havens as part of our admission avoidance work. This work will be completed in 2025/26.

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 December **194** days were spent by patients in beds away from their closest hospital.

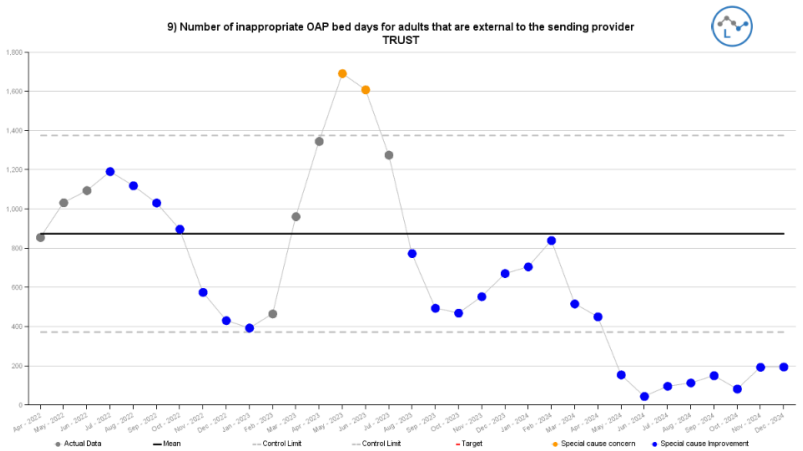
There is special cause improvement at Trust and Care Group level in the reporting period.

There were 0 active OAP placements as at 31st December 2024.

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

Actions:
See measure 8) Bed Occupancy

DQ 73%



ICB Trajectories versus actual performance for Active Inappropriate Adult Acute Mental Health Out of Areas 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	6	4	4	4	0	2	1	0
	Actual	0	0	0	0	0	2	3	2	2			
North East & North Cumbria ICB	**Plan**	7	7	6	5	4	3	3	3	2	2	1	0
	Actual	0	0	0	0	0	1	2	0	0			
Humber & North Yorkshire ICB	**Plan**	3	3	2	2	2	1	1	1	0	0	0	0
	Actual	0	0	0	0	0	1	1	2	0			

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

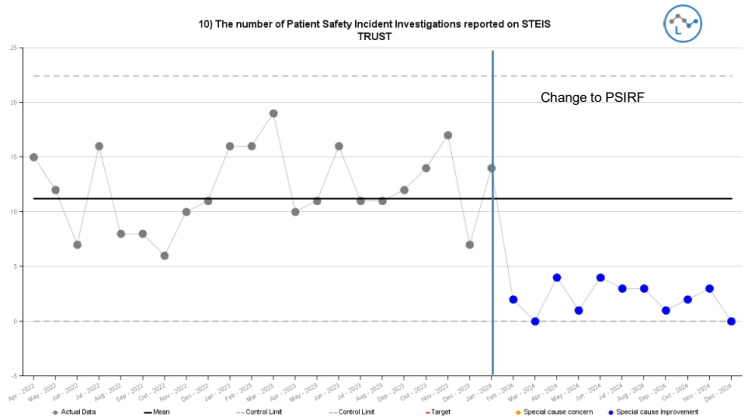
Tees, Esk and Wear Valleys NHS Foundation Trust

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

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.*

Underlying issues:
Once a PSII is identified, it is recorded on StEIS and allocated for investigation. The majority of cases that progress to PSII are identified at the point of the incident being reported. On occasions, some incidents identified as requiring investigation by an After-Action Review (AAR) may need to be escalated to a PSII after the AAR is completed based on information identified. Currently there is a delay in receiving completed AARs and potentially this could lead to a delay in identifying PSIIs.

Actions:
- The Patient Safety Team triage all incidents through a daily huddle. Where an AAR has potential to progress to a PSII, this is noted on the patient safety AAR tracker so these can be actively followed up when due.
- Care Groups have sight of the AAR tracker so they can be sighted on all AAR due dates and any AARs that are overdue.
- Patient Safety Team are actively engaged with Care Group leaders on any potential PSIIs that are delayed at AAR stage to address blockages to completion.



11) The number of Incidents of moderate or severe harm

Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is a reduction (not necessarily an improvement as indicated in the SPC chart) at Trust and Care Group level in the reporting period, as this change looks to align to the new system implementation. This is mirrored for Adult Learning Disabilities, Adult Mental Health, Children & Young Peoples Services and Health & Justice 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.

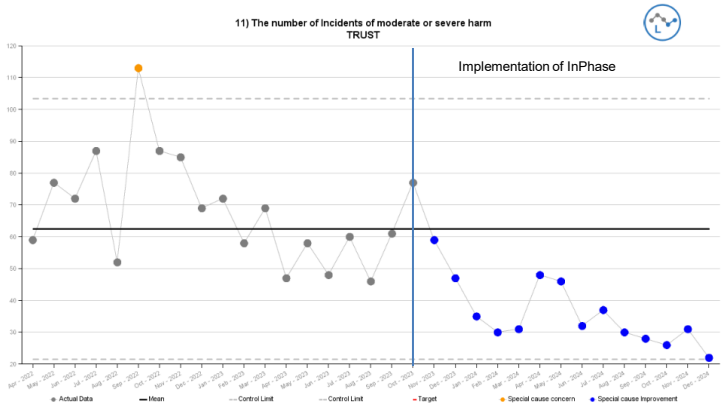
As incidents are reviewed, the severity could be reduced or increased (severity is usually reduced).

Underlying issues:
As at the 13th January 2025, there were 655 patient safety incidents in the 'awaiting investigation' stage. All will have been reported as no or low physical harm, as moderate or above severity incidents are reviewed through the Patient Safety huddle process within 1 working day. There may be a very small number of incidents of moderate or severe harm that have not been identified at the reporting stage at this severity level. This means a potential delay as these will not be identified until the incident has its first review which should be within 4 days.

Actions:
- Care Groups and Directorates are asked to embed clear monitoring processes within local governance, taking action as appropriate to support teams that may be struggling to undertake initial reviews in a timely way.
- A Quality Improvement project is underway to enable the development of a robust ward to Board incident management governance and oversight flow.
- New e-learning training has been developed and will be available via ESR by the end of January 2025.
- Patient Safety Team to provider bitesize training sessions focussing on key areas from February 2025 to provide additional support to staff when reporting and reviewing incidents.

DQ 87%

Updated November 2024



12) The number of Restrictive Intervention Used

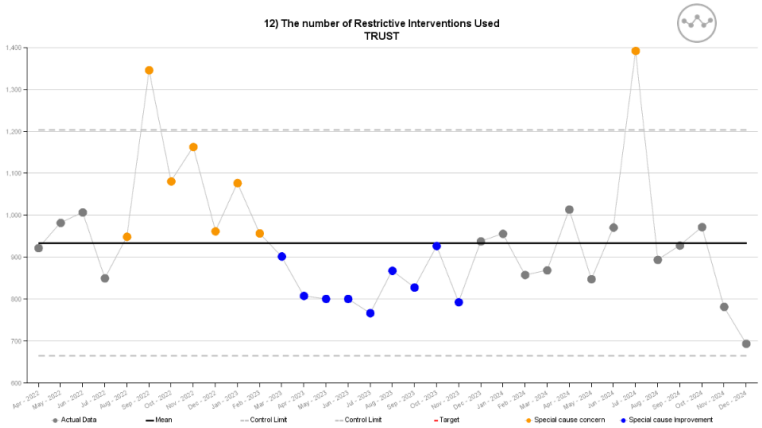
Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is no significant change at Trust and Care Group level in the reporting period. There is special cause concern in Adult Mental Health Services within Durham, Tees Valley & Forensic Care Group. Whilst there is special cause improvement indicated for Adult Learning Disabilities in DTVFCG, there are significant concerns (*see underlying issues below*). There is also special cause improvement in Children & Young Peoples Services in DTVFCG and Adult Learning Disabilities in NYYSCG.

Underlying issues:
- Concerns remain on Overdale (DTVFCG AMH Assessment & Treatment). However, the number of interventions used have significantly reduced.
- There is special cause concern for Tunstall Ward, which relates to a small number of patients.
- Concerns remain in DTVFCG ALD where there are a high number of interventions used for a small number of patients presenting with complex needs.

Actions
- There are several actions to support improvement in AMH services, which include:
  - Specialist Practitioner for Positive & Safe continues to work with Overdale Ward, to review the use of restrictive interventions and to provide education.
  - Trust-wide Autism Team providing an Autism-Informed Care Project into Overdale Ward.
  - Clinical Psychologist undertaking a piece of work on Tunstall Ward to reduce the number of headbanging incidents for a small number of patients.
  - Positive & Safe Team are providing support into Tunstall Ward to ensure that the least restrictive interventions are used.
  - DTVFCG ALD services continue to monitor the use of restrictive interventions, seeking support from the Specialist Practitioner for Positive & Safe where appropriate.



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

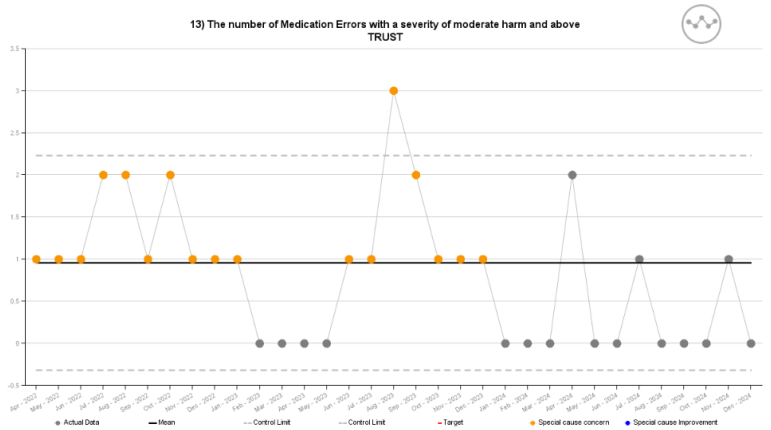
What does the chart show/context:
0 medication errors were recorded with a severity of moderate harm, severe or death during December.

There is no significant change at Trust and for North Yorkshire, York & Selby in the reporting period. There is special cause improvement for Durham, Tees Valley & Forensic Care Group and for all services within that Care Group, and for MHSOP within North Yorkshire, York & Selby Care Group.

As incidents are reviewed the severity could be reduced or increased (usually reduced), which would then be refreshed in future reports.

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

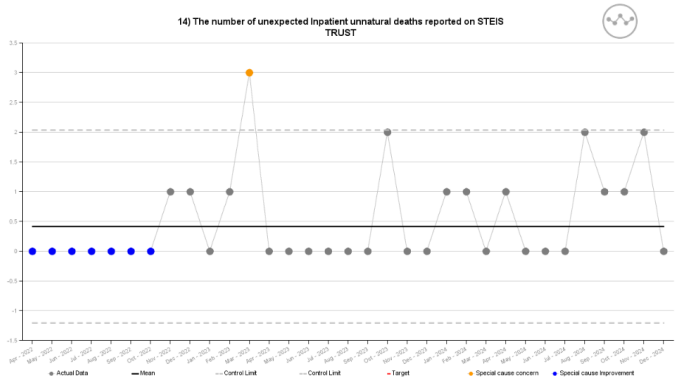
What does the chart show/context:
0 unexpected inpatient unnatural deaths on an inpatient ward (including those on leave) were reported on the Strategic Executive Information System (STEIS) during December.

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:
There are no specific improvement actions required.

DQ ✓✓ 87%



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

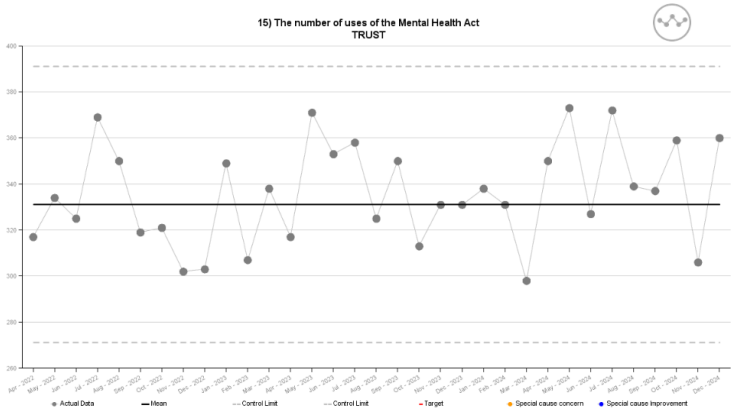
What does the chart show/context:
There were **360** uses of the Mental Health Act during December.

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

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

DQ ✓✓ 87%



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:
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.

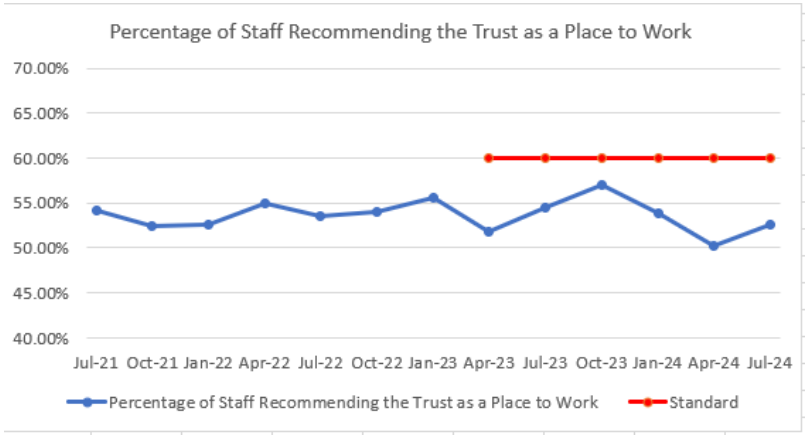
NB: *We previously identified that the number of responses being used in the calculation was not consistent. Whilst we have resolved the quarterly Pulse Survey data, we are still progressing the Annual Staff Survey data.*

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

Actions:
Organisational Development are currently visiting Trust sites to encourage staff to complete the quarter 4 National Quarterly Pulse Survey and are actively promoting the survey through a variety of communication channels, including TeamTEWV, email and Trust bulletins. Promotional activity for the Quarter 1 2025/26 survey will be undertaken in April 2025 and for the Quarter 2 survey in July 2025. *This is business as usual for the team.*

DQ

80%



** 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:
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".

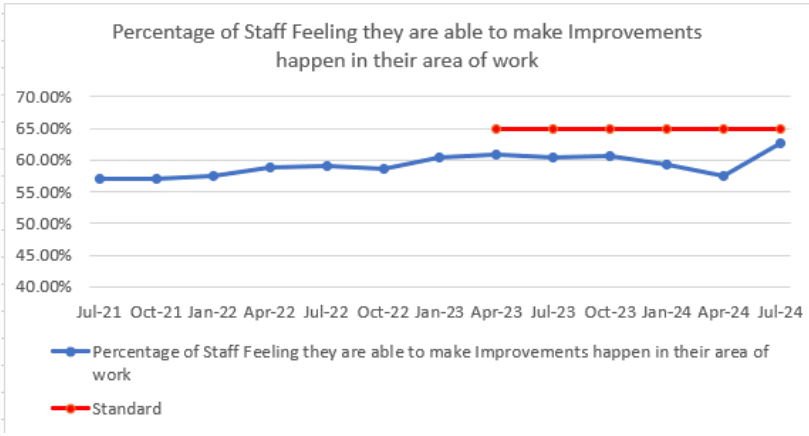
The NHS Staff Survey Benchmarking report 2023, shows the "best result" as 67.81% and the "average result" as 61.37% for similar organisations.

NB: *We previously identified that the number of responses being used in the calculation was not consistent. Whilst we have resolved the quarterly Pulse Survey data, we are still progressing the Annual Staff Survey data.*

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

Actions:
Organisational Development are currently visiting Trust sites to encourage staff to complete the quarter 4 National Quarterly Pulse Survey and are actively promoting the survey through a variety of communication channels, including TeamTEWV, email and Trust bulletins. Promotional activity for the Quarter 1 2025/26 survey will be undertaken in April 2025 and for the Quarter 2 survey in July 2025. *This is business as usual for the team.*

DQ ✓✓ 80%



** 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 **7,316.42** staff in post, 791.67 **(10.82%)** had left the Trust in the 12-month period ending December 2024.

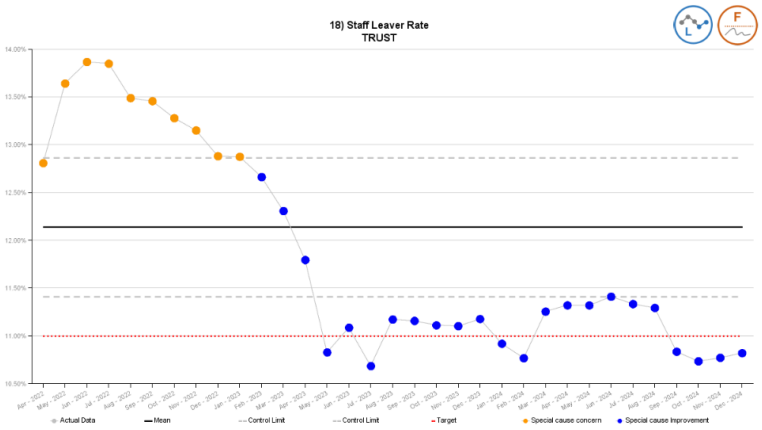
There is special cause improvement at Trust level and for most Directorates in the reporting period. However, there is special cause concern for the Assistant Chief Executive Directorate, Health & Justice and Mental Health Services for Older People within DTVFCG and Children & Young Peoples Services within NYYSCG (the directorates have confirmed there are no underlying issues).

Reasons our staff have told us why they are leaving, include:
- Staff wanting a new challenge
- Promotion
- Role not being as expected
- Work-life balance/wellbeing
- Management/team relationships
- Workload

Underlying issues:
There are no underlying issues to report.

Actions:
There are no specific improvement actions required.

DQ ✓✓ 87%



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)

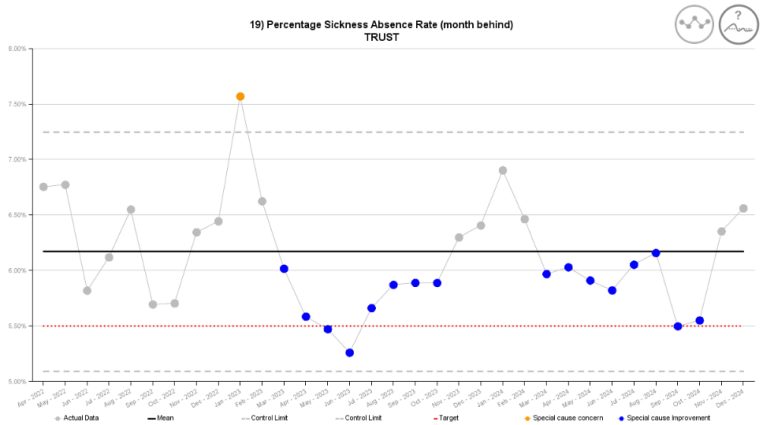
What does the chart show/context:
There were **225,258.38** working days available for all staff during November (reported month behind); of those, **14,779.27 (6.56%)** days were lost due to sickness.

There is no significant change at Trust and for most Directorates in the reporting period. There is special cause concern for Corporate Affairs & Involvement; however, the Directorate has confirmed there are no underlying issues. There is also special cause concern for Adult Mental Health Services within Durham, Tees Valley and Forensic Care Group and Management within North Yorkshire, York & Selby Care Group; however, the directorates have confirmed there is no actual concern.

National Benchmarking for NHS Sickness Absence Rates published 9th January 2025 (data ending August 2024) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.53**%** compared to the Trust mean of **6.08%**, with the Trust ranked 31 of 48 Mental Health Trusts (1 being the best with the lowest sickness rate).

Underlying issues:
- Impact of organisational processes on sickness (eg disciplinary process)
- Sickness audits have shown that the Short-Term Sickness Procedure is not being consistently followed through Trust services.

Actions:
- 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. **(Not completed)** The report will be presented to Care Group Board in January 2025.
- NYYSCG Principal People Partner has reviewed causes of long-term sickness to identify the impact of organisational processes. The findings were presented to the Care Group Governance Meetings in December 2024 **(Completed)**
- Principal People Partners to oversee the refresh of the sickness audit tool to ensure it fully captures adherence to the sickness procedure. This work will be completed by end of January 25.



20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
167,072 training courses were due to be completed for all staff in post by the end of December. Of those, **144,871 (86.71%)** were completed.

There is special cause improvement at Trust level and for most Directorates in the reporting period. There is special cause concern for Estates & Facilities Management; however, above standard. There is also special cause concern for Management in Durham, Tees Valley & Forensic Care Group.

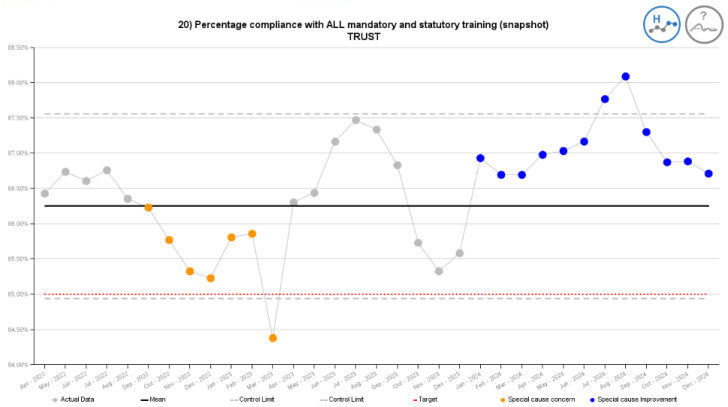
As at the 31st December 2024, by exception compliance levels below 85% are shown in the bottom right-hand table. We are currently focusing on the lowest 5 compliance levels.

	Number Compliant	Total Number	% Compliant
1) TRUST FINANCING	385	649	59.32%
2) COMPANY SECRETARY	128	157	81.53%
3) THERAPIES	2541	2998	84.76%
4) NORTH YORKSHIRE, YORK AND SELBY	35980	42380	84.90%

Underlying issues:
- A significant number of Bank staff (Trust Financing) have not completed Information Governance Data Security training; the majority of which are not actively working.
- The volume of courses that staff have to complete is extremely time consuming and above the current headroom calculation.
- Staff and managers have reported that a number of competency profiles are incorrect, which makes it difficult to understand actual compliance.
- Staff and managers find it difficult to monitor compliance due to a variety of information sources.

Actions:
- Temporary Staffing Manager to ensure the outstanding Information Governance training for Bank Staff is undertaken by the end of December 2024. **(Not Completed)** Notifications have been sent to all outstanding workers. Revised timescale to be confirmed.
- Temporary Staffing Team to target inactive Bank workers from January 2025, to ensure that any worker can only pick up a shift if they are fully compliant with training.
- Company Secretary team leaders to consider how compliance can be achieved by the end of January 2025.

93%



Actions continued:
- DTVFCG Management to review outstanding training and ensure any face to face is booked as soon as possible and any online training is completed as a priority.
- Executive Director of Therapies to ensure outstanding training is undertaken by the end of February 2025, where possible.
- A review of the process of adding new courses or a change to an existing course has concluded in December 2024. (**Completed**)
- A session with lead Directors and subject experts took place on the 6th January 2025 with a view to optimise, rationalise and reduce the training portfolio. (**Completed)**
- A systematic review of the various training courses started with Immediate Life support (ILS) at the beginning of January 2025.
- An action plan has been developed, which will rationalise the training portfolio. Actions include reducing the duration and frequency of some competencies and the removal of others. Work on the action plan, led by the Subject Matter Experts and the Education & Training Team. will start in January 2025 and will be overseen by the new Training & Education Governance Group.

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Lowest 5 Compliance

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

What does the table show/context:
We have **18** courses that are currently below the standard. We are currently focusing on the lowest 5 compliance levels.

The trajectory for Resuscitation – Level 3 – Adult Immediate Life Support – 1 Year has not been achieved and we are now expecting to achieve 81% compliance by the end of March 2025, pending the release of new training dates in April.

Underlying issues:
- 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 North Yorkshire
- Incident Reporting Level 1 is currently not available on ESR to complete and there are not enough face-to-face courses available.

Actions:
- Training Department are actively following up all staff who do not attend their training sessions.
- The training portfolio for Positive & Safe is 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.
- Extra dates have been added to support Incident Reporting Level 1 training, and E-Learning is expected to be available by the end of November 2024. **(Not completed)** Work to create the e-learning will be completed by the end of February 2025.
- Education & Training Team will work with Managing Directors and Directors of Operations to support any lack of training rooms in North Yorkshire as they arise.
- Workforce Development Lead to complete a capacity and demand exercise for all face to face or Microsoft Teams training to identify any gaps and to support the production of trajectories for the year. This will be completed by the end of January 2025.
- Daily reviews of staffing are in place across the Care Groups to ensure that the right staff with the right training are in place to respond to any issues that arise, and staff will be moved to ensure we have the right skill mix available on our wards.

	Number Compliant	Total Number	% Compliant
1) Incident Reporting Level 1	5085	7827	64.97%
2) Positive and Safe Care Level 2 Update*	1170	1786	65.51%
3) Resuscitation - Level 1 - 1 Year*	1706	2594	65.77%
4) Rapid Tranquilisation 1	208	300	69.33%
5) Positive & Safe Care Level 1*	3046	4356	69.93%
6) Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	666	943	70.63%
7) Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1468	2015	72.85%
8) Safe Prescribing	229	294	77.89%
9) Moving and Handling - Level 2 - 2 Years	727	917	79.28%
10) Infection Prevention and Control - Level 2 - 1 Year	4989	6167	80.90%
11) Annual Medicines Optimisation Module	1799	2218	81.11%
12) MCA - MCA and Young People Aged 16/17	755	929	81.27%
13) Mental Health Act Level 2	3219	3953	81.43%
14) MCA - Relationship Between MCA and MHA	3434	4176	82.23%
15) MCA - Restraint	3438	4172	82.41%
16) Rapid Tranquilisation 2	486	585	83.08%
17) MCA - Deprivation of Liberty	3477	4168	83.42%
18) Controlled Drugs - Inpatient	469	554	84.66%

**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 **6,874** eligible staff in post at the end of December; **6019 (87.56%)** had an up-to-date appraisal.

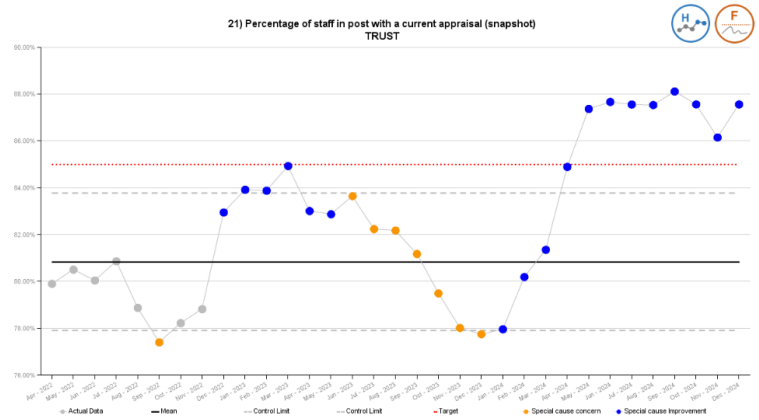
There is special cause improvement at Trust level and for most areas in the reporting period. Whilst there is special cause improvement for Digital & Data Services and Mental Health Services for Older People in NYYSCG and there is no significant change for Estates & Facilities Management, decreasing positions are seen.

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

	Number Compliant	Total Number	% Compliant
1) COMPANY SECRETARY	7	14	50.00%
2) CAPITAL PROGRAMME	7	10	70.00%
3) CORPORATE AFFAIRS AND INVOLVEMENT	30	38	78.95%
4) THERAPIES	35	42	83.33%
5) ESTATES AND FACILITIES MANAGEMENT	333	392	84.95%

Underlying issues:
- We have a small number of directorates not achieving standard (*see above*).
- A number of NYYSCG staff are aligned to an incorrect service on ESR.

Actions:
- The Company Secretariat has been impacted by staff absence on which EDG are fully cited. Team leaders to consider how compliance can be achieved by the end of January 2025.
- Outstanding appraisals will be undertaken in Capital Programme and Therapies by the end of February 2025.
- Outstanding appraisals were to be undertaken in Corporate Affairs & Involvement by the end of December 2024. (**Not Completed**) All outstanding will be completed by the end of February 2025.
- Outstanding appraisals were to be undertaken in Estates & Facilities Management by the end of December 2024 (delayed from November). (**Not Completed)** noting as at the 7th January 2025, the directorate is achieving 85%.
- Outstanding appraisals will be undertaken in DTVFCG Children & Young Peoples Services by the end of January 2025.



Actions continued:
- It has been identified that in NYYSCG a group of staff are incorrectly aligned on ESR. Medical Staffing to realign the staff by the end of January 2025.
- Associate Director of Improvement & Redesign to provide further advice and guidance on how to log appraisals (and supervision) on TEWVVision by the end of March 2025.
- The new Appraisals Procedure has been developed and will be presented at Joint Consultative Committee in December 2024. **(Completed)**

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

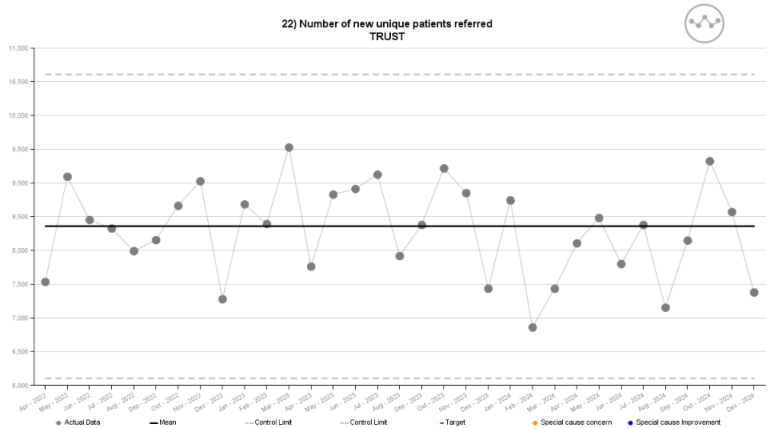
What does the chart show/context:
7379 patients referred in December that are not currently open to an existing Trust service.

There is no significant change at Trust and Care Group level in the reporting period. However, there are a number of unexpected shifts of referrals. There are low shifts for Children & Young Peoples Services and Health & Justice within Durham, Tees Valley & Forensic Care Group and for 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

DQ ★ 93%



23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

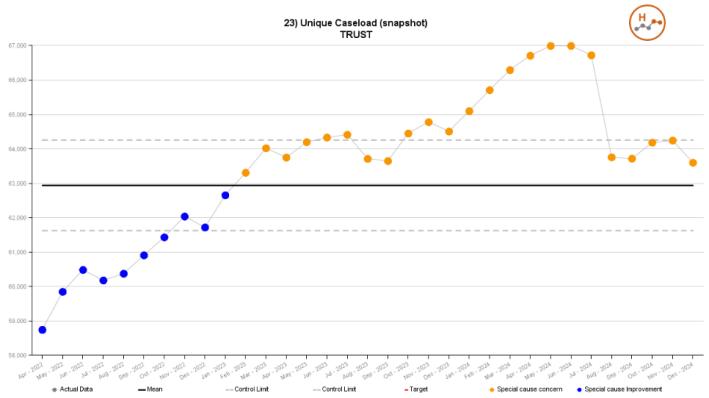
What does the chart show/context:
63,600 cases were open, including those waiting to be seen, as at the end of December 2024; **53132** were active.

There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period (including in AMH and CYP in that Care Group). There is also special cause concern for ALD and H&J; however, the service has confirmed there is no actual concern. Whilst there is no significant change for North Yorkshire, York & Selby Care Group, there is special cause improvement for ALD and AMH. There is also special cause improvement for MHSOP and SIS within Durham, Tees Valley & Forensic Care Group.

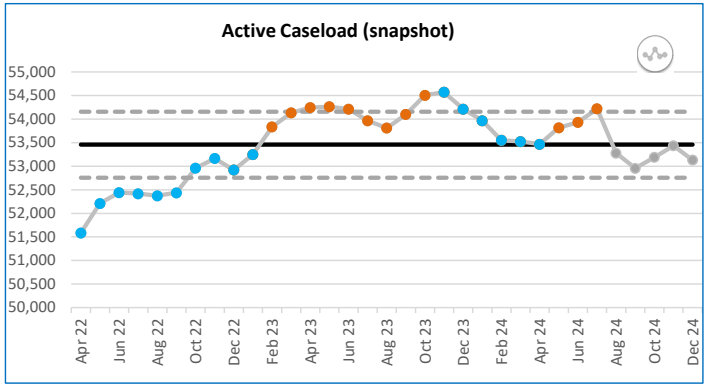
The **new SPC chart** representing **Active Caseload** (excluding patients waiting for first contact) shows no significant change at Trust level and for Durham, Tees Valley & Forensic Care Group and there is special cause improvement for North Yorkshire, York & Selby Care Group.

Underlying issues:
Whilst there is special cause concern in Unique Caseload, the new Active Caseload measure demonstrates no significant change; however, given this is a new measure we are unable to confirm whether there is any cause for concern at specialty level.

Actions:
- Business Intelligence teams to develop a supporting measure for active caseload by the end of December 2024. **(Completed)**
- Business Intelligence team to promote the Active Caseload measure within the Integrated Information Centre by the end of January 2025, which will support the identification of any issues at specialty level.
- Findings of the caseload deep dive on CYP services have been shared with the Care Groups who will now collectively agree next steps by the end of January 2025 and present back to EDG.



The below chart represents the active caseload, excluding patients waiting for their first contact.



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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

P — Our system is hitting the target/expectation

DQ ★ — 93%

What does the data show/context:

The financial position to 31st December 2024 against which Trust performance is assessed is a deficit of **£2.128m which amounts to a £0.905m 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 Schemes (CRES).

- **Agency expenditure** for the year to date is £7.87m, which is £1.57m below plan and showing a continued downward trajectory. In month costs were £0.39m which is a decrease of £0.40m from prior month, and well below the national cap of 3.2% of paybill; being 2.15% in month, and 2.74% year to date. The Trust has achieved significant agency WTE and expenditure reductions since April 2023. This reflects sustained impacts from actions to exit non-clinical agency assignments, reducing costs relating to complex care packages following the discharge of a small number of adults with a learning disability, and reducing inpatient agency headcount. Ongoing usage includes high premia rate locum costs for cover of Health and Justice nursing and Trustwide medical vacancies. The Temporary Staffing Service is now supporting incremental rate reductions in the former. The trust continues to have **no off-framework agency assignments**.
- **Independent sector beds** - the Trust used 151 non-Trust bed days in month (201 in November); a decrease of 50 bed days compared with the previous month. Year to date costs were £0.87m, which includes estimates for unvalidated periods of occupancy and average observation levels pending billing and is £0.46m below plan. 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. It is hoped that new OPEL and bed management processes (Monday to Friday) will support optimal daily management and flow.
- **Taxis and Secure Patient Transport** costs were £1.80m (£201k average run rate) to 31st December compared to a plan, based on exit run rates, of £178k per month (or £1.602m for 9 months), and a £201k 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. Due to limited sustained impact an improvement workshop took place on 20th November including both Care Groups and corporate teams. Procurements for both taxis and secure transport are expected to reduce unit costs / improve oversight during the later stages of 2024/25.
- 2024/25 plans assume delivery of 4.5% £21.78m **Cash Releasing Efficiency Savings (CRES)** for the year, with £15.7m plans being recurrent and £6.055m non–recurrent. £2.055m unidentified non-recurrent CRES assumed at plan has now been fully identified from corporate, estates/facilities and central directorates. Year to date CRES are £0.236m ahead of plan, but with recurrent schemes delivering £0.484m lower, and non-recurrent schemes delivering £0.721m higher, than planned.

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

Pay Awards for colleagues were paid in Months 7 and 8. Whilst tariff-based national funding was received for pay awards, this does not cover the higher impact for non-acute providers of our higher pay cost weight. Additional non-recurrent funding was received from Commissioners in 2024/25 to mitigate the impact in-year. Plans have been adjusted to reflect the additional tariff-based income and expenditure, to better reflect the funded position.

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 high occupancy, safe staffing requirements and agency expenditure are impacting our financial plan, with ward staffing remaining above funded levels. Agency price cap breaches at premia rates, with 42% of (a reducing number of overall) agency shifts being above price cap, are impacting overall value for money, with medical and Health and Justice vacancy hotspots.
- 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 approval is sought for a further extension to the end of March 2025 (from October 2024).
- The Agency Reduction PIP is progressing. Three actions have been completed and have had the desired impact: an increased number of bank workers to reduce Health Care Assistant Agency usage in DTVFCG, a review of the outsourcing timeframes within DTVFCG, and an increased number of bank workers to reduce Health Care Assistant Agency usage in NYYSCG. In DTVFCG work to reduce the number of shifts filled by agency has been completed and whilst the desired 23% reduction has not been achieved, there has been a 15% reduction. The cessation of accommodation costs has not been completed and an extension is requested to the 30th September 2025. 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 not be completed by the 31st January 2025 and an extension is requested to the end of September 2025.
- An Efficiency Hub oversees 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.
- Information on workforce costs and Whole Time Equivalents (WTE) has been enhanced and is being shared to support a renewed focus on driving cost efficiency.

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 £7.87m at Month 9 are £1.57m below plan. In-month expenditure of £0.39m is £0.56m lower than plan and £0.4m less than in month 8.

NHS planning guidance for 2023/24 introduced system agency cost caps of 3.7% pay bill, reducing to 3.2% pay bill for the current financial year. Performance in month was 2.15%, and 2.74% for the year to date, having reduced from around 4.5% on average through 2023/24 and 5.4% on average through 2022/23.

Reducing reliance on agency shifts and on medical / health and justice shifts paid above national price caps remains a key focus. Agency shifts have reduced by the equivalent of 159 worked Whole Time Equivalent (WTE) since April 2023 (240 WTE) to December 2024 (81 WTE), and related annualised premia reduced from £4.0m in April 2023 to £2.4m in December 2024 (£1.6m reduction). Whilst the trend for medical WTE and price cap breaches was broadly positive between April 2023 and December 2024, assignments increased in October 2024, going against trend and impacting premia incurred. With that exception, run rates demonstrate the positive impacts from actions taken to date and the benefit from sustained focus to improve framework compliance and reduce numbers of shifts filled using agency.

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 developed a **Performance Improvement Plan** to track actions 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 (the latter notably to tackle price cap breaches in Health and Justice), to manage high occupancy levels and delayed transfers from inpatient wards (including with system collaboration) and to use temporary staffing more optimally including through improved rostering and by regularly reviewing our safer staffing levels relative to clinical need.

Actions:

The Executive Directors Group (formerly Executive Workforce and Resources Group) will oversee 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 to optimise their use of the roster. Care Groups are being asked to hold monthly governance meetings reviewing roster KPIs such as timely publications of rotas and management of headroom.
- 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:

1,526 agency shifts were worked in December 2024, with **940 shifts compliant** (62%) and **586 non-compliant** (38%) (prior month 1,085 shifts compliant or 60% and 722 non-compliant or 40%) **with national price caps**.

Most price cap breaches during 2024/25 have related to medical or prison nursing cover for hard to fill vacancies. In month 76% of non-compliant shifts (93% by value of breaches) are medical and 22% of non-compliant shifts (7% by value of breaches) are nursing. Of the nursing agency breaches, 98% of shifts relate to prisons (99.81% by value of breaches). Medical shifts breaching decreased from 541 shifts in November to 445 in December 2024 (100% shifts breach price cap).

270 fewer overall agency shifts were worked this month compared to last, with shifts worked being equivalent to **approximately 49 shifts per day** (60 in November and 69 in October). The 270 agency shift decrease in month includes 96 fewer medical (36% decrease), 86 fewer nursing agency (32% decrease), 13 fewer AHP agency shifts (0.05% decrease), and 75 fewer HCA agency shifts (28% decrease). Actions are in train to review the financial forecast, including looking at numbers of medic working days.

This reflects a reduction in total shifts worked of 1,256 (45%) over the 12 months from 2,782 shifts worked in December 2023 and **a reduction of 45% or 482 shifts breaching price cap since December 2023** (1,068 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, but with both on downward trajectories currently.
- 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:
Particularly 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.
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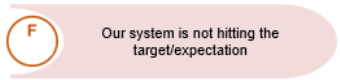
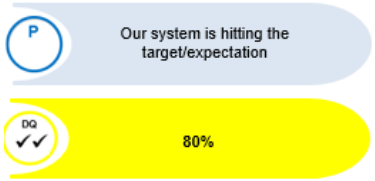


Updated November 2024

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 December.
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 -0.56% which is a **rating of 3**.
- The Income and Expenditure **(I&E)** margin distance from plan is 0.33% 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 £7.87m are below plan and would therefore be **rated as a 1.** The Trust's year to date agency costs were 2.74% 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 December 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 December was £11.286m which was below plan by £0.48m. The previous month reported recurrent CRES was £0.64m behind plan, the £0.16m in month improvement against plan includes the confirmed over-delivery of agency reduction CRES in Adult Mental Health within DTVCG.

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.
- Schemes that are underperforming include International Nurse recruitment (behind by £0.62m) second cohort not progressing, LED lighting (behind by £0.27m), Over Establishment (behind by £0.29m) and EFM non-pay (behind by £0.20m).

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.

Updated November 2024

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:
Non Recurrent CRES performance was ahead of plan by £0.72m for the period ending 31st December, with £2.95m having being achieved.

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

The Trust planned to deliver **£6.055m 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 £2.055m to be identified. This has now been fully identified from corporate, estates/facilities and central directorates. Work is ongoing to assess whether any of the additional schemes are recurrent schemes, potentially offering some mitigation to recurrent under performance.

Of the £0.72m overachievement year to date, £0.60m reflects non-recurrent mitigation of the Over Establishment Target, with an additional £0.073m reflecting a negotiated water rebate.

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.

Updated November 2024

29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

Capital expenditure was **£3.96m** at the end of December and **less than allocated by £1.70m**.

£8.51m 2024/25 capital schemes were 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 secured £2.14m 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 £11.43m** (including £0.37m PFI life-cycle).

The underspending for the year to date is linked to slippage against schemes and will be managed, including with Integrated Care System Partners, within this financial year.

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, with significant oversight now needed to ensure commitment of resources in the remaining 3 months of the financial year. 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)

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:

The Trust had cash balances of **£51.31m** at the end of December 2024 which exceeded planned cash balances of **£48.78m** by **£2.44m** (favourable variance).

- This is mainly linked to the slippage in the capital programme and the favourable revenue plan variance, 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 a combined Better Payment Practice Code (BPPC) compliance of 95.2% to date for the prompt payment suppliers, which is ahead of the 95% target. 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 at 31 December 2024 was £1.82m, with debts exceeding 90 days amounting to £0.55m (excluding amounts being paid via instalments and PIPS loan repayments). Progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged.

Underlying issues:

In addition 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 - supporting change	6. Estate / Physical Infrastructure	7. Data Security and Protection	8. Quality Governance	9. Partnerships and System Working	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

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines*

- **72 hour follow up** Achieved target in all areas.
- **EIP waiting times** We have failed target in Vale of York and there is no significant change; however, we have achieved target in all other areas.
- **Talking Therapies waiting times (6 and 18 weeks)** Achieved target in all areas.
- **Child Eating Disorders waiting times:** Whilst we have failed target in all areas for **routine** referrals, there is special cause improvement indicated in the SPC charts. We have failed target in all areas for **urgent** referrals and there is cause for concern in North Yorkshire and Vale of York; however, there is no significant change in County Durham and improvement in Tees Valley. These are not areas of concern as the reasons were patient choice, patients required hospital admission, data quality and CITO issues; the latter of which have been addressed.
- **Talking Therapies: 1st to 2nd treatment waits** – We have 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** We have failed target in County Durham and there is no significant change. **Reliable Improvement** failed targets in County Durham and Tees Valley and there is no significant change.
- **Children: 1 contact** We have failed target and there is special cause concern in all areas. **Paired Outcomes** failed target and no significant change in all areas, except for County Durham where there is special cause concern.
- **Access to transformed community services** We have failed target in County Durham, however achieved target in Tees Valley; there is special cause improvement for both areas as an increased number of PCNs (all in Tees Valley) have now completed transformation. We have failed target and there is special cause concern in North Yorkshire and Vale of York.
- **Active OAP (inappropriate)** Achieved target in both areas.
- **Specialist Community Perinatal Mental Health (PMH) services** We have achieved target in County Durham and Tees Valley. We have failed target in North Yorkshire and Vale of York; however, there is special cause improvement in both areas.

*All headlines are based on financial year to date unless otherwise stated.

National Quality Standards and Mental Health Priorities Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

- 72 Hour Follow Up
- Talking Therapies waiting times (6 and 18 weeks)
- Active OAP (Inappropriate)

Risks & Issues

- EIP Waiting Times (Vale of York)
- Talking Therapies 1st to 2nd treatment (County Durham, Tees Valley, Vale of York)
- Talking Therapies Reliable Recovery (County Durham)
- Talking Therapies Reliable Improvement (County Durham & Tees Valley)
- CYP 1 contact
- Childrens Paired Outcomes
- Access to transformed community services (North Yorkshire & Vale of York)
- Specialist Community PMH services (North Yorkshire & Vale of York)

Mitigations

EIP Waiting Times (Vale of York)

Originally anticipated for the end of December, it is expected the backlog of patients waiting will be addressed and new patients will start treatment within 2 weeks by the end of January 2025.

Talking Therapies:

- **1st to 2nd treatment (County Durham, Tees Valley, Vale of York)**
- **Reliable Recovery (County Durham)**
- **Reliable Improvement (County Durham & Tees Valley)**

A Task & Finish Group has been established to oversee a Trust-wide deep dive. Data is currently being sourced to provide a triangulated understanding of the service from a staffing, finance, activity and clinical outcomes perspective. This will be completed by the end of February 2025 to inform the development of a Trust-wide action plan by the end of March 2025. In addition, the Care Groups are still progressing their individual performance improvement plans in relation to these services.

National Quality Standards and Mental Health Priorities Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Mitigations

CYP 1 contact

The 2023/24 baseline data used to develop the 2024/25 County Durham and Tees Valley plans was influenced by the short-term realignment of staff and overtime, particularly to address screening backlogs in neurodevelopmental services. This has now ended, resulting in expected 5% lower activity levels. The General Manager is to work with Finance to confirm the 5% drop in access is attributable to the return of staff to their substantive posts and the cessation of overtime; this work has been delayed (from December 2024) and will now be completed by the end of January 2025. In North Yorkshire & York, the 2023/24 baseline data was influenced by the use of a number of surge and other posts. Following the removal of these posts, the York and Selby SPA teams were placed in business continuity. The service has recruited to all vacancies and new staff will undergo induction processes and shadowing, and the teams are expecting to come out of business continuity at the end of January 2025. Whilst increased access is anticipated by the end of March, achievement of the plans is not anticipated. Analysis will be undertaken to provide assurance that any reduction is directly attributable to the removal of surge and other unfunded posts.

Childrens Paired Outcomes

The Trust-wide Outcomes Improvement Plan is being monitored on a monthly basis by EDG. The first update on progress is going to EDG on 28th January 2025.

Access to transformed community services (County Durham, North Yorkshire & Vale of York)

In County Durham the remaining three PCNs will be transformed by the end of March 2025; however, the chart shows that were all PCNs transformed, the target would still not be achieved. Further work has been agreed to restructure the Durham Adult Mental Health Community Teams which should help to improve access. In North Yorkshire & York, the Ripon and Scarborough Community team are in business continuity with recovery plans in place. Recruitment of staff is underway and in the interim, some posts have been back filled through agency staff and overtime is being offered. Data is currently being sourced to provide a triangulated understanding of the access to our adult and older adult services. This will be completed by the end of January 2025 to inform the identification and development of any required improvement actions.

Specialist Community PMH services (North Yorkshire & Vale of York)

The Perinatal teams are in business continuity and have a recovery plan in place. There are several key mitigating actions in place to support improvement which are the completion of a capacity and demand exercise (first draft will be produced by the end of January 2025). A Rapid Process Improvement Workshop was held in January, with a more efficient referral, screening and allocation process being implemented across the service. Local leadership has been strengthened with interim cover put in place for vacancy whilst recruitment continues. The output from these mitigating actions will inform the longer term structural and capacity requirements and any inefficiencies in process and structure.

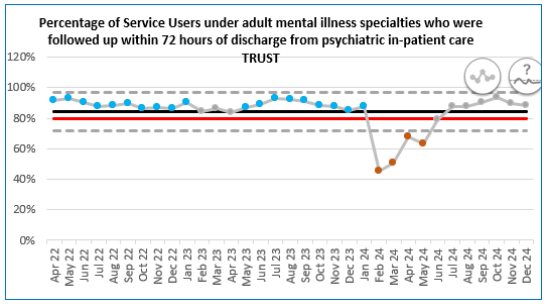
National Quality Standards and Mental Health Priorities Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

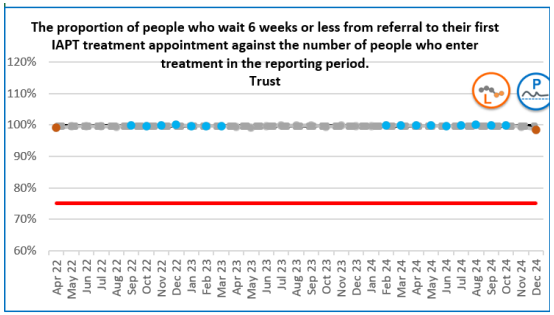
National Quality Requirements	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care		?	80%	83.07%	80%
Percentage of Service Users experiencing 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%	63.87%	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	L	P	75%	99.64%	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%	73.68%	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	F	<10%	30.34%	<10%
Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness		?	48%	48.51%	48%
Talking Therapies: Reliable improvement rate for those completing a course of treatment		?	67%	66.88%	67%
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months)	L	P	29797	28486	29797
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	L	F	40%	20.40%	40%
Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12 months)	H	F	22955	21609	22955
Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs)		?	2	0	0
Number of women accessing specialist community PMH services in the reporting period (rolling 12 months)	H	?	1427	1523	1427

National Quality Requirements

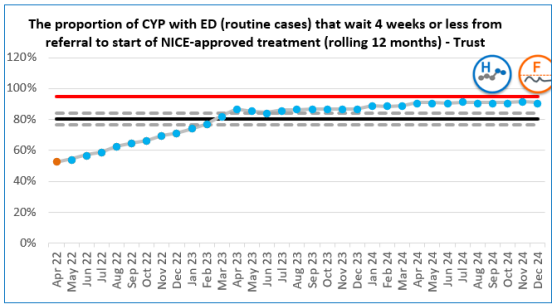
NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



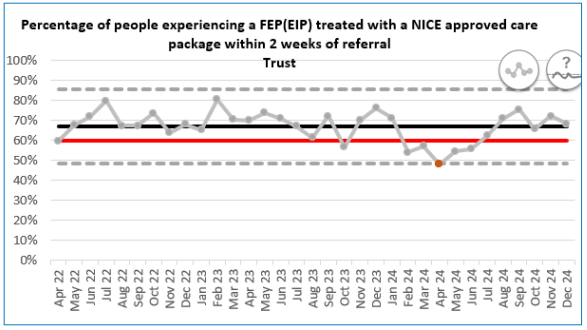
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	80%	83.07%			
County Durham	80%	82.66%			
Tees Valley	80%	81.97%			
North Yorkshire	80%	84.38%			
Vale of York	80%	86.00%			



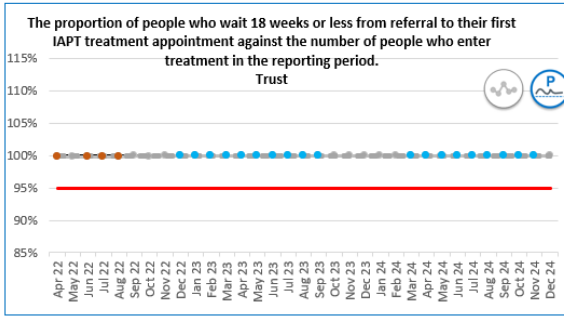
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	75%	99.64%			
County Durham	75%	99.87%			
Tees Valley	75%	99.82%			
North Yorkshire	75%	99.54%			
Vale of York	75%	99.16%			



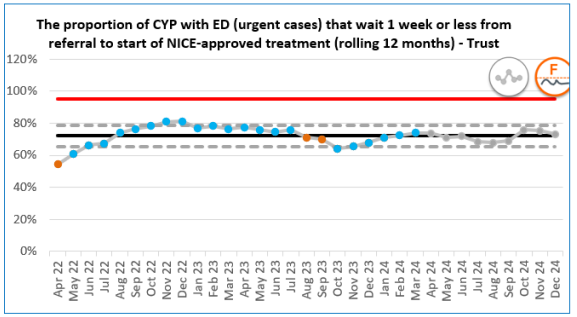
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	90.79%			
County Durham	95%	86.36%			
Tees Valley	95%	94.05%			
North Yorkshire	95%	91.49%			
Vale of York	95%	94.44%			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	60%	63.87%			
County Durham	60%	65.59%			
Tees Valley	60%	67.58%			
North Yorkshire	60%	67.86%			
Vale of York	60%	38.60%			



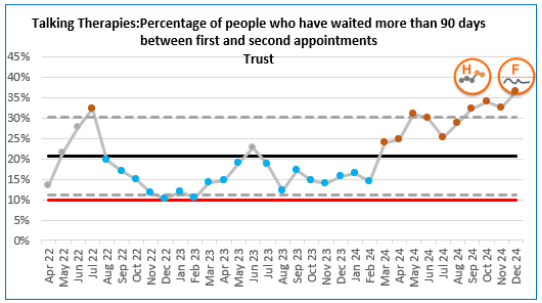
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	99.99%			
County Durham	95%	100%			
Tees Valley	95%	100%			
North Yorkshire	95%	100%			
Vale of York	95%	99.94%			



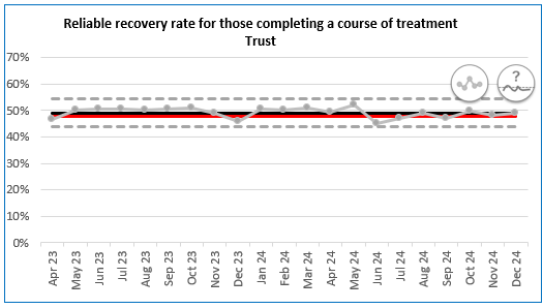
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	95%	73.68%			
County Durham	95%	76.67%			
Tees Valley	95%	92.31%			
North Yorkshire	95%	63.64%			
Vale of York	95%	33.33%			

Local Quality Requirements

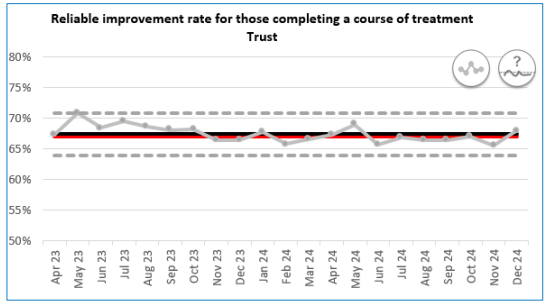
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	<10%	30.34%			
County Durham	<10%	44.07%			
Tees Valley	<10%	50.26%			
North Yorkshire	<10%	8.29%			
Vale of York	<10%	33.66%			



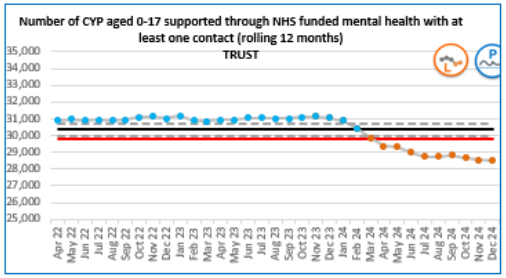
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	48%	48.51%			
County Durham	48%	45.95%			
Tees Valley	48%	49.38%			
North Yorkshire	48%	50.02%			
Vale of York	48%	51.83%			



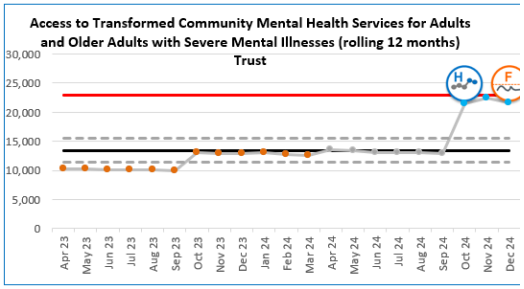
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	67%	66.88%			
County Durham	67%	63.47%			
Tees Valley	67%	63.37%			
North Yorkshire	67%	69.01%			
Vale of York	67%	72.21%			

Local Quality Requirements

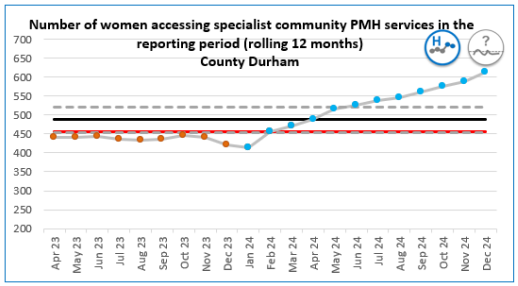
Tees, Esk and Wear Valleys NHS Foundation Trust



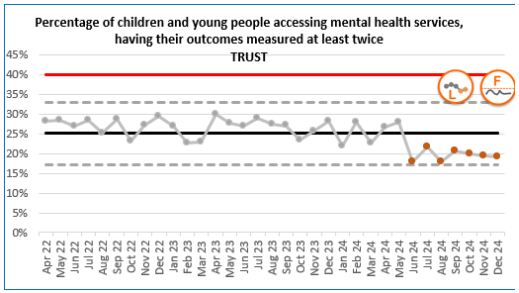
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	29797	28115			
County Durham	10012	9715			
Tees Valley	11218	11015			
North Yorkshire	5429	4574			
Vale of York	3138	2811			



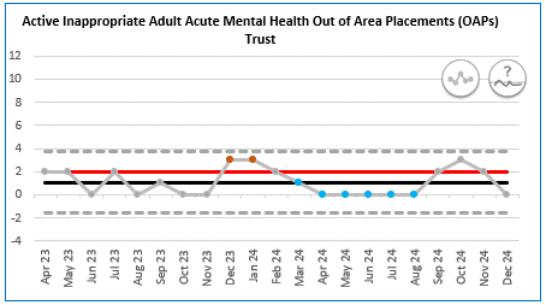
Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	22955	21609			
County Durham	8240	6330			
Tees Valley	7535	8777			
North Yorkshire	4853	4434			
Vale of York	2327	2068			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	1427	1523			
County Durham	456	612			
Tees Valley	447	484			
North Yorkshire	368	293			
Vale of York	156	134			

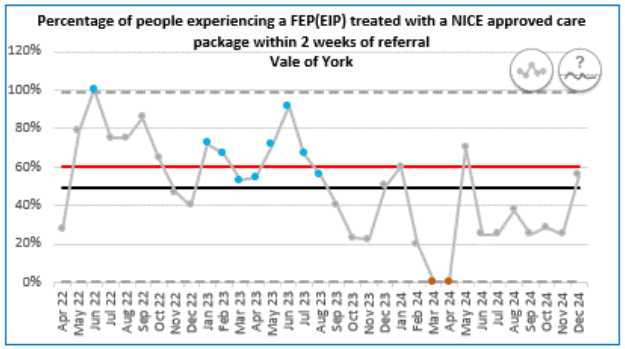


Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	40%	20.59%			
County Durham	40%	17.64%			
Tees Valley	40%	24.01%			
North Yorkshire	40%	25.11%			
Vale of York	40%	14.76%			



Organisation	Target	Actual	Variation	Assurance	Plan Met
Trust	2	0			
County Durham	2	0			
Tees Valley		0			
North Yorkshire	0	0			
Vale of York		0			

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 – *by exception*



Background / standard description:
We are aiming to see **60%** of service users experiencing a first episode of psychosis or ARMS (at risk mental state) within two weeks to start a NICE-recommended package of care

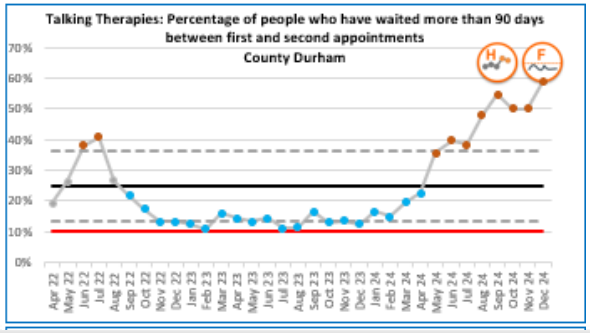
What does the chart show/context:
During December 9 patients were placed on Early Intervention of Psychosis (EIP) pathway; of these, 5 **(55.56%)** commenced a NICE approved treatment within 2 weeks within **Vale of York**.

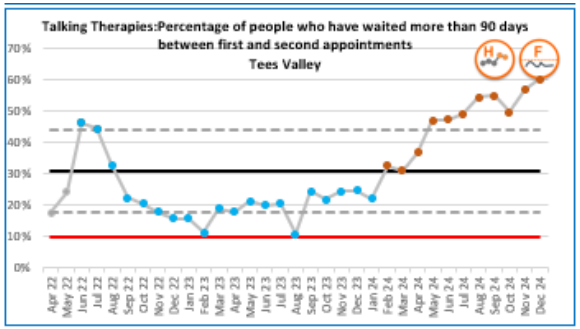
Underlying issues:
There are no underlying issues identified.

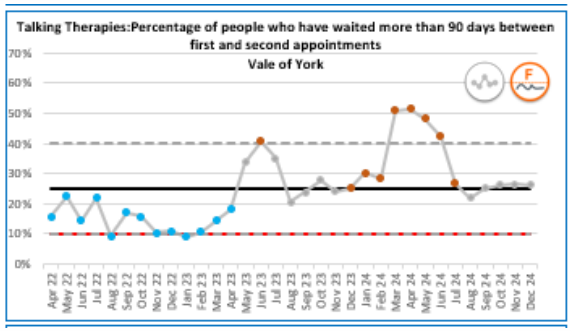
Update:
- Originally anticipated for the end of December, it is expected the backlog of patients waiting will be addressed and new patients will start treatment within 2 weeks by the end of January 2025.
- We are developing an EIP Waiters Dashboard on our Integrated Information Centre (IIC) with a corresponding patient tracker list so there is oversight and full transparency of the patients waiting and whether they have appointments booked that can initiate treatment (Currently this is a manual dashboard which is only updated once each week)

Talking Therapies: Percentage of people who have waited more than 90 days between first and second appointments – *by exception*

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust







Background / standard description:
We are aiming to have less than 10% of people waiting more than 90 days between their first and second Talking Therapies appointment.

What does the chart show/context:
During December **536** had a second appointment with our services, of those **314 (58.66%)** people waited over 90 days between their 1st and 2nd appointment within **County Durham**.

Background / standard description:
We are aiming to have less than 10% of people waiting more than 90 days between their first and second Talking Therapies appointment.

What does the chart show/context:
During December **83** had a second appointment with our services, of those **50 (60.24%)** people waited over 90 days between their 1st and 2nd appointment within **Tees Valley**.

Background / standard description:
We are aiming to have less than 10% of people waiting more than 90 days between their first and second Talking Therapies appointment.

What does the chart show/context:
During December **141** had a second appointment with our services, of those **37 (26.24%)** people waited over 90 days between their 1st and 2nd appointment within **Vale of York**.

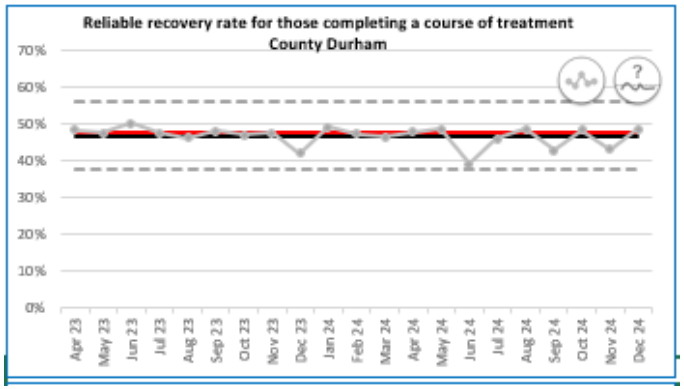
Underlying issues:
- Capacity of Psychological Wellbeing Practitioner (PWP) (high levels of step 2 vacancies/absence/sickness)
- High levels of people accessing Step 3 care, bypassing Step 2 appropriately
- Fewer people being allocated to Computerised Cognitive Behaviour Therapy (cCBT) and workshops due to their complexity of need
- Higher demand for face-to-face appointments in specific localities
- Counselling for Depression demand exceeds capacity
- High levels of priority group (perinatal, veterans, high risk) patients

Underlying issues:
Underfunding within Step 2 and Step 3

Actions (Trust-wide):
A Task & Finish Group has been established to oversee a Trust-wide deep dive. Data is currently being sourced to provide a triangulated understanding of the services from a staffing, finance, activity and clinical outcomes perspective. This will be completed by the end of February 2025 to inform the development of a Trust-wide action plan by the end of March 2025. In addition, DTVFCG have revised their PIP and have used PWP capacity to increase treatment capacity (**Completed**). Further actions include a review of patient pathways and the provision of rapid access through online wellbeing groups and cCBT, which will now be completed by the end of January 2025 (originally December 2024), along with an increase in the number of Step 2 workshops; and improved Single Point of Access referral management processes. In NYYSCG, Care Group Directors have requested additional information regarding the impact on quality and waiting times to inform further PIP actions; this will be completed by the end of January 2025.

Talking Therapies: Reliable recovery rate for those completing a course of treatment and meeting caseness – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



Background / standard description:
We are aiming for 48% of patients to demonstrate reliable recovery following completion of a course of treatment.

What does the chart show/context:
During December **441** patients completed a course of treatment, of which **215** demonstrated reliable recovery **(48.64**%) within **County Durham**.

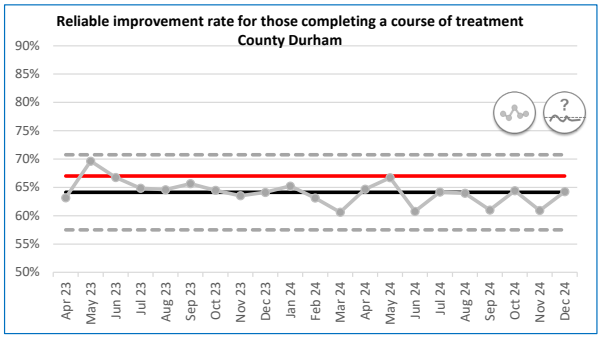
Underlying issues:

- Increase in complexity and severity of patient's presentation, which makes it more challenging to see a 6-point (Patient health questionnaire - PHQ9) or a 4-point (Generalised anxiety disorder - GAD) shift.
- A high number of patients do not attend appointments and, therefore, are not attending enough appointments to enable reliable recovery to be achieved.

Actions:
A Task & Finish Group has been established to oversee a Trust-wide deep dive. Data is currently being sourced to provide a triangulated understanding of the service from a staffing, finance, activity and clinical outcomes perspective. This will be completed by the end of February 2025 to inform the development of a Trust-wide action plan by the end of March 2025.

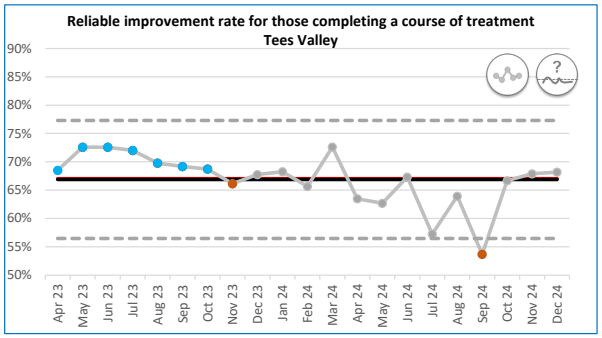
Talking Therapies: Reliable improvement rate for those completing a course of treatment – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



Background / standard description:
We are aiming for 67% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:
During December **480** patients completed a course of treatment, of which **309** demonstrated reliable improvement **(64.24**%) within **County Durham**.



Background / standard description:
We are aiming for 67% of patients to demonstrate reliable improvement following completion of a course of treatment.

What does the chart show/context:
During December **110** patients completed a course of treatment, of which **75** demonstrated reliable improvement **(68.18**%) within **Tees Valley**.

Underlying issues:

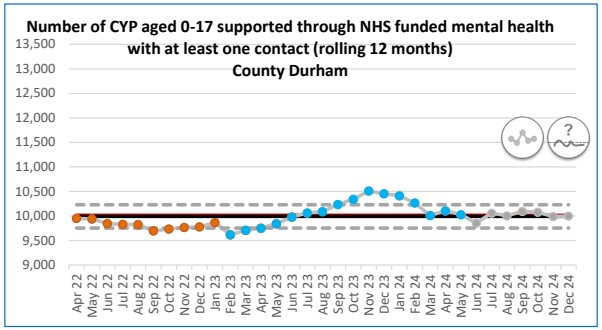
- High levels of complex patients are seeing a reliable improvement on two outcome measures (Patient health questionnaire - PHQ9 and Generalised anxiety disorder - GAD7); however, if an Anxiety Disorder Specific Measures (ADSM) is also undertaken and does not report an improvement, that supersedes the other scores.
- The measure includes patients that are not at clinical caseness (as per national construction) and therefore, may not show reliable improvement.
- A high number of patients do not attend appointments and, therefore, are not attending enough appointments to enable reliable improvement to be achieved.

Actions:

- A Task & Finish Group has been established to oversee a Trust-wide deep dive. Data is currently being sourced to provide a triangulated understanding of the service from a staffing, finance, activity and clinical outcomes perspective. This will be completed by the end of February 2025 to inform the development of a Trust-wide action plan by the end of March 2025. In addition, DTVFCG have revised their PIP. Actions include a review of patient pathways and the provision of rapid access through online wellbeing groups and cCBT , which will now be completed by the end of January 2025 (originally December 2024), along with an increase in the number of Step 2 workshops; and improved Single Point of Access referral management processes.

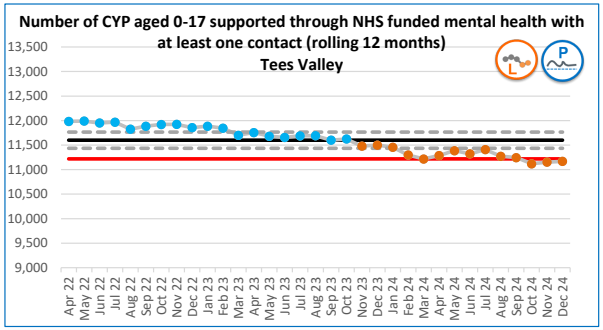
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months) – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



Background / standard description:
We are aiming for **10,012** children or young people to be supported through NHS funded mental health with at least one contact in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending December 2024 **9997** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **County Durham**.



Background / standard description:
We are aiming for **11,218** children or young people to be supported through NHS funded mental health with at least one contact in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending December 2024 **11169** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **Tees Valley**.

Underlying issues:

- The implementation of the Cito roll out is having an impact on performance due to issues with activity recording and lack of understanding around document sign off procedures.
- 2023/24 baseline data used to develop the 2024/25 plans was influenced by the short-term realignment of staff and overtime, particularly to address screening backlogs in neurodevelopmental services. This has now ended, resulting in expected 5% lower activity levels.
- Vacancies, sickness and maternity leave are impacting capacity

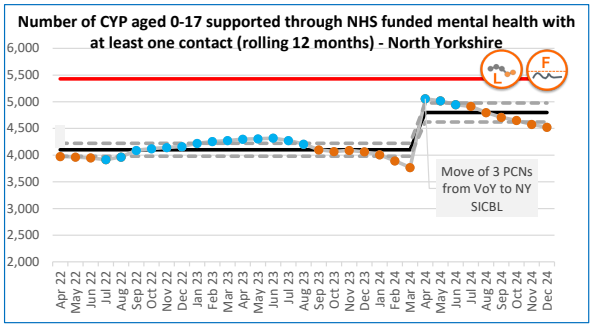
Actions:

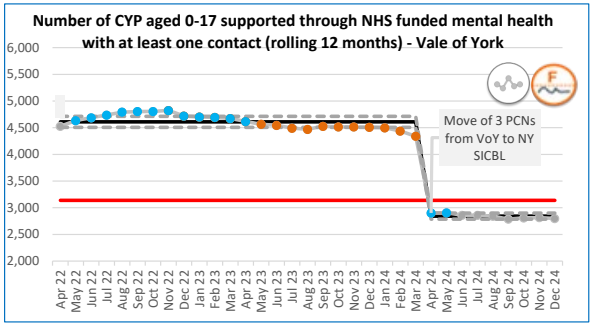
- General Manager to work with Finance to confirm the 5% drop in access is attributable to the return of staff to their substantive posts and the cessation of overtime. This work was to be completed by the end of December 2024 (originally November). **(Not completed)** This will now be completed by the end of January 2025.
- The service are recruiting to the vacant nursing posts in the neuro pathway and Tees Getting More Help Team, in addition to 2 clinical nurse specialists in South Durham. A number of posts are currently out advert with some interviews commencing in January 2025.

To Note:
If we are able to confirm that we are within 5% of the planned activity due to the short-term re-alignment of staff and overtime *(see action)*, we will remove this as an area of concern.

Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact (rolling 12 months) – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust





Background / standard description:
We are aiming for **5429** children or young people to be supported through NHS funded mental health with at least one contact in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending December 2024 **4522** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **North Yorkshire**.

Background / standard description:
We are aiming for **3138** children or young people to be supported through NHS funded mental health with at least one contact in a 12-month rolling period.

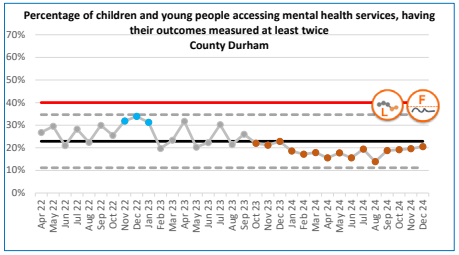
What does the chart show/context:
In the 12-month period ending December 2024 **2798** children and young people aged between 0-17 were supported through NHS funded mental health with at least one contact within **Vale of York**.

Underlying issues:
- Staff vacancies within the Single Point of Access teams
- New staff within the Single Point of Access team are taking time to learn processes and, therefore, not completing as many assessments as full-time staff.
- Reduced staffing following the removal of surge and other unfunded posts

Actions:
- A business continuity plan will remain in place for the North Yorkshire and York and Selby SPA teams until the end of January 2025. The service have recruited to all vacancies and new staff will undergo induction processes and shadowing. The service are expecting an improvement by the end of March; however, achievement of the plans is not anticipated.
- Analysis will be undertaken to provide assurance that any reduction is directly attributable to the removal of surge and other unfunded posts. Timescale to be confirmed and if this is not directly attributable to the removal of surge and other unfunded posts, to then consider what other actions could possibly be taken to understand the issue and identify improvement actions.

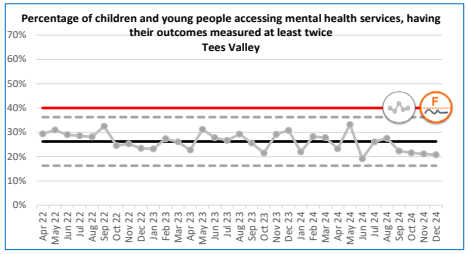
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



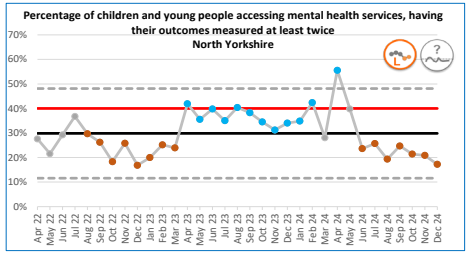
Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During December **472** patients were discharged with at least two contacts; **97 (20.55%)** of these had a paired outcome measure within **County Durham**.



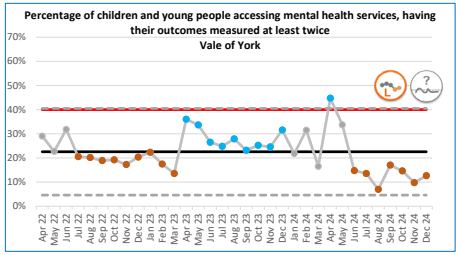
Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During December 424 patients were discharged with at least two contacts; **88 (20.75%)** of these had a paired outcome measure within **Tees Valley**.



Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During December **319** patients were discharged with at least two contacts; 55 **(17.24%)** of these had a paired outcome measure within **North Yorkshire**.



Background / standard description:
We are aiming for **40%** of closed referrals that have at least two contacts with a paired outcome measure completed.

What does the chart show/context:
During December **119** patients were discharged with at least two contacts; **15 (12.61%)** of these had a paired outcome measure within **Vale of York**.

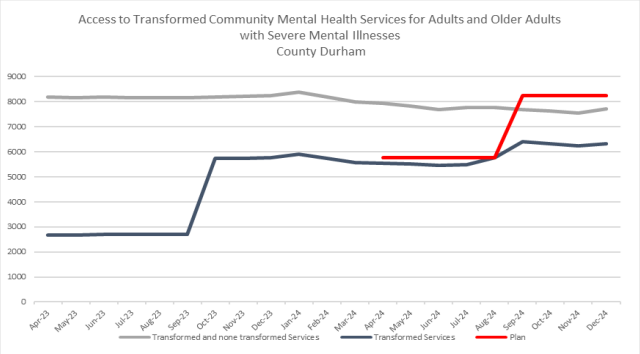
Underlying issues (Trust-wide):
- Staff are not completing paired outcomes.
- It is taking significantly longer to record an outcome measure on Cito than on Paris, which increases dependent on the number of outcomes that are measured with a patient during a contact.
- The rollout of Cito is impacting on performance due to issues with activity recording and lack of understanding of document sign off procedures.

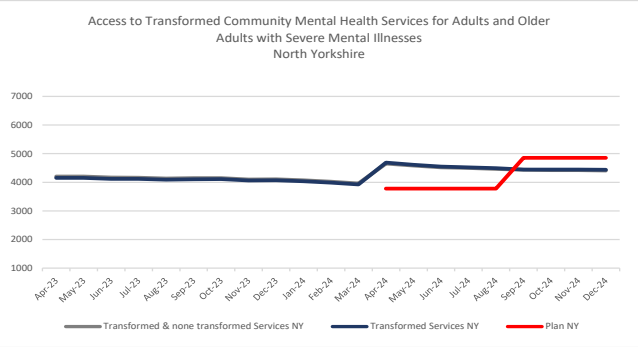
Underlying issues (specific to North Yorkshire & York):
- Community, Autism and ADHD teams are not recording clinical outcome consistently during patients' journeys.

Actions (Trust-wide):
- The Trust-wide Outcomes Improvement Plan is being monitored monthly by EDG. The first update was presented to EDG at the end of January, and it was agreed that the steering group would be asked to prioritise areas with the biggest impact and bring this back next month.
- The Associate Director of Performance will discuss with the Section Head of Research & Statistics, Clinical Outcomes and Business Analytics what possible additional information could be provided to help understand whether we are improving the completion and recording of outcomes if there is potentially a lag in demonstrating paired outcomes.

Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12 months) – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust





Background / standard description:
We aim to have **8240** adults and older people with severe mental illness accessing transformed community mental health services in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending December 2024 **6330** adults and older people were accessing Transformed Community Mental health services within **County Durham**.

Underlying issues:
Findings from a deep dive have not highlighted any areas of concern.

Actions:
- The remaining three PCNs will be transformed by the end of March 2025; however, the chart above shows that were all PCNs transformed the target would still not be achieved.

Background / standard description:
We aim to have **4853** adults and older people with severe mental illness accessing transformed community mental health services in a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending December 2024 **4434** adults and older people were accessing Transformed Community Mental health services within **North Yorkshire**.

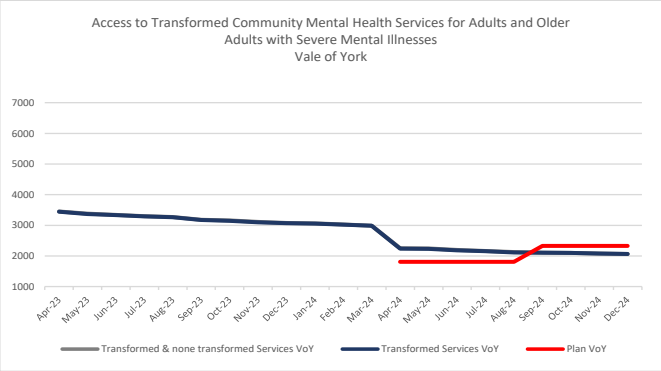
Underlying issues:
- Ripon Community is impacted by vacancies and long-term sickness absence.
- Scarborough Community is impacted by vacancies

Actions:
- Ripon Community team is in business continuity with a recovery plan in place. Recruitment of staff is underway, several commenced in September and October however 3 posts remain out to advert. In the interim, posts have been back filled through 4 agency staff.
- Scarborough Community Team has a recovery plan in place. Recruitment to a number of Band 6 vacancies is underway; in the interim the impact is being mitigated by overtime within the service.

Actions (Trust-wide):
Data is currently being sourced to provide a triangulated understanding of the access to our adult and older adult services. This will be completed by the end of January 2025 to inform the identification and development of any required improvement actions.

Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses (rolling 12 months) – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust



Background / standard description:
We aim to have **2327** adults and older people with severe mental illness accessing transformed community mental health services in a 12-month rolling period.

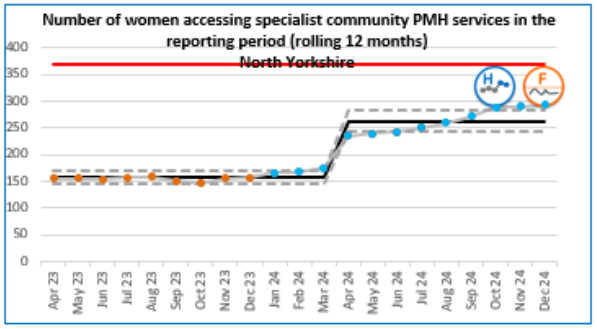
What does the chart show/context:
In the 12-month period ending December 2024 **2068** adults and older people were accessing Transformed Community Mental health services within **Vale of York**.

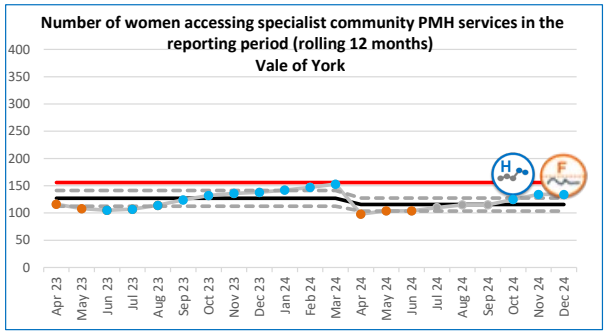
Underlying issues:
- York and Selby Early Intervention team is impacted by vacancies, maternity leave and long-term sick leave.
- There are a number of teams demonstrating special cause concern (a reduction in the number of people accessing services).

Actions:
- York & Selby EIP team is in business continuity until the end of January 2025 with a recovery plan in place to address vacancies and sick leave. All posts have been recruited to and 3 of the 4 staff on maternity leave or long-term sick leave have returned.
- The teams indicating a concern were discussed with the General Manager early January; however, no particular issues were identified.
- Performance Lead to triangulate other data, ie referrals, with this measure to help identify next steps. This work will be completed by the end of January 2025.

Number of women accessing specialist community PMH services in the reporting period (rolling 12 months) – *by exception*

Tees, Esk and Wear Valleys NHS Foundation Trust





Background / standard description:
We are aiming to achieve **368** number of women to access a specialist community Perinatal Mental Health Service within a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending December 2024 there were **293** women accessing a specialist community Perinatal Mental health services.

Background / standard description:
We are aiming to achieve **156** number of women to access a specialist community Perinatal Mental Health Service within a 12-month rolling period.

What does the chart show/context:
In the 12-month period ending December 2024 there were **134** women accessing a specialist community Perinatal Mental health services.

Underlying issues:

- Capacity issues within the Perinatal services, including short term sickness and vacancies.
- Longer-term funding and structural issues affecting the service, which are impacting on the ability to meet demand.

Actions:

The Perinatal teams are currently being supported through a service recovery plan in line with business continuity processes. Mitigating actions are:

- Short term sickness and vacancy is currently being mitigated by support from the wider Multi-Disciplinary Team for care co-ordination and implementation of a Band 5-6 run-through post to mitigate against the difficulties to recruit to a B6 care-coordination post.
- The Service Manager is working with the Planning Team to undertake a capacity and demand exercise by the end of December 2024 to inform the ongoing actions for the recovery of the longer term structural and capacity pressures. (**Not completed**) The first draft will be produced by the end of January 2025.
- A Rapid Process Improvement Workshop is planned for January 2025 with the whole PMH service to identify and remedy inefficiencies in process and structure, which will further inform the service recovery plan.

Waiting Times Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Headlines

Children & Young People Services

- There is special cause improvement (a reduction) in the number **waiting for an assessment**. Our longest wait time is currently **1015** days (DTVFCG).
- There is special cause improvement (a reduction) in the number **waiting for treatment (excluding Neuro)**. Our longest wait time is currently **2123** days (DTVFCG).
- There is no significant change in the number waiting from an **urgent referral within our Eating Disorder Service**. Our longest genuine wait time is **82** days (NYYSCG) (*the longest wait time shown is 279 days; however, this is a data quality issue*). There is no significant change in the number waiting from a **routine referral within our Eating Disorder Service.** Our longest genuine wait time is **82** days (NYYSCG) (*the longest wait time shown is 252 days; however, this is a data quality issue*).
- There is special cause concern (an increase) in the numbers **waiting for a neurological assessment** (autism assessment, ADHD assessment and both or not yet categorised). Our longest wait for an **autism** assessment is **1346** days (DTVFCG). Our longest wait time for an **ADHD** assessment is **1611** days (DTVF). Our longest wait time for **both/not yet categorised** is **1344** days (DTVFCG).

Adult Mental Health Services

- There is special cause improvement (a reduction) in the number of adults **waiting for an assessment**. Our longest genuine wait time is **651** days (NYYSCG).
- There is no significant change in the number of Adults **waiting for EIP Treatment**. Our longest wait time is currently **115** days (DTVFCG).
- There is special cause concern (an increase) in the number of adults waiting **for their second contact with Talking Therapies**. Our longest wait time is currently **416** days (NYYSCG).
- There is special cause concern (an increase) in the number of **Adults waiting for an Autism Assessment**. Our longest genuine wait time is **1746** days (DTVF) (*the longest wait time shown is 1967 days; however, this is a data quality issue*).

Adult Learning Disability Services

There is special cause improvement (a reduction) in the number waiting for an assessment. Our longest genuine wait time is **178** days (NYYSCG).

Adults in Health & Justice Services

There is no significant change in the number waiting for an assessment. Our genuine longest wait time is **93** days (DTVFCG).

Older People waiting for an assessment

There is no significant change in the number waiting for an assessment. Our longest wait time is currently **394** days (NYYSCG).

NOTE: Further work will be undertaken to add details of numbers of patients in each waiting time banding for next month's report

Waiting Times Headlines

Tees, Esk and Wear Valleys NHS Foundation Trust

Positive Assurance

Not applicable

Risks & Issues

- Children and Young People waiting for neurological assessments
- Adults waiting for an autism assessment
- Adults waiting for their second contact with Talking Therapies

Mitigations

Waiting for neurodevelopmental assessments (Children & Young People and Adults)
The newly established all-age neurodiversity group across the NENC ICB have both providers reviewing their current processes, levels of demand and activity, financial positions and clinical thresholds. A specification is being finalised to facilitate partnership-working with alternative, accredited private providers, with a view to reducing the backlogs in the NENC area and two prospective providers have been identified.

DTVFCG CYPS - In Tees the new clinical protocol has been applied to the single assessment pathway and has freed up clinical time for psychologists and speech and language therapy. The additional psychology capacity is being used to lead on diagnostic decision making, which is anticipated to release medic time to lead on ADHD diagnostic decision-making meetings. Phase 2 testing on dual assessments will be undertaken in Darlington from February 2025 and the full Evaluation of the clinical protocol work is due to be completed by the end of March 2025. Additional funding has been agreed with the NENC ICB for 3 posts in Tees Valley to support the development of a needs-led profiling too and to support the provision of additional assessments. The team have also recruited a psychologist; commencing in March/April 2025 which will also be used to support and increase diagnostic decision-making capacity. The Care Group Board have agreed to establish an all-age ADHD and Autism Clinical Transformation Group and Terms of Reference will be developed in the coming month.

The North Yorkshire & York service continues to engage with commissioners, Humber & North Yorkshire ICB and the Provider Collaborative regarding capacity within our CYP services versus demand and the subsequent impact on waiting times, and the ICB is reviewing the process around “Right to Choose”, developing system wide guidance that will be shared with providers. Within the Humber and North Yorkshire provider collaborative there is ongoing discussion around aligning assessment pathways across providers in the area to support best use of resources across the HNY ICB area, at present there is no timescale around this work.

A review of operational and clinical working within the Selby and York teams has been completed and it has been agreed that the teams will explore sharing resources to manage neuro waiters. A Task and Finish group are reviewing the existing model for the assessment and treatment of neurodevelopmental conditions to see if there are more efficient ways to deliver services which improve the patient’s journey. The clinical network has considered possible changes to neuro pathways across the Trust to support best use of clinical time and increase the number of assessments available; however, most areas have already been implemented in North Yorkshire and York in previous improvement work or are limited by current resource and that this is unlikely to have a significant impact. The Scarborough ADHD team has been placed in business continuity and has a recovery plan in place. Whilst some improvement can be made, it is clear that the demand outstrips the capacity of the service, and this has been raised with commissioners and will be subject to ongoing discussion.

Mitigations

Adults waiting for their second contact with Talking Therapies
A Task & Finish Group has been established to oversee a Trust-wide deep dive. Data is currently being sourced to provide a triangulated understanding of the service from a staffing, finance, activity and clinical outcomes perspective. This will be completed by the end of February 2025 to inform the development of a Trust-wide action plan by the end of March 2025. In addition, the Care Groups are still progressing their individual performance improvement plans in relation to these services.

Waiting Times Dashboard

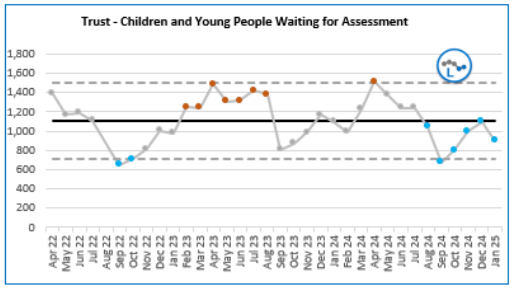
Tees, Esk and Wear Valleys
NHS Foundation Trust

Waiting Times Dashboard	Variation	Actual Number Waiting (Snapshot)	Average Wait (days)	Longest Wait (days)
Children and Young People Waiting for an Assessment	L	900	52	1015
Children and Young People Waiting for Treatment (excluding Neuro)	L	1938	245	2123
Children & Young People Waiting for Eating Disorders Services - Urgent Referral (1 week standard)		3	125	279*
Children & Young People Waiting for Eating Disorders Services - Routine Referral (4 week standard)		54	46	252*
Children and young people waiting for an Autism Assessment	H	5850	494	1346
Children and young people waiting for an ADHD Assessment	H	4470	448	1611
Children and young people waiting for both Autism/ADHD Assessment or Not Categorised	H	2189	552	1344
Adults Waiting for an Assessment	L	3236	78	651
Adults Waiting for EIP Treatment (2 week standard)		74	29	115
Adults waiting for their second treatment contact in Talking Therapies	H	4764	94	416
Adults waiting for an Autism Assessment	H	3859	660	1967*
Adults with a learning disability Waiting for an Assessment	L	77	34	178
Adults in Health and Justice services Waiting for an Assessment		47	25	93
Older People Waiting for Assessment		2435	82	394

NOTE: *an asterisk denotes a data quality issue*

Patients Waiting

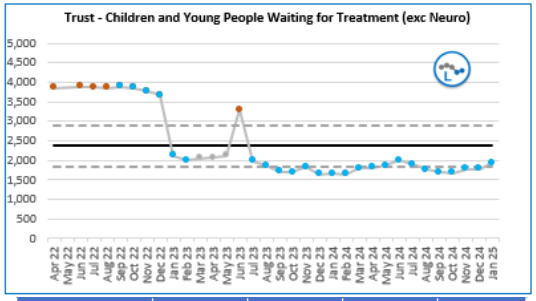
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	900	52	1015	
DTVF Care Group	543	62	1015	
NYY&S Care Group	357	36	307	

Commentary on Longest waits

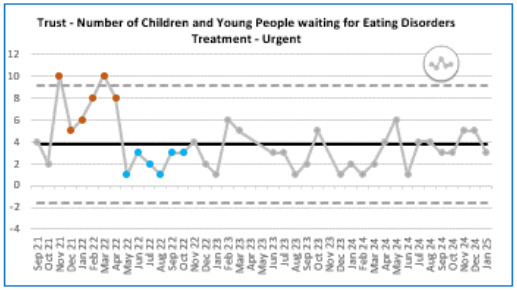
DTVF: Genuine wait - Assessment Required
NYY&S: Data Quality - Assessment Complete (longest genuine wait - 101 days - Assessment booked)



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	1938	245	2123	
DTVF Care Group	1212	236	2123	
NYY&S Care Group	726	260	1793	

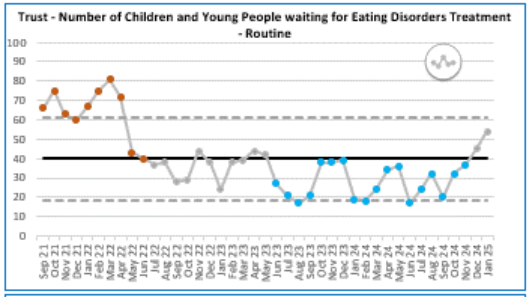
Commentary on Longest waits

DTVF: Genuine Wait - Treatment not yet commenced
NYY&S: Genuine Wait - Treatment not yet commenced



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	3	125	279	
DTVF Care Group	2	147	279	
NYY&S Care Group	1	82	82	

DTVF: Data Quality - Assessment Complete and treatment commenced (there are no patients genuinely waiting).
NYY&S: Genuine Wait - Treatment not yet commenced

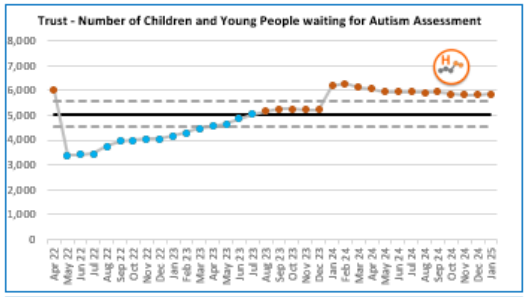


Organisation	Actual	Average wait	Longest wait	Assurance
Trust	54	46	252	
DTVF Care Group	26	37	217	
NYY&S Care Group	28	54	252	

DTVF: Data Quality - Treatment commenced (longest genuine wait - 56 days - treatment not yet commenced)
NYY&S: Data Quality - Treatment Commenced (longest genuine wait - 82 days - treatment not yet commenced)

Patients Waiting

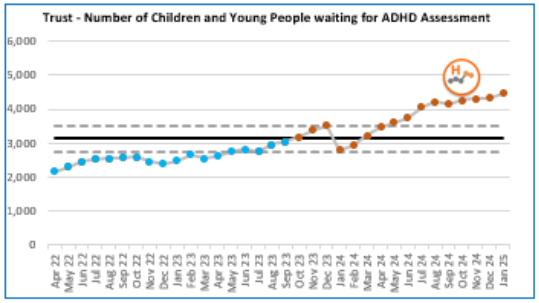
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	5850	494	1346	
DTVF Care Group	4986	530	1346	
NYY&S Care Group	864	286	818	

Commentary on Longest waits

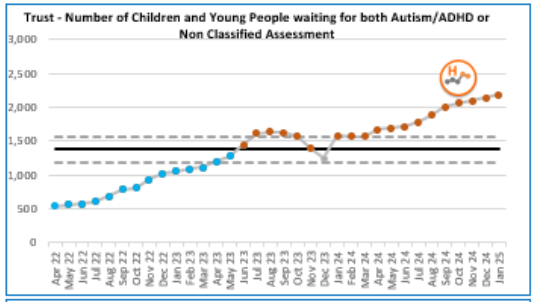
DTVF: Genuine Wait - Specialist Assessment Required
NYY&S: Genuine wait - Specialist Assessment Required



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4470	448	1611	
DTVF Care Group	3676	479	1611	
NYY&S Care Group	794	305	729	

Commentary on Longest waits

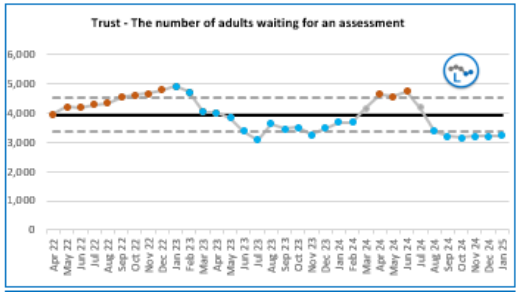
DTVF: Genuine Wait - Specialist Assessment Required
NYY&S: Data Quality - Specialist Assessment commenced (longest genuine wait - 716 days - specialist assessment booked)



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2189	552	1344	
DTVF Care Group	1740	660	1344	
NYY&S Care Group	449	136	856	

Commentary on Longest waits

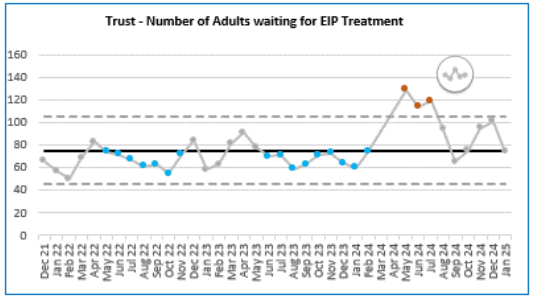
DTVF: Genuine wait - Specialist Assessment Required
NYY&S: Data Quality - Specialist Assessment Complete (longest genuine wait - 569 days - Specialist Assessment Required)



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	3236	78	651	
DTVF Care Group	1749	59	542	
NYY&S Care Group	1487	101	651	

Commentary on Longest waits

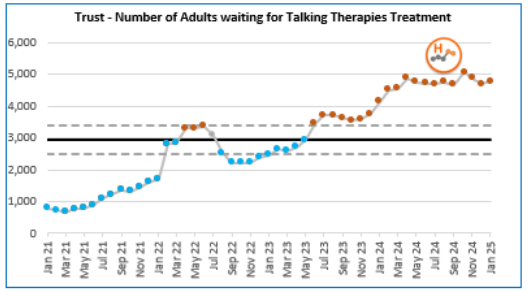
DTVF: Data Quality - Assessment Complete (longest genuine Wait - 569 days - Assessment required
NYY&S: Genuine Wait - Assessment booked



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	74	29	115	
DTVF Care Group	30	29	115	
NYY&S Care Group	44	30	90	

Commentary on Longest waits

DTVF: Genuine Wait - Treatment not yet commenced
NYY&S: Genuine Wait - Treatment not yet commenced



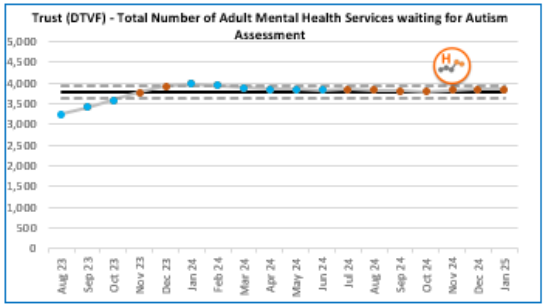
Organisation	Actual	Average wait	Longest wait	Assurance
Trust	4764	94	416	
DTVF Care Group	2955	98	357	
NYY&S Care Group	1809	88	416	

Commentary on Longest waits

DTVF: Genuine Wait - 1st Treatment Booked
NYY&S: Genuine Wait - 1st Treatment Required

Patients Waiting

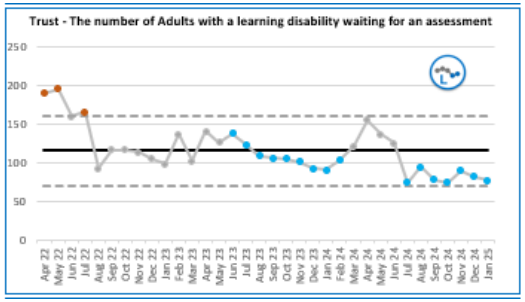
Tees, Esk and Wear Valleys NHS Foundation Trust



Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	3859	660	1967	

Commentary on Longest waits

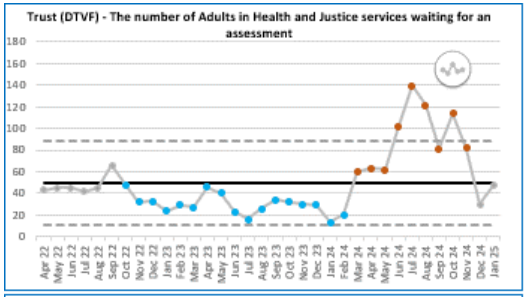
DTVF: Data Quality - Assessment complete (longest genuine wait - 1746 days - specialist assessment required).



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	77	34	178	
DTVF Care Group	39	28	87	
NYY&S Care Group	38	39	178	

Commentary on Longest waits

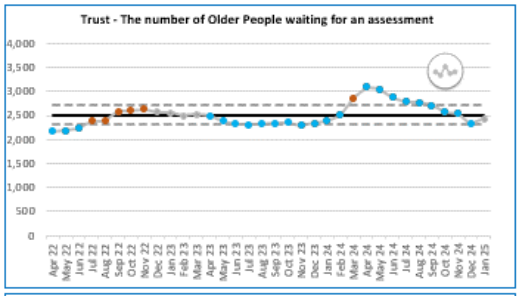
DTVF: Data Quality - Assessment complete (longest genuine wait - 72 days - assessment booked)
NYY&S: Genuine Wait - Assessment Required



Organisation	Actual	Average wait	Longest wait	Assurance
Trust (DTVF Care Group)	47	25	93	

Commentary on Longest waits

DTVF: Genuine Wait - Assessment Required



Organisation	Actual	Average wait	Longest wait	Assurance
Trust	2435	87	394	
DTVF Care Group	958	43	231	
NYY&S Care Group	1477	116	394	

Commentary on Longest waits

DTVF: Genuine Wait - Assessment Booked
NYY&S: Genuine Wait - Assessment Booked

Tees, Esk and Wear Valleys
NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report	
Report Date: 13 February 2025	**Report of: People, Culture and Diversity Committee**
Date of last meeting: 11 December 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 16 September 2024
- Key Issues Report 16 September 2024
- Corporate Risk Register
- Board Assurance Framework
- People Journey Delivery Report
- Equality, Diversity, Inclusion and Staff Network Update
- Equality Delivery System (EDS) 2022
- Duty Nurse Co-ordinator Update
- Violence Prevention and Reduction Update
- Freedom to Speak Up Guardian Update Report
- Quarterly Apprenticeship Update
- Safer Staffing – use of Resources (deferred)

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 agrees reasonable assurance in respect of the risk management processes in place, the consideration of risks for inclusion in the Corporate Risk Register and the ongoing management of these risks. It notes the improvement in risk review compliance and the proposal to transfer the CITO risks from the InPhase project plan across to the 'live system' in order that they would be reported to future meetings, particularly given the impact of CITO on staff working processes and lives over the previous 12-months. The Committee agrees to consider an overview of risk management and the touch points to provide a better understanding about the process, who is involved, the movement of risk scores and give assurance at the Time Out on 23 January 2025.

Board Assurance Framework

The Committee notes that there is good assurance on the Board Assurance Framework, the risk continued to be aligned to its trajectory and agrees actions proposed in relation to completing outstanding updates on 'Working Differently', for example, concerning the delayed DTVF 'roadmaps' action to reduce unfunded posts. It notes that a new procedure will be available from January 2025 on hybrid working and further work is taking place on guidance on flexible working following review of the DTVF Care Group pilot.

People Journey Delivery Report

The Committee confirms good assurance, noting the progress on the following:

- Appraisals and Supervision – increase in compliance;
- Range of initiatives on Anti-discriminatory culture - Show Racism the Red Card, Transgender awareness training, 'Just Do One Thing Project';
- Developing proposals for a new model for Culture and Diversity leadership, following the retirement of the EDI specialist;
- Invitation for the Trust to participate in the national #Inclusive HR Programme and to share its journey with others;
- Absence Management – provision of additional support to the individual and manager once the 28-day mark reached;
- Movement of the digital employment checks process from the Business Services Authority (BSA) to in-house provision and improvement in KPIs, for example, 'time to hire' with more than half of

successful applicants being cleared in 28 days, with proposals to reduce the average time for internal hires further in the near future;
- Central recruitment for HCAs – to reduce duplication following the change in Under-18s policy;
- New Management Training to be rolled out in the New Year to all managers.

The Committee expresses concern in relation to the potential for 'survey fatigue' with the timing of the Pulse and Staff surveys and notes that the issue is being explored with national leads.

Equality, Diversity, Inclusion and Staff Network Update

The Committee notes that good assurance can be taken on the progress on Equality, Diversity, Inclusion and Staff Networks, brief examples are set out below:

- Armed Forces Network – 2 new Deputy Chairs appointed to support Hannah Crawford and Help for Heroes had provided a presentation;
- BAME Network – Feedback provided on the support given following the riots, a stall at Middlesbrough Mela, a talk about Black History month and discussion held on Show Racism the Red Card. Plans to put in place the actions from the Anti-Racist Charter by October 2025;
- Neuro-divergent (ND) Network – Issues with 'Easy Expenses' escalated to IT to seek a solution/support with training and individuals participated in a Schwartz round to raise awareness of ND;
- Rainbow Network – A 5-member committee formed to support the network meetings and share leadership with Executive Leads Kate North and Zoe Campbell with focus upon pronouns, title and sexual orientation categories;
- Long-Term Health Conditions (LTHC) Network – recent meeting attended by David Jennings; policy updates on Trust-wide hybrid working guidance to be brought to future meetings; co-created video messages planned about working for the Trust with a LTHC;
- Menopause Café – 30 people attended the in-person event for World Menopause Day on 18 October, up to 103 attend the usual Teams Call; and
- Working Carers Network - 2 members attended the Nursing Conference on 10 October 2024. Future plans include sessions on dementia, financial information, services of Durham and York carers' organisations, further consultation on what network members would like.

Equality Delivery System (EDS) 2022

The Committee agrees there is good assurance that the Trust had followed a robust process to measure both successes and challenges against the 11 outcomes for the protected characteristic and vulnerable community groups using evidence and insight. The 11 outcomes are spread across the following 3 domains:

- Domain 1 - Commissioned or provided services;
- Domain 2 - Workforce health and well-being; and
- Domain 3 - Inclusive leadership.

The overall score was 24 for 2024, compared with 19 in 2023, giving an improved rating of 'Achieving' compared with the previous rating of 'Developing' due to the increased score from 8 to 12 for Domain 1 and improved score from 1 to 2 for Outcome 3A, within Domain 3. This relates to Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities. This Domain was assessed by Sarah Dexter-Smith and validated by Chris Rollings from CNTW.

Violence Prevention and Reduction Update

The Committee notes that the Staff Experience Survey (675 participants) informed the identification of themes for the activities of the monthly Violence Prevention and Reduction Steering Group:

- Continuing Domestic Abuse and Sexual Violence work (in line with the National Charter);
- Aligning clinical and health and safety processes;
- Ensuring feedback to teams about learning and proactive support; and
- Working more effectively with local police forces.

An infographic has been developed to share the quantitative findings from the Staff Experience Survey to give assurance to those who completed it that their feedback was listened to, and that further work was planned to improve their experience. The infographic has been discussed at the 'Working in TEWV coffee break' session and will be shared across Care Groups and temporary staffing. The qualitative findings from the survey will be available early in 2025.

The knowledge from this survey is being considered within the context of new national standards for the prevention and reduction of violence which outlines the processes for reporting and reviewing incidents through a multi-disciplinary approach. Examples of specific pieces of work which are being undertaken are set out below:

- Trialing new ways to review, report and sign off RIDDOR incidents within PICU and Bankfields, to ensure that this was multidisciplinary at all stages and met HSE, clinical and workforce demands;
- Developing a new flowchart to align HSE work with the After-Action Review (the clinical response to an incident);
- Working with police forces to clarify the responses from each agency during and after an incident; and
- Environmental audits are ongoing in all wards.

Freedom to Speak Up Guardian Report (FTSU)

The Committee takes good assurance from the processes in place in relation to FTSU and notes that whilst the numbers of cases have stabilised recently, the case mix is changing with, for example, more people contacting the service with protected characteristics, including hidden disabilities which were not accepted by the Manager. Recent changes to the FTSU arrangements involved Roberta Barker's Non-Executive Director role transferring to Jules Preston. In addition, the service is planning for the forthcoming award of the contract for FTSU services. The Committee notes concerns regarding the need to maintain the proactive role of FTSU and suggests that close monitoring of the new service takes place.

A link has been established with the lead for the Professional Nurse Advocates (PNAs) with 40 PNAs being trained in December 2024 as Speak Up Ambassadors, 5 of which volunteered as FTSU Champions as it fits well with their role. In addition, the Committee welcomes the work being undertaken to build on the model of reflective practice used by the PNAs across other professions/groups involved in FTSU during 2025.

Quarterly Apprenticeship Update

The Committee notes that there is good assurance that the right actions are being taken to maintain the Trust's apprenticeship workforce, with current funds in the apprenticeship levy standing at £2m. There is a total of 482 Apprenticeships at the Trust. Over the forthcoming 12 months a new body, Skills England, will take over the functions currently overseen by the Institute for Apprenticeships and Technical Education. It is anticipated that the apprenticeship levy will become an expanded 'growth and skills' levy, enabling funds to be used for training routes other than apprenticeships. There is the potential for some Level 7 Options to be de-funded, although that remains unconfirmed.

Foundation Apprenticeships will be available from next year, including an offer for 'Under 18s' supported by the introduction of the new 'Under 18's' procedure, enabling the Trust to provide apprenticeships to 16 and 17-year-olds. In addition, the Trust is receiving increasing numbers of requests for work experience placements for T-level 'Health' students who required a placement to achieve their qualification. All work experience students will be placed in accordance with the 'Under 18's procedure'. The Committee notes that the concerns of Staff side are being worked through.

HCAs are expected to complete the Level 3 Diploma within 18 months, however, some of the in-house HCA learners have been reported to the awarding body (City and Guilds) for using Artificial Intelligence to write assignments. As a City and Guilds Centre, the Trust must report all suspected plagiarism and use of AI. Any further episodes could result in tougher sanctions, with the potential removal of learners from the programme and de-barring from City and Guilds for a period of 2-years. In addition, this is an issue for the Trust as the staff are already employed.

2c	**Advise: The Committee would like to advise the Board on the following matters:** **Colleague Story/Experience** Two members of the Clinical Skills Team who both have lived experience provided their stories, explaining that their jobs as Peer Trainers involved developing, delivering and evaluating training. One element of the training was the use of the 'Talk Well' model for effective communication. In addition to facilitating the theory part of the training, particularly in relation to avoiding use of restraint, they also discuss their own experience. Furthermore, they provide administrative support to the team. Both colleagues describe access to both formal and informal supervision within the team on a regular basis for support and receiving lived experience peer supervision. They note that there could be a 'hard cross-over' between being a service user and an employee. Both praised their Line Manager, whom they described as 'amazing'. The Committee acknowledges the positive way in which the Peer Trainers approached their work and used their lived experience to support others. **Duty Nurse Co-ordinator (DNC) Update** The Committee notes that the DNC job description has been reviewed, evaluated and confirmed at Band 7 and an organisational change process is to take place for the staff currently employed in these roles, with the next stage of the process being the responsibility of the Care Groups, under the leadership of the Group Directors of Nursing. A report is to be submitted to Local Consultative Committee on the new arrangements and the backdating of pay to the date when the Job Description was evaluated.	
2d	**Risks**	No new risks were identified for inclusion in the BAF at this point, although concerns were expressed in relation to FTSU. It was suggested that the position regarding the outsourcing of the FTSU service should be closely monitored.
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, Roberta Barker, Non-Executive Director (Committee Chair), Kate North, Joint Executive Director of People and Culture	

DM/27/01/2025

Tees, Esk and Wear Valleys
NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 13 February 2025		**Report of: People, Culture and Diversity Committee**
Date of last meeting: 23 January 2025		The meeting was quorate.
1	**Agenda: The following agenda items were considered during the meeting:** • Pay Gaps (Gender, Ethnicity and Disability)	
2a	**Alert: The Committee wishes to alert the Board on the following matters:** -	
2b	**Assurance: The Committee can confirm assurance on the following matters:** **Pay Gaps (Gender, Ethnicity and Disability)** The Committee notes that the Equality Act 2010 introduced a statutory requirement to produce information outlining details of any gender pay differences within an organization. From 2018, the requirement was to report gender pay gaps against 6 different measures. In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination, one of these actions related to pay gaps. This is the second ethnicity pay gap report produced, and the first disability pay gap report. By 2026, the Trust will be required to complete seven pay gap reports for all protected characteristics. Ideas will be sought as to how to make the reporting process interactive and meaningful, for example, 'pay gaps on a page'. At the current time, clear guidance has only been given for gender pay. Accordingly, the analysis for the other protective characteristics has been mirrored on the approach to gender pay. The Committee notes the findings for Gender pay as follows: • The mean and the median pay gap has reduced from 2023; • The overall median gender pay gap has decreased from the previous year from 5.26% to 0.00%; • When comparing 2024 and 2023, the ratio between males and females has shown little change within Band 9 and VSM roles. In 2023, females accounted for 52% of this group whereas in 2024 they accounted for 56%. Males in this banding had decreased from 48% in 2023 to 44% in 2024; • Comparing data from 2017 with 2024 showed that the proportion of females in Bands 8d, 9 and VSM pay and in Medical Consultant posts had the largest increases. Females in 8d posts had increased from 57% to 67% between 2017–2024. Band 9 and VSM pay grades had seen an increase in females from 43% to 69% in 2022, this had then reduced in 2024 to 56%; • There had been a decrease in the mean gender pay gap from the previous year of 3.61% to 1.75%, however, the median gender pay gap had increased from 4.42% to 13.43% for staff in AFC and VSM pay grades; and • Whilst there were relatively equal numbers of males and females receiving clinical excellence awards, overall, there were more males receiving larger monetary amounts which was evident from the mean bonus gender gap percentage. This was likely to be a result of the historical awards that some Medical Consultants hold. The Committee notes the findings for Ethnicity Pay gap as follows: • The number of BAME staff within the organisation was low and a high percentage of the BAME workforce in the Trust were medical. Therefore, when calculating average pay for BAME staff, data could be skewed by smaller numbers of higher paid staff; • Whilst overall data showed that the average hourly pay for BAME staff was higher than white staff, when separating non-medical and executive pay and medical pay grades, the data shows that there was a pay gap evident in both groups; • As with the 2023 data, BAME Medical Consultants were receiving higher bonus payments.	

	• Proportionally, fewer BAME staff were eligible for long service awards; and • Very low levels of BAME staff were within higher bands, (excluding medical grades). The Committee notes the findings for Disability Pay gap as follows: • The number of staff who declared themselves as having a disability is likely to be underreported, which was likely to have impacted on the analysis of the data; • A total of 23% of Medical Consultants had not declared their disability status. This will have impacted on the bonus section of the report; and • The mean showed that staff declaring they do not have a disability were paid £0.64 more that staff who declare having a disability but zero when looking at the median. The Committee notes that arrangements are in place to encourage staff to update their demographics on an annual basis and that the Equality Diversity and Inclusion (EDI) Team undertake sporadic campaigns to encourage and promote this. In addition, it is positive that benchmarking of Gender Pay Reports has taken place, for example, Ambulance Trusts where it has been identified that the reports were not as detailed as those produced by the Trust. The Gender Pay gap findings of both TEWV and CNTW were similar and same issues have been experienced with Clinical Excellence Awards. The Committee notes the proposal to use the infographic 'Pay Gap on a Page' for the 7 pay gap reports, recognising that there will be a cost implication to this. It confirms that it has good assurance that a robust process has been undertaken when completing the Pay Gap reports, including the proposed actions and supports the publication of Gender Pay Gap data on the Trust and government website by 30 March 2025.	
2c	**Advise: The Committee would like to advise the Board on the following matters:** N/A	
2d	**Risks**	No new risks were identified for inclusion in the BAF at this point, although concerns were expressed in relation to the sheer volume of reporting.
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, although further consideration was required as to how the Trust should respond to the volume of requests for reporting to external bodies.
4	**Report compiled by:** Deborah Miller, Corporate Governance Manager, Roberta Barker, Non-Executive Director (Committee Chair), Kate North, Joint Executive Director of People and Culture	

DM/27/01/2025

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**
Date: **13 February 2025**
Title: **Guardian of Safe Working Interim Report**
Executive Sponsor(s): **Dr Kedar Kale**
Author(s): **Medical Staffing Team**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	Safe staffing	The Guardian of Safe Working will monitor the experience of post graduate doctors, and compliance with their terms and conditions of employment to ensure that there is an early understanding of when things are not as they should be.

Executive Summary:

Purpose: The post of Guardian of Safe Working has remained unfilled for several months. At the end of January, interviews were held and an appointment was made. Dr Sharon Beattie was subsequently appointed and will take up post in early March.

The Guardian is required to produce an independent report to Board each quarter to update on the Trust compliance levels in relation to the terms and conditions of employment for resident doctors, focussing on their hours of work and their rest periods.

Much of the data in this report from is produced by the medical staffing team and so it was felt appropriate to continue to provide this analysis to Board, without the accompanying Guardian narrative, rather than wait with no oversight until the next Board meeting.

Overview: The summary on Appendix A and B demonstrates that compliance with the contract remains high despite a few exceptions as outlined in the period.

In NYY, 20 exception reports were submitted in Quarter 3, totaling £1.8k, with all exception reports from non-residential on-call rotas. This compares with 39 in Quarter 2 and 15 in Quarter 1.

In DTV, 17 exception reports were submitted in Quarter 3, with no fines. This compares to 6 in Quarter 2 and 5 in Quarter 1.

Recommendations: That the Board considers the data contained in this report.

Appendix A

NYY QUARTERLY REPORT ON SAFE WORKING HOURS FOR RESIDENT DOCTORS

Number of doctors / dentists in training (total): 72
Number of doctors / dentists in training on 2016 TCS (total): 72
Amount of time available in job plan for guardian to do the role: 1 PA
Admin support provided to the guardian (if any): 4 days per quarter
Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st Oct to 31st Dec 2024

Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
NYY (F2/CT1-3/ GP/trust doctor)	0	11	11	0
Scarborough (F2/CT/GP/TD)	0	1	1	0
NYY middle tier	0	7	7	0
Scarborough middle tier	0	0	0	0
South CYPS middle tier	0	2	2	0
Total	**0**	**21**	**21**	**0**

All exceptions reported in this quarter were by non-resident on calls (NROC).

There was 1 exception report submitted by a Scarborough resident doctor for a breach of not having 5 continuous hours of rest from 10pm to 7am.

Twenty exception reports were submitted by NYY resident doctors, 9 were from senior registrars and there was payment for 3 breaches of not having 5 continuous hours of rest from 10pm to 7am. The reasons for the exceptions were telephone advice, seclusion review, administrative duties and mental health assessment. There was no additional payment for 6 exceptions reported by senior registrars.

11 exceptions were reported by registrars, out of which 6 payments were made for breach of not having 5 continuous hours of rest, and 1 was claiming for additional enhanced hours. There was no additional payment for 4 exceptions reported by registrars. The exception response time was:

Specialty	Addressed in 48 hours	Addressed in < 7 days	Addressed in > 7 days	Still open
NYY PG doctors	10	1	0	0
NYY Middle tier	7	2	0	0
Scarborough PG doctors	1	0	0	0
Scarborough Middle tier	0	0	0	0
Total	**18**	**3**	**0**	**0**

Work Schedule reviews

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

ST4 - 6	0

Bank Shifts Via Patchwork by Locality and Grade

Locality	Grade	Number of shifts requested	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Harrogate, Northallerton, Selby & York	F2	0	10	0	0	82.5
	CT1/CT2/GP	57	43	0	498	365.5
	CT3	0	4	0	0	50
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	46	46	0	784	784
Scarborough	F2	0	5	0	0	96
	CT1/CT2/GP	25	20	0	440	344
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	Middle Tier (SR/SAS)	58	58	0	1072	1072
Total		**186**	**186**	**0**	**2794**	**2794**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
On call cover	52	52	0	821	821
Vacancy	88	88	0	1476.5	1476.5
Sickness	41	41	0	423.5	423.5
Increase in workload	0	0	0	0	0
Special leave	4	4	0	57	57
Extra weekend support	0	0	0	0	0
Annual Leave	1	1	0	16	16
Total	**186**	**186**	**0**	**2794**	**2794**

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	1	£ 238.5
Harrogate, Northallerton & York	9	£ 1602.83
Total	**10**	**£ 1841.33**

All fines were due to 5 hours continuous rest breaches submitted by different doctors and there were no trend identified. Fines will be processed by finance in Q4.

Appendix B

DTV QUARTERLY REPORT ON SAFE WORKING HOURS FOR RESIDENT DOCTORS

Number of doctors / dentists in training (total): 134
Number of doctors / dentists in training on 2016 TCS (total): 134
Amount of time available in job plan for guardian to do the role: 1 PA
Admin support provided to the guardian (if any): 4 days per quarter
Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (regarding working hours) from 1st Oct 2024 up to 31st Dec 2024.

Exception reports by Rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services (F2/CT/GP/TD)	0	3	3	0
North Durham (F2/ CT1-3/GP/trust)	0	5	5	0
South Durham (F2/ CT1-3/GP/trust)	0	8	8	0
Teesside & Forensic Senior Registrars	0	1	1	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
DTV CYPS Senior Registrars	0	0	0	0
Total	**0**	**17**	**17**	**0**

- North Durham – The same CT1 reported x3 working over hours and x1 missed education. Another CT1 reported x1 working over hours.
- South Durham – The same CT1 reported x7 working over hours. Another CT1 reported x1 working over hours.
- Teesside – The same CT1 reported x3 working over hours. A ST4 reported NROC work above schedule.

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside Juniors	0	2	1	0
Teesside Senior Reg	0	0	1	0
North Durham Juniors	0	0	5	0
South Durham Juniors	0	0	8	0
South Durham Senior Reg	0	0	0	0
North Durham Senior Reg	0	0	0	0
Total	**0**	**2**	**15**	**0**

Work schedule reviews.

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

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

Bank Shifts Via Patchwork

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside	F2	0	0	0	0	0
	CT1	22	7	0	201	70
	CT2			0		
	GP			0		
	CT3	0	3	0	0	32
	Trust Doctor	0	9	0	0	78.5
	Middle Tier (SR/SAS)	20	23	0	360	380.5
North Durham	F2	0	0	0	0	0
	CT1	29	28	0	286	282
	CT2			0		
	GP			0		
	CT3	0	0	0	0	0
	Trust Doctor	0	1	0	0	4
	Middle Tier (SR/SAS)	49	49	0	912	912
South Durham	F2	0	0	0	0	0
	CT1	28	24	0	289.5	248
	CT2			0		
	GP			0		

	CT3	0	0	0	0	0
	Trust Doctor	0	4	0	0	41.5
	Middle Tier (SR/SAS)	12	12	0	232	232
CAMHS	Middle Tier (SR/SAS)	82	81	0	1513	1489
Total		**242**	**241**	**0**	**3793.5**	**3769.5**

The discrepancies in the figures are due to:

- *1 shift in North CAMHS was not picked up by middle tier so the on-call Consultant acted down.*
- *3 CT1/2 shifts picked up by middle tier in Teesside (IFD gaining rota experience).*

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	16	16	0	193	193
Service requirement	3	3	0	20.5	20.5
Sickness	53	53	0	565.5	565.5
On call cover	134	133	0	2470.5	2446.5
Paternity leave	0	0	0	0	0
Maternity leave	15	15	0	280	280
Special leave	11	11	0	154.5	154.5
Annual Leave	10	10	0	109.5	109.5
Total	**242**	**241**	**0**	**3793.5**	**3769.5**

Fines

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

There were no fines for quarter 3.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**The Board of Directors**
Date:	**13 February 2025**
Title:	**Pay Gaps (Gender, Ethnicity and Disability)**
Executive Sponsor(s):	**Sarah Dexter-Smith & Kate North, Directors of People and Culture**
Author(s):	**Abigail Holder, EDI & HR Officer** **Helen Cooke, Health & Wellbeing Strategic Lead**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
1	**Safe staffing**	The following report includes both the statutory requirements of the gender and ethnicity pay gap reporting and pay gap reporting relating to disability which is a new requirement for 2024. Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post. The Trust is committed to understanding any pay differentials and taking appropriate action.

Executive Summary:

Purpose:

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

The purpose of the report is to demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation along with further context to explain any gender

pay differences with a view to demonstrate our commitment to equality.

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination. One of these related to pay gaps and the requirement to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. Gender and ethnicity pay gap reporting had to be in place by 2024.

While there is currently no legal requirement for ethnicity or disability pay gap reporting, these matters are proposed as part of the upcoming Equality (Race and Disability) Bill. The proposal for these matters is to mirror the requirements of gender pay gap reporting.

Religion, sexual orientation, age and marriage/ civil partnership status pay gap analysis has to be in place by 2025 which means in 2026 the Trust will be completing seven pay gap reports in total.

Attached to this report are detailed Gender (Appendix 1), Ethnicity (Appendix 2) and Disability (Appendix 3) pay gap reports. These reports include the required reporting fields, associated context and proposed actions.

Proposal:

To request confirmation that the Board of Directors has good assurance that the Trust is meeting its statutory requirements by producing data in relation to pay differences that exist within the organisation.

To recommend to the Board of Directors that they agree to the actions identified within all reports and to the publication of the gender pay information on the Trust and government website as is required.

Overview:

Reporting on gender pay differences is a statutory requirement of the Equality Act 2010. This must be completed annually, reporting on the specific measures. The proposal for good assurance that we understand and are acting on our data is based on the information in the appendices which demonstrates that that the following has been reported upon in line with national guidance:

- The mean gender pay gap
- The median gender pay gap
- The mean bonus gender pay gap
- The median bonus gender gap
- The proportion of males and females receiving a bonus payment

- The proportions of male and female in each quartile of pay.

The same metrics have been produced for the Trust's second Ethnicity Pay Gap report and the first Disability Pay Gap report.

Summary of key findings

Gender Pay Gap Report:

- The mean and the median pay gap have reduced from 2023.
- The overall median gender pay gap has decreased since last year from 5.26% to 0.00%.
- The ratio between males and females comparing 2024 and 2023 have shown little change within Band 9 and VSM roles. In 2023, females accounted for 52% of this group whereas in 2024 they account for 56%. Males in this banding have decreased from 48% in 2023 to 44% in 2024.
- Comparing data from 2017 with 2024 shows that the proportion of females in bands 8d, 9 & VSM pay and in consultant posts have had the largest increases. Females in 8d posts have increased from 57% to 67% between 2017 – 2024. Band 9 and VSM pay grades have seen an increase in females from 43% to 69% in 2022, this has then reduced in 2024 to 56%.
- There has been a decrease in the mean gender pay gap from the previous year of 3.61% to 1.75% however the median gender pay gap has increased from 4.42% to 13.43% for staff in AFC & VSM pay grades.
- Whilst there were relatively equal numbers of males and females receiving clinical excellence awards, overall, there were more males receiving larger monetary amounts which is evident by the mean bonus gender gap percentage. This is likely to be a result of the historical awards that some consultants hold.

Ethnicity Pay Gap Report

1) The number of BAME staff within the organisation is low and a high percentage of the BAME workforce in the Trust are medical. Therefore, when calculating average pay for BAME staff, data could be skewed by smaller numbers of higher paid staff.
2) Whilst overall data shows that BAME staff average hourly pay is higher than white staff, when separating non-medical & executive pay and medical pay grades

the data shows that there is a pay gap evident in both groups.

3) Similar to last year our BAME consultants are receiving higher bonus payments.
4) Proportionally, fewer BAME staff were eligible for long service awards.
5) Very low levels of BAME staff are within higher bands, (excluding medical grades).

Disability Pay Gap Report

- This is the first disability pay gap report that the Trust has produced and will be used as baseline for annual reporting.
- The number of staff who have declared themselves as having a disability is likely to be underreported, therefore the data analysis is likely to be impacted by this.
- 23% of consultants had not declared their disability status. This will have impacted on the bonus section of the report.
- The mean shows that staff declaring they don't have a disability are paid £0.64 more that staff who declare having a disability but zero when looking at the median.

Prior Consideration and Feedback

This report was considered and approved by the Executive Directors Group on 14.1.25, JCC on 21.1.25 and PCDC on 23.1.25.

It has been agreed in 2024 that future reports should be more brief and more visual in presentation to ensure that they are more accessible to colleagues and the public.

Implications:

Failure to complete and publish the Pay Gap reports in accordance with the requirements of the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 may have regulatory consequences

Recommendations:

The purpose of the report is to demonstrate adherence to the statutory requirements of the gender pay gap reporting legislation, ethnicity and disability pay gap reporting along with further context to demonstrate our commitment to equality.

The proposal to use infographic to present 'Pay Gap on a Page' for the 7 pay gap reports that will be presented for 2025 is a topic for discussion and approval. The communication department have advised that there will be a

cost implication as this work will need to be outsourced.

The Board of Directors is asked to confirm that it has good assurance that a robust process has been undertaken when completing the Pay Gap reports, including the proposed actions and comment accordingly.

The Board of Directors is asked to agree to the publication of Gender Pay Gap data on the Trust and government website by 30 March 2025.

Appendix 1

Tees, Esk and Wear Valleys NHS Foundation Trust Gender Pay Gap Report – 2024

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 introduced a statutory requirement to produce information outlining details of any gender pay differences that exist within an organisation. As from April 2018 public, private and voluntary sector organisations with 250 or more employees were required to report on their gender pay gaps using six different measures.

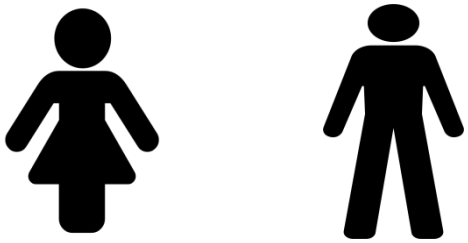
This is the seventh report and is based upon a snapshot date of **31st March 2024.** We are required to publish data on the Government Equalities Office website and on the Trust website by 30th March 2025 and annually going forward.

The gender pay gap shows the difference between the average (mean or median) earnings of men and women. This is expressed as percentage of men's earnings e.g.; women earn 15% less than men). The gender pay gap differs from equal pay in the following way. Equal pay deals with the pay differences between men and women who carry out **the same jobs, similar jobs or work of equal value**. It is unlawful to pay people unequally because they are a man or a woman. The gender pay gap shows the differences in the average pay between men and women.

The following report includes the statutory requirements of the gender pay gap reporting legislation along with further context to demonstrate our commitment to equality. Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post. The Trust is committed to understanding any differences identified in the gender pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

Finally, it is important to note that analysis of pay gaps are multi-dimensional and complex. Undertaking pay gap reports helps us to identify where pay differences exist and identify actions to understand those disparities better. Reporting annually is an important step to allow us to see how our pay disparities are changing.

The gender profile of the Trust 2024



80.0% **20.0%**

The gender profile split in the Trust has changed by 3% in the past year and since reporting commenced in 2017 it has changed minimally from 77% female and 23% male.

Please note these figures exclude bank workers. The remainder of the report includes data pertaining to substantive staff plus any bank workers who worked on 31 March 2024. This is in accordance with the Gender Pay Gap reporting requirements.

In line with gender pay gap reporting we are required to report annually on the following:

- Mean gender pay gap
- Median gender pay gap
- Mean bonus gender gap *
- Median bonus gender gap *
- The proportion of males receiving a bonus payment *
- The proportion of females receiving a bonus payment *
- Proportions of males and females in each quartile of pay band

*Under the regulation payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

Mean and Median Gender Pay Gap

The mean gender pay gap and median gender pay gap for **all employees** is detailed below. Gross pay calculations are used for these purposes.

In line with guidance, only staff on full pay are included in the calculations therefore staff on reduced pay for sickness, maternity or other reasons are excluded. Overtime payments are also excluded from these calculations.

Mean Gender Pay Gap

Median Gender Pay Gap

10.82% less than males - equating to £2.23 per hour less	0.00% less than males - equating to £0.00 per hour less

2024

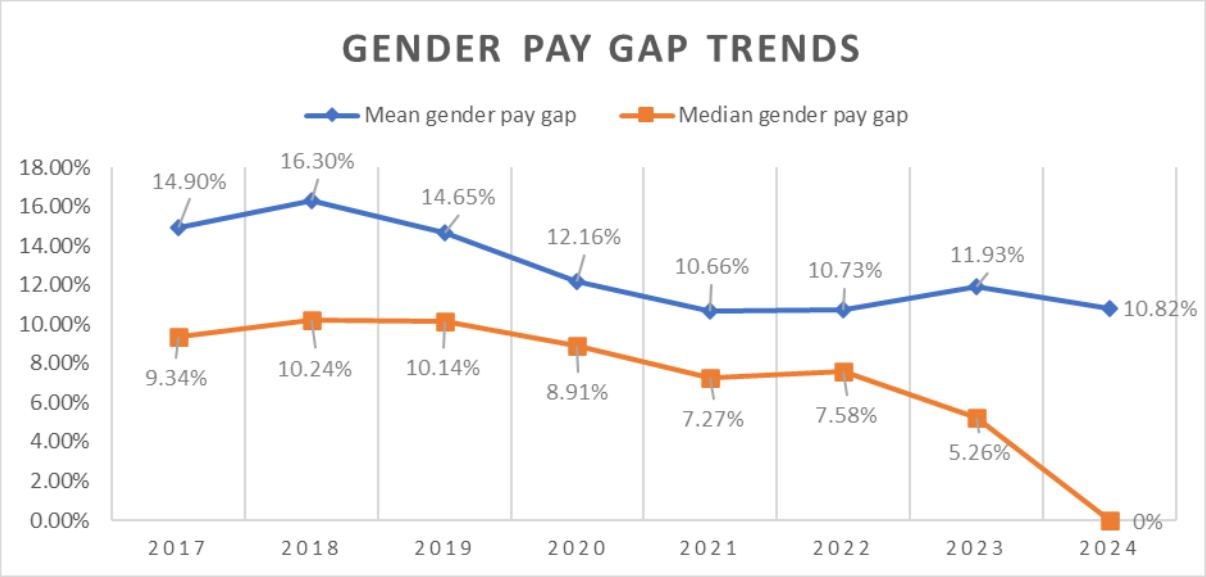
Mean	Gender	Mean Hourly Pay	Difference	Gap
Overall	Male	£20.56	£2.23	10.82%
	Female	£18.34		
Median	**Gender**	**Median Hourly Pay**	**Difference**	**Gap**
Overall	Male	£17.73	£0.00	0.00%
	Female	£17.73		

The mean gender pay gap linked to the amount a female is paid has decreased in the past year from 11.91% to 10.82%. From an hourly rate perspective this equates to a mean gender pay gap decrease in the past year from £2.38 per hour to £2.23 per hour less than males.

The median gender pay gap has reduced from 5.26% to 0.00% which from an hourly rate perspective equates to a median gender pay gap change in the past year from £0.91 per hour to £0.00 per hour less than males.

The graph below highlights the mean and median gender pay gap reported figures between March 2017 and March 2024 for comparison purposes.

2024



There are number of possible contributory factors which can influence the gender pay gap differences. The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car.

The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median gender pay gap and will be one of a number of contributory factors which may be causing the differences being reported.

It is important to note that some staff have more than one salary sacrifice in place (some have up to 5) and that amounts of deductions can vary considerably.

2024

Row Labels	Count of Employee Number	%
Female	1263	76.9
Male	380	23.1
Grand Total	**1643**	100

As you would expect, in line with the gender split within the organisation, the majority of staff opting to participate in one or more salary sacrifice schemes are female (accounting for 76.9% of the salary sacrifices).

Agenda for Change and Very Senior Manager Pay

When medical staff are removed from the calculations, the gender pay gap decreases which is common amongst NHS Trusts. The mean and median gender

pay gaps for those staff employed on Agenda for Change terms and conditions and Very Senior Managers (VSM) Pay is detailed below.

Mean Gender Pay Gap (AfC & VSM Pay)

1.75% less than males - equating to £0.32 per hour less

Median Gender Pay Gap (AfC & VSM Pay)

13.43% less than males – equating to £2.44 per hour less.

Comparing this 2024 data with the previous year shows the mean gender pay for staff on AFC & VSM pay has decreased from the previous year of 3.61% to 1.75%. The median gender pay gap has increased from 4.42% to 13.43%.

AFC and VSM - 2024 data

Mean	Gender	Mean Hourly Pay	Difference	Gap
Overall	Male	£17.97	£0.32	1.75%
	Female	£17.65		
Median	**Gender**	**Median Hourly Pay**	**Difference**	**Gap**
Overall	Male	£18.15	£2.44	13.43%
	Female	£15.71		

Medical and Dental

The information below highlights the mean gender pay gap and median gender pay gap for those staff employed on **Medical and Dental terms and conditions**. The figures include the Clinical Excellence Awards payments that are paid to eligible medical staff.

Mean Gender Pay Gap (M&D)

Median Gender Pay Gap (M&D)

3.70% less than males -
equating to £1.67 per hour less

0.01% less than males –
equating to £0.01 per hour less

2024

Mean	Gender	Mean Hourly Pay	Difference	Gap
Overall	Male	£45.07	£1.67	3.70%
	Female	£43.40		
Median	**Gender**	**Median Hourly Pay**	**Difference**	**Gap**
Overall	Male	£52.11	£0.01	0.01%
	Female	£52.10		

Compared with last year there has been a reduction in the gender pay gap within the medical workforce from both a mean and median calculation. The mean gender pay gap within the medical workforce has decreased from 7.92% in 2023 to 3.70% in 2024. The median gender pay gap has also decreased between male and females in the past year from 3.19% to 0.01%.

Bonus Payments

Under the regulations, payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

- **Clinical Excellence Awards (CEA)**

Under the national Medical & Dental terms and conditions consultants are eligible to apply for Clinical Excellence Awards (CEA). These awards recognise individuals

who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role and are part of a commitment to the continuous improvement of the NHS.

At the time of reporting the Trust was operating a local clinical excellence award scheme based on the national terms and conditions. For the 2024 award year it was agreed locally that due to industrial action that the Trust would follow the same process as that which took place in the preceding years linked with the pandemic. This meant that the Trust could again stand down the usual formal process of application and review for CEA's. Instead, the money could be divided equally between all eligible individuals, and they received a non-consolidated and non-pensionable payment for the year. Therefore, everyone received the same amount of award for 2024.

There are also however several individuals receiving historic awards from 2017 which are recurrently paid each year. Once an award had been made the consultant continues to receive that level of award going forward. A further submission may be made the following year and as a consequence progression through the varying payment levels occurred.

As part of the new terms and conditions following agreement to the pay settlement, from 1st April 2024 the contractual entitlement to access annual CEA awards stopped. Therefore, there will be no new award rounds. Any doctor who has a pre-2018 CEA will be retained and remain pensionable and consolidated. The value of these awards will be frozen, and the review process has been removed. These changes will impact on future pay gap reports.

Based on current guidance the table below shows the mean and median bonus pay linked to clinical excellence awards only.

2024

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£8,611	£5,682
Female	£4,835	£2,666
Difference	£3,776	£3,016
Pay Gap %	43.85%	53.08%

All of the Trust eligible 114 Consultants received a Clinical Excellence Award in the reporting year. Of which 53 are female and 61 are male eligible consultants.

Whilst there was a generally equal split of males and females receiving Clinical Excellence Awards, overall, there were more males receiving larger monetary amounts due to the historical awards which is evident by the mean bonus gender

gap percentage. It is important to note that compared to the Trust gender split, within this staff group there is more even split of male and females.

Comparing this year's data with 2023, the pay gap for mean bonus payments amounts are relatively unchanged. The median bonus in 2023 was 0%. The change in 2024 is as a result of more males in receipt a higher level of awards.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 167 staff received an award. **134 females (80%) and 33 males (20%)** received an award.

Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above. Guidance from ACAS states that such payments with a monetary value should be included in the bonus calculations.

Total Bonus Payments

The table below provides **combined details of the clinical excellence awards and long service awards**. These figures are very similar to last years.

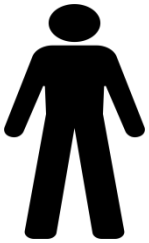
2024

Gender	Mean Bonus Pay	Median Bonus Pay
Male	£5,683	£2,666
Female	£2,012	£100
Difference	£3,671	£2,566
Pay Gap %	64.59%	96.25%

It is important to recognise when combining the bonus awards in this way the data is skewed as long service awards are predominantly paid to women, with a higher proportion of males receiving clinical excellence award payments. These payments are also not prorated.

Overall percentage of males and females receiving bonus payments

2.9 %



5.5%

The guidance requires us to calculate the percentage of males and females who have received a bonus as a percentage of all employed males and females (not just those on full pay which other aspects of the gender reporting require us to do).

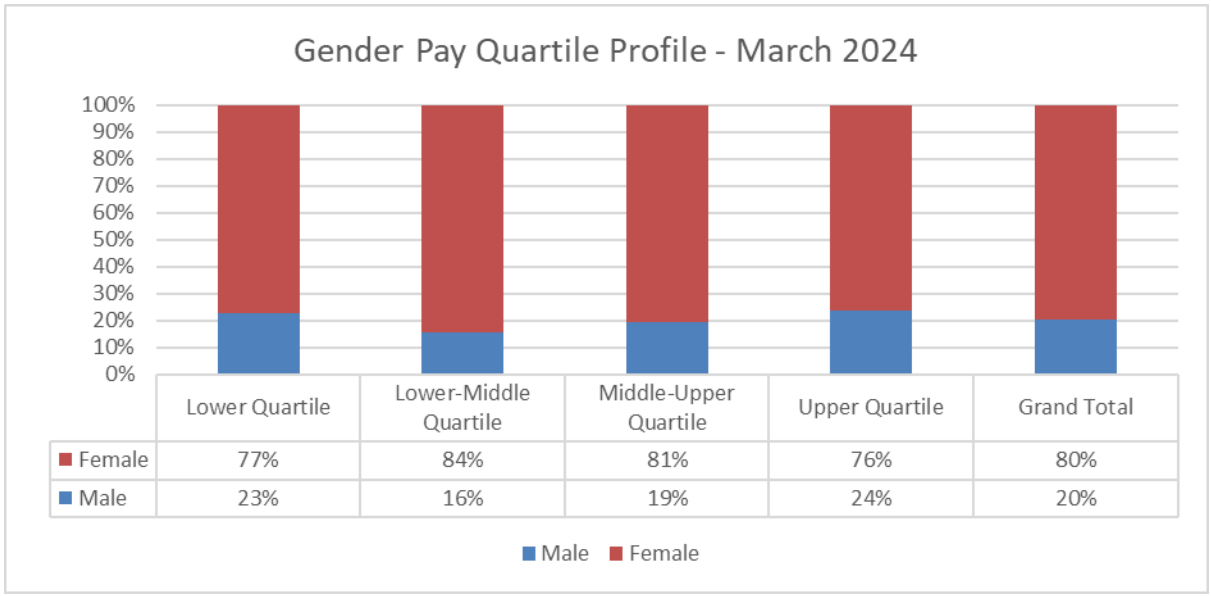
Gender Pay Quartile Profile

The following graph shows the proportion of males and females in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more women than men in every quartile.

The middle-upper quartile in 2024 has shown a decrease in the proportion of females within that quartile from 82% in 2023 to 81% in 2024.

The remaining quartiles have remained broadly the same.

2024



	Lower Quartile	Lower-Middle Quartile	Middle-Upper Quartile	Upper Quartile	Grand Total
Female	77%	84%	81%	76%	80%
Male	23%	16%	19%	24%	20%

Gender Breakdown by Pay Band

The three graphs below provide a comparison of the Trusts gender profile breakdown by pay band as at March 2024, 2023, and March 2017 when reporting commenced.

The ratio between males and females comparing 2024 and 2023 have shown little change within Band 9 and VSM roles. In 2023, females accounted for 52% of this group whereas in 2024 they account for 56%. Males in this banding have decreased from 48% in 2023 to 44% in 2024.

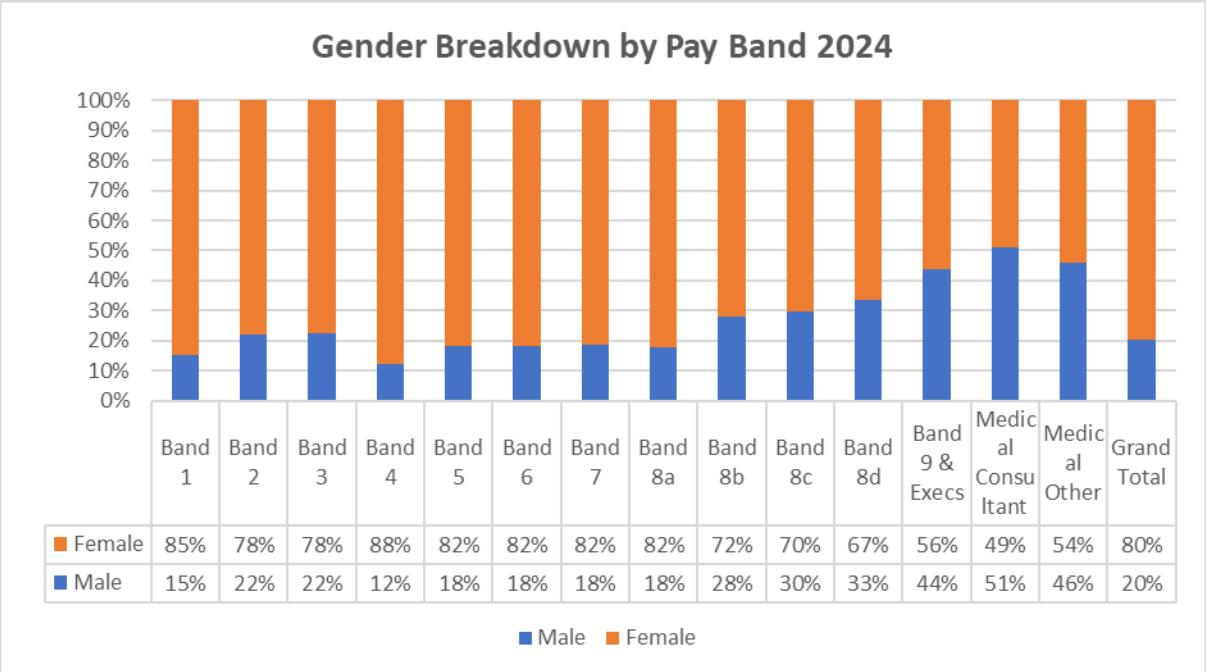
Comparing data from 2017 with 2024 shows that the proportion of females in bands 8d, 9 & VSM pay and in consultant posts have had the largest increases. Females in 8d posts have increased from 57% to 67% between 2017 – 2024. Band 9 and VSM pay grades have seen an increase in females from 43% to 69% in 2022, this has then reduced in 2024 to 56%.

The female consultant workforce has increased from 42% in 2017, to 49% 2023 and stayed the same in 2024.

Females in other medical grades have seen a slight fluctuation, starting at 62% in 2017 and has reduced to 54% in 2024.

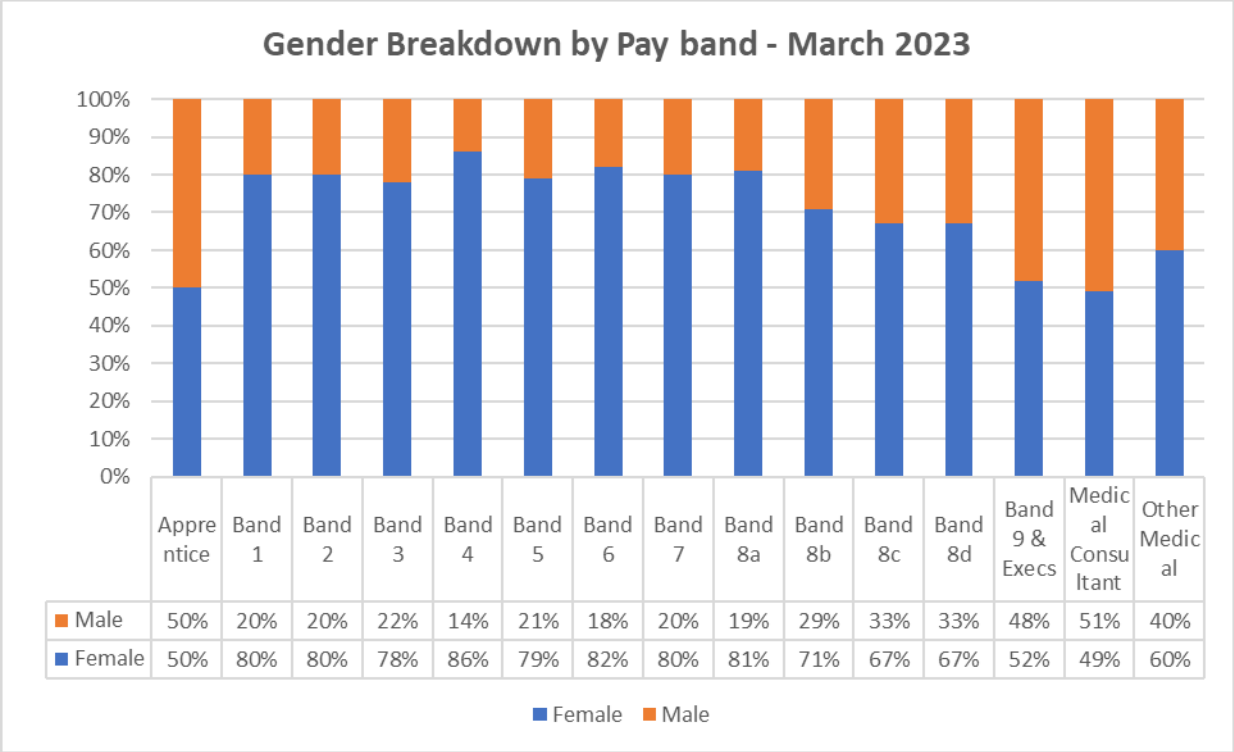
Band 1 was closed to new entrants from 1 December 2018, therefore the number of overall staff in this banding will continue to reduce as people leave the role. Currently there are 13 staff employed in Band 1 roles.

2024



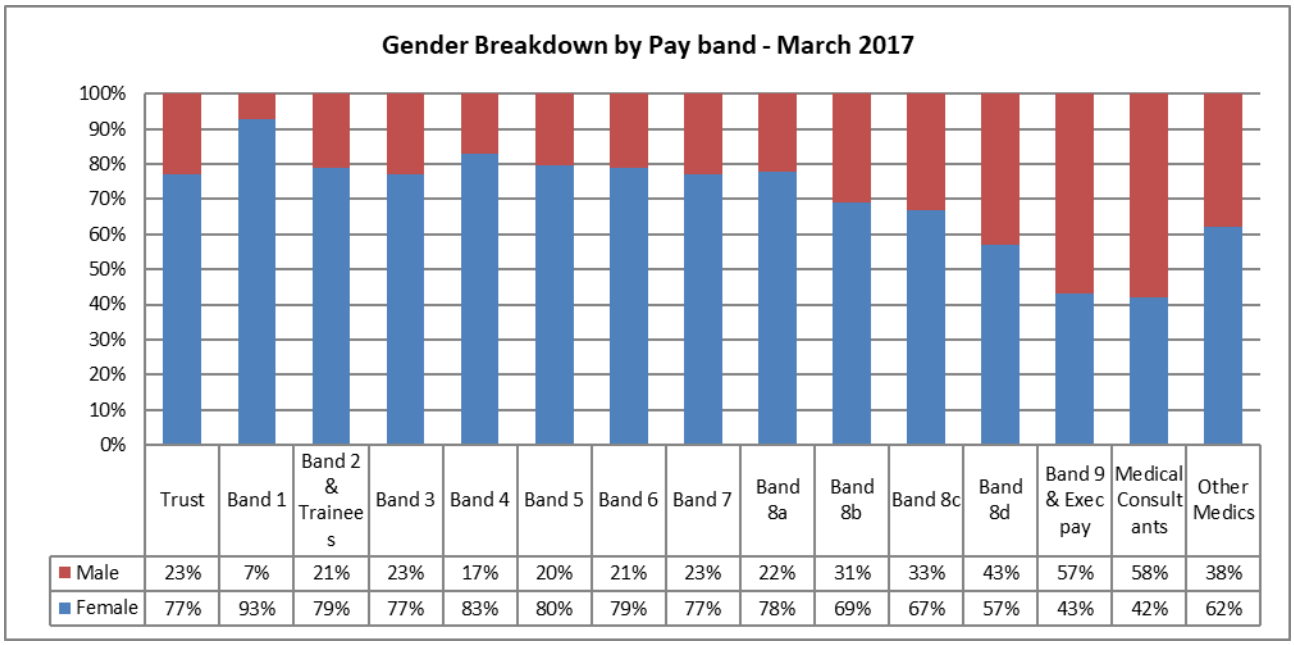
	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Medical Other	Grand Total
Female	85%	78%	78%	88%	82%	82%	82%	82%	72%	70%	67%	56%	49%	54%	80%
Male	15%	22%	22%	12%	18%	18%	18%	18%	28%	30%	33%	44%	51%	46%	20%

2023



	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Other Medical
Male	50%	20%	20%	22%	14%	21%	18%	20%	19%	29%	33%	33%	48%	51%	40%
Female	50%	80%	80%	78%	86%	79%	82%	80%	81%	71%	67%	67%	52%	49%	60%

2017



	Trust	Band 1	Band 2 & Trainees	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Exec pay	Medical Consultants	Other Medics
Male	23%	7%	21%	23%	17%	20%	21%	23%	22%	31%	33%	43%	57%	58%	38%
Female	77%	93%	79%	77%	83%	80%	79%	77%	78%	69%	67%	57%	43%	42%	62%

Key Findings:

- The mean and the median pay gap have reduced from 2023.
- The overall median gender pay gap has decreased since last year from 5.26% to 0.00%.

- The ratio between males and females comparing 2024 and 2023 have shown little change within Band 9 and VSM roles. In 2023, females accounted for 52% of this group whereas in 2024 they account for 56%. Males in this banding have decreased from 48% in 2023 to 44% in 2024.
- Comparing data from 2017 with 2024 shows that the proportion of females in bands 8d, 9 & VSM pay and in consultant posts have had the largest increases. Females in 8d posts have increased from 57% to 67% between 2017 – 2024. Band 9 and VSM pay grades have seen an increase in females from 43% to 69% in 2022, this has then reduced in 2024 to 56%.
- There has been a decrease in the mean gender pay gap from the previous year of 3.61% to 1.75% however the median gender pay gap has increased from 4.42% to 13.43% for staff in AFC & VSM pay grades.
- Whilst there were relatively equal numbers of males and females receiving clinical excellence awards, overall, there were more males receiving larger monetary amounts which is evident by the mean bonus gender gap percentage. This is likely to be a result of the historical awards that some consultants hold.

Proposed Areas for Further Action Specific to the Gender Pay Gap Report:

- To review how changes to the Clinical Excellence Awards impact on the gender pay gap.

Appendix 2

Tees, Esk and Wear Valleys NHS Foundation Trust Ethnicity Pay Gap Report – 2024

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. High Impact action 3 requires us to develop and implement an improvement plan to eliminate pay gaps.

We are required to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Plans were put in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026. The Trust already report on gender pay gaps.

A pay gap is the difference between the average hourly pay of employees in one group in comparison to another group. For example, women in comparison to men or LGBTQ+ in comparison to heterosexual.

This is different to equal pay. Equal pay is a person being paid the same for the same role and it is unlawful to pay someone differently for doing the same job based on a protected characteristic.

The Trust is committed to understanding any differences identified in the ethnicity pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate. Pay gaps can negatively affect the retention of the NHS workforce. They can make it harder to recruit and can have a detrimental impact on staff experience when in post.

This is our second ethnicity pay gap report. We have analysed information using the categories: White, Not Stated (which includes not known) and BAME. BAME is all other ethnic minority groups combined. At this stage we have not broken down BAME any further due to the small numbers in each category and recommendations are that there should be at least 50 staff in each group to ensure statistical robustness.

Guidance on ethnicity pay gaps has been produced in May 2023 with recommendations as to what metrics organisations can consider using to measure their ethnicity pay gap. We have applied the calculations and analysis methods used in Gender Pay Gap reporting.

It is recommended that we review the mean and median ethnicity pay gaps, mean and median bonus gaps and proportions of ethnicities in each quartile of pay bands.

Under the regulations, payments that would fall under the remit of a bonus includes Clinical Excellence Awards for consultants and Long Service Awards.

Finally, it is important to note that analysis of pay gaps are multi-dimensional and complex. Undertaking pay gap reports helps us to identify where pay differences exist and identify actions to understand those disparities better. Reporting annually is an important step to allow us to see how our pay disparities are changing.

The ethnicity profile of the Trust 2024

Ethnicity	Percentage
BAME	8%
Not Stated	1.3%
White	90.7%

Please note these figures exclude bank workers. The remainder of the report includes data pertaining to substantive staff plus any bank workers who worked on 31 March 2024.

Mean and Median Ethnicity Pay Gap

The mean ethnicity pay gap and median ethnicity pay gap for **all employees** is detailed below. Gross pay calculations are used for these purposes. This includes

enhancements, clinical excellence awards and long service awards. Overtime payments are excluded from these calculations.

In line with guidance, only staff on full pay are included in the calculations therefore staff on reduced pay for sickness, maternity or other reasons are excluded. Staff who did not state their ethnicity or are classified as unknown are not included within these figures.

2024

Mean	Ethnicity	Average Hourly Pay	Difference	Gap
Overall	White	£18.57	-£2.38	-12.80%
	BAME	£20.95		
Non-medical & exec	White	£17.87	£2.31	12.94%
	BAME	£15.56		
Medical only	White	£48.49	£7.56	15.59%
	BAME	£40.93		

The **overall** figures show that BAME staff are paid higher than white staff by £2.38.

By breaking down the pay gap to non-medical and staff on Very Senior Manager (VSM) pay and medical separately it can be seen that there is an ethnicity pay gap evident. The reason for this difference is that overall, we have a low number of BAME staff employed compared to white staff. This impacts on the average hourly pay of that group of staff compared with the average hourly rates of the much larger white workforce in each grade.

Also, our BAME workforce has a significantly higher proportion of medics within it which results in a higher average hourly rate.

The overall median ethnicity pay gap table below also appears to demonstrate that there is an ethnicity pay gap between white and BAME staff and that white staff are paid higher than BAME staff by £3.17. A breakdown by non-medical and VSM pay and medical also shows that a pay gap exists.

2024

Median	Ethnicity	Median Hourly Pay	Difference	Gap
Overall	White	£17.73	£3.17	17.85%
	BAME	£14.57		
Non-medical & exec	White	£17.73	£3.58	20.20%
	BAME	£14.15		
Medical	White	£52.11	£12.50	23.98%

only	BAME	£39.62		

In addition to the proportion of BAME staff employed by the Trust, there are other possible contributory factors which can influence the pay gap differences. The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car.

The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median ethnicity pay gap and will be one of a number of contributory factors which may be causing the differences being reported.

2024

Row Labels	Count of Employee Number	%
BAME	87	5.3%
White	1479	90%
Not stated	77	4.3%
Grand Total	**1632**	100

The numbers of BAME staff who have salary sacrifice deductions is very low, with 87 staff accessing this benefit compared with 1479 white staff. BAME staff accessing the scheme equates to 5.3% of all salary sacrifices within the Trust which shows BAME staff are less likely to access salary sacrifices.

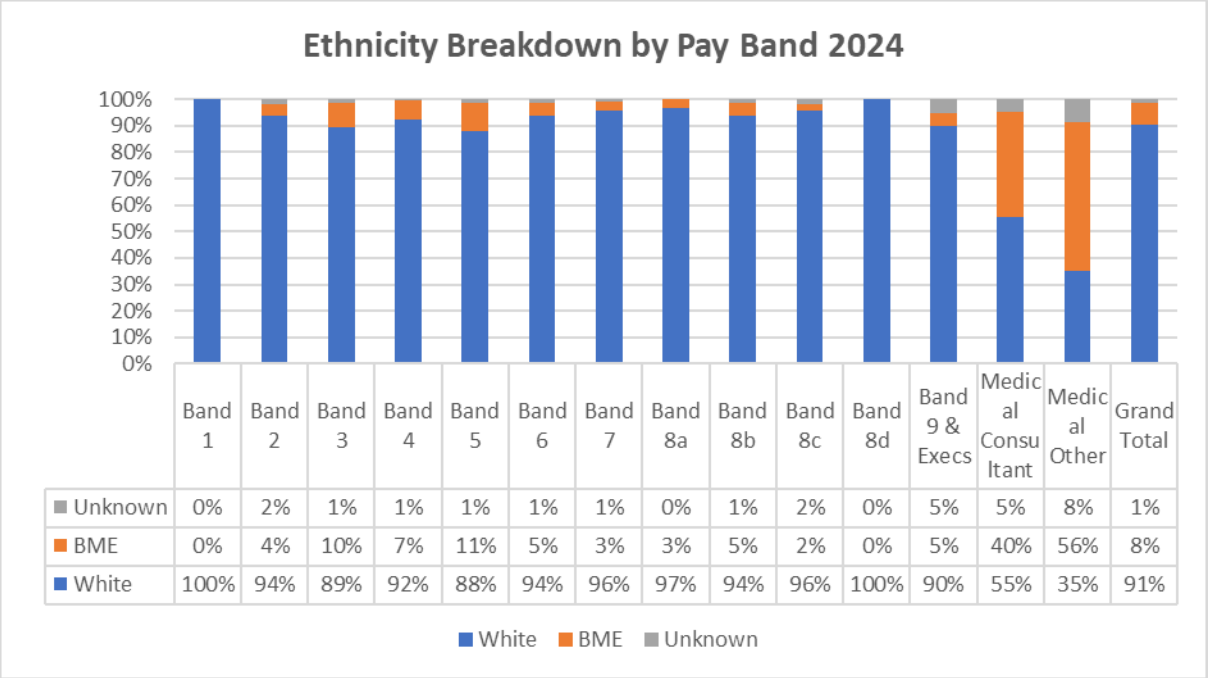
A breakdown by type of salary sacrifice for BAME staff has not been provided due to staff being potentially identifiable due to the low numbers involved.

Ethnicity Breakdown by Pay Band

The following graph provides a breakdown of ethnicity by pay band. It is clear that largest numbers of our BAME workforce are within the medical workforce.

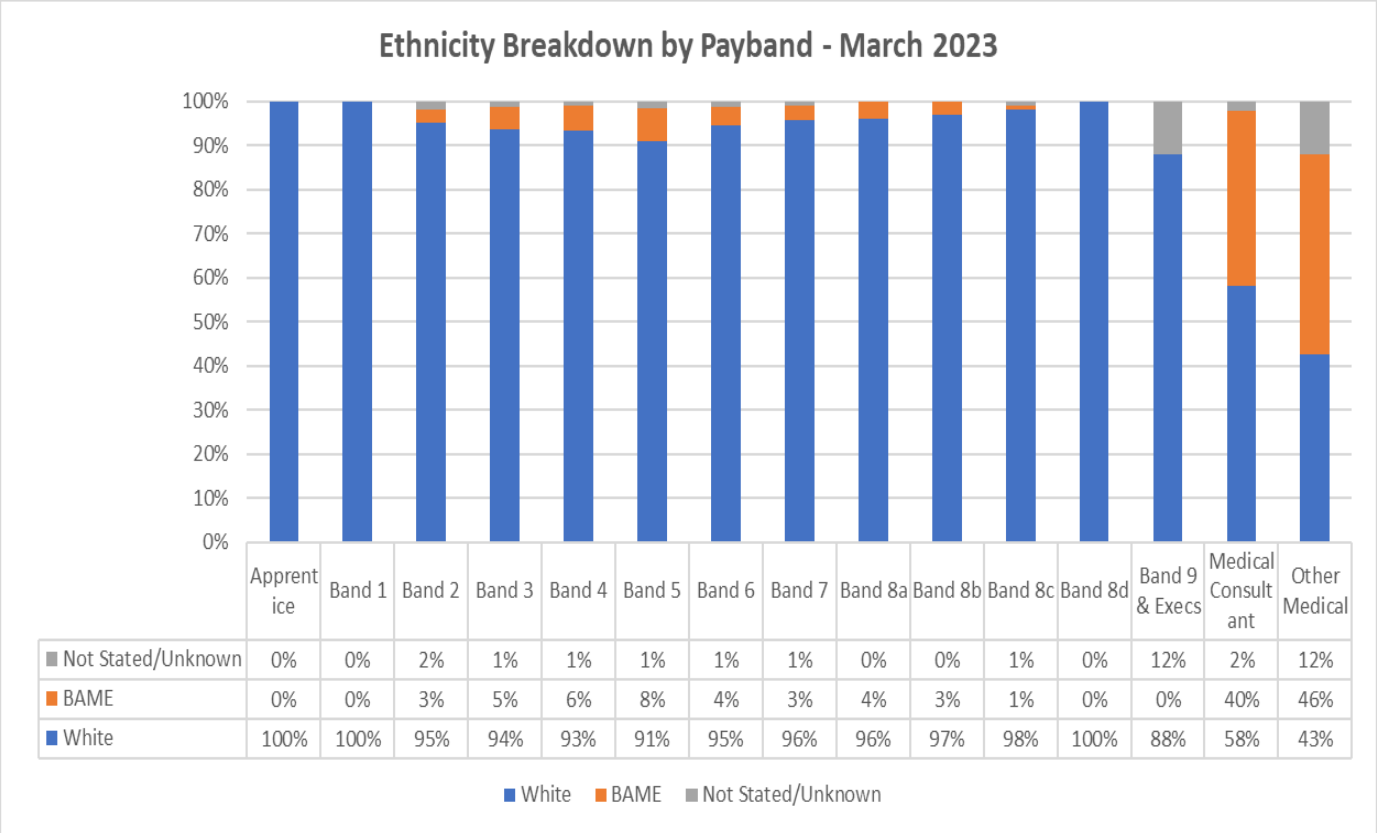
Band 1 was closed to new entrants from 1 December 2018, therefore the number of overall staff in this banding will continue to reduce**.**

2024



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Medical Other	Grand Total
Unknown	0%	2%	1%	1%	1%	1%	1%	0%	1%	2%	0%	5%	5%	8%	1%
BME	0%	4%	10%	7%	11%	5%	3%	3%	5%	2%	0%	5%	40%	56%	8%
White	100%	94%	89%	92%	88%	94%	96%	97%	94%	96%	100%	90%	55%	35%	91%

2023

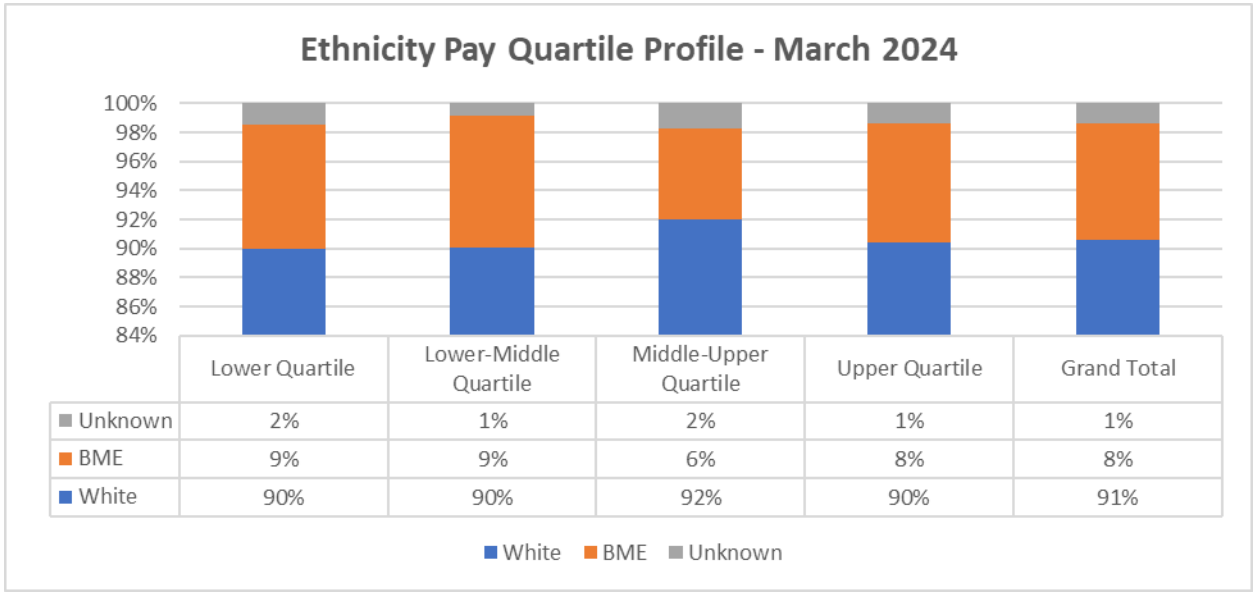


	Apprentice	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Other Medical
Not Stated/Unknown	0%	0%	2%	1%	1%	1%	1%	1%	0%	0%	1%	0%	12%	2%	12%
BAME	0%	0%	3%	5%	6%	8%	4%	3%	4%	3%	1%	0%	0%	40%	46%
White	100%	100%	95%	94%	93%	91%	95%	96%	96%	97%	98%	100%	88%	58%	43%

Ethnicity Pay Quartile Profile

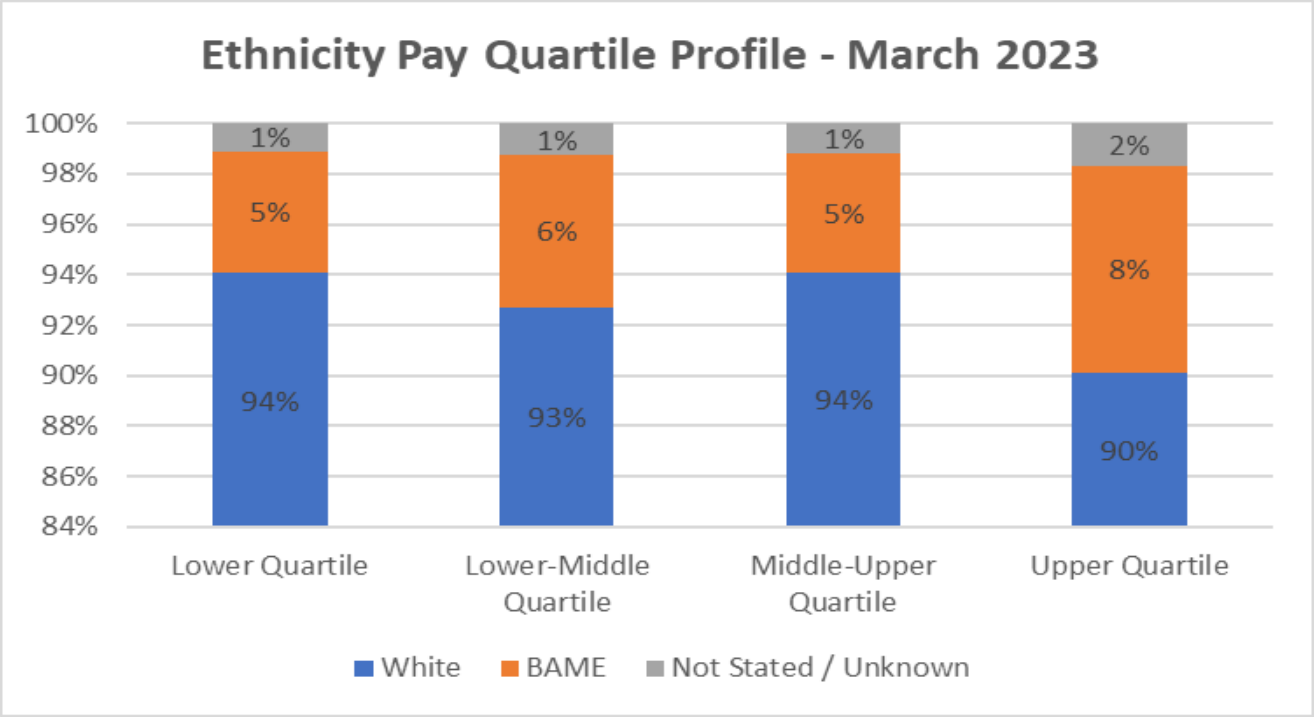
The following graph shows the proportion of staff by ethnicity in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more white staff than BAME staff in every quartile. The highest percentage of BAME staff are within the lower quartile and lower-middle quartile

2024



	Lower Quartile	Lower-Middle Quartile	Middle-Upper Quartile	Upper Quartile	Grand Total
Unknown	2%	1%	2%	1%	1%
BME	9%	9%	6%	8%	8%
White	90%	90%	92%	90%	91%

2023



Bonus Payments

Under the regulations, payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

- **Clinical Excellence Awards (CEA)**

Under the national Medical & Dental terms and conditions consultants are eligible to apply for Clinical Excellence Awards (CEA). These awards recognise individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role and are part of a commitment to the continuous improvement of the NHS.

At the time of reporting the Trust was operating a local clinical excellence award scheme based on the national terms and conditions. For the 2024 award year it was agreed locally that due to industrial action that the Trust would follow the same process as that which took place in the preceding years linked with the pandemic. This meant that the Trust could again stand down the usual formal process of application and review for CEA's. Instead, the money could be divided equally between all eligible individuals, and they received a non-consolidated and non-pensionable payment for the year. Therefore, everyone received the same amount of award for 2024.

There are also however several individuals receiving historic awards from 2017 which are recurrently paid each year. Once an award had been made the consultant continues to receive that level of award going forward. A further submission may be made the following year and as a consequence progression through the varying payment levels occurred.

As part of the new terms and conditions following agreement to the pay settlement, from 1st April 2024 the contractual entitlement to access annual CEA awards stopped. Therefore, there will be no new award rounds. Any doctor who has a pre-2018 CEA will be retained and remain pensionable and consolidated. The value of these awards will be frozen, and the review process has been removed. These changes will impact on future pay gap reports.

Based on current guidance the table below shows the mean and median bonus pay linked to clinical excellence awards only.

2024

Ethnicity	Mean Bonus Pay	Median Bonus Pay
White	£6,408	£2,666
BAME	£7,448	£5,682
Difference	-£1,040	-£3,016
Pay Gap %	-16.23%	-113.12%

All of the Trust eligible 114 Consultants received a Clinical Excellence Award in the reporting year. 68 were white (59.6%), 41 were from BAME backgrounds (36%) and 5 had not stated / unknown ethnic origins (4.4%).

The data suggests that white consultants are paid less CEA amounts compared with BAME consultants. However, due to the small number of staff receiving these payments, one or 2 staff with high or low CEA levels can have a significant impact on the overall averages.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 167 staff received an award. Of which 157 were White (94%), 7 were from a BAME background (4.2%) and 3 had not stated their ethnicity (1.8%).

Whilst the percentage of BAME staff receiving a long service award has increased from last year (2.5 %) it is disproportionately low compared with the 8% of the Trust workforce that the BAME workforce make up.

Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above. Guidance from ACAS states that such payments with a monetary value should be included in the bonus calculations.

Total Bonus Payments

The table below provides **combined details of the clinical excellence awards and long service awards**. It should be noted that the numbers of BAME staff involved in these calculations is very low and overall, as a proportion of the workforce, the numbers of staff receiving bonus's as per these guidelines is very small. These payments are also not pro-rated.

When combining CEA and long service awards, this data suggests that BAME staff receive higher pay than white staff in relation to bonus.

2024

Ethnicity	Mean Bonus Pay	Median Bonus Pay
White	£2,006	£100
BAME	£6,512	£2,666
Difference	-£4,506	-£2,566
Pay Gap %	-224.58%	-2566.20%

Overall percentage of receiving bonus payments

The guidance requires us to calculate the percentage of white and BAME staff who have received a bonus as a percentage of all employed white and BAME staff (not just those on full pay which other aspects of the reporting require us to do).

7.3% of BAME staff received a bonus in 2024 compared to 8.3% in 2023.
3.02% of white staff received a bonus in 2024 compared to 2.4% in 2023.

The difference in percentages will be linked to the proportion of the BAME workforce which are medical and are therefore eligible for clinical excellence awards.

Key Findings:

6) The number of BAME staff within the organisation is low and a high percentage of the BAME workforce in the Trust are medical. Therefore, when calculating average pay for BAME staff, data could be skewed by smaller numbers of higher paid staff.
7) Whilst overall data shows that BAME staff average hourly pay is higher than white staff, when separating non-medical & executive pay and medical pay grades the data shows that there is a pay gap evident in both groups.
8) Similar to last year our BAME consultants are receiving higher bonus payments.
9) Proportionally, fewer BAME staff were eligible for long service awards.
10) Very low levels of BAME staff are within higher bands, (excluding medical grades).

Proposed Areas for Further Action Specific to the Ethnicity Pay Gap Report:

1) To explore the reasons for low numbers of BAME staff being eligible for long service awards and if this is linked with retention of our BAME workforce in the NHS and associated reasons.

2) Explore if there are any reasons for the lower numbers of BAME staff in certain pay grades within the Trust.

Appendix 3

Tees, Esk and Wear Valleys NHS Foundation Trust
Disability Pay Gap Report – 2024

In June 2023 the Equality, Diversity and Inclusion Plan set out six targeted actions to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. High Impact action 3 requires us to develop and implement an improvement plan to eliminate pay gaps.

We are required to analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Plans were in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.

A pay gap is the difference between the average hourly pay of employees in one group in comparison to another group. For example, women in comparison to men or LGBTQ+ in comparison to heterosexual.

This is different to equal pay. Equal pay is a person being paid the same for the same role and it is unlawful to pay someone differently for doing the same job based on a protected characteristic.

The Trust is committed to understanding any differences identified in the disability pay report and will undertake further analysis to gain a better understanding as to the reason for the differences and to take action where appropriate.

This is our first disability pay gap report. We have analysed information using the categories: Declared a Disability, Not Declared (which includes not known) and Declared no Disability.

In the absence of specific guidance under this new reporting requirement, we have applied the calculations and analysis methods used in Gender Pay Gap reporting.

The disability profile of the Trust 2024

Disability	Percentage
Declared a disability	**10.3%**
Not Stated	**13.2%**
Declared no disability	**76.5%**

Please note these figures exclude bank workers. The remainder of the report includes data pertaining to substantive staff plus any bank workers who worked on 31 March 2024. This is in accordance with the Gender Pay Gap reporting requirements.

In line with gender pay gap reporting we are required to report annually on the following:

- Mean gender pay gap
- Median gender pay gap
- Mean bonus gender gap *
- Median bonus gender gap *

- The proportion of males receiving a bonus payment *
- The proportion of females receiving a bonus payment *
- Proportions of males and females in each quartile of pay band

*Under the regulation payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

Mean and Median Disability Pay Gap

The mean disability pay gap and median disability pay gap for **all employees** is detailed below. Gross pay calculations are used for these purposes.

In line with guidance, only staff on full pay are included in the calculations therefore staff on reduced pay for sickness, maternity or other reasons are excluded. Overtime payments are also excluded from these calculations.

2024

Mean	Disability	Mean Hourly Pay	Difference	Gap
Overall	Declared no disability	£18.87	£0.64	3.41%
	Declared a disability	£18.23		
Non-medical & exec	Declared no disability	£17.82	£0.04	0.21%
	Declared a disability	£17.78		
Medical only	Declared no disability	£45.19	£2.15	4.75%
	Declared a disability	£43.05		

The mean disability pay gap shows that staff who declared they had a disability are paid £0.64 per hour less than staff that declared no disability.

2024

Median	Disability	Median Hourly Pay	Difference	Gap
Overall	Declared no disability	£17.73	£0.00	0.00 %
	Declared a disability	£17.73		
Non-medical & exec	Declared no disability	£17.73	£0.00	0.00 %
	Declared a disability	£17.73		
Medical only	Declared no disability	£52.11	£4.26	8.17 %
	Declared a disability	£47.85		

The median disability pay gap shows that there is no pay gap identified.

When medical staff are removed from the calculations, the mean disability pay gap decreases which is common amongst NHS Trusts.

There are number of possible contributory factors which can influence the disability pay gap differences. The Trust operates a number of **salary sacrifice schemes** which affords staff the opportunity to purchase vouchers towards childcare costs, purchase a cycle, electrical goods or a lease car.

The costs associated with salary sacrifice schemes are deducted prior to calculating gross pay. This will have an impact on the gross pay calculations undertaken to determine the mean and median disability pay gap and will be one of a number of contributory factors which may be causing the differences being reported.

It is important to note that some staff have more than one salary sacrifice in place (some have up to 5) and that amounts of deductions can vary considerably. The table below details the percentage of staff with salary sacrifices and their disability status.

2024

Row Labels	Percentage of Employees
Declared a disability	10.5%
Declared no disability	81.2%
Not stated	8.3%
Grand Total	**100%**

The schemes which are most popular are electronics and lease cars, the latter of which has the largest cost associated.

Bonus Payments

Under the regulations, payments that would fall under the remit of bonus would include Clinical Excellence Awards for consultants and Long Service Awards.

- **Clinical Excellence Awards (CEA)**

Under the national Medical & Dental terms and conditions consultants are eligible to apply for Clinical Excellence Awards (CEA). These awards recognise individuals who demonstrate achievements in developing and delivering high quality patient care over and above the standard expected of their role and are part of a commitment to the continuous improvement of the NHS.

At the time of reporting the Trust was operating a local clinical excellence award scheme based on the national terms and conditions. For the 2024 award year it was agreed locally that due to industrial action that the Trust would follow the same process as that which took place in the preceding years linked with the pandemic. This meant that the Trust could again stand down the usual formal process of application and review for CEA's. Instead, the money could be divided equally between all eligible individuals, and they received a non-consolidated and non-pensionable payment for the year. Therefore, everyone received the same amount of award for 2024.

There are also however several individuals receiving historic awards from 2017 which are recurrently paid each year. Once an award had been made the consultant continues to receive that level of award going forward. A further submission may be made the following year and as a consequence progression through the varying payment levels occurred.

As part of the new terms and conditions following agreement to the pay settlement, from 1st April 2024 the contractual entitlement to access annual CEA awards stopped. Therefore, there will be no new award rounds. Any doctor who has a pre-2018 CEA will be retained and remain pensionable and consolidated. The value of these awards will be frozen, and the review process has been removed. These changes will impact on future pay gap reports.

Based on current guidance the table below shows the mean and median bonus pay linked to clinical excellence awards only. The data below excludes staff who have not declared whether they had a disability or otherwise.

2024

Disability	Mean Bonus Pay	Median Bonus Pay
Declared a disability	£3,671.53	£2,666.20
Declared no disability	£5,796.88	£2,666.20
Difference	£2,125.35	£0.0
Pay Gap %	36.66%	0.0%

All of the Trust eligible 114 Consultants received a Clinical Excellence Award in the reporting year. 74.6% had declared that they did not have a disability, 2.6% of consultants had declared that they had a disability and 22.8% had not stated / unknown disability status.

The data suggests that consultants who have declared a disability are paid less CEA amounts compared with those consultants who have not declared a disability. However, due to the small number of staff declaring that they have a disability and the relatively high percentage of consultants not declaring their disability status, this conclusion should be read with caution.

Long Service Awards

The Trust operates a locally agreed long service award scheme to recognise the service of staff who have 25 years NHS service. The award is a £100 gift voucher. In the reporting period a total of 167 staff received an award. Of which 100 had declared that they did not have a disability (59.9%), 23 staff had declared that they had a disability (13.8%) and 44 had not stated their disability status (26.3%).

Under the Regulation we are required to include payments which relate to profit sharing, productivity, performance, incentive or commission should be included in the bonus calculations. It could be argued long service awards do not provide the incentive usually associated with the criteria outlined above. Guidance from ACAS states that such payments with a monetary value should be included in the bonus calculations.

Total Bonus Payments

The table below provides **combined details of the clinical excellence awards and long service awards**. It should be noted that the numbers of staff involved in these calculations and declaring that they have a disability is very low. Overall, as a proportion of the workforce, the numbers of staff receiving bonus's as per these guidelines is very small. These payments are also not pro-rated.

2024

Disability	Mean Bonus Pay	Median Bonus Pay
Declared a disability	£409.55	£100.00
Declared no disability	£2,717.76	£100.00
Difference	£2,308.21	0.0
Pay Gap %	84.9%	0.0%

Overall percentage of receiving bonus payments

The guidance requires us to calculate the percentage of staff, by their disability status, as a percentage of all employed staff (not just those on full pay which other aspects of the reporting require us to do).

0.32% of staff who have declared themselves as having a disability received a bonus in 2024.
2.24% of staff who declared that they did not have a disability received a bonus in 2024.

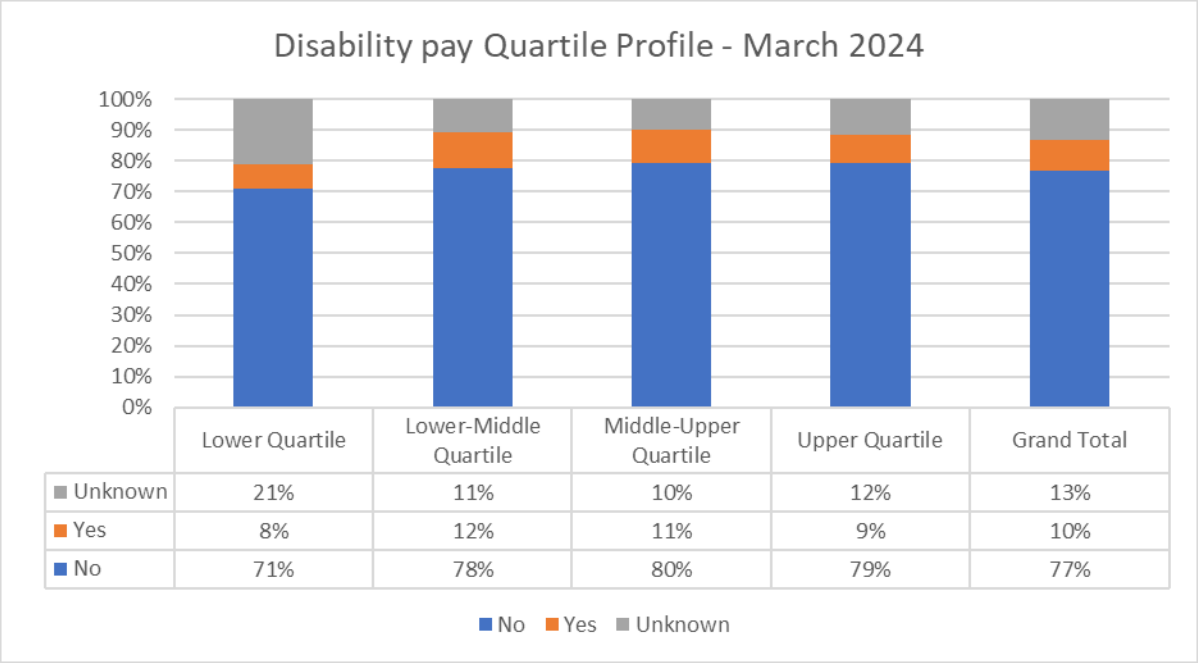
It is likely that the number of staff who have not declared their disability status and received bonus payments this year impacts on the above percentage rates.

It is important to recognise when combining the bonus awards in this way the data is skewed as more staff receive long service awards than clinical excellence awards and long service awards are significantly lower monetary amounts. These payments are also not prorated.

Disability Pay Quartile Profile

The following graph shows the proportion of disabled staff and non disabled staff in each pay quartile. The lower quartile represents the lowest salaries in the Trust and the upper quartile represents the highest salaries. The Trust employs more staff that declare no disability than staff who declare a disability in every quartile.

2024

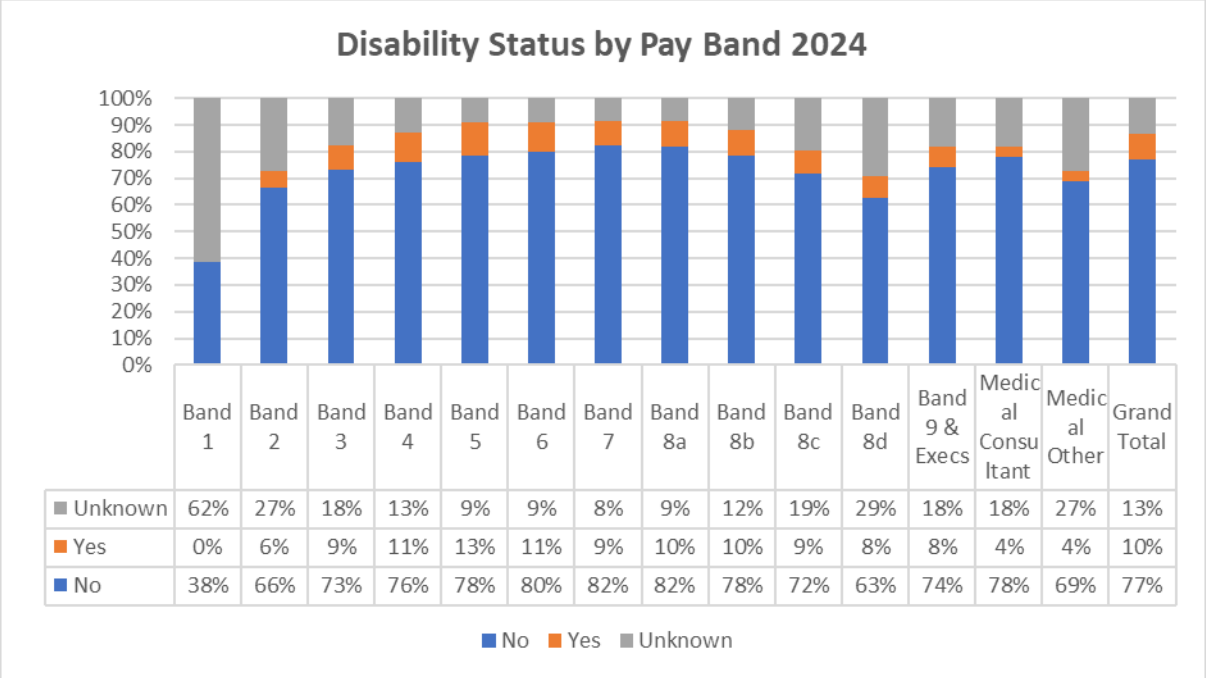


	Lower Quartile	Lower-Middle Quartile	Middle-Upper Quartile	Upper Quartile	Grand Total
Unknown	21%	11%	10%	12%	13%
Yes	8%	12%	11%	9%	10%
No	71%	78%	80%	79%	77%

Disability Breakdown by Pay Band

The graph below provides the Trusts disability profile breakdown by pay band as of March 2024 when reporting commenced.

2024



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9 & Execs	Medical Consultant	Medical Other	Grand Total
Unknown	62%	27%	18%	13%	9%	9%	8%	9%	12%	19%	29%	18%	18%	27%	13%
Yes	0%	6%	9%	11%	13%	11%	9%	10%	10%	9%	8%	8%	4%	4%	10%
No	38%	66%	73%	76%	78%	80%	82%	82%	78%	72%	63%	74%	78%	69%	77%

Key Findings:

- This is the first disability pay gap report that the Trust has produced and will be used as baseline for annual reporting.
- The number of staff who have declared themselves as having a disability is likely to be under reported, therefore the data analysis is likely to be impacted by this.
- 23% of consultants had not declared their disability status. This will have impacted on the bonus section of the report.
- The mean shows that staff declaring they don't have a disability are paid £0.64 more that staff who declare having a disability but zero when looking at the median.

Proposed Areas for Further Action Specific to the Disability Pay Gap Report:

- Encourage staff, particularly medical staff, to declare on ESR their disability status.
- Review 2025 disability pay gap report to compare / identify any trends or changes.

Current Trust actions that impact on all Pay Gaps:

- Continue to pilot the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process.
- Develop new managers training which will include unconscious bias.
- Carry out third mid-career programme.
- Continue with reasonable adjustments pilot to enable staff with underlying health conditions to fulfil their potential.
- Promote the Steps Towards Employment Programme (STEP) to people from communities who don't usually work for the NHS and carry community engagement events across these communities.

Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 February 2025**
Title:	**Equality Delivery System (EDS) 2022**
Executive Sponsor(s):	**Sarah Dexter- Smith, Director of People and Culture**
Author(s):	**Abigail Holder EDI and Human Rights Officer** **Sarah Dallal, EDI and Human Rights 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***
5	**Staff Retention**	The Trust has a minimal appetite for risks relating to quality. Although the present score is above tolerance, an acceptable level of exposure can be achieved. Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels
4	**Experience**	The Trust has a minimal appetite for risks. relating to quality. Although the present score is above tolerance, an acceptable level of exposure can be achieved
11	**Governance and Assurance**	The target risk score is above tolerance levels, and the Trust has a minimal appetite for regulatory risks. Urgent action to be taken to strengthen controls but a higher degree of exposure than acceptable will need to be tolerated

Executive Summary:

Purpose:

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

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

Tees, Esk and Wear Valleys
NHS Foundation Trust

Proposal:	The Board is asked to confirm that it has good assurance that the Trust has followed a robust process in completing EDS 2022 and is meeting its obligations in regard EDS 2022. The Board is asked to ratify the scores of EDS 2022 for 2024 and to agree to the publication of EDS 2022 on the Trust website as is required.
Overview:	EDS 2022 is a requirement of the NHS contract and must be completed annually using the evidence available for each of the outcomes. The proposal for good assurance is based on the information in the appendix which demonstrates that: • Appropriate evidence has been gathered for each outcome. • Consultation on the draft scoring has taken place as required by the technical guidance. • EDS 2022 for 2024 has gone through the appropriate approval routes. The Trust has scored 1(developing) for 2 criteria and further detail on this and plans to improve the scoring are contained in the Appendix. The Trust's overall score is 24 (achieving).
Prior Consideration and Feedback	The paper will be considered by the Executive Directors Group on 26.11.24, PCDC 11.12.24 and JCC 21.1.25.
Implications:	Failure to complete EDS 2022 in accordance with the requirements of the NHS contract may have regulatory consequences.
Recommendations:	The Board is asked to confirm that it has good assurance that a robust process has been undertaken when completing the proposed scoring and evidence for EDS 2022 for 2024. The Board is asked to ratify the scores of EDS 2022 and to agree to the publication of EDS 2022 on the Trust website as is required.

Tees, Esk and Wear Valleys
NHS Foundation Trust

EDS 2022 for 2024

1. BACKGROUND INFORMATION AND CONTEXT.

1.1 EDS 2022 has been developed by NHS England and NHS Improvement and supported by the NHS Equality and Diversity Council as an improvement tool to support NHS organisations to review and develop their services, workforces, and leadership. The completed version must be published on the Trust's website by 28th February 2025 following approval at Board level. EDS 2022 should be carried out annually.

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

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

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

- Undeveloped activity 0
- Developing activity 1
- Achieving activity 2
- Excelling activity 3

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

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

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

- One which where data indicates it is doing well - EIP Middlesbrough
- One where data indicates a service is not doing so well – MHSOP Middlesbrough
- One where its performance is unknown – CAMHS Middlesbrough

1.6 The rating process is as follows:

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

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

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

2. KEY ISSUES

The key issues for consideration are as follows: -

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

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

- Outcome 2 B (score 1) – When at work, staff are free from abuse, harassment, bullying and physical violence from any source. During the review / consultation process, it was recognised that a lot of work was going on in this area, there hasn't been a significant change from 2023 which would warrant an increase in the score for this domain. Further work on this will continue to be led by the Violence Reduction prevention strategy development and working group.

- Outcome 2D (score 1) – Staff recommend the organisation as a place to work and receive treatment. In the 2024 staff survey 57.2% of staff recommended TEWV as a place to work and 55.4% were happy for a friend or relative to be cared for by the Trust. To score a 2 over 70% of staff would recommend the organisation as a place to work and receive treatment.

2.3 The Trust's overall score for EDS 2024 is 24 which is classed as achieving. The action plan at the back of the attached score card details actions the Trust will take in the next year to improve its score.

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

Classification: Official

Publication approval reference:

NHS Equality Delivery System 2022

EDS Reporting Template

Third Version (test)

Version 0.8, 18 February 2022

Contents

Equality Delivery System for the NHS

The EDS Reporting Template

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

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

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

NHS Equality Delivery System (EDS)

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

EDS Lead	Sarah Dallal		**At what level has this been completed?**	
				***List organisations**
EDS engagement date(s)	Staff Networks, staff, unions, chaplaincy, Freedom to Speak Up Guardians – 28.10.24. Executive Directors Group – 11.12.24 NY&Y Care Group Board – 14.11.24 Durham, Tees Valley and Forensic Services – 27.11.24 JCC – 14.1.24 People, Culture & Diversity Committee – 23.1.25		**Individual organisation**	Tees Esk and Wear Valleys NHS Foundation Trust
			Partnership* (two or more organisations)	County Durham and Tees Valley Mental Health, Learning Disability and Autism Partnership

			Integrated Care System-wide*	Reviewed by Cumbria, Northumberland, Tyne and Wear Foundation Trust

Date completed		**Month and year published**	February 2025
Date authorised		**Revision date**	

EDS Rating and Score Card

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

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

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

Domain 1: Commissioned or provided services

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

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service	**Middlesbrough EIP – Score 2** We aim to offer all service users an assessment within 2 weeks of being referred to the service. To promote accessibility, we accept referrals from multiple sources, including self-referral, GP, access, crisis, inpatient and other community services (with the consent of the service user). Our annual NCAP audit demonstrates that we continuously meet the NCAP standard of over 60% for accepting people onto a pathway of care within 2 weeks of referral into TEWV (66% in 2024). In relation to Ethnicity the most recent census indicated that 82% of resident in Middlesbrough where White British or White other, while 18% or residents were from other ethnic groups. However, NCAP sample 2024 data indicated that 65% of EIP service users are white and 35% are from other ethnic groups. Further to this 32% of the white EIP SU accessed EIP through the wards whereas 57% of people from other ethnic groups are referred to EIP through the inpatient services. This indicates that people from Ethnic minoritised groups are accessing mental health services and EIP services later than their white counterparts. This perhaps reflects a lack of awareness of MH services and specifically EIP as well as different cultural understandings of MH and Psychosis.	**2**	Jennifer Simpson (Consultant Clinical Psychologist)

		In this knowledge the teams are doing work to raise awareness of the services by developing posters to go out in GP, schools, colleges and the university. The team are also building relationships with Health Watch in Middlesbrough to think about how to raise awareness of the service with local communities and making links with local community organisations such as the Ubuntu centre. Age was also explored and over 35s were also more likely to access EIP through wards rather than through the community, which may again reflect different attitudes towards mental health in the older population. An action plan is still to be identified in relation to this. **Middlesbrough MHSOP – Score 3** The service recognised that it covers an ethnically diverse community and that given this, the service was not receiving as many referrals for cognitive assessment as may be expected from people of BAME background. To support inclusion, we have made visits to several local BAME community spaces to spread awareness and build links. The service recognised however that there was an increase in referrals from patients from refugee and asylum seeker background. Middlesbrough is one of the largest areas for settlement packages within the country. On assessment, themes were recognised around potential of PTSD symptoms on cognition, and we continue to work alongside the adult mental health service in line with community transformation to support these patients receiving support from the most appropriate service to meet their needs. The Service has also worked with community partners to develop a video in Urdu/Punjabi about Dementia and how to access support. The Team is also working in collaboration with Public Health and Teesside University looking at “Improving mental health and dementia awareness in South Asian	**3**	Aliyah Akhtar (Service Manager)

		communities in Middlesbrough". We are also a need's led service and accept referrals for Dementia Assessments regardless of age, gender, disability, sexual orientation, race, religion and other protected characteristics. We will tailor assessments towards patient need and can offer appointments at an alternative location appropriate for them if required. We will offer home assessments or at a place that is the patient's choice. **Tees CAMHS Getting Help Service – Score 3** • Getting Help Process and Patient Journey updated as part of Transformation of CAMHS embedded across Teesside to limit barriers to access. <u>Referral to Service is via SPOC Single Point of Access</u> • Average appointment following referral to CAMHS SPOC is 5 days for standard referral. Urgent referrals same day. SPOC -Standard Practice and Process • Referral Route via free phone for patient/ carers • Paper referral for external agencies • Direct transfer of services from Universal/ VCS agencies for step up care, consultation, and support. Direct face to face Access for Patients via: • GP based TEWV Primary Mental Health Nurses • School consultation leads in education for school to consult and concerns. - All schools have identified leads from TEWV or wider Getting Help Teams.	**3**	Jude Rose (Clinical Lead) & John Stamp (Associate Director of Partnerships & Strategy)

		• Fortnightly Multi agency Neurodevelopmental Triage Panel alongside representation: Local Authority, Speech and Language, VCS, Education, Health, SEN Department • Daily Multi Agency Local Authority First Access Meetings • Monthly Drop in sessions community events as part of Multi agency Offer. Protected Characteristics: All referral routes consider accessibility or specialist consideration for protected characteristics - Religion, race, Armed forces, gender, sex, trauma, poverty-access to phone line/internet, Relationships, age, language, disability, address for contacts, or reasonable adjustments. • Admin/clinicians update clinical records to evidence protected characteristic from referral information.: Cito record, Alerts, Share with Staff team. <u>Triage of referrals:</u> • Protected characteristics taken into consideration for triage contact. If additional support is needed in relation to communication needs interpreters and translation services are considered and booked as required. Specialist services such as Text to speech are also considered where required. Other considerations can include appropriate adult, carer needs or additional support. • Allocated triage clinicians in line with patient need, characteristics of race, gender, preference, disability awareness, religion considered.		

		Communicating Triage appointment: • Offer of appointment sent via text, telephone call, letter to referrer and Parent/child in accessible format- coloured paper, font, simplified language. Reminder text and call. • Agree suitability of venue with parent/ referrer/ child in advance. If in doubt, contact referrer to discuss accessibility needs. Appointments offered as: • Telephone appointment. • Face to face triage on Trust site, community hubs, GP surgery, school, community location for ease of access. • Online if required. • Triage can be 15 minutes to hour if needed and split into sessions based on need. • Flexible times of appointments <u>Collaborative Outcomes of Triage</u> • Informed consent and psychoeducation given verbally when signposting to agencies based on patient and carer characteristics. Discussion includes advantage, disadvantaged of each service discussed. • Agree best way to signpost. - carer/ young person self-refer, guidance letter to referrer to support, referral by service, daily huddle with VCS. • Explore any barriers to accessing advice and advice given on support available, reasonable adjustments patient would benefit from: taxi's, supportive adult, location.		

		• Explanation of agreed signposting given verbally, written- easy read available, translated letters, consent gained to share outcomes with relevant support agencies. • Supporting visual literature provided from clinician in the outcome letter and agree copy of letter recipients. <u>Progress to Assessment in CAMHS Getting Help Team</u> • Direct access internally in CAMHS via weekly Meetings, referral forms, clinical discussions, Neuro Panel. • Trusted assessment processes in place with partner agencies • Triage information consulted and consideration for barriers to service and likelihood of support, adaptions needed, access to appointment, transport costs, communication support, time of assessment, location. • Identify best skilled clinician to assess based on needs and characteristics, considering gender of clinician, race, skill base etc. • Assessment location identified based on need in appointment letter/ text state offer of alternative option if unable to attend. • Appointment sent in text, letter, telephone discussion in accessible format- coloured paper, font, easy read. Reminder text and call, • Location of appointments considered near to patient address: Trust site, community hubs, GP surgery, school, community location. If in doubt, contact patient contact/ referrer to discuss access needs/ preference. • Telephone or Online offer available. • Assessment appointments range 45 minutes to hour or numerous appointments offered based on individual need, complexity, patient, carer health and characteristics and engagement.		

		• Flexible times of appointments considering childcare and carer responsibilities. • All adult parent figures are included in assessment to involve separated parents/ extended families/ foster carers. Communicating collaborative assessment outcomes with patient: • Feedback provided verbally and written format in line with needs and shared with consent to wider support services identified as helpful to family. • If young person requests confidentiality – based on risk, considered and alternative address for letter agreed if needed. • Update information on clinical records to evidence protected characteristics and additional information. • Parent Carer document on Cito completed with information applicable to include future access to services. • Collaborative safety summaries and plan include information for supporting and promoting patient and carers protected characteristic. • Ensure patient and carer voice obtained to identify characteristic i.e.: ethnicity, gender, identity, disability status and documented in Safety Summary Feedback from Patient to Service: • Positive FFT for patient and carers • Routine Outcome Measures • Wider agency feedback form • Telephone feedback calls to patient and carers. • Clinical response when patient barriers identified.		

		• Call to patient if DNA offer to explore barriers. • Barriers to access discussed in daily huddles, Supercell meetings, DNA data, clinical supervisions, team meetings, Session Rating scales, complaints, or concerns. • If service barrier identified, then re-engage patient and consider change in access arrangements and document in Cito Safety Summary, Patient carer. • Meetings with Parent Carer Forums. • VCS Forums • Drop-in Parent Carer sessions. • ICB Feedback on transformation of services and local need • Representation on Joint Service Needs Assessment • Attendance at all Early Intervention Forums with agencies • Service development events to include Patient and carers.	**Average Score: 3**	

	1B: Individual patients (service users) health needs are met	**Middlesbrough EIP – Score 2** When anyone is accepted into the service, they are offered a 12-week assessment to help understand their needs. This includes and assessment of their current circumstances, mental health needs, social needs, background history and risk. As part of the assessment, they will have their medical needs assessed usually by a psychiatrist but sometimes by a nonmedical prescriber under the supervision of a psychiatrist. They will also be offered an assessment of the Physical wellbeing. At the end of the assessment a formulation is offered with the service user and any significant others they would like to attend. At this meeting a person-centred care plan to address these needs will be developed. The service works closely with other third secret and voluntary organisations within the community to meet their needs. This includes taking consideration of a person's cultural needs and supporting people who may feel more isolated to link it with community they feel they have some connection with. The service is commissioned to deliver CBT, Family Intervention and Employment support to everyone on the First Episode in Psychosis Pathway. These interventions are offered to everyone through the formulation process. 32.5% or the case load had taken up CBT which is considered performing well by the standards set by NCAP, and 42.5% of the case load had taken up Family Intervention which is Top performing by NCAP standards. While take up for FI was similar across ethnicities, there was a greater take up for CBT from white SU (38%) compared with SU from other ethnic groups (21%). In part this may have been due to reduced staff at this time period, but this staff shortage was unequable across ethnic groups. Formulations will be used as an avenue to continue to show the value of CBT for everyone but if things continue to be inequitable this can be explored further. The service offers reasonable adjustments to help increase access to therapies, e.g. time and places of appointments, appointments at GP surgeries	**2**	Jennifer Simpson (Consultant Clinical Psychologist)

		and in the community to increase accessibility. The services always offer interpreters where first language is not English and Interpreters are regularly used in therapy. Key documents, such as formulation letters and therapy tools are also routinely translated if person's first language is not English. **Middlesbrough MHSOP – Score 3** The team recognised that we have a higher-than-average level of patients (compared to other areas within the locality) for whom English is not first language. As the generic assessment tool (ACE111) was not developed with this in mind we provided training for all our team on RUDDAS (Rowland University Dementia Assessment Scale), which is a cognitive screening tool which can minimise the effects of cultural learning and language diversity. We also optimise trust approved interpreters to support our assessment process. We also have BAME staff working within the Dementia and Wellbeing Hub in Middlesbrough to support with any language barriers. Our care and treatment is provided in line with patient need and choice, if we have a referral where we feel we are not the right team for the patient, we will discuss the referral within the multi-disciplinary team and multi-agency huddle to ensure the patient receives the right care by the right person. **Tees CAMHS Getting Help Service – Score 3** Examples of where staff have considered individual characteristics in care: • Waiting at external door for patient to arrive to reduce triggers. • Booked rooms that do not require walking through waiting rooms. • Sessions pre-planned and shared to reduce uncertainty and expectations. • Flexibility in appointments with combined offers of online, telephone, face to face.	**3** **3**	Aliyah Akhtar (Service Manager) Jude Rose (Clinical Lead) & John Stamp (Associate Director of Partnerships & Strategy)

		• Offering consistent rooms • Ordering and funding taxis to appointments. • Resource making to reduce poverty inequalities. • Providing recommended resources in treatment to reduce inequality. • Offering books/resources/self-help material in alternative formats: audio, written, simplified, alternative languages. • Upgrading Manualised Treatment Programs that are available in multilingual options, so treatment is culturally sensitive and appropriate. • Updating treatment programs and investing in new training for staff to meet local need and protected characteristics: North England videos oppose US, Neurodiverse parents and children, culturally appropriate videos, and option of all languages. • Coloured paper for correspondence and in sessions. • Triangular, bigger pens to support fine motor skills. • Easy read resources • A reader for resources to ensure able to understand information: via telephone or weekly mid-week sessions face to face/ online. • Text reminders of sessions and key points of home tasks. • 1:1 treatment option if unable to access group offers • Aligning characteristics and need of patient and carers in group offers. • Location of sessions close to home • Home visits out of hours • Seeing young people in schools • Makaton		

		• Carers for disabled parents involved in appointments and accessible venue for parent to attend group therapy. • Increasing staff delivering groups to enable epileptic parent to access group treatment and agrees epilepsy support plan. • Signer for deaf carer to access group offer. • Referring to parent by two different names session by session in line with their trauma needs. • Parking away for family home based on cultural community needs. • Staff alternatively dressing in line with cultural needs: family home, appointments, schools. • Additional training to meet needs of patients to reduce signposting and referrals to wider agencies. • Weekly meeting in Getting Help Triangle of Care Champions to explore access and engagement for all protected characteristics. • Terminology on forms refer to as: Parents, biological parents, gender, preference, identity. **Feedback Patient to Service** • FFT for patient and carers • Culture of open discussion when concern raised to explore barriers and experience. • Review of engagement and barriers to session at each contact • Wider agency feedback from VCS, ICB, Education, Local Authority, GP's • Engagement in treatment data • Clinical response when patient barriers to engagement.		

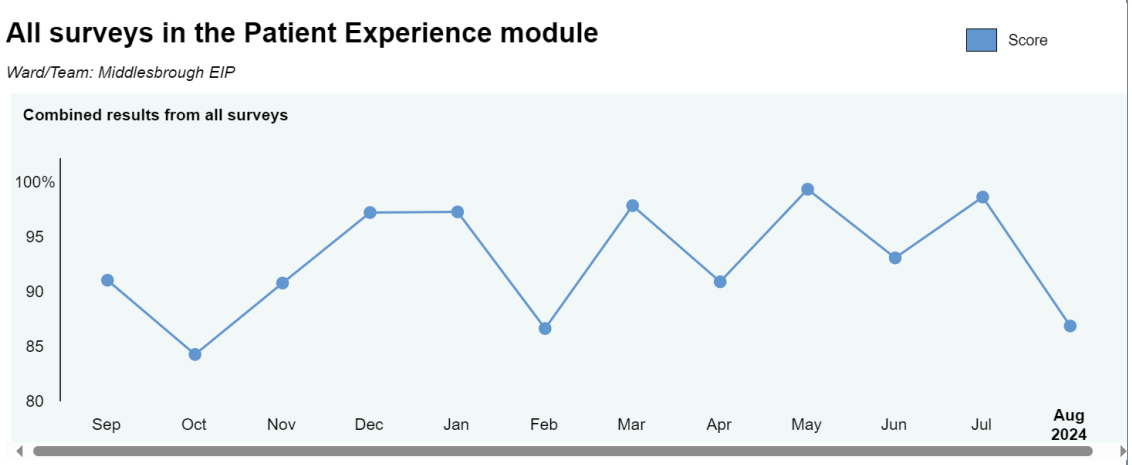
		• All non-engagements are discussed timely in daily huddle, supervision to explore barriers. Review appointment then actioned with family to explore alternative adaptions. • Call to patient if DNA offer to explore barriers. • Barriers to access reviewed in team meetings, weekly Supercell review on data. • Supercell review and feedback to team, lessons learnt/ good practice following praise, complaints, or concerns. • Share good practice in Triangle of Care Meetings • Service evaluations. • Involve Patient and carers in peer review. • If service barrier identified, re-engage patient, and consider change in access arrangements and document in Cito Safety Summary, Patient carer. • Meetings with Parent Carer Forums. • Parent Feedback • ICB Feedback on transformation of services and local need • Multi-faceted level of joint working with VCS and wider agencies: strategic to clinical across all levels of workforce.	**Average Score:3**	
	1C: When patients (service users) use the service, they are	**Middlesbrough EIP – Score 3** Comprehensive risk assessment is undertaken and maintained throughout the patient journey. Safeguarding is central to the delivery of the service. There has only been one SUI in the last 12 months following a discharge from hospital. This now has led to an increased priority in ensuring that interpreters are offered to all whose first language is not English and this finding was	**3**	Jennifer Simpson (Consultant Clinical Psychologist)

	free from harm	shared with the ward. It sadly does however highlight an issue that in this instance all steps to prevent harm were not made for a person whose first language was not English. However, thorough processes identified this error so that lessons could be learnt from it. **Middlesbrough MHSOP – Score 3** All patients have a comprehensive risk assessment when first seen by staff within the service. This will take into account any risk of harm and implement measures to reduce this as much as possible through development of person-centred care plans taking into account the needs and wishes of individual patients and their care and support network. Regular engagement with local safeguarding teams to ensure practice is reflective of current policy. Daily and weekly MDT processes are undertaken to allow sharing of any concerns and take appropriate actions. **Tees CAMHS Getting Help Service – Score 3** Examples of where staff have considered individual protected characteristics: • Waiting at external door for patient to arrive to reduce triggers in waiting rooms. • Booked rooms that do not require walking through waiting rooms. • Sessions pre-planned and shared with patients to reduce uncertainty in expectations. • Flexibility in appointments: combined offers of online, telephone, face to face. • Offering consistent clinical rooms • Ordering and funding taxis to appointments. • Resource making to reduce poverty inequalities for families needing resources in treatment: toys, puppets. • Providing recommended treatment resources to reduce inequality.	**3** **3**	Aliyah Akhtar (Service Manager) Jude Rose (Clinical Lead) & John Stamp (Associate Director of Partnerships & Strategy)

		• Offering books/resources/self-help material in alternative formats: audio, written, simplified, alternative languages. • Upgrading Manualised Treatment Programs to ones available in multilingual option so treatment culturally sensitive and appropriate. • Updating treatment programs and investing in new training for staff to meet local need and protected characteristics: North England videos oppose US, Neurodiverse parents and children, culturally appropriate videos, and option of all languages. • Coloured paper for correspondence and in sessions. • Triangular, bigger pens to support fine motor skills. • Easy read resources • A reader for resources provided to patient and carer to ensure able to comprehend information needed: via telephone or weekly mid-week sessions face to face/ online. • Text reminders of sessions and key points of home tasks. • 1:1 treatment option if unable to access group offers • Aligning characteristics and need of patient and carers in group offers so similar peer group if preferred. • Offering treatment in alternative localities if emotional/ physical safety is of concern for the patient. • Location of sessions close to home • Home visits out of hours • Seeing young people in schools • Makaton • Carers for disabled parents/patients involved in appointments.		

		• Paid carers have attending group treatment to provide care for parent and promote inclusivity. • Accessible venue for treatment. • Increasing staff delivering groups to enable epileptic parent to access group treatment and agrees epilepsy support plan. • Signer for deaf carer to access group offer. • Referring to parent by two different names, session by session in line with own trauma care plan in adult services. • Parking away from family home based on cultural community needs. • Staff considering dress in line with cultural needs: family home, appointments, schools. • Additional training to meet needs of patients and reduce signposting and referrals to wider agencies oppose service not suitable for the patient need. • Weekly meeting of Getting Help Triangle of Care Champions to explore access and engagement for all protected characteristics. • Terminology on forms refer to: Parents, biological parents, gender, preference, identity. Feedback Patient to Service: • Positive FFT for patient and carers • Review of engagement and barriers to sessions with patient each session • Wider agency feedback • Engagement in treatment data • Clinical response when patient barriers identified and engagement.		

		• All non-engagements offered review appointment to explore barriers and concern then agreed actions with family to explore alternatives. • Call to patient if DNA offer to explore barriers. • Barriers to access reviewed in team meetings, weekly Supercell review on data. • Supercell review and feedback to team lessons learnt/ good practice. • Share good practice in Triangle of Care Meetings/ fundamental standards. • Service evaluations. • Involve Patient and carers in peer review. • Accurate documentation in Cito Safety Summary, Patient carer. • Inphase • Meetings with Parent Carer Forums. • Parent/ patient Feedback • ICB Feedback on transformation of services and local need	**Average Score: 3**	

	1D: Patients (service users) report positive experiences of the service	**Middlesbrough EIP – Score 2** We continually monitor trust FFT system (Meridian) with quantitative and qualitative feedback and act upon comments / suggestions – and produce actions plans for any areas for improvement. We follow trust complaints / PALS process. The FFT data for the last 12 months is presented below and indicates positive patient experience.  FFT data also shows that the service has received a significant amount of positive feedback in relation to Carers support. The service has received nil complaints from January 2024 – August 2024. There is also a Trust Wide EIP service user involvement group which is an opportunity for service users and their carers to provide feedback to services and be involved in the continuous improvement.	**2**	Jennifer Simpson (Consultant Clinical Psychologist)

		A number of young carers from Middlesbrough have also been involved in a young carers group which received positive feedback. Feedback has not been looked at in relation to ethnic diversity, but this could be a way we could improve out access to EIP for people from non-white ethnic groups. **Middlesbrough MHSOP – Score 2** Patients are given opportunity throughout input with the service to give verbal or formal written feedback on their care. Any concerns can be discussed, and service changes made if needed to support patient care. We will be completing a study in line with Teesside University and Public Health, reviewing episodes of care and patient experience in line with the associated episode of care. The Team also receives monthly patient and carer feedback which is discussed through the governance channels and used to improve patient care. We also have a patient and carer participation group, which is a group of participants through lived experience of using and accessing services that will offer support in improving the service. Additional work is planned to improve engagement with local VCSE organisations supporting our client group. **Tees CAMHS Getting Help Service – Score 3** • FFT • Active engagement Parent Forum Groups • Active engagement VCS • Daily huddles and staff feedback • Routine outcome Measures • End of treatment evaluations • School and wider agency feedback forms/ meetings • Patient cards/ letters/ reports	**2** **3**	Aliyah Akhtar (Service Manager) Jude Rose (Clinical Lead) & John Stamp (Associate Director of Partnerships & Strategy)

		• Staff advocating for patients and carers in Supercell what works well. • ICB events to gain strengths of service. • Monthly team meetings clinical feedback reviewed and focus on positive experience.	**Average Score:3**	
Domain 1: Commissioned or provided services overall rating			**12**	

Domain 2: Workforce health and well-being

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

main 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	• Occupational Health and physiotherapy Service Provision • Employee Support Service/Employee Psychology Service (including support groups such as Burnout group/Resilience) • VIVUP wellbeing platform (includes Counselling service for staff) • Long Term Health Conditions staff network, BAME staff network, Rainbow staff network, Neurodivergent staff network, Armed Forces staff network, Menopause Café, Working Carers staff network and numerous other support network groups which meet regularly. • Achieved Better Health at Work Silver level, in 2024 working towards Gold level (assessment October 2024 – campaigns have included Domestic Abuse & Sexual Safety, Alcohol, Substance & Other Drugs Safe Use, Active Travel & Moving More in 24!, Work-Life Balance for harder-to-reach staff groups, such as Estates staff, Bank staff and those who work in Health & Justice Services, Stress (focus on Men's Health and harder to reach staff groups). • Long term sickness absence team • Nutrition and weight management programmes	2	Sarah Dallal

		• 337 Health & Wellbeing (H&W) champions • Staff led Health Council meets every two months, two rounds of charitable monies have been allocated staff following successful project bids, amounting to over £100,000. • H&W pages on the staff Intranet reviewed and updated. • Smarter Working initiative • Reasonable adjustments – Central Team • Working carer support – including monthly network • Staff Mindfulness Programme • Bereavement Support • Increased capacity within the central staff Health and Wellbeing team (2.25 wte's) • Bi-monthly Strategic Health & Wellbeing Group which meets made up of MDT staff and Services. • H&W coordinator (Durham & Darlington Locations) • Health & Wellbeing Conversations training programme to be rolled out across the Trust during 2024 • Face to face Trust Welcome for new staff (Induction) to be re-started from October 2024 • Review of Trust wide Managers Bitesize training programme to include health and wellbeing.		

		• Staff Wellbeing Hub – Accessible via CNTW.		

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	• Violence Reduction and prevention strategy development and working group. • Verbal & Physical Aggression procedure • Indicator 5 WRES – Staff experiencing harassment, bullying or abuse from patients, relatives, public. • Indicator 6 WRES - Staff experiencing harassment, bullying or abuse from staff. • Indicator 4 WDES • Indicator 5 SOWES • Indicator 6 SOWES • Professional Nurse Advocacy Service (PNA) • LGBTQ+ Awareness training including lived experience. • Publication of information Staff survey results (harassment, bullying & abuse) - Age and Gender • WRES/WDES/SOWES action plans • Equality objectives (include verbal & physical aggression actions) • Disciplinary data • Support offered after incidents – Post incident Peer Support (PIPS) • Hate crime campaigns. • Staff Council • Staff Support – Speak Up Guardian, ESS, EPS • Show Racism the Red Card Programme	1	Sarah Dallal

		• Training available including in leadership programmes. • Domestic violence workstream, including toolkit and planned training. • Sexual Safety in the workplace workstream, including toolkit and planning training.		

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

		• Overall recommend as a place to work: 57.2% • Overall happy for friend or relative to be cared for: 55.4% • Reasons for leaving data broken down by demographics. • Disciplinary data broken down by demographics. • Recruitment data by demographics		
	2D: Staff recommend the organisation as a place to work and receive treatment	• Staff Survey Q21c & Q21d – Age, Ethnicity, Gender, LTHC, Sexual Orientation. • Overall recommend as a place to work – 57.23%. • Overall happy for friend or relative to be cared for 55.41%. • Reasons for leaving data broken down into demographics. • Disciplinary data broken down into demographics. • Recruitment data broken down into demographics. • Exit data presented by directorates/areas only.	1	Sarah Dallal
Domain 2: Workforce health and well-being overall rating			**6**	

Domain 3: Inclusive leadership

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)

Domain 3: Inclusive leadership	3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	• Brents/Senior staff Blogs/Vlogs include EDI. • BoD & committees – EDI & Health Inequalities discussed (minutes) • Board members & senior leaders sponsor & attend staff networks. • EDI Lunch & Learn sponsorship from BoD and Senior Leaders. • Significant increase in board declarations of EDI characteristics and over representation of some characteristics at board compared to community. • Commitment to review the new structure brought in April 2022 to check impact on protected characteristics which was completed. • All execs have EDI specific objective. • All networks have exec sponsor. • Rates of discrimination reducing on staff survey • SRTRC has board sponsorship. • Staff stories (and patients) are now a regular feature of board – including specific stories from our neurodiverse, AF, and trans colleagues. • Management group papers on health inequalities	2	Sarah Dexter-Smith

		• Management group minutes inequalities team challenge • Exec sponsorship and chairing of patient safety summit on health inequalities and reflective session		
	3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	• EDI & Health inequalities are discussed at BoD (minutes) • BAME staff risk assessments were completed during the pandemic. • EIAs are complete for policies & procedures and projects • Health inequalities challenge adopted by EDG.	2	Sarah Dexter-Smith

	3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	• BoD and committees monitor Gender Pay Gap, WRES (including Model Employer), WDES & SOWES, EDS, leavers information. • Executive clinical lead identified to oversee EDI data related to patient care. • CG leads in place to support this work. • Employee relations reports to EDG and committee now have detailed focus on protected characteristics and processes are changing as a result. • Health inequalities is a cross cutting priority this this year's annual plan. Key milestones and objectives are monitored as part of annual plan governance. • A statement if information of health inequalities has been developed and will be published alongside this year's • annual report and prevented at AGM	2	Sarah Dexter-Smith
Domain 3: Inclusive leadership overall rating			**6**	
Third-party involvement in Domain 3 rating and review				
Trade Union Rep(s): JCC approval		**Independent Evaluator(s)/Peer Reviewer(s): Chris Rowlands CNTW**		

EDS Organisation Rating (overall rating): 24
Organisation name(s): Tees, Esk and Wear Valleys NHS Foundation Trust
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped** Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing** Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving** Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

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

Middlesbrough EIP

Domain	Outcome	Objective	Action	Completion Date
Domain 1: Commissioned or provided services.	1A: Patients (service users) have required levels of access to the service	To ensure people from all ethnic back grounds are aware of EIP and how to access this. We will know that we have achieved this when the referral route to EIP is equivalent across all ethnic back grounds	Working with Health Watch Middlesbrough to liaise with local community group to find ways to raise awareness of Psychosis, The Early Intervention Service and how to access this. Adapt our posters aimed at raising awareness to meet the needs of the individual communities. Complete a case note review to identify any missed opportunities for supporting people to access services sooner.	1/4/24 1/4/24 31/10/24
	1B: Individual patients (service users) health needs are met	To increase offer and take up f CBT for people from the BAME community. This will be picked up within the data collected as part of the National Clinical Audit of Psychosis.	To ensure time is given with in formulation to offer CBT to everyone irrespective of cultural and ethnic back grounds, informing all of the potential benefits. Share current PCI on CBT with our communities to help inform how our information can be more targeted for different community groups.	1/4/24

	1C: When patients (service users) use the service, they are free from harm	To minimise risk to all and ensure language barriers do not a contributing factor for SUIs within the service. This will be evidenced within SUI reports	Ensure all people who's first language is not English are offered an interpreter for every appointment.	Ongoing
	1D: Patients (service users) report positive experiences of the service	To understand better what the perspective of EIP is for people from various background and cultures.	To invite a selection of SU and carers from a range ethnic back grounds to provide qualitative feedback on their experiences of accessing the service and experience within the service. Including exploration of both met and unmet needs.	1/4/24

Middlesbrough MHSOP

Domain	Outcome	Objective	Action	Completion date
Domain 1: Commissioned or provided services.	1A: Patients (service users) have required levels of access to the service	Patients have required level of access to the service and reducing health inequalities and access to service within the local population	We will be actively engaging the community to reduce stigma and discrimination of mental health. We have attended places of worship and will be attending community centres. We will be using digital technology to raise awareness of the service	October 2025
	1B: Individual patients (service users) health needs are met	Patients and Carers have their needs met, identifying appropriate use of cognitive assessment tools for patients from a BAME background	We are completing an audit of BAME patients to ensure effective assessment. We are reviewing dementia assessment tool and ensuring efficacy and appropriateness for BAME patients. We are providing cultural awareness and education to staff within the team. We are collaborating with Voluntary Care Agencies, Public Health and Local University to tackle health inequality.	October 2025

	1C: When patients (service users) use the service, they are free from harm	All patients are free from harm when using our services	We will review any incidents relating to BAME patients/ carers whilst using our services.	October 2025
	1D: Patients (service users) report positive experiences of the service	Patients and carers report positive experiences of the service	If ethics approval, we will be setting up a focus group of individuals who have experience of the service to allow feedback for BAME patients and carers We will be focussing on active recruitment of BAME patients/carers into the speciality Patient and carer Participation Group to support co-creation of services	October 2025

Tees CAMHS Getting Help Service

Domain	Outcome	Objective	Action	Completion Date
Domain 1: Commissioned or provided services.	1A: Patients (service users) have required levels of access to the service	Patients with mobility equipment will be offered accessible buildings for treatment	Maintain list of accessible buildings to use for appointments in community and stored by admin.	Ongoing
	1B: Individual patients (service users) health needs are met	Disseminate and share good practice of supporting protecting characteristics and reducing health inequalities	• Completion of health inequalities video to be shared in clinical network, Health Inequalities presentation event, CAMHS website via co-corporate TEWV teams and Service Managers • Monitor standards. • Share good practice with partner agencies to promote inclusivity. Monitor outcomes of piloting carers assessments and impact on appointments attended.	Ongoing

	1C: When patients (service users) use the service, they are free from harm	Continue to monitor standards of and share good practice. TO include Health inequalities video and Poverty proofing video with staff and wider services to promote reducing health inequalities	• Shared health inequalities video for wider dissemination • Awaiting official release of poverty proofing video via Catherine Parker	31/10/24
	1D: Patients (service users) report positive experiences of the service	Continue to monitor feedback in huddles, team meetings, senior management and maintain current standard	Continue to monitor standards	Ongoing

Domain	Outcome	Objective	Action	Completion date
Domain 2: Workforce health and well-being	2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	Continue to develop data and intelligence-led Wellbeing initiatives and evaluate Wellbeing sessions that have taken place to ensure topics are relevant and effective.	Agree outcome measures for specific wellbeing initiatives and continue to use pre and post evaluation metrics.	Ongoing
		Deliver Health & Wellbeing Conversations Training and other Wellbeing training such as Bitesize Leadership & Management training.	Include scenarios on recent themed work such as DASV, Financial Wellbeing and Alcohol, Substance & Other Drugs Safe Use	03/25
		Review, consult and implement Staff Health, Wellbeing and Attendance procedure.	Procedure requires full review, consultation and implementation Trust wide.	02/25

	2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	Establish how effective the toolkits for domestic abuse and sexual safety are in the workplace. Establish required actions / risk assessments that are needed to prevent inappropriate sexualised behaviours in the workplace.	Carry out review of newly implemented toolkits. Carry out scoping exercise with operational HR.	07/25 07/25
	2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	To have a robust, high-performing and efficient Occupational Health and Physiotherapy Services.	Commence new contract awarded from 1.4.25.	04/25
	2D: Staff recommend the organisation as a place to work and receive treatment	To improve the % of staff reporting that they would recommend the organisation to work or receive treatment.	Promote exit interviews – Thinking about leaving or moving roles questionnaire. Promote People Management Bite Size Training sessions. Promote New Managers Programme. Promote TEWV Leadership Academy.	Ongoing

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

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

Domain 1 - detailed ratings & evidence

Kestrel Kite

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service			
	1B: Individual patients (service users) health needs are met			
	1C: When patients (service users) use the service, they are free from harm			
	1D: Patients (service users) report positive experiences of the service			
Domain 1: Commissioned or provided services overall rating				

Bedale

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service			
	1B: Individual patients (service users) health needs are met			
	1C: When patients (service users) use the service, they are free from harm			
	1D: Patients (service users) report positive experiences of the service			
Domain 1: Commissioned or provided services overall rating				

Scarborough CAMHS

Domain	Outcome	Evidence	Rating	Owner (Dept/Lead)
Domain 1: Commissioned or provided services	1A: Patients (service users) have required levels of access to the service			
	1B: Individual patients (service users) health needs are met			
	1C: When patients (service users) use the service, they are free from harm			
	1D: Patients (service users) report positive experiences of the service			
Domain 1: Commissioned or provided services overall rating				

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

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13 February 2025**
Title:	**Niche Quality Assurance Review 2024**
Executive sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Niche Health and Social Care Consulting**

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	✓

BAF ref no.	*Risk Title*	*Context*
8	**Quality Governance**	The delivery of the Niche recommendations relates specifically to the BAF Risk 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.

Strategic Risks relating to this report:

Executive Summary:

Purpose: The purpose of this report is to present to the Board the final Niche Quality Assurance Review undertaken September to November 2024 and published January 2025.

Proposal: It is proposed that the Board receive the final report with good assurance that we have met the recommendations in the NICHE independent reports commissioned by NHS, that we have good assurance about the delivery of community child and adolescent services in line with expectations and good assurance that quality governance in line with expectations.

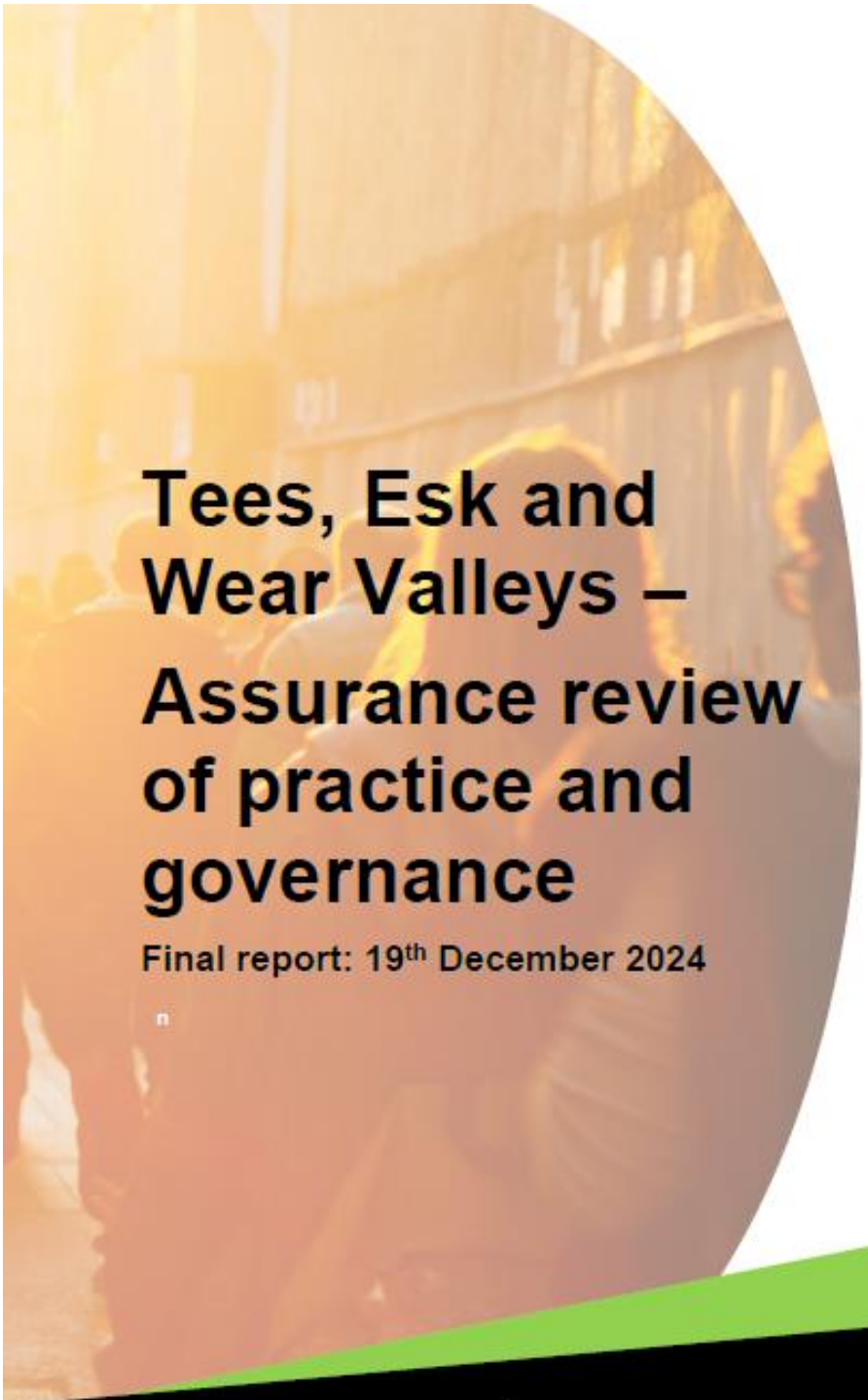
Overview: Presented to the Board is the final report in relation to a Quality Assurance Review undertaken by Niche Health and Social Care Consultancy. The Review was commissioned by NHS England in follow up to the recommendations resulting from historic serious incident investigations and governance reports involving the Trust and other local stakeholders. The Quality Assurance Review was undertaken in line with the agreed Terms of Reference. The final report is presented to the Board for assurance that the original recommendations have been met.

Prior Consideration and Feedback The draft report was shared with those who contributed to the review for consideration of factual accuracy. This includes the Trust Leads for Patient Safety (PSIIs), Safeguarding and Complaints and the Child and Adolescent Mental Health Service Leads. The QAC, EDG and Board have previously received the final draft report for information and assurance.

Implications: There are Regulatory implications should the Trust fail to deliver the improvements identified by the Niche Independent Investigation and maintain ongoing compliance with the CQC Quality Standards.

Recommendations: The Board is asked to receive the final Niche Report and to take good assurance about the quality of services and quality governance in relation to children and young people's care in the community at TEWV.

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust



Tees, Esk and Wear Valleys – Assurance review of practice and governance

Final report: 19th December 2024

info@nicheconsult.co.uk

www.nicheconsult.co.uk

niche
HEALTH & SOCIAL CARE CONSULTING

Contents

NHS England (North East and Yorkshire)
Quarry House,
Leeds,
LS2 7UE

Niche Health and Social Care
Consulting
4th Floor
Trafford House
Chester Road
Old Trafford
Manchester
M32 0RS

19th December 2024

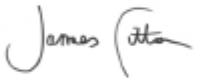
Quality Assurance Review – Tees, Esk and Wear Valleys – Phase Two

Please find attached our Final Report of 19th December 2024 in relation to a Quality Assurance Review for the recommendations resulting from several serious incident investigation and governance reports involving Tees, Esk and Wear Valleys NHS Foundation Trust and other local stakeholders. Our Report has been written in line with the scope and approach as set out in our proposal which was submitted in June 2024.

This report is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Our report has not been written in line with any UK or other auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information.

Different versions of this report may exist in both hard copy and electronic formats and therefore only this final signed version of this report should be regarded as definitive.



James Fitton
Niche Health and Social Care Consulting

SUMMARY

This report presents the findings of an assurance review of practice, and of the governance of practice, within aspects of Child and Adolescent Mental Health Services provided by the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). This review was aimed at examining the present-day situation - to assess whether, and to what extent, patient/client care is now being provided in ways compliant with current standards and expectations.

The review follows several patient safety investigation reports which addressed aspects of care, treatment, and governance across agencies in areas covered by the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). There were specific investigations relating to four cases, and an over-arching governance review.

It should be noted that TEWV no longer provides inpatient mental health services for children and young people; provision has been transferred to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW).

The assurance review involved the following work:

- Working with staff across both TEWV and CNTW, we developed and agreed a framework for the practice audit.
- A total of 18 cases were identified which were similar to the relevant index cases. The records relating to these cases were audited in detail.
- Audit findings were discussed and validated with staff from TEWV
- Working with staff from TEWV, we developed and agreed a framework for the governance audit.
- A total of 18 cases (coincidentally, as the criteria were different) were identified in which governance-related concerns had arisen. We audited the records relating to
    - One patient safety incident investigation
    - Six complaints
    - Eleven safeguarding events
- We also reviewed a range of documentary and policy evidence relating to governance of incidents and quality management.
- Findings of the governance audit were discussed and validated with staff from TEWV.
- Presentation of draft findings to an extraordinary meeting of TEWV's Quality Committee, including attendance by the Trust's CEO, Executive and Non-Executive Directors, and relevant clinical leads.

Overall, our findings were:

- A good level of assurance that clinical practice within CAMHS offered to complex cases is now compliant with expected standards
- A good level of assurance that the governance of quality concerns within these services is now compliant with expected standards
- A good level of assurance that the overall governance of quality within these services is now compliant with expected standards

Any assurance review is a point-in-time judgement. We know that TEWV are conscious of the need for continuing work, oversight, and vigilance to ensure these

improvements in practice are sustained, and indeed built upon further. We make no specific recommendations related to overall quality management.

There are two residual recommendations:

One: TEWV should ensure that carers and family members of young people with complex mental health needs are themselves also offered relevant psycho-educational training and advice.

Two: TEWV should ensure that written responses to complaints fully address all of the concerns raised, and provide full explanations of resultant Trust actions.

1 INTRODUCTION

1.1 Context

Several patient safety investigation reports addressed aspects of care, treatment, and governance across agencies in areas covered by the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV). There were specific investigations relating to four cases, and an over-arching governance review.

Our analysis identified a total of 120 resultant recommendations arising (with some duplication noted). These recommendations were addressed to a wide range of key stakeholders, and combinations of stakeholder agencies.

It was agreed with NHS England that the approach to undertaking an assurance review in these cases needed to pay proper regard to the scale and complexity of these overlapping recommendations. It was agreed that the aim must be to ensure that an appropriate balance is struck between ensuring proper assurance, and avoiding unproductive and burdensome review work.

It should be noted that a significant number of recommendations were addressed to TEWV, as they were directly responsible for the inpatient services where some of the index incidents occurred. These services were, however, closed in August 2019. TEWV no longer provides inpatient mental health services for children and young people; provision has been transferred to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW).

1.2 Phase One work

A first phase of scoping work reported to NHS England in June 2024. This scoping work encompassed:

- a series of single-organisation review meetings, for up to half a day for those with the most recommendations. These considered any action plans which had been prepared, and discussed:
  - The extent to which actions were already being addressed by other independent assurance processes, such as the work of Ofsted, the Care Quality Commission (CQC) or other independently commissioned evaluations.
  - The extent to which actions were already being overseen by internal or system-wide assurance processes.
  - The extent to which organisations would consider some form of independent validation of the impact of their actions useful.
  - The form that such validation might take; this could be statistical analysis, case note review, qualitative interviews or other forms of assurance.
- preparation and circulation of a draft report, summarising the material above, and proposing potential assurance review actions.
- preparation of a final report, including organisations' responses to the potential assurance review actions, and outlines of two resultant projects.

1.3 Purpose and structure of report

This report is intended to provide an independent perspective on changes in both practice and governance which have taken place within relevant services since the events which led to the patient safety reports. It does not re-review any aspect of the care and treatment provided in those original cases. Nor can this report provide complete assurance that no safety incidents will ever recur – such a level of assurance cannot of course ever be offered.

What this report does provide is an analysis of both current practice, and the governance of current practice which, taken together, offer a detailed perspective on the risk of safety incidents within these services. Essentially, it aims to answer the question as to how people presenting with similar needs and concerns to those in the originating cases are now being cared for and treated within current services.

After this introduction, the report is structured as follows:

- Section 2 provides a detailed description of the method used
- Section 3 explains the findings of our audit of current practice
- Section 4 explains the findings of our audit of the governance of safety incidents
- Section 5 adds some perspectives as to the nature of the work and the changes which have led to these findings
- Section 6 contains the residual recommendations arising

2 METHOD

This section sets out the work required for the two projects which emerged from phase one work.

2.1 Project one: audit of current practice

Purpose: To assess whether, and to what extent, patient/client care is now being provided in ways compliant with current standards and expectations

2.1.1 Scope

Cohort

The relevant cohort was defined to meet the following principles:

- Sufficiently similar to the index cases to test changes in practice
- Sufficiently recent to ensure practice is current

The audit therefore considered services provided to young people who:

- Were receiving some form of specialist child and adolescent mental health services on 31st December 2023
- Were still receiving some form of specialist mental health services on 30th June 2024
- Were between 15 and 18 years old as at 31st December 2023
- Were discharged from inpatient CAMHS at some point in the period between 31st December 2023 and 30th June 2024

We broadened the fourth criterion to include young people whose cases were similar in complexity to the index cases, but who had not required inpatient admission.

We completed a case note audit of a sample of 18 case notes within the TEWV community services to determine how the current pathway would manage service users with a similar profile. We then completed an audit with CNTW to assess the pathway for the nine cases which had involved an inpatient admission during the timescale identified.

2.1.2 Terms of Reference

This review was aimed at examining the present-day situation - to assess whether, and to what extent, patient/client care is now being provided in ways compliant with current standards and expectations.

The following terms of reference were therefore agreed:

- Carry out a review of the current pathway with reference to the themes and issues arising from the index cases.
- Review and assess evidence of compliance with local policies, national guidance and statutory obligations, in so far as these policies and guidance are relevant to the specific issues arising from these cases.

- Via the review, identify areas of good practice, opportunities for learning and areas where continuing improvements to services may be required.
- Produce a learning document, suitable for sharing with other providers, on the learning from the review.

2.1.3 Method

- Development of agreed audit framework

Working with staff across both TEWV and CNTW, we developed and agreed a framework for the practice audit.

We developed an audit template consisting of standards, each of which fell under one of the following themes.

	Theme
1.	Planning and implementation of transition arrangements (children to adult services)
2.	Planning and implementation of discharge from inpatient care
3.	Approaches to risk management, including involvement of the young person and family members in the development of risk assessments and their care plan
4.	Approaches to care planning, including the development of psychological formulations
5.	Arrangements for listening to and involving young people and families
6.	Involvement of the multidisciplinary team and relevant agencies
7.	Implementation of trauma-informed practices
8.	Identification and appropriate escalation of safeguarding concerns
9.	Appropriate capture and responses to race, ethnicity, gender and religion
10.	Care for young people with complex presentations, particularly autism

For each of the standards audited, we described what information would need to be seen via the clinical audit in order to be considered 'good' or 'acceptable' evidence. The definitions for 'good' and 'acceptable' and the standards are presented in Appendix one. We also included a category 'N/A' or 'not applicable' to indicate that the question being audited was not relevant to that particular case.

- Case note audit

The audits were conducted on site with relevant TEWV/CNTW staff involvement, both to simplify the process of access (as no copying of records was required), and to permit minor access queries to be resolved quickly and simply. We are very grateful for the advice, support and hospitality offered to our auditor throughout this process.

The clinical audit was conducted by one member of the Niche project team. The TEWV audit was undertaken on site at North End House in Durham; the CAMHS community modern matron provided support to the member of Niche staff conducting the audit. She identified the correct set of case notes and supported Niche staff to locate the information they were seeking. Senior managers from the CAMHS services were also available to support and answer queries.

The audit of inpatient records was undertaken at St Nicholas Hospital in Newcastle. The audit sample from TEWV was cross referenced and case notes audited for the smaller cohort of inpatient admissions. The Niche staff member was supported by senior managers within the CAMHS inpatient service to identify the correct case notes and locate information.

- **Interpretation and clarification meetings**

Following initial analysis of findings, we discussed with key contacts:

- whether the casenote findings represent a fair summary of practice.
- where there are examples of poorer compliance, realistic steps which could be taken to improve that compliance.
- where there are examples of good compliance, steps which could be taken to spread good practice.

2.2 Project two: review of handling of incidents, information flows and decision-making

Purpose: To assess whether patient safety incidents, safeguarding events, and complaints are now being handled in accordance with local policies and expected good practice; and to assess the clarity of organisations' roles and responsibilities in oversight and governance of the quality of services and practice.

2.2.1 Scope

Sample

Relevant patient safety incidents, complaints and safeguarding events were defined to meet the following principles:

- Sufficiently similar to the index cases to test changes in practice
- Sufficiently recent to ensure practice is current

It was therefore agreed that patient safety incidents, complaints and safeguarding events should be selected from the following categories:

- The incident/complaint/safeguarding concern should have been raised in 2024
- They should involve young people between the ages of 15-18 years old in receipt of specialist child and adolescent mental health services in 2024

- They should involve aspects of care that have been highlighted through the index investigation reports such as concerns regarding discharge and transition, risk assessment and care planning, service user and family involvement, ligature risks, race, ethnicity, gender and religion.

This resulted in a sample of 18 cases:

- One PSII
- Six[1] complaints
- Eleven[2] safeguarding events

We set out below a summary of the cases by category:

Complaints

Identifier	Summary information	Young person age
783	Neurodevelopment Pathway Assessment Team (process) and family support	Unknown
789	Assessment process (timeliness) and family support	c. GCSE age
1073	ADHD assessment process	13 years old
1199	ASD assessment appointment did not occur as scheduled (3 year wait for apt)	13 years old
1728	ASD assessment pathway (52 month wait)	Unknown
931 (formal)	Failure to follow process, inappropriate discharge from services	6 years old

PSII

Community suicide of 16-year-old male in receipt of CAMHS.

Safeguarding events

Identifier	Summary information	Young person age
464800	Sexual, physical and emotional abuse	17 years old
589366	Alleged perpetrator of historic sexual assault (sibling)	17 years old

[1] To note, three of the complaints related to young people aged 13 and under. We kept these as part of the sample given the small number of cases and that our focus was primarily on how the complaint was managed.

[2] Further safeguarding events have occurred in 2024, but we did not ask for additional cases given the original criteria of ten per category.

Identifier	Summary information	Young person age
639449	Mother's physical and mental health causing unintentional emotional harm and neglect	16 years old
718457	Allegations of sexual assault and failure by parent to report to police.	15 years old
723442	Sexual abuse/exploitation	15 years old
751667	Long standing MH concerns, self harm, poor school attendance	14 years old
777755	Emotional abuse, history of witnessing DV.	17 years old
830500	Deterioration in MH and self care due to impact of parental MH and substance misuse	16 years old
862923	Concerns around drug use, involvement in organised criminal gangs, and parental compliance.	16 years old
1018807	Parent potentially blocking access to MH support	16 years old
1074046	Attended ED following paracetamol overdose. No adult present in UK. Known to MH services in home country: anxiety and depression.	17 years old

The PSII and complaint responses were single documents. In contrast, whilst we were able to look at single safeguarding referrals, numerous supporting documents had to be provided separately by the Safeguarding Children team to address our review criteria e.g. InPhase report and Local Authority receipt of referral. We were not involved in compiling the sample and did not have access to the Trust IT system. We are mindful that this will have been a resource intensive exercise for all of the teams, but particularly the Safeguarding Children team; we would like to thank them for their support with this element of the review.

2.2.2 Terms of reference

This review was aimed at examining a sample of patient safety incidents, safeguarding events and complaints, either at a service and/or divisional level, to assess whether these are now being handled in accordance with local policies and expected good practice. It was also intended to assess whether patterns in reported incidents, safeguarding events and complaints remain reflective of themes identified in reviews of the index incidents.

The following terms of reference were therefore agreed:

- Carry out a review of the current patient safety incident, safeguarding and complaints reporting processes to assess compliance with national guidance and statutory obligations.

- Undertake a high-level thematic review to assess whether patterns in reported patient safety incidents, safeguarding events and complaints remain reflective of themes identified in the index incidents.
- For each of the sample, review and assess evidence of compliance with relevant local policies.
- For each of the sample, review and assess the appropriateness of case escalation and closure.
- Via the review, identify areas of good practice, opportunities for learning and areas where further improvements to services and processes may be required.
- Produce a document, suitable for sharing with other providers, on the learning from the review.

2.2.3 Method

- **Review of information flows and escalation processes**

  Evidence was sought to demonstrate whether there is a clear organisational structure that cascades responsibility for delivering quality governance for patient safety incidents, safeguarding and complaints from front line services to the board and system, and that this is described in the processes above. This assessed whether the following are in place:

  - up to date and relevant terms of reference for meetings within the governance structure
  - clear and consistently applied levels of delegations and processes for recording decisions and escalation, which are monitored for compliance
  - appropriate information which supports decision-making and the timely resolution of risks and issues
  - protocols for the escalation and resolution of issues between parties
  - completion and oversight of agreed actions
  - appropriate stakeholder membership and attendance (either internal or external)

- **Thematic review of patient safety incidents, safeguarding events and complaints**

  A high level thematic review was undertaken to assess whether patterns in reported patient safety incidents, safeguarding events and complaints for 2024 remain reflective of themes identified in the index incidents.

- **Handling of complaints, patient safety incidents and safeguarding events**

  Working with TEWV staff, we developed and agreed a framework for the governance audit. The framework was tailored to reflect the different criteria of the three categories: complaints (24 standards), PSIIs (25), and safeguarding events (25). These frameworks were based on National and Trust policy and guidance; please refer to Appendix two for details. The framework criteria were divided into three areas:

  - *Credibility* – that the report/response is accurate, contains no errors and has been signed off through the appropriate channels.

- *Thoroughness* – that the report/response is comprehensive, contains the necessary information, identifies and analyses concerns, and reflects Trust policy/practice
- *Impact* – that the report/response addresses the concerns identified, setting out an appropriate response and learning.

Our frameworks were informed by the guiding principles that underpin the NHS Patient Safety Incident Response Framework (PSIRF):

- Strategic: This includes an assessment of whether the response was timely, responsive and objective.
- Preventative: Assessing whether the response clearly identified contributory or causal factors to prevent recurrence.
- Collaborative: Where multiple agencies are involved, we will consider whether there is evidence of engagement, information sharing and action planning.
- Fair and just: This includes evidencing an open, honest and transparent approach to the case, including applying the duty of candour with patients, families and carers and avoiding any unfair blame of individuals.
- People-focused: Considering how patients, families or carers and staff have been active and supported participants in the complaint/SG/investigation process.
- Expert and credible: Our assessments include a review of established methods and techniques, the application of current national guidance and the range of information and evidence that has been considered to reach the conclusions made.

Please refer to Appendix three for the framework templates.

- **Interpretation and clarification meetings**

Following initial analysis of findings, we discussed with key contacts:

- whether the case review findings represent a fair summary of practice.
- where there are examples of poorer compliance, realistic steps which could be taken to improve that compliance.
- where there are examples of good compliance (and again within a PSIRF approach) realistic steps which could be taken to spread good practice.

3 FINDINGS – PRACTICE AUDIT

3.1 Planning and implementation of transition arrangements (children's to adult services) – Sample size 18

Audit question	Good	Acceptable	No	N/A
Is the young person within six months of their 18th birthday?	11	0	0	7
Is there evidence in the case records of transition planning?	11	0	0	0
Has there been a joint conversation between CAMHS and adult mental health/primary care/other services?	9	0	0	2
Has a co-created transition plan been completed or is being developed? (young person/family involvement)	8	0	0	3

Seven young people were not within six months of their 18th birthday. Where there was no planning, we determined that this was appropriate because young people had indicated they did not wish to be referred to adult services. One young person had initially refused to transition to adult services but had changed their mind and so planning had resumed.

3.2 Planning and implementation of discharge from inpatient care – Sample size 9

Audit question	Good	Acceptable	No	N/A
Is there evidence of discharge planning in the records?	9	0	0	0
Is there evidence of communication between community and inpatient teams?	9	0	0	0
Is there a clear discharge care plan or plan completed (involving community team & in-patient teams)?	8	0	0	1

Nine young people had had inpatient admissions within the time frame. In both inpatient and community records there was good evidence of discharge planning taking place and good communication maintained between community and inpatient teams.

3.3 **Approaches to risk management, including involvement of the young person and family members in the development of risk assessments and their care plan – Sample size 18**

Audit question	Good	Acceptable	No	N/A
Risk assessment present, reviewed to timescale and covers all expected risks	18	0	0	0
Risk assessment includes formulation	18	0	0	0
Risk assessment includes relevant inpatient/community information	18	0	0	0
Risk assessment includes views or evidence of discussion with YP	18	0	0	0
Risk assessment includes views or evidence of discussion with family/carers	15	0	0	3
Community services: Inpatient risk assessment and/or risk information at discharge uploaded to /recorded in electronic patient records	9	0	0	0
Inpatient services: Access (form 1) contains key risks	9	0	0	9

The penultimate question in this section related only to young people who had previously been inpatients, and sought evidence of inpatient risk information being held within subsequent community records. This is the reason for the smaller sample in this case.

Three children were in the local authority's care, and there had been no discussions with their families or carers.

3.4 Approaches to care planning, including the development of psychological formulations – Sample size 18

Audit question	Good	Acceptable	No	N/A
Care plans present	17	0	1	0
Care plans cover all areas of need	18	0	0	0
Care plans reviewed as per trust guidance	18	0	0	0
Care plans signed and dated	18	0	0	0
Care plans reflect risk assessment and include relevant risk information	18	0	0	0
Inpatient services: 5 P formulation document includes evidence of formulation, psychological support and plan	9	0	0	0
Community services: Care plans reflect risk assessment (safety summary/safety plan) and include relevant risk information. Plans include evidence of formulation and psychological support.	17	0	1	0
Community services: Is there evidence of care plans being co-created with young people (and/or families)	17	0	0	1

One community case note did not include a care plan but all information needed was within the safety plan and transition plan, as transition to adult services was immediately indicated when accepted into service given their age.

Within community services, the electronic system did not allow for electronic signing of care plans; but, within progress notes, we were able to see where young people had been involved in creating and reviewing plans and been given copies.

3.5 **Arrangements for listening to and involving young people and families – Sample size 18, inpatient service questions sample size 9.**

Audit question	Good	Acceptable	No	N/A
Evidence of involvement of YP	18	0	0	0
Evidence of involvement of families	15	0	0	3
Is there a process for routine updates to families?	15	0	0	3
Are carers routinely invited to reviews?	13	0	0	5
Are carers assessments routinely offered to carers?	8	0	9	1
Are carers offered psychoeducation or training?	5	0	13	0
Inpatient services: Have carers received written information about the service? ("Getting to know you")	8	0	0	1
Inpatient service: Is there a family therapist in the team and if needed have they made contact with family?	1	0	0	8

Where we looked for evidence of family approaches and carer invitations to reviews, three young people had no carer contact and were children looked after by the local authority, and two cases included specific instructions about carers not attending reviews although there were arrangements to link in with those carers informally.

Community teams did not routinely offer carers' assessments as the local authority completes these, but all the community case records we reviewed had evidence of family and carer involvement.

For the question relating to psychoeducation and training, we were seeking evidence of formal sessions or groups offered to parents and carers. It is likely that informal psychoeducation and support was also taking place.

We also saw evidence of several families who had been referred to third-sector support and peer parent workers, which was not specifically captured within the audit.

3.6 Involvement of the multidisciplinary team and relevant agencies – Sample size 18

Audit question	Good	Acceptable	No	N/A
Evidence of regular multidisciplinary team (MDT) discussion	18	0	0	0
Evidence of referrals made and followed up as needed	15	0	0	3
Evidence of liaison with the local authority if applicable	14	0	0	4
Complex care discussions, including multiagency, Dynamic Support Register (DSR)[3]; Care, Education and Treatment reviews (CETR); Child in Need; Education, Health and Care planning[4].	13	0	0	5
Information back to GP and referrer	18	0	0	0

3.7 Implementation of trauma-informed practices – Sample size 18

Audit question	Good	Acceptable	No	N/A
Case notes reflect empowerment, e.g. strengths and skills	18	0	0	0
Formulations in care plans/risk assessments which reflect trauma-informed principles - safety, trustworthiness, choice, collaboration, empowerment, cultural consideration	18	0	0	0
Recognition of key risk and protective factors for vulnerability and adverse childhood experiences	18	0	0	0

[3] Dynamic Support Register see https://www.england.nhs.uk/long-read/dynamic-support-registers-and-care-education-and-treatment-review-code-of-practice/

[4] https://www.gov.uk/children-with-special-educational-needs/extra-SEN-help

3.8 Identification and appropriate escalation of safeguarding concerns – Sample size 18

Audit question	Good	Acceptable	No	N/A
Safeguarding referrals made where appropriate	3	0	0	15
Follow up information evident	5	0	0	13
Safeguarding information captured where necessary, e.g. alerts, care plans	5	0	0	13
Community services: Contact with TEWV safeguarding team (where appropriate)	2	0	0	16
Community services: Evidence of attendance and engagement in child protection meetings (as relevant)	6	0	0	12

3.9 Appropriate capture and responses to race, ethnicity, gender and religion – Sample size 18

Audit question	Good	Acceptable	No	N/A
Information captured at first contact	18	0	0	0
Reasonable adjustments and preferences recorded if needed	18	0	0	0
Are preferences reflected in care plans and progress notes	18	0	0	0
Signposting to specialist services where appropriate	15	0	0	3

3.10 Care for young people with complex presentations, particularly autism – Sample size 18

Audit question	Good	Acceptable	No	N/A
Community services: Is information captured at the initial referral/assessment regarding autism (or associated needs where a diagnosis is not evident)? (where appropriate)	14	0	0	4
Where appropriate, are reasonable adjustments considered?	11	0	0	7
Referrals to specialists take place as needed e.g. Speech and Language Therapy (SALT)	6	0	0	12
Is information from diagnostic and specialist assessments incorporated into care plans and risk assessments?	8	0	0	10

One young person was awaiting assessment for autism.

4 FINDINGS – GOVERNANCE AUDIT

4.1 Handling of complaints, patient safety incidents and safeguarding events

Complaints

The Trust provided six complaint responses for our review: five early resolution, one formal. Three related to children younger than our sample age criteria of 15-18 years old. However, we retained these as part of the sample because we were looking at the substance of responses rather than care and treatment (i.e. the age of the service user was secondary to the review).

The table below provides a summary of how we scored each complaint.

Identifier	Standard met	Partially met	Not met	Could not be answered
783	16	3	3	2
789	18	4		2
931	18	4		2
1073	20	1	1	2
1728	19	3		2
1199	16	5	1	2

Please refer to Appendix four for a detailed breakdown of scores.

During our review, we found two of the criteria questions could generally not be addressed by reviewing the complaint file. These were:

- *There is evidence the complaints department has communicated the final response and action plan to the local manager/service lead for actioning, as appropriate*
- *Details of the closed complaint have been shared as required, in keeping with the Trust governance and reporting pathways.*

We do not consider this to be a negative indicator of the quality of response, rather that the questions are better addressed in in the broader context of information sharing and complaints governance (see 4.3). The Trust later provided information about how learning from complaints is shared internally. The Trust explained that InPhase is the main vehicle for sharing learning internally, from the point of a complaint being completed and actions identified for staff. We were shown an audit trail in this respect for case 931 e.g. action plan saved on InPhase; updates from action owner, an all staff email sharing learning, and minutes[5] from 'Tees getting Help & Getting More Help Service Level Governance Group'. Examples of broader reporting were to the Durham, Tees Valley and Forensic services (DTV&F) Quality Assurance and Improvement (QAIG) Care Group (example: 18 July 2024) and July 2024 Executive Review of Quality report.

Discounting the above two criteria, reducing the number of standards to 22, over 70% of the standards were met by the six complaint responses. We identified instances for each response where a small number of criteria were partially met, and two cases where a small number of standards were not met.

[5] To note, attender roles are not recorded, therefore it is not obvious to an external audience how the meeting is represented.

We consider the complaint responses to be well written and of an acceptable standard. Complaints were acknowledged promptly, and the complainants were provided with details of the process and escalation pathway. Of note, some of the email communications to the complainant during the complaint process were compassionate and personalised.

The primary area in which the quality of complaint response could be strengthened (acknowledging the small sample size) was in relation to fully addressing the complainant's concerns. In most cases we found that the responses either did not address all the concerns detailed in the original complaint – something later identified by two complainants – or provided vague responses in terms of how the matter was being addressed. For example, the response to 1728, a complaint about a 52-month wait for an ASD assessment, acknowledged lengthy waits for assessments and said that the Trust was working with commissioners to reduce waiting times. We appreciate waiting times are a national challenge, but this is a general response that would benefit from more detail to make it meaningful – how is the Trust trying to reduce waiting times; is the Trust scheduling weekend or evening appointments? Has the Trust engaged locum staff to support appointments? The response could have information about the Trust 'keeping in touch' process. The response to 783 provides similar general response in relation to addressing waiting times.

Similarly, the response to complaint 1199 (about an appointment not taking place) apologised for the situation, but largely omitted the complainant's timeline of events, which differed from the Trust's, without acknowledging this. Whilst we appreciate there is a balance when reflecting different accounts of the same event, it would have been diplomatic to have acknowledged that the Trust team's recollection of events did not mirror that of the complainant. Not comprehensively addressing the original complaint prompted further correspondence from three of the six complainants, and in one instance escalation to a Final Stage Resolution (FSR).

A further impact of not fully addressing complaints is that learning and actions identified could potentially be strengthened. In some cases, the actions did not address all the concerns and/or placed the responsibility with the complainant rather than the Trust. For example, 789 detailed concerns about the ASD assessment process and support to the family; the Trust response was non committal in terms of timeframes and advised the complainant to contact the duty team to discuss their concerns. It would have been helpful to have offered to arrange the meeting. Similarly, some actions in response to 931 (e.g. staff advised to check their letters and one member of staff to reflect on the case) were not comprehensive and provide limited assurance that the concerns have been addressed. Is the Trust assured that this action will ensure letters are checked during periods of high demand and stress? It would have been more effective for the action plan to focus on assurance and oversight elements of the issue.

Whilst acknowledging the above and the small sample size, we remain of the view that the Trust complaint responses are of an acceptable standard. The Trust demonstrated a robust approach to complaints, undertaken in line with Trust policy; limited improvement action, primarily focusing on learning, is required to strengthen the quality of responses.

PSII

A report examined the care and treatment provided to a 16-year-old male, who sadly took his own life in the community. The report is a good standard, meeting 23 of 25

standards, and partially meeting the remaining two standards.[6] The report is well written and provides a balanced evidence-based account, detailing areas for improvement, whilst noting good practice.

Our primary feedback would be that the analysis - specifically the 'why' - of the case could have been strengthened. The report provides a clear summary of what happened, but more detail would have been helpful to explore the concerns identified. Four areas for improvement are identified but the underpinning rationale is vague. For example, it is noted that the service user's care record was not updated and this is in part attributed to 'IT issues'. More information is provided in the action plan, but it is still limited. Similarly, it is noted the 'Did Not Attend (DNA)/Was Not Brought' policy was not implemented in response to the service user missing appointments. It is detailed that practitioners discussed the matter, but that the discussion was not recorded in the electronic record: this does not explain why the policy was not implemented. For example, were practitioners aware of the policy, was it readily available, and were individuals confident implementing it? It is our view that the standard of the PSII is such that it would be relatively easy to explore these points further, for example via a focus group with practitioners.

One PSII met the sample criteria for this review. As such, we cannot make wider judgements about the PSII reporting process, but note the report was comprehensive and completed in line with Trust policy and national guidance. We did not identify any concerns in relation to the PSII approach, content or findings.

Children's safeguarding events

The Trust provided eleven safeguarding events for review. In most of the cases, the service user was already known to services, therefore contact with the local authority was an update, as opposed to a new referral.

The table below sets out how these were scored against our framework.

Identifier	Standard met	Partially met	Not met	Could not be answered
464800	19	2		3
589366	24		1	
639449	22		2	1
718457	24			1
723442	23	1		1
751667	25			
777755	24			1
830500	23	1		1
862923	24			1
1018807	25			
1074046	24			1

Please refer to Appendix four for a detailed breakdown of scores.

As previously noted, several documents were shared in relation to each case, so our review was slightly different to that of complaints and the PSII; we were more reliant on the Children's Safeguarding Team providing the information (by default a form of self-assessment). However, when we followed-up with the team in relation to some points,

[6] *2.7: The report adopts a systems-based approach to understanding what has happened i.e. broader system issues are described, and, 3.1 The report examined the problems (what happened), sets out clear analysis (the how) and the fundamental issues (the why).*

we were shown several documents (e.g. safety plans) for different service users 'live' via MS Teams.

All the safeguarding events we reviewed were completed in line with Trust policy and practice. Almost all standards were met (compliance exceeding 90%), although as with the complaints review, we identified instances where it was not possible to assess compliance with our criteria based on the information available, specifically the requirement of supervision being logged and actions noted, as appropriate. Again, we do not consider this to be a negative indicator of practice, but a reflection of how the information is stored. In instances where standards were partially or not met, these appeared to case specific rather than being indicative of broader practice issues e.g. an InPhase report was not completed for 639449; parental responsibility was not recorded in 830500.

We consistently found that service user capacity was not specifically documented in the notes. However, the detail recorded in the cases indicated that practitioners were spending time with the service users, and exploring the concerns with them. As such, we are of the view that whilst a lack of capacity would probably be documented, generally, capacity was inferred through the dynamics of the relationships staff developed with the service users.

We identified no concerns in relation to how the Trust is managing children's safeguarding events.

4.2 Themes

We were asked to consider whether patterns in reported PSIIs, children's safeguarding events, and complaints in 2024 were reflective of the themes identified in the index events e.g. discharge and transition, risk assessment and care planning, service user and family involvement, ligature risks, race, ethnicity, gender and religion.

We cannot draw themes in relation to one PSII, but acknowledging the limitations of the sample size, do for six complaints and eleven safeguarding events.

Acknowledging the small sample size for complaints, we did not identify commonality with the themes identified by the index events, but found complaints tended to focus on the ASD and ADHD pathways. Specifically, waiting times, the assessment process, and communication with families.

Themes in relation to safeguarding events generally pertained to cases of service users already known to services, and: self-harm, identity/transition, ASD and ADHD, substance misuse, emotional abuse, witnessing domestic violence, and sexual assault/abuse.

4.3 Information reporting and governance

The Trust shared its governance structure and Accountability Framework (including risk escalation process). These included details of the PSII, complaints and safeguarding reporting pathways, from Care Group Quality Assurance and Improvement (QAIG) sub groups through to the Executive Review of Quality Group, the Quality Assurance Committee, and the Board of Directors, via the Care Group Boards and Executive Directors Group. The Trust provided terms of reference for the key groups within or reporting into the structure, all of which were in date and set out the purpose, objectives and management of each group (e.g. membership, duties of chair, quorum, scope and duties). Please refer to Appendix five for full details of information shared with us.

Complaints

The Complaints Department evidenced its internal management of the sample of six complaints from receipt of complaint to signed final response. This included examples of feedback about the content of the responses, and director level sign off.

The Complaints Department is routinely engaging in the Trust governance and reporting structure. We were provided with examples of the monthly 'Complaints and Patient & Carer Experience' report being shared with:

- DTV&F QAIG Care Group Board
- Quality Assurance Committee
- Executive Review of Quality Group

As noted in section 4.1, we identified examples of learning from the complaints we reviewed being reported in July 2024 to the Executive Review of Quality Group and the DTV&F Care Group QUAIG.

The 'Complaints and Patient & Carer Experience' report provides a comprehensive account of Patient Advice and Liaison Services (PALS) and complaint activity, and a helpful summary overview to signpost the reader to key points. The broader report provides dashboard reporting (KPIs) and again, highlights key points; with granular detail also provided. The monthly nature of the reports allows the reader to track changes and progress across the year.

The Trust demonstrated a mechanism for regular, detailed complaint and PALS reporting and monitoring from Complaints Department through to executive level.

PSII

The Trust provided a comprehensive account of the reporting and governance of one report, from initial reporting on Inphase, through to written confirmation to the ICB six months later that the incident had been closed. In keeping with the governance structure, the report was presented at the DTVF Service Panel and Director Panel (part of the PSII Care Group framework), in July and August, respectively. The Trust told us the output of the panel is to contribute to final reports such as the PSII. These meetings are not minuted, therefore there is no record of meeting attenders,[7] or the extent to which the report was discussed/tested. We cannot comment as to the whether the panel provides robust challenge and if there is sufficient oversight of the detail of PSIIs. However, we were told there was a lot of check and challenge during these meetings, and the different iterations of the report served as a record of any changes made. We were told the meetings are cancelled if they are not quorate.

Once a PSII has been agreed it is shared with the ICB for review and closure. The Patient Safety team has monthly meetings with the ICB to review cases and provide additional evidence as required re action plans and learning.

We were given a copy of the detailed Trust Level Quality and Learning Report, submitted to the Quality Assurance Committee in September 2024. This PSII was included in reporting, under 'key learning from serious incidents and how we are

[7] Attenders are listed on the meeting agenda but there is no record of actual attendance.

using this', although we did not identify any learning from the case being specifically referenced.

The Trust demonstrated internal oversight and (mechanism of) executive review of the PSII.

Safeguarding events

CITO, the patient record system, was implemented in February 2024. This implementation is largely complete, although some elements of automatic reporting are yet to be reestablished; the Safeguarding team said they have been liaising with individual teams during this time to ensure ongoing access to information and reporting. Reporting to the Safeguarding Public Protection Team is anticipated to be fully automated by the end of 2024. This will enable them to undertake checks and audits in relation to the quality of referrals being made to the Local Authorities.

The Safeguarding team submits reports every two months to the DTV&F and North Yorkshire and York (NYY) Care Group Boards. These detail:

- Safeguarding training compliance
- Multi-agency reviews – new notifications, published reviews and any relevant action plans
- Internal and external safeguarding audits
- Safeguarding partnership work
- Any escalation from the quarterly Safeguarding and Public Protection meeting

We were provided with example reports submitted to the Care Group Boards.

Further reporting occurs at the quarterly Safeguarding Public Protection meeting, Quality Assurance Committee (e.g. Safeguarding report submitted twice a year, and Safeguarding Annual Report) and internal monthly team meeting.

The Trust demonstrated a clear reporting pathway for complaints, individual PSIIs and safeguarding events from care subgroup to the Board.

5 PERSPECTIVES ON RECENT CHANGES

5.1 Practice

We held a joint clarification meeting with senior managers from both Trusts following the practice audits.

Audit criteria

We were assured that the case notes sampled reflected the audit criteria. Both organisations had developed their own case note lists following the audit criteria with the same cases represented across the inpatient pathway that were identified initially within the community case note audit. Additional cases within the community were children and young people with high levels of complexity and multiple services involved.

CAMHS community service developments

Within community services, there have been a number of developments which support young people and families. We heard that TEWV now has several services and teams which provide good support for young people:

- CAMHS crisis and liaison teams which can offer short-term help and support in crisis. These operate 24 hours a day over seven days a week.
- Intensive home treatment (IHT) teams can work with young people to offer increased support at home, both to prevent admission if possible and facilitate discharge planning and home leave.
- Intensive Positive Behaviour Support (IPBS) multidisciplinary teams, who work with young people who have a learning disability and or autism and their families to provide behavioural support following the positive behaviour support (PBS) framework.

Within case notes, we were able to review records from these services and gain a sense of the impact of these. We saw records where the crisis team had been contacted by young people and on occasion by family members, and the safety planning which then took place.

We spoke about the changes to inpatient services and a focus on working with young people in the community. We saw good examples within this audit of staff recognising the harm which can occur when young people are admitted to hospital in terms of trauma and re-traumatisation, restrictive practices and young people developing further maladaptive behaviours. When young people met the threshold for admission, crisis services, including IHT teams, were deployed to avoid admission and intensively support young people outside hospital. Staff were aware and strived to ensure the least restrictive options were explored.

Inpatient admissions

A small number of our sample required inpatient admission.

When admission was needed, community and inpatient staff worked together to ensure that there were clear aims to admission and that this would be for the shortest time possible. The inpatient team convened an admission meeting within the first five days and these were well attended with key people, including community team members and local authority representation where needed. IHT teams also played a role in facilitating discharge and leave with increased support at home for a short period, which was individually planned. There was creative, flexible use of IHT teams seen within inpatient and community case notes.

With CNTW, we were able to review the process for admission panels and the plans made between the inpatient and community teams when admission was requested, including when admission was declined.

Care for young people with autism

There were 13 young people with a diagnosis of autism, with one additional young person awaiting assessment, within our sample. Both Trusts have developed specialist IPBS community teams which focus on positive behaviour support planning. These teams completed assessments and planning which reflected good practice guidance,[8][9][10] and showed collaborative work undertaken with young people, families and wider services. The records we reviewed with IPBS input highlighted the multidisciplinary nature of the team, with specialist occupational therapy assessment and speech and language therapy input. The team completed detailed, trauma-informed, positive focused formulations of young people and their needs. They were able to work through these formulations with young people and their families and teams to produce positive behaviour support plans which were meaningful and individualised. This included ensuring information was presented in a form which was understandable to young people and their families, including pictorial and easy read versions, where needed. These were presented to young people and families, CAMHS teams and other care providers, for example, residential support teams and community support staff. Most teams also had PBS champions who could support staff in developing plans and formulations using the framework.

These community teams had been developed as a collaborative project between the two Trusts focusing on young people and autism. This was a good example of closer collaborative working, in part since the development of the CAMHS provider collaborative. TEWV reported there had also been highly positive family feedback for the work undertaken by IPBS teams.

Carer and family involvement

We gathered information about contact with families and family involvement in care. At CNTW families were provided with information when young people were admitted in the form of "Getting to know you" documents. This included information about carers' assessments. In the community, information about family and significant others was recorded in a specific section of the records. Staff did not routinely offer carers' assessments as these were completed by the local authority. Staff made plans for routine updates to families and we saw progress notes recording these taking place.

Trauma-informed care and formulation

Both Trusts had introduced documentation to capture formulations. TEWV had introduced safety summaries and safety plans. Safety summaries included risk-based sections (to self, to others, from others, vulnerability, offending and iatrogenic harm), young person and family/carer views, patterns of behaviour along with predisposing, precipitating, perpetuating and protective factors and what has worked/not worked previously to form an intervention plan. These were well-

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[8] NICE (2013) Autism spectrum disorder in under 19s: support and management CG170, Chapter 1.4 https://www.nice.org.uk/guidance/cg170/chapter/Recommendations#specific-interventions-for-the-core-features-of-autism

[9] NICE (2015) Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges (NG11) Chapter 1.6 https://www.nice.org.uk/guidance/ng11/chapter/recommendations#behaviour-support-plan

[10] Care Quality Commission (2018) Brief guide: Positive behaviour support for people with behaviours that challenge https://www.cqc.org.uk/sites/default/files/20180705_900824_briefguide-positive_behaviour_support_for_people_with_behaviours_that_challenge_v4.pdf

completed and detailed in all the case notes we reviewed. CNTW had developed a 5 'P's[11] formulation tool which staff had completed during inpatient admissions that we reviewed.

Staff completed progress notes and documentation reflecting an understanding of trauma-informed care and the impact on young people of adverse childhood experiences. Care plans were written positively with a focus on building skills and resilience. The language used was positive, individualised and supportive.

Where young people had expressed preferences there were good arrangements made for these, for example, communications by text, where visits could take place and how people should be addressed. We saw several young people had expressed preferences in terms of their gender, name and pronouns and these were reflected throughout the case notes we reviewed. However, both Trust's electronic systems were not well configured for aliases, and alternate forms of address. TEWV noted this was an issue since their system had been updated and they were working on this with the company. CNTW noted their issue was more in clarifying for staff how to complete changes of names and aliases.

Transition planning

Transition planning was evident in all the case notes we reviewed where young people were approaching their 18th birthday. We reviewed records where young people had moved entirely over to adult mental health services following extended periods of joint working. All adult teams had their own protocol for referrals into service for young people, with some teams accepting referrals for young people over the age of 16 and some teams, whilst informally working with young people, would only formally accept the referral at 18 years old. TEWV had developed a working group who were looking at transition. These issues were reflected nationally in terms of the threshold for children moving to adult services, and the recognised gap in commissioning. CNTW similarly have a transition group looking at these issues. From an inpatient perspective, there had been work resulting in a new policy and improved pathways. Both services were auditing transition processes.

Several young people in our sample did not wish to transfer to adult services and we saw good arrangements made for safety planning for the future and work completed to facilitate planned, positive endings.

Both Trusts spoke of working well together, having close relationships between the two Trusts and this enabling discussion and learning from each other. They felt the close working definitely benefited young people and improved outcomes for them and their families.

[11] The 5 P's are Presenting Problem, Predisposing factors, Precipitating factors, Perpetuating factors and Protective factors.

5.2 Governance

We held clarification meetings with the following TEWV staff:

- Head of Assurance and Effectiveness
- Associate Director for Nursing (Safeguarding)
- Named Nurse Safeguarding Children
- Associate Director of Patient Safety
- Head of Patient Experience
- Executive Director of Corporate Affairs & Involvement

Noting the positive results across the three categories, we explored the steps the teams had taken to strengthen their processes.

Complaints

We were told that the Complaints Department had undertaken a substantial amount of work as part of its review of how the Trust handles and manages complaints. The move to facilitating local complaint resolution, whilst still relatively new, was providing positive results, in terms of response times and reducing the number of formal complaints. Placing emphasis on local resolution was thought to be improving communication between staff and service users. To date, 198 staff have received training on how to manage complaints locally, and the programme is ongoing. The long-term intention is to move to e-learning but emphasis is currently on ensuring the foundations of local complaint management are embedded.

The Complaints Department shared the 'Benefits Realisation PALS and Complaints review' August 2024, which detailed the impact of the review of the complaints handling service and the move to more local resolution. These included:

- A 42% reduction in the volume of concerns being received by the Complaints Department, resulting in smaller caseloads.
- More complaints were being managed locally (47%) or as an early resolution complaint (40%). On average, 11% of complaints were being managed as a formal complaint.
- Compliance with originally agreed timeframes had improved to 54% in 2023/24.

We were also shown the results of the AuditOne audit of complaint action plans, undertaken as part of the Trust's response to the original Niche review. The report described the Trust's review of its complaint process as:

"A full and comprehensive end-to-end review of the Trust's patient advice and liaison service (PALS) and complaints function, taking into consideration the new NHS Complaints Standards, including exploration of a more restorative approach to PALS and complaints resolution, that helps to demonstrate that it takes concerns raised, feedback and complaints very seriously. The review involved service users, families and carers, staff providing Trust services as well as partners including those in the voluntary and community sector to co create and shape what the services look like in the future".

The report sets out further positive feedback in relation to the training programme, particularly the delivery of compassion and empathy training, and the different assurance mechanisms in relation to learning, recording and escalation.

PSIIs

The ongoing implementation of PSIRF and systems approach to investigations, and the work undertaken to facilitate this, were both highlighted to us as factors in helping drive forward the standard of PSII reports, and how recommendations and actions are developed.

The Patient Safety team has attended 'train the trainer' days to support the embedding of the PSIRF and systems based human factors approach across TEWV. We were told feedback about the resultant one-day training across leadership positions has been positive.

The Patient Safety team seeks to attend as many After Action Reviews (AARs) as possible with a view to helping teams develop their approach to investigating incidents. There is no longer a backlog of incidents; cases are allocated within a day of being identified.

We were given examples of system-based thematic work, including a recent review of 12 months of serious incidents, identifying 55 actions related to physical healthcare. This information was then shared with the physical health group to develop a targeted response.

The Patient Safety team holds a monthly meeting to review cases that may involve organisations, the intention being to improve joined up working, reduce duplication and provide families with cohesive responses as opposed to reports from each organisation. The team is seeking to work with staff across the region. Examples shared were:

- A half day workshop with County Durham and Darlington NHS Foundation Trust (CDDFT), looking at patient safety incidents that involved both organisations.
- A mortality review with South Tees Hospitals NHS Foundation Trust. The Trust recently contacted the Patient Safety team for advice about a case; the service user was not under the care of TEWV.
- A joint investigation with North East Ambulance Service (NEAS). The involvement of NEAS in the reporting process meant that the family received one, as opposed to two, reports.

We were told organisations recognised the benefits of joint working, in terms of involvement, oversight and the positive output in terms of systems-based learning.

Safeguarding

The Safeguarding team partly attributed the governance audit positive results to the work they have undertaken to be more visible to the clinical teams and services. As detailed above, they report into several meetings, including the Fundamental Standards Group, and use the Care Group board in particular as a mechanism to facilitate a dialogue with services.

The team is involved in a lot of cases and therefore visible to services. This is thought to have bridged the gap between services and safeguarding. Equally, within services, clinical and caseload supervision have been separated, allowing practitioners more time to consider complex cases and any safeguarding implications.

It is anticipated that CITO will improve oversight and consistent reporting across the Trust. Longer-term, it is intended a dashboard will be available in the Integrated Information Centre (IIC) to all services. This will facilitate service access to live information and again, help to improve reporting and oversight. The Trust is not yet

in a position to develop a dashboard, whilst the embedding of CITO and any necessary refinement is ongoing (i.e. the Trust is still looking at CITO reporting).

The Safeguarding team said they had worked hard to build staff confidence in using CITO and had developed clear guidance to support this. The team has received extensive positive feedback about the one-day safeguarding training package they deliver which was fully embedded in Q1 2023/24 (evaluation scores varying between 4.57 and 4.71, Annual report 2023/24). Examples of feedback for this year included describing the training as 'excellent', 'informative' and 'superb'.

The team said that there were still some areas of reporting, particularly around the use of InPhase, and that improvement work was ongoing. Similar work had been undertaken to improve safety plans; the detailed nature of which in some cases, we noted during our review.

General

The Trust Organisational Learning Group has recently agreed the 12 areas of learning for the year ahead – each the subject of a monthly deep dive meeting. The most recent meeting took place in early November and focused on suicide prevention and risk management from a safety summary perspective (the previous meeting considered the implementation of CITO). Attenders were given a presentation on the intended training and details of how it will be rolled out across the Trust.

The Organisational Learning Group reports into the Quality Assurance Committee. Equally there is a monthly quality assurance report submitted to the Committee, detailing performance across the Trust, including complaints, PSIIs and safeguarding.

The Trust has a clear governance structure which provides numerous reporting and escalation mechanisms that ultimately lead to the Trust Board.

The leads we met all spoke highly of the positive changes at the Trust in the past couple of years, and of a shift towards a proactive, rather than reactive, culture. It is clear that a great deal of work has been undertaken across the three categories (and beyond), the positive impact of which is gradually coming to fruition e.g. there is no backlog of patient safety incidents, the safeguarding team is more visible to services, and the number of complaints within the Trust has reduced, as the localities assume more ownership of these.

6 RECOMMENDATIONS

We make no specific recommendations related to overall quality management, as we know that TEWV are conscious of the need for continuing work, oversight, and vigilance to ensure these improvements in practice are sustained, and indeed built upon further

There are two residual recommendations:

One: TEWV should ensure that carers and family members of young people with complex mental health needs are themselves also offered relevant psycho-educational training and advice.

Two: TEWV should ensure that written responses to complaints fully address all of the concerns raised, and provide full explanations of resultant Trust actions.

Appendix One – practice audit framework

Planning and implementation of transition arrangements (children's to adult services)			
	Good evidence	Acceptable evidence	N/A
Is the YP within 6* months of their 18th birthday?	Transition date is clearly identified and clearly visible e.g. front page or specific prompt on system.	The transition date is identified elsewhere in the care record	YP is not within the timescale for transition.
Is there evidence in the case records of transition planning?	There are clearly defined entries which link to the transition plan.	There is reference within the case records to planning for transition e.g. within ward rounds.	YP is not within the timescale for transition.
Has a transition plan been completed?	There is a transition plan, completed in the agreed Trust format, which identifies how transition arrangements and transfer between services will occur.	There are plans within other documentation or progress notes outlining transition and transfer.	YP is not within the timescale for transition.
Planning and implementation of discharge from inpatient care			
	Good evidence	Acceptable evidence	N/A
Evidence of communication with community teams when planning discharge	The community team are actively involved in plans for discharge and invited and consulted, including MDT meetings, during the admission.	Community team are involved prior to discharge as evidenced in MDT meeting minutes.	
Is there evidence of discharge planning in the records?	Discharge planning starts at admission and is reviewed at each MDT meeting.	Discharge planning is referenced in MDT records and/or case notes.	
Is there a discharge care plan or plan completed involving the community team?	A discharge plan is formulated which is multidisciplinary, has clear actions and timescales moving toward discharge and is co-produced and reviewed regularly with the YP.	A discharge plan is evident within the notes and updated regularly.	
Approaches to risk management, including involvement of the young person and family members in the development of risk assessments and their care plan			
	Good evidence	Acceptable evidence	N/A
Risk assessment present, reviewed to timescale and covers all expected risks	There is an up-to-date risk assessment detailing triggers, relapse indicators and early warning signs, completed in the agreed Trust risk template.	There is a risk assessment completed in the agreed risk template.	
Risk assessment includes formulation	There is a formulation which captures risk-elevating factors, risk-reducing factors and the 5 P's (presenting, precipitating, perpetuating, predisposing and protective factors).	In the clinical record, there is a narrative risk formulation, with some detail of triggers, relapse indicators and early warning signs.	

Risk assessment includes relevant community information	Assessment and formulation include community-based scenarios, risk factors and recognition and planning relating to risks beyond immediate inpatient stay.	Risk assessment includes key risk information relating to the community.	
Risk assessment includes views or evidence of discussion with the young person	A risk assessment shows evidence of young person involvement including direct quotes, and may be written in first person if appropriate.	A risk assessment shows that the young person has signed.	This may be because the YP is too ill to be engaged or has refused.
Risk assessment includes views or evidence of discussion with family/carers	A risk assessment shows evidence of carer involvement including direct quotes, and additional completion of forms/questionnaires.	A risk assessment or care records show discussion or involvement of carer.	This may be several factors including looked-after children and YP refusing carer or family involvement.
Community services: Inpatient risk assessment and/or risk information at discharge uploaded to /recorded in electronic patient records	The risk assessment contains relevant content and updated risk information following inpatient admissions.	There is a reference to relevant inpatient risk information within the care records/progress notes.	
Inpatient services: Access (form 1) contains key risks	The most recent community risk assessment/information is present in the Form 1 (NHSE).		
Approaches to care planning, including the development of psychologically informed formulations			
	Good evidence	Acceptable evidence	N/A
Care plans present Care plans cover all areas of need Care plans reviewed as trust guidance Care plans signed and dated Care plans reflect risk assessment and include relevant risk information	The care plan reflects the young person's areas of need documented in the records. There is evidence of all of: • regular review • the young persons involvement in the development and review of the care plan • carer involvement in plan development and review • multi-agency involvement in the development and review of plan • a copy of the plan being shared with the service user, carer, and other agencies.	There is an up-to-date care plan in place. There is evidence that it was shared with the service user, carer, and other agencies.	

Inpatient services: 5 P formulation document includes evidence of formulation, psychological support and plan	A formulation is present and covers scenarios which may present with recognition of history, past trauma and how this manifests.	Evidence of MDT involvement in the plan.	Not all young people have been inpatients.
Community services: Care plans reflect risk assessment (safety summary/safety plan) and include relevant risk information. Plans include evidence of formulation and psychological support.	A formulation is present and covers scenarios which may present with recognition of history, past trauma and how this manifests.	Evidence of MDT involvement in the plan.	
Community services: Is there evidence of care plans being co-created with young people (and/or families)	A care plan shows evidence of young person involvement including direct quotes, and may be written in first person if appropriate.	A care plan shows that the young person has signed.	
Arrangements for listening to and involving young people and families			
	Good evidence	Acceptable evidence	N/A
Evidence of involvement of YP	YP involvement evident in care records, care planning, risk assessment and crisis planning. Involvement is planned and proactive.	YP involvement evident in progress notes. Involvement is often reactive.	
Evidence of involvement of families	Carer involvement evident in care records, care planning, risk assessment and crisis planning. Involvement is planned and proactive.	Carer involvement evident in progress notes. Involvement is often reactive or prompted by carer not staff.	May not be involved
Inpatient service: Is there a family therapist in the team and if needed have they made contact with family?	Family therapy input evident in records and part of the MDT approach.	Family therapy evident in records in isolation from team.	May not be involved
Is there a process for routine updates to families?	Family updates set in conjunction with family and evidence they are met.	Family updates in records but not part of a plan.	
Are carers routinely invited to reviews?	Evidence of inviting with notice, arrangements to meet carer needs, prompts and reminders if needed and support to attend.	Evidence of inviting carers.	May not be involved
Inpatient service: Have carers received written information about the service? (The "Getting to know you" package).	Carers have received information and the opportunity to discuss with staff, ask questions and have a point of contact.	Carers have received information.	May not be involved

Are carers assessments routinely offered to carers?	Evidence of carers assessment offered at start of treatment/ admission.	Evidence of carers assessment offered.	Carers may not be involved. Assessments may have been offered previously outside the audit period.
Are carers offered psychoeducation or training?	Support options are outlined to carers with notice and relevant information and people to contact.	Evidence of support offered to carers.	Carers may not be involved. Carers may decline.
Involvement of the multidisciplinary team and relevant agencies			
	Good evidence	Acceptable evidence	N/A
Evidence of regular MDT discussion	Evidence of effective MDT meetings, with actions which are SMART and all key individuals contributing. Linking across parallel processes including CIN/CP (LA led), EHCP, CETR.	Evidence of MDT meetings planned and conducted effectively.	Some organisations and processes may not be relevant
Evidence of referrals made and followed up as needed			
Evidence of liaison with local authority if applicable			
Complex care discussions, including multiagency, DSR, CIN, EHCP, CETR, CP			
All key staff invited and in attendance			
Information back to GP and referrer	Proactive and comprehensive information was relayed to GP in a timely fashion following MDT meetings and decisions.	Information relayed to GP following MDT, there may be some delay in sending or information may be basic level.	
Implementation of trauma-informed practices			
	Good evidence	Acceptable evidence	N/A
Case notes reflect empowerment, e.g. strengths and skills	Linked to YP involvement in care and documentation which is person-centred, positively worded and clearly articulates formulation, strengths and skills. There is evidence of practitioners understanding of behaviour and presentation reflecting complex factors, including diagnoses and adverse experiences.	Documentation shows some linking of formulation and trauma-informed practice.	
Formulations in care plans/RA's which reflect trauma-informed principles - safety, trustworthiness, choice, collaboration, empowerment, cultural consideration			
Recognition of key risk and protective factors for vulnerability and ACE's			

Identification and appropriate escalation of safeguarding concerns			
	Good evidence	Acceptable evidence	N/A
Safeguarding referrals made where appropriate	Safeguarding concerns are immediately recognised and escalated.	Safeguarding concerns were identified later and escalated.	
Follow-up information was evident	Responses and actions are completed immediately with proactive engagement with safeguarding teams and individuals.	Responses and meetings are recorded appropriately in the records.	
Safeguarding information captured where necessary, e.g. alerts, care plans	Safeguarding plans are in place where needed and reviewed regularly.		
Community services: Contact with TEWV safeguarding team (where appropriate)	Where advice or support had been requested this is documented clearly.		
Community services: Evidence of attendance and engagement in child protection meetings (as relevant)	Records show meeting minutes or progress notes relating to attendance and engagement.		
Appropriate capture and responses to race, ethnicity, gender and religion			
	Good evidence	Acceptable evidence	N/A
Information captured at first contact	Information about race, ethnicity, gender and religion is recorded at admission or as soon as possible at the front of the records or in an accessible place.	Information about race, ethnicity, gender and religion is recorded in progress notes/other area of records.	
Reasonable adjustments and preferences recorded if needed	Relevant information relating to adjustments and preferences is recorded as soon as practicable and in an accessible place.	There is evidence of relevant adjustments and preferences within the case records.	
Are preferences reflected in care plans and progress notes	Care plans are in place to guide staff where necessary. Progress notes show staff are aware of any requirements and actively follow these.	Progress notes show staff are aware of any requirements.	
Signposting to specialist services where appropriate	Evidence in care records, care plans or progress notes showing proactive sourcing of information and services.	Evidence in care records showing ad hoc signposting.	
Care for young people with complex presentations, particularly autism			
	Good evidence	Acceptable evidence	N/A

Community services: Is information captured at initial referral/ assessment regarding autism (or associated needs where a diagnosis is not evident)? (where appropriate)	Information is clearly identified in the right section of the records relating to autism and within the progress notes or documentation.	Information is captured within the progress notes or documentation relating to autism.	
Where appropriate, are reasonable adjustments considered?	Staff proactively seek to identify potential issues with the environment, communication, peer relationships and care and treatment plans and devise strategies with YP to aim to address these. Evidence of these being followed is shown in case notes.	Staff record information relating to assessments and potential needs. Plans relating to reasonable adjustments are accessible and referenced by staff.	The young person does not have a diagnosis of autism.
Referrals to specialists take place as needed e.g. SALT	Staff proactively assess and identify any specialist opinions or referrals needed.	Staff identify specialist opinions or referrals needed reactively when there are concerns or crisis.	The young person does not have a diagnosis of autism.
Is information from diagnostic and specialist assessments incorporated into care plans and risk assessments?	Care plans include information about specific neurodiverse features as part of a comprehensive formulation which identifies how this information fits into intervention plans.	Care plans include information from specialist assessments.	The young person does not have a diagnosis of autism.

Appendix Two – policy and guidance

Trust guidance (all TEWV)

Safeguarding children policy, v8.4

CITO safeguarding documentation: practical 'how to guide', July 2024

How to make quality safeguarding referrals crib sheet

Joint Level 3 Adult and Child Safeguarding training 2022/23

Best practice guidance – PAMIC tool

Incident recording and response policy, v10

Complaints policy, v12

National guidance

The Local Authority Social Services and national Health Service Complaints (England) Regulations, 2009

Regulation 20, Duty of Candour, CQC

Serious Incident Framework, NHS England 2015

NHS Patient Safety Strategy: Safer Culture, Safer Systems, Safer Patients, NHS England & NHS Improvement, 2019

NHS Complaints Standards, summary of expectations, 2022

Engaging and involving patients, families and staff following a patient safety incident, NHS England, 2022

Working together to safeguard children, a guide to multi-agency working to help, protect and promote the welfare of children, HM Government, 2023

Working together to safeguard children, Statutory framework: legislation relevant to safeguarding and promoting the welfare of children, HM Government, 2023

Safeguarding children, young people and adults at risk in the NHS, 2024

Patient Safety Incident Response Framework, NHS England, 2024

Appendix Three – governance audit frameworks

Rating	Description	Number
	Standards met	
	Standards partially met	
	Standards not met	

Safeguarding children events framework

Standard		Niche commentary and rating
Theme 1: Credibility		
1.1	CITO alerts have been completed (e.g. CiN, CPP, LAC, PREVENT, MAPPA etc)	
1.2	Safeguarding e-form completed	
1.3	Attachments and progress notes completed as required (e.g. meeting minutes)	
1.4	Safeguarding referral copied to TEAWVNT.safeguardingChildren@nhs.net	
1.5	InPhase report has been completed (nb: acknowledgement only, not full report).	
1.6	Local Authority receipt of referral logged (if not received within three working days, follow-up documented)	
Theme 2: Thoroughness		
2.1	Details of the family members involved and who is at risk documented	
2.2	First names and surnames have been spelt correctly and consistently	
2.3	Parental responsibility documented	
2.4	Dates and times of incident/s detailed	
2.5	Details of the injuries or alleged harm recorded	
2.6	Category of alleged abuse or neglect recorded	
2.7	Consent from those with parental responsibility documented (unless this would place the child at risk; decision to not seek consent recorded)	
2.8	Suggested actions to address concerns documented	
2.9	Support currently available to the family documented	

Standard		Niche commentary and rating
2.10	Child's voice and lived experience reflected and any actions detailed	
2.11	Evidence that capacity (for those aged between 16 & 18yrs) has been considered	
2.12	The referral is written clearly, without typos or grammatical errors.	
Theme 3: Impact		
3.1	Safeguarding referral (or update if already known to services) submitted within 24hours of concerns being raised	
3.2	Safety summary and plan documented	
3.3	Local Authority outcome logged e.g. S47, child protection.	
3.4	Requirement of supervision logged and actioned, if appropriate	
3.5	Other agencies contacted as appropriate	
3.6	Any immediate actions recorded	
3.7	Status of SG process at time of review and impact for future learning e.g. any concerns remaining, difficulties sharing information etc?	

Patient Safety Incident Investigations framework

Standard		Niche commentary and rating
Theme 1: Credibility		
1.1	The rationale/agreement for undertaking a PSII is documented (to note: may be logged in AAR).	
1.2	The investigation has clear terms of reference that includes what is to be investigated, the scale and scope, PSIRF methodology and type of investigation; case specific points are captured.	
1.3	The person leading the investigation has the appropriate skills and training in effective systems investigation processes (plus subject matter expert as required).	
1.4	The investigation was completed within internally agreed timeframes or there is clear evidence of the reasons for delay and process for approving this with commissioners.	
1.5	The report is a description of the investigation, it is accessible to readers and written in plain English, without typographical errors.	

Standard		Niche commentary and rating
1.6	Staff have been supported following the incident, provided with information about the investigation and had an opportunity to contribute to the process.	
1.7	Internal locality panel and director panel review and sign off of the report is documented.	
Theme 2: Thoroughness		
2.1	The methodology used for the investigation is described and includes the use of any analytical tools (e.g. SEIPS) and how the information and evidence was obtained (interviews, mapping, review of clinical records, observations).	
2.2	Bereaved or affected patient, families and carers are informed about the incident and of the investigation process (in instances where they are not involved, the reason is documented); evidence of FLO engagement.	
2.3	Bereaved/affected patients, families and carers were offered the opportunity to have input into the investigation; their experience/concerns/questions have been reflected (e.g. in ToR). Families have had an opportunity to provide a pen portrait and photo of the patient.	
2.4	It is clear how the Duty of Candour regulations have been met for this incident or reasons why this hasn't been possible are included *(to note this is captured at part of the panel sign off process)*.	
2.5	Background/context of the service user's care and description of the incident is included.	
2.6	Findings are identified and underpinning analysis detailed e.g. benchmarking of practice. The 'how' is set out.	
2.7	The report adopts a systems-based approach to understanding what has happened i.e. broader system issues are described.	
2.8	The report reflects areas of learning and where improvement action is required.	
2.9	Areas for learning are described.	
2.10	Areas of good practice are described.	
2.11	There should be no obvious areas of incongruence.	
2.12	The way the terms of reference have been met is described; with an explanation in relation to any areas that have not been explored.	
Theme 3: Impact		
3.1	The report examined the problems (what happened), sets out clear analysis (the how) and the fundamental issues (the why).	
3.2	Learning and action plan/s clearly relate to the findings.	
3.3	It should be clear that the learning supports measurable, and outcome focused actions/improvement plans.	

Standard		Niche commentary and rating
3.4	The affected service user(s)/ families have had an opportunity to review and comment on the draft report (*to note this is picked up as part of the panel review process).*	
3.5	The action plan/s reflects and responds to each of the recommendations, with action owners and realistic timeframes identified.	
3.6	The actions will address the concerns identified.	

Complaints framework

Standard		Niche commentary and rating
Theme 1: Credibility		
	The complaints file contains the following:	
1.1	The original complaint	
1.2	Consent, if required.	
1.3	Details of the complaint acknowledgement; verbally (file note) or in writing (acknowledgement letter) sent within three working days	
1.4	Internal emails and communications	
1.5	Clinical records, feedback from clinical services, policies, and other working papers	
1.6	Draft response with evidence of comments and quality control	
1.7	Updates have been provided to the complainant in line with the keeping in touch process	
1.8	Final response to all allegations and information about how to request a Final Stage Review if unhappy with the outcome (and PHSO contact details for post FRS)	
1.9	Final response to the complainant sets out what actions have been taken in response to the complaint	
Theme 2: Thoroughness		
2.1	The complaint has been appropriately triaged (local management, early resolution complaint (ERC) or formal complaint) with evidence underpinning the decision	
2.2	The complaint investigation has been completed in the agreed timeframe	
2.3	If an extension was required, delays were communicated to the complainant, along with an apology	
2.4	The complaint was managed by • Complaints officer (ERC) • Complaint manager (formal complaint)	

Standard		Niche commentary and rating	
2.5	Staff are trained in how to investigate complaints e.g. PHSO standard training		
2.6	The complaint response included a review of all areas highlighted as issues		
2.7	Each issue was addressed with an explanation in a non-defensive manner		
2.8	There is evidence that services had an opportunity to review and comment on the intended response		
2.9	Complainants were offered an apology where due		
2.10	The resultant action or remedy was clearly described		
2.11	The response was written in plain, accessible language		
Theme 3: Impact			
3.1	The complainant has accepted the Trust response to their complaint e.g. they have not instigated the Final Stage Review within 30 days of being sent the Trust response		
3.2	The actions address the problems identified in the original complaint		
3.3	There is evidence the complaints department has communicated the final response and action plan to the local manager/service lead for actioning, as appropriate		
3.4	Details of the closed complaint have been shared as required, in keeping with the Trust governance and reporting pathways		

Appendix Four – full audit scores (Complaints & safeguarding events)

Safeguarding events

Standard	Case number										
	464800	589366	639449	718457	723442	751667	777755	830500	862923	1018807	1074046
1.1 CITO alerts have been completed (e.g. CiN, CPP, LAC, PREVENT, MAPPA etc)											
1.2 Safeguarding e-form completed											
1.3 Attachments and progress notes completed as required (e.g. meeting minutes)											
1.4 Safeguarding referral copied to TEAWVNT.safeguardingChildren@nhs.net											
1.5 InPhase report has been completed (nb: acknowledgement only, not full report).											
1.6 Local Authority receipt of referral logged (if not received within three working days, follow-up documented)											
2.1 Details of the family members involved and who is at risk documented											
2.2 First names and surnames have been spelt correctly and consistently											
2.3 Parental responsibility documented											
2.4 Dates and times of incident/s detailed											
2.5 Details of the injuries or alleged harm recorded											
2.6 Category of alleged abuse or neglect recorded											
2.7 Consent from those with parental responsibility documented (unless this would place the child at risk; decision to not seek consent recorded)											
2.8 Suggested actions to address concerns documented											
2.9 Support currently available to the family documented											
2.10 Child's voice and lived experience reflected and any actions detailed											

2.11 Evidence that capacity (for those aged between 16 & 18yrs) has been considered											
2.12 The referral is written clearly, without typos or grammatical errors.											
3.1 Safeguarding referral (or update if already known to services) submitted within 24hours of concerns being raised											
3.2 Safety summary and plan documented											
3.3 Local Authority outcome logged e.g. S47, child protection.	N/A										
3.4 Requirement of supervision logged and actioned, if appropriate											
3.5 Other agencies contacted as appropriate											
3.6 Any immediate actions recorded											
3.7 Status of SG process at time of review and impact for future learning e.g. any concerns remaining, difficulties sharing information etc?											

Complaints

Standard	**Complaint identifier**					
	783	789	931	1073	1728	1199
The complaints file contains the following:						
1.1 The original complaint						
1.2 Consent, if required						
1.3 Details of the complaint acknowledgement; verbally (file note) or in writing (acknowledgement letter) sent within three working days						
1.4 Internal emails and communications						
1.5 Clinical records, feedback from clinical services, policies, and other working papers						
1.6 Draft response with evidence of comments and quality control						
1.7 Updates have been provided to the complainant in line with the keeping in touch process						

1.8 Final response to all allegations and information about how to request a Final Stage Review if unhappy with the outcome (and PHSO contact details for post FRS)						
1.9 Final response to the complainant sets out what actions have been taken in response to the complaint						
2.1 The complaint has been appropriately triaged (local management, early resolution complaint (ERC) or formal complaint) with evidence underpinning the decision						
2.2 The complaint investigation has been completed in the agreed timeframe						
2.3 If an extension was required, delays were communicated to the complainant, along with an apology						
2.4 The complaint was managed by • Complaints officer (ERC) • Complaint manager (formal complaint)						
2.5 Staff are trained in how to investigate complaints e.g. PHSO standard training						
2.6 The complaint response included a review of all areas highlighted as issues						
2.7 Each issue was addressed with an explanation in a non-defensive manner						
2.8 There is evidence that services had an opportunity to review and comment on the intended response						
2.9 Complainants were offered an apology where due						
2.10 The resultant action or remedy was clearly described						
2.11 The response was written in plain, accessible language						
3.1 The complainant has accepted the Trust response to their complaint e.g. they have not instigated the Final Stage Review						

within 30 days of being sent the Trust response						
3.2 The actions address the problems identified in the original complaint						
3.3 There is evidence the complaints department has communicated the final response and action plan to the local manager/service lead for actioning, as appropriate						
3.4 Details of the closed complaint have been shared as required, in keeping with the Trust governance and reporting pathways						

Appendix Five – TEWV documents reviewed

Terms of reference

- Quality Assurance Committee
- Directors Assurance Panel, February 2024 (review date December 2024)
- Durham, Tees Valley and Forensics Care Group Board, August 2024 (review date August 2025)
- Durham, Tees Valley and Forensics Care Group Combined Governance Group, August 2024 (review date July 2025)
- Speciality Level Governance Meeting – AMH Planned Care, May 2023 (review date January 2025)

Safeguarding

- Summary of floor to board SG reporting
- TEWV SP Annual report 2023-24 FINAL
- DTVG SPPT Report Sept-24
- NYY SPPT Report Sept-24
- SGPP update presentation for QUAC Sept 24
- SGPP Quarterly update Sept 24
- Q1 24-25 Joint SGA-SGC KPI Report FINAL Aug 24
- Q3 Joint SGA-SGC KPI report FINAL Feb 24
- SA Reviews Dashboard Q1 24-25
- Sc Reviews Dashboard Q1 24-25

Complaints

- Benefits Realisation PALS and Complaints review Aug 24
- TEWV 1624 NICHE complaints review – action plans final report
- QuAC PALS Complaints and Patient Experience Reports, Jan & Feb 24
- Executive Quality Assurance & Improvement Subgroup, Group Complaints and Patient Experience Reports, Jan-Mar 24
- Executive Review of Quality Group, Apr 24
- DTV&F QAIG Care Group Board, Jul 24
- PALS and Complaints 2023-2024 Annual Report

PSIIs

- InPhase report
- PST Huddle report (Apr & May 24)
- AAR tracker screenshot
- AAR submitted to ICB
- PST case tracker screenshot
- AMH Planned/Urgent Service panel agenda, Jul 24
- Directors Assurance Panel, Aug 24
- Trust Level Quality Assurance and Learning Report (undated but the file name includes August 24)
- Emails

Tees, Esk and Wear Valleys
NHS Foundation Trust

Our address is:
4th Floor
Trafford House
Chester Road
Manchester
M32 0RS

Tel: 0161 785 1000
www.nicheconsult.co.uk

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HEALTH & SOCIAL CARE CONSULTING

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**13th February 2025**
Title:	**Learning from Deaths**
Executive Sponsor(s):	**Kedar Kale, Executive Medical Director**
Author(s):	**Amy Taylor, Interim Associate Director of Patient Safety**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
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.	There is a risk that if we fail to embed key learning from deaths, patient safety and quality will be compromised and the people we serve will lose confidence in the services we provide. This paper sets out key processes for mortality reviews and learning from deaths including patient safety incident investigations across the Trust to reduce and mitigate this risk.
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	

Executive Summary:

Purpose:

The national guidance on learning from deaths requires each Trust to collect and publish specific information. This report covers the period from October to December 2024 (Quarter 3). The Board of Directors is receiving the report for information and assurance of the Trust's approach in line with national guidance.

All NHS Trusts must publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy and have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all the deaths categorised as in scope for the Learning from Deaths policy are subject to an initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) are in Appendix 2.

Proposal:
That the dashboard and the learning points are provided as good assurance of reporting and learning in line with national guidance.

Overview:
In line with National Guidance the Learning from Deaths Dashboard at appendix 1 details Q3 information for the Trust and includes 2023/24 data for comparison.

- During Q3 the Trust received 355 death notifications of patients who had been in contact with our services in the preceding 6 months. The Trust received 12 death notifications of people with a learning disability or autism in the time frame. These figures represent all deaths (including natural expected/unexpected, and unnatural/unexpected) in relation to people who were currently open to the Trust's caseload which is largely community and includes older people and memory services (>70,000).
- 8 inpatient deaths were reported. 3 of these deaths occurred within an inpatient setting and were expected deaths, subject to Part 1 reviews. 1 of these deaths was unexpected natural causes and is subject to a joint After Action Review with an acute trust.
- 4 out of the 8 inpatient deaths occurred in Adult Mental Health wards and have been reported on the national Strategic Executive Information System (StEIS) and are subject to a Patient Safety Incident Investigation (PSII). 3 of these deaths are suspected suicide, 2 of which occurred on the ward, with one occurring off the ward. 1 death was unexpected, suspected natural causes which occurred on the ward. All PSII investigations are in progress.
- 1 unexpected community death was reported on StEIS during the reporting period and is being investigated as a PSII.
- Immediate After Action Reviews were conducted for all the above PSII deaths and where appropriate, rapid improvements have been made to improve patient safety.
- 16 Part 2 Structured Judgement Reviews (SJRs) were requested.
- 43 Part 1 reviews and 8 SJRs were completed.
- 14 serious incident investigations / Patient Safety Incident Investigations for unexpected deaths were completed.
- All deaths of people with either a learning disability or a diagnosis of autism require reporting to LeDER in line with national requirements over the reporting period. Deaths are reported to LeDER via the clinical teams and the Patient Safety team have added a prompt to all After Action Review and Mortality Review documents. It has also been built into the InPhase reporting system since 30th October 2023. Any discrepancies in reporting are being followed up by the Patient Safety team. Reasons given for not reporting have been identified as deaths occurring in the Acute Trust or a Care home and it was assumed by the TEWV clinical team that the team providing 24-hour care had submitted the referral. Teams are being asked to confirm this with those providers.

Appendix 3 sets out in detail the specific areas of learning, Trust themes, progress within the Quality Assurance programme and structures to support and embed learning from incident investigations.

10 Patient Safety Briefings were circulated Trust wide during this reporting period, examples included:

- 3 in relation to environmental risks and issues
- 2 in relation to medication management
- 2 in relation to Cito recording and alerts
- 1 in relation to emollients and fire risk
- 1 in relation to physical health
- 1 in relation to referrals to additional services

To improve learning and measure progress against the Trusts main themes, all learning requires a SMART action plan. To support learning at the earliest opportunity all incidents that are identified as a PSII are subject to an After-Action Review overseen by daily patient safety huddles.

The transition, to InPhase incident reporting in 2023/24 supports additional benefits in terms of triangulating learning and monitoring of actions as well as greater monitoring of Duty of Candour as it is further embedded and refined. It has also highlighted anomalies in reporting processes and in addition to incident reporting for unexpected deaths we now report expected natural cause deaths as outcomes following guidance from NHS England. Some unexpected deaths, once fact finding has been completed to establish if a patient safety incident has occurred can also be moved into outcomes and the patient safety team are currently reviewing and updating processes to reflect this.

Prior Consideration and Feedback

Updates and assurance aligned to improvement work relating to learning from deaths is reported to the Quality Assurance Committee. This includes regular updates on the Quality Assurance schedule (providing assurance of compliance against key patient safety policies such as leave, clinical record keeping, risk assessment and management, observation and engagement) as well as updates on key areas that sit within our Quality and Clinical journeys that relate to themes from patient safety incidents such as progress following implementation of the patient safety incident response framework (PSIRF). Themes of learning are reported into the Trust wide Organisational learning group to support organisation wide learning.

Implications:

There is a risk that the data published is utilised or interpreted without context as there is no current national benchmarking or methodology within mental health and learning disability services for mortality data.

There are financial and reputational implications associated with poor standards of care. A focus on learning helps the Trust to improve the quality and safety of our care services.

Recommendations:

The Board of Directors is requested to note the content of this report, the dashboard and the learning points as good assurance of reporting and learning in line with national guidance and consider any additional actions to be taken.

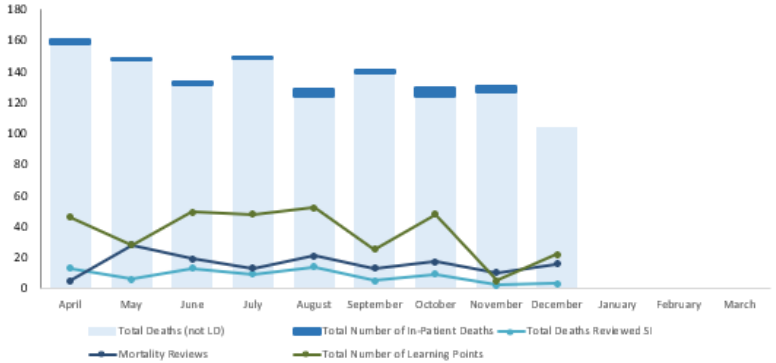
Appendix 1: Learning from Deaths Dashboard Q3 2024/25

Learning from Deaths Dashboard - Data Taken from Paris/CITO
Reporting Period - Q3 2024-25

Summary of total number of deaths and total number of cases reviewed under the SI Framework/Patient Safety Incident Response Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

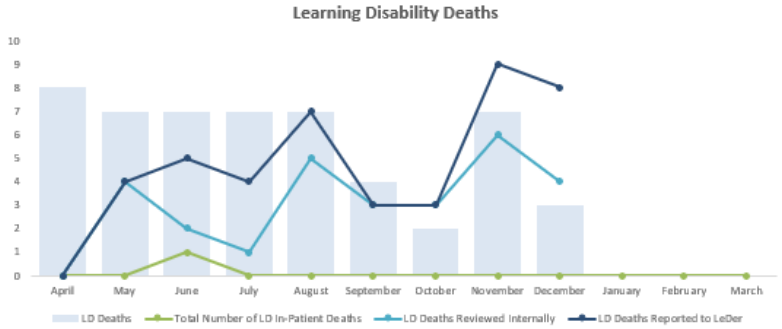
	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
Q1	436	↘ 510	5	↗ 4	32	↗ 13	52	↘ 175	123	↗ 38
Q2	411	↘ 437	7	↘ 8	28	↘ 41	47	↔ 47	125	↘ 159
Q3	355	↘ 531	8	↘ 9	14	↘ 48	43	↗ 38	75	↘ 169
Q4	0	↘ 524	0	↘ 6						
YTD	1202	↘ 2002	20	↘ 27	74	↘ 102	142	↘ 260	323	↘ 366



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework/Patient Safety Incident Response Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
Q1	22	↘ 26	1	↗ 0	6	↘ 12	9	↔ 9
Q2	18	↔ 18	0	↔ 0	9	↗ 7	14	↗ 7
Q3	12	↘ 38	0	↔ 0	13	↗ 8	20	↗ 5
Q4	0	↘ 26	0	↔ 0				
YTD	52	↘ 108	1	↗ 0	28	↗ 27	43	↗ 21



Appendix 2

Mortality Reviews 2024/2025

Mortality reviews are completed in-line with guidance from the Royal College of Psychiatrist and peer organisations across the region.
The mortality review tool used consists of a Part 1 and Part 2 review.
Part 1 is a review of the care records, if any red flags or concerns are noted a Part 2 (Structured Judgement Review) will be considered and completed if required.

The “red flags” to be considered during the Part 1 review are as follows:

- Family, carers, or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)
- Random Selection
- Specific area of interest to the Trust (e.g., Clozapine)

This criterion allows for greater learning from a more suitable selection of cases reviewed. To prioritise the most significant cases for learning from unexpected and expected physical health deaths, the following actions have been taken for those deaths reported via inphase.

- All in-patient deaths, not subject to a Patient Safety Incident Investigation (PSII) have either had a Part 1 completed or are in the process of having one completed.
- All LD deaths of those open to TEWV have either been reviewed or are being reviewed under Part 1 of the mortality review process. Where any concerns are identified, a Structured Judgement Review has been or will be requested. All these cases are to be reported to LeDER for review. The LeDER referral will not necessarily be completed by TEWV if the individual is receiving their main care from another provider.
- All community deaths for patients aged 64 and under have been or are being reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested.
- 20% of community deaths for patients aged between 65 and 74 have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested. This 20% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.
- 10% of community deaths for patients aged 75 onwards have been reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review has been requested. This 10% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.

Appendix 3

1. Mortality Reviews and Learning

Mortality Review 2024/2025

8 structured judgement reviews were discussed and reviewed by the Mortality Review Panel during Q3.

A number of Actionable learning points were identified:

- Care planning, interventions and record keeping
- Patient and carer experience
- Safeguarding
- Multi-agency working

Learning from actions/assurance

- Findings from SJRs are fed back to the clinical networks, where appropriate, to ensure that learning feeds into existing improvement work. Outcomes are captured in minutes at the following mortality review panel. These will be fed into the re-established Organisational Learning Group for future quarters.
- Where the learning identified is related to the work of a specific professional group, for example Pharmacy, the relevant mortality review panel member ensures this is actioned and shared Trust-wide. Good examples of assurance can be evidenced from the workstreams related to Clozapine, Lithium and Depot Injections.
- Learning for individuals is shared with operational teams where appropriate and addressed via supervision and local governance processes.

Learning from mortality reviews often demonstrate similar themes identified during Serious Incident reviews / Patient Safety Incident Investigations. The themes from mortality reviews are triangulated with learning from serious incidents reviews to establish any new themes occurring.

1.2 Learning from deaths and patient safety incidents

Within Quarter 3 there were a total of 75 learning points from both Patient Safety Incident Investigations and mortality reviews. In addition, there were 108 learning points from After Action Reviews undertaken following patient deaths. The most frequent actionable learning theme identified related to record keeping and documentation, followed by processes and communication. Another theme related to the lack of handover from local acute trusts when patients from TEWV inpatient wards have been under their care for a period of time.

1.3 Structures to support and embed learning

1.3.1 Fundamental standards group

Practice Development Practitioners are now integrated into the Care Group Fundamental Standards meetings where wider learning and good practice can be shared to facilitate improvements Trust-wide.

1.3.2 Organisational Learning

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group (OLG). Any significant issues identified by the OLG are

escalated to the Executive Review of Quality Group for further discussion and or actions. The OLG now has a 12 month workplan based on the recurring themes identified.

1.3.3 Patient Safety Incident Management/Investigation

The Trust has a continued focus on improving the quality of incident reporting, investigation, and identification of key actionable learning. Key improvements across the incident reporting and investigation pathway have been implemented incrementally and we continue to develop and embed these changes ensuring they are compliant with the requirements of the National NHS Patient Safety Strategy and the Patient Safety Incident Response Framework (PSIRF).

The Patient Safety Programme Board (PSIM) provides oversight on the Risk management system procurement, and the embedding of the Patient Safety Incident Response Framework (PSIRF) and Learning from Patient Safety Events (LFPSE). The Programme Board reports into the Transformation and Strategy Board.

1.3.4 The Environmental Risk Group

This group receives information where environmental factors may have contributed to harm, as well as progression of initiatives to reduce harm. Any urgent learning identified through this group is distributed Trust-wide via Patient Safety Briefings. The annual Environmental survey programme with a multi professional input from estates, health and safety and clinical services continue. The ligature reduction programme is monitored through this group with assurance provided through the Trusts quality governance structures. Significant investment has been dedicated to assistive technology in the form of Oxehealth and door sensors to make wards safer.

1.3.5 Recruitment and Retention/staffing establishment reviews

When looking at patient safety incidents through a systems and human factors lens, it can be seen that workforce pressures and capacity including community caseloads can impact on the quality of care delivered. Significant work is being undertaken to ensure that we have a suitably skilled and resourced workforce who can carry out their duties in a safe and compassionate way. Further details can be seen within the safe staffing and establishment review papers.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**February 2025**
Title:	**Patient Carer Race Equality Framework (PCREF) 2025**
Executive Sponsor(s):	**Hannah Crawford, Director of Therapies**
Author(s):	**Rachel Nye, Research and Statistics Manager** **Danielle Rome, Lead Information Analyst** **Sarah Dallal Equality, Diversity, Inclusion and Human Rights 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***
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
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

Executive Summary:

Purpose:

This paper is presented to the Executive Directors & Committee to provide assurance that the Trust is meetings its obligations under the Patient Carer Race Equality Framework (PCREF).

NHS England (NHSE) has developed the PCREF to support Mental Health Trusts to become anti- racist organisations by ensuring they co-produce and implement actions to reduce racial inequalities within their services. It will become part of the CQC inspections in the future. The ICBs are monitoring Trust's progress with the PCREF.

Following engagement with the ICB it has been agreed that data

flows and governance structures that comply with the PCREF part 1 should be established for this first year of the PCREF.

As a minimum Trusts must publish:

- The number of cases of detention under the Mental Health Act and the cause (section) and duration of these detentions by ethnicity
- Restraint including the type of restraint by ethnicity, age and gender.
- Physical health checks for those adults with Severe Mental Illness by ethnicity.

  The Trust is currently not able to produce this data as it is not something as a Trust we collect data and report on. The guidance states that the registers are held within primary care. Contact has also been made with NHS digital who are planning to produce this data at a regional level but were unable to provide any timescales. The ICBs have also been contacted to provide support to progress this agenda.

  Physical health data is recorded on Cito however the data does not currently flow within the IIC and would require thorough development and testing. The information is recorded quite differently to how it was on Paris and therefore some time is required to ensure the developments match the clinical processes. This will be available after April 2025 from the Trust.

- Improved access rates to Children and Young People's mental health services for 0 – 17-year-olds
- A sample of locally agreed access, experience and outcome metrics. Information which previously formed part of the patient publication of information has been included under this heading.
- The Trust will report on any deaths in mental health inpatient units to the CQC by protected characteristics. The Trust is complaint with this and currently reports to the CQC on all deaths of patients detained under the Mental Health Act by gender, ethnicity, disability, religion/ belief, sexual orientation and age. This data is not collated centrally, the Mental Health Legislation office save a copy of the death notification once it is sent to CQC.

The data charts are attached to this report as Appendix 1.

The PCREF asks the Trust to produce the above data as simple counts and at this stage does not require any analysis of the data. However, as an organisation we are committed to not only publishing the data, but to analysing and understanding it in order to make improvements at place for our service users, carers and communities.

Proposal:

Executive Directors & the Committee are asked to confirm that it has good assurance that the Trust has followed a robust process in developing the PCREF data flows and governance process as required by the ICBs.

Executive Directors & the Committee are asked to approve the publication of the PCREF data on the Trust website.

Overview:

The Trust is required to publish the PCREF data by March 2025 as outlined above. The proposal for good assurance is based on the information contained in this report and the data in appendix 1, taking in to account:

- The data required for the PCREF has been produced in a robust manner excepting the SMI/physical health check data.
- The data on detentions, restraint and access to Children and Young People's services is for the period from 1.4.23 – 31.3.24. The data on rates of access to clinical services compared to admissions and clinical outcomes is for the calendar year 2023.
- *The data in the appendix 2 includes trustwide information on rates of access to services compared to admissions and clinical outcomes for both adults and children. This data has previously been published as part of the Trust's publication of service user information and is for the calendar year 2023.*
- Moving forward we will bring the reporting period for PCREF and for reporting on our public sector equality duties together, so all data will be for the same time period.

PCREF data (Data in Appendix 1)

Detention data produced for Mental Health Act Legislation Committee (Fig 3).

Information has been produced by calculating the expected rates of detention by gender and ethnicity for the Trust based on standardised rates of detention per 100,000 population. The trust's anticipated rates are based on the 2021 census for ethnicity, sex, age and gender. These have been compared to the Trust's detention rates and NHS Digital's detention rates for 2023/24.

- Compared to the national rates of detention per 100,000 population the Trust detains more people from all ethnicities than the national rates (Fig. 3). Those who are mixed race, Black/ Black British and Other Ethnicities have higher rates of detention per 100,000 population than White people and Asian/ Asian British people have lower rates of detention per 100,000

population compared to White people.

- This is confirmed by the table in fig. 4 which shows that per 100,000 population those who identify as Mixed race and Other Ethnicities are detained 1.32 times more than White people and Black/ Black British people are detained 2.61 times more than White people per 100,000 population.
- Further analysis of relative rates of detention by ethnicity and gender per 100,000 population (Fig 5.) show that compared to White women, Black/ Black British women are detained 3.39 times more, compared to Asian/Asian British women 4.08 more, and are detained at higher rates than any other female ethnic group. Black/ Black British men are detained 1.94 times more than White men; Mixed women are detained 1.15 times more than White women and Mixed men 1.51 times more than white men. Men who identify as other Ethnicities are detained 1.77 times more than White men. Women from other Ethnicities are detained less than White women (0.85)

Restraint (Figs. 6-9)

The data on restraint is included in fig.6 -9. Further analysis is required to understand differentials and patterns. In particular understanding where individuals appear in more than one category and also being aware of the possibility of variation due to the small numbers within each ethnicity and type of restraint category.

Initial analysis suggests that women are more likely to be physically restrained compared to men and men are more likely to be in seclusion compared to women. Physical interventions and isolation for those aged 18 – 29-year-olds are significantly higher than for other age groups; mechanical restraint is low across the board but there appears to be an outlier in the 30 – 34 age group.

CYP Access (Fig. 10)

Data on CPY access is included in fig. 10. Further analysis is required to understand any differentials and patterns. We have been unable to calculate population rates as children and young people are not included in the census so that work to develop a proxy would need to be undertaken.

PROMS and CROMS (Figs. 11 & 12)

For adults and older people, the percentage of discharged patients showing measurable improvement on the CROM tool is significantly higher for our Black/ Black British population than other groups.

For CYP CROMS for Other Ethnicities is significantly lower but for PROMS our Black/ Black British children, the proportion of discharged patients showing measurable

improvement is around double. Caution needs to be applied as the numbers of patients will be significantly lower.

PCREF requirements 2 – 8
Information and actions relating to the PCREF requirements 2 – 8 are included in Appendix 2 of this document. Information and actions against requirement 1 are those detailed in the body of this report and Appendix 1. All the data outlined in these requirements is currently available with the exception of:

- **Action 3 – Patient safety incidents are reviewed by ethnicity.** An initial review of existing data on patient safety incidents within ethnically diverse groups to identify key themes is to be undertaken by the Patient Safety team.
- **Action 4 – Complaints from racialised patients and carers are appropriately actioned.** The Complaints team are currently implementing the processes adopted by one of the PCREF pilot sites to capture this information.
- **Action 6 – Advance choice decisions are routinely reviewed with racialised patients and carers.** Advance choice decisions are currently recorded on CITO and should be reviewed in line with care planning.
- **Action 8 – Feedback from racialised carers is appropriately actioned in line with the triangle of care.** Carer demographics are to be captured in the carer survey from August 2025

Description of ongoing activity
The Trust is developing relationships with our communities and engaging in exploratory work to understand actions required. This also includes actions around further analysis of the data provided in this report to understand where there are differentials and patterns that the Trust needs to pay attention to. Of particular importance we need to understand how we can integrate data with respect to protected characteristics within quality and positive and safe dashboards.

Prior Consideration and Feedback	The Trust's Business Analytics and Clinical Outcomes Information Department have undertaken the development of the service user data. The information has been reviewed by Executive Clinical Leaders subgroup.
Implications:	Failure to understand the differences in outcomes and experiences of our BAME service users in accordance with the requirements of the PCREF, and more broadly those with protected characteristics in accordance with our public sector equality duties may have regulatory and reputational consequences. Failure to act to reduce differences in outcomes and experiences of our service users with protected characteristics may impact on their outcomes and experiences.

Recommendations: Executive Directors and the Committee are asked to:

- confirm that it has good assurance that the Trust has developed data flows and a governance process as required by the ICBs.
- confirm that it has good assurance that the Trust has followed a robust process in producing and analysing the data required for the PCREF and in doing so is meeting its obligations as outlined above.
- to approve the proposed publication of the PCREF prior to publication on the Trust website.

Appendix 1 – Data required for PCREF publication

Number of Cases of detention under the Mental Health Act by cause and duration by ethnicity

Figure 1: Number of Detentions by Ethnicity & Section Type (1.4.23 – 31.3.24)

Number of Detentions by Ethnicity & Section Type							
Ethnicity x Section Type	**White**	**Asian/Asian British**	**Black/Black British**	**Mixed**	**Other Ethnicities**	**Unknown**	**Grand Total**
2	1514	41	25	27	17	155	**1779**
3	841	18	17	13	6	53	**948**
37	*<5*	0	0	0	0	*<5*	*<5*
37/41	5	0	0	0	0	0	**5**
37N	*<5*	0	0	0	0	0	*<5*
4	6	*<5*	0	0	0	*<5*	**8**
47/49	*<5*	0	0	0	0	*<5*	*<5*
48/49	7	0	0	0	0	0	**7**
5(2)	290	*<5*	*<5*	*<5*	*<5*	16	**318**
5(4)	90	*<5*	*<5*	*<5*	0	*<5*	**97**
Grand Total	**2762**	**66**	**46**	**43**	**26**	**230**	**3173**

Figure 2: Average Duration of Detention by Ethnicity & Section type (1.4.23 – 31.3.24)

Average Duration in Days by Ethnicity & Section Type							
Ethnicity x Section Type	**White**	**Asian/Asian British**	**Black/Black British**	**Mixed**	**Other Ethnicities**	**Unknown**	**Grand Total**
2	19	19	19	17	19	18	**19**
3	70	58	61	79	35	71	**69**
37	131	*n/a**	*n/a*	*n/a*	*n/a*	182	**144**
37/41	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
37N	153	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	**153**
4	*<5*	*<5*	*n/a*	*n/a*	*n/a*	0	*<5*
47/49	67	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	**67**
48/49	75	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	**75**
5(2)	*<5*	*<5*	*<5*	*<5*	*<5*	*<5*	*<5*
5(4)	0	0	0	0	*n/a*	0	**0**
Grand Total	**32**	**28**	**33**	**34**	**21**	**30**	**32**

**n/a applies where either there were no detentions of type by ethnicity, or where the detention hasn't ended at time of data collection*

Figure 3: Actual detention rates per 100,000 population compared with anticipated detention rates and compared with national rates (2023)

Actual detention rates per 100,000 population compared with anticipated detention rates and compared with national rates					
Ethnicity	**National rates of detention per 100,000 population**	**Anticipated numbers of detentions in TEWV based on national rates**	**Actual numbers of detentions in TEWV**	**TEWV rates of detention per 100,000 population**	**Relative rate between TEWV detention figures and National Figures**
White	69.5	1329	2376	124.2	1.79
Mixed	115.9	28	40	163.4	1.41
Asian/Asian British	79.9	43	59	110.0	1.38
Black/Black British	239.0	31	42	324.2	1.36
Other Ethnicities	130.6	18	23	164.1	1.26
Unknown	-	-	210	-	-

Figure 4: Comparisons of TEWV detention rates by ethnicity (1.4.23 – 31.3.24)

Comparisons of TEWV detention rates by ethnicity					
Ethnicity	**White**	**Mixed**	**Asian/Asian British**	**Black/Black British**	**Other Ethnicities**
White		0.76	1.13	0.38	0.76
Mixed	1.32		1.49	0.50	1.00
Asian/Asian British	0.89	0.67		0.34	0.67
Black/Black British	2.61	1.98	2.95		1.98
Other Ethnicities	1.32	1.00	1.49	0.51	

Interpretation guide:
The rates are calculated against the row labels so if the figure is >1 the characteristic in the row label shows a higher detention rate than the comparator in the column label, if the figure is <1, they show a lower rate of detention.
An example of interpretation would be "per 100,000 population Black/Black British people are detained 2.61 times more than White people".

Figure 5: Comparisons of TEWV detention rates by ethnicity and gender (1.4.23 – 31.3.24)

Comparisons of TEWV detention rates by ethnicity and gender									
Ethnicity x Gender	**Asian/ Asian British - Female**	**Asian/ Asian British - Male**	**Black/ Black British - Female**	**Black/ Black British - Male**	**Mixed - Female**	**Mixed - Male**	**Other Ethnicities - Female**	**Other Ethnicities - Male**	**White - Female**
Asian/ Asian British - Female		1.03	0.25	0.48	0.75	0.61	1.00	0.52	0.86
Asian/ Asian British - Male	0.97		0.25	0.46	0.72	0.80	1.30	0.51	0.67
Black/ Black British - Female	3.95	4.08		1.89	2.96	2.41	3.97	2.07	3.39
Black/ Black British - Male	2.10	2.16	0.53		1.57	1.28	2.10	1.10	1.80
Mixed - Female	1.34	1.38	0.34	0.64		0.82	1.34	0.70	1.15
Mixed - Male	1.64	1.69	0.41	0.78	1.23		1.65	0.86	1.41
Other Ethnicities - Female	1.00	1.03	0.25	0.48	0.75	0.61		0.52	0.85
Other Ethnicities - Male	1.91	1.97	0.48	0.91	1.43	1.17	1.92		1.64
White - Female	1.17	1.20	0.30	0.56	0.87	0.71	1.17	0.61	
White - Male	1.08	1.12	0.27	0.52	0.81	0.66	1.09	0.57	0.93

Number of Cases of restraint, including type of restraint by ethnicity age and gender

Figure 6: Total Number of Restraint Interventions by Type (1.4.23 – 31.3.24)

Total Number of Interventions	No. Physical Interventions	No. Mechanical Interventions	No. Chemical Interventions	No. Isolation Interventions
	4748	29	1093	979

Figure 7: Number of Restraint Interventions by Gender (1.4.23 – 31.3.24)

Number of Interventions by Gender				
Gender	**No. Physical Interventions**	**No. Mechanical Interventions**	**No. Chemical Interventions**	**No. Isolation Interventions**
Birthsex Female - Gender Neutr	*<5*	0	0	0
Female (Including Trans Woman)	2659	7	594	187
Male (Including Trans Man)	1971	22	471	788
Non-Binary	*<5*	0	*<5*	0
Unknown	113	0	27	*<5*

Figure 8: Number of Restraint Interventions by Age (1.4.23 – 31.3.24)

Number of Interventions by Age				
Age Groupings	**No. Physical Interventions**	**No. Mechanical Interventions**	**No. Chemical Interventions**	**No. Isolation Interventions**
<20	773	*<5*	209	*<5*
20-29	1618	*<5*	263	720
30-44	886	20	175	200
45-64	611	*<5*	206	48
65+	757	0	221	5
Unknown	103	0	19	*<5*

Figure 9: Number of Restraint Interventions by Ethnicity (1.4.23 – 31.3.24)

Number of Interventions by Ethnicity				
Ethnicity	**No. Physical Interventions**	**No. Mechanical Interventions**	**No. Chemical Interventions**	**No. Isolation Interventions**
Asian/Asian British	91	0	13	*<5*
Black/Black British	39	*<5*	22	*<5*
Mixed	85	0	23	*<5*
White	4300	27	959	958
Other Ethnicities	19	0	13	0
Unknown	214	*<5*	63	14

Improved Access to CYPS for ages 0-17 (2023)

Figure 10: CYP Access by ethnicity

Ethnicity	Number of Patients
Asian/Asian British	201
Black/Black British	61
Mixed	336
White	25025
Other Ethnicities	144
Unknown	4090

Sample of locally agreed outcome metrics (2023)

Figure 11a & 11b: CROMS and PROMS CYP (2023)

CYP - CROM	
Ethnicity	% showing measurable improvement
Asian/Asian British	35%
Black/Black British	40%
Mixed	45%
Other Ethnicities	20%
Unknown	46%
White	46%

CYP - PROM	
Ethnicity	% showing measurable improvement
Asian/Asian British	17%
Black/Black British	67%
Mixed	23%
Other Ethnicities	0%
Unknown	16%
White	25%

Figure 12 a & 12b: CROMS and PROMS AMH/MHSOP (2023)

AMH/MHSOP - CROM	
Ethnicity	% showing measurable improvement
Asian/Asian British	19%
Black/Black British	31%
Mixed	24%
Other Ethnicities	13%
Unknown	23%
White	16%

AMH/MHSOP - PROM	
Ethnicity	% showing measurable improvement
Asian/Asian British	52%
Black/Black British	42%
Mixed	50%
Other Ethnicities	30%
Unknown	50%
White	44%

Appendix 2

Core Requirements of the Patient and Carer Race Equality Framework (PCREF)

Req No	Requirement Description	Activity	Staff Contact
1	Practices that work towards the shared values of dignity, fairness, equality, equity, respect, least restrictive practices, independence, empowerment and involvement are routinely published to national datasets (Mental Health Service Data Sets – (MHSDS) and Public Sector Equality Duty (PSED) objectives annually). Trusts and mental health providers should have in place a responsible lead person whose role will be to collect and monitor data broken down by ethnicity and publish the data at the end of each financial year. This should include at a minimum: 1. The number of cases of detention under the MHA, and the cause and duration of these detentions. 2. Restraint including the type of restraint (physical, mechanical, chemical or use of isolation) and by ethnicity, age and gender as aligned by the MHA Code of Practice guiding principles. 3. As required by Core20Plus5 Trusts: a. physical health checks for those adults (18+) with Severe Mental Illness (SMI). b. improve access rates to Children and Young People's mental health services for 0-17 year olds. 4. A sample of locally agreed access, experience and outcomes metrics where inequalities are the most evident. This may include Mental Health Act	See paper above re report on this activity	Hannah Crawford (Executive Lead) Data collection and review position currently (27.1.25.) vacant and preparing for recruitment.

	detentions (i.e. the duration of community treatment orders, out of area placements, aftercare placements and suicidal rates by ethnicity). 5. Trusts/mental health providers will report on any deaths in mental health inpatient units to CQC by protected characteristics. Please also refer to CQC's notifications on incidents.		
2	Trusts and mental health providers routinely provide accessible information in accordance with NHS England's Accessible Information Standard in regards to patients on their rights, complaints procedures, and advocacy services available to them.	We have an accessibility statement on our website: https://www.tewv.nhs.uk/accessibility/ We also have an accessibility roadmap: https://www.tewv.nhs.uk/about/publications/accessibility-roadmap-2023-2024/	Communications Officer (Stephanie Steel)
3	Trust and mental health providers board routinely reviews data on patient safety incidents and near misses this includes the inappropriate use of force, with an ethnicity lens applied, involving experts by experience.	• Patient Safety Partner (PSP) working group has been established which has brought together people with lived experience and staff members to discuss and co-develop the PSP role in line with the Patient Safety Incident Response Framework (PSIRF). The PSP role will play a lead role in developing the lived experience voice in the approach TEWV is taking to implementing PSIRF across the trust. • Lived Experience Directors for each Care Group are routinely invited to attend and contribute to Directors Assurance Panels where Patient Safety Incident Investigations (PSIIs) are reviewed and finalised. • A representative from the Patient Safety Team will attend the trust wide EDI&HR steering group from January 2025 onwards. • An initial review of existing data on patient safety incidents within ethnically diverse groups to identify key themes will be undertaken by the Patient Safety Team. The data will be broken down to geographical areas to enable comparisons to be made using local census data. The data will be presented to the trust wide EDI&HR steering group where key areas of future focus will be determined. Timescales to be confirmed at time of writing. • The Positive and Safe team review the numbers of incidents of restrictive practice by protected characteristic	Associate Director of Patient Safety (Amy Taylor) Head of Risk Management (Kendra Marley)

4	Trusts and mental health providers evidence that complaints received from racialised and ethnically and culturally diverse patients and carers are actioned appropriately. Refer to NHS Complaint Standards on what good standards are in actioning appropriately complaints.	Conversations have taken place with colleagues from Birmingham and Solihull Mental Health NHS Foundation Trust (one of the pilot sites) 26.9.24 who provided guidance around how they were able to capture this information. This information has been passed onto Head of Quality Data and Patient Experience who is exploring how to implement this.	Head of Quality Data and Patient Experience (Emma Haimes) Senior Equality, Diversity and Inclusion Lead, BSMHNHSFT (Manisha Panesar)
5	New policies and practices are assessed for their equalities impact on protected characteristics, especially ethnicity/race, and mitigating actions are clearly identified as aligned under the Public Sector Equality Duty (Equality Act 2010). Further, the Trust and mental health providers should demonstrate regular reviews of these policies and practices, with an equalities angle forming part of this.	Action is carried out during each EIA review.	Equality and Diversity Officer (Abigail Holder) Senior Information Compliance Officer (Martin Foran)
6	Trusts and mental health providers are to document treatment preferences through the use of Advance Choice Documents, and routinely review them with patients and carers from racialised and ethnically and culturally diverse communities.	The advanced care planning section in CITO should be used and should be reviewed and considered in line with care planning. There is also a replica of this section on the DIALOG assessment form so it is considered as part of the assessment and review process. There is an advanced care planning pathway that will support clinicians when to consider relevant parts however this is not currently live and will form part of later releases.	Head of EPR (Gemma Pickering)
7	Trusts and mental health providers evidence that feedback from culturally appropriate advocacy services have been actioned appropriately, and that any reasons for not actioning feedback are recorded.	Work that has started with advocacy services looking into the referral rates, awareness of different types of advocacy services available, supporting staff knowledge with when to refer and any current challenges faced such as the current waiting times. North East and North Cumbria People First have advised that there is a national pilot looking at culturally appropriate advocacy for which an update is due. They will share this update with TEWV and any appropriate support. The MHL department work closely with one of the main advocacy providers, 'We Are People First'. Work being lead by Mental Health Legislation Practitioner. Pilot work has been agreed which is starting in December 2024. This entails sessions taking place on two wards at Roseberry Park for both service users and staff, raising awareness of the different types of advocacy services, when to refer, what the services provide etc. These sessions will be led by advocates and co-facilitated by an expert by experience.	Associate Director of Mental Health Legislation (Rachel Ann Down) Mental Health Legislation Practitioner (Bethany Corbett) North East and North Cumbria: People First (Kellie Woodley)

		The main advocacy providers (Cloverleaf & People First) are both invited to the Multi-Agency MHL Operational Groups which take place quarterly, there is one for each Care Group. This also provides a forum for feedback to be discussed and actioned. Some individual ward/team based work being undertaken at place. The complaints policy also references where all complainants can obtain support, including the Advocacy Services the Trust uses.	
8	Trusts and mental health providers evidence that feedback and involvement from racialised carers have been actioned appropriately in line with the principles of The Triangle of Care, or where Trusts have embedded their local principles in supporting carers.	We currently do not collect demographics from Carers, but Patient & carer experience leads have confirmed that this will be included with the survey refresh from August 2025.	Patient and Carer Experience Team Manager (Karen Coleman)

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Tees, Esk and Wear Valleys
NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report to the Board of Directors	
Report Date:	13 February 2025
Date of last meeting:	13 January 2025 – 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
- Positive and Safe Care Quarter 2 and Mental Health Units Use of Force Act
- NYYS and DTVF Multi Agency Mental Health Legislation Operational Group Reports
- Summary Report from the Internal Mental Health Legislation Operational Group
- Mental Capacity Act/Deprivation of Liberty Safeguards
- Individual Case Study
- Revised policies: Section 117 MHA Aftercare Guidance, Death of a detained patient (procedure), Patients Correspondence, Section 136: Removal of mentally disordered persons without warrant.
- MHLC Workplan 2024/25 - noted

2a **Alert: The Committee alerts members of the Board to the following:**

- **Deprivation of Liberty (DoLS)**

Middlesbrough Local Authority wrote to the Trust in August 2024 explaining about significant backlogs with DoLS applications and assessment processes. This led to a large proportion of residents who received respite at Bankfields without an authorisation in place. The Trust responded with a letter from DAC Beachcroft to highlight concerns. A further meeting was due to be held in January 2025 between Beachcroft and Middlesbrough Legal Team.

2b **Assurance: The Committee assures members of the Board on the following:**

- **CQC MHA monitoring Annual Report and quarterly report** – there is good assurance regarding the oversight of inspection activity and completion of actions.
  Committee agreed that it would be helpful to have further discussion outside the meeting with the Executive Chief Nurse and chair of QAC about the governance and reporting for MHLC and QAC and the overlap between the cross-cutting themes following the outcome of CQC MHA inspections.

- **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 the reported period there was one discharge by the Hospital Managers (0.6%) and seven by the Tribunal (3.5%). One patient discharged by the Hospital Managers had been re-detained under the Mental Health Act 14 days following discharge. One of the section 3 discharges had been a patient subject to a CTO at the point the mental health team discharged them.

- **Section 136 –** There is good assurance that the legislative requirements for patients held in the Trust on a s136 are being met in all areas.
  The s136 report is currently skewed as it includes admissions to the s136 suite of people who were not brought there subject to s136. As clinical services are now capturing that information separately, the report to MHL Committee will only include those admitted to the s136 suite following being brought there subject to s136, as well as those admitted to wards as an outcome and all other outcomes.
  DTVF care group noted extra scrutiny was being given to the use of the 136 suite.

- **Section 132b –** there is substantial assurance that there is a robust escalation process in place for any patients who have not had their rights within three days of detention.

- There were 946 new detentions (973 in the last period), during the reported period and the escalation process was used 153 times – 16% (13% last quarter). Committee are keen to understand how proportionate the use of the escalation process is based on the various wards against the different bed base numbers.

	• **Positive and Safe Strategy** - Reasonable assurance on progress with the Positive and Safe Strategy. Analysis of Quarter 2 demonstrated an improving trend in many areas of restrictive practice; however incidents remain high within AMH services, particularly on female wards. Committee are keen to ensure that it hears about compliance with the Use of Force Act and further discussions will be held with the Executive Chief Nurse about the levels of assurance fed into Quality Assurance Committee and the MHL Committee. • **Mental Capacity 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 85%.	
2c	**Advise: The Committee advises the Board on the following:** • **Compliance with section 17 leave and time away from the ward** Reports were received from the DTVF and NYYS care groups on making improvements related to section 17 leave. DTVF proposed that there was good assurance that Trust wide service improvement outputs had improved staff knowledge of their roles and responsibilities. There was limited assurance from the period of three months post implementation that improvements have been made in compliance with section 17 leave standards. NYYS highlighted that whilst progress has been made, the position was similar to DTVF care group, in that sustainability would need to be evidenced over the coming months. Additional support has been provided to wards that need it most. The MHL team queried whether the small samples audited were after the forms had been returned for correction by the MHL Department, which could give a false assurance. This was unclear at the time, however ongoing audits to ensure a consistent change has occurred will remain in place. • **Internal Mental Health Legislation Operational Groups** There is good assurance that the Groups have identified key issues to take forward and to forge links with the Multi-Agency MHL Operational Groups. One of the workstreams includes the care groups exploring patients who have been subject to multiple uses of section 5 and some actions have been identified. The Research and Statistics teams are supporting a piece of work. Both internal MHL operational groups have identified that further targeted Mental Health Act and Mental Capacity Act training will be beneficial and this will be provided by the MHL team. • A **case study** was received, which set out the care of a 24 year old gentleman admitted to Lustrum Vale in January 2024 and discharged in December 2024, with a complex and long standing history with mental health services. where learning was demonstrated by teams working together to prevent individuals going absent without leave and ultimately this shared learning will help to prevent delayed discharges. The following policies/procedures were approved: • Section 117 MHA Aftercare Guidance • Death of detained patient procedure • Patients' Correspondence • Missing Patients Procedure • Section 136: Removal of mentally disordered persons without warrant	
2d	**Review of Risks**	No additional risks were identified.
Recommendation: The Committee proposes that the Board of Directors: *i) Note the report and confirm the levels of assurance provided across reporting.*		
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*	

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**

Date: **13 February 2025**

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**
442	Deed of easement related to the Chester Le Street Library site, Newcastle Road, Chester Le Street	Naomi Lonergan Interim Managing Director, DTVF Care Group 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.