MEETING OF THE BOARD OF DIRECTORS
Thursday 26th May 2022
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.

AGENDA

Standard Items (1.00 pm – 1.20 pm):

1	Apologies.	**Chair**	**-**
2	Chair's welcome and introduction.	**Chair**	**Verbal**
3	To approve the minutes of the last meeting held on 28th April 2022.	**-**	**Draft Minutes**
4	To receive any declarations of interest.	**-**	**Verbal**
5	Board Action Log.	**-**	**Report**
6	Chair's Report.	**Chair**	**Verbal**
7	To note any matters raised by Governors.	**Board**	**Verbal**

Strategic Items (1.20 pm – 1.40 pm):

8	Chief Executive's Report.	**CEO**	**Report**

9	To consider the report of the Chair of the Audit and Risk Committee.	**Committee Chair (JM)**	**Committee Key Issues Report**
10	Board Assurance Framework summary report.	**Co Sec**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (1.40 pm – 2.05 pm):

11	To consider key issues and risks arising from recent Directors' Visits.	**DoCA&I**	**Report**
12	To consider the report of the Chair of the Quality Assurance Committee.	**Committee Chair (BR)**	**Committee Key Issues Report**
13	To consider the report of the Chair of the Mental Health Legislation Committee.	**Committee Chair (PH)**	**Committee Key Issues Report**

Goal 2: To Co-create a Great Experience for our Colleagues (2.05 pm – 2.25 pm):

14	To consider the report of the Chair of the People Culture and Diversity Committee.	**Committee Chair (SR)**	**Committee Key Issues Report**
15	To receive and note the report of the Guardian of Safe Working.	**Dr Jim Boylan to attend**	**Report**

Governance (2.25 pm – 2.30 pm):

16	To approve amendments to the Constitution relating to the composition of the Board of Directors.	**Co Sec**	**Report**

Matters for Information (2.30 pm – 2.35 pm):

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

Exclusion of the Public (2.35 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.* *Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.* *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.* *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.*	**Chair**	**Verbal**

Paul Murphy
Chair
20th May 2022

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

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 28th APRIL 2022 COMMENCING AT 1.00 PM

The meeting was held via MS Teams

Present:
Mr P Murphy, Chair
Dr C Carpenter, Non-Executive Director
Ms J Haley, Non-Executive Director
Prof P Hungin, Non-Executive Director
Mr J Maddison, Non-Executive Director
Mrs B Reilly, Non-Executive Director
Mrs S Richardson, Senior Independent Director and Deputy Chair
Mrs R Barker, Associate Non-Executive Director (Non-voting)
Mr J Preston, Associate Non-Executive Director (Non-voting)
Mrs E Moody, Director of Nursing and Governance/Deputy Chief Executive
Mrs L Romaniak, Director of Finance, Information and Estates
Mr P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
Dr S Wright, Interim Medical Director
Mrs A Bridges, Director of Corporate Affairs and Involvement (Non-voting)
Dr S Dexter-Smith, Director of People and Culture (Non-voting)
Mrs S Pickering, Assistant Chief Executive (Non-voting)

In Attendance:
Mr P Bellas, Company Secretary
Mrs. D Keeping, Corporate Governance Manager
Mrs. W Johnson, Team Secretary

Observers/Members of the Public
Ms H Griffiths, Public Governor for Harrogate and Wetherby
Mr S Double, Alders
One Member of the Public

22/01 WELCOME AND INTRODUCTIONS

The Chair welcomed Board Members and attendees to the meeting.

He reminded Board Members that, following the last meeting, it had been agreed to seek to achieve a more appropriate balance between introductions to papers and discussions on them.

22/02 APOLOGIES

Apologies for absence were received from Mr B Kilmurray, Chief Executive, who was attending a meeting in London with NHS England/Improvement (NHS E/I).

22/03 MINUTES

Agreed *– that, subject to the following amendments, the minutes of the last meeting held on 31st March 2022 be approved as a correct record and signed by the Chairman:*

(1) the deletion of Mr. Preston from the list of those attending the public part of the meeting; and

(2) the replacement of "Capital" with "CRES" in paragraph 10.2 of minute 22/03/190/222.

22/04 DECLARATIONS OF INTEREST

There were no declarations of interest.

22/05 PUBLIC BOARD ACTION LOG

The Board received and noted the Board Action Log.

Further to minute 22/03/11/233/11.3 the Chair drew attention to the information provided on the longest waiting times for first appointment and treatment which had been circulated to Board Members, by email, on 27th April 2022 and noted that discussions on this matter between Mrs. Pickering and Mrs. Reilly were continuing.

Mrs. Pickering advised that:

(1) Work continued to be undertaken on the development of waiting list reporting, including the introduction of patient trackers, so that the waiting times of individual patients were understood. Keeping in touch processes were also being established. These developments were more advanced in children and young people's services (C&YPS) but discussions were being held on extending them to other specialties.

(2) National waiting time measures, which had been the subject of consultation by NHS E/I, had not yet been published. It was expected that, once published, they would be included within the System Oversight Framework and be reported to the Board.

(3) Although waiting time measures would not feature in the Integrated Performance Dashboard the data would continue to be collected and monitored with escalation to the Board as appropriate.

Mrs. Reilly, who had originally raised the matter, welcomed the initiatives in C&YPS and advised that she was content to continue the discussions outside the meeting.

22/06 CHAIRMAN'S REPORT

Mr. Murphy reported on his and Mrs. Richardson's visits to services in North Yorkshire on 27th April 2022 which had included:

(1) Cross Lane Hospital in Scarborough to present two Living the Values awards to staff for their response to the fire on Danby Ward on 22nd January 2022.

The recipients of the awards had accepted them on behalf of all colleagues involved in the incident, which had required patients to be moved during the night from smoke filled environments. They had also recognised the tremendous support provided by Dominic Gardner (Director of Operations) and Martin Dale (Strategic Projects Manager).

The increasing work undertaken in partnership with the voluntary sector in Scarborough had also been highlighted during the visit.

(2) The Easington Learning Disability Team.

Discussions had focussed on the challenges in the provision of autism services in the area.

The high value staff placed on visits by Board Members had also been evident during the visit.

(3) Worsley Court in Selby.

Staff had been very open about the challenges faced by the team including vacancies and backlogs.

Overall Mr. Murphy and Mrs. Richardson had found staff to be open, engaged, focussed on improving services and committed to the Trust and the NHS. All those they had spoken to had agreed that progress was being made and recruitment was having tangible benefits. The re-opening of Esk Ward had also contributed to a positive feeling across the whole Cross Lane Hospital site.

Mr. Murphy urged colleagues to make time to visit smaller teams in the Trust as they would be greatly appreciated by the staff.

22/07 MATTERS RAISED BY GOVERNORS

It was noted that no matters had been raised by Governors for consideration at the meeting.

22/08 DIRECTORS' VISITS

Board Members provided feedback on their visits to Child and Adolescent Mental Health (CAMHS) Community Services on 11th April 2022.

Overall, the visits had highlighted a range of positive aspects including: high levels of participation and engagement in the multi-disciplinary teams (MDT) including peer mentors; the passion and dedication of staff; the development of partnership arrangements to support young people; the work being undertaken with schools and local authorities on prevention; and the good areas of practice being demonstrated to transform services and reduce waiting lists.

On the latter point it was recognised that the restructuring of the Trust, with the establishment of care groups and clinical networks, would provide leadership and consistency and support the sharing of good practice.

The key issues raised during the discussions were as follows:

(1) Some frustrations had been raised during the visits about commissioning arrangements and the resulting constraints on the ability of services to support a wider demographic of young people.

(2) The potential risks that the work being undertaken to manage waiting lists, with less urgent cases being signposted to other agencies, might result in individuals falling between providers.

Prof Hungin also highlighted that the Trust did not gain assurance on the quality of care provided by the other organisations.

Mrs Pickering responded that it was the Commissioners' role, under the system-wide approach, to gain assurance on the quality of care provided by the partner agencies to which young people were triaged and referred.

Prof. Hungin considered that it should remain the Trust's responsibility to ensure that young people were triaged to the right place.

Mrs. Richardson observed that the national approach to the delivery of CAMHS raised issues about how the Trust worked in partnership with other agencies. This was a very

different system and raised potential risks of confusion for parents and young people. The structural changes within the Trust would help together with improved engagement with partners. A change in mindset was also required and staff were willing to play their part in the new arrangements.

(3) Staff being potentially wary of the visits.

Mrs. Richardson reported that a meeting was being arranged to discuss moving to an approach based on "walkarounds" including how they might work, the preparations required for them and standardisation.

It was noted that services in North Yorkshire were very welcoming of any Directors who visited them informally and unannounced.

Mrs. Bridges highlighted the opportunities through the development of the leadership walkaround approach including the benefits of Directors embedding themselves in services.

(4) The need to ensure that information and communications about the services were appropriate for their target audience.

Mrs. Bridges undertook to raise this matter with the Communications Team.

(5) The importance of staff wellbeing, including their psychological safety, and the benefits of creating spaces for reflection.

22/09 CHIEF EXECUTIVE'S REPORT

The Board received and noted the Chief Executive's Report.

Mrs. Moody, who presented the report on behalf of Mr. Kilmurray, highlighted the following matters:

(1) The update on the continuing development of the Integrated Care Systems.

The following matters were noted:

(a) The rebranding of the Humber Coast and Vale (HCV) ICS as the Humber and North Yorkshire (H&NY) ICS.

(b) The inclusion of a seat on the H&NY Integrated Care Board for a mental health and learning disability member. This was welcomed by the Trust. The Chief Executive of the ICS, Steven Eames, had written to the Chief Executives of the three NHS providers seeking confirmation of which of them would be taking on this role.

(c) Mr. Kilmurray had held a very positive first meeting with the Chief Executive of the North East and North Cumbria (NENC) ICS, Sam Allen. Ms Allen had also agreed to become the Co-Chair of the Regional Quality Board.

(2) The stepping down of Covid-19 restrictions in accordance with national guidance.

Mrs. Moody advised that, whilst infection rates remained quite high, there were signs of a decrease.

Board Members noted that the return to pre-pandemic physical distancing would support increases in mandatory training and facilitate a return to normal routines in inpatient services to the benefit of patient well-being.

(3) The update provided on the organisational restructure.

Board Members noted that:

(a) Zoe Campbell had been appointed to the role of Managing Director for the North Yorkshire, York and Selby Care Group.
(b) An announcement would be made shortly on the appointment of the Medical Director.
(c) Interviews for the post of Assistant Chief Executive would be held in mid-May 2022.

Mrs. Moody advised that good progress was being made on the implementation of the new governance structures and it was expected that they would be fully operational in May 2022.

Mrs. Moody also drew attention to the update provided on the incident at Roseberry Park Hospital on 3rd April 2022, which had been reported in the press and on social media, where a patient had driven a car through the front doors of the Dalesway reception area. This had caused damage to the front of the hospital building but no injuries had been sustained by people in the vicinity.

It was noted that the safety reviews of all inpatient wards had been updated and a security proposal was being produced by the Head of Safety in response to the incident.

22/10 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

The Board Assurance Framework (BAF) Summary Report, which provided information on the alignment between the strategic risks and the matters due for consideration during the meeting, was received and noted.

(See also minute 22/C/30)

22/11 FINANCE REPORT

The Board received and noted the Finance Report as at 31st March 2022.

Mrs. Romaniak advised that:

(1) The year-end position, as set out in the report, formed the basis of the draft accounts which had now been submitted for audit.
(2) The achievement of a pre-submission forecast surplus of £6.1m was £900k ahead of plan and £1.2m ahead of requirement. This position was an increase on that previously reported with the movement principally due to late invoices.
(3) The impact of agency expenditure on the Trust's financial position had been previously discussed and was reflected in the Trust's financial plans for 2022/23 (minute 22/C/29 refers).
(4) The surplus reflected technical adjustments of £10.7m principally related to asset revaluations.
(5) In terms of capital, the Trust's position at month 12 at £12.9m, against the allocation of £13.6m, was £700k under the CDEL limit and reflected the full VAT recovery in relation to Roseberry Park.
(6) The financial position of the NENC at month 12 (subject to audit) was that revenue targets had been met and performance on capital was close to budget.

The Chair and Board Members congratulated Mrs. Romaniak and her team on achieving financial performance close to plan in a very challenging year.

Mr. Maddison assured the Board that the Trust's financial position had been fully discussed at the last meeting of the Strategy and Resources Committee (minute 22/C/27 refers). He also cautioned that 2022/23 might be more challenging.

Mrs. Reilly, with reference to section 3.6 of the Report, questioned whether there was confidence that recruitment would be sufficient to reduce agency staffing expenditure to the level required to deliver the Trust's 2022/23 financial plans.

Mrs Romaniak responded that, in addition to recruitment, the Trust would need to reduce sickness absence levels due to the combined effect of staff being paid whilst absent and the costs of backfill arrangements either through bank or, as a last resort, agency staff. Nationally it was expected that sickness absence would reduce during the summer months; however, higher than expected rates were being experienced. There were also challenges to moving from off to on framework agency providers for LD packages.

The Chair highlighted the importance of the Strategy and Resources Committee maintaining oversight of the financial position as it presented a key risk for the Trust.

22/12 PERFORMANCE DASHBOARD

The Board received and noted the Performance Dashboard Report as at 31st March 2022.

Mrs. Pickering drew attention to the following matters:

(1) The report represented the year-end position.
(2) Issues had remained constant during the year with pressures arising from acuity, demand and capacity; however, as shown in the report, there were indications of improvement.
(3) In regard to out of area placements (OAPs), four beds had re-opened on Esk Ward on 26th April 2022, which was welcomed, and the position was expected to further improve when it became fully operational.
(4) This was the last performance dashboard report to be presented to the Board as it was due to be replaced with the introduction of the new integrated performance assurance approach.

The following matters were raised by the Non-Executive Directors:

(1) Ms Haley sought further information on eliminating OAPs by Quarter 3 (as referenced in the report) in terms of the present numbers and plans as, in the latter case, the re-opening of Esk Ward was the only solution mentioned.

Mrs. Pickering explained that:

(a) On average, over recent months, there had been approximately nine OAPS at any one time.
(b) The full re-opening of Esk Ward, with 13 beds, represented the primary solution to eliminating them.
(c) Although the ward was expected to fully re-open in May 2022 the target would not be achieved until Quarter 3 as the indicator was based on a three-month rolling average.
(d) The Trust was also working to reduce lengths of stay, which were contributing to the levels of bed occupancy, and was working with partners to discharge people appropriately.

(2) Mrs Reilly highlighted the comments in the report that there was assurance that the Trust was meeting its financial plan but overall patient experience, despite showing an improvement, was not achieving ambition.

Mrs Reilly also sought further discussions with Mrs Pickering, outside the meeting, on the position in forensic services given the concerns raised in the report.

(3) Dr Carpenter sought clarity on whether non-covid sickness absence was higher than expected as this might indicate underlying issues such as low morale.

Dr Dexter-Smith:

(a) Advised that sickness absence was higher than the Trust would like but lower than that being experienced by some comparable organisations.

(b) Offered to circulate a slide deck, which provided further information on sickness absence levels, to Board Members for information.

Action: Dr. Dexter-Smith

Dr Carpenter also asked for Board level discussions to be arranged on sickness absence given its implications.

(4) Dr Carpenter questioned whether the Trust was certain of the underlying causes impacting on performance as, for example in the case of metric TD01 (Percentage of patients seen within 4 weeks for a 1st appointment following an external referral), all remedial actions had been taken but they had not delivered the expected improvements.

Mrs. Pickering acknowledged the position in regard to metric TD01 and advised that, in such instances, the performance team would seek to understand whether the situation arose from actions not being embedded or whether other actions were necessary.

(5) Mr. Maddison sought clarity on when the Trust expected to return to achieving appraisal rates of 95%.

Dr. Dexter-Smith was unable to provide a date for the achievement of the target but considered that of greater importance, from the feedback received from the “Big Conversation”, was the quality of appraisals and this was the present focus of work.

The Chair sought assurance that the improvements made to performance reporting would be maintained with the introduction of the new approach.

Mrs Pickering responded that, whilst the indicators would change and more information would be provided, the plan was for the format of the dashboard to be similar to that of the present report.

22/13 QUALITY ASSURANCE COMMITTEE

The Board received and noted the key issues report on the business transacted and matters arising from the meeting of the Quality Assurance Committee held on 7th April 2022.

No risks had been identified by the Committee for escalation to the Board.

In her introduction Mrs. Reilly, the Chair of the Committee, reported that:

(1) Mr. Carl Best, the Trust's Head of Internal Audit, had attended the meeting on her invitation.

(2) There had been a long agenda for the meeting but no new matters had been raised.

(3) The meeting had focussed on the Board Assurance Framework (BAF) and Corporate Risk Register.

It was noted that discussions at the meeting, and subsequently amongst Members of the Audit and Risk Committee, had recognised the progress being made on risk management. However, they had also highlighted the need to further strengthen arrangements through the recruitment of the new Head of Risk Management (which had been subject to delays); staff being supported in understanding the role and functions of the BAF; clear ownership of risk at all levels; and the BAF being used to drive the agenda.

(4) Due to the nature of the Committee's discussions, and its role in providing assurance, the positive information provided to it did not tend to be discussed or included in reports to the Board.

The Chair thanked Mrs. Reilly for her clear report which demonstrated the significant workload of the Committee and provided assurance that it was fulfilling its role.

Prof Hungin observed that a critical risk to the Trust, which featured in the BAF and most reports, was staffing. He considered that continuing discussions on mitigating the risk through the recruitment of staff was fruitless, as the position was not solvable due to the national situation, and the Trust needed to consider how it could work within the staffing complement it had available.

On this matter:

(1) Mr. Murphy recognised that the Board needed to be more prepared to tolerate risks if they could not be adequately mitigated; however, the BAF and other reports demonstrated the importance of the staffing issues to the Trust and provided assurance that recruitment was taking place and appointments were being made.

He also reminded Board Members that the Trust had increased its headcount over the last 12 months and was in a comparatively good position against other Trusts.

(2) Mrs Moody advised that reporting on safe staffing was required by national guidance and the importance of safe staffing levels was identified as a quality issue in a range of national reports e.g. the Ockenden report. However, it was recognised that from a strategic perspective the Board needed to consider the Trust's response if safe staffing could not be maintained, for example through the temporary closure of services, and reporting should inform those discussions.

(3) It was acknowledged that safe staffing underpinned all the Trust's activities and "Our Journey for Change" could not be delivered without it.

(4) Dr Carpenter suggested that time should be set aside for the Board to hold a strategic discussion on the issues.

(5) It was noted that Health Education England had recently published a report on a major review of mental health nursing which included eight recommendations under four themes. The review had found that 28% of nursing vacancies in the NHS were in mental health services (in North Yorkshire and York the figure was 12%) and had also found that leaver rates were increasing. It was considered that reviewing the recommendations of the report might prove useful at both organisational and system levels.

(6) Dr Wright considered that workforce issues including training and skill levels, rather than only staffing numbers, were the Trust's biggest challenge. He supported the issues having greater visibility at the Board.

In conclusion the Chair agreed it was appropriate for the Board to review the Trust's position and to consider what further actions could be taken on this intractable problem.

In addition:

(1) Mrs. Moody advised that the new governance arrangements should act as a filter for the provision of information and improve the assurances to, and discussions at, meetings of the Committee.

Mr. Preston suggested that the development of the Committee's business cycle with a greater focus on prioritisation and quarterly reporting of routine matters might assist its meetings become more manageable.

(2) Mrs. Moody confirmed that the candidate for the post of Head of Risk Management had now received a conditional offer letter and was working her notice period with her present employer; however, her start date with the Trust was not yet known.

Board Members expressed their disappointment at the time taken to recruit to this important post.

(3) Dr. Carpenter sought clarity on the arrangements for the consideration of the deep dive on incidents of self-harm.

It was noted that the report would be considered by the Quality Assurance Committee and fed into the Board.

22/14 CQC ACTION PLAN

The Board received and noted the report which provided a detailed update on the current status of the delivery of the CQC Action Plan which had been submitted to the regulator on 21st January 2022.

A full status update for all the "must do" actions was presented as Appendix 1 of the above report.

Mrs. Moody drew attention to the following matters:

(1) The governance and reporting arrangements against the fundamental standards described in the report. These included the re-establishment of the Fundamental Standards Group which had been stepped down due to Covid-19.

(2) The three actions identified in the report as "not delivered with a significant risk to delivery".

Mrs. Moody advised that there were no fundamental barriers to the completion of the actions but the Trust had been overly ambitious in terms of the timescale for their delivery. The Quality Assurance Committee would be asked to amend the action plan to provide more appropriate delivery dates.

(3) The CQC Fundamental Standards Baseline Self-assessments being undertaken in Specialist Inpatient Services and CAMHS which would test the embeddedness of actions taking into account patient and staff perspectives.

The Board noted that, overall, it was considered that there was reasonable assurance in regard to oversight and delivery of the Plan.

Dr Carpenter observed that, as the CQC concentrated on experience rather than activity, the focus should be on ensuring that the actions had their intended benefit at the frontline, not on timescales, as otherwise there were risks that the regulator would find the same issues as it had during the inspection in 2021.

Mrs Moody considered that there were differences between the actions under the well-led domain, which would not be included in the forthcoming reinspection and where there would be a longer time for implementation, and those in response to the 29A Notices. In regard to the latter actions there was a lot of information about the changes that had been made but until the baseline assessments had been completed there was uncertainty on their impact.

Non-Executive Directors also raised the following matters:

(1) Whether the CQC was aware of the Trust's position on the delivery of the action plan particularly on the risks to those actions where the Trust had been ambitious on the timescales for their delivery.

Mrs Moody advised that the key issue for the Trust was to demonstrate that it was "safe today and safe tomorrow" in compliance with the fundamental standards. The CQC had not asked for an update on the delivery of the action plan; however, it was represented on the Regional Quality Board to which progress was reported. In regard to the Section 29A Notices, the regulator would gain assurance through its reinspection of the services.

(2) The timescales for the reinspection.

It was noted that the reinspection by the CQC was expected to be held before July 2022 and, with the exception of CAMHS where 24 hours' notice would be provided to support staff availability, would be unannounced.

(3) The position on the recruitment of the Head of Corporate Risk and Statutory Reporting (action 10b).

It was noted that an investment decision was still awaited.

Mrs. Romaniak advised that the investment was referenced amongst the Business Plan Priorities included as Appendix 1b to the report on the 2022/23 Final Draft Financial Plan (minute 22/C/29 refers).

(4) The level of assurance provided on actions included in the Plan with some being marked as completed but only assigned reasonable assurance.

Mrs. Moody advised that action owners had been asked to self-assess the delivery of actions and provide a level of assurance. The position described could occur when, for example, an activity had been completed but further assurance was required on whether

improvements had been sustained or whether they had had the desired impact from a patient experience perspective.

The Chair advised that the Board would be ensuring continued oversight of the delivery of the Action Plan.

22/15 OCKENDEN REPORT

Consideration was given to the final report of the independent review of maternity services at Shrewsbury and Telford NHS Trust, the "Ockenden Report", which had been published on 30th March 2022.

It was noted that NHS E/I had written to all Trusts to ask that the report should be taken to their next public Board meeting and be shared with all relevant staff. Trusts were expected to take action to mitigate any risks identified and develop robust plans against areas where services needed to make changes, paying particular attention to the report's four key pillars:
1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

Prof. Hungin observed that a longstanding issue within obstetrics had been the professional competition between midwives and medical staff and which was alluded to in the report. He considered that the risks should be kept under review as he had been aware of similar professional tensions in the Trust.

On this matter it was noted that key areas of learning for the Trust included:
(1) Staff being reluctant to raise concerns with members of the clinical team and, in particular, how conversations with them were framed.
(2) The operation of the MDTs, which had been identified from serious incidents, and the importance of all staff having the skills to escalate concerns.

Clarity was sought on the arrangements for taking the recommendations of the report forward within the Trust.

Mrs Moody referenced the recommendations of the covering report that the Organisational Learning Group should review the Ockenden Report in detail. It was not intended to create a new action plan but to take a more integrated approach by considering whether the Trust had actions already in place; the impact of those actions; and whether it needed to do more in response to the report's recommendations. It was anticipated that a report on the findings of the review would be considered by the Quality Assurance Committee and then the Board.

Prof. Hungin considered that, as serious incidents highlighted risks at every level of the organisation, the report of the Organisational Learning Group should be presented directly to the Board.

This was supported.

Agreed

(1) that the Organisational Learning Group review the Ockenden Report in detail and agree any additional actions to mitigate any risks identified paying particular attention to its four key pillars; and

(2) *that arrangements be made for further assurance on the Trust's approach and the impact of changes, following the review by the Organisational Learning Group, to be presented to the Board.*

Action: Mrs Moody

22/16 LEARNING FROM DEATHS REPORT

The Board received and noted the Learning from Deaths Report for Quarter 4, 2021/22 which included:

(1) The Learning from Deaths Dashboard - Appendix 1 to the report.
(2) The Locally agreed criteria for Mortality reviews and Structured Judgement Reviews (SJRs) - Appendix 2 to the report.

In presenting the report, Mrs Moody highlighted:

(1) The priorities of the Journey to Safer Care (as part of Our Journey to Change). Five workshops were being held to co-create and agree key performance indicators in order to enable its impact to be measured and reported upon.
(2) The new Patient Safety Incident Response Framework (PSIRF) which was focussed on learning and themes and improving the quality of reviews and the experience of families.

Mrs. Richardson welcomed the work being undertaken to bring together the approach to quality. In terms of co-creation the key issue was having systems in place to understand their impact, and which captured and demonstrated improvement, and for families to feel that the response to incidents had been managed in the best way for them.

Dr Carpenter considered that, although it was evident from the report that significant activity was being undertaken, it was difficult to follow a clear narrative on the number of incidents, where they had occurred, their type, and trends. The actions included in the report also seemed fragmented.

The Chair supported Dr. Carpenter's suggestion that a more compact report which set out the actions under themes should be provided in the future.

It was noted that learning from deaths was very complicated. Significant work had been undertaken following the incidents at Southern Health NHS Foundation Trust including at a regional level. The challenge would be how to draw the information out from the arrangements which had been put in place. These included the Trust's investigation procedure, which had been developed with national support and the involvement of families, and a new Patient Safety Strategy which was awaiting approval.

Mrs. Moody suggested that, in the circumstances, it might be worthwhile for the Board to set aside some time to reflect on those approaches.

This was accepted taking into account the need for the Board to gain assurance that the new approaches would have the required impact.

Action: Mrs. Moody

22/17 NHS SYSTEM OVERSIGHT FRAMEWORK REPORT

The Board received and noted the report on the NHS System Oversight Framework (SOF) as at Quarter 4, 2021/22.

In response to a question, it was noted that the key means by which the Trust could improve its segmentation would be through the delivery of the CQC Action Plan.

Mrs. Moody also highlighted a broader conversation which was being undertaken within the Quality Board on how the Trust would exit the present level of support and oversight. This had recognised the importance of the delivery of the CQC Action Plan and workforce and performance improvements.

Mrs. Pickering commented that, for those metrics where the SOF standards had not been achieved at Quarter 4, the positions were reflected nationally and the Trust was not an outlier.

22/18 REGISTER OF INTERESTS OF THE BOARD OF DIRECTORS

The Board received and noted the Register of Interests of the Board of Directors which had been compiled in accordance with paragraph 20(1) of schedule 7 of the NHS Act 2006 (as amended).

22/19 REGISTER OF SEALINGS

The Board received and noted the report on the use of the Trust's seal in accordance with Standing Order 15.6.

22/20 CONFIDENTIAL MOTION

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

Information relating to a particular employee, former employee or applicant to become an employee of, or a particular office-holder, former office-holder or applicant to become an office-holder under, the Trust.

Information relating to any particular applicant for, or recipient or former recipient of, any service provided by the Trust.

Any documents relating to the Trust's forward plans prepared in accordance with paragraph 27 of schedule 7 of the National Health Service Act 2006.

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 4.58 pm.

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	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
27/01/22	22/01/09/185/9.1.6.1	Chief Executive's Report	Agreed that the outcome of the ICO Audit would be presented to the next Strategy and Resource Committee; and the next Audit and Risk Committee.	Co Sec/DoF	April/May 22	Completed	Reports provided to the meetings of the Strategy and Resources Committee on 12/4/22 and the Audit and Risk Committee on 20/5/22
31/03/22	22/03/14/226/14.2	Outcome of the Establishment Reviews	Further updates to be presented to the People, Culture and Diversity Committee; and the Strategy and Resource Committee	DoN&G	~~May-22~~ Jun-22		
28/04/22	22/15	Ockenden Report	Arrangments to be made for further assurance to be provided to the Board on the Trust's approach and the impact of changes following the Organisational Learning Group's review of the Ockenden Report	DoN&G/Co Sec	-		
28/04/22	22/16	Learning from Deaths	Arrangements to be made for the Board to gain assurance that the revised investigation procedure and patient safety strategy will have the desired impact	DoN&G/Co Sec	-		

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 8

PUBLIC

BOARD OF DIRECTORS

DATE:	**Thursday 26 May 2022**
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 (CQC)

We continue to make progress with our CQC action plan and there was a comprehensive update given at the April board meeting. We are aware that the CQC will be re-inspecting secure inpatients and CAMHS teams. We have been undertaking further assurance work using the fundamental standards, rather than simply completeness of our actions, as the basis of this. The services have been developing well and, in both services, we can demonstrate significant improvements. However, again in both services, there is still much to do to embed the improvements. Some of this has been a challenge due to staffing pressures.

More broadly progress has been good on the overall CQC action plan and a further update will be presented in July.

Directors will be aware that the Tees Valley Joint Health and Care Scrutiny Committee will be running its next meeting from Roseberry Park on 8 June, following our attendance previously to discuss our CQC challenges. We look forward to

updating members and introducing them to members of staff and showing them our facilities.

Integrated Care System Developments (ICS)

Northeast North Cumbria - the Integrated Care Board is making progress with the organisational change process. There will be an announcement shortly regarding the successful appointment of a Chief Nurse. There is also an active consultation regarding phase 2 of the transfer of CCG staff to the ICB into their new structure.

Further work is being done to identify the broader partnership and sector members of the Board. There has been agreement that the mental health and learning disability member will be a clinical executive. We have supported the nomination of Dr Rajesh Nadkani, Executive Medical Director at Cumbria, Northumberland, Tyne and Wear NHSFT, as our choice for the role. Ken Bremner, chair of the regional Provider Collaborative (and acute Trust CEO) will take the other provider seat.

With regards to Mental Health, Learning Disability and Autism services, Sam Allen, Chief Executive, has written to me and my colleague James Duncan at Cumbria, Northumberland and Tyne and Wear NHSFT, to ask us to work with colleagues from across the area, from all sectors to create a partnership or collaborative that would take on responsibility for the strategic planning and delivery of services across the Northeast North Cumbria. This has the potential to create an inclusive process for setting clear clinical and social standards, provide frameworks for the consideration of investments at a place level, drive clinical networking and good practice, and bring together whole pathway strategic developments. A meeting took place with a range of partners on 13 May, where there was broad support for this approach. Further work now needs to be done to progress this and start the process of engagement and co-creation.

Humber and North Yorkshire – similar to the NENC team, there is a consultation taking place regarding the operating model and future structure of the new statutory organisation. This is slightly further ahead than in NENC. We are starting to have some of the senior officers below board level now identified.

From a Mental Health, Learning Disability and Autism perspective we have agreed Michele Moran, CEO at Humber Teaching NHSFT will take the mental health seat at the ICB. This means that I have been asked to chair the Humber and North Yorkshire Mental Health, Learning Disability and Autism provider collaborative. I will also take on the role of Senior Responsible Officer for the mental health and learning disability programmes, whilst the SRO role is being reviewed. I will take up these roles from 1 June.

Board Development Programme/GGI (Phil Bellas)

At its meeting held on 31 March 2022 the Board closed the implementation plan arising from the independent leadership and developmental (well-led) review conducted by the Good Governance Institute (GGI) in 2021. Whilst most of actions had been completed, it was recognised that there were benefits in taking forward the few remaining through existing plans and programmes.

The Board Development Programme, which had been commissioned from Deloitte LLP on the recommendation of the GGI, was concluded on 5 May 2022. The fifth and final workshop focussed on the findings of the Board evaluation survey which covered strategy development and oversight, the Board's committees, reporting, Board engagement; and Board debate.

The survey provided some positive reflections on the Board operating as a unitary Board; the motivation of Board Members' contributions being a genuine concern for the good of patients, service users, carers and staff; Board Members feeling free to express their thoughts, feelings and doubts in debates; and on the changes to the operation of the Board from learning on past issues and experiences.

It also highlighted the following key strengths of the Board:

- An atmosphere conducive to constructive challenge
- Effective and respected relationships
- Integrity and shared values
- Breadth of experience
- Leadership from the Chair and team

The findings of the survey were used to frame the Board's aspirations and priorities. These will form the basis of further development activities with a governance review planned for 2023 to provide assurance on the progress made.

Thirteen Group Meeting

A small group of executives met with peers from the Board of Thirteen Group. Thirteen is a local social housing organisation. They are based in Teesside but cover a large part of the TEWV patch. It was evident that there was a good deal of common ground, and we agreed a range of actions linked to: the community mental health transformation agenda, learning disabilities accommodation and housing solutions, mutual learning regarding the use of technology in care settings and links regarding estates planning. We would hope to have discussions with other similar organisations over the coming weeks, as part of our commitment to be a great partner, but also in support of our commitment to system working in the interests of improving patient and carer outcomes.

Visit from Tom Cahill, NHS National Director for Learning Disability and Autism

On 17 and 18 May Tom Cahill visited the Trust. I had invited Tom shortly after his appointment in November 2021. We had the opportunity to share with Tom our current experience of learning disability services and our perspectives on the autism agenda. We also took him out to visit a community team and to meet the learning disability leadership team from North Yorkshire and York and then he visited Bankfields Court.

Tom is keen to re-emphasise the need to ensure that care is provided in the right, least restrictive settings, but there is a clear sense of there being people who will always require a short admission to hospital, those who will struggle to be discharged in a timely way due to legal issues and those who are delayed discharges. Tom's message was that we need to focus on the delays and work with system on these cases as the main priority, however he was keen to emphasise the need for quality in those cohorts that are in beds and have limited other options.

As part of this agenda, I also introduced Tom to Paul Newton, Managing Director of PIPS Ltd, our complex care provider subsidiary company. Tom was interested to hear about this and commented it was a good solution to the issues of a challenged provider market.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report

Report Date: 26th May 2022	**Report of: The Audit and Risk Committee (ARC)**
Date of last meeting: 20 May 2022	**Membership Numbers: 4** Quoracy met -100%

Agenda: The Committee considered the following matters:

Update from the first Executive Risk Group meeting
The findings of the recent audit conducted by the Information Commissioners Office
A Counter Fraud Progress Report
A Counter Fraud Workplan 2022/23
An Internal Audit Progress Report
The draft Annual Report and Head of Internal Audit's Annual Opinion
An Internal Audit, Strategy and Operational Plan
An Internal Audit Charter and Protocol Annual Review
An External Audit Progress Report
Draft Annual Accounts
The Annual Board Certificates required by NHS E/I
The Draft Annual Governance Statement
The tender waiver Report – (no changes since the SFI report submitted in January 2022)
Annual Report on Registration of Conflicts of Interest and Declarations of Gifts and Hospitality
The revised Risk Management Policy
The Committee's Assurance Tracker

2a	**Alert**	**Mazars Audit Progress Report:** The Board will recall that the External Auditors identified significant weaknesses, and made recommendations, regarding governance (as part of the VFM conclusions) in the 2020/21 audit arising from the CQC inspection in January 2021. Whilst significant work has been undertaken to address the deficiencies, the External Auditors are considering whether the CQC report of December 2021 highlights potential further weaknesses. These are being discussed with management and will be referenced, in the Audit Completion Report (ISA 260) presented to the special meeting of the ARC on 10th June 2022.
2b	**Assurance:** The Committee wishes to draw the following positive assurances to the attention of the Board: ▪ That the action plan in response to the ICO audit will be given more scrutiny at the next Strategy & Resource Committee. Members were satisfied that the timetable for completion of actions will be met in early September 2022. ▪ That the briefing on the draft accounts and the accounting treatment of significant items was accepted by the Committee as providing a clear description of key changes in year to financial estimates/valuation methods and material balances in the draft accounts, with no requirement to hold a further meeting before receipt of the audited accounts. ▪ The compliance rate for declarations of interest has increased from 44% in 2020/21 to 68% in 2021/22. ▪ The Committee noted that the annual internal audit planning cycle for 2021/22 is on track to deliver a robust Head of Internal Audit Annual Opinion. ▪ The draft Internal Audit Operational Plan 2022/23 (longlist) is aligned to the BAF but will be subject to further review and refinement by the Executive Team prior to presentation to the next ARC meeting. ▪ The Committee noted the content of the Annual Report and Draft Head of Internal Audit Opinion for 2021/22, which is – good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives and that controls are generally being applied consistently.	

	▪ The annual Internal Audit charter and Protocol for 2022/23 were approved and adopted. Updates have been made to section 4 regarding engagement throughout the audit process and section 7 and Appendix A (the protocol) which outlines the values of Trust, Respect, Quality, and Innovation that AuditOne is committed to. ▪
2c	**Advise:** The Committee wishes to advise Members of the Board that: **Executive Risk Group:** The new Head of Risk will be in post from 1st August 2022. Areas of focus will be the linkages between the BAF and the corporate risk register, a refresh of local risks and a training package in risk management for delivery Trust wide. The Quality Assurance Committee at its meeting in May 2022, has gained some positive assurance that the BAF and CRR are moving in the right direction. **Internal Audit Progress Report:** The final eight audits for 21/22 are in progress for completion by the end of May 2022, subject to continued engagement with key audit contacts in the Trust. One of the seven final reports for 2021/22 issued since March 2022, is a Limited Assurance report on Patient's Property, Monies and valuables where the audit found a high level of non-compliance with Trust procedure for recording and securing patient's properties and valuables on four wards and is referenced in the Annual Internal Audit Head of Audit Opinion. The recommendations are to be picked up by the new Managing Directors and as such members requested the Executive Team to focus oversight on the issues prior to an update at the next full Audit & Risk Committee. The Committee sought further assurance on the outstanding recommendation, of four years, for all appointing managers to complete the mandatory training in equality and diversity. This will be pursued. **Counter Fraud:** The Committee received an update on positive progress with delivery of outstanding counter fraud recommendations and the Counter Fraud Workplan 2021/22. **Draft Annual Governance Statement:** A comprehensive and well-articulated list of controls and evidence were provided relating to governance, risk and control of the organisation. The conclusions drawn by the Accounting Officer, following his review, are reasonable. The principal risks to compliance with license condition 4 of the foundation trust are included in the BAF. The Board has previously, in assessing the validity of its Corporate Governance Statement, confirmed four out of six risks. These relate to the embeddedness of the Trust's operational and governance arrangements, uncertainty about the outcome of the NHSEI investigation, continued regulatory oversight by the CQC and availability of staffing. **Annual Certificates:** The Committee recommends that the Board of Directors confirm the annual certificates, as set out in the Recommendation below. The Committee recognised a potential control issue relating to the completion of DBS checks by Governors and requested management to progress discussions on this matter with the Lead Governor. **Risk Management Policy:** In view of the late receipt of the report, the Committee will be providing comments on the revised Operational Risk Management Policy outside the meeting. **Annual Report on Registration of Conflicts of Interest and Gifts and Hospitality:** Compliance with requirements to declare conflicts of interest is increasing. Declarations of gifts and hospitality have reduced significantly compared to 2020/21, which was an atypical year due to the Covid-19 pandemic and the outpouring of goodwill towards the NHS. Escalation processes, not undertaken this year, will be reintroduced for 2022/23.
2d	**Review of Risks** In undertaking the duty of gaining assurance that risk management processes are operating effectively, the Committee recognised that there is some good progress. Further work is required

	linked to the finalisation of the Trust Risk Management Policy, embedding the new governance structures and reporting arrangements, particularly in the Care Group Boards and Executive Groups.	
3	**Actions to be considered by the Board:** **Recommendation:** *(i) That the Certificate on Systems for compliance license conditions should be confirmed.* *(ii) The first (of three) statement of the certificate on the "availability of resources" should be confirmed.* *(iii) The certificate on the "training of Governors" should be confirmed.* *(iv) Four of the components of the corporate governance statement should be confirmed with the remaining two "not confirmed".*	
4	**Report compiled by**	*John Maddison, Chair of Committee, Donna Keeping, Corporate Governance Manager*

ITEM NO. 10

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th May 2022**
TITLE:	**Board Assurance Framework – Summary Report**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Information & Assurance**

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.

A summary of the BAF, highlighting relevant reports included on the agenda, is provided in Annex 1 to this report.

This summary is intended to act as an aide memoire to support the Board to focus on the strategic risks in its discussions. It also provides assurance on the alignment of the BAF with the matters due for consideration at the meeting.

Recommendations:

The Board is asked to receive and note this report.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Present Risk Grade	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**	**Good**	Risk significantly above tolerance Strengthening of controls required, at pace, to reduce exposure to tolerable levels	▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 14 – People Culture and Diversity Committee Key Issues Report ▪ Public Agenda Item 15 – Report of the Guardian of Safe Working
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 (CEO)**	**High**	**Reasonable**	Opportunities to improve controls; however, new controls (if available) are required to reduce exposure to tolerable levels	▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report
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**	**Reasonable**	Controls are, generally, considered to be operating effectively; however, further strengthening is required, at pace, to reduce exposure to tolerable levels	▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 13 – Mental Health Legislation Committee Key Issues Report ▪ Public Agenda Item 14 – People Culture and Diversity Committee Key Issues Report ▪ Confidential Agenda Item 1 – Patient Story

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 11 – Directors' Visits Feedback ▪ Public Agenda Item 14 – People Culture and Diversity Committee Key Issues Report ▪ Public Agenda Item 15 – Report of the Guardian of Safe Working
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 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 13 – Mental Health Legislation Committee Key Issues Report ▪ Confidential Agenda Item 4 – Reportable Issues Log
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 12), Cyber security (see risk 8) and RPH (see risk 14)].	**DoF&I**	**Medium**	**Good**	The risk is within tolerance and controls are operating effectively. Continued delivery of mitigations is required to achieve target score.	▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Confidential Agenda Item 6 – Update on the Financial Plan 2022/23 and month 1 run rate
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	
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.	▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Confidential Agenda Item 4 – Reportable Issues Log ▪ Confidential Agenda Item 5 – Chief Executive's Report ▪ Confidential Agenda Item 8 – Annual Board Certificates

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.	
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 – Quality Assurance Committee Key Issues Report ▪ Confidential Agenda Item 8 – Annual Board Certificates
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 is significantly in excess of tolerance. Urgent action is required to reduce exposure.	▪ Confidential Agenda Item 5 – 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 if the Trust is not able to demonstrate the necessary improvements and approach	**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.	▪ Confidential Agenda Item 5 – Chief Executive's Report
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	

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**	**Very High**	**Reasonable**	Urgent action is required to strengthen controls, where practicable due to national/regional constraints, to reduce the risk score to target (within tolerance) through the delivery of mitigations	▪ Confidential Agenda Item 6 – Update on the Financial Plan 2022/23 and month 1 run rate ▪ Confidential Agenda Item 8 – Annual Board Certificates

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26 May 2022**
TITLE:	**Feedback from Directors' Visits**
REPORT OF:	**Director of Corporate Affairs & Involvement**
REPORT FOR:	**Information & Assurance**

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:

1 **Purpose**

1.1 The purpose of this report is to enable the Board to consider high-level feedback from recent Directors' visits.

2 **Background**

2.1 The Trust has a programme of regular visits to services. These visits are not inspections but enable teams to hold conversations directly with Board Members to raise any matters of importance.

2.2 From the perspective of Board Members, the visits support a fuller understanding of the issues and risks facing services and enable information and assurances, presented in Board reports, to be triangulated.

3 **Key Issues**

3.1 Directors' visit took place face-to-face on 9 May 2022, in the services outlined below:

- NE Community York
- Durham and Chester-le-Street MHSOP CMHT
- Easington MHSOP CMHT
- Hartlepool MHSOP CMHT
- Harrogate CMHT
- Rydale CMHT

3.2 Feedback from the visits identified a number of themes which are summarised below.

Strengths:

- Multi-disciplinary team approach to service provision including huddles leading to improved shared decision making.
- Teams are fully committed to patient care, the communities they serve and each other.
- Overarching theme around team cohesion, positive team dynamics and innovation – this came into its own particularly through the pandemic, where innovative practices thrived – wellbeing and support for each other shone through.
- Strong partnership working eg Age UK, Alzheimer's Society, local authorities dementia advisors, voluntary and community sector – this extended internally in specialist areas eg collaboration with AMH.

Challenges:

- Recruitment was raised as an issue across teams visited, at different levels / specialities to support patients through dementia pathway.
- Caseload management due to the success of continued dementia assessment throughout the pandemic.
- Fragility of the care sector, including staffing pressures / burnout.
- Need for awareness raising in primary care in relation to dementia diagnosis.

3.3 For assurance, Directors have followed up on feedback received to escalate issues and areas of concern where relevant and agree next steps.

3.4 A review of Directors' visits is being undertaken, and further details will be provided in due course.

Recommendations:

The Board is asked to:

1. Receive and note the summary of feedback as outlined.

2. Consider any key issues, risks or matters of concern arising from the Directors' Visits held on 9 May 2022.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Item 12

Quality Assurance Committee: Key Issues Report

Report Date to Board: 26th May 2022

Date of last meeting: 7th April 2022. **Membership:** Quoracy was met. Apologies - none

1 **Agenda items considered:**

- "No one will remember me or grieve me"- Viktor's story.
- Board Assurance Framework and Corporate Risk Register – risks to Quality and Safety
- Trust Level Quality Assurance & Learning Report
- Trust Action Plan in response to Well-led CQC Inspection
- Locality updates (North Yorkshire & York, Teesside, Durham & Darlington, Secure Inpatient Services, Health and Justice)
- Safe Staffing
- Positive and Safe Annual Report
- Draft Quality Account 2020/21
- Update from the Environmental Risk Group
- Suicide and self-harm work
- Learning from Deaths

2a **Alert (by exception) The Committee alerts the Board to the following:**

No one will remember you or grieve you – Viktor's story

The Board is to note that the Committee spent a substantial portion of the agenda listening to Viktor's story, a 23-year-old young man who sadly took his own life at home while under the care of the Trust. The presentation focused upon the findings of an independent review commissioned by the Trust because of several unresolved concerns on behalf of the parents of Viktor, relating to the care and treatment offered to their son and an inability to seek satisfactory resolution. This included being dissatisfied with the process and outcome associated with the Trust's internal Serious Incident review that followed the incident. The review highlighted many areas of learning throughout Viktor's care and concluded that:

- Viktor did not receive an evidence based, multi-disciplinary care and treatment programme, in line with his presenting needs. This was due to the poor clinical practice of individuals concerned, which was caused by a combination of limited capacity and limited adherence to professional standards.
- There were some weaknesses in the investigatory process of the Trust's report. The most significant absence was a lack of exploration to enable an understanding of the relationship between the acts and omissions identified in relation to Viktor's care and the reasons for those acts and omissions in practice relating to workload/capacity of individuals.

The Independent Review is an important legacy document in supporting TEWV's commitment to the continued development of high standards of safe and effective services and robust clinical governance.

The Trust accepts the recommendations made in the report and has developed an improvement plan to address key areas of learning.
The Committee agreed that whilst the governance route for the oversight and delivery of the improvement plan was through the Care Groups, as a commitment to Viktor's and his family, they would like to receive an update on progress in six months' time.

Board Assurance Framework (BAF) and Corporate Risk Register - risks relating to quality and safety

There has been little change to the BAF since the last QuAC meeting in April and members were advised to use the BAF as an aide memoir for reflection on the business discussed at the end of the meeting.

Members concluded that there are no new risks to be recommended to the Board for inclusion in the BAF or any other material changes to be made.

For the month of March 2022, there were 31 risks open on the Corporate Risk Register, of which 27 related to quality and safety. No new risks were added and seven were downgraded or removed. The progress month on month is noted.

The revised Risk Management Policy will go to the Executive Risk Group on 17th May 2022, with an opportunity for comments before formal recommendation to the Board for approval. The new Head of Risk Management will start work with the Trust on 1st August 2022.

Trust Level Quality and Learning Report:
The key messages from this report are that the information triangulates the messages coming out of the localities. There was positive assurance in that the backlog of approval of Datix incidents had reduced significantly.
The ongoing measures of quality and safety showing SPC cause for concern during March 2022 were related to self-harm, patients in beds longer than 90 days, mandatory training (ongoing concerns for Basic Life Support and Positive Approaches Team training) and appraisals.

In terms of patient safety incidents, there had been a trust wide increase and above the mean in our SPC data. Following a request by Committee members in March 2022, there will be a piece of work undertaken to better understand this. Specifically concerning self-harm increases, particularly in relation to ligatures. A report will come back to QuAC in June 2022, outlining the scope, aims and remit of the work.

Learning from Deaths Q4 2021/22
This report was noted retrospectively for the Committee as it had been presented to the Board of Directors at the April 2022 meeting. The governance trail for this report will in future be through the Executive Quality, Assurance and Improvement Group (EQAIG).

Locality Updates:
The messages from the four localities remained consistent. Staffing challenges, recruitment and retention and a lack of Registered Nurses for some shifts. Staff resilience, health and wellbeing in managing busy wards. High bed occupancy with continued high acuity of patients and increasing levels of self-harm, particularly among female patients. Lack of community infrastructure to support discharges. The ongoing challenges to meet mandatory training and appraisal compliance, however there were some positive areas. Each locality provided mitigating actions in place and significant efforts that are being undertaken to address concerns. Of particular concern were staffing levels in SIS who remain in business continuity.

Monthly Safe Staffing Exception Report

From the March 2022 report the Board should be alerted to the following matters:
35 of rostered wards had a Registered Nurse (RN), on day shifts below the fill rate threshold of 90%. Services continue to skill mix and backfill to mitigate against this. The top three concerning areas were Westerdale South, Bilsdale (AMH) and Merlin (SIS).

There was a significant increase of shifts worked across the Trust that exceeded 13 hours from 74 to 106, which was to support the management of incidents and clinical response.

Business Continuity Arrangements remained in place during March for SIS, Bankfields Court (LD), Bek and Ramsey Talbot (LD), Esk (AMH), Northallerton CAMHS and York CAMHS (CYPS) and D&D Crisis Team.

The average use of agency over the 54 wards reviewed had increased from 14.6% to 15.4% from the previous month (upper target 4%) and bank usage increased slightly by 0.5% to 23.8%. Jay Ward and Harrier Hawk were the highest users.

	There were 59 incidents citing issues with staff cover for inpatient wards, which is an increase of 38 from February 2022. Forensic services (25) and Teesside (31) were the highest. With the introduction of the Care Group Boards and linked governance structures, this report will also go to the Executive Quality, Assurance and Improvement Group for consideration in future
2b	**Assurance: The Committee assures members of the Board on the following matters:** **CQC Well-led Inspection and NHSEI Quality Board Update** The Board is to note that QuAC received and noted a retrospective update on the "must do action" plan in response to the Well-led CQC inspection which had been presented to the April 2022 Board of Directors meeting. Rationale was provided to the Committee about "reasonable assurance", rather than "good assurance", which is linked to the actions in relation to the S29A in SIS, where a base line assessment is underway by the service. Members challenged the lack of attendance at staff team meetings in SIS and some reassurance was given that there were other methods of communicating with staff, that supported the team meetings. **Positive and Safe Annual Report 2021/22** There are some positive assurances coming out of the last years work to support the reduction of restrictive interventions, including reductions in the use of prone, mechanical restraint and tear proof clothing. There is however more work to do, particularly to support learning disabilities, PICU and medium secure wards, where we know there are patients of a very high acuity requiring support. Members discussed and recognised that the model of care to support these individuals requires the appropriate behavioral care plan in place. For the 8 restrictive interventions, the SPC Trust set metrics, advises that all are within "normal variation". However, the trend for rapid tranquilisation, seclusion and self-harm is upwards. This links to the work that QUAC have requested an update on in June 2022. **Draft Quality Account 2020/21** The Board is to note that QuAC considered the proposed Quality improvement priorities, the process and timescale for engagement with stakeholders and that the full QA will be presented to the June QuAC meeting for a fuller discussion. **Update from Environmental Risk Group** The Board can be assured that following a request by Committee members in the March 2022 QUAC meeting, where further information was requested in relation to risks to the environment, an update report was presented on the remit of the Environmental Risk Group, including a summary of progress and assurances linked to the work undertaken in phase 1 and 2 of the ligature reduction programme. Phase 1 being replacements of ensuite bathroom taps, shower fittings and toilet seats and Phase 2 being replacement ensuite doors, windows and bedroom doors. Phase 1 work is complete apart from ongoing work on two older persons wards. Key to note is that the ligature programme was prioritised, according to areas of greatest risk, due to capital spend limits and Covid, with some risks remaining. Bedroom door replacements for this year are only to female acute and PICU wards where incident data would suggest risks are highest. The group meet monthly and review incident data and any alerts that have been flagged with regard to the environment. A current risk has been escalated regarding patients access to the roof across acute inpatient sites. A review has been undertaken and the ERG will receive a report detailing work completed to consider further mitigations. **Positive Practice Examples** Localities shared some of the positive news and developments and successes over the month of March which included in Health and Justice mobilizing a new contract in HMP Hull and Humber. The Chair of the Committee raised concern about the time spent on mobilization and how this should not distract from the current service provision. Some positive verbal feedback has also been received following a CQC visit to HMP Frankland. Formal feedback is awaited.

2c	**Advise:** The Committee members agreed that the key issues to draw to the Boards attention are: 1. The learning lessons, following the death of Vicktor and ongoing recommendations and associated action plan. 2. The updates on the Corporate Risk Register and BAF. 3. To note the progress on the CQC action plan. 4. Key locality concerns – recruitment and retention, staffing and ongoing challenges in SIS. 5. Concerns in relation to the rising incidents of self-harm and ligatures, harm to staff and patients. harming patients and that a piece of work will be scoped to unpick some of these trends. 6. To note the updates from the Environmental Risk Group, Positive and Safe Annual Review and Learning from Deaths. 7. Ongoing concerns for staff resilience, wellbeing, and morale. 8. That reflection was given to the BAF with no recommended material changes to be made.
Recommendation: **The Board is asked to** note the contents of the report.	
3	**Risks to be considered by the Board:** There were no risks that were considered should be escalated to the Board.
	Report compiled by Bev Reilly, Chair of Quality Assurance Committee, Elizabeth Moody, Director of Nursing & Governance, Donna Keeping, Corporate Governance Manager

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ITEM NO 13

Mental Health Legislation Committee: Key Issues Report	
Report Date: 26th May 2022	**Report of: Mental Health Legislation Committee (MHLC)**
Date of last meeting: 17th May 2022	The meeting was quorate, there were two apologies for absence

1 **Agenda: The Committee considered the following agenda items during the meeting:**

- Notes of the MHLC developmental session, held on 22nd April 2022
- CQC Mental Health Act Inspections
- Discharges from Detention
- Section 136
- Section 132 b
- Section 18 AWOL
- Section 5 (2) & 5 (4) Doctors and Nurses Holding Powers
- Mental Capacity Act and DoLs
- Positive and Safe
- Case Study

2a **Alert: The Committee alerts members of the Board to the following:**

MHLC Developmental Session

The Committee held a development session to review its terms of reference, to ensure congruence with the Board Assurance Framework, to review information provided through reports and how assured members could be that the Trust is compliant with Mental Health legislation requirements, ensuring that patients receive high quality care.

The outcome of the session led to agreement on progressing the following:

- *That the MHLC terms of reference will be revised to give more weight to strategic functions.*
- *Recognition that the Mental Health Act and Mental Capacity Act will be split and considered separately in reports to the Committee, and consideration will be given to reflect any identified risks/lack of assurance in relation to the Mental Capacity Act in the corporate risk register or the Board Assurance Framework.*
- *That seclusion and segregation reporting will be provided to MHLC by the Positive and Safe lead, to prevent duplication of work.*
- *That consideration will be given to the attendance of a Lived Experience Director at future meetings.*
- *That a risk register will be created for MH legislation.*

CQC Mental Health Act Inspections

Members were concerned that recurring themes have been picked up in the inspections in relation to ongoing restrictive practices – access to doors, blanket restrictions, poor communication with family and relatives and missing keys for bedroom doors.

Actions are being taken to rectify these and there is a base line assessment underway against the fundamental standards. However, there is more to be done in relation to ward ownership and leadership and staff being able to articulate at MHA inspections the background to some of the reasons and mitigations linked to the themes.

	Members challenged where and how the improvements on compliance with the fundamental standards will be managed and this will be through the Care Group Fundamental Standards Groups, with one in each Care Group Board, where there is representation by clinicians and matrons. **Mental Capacity Act & DoLs Update** Over the next 18 months there will be significant work required to prepare for the legislative changes as Deprivation of Liberty (DoLs) changes to Deprivation of Liberty Safeguards (LPS). The impact on the Trust will need to be considered; there will be a shift in emphasis from the authorising body being at Local Authority level to the Trust. In terms of claims in relation to LPS or infringement on human rights, these will be directed at the Trust. The Committee will provide a briefing for the Board as developments progress.	
2b	**Assurance**	**The Committee assures members of the Board on the following:** **Discharge from Detention** There are no exceptions to note, and the 109 Hospital Managers' reviews were within normal range. There were 116 First Tier Tribunals, which resulted in six patients being discharged from their section. Continued assurance can be provided that the Trust has a high number of Frist Tier Mental Health Tribunals and Hospital Managers hearings, which is an indication of patients exercising their right to appeal and their requests being taken forward. **Section 136** This report currently provides the numbers of people brought to a place of safety under S136 by the Police. Members recognised that to provide assurance, there needs to be a deeper examination behind the numbers to establish whether quality care is being provided to those individuals who are within the Trust when they are placed on a S136. There were significant increases in the use of S136 in York – 58 (28 previous quarter), reasons not known. Consideration was given to presenting these data to the Clinical Leaders subgroup and MH Legislation group where the detailed work and review can be carried out before it comes to Board Subcommittee level. **Section 132 – Information to Detained Patients** The MHL team undertook an audit in March 2022 of 100 random patient records to ascertain the robustness of processes supporting patients being given their rights. This audit has led to weekly spot checks within the department to check the quality of information being recorded. Meetings are planned in May 2022, with Modern Matrons for the three wards with the highest use of escalation processes, to improve practices and reduce the need for escalating requests to the next stage132b forms. Assurance can be provided that patients are in almost all instances given their rights under S132 on the day of admission. Where is not the case this is identified and rectified quickly. The implementation of CiTo is expected to allow improvements to the process. **Section 18 AWOL** This is another area of reporting to the Committee where members recognise that the assurances could be stronger. Work will be undertaken to examine these data over longer time periods, in more granular detail, to ascertain any emerging patterns and hotspot areas. There are no patterns emerging currently. **Section 5 (2) & 5 (4) Doctors, AC and Nurses Holding Powers**

		This information, over a six-month period shows that there were 30 uses of section 5(4) and 170 uses of section 5(2). One section 5(4) had lapsed before the doctor could attend the ward. Going forward, the MHL team, where any issue arises, will ensure that the responsible practitioners are made aware of the correct application. **Positive & Safe Annual Report** Following discussions between the Positive and Safe lead, clinical leaders and matrons it has become apparent that reporting of restrictive practices is taking place in multiple areas. The Quality Assurance Committee also receive six monthly and annual positive and safe updates. At the developmental session of the MHLC this was acknowledged, as the seclusion and segregation data pulled for reporting did not have as much meaningful narrative to support it. Also, seclusion and segregation are only one of the domains monitored under the CQC fundamental standards. The caveat to the reporting coming into MHLC from positive and safe is that it will need to include the legislative perspective, for example compliance with policy, the Code of Practice and the length of time individuals are held in long term segregation, particularly as the CQC are focusing on LD and autism. It was decided that current reporting arrangements will be maintained until the end of this year even if duplication with QuAC occurs.
2c	**Advise: The Committee advises the Board on the following:** **Case Study** The individual described and their care with TEWV, brought home to members the very real and challenging issues with long term seclusion. The significance of these complex cases, which have been steadily rising, can be seen in the numbers, where five years ago it was around 1-2 individuals, compared with seven now. Environmental factors are challenging and having the right, highly skilled and trained nurses with the high patient-staff ratios is difficult.	
2d	**Review of Risks**	There were no risks to be escalated to the Board of Directors
Recommendation: The Committee proposes that the Board: *i) Note the potential impact of the changes to MH legislation, which will shift the responsibility of being an authorising body from Local Authority level to the Trust, which will mean claims about infringement of human rights will come to the Trust.* *ii) Note the outcomes of the MHLC developmental session and actions to be taken forward, particularly the consideration of inclusion of a Lived Experience Director to attend meetings and that there will be a risk register established for mental health legislation.* *iii) Note the updates on S136, 132, Section 18 AWOL and Section 5 (2) & 5 (4), Doctors and Nurses Holding powers and the actions being taken forward in the pursuit of better evidenced, more robust assurances to enable the Committee fulfilling its terms of reference.* *iv) The reporting of seclusion and segregation will be provided through the Positive and Safe lead, which will provide more wide-ranging assurance on the other CQC fundamental standards for reducing restrictive practices.*		
3	**Actions to be considered by the Board:** There are no actions for the Board to consider.	
4	Report prepared by: Donna Keeping**, Corporate Governance Manager,** Pali Hungin, **Chair of the Committee/*Non-Executive Director and Dr S Wright, Medical Director***	

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ITEM NO. 14

People, Culture and Diversity Committee: Key Issues Report	
Report Date: 26 May 2022	**Report of: People, Culture and Diversity Committee**
Date of last meeting: 10 May 2022	The meeting was quorate, there were apologies for absence from Patrick Scott, MD for DTVF Care Group

1	**Agenda: The following agenda items were considered during the meeting:** • Colleague Story • Board Assurance Framework and Corporate Risk Register • Deep Dives: Culture, including presentations on "Our Journey to Change Goal 2: 'To co-create a great experience for our colleagues'. Improved Staff experience will also improve the experience for patients, families and partners" and 'Attracting and Retaining the best workforce in TEWV', information on "Freedom to Speak Up Guardian work and a report on the Publication of Information on Compliance with the Public Sector Duty under the Equality Act • Performance report including Staff Networks update
2a	**Alert** **The Committee alerts members of the Board that:** None to report
2b	**Assurance** **The Committee assures members of the Board that:** **Board Assurance Framework & Corporate Risk Register** The Board Assurance Framework (BAF) and Corporate Risk Register has been reviewed. The Committee welcomes the proposed changes to the future reporting of risks which were reported to the meeting. The importance of ensuring that risk descriptions are worded in a way which describes the situation accurately is highlighted. Work is now underway to review the CRR in detail in relation to this Committee's focus **Publication of information on compliance with the Public Sector Duty under the Equality Act** The Trust must publish information to demonstrate its compliance with the general equality duty. This information must include information relating to service users who share a relevant protected characteristic who are affected by its policies and practices. The protected characteristics are sex, race, sexual orientation, gender reassignment, disability, religion and belief, marriage and civil partnership, age and pregnancy and maternity. An in-depth analysis of data from the patient record system and Meridien has been performed to identify any statistically significant differences within protected characteristic groups across a number of measures: Access to Service (including weighting by census), Waiting times, contacts (frequency), Interventions, Clinical Outcomes, Disengagement (dropout rates), Inpatient Spells and Patient Experience. This information will be available on the Trust's website in line with reporting requirements. Services will also be provided with the raw Excel sheet so that they can identify their own specific areas of concern in relation to EDI characteristics and service provision. The Committee looked forward to the Excel summary table provided being used as the starting point for the development of a 'dashboard' to be added to IIC with a map function. This would enable data to be available at a far more granular level. The Committee notes issues in relation to missing data which were quite high for two categories: marital status and sexual orientation. For the former 25% of records were 'not known' and the latter, 20% were blank.

	The Committee looks forward to a further report on the Publication of Information on Compliance with the Public Sector Duty under the Equality Act, in relation to staff data which will be submitted to the August meeting of the Committee.	
2c	**Advise** **The Committee advises the Board that:** As part of a wide range of work on improving the workforce and culture of the organisation, a report to the Quality Board has been circulated to Board Members on 20/05/2022. The following specific initiatives are taking place: **Recruitment and Retention:** • There is considerable progress being made on recruitment with the team recently processing 60 adverts in 3 days – a massive increase in numbers, given that previously the adverts were at a level of 40 per month. In addition, one third of the people recruited were external to the Trust • Offers are now being made within 2 weeks of checks being completed (previously over 8 weeks) and trajectory is this that the timescale will be reduced to a week from the end of May • A new metric has been introduced - 'fill vacancy rate' • There are retention issues in specific areas, not across the whole Trust – without granular data, however, it is challenging to evidence this • A Trust-wide Retention Group is reviewing the various ways in which we can increase retention • This Group has reviewed what is available across other North-Eastern, Cumbrian and North Yorkshire Trusts to establish benchmarks in relation to tangible reward and recognition offers **Reward and Recognition:** • The potential for a reward and recognition package for staff including staff earning possible 'loyalty points' which could be used to buy a range of offers of the person's preference and; • Discussions are also taking place with Angie and Tony Russell from Positive Practice in Mental Health regarding a 'Well-being' board or Committee which could have oversight of some of the staff 'offer' and an allocated budget	
2d	**Risks**	Consideration was given as to whether there were any new risks raised during the meeting for consideration or inclusion on the BAF or CRR. There was one additional risk which it was considered should be added to the Corporate Risk Register (CRR) in relation to 'missing data'. Firstly, in relation to retention across the Trust, which due to the limitations of Trust data systems could not easily be demonstrated to be an issue in specific areas only, nor could evidence of what worked be readily identified and; secondly, statistically sound data analysis was also not available in relation to, amongst other factors, promotion opportunities for those with protected characteristics. The above will be addressed by our statistician colleagues over the summer to ensure that the data collected is more accurately analysed.

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 no items agreed to be escalated to the Board.
4	**Report compiled by:** *Deborah Miller,* ***Corporate Governance Manager*** Shirley Richardson, ***Non-Executive Director/Interim Deputy Chair (Committee Chairman)*** Sarah Dexter-Smith, **Director of People and Culture** Minutes are available from: *Deborah Miller*	

ITEM . 15

Trust Board of Directors

DATE:	**May 2022**
TITLE:	**Guardian of Safe Working Annual Report 2021-2022**
REPORT OF:	**Dr Jim Boylan - Guardian of Safe Working**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
To provide excellent services working with the individual users of our services and their families to promote recovery and wellbeing	
To continuously improve the quality and value of our work	✓
To recruit, develop and retain a skilled, compassionate and motivated workforce	✓
To have effective partnerships with local, national and international organisations for the benefit of the communities we serve	
To be recognised as an excellent and well governed Foundation Trust that makes best use of its resources for the benefit of the communities we serve.	✓

Executive Summary:

It is the responsibility of the Guardian of Safe Working to provide Annual & quarterly reports to the Trust Board for assurance that Junior Doctors are safely rostered and working hours that are safe and in compliance with Terms and Conditions of Service. I am satisfied that the Trust continues to fulfil the spirit and terms of the contract and that the Trust board has been attentive and supportive of the concerns and wellbeing of Junior Doctors over the past year.

There has been a continuing impact on working conditions by the CoVID 19 pandemic for all staff, including Junior Doctors, over the past year and both the Trust and the Junior Doctors have worked constructively and diligently together to try to maintain the delivery of effective care and a safe workforce.

The Junior Doctor Exception Reports and particularly Guardian fines levied over the past year mainly reflect an increase in work intensity on non-resident rotas and the breach of the 5 hours continuous rest rule which has been evenly spread throughout the year. There is a continuing monitoring of the process for exception reporting to try to ensure timely reporting by Junior Doctors and accurate intelligence of work intensity across all localities. There are continuing challenges in providing adequate supervision and support for trainees in some localities linked to the ongoing difficulties with recruitment and retention of Consultant supervisors. Processes are in place for ongoing scrutiny and review of work schedules and Junior Doctor working experiences

in all localities to provide assurance of safe working environments and consideration of training and service needs. There continues to be extensive Junior Doctor engagement in planning & implementation of rota changes and recording activity.

Recommendations:
The Board are asked to read and note this Annual report from the Guardian of Safe Working.

MEETING OF:	**Trust Board**
DATE:	**26th May 2022**
TITLE:	**Annual Report by Guardian of Safe Working for Junior Doctors**

1. INTRODUCTION & PURPOSE:

The Board receive Annual & quarterly reports from the Guardian of Safe Working as a requirement of the 2016 terms and conditions of service for Junior Doctors. This report contains both annual and quarterly data in the appendices and includes aggregated data on exception reports, details of fines levied against departments with safety issues, data on rota gaps/vacancies/locum usage and a qualitative narrative highlighting good practice and/or persistent concern. This will provide assurance to the Board and if needed, ask for approval for action to rectify a safety concern.

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours and during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and ensure they are not working unsafe hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.

The Guardian role sits independently from the management structure, with a primary aim to represent and resolve issues related to working hours. The guardian is required to levy a fine against a department(s) if a Junior Doctor :-

- works on average over 48 hours/week
- works over 72 hours in 7 days
- misses more than 25% of required rest breaks
- on non-residential on call (NROC) does not have a minimum of continuous rest for 5 hours between 22:00 and 07:00
- does not have the minimum 8 hours total rest per 24 hour NROC shift
- has more than the maximum 13 hour residential shift length
- does not have the minimum 11 hours rest between resident shifts

The work of the Guardian is subject to external scrutiny of doctors' working hours by the Care Quality Commission and by the continued scrutiny of the quality of training by Health Education England.

3. KEY ISSUES:

- I continue to work closely with my colleagues in Medical Staffing and Medical Development in TEWV and also with my colleague Dr Jenny Forge, as the Champion of Less than Full Time Working and Deputy Guardian of Safe Working within the trust.

- I am pleased to announce the establishment of a new role within recent months of a Dignity at Work Champion for Junior Doctors in TEWV. This is a role, which was first successfully implemented by our Nursing colleagues, and so we took their lead. It is a role for a Junior Doctor to act as a first point of contact and support, but also a conduit for any other Juniors who may feel sensitive about raising personal concerns about bullying and harassment within the workplace to a more senior doctor in the first instance. Although I believe we have a good culture of proactive support for Junior Doctors in TEWV we hope that this role can reduce even further any barriers to raising concerns. We have appointed one of our Senior Registrars, Dr Ayat Agabani, who has already made an excellent and proactive start.

- Over the past year working practices of all staff within the Trust continue to be subject to the continuing impact of the CoVID 19 pandemic. This has most noticeably affected staff availability and cover at all levels and across all professional groups and can be a source of strain within the workplace. I continue to be impressed by the ways that our Junior Doctor workforce have risen to this challenge and showed diligence, compassion and professionalism in support of the care of patients right across the Trust. This was clearly evident with the level of Junior Doctor support for the rapid necessity of establishing a new inpatient unit (Holgate Ward) on the Roseberry Park site on a temporary basis.

- There have been a very few (2 or 3) instances of particular concerns raised by individual junior doctors over the last year about interprofessional relations, and increased workload in different localities and these have been partly linked to difficulties in providing consistent senior supervision in the face of cross cover for vacant consultant posts and reduced nursing cover in some teams. I have seen these to be proactively and promptly responded to by both educational and clinical managers where they have arisen.

- Medical Development in TEWV have continued to deliver regular high quality training and webinar meetings for all Junior doctors in order to provide updates and support and the Trust continues to be a highly ranked educational institution for doctors in training. As Guardian I link in with these webinars and also attend all induction events for new intakes of Junior Doctors to the trust through the year

in order to provide an overview of our support structures and encourage exception reporting where necessary and appropriate.

- I am satisfied that all exception reports submitted by doctors on the new contract continue to be actioned within specified and reasonable timeframes. The medical staffing department have supported doctors' supervisors to action these appropriately and maintain a log that enables trends to be spotted and reports submitted to our locality forums.

- It appears that new format of the TEWV Junior Doctors Forum (JDF) which is now divided into a separate North and South sector meeting every quarter (instead of one trust-wide meeting) is working well and provides adequate time for review and discussion of locality concerns and also planning for any necessary actions. A very useful additional, and less formal, meeting with Junior Doctors is provided by our Medical Staffing Manager, Mr Paul Haytack, on a monthly basis, which means we can be even more rapid in our response to raised concerns and I am kept regularly briefed on these.

- The Trust continue to provide solid support for the Wellbeing of Juniors with the continuation of the role of a Junior Doctor Wellbeing Rep from among their ranks and an annual Wellbeing Conference and other events. A new initiative will see the establishment of a Bi-Annual residential event provided by the Trust for Higher Trainees to support preparation for a Consultant Role.

- **Appendix 1** to this report provides a summary of Junior Doctor vacancies and rota gaps over the last year and I am pleased to note excellent fill rates with very few uncovered shifts despite the challenges already described. **Appendices 2 and 3** provide more details for North (Durham & Teesside) and South (York and North Yorks) sectors respectively for the quarter January to March (inclusive) 2022 with a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendices are routinely shared with the corresponding Health Education England body for the different sectors.

- The two localities most notably affected by increased work intensity for Juniors continue to be Teesside and Scarborough to a significant extent due to out of area admissions. The situation in Scarborough had improved to some extent following the closure of Esk Ward but this has now recently re-opened and so the situation will require continued close monitoring there. I have had reassurances from the senior medical clinical management in the locality that the re-opening will be managed carefully and monitored closely over the next period of time.

- The majority of exception reports over the year have been placed for additional hours of work. Higher levels of exception reports in different localities relate to the degree of variation in out of hours non-resident on call rota work. We continue to utilise a non residential on-call log form which appears to be well accepted by the trainees and the continuing effectiveness of this system is under review. I am satisfied that Junior Doctors are appropriately paid for work undertaken and have appropriate compensatory rest following busy shifts. As can be seen from **Appendices 2 and 3** the internal locum system appears to continue to work effectively and maintains the use of external agency locums at zero.

- During the course of the last year it has been necessary to continue to levy fines on the trust for technical breaches of the contract (detailed and summarised in **Appendix 1**). The total sum of fines levied over the past year was just under £22,854 which is a 33% increase in the previous year. The rate of fines was spread evenly through all quarters which suggests a consistent increase in workload intensity throughout the year. During this year the level of fines were fairly evenly spread across North and South Sectors with about 54% of these arising in the North and 46% in the South. It is worth noting though that 41 of the 45 fines levied in the North were from theTeesside locality (91%). As was the case for the preceding year it is the one threshold of doctors on a non-residential on call rota requiring a minimum of 5 hours continuous rest between 10pm and 7am which has resulted virtually all of the fines levied at this point. A significant proportion of the fines levied on Teeside arise from Higher trainees on NROC rotas working as first on call for Consultant rotas. **Appendix 1** also provides a summary of additional spending through the course of the past year on resources to improve Junior Doctors working conditions, which has been largely funded from the monies levied through the fines system.

- The Trust continues to monitor and provide compensatory rest arrangements that exceed requirements set out in the contract.

- During the course of this year a middle tier on-call rota system was successfully introduced for Higher Trainees and SAS Doctors in Durham (North and South) which has supported the consultant on call rotas in that locality.

- Over the past year improvements have been made for the provision of adequate on call and rest facilities for Junior Doctors on both the Cross Lane Hospital (Scarborough) and Lanchester Road Hospital (Durham) sites.

- We continue to monitor the issue of junior doctors access to the WebIce clinical results on-line service and while noting that this appears to have improved significantly there were still occasional reports of difficulties in some areas – most notably Teesside.

4. IMPLICATIONS:

4.1 Compliance with the CQC Fundamental Standards:

The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour. This report evidences maintenance of these standards.

4.2 Financial/Value for Money:

The new contract is underpinned by the principle that junior doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board understands that extra costs will be incurred for additional anti-social hours work and breaches of hours and rest

agreements. It is vital that broader resources are effectively utilised to ensure work passed to junior doctors is necessary and appropriate.

4.3 **Legal and Constitutional (including the NHS Constitution):**
The Learning and Development Agreement signed by the Trust with Health Education England clearly sets out the expectations on placement providers. The organisation must ensure that the work schedules in the new contract allow junior doctors to fulfil their curriculum needs within a sound learning environment.

4.4 **Equality and Diversity:**
The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity has therefore been invited to the quarterly trustwide Junior Doctor Forum. An Equality Impact Assessment has been completed and is updated within the forum. The Champion of Less Than Full-time Working is a core member of the Junior Doctor forum and holds an additional forum / network for less than full time doctors.

4.5 **Other implications:**
It is important that our junior doctor colleagues continue to believe that we are supporting them in providing an appropriate and safe learning environment.

5. RISKS:

- Continuing concerns across different localities with staffing levels, particularly with Consultant vacancies mean there are continuing challenges in providing adequate supervision and support for Junior Doctors at some times and in some localities which is particularly important for the most Junior grades.

- Continuing increased demand for services and particularly out of area admissions has led to a consistent increase in the intensity of service based working for Junior Doctors particularly in the Scarborough and Teesside localities, and together with an increased administrative load this may lead to dis-satisfaction with the training environment and impact on future recruitment into Higher Training and Consultant posts within the trust

- Failure to anticipate the impact on Junior Doctors working situations of any major service changes remain a generic risk for a large and dispersed organisation such as the Trust and may lead to a Junior Doctor being placed in an unsafe situation. Close communication between service managers and educational management within the trust remains an important necessity

- The Trust rightly encourage high levels of necessary exception reporting and with current levels of negative media attention – these may be misunderstood and be reported in the media without adequate understanding of Trust policy and processes – which may lead in turn to reputational risk.

- If there remain any continuing difficulties in access for Junior Doctors in some localities to clinical lab results through WebIce licensing issues this could provide potential risks in clinical safety for patients and a reputational risk for the trust.

6. CONCLUSIONS:

Despite the ongoing concerns about staffing levels throughout the past year the Trust continues to fulfil the requirements of the 2016 Junior Doctor Contract and the Executive Board have been supportive of the different agendas for Junior Doctors working conditions and wellbeing. The quality of training remains high overall within the trust but difficulties in providing appropriate levels of senior supervision and support has been a concern in some localities over the past year. This is of most concern for the most junior trainees on placement but also has an important impact on the levels of satisfaction of all trainees and potentially on future recruitment.

Junior Doctors are appropriately submitting exception reports which are also being appropriately and fairly processed by Medical Staffing.. I am satisfied that reasonable structures and processes continue to be in place at an individual and group level to identify, monitor and attempt to rectify issues of safety for Junior Doctors working.

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7. RECOMMENDATIONS:

The Board are asked to read and note this Annual report from the Acting Guardian of Safe Working.

Author: Dr Jim Boylan
Title: Guardian of Safe Working for Junior Doctors

Background Papers:
Appendix 1: Annual summary of fill rates, vacancies and rota gaps – also Guardian fines levied and use of monies for Junior Doctors wellbeing
Appendices 2 & 3: detailed information on numbers, exception reports and locum usage- first quarter 2022.

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS AND DENTISTS IN TRAINING

Annual data summary from 1st April 2021 to 31st March 2022

Vacancies

Locality	Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps (average wte)	Number of shifts uncovered (over the year)
North Durham	F1	0	0	0	0	0	0
	F2	0	0	0	0	0	0
	CT1	0	0	0	0	0	0
	CT2	0	0	0	0	0	0
	CT3	0	0	0	0	0	0
	ST4 -6	0	0	0	0	0	0
	GP	2	2	0	0	2	0
	Trust Doctor	0	0	0	0	0	0
South Durham	F1	0	0	0	0	0	0
	F2	0	0	0	0	0	0
	CT1	0	0	1	1	1	0
	CT2	0	0	0	0	0	0
	CT3	0	1	0	0	1	0
	ST4 -6	2	3	1	1	3	0
	GP	1	0	0	0	1	0
	Trust Doctor	0	0	0	0	0	0
Teesside & Forensics	F1	0	1	1	0	0.5	0
	F2	0	3	3	0	1.5	0
	CT1	1	1	1	1	1	0
	CT2	0	0	0	0	0	0
	CT3	0	0	0	0	0	0
	ST4 -6	0	1	1	0	0.5	0
	GP	2	0	0	0	0.5	0
	Trust Doctor	0	0	0	0	0	0
North Yorkshire & York	F1	0	0	0	0	0	0
	F2	0	0	0	0	0	0
	CT1	3	0	0.2	1.8	1.25	0
	CT2	0	0	0	0	0	0
	CT3	0	0	0	0	0	0
	ST4 -6	8	8	8	8	8	0
	GP	0	0	0	0	0	0
	Trust Doctor	0	0	0	0	0	0
Total		**19**	**20**	**16.2**	**12.8**	**21.25**	**0**

Fines

Locality	Quarter 1 Number of fines levied	Quarter 2 Number of fines levied	Quarter 3 Number of fines levied	Quarter 4 Number of fines levied	Annual Total
North Durham	0	1	0	1	**2**
South Durham	0	0	2	0	**2**
Teesside & Forensics	13	11	11	6	**41**
North Yorkshire & York	4	10	11	14	**39**
Total	**17**	**22**	**24**	**21**	**84**

Locality	Quarter 1 Value of fines levied	Quarter 2 Value of fines levied	Quarter 3 Value of fines levied	Quarter 4 Value of fines levied	Annual Total
North Durham	£0.00	£236.15	£0.00	£188.92	**£425.07**
South Durham	£0.00	£0.00	£567.40	£0.00	**£567.40**
Teesside & Forensics	£6,557	£3,070	£3,394	£1,903	**£14,924**
North Yorkshire & York	£852.14	£1,473.40	£1,886.16	£2,725.97	**£6,937.67**
Total	£7,409.14	£4,779.55	£5,847.56	£4,817.89	**£22,854.14**

The following has been spent within the past year:

- *Food Supplies for Junior Doctors Rooms at Roseberry Park, Cross Lane, Foss Park, West Park and Lanchester Road - approx. £2,500 pa*
- *Kettle for Junior Doctors Office, West Park - £23.82*
- *Desk Lamp for Junior Doctors Office, Foss Park - £18.95*
- *Aromatherapy Oil Diffusers and Oils for Junior Doctors Rooms at Roseberry Park, Cross Lane, Foss Park, West Park and Lanchester Road - £269.80*
- *Tassimo Coffee Machines for Junior Doctors Rooms at Roseberry Park, Cross Lane, Foss Park, West Park and Lanchester Road - £194.95*
- *Coffee Pods for Machines - £232.15*
- *Beanbags for Junior Doctors Rooms at Roseberry Park, Cross Lane, Foss Park, West Park and Lanchester Road - £645*
- *Plants and Pots for Junior Doctors Rooms at Roseberry Park, Cross Lane, Foss Park, West Park and Lanchester Road - £519.96*
- *Mugs for Junior Doctors Office, West Park £22.43*

TOTAL Disbursements for Year 2021-22 £4,427.06

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	74
Number of doctors / dentists in training on 2016 TCS (total):	72
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st January up to 31st March 2022

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	3	3	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	11	11	0
F2 - Teesside & Forensic Services Juniors	0	4	4	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	3	3	0
CT1-2 Teesside & Forensic Services Juniors	0	15	15	0
CT1-2 –North Durham	0	0	0	0
CT1-2 – South Durham	0	2	2	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	0	0	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	6	6	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	3	3	0
Trust Doctors - Teesside	0	0	0	0
Total	**0**	**47**	**47**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	22	22	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	19	19	0
South Durham Senior Registrars	0	4	4	0
North Durham Senior Registrars	0	2	2	0
Total	**0**	**47**	**47**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	1	6	15	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	19	0	0
South Durham Senior Registrars	0	3	1	0
North Durham Senior Registrars	0	0	2	0
Total	**1**	**28**	**18**	**0**

Narrative for Exception Reports

Exception reports in South Durham where due to missed education or late finishes.

In Teesside, there were 4 reports for late finishes (3 from F1s and 1 from CT1) all from AMH RPH inpatient wards. The rest for were for shadowing shifts prior to starting on calls and regular work on non resident on calls.

Work schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	3	5	0	44	28.5
	CT1/2/GP	35	22	0	397	276
	CT3	0	9	0	0	128.5
	Trust Doctor	0	2	0	0	8
	SPR/SAS	0	0	0	0	0
North Durham	F2	0	0	0	0	0
	CT1/2/GP	12	12	0	133	133
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	SPR/SAS	18	18	0	344	344
South Durham	F2	2	2	0	25	25
	CT1/2/GP	41	33	0	281.5	249.5
	CT3	9	9	0	65	65
	Trust Doctor	0	0	0	0	0
	SPR/SAS	66	66	0	1115	1115
Total		**186**	**178**	**0**	**2404.5**	**2372.5**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Special Leave	3	3	0	56	56
COVID isolation	20	20	0	242	242
Maternity leave	0	0	0	0	0
On call cover	102	101	0	1591	1587
Vacancy	0	0	0	0	0
Sickness	42	42	0	439.5	439.5
Extra support	19	12	0	76	48
Total	186	178	0	2404.5	2372.5

Locum usage in Teesside increased due to the opening of Holgate Ward temporarily.

Vacancies

Vacancies by month						
Locality	**Grade**	**January 2022**	**February 2022**	**March 2022**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
South Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	1	0	0	1	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	1	1	1	1	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**2**	**1**	**1**	**2**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	6	£1903.02
North Durham	1	£188.92
South Durham	0	£00.00
Total	7	£2,091.94

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
£3,106.05	**£2,091.94**	**£00.00**	**£5,197.99**

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

High level data

Number of doctors / dentists in training (total):	76
Number of doctors / dentists in training on 2016 TCS (total):	76
Amount of time available in job plan for guardian to do the role:	1.5 PAs
Admin support provided to the guardian (if any):	4 Days per quarter
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st January 2022 up to 31st March 2022

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F1 - Scarborough	0	0	0	0
F1 - York	0	0	0	0
F2 - York	0	0	0	0
CT1-2 - Northallerton	0	3	3	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	5	5	0
CT1-2 - York	0	3	3	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	7	7	0
CT3/ST4-6 – Scarborough	0	0	0	0
CT3/ST4-6 – York	0	5	5	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	1	1	0
Trust Doctors - York	0	2	2	0

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Total	**0**	**26**	**26**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton/ Harrogate/ York	0	20	20	0
Scarborough	0	6	6	0
Total	**0**	**26**	**26**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Northallerton/ Harrogate/ York	5	6	9	0
Scarborough	4	1	1	0
Total	**9**	**7**	**10**	**0**

Narrative around Exception Reports

The exception reports submitted by doctors in Scarborough were a mixture of of late finishes to the normal working day, to either claim additional payment following the submission of the NROC form, or to report inadequate rest whilst on call.

The majority of exception reports submitted by doctors in Northallerton/Harrogate/York were to claim additional payment following the submission of the NROC form. There was one to report inadequate rest whilst on call.

All exception reports submitted by doctors on the middle tier rota were to either claim additional payment following the submission of the NROC form, or to report inadequate rest whilst on call.

Work Schedule reviews

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

Work schedule reviews by locality	
Northallerton	0
Harrogate	0

Scarborough	0
York	0

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Northallerton/ Harrogate/ York	F2	5	5	0	59.5	59.5
	CT1/2/GP	29	29	0	338	338.5
	CT3	19	19	0	198	197.5
	Trust Doctor	0	0	0	0	0
	ST4-6/SAS	18	18	0	311	311
Scarborough	F2	4	4	0	64	64
	CT1/2/GP	25	25	0	464	465.25
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	ST4-6/ SAS	88	87	0	1623	1599
Total		**188**	**187**	**0**	**3057.5**	**3034.75**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	0	0	0	0	0
Sickness	23	23	0	329	329
Other	165	164	0	2728.5	2705.75
Total	**188**	**187**	**0**	**3057.5**	**3034.75**

Vacancies

Vacancies by month						
Locality	**Grade**	**January 2022**	**February 2022**	**March 2022**	**Total gaps (average)**	**Number of shifts uncovered**
Northallerton/ Harrogate/ York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	0	1.6	1.6	1.06	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	0.2	0.2	0.2	0.2	0
	CT3	0	0	0	0	0

	ST4 -6	8	8	7	7.6	0
	Trust Doctor	0	1	1	0.6	0
Total		**8.2**	**10.8**	**9.8**	**9.46**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	12	£2147.02
North Yorkshire & York	13	£2456.11
Total	25	£4603.13

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£2325.54	**£4603.13**	**£ 0**	**£6,928.67**

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th May 2022**
TITLE:	**Constitutional Change – Composition of the Board of Directors**
REPORT OF:	**Phil Bellas, Company Secretary**
REPORT FOR:	**Decision**

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:

1 Introduction:

1.1 The purpose of this report is to seek the approval of changes to paragraph 22.2 of the Constitution (Composition of the Board of Directors).

2 Background:

2.1 Under the NHS Act 2006, as amended, changes to the Constitution must be approved by both the Board of Directors and the Council of Governors.

3 Key Issues

3.1 It is proposed to amend paragraph 22.2 of the Constitution as set out in the following table:

Present version	**Proposed version**
22.2 The Board of Directors is to comprise: 22.2.1 a non-executive Chairman; 22.2.2 5-7 other non-executive Directors; and 22.2.3 5-7 executive Directors.”	22.2 The Board of Directors is to comprise: 22.2.1 a non-executive Chairman; 22.2.2 a non-executive Deputy Chairman; 22.2.3 5-9 other non-executive Directors; and 22.2.4 5-9 executive Directors.

3.2 The reasons for the proposed changes are as follows:

(a) To provide emphasis and recognise the important role of the Deputy Chair.

(b) To enable flexibility in the composition of the Board in response to the changes to the executive team and the forthcoming appointment of the new Chair.

3.3 The proposals were approved by the Council of Governors at its meeting held on 12th May 2022.

Recommendations:

The Board of Directors is recommended to approve the amendment of paragraph 22.2 of the Constitution to be as follows:

"22.2 The Board of Directors is to comprise:

22.2.1 a non-executive Chairman;

22.2.2 a non-executive Deputy Chairman;

22.2.3 5-9 other non-executive Directors; and

22.2.4 5-9 executive Directors."

ITEM NO. 17

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**26th May 2022**
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
422	22.4.22	Contract for internal refurbishment works at Worsley Court, Selby	Brent Kilmurray, Chief Executive Phil Bellas, Company Secretary
423	22.4.22	Appointment of BGP Consulting in relation to Block 9, Roseberry Park Hospital	Brent Kilmurray, Chief Executive Phil Bellas, Company Secretary

Recommendations:

The Board is asked to receive and note this report.