MEETING OF THE BOARD OF DIRECTORS
Thursday 25th November 2021
at 1.00 p.m.

The meeting will be held via MS Teams

Board Members:
Board Members are asked to raise any questions for clarification on matters contained within the reports with the lead Executive Director prior to the meeting.

The 'chat' function on MS Teams should not be used during the meeting.

Governor/Public Observation:
Invitations to observe the meeting have been sent to all Governors and posted on social media and the Trust's website. Those responding will be sent instructions to join the event using MS Teams.

If you are observing the meeting please keep your microphone on mute. No questions or statements are allowed.

The timings provided in the agenda are indicative only.

Pre-Meeting Governor Session with the Chair:
The Chair has invited all Governors to join him for a pre-meeting question and answer session from **12.00 noon**. This provides an opportunity for them to raise any matters on the reports due for consideration during the meeting.

Joining instructions for the event have been circulated separately.

AGENDA

Standard Items (1.00 pm – 1.15 pm):

1	Apologies.	**Chair**	**-**
2	Chair's Introduction.	**Chair**	**Verbal**
3	To approve the minutes of the last meeting held on 28th October 2021.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	To review the Board Action Log.	**-**	**Report**
6	Chairman's Report.	**Chair**	**Verbal**
7	To note any matters raised by Governors.	**Board**	**Verbal**

Strategic Items (1.15 pm – 2.15 pm):

8	Chief Executive's Report.	**CEO**	**Report**
9	BAF summary report.	**Co Sec**	**Report**
10	To consider the Finance Report to 31st October 2021.	**DoF&I**	**Report**
11	To consider the Performance Dashboard Report as at 31st October 2021.	**Asst CEO**	**Report**
12	To approve the revised organisational governance structures.	**CEO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (2.15 pm – 3.00 pm):

13	(a) To consider updates from the Directors' Visits to: ▪ North Durham MH Liaison team ▪ Harrogate CMHT ▪ ICLS & Middlesbrough CMHT ▪ Redcar & Cleveland CMHT ▪ D&D Care Home Liaison Hub ▪ York CHAD (b) To discuss the future arrangements for Directors' visits.	**Board Members**	**Verbal**
14	To consider the report of the Quality Assurance Committee.	**Committee Chair (BR) DoN&G**	**Report**
15	To discuss the arrangements for patient stories at Board meetings.	**Chair**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (3.00 pm – 3.10 pm):

16	To consider the report of the People and Culture Committee.	**Committee Chair (SR) DoP&C**	**Report**

Matters for Information (3.10 pm – 3.15 pm):

17	To receive and note a report on the use of the Trust's seal.	**Co Sec**	**Report**

Exclusion of the Public (3.15 pm):

18	**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.* *Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information."*	**Chair**	**Verbal**

Paul Murphy
Interim Chair
19th November 2021

Contact: Phil Bellas, Company Secretary Tel: 01325 552312/Email: p.bellas@nhs.net

MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON 28th OCTOBER 2021 COMMENCING AT 1.00 PM via MS Teams

Present:
Mr P Murphy, Interim Chair
Dr C Carpenter, Non-executive Director
Ms J Haley, Non-executive Director
Prof P Hungin, Non-executive Director
Dr S Wright, Interim Medical Director
Mr J Maddison, Non-executive Director
Mrs B Reilly, Non-executive Director
Mrs S Richardson, Non-executive Director/Senior Independent Director/Interim Deputy Chair
Mr B Kilmurray, Chief Executive
Mr R Patton, Interim Chief Operating Officer
Mrs A Bridges, Director of Corporate Affairs and Involvement (Non-voting)
Mrs E Moody, Director of Nursing and Governance/Deputy Chief Executive
Mrs L Romaniak, Director of Finance, Information and Estates
Mrs S Pickering, Director of Planning, Commissioning, Performance and Communications/Assistant Chief Executive (Non-voting)

In Attendance:
Mr P Bellas, Company Secretary
Ms L Hughes, Interim Corporate Governance Advisor
Mrs W Johnson, Team Secretary
Ms D Oliver, Deputy Trust Secretary (Corporate)

Observers/Members of the Public
Dr S Baxter, Elected Public Governor
Ms H Griffiths, Elected Public Governor
Mr J Preston, Elected Public Governor
Mrs J Wardle, Elected Public Governor

Mr S Double, Alder UK
Ms Liu, Doctoral research, York University

21/07/1/158 APOLOGIES

1.1 Apologies were received from Dr S Dexter-Smith, Director of People and Culture (Non-voting).

21/07/2/159 CHAIRMAN'S INTRODUCTION

2.1 The Interim Chair welcomed everyone to the meeting. He formally welcomed Steve Wright, Russell Patton, Ann Bridges, Jill Haley and Charlotte Carpenter to their first Board meeting held in Public since they had joined the Trust.

2.2 He paid thanks to Miriam Hart for her chairmanship and wished her well for the future.

21/07/3/160 MINUTES OF PREVIOUS MEETING

3.1 **Resolved:** the minutes of the previous meeting held on 29 July 2021 were approved as a correct record and agreed to be signed by the Chairman.

21/07/4/161 DECLARATIONS OF INTEREST

4.1 There were no new interests declared and no declarations of interest received in relation to open agenda items.

21/07/5/162 PUBLIC BOARD ACTION LOG

5.1 The Board noted that there were no actions outstanding on the action log.

21/07/6/163 CHAIRMAN'S REPORT

6.1 Paul Murphy confirmed he was delighted to cover the Chair position on an interim arrangement with the support of Shirley Richardson, Non-executive Director. Over the last three weeks since taking on the Interim Chair Designate role he drew reference to the following:

6.1.1 One to one meetings had taken place with the Trust's Executive Director colleagues.
6.1.2 Locality Governor meetings had been held, this arrangement would continue going forward.
6.1.3 External meetings included ICS and Mental Health NHS provider Chair meetings.
6.1.4 Discussions with Liam Donaldson had proved most supportive. It had been agreed that future external meetings would be shared between Paul Murphy and Shirley Richardson.

6.2 The Interim Chair explained that, subject to COVID pandemic restrictions allowing, a face to face meeting would be held with Governors before the end of 2021.

6.3 **Resolved:** the Interim Chair's verbal report was noted.

21/07/7/164 MATTERS RAISED BY GOVERNORS

7.1 The Interim Chair reported that at the information meeting held with Governors prior to the Board meeting, Governors had queried why details on the temporary closure of Esk Ward at Scarborough were not included in Board papers. Governors felt this was a matter of public interest. Jules Preston, Elected Public Governor was unable to attend the meeting with Governors and had forwarded his queries to the Interim Chair to be put forward to the Board. The Interim Chair confirmed he would filter Jules's questions into discussions throughout the meeting.

7.2 In response, the Chief Executive explained that Esk Ward in Scarborough had been closed temporarily in response to staffing pressures. Russell Patton confirmed that work was taking place to find a medium-term solution to the current staffing issues. The feasibility of adopting recruitment and retention premiums is being explored. Work is also taking place with the crisis team to establish which patients can safely be discharged and only as a last resort would patients be transferred to other Trust resources. Following discussion, Jill Haley, Non-executive Director confirmed that she supported the proposals and had confidence in the explanations provided to temporarily close Esk Ward with patient safety being the primary rationale. The Interim Chair noted that the closure of Esk Ward was a temporary measure and the Board would be updated as appropriate going forward.

7.3 **Resolved:** the matters raised by Governors were received, discussed and noted.

21/07/8/165 CHIEF EXECUTIVE'S REPORT

8.1 The Chief Executive's Report was received and noted. The Chief Executive drew attention to the following:

8.1.1 The Care Quality Commission (CQC) feedback following their August 2021 Well Led inspection - The CQC well led inspection followed several weeks of inspections in relation to four core services (crisis and healthcare based places of safety, children and adolescent mental health services (CAMHS), adult mental health community services, and adult secure inpatient services (Forensics)). Initial feedback had been received from the CQC as previously reported to the Board. The Trust had developed and made progress against its action plan into the concerns raised by the CQC in advance of the final report being received. The Trust has been informed by the CQC that the final report is planned to be submitted to the Trust within the next few weeks for factual accuracy checks to be carried out before publishing on their website.

8.1.2 Integrated Care System (ICS) Development continued, and further guidance had been published, with legislation anticipated to be in place by April 2022. Leadership structures at the two ICS's that cover the Trust's footprint were progressing with interviews for the Chief Executive positions held earlier that month.

8.1.2.1 Sir Liam Donaldson, North East and North Cumbria ICS has been working with partners to design the system across the ICS footprint.

8.1.2.2 Sue Symington, Chair of York and Scarborough NHS Foundation Trust has been appointed as Chair designate of Humber Coast and Vale (HCV) ICS. HCV are progressing discussions through the multi sector Partnership Board and are currently consulting on transitional arrangements, future structure and key functions of the ICS.

8.1.2.3 Bev Reilly, Non-executive Director queried if the Trust was represented in the ICS Chief Executive appointments. In response, the Chief Executive explained that he and the Interim Chair had participated in the North East and Cumbria ICS Chief Executive appointment process.

8.1.3 COVID booster vaccinations and the 2021/22 staff flu vaccination programme were noted to be progressing well with plans in place to target any low uptake areas. The Flu Team continued to work closely with the Communications Team to raise awareness, which is in addition to information regularly included in the Chief Executive's Blog.

8.3 The clinical and operational leadership structure consultation had closed, which had resulted in over 300 people contributing. Feedback from the consultation exercise had resulted in several changes to structures, which had been incorporated into the business case that was planned to be presented to the Board at its meeting held in private later that day. It was noted that the proposals within the business case focussed on the Trust being clinically led, operationally enabled via collective leadership across a multi-disciplinary team. Discussions with staff were underway with staff being offered access to a range of support.

8.4 John Maddison, Non-executive Director queried if there was any update to report on the Tees Valley and York financial position. In response, Liz Romaniak provided an update on the plans across Tees Valley to develop a longer-term clinical strategy and it was noted work continued across York and Scarborough. The Interim Chair confirmed that further discussions would be taken forward at the Strategy and Resource Committee.

8.4 **Resolved:** the Chief Executive's Report was noted.

21/07/9/166 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

9.1 The Board Assurance Framework (BAF) summary report, which included risks that posed a threat to the achievement of the Trust's strategic objectives was received. It was noted that there had been one risk added to the BAF since the last meeting (financial sustainability) which was accepted.

9.2 **Resolved:** the Board Assurance Framework summary report was received, noted and accepted.

21/07/10/167 REPORT OF THE AUDIT AND RISK COMMITTEE

10.1 John Maddison, Non-executive Director, Chair of Audit and Risk Committee spoke to the Audit and Risk Committee key issues report, which was received and noted. He drew reference to the positive assurances received, which included the findings of the independent audit of the Trust's General Charitable Funds 2020/21; the continued reduction of overdue high and medium priority Internal Audit recommendations; and the findings of the Trust's self-assessment against the EPRR standards. The Committee were satisfied with the development of the BAF and requested that: recruitment and retention; quality; and regulatory action risks on the BAF were revisited and noted that improvements are required to risk management, which are planned to be taken forward through the Board Development Programme.

10.2 There were no significant matters of concern to bring to the Board's attention.

10.3 Bev Reilly, Non-executive Director reported that there were 45 quality risks included on the Corporate Risk Register aligned to the Quality and Assurance Committee. She welcomed changes to strengthen risk management going forward, which initiated discussion around the benefits of Non-executive Director cross Committee membership. The Interim Chair explained that consideration would be made to ensure cross membership can continue in future.

10.4 John Maddison reported that the Committee recommends that the Board approve the EPRR self-assessment, action plan and statement of compliance for submission to the Head of EPRR for Yorkshire and the Humber and approval of the Annual Report and Accounts of the Charitable Trust Funds for 2020/21 for submission to the Charity Commission.

10.5 **Resolved:** the Audit and Risk Committee report from the meeting held on 9 September 2021 was received and noted.

21/07/11/168 FINANCE (QUARTER 2) REPORT

11.1 The Finance Report as at 30 September 2021 was noted. Liz Romaniak drew reference to the year to date statement of comprehensive income, which showed a surplus of £5m (£3m) ahead of the submitted plan for a £4.7m surplus. The position was before £0.4m additional unplanned profit on disposal of fixed assets, which is excluded when assessing NHS provider financial performance.

11.2 The Trust's cash position showed a £83.6m balance, which is £0.7m ahead of plan; and funding had been included within budgets to support sickness absence.

11.3 As a result of COVID-19 national monitoring of the Use of Resources Risk Rating (UoRR) has been suspended. The Trust continues to assess the UoRR based on run rate assumptions approved in the first half of the 2021/22 financial year.

11.4 Work is taking place to draft budgets and workforce plans following the publication of the H2 planning guidance for the second half of 2021/22.

11.5 John Maddison, Non-executive Director queried the plans for the 2022/23 capital programme. In response, Liz Romaniak explained that the Trust is aiming to include non-recurrent schemes and it was noted that further discussion would take place at the next Strategy and Resource Committee.

11.6 Bev Reilly, Non-executive Director queried what arrangements are in place to review and monitor the safe staffing establishments and headroom allowances. In response Liz Romaniak explained that work was currently taking place, which would be reported to the People, Culture and Diversity Committee in future.

11.7 **Resolved:** the Finance Report for the period ending 30 September 2021 was received and noted.

21/07/12/169 PERFORMANCE (QUARTER 2) REPORT

12.1 The Performance Dashboard as at 30 September 2021 was received and noted. The Interim Chair congratulated Sharon Pickering on the progress made to provide an improved report format.

12.2 Sharon Pickering highlighted the 12 areas of concern and the mitigating actions in place, drawing reference to the following:

12.2.1 Access targets for patients seen within 4 weeks for their first appointment was below the 90% target at 82.66%; and patients receiving treatment within 6 weeks was below the 60% target at 52.35%. She confirmed the plans are in place with investment secured to help support the required improvements.

12.2.2 The number of staff appraisals was below the 95% target at 66.22%; and compliance with mandatory and statutory training was below the 92% target at 83.98%. Discussions were taking place across locality and corporate divisions to gain a greater understanding, which would help to inform action plans.

12.3 Shirley Richardson drew reference to Trust Dashboard reference number 15) Finance Vacancy Rate and explained that the People, Culture and Diversity Committee is due to meet for the first time on 16 November 2021. The Committee would look at this in greater detail.

12.4 Bev Reilly, Non-executive Director confirmed that she found the Executive Summary within the report most valuable but some information was difficult to read. In response Sharon Pickering explained that there had been marginal improvements made but this was not reflected in the information provided to date due to the statistical process control (SPC) tool used. It was anticipated that if improvements continued this would be reflected in future reports.

12.5 Discussion took place around the work underway to gain a greater understanding on: Adult and Older Persons outcomes, particularly in Durham and Darlington; the number of patients referred was higher than expected; completed patient assessment forms; patient discharges in Tees; and the number of patients in beds in excess of 90 days.

12.6 It was noted that the Trust has work underway to look at the requirements needed to ensure capacity is optimised specifically to operationalise referrals. Externally, discussions continue with partner organisations including acute NHS providers over the importance of early intervention and creativity around waiting list strategies.

12.7 The Board acknowledged that staff are working very hard to support the Trust's plans to provide safe, quality care.

12.8 **Resolved:** the Performance Report as at 30 September 2021 was discussed and noted.

21/10/13/170 NHS ENGLAND CORE STANDARDS FOR EMERGENCY PREPARDNESS RESILIENCE AND RESPONSE

13.1 The Board noted that the Audit and Risk Committee had reviewed the Trust's Emergency Preparedness Resilience and Response (EPRR) self-assessment, which was led by NHS England and Improvement via the Local Health Resilience Partnerships. The Audit and Risk Committee had confirmed their assurance and approval in relation to the Trust's and commissioners' preparedness against the core standards and its ability to effectively respond to emergency planning and business continuity whilst maintaining services to patients. Following consideration, the Board supported the approval.

13.2 **Resolved:** the Emergency Preparedness Resilience and Response self-assessment, action plan and statement of compliance was approved for submission to NHS England and Improvement by 29 October 2021.

21/10/14/171 WINTER PREPAREDNESS

14.1 The Winter Preparedness paper, which included a summary of the Trust's planned response to manage and respond to challenge during Winter 2021/22 was received and assurances noted.

14.2 Bev Reilly, Non-executive Director queried if the Trust had undertaken a desk top winter preparedness review with NHS England and Improvement. In response, Russell Patton confirmed that a desk top exercise had taken place earlier that day and the Trust had contributed. The Chief Executive added that this is a live process and there were many other system planning exercises ongoing.

14.3 Jill Haley, Non-executive Director thanked Russell Patton for the standard of the Executive Summary, which she found most useful.

14.4 **Resolved:** the Winter Preparedness paper was received and noted.

21/10/15/172 QUALITY ASSURANCE COMMITTEE REPORT

15.1 Bev Reilly, Non-executive Director, Chair of Quality Assurance Committee (QAC) spoke to the QAC report from meetings held on 2 September and 7 October 2021. She explained that Shirley Richardson had chaired the October 2021 meeting in her absence and confirmed that there were no actions to be escalated to the Board for consideration. She was pleased to report that she had met with Jill Haley and Ann Bridges to discuss the opportunities to recognise staff for their commitment and hard work going forward.

15.2 Bev Reilly drew reference to the following of note:

15.2.1 Staff health, wellbeing and morale continued to be of concern due to the continued pressures.

15.2.2 Director visits attended earlier that week observed the increased acuity of patients with one patient requiring a 1:5 ratio of care. The visit had been beneficial to help triangulate information from what is reported and discussed at Committee and Board meetings together with the personal observations.

15.2.3 Quality and Safety Corporate Risk management process and the plans in place to improve the risk management process - there are plans in place to appoint a Risk Manager to support this area of work.

15.2.4 Verbal updates received from the CQC/NHS England and Improvement/TEWV Quality Improvement Board, which continued to monitor the CQC Action Plan. There are plans in place to oversee a combined action plan, which will incorporate the various action plans.

15.2.5 Trust level quality assurance and learning, which is planned to be further discussed at the QAC Development Day. Any additional actions following receipt of the pending CQC report will be included.

15.2.6 Gold Command and Senior Leadership Team oversight on bed occupancy, which the Committee was pleased to note.

15.3 The Chief Executive explained that the staff restructure will help to drive forward and embed the required changes to quality and culture. This will be achieved through a multidisciplinary way of working, that is clinically led and supported by quality governance structures to ensure quality and patient safety; people, culture and diversity; finance, business developments, strategy and risk management are covered from ward to Board.

15.4 Charlotte Carpenter queried if the increase in acuity of patients was attributable to the COVID pandemic. In response, Russell Patton explained that the cohort of patients had seen a notable change over recent years before the onset of the COVID pandemic.

15.5 The Interim Chair raised a question received from Jules Preston, Elected Public Governor prior to the meeting with regards to number of outstanding approvals for Datix Incidents. In response Elizabeth Moody explained that the Trust had experienced a delay in reviewing and signing off Datix Incidents but had put measures in place throughout this time to oversee and sign off those categorised as moderate and high harms. Following focussed effort over the last few months the number had significantly improved and the backlog now minimal. She advised that the Trust is still experiencing delays in completing Serious Incidents within the 60 day target and there was a recovery plan in place to address this.

15.6 The Interim Chair drew reference to the number of risks on the BAF and Corporate Risk Register aligned to the Quality and Assurance Committee, covering the quality and patient safety agenda. He thanked Shirley Richardson and Bev Reilly for their chairmanship whilst seeking assurances on key agenda items. He was pleased to report that there are plans in place to introduce a Patient Story at the beginning of Board meetings held in Public in the near future.

15.7 **Resolved:** the Quality Assurance Report from meetings held on 2 September and 7 October 2021 was received and noted.

21/10/16/173 LEARNING FROM DEATHS (QUARTER 2) REPORT

16.1 The Learning from Deaths report was received, which outlined the Trust's approach to identifying categorising and investigating deaths in line with national guidance.

16.2 It was noted during the reporting period there had been 15 deaths reported as Serious Incidents: 14 within the community; one unexpected in-patient death and there were 286 cases that met the mortality review criteria. Serious Incident reviews had taken place with the learning obtained from 18 reviews identifying themes in relation to care planning, risk assessment, record keeping, safeguarding and lack of compliance with clinical pathways.

16.3 Jill Haley, Non-executive Director queried the two-month pilot, which is due to commence on 4 October 2021, entitled Trying New Ways of Working. In response, Elizabeth Moody explained that the pilot exercise will use personalised plans based on need using DIALOG

to support the care planning process. This is a paper based process used by an outstanding NHS provider. This process will be supported by the introduction of a ward information booklet that includes non-personalised plans such as the right to privacy and dignity with the outcome of the pilot overseen by the Quality Improvement Board and the Clinical Leaders Group and reported to the Board through the Learning from Deaths report.

16.4 It was noted that there were no actions to escalate to the Board.

16.5 **Resolved:** the Learning from Deaths Dashboard and lessons learned for the period ending 30 September 2021 was received and noted.

21/07/17/174 MENTAL HEALTH LEGISLATION COMMITTEE

17.1 Pali Hungin, Non-executive Director and Chair of the Mental Health Legislation Committee (MHLC) spoke to the report from the meeting held on 21 October 2021. He explained that several items discussed were in relation to patient safety and quality, which initiated discussion around the role of the MHLC and the role of the Quality Assurance Committee. It was noted that the feasibility of forming task and finish groups when required to take forward areas of work reporting into the Quality Assurance Committee was being considered. It was noted that Pali Hungin, Elizabeth Moody and Bev Reilly would meet outside of the meeting to discuss further. **ACTION (P Hungin, E Moody, B Reilly)**

17.2 It was noted that there were no matters to escalate to the Board for action.

17.3 **Resolved:** the Mental Health Legislation Committee report from the meeting held on 21 October 2021 was received and noted.

21/07/18/175 GUARDIAN OF SAFE WORKING QUARERLY REPORT

18.1 The Guardian of Safe Working quarterly report was presented by Jim Boylan, the Trust's Guardian of Safe Working. He explained that there continued to be an impact on working conditions for all staff, including junior doctors following the COVID pandemic. Over the reporting period there had been an increase in staff sickness absence as a result of staff suffering from COVID or requiring self-isolation.

18.2 It was noted that following concerns raised, Esk Ward at Scarborough had been closed with mitigating actions put in place. The Trust continued to monitor and review the process for exception reporting to ensure timely reporting going forward by Junior Doctors.

18.3 Steve Wright explained that he will continue to meet with Jim Boylan on a regular basis and it is essential that the Junior Doctors feel their contributions are valued and that they are listened to. He drew reference to the outcome of the GMC Survey, which the Board were pleased to note confirmed the Trust as top in the region.

18.4 **Resolved:** the Guardian of Safe Working Quarterly Report was received and noted.

21/07/19/176 CHARITABLE TRUST FUNDS ANNUAL REPORT AND ACCOUNTS

19.1 The Charitable Trust Fund Annual Report and Accounts (2020/21) were reviewed and approved by the Audit and Risk Committee at its meeting held on 9 September 2021 for submission to the Board for formal approval.

19.2 The Board noted that the overall balance of the funds as at 31 March 2021 was £618,000 and the CTF increased by £179,000, which was mainly in relation to grants received from

NHS Charities Together. The independent audit carried out by Mazars found no material matters to draw attention to, or to suggest that the accounts had been compiled incorrectly.

19.3 The Board were pleased to approve the Charitable Trust Funds Annual Report and Accounts for the period ending 31 March 2021 for submission to the Charities Commission.

19.4 **Resolved:** the Charitable Trust Funds Annual Report and Accounts for the period ending 31 March 2021 were unanimously approved for submission to the Charities Commission.

21/07/20/177 REVIEW OF ARRANGEMENTS FOR BOARD OF DIRECTORS UP TO 31 MARCH 2022

20.1 The Interim Chair proposed that the frequency of Board meetings held in Public revert to monthly (subject to the December recess) with a review of this arrangement taking place in Spring 2022; and reflecting on Board visits should be factored into future Board agendas to enable formal feedback to the Board.

20.2 The Board supported and approved the proposals and noted that the Board meetings would meet monthly with immediate effect. **ACTION (P Bellas)**

20.2 **Resolved:** Board meetings held in Public will take place monthly with immediate effect (subject to the December recess) and the arrangement would be reviewed in Spring 2022.

21/07/21/178 APPOINTMENT OF NON-EXECUTIVE DIRECTOR CHAIRS AND MEMBERS OF BOARD COMMITTEES

21.1 The Interim Chair reported that consideration is being given to appoint up to two Associate Non-Executive Directors to support the capacity on the Board. In accordance with Standing Order 6.7 it was proposed that subject to formal appointment Associate Directors would be granted voting rights (when attending meetings as either full or deputy members) in order for the Committees to operate effectively, which was considered and approved.

21.2 It was proposed that the Terms of Reference of the Strategy and Resources Committee should be amended to increase the number of Non-Executive Directors seats to two, which was considered and approved.

21.3 **Resolved:** following appointment of Associate Non-executive Directors voting rights would be granted (when attending Committee meetings as either full or deputy members) to enable Committees to operate effectively.

21/07/22/179 REPORT ON REGISTER OF SEALING

22.1 **Resolved:** in accordance with Standing Order 15.6, the Board received and noted the update report on the use of the Trust Seal.

21/07/23/180 CONFIDENTIAL MOTION

23.1 **Resolved:** 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 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.

Any advice received or information obtained from legal or financial advisers appointed by the Trust or action to be taken in connection with that advice or information.

Information which is held by the Trust with a view to its publication, by the Trust or any other person, at some future date (whether determined or not), and it is considered reasonable, in all the circumstances, to withhold the information from disclosure until that date.

Following the transaction of the confidential business the meeting concluded at 3.20 pm.

Paul Murphy
Interim Chair
25 November 2021

Board of Directors

Public Action Log

RAG Ratings:

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

Date of Board Meeting	Minute Ref No.	Action	Owner(s)	Timescale	Update	Status
28 October 2021	21/07/17/174/17.1	MENTAL HEALTH LEGISLATION COMMITTEE - Pali Hungin, Elizabeth Moody and Bev Reilly would meet outside of the meeting to discuss the feasiblity of task and finiish group(s) if necessary to take forward specific items to provide assurance to the Quality Assurance Committee	E Moody, P Hungin, B Reilly	25 November 2021	Update to be provided at the meeting	Open
28 October 2021	21/07/20/177/20.2	REVIEW OF ARRANGEMENTS FOR BOARD OF DIRECTORS UP TO 31 MARCH 2022 - The Board supported and approved the proposals and noted that the Board meetings would meet monthly with immediate effect	P Bellas	05 November 2021	Completed, meeting dates set	Completed

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 25 November 2021**
TITLE:	**Chief Executive's Report**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Information**

This report supports the achievement of the Strategic Goals:	
To co-create a great experience for our patients, carers and families	✓
To co-create a great experience for our colleagues	✓
To be a great partner	✓

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

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

Care Quality Commission

Following the core services and well led inspections that took place between June and August this year the Trust has received the confidential draft reports and has had the opportunity to complete a factual accuracy check and submit comments. The CQC visited: Rorensics; CAMHS; Adult Mental Health Community Services; Crisis and Health Based Places of Safety.

The CQC will review our submission and work towards publication of the report. The CQC anticipate that this could be on the week commencing 6 December.

Until the report is finalised we cannot say a great deal publically, Board members have received a copy of the draft and there was a briefing at our development session on 2 November. I can confirm that the Trust has started to make progress with action planning and implementing a number improvements, specifically within Forensics and CAMHS.

A communications plan is being developed.

Structures Update

Further to agreement of the business case at the October Board meeting we are now well underway with implementation. The Managing Director roles are out to recruitment and the rest of the Care Group Board level roles will be progressed over the coming weeks. Similarly the General Management tier will be progressed during December. Service Management tier roles will be progressed from the beginning of January.

The People and Culture team are preparing the organisational development and leadership training, which all postholders in each of the new structures will be required to participate in.

Separate to the clinical and operational structure implementation we are also progressing the appointment of the Director of Estates, Facilities and Capital role, which is required as a result of Paul Foxton's planned retirement in the New Year.

Integrated Care Systems Update

Since last months report the appointment of Sam Allen as Chief Executive of the North East and North Cumbria ICS has been announced. Sam is currently the Chief Executive of Sussex Partnership NHS FT, a mental health and learning disability provider. Humber, Coast and Vale ICS has yet to announce the appointment of their CEO.

Development work in both ICSs has been focussed on the constituitions of the Integrated Care Boards. As yet these are not finalised for submission to NHS England and Improvement. They will include details on membership of the Board including provider representations. In both ICSs the Trust has submitted comments requesting that mental health, learning disability and autism services are represented at Board level.

Veterans Covenant

The Trust has recently made a commitment to sign the Veterans Aware Covenant. Colleagues have been working with governors and involvement volunteers who are veterans and have lived experiences of services. The commitment is to raise awareness of veterans and seek to better accommodate veterans' needs, this will involve initially identifying veterans, understanding if they have any additional needs, and signposting extra services available within the community. There is also an opportunity for us to ensure we engage with veterans more proactively as part of our co-creation approach. And additionally we are interested in the Defence Employer Recognition Scheme, which requires us to make a commitment to employing reservists, veterans and military spouses.

A working group has been established to take this forward, which involves people with lived experience. Additionally, I have had an initial meeting with the

Commanding Officer of Catterick Garrison to discuss how we might work together on this important agenda.

2021/22 Staff Flu and Covid-19 Booster Vaccination Campaign

The Trust's 2021-22 staff flu vaccination programme is now into its 5th week with many clinics and vaccinations taking place across the Trust since then, lots of clinics are planned for the rest of November and localities are also planning clinics for the first three weeks of December and into January 2022.

The Trust continues to work closely with the acute trusts to deliver boosters; South Tees, County Durham & Darlington and York & Scarborough. Staff have also been accessing boosters via GPs, community pharmacists and local vaccination centres.

Flu vaccination uptake was 39% (frontline healthcare workers) and 42% (Trust staff overall) as at 11 November 2021. This is down from 49% on the corresponding period in 2020. NHSE/I are reporting our frontline uptake at 42%. Booster vaccination uptake was 27% (frontline healthcare workers) and 27% (Trust staff overall) as at 11 November 2021. NHSE/I are reporting our frontline uptake at 57% frontline and 46% total. The Trust data does not match with NHSE/I reporting. The issue relates to the challenges of some staff receiving vaccinations from a number of different external organisations, how this is recorded and also how extensively we are receiving such notifications from Trust staff themselves; to date staff in record numbers are having their flu vaccination at their GP practice and uptake of the booster is greater in other venues than the acute trusts.

It is estimated that flu vaccination levels for the Trust overall will be around the same levels as this time in 2020 if not higher by later in December as flu clinics will be able to continue late into December and into January 2022 which the Trust was not able to do last year due to the need to concentrate on the Covid vaccination programme. Although we are comfortable with these timelines they don't reflect the urgency with which the region is following up with individual trusts.

Weekly flu vaccination uptake reports are circulated to localities and members of the Trust's flu group. Low uptake areas in localities and services are being targeted following analysis of the first low uptake report. There has been a focus on improving uptake in Forensic services with additional clinics, assistance from the IPC flu nurse to provide extra vaccination opportunities, late training provided to an experienced Chief Flu Fighter who had been on sickness leave to enable them to vaccinate going forward for the rest of the 2021-22 campaign and clinics being arranged for Selby in North Yorkshire and York locality. We expect localities to also undertake their own analysis of this data to assist their decisions as to where to focus resources.

Three flu prize draws have taken place since 25 October, 15 staff each week can win a Love to Shop gift card as an incentive/thank you for having their flu vaccination, lots of positive reactions have been received from staff who have already won this campaign, draws will continue until 23 November with a possible extra draw before Christmas.

Flu operational huddles with locality/MDT representatives continue to take place each week to allow issues to be raised and solutions implemented.

The flu team continue to work daily on progressing the campaign, data inputting into the national vaccinations database, cleansing data, advising staff with flu vaccination queries and helping with booking appointments and offering support to operational localities and Chief Flu Fighters to ensure the best flu campaign across the Trust is offered.

The Team continue to work closely with the Communications Team to raise awareness of the staff flu & booster vaccination campaign across Trust platforms such as the intranet and within the Enquiries bulletin, Brent's Blog has also referenced the campaigns a number of times and there has been a recent desktop message featured about 'Boosting your Immunity'

At the current time the Trust is required to submit a weekly action plan to NHSE/I advising on how we will be working to improve our vaccination uptake position and providing a response to a number of specific questions. The Trust is not unique in this as a number of Trusts regionally and nationally are in the same position.

Mandatory COVID Vaccination

The Trust is currently awaiting further guidance. At the moment we know the following:

- Applicable staff will be required to have both primary doses of the Covid vaccine before 31st March.
- The booster dose is not currently part of the mandated vaccines.
- According to NHSE&I the Trust's rates were 95% uptake for dose 1 and 93% for dose 2.
- We are currently working through the data to identify staff who have not completed or started the primary course.
- We are mapping out who goes into clinical areas across all our services including corporate.
- Q&A sessions have been arranged for staff who would like to ask further questions about having the vaccine.

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th November 2021**
TITLE:	**Board Assurance Framework – Summary Report**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Report:

The Board Assurance Framework (BAF) is a key means of providing assurance to the Board that the Trust's strategic risks are being managed effectively across the organisation.

The schedule, attached as Annex 1 to this report, highlights the alignment between the BAF risks and the matters for consideration at the meeting.

It is intended to support the Board, in its discussions, to focus on the strategic risks.

Recommendations:

The Board is asked to note this report.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade (& Movement)	Indicative Controls Assurance Rating	Risk Management Approach	Related Agenda Items
	1	2	3						
1	✓	✓		**Recruitment and Retention** Inability to recruit and retain sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services	**DoP&C**	**Very High** ↑	**Reasonable**	Score significantly above tolerance Strengthening of controls required, at pace, to reduce exposure to tolerable levels	Public Agenda Item 14 – Report of the Quality Assurance Committee Public Agenda Item 16 – Report of the People Culture and Diversity Committee
2	✓			**Demand** Demand for our services, particularly as a result of the post-Covid surge, might result in us not being able to meet patient/carer expectations or commissioner requirements	**COO**	**High** ↔	**Reasonable**	Opportunities to improve controls; however, new controls (if available) are required to reduce exposure to tolerable levels	Public Agenda Item 12 – Revised Organisational Governance Structures Public Agenda Item 11 – Performance Dashboard Public Agenda Item 14 – Report of the Quality Assurance Committee
3	✓			**Involvement and Engagement** A fragmented approach to service user and carer engagement and involvement might prevent us from co-creating a great experience	**DoC&I**	**High** ↔	**Good**	Present controls are, generally, considered to be operating effectively; however, achievement of the target risk score is dependent on the implementation of identified new controls.	-
4	✓			**Experience** We might not always provide a good enough experience for those who use our services, their carers and their families, in all places and all of the time (see also BAF refs 1 (recruitment and retention) and 6 (Learning))	**DoN&G**	**High** ↔	**Good**	Controls are, generally, considered to be operating effectively; however, further strengthening is required, at pace, to reduce exposure to tolerable levels	Public Agenda Item 14 – Report of the Quality Assurance Committee

5	✓	✓		**Culture & Wellbeing** Pockets of poor culture or low staff wellbeing could undermine our ability to provide a safe and sustainable service as well as putting individual staff and patients at risk of harm	**DoP&C**	**High** ↔	**Reasonable**	Controls need to be strengthened. This is required at pace, through the delivery of mitigations, to reduce the risk to tolerable levels.	Public Agenda Item 16 – Report of the People Culture and Diversity Committee
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	**DoN&G**	**High** ↔	**Good**	Controls are, generally, considered to be operating effectively; however, further strengthening, through the delivery of mitigations, is required at pace to reduce the risk to tolerable levels.	Public Agenda Item 12 – Revised Organisational Governance Structures Public Agenda Item 14 – Report of the Quality Assurance Committee
7	✓	✓	✓	**Infrastructure** Poor quality physical or digital infrastructure could impede our ability to co-create a great experience both for staff and for patients [excludes CITO (see risk 14), Cyber security (see risk 8) and RPH (see risk 12)].	**DoF&I**	**Medium** ↔	**Good**	The risk is within tolerance and controls are operating effectively. Continued delivery of mitigations is required to achieve target score.	Private Agenda Item 4 – Chief Executive's Report Private Agenda Item 5 – Report of the Strategy and Resources Committee
8	✓	✓	✓	**Cyber Security** A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage	**DoF&I**	**Very High** ↔	**Reasonable**	Ongoing strengthening of controls required due to the constantly evolving nature of the risk	Private Agenda Item 5 – Report of the Strategy and Resources Committee
9	✓	✓	✓	**Regulatory Action** Further regulatory action could result in loss of confidence and affect our reputation among service users, staff, and other key stakeholders (see also BAF ref. 11 – Governance and Assurance)	**CEO**	**High** ↔	**Good**	Controls considered to be operating effectively and scope for improvements limited. Higher degree of exposure than acceptable will need to be tolerated. Regular monitoring of the risk advisable.	Private Agenda Item 4 – Chief Executive's Report Public Agenda Item 14 – Report of the Quality Assurance Committee

10			✓	**Influence** Changes in the external environment, and insufficient capacity to respond or to align our objectives with those of partners, might lead to loss of strategic influence and reputation	**Asst CEO**	**High** ↔	**Good**	The risk is within tolerance. Further strengthening of controls required through the delivery of mitigations to achieve target score.	Private Agenda Item 5 – Report of the Strategy and Resources Committee Private Agenda Item 6 – Report of the Commissioning Committee
11	✓			**Governance & Assurance** The absence of a clear line of sight from ward to Board, due to ineffective governance and assurance processes, could result in the inconsistent quality of services and increased risks to patients	**CEO**	**High** ↔	**Good**	Urgent action to be taken to strengthen controls but a higher degree of exposure than acceptable will need to be tolerated. Regular monitoring of the risk advisable.	Public Agenda Item 12 – Revised Organisational Governance Structures Public Agenda Item 14 – Report of the Quality Assurance Committee Private Agenda Item 4 – Chief Executive's Report
12	✓	✓	✓	**Roseberry Park** The necessary Programme of rectification works at Roseberry Park and associated legal case could adversely affect our service quality/safety and financial, reputational and regulatory standing	**DoF&I**	**Very High** ↔	**Good**	The risk score is significantly in excess of tolerance. Urgent action is required to reduce exposure.	Private Agenda Item 4 – Chief Executive's Report
13	✓	✓	✓	**West Lane** The outcome of the independent enquiry, coroners' investigations, and civil legal actions could affect our reputational and regulatory standing	**CEO**	**Very High** ↔	**Good**	Opportunities to strengthen controls but this will have a limited impact due to third party decision-making. Exposure above tolerance will need to be accepted.	-
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	**DoFI**	**High** ↑	**Good**	Whilst controls are, generally, considered to be operating effectively further strengthening is required at pace, through the delivery of identified mitigations, to reduce exposure to tolerable levels	Private Agenda Item 5 – Report of the Strategy and Resources Committee

15	✓	✓	✓	**Financial Sustainability** Failure to gain a fair share of resources for the Trust and mental health could impact on the delivery of Our Journey to Change and the sustainability of services	**DoFI**	**High (New)**	**Good**	Although controls are generally operating effectively, action is required where practicable due to national/regional constraints, to reduce the risk score to target (within tolerance) through the delivery of identified mitigations	Public Agenda Item 10 – Finance Report Private Agenda Item 5 – Report of the Strategy and Resources Committee

Tees, Esk and Wear Valleys
NHS Foundation Trust

Item 10

PUBLIC
BOARD OF DIRECTORS

DATE:	**25th November 2021**
TITLE:	**Finance Report for Period 1 April 2021 to 31 October 2021**
REPORT OF:	**Liz Romaniak, Director of Finance, Information and Estates**
REPORT FOR:	**Assurance and Information**

This report supports the achievement of the Strategic Goals:	
To co-create a great experience for our patients, carers and families	✓
To co-create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

The Month 7 report continues to reflect performance within the context of national financial arrangements supporting the NHS to respond to the Coronavirus Pandemic.

National planning guidance was released for the second 6 months (H2) on 1st October and detailed run rate analysis indicates a H2 surplus of (£47k) is expected, providing a full year planned surplus of £5.1m. Plans were submitted during November following approval at Senior Leadership Group (SLG) and Strategy and Resources Committee who will recommend the plan for private Trust Board approval. As plans were not due to be submitted in time for month 7 reporting, national guidance advised that in-month budgets should match actual income and expenditure for month 7, meaning there are no in-month variances from plan.

Full year Integrated Care System (ICS) capital envelopes were confirmed in March 2021, allowing organisation level funding to be agreed. We will work with ICS colleagues when more is understood about the implications of the Comprehensive Spending Review on capital resource assumptions for the next 3 years.

- **Statement of Comprehensive Income:** The year to date position is a surplus of £5.4m, which is £0.3m ahead of the planned £5.1m surplus (a H1 brought forward variance). This is before £0.4m additional unplanned asset disposal profits, which are excluded when assessing NHS provider financial performance.
- **Capital Programme:** Annual capital requirements were prioritised in a 2021/22 programme that was affordable within the Trust's ICS allocation of £13.6m. Schemes were impact assessed to inform the final plan. Capital expenditure is £0.2m above plan. Three delayed planned asset sales take aggregate net expenditure to £0.9m above plan at month 7. In July commitments and phasing were re-forecast and net expenditure is behind the re-forecast by £0.3m, with a number of minor schemes commencing later than anticipated. The Trust expects to fully commit the £13.6m annual capital allocation.
- **Cash:** Balances are £89.4m, or £7.1m ahead of plan, with details in section 3.7.

Recommendations:

The Board of Directors is requested to receive the report, consider the issues and risks raised and any related further assurances needed.

1. INTRODUCTION & PURPOSE:

This report sets out the financial position for month 7 of 2021/22; 1 April to 31 October 2021 against a planned surplus of £5.1m.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 This report will enable the Board of Directors to monitor the Trust's key financial duties and key performance indicators (KPIs) which are both statutory requirements. Appendix 1 provides an overview of the Trust's KPIs for the year to date.

2.2 NHS Improvement's (NHSI) Use of Resources Rating (UoRR) evaluates Trusts based on ability to service debt, liquidity, income and expenditure (I&E) margin, achievement of planned I&E margin, and agency expenditure.

2.3 National financial arrangements operated throughout 2020/21 and H2 block funding mechanisms continued into 2021/22 to support the NHS in responding to the Covid-19 pandemic. The Trust supported the submission of high level systems plans for H1 that would deliver a H1 surplus of £4.7m for the Trust and a breakeven plan for the Tees Valley 'place' and wider North East and North Cumbria Integrated Care System (NENC ICS). It is important to note however that the Trust's H1 funding incorporated £9.1m net (of a £3m required minimum surplus) non-recurrent income allocated at 'place' level for growth and Covid costs, meaning an underlying recurrent deficit position for the same period at plan. This was largely due to the pump priming of £5.4m adult acute and forensic inpatient staffing investment. In subsequent months three out of four host CCG partners were able; through our collaborative Mental Health Partnership Boards, to support £3.1m (of £3.6m in aggregate) of the related CCG commissioned adult acute inpatient investment.

2.4 The Trust submitted its H2 plan in November with an anticipated surplus position of £47k for H2. This results in a £5.1m surplus for the financial year. Included within this plan is an efficiency requirement of £1.8m. Due to the timing of planning submissions, national guidance advised that month 7 plans should equal performance in month, meaning there would be no movement from the month 6 variance from plan.

2.5 The NENC ICS received a 2021/22 allocation from the national capital departmental expenditure limit (CDEL) at the end of March 2021. The ICS envelope of £185m was less than the sum of organisations' composite 'aspirational' plans. Individual plans were re-visited and prioritised on a more consistent 'pre-commitment' and 'safety' basis, to inform envelopes for individual organisations. The Trust's capital funding envelope on this basis is £13.6m.

2.6 Planning guidance for 2022/23 is not expected until mid-December 2021, with ICS-level allocations anticipated alongside (or potentially soon-after), with draft

planning submissions expected in February 2022 and final plans in March 2022.

3.1 Key Performance Indicators (KPIs)

Appendix 1 provides a summary of KPIs for the period ending 31 October 2021.

3.2 Statement of Comprehensive Income – Year to date

The Trust is reporting a year to date surplus of £5.4m at month 7, which is £0.3m ahead of its draft plan. Excluded from the Trust's £5.4m surplus is an adjustment relating to a profit on disposal of land in July of £0.4m. This adjustment is excluded when assessing NHS provider performance financially and is therefore included as a 'below the line' adjustment at Table 1.

Performance is summarised in table 1:

Table 1	**Year to Date**		**YTD**	**YTD**
	Plan	**Actual**	**Variance**	**Last Month Variance**
	£0	**£0**	**£0**	**£0**
Income From Activities	225,582	231,366	-5,784	-5,784
Other Operating Income	11,342	11,707	-365	-365
Total Income	**236,924**	**243,073**	**-6,149**	**-6,149**
Pay Expenditure	-186,920	-191,905	4,985	4,985
Non Pay Expenditure	-40,590	-41,454	864	864
Depreciation and Financing	-4,306	-4,304	-2	-2
Surplus / (Deficit)	**5,108**	**5,410**	**-301**	**-301**
Profit on sale of Assets	0	420	-420	-420
Surplus / (Deficit) incl adjustments	**5,108**	**5,830**	**-721**	**-721**

Income from patient care activities was £5.8m higher than plan, with additional income received including for Mental Health spending review allocations that were clarified after plan submission. Pay award outcomes, and related national funding of £4.2m was also not known or included in the plan.

Other operating income is £0.4m higher than planned due to increased research and development and non-patient care income not anticipated at plan.

Pay expenditure was £5.0m higher than planned due to:

- £4.2m nationally determined pay award not confirmed at plan;
- £2.3m higher than planned agency and bank expenditure, largely relating to the Trust Board's decision to bolster acute and forensic inpatient safer staffing, but also reflecting observations and sickness and vacancy cover;
- £0.5m higher than planned trainee grade expenditure due to successful recruitment within the last medical rotation; and

- This was offset by £2.0m net vacancies across the Trust. Activities to progress recruitment and attract and retain staffing are ongoing, with financial impacts expected in H2.

Non pay expenditure is £0.9m higher than planned, due to:

- £0.4m higher than planned prescribing costs, largely relating to changes implemented in response to the covid pandemic;
- £0.3m higher than planned clinical supplies and services largely relating to voluntary and community sector collaboration associated with Community Mental Health Transformation. The Trust has also block contracted (and is utilising) four independent sector adult Mental Health assessment and treatment beds; and
- £0.2m of minor variances across other operating expenditure categories.

3.4 Cash Releasing Efficiency Savings (CRES)

The Trust has offset its CRES requirements in full, using non-recurrent under spending linked to a reduction in travel expenditure due to remote working arrangements and other non-recurrent savings. These 'fortuitous' offsets arising due to pandemic ways of working are reported as non-recurrent CRES and have therefore not been subject to quality impact assessment. Recurrent related smart working schemes are however being worked up for 2022/23.

The Trust continues to identify and consider schemes to deliver future requirements and will include quality impact assessments (QIA) where schemes have been identified and due to commence.

3.5 Capital

The month 7 report shows capital expenditure is £0.2m higher than plan. Three individually modest planned asset sales have been delayed meaning the Trust is above its net Capital Allocation by £0.9m at the end of month 7. One asset sales is not now expected to complete during 2021/22, one sale is expected to complete during November and a third disposal is anticipated in 2022.

The Trust is forecasting to fully commit its allocation of £13.6m, however plans have required re-prioritisation to keep required expenditure within the overall envelope plus disposals and estimated VAT recovery. Work is in train through the Trust's advisers to confirm expected VAT recovery.

3.6 Workforce

Tolerances for flexible staffing expenditure are set at 1% of pay budgets for overtime, 2.4% for agency (based on NHSI agency cost cap metric), and are flexed in correlation with staff in post for bank and additional standard hours (ASH).

The NHSI agency cap has not applied during the pandemic but would equate to a cost cap equivalent to £4.4m for the year to date. Agency expenditure to date is £7.0m; which is £2.6m above the indicative cap for the period ending 31

October 2021. Expenditure is across all localities and reflects operational and business continuity staffing pressures experienced due to community infection rates and the impact on staffing levels, and substantive staff recruitment gaps. Levels have been volatile during the pandemic, but elevated use of inpatient 'headroom' has been observed in the Autumn.

Nursing and Medical expenditure headings account for 94% of total agency expenditure; cover is required to maintain essential services and to cover vacancies, sickness, increased test and trace isolation levels and to support enhanced observations with complex clients.

The Senior Leadership Group is considering actions to target improved substantive recruitment and retention and will consider related resource implications as Business Plans for 2022/23 are developed.

3.7 Statement of Financial Position

Cash balances are £89.4m as at 31 October 2021 and £7.1m ahead of plan (£82.3m). This is largely due to receipt of a prepayment for H2 training income, working capital and capital movements, and reflecting the I&E surplus against plan. Cash has increased in month due to the receipt of pay award funding and the training prepayment.

The Trust achieved the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of non-NHS suppliers, and is marginally behind (94.7%) for NHS bodies.

Conversations are ongoing with organisations to take collection of all debt over 90 days. 80% of aged debt relates to unpaid invoices from NHS organisations or Local Authorities. None of the amounts outstanding are currently disputed, the delay in payment is linked to process delays within organisations e.g. purchase orders not raised, invoices gone missing.

42% (£292k) of the value of outstanding debts over 90 days have been collected (or payment agreed) by the time this report was circulated. Discussions continue as we support organisations to settle all debts.

3.8 Use of Resources Risk Rating (UoRR) and Indicators

3.8.1 The UoRR is impacted by Covid-19 and national monitoring is currently suspended. However, the Trust continues to assess the UoRR based on planning submissions and actual performance. Detail can be found in table 2 below.

Table 2: Use of Resource Rating at 31 October 2021

NHS Improvement's Rating Guide	Weighting	Rating Categories			
	%	1	2	3	4
Capital service Cover	20	>2.50	1.75	1.25	<1.25
Liquidity	20	>0	-7.0	-14.0	<-14.0
I&E margin	20	>1%	0%	-1%	<=-1%
I&E margin distance from plan	20	>=0%	-1%	-2%	<=-2%
Agency expenditure	20	<=0%	-25%	-50%	>50%

Actual performance 31 October 2021	Actual		YTD Plan		RAG
	Achieved	Rating	Planned	Rating	Rating
Capital service cover	3.47x	1	3.23x	1	
Liquidity	36.9	1	34.4	1	
I&E margin	2.4%	1	2.2%	1	
I&E margin distance from plan	0.2%	1	0.0%	1	
Agency expenditure (£000)	£6,976k	4	£4,417k	1	
Overall Use of Resource Rating		**2**		**1**	

3.8.2 The **capital service capacity** metric assesses the level of operating surplus generated, to ensure Trusts are able to cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 3.47x (can cover debt payments due 3.47 times), which is ahead of plan and is rated as a 1.

3.8.3 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 36.9 days; this is ahead of plan and is rated as a 1.

3.8.4 The **Income and Expenditure (I&E) margin** metric assesses the level of surplus or deficit against turnover, excluding exceptional items e.g. impairments. The Trust has an I&E margin of 2.4%, this is ahead of plan and is rated as 1.

3.8.5 The **I&E margin distance from plan ratio** metric assesses the I&E surplus/deficit relative to planned performance. The Trust I&E margin is 0.2% ahead of plan, which is rated as a 1.

3.8.6 The **agency expenditure** metric assesses agency expenditure against a capped target (pre-pandemic) for the Trust. Agency expenditure of £7.0m is in breach of the capped target by £2.6m (58%) and is rated as a 4. This metric drives an overall UoRR of 2 (compared to 1 at plan).

3.8.7 The 'headroom' margins on the individual metrics are as follows:

- Capital service cover - to deteriorate to a 2 rating the Trust's financial position would have to decrease by £5.0m.
- Liquidity - to deteriorate to a 2 rating the Trust's working capital position would have to decrease by £47.0m.
- I&E Margin – to deteriorate to a 2 rating the Trust's financial position would have to decrease by £3.4m.

- Agency Costs – to improve to a 3 rating the Trust's agency expenditure would have to decrease by £0.4m.

4. IMPLICATIONS:

4.1 There are no direct CQC, quality, legal or equality and diversity implications associated with this paper.

5. RISKS:

5.1 There are no risks arising from the implications identified in section 4.

5.2 Despite including an increased efficiency requirement in H2, national financial arrangements provide short term assurance on the 2021/22 financial position. However, uncertainty in relation to 2022/23 funding arrangements / allocations and regulation makes coherent longer-term financial planning challenging. Key concerns include the extent to which real terms mental health investment standard funding is maintained. Risks include the impact of Agenda for Change pay award costs and the future mechanism for funding the 6.3% increase in employers' NHS Pensions contributions (currently remitted centrally). These significant uncertainties have the potential to impede progress of delivering long term plan priorities by diluting real terms growth. Discussions are continuing, including through local Partnership Boards, to agree immediate and future investment priorities.

5.3 CRES targets have been offset by non-recurrent underspending for the year to date and forecast to continue for the financial year. The Trust's Financial Sustainability Board (FSB) oversees CRES planning and delivery and coordinates overall financial planning activities. Nationally efficiency requirements in H2 are more challenging; equivalent to 1.1% - this equates to £1.8m for TEWV in H2. There has also been a 5% national reduction in place-level non-recurrent Covid support funding. The FSB and Business Planning work will take account of anticipated CRES requirements as the Trust begins to formulate sustainable recurrent plans for future years.

5.4 The UoRR is impacted by Covid-19 and national monitoring is currently suspended. However, agency usage is increasing, and the Trust would report a score of 4 against this individual metric, and UoRR overall of 2.

6. CONCLUSIONS:

6.1 For the period ending 31 October 2021 the Trust has achieved a surplus of £5.4m which is £0.3m ahead of plan. This is before £0.4m additional unplanned profit from disposal of fixed assets, which is excluded when assessing NHS provider financial performance.

6.2 The CRES framework is yet to be agreed for 2022/23, however the Trust has stepped up work to identify schemes to deliver requirements on a recurrent basis and will provide an update in due course. Mitigations to offset efficiency

requirements during 2021/22 have been identified, with scope to make some savings recurrent.

6.3 A breakeven financial plan for H2 was submitted during November 2021 and was considered by the Strategy and Resources Committee on 18th November. A recommendation to approve the H2 and overall 2021/22 final plan will be made by the Committee to the private November Trust Board.

6.4 The UoRR for the Trust is assessed as 2 for the period ending 31 October 2021 and is behind plan due to the level of expenditure on agency workers.

7. RECOMMENDATIONS:

7.1 The Board of Directors is requested to receive the report, consider the issues and risks raised and any related further assurances needed.

Liz Romaniak
Director of Finance, Information and Estates

Appendix 1

Key Financial Indicators for the period ending 31 October 2021

Surplus variances are shown as negative	Year to date			RAG	Prior Month	RAG
	Plan	Actual	Variance		Variance	
I&E (Surplus) / Deficit £m	-5.1	-5.4	-0.3	●	-0.3	●
Profit on sale of Asset (Excl in H1 totals)	0.0	-0.4	-0.4	●	-0.4	●
Income £m	-236.9	-243.1	-6.1	●	-6.1	●
Pay Expenditure £m	186.9	191.9	5.0	◆	5.0	◆
Non Pay Expenditure £m	40.6	41.5	0.9	◆	0.9	◆
Non Operating Expenditure £m	4.3	4.3	0.0	●	0.0	●
Capital Expenditure (including disposals) £m	6.6	7.5	0.9	◆	1.0	◆
Capital Service Cover	3.23x	3.47x	-0.24x	●	-0.14x	●
Liquidity Days	34.4	36.9	-2.5	●	-2.1	●
I&E Margin	2.20%	2.40%	-0.20%	●	-0.1%	●
Variance from I&E Margin plan	0.0%	0.2%	-0.20%	●	-0.1%	●
Agency Expenditure £m	4.4	7.0	2.6	◆	2.0	◆
Cash Balances £m	82.3	89.4	-7.1	●	-0.7	●
Total debt over 90 days	5.0%	23.3%	18.3%	◆	5.4%	◆
BPPC NHS invoices paid < 30 days	95.0%	94.7%	0.3%	◆	-0.9%	●
BPPC Non NHS invoices paid < 30 days	95.0%	95.8%	-0.8%	●	-0.7%	●

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Board Performance Dashboard
As at 31st October 2021

journey to change

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CONTENTS

Executive Oversight

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Out of our 21 key performance measures, there are 14 areas of concern identified within the October 2021 report that we are trying to improve; this includes 2 measures for which we have previously had additional monitoring in place.

Our key concerns are within our Quality and Workforce domains and our challenges are in relation to staff sickness and our ability to recruit to staff vacancies, which are significantly impacting the quality of services being provided. In addition, within our Activity domain increasing demand on our inpatient services has resulted in occupancy rising to a level that is impacting on the delivery of our services.

Quality

We are not assessing or treating our patients in as timely manner as we would like and whilst a number of initiatives are being pursued in relation to service models, our performance is mainly being impacted by national pressures throughout the NHS and locally within Trust services in respect of high demand and staff capacity. Services are implementing a number of initiatives to try to mitigate any risk to service provision, but staff sickness and difficulties to recruit new staff continue to be challenging.

We are concerned that our Adult and Older Persons' teams are not demonstrating the improvement in patient outcomes that we would aspire to. First identified in respect of our clinician-rated HoNOS model, we are now seeing a deterioration in our patient-rated model (SWEMWBS). The need for staff training has been highlighted across all Trust services but the ability to release staff for training or to train, is challenging for services that are already under-staffed.

Our inpatient services are under increasing pressures with bed occupancy higher than we would like and we are starting to see an increase in the number of patients remaining in beds for over 90 days. These high occupancy levels are having a subsequent impact on our out of area placements and we are placing more patients in hospitals other than their local hospital than we would aspire to, although these admissions are mainly still within TEWV hospitals. Work has been undertaken to ensure the NHS England Continuity of Care Principles are robustly embedded across Trust services but whilst this will reduce the number of out of area placements reported within Trust hospitals, we are concerned that increased demand will still necessitate patients being admitted to other Trusts or independent providers.

Workforce

The challenges facing our workforce are impacting on the delivery of our services, as referenced above. We have a significant number of vacancies across most Trust services and our sickness levels continue to be higher than we aspire to. This is a Trust-wide issue and recruitment exercises are underway to minimise the impact on patient care, but this is a national challenge and our recruitment campaigns are having mixed success.

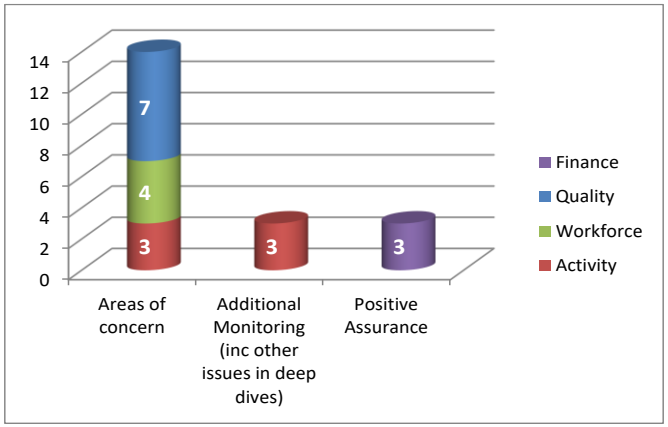
In addition, we have more members of staff without up to date appraisals and mandatory & statutory training than we would like. This is an issue across all Trust services, corporate and clinical and work is underway to identify the resources required to make improvements in this area.

Summary Position

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

These are the areas of concern we are trying to improve:

- We are not seeing as many patients **within 4 weeks for a first appointment** as we would like (6453 patients out of 7425 in October which is 86.91% compared to our standard of 90%).
- The number of **patients receiving treatment within 6 weeks** is not as high as we would like (947 patients out of 1740 in October which is 54.43% compared to our standard of 60%).
- We are not treating as many people in their local hospital as we would like. There were 175 patients placed in a bed outside their local hospital accounting for 2583 **inappropriate OAP days** in the 3 months ending October.
- Whilst **patients report their overall experience** as very good it is not as positive as our ambition (800 patient surveys out of 859 in October which is 93.13% compared to our standard of 94%). An increasing position is now visible and whilst this does not yet denote an actual improvement, it is positive progress indicating the actions we are taking are having the desired impact.
- We recognise the potential to improve our learning from **Serious Incidents.** In October, 2 Serious Incidents (from a total of 4) were found to have a root cause or contributory finding. This is 50% compared to our standard of 32%.
- Our Adult and Older Persons' teams are not demonstrating the **improvement we would like in patient outcomes (HONOS)** (45 out of 95 in October which is 47.37% compared to our standard of 60%).
- The number of **patients being referred and taken on for treatment** is fewer than we would expect (1912 patients out of 8106 referred in July which is 23.59%). No standard has been set for this measure.
- Our wards are extremely busy and **bed occupancy** is higher than we would like it to be (10,873 occupied bed days out of 10,912 available bed days which is 99.64% in October compared to our standard of 90%).
- The number of **vacancies** is higher that we would like (479 out of 7558 (6.34%) whole time equivalent staff in October). No standard has been set for this measure.
- The number of **staff with a current appraisal** is not as high as it was previously (4365 members of staff out of 6276 in October which is 69.55% compared to our standard of 95%).
- The number of **staff compliant with their mandatory and statutory training** is not as high as we would like it to be (85,210 training courses out of 101,066 in October which is 84.31% compared to our standard of 92%)
- **Sickness Absence rates** for staff are higher than we would like them to be (14,506 working days out of 206,081 in September which is 7.04% compared to our standard of 4.3%)



Two measures previously under additional monitoring are now areas of concern we are trying to improve:

- Our Adult and Older Persons' teams are not demonstrating the **improvement we would like in patient outcomes (SWEMWBS)** (51 out of 89 in October which is 57.30% compared to our standard of 60%).
- The number of Adult and Older People **staying in beds longer than 90 days** is higher than we would like (62 patients in October compared to our standard of no more than 61).

These are the areas that require monitoring to better understand what's happening before we are certain that they are an area of concern or that the actions we have taken are having the desired impact:

- The number of **patients referred** is higher than we would expect, particularly within Forensics Services.
- The number of **patients with an assessment completed** is lower in North Yorkshire & York than we would expect.
- The number of **patients discharged** is lower in Tees than it was previously.

All three finance measures are providing assurance that we are delivering in line with our financial plan.

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

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

Special Cause Improvement Low is good	We're aiming to have low performance and we're moving in the right direction.
Special Cause Improvement High is good	We're aiming to have high performance and we're moving in the right direction.
Common Cause – no significant change	There is no significant change in our performance. – it is within the expected levels.
Special Cause Concern Low is good	We're aiming to have low performance and we're moving in the wrong direction.
Special Cause Concern High is good	We're aiming to have high performance and we're moving in the wrong direction.

Assurance: is the target/standard achievable?

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

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Data Quality
We regularly undertake a data quality assessment on the Trust's Performance Dashboard measures. Our assessment focusses on 4 key elements: data source, data reliability, construct/definition of the measures, and when it was last amended/tested. Liaising with Trust leads for each measure, we assess and score against each element to calculate an overall Data Quality Assessment (DQA) status.

Action Status
Our action status is informed by a combination of current performance, performance over time (including trends) and general intelligence. When we interpret an SPC chart we look at how our performance is compared to what we are trying to achieve, whether we have assurance that we will achieve the standard and whether our performance over time is improving.

Data Quality Assessment status

DQ ★	Data Quality Assessment Score **100%**	No action required
DQ ✓	Data Quality Assessment Score **85% to 99%**	Some work is required
DQ ✗	Data Quality Assessment Score **less than 80%**	Significant work is required

Action status

	Positive Assurance	We are doing well in this area and therefore no action is required
	No Concerns	No further action is needed at this point in time
	Additional Monitoring	We need to monitor this more closely to better understand what's happening before it becomes an area of concern
	An Area of Concern	We need to investigate this to understand what's happened and/or take action

Trust Dashboard Summary

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Quality

Measure Name	Variation Ending Oct - 2021	Assurance Ending Oct - 2021	Standard (YTD)	Actual (YTD)	Annual Standard
1) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral	L	?	90.00%	86.99%	90.00%
2) Percentage of patients starting treatment within 6 weeks of an external referral	L	?	60.00%	57.34%	60.00%
3) The total number of inappropriate OAP days over the reporting period (rolling 3 months)	H	?	1,833	2,583	1,833
4) Percentage of patients surveyed reporting their overall experience as excellent or good		?	94.00%	89.26%	94.00%
5) The percentage of Serious Incidents which are found to have a root cause or contributory finding		?	32.00%	55.93%	32.00%
6) % of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) - month behind	L	?	60.00%	47.75%	60.00%
7) % of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) - month behind		?	65.00%	64.77%	65.00%

Activity

Measure Name	Variation Ending Oct - 2021	Assurance Ending Oct - 2021	Standard (YTD)	Actual (YTD)	Annual Standard
8) Number of new unique patients referred				56,770	
9) The percentage of new unique patients referred with an assessment completed (2 months behind)				76.47%	
10) The percentage of new unique patients referred and taken on for treatment (3 months behind)	L			30.08%	
11) Number of unique patients discharged (treated only)				20,350	
12) Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	H	?	90.00%	97.92%	90.00%
13) No. of patients occupying a bed with a LoS from admission > 90 days (AMH & MHSOP A&T Wards)-Snapshot	H	P	61	62	61
14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days (AMH & MHSOP)		?	9.90%	8.91%	9.90%

Workforce

Measure Name	Variation Ending Oct - 2021	Assurance Ending Oct - 2021	Standard (YTD)	Actual (YTD)	Annual Standard
15) Finance Vacancy Rate	H			-6.34%	
16) Percentage of staff in post with a current appraisal	L	F	95.00%	69.55%	95.00%
17) Percentage compliance with ALL mandatory and statutory training (snapshot)	L	?	92.00%	84.31%	92.00%
18) Percentage Sickness Absence Rate (month behind)	H	?	4.30%	6.04%	4.30%

Money

Measure Name	Plan (YTD)	Actual (YTD)
19) Delivery of our financial plan (I and E)	-5,109,420	-5,829,771
20) CRES delivery	0	0
21) Cash against plan	82,231,000	89,434,011

TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral – *Trust Standard 90%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and treatment is timely as we know this supports patient safety, wellbeing and quality of care. We want to ensure our patients receive an assessment at the earliest opportunity so they are placed on the most appropriate treatment pathway in a timely manner, enhancing their experience and outcomes and reducing the risk of a deterioration in their condition and the potential need for admission.

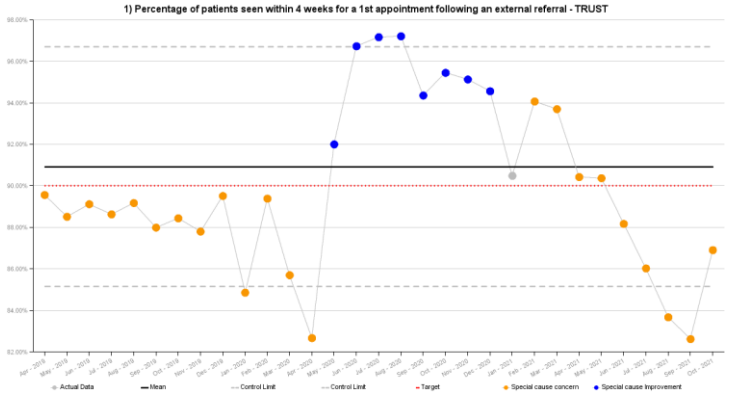
7425 patients attended a first appointment during October; of those, **6453 (86.91%)** were within 4 weeks of referral

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

We need to investigate this to understand what's happened and/or take action

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

DQ ★ **100%**



Locality	Variation	Assurance
TRUST	L	?
DURHAM AND DARLINGTON		?
FORENSIC SERVICES	L	P
NORTH YORKSHIRE AND YORK	L	?
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we are not seeing as many of our patients in a timely manner as we would like. This was first identified as a potential area of concern in July 2021.	Actions are detailed on the following pages.		Although an increasing position is now visible within the data, this does not yet denote an actual improvement. Actions remain ongoing.

TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Tees Locality			
Children & Young People's Services (CYPS), a delay in processing referrals through the Single Point of Access Team has led to a reduction in the number of patients being triaged to the community teams in a timely manner.	A plan to be developed to clear the current waiting list.	**Completed**. The plan has been developed and completed. The backlog is now cleared.	Although an increasing position is now visible within the data, this does not yet denote an actual improvement.
High levels of sickness and an increase in referrals has impacted capacity within the Adult Mental Health (AMH) Stockton Access Team.	Overtime support is to be provided by the Affective Disorder Team and Perinatal Services during October. The Associate Nurse Consultant is to work with the team during October to review processes and identify potential blockages in the system.	**Ongoing.** Overtime slots had been filled to enable the backlog to be cleared by the end of October. However sickness levels remain high and this has impacted the work. Additional overtime has been planned through November. Recruitment is underway for an Access Clinician to build capacity within the team.	No visible impact at this point; however actions remain ongoing.
Whilst waiting times within Mental Health Services for Older People have been impacted by support provided into our Forensic Wards to help manage current pressures, the main concerns have been staff sickness, vacancies and increased acuity.	Recruitment is ongoing to appoint new staff to enable demand to be met.	**Ongoing**. Additional clinical staff have been recruited and will be in post mid December, however there remains a number of vacancies across all teams. Work is being completed to scope recruitment difficulties across the Trust.	No visible impact at this point; however actions remain ongoing.
Further analysis of Learning Disability services has shown that there has been increased sickness and acuity.	Increased monitoring to be undertaken during October to confirm whether this is an area of concern.	**Ongoing**. This is predominantly non work-related sickness and Workforce are supporting the process. Acuity remains high and agency staff and CYP and AMH service support is being used to ensure the 'safe'' staffing position on the wards are maintained. The position is being monitored daily.	No visible impact at this point; however actions remain ongoing.

TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
North Yorkshire & York Locality			
Within Children and Young People's (CYP) Services are being impacted by staffing resources within the Single Point of Access Team.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing.** Recruitment continues with a November closing date.	Although an increasing position is now visible within the data, this does not yet denote an actual improvement. Actions remain ongoing.
There are a number of vacancies within the Mental Health Services for Older People (MHSOP) Harrogate, Scarborough and Ryedale community teams and Harrogate Memory team.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing.** The closing dates for the Harrogate and Ryedale community posts are November 2021. The Scarborough team is almost at full capacity; all patients waiting 3-6 months have appointments. New staff in the Memory team are working through induction.	No visible impact at this point but actions remain ongoing. It must be noted this is a retrospective measure and whilst recruitment will enable more patients to be assessed, many patients currently on the waiting list have already exceeded the 4 week standard.
The York Memory Service has been impacted by capacity issues due to an increase in referrals and under-establishment.	A pilot to be undertaken with GPs to support the referral process and minimise inappropriate referrals.	**Ongoing.** The service has a trajectory to reduce the number of patients waiting to below 100 by December 2021 and all waiters to be eliminated by April 2022.	
	A 0.6 whole time equivalent clinical staff to return from secondment to increase support.	**Ongoing.** Member of staff due to return November 2021.	

TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Within Adult Mental Health Services, there has been reduced staff capacity due to vacancies and sickness within the Hambleton & Richmondshire East community team.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing.** All staff absent through sickness have returned to work. One post has been appointed to and will start in November; recruitment continues for a further 2 posts.	Although an increasing position is now visible within the data, this does not yet denote an actual improvement. Actions remain ongoing.
The York North, York South, Scarborough and Whitby & Ryedale community teams have been impacted by vacancies. The Scarborough team has been unsuccessful in sourcing permanent or agency staff.	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing**. The York North and Whitby & Ryedale teams are almost fully recruited. Recruitment is ongoing for 2 posts within the York South team and 6 in the Scarborough team; closure dates are December 2021.	
	Third sector support as part of winder pressures monies to be explored with commissioners to assist the Scarborough team.	**Ongoing.** Plans are currently being explored and an update will be provided in December.	
The York & Selby Wellbeing Access service has received a significant increase in referrals, which has impacted staff capacity. The team has a number of vacancies and some staff sickness, which has reduced the number of assessments that can be completed and consequently, the number of patients taken on for treatment.	'Stop the line' process to be established to enable current processes to be reviewed.	**Ongoing.** Daily reviews are in place and support is being provided by the York & Selby Community Teams.	
	All referrals for patients that have been discharged within the last year to be allocated directly to the community teams in York and Selby.	**Ongoing.** The community teams are embedding new processes but this has initially impacted the number of patients seen for assessment.	
	The service to initiate a triage process to address the backlog of patients waiting for assessment from November 2021.	**Not Started**. Due to commence 2nd November 2021.	
	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing**. The closing dates for vacancies is November 2021. All staff have returned to work following sickness.	
Capacity within the North Yorkshire & York Perinatal team has been impacted by staff sickness.	Sickness to be managed through the Trust sickness procedure.	**Ongoing.** All members of the team are due to return to work in November 2021.	

TD01) Percentage of patients seen within 4 weeks for a 1st appointment following an external referral continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Durham & Darlington Locality			
Within Children & Young People's (CYP) Services potential concerns were identified within the Darlington, Easington, North Durham and South Durham Targeted Teams and the specialist Autism and Eating Disorder teams.	A review of waiting list management across all Locality CYP services to be undertaken, with support from the Heads of Service, Information team, Performance Team, Quality Improvement and the Service Development Manager.	**Ongoing**. A shared and standardised procedure for tracking patients waiting for assessment and treatment has been implemented. Daily huddles are established and a visual control board has been introduced to ensure progress is maintained and any concerns identified immediately and actioned.	Although an increasing position is now visible within the data, this does not yet denote an actual improvement. Actions remain ongoing.
A potential concern was highlighted within MHSOP in September 2021.	Further analysis is required to understand the teams that are impacted and whether this is an actual area of concern.	**Ongoing.** Initial analysis has not identified a concern in any teams; further analysis will be undertaken by the Corporate Performance Team to understand whether there is an actual concern.	No visible impact at this point; however actions remain ongoing.

TD02) Percentage of patients starting treatment within 6 weeks of an external referral – *Trust Standard 60%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring access to the right care and treatment is timely as we know this supports patient safety, wellbeing and quality of care. We want our patients to begin their treatment at the earliest opportunity to improve their experience and outcomes and also to reduce the risk of a deterioration of their condition and the potential need for admission.

1740 patients started treatment during October; of those, **947 (54.43%)** started within 6 weeks of being referred

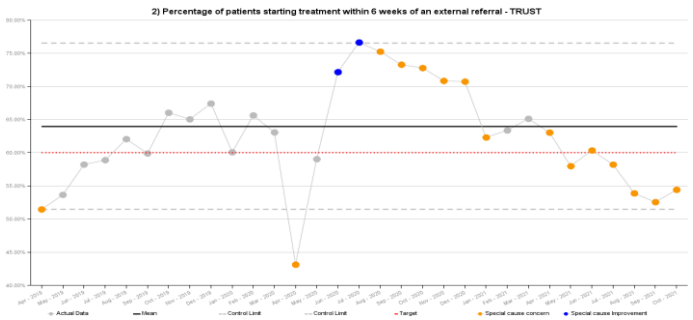
We're aiming to have high performance and we're moving in the wrong direction.

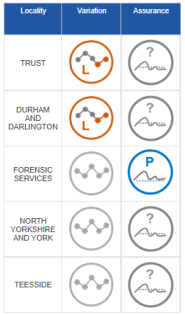
We need to investigate this to understand what's happened and/or take action

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

DQ

85%





KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we are not starting treatment for patients in a timely manner. This was first identified in January 2021.	Actions are detailed below and following for each locality.		No visible impact; however actions remain ongoing.
Durham & Darlington Locality			
In Children & Young People's Services (CYP) we have been impacted by staff vacancies.	Recruitment is underway, which would provide more staff to offer treatment.	**Ongoing.** There are 27 vacancies across, the five community teams (whole and part time). Whilst some staff are due to start in post in November, recruitment continues for the majority and it is anticipated to be December/ January before many of posts are filled.	No visible impact; however actions are still ongoing.
Waits for CYP on a neurological pathway to start treatment are longer due to the complexity of assessments.	Service Development Group (SDG) to consider whether these patients should be counted in this measure as they are not waiting for treatment but further assessment.	**Ongoing.** SDG have had initial discussions; however the September and October meetings did not take place as focus was given to the Care Quality Commission work. This discussion is to take place on the 4th November 21.	
Some data quality issues were identified within the Darlington Team and Mental Health Services for Older People.	Work to be undertaken to understand and correct data quality issues.	**Ongoing.** All newly identified issues within MHSOP are resolved. Work continues to correct those in CYPS.	

TD02) Percentage of patients starting treatment within 6 weeks of an external referral – continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Within Adult Mental Health Services, a potential issues has been highlighted within the Access team.	Analysis to be undertaken to identify whether this is an actual area of concern.	**Ongoing**. Analysis is underway and an update will be provided in December.	No visible impact; however actions are still ongoing.
Tees Locality			
In Adult Mental Health patients have been impacted by appointment availability for medication reviews.	The AMH Associate Clinical Director to ensure there are no blockages to patients starting treatment.	**Completed.** These were data quality issues (not medic capacity) and training has been provided.	Although an increasing position is now visible within the data, this does not yet denote an actual improvement. Actions remain ongoing.
High levels of sickness and an increase in referrals has impacted capacity within the Adult Mental Health (AMH) Stockton Access Team.	Overtime support is to be provided by the Affective Disorder Team and Perinatal Services during October. The Associate Nurse Consultant is to work with the team during October to review processes and identify potential blockages in the system.	**Completed.** An increase in the number of patients starting treatment has been observed. Monitoring will continue to ensure the actions taken continue to have the desired impact.	
There is a delay in the assessment process within the CYP Single Point of Contact (SPOC) team.	The Service is to review SPOC processes to improve efficiency. Backlog of referrals to be managed with support from the Getting Help Teams. Following clearance of the backlog, patients are to be prioritised for treatment according to clinical need.	**Completed.** Review completed and process streamlined. **Completed.** The backlog has been cleared and triaged as appropriate. **Ongoing.** A review of all patients waiting for assessment and treatment has been undertaken and treatment has been prioritised for those with the greatest clinical need. An update on progress will be provided in December.	No visible impact; however actions are still ongoing. As the 6 week standard has already lapsed it will take some time before we start to see an improvement in the waiting times for our patients.
High levels of sickness and vacancies have impacted capacity within the Mental Health Services for Older People (MHSOP).	Recruitment is underway, which would provide more staff to offer treatment.	**Ongoing.** Additional clinical staff have been recruited and will be in post in December; however there remains a number of unfilled posts across all teams.	

TD03) The total number of inappropriate OAP days over the reporting period – *Trust Standard 1833 days*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

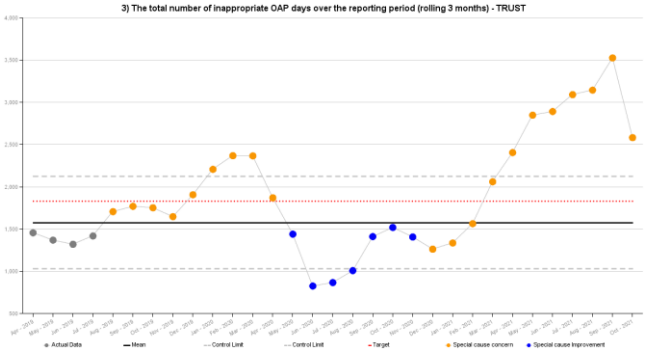
2583 days spent by patients in beds away from their closest hospital during August, September and October 2021.

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

We need to investigate this to understand what's happened and/or take action

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

DQ ✓ **90%**



Locality	Variation	Assurance
TRUST	H	?
DURHAM AND DARLINGTON	H	
NORTH YORKSHIRE AND YORK	H	
TEESSIDE	H	

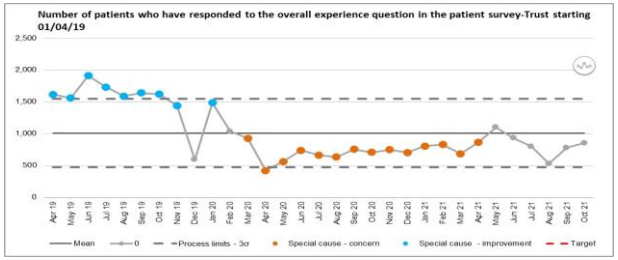
KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
More patients in our Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP) services are spending time in Trust beds away from their closest hospital. This was first identified in March 2021 and is being largely impacted by current pressures on our inpatient services. The Executive Team has agreed that we need some external support to help with this and this is currently being progressed. Four beds have been purchased in the independent sector until the 31st January 2022 (extended from September 2021) for AMH and MHSOP patients; 3 patients occupied these beds during October (41 bed days) and 3 patients were admitted externally to the Trust and these commissioned beds due to no beds being available (55 bed days).	Analysis to be undertaken to understand the impact of inpatient and community pressures on our out of area placements, to identify any areas of concern. A Trust-wide review to be undertaken to ensure the Continuity of Care Principles are embedded within all Service processes by the 30th September 2021. The Out of Area Protocol to be reviewed to ensure is up to date and fit for purpose.	**Completed.** Following initial analysis, data is monitored monthly. **Completed.** A paper was presented to the Executive Oversight Team on the 5th October 2021. All recommendations were supported and regular assurance monitoring has been requested. **Ongoing.** An updated protocol has been drafted and is now going through approval processes.	A decreasing position is now visible within the data, reflecting the reduction in internal OAPs from October and compliance to the Continuity of Care Principles. Actions remain ongoing and it will be December before we see the true impact on our patients of our adherence to the principles.

TD04) Percentage of patients surveyed reporting their overall experience as excellent or good – *Trust Standard 94%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

859 patients responded to the patient survey question "Overall how would you rate the care you have received?". Of those, **800 (93.13%)** scored 'excellent' or 'good'



KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
A number of our patients are not rating our services as excellent or good. First identified in September 2020, concerns included waiting times, access to services, activities and feeling safe. The number of responses to our surveys are lower than we would like and have been impacted by Infection, Prevention & Control restrictions on the use of touch screen technology (Tablets and Kiosks) and the continued lack of face to face contact.	Patient Experience Improvement Plans to be established in all localities to monitor response rate, response numbers and the nature of feedback concerning patient experience. Monthly monitoring of response rates and progress against the Patient Experience Improvement Plans to be established. A comparison exercise to be undertaken with Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust on the 'Feeling Safe' theme. This is due to be completed December 2021.	**Completed.** Improvement plans have been agreed in all localities and monitoring will be through local governance processes, with updates presented to the Quality Improvement and Assurance Subgroup (QA&I). **Ongoing**. 7 out of 18 actions completed (with an additional 3 partially complete) across all localities**.** The work continues to be impacted by operational pressures, acuity and demand. There are a number of actions that have been implemented including the updating of carer leaflets, offering intensive support in Early Intervention in Psychosis services, promoting the use of alternative technology to disseminate surveys and the recruitment of new activity co-coordinators. Most recently, North Yorkshire and York have appointed Patient Experience champions to support increasing FFT numbers and address themes. However, a number of actions across localities have not been completed. **Ongoing.** Initial meeting with CNTW was held in October. CNTW agreed to undertake similar comparison work to identify themes. Next meeting is scheduled to take place in November (10th) where key staff from both trusts will consider the findings and agree the next steps.	An increasing position is now visible within the data, with October reporting within 1% of the standard. Whilst this does not yet denote an actual improvement, it is positive progress indicating that the actions we are taking are having the desired impact.

TD05) Percentage of Serious Incidents which are found to have a root cause (significant lapse) or contributory finding (lapse) (month behind) – *Trust Standard 32%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

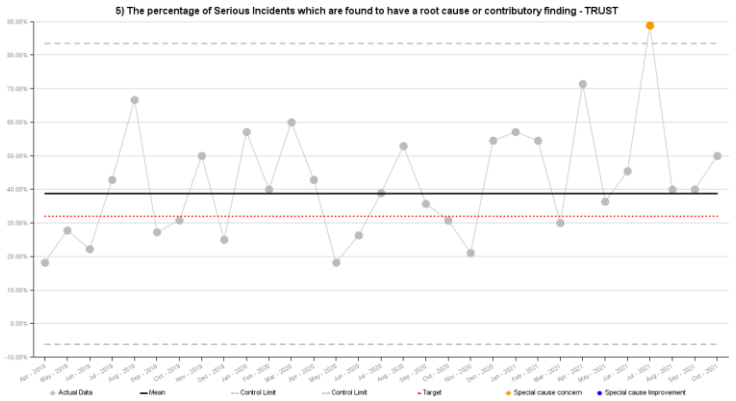
4 serious incidents were reported to the Trust Director Panel during September; of those, **2 (50%)** were found to have a root cause or contributory finding

Nothing to note. Our activity is within the expected levels of performance

We need to investigate this to understand what's happened and/or take action

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

DQ ✓ **85%**



Locality	Variation	Assurance
TRUST		
DURHAM AND DARLINGTON		
NORTH YORKSHIRE AND YORK		
TEESSIDE		

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we have not seen a reduction in the number of serious incidents in which lapses and/or serious lapses in patient care and treatment have been identified. First identified in August 2021, this was discussed at the September Organisational Learning Group Meeting. Themes identified included sexual safety, perinatal care and safeguarding.	Work to be undertaken to identify the nature of Serious Incidents and any emerging themes. These will inform any areas of learning and will be used to drive forward any improvements or changes to practice where necessary.	**Ongoing.** All findings are captured on a central database within the Patient Safety Department to enable the identification of themes and key learning. This is reviewed monthly and informs any actions or improvement work to be initiated and existing work programmes. Updates are provided to the Organisational Learning Group to provide assurance and learning bulletins are issued following Serious Incident Assurance Panels.	No visible impact; however whilst our improvement work helps us to understand the nature of incidents and prevent recurrence, the wide variance of incidents means that there will not always be a visible impact on the data.

TD06) Percentage of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) (month behind) – *Trust Standard 60%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

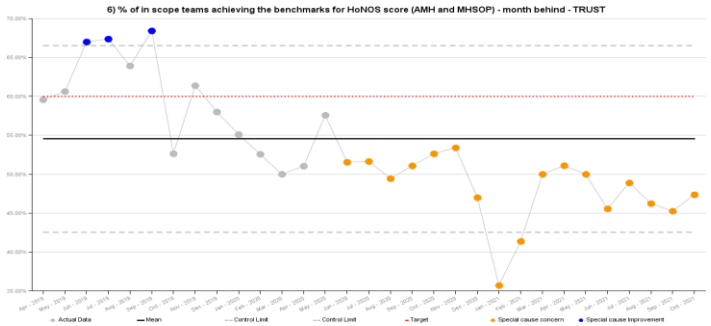
95 in scope teams have discharged patients from Trust services in the last three months; of those, **45 (47.37%)** achieved the agreed improvements in their Health of the Nation Outcome Score (clinician rated outcome measure)

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

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

We need to investigate this to understand what's happened and/or take action

DQ ✓ 95%



Locality	Variation	Assurance
TRUST	L	?
DURHAM AND DARLINGTON		?
NORTH YORKSHIRE AND YORK		?
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
A number of our teams are discharging patients that have not shown as much improvement as we would like. This was first identified as a concern in October 2020 and work is required to understand the underlying reasons. Please see below and overleaf for Locality concerns.	The Clinical Outcomes Steering Group (COSG) to develop a work plan that will include an approach for integrating outcome measures within our clinical services. This will include training for staff and analysis to understand what is impacting on our patients' improvement. Information to be analysed to understand why our patients feel that they have experienced an improvement (see TD07 SWEMWBS) but clinically have not shown that.	**Ongoing.** Progress on the high level plan continues and all actions and action owners will be agreed at the December meeting as scheduled. A further update will be provided in January 2022.	No visible impact; however actions are still ongoing.
North Yorkshire & York Locality			
We are concerned that patients within our Mental Health Services for Older People (MHSOP) are not showing as much improvement as we would like due to staff training requirements.	The Head of Service to arrange training to support staff's knowledge regarding the completion of HoNOS.	**Ongoing.** The MHSOP Service Development Manager (SDM) has re-circulated guidance and videos on the use of HoNOS to all AMH and MHSOP teams across the Trust. Clinical Outcomes monitoring training for team and ward managers is being arranged by the SDM; dates to be confirmed. The SDM has also approached the Patient & Carer Participation Group with a view to developing some co-created outcomes training.	An increase has been visible since June 21; however this does not yet denote an actual improvement.

TD06) Percentage of in scope teams achieving the benchmarks for HoNOS score (AMH and MHSOP) (month behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Durham & Darlington Locality			
We are concerned that patients within our Adult Mental Health (AMH) services are not showing as much improvement as we would like.	Analysis at patient level to be undertaken by the clinical leadership team to identify any key areas of concern.	**On hold.** The discussion at the October Locality Quality Assurance & Improvement meeting to agree actions did not take place. Due to pressures within the Locality, the Director of Operations has been asked to identify two key issues to focus on within the coming weeks. The focus on HoNOS has currently been put on hold. However, please note the actions within the **North Yorkshire & York** on the previous page.	An increase is now visible; however this does not yet denote an actual improvement..
Tees Locality			
We are concerned that patients within our AMH and MHSOP services are not showing as much improvement as we would like.	A caseload management review at patient level to be undertaken by the clinical leadership team to identify any key areas of concern.	**Ongoing**. Pressures on clinical services due to vacancies and sickness continue and the Community Matrons, who are to undertake the caseload management reviews, are not yet able to confirm a timescale when this work will be completed.	No visible impact; however actions remain ongoing.
	AMH Community Matrons to reinstate clinical outcomes monitoring within huddles, reinstate caseload management reviews and arrange training for staff.	**Ongoing.** Please note the actions within the **North Yorkshire & York** on the previous page.	
	MHSOP Service Development Group to consider an appropriate approach for monitoring outcomes for patients with degenerative illness.	**Ongoing.** The MHSOP SDG has asked the Clinical Outcomes Steering Group to consider using HONOS 65+ as a more appropriate tool for elderly patients, particularly those with degenerative illness. This will be discussed at the November meeting and an update provided in December.	
	The SDM to review the clinical pathways within MHSOP to ensure they remain in line with Trust policy, sit with the clinical risk management process and the MHSOP specific harm minimisation modules.	**Ongoing.** As each pathway is refreshed and each harm minimisation module delivered, there is an emphasis on clinical outcomes. Pathway groups are to meet monthly to monitor progress on applying the interventions and clinical outcome data. Pathway leads will report back to the Service Development Group on a quarterly basis.	

TD07) Percentage of in scope teams achieving the benchmarks for SWEMWBS score (AMH and MHSOP) (month behind) – *Trust Standard 65%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

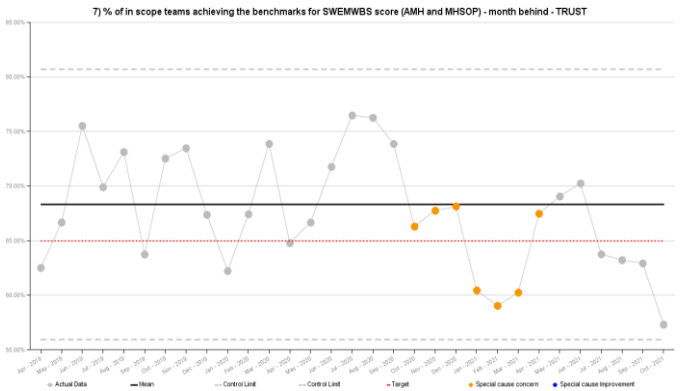
89 in scope teams have discharged patients from Trust services in the last three months; of those, **51 (57.30%)** achieved the agreed improvements in the short version of the Warwick–Edinburgh Mental Wellbeing Scale (patient rated outcome measure)

There is no significant change in our performance. – it is within the expected levels.

We need to investigate this to understand what's happened and/or take action

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

DQ ✓ **95%**



Locality	Variation	Assurance
TRUST		?
DURHAM AND DARLINGTON	L	?
NORTH YORKSHIRE AND YORK	L	?
TEESSIDE	H	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that a number of our teams are discharging patients that have not reported as much improvement as we would like. This was first identified as a concern in August 2021 within our **Durham & Darlington** Adult Services.	Analysis to be undertaken to identify any areas of concern.	**Completed.** This was included within the August 21 report and highlighted a potential concern within Adult Mental Health Services (AMH).	No visible impact; however further work is required to identify any appropriate actions for improvement.
A potential concern has been identified within a number of teams: Tunstall/Farnham Inpatient service, Derwentside & Chester le Street Affective team, Durham City Affective team, North Durham & South Durham Psychosis team, Eating Disorders Community team and Durham and Darlington Crisis team.	The Corporate Performance Team is to work with the team and Locality Managers to investigate further to confirm whether these are actual areas of concern. This work will be undertaken during September and findings reported in October 2021.	**On hold.** At the October Locality Quality Assurance & Improvement meeting, due to capacity issues within the Locality, the Director of Operations was asked to identify two key issues to focus on within the coming weeks. The focus on SWEMWBS has currently been put on hold.	
A potential concern is now visible in **North Yorkshire & York** Locality; however there has been no previous concern identified.	Close monitoring to be implemented to confirm whether this is just monthly variation or further investigations are required.	**Not started.** Close monitoring will be undertaken during November and an update provided in December.	

TD08) Number of new unique patients referred – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

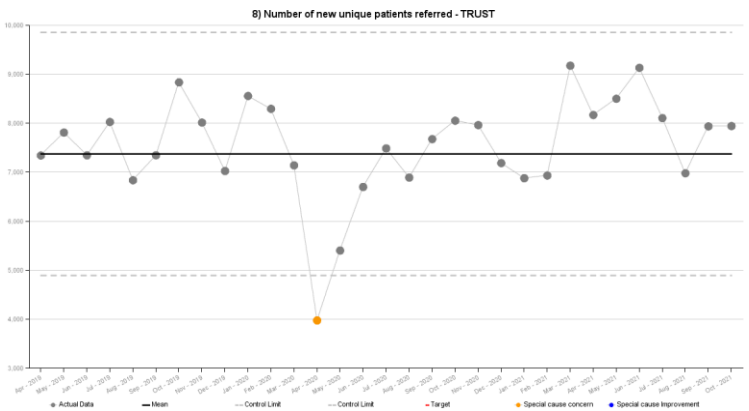
7944 patients referred in October that are not currently open to an existing Trust service

There is no significant change in our performance. – it is within the expected levels.

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ

100%



Locality	Variation
TRUST	
DURHAM AND DARLINGTON	
FORENSIC SERVICES	
NORTH YORKSHIRE AND YORK	
TEESSIDE	

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We have received a high number of referrals for new patients into our **Forensics** services due to an increase in referrals to the Cleveland and Durham Liaison & Diversion teams. This was first identified in May and is anticipated to continue. The service has reviewed their processes to ensure those with the greatest need are prioritised but without further support from commissioners they cannot manage increasing demand.	The Head of Health & Justice Services to submit a business case to commissioners outlining options to manage the current demand by the end of May 2021. The Service, with support from the Corporate Performance Lead, will continue enhanced monitoring of progress. Referrals to be reviewed over the next 6 months to understand demand and to inform the discussion and business case with commissioners.	**Completed.** A business case was submitted and the commissioners requested more information. **Completed.** The number of referrals for Forensics and all three L&D teams are now at a level we would expect to see. **Ongoing.** Update to be in December	The service is reporting lower numbers of referrals and activity is now at a level that we would expect to see.

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

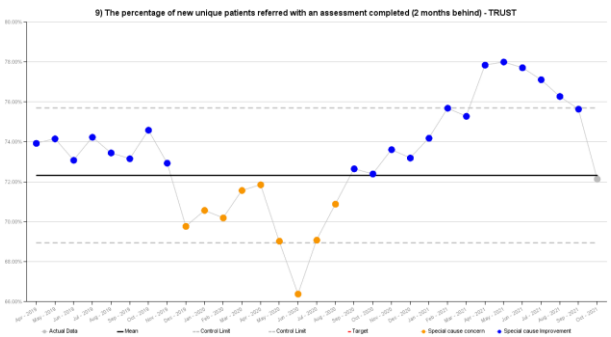
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

6980 patients referred in August; of those **5035 (72.13%)** patients have now had an assessment

Nothing to note. Our activity is within the expected levels of performance

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ ★ **100%**



KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Whilst as a Trust we are not assessing the numbers of new patients that we would aspire to, potential concerns were first highlighted in September 2020.	Analysis to be undertaken to understand whether there were any areas of concern.	**Completed.** Since September analysis has been undertaken in three localities and a number of issues have been identified. These are detailed on the following pages.	A decreasing position is visible and performance is now at a level we would expect to see.

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Tees Locality			
We are not assessing as many children & young people (CYP) within our generic Middlesbrough Community Team as we would like due to staff movement and sickness.	Plans to address staff absence and recruitment within the Middlesbrough Community team are underway.	**Ongoing. T**he Assistant Psychologist has started with the team; however the band 6 appointment withdrew and the interviews for the Psychological Therapist were unsuccessful. Both posts will be readvertised	No visible impact; however actions remain ongoing.
There has also been an increase in the number of referrals to the Hartlepool and Stockton Autism Spectrum Disorder (ASD) Team.	To support demand, 2½ days triage for waiting patients is to be implemented.	**Completed.**	
	A discreet 'triage service' is to be established.	**Ongoing**. The Triage Co-Ordinator and 0.5 whole time equivalent Applied Psychologist are in post. The remaining 0.5 post will commence in the New Year. The Applied Psychologist is going through recruitment clearances.	

TD09) The percentage of new unique patients referred with an assessment completed (2 months behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
North Yorkshire & York Locality			
Within Adult Mental Health (AMH) the York & Selby Mental Wellbeing Access service has been impacted by a significant increase in referrals.	'Stop the line' process to be initiated.	**Ongoing.** Urgent referrals are being risk managed through a triage process on the day of receipt and prioritised according to clinical need.	A decreasing position and concern is now visible; however actions remain ongoing.
	Routine triage to be offered to the backlog of patients waiting for assessment.	**Not started.** This will be established on the 2nd November.	
Within Mental Health Services for Older People the Hambleton and Richmondshire Memory service has been impacted by reduced consultant capacity.	The Locality Manager to develop a process enabling simpler diagnostic decisions to be made in a multi disciplinary meeting to facilitate quick assessment completion.	**Ongoing.** A process has been agreed with the Multi-Disciplinary Team and work is underway to embed within the service. This will be completed by the end of December 2021.	No visible impact; however actions remain ongoing.
There are a number of vacancies in Scarborough and Harrogate Memory Services. In addition, there has been a reduction in the number of venues in Ripon and Wetherby at which the Harrogate team can provide assessments.	Recruitment is underway to provide more staff to undertake assessments.	**Ongoing.** Posts within the Scarborough team are out to advert until November. The Harrogate team is recruited to and all staff are currently progressing through induction.	
	The Harrogate service to agree with primary care services the use of Ripon community building in and a Wetherby GP surgery.	**Ongoing**.	

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment is important to ensure we maintain high standards of care. Without this there may be an impact on the delivery of care and may affect our patients' recovery, as well as the wellbeing of our staff.

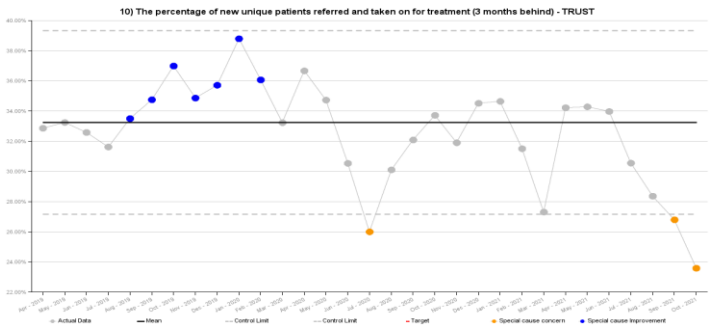
8106 patients were referred in July; of those, **1912 (23.59%)** patients have now been taken on for treatment

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

We need to investigate this to understand what's happened and/or take action

DQ

100%



KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we are not starting treatment with as many of our patients as we would like. Potential concerns were first highlighted in September 2020.	Analysis to be undertaken to understand whether there were any areas of concern.	**Completed.** Since September analysis has been undertaken in all localities and a number of issues have been identified. These are detailed on this and the following page.	A decreasing position and hence a concern is now visible; however actions remain ongoing.
Forensic Services			
We are treating fewer patients within our Liaison & Diversion Services than we would like. Many referrals are not appropriate for the service and are redirected for appropriate care and a number of clients leave custody prior to receiving assessment and treatment. Many contacts are via telephone, which is currently excluded from this measure.	A list of appropriate treatment codes to be agreed with Team Managers and Paris options to be limited to those relevant to the service. The Head of Health & Justice Services to raise the appropriateness of telephone contacts as a treatment method at the Service Development Group (SDG) in June 2021.	**Completed.** Agreed codes were circulated to staff with effect from December 2020. Paris changes implemented in June 2021. **Ongoing**. Following a review with the service, SDG agreed at its meeting on 20 October 2021 that the care provided by the service cannot be deemed clinically to be treatment. Approval will now be sought from Quality Assurance & Improvement Group to remove the L&D teams from the scope of this measure.	There has been some improvement visible but actions remain outstanding.

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Tees Locality			
We are treating fewer patients within Mental Health Services for Older People teams than we would like due to waits for a Computed Tomography scan to support a dementia diagnosis.	The Service to review the dementia pathway to minimise the number of patients referred for a scan to support pressures experienced during the pandemic.	**Completed.** The changes made to during the pandemic enabled us to offer a memory service to patients without interruption.	No visible impact; however actions remain ongoing.
	The Consultant Psychiatrist to lead a wider review of the dementia pathway to strengthen pathway leadership.	**Ongoing.** Planning meetings are scheduled for November.	
Some treatment codes are not recorded correctly.	Service Development Manager (SDM) to review all data quality issues.	**Completed**. The SDM has developed training which was rolled out to all staff on the 1st October 2021.	
Potential concerns have been identified within the MHSOP Middlesbrough and Hartlepool generic community teams. Sickness and vacancies within the teams is impacting the ability to progress as many patients to treatment as would be expected.	Sickness to be managed through the Long Term Sickness Team.	**Completed.** All episodes of long term sickness have ended and staff have returned to work.	
	Recruitment to be undertaken to fill all vacancies.	**Ongoing.** Recruitment issues are continuing. The closing date for current vacancies is 1st November 2021.	
Potential concerns have been identified within the MHSOP North Tees Liaison and South Tees Frailty teams.	Analysis to be undertaken by the Service Development Manager and Head of Service to determine whether this is attributable to the service model.	**Complete.** Analysis has confirmed that performance is attributable to the service model, as the teams primarily do not take patients on for treatment but signpost patients to the most appropriate services.	
Children & Young People's Services have a new service model, triaging referrals in a Single Point of Contact team so they can be directed to appropriate services for their needs. A high number of referrals has resulted in delay.	Development of an interim plan to streamline the referral processes	**Complete.** The plan is in place, incorporating temporary support from the Getting Help Teams to process the back log of referrals. Monitoring will continue to ensure the actions have had the desired impact.	No visible impact; however as the delay to assessment has already occurred within the backlog, it will take some time before we will see some visible improvement in the data.

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
North Yorkshire & York Locality			
We are concerned that within our Mental Health Services for Older People (MHSOP), there is a high number of patients waiting for treatment within the Harrogate Memory Service and this is attributable to capacity within the team.	Recruitment is underway with all staff due in post by the 15th October 2021, with an aim is to complete 20 assessments per week from November.	**Completed.** All staff are in post. Work is underway to complete assessments, ensuring that all patients requiring treatment can than progress appropriately.	No visible impact; however actions remain ongoing.
Potential data quality issues have been identified in the Harrogate Vanguard Community Care service.	The Locality Manager to undertake a deep dive during October to understand the underlying reasons; findings will be reported in November 2021.	**Completed**. The deep dive identified that assessment and treatment intervention codes are not recorded consistently on PARIS as this is not the team's primary patient based system.	
	The team manager to work with the team to resolve the current data quality issues and agree a data recording process. This work will be completed in November.	**Ongoing**.	
Within Children & Young People Services (CYP) the Northallerton, Selby, Harrogate and York East community teams have reduced staffing capacity due to a number of vacancies. This has been further affected by support they have been providing to the York CYP Crisis service.	Recruitment is underway, which would provide more staff to be able to provide treatment appointments.	**Ongoing.** The closing dates for vacancies is November 2021.	No visible impact; however actions remain ongoing.
	'Stop the line' process to be established to enable current processes to be reviewed.	**Ongoing.** A team away day is arranged for the 1st November to review the current status and agree the next steps to support team capacity and current clinical pressures.	
Potential recording issues have been identified within the Scarborough Community team.	The team manager to reviewing the use of treatment codes within the team during November. An update will be provided in December.	**Not started.** This work will be started in November.	

TD10) Percentage of new unique patients referred and taken on for treatment (3 months behind) continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Within Adult Mental Health (AMH) the Harrogate Community service has a number of vacancies that they are struggling to appoint to.	Recruitment is underway, which would provide more staff to be able to provide treatment appointments.	**Ongoing**. In response to difficulties to recruit staff, the team has amended their adverts, highlighting the virtues of working in the Harrogate area.	A decreasing position is visible and a concern is now shown; however, actions remain ongoing.
The York & Selby Wellbeing Access service has received a significant increase in referrals, which has impacted staff capacity as the team has a number of vacancies and some staff sickness. This has reduced the number of assessments that can be completed and consequently, the number of patients taken on for treatment.	'Stop the line' process to be established to enable current processes to be reviewed.	**Ongoing.** Daily reviews are in place and support is being provided by the York & Selby Community teams.	
	All referrals for patients that have been discharged within the last year to be allocated directly to the community teams in York and Selby.	**Ongoing.** The community teams are embedding new processes but this has initially impacted the number of patients seen for assessment.	
	The service to initiate a triage process to address the backlog of patients waiting for assessment from November 2021.	**Not Started**. Due to commence 2nd November 2021.	
	Recruitment is underway, which would provide more staff to undertake assessments.	**Ongoing**. The closing dates for vacancies is November 2021. All staff have returned to work following sickness.	
Durham & Darlington Locality			
A potential concern is now visible in Locality; however there has been no previous concern identified.	Close monitoring to be implemented to confirm whether this is just monthly variation or further investigations are required.	**Not started.** Close monitoring will be undertaken during November and an update provided in December.	

TD11) Number of unique patients discharged (treated only) – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

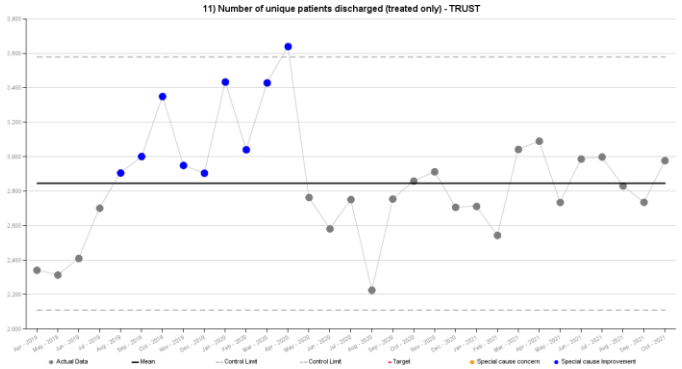
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are discharged from our services is important as it demonstrates that our patients are recovering and allows us to ensure we can maintain sufficient capacity to take on new patients.

2977 have been discharged in October after receiving treatment

There is no significant change in our performance. – it is within the expected levels.

We need to monitor this more closely to better understand what's happening before it becomes an area of concern

DQ ✓ **85%**



Locality	Variation
TRUST	
DURHAM AND DARLINGTON	
FORENSIC SERVICES	H
NORTH YORKSHIRE AND YORK	
TEESSIDE	L

SUMMARY

Whilst there is no concern with regards to the number of patients we are discharging from a Trust perspective, at a locality level there is a visible concern highlighted for **Tees**. First identified in July 2021, this has been fully investigated and attributed to:

- a restructure within the Children & Young Peoples Services generic community teams
- work with the Local Authority and commissioners to discharge Mental Health Act Section 117 patients back to local care from the Mental Health Services for Older People Intensive Community Liaison & Psychiatry team

Therefore at this point we can conclude this is not an area of actual concern.

TD12) Bed Occupancy (AMH & MHSOP A & T Wards) – *Trust Standard 90%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

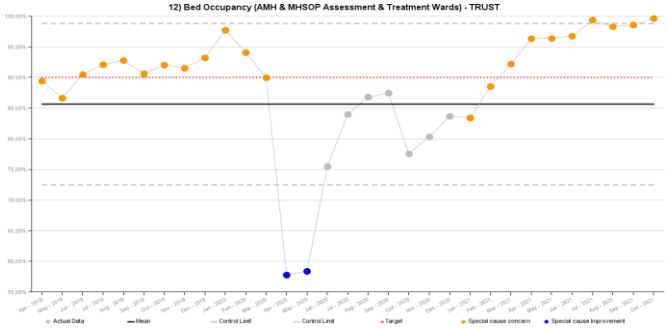
During October **10,912** daily beds were available for patients; of those, **10,873 (99.64%)** were occupied.

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

We need to investigate this to understand what's happened and/or take action

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

DQ ✓ **85%**



Locality	Variation	Assurance
TRUST	H	?
DURHAM AND DARLINGTON	H	?
NORTH YORKSHIRE AND YORK	H	?
TEESSIDE	H	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned we have a greater number of patients occupying our inpatient beds than we would expect. Whilst this was first identified as a concern in June 2021, it has been monitored since September 2020 as there are a number of pressures on inpatient services within Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP). Whilst the number of admissions are at a level we would expect, occupancy is above a safe level and we have been unable to identify a safe, sustainable and robust plan to enable us to be flexible with bed capacity when required.	Analysis to be undertaken to understand the impact of community pressures, available resources and other factors, including out of area placements, to identify any areas of concern.	**Completed.** Following initial analysis, data is monitored monthly.	No visible impact; however actions are still ongoing.
	Demand forecasting analysis to be undertaken to understand future pressures.	**Completed.** Analysis shared with Chief Operating Officer, directors and key representatives of inpatient management. Routine monitoring agreed.	
	Four beds to be purchased in the independent sector for AMH and MHSOP patients.	**Completed:** Contract commenced 13th August 21 and will run to the 31st January 22. All 4 beds are occupied.	
	Increased focus to be given to inpatient pressures at Locality Quality Assurance & Improvement Groups.	**Ongoing.** Initial discussions took place within the October meetings and concern remains in respect the shortage of staff on the wards. Further discussions will take place at the November meetings.	
	External support to help us to understand if there is anything further we can do to manage inpatient pressures and out of area placements to be commissioned.	**Ongoing**. The specification has been completed and is currently with County Durham & Darlington Foundation NHST Trust for process of the procurement request.	

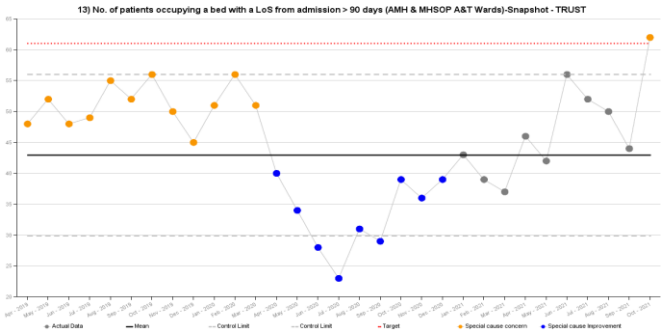
TD13) Number of patients occupying a bed with a length of stay (from admission) greater than 90 days (AMH & MHSOP A&T Wards – *Trust Standard no more than 61 patients*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

As at the 31st October 2021, **62** inpatients had a length of stay longer than 90 days

H – We're aiming to have low performance and we're moving in the wrong direction.	! – We need to investigate this to understand what's happened and/or take action
P – Our system is expected to consistently hit the target/expectation	DQ ★ – **100%**



Locality	Variation	Assurance
TRUST	H	P
DURHAM AND DARLINGTON	H	?
NORTH YORKSHIRE AND YORK		P
TEESSIDE	H	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Whilst we are achieving standard, we are concerned there are a small number of our Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP) patients staying in beds longer than they need to be. This was first identified as a potential area of concern in **Durham & Darlington** in June 2021 and is due to the needs and level of support required for the patients in their care.	Analysis to be undertaken to understand the impact of community pressures, available resources and other factors, including out of area placements, to identify any areas of concern.	**Completed.** Following initial analysis, data is monitored monthly.	A significant increase is now visible within the data; however, actions remain ongoing.
	Demand forecasting analysis to be undertaken to understand future pressures.	**Completed.** Analysis shared with the Chief Operating Officer, directors and key representative of inpatient management. Routine monitoring agreed.	
	AMH service to form a Quality Assurance Group (QuAG) sub group to discuss and agree further actions.	**Ongoing.** QuAG met on the 3rd November 2021 and a further meeting has been arranged for the 19th November to discuss this measure.	
	Work is underway within MHSOP with Local Authorities to facilitate discharges into local care following the issue of new legislative guidance. An update will be provided in December.	**Ongoing.** Conversations are continuing with commissioners.	

TD14) Percentage of patients re-admitted to Assessment & Treatment wards within 30 days – *Trust Standard 9.90%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

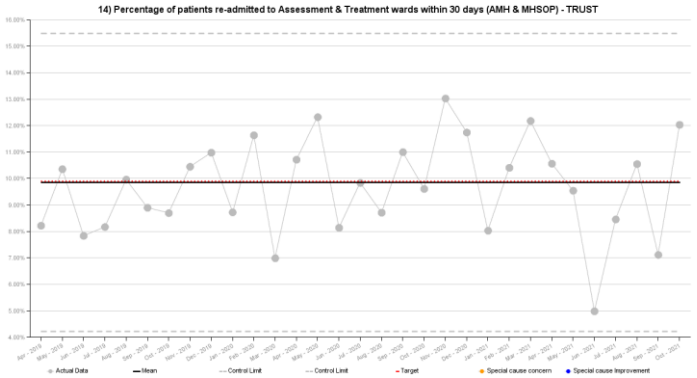
241 patients were discharged during October; of those, **29 (12.03%)** were readmitted within 30 days

There is no significant change in our performance. – it is within the expected levels.

No further action is needed at this point in time

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

DQ ✓ **85%**



Locality	Variation	Assurance
TRUST		
DURHAM AND DARLINGTON		
NORTH YORKSHIRE AND YORK		
TEESSIDE		

SUMMARY

Whilst we have achieved the standard we have set ourselves, we are concerned there are a number of pressures on inpatient services within Adult Mental Health (AMH) and Mental Health Services for Older People (MHSOP); however the number of patients being readmitted within 30 days of their previous admission are not a concern at this time.

All of these patients have 'Familiar face' plans in place to support their care and transition into the community. These plans continue to be reviewed and updated following each admission.

TD15) Finance Vacancy Rate – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

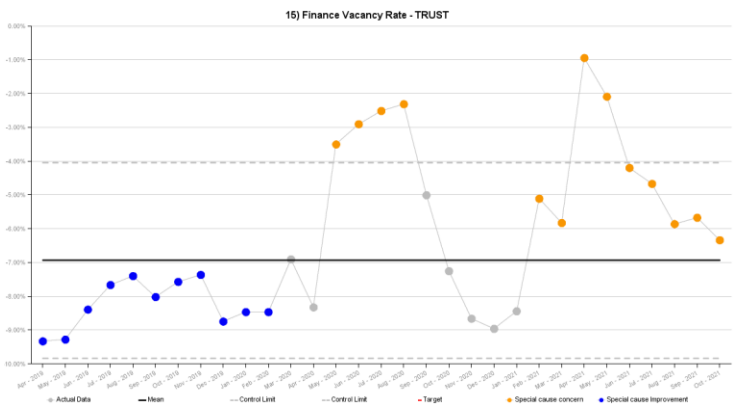
We are all committed to co creating a great experience for patients, and carers and families by ensuring we have staff available in the right place and with the right skills, supporting continuity of care for our patients. As a Trust having a full establishment ensure we can manage our resources and finances effectively.

During October we budgeted for **7557.57** full time posts; however **478.99 (6.34%)** of these were vacant

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

We need to investigate this to understand what's happened and/or take action

DQ ✓ **80%**



KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that we have a high number of vacancies across the Trust. First identified in August 2021, the highest levels were identified within Tees and North Yorkshire & York.	Analysis to be undertaken to understand whether there were any areas of concern.	**Completed.** Analysis has been undertaken and a number of issues have been identified. These are detailed on this and the following page.	No visible impact; however investigations are still continuing.
Tees Locality The current position within Children and Young People's (CYP) services is impacted by significant investment into the Child Eating Disorder service earlier in the year. Whilst a number of people are in post, the service model is in the process of being developed and the remaining posts will not be recruited to until the end of this financial year.	Head of CYP and team managers to agree the service model and complete recruitment by the 31st March 2022. An update will be provided in December 2021.	**Ongoing**.	No visible impact; however actions are still continuing.

TD15) Finance Vacancy Rate – *No Trust Standard monitoring only*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
There is a high number if vacancies within Adult Learning Disability (ALD) Services.	To undertake a recruitment campaign with the external company Indeed, to support the recruitment of up to 18 Health Care Assistants (HCA). This work is being led by the Head of ALD and is part of the work around changing the workforce model for Inpatient services.	**Ongoing.** A rolling job advert is in place and 13 posts have been recruited to; the recruitment team are working to agree start dates.	Although a decreasing position is now visible within the data, this does not yet denote an actual improvement.
	Head of ALD to develop a 12 month recruitment strategy for LD services. The aim is to market the service and nursing roles and includes linking with local schools and colleges to promote the role of ALD nurses. An update will be provided in January 2022.	**Ongoing**.	
North Yorkshire & York Locality			
All specialities within the locality are struggling to recruit, with nursing posts, in general, and the Scarborough, Whitby & Ryedale area, in particular, being impacted the most.	Employment of a Project Manager for Recruitment & Retention to support intensive improvement work.	**Completed.**	No visible impact; however actions are still continuing.
	Vacancy advertisements to be improved, including communication methods (eg using social media) and international recruitment. An update will be provided in February 2022 once these have been embedded.	**Ongoing**.	
	A 1-year pilot to be undertaken for Scarborough Inpatient services, to enable a premier to be paid to staff recruited to these posts.	**Ongoing**. The Director of Operations is to hold a meeting with Locality Managers on the 15th November to agree how to monitor progress.	
	A community bank service to be created within the Trust to reduce the use of agency staff. An update will be provided in January 2022.	**Ongoing**.	
	An exercise to be undertaken by the Senior Project Officer Recruitment & Retention to identify the reasons for staff leaving and actions we can take to improve retention. An update will be provided in January 2022.	**Ongoing.**	

TD16) Percentage of staff in post with a current appraisal (snapshot) – *Trust Standard 95%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our staff having the appropriate levels of training to maintain their skills, which is vital if we are to provide high quality and safe services.

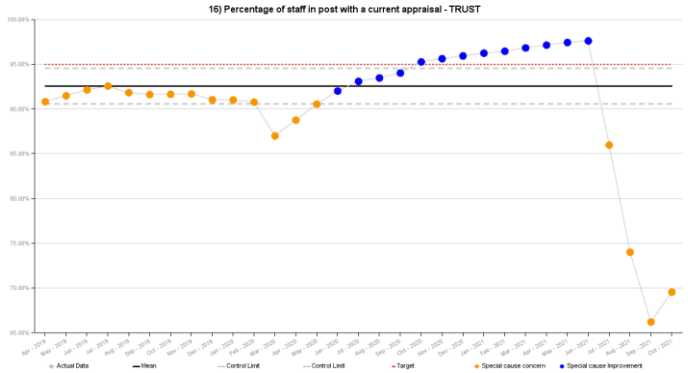
Of the **6276** eligible staff in post at the end of October; **4365 (69.55%)** had an up to date appraisal

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

Our system is expected to consistently fail the target/expectation

We need to investigate this to understand what's happened and/or take action

DQ **100%**



Locality	Variation	Assurance
TRUST	L	F
DURHAM AND DARLINGTON	L	?
FORENSIC SERVICES	L	?
NORTH YORKSHIRE AND YORK	L	F
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that staff within our Localities have not received timely appraisals. To support business need during the pandemic, staff were given a series of extensions to ensure clinical care was prioritised. These grace periods started to expire in June and as a result we are starting to see the reduction in compliance.	Services to provide trajectories to be presented to the Locality Quality Assurance & Improvement (QA&I) Groups in October 2021.	**Ongoing.** A Trust-wide tool has been developed that will enable the localities to map their existing resources and identify the appropriate trajectories towards ensuring all staff have up to date appraisals. Work is now underway within the localities to complete the tool.	No visible impact; however actions remain ongoing.

TD17) Percentage compliance with ALL mandatory and statutory training (snapshot) – *Trust Standard 92%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our staff having the appropriate levels of training to maintain their skills, which is vital if we are to provide high quality and safe services.

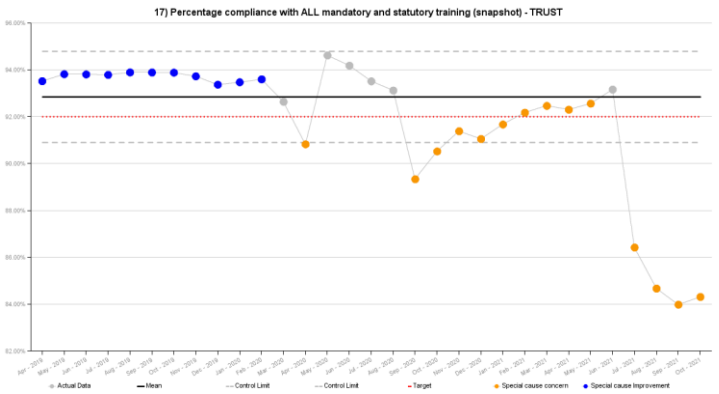
101,066 training courses were due to be completed for all staff in post by the end of October. Of those, **85,210 (84.31%)** courses were actually completed

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

We need to investigate this to understand what's happened and/or take action

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

DQ ★ **100%**



Locality	Variation	Assurance
TRUST	L	?
DURHAM AND DARLINGTON	L	?
FORENSIC SERVICES	L	P
NORTH YORKSHIRE AND YORK	L	?
TEESSIDE	L	?

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that staff within our Localities have not undertaken training in the required timescales. To support business need during the pandemic, staff were given a series of extensions to ensure clinical care was prioritised. These grace periods started to expire in June and as a result we are starting to see the reduction in compliance.	Services to provide trajectories to be presented to the Locality Quality Assurance & Improvement (QA&I) Groups in October 2021.	**Ongoing.** A Trust-wide tool has been developed that will enable the localities to map their existing resources and identify the appropriate trajectories towards ensuring all staff have up to date training. Work is now underway within the localities to complete the tool.	No visible impact; however actions remain ongoing.

TD18) Sickness Absence – *Trust Standard 4.30%*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work.

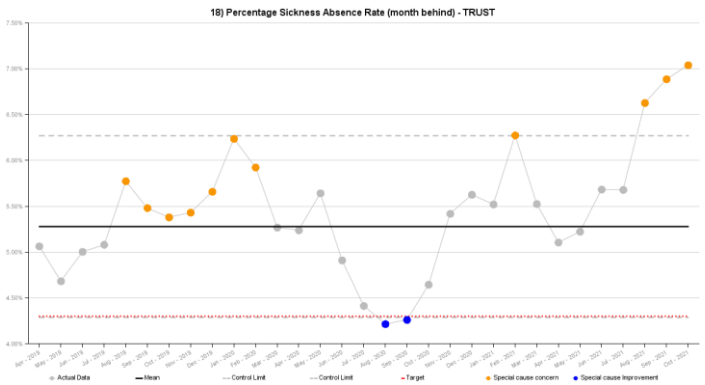
There were **206,080.60** working days available for all staff during September; of those, **14,505.65 (7.04%)** days were lost due to sickness.

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

We need to investigate this to understand what's happened and/or take action

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

DQ ✓ **85%**



Locality	Variation	Assurance
TRUST	H	?
DURHAM AND DARLINGTON	H	?
FORENSIC SERVICES	H	F
NORTH YORKSHIRE AND YORK		?
TEESSIDE	H	F

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
We are concerned that more members of our staff have been absent from work due to sickness than we would like.	Actions are detailed overleaf and following for each locality.		No visible impact; however actions are still ongoing
Durham & Darlington Locality			
Sickness within the Crisis team in Adult Mental Health Services is being impacted by current low staffing levels.	Team Manager to ensure all long term sickness Is managed in line with Trust policy.	**Ongoing.** Regular reviews are in place.	No visible impact; however actions are yet to be identified
	Recruitment is underway to increase capacity within the team.	**Ongoing.** Recruitment is underway for 17 posts; an update will be provided in December.	

TD18) Sickness Absence continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

KEY ISSUES	ACTIONS BEING TAKEN	PROGRESS	IMPACT
Forensic Services			
This was first identified as a concern in May 2020 and issues identified included a number of long term sickness episodes and the impact of Covid-19.	An action plan is in place for Forensic Services.	**Ongoing.** There are 6 actions within the plan; 2 completed, including the quarterly reviews for any staff within restrictions. A number of actions were due for delivery in October but have been delayed due to staffing and business continuity pressures. • Review leaver information to establish if there are factors relating to sickness from staff leaving the teams. There have been no returned leavers questionnaire from SIS between April – Sept 21 to enable any analysis. This has been escalated within the service to ensure that all leavers questionnaires are being forwarded to Human Resources. • Review vacancy/use of bank staff. Completed within SIS; actions are being developed. This has been delayed in H&J and whilst bank staff are used to a lesser extent, a review will still be completed by the end of December 21. • Review absences in Apr 20 – Mar 21 relating to anxiety/stress and other psychiatric issues to establish any themes. The review is complete and findings are to be shared and any actions agreed by the end of December 21. • Review with Service if any additional support is required for staff with anxiety relating to COVID-19. Originally due in November 21, the review is complete and findings are to be shared and any actions agreed by the end of December 21. • Human Resources to carry out audits of staff personal files / sickness data to ensure sickness is being managing in line with the Trust Sickness Absence Management procedure. Due for completion in November 21, this work has commenced with one ward complete but has been delayed due to capacity issues within the Operational Human Resources team. HR expect to be in a position to restart audits in April 2022 but are looking at an alternative way of undertaking the audits as part of the sickness procedure review, which will help ensure these are not only timely but any actions are picked up appropriately.	No visible impact; however actions are still ongoing.
Tees Locality			
A potential concern is now visible in Tees Locality; however there has been no previous concern identified.	Close monitoring to be implemented to confirm whether this is just monthly variation or further investigations are required.	**Completed.** Close monitoring has been undertaken during October and further analysis will be undertaken to confirm whether this is an actual area of concern.	An increasing position is visible since July 2021.

Finance Measures

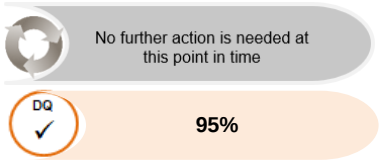
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

TD19) Delivery of our Financial Plan (I&E)

We delivered a (**£5,830k)** surplus to 31st October against a planned year to date surplus of **(£5,109k),** including £420k unplanned profit on asset disposal.

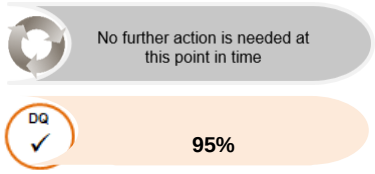
(£721k) Favourable variance from plan



TD 21) Cash against Plan

We have an actual cash balance of (**£89,434k)** against a planned year to date cash balance of (**£82,231k)**.

(£7,203k) Favourable variance from plan



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

SUMMARY

The Trust has an approved plan for the first 6 months of the financial year (H1) to achieve a surplus of (£4,720k), and operational performance for the same period of £5,021k surplus. National planning guidance was released for the second 6 months (H2) on 1st October and detailed run rate analysis indicates a H2 surplus of (£47k) is expected, providing a full year plan equivalent to (£5,068k). The year to date surplus at 31st October is (£5,830k), against (£5,109k) year to date plan. This includes (£420k) of unplanned profits from a fixed asset disposal (land); which are excluded when assessing financial performance compared to plan.

Plan guidance for 2022/23 is not expected until mid-December 2021, with ICS-level allocations potentially issued alongside or early in 2022, with draft planning submissions expected February and final plans in March. In anticipation of the 2022/23 guidance, Business Planning activities to assess, coordinate and prioritise resource requirements for the new financial year, have commenced. This includes assessing options for delivering recurrent cash releasing efficiency savings and the scoping of opportunities identified pre-Covid. Key programmes of work include:

- reconciliation of our anticipated income compared to forecast expenditures
- agreeing key planning assumptions, including for workforce recruitment, turnover, vacancy profiles and their management
- agreeing key planning assumptions for risks associated with inflation risk on funding mechanisms for nationally negotiated Agenda for Change and increased employer contributions for NHS Pensions, which are currently funded nationally, but for which recurrent funding arrangements are not known.

Cash balances are higher than planned due to fluctuations in working capital, particularly relating to deferred income (largely HEE income received to January 2022) and higher accounts payable accruals.

Financial performance and planning is discussed periodically at the Board of Directors, Financial Sustainability Board, Locality Management meetings and Strategy and Resources Committee.

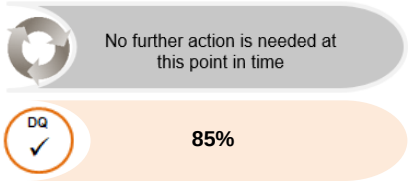
TD20) CRES Delivery

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We have **£767k** Cash-Releasing Efficiency Savings planned to October and have identified **£767k non-recurrent** Cash-Releasing Efficiency Savings

£0k Variance to plan



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

SUMMARY

Cash-Releasing Efficiency Savings (CRES) requirements arise where NHS organisations need to balance expenditure to within overall income, including to deliver national efficiency expectations (set out in national tariff assumptions) and to deliver relevant organisational and / or system financial plan requirements. Tariff adjustments are usually applied to provider contracts annually and comprise:

- a national % uplift for estimated pay and price inflation
- A national % deduction for the required annual efficiency requirement

Providers receive the 'net' of an inflationary % uplift less the efficiency % deduction, meaning cash releasing efficiency savings are needed to maintain real terms funding levels. CRES requirements for organisations may exceed the national tariff efficiency level where other cost pressures need to be managed. The NHS seeks to find more cost efficient ways of delivering services and utilising resources. CRES might, for example include reviewing processes, staffing skills mix, premises utilisation, procurement and digital solutions.

As a result of national financial arrangements operating during the pandemic, the focus on CRES was initially suspended. More recently, the NHS has been asked to deliver CRES during 2021/22 with a view to returning to business as usual processes and arrangements from 2022/23. Nationally, 0.28% was targeted during H1 (April to September) with a national requirement of 1.1% during H2 (October to March).

It is anticipated that a higher level of CRES will be targeted nationally from 2022/23 as the NHS and wider public sector look to re-establish more normal financial flows. In preparation, the Trust is starting to focus on identifying 2022/23 recurrent efficiency or waste reduction schemes through annualised Business Planning arrangements and with Financial Sustainability Board oversight.

NHS Oversight Framework

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

SUMMARY

The majority of national standards within the NHS Oversight Framework have been achieved for October 2021; however there is 1 exception to this:

1. **Inappropriate out of area placements for adult mental health services -** *This measure is contained within the Board Performance Dashboard (TD03) please see page 15 for further details.*

A new System Oversight Framework was released in June 2021, setting out NHS England and NHS Improvement's (NHSE/I) approach to the oversight of integrated care systems, CCGs and trusts, with a focus on system-led delivery of care. A review is underway to identify the requirements and work that needs to be undertaken to establish Trust assurance mechanisms. Pending the development of that report, monitoring of last year's Oversight Framework has continued.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 12

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday, 25 November 2021**
TITLE:	**Revised Organisational Structures**
REPORT OF:	**Brent Kilmurray, Chief Executive**
REPORT FOR:	**Approval**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	√
To co create a great experience for our colleagues	√
To be a great partner	√

EXECUTIVE SUMMARY:

Tees Esk and Wear Valley NHS Foundation Trust is a public benefit organisation that was authorised in accordance with the provisions of the National Health Service Act (2006) as amended by the Health and Social Care Act 2012. The 2006 and 2012 NHS Acts set out the legal framework that the Trust is required to operate. In addition to this, since 2013, all NHS Foundation Trusts were issued with a Licence from NHS Improvement.

The Trust is regulated by the Care Quality Commission (CQC) and NHS England and Improvement (NHSE/I) via a provider licence.

To support the Trust in meeting its legal, regulatory duties and delivering its strategy it has a governance structure in place. Evidence collected from the Trust's internal learning, feedback obtained through Our Big Conversation, the Good Governance Institute's (GGI) Independent Well-led review; and the CQC's feedback confirm that there is a need to make changes to deliver services and how they are implemented through the Trust's internal governance structures and processes.

This paper includes a revised governance structure that has been developed to strengthen governance arrangements from ward to Board, which is supported by Executive Team. It has been developed following engagement with staff and staff side supporting the case for change restructure of clinical and operational services.

RECOMMENDATIONS:

The Board of Directors is asked to:

1. Receive, note and approve the proposed governance structure; and

2. Note that subject to Board approval on the revised governance structure work will begin to produce Terms of Reference, an Accountability Framework; and update Standing Orders, Standing Financial Instructions and the Risk Management Strategy/Policy.

Board of Directors (held in Public)

25 November 2021

Revised Organisational Structures

Report of the Chief Executive

1.0 Introduction and Purpose

1.1 The purpose of this paper is to provide the Board of Directors with rationale for changing its current governance structure to strengthen governance from ward to Board.

2.0 Background

2.1 Tees Esk and Wear Valley NHS Foundation Trust (the Trust) is a public benefit organisation that was authorised in accordance with the provisions of the National Health Service Act (2006) as amended by the Health and Social Care Act 2012. The 2006 and 2012 NHS Acts set out the legal framework that the Trust is required to operate. In addition to this, since 2013, all NHS Foundation Trusts were issued with a Licence from NHS Improvement.

2.2 The Trust's constitution sets out how it should conduct its business as an organisation providing NHS health care services. The Trust is regulated by the Care Quality Commission (CQC) and NHS England and Improvement (NHSE/I) via a provider licence. Compliance to the CQC and NHSE/I is regularly monitored with the CQC and NHSE/I regularly sharing information about providers to agree the most appropriate form of support or action if appropriate.

2.3 To support the Trust in meeting its legal, regulatory duties and delivering its strategy it has in place a governance structure (**Appendix A**). Evidence collected from the Trust's internal learning, feedback obtained through Our Big Conversation, the Good Governance Institute's (GGI) Independent Well-led review; and the CQC's feedback confirm that there is a need to make changes to deliver services and how they are implemented through the Trust's internal governance structures and processes. To address this a revised governance structure has been developed to strengthen governance arrangements from ward to Board, which is supported by Executive Team. It has been developed following engagement with staff and staff side supporting the case for change restructure of clinical and operational services.

3.0 Key Issues

3.1 A revised governance structure (**Appendix B, Appendix B.1 and Appendix B.2**) has been developed, a description of the different levels that form part of this structure is described below:

3.2. Board of Directors and Council of Governors Relationship

3.2.1 The relationship between the Board of Directors and Council of Governors remains unchanged. The Council has a statutory duty to hold the Non-executive Director individually and collectively to account for the performance of the Board. This includes ensuring the Board acts so that the Trust does not breach the conditions of its License. It remains the responsibility of the Board to design and implement agreed priorities, objectives and the overall strategy of the Trust. The Council is responsible for representing the interests of the Trust members, the public and staff in the governance of the Trust.

3.3 Board of Directors and Board Committees

3.3.1 The Chair is responsible for the leadership of the Board (and the Council of Governors) and chairing all Board (and Council) meetings when present. The Chair ensures effectiveness in all aspects of the Board's role and leads on setting the agenda for meetings to ensure that adequate time is available for discussion of agenda items and strategic issues. The Chair is also responsible for ensuring the Board and Council of Governors work effectively together.

3.3.2 Board Committees are chaired by Non-executive Directors. The Trust's objectives are aligned to Board Committees and they are tasked to provide assurance to the Board on the duties and responsibilities delegated by the Board to them.

3.3.3 The Board Committees and supporting Terms of Reference were approved by the Board in May 2021. There are no changes proposed to Board Committees Terms of Reference at this time, the outcome of their annual effectiveness is planned to be reported to the Board in May 2022. The redesign of the governance structure is aimed to enhance the working of the Board and Board Committees. Evidence[1] suggests that the current governance structure has resulted in a number of Board Committees being operational, the revised governance structure aims to change this with Executive and Care Boards having responsibility for clinical/operational delivery through an accountability framework.

3.4 Executive Director Team and Sub-Groups

3.4.1 Executive Director Team is defined as a company's most senior executives as designated by the Board of Directors. Executive Director Team will report directly to the Board of Directors, it will meet weekly and will be chaired by the Chief Executive as the Accountable Officer responsible for running the Trust's business, ensuring the discharge of obligations and guidance issued by the Trust's Regulators or any other relevant body. The Executive Team membership will include all Executive Directors who shall exercise their authority within Standing Orders, Standing Financial Instructions and Delegation of Powers.

3.4.2 The Executive Director Team will provide focus for discussion on the operational running of the Trust, receiving and considering information for approval prior to release to Board and the Board Committees. Essentially with the support of its Sub-groups, Executive Director Team will monitor operational delivery with the aim of providing a well governed and formal mechanism as part of holding the Care Boards to account.

3.4.4 Sub-groups of Executive Director Team will have a dotted line to Board Committees to support their assurance function. An example of this can be found below:

Risk Management Group, a sub-group of Executive Director Team will directly report to Executive Director Team meeting but will have a dotted reporting line to the Audit and Risk Committee to provide assurance on risk management and the effective system of internal control. The Audit and Risk Committee at each meeting will receive its assurance through minutes of the Risk Management Group meetings, the Corporate Risk Register and the Board Assurance Framework.

3.5 Management Group

3.5.1 Management Group (MG) will meet monthly, chaired by the Chief Executive with membership bringing together Executive Directors and leaders from across the organisation. MG's key aim is to ensure communication, engagement and consultation takes place.

[1] the Trust's internal learning, feedback obtained through Our Big Conversation, the Good Governance Institute's (GGI) Independent Well-led review; and the CQC's feedback

3.6 Care Group Boards and Sub-Groups

3.6.1 There will be two Care Group Boards, which will directly report to the Executive Team Meeting with oversight on specific areas of work by Executive Team Sub-groups (dotted line) prior to approval made by the Executive Directors Meeting.

3.6.2 Care Group Boards will meet monthly, chaired by a Managing Director with Care Group senior leadership team membership. The senior leadership team within the Care Groups will have a direct reporting line to the Managing Director and will be professionally accountable to their executive professional lead. This arrangement will require the Care Board's to be accountable for operational delivery, giving them the autonomy through an Accountability Framework.

3.6.3 The governance structures will be supported by clinical networks, integrated performance reporting and risk management arrangements.

3.7 Clinical Networks

3.7.1 Clinical Networks are integral to the success of the revised structures, they will run across all areas Trust wide, which are displayed in **Appendices B, B.1 and B.2** and they will require proactive clinical leadership to embrace expertise, that is evidence based, research driven and knowledgeable about best practice. Clinical Networks will be innovators, with strong internal and external relationships and will look to inform best practice nationally through publishing and promoting the Trust successes and learning.

3.7.2 The networks will be chaired and led by Clinical Directors, each paired with a Care Group Director and supported by a clinical manager. Members of the networks will be drawn from the working clinical body and include colleagues that have key expertise. Members will be nominated for a term by their Care Group Board. These will be prestigious and valued positions; managers will ensure that there is a fair provision of time available within individuals' job plans to contribute to the work to be done. Being a member of a clinical network will mean more than attending meetings or commenting on the work of others; they will be actively engaged in what the Trust is aiming to achieve and are expected to make a key contribution to the Trust and the ICS.

3.7.3 As part of the updated governance structure, Clinical Networks will have a dotted reporting line into the Clinical Leaders Group and Executive Sub-groups, they will be members of Management Group and will provide updates on progress against their plans.

3.8 Risk Management

3.8.1 Risk Management is recognised as an integral part of quality improvement and good governance. The introduction of Risk Management groups within the governance structure aims to strengthen the oversight and management of risk throughout the organisation.

3.8.2 A Risk Framework (**Appendix C**) has been designed as a working example of how risk can be managed at the different levels of the Trust, to provide a mechanism for escalating risks from ward to Board whilst retaining the sensitivity to monitor changes at a local level.

4.0 Implications

4.1 Following Board approval Terms of Reference, Standing Orders, Standing Financial Instructions, the Scheme of Delegations, Risk Management Strategy/Policy and an Accountability Framework will need to be developed or updated as appropriate.

4.2 Communication and engagement with staff as well as relevant training across the organisation will be key to embed the required changes.

4.3 Work is underway to develop an integrated performance report, which will support the revised governance structure. Plans are also in place to strengthen risk management support through the appointment of a Risk Manager. Risk management support within the Care Boards will be needed to support this revised governance structure.

5.0 Compliance with the CQC Fundamental Standards

5.1 The revised governance structure aims to support the Trust as a vehicle to improve its governance systems and processes to support compliance against the CQC fundamental standards.

6.0 Financial/Value for Money

6.1 The revised governance structure aims to enable the Trust to receive assurance on its responsibilities, failure to do so can be costly.

7.0 Legal and Constitutional (including the NHS Constitution)

7.1 Supports the Trust's compliance with legal and regulatory requirements, including the NHS Act 2006 as amended by the NHS 2012 Act.

8.0 Equality and Diversity

8.1 None identified.

9.0 Other Implications

9.1 None identified.

10.0 Risks

10.1 Subject to Board approval the revised governance structure will be reliant on the following to support its successful implementation: the development of Terms of Reference for everything below Board Committee level; development of an Accountability Framework, updating the Trust's Risk Management Strategy/Policy, Standing Orders, Standing Financial Instructions and Delegation of Powers; ensuring clear communication, engagement and relevant training plans are in place.

10.2 Risk management support is key to ensure an increased focus on the management of risk from ward to Board. The appointment of a Risk Manager will require support within the Care Boards to help change the culture and to drive forward the required changes.

11.0 Recommendation

The Board of Directors is asked to:

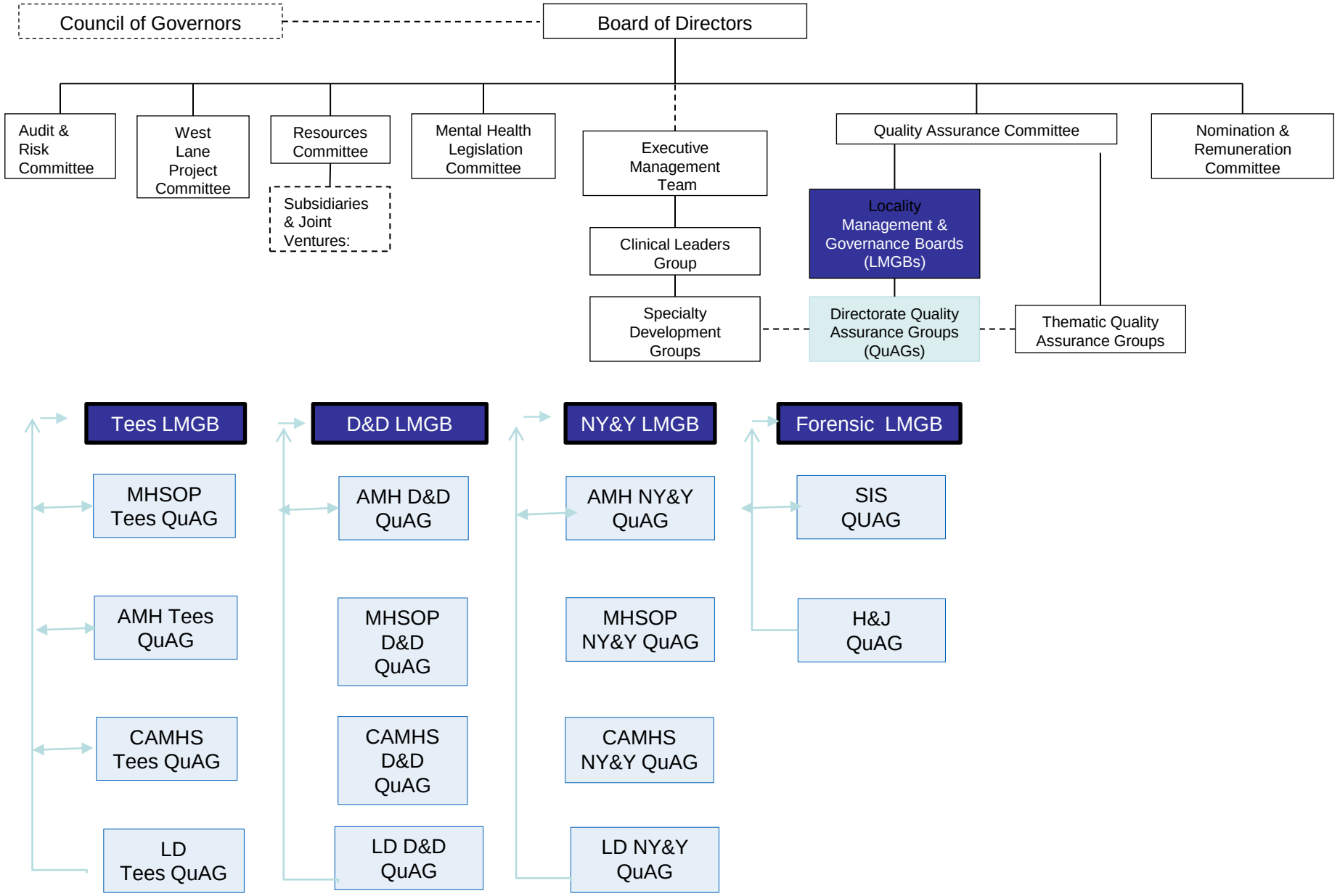
i) Receive, note and approve the proposed governance structure; and

ii) Note that subject to Board approval on the revised governance structure work will begin to produce Terms of Reference, an Accountability Framework; and update Standing Orders, Standing Financial Instructions and the Risk Management Strategy/Policy.

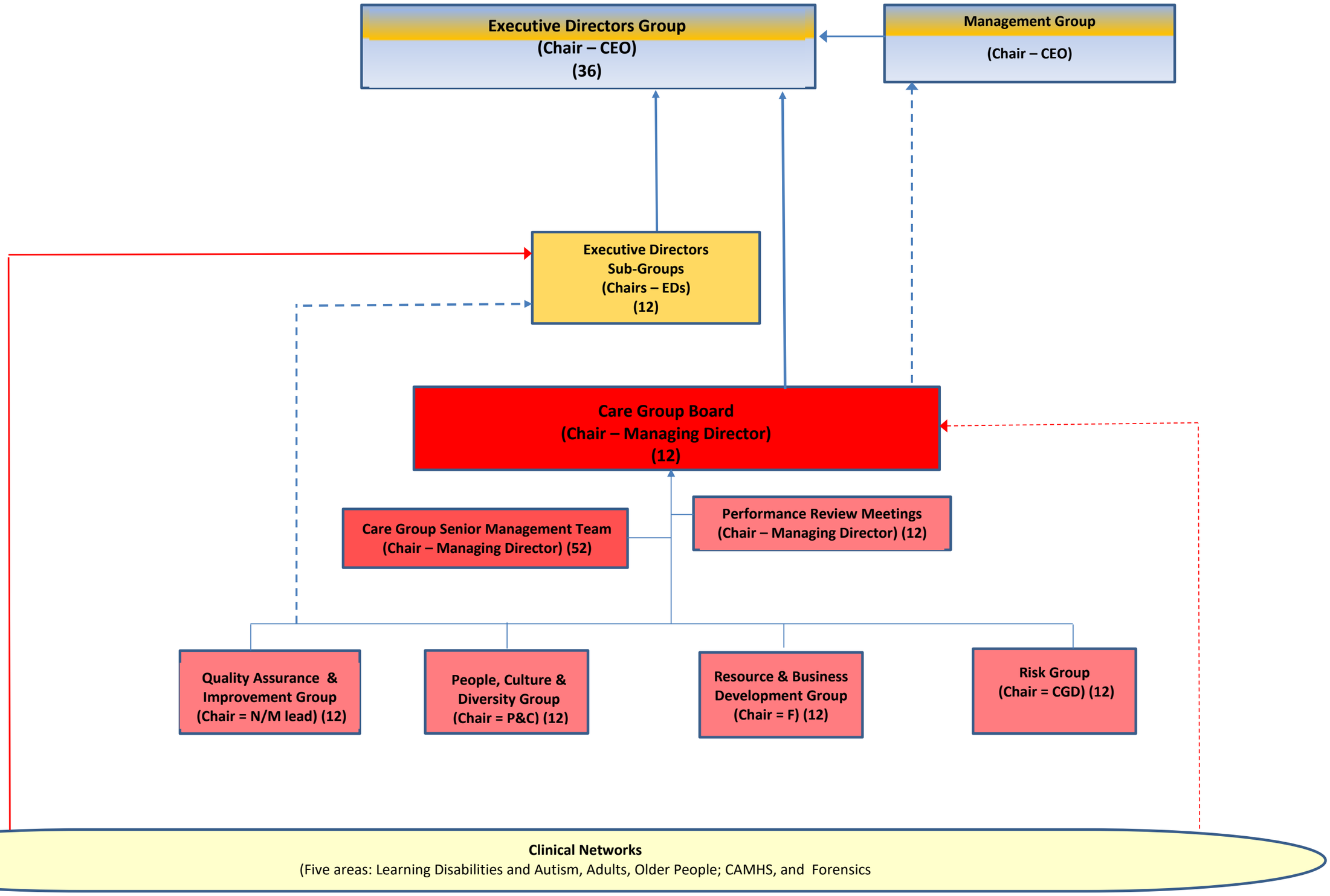
Supporting Papers:

Appendix A Current Governance Structure
Appendix B Revised Governance Structure
Appendix B.1 Revised Care Board Structure (Durham, Tees Valley and Forensic)
Appendix B.2 Revised Care Board Structure (North Yorkshire, York and Selby)
Appendix C Risk Management Framework

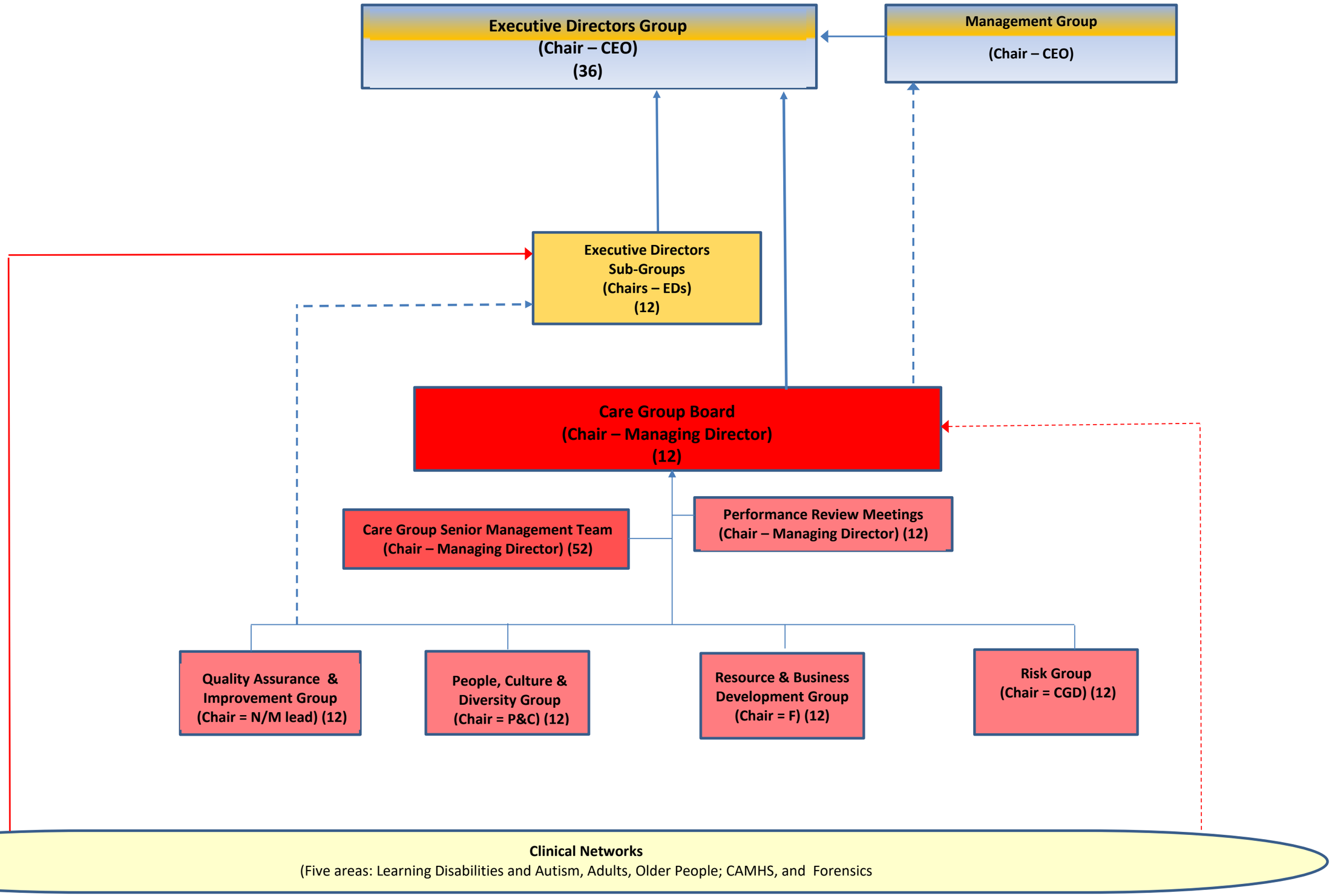
Appendix A: Current Trust governance structure



Care Group - Durham, Tees Valley and Forensic



Care Group - North Yorkshire, York & Selby



Appendix C

Risk Escalation Framework

Risk Review and Escalation

The diagram below illustrates the role that each forum is required to undertake in relation to the Board Assurance Framework (BAF) and the Risk Register. It takes into consideration what each group should be in receipt of and the role it is accountable for discharging:

In receipt of….		Accountable for….
• BAF (in full at start of year, then quarterly or bi-annual review) • 15+ risks (summary of corporate risk register)	**Board of Directors**	• Seeking assurances through Board Committees that the risks are being managed effectively at the Trust and the BAF is being kept up to date • Ensuring that the BAF/corporate risks are driving appropriate debate
• Risk strategy and risk policy • BAF • 15+ Risk Register	**Audit and Risk Committee**	• Seeking assurances on the risk management and internal control
• Relevant section of the BAF allocated to each Committee for ongoing review	**Board Committee**	• Seeking assurance on behalf of the Board that strategic risks identified through the BAF are being appropriately managed by Executive leads, assurances/mitigations are correctly identified and actioned, and strategic risks updated accordingly
• 15+ Risk Register • Risk movement log • Risk Dashboard • BAF	**Executive Risk Group**	• Scrutiny and challenge on organisational risks scoring 15+ • Review, accept/refuse any new 15+ risks • Holding Care Group/Corporate Divisions to account for timely and appropriate management of risk
• 12+ Risk Register • Risk Movement log • Care Group Risk Dashboard	**Care Group**	• Scrutiny and challenge of 12+ Care Group risks • Identify common risks/trend
• Care Group Risk Dashboard	**Care Group Risk Meeting**	• Scrutiny and challenge of 8+ Care Group risks • Holding services/departments to account for effective and timely management of risks
• Speciality/Department Risk Register	**Specialty/Department**	• Ensuring effective and timely management of risks held by the Speciality/Department with risk registers updated and maintained in a timely manner

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item no 12

Quality Assurance Committee: Key Issues Report

Report Date: 25th November 2021		
Date of last meeting: **4th November 2021**		**Membership** Quoracy was met. Apologies: None **Summary of key issues:** This report captures the key issues and risks that were brought to the attention of the Committee.
1	**Agenda**	The Committee considered: • Corporate Risk Register (risks relating to quality and safety) • Trust Level Quality Assurance & Learning Report • Quality Account Q2 2021/22 Progress Report • CQC Inspections and updates from NHSE/I and TEWV Quality Improvement Boards • Locality updates from Forensics, Durham & Darlington, Teesside and North Yorkshire & York • Safe Staffing Monthly Report • Positive & Safe Six-Monthly Review • Ethics Committee Report
2a	**Alert (by exception)**	**The Committee Members alerts the Board to the following:** **Corporate Risk Register - Risks relating to Quality and Safety** From the corporate risk register, there are 40 risks which relate to quality and safety issues. There were five risks removed in September and 2 risks added. The Trust Risk Management policy is currently being reviewed to reflect the new governance structures and processes. It is acknowledged that there is more work to be done around the reporting and management of risks, as well as reviewing old risks. Some funding has been agreed to appoint a corporate senior post, who will lead on risk management. **Cross Locality Issues:** • Recruitment, retention and staffing levels • Managing high levels of acuity and complexity • Bed management and high levels of occupancy • Increasing number of business continuity arrangements across some wards and services • Staff health and well being **Durham & Darlington** • Cause for concern at SPC level are in relation to self-harm

		incidents, friends and family test (FFT), compliance with mandatory training and appraisals. • Patient acuity exceptionally high across all inpatient areas. • LD complex packages and bed pressures. • Low compliance with Basic Life Support Training. **Teesside** • Cause for concern at SPC level are in relation to self-harm incidents, compliance with appraisal and mandatory training. A programme of environment work has been undertaken to reduce risks within AMH inpatient settings using reduced ligature alternatives. • There were two incidents that occurred in September which were classified as severe harm incidents. • High use of temporary staffing due to a continued difference between planned and actual nursing hours within inpatient services. **North Yorkshire & York** • Cause for concern areas at SPC level are in relation to compliance with mandatory training and appraisal, self-harm incidents and complaints. • The perinatal mental health service remains in business continuity measures with other teams in escalated positions. • Esk ward was temporarily closed on 12th November. • Oak Rise may be unoccupied due to one patient discharge in November/December. There are several vacancies and staff expressing intent to leave. • Emerging risks are the increasing bed pressures, care home/system pressures anticipated when care staff will need to be compliant with being Covid vaccinations. It was noted that some Nursing homes were de registering from the provision of Nursing. **Forensics** • Cause for concern areas at SPC level are in relation to compliance with mandatory training and appraisal. • Ongoing concerns in relation to Thistle ward led to the closure of the ward. Alternative care packages were provided where needed and in collaboration with the Provider Collaborative. A new clinical model will be developed appropriately. • Staffing is on the service risk register as very high. • The application for Park House to be registered by the CQC was declined, meaning that the service currently based in Oakwood could not transfer to more suitable accommodation. • Increased sickness in Health and Justice, which is thought to be linked to the high number of vacancies. **Monthly Safe Staffing Exception Report** Business continuity arrangements remained in place during September for Secure Inpatient Services, Bankfields Court (Teesside Adult Learning Disabilities Services) and the Durham and Darlington

		Crisis Team. New areas to move into these arrangements were NY & York Perinatal Mental Health Team and the MHSOP Liaison Psychiatry Teesside, north and south teams. All services are subject to Gold Command oversight. Monitoring the levels of safe staffing continues with close management and daily huddles for inpatient services. Feedback following the introduction of SafeCare to support decision making and prioritising staff deployment based on acuity and dependency has been positive. Two bespoke packages of care have been implemented for service users with complex needs. This is relying heavily on agency staff working alongside Trust staff to support two rosters. Emphasis is being placed on ensuring that any staffing related Datix incidents are recorded as there was a dip in September. Plans to over recruit an additional 150 staff was approved at Senior Leaders Group. This will be to source registered and non-registered nurses to support seven wards.
2b	**Assurance**	**The Committee assures members of the Board on the following matters:** **Positive & Safe Six-Monthly Update** The use of restraint continues to reduce across the organisation and this has been the ongoing pattern of a downwards trend for the past few years. For the first time, the organisation can report that there were no instances of the use of prone over a one-week period. This is a significant achievement for the Trust, and it is anticipated that the various initiatives in place across wards and areas will continue to support further reductions. During the period of April – September 2021, the Trust had 64 incidents of prone restraint. For the same period in 2020 there were 167. There are some areas however, which are showing cause for concern when applying statistical process control, in particular services in Teesside with an escalation/trend in self harm. This relates to the Lodge, Bankfields Court and Overdale Ward at Roseberry Park Hospital. These wards are being supported appropriately. Whilst within SPC normal variation, there is also some high use of prone restraint and rapid tranquilisation and seclusion on Cedar, Bedale and Sandpiper wards.
2c	**Advise**	**The Committee would like to advise the Board of the following matters for information:**

		CQC Update and NHSEI Quality Board The Committee received a presentation that gave an overview of regulator communications since the last Committee meeting. The Trust had received a first draft of the CQC Well Led and 4 Core Services report. When the final draft is formally received, the Trust will be granted 10 working days for factual accuracy checking. It was noted that the CQC were having some technical administrative problems, which had caused some slight delays to issuing reports to the Trust. This was a national issue. Updates from the NHSEI Quality Board included discussions on the importance of the communications plan with the pending publications over the coming weeks and months. An issue had been flagged with the provider collaborative regarding two female individuals who did not have a package of care in the community that would be ready until the end of the year. There were no matters of concern to escalate to the Committee from senior meetings with CQC and NHSE/I that were not being dealt with appropriately. **Ethics Committee Report** The Ethics Committee was established as part of the Trust's emergency response to Covid-19 as a sub-committee of the Clinical Advisory Committee. Over the last 18 months most referrals to this Committee have been related to Covid-19 and specifically the ethical challenges that clinicians face in the delivery of care for patients. Some non-Covid referrals have also started to go to the Committee. The ongoing work of the Ethics Committee will provide opportunities for involvement in restrospective referrals, ethical advice on the development of policies and procedures, particularly when there is an ethical dilemma. The membership of the Committee is inclusive and has been strengthened to include the voice of experts by experience and families by appointing additional members. **Quality Account (Q2) 2021/22 Progress Report** There were delays to completing the actions in the Quality Account for Q1 due to Covid and the need to redeploy staff to help with front line work. The Strategy & Resources Committee then considered and agreed some changes to the plan and revised timescales. Delivering the milestones for this year is now on track at 94% completed and five of the metrics have improved. These are in relation to: number of incidents of falls, patients being followed up

		within 72 hours following discharge, bed occupancy over 90 days, feeling safe, overall experience good or excellent and respect from staff. One of the areas for improvement is patients feeling safe on the wards and there is currently a deep dive underway to explore this. It was noted that Teesside was reporting the highest levels of good experience from patients, where it is known that acuity is high with challenging behaviours. Members sought assurance that reported increases in the numbers of restraints were not linked to a shortage of staff numbers on wards. An explanation was given that this was linked to the rising acuity across adult, MHSOP, organic and LD wards over recent months. **QuAC Development – 2nd December 2021** Members discussed plans for a session to be held at the beginning of December, which will replace the formal Committee meeting for that month. This will be to consider and discuss how QuAC must function in 2022/23, reflecting on the changes to the organisational structure, which will see the introduction of the new Management Group and Care Group Boards, together with new governance structures. On reviewing and evaluating the meeting, Committee members would like to advise the Board that the organisation needs to reflect on how we capture appropriate information. There are examples of good practice contained within the Committee reports which are often not aired due to the need to pursue assurance. **Confidential Minutes – 7th October 2021** The Committee met in confidential session to approve the minutes from the meeting held on 7th October 2021. There were no matters arising and no other business to discuss.

Recommendation: The Board is asked to:

- Note the key issues report, following the meeting held on 4th November 2021.
- Note the assurances provided regarding mitigations, where demonstrated in reporting.
- Note that there were inadequate assurances that risks are being managed appropriately on the Corporate Risk Register, however that there is process in place to address the risks.
- Note the developments in relation to Thistle Ward in Forensics and the work commenced with the Provider Collaborative to develop a new model of care.
- Note the achievement of zero use of prone for the first week across the organisation.
- Note that there are ongoing concerns for the localities, in terms of levels of acuity and complexity, compliance with mandatory training and appraisals.
- Note that there are staffing concerns in Health & Justice.
- Note the progress with the Quality Account, Quarter 2.

3	**Risks to be considered by the Board**			
4	**Report compiled by**	Bev Reilly, Chair of Committee Donna Keeping, Deputy Trust Secretary, (Corporate) Avril Lowery, Director of Quality Governance	**Minutes available from**	Donna Keeping, Deputy Trust Secretary (Corporate)

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 15

FOR GENERAL RELEASE

Board of Directors

DATE:	**25th November 2020**
TITLE:	**Using Patient Stories at the Board**
REPORT OF:	**Elizabeth Moody, Director of Nursing and Governance**
REPORT FOR:	**Trust Board of Directors**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Executive Summary:

The Trust aims to provide the highest quality of care and experience for patients, families and carers. Critical to this is achieving a standard of compassionate care with a focus on our patients' and communities' needs that we can sustain and deliver over the coming years. Within 'Our Journey to Change', its identified goals and priorities, a key priority is that co- creation is at our core. We recognise patients and carers have a strong and authentic voice and the Trust is committed to ensuring their opinions, feedback, concerns and ideas are always sought out and that this valuable insight is used proactively to improve the quality and the experiences of our service users.

This paper informs the Board of the intention to introduce patient stories at future board meetings commencing in January 2022. It highlights the benefits of this approach as well as the need for careful consideration of a number of specific areas to ensure successful implementation and the wellbeing of those involved. A number of documents are presented in the appendices with the intent of providing the board with a range of useful information in preparation for the introduction of patient stories.

Recommendations:

The Board is asked to consider and discuss the information provided in the appended documents in preparation for the first patient story being told at the Board in January 2022

Following Board discussion, it is recommended a patient story resource is developed in the form of a tool kit to support the successful implementation of this approach.

MEETING OF:	**Board of Directors**
DATE:	**25th November 2022**
TITLE:	**Using Patient Stories at the Board**

1. INTRODUCTION & PURPOSE:

1.1 The Trust aims to provide the highest quality of care and experience for our patients. Critical to this is achieving a standard of compassionate care with a focus on our patients' and communities' needs that we can sustain and deliver over the coming years. 'Our Journey to Change' sets out why we do what we do, the kind of organisation we want to be and the three big goals we're committing to over the next five years:

- To co-create a great experience for our patients, carers and families.
- To co-create a great experience for our colleagues.
- To be a great partner.

1.2 A key Trust priority is that co- creation is at our core, we recognise patients and carers have a strong and authentic voice and the Trust is committed to ensuring their opinions, feedback, concerns and ideas are always sought out.

1.3 The Trust is dedicated to creating a culture whereby we listen to patient feedback and we currently do this via a variety of channels including national and local surveys, the Friends and Family Test, comments provided through NHS Choices, focus groups and forums. We intend to build on this foundation by reviewing our PALs and complaints service to ensure it is robust and responsive and learning drives improvements in care and experience. A further development is the use of patient stories at Board meetings.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 Patient stories are used widely across the NHS as a methodology to enable sharing of meaningful feedback on the patient experience, drive change and improve the quality and safety of care. Listening to a patient telling their story in their own words is a powerful experience. It reminds us of why we do what we do in the NHS and it has the power to capture both our hearts and minds.

2.2 Patient stories can assist board members to see through the eyes of the patient as they approach the business of the meeting and provide directors with a touchstone of the Boards purpose in assuring quality of services to patients.

3. KEY ISSUES:

3.1 From January 2022 the Trust will be introducing patient stories at the Board and to do this successfully careful consideration needs to be given to a range of important areas. These include:

- Defining the purpose of using patient stories at the Board
- Agreeing which part of the Board will the story be told
- Understanding how storytellers will be prepared and supported
- Ensuring robust and sensitive approaches to consent and confidentiality
- Awareness of potential safeguarding issues
- Ethical awareness
- Insight into story telling methods and approaches
- Defining post interview processes, what happens afterwards and how will this be monitored.
- How information will be shared

3.2 To assist he Board in these considerations a selection of documents is provided within the appendices:

- Appendix 1, 'Leadership for Safety: How to guide supplement: Using Patient stories with Boards' , is aimed at senior leaders who wish to embark on using patient stories at Board level and those staff members who will be involved in the process. It outlines the process of selecting and gathering stories and guidance on presenting them in the boardroom.
- Appendix 2 provides a range of useful questions and considerations for Board members.
- Appendix 3 provides an example Patient Stories Process Checklist
- Appendix 4 provides an example action planner and tracker

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:** The valuable insights into the experiences of patients and families will support improvements in quality and safety.

4.2 **Financial/Value for Money:** None

4.3 **Legal and Constitutional (including the NHS Constitution):** This initiative is in line with the principles within the NHS Constitution.

4.4 **Equality and Diversity:** This provides an opportunity to present a diverse range of stories reflecting their unique experiences.

5. **RISKS:** Potential risk to patients, service users and families in relation to any negative experiences. This is being mitigated through careful planning and covering areas such as consent, safeguarding, debriefing and support.

6. CONCLUSIONS:

Patient stories are being introduced at Trust Board meetings. These are seen as a valuable way to enable Board members to actively listen to the real experiences of patients and relatives in each Board meeting; to learn how problems in care provision affect and impact upon patients and their families, and to maintain a focus on continually improving patient safety and experience in line with the goals of the organisation. However, in reality it is acknowledged that this requires careful planning and consideration of a range of important areas.

7. RECOMMENDATIONS:

The Board is asked to consider and discuss the information provided in the appended documents in preparation for the first patient story being told at the Board in January 2022

Following Board discussion, it is recommended a patient story resource is developed in the form of a tool kit to support the successful implementation of this approach.

Author: Avril Lowery
Title: Director of Quality Governance

Appendix 2

Preparation

What is the purpose for our board of hearing patient stories?

- To understand the impact of causing harm to a patient?
- To use stories to set priorities?
- To nurture a quality-centred culture?
- To road-test the organisation's quality assurance mechanisms?
- To explore how decisions made by the board impact on patient experience?
- To improve our understanding of how harm happens?

Why are we hearing this particular story?

- What sort of story is it?
- How has the story been selected?
- What type of emotional response might the story evoke?
- Will the story show the organisation/staff negatively?
- What questions need to be surfaced from this story?

How is the item going to be managed?

- Who is going to lead this item?
- How is the story going to be told (e.g. verbally, PowerPoint, audio recording, film)?
- If a patient or relative is going to tell the story in person, what preparation have they been given and what support do they need during the meeting?
- If a staff member is going to tell the story what support might they need?
- What preparation will board members need to ensure their questioning is appropriate?
- How much time will be needed for this item?

Discussion

What does this story add to our understanding of the quality of our services?

- How does the story relate to the information contained in our quality or performance report?
- What does this story tell us about progress towards our quality improvement goals?
- What additional information does the board require to help it make sense of the story / put it in context?

What does this story reveal about our staff?

- What does it suggest about morale and organisational culture?
- What does it reveal about the context in which clinicians work?
- What does it reveal staff attitudes to harm?

What actions need to be taken as a result of what we have heard?

- What needs to be done immediately to make things right for the patient and prevent a recurrence for other patients?
- What implications does it have for board decisions?

Review

How did we do in hearing this story?

- Did we give enough time to this item?
- Were we sufficiently prepared?
- What could we have done differently?

Does this story raise any learning needs for board members?

- What additional support do board members need in hearing patient stories?
- Do board members wish to find out more about the processes for examining failures (e.g. significant event analysis, root cause analysis)?
- Has the story evoked anxieties that members wish to talk through outside of the meeting?

Additional key considerations for Boards arising from feedback from organisations in the use of Patient Stories;

- What additional support do board members need in hearing patient stories?
- Do board members wish to find out more about the processes for examining failures (e.g. significant event analysis, root cause analysis)?
- Has the story evoked anxieties that members wish to talk through outside of the meeting?

Appendix 3

Using Patient Stories Process Checklist (Example)

Please use this checklist as a helpful framework for using patient stories, not every step will apply to every story.

Name of person collecting the story ……

Name or alias of storyteller ……

1.	Contact the storyteller to arrange meeting	
2.	Decide together how to record the story (written, audio, video)	
3.	Before meeting check equipment is working (if needed)	
4.	Meet storyteller: give information sheet and explain consent, confidentiality and safeguarding	
5.	Get consent form signed, and complete the information sheet for the storyteller to keep	
6.	Take/record the story.	
7.	Agree date to meet again to check, edit, confirm the story. Take into consideration storytellers' preferences - this could be done virtually.	
8.	Decide how to use the story. Where, when, with whom? Who will present it? Take into consideration the storytellers' preferences.	
9.	Inform the storyteller when and how it is being used. If the storyteller is presenting, offer support and preparation, before and during presentation.	
10.	During or after presenting the story, work with the team or service manager to complete the action planning template.	
11.	Send a copy of the template electronically to the Patient Experience Co-ordinator.	
12.	Inform the storyteller what actions have been identified.	
13.	Give/send the script or digital copy of the story, your notes, this list and Dictaphone (if used), to the Patient Experience Co-ordinator for secure storage	
14.	Delete notes or audio/film from your Trust smartphone	
15.	Within three months, speak to the storyteller about what has happened as a result of the story being used.	
16.	**Celebrate your hard work with your team.** What available mechanisms can you use so you can share what you have done as result of this story?	

Appendix 4

Patient, Staff. Carer Experience Action Planner and Tracker

Date: DD/MM/YY	**Name of story:**		**Service:**		**Ref no:**
Unmet need or negative experience and the change you want to see Or Good practice you want to see celebrated and replicated	Action required	Lead person	Date completed	Date action reported to storyteller	Date completed

PATIENT SAFETY FIRST

Making the safety of patients everyone's highest priority

Leadership for safety, 'How to' guide supplement:

Using patient stories with boards

Version 1 20100221

To find out more visit
www.patientsafetyfirst.nhs.uk

Acknowledgements

Special thanks to the team from 1000 Lives campaign in Wales. With their permission many parts of this guide have been copied or adapted from their document “Guidance on the use of patient stories” (reference in Useful Links section at the end of this guide).

Author:
Clarke, Julia: Field Operations Manager/Content Development Lead; Patient Safety First.
Associate (Safer Care Priority Programme); NHS Institute for Innovation and Improvement

Thanks also to the following for sharing their experiences:
Bedford Hospital NHS Trust: Alan Dickinson, Trust Board Secretary

United Lincolnshire Hospitals NHS Trust: Sylvia Knight, Chief Nurse

Winchester & Eastleigh Healthcare NHS Trust: Alison Huggett, Head of Patient Safety and Healthcare Governance. Paula Shobrook, Chief Nurse.

Contents

Introduction

Patient Safety First's 'Leadership for safety' intervention suggests that organisations working to improve patient safety should bring the patient's voice to the Board. Whilst the idea of starting each Board meeting with a patient story may initially sound easy to accomplish, in reality it is a challenging goal that requires careful planning, consideration of a number of ethical issues and skilled presentation.

Everyone has experienced the power of narrative and storytelling at some time or another in their professional or personal lives, or both. True stories engage the listener in a way that hypothetical scenarios can not and at times trigger significant emotional responses. Such emotional reactions are often even more powerful when the listener feels some kind of personal connection with the experience described. This might be due to them having had a similar personal experience (or knowing someone who has), relevance to an area of personal interest or a sense of responsibility for those in a similar position.

The Leadership for safety intervention also highlights the importance of the Board's responsibility for patient safety, not in a generic sense where the responsibility is that of 'the Board' and therefore diffuse but in highly personal sense. Each leader should recognise their personal accountability for patient safety and know their own role in improving it. Patient stories can help forge and maintain a connection between an organisation's leaders and their primary purpose; providing high quality, safe care. Patient Safety Leadership Walkrounds (see useful links) also serve to bring leaders into contact with patients and their stories and experiences, but in these situations the function of the walkround is wider and time limited. Using a patient story with a Board is more focused on one event or episode and really understanding what happened and why.

PATIENT SAFETY FIRST

About this guide

This guide is aimed at senior leaders who wish to embark on using patient stories at Board level and those staff members who will be involved in the process. It outlines the process of selecting and gathering stories and guidance on presenting them in the boardroom. There are a number of issues involved in using patient stories such as consent, storage, confidentiality and safeguarding the emotional wellbeing of patients. At the end of each chapter of this guide there is a section entitled "Take care" which highlights some of key issues or tips for consideration to ensure the process is carried out in an ethical way.

For conciseness this document refers to the person sharing the story as the patient but when taking and sharing stories it may not actually be the patient who is directly involved in the process. If the patient would like their story to be used but does not wish to participate personally it could be anyone they choose such as a relative, care or friend.

Why use patient stories?

- Connect with patients and relatives. All healthcare leaders care about what happens to patients in their organisation but the detail of patient experiences of harm can help them to connect on a more emotional level
- Connect with front line staff. Leaders should never underestimate the emotional impact that staff involved in incidents of patient harm can experience. It can be an opportunity for staff to talk in depth about an event and discuss with senior leaders their thoughts and opinions on why it happened and how it could be avoided in future
- Improve understanding of human factors in harm and error. Boards are advised to concentrate on strategy but an in depth story can give useful detail that provides a window into the workings of the system. This can be particularly useful in building understanding of what it means to have a culture that is just; one that recognises why people make mistakes and exactly what they are asking of their staff when they put them to work in their organisation
- Make patient safety personal. When stories of patient harm appear in the media it is not uncommon for healthcare leaders to feel such an event would not happen in their organisation. Hearing stories of their patients who have been harmed or had a near miss brings it into their own sphere of accountability – 'this is here, **we** did this'.

"The Board is committed to learning from actual patient experience. Board members actively listen to the real experiences of patients and relatives in each Board meeting; to learn how problems in care provision affect and impact upon patients and their families, and to maintain a focus on continually improving patient safety and experience. Patients and relatives have shown a willingness to share their stories so that the Board is aware of and learns from their experiences of care at Bedford Hospital."

Bedford Hospital NHS Trust

Take care

- Don't rush in - stories should not be taken simply to 'tick the box' or because other organisations are using them. If the time is not right to do this in a well planned way, make this explicit but start to work up a plan and timeline to start using them in the future.
- Think about why you want to use the stories. As senior leaders, what is it you want to find out?
- Consider what will be done with this information when it is obtained. How will the Board support actions arising?

Finding and choosing which stories to tell

There are different approaches that can be taken to identify patients. You could set yourself criteria for the identification process, for example have been an inpatient for a minimum period or you may have a number of methods of accessing possible stories that may already be available to you.

Suggestions for consideration could include

- Promotion within a service area such as a ward or GP practice by displaying posters, providing information leaflets or asking patients whether they want to take part
- Inviting a random selection of patients that have received care from your service to take part
- Incident forms
- Serious Untoward Incidents/Deaths
- Complaints
- Suggestions from clinical or operational management staff.

A good time to approach in-patients is during the time following a decision that they are ready for discharge and before they leave the hospital. Allow patients adequate time to consider the information that you provide and to ask any questions about the process. If a patient agrees they can then decide whether they would prefer to tell their story before they leave or give permission for contact to be made after discharge.

It is also worth considering patients different abilities to tell their stories. It is easier to approach patients who are able to talk but those that find communication more difficult may have different experiences that are incredibly valuable. In these situations consider who may be able to help the patient tell their story, for example a relative or carer, or a speech and language therapist.

Take care

- Provide the patient with adequate information that is easy to understand and explicit about what will actually happen; how you will take the story (notes / tape recorder / video), what type of questions they may be asked. Make it clear that if you hear something that puts others at risk that you may have to take immediate action. Most

hospitals have teams that assist with the development of good quality patient information.

- Don't pressurise the patient into telling their story
- Be careful about the ethics of contacting people after they have been discharged from care. Discuss any such plans with your senior colleagues as it may be considered unethical to use the information on your systems for a different reason
- It is vital that patients feel free to choose whether to tell their story, and have the capacity to make that decision for themselves.
- There is a real fear amongst patients that if they make negative comments their future care may be affected and therefore may find it difficult to discuss negative experiences openly
- Over time, if no action is seen to be taken as a result of using patient stories it will become seen as a waste of time.

Specific notes on consent

It is worth regarding the stories as remaining the property of the patient. Make sure that you get consent from the patient before you start which clearly states how and where the story may be used and by which method(s). If you think you may wish to use the story for another purpose in the future you will need to get the patient's permission to contact them again to discuss this and obtain their consent.

You will need to be clear that you may have to retain some information from the story in order to remember the range of issues described, but that you will not keep the whole story.

Taking the stories

Taking a story takes time. Allow a couple of free hours to take the story and schedule in time to listen and reflect on the story afterwards.

Who

Most people can take a patient story. The essential requirement is that they need to be able to listen. It is however recommended that the person taking the story should have no involvement in the patient's care. The storyteller may need prompts to continue or explain something a little better but it is not the listener's role to give opinion, advice or recommendations; it is to help them talk. Some people are naturally better than others at taking stories and as with any meeting between two personalities; some patients will immediately feel more comfortable with some listeners than others.

It is advisable that whoever is taking a story fully understands the process and has insight into the communication issues involved such as recognising when the storyteller is feeling uncomfortable or upset, reluctant to discuss certain details and how to manage these situations sensitively. They need to be aware of personal reactions and how they can influence the storyteller. For example, looking shocked at something they say may

encourage them to make more or less of that issue. Conversely no reaction would appear strange so a healthy balance of empathy is required to encourage the story to be told.

Different people will hear different things from the same story. A team that is made up of people with different professional backgrounds can help to get the most out of the story. Whilst it is easier to do this in a conversation you need to consider how a particular patient may feel if they are outnumbered by hospital staff in the discussion.

Training is available in this area. Many NHS organisations will have a team of people who have been through the Royal College of Nursing Clinical Leadership Programme. A key part of this programme is around patient stories and these people are a valuable resource to tap into.

Where
Meet somewhere away from the patient's treatment area that is quiet and free of interruptions. If the patient prefers to meet in their own home consider the organisation's policy on lone working and make sure this does not put either party at any risk.

Take care

- Maintain the patient's confidentiality and if agreed, their wish to remain anonymous
- Make sure that the patient feels able to talk. The person taking the story should not be someone involved in providing direct care to the patient, either in the past or in the foreseeable future
- Be able to offer support after the story if needed. Story telling can be an emotional experience for both the patient and the person taking the story. This could be in the form of access to counselling support or a debrief session if required
- Allow the patient to stop at any time. Ensure the patient is aware that they can withdraw their consent for the material to be used further at any time after the story has been taken.

Methods of taking and sharing the stories

There are a number of ways of collecting and presenting stories. Ideally once Boards are familiar with the use of stories it might be helpful to vary the method so the Board get to hear or consider stories in different ways. The presenter can also find other ways to help the Board see deeper into the story. For example different tools are used in the process of investigating incidents or complex processes – use of an issue tree/driver diagram as part of the discussion following a patient story can really bring a problem to life, help the Board to see all of its complexity and stimulate a more detailed discussion.

Written notes
This is the simplest way to take the story and can be later prepared into a written case study or PowerPoint presentation. You may need to consider having a scribe in the room if you think your notes may be hard to decipher after the event!

Audio recording
This allows you to concentrate solely on the discussion instead of worrying about keeping accurate notes of what is being said. It also allows you to re-listen to the story with a colleague who may identify different things to you. Patients can be asked to tell their story independently onto a tape or write it down but where this happens important details may be missing and can leave the listener with a host of important questions unanswered later as it is harder for the patient to talk in isolation.

Filming
This approach requires a lot more planning and resources therefore it may be that you decide to take stories initially via another mechanism and film specific ones afterwards. Your communications department should be able to provide basic filming equipment and would need to spend time afterwards helping with the editing process. The editing process can be quite time consuming as there will be a lot of footage and it takes considerable skill to extract all the necessary clips of information that give the full picture of the story whilst retaining its emotional impact. Remember also that the storyteller and the facilitator may be more nervous in front of camera as they know they will be watched by others and recognised.

If you have a specific story that you would like to use more widely in the organisation for training and education purposes then it may be advisable to secure funds and use a company that specialises in this type of media in healthcare settings. The issues around consent become even more crucial when using this method.

Presenting in person
This means the patient or relative tells their story in person. Whilst this can be the most powerful way of presenting a story it is also the most difficult and high risk – particularly for the patient or relative doing it. This is because it is hard to prepare someone for how it will feel to stand in front of a board and talk about an experience that is deeply personal and may still be traumatic for them to discuss, even if they want to. Their emotional response may occasionally be unpredictable and depend on other factors such as how the patient is feeling and the mood in the boardroom on that day, and the thread and tone of the discussion. Some factors will always be out of your control no matter how well you prepare the patient and Board. For this reason there will be very few occasions where this method will be appropriate or the patient would want to go into the boardroom. A patient could be identified during collection of their story using another method and if they agree, a decision made to spend more time together preparing for this.

Take care

- Double check that equipment is working correctly and at the right volume – there is nothing worse than taking a story only to find out that the tape did not work or you cannot clearly hear what is being said
- If presenting in person, even a confident patient will require a great deal of support in preparing and presenting the story. There is a particular risk if the Board have a lot of

questions as a constant stream of challenging questions could come across as aggressive or make the patient feel they are being interrogated

- The Board will also need preparation and guidance in terms of how to deal appropriately with patients and staff in the boardroom. They need to be acutely aware of how intimidating an environment the boardroom can be. Their tone of voice and style of questioning could exacerbate this. Phrasing of questions is important; any suggestion that they are seeking to justify what happened or apportion blame will make the patient feel uncomfortable and reluctant to talk openly.

After the story has been used

Actions should result from the use of a story. This may require agreeing actions to be taken or revising an existing ones. If a suitable action plan is already in place then there needs to be a more depth review of its progress. Previous actions may have been meant to have been implemented earlier to prevent recurrence. If this is the case then it is helpful to find out what the barriers were to implementation so that steps can be taken to improve the likelihood of the changes being fully implemented and sustained.

If the patient has stated they would like to be given feedback then they should be called and or written to outlining the outcomes and thanking them for their participation. If any staff members have inputted into the overall story they should also get feedback. Whether or not the area involved in the incident was named, feeding back to its staff is a great opportunity to connect directly with them and have a detailed discussion about the story and what can be learned from it.

Case studies

Winchester & Eastleigh Healthcare NHS Trust

Choosing and taking patient stories is an executive led process. All serious untoward incidents (SUIs) are presented to the Board focussing on what has been learnt and what is being done next. However the CEO also sees all letters of complaint and compliment so the stories chosen are not purely based on incidents, they can include positive feedback. If a death has occurred then any related story wouldn't be used until the outcomes of any inquest and related disciplinary proceeding were known. Stories from completed inquests are easily accessible.

Where stories are collected from a patient or relative this is done by the Chief Nurse who then follows up the discussion with a letter. All stories used are fully anonomised which means the narrator and the Trust have fewer concerns about the ethical issues that can result from needing to store the story and use it in other ways.

On one occasion a video story was used and again it was fully anonomised. On that occasion the process was led by the Education centre and developed for training purposes but it was also shown to the Board. As this story was filmed and going to be widely seen in the Trust the CN spoke to the staff on the ward involved and went to show them the video. This was a good opportunity for the staff to discuss what had happened and learn from it.

Using patient stories is not seen as a separate raft of work, they just draw on what they already have available to them. They want to keep any process as simple as possible, they feel the simpler and less effort involved in doing it the more likely it is that they can sustain it over time. This is particularly important within the current financial climate where resources may become more constrained. If other hospitals are just starting out using patient stories that's the advice they would give – keep it simple. If the process is complicated, overly bureauocratic or labour intensive from the beginning "it gives them a reason not to start".

They have seen great impact from using these stories. There is a different feel at the Board, they talk in more detail about safety and related mortality measures. "It focuses their minds for the day".

United Lincolnshire Hospitals NHS Trust

The Chief Nurse (CN) chooses which stories are presented to the Board. It may a choice based on a particular policy driver but when using an SUI or incident of avoidable harm often one is chosen that is related to a specific strand of their safety strategy. The Trust has participated in the Leading Improvement in Patient Safety (LIPS) Programme so the story may be relevant to a stream of work being undertaken as a result of that. Occasionally it will be a story taken at the patient's request. Mostly the stories are about patients who experienced harm.

The CN takes the stories herself. She calls the patient to make the arrangements then makes notes before the meeting. All interviews are audiotaped and consent issues are discussed at the start such as how they want to use the story, how the patient /relative wish to be referred to in the story (full name or anonymous) and whether they are happy to be contacted in the future if they'd like to use the story for a different purpose. They also agree if and how she will feedback to them after the story has been presented. They do not use a paper based consent form as it's all on the tape.

After the discussion the tape or its transcript is edited so the story is an appropriate length and to ensure the patient's wishes around disclosure of their identity is honoured. Where appropriate the perspectives of staff involved are included in the final presentation.

After the story has been used the CN gives feedback to the patient if this has been agreed and where necessary, information passed to the Trust's Sharing Lessons Learned Forum. Feedback is also given to ward/unit staff.

The use of patient stories has helped to keep the meetings focussed on patient safety.

The CN feels that if Trusts are just starting out with using patient stories it is important to be very clear how the patient wishes to be referred to – the level of anonymity. Some patients very much want to have their names used but obviously some do not. Preparation of the Board also needs to be considered. Actions need to result and there may be a tendency for Non Executive Directors to focus on the story told, the related assurances and how it will be seen.

In the future the Trust are considering giving patients/relatives the opportunity to talk directly to the Board but recognise this will require much greater preparation of the patient and the Board.

Useful links

1000 Lives Campaign
See the document Wales produced on using patient stories
http://www.wales.nhs.uk/sites3/page.cfm?orgid=781&pid=41303

Institute for Healthcare Improvement
Copy of the notes produced by Delnor-Community Hospital, Geneva, Illinois, USA on using patient stories with Boards.
http://www.ihi.org/IHI/Topics/LeadingSystemImprovement/Leadership/Tools/GuidelinesforUsingPatientStorieswithBoardsofDirectors.htm

Patient Safety First
Information regarding the Leadership for safety intervention and a copy of its related How to Guide.
http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/Leadership/

Patient Safety First
Short films on safety walkrounds and a copy of the related How to Guide supplement.
http://www.patientsafetyfirst.nhs.uk/Content.aspx?path=/interventions/Leadership/walkrounds/

Patient Safety First
Download a copy of the How to Guide on Human Factors in Healthcare.
http://www.patientsafetyfirst.nhs.uk/ashx/Asset.ashx?path=/Intervention-support/Human%20Factors%20How-to%20Guide%20v1.2.pdf

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 25 November 2021		**Report of: People, Culture and Diversity Committee**
Date of last meeting: 16 November 2021		The meeting was quorate, there were no apologies for absence
1	**Agenda**	**This was the first meeting of the Committee and it considered the following agenda items during the meeting:** • Colleague Story/Experience • Terms of Reference • Board Assurance Framework and Corporate Risk Register • Performance Workforce Dashboard • Deep Dive of Recruitment/Vacancy Review • Staff Networks Update • Draft Committee Workplan • Any Additional Risks Raised During Meeting for consideration of adding to Board Assurance Framework or Corporate Risk Register
2a	**Alert**	**The Committee alerts members of the Board that:** **Corporate Risk Register (CRR)** A verbal update was provided on the process being undertaken to ensure the risks in relation to people, culture and diversity are included on the CRR and are up to date and accurate with risks planned to be considered by the Workforce Group at its meeting on 18 November 2021. It was noted that the risks aligned to this Committee on the CRR would be provided to the Committee at its next meeting in January 2022.
2b	**Assurance**	**The Committee assures members of the Board that:** **Revised PC&D Terms of Reference** Following the Independent Well-led review carried out by the Good Governance Institute and the issues raised by the Care Quality Committee, the Board agreed to establish a People, Culture and Diversity Committee. The Committee received, noted and accepted the Terms of Reference. **Board Assurance Framework** The Board Assurance Framework (BAF) has been redeveloped and accepted by the Board to include key risks that threaten the achievement of the Trust's strategic objectives. The risks included on the BAF in relation to people, culture and diversity helped to inform the agenda with a deep dive carried out on recruitment/vacancies. The Committee agreed that the recruitment BAF risk would be increased due to the increase in activity and problems reporting with moving colleagues through the process. Target dates and updates omitted from the BAF were discussed and it was noted these would be included before the BAF is presented to the Board on 25 November 2021.

		Deep Dive – Recruitment/Vacancy Review It was noted that: • Revised Staff Clearance process has been put in place for any delays in the system to ensure services can recruit in a timely manner to provide safe patient care. This requires completion of a risk assessment and approval by the Director of People and Culture and the Chief Operating Officer. • Central HR support has been put in place for the new Care Groups, which enables the team to focus their work more effectively. • Improvement to the Vacancy Form has been made with 20 steps reduced to 3, which is being piloted by the Customer Task and Finish Group. • Changes have been made to phone lines and email inboxes to ensure better accessibility and oversight. • More staff are being brought in as well as staff working overtime, to assist the clearance of the recent backlog. **Draft Workplan** A draft workplan was presented for discussion. It was noted this aimed to include both legal/regulatory as well as internal Trust specific items. An additional Deep Dive was agreed to be included on Equality, Diversity and Inclusion; and national reports specific to the Committee's remit will be received. It was agreed any additional items members felt needed to be included would be considered, which would be captured under themes for consideration at the next meeting. (*All actions from the GGI Action Plan, CQC, ICS etc relevant to this Committees remit will be added to ensure the Committee can be assured on progress against these*).
2c	**Advise**	**The Committee advises the Board that:** **Colleague Story/Experience** A Colleague shared their experience of working in the Trust as a BAME member of staff. The Committee were moved by what they heard and most grateful that this experience could be shared with the Committee. Despite the negative experience the Committee learned that this Colleague was courageous and determined to overcome the obstacles she had experienced and were pleased to note had been successful in securing a management position. It was agreed that communication and engagement on BAME and all staff networks required improving to ensure all colleagues are aware of the support available across the Trust. **Performance/Workforce Report** It was noted that work was ongoing to finalise the integrated assurance report for the Board and Board Sub-committees. The indicators that have been agreed to be included in this report were circulated and members were asked to inform the Director of People and Culture of anything additional to add. The Committee received an update on the key issues, actions being taken, progress and impact on the following performance standards:

		• TD15 Finance vacancy rate (no Trust standard, monitoring only) • TD16 Percentage of staff in post with a current appraisal • TD17 Percentage compliance with all mandatory and statutory training • TD18 Sickness absence **Staff Networks** An update was received on the staff networks in place across the Trust. The Committee noted the large remit of networks that are currently in place. It was noted that there are plans to develop an additional Veterans and Armed Forces Staff Network and it was agreed that arrangements would be made to improve communication and engagement with staff to ensure all Staff Networks are known and accessible to all staff. **Deep Dive – Recruitment/Vacancy Review** A presentation was received to inform the Committee of the findings of the Recruitment/Vacancy Review, which is a significant risk included on the BAF. • Work continues to prepare for a move from the current Trac system to NHS jobs – this is dependent on national changes to NHS Jobs. • QI work is underway with the team and processes.
2d	**Risks**	Consideration was given if there are any new risks raised during the meeting for consideration of including on the BAF or CRR. A risk of the Trust not being representative of the community it serves in relation to BAME was raised and it was agreed a survey would be carried out with the outcome and assurances on any required actions reported to the Committee in future.
Recommendation: The Board is asked to note the contents of this report.		
3	**Any Items to be Escalated to another Board Sub-Committee/Board of Directors**	There were no items agreed to be escalated to another Board Sub-Committee. There were two items that were agreed to be escalated to the Board: **Colleague Story/Experience** The Committee found the experience shared by a Trust colleague very moving, which helped to connect with members of staff and triangulate against the information provided in papers and discussions at meetings. It is recommended that the Colleague Story/Experience continues to be a standard agenda item for this Committee with an update provided to the Board following each meeting. **Risk Management** Review of the people, culture and diversity risks on the CRR is taking place to ensure they are accurate and up to date, which will be reviewed and approved by the Workforce Group before being presented to the Committee at its next meeting.

4	**Report compiled by:**	Lynn Hughes ***Interim Corporate Governance Advisor*** Shirley Richardson ***Non-executive Director/Interim Deputy Chair (Committee Chairman)*** Sarah Dexter-Smith **Director of People and Culture**	**Minutes are available from:**	Lynn Hughes ***Interim Corporate Governance Advisor***

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**25th November 2021**
TITLE:	**Report on the Register of Sealing**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Information**

This report supports the achievement of the following Strategic Goals:	
To co create a great experience for our patients, carers and families	✓
To co create a great experience for our colleagues	✓
To be a great partner	✓

Report:

In accordance with Standing Order 15.6 the Board is asked to note the following use of the Trust seal:

Ref.	Date	Document	Sealing Officers
412	11.11.21	TR1 form (transfer of registered title) relating to 22 Brompton Road, Northallerton	Brent Kilmurray, Chief Executive Russell Patton, Interim Chief Operating Officer

Recommendations:

The Board is asked to receive and note this report.