MEETING OF THE BOARD OF DIRECTORS
Thursday 28th July 2022
Redworth Hall Hotel, Surtees Rd, Newton Aycliffe DL5 6NL
at 3.00 p.m.

AGENDA

Standard Items (3.00 pm – 3.20 pm):

1	Apologies.	**Chair**	**-**
2	Chair's welcome and introduction.	**Chair**	**Verbal**
3	To approve the minutes of the special meeting held on 15th June 2022 and the last ordinary meeting held on 30th June 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 (3.20 pm – 3.45 pm):

8	Chief Executive's Report.	**CEO**	**Report**
9	Board Assurance Framework summary report.	**Co Sec**	**Report**
10	To consider the Integrated Performance Dashboard Report.	**Asst CEO**	**Report**

Goal 1: To Co-create a Great Experience for our Patients, Carers and Families (3.45 pm – 4.20 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 receive and note the report of the Freedom to Speak Up Guardian.	**Dewi Williams to attend**	**Report**
14	To receive and note the Learning from Deaths Report.	**DoN&G**	**Report**

Goal 2: To Co-create a Great Experience for our Colleagues (4.20 pm – 4.30 pm):

15	To receive and note the report of the Guardian of Safe Working.	**Dr Jim Boylan to attend**	**Report**

Goal 3: To be a Great Partner (4.30 pm – 4.40 pm):

16	To approve the NENC Provider Collaborative Governance documents.	**CEO**	**Report**

Governance (4.40 pm – 4.45 pm):

17	To appoint the Chairs and Non-Executive Director Members of the Board's Committees.	**Chair**	**Verbal**
18	To approve the Organisational Risk Management Policy.	**DoN&G**	**Report**

Matters for Information (4.45 pm – 4.50 pm):

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

Exclusion of the Public (4.50 pm):

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

Paul Murphy
Chair
22nd July 2022

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

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 15TH JUNE 2022 COMMENCING AT 1.00 PM

The meeting was held via MS Teams

Present:
Mr P Murphy, Chair
Mr B Kilmurray, Chief Executive
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 Z Campbell, Managing Director, North Yorkshire, York and Selby Care Group
Mrs L Romaniak, Director of Finance, Information and Estates/Facilities
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)
Mrs H Crawford, Director of Therapies (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 A Lowery, Director of Quality Governance (representing Mrs Moody)
Mrs W Johnson, Team Secretary

22/64 WELCOME AND INTRODUCTIONS

The Chair welcomed those present particularly Mrs Campbell and Mrs Crawford who were attending their first meeting of the Board.

Mr Murphy also undertook to report on his recent visits to Forensic Services at the next ordinary Board meeting.

22/65 APOLOGIES

Apologies for absence were received from Dr C Carpenter, Non-Executive Director, Mrs R Barker, Associate Non-Executive Director, Mr. J Preston, Associate Non-Executive Director, and Mrs E Moody, Director of Nursing and Governance and Deputy Chief Executive.

22/66 DECLARATIONS OF INTEREST

There were no declarations of interest.

22/66 CHIEF EXECUTIVE'S REPORT

Mr Kilmurray advised that:
(1) Dr Kedar Kale, the new Medical Director, and Mr Mike Brierley, the new Assistant Chief Executive, would be joining the Trust on 27th June 2022 and 1st July 2022 respectively.
(2) The CQC had recently visited the Trust's Adult Learning Disability Inpatient Services; the feedback from which would be considered later in the meeting.

22/67 AUDIT AND RISK COMMITTEE

The Board received and noted the key issues report from the meeting of the Audit and Risk Committee held on 20th May 2022.

Mr Maddison, the Chair of the Committee, reported that:

(1) The meeting had focussed on the Head of Internal Audit's Annual Report and Opinion; the Internal Audit Plan for 2022/23; the Annual Report and Accounts, including the External Auditors' audit completion report; and the Quality Account.

(2) As the Committee had previously seen drafts of the documentation there had been few questions and comments at the meeting.

(3) The Committee had recommended to the Board that the Annual Report and Accounts should be approved, signed off by the Chair, Chief Executive and Director of Finance, Information and Estates/Facilities, as appropriate; and submitted to NHSI and Parliament; however, as the audit had not yet been completed it might be necessary to seek further approval, under emergency powers, if any material issues arose.

(4) The Committee had also reviewed and, taking assurance from the Quality Assurance Committee, recommended the approval and submission of the Quality Account. Unlike a Quality Report, which was not required for 2021/22, the Quality Account was not reviewed by the External Auditors.

(5) Although the Head of Internal Audit's Annual Report and Opinion provided good assurance on the Trust's systems of internal control, it had also highlighted three areas of weakness relating to patient property, monies and valuables, safety alerts and training needs analysis. The Committee had noted that these were longstanding issues and wished to receive written assurance that progress was being made on addressing the findings of the Internal Auditors either before or at its next meeting.

(6) The Committee had noted the excellent work undertaken during the year to reduce the number of outstanding high and medium Internal Audit recommendations. This had been recognised as an impressive achievement given the context in which the Trust was operating during the year.

(7) The Internal Audit review of risk management had provided reasonable assurance. Whilst improvements had been made, the Committee considered that, given its fundamental impact on quality and safety, progress should be kept under review.

(8) The Committee was content that the Internal Audit Plan for 2022/23 provided sufficient coverage and was aligned to the Trust's key risks as included in the Board Assurance Framework

He also advised that there was a matter concerning the approval of the Annual Report which would need to be considered in confidential business.

On behalf of the Committee, Mr Maddison thanked Mrs. Kirkbride (Public Governor) for observing the meeting on behalf of the Council of Governors and Mrs. Romaniak and staff in the Company Secretary's, finance, communications and planning departments and in the Nursing and Governance Directorate for producing the Annual Report and Accounts and the Quality Report.

The Chair congratulated the Members of the Audit and Risk Committee for their work.

22/68 ANNUAL REPORT AND ACCOUNTS 2021/22

On the recommendation of the Audit and Risk Committee and taking into consideration the report of the Director of Finance, Information and Estates/Facilities on the approval of the Annual Accounts and related matters it was:

Agreed -

(1) that subject to (2) below:

(a) the Annual Report and Accounts 2021/22 be approved and by doing so:

- *the Trust's status as a "going concern" be re-affirmed;*
- *the Directors' statement "that as far as they are aware, there is no relevant information of which the Trust's auditors' are not aware" be confirmed;*
- *the Modern Slavery Act disclosure, as contained in the Annual Report, be confirmed;*

(b) the letter of representation be approved;

(c) the Chair, Chief Executive and Director of Finance, Information and Estates/Facilities be authorised, as appropriate, to sign the Annual Report and Accounts, the letter of representation and any certificates required by NHS Improvement;

(2) that any required changes to the Annual Report and Accounts, in response to material issues being raised by the External Auditors, be agreed under the emergency powers provisions of the Constitution; and

(3) that the Annual Report and Accounts be submitted to NHS Improvement and Parliament.

22/69 QUALITY ACCOUNT

On the recommendation of the Audit and Risk Committee, and following a review by the Quality Assurance Committee, consideration was given to the approval and submission of the Quality Account 2021/22.

Mrs. Pickering advised that the Committees had not had the opportunity to review the letters from stakeholders due to the timing of their receipt. The Vale of York CCG was also intending to provide an updated letter and one further letter was awaited.

The Board noted that:

(1) In general, the feedback provided by the stakeholders had been positive.
(2) Where concerns had been raised, they mirrored those of the Board.
(3) Some stakeholders had requested further information.
(4) Responses would be provided to the stakeholders.

Agreed *– that the Quality Account 2021/22 be approved and submitted to the Department of Health and Social Care.*

22/70 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 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.

Following the transaction of the confidential business the meeting concluded at 2.23 pm.

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 30TH JUNE 2022 COMMENCING AT 1.00 PM

The meeting was held via MS Teams

Present:
Mr P Murphy, Chair
Mr B Kilmurray, Chief Executive
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 Z Campbell, Managing Director, North Yorkshire, York and Selby Care Group
Dr K Kale, Medical Director
Mrs E Moody, Director of Nursing and Governance and Deputy Chief Executive
Mrs L Romaniak, Director of Finance, Information and Estates/Facilities
Mr P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
Mrs A Bridges, Director of Corporate Affairs and Involvement (Non-voting)
Mrs H Crawford, Director of Therapies (Non-voting)
Dr S Dexter-Smith, Director of People and Culture (Non-voting)

In Attendance:
Mr P Bellas, Company Secretary
Miss S Theobald, Associate Director of Performance (representing Mrs Pickering)
Mrs D Keeping, Corporate Governance Manager
Mrs W Johnson, Team Secretary

Observers/Members of the Public
Mrs K Christon, Deputy Company Secretary (Designate)
Mr S Double, Alders
One member of the public

22/75 WELCOME AND INTRODUCTIONS

The Chair welcomed:
(a) Dr Kale to his first meeting of the Board following the commencement of his appointment with the Trust earlier in the week.
(b) Mrs Campbell and Mrs Crawford to their first ordinary meeting of the Board.
(c) Miss Theobald who was attending the meeting on behalf of Mrs Pickering.

As this would have been her last Board meeting prior to her retirement, Mr Murphy, on behalf to the Board, recognised the incomparable service provided to the Trust by Mrs Pickering over the last two decades.

22/76 APOLOGIES

Apologies for absence were received from Mrs S Pickering, Assistant Chief Executive.

22/77 MINUTES

***Agreed** – that the minutes of the last ordinary meeting held on 26th May 2022 be approved as a correct record and signed by the Chairman.*

22/78 DECLARATIONS OF INTEREST

There were no declarations of interest.

22/79 PUBLIC BOARD ACTION LOG

The Board reviewed the Board Action Log and noted that there were no matters requiring attention.

22/80 CHAIRMAN'S REPORT

The Chair reported that:

(1) On Saturday 25th June 2022 he had attended an armed forces national event on the beachfront in Scarborough with Dr Dexter-Smith, Kathryn Atkinson (the Associate Director of Leadership and Development), volunteers and staff from Cross Lane Hospital and the Ellis Centre.

The Board noted that the Trust's stand had been very popular, demonstrating affection and respect for the NHS, and there had been interest in joining the organisation as both volunteers and staff.

(2) At his invitation, the Tees Valley Joint Health Scrutiny Committee had held a formal meeting at Roseberry Park on 8th June 2022.

Mr Murphy considered that the event had gone very well, staff and patients had been brilliant and the Trust had received good feedback. He thanked Mrs. Bridges for organising the visit.

(3) During June he had continued his visits to Secure Inpatient Services.

Mr Murphy considered that the Trust should be proud of the services and that he had had some of his most memorable moments at the Trust during his visits.

The Board noted that he had:

(a) Shadowed a dietician and observed the personalised services provided to patients.
(b) Attended psychology-led groups including one on male mental health.
(c) Attended the HCA Council which he had found to be solution focussed.
(d) Had the pleasure of meeting patients and had been given a portfolio of poems and rap songs by one of them.

Mr Murphy also passed on the following message for Board Members which he had received from Bethany Parry, the Ward Manager of Mallard Ward:
"Tell them the staffing pressures are very real – it was bad at the weekend, and as I was on call I had to come in and was here till 3.00 am on Saturday. But we know everyone is doing their best to solve the issue. Tell them that we can see the light at the end of the tunnel – and that we've got the fire in our bellies again."

22/81 MATTERS RAISED BY GOVERNORS

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

22/82 CHIEF EXECUTIVE'S REPORT

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

In his presentation of the report Mr. Kilmurray:

(1) Advised that Mike Brierley, the new Assistant Chief Executive, would be joining the Trust on 1st July 2022 and commencing in his role on 11th July 2022.

(2) Drew attention to the information provided in the report on the Integrated Care Systems (ICSs) which would formally come into being on 1st July 2022.

A document setting out the operating model and which provided details of the Board Members and senior officers of each of the Integrated Care Boards (ICBs) in the North East and North Cumbria and Yorkshire and Humber regions was appended to the report.

The Board noted that the initial meetings of the ICBs, which would be held in public, would focus on the structure of the organisations; the arrangements for delivering their four core purposes; and actions to be taken over the coming weeks to support the development of their strategies and plans.

The Non-Executive Directors questioned whether the Trust would be able to achieve a reasonably uniform approach to the provision of services given its spread across the relevant localities of the two ICSs.

Mr Kilmurray responded that, in developing the new organisational structure, consideration had been given to variation and allowing services to flex in response to the needs of local communities. The establishment of the clinical networks would facilitate this by enabling conversations on the setting of minimum standards.

He also advised that partners were coming together and seeking to make sense of the requirements of the ICBs and how to support the delivery of their responsibilities.

(3) Provided, further to minute 22/40 (26/5/22), an update on the development of the North East North Cumbria (NENC) Mental Health and Learning Disability Collaborative, a multi-agency partnership approach with a strong emphasis on lived experience, which he and James Duncan, the Chief Executive of Cumbria Northumberland Tyne and Wear NHS Foundation Trust, had been tasked to establish by Sam Allen, the ICS Chief Executive.

The significant engagement being undertaken on the development of the collaborative was noted.

In response to a question on how the collaborative would differ from working in partnership, Mr. Kilmurray explained that it created opportunities for a more multi-agency approach. The transparency and engagement in prioritisation provided by partnership arrangements in Durham and the Tees Valley had provided the blueprint for the approach.

(4) Drew attention to the update provided on the delivery of the 2021/22 Business Plan at Quarter 4, following a review by the Members of the Strategy and Resources Committee. This highlighted that of the 28 (of 59) actions not successfully delivered:
   (a) 18 would be transferred into the new 2022/23 - 2024/25 Business Plan.
   (b) The remaining 10 actions were considered to be either "business as usual" or to have been completed prior to the publication of the new Business Plan.

(5) Advised, in regard to the CQC, that:
   (a) It was expected that the regulator would be conducting a re-inspection of CAMHS Community Services and Forensic Services as, in accordance with its duties, three months had elapsed since the completion of the action plans.

   It was noted that no further information was available on the re-inspections at this time.
   (b) Time had been set aside in the confidential session of the meeting to discuss the regulator's response to its inspections of Adult Learning Disability Inpatient Services at Lanchester Road Hospital and Bankfields Court.

   Mr. Kilmurray explained that:
   - The services were characterised as being of high acuity and complexity and required significant levels of resources.
   - The CQC had sought further assurances in response to its visits. These had been provided by the Trust to the satisfaction of the regulator.
   - In response to feedback from the CQC, Mersey Care NHS Foundation Trust had been engaged to undertake a review of restrictive practices. The report was expected to be received during the week commencing 11th July 2022, and it would be expected that the CQC would reflect on its contents.

22/83 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.

22/84 INTEGRATED PERFORMANCE DASHBOARD REPORT

The Board received and noted the first Board Integrated Dashboard Report which had been developed during 2020/21 to provide a more integrated approach to the oversight and monitoring of quality and performance assurance and improvement.

Board Members welcomed the introduction of the new report. They also expressed their appreciation for the significant work undertaken by Miss Theobald on the development of the integrated approach and for her engagement with the Chairs of the Board's Committees during the process.

The Board also noted that the report had been adopted by the CCGs for their own assurance purposes.

The Non-Executive Directors:

(1) Questioned whether the Trust required more beds in view of present and persistent challenges.

Mr Kilmurray advised that resources had been made available through the Business Plan to gain a better understanding of demand and he had asked Dr Kale to lead this work.

He also highlighted a range of work being undertaken to manage bed usage including the successes of crisis teams as gatekeepers to admissions; improvements to the therapeutic approaches on wards; and the re-establishment of processes which had been in place before the Covid-19 pandemic e.g. PIPA.

Mr Kilmurray considered that, whilst short-term mitigations through the management of facilities and pathways were being progressed, the longer-term approach would need to await the outcome of the analysis of demand.

(2) Questioned whether the Board was sufficiently sighted on the quality measures which were not achieving standard and, in particular, those highlighting special cause for concern.

Miss Theobald advised that the next stage of the integrated approach was the development of the full quality dashboard (the quality section of the Integrated Performance Dashboard) which would be presented to the Quality Assurance Committee on a quarterly basis.

(3) Sought clarity of the reasons for the limited data supporting the staff experience and leavers metrics.

It was noted that:

(a) The data on staff leavers had been updated, following technical delays, and would be included in the next report.

(b) The Executive Directors had agreed to undertake more routine surveys of staff experience, which were due to be piloted, in addition to the pulse and annual surveys.

(4) Considered that, in regard to the metric “Percentage of inpatients reporting that they feel safe whilst in our care”, there would be benefits in providing the overall number of responses to the survey so that the 79 patients, who had responded to the relevant question, could be seen in context.

(5) Raised concerns about the downward trend on metric 5 (“Percentage of Adults and Older Persons showing measurable improvement following treatment”) in the context of discharges from services.

Miss Theobald advised that, for certain new indicators relating to improvement, further understanding was required including on the variation between the Care Groups. Consideration was being given to the information and assurances to be provided on the metrics in the future and this would be discussed with Dr Kale.

(6) Highlighted the benefits of providing benchmarking information in order that the Board could contextualise the Trust’s performance.

It was noted that national and local benchmarking information was available for some of the metrics and this would be incorporated in future reports.

(7) Sought clarity on the progress being made in the Care Groups on the establishment of timescales for the actions included in the report.

The Board noted that the integrated assurance approach was designed so that assurances flowed through the governance structure to the Board and provided a greater focus on action. As this was the first report, the integrated approach had not yet been through a full cycle and further details would be available going forward.

From a Care Group perspective, Mr Scott observed that, whilst at an early stage, the benefits of the integrated approach and the new governance structure could be seen in the focus being given to specific issues and in enabling, with daily management processes, greater oversight and control.

(8) Questioned the statement in the report that "There are no areas of positive assurance identified within the IPD at this point."

It was noted that positive assurances would be included in future iterations of the report.

(9) Highlighted an article by Dido Harding, the then Chair of NHSI, published in 2019 which provided guidance on the data on investigation and disciplinary procedures which should be regularly and openly reported to the Board. It was suggested that this should be reviewed and consideration be given to its inclusion in the Integrated Dashboard Report.

Dr Dexter-Smith advised that discussions were being held by the Executive People and Culture Sub-Group on information requirements which would inform consideration of future reporting to the Board.

It was noted that information presented recently to the Joint Consultative Committee and the Group showed a reduction in the number of staff subject to investigation and disciplinary processes and the time taken to complete them.

The Non-Executive Directors also advised that they would contact Miss Theobald, outside the meeting, on certain matters.

In addition, Mrs. Romaniak reported that the financial information provided in the report related to the draft Financial Plan agreed in April 2022 rather that the revised plan approved and submitted in June 2022.

In conclusion the Chair:
(1) Considered that the report enabled understanding, at a glance, of the Trust's position.
(2) Welcomed the triangulation of issues provided.
(3) Noted the intention for the integrated approach to evolve.
(4) Thanked Miss Theobald and Mrs Pickering for the work on the development and implementation of the integrated approach.

22/85 DIRECTORS' VISITS

The Board received and noted a report on the Directors' visits held on 13th June 2022 to the following wards/services at Roseberry Park Hospital, Middlesbrough:

- Activity Hub
- Brambling
- Linnet
- Crisis Assessment Suite(CAS)

- Bedale / PICU
- Bilsdale Ward

Arising from the report:

(1) Mrs Reilly advised that two Governors had accompanied the team on their visit to the CAS and welcomed their participation and insightful questions.

The Chair recognised that Governors were very interested in undertaking visits but the number attending each one needed to be considered.

(2) A Board-level discussion was sought on recruitment given the challenges highlighted in the report and across services generally.

It was noted that the next Board Seminar on 12th July 2022 would focus on workforce issues.

(3) Dr Carpenter questioned whether arrangements were in place which would allow individuals to be appointed without formal qualifications and to train to become registered nurses.

Mrs Moody advised that the Trust had been one of the first, nationally, to introduce nursing apprenticeships. These allowed an individual to be employed at band 2 and to undertake a healthcare certificate before progressing into formal nurse training. The approach enabled staff to become qualified as a registered nurse in five years. The Trust supported a minimum of 20 registered nurse apprentices each year as well as apprentice trainee nurse associates and work was being undertaken to seek to expand the scheme.

The Board noted that two recent recruitment events for healthcare assistants, advertised through social media, had generated significant interest in working for the Trust.

22/86 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 9th June 2022.

It was noted that there were no risks for escalation to the Board.

Mrs. Reilly, the Chair of the Committee, reported that:

(1) Discussions at the meeting had echoed those at a recent meeting of the Audit and Risk Committee in that, whilst there had been improvements to the BAF and the Corporate Risk Register, concerns remained about the capacity and capability to support risk management in the organisation. It had been recognised that training was required at all levels. The Committee was seeking assurance that this was being addressed and that the Head of Risk Management, who was due to commence in role in August 2022, would be adequately supported.

(2) The Committee had received a brief update on the responsive review of Adult Learning Disability Inpatient Services which had only recently commenced at the time of the meeting.

The Board noted that discussions on this matter would be held later in the meeting.

(3) No new issues had been raised by operational services. The continuing challenges relating to staff health and wellbeing, recruitment, sickness absence and vacancy rates impacting on safe staffing, particularly in Secure Inpatient Services, had been noted.
(4) Discussions were being held with the Managing Directors on the scope and approach to reporting from the Care Groups to the Committee. There was general agreement on the way forward and that too much information was being provided to the Committee at present.

Mrs Reilly also drew the Board's attention to the Committee's concerns about the Durham and Darlington Crisis Team. In response to the issues raised in the Reportable Issues Log (minute 22/C/56 – 26/5/22 refers) the Care Group Director had provided a brief overview and it had been agreed that the Committee would receive a more detailed update at its meeting to be held on 7th July 2022.

The Chair:
(1) Considered that the report was the best he had seen from the Committee.
(2) Advised that he looked forward to receiving an update on the points raised in the report at the Board's next meeting.
(3) Hoped that the discussions on the future reporting arrangements to the Committee would be successful.

22/87 CQC ACTION PLAN

Further to minute 22/40 (26/5/22) the Board received and noted a progress report on the delivery of the CQC Action Plan.

In her presentation of the report Mrs. Moody:
(1) Drew attention to the absence of red-rated risks to delivery.
(2) Highlighted that, in addition to the "must do" actions included in the report, work was also required on the delivery of the "should do" actions contained in the CQC's report published in December 2021. It was intended to provide a report on this matter to the Quality Assurance Committee in August 2022 to enable oversight of the delivery of those actions.
(3) Reported that the Internal Auditors had provided substantial assurance on the design and application of controls governing the delivery of the CQC Action Plan.
(4) Advised that the first reporting cycle of the Care Groups' Fundamental Standards Groups to the Executive Quality and Improvement Group had been completed. Two important issues had been considered by the latter Group at its meeting earlier in the week: compliance with and reporting of supervision; and restrictive interventions.
(5) Reported that feedback had been received from Mersey Care NHS Foundation Trust who, as national leaders in the field, had been engaged by the Trust to review and provide advice on restrictive interventions. Overall the review had found that the Trust's data sources were good but improvements could be made to the flow and utilisation of the information. In response it had been agreed to establish Positive and Safe Sub-Groups for each Care Group which would commence in July 2022 to review and monitor restrictive interventions for those individuals most affected . These arrangements would be in addition to reporting through the dashboards.

The Board also noted certain minor typographical issues in the report.

The Chair thanked Mrs Moody for her work on distilling a significant amount of detail into a succinct report.

22/88 PATIENT SAFETY SPECIALISTS

In accordance with NHS E/I guidance the Board received a briefing on the role, key deliverables, early milestones, priorities and support requirements of Patient Safety Specialists (PSS).

Mrs Moody advised that:

(1) Consideration was being given to holding a Board Seminar on the Patient Safety Incident Response Framework (PSIRF) which outlined how providers should respond to patient safety incidents and how and when patient safety investigations should be conducted.

(2) Lesley Munshi, the Head of Patient Safety, was the Trust's Patient Safety Specialist. This role was key to the delivery of the Trust's Journey to Safer Care and aligned to the national Patient Safety Strategy.

(3) In regard to the PSSs' role in leading and supporting the delivery of the "3 Is" set out in the National Patient Safety Strategy:
   (a) Insight – data relating to patient safety was being aligned to Our Journey to Safer Care.
   (b) Involvement – the introduction of patient safety partners was being considered. Early conversations were being sought with the Lived Experience Directors on these roles which would be involved in service and pathway design; safety governance; and strategy and policy.
   (c) Improvement – the PSS had a lead role in patient safety improvement activity including the Trust's approach to the Improvement Collaborative Programme which focussed on reducing restrictive interventions and improving sexual safety.

(4) Training for PSSs was based on the patient safety syllabus. PSSs were required to be trained to level 5 . Discussions had been held with the Executive People and Culture Sub-Group on the inclusion of level 1 in essential training.

In conclusion the Board noted that the requirements to have a PSS in post, full-time, in 2021 had been achieved. In regard to capacity it would also be beneficial to increase the number of PSSs in the Trust through, for example, the appointment of one for each Care Group.

Prof Hungin questioned whether there was evidence that the role could be effective in improving patient safety as one or several could not have oversight of all activities and influence culture.

He also highlighted his recent experience during a visit to services where cleaning equipment, left unattended, created a ligature risk and sought assurance that staff, including cleaners and housekeepers, were aware of the patient safety culture and approach that the Trust was seeking to instil.

Mrs. Moody explained that patient safety was the responsibly of all staff and the role of the PSS was to demonstrate commitment; provide leadership and to be a figurehead; lead the delivery of Our Journey to Safer Care; and ensure all staff were aware of their roles and responsibilities for patient safety.

Mr Scott observed that these types of leadership roles provided great opportunities but also risks with success depending on how well they were delivered. He advised that he would be seeking discussions with Mrs. Moody on the appointment of Care Group PSSs as these roles could be beneficial in the delivery of the patient safety agenda.

Mrs Romaniak added that the important roles of housekeeping staff had been referenced at the fundamental standards event held in May 2021. Actions had been identified which the Estates and Facilities Management Directorate was taking forward.

The Non-Executive Directors sought assurance that the Trust's appointment of its PSS had met the national requirements.

Mrs Moody advised that Mrs Munshi had been appointed to the position in March 2021, ahead of timescale included in the national guidance; however, her role also encompassed management of the patient safety team.

The Board noted that the Trust had not yet seen the full benefits of the role due to the impact of a number of issues since Mrs. Munshi's appointment.

The Chair highlighted that, if patient safety was the responsibility of all, Board Members might need to receive training.

Mrs Moody advised that within level 1 of the Patient Safety Syllabus there was training on the "essence of patient safety" and the "essence of patient safety for Board Members" which they should undertake.

22/89 PEOPLE CULTURE AND DIVERSITY COMMITTEE

The Board received and noted the key issues report on the business transacted and matters arising from the meeting of the People Culture and Diversity Committee (PCDC) held on 20th June 2022.

It was noted that there were no risks for escalation to the Board.

Mrs Richardson, the Chair of the Committee, drew attention to the following matters:

(1) The "alert" to the Board on recruitment and retention, following a challenge by Miss Haley in regard to the provision of external interviews for staff leaving the Trust and the collation and application of the feedback received.

The Committee had noted the arrangements in place, at present, and the need for further work to improve the processes and learning from staff exit interviews.

The Board noted that:

(a) Common themes arising from exit interviews included the growth in the private sector, on which the Trust needed further understanding, and pressures on staff.

(b) A focussed paper would be provided to the PCDC to bring together recruitment and retention issues.

Mrs Richardson considered that it was also important to understand why staff preferred to remain with the Trust and asked for this matter to be considered at the forthcoming Board Seminar on workforce issues.

(2) The briefing provided by Prof Reilly on Schwartz Rounds.

The Committee had also heard the experiences of a member of staff who had participated in the forum and received assurance that he felt supported.

(3) The review of risks and the recognition that further work was required on the Corporate Risk Register.

Dr Dexter-Smith confirmed that the BAF risk on recruitment and retention had been updated to reflect the controls and gap in assurance relating to exit interviews.

(4) The updates provided by the Staff Networks.

(5) The position on sickness absence which remained consistently under 7%.

It was noted that a new report, which would enable workforce data to be reviewed in the round, should be available for the Committee's next meeting.

The Non-Executive Directors emphasised the need for the Trust to support the concept of Schwartz Rounds

The Chair observed that he had attended one of the forums and had found it revelatory and reflective.

Mrs Richardson advised that Prof Reilly was considering the introduction of a shorter version of the forum to enable discussions on performance concerns and to enable staff to receive empathy and support from colleagues.

The Chair thanked Mrs. Richardson for her very clear report.

22/90 DATA SECURITY AND PROTECTION TOOLKIT

Consideration was given to the report which provided a briefing on the activities undertaken in regard to the Data and Security Protection Toolkit (DSPT) and which sought the Board's approval to the reporting and publication of the Trust's compliance with the Toolkit as at 30th June 2022.

In her presentation of the report Mrs Romaniak:

(1) Reported that the Trust had received the initial findings of the Internal Audit review, undertaken in parallel to the submission, which rated the accuracy of the self-assessment and checked the evidence. This had provided moderate assurance; however, following the submission of additional evidence, the rating had increased to substantial assurance.

(2) Advised that correspondence with the DSPT Lead at NHS Digital had confirmed that an action plan was required if the standard for training was not met. The final compliance level with this standard was 87% and the Board was asked to report a status of "not met". So long as the standard (95%) was achieved by the end of December 2022, with evidence checked by Internal Auditor, the Trust would move to "fully met".

(3) Highlighted that a scheduled review of all data and security risks would be undertaken by the Strategy and Resources Committee in the Autumn. This was aligned to an ongoing external cyber review which had already provided some helpful advice.

Board Members sought clarity on the following matters:

(1) Whether the Trust had an electronic tracking system for medical records.

It was noted that the Trust had a significant number of paper records which were held in storage. These needed to be moved to an electronic format but this would take significant work.

(2) Whether the three incidents reported to the ICO (Appendix 1 to the report) concerning the records of a family member being accessed by a clinician, without a business need to do so, related to the same member of staff.

The Chair asked for a conversation on this matter to be undertaken outside the meeting.

(3) Whether the cyber security was covered in the Trust's inductions and included in mandatory training.

Mrs. Romaniak confirmed that cyber security was included in mandatory training but not inductions and a conversation was needed with Dr Dexter-Smith on this matter.

Dr Carpenter highlighted that it was normal practice for cyber security training to be provided before staff were allowed network access.

Dr Dexter-Smith advised that consideration was being given to the support provided to new staff when joining the organisation including, for example, early access to IT networks.

***Agreed** – that the final publication of the Data Security and Protection Toolkit as at 30th June 2022, with all evidence items in place and an internal action plan for the standard not yet met based on anticipated DSPT training compliance, be approved.*

22/91 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.

22/92 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.

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.

Following the transaction of the confidential business the meeting concluded at 4.45 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
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	Aug-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	Oct-22		
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	Jul-22		Agenda Item 14

ITEM NO. 9

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th July 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**	**Reasonable** ↓	Level of exposure not acceptable Strengthening of controls required at pace	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 13 – Report of the Freedom to Speak Up Guardian ▪ 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	**MD (DTV&F)**	**High**	**Reasonable**	Opportunities to improve controls; however, new controls (if available) are required to reduce exposure	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ 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 operating effectively 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**	An acceptable level of exposure can be achieved Strengthening of controls is required, at pace	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report
5	✓	✓		**Culture & Wellbeing**	**DoP&C**	**High**	**Good**	Controls are, generally,	▪ Public Agenda Item 10 – Board Integrated

				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			↑	operating effectively Further strengthening, through the delivery of mitigations, is required at pace to reduce exposure.	Performance Dashboard ▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 13 – Report of the Freedom to Speak Up Guardian
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	**DoN&G**	**High**	**Good**	Controls are, generally, operating effectively; Further strengthening, through the delivery of mitigations, is required at pace to reduce exposure.	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 11 – Directors' Visits Feedback ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 14- Learning From Deaths Report ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report
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**	**High** ↑	**Good**	The risk is being managed within acceptable limits and controls are. Generally. operating effectively. Continued delivery of mitigations is required to achieve target score.	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard
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 improvement is limited High degree of exposure will need to be accepted	▪ Public Agenda Item 8 – Chief Executive's Report ▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report

								Regular monitoring of the risk advisable.	
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**	**Medium** ↓	**Substantial**	The risk is within acceptable limits. Controls are operating effectively	▪ Public Agenda Item 16 – NENC Provider Collaborative Governance Arrangements ▪ Confidential Agenda Item 5 – Commissioning Committee Key Issues Report
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 exposure will remain higher than acceptable Regular monitoring of the risk advisable	▪ Public Agenda Item 12 – Quality Assurance Committee Key Issues Report ▪ Public Agenda Item 10 – Board Integrated Performance Dashboard ▪ Public Agenda Item 18 – Organisational Risk Management Policy ▪ Confidential Agenda Item 3 – Reportable Issues Log ▪ Confidential Agenda Item 4 – Chief Executive's Report
12	✓	✓	✓	**Roseberry Park** The necessary Programme of rectification works at Roseberry Park and associated legal case could adversely affect our service quality/safety and financial, reputational and regulatory standing	**DoF&I**	**Very High**	**Good**	The level of exposure is not acceptable Urgent action is required	
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 acceptable levels will need to be accepted.	▪ Confidential Agenda Item 6 – WLPC Key Issues Report
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	**DoFI**	**Very 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	
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 exposure	▪ Public Agenda Item 10 – Board Integrated Performance Dashboard

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Board Integrated Performance Dashboard (IPD)
As 31st May 2022

journey to change

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

CONTENTS

Introduction

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Background and Context

As part of the continuous improvement of the Trust's Performance Management Framework, we have developed a more integrated approach to quality and performance assurance and improvement to enable us to have oversight, monitor and report key measures that demonstrate the delivery of the quality of services we provide and provide assurance to the Board through its sub-committee structure.

The measures for the Integrated Performance Dashboard (IPD) were identified by the relevant Board Sub Committees and agreed by the Board of Directors. All the measures have been aligned to one of our three strategic goal(s) and where appropriate, support the monitoring of the Board Assurance Framework risks.

Each month the IPD which will give oversight and assurance against the agreed key measures through the agreed assurance processes. On a quarterly basis this will be expanded into wider Integrated Performance Report (IPR) which will incorporate reports from the Board Sub Committees which will include other key information issues and risks (not already included in the IPD) but which the sub committees (Quality Assurance, Mental Health Legislation, People, Culture & Diversity and Strategy & Resources) wishes to escalate to the Board. The IPR will also provide progress against the System Oversight Framework and any other key National Standards.

Further work is planned to develop relevant dashboards for each of the Board Sub Committees within the Integrated Approach this financial year. This will provide additional oversight and assurance of the key measures identified by each Board Committee.

Latest Board Integrated Performance Dashboard

It is important to note that this new approach is still being embedded within the agreed information and assurance flows and we expect the level of assurance and the triangulation of information, to increase and improve in the coming months.

Initial discussions have taken place with each Executive Lead for each of the Board Sub Committees on how to approach the identification and proposal of standards for each of the measures (where appropriate). Given the work involved to better understand the measures, additional information required to support standard setting and with other priorities currently in the organisation, we have decided to delay this work for two months. We will start this work in the summer and have the discussions in the October Executive Meetings which will inform the Board Sub Committees in the beginning of November with the final proposals going to the Board late November for discussion and approval. This will also enable us to have 6 months "current" data to inform the process. In the interim we will continue to use the Statistical Process Control (SPC) charts and other intelligence to identify both areas of concern and good practice.

The key areas of concern identified from the Integrated Performance Dashboard (IPD), with triangulation of any other relevant information

The following are areas of concern which require improvement.

Our quality

- Feeling Safe: *03) Percentage of inpatients reporting that they feel safe whilst in our care* – whilst we are not indicating a statistical cause for concern in the SPC Chart (i.e. there has been no significant deterioration in performance); this is a key priority for the Trust and is one of the priorities within our Quality Account. We haven't identified a standard yet; however, the target within the Quality Account for 21/22 was 88% and our latest FYTD performance is only 57.59% which is a concern.
- Outcomes: *05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported; 06) Percentage of CYP showing measurable improvement following treatment - clinician reported and 07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported* – The new Medical Director will be chairing the Outcomes Steering Group from July 22 and we will be looking at the Terms of Reference for the group going forward. We are also undertaking a piece of analysis to triangulate and correlate the completion rates and timeliness data in order to better understand the variation shown.
- Bed Pressures:*08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider* – A new trust-wide working group has been set up to oversee how we manage current levels of occupancy and the longer-term requirement for beds. A system approach has also been agreed following the identification of Serious Incidents occurring whilst patients have waited for a bed or a Mental Health Act Assessment.
- *Safety: 10) The number of Serious Incidents reported on STEIS* and*12) The number of Restrictive Intervention Incidents* – there are specific concerns in Learning Disability Services within the Durham, Tees Valley and Forensics Care Group – additional safeguards have been put in place within this service. We are working with the Hopes Team and the National Team to support our improvement work in this area. We are also reviewing the resources required to ensure that we can progress our ambition to reduce the use of restrictive practices and become an Exemplar in this area.

Our People

- *18) Staff Leaver Rate* – **new this month** following inclusion of historic data. Whilst this is an area of concern to us to add some context we are ranked 19 of 72 Trusts (1 being the best with the lowest leaver rate) and are placed in the inter-quartile range. The trust has held 2 successful recruitment events over a week period (late June/early July) and made 57 (44.65wte) appointments to Healthcare Assistant posts within Secure Inpatient Services and Learning Disability services, with further candidates due to be interviewed.
- *19) Percentage Sickness Absence Rate* – Covid infection rates in the wider community area are increasing and we are seeing an increase in covid related sickness, although not to the levels we have seen previously.
- *20) Percentage compliance with ALL mandatory and statutory training and 21) Percentage of staff in post with a current appraisal* remains a concern. We are continuing to work with our colleagues in the People and Culture Directorate to look at what possible improvement actions will be required in the Care Groups and Corporate Directorates.

Our Activity and Finance

- *23) Unique Caseload (snapshot) - W*ork is continuing to analyse and better understand this information in order to identify next steps.
- *24) Financial Plan: SOCI - Final Accounts - Surplus/Deficit* - Expenditure run rates in months 1 and 2 include material 'hot spots' that are concerning:
  - High temporary staff - unprecedented agency cost - £3.1m to 31st May (continuation to March would be equivalent to double plan);
  - High and rising independent sector bed use (5 block and 17 spot purchase at end May, rising to 20 spot purchase at 11th July). £1.1m spend to 31st May versus plan for 2022/23 financial year of £320k (plan assumed Q1 only).

The areas of positive assurance identified within the IPD

11) The number of Service Reviews relating to incidents of moderate harm and near misses - Whilst the SPC Chart is indicating positive assurance we are going to review this measure to ensure it's fit for purpose.

Other key information, issues, and risks (not already included in the IPD) that the Executives wishes to highlight and/or escalate to the Board

Areas of positive assurance to highlight to the Board

- There has been two Consultant Psychiatry appointments in the North Yorkshire, York and Selby Care Group. One for Adult Services in Scarborough and one in Children & Young People's Services in Harrogate.
- In May and June 22, we had 144 new starters (132.12 wte) compared to 119 leavers (103.20 wte)
- As part of the CQC data requests for Children & Young People's Community Services we were able to evidence that the current average waiting times for an assessment is 28 days. This is based on an actual assessment taking place as opposed to a first direct contact with the child/young person (the national proxy measure for waiting time to assessment).
- The Chief Executive has received a number of positive personal emails from team leaders in Children & Young People's Services within the North Yorkshire, York and Selby Care Group.

Issues to highlight to the Board

- The CQC Inspection Team have revisited both Secure Inpatient Services and Children & Young People's Community Teams. Whilst feedback is very high level, in all cases the CQC were very complimentary about the people they met, their candour, enthusiasm and passion for doing the right things.
- Staffing – recruitment and retention of suitably experienced and skilled staff along with high bank and agency use is impacting upon patient experience, staff well-being, effectiveness and safety
- Our ability to respond to demand for services is impacting upon patient experience, effectiveness and safety
- There are high levels of self harm which is the highest cause of concern in terms of incidents. Improvement work has been discussed and agreed in the Quality Assurance Committee.
- Crisis lines – a number of issues have been identified in the operation of the Crisis lines including the matching of capacity to demand – the Managing Director for Durham, Tees Valley and Forensics Care Group is leading the improvement work on this
- Financial Plan delivery - stepped CRES assumed from Q2 relating to agency usage and rate reduction will be challenging alongside operational pressures. OAPs / Agency / AMH prescribing a key cause for concern given M1-2 run rates. Additional assurance and mitigating actions to be discussed and clarified with Care Groups and / or Directorates
- From late July, the proposed ambitions and areas of focus from our strategic journeys will be shared with service users, carers, staff and partners through a special page on our website, and we will invite comment about how well they fit together and support the delivery of Our Journey to Change. We are also inviting many involvement members, partners and staff to our Our Journey to Change conference on 13th/14th September.

Other key information, issues, and risks (not already included in the IPD) that the Executives wishes to highlight and/or escalate to the Board

Risks to highlight to the Board

We monitor progress against the Long Term Plan ambitions, that have been agreed in partnership with our Commissioners, on a monthly basis through the Care Group Boards and report this to our Commissioners; however we are assessed on a quarterly basis against the agreed trajectories. For the period ending May 2022, we are at risk of not delivering the individually agreed ambitions for Quarter 1 22/23 in the following areas:

IAPT Services

1) Total access to IAPT services -Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy: County Durham CCG; Vale of York CCG and North Yorkshire CCG
2) The proportion of people who are moving to recovery - Vale of York CCG
3) Percentage of people who have waited more than 90 days between first and second appointments (IAPT) - County Durham CCG; Tees Valley CCG and Vale of York CCG

CYP Eating Disorders

4) The proportion of CYP with ED (routine cases) that wait 4 weeks or less from referral to start of NICE-approved treatment - County Durham CCG; Tees Valley CCG; Vale of York CCG and North Yorkshire CCG
5) The proportion of CYP with ED (urgent cases) that wait 1 week or less from referral to start of NICE-approved treatment – Tees Valley CCG, Vale of York CCG and North Yorkshire CCG

EIP Services

6) Percentage of people experiencing a FEP treated with a NICE approved care package within 2 weeks of referral -County Durham CCG and Vale of York CCG

Out of Area Placements

7) Inappropriate adult acute mental health Out of Area Placement (OAP) bed days –North East and North Cumbria Integrated Care System and Humber Coast & Vale Integrated Care System

For measures 1-6, key issues and actions have been identified by each of the Care Groups and are being monitored by the Executive Directors Meeting. For measure 7, please see *09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider* within the report for further details.

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

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

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

Assurance: is the standard achievable?

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

Please note assurance on whether the standard is achievable is currently not in this report as this is pending the work around standards that is referenced in the Introduction section.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

A development is underway to review our current assessment tool and work will be undertaken to complete the assessment for all measures using the new tool, by the 30th September 2022.

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

Data Quality Assessment status

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

Please note the Data Quality Assessment status has only been included for those measures that we reported in the 21/22 Trust Performance Dashboard. Work will be undertaken to complete this assessment for all measures by the 30th September 2022.

Action status

Positive Assurance	We are doing well in this area and therefore no action is required
No Concerns	No further action is neededat this point in time
Continuous Improvement	Whilst there are no specific concerns at present, we wantto continuously improve in this area
An Area of Concern	We need to investigate this to understand what's happened and/or take action

Please note in the absence of agreed standards, the action status has been determined upon the current variation depicted within the Statistical Process Chart or other relevant information.

Board Integrated Performance Dashboard Summary as at 31st May 2022

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC				93.03%	
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC				72.46%	
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC				57.59%	
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L			46.81%	
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC				45.10%	
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC				21.61%	
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC	H			99.23%	
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			1,067	
10)	The number of Serious Incidents reported on STEIS	QAC				27	
11)	The number of Service Reviews relating to incidents of moderate harm and near misses	QAC	L			127	
12)	The number of Restrictive Intervention Incidents	QAC	H			1,241	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				2	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				0	
15)	The number of uses of the Mental Health Act	MHLC				703	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work*	PC&D				55.01%	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work*	PC&D				58.76%	
18)	Staff Leaver Rate	PC&D	H			13.63%	
19)	Percentage Sickness Absence Rate (month behind)	PC&D	H			6.73%	
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D	L			86.62%	
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	L			80.11%	

Rep Ref	Our Financial and activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				16,509	
23)	Unique Caseload (snapshot)	S&RC	H			60,482	

Rep Ref	Our Financial and activity measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - Surplus/Deficit	S&RC	1,560,000	1,578,014
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	1,428,000	1,228,578
28)	CRES Performance - Non-Recurrent	S&RC	0	102,758
29)	Capital Expenditure (CDEL)	S&RC	1,868,000	1,573,187
30)	Cash against plan	S&RC	76,034,000	78,099,251

Please Note:

Measure 04) Percentage of CYP showing measurable improvement following treatment - patient reported – is under development.

Measure 25) Underlying Performance - run rate movement - the Oversight Framework is still in consultation and this indicator is yet to be defined.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

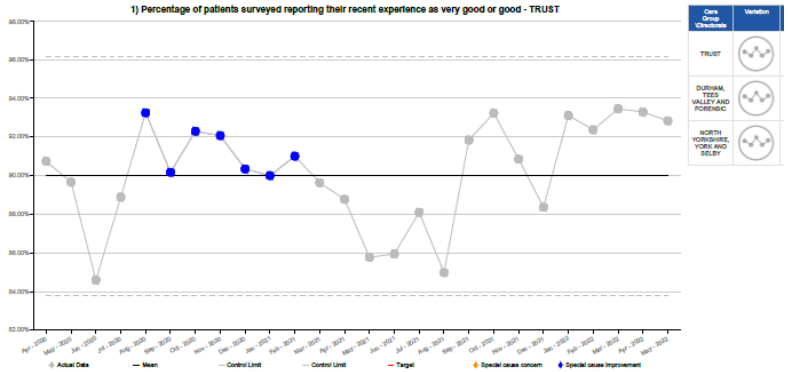
During May, **865** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **803 (92.83%)** scored "very good" or "good"

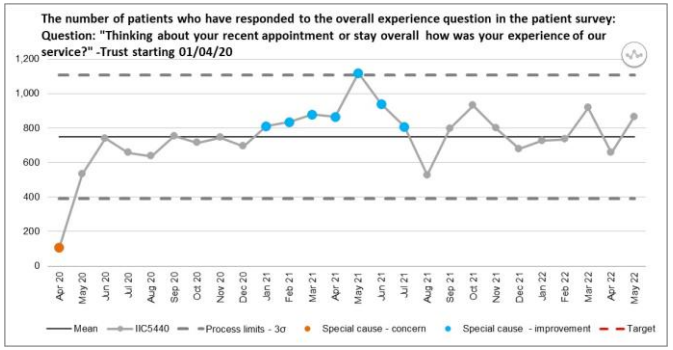
Nothing to note. Our activity is within the expected levels of performance

DQ

85%

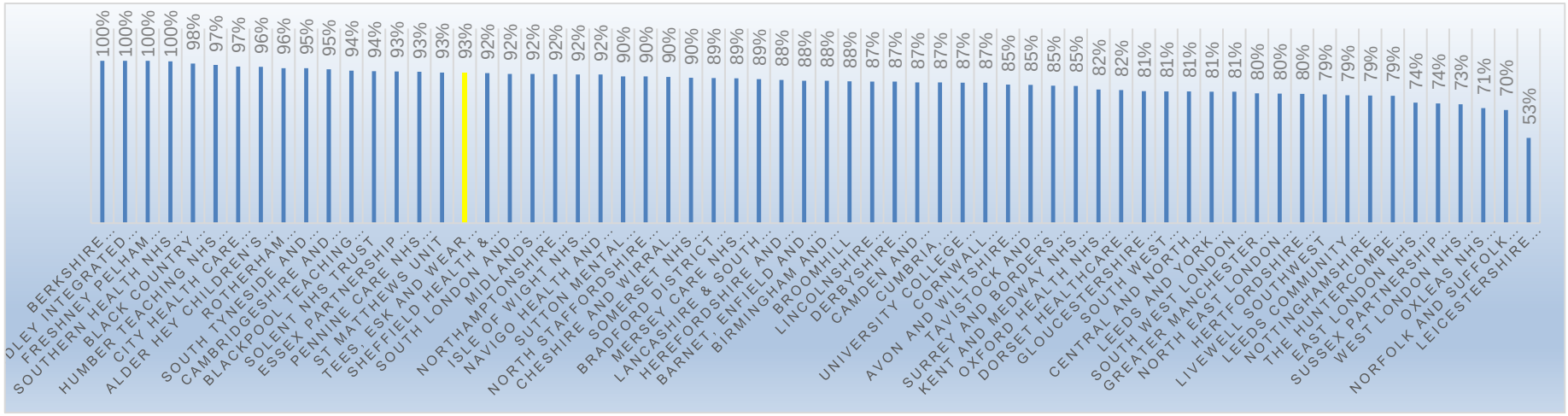
Whilst there are no specific concerns at present, we want to continuously improve in this area





National Benchmarking - Mental Health Friends and Family Test (FFT) data - April 2022

The Mental Health FFT dataset includes FFT responses for the latest month from providers of NHS funded mental health services. The England average (including Independent Sector Providers) percentage positive responses about their overall experience was **86%**, our Trust is identified by the yellow bar in the chart below. We are ranked 17 in the list of providers shown.



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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Whilst our patients have continuously rated our care as very good or good, we are concerned that the number of responses we receive to our surveys are not as high as we would like. This has been impacted by operational pressures and a reduction in face to face contact, as remote clinical contacts have increased in response to pandemic pressures.	Head of Patient Experience to review the outstanding actions in line with the organisational changes, to identify what needs to be taken forward in terms of a new plan for 2022/23. This work will commence in May 2022.	**Ongoing.** This was discussed at the Care Group Quality Assurance & Improvement Sub Groups early June. Work is now underway within the Corporate Patient Experience Team in collaboration with the Care Group representatives to identify what actions are to be taken forward. This will be discussed and agreed at the July Quality Assurance & Improvement Sub Groups.	
A data quality issue has been identified as a number of survey responses have not been aligned to Trust cost centres and are, therefore, incorrectly excluded from the measure.	The IIC Team Manager and Corporate Systems Manager to work with Meridian, the survey provider, during April 2022 to investigate and identify appropriate actions to correct the measure.	**Ongoing**. We have received the refreshed data for January 2022 and this has been included in this dashboard. There were some other discrepancies identified and we are contacting the system supplier to provide the missing data which we hope to have by the end of June 2022.	

NB. In last month's report we included a key issue/action around work we are undertaking with Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust on the 'Feeling Safe' theme – this has now been moved to measure *03) Percentage of inpatients reporting that they feel safe whilst in our care* where this is more relevant.

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

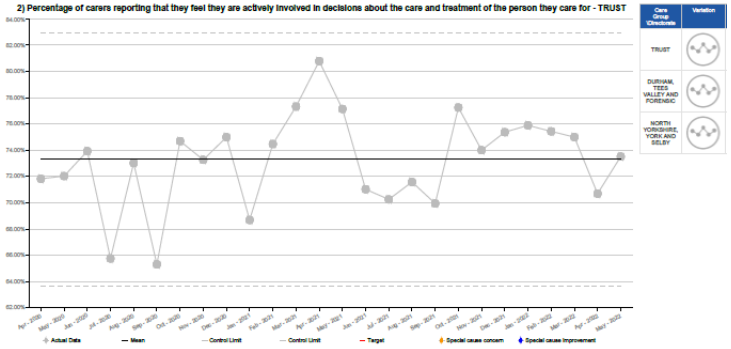
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

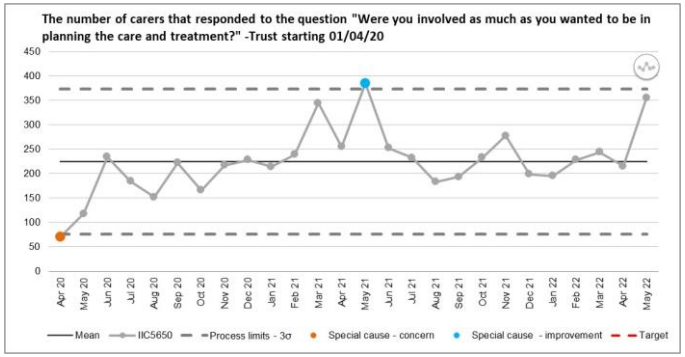
We are all committed to co creating a great experience for patients, carers and families by including carers in any decisions about the person they care for and working with them to provide quality care, and that carers will tell us this is the case from their experience.

During May, **355** carers responded to the question in the carer survey: Question: “Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?”. Of those, **261 (73.52%)** scored “yes, always”.

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

Whilst there are no specific concerns at present, we want to continuously improve in this area





Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that carers of patients within our North Yorkshire, York & Selby Mental Health Services for Older People do not feel they are actively involved in decisions regarding those they care for.	Head of Performance/Senior Performance Manager to engage with the Head of Patient Experience to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group.	**Completed.** The Associate Director of Performance met with the Head of Patient Experience on 10th June 2022 and this was discussed at the Care Group Quality Assurance & Improvement Sub Groups early June 2022. Within North Yorkshire, York & Selby Care Group there is a bi– monthly participation group with a number of supporting groups at speciality level.	Based on the latest data, Mental Health Services for Older People are no longer indicating a cause for concern and are now within expected levels.

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

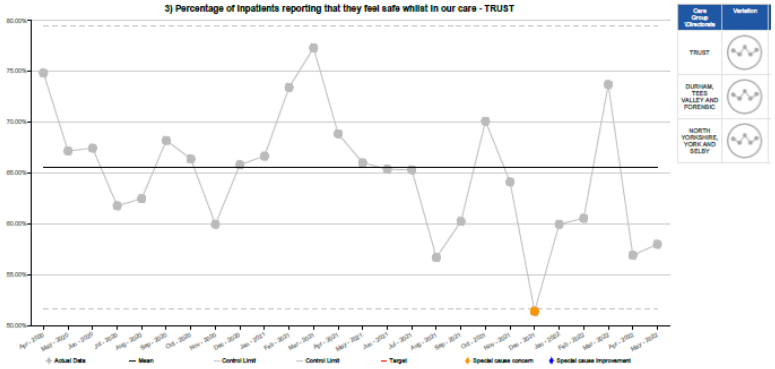
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

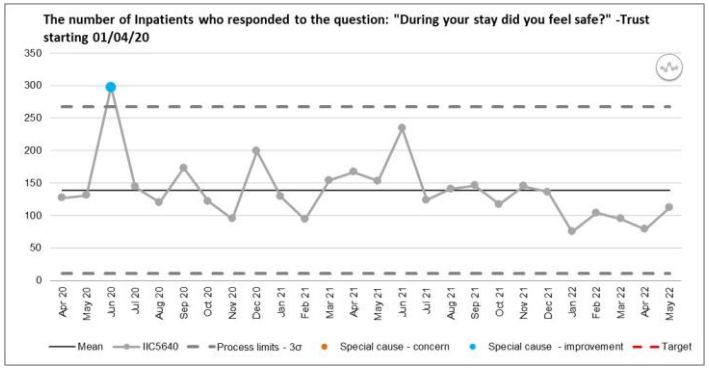
We are all committed to co-creating safe and personalised care, preventing people from receiving unsafe care and treatment and preventing avoidable harm or risk of harm to inpatients within our services, and that patients will tell us this is the case from their experience.

During May, **112** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **65 (58.04%)** scored “yes, always"

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

Whilst there are no specific concerns at present, we want to continuously improve in this area





Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that inpatients within our Durham and Tees Valley Adult Mental Heath Services do not feel safe during their stay with us.	Senior Performance Manager to engage with the Head of Patient Experience to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group.	**Completed.** This was discussed at the Care Group Quality Assurance & Improvement Sub Group early June 2022. Focused work is being undertaken within Secure Inpatient Services (see action below) and findings will be shared across the Care Group. Patients have reported that having activities to do increases their feeling of safety on the wards therefore activity co-ordinators are being recruited for all wards with some commencing in post from April 2022. This work is being incorporated into the wider service improvement plan for patient and carer experience.	Based on the latest data, Adult Mental Health Services are no longer indicating a cause for concern.

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We previously identified a concern that inpatients within our Secure Inpatient Services did not feel safe during their stay with us. Work was undertaken with Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust on the 'Feeling Safe' theme late 2021, which identified similarities in feedback from inpatients in relation to feeling safe, witnessing violence and aggression and the number of activities available	Head of Patient Experience to hold focus groups initially within secure services during April 2022 to explore these themes further and identify areas of improvement.	**Ongoing.** Secure Services focus groups have been running during April and May 2022 and there are some further focus groups planned for June 2022 for the remaining wards. Areas of improvement have been identified from the initial focus groups and these will be consolidated with the output from the remaining focus groups.	
We are concerned that inpatients within all our Services do not feel as safe as we would like during their stay with us.	**New** A number of actions have been identified in our Quality Account around "Feeling Safe". We should see an improvement in this measure as a result of the work being progressed. We will review progress within the Quality Account on a quarterly basis and assess whether these actions are having the desired impact.	**Not yet started**	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

This measure will be included in next month's report

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

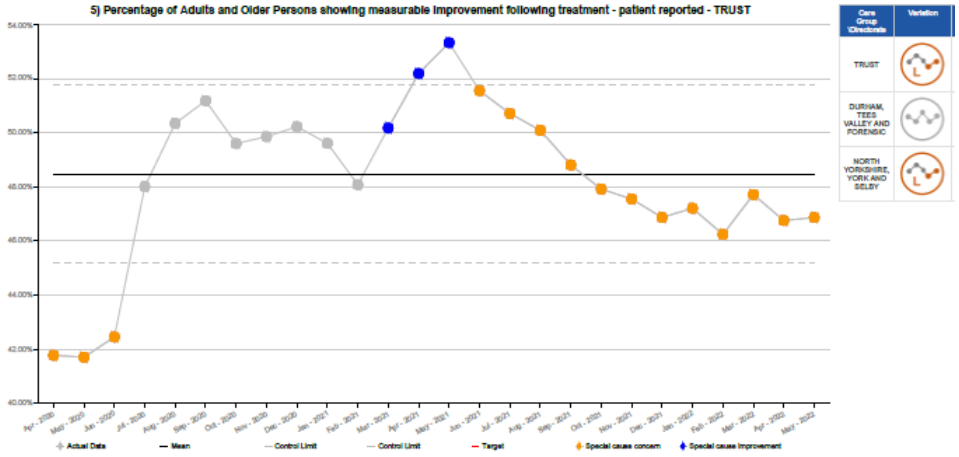
We are all committed to co creating a great experience for patients, and carers and families by ensuring they experience outstanding care. Knowing that the work we do with patients, families and carers is improving the outcomes for each service user, from a patient perspective, is one way we will know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

For the 3 month rolling period ending May, **2012** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 943 (46.87%)** made a measurable improvement.

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

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

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



Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, York & Selby Adult and Older People Services are showing an improvement in their patient-rated outcome measures than we would like.	Care Group Director of Nursing & Quality to facilitate a discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group to identify the actions that are required to address this. Contact will be made with all General Managers before the meeting to ensure that the discussion will be meaningful.	**Completed.** Actions have been identified by both specialities and reported to the June Quality, Assurance & Improvement Sub Group (see new actions included overleaf).	N/A
As above	Head of Performance to engage the Adult Mental Health and Mental Health Services for Older People Service Development Managers in undertaking a team-level deep dive into the data to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** There was a delay with the deep dive work due to the availability of team level data. This work has now commenced and will be completed by the end of June. Initial findings will then be shared with the General Managers and Service Development Managers to agree next steps.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, York & Selby Adult and Older People Services are showing an improvement in their patient-rated outcome measures than we would like.	The Adult Mental Health and Mental Health Services for Older People Service Development Managers to develop a clinical network work plan, which will include actions on training and the support required to improve outcomes from a network point of view. This will be completed in July 2022.	**Ongoing.** The work plans are being drafted and will be shared with the Clinical Networks in July 22 for agreement.	
As above	**New** Adult Services have identified the following 2 key actions to support improvement in this area: • Service to introduce team level compliance to the weekly report out so there can be a targeted approach to understand the gaps in knowledge and process • To be built into the role & function of caseload supervision action (AMH trust-wide action)	**Ongoing.** Team level compliance has been introduced.	
As above	**New** MHSOP Services have identified the following 2 key actions to support improvement in this area: • Agree a lead measure in the weekly performance meeting aimed at increasing number reported on. • Training for staff	**Not yet started**	
We are concerned we are aiming to have high performance and we are moving in the wrong direction	**New** The Section Head of Research & Statistics will undertake a piece of analysis to triangulate and correlate the completion rates and timeliness data in order to better understand the variation shown in the SPC chart (previous slide). This work will be completed by the end of July 2022.	**Not yet started**	

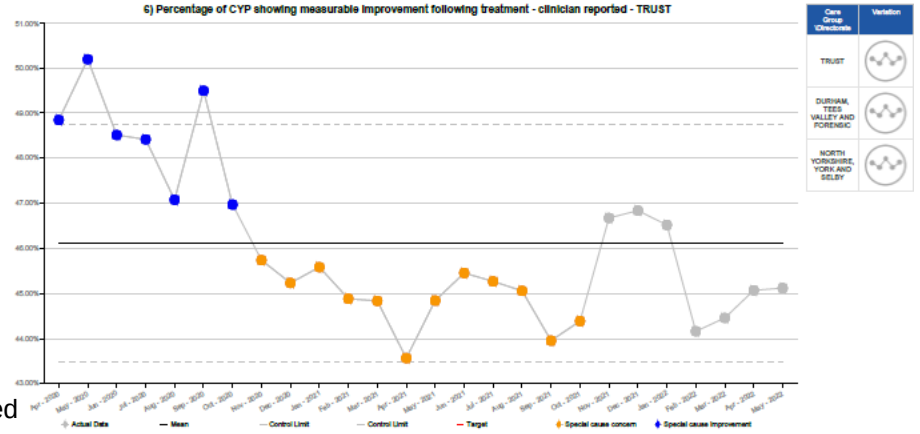
06) Percentage of CYP showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

For the 3 month rolling period ending May, **789** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 356 (45.12%)** made a measurable improvement.

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



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

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

NB. This is due to the key issues outlined below

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, Children & Young People Services are showing an improvement in their clinician-rated outcome measures than we would like.	Care Group Director of Nursing & Quality to facilitate a discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group to identify the actions that are required to address this. Contact will be made with all General Managers before the meeting to ensure that the discussion will be meaningful.	**Completed.** Actions have been identified by the speciality and reported to the June Quality, Assurance & Improvement Sub Group (see new actions included overleaf).	N/A
As above	Head of Performance to engage the Service Development Manager in undertaking a team-level deep dive into the data to support the discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** There was a delay with the deep dive work due to the availability of team level data. This work has now commenced and will be completed by the end of June. Initial findings will then be shared with the General Managers and Service Development Managers to agree next steps.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, Children & Young People Services are showing an improvement in their clinician-rated outcome measures than we would like.	**New** A working group to be set up to progress the Routine Outcome Monitoring (ROMs) agenda in the clinical workforce through huddles, clinical supervision and caseload management supervision. Service Development Manager to table this at the next Clinical Network meeting in July to agree representatives on this group.	**Not yet started**	
We are concerned we are aiming to have high performance and we have no significant change in our performance which remains below the mean (average)	**New** The Section Head of Research & Statistics will undertake a piece of analysis to triangulate and correlate the completion rates and timeliness data in order to better understand the variation shown in the SPC chart (previous slide). This work will be completed by the end of July 2022.	**Not yet started**	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

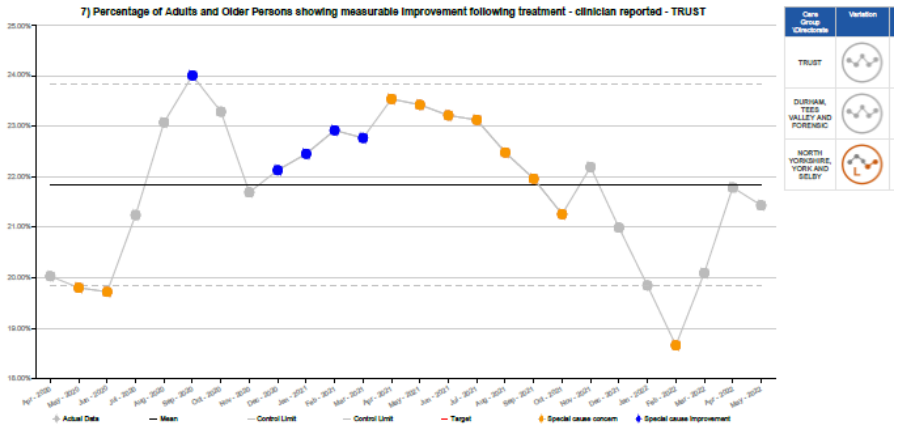
For the 3 month rolling period ending May, **3359** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 720 (21.44%)** made a measurable improvement.

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

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

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

NB. This is due to the key issues outlined below



Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that fewer of our patients within our North Yorkshire, York & Selby Adult and Older People Services are showing an improvement in their clinician-rated outcome measures than we would like.	Care Group Director of Nursing & Quality to facilitate a discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group to identify the actions that are required to address this. Contact will be made with all General Managers before the meeting to ensure that the discussion will be meaningful.	*See Progress Update within measure 05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported*	
In addition to above, we are also concerned that fewer of our patients within our Durham & Tees Valley, Adult Services are showing an improvement in their clinician-rated outcome measures than we would like.	Head of Performance/Senior Performance Manager to engage the Service Development Managers in undertaking a team-level deep dive into the data to support the discussions at the June 2022 Care Group Quality Assurance & Improvement Sub Groups. Work will start the week commencing 23rd May 2022.	**Ongoing.** There was a delay with the deep dive work due to the availability of team level data. This work has now commenced and will be completed by the end of June. Initial findings will then be shared with the General Managers and Service Development Managers to agree next steps.	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

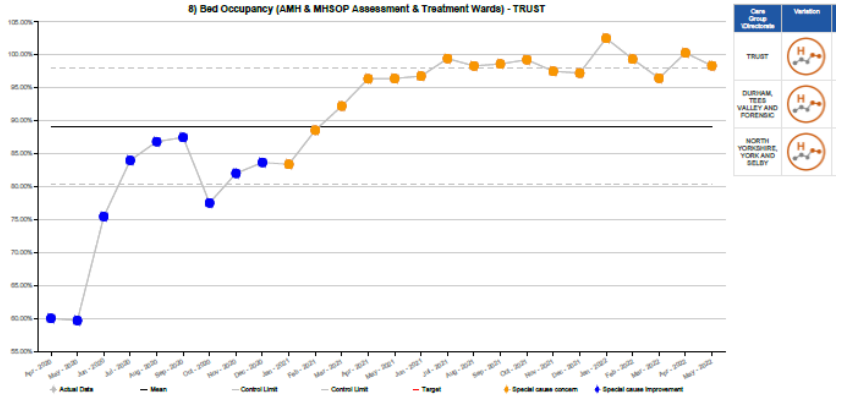
Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned we are aiming to have high performance and we have no significant change in our performance which remains below the mean (average)	**New** The Section Head of Research & Statistics will undertake a piece of analysis to triangulate and correlate the completion rates and timeliness data in order to better understand the variation shown in the SPC chart (previous slide). This work will be completed by the end of July 2022.	**Not yet started**	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

During May, **11,098** daily beds were available for patients; of those, **10,908 (98.29%)** were occupied.



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

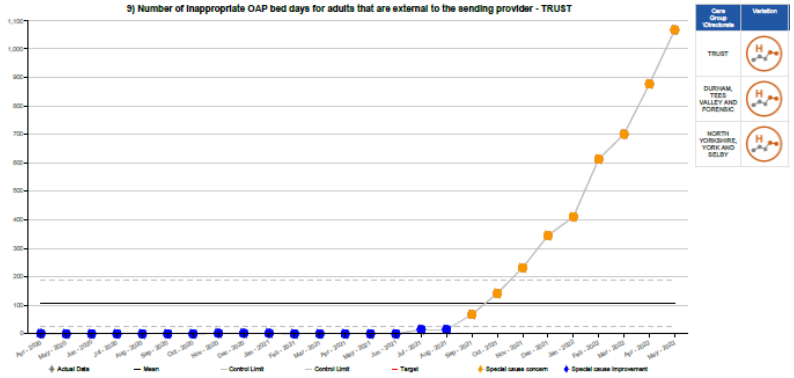
We need to investigate this to understand what's happened and/or take action

DQ ★ 100%

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

We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending May, **1067** days were spent by patients in beds away from their closest hospital.



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

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

DQ ★ 100%

Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Please note the key issues for bed occupancy and inappropriate Out of Area bed days have been consolidated and some actions revised following the Executive Meeting on the 22nd Jun 22			
Bed occupancy remains high as a result of bed reductions in the North Yorkshire, York and Selby Care Group which is impacting on the number of out of area placements	General Manager for Mental Health Services for Older Persons to open 2 beds on Rowan Lea on 4th April 22 which would create an additional 52 available bed days in April then proportionate amount thereafter	**Completed.** 2 beds were opened on Rowan Lea on the 4th April 2022.	Whilst this created additional bed capacity it did not impact on the overall performance.
As above	General Manager for Adult Mental Health to open 13 beds on Esk Ward by the end of June 22 which would create an additional 403 available bed days in July then proportionate amount thereafter	**Completed.** 13 beds were opened on Esk Ward on 26th April 2022 (earlier than planned); however there was a reduction of beds on Danby Ward (from 13 to 4) on 26th April 2022 to support safe staffing (see below action).	Whilst this created additional bed capacity it did not impact on the overall performance.
As above	General Manager for Adult Mental Health Service to support the increase of beds on Danby Ward to full capacity (13 beds) by September 22.	**Ongoing.** The ward is currently operating with 10 beds and is on plan to increase to full capacity by September 2022.	
As above	Director of Partnerships and Case Management to review the contract for the Priory for 5 beds which are due to cease at the end of June 22, during May 2022.	**Completed.** Gold Command agreed an extension to the end of September 2022, on the 20th May 2022.	Whilst this creates additional bed capacity it is not yet possible to know if this will impact on overall performance.
There are a range of issues impacting on bed occupancy (e.g. increased length of stay, delayed transfers of care) which is impacting on the number of out of area placements	The Associate Director of Strategic Planning & Programmes to form a trust-wide working group, with executive oversight of inpatient bed pressures. This group will be led by the new Medical Director from July 22.	**Ongoing.** A meeting was held on the 9th June 2022 which identified a short-term agenda on bed management as well as a long-term agenda around the number of beds required. Following discussion at the Executive Meeting on the 22nd June 22, more specific direction has been given to the group to oversee how we manage current levels of occupancy and the longer-term requirement for beds.	

Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We need to determine the longer term requirement for beds which is linked to our Clinical Journey	The Associate Director of Strategic Planning and Programmes to lead a procurement for external support to help us to identify the appropriate number of beds required in the longer-term	**Ongoing.** This procurement will be informed by the work of the new Trust-wide working group *(see previous action)*	
Bed pressures are continuing to impact on our services; however this measure only includes our own Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards therefore is not providing a comprehensive picture of overall occupancy	Senior Performance Manager to facilitate wider analysis of bed pressures which incorporates the available and occupied beds days purchased from the Priory and the occupied bed days for the external out of area placements by the end of June 22.	**Completed.** See slide 24	N/A
Bed Pressures within our Durham and Tees Valley beds, including increased length of stay and out of area placements, are impacting on our service; however further work is required to understand any additional underlying issues and consolidate actions	Senior Performance Manager to engage the Bed Services Manager in undertaking a ward-level deep dive to support the General Managers in a discussion on this measure and the key areas of concern at the June 2022 Care Group Quality & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Completed.** Ward level analysis completed and discussed with Bed Services Manager. The areas of concern identified included some patients with long lengths of stay and high level of occupancy across all inpatient wards. Further analysis will be now picked up by the Trust-wide working group.	N/A
There is concern that a high number of beds within the Care Groups are being occupied by patients outside of their respective Care Group; however still within the Trust.	Head of Performance and Senior Performance Manager to investigate whether we can identify the current patient base (e.g. the use of total bed capacity by the different populations and how long their LOS is) to support discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Groups. Work will start the week commencing 23rd May 2022.	**Ongoing.** Bed base analysis focusing on the different populations has been completed and work has now begun looking at length of stay and identifying other key measures which may be impacting. This will now be picked up by the Trust-wide working group.	

Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue: Bed pressures are continuing to impact on our services; however this measure only includes our own Adult Mental Health and Mental Health Services for Older People Assessment & Treatment Wards therefore is not providing a comprehensive picture of overall occupancy

Action: Senior Performance Manager to facilitate wider analysis of bed pressures which incorporates the available and occupied beds days purchased from the Priory and the occupied bed days for the external out of area placements by the end of June 22.

Outcome: The following table incorporates available and occupied bed days within our Trust beds, the beds we have purchased from the Priory at Middleton St George and actual out of area placements. This shows our level of occupancy over the past two months exceeding 100%.

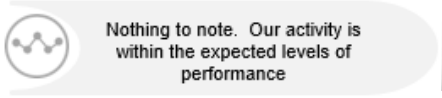
		Apr-22	May-22
Trust Beds (measure 8)	Number of Occupied Bed days	10,453	10,908
	Number of Bed days available	10,428	11,098
	% bed occupancy	**100.24%**	**98.29%**
Block Booked Beds - Priory, Middleton St George	Number of Occupied Bed days	149	154
	Number of Bed days available	150	155
	% bed occupancy	**99.33%**	**99.35%**
Out of Area Placements (measure 9 but monthly)	Number of Occupied Bed days	310	489
	Number of Bed days available	N/A	
	% bed occupancy		
Overall Occupancy	Number of Occupied Bed days	10,912	11,551
	Number of Bed days available	10,578	11,253
	% bed occupancy	103.16%	102.65%

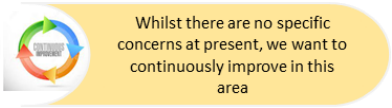
10) The number of Serious Incidents reported on STEIS

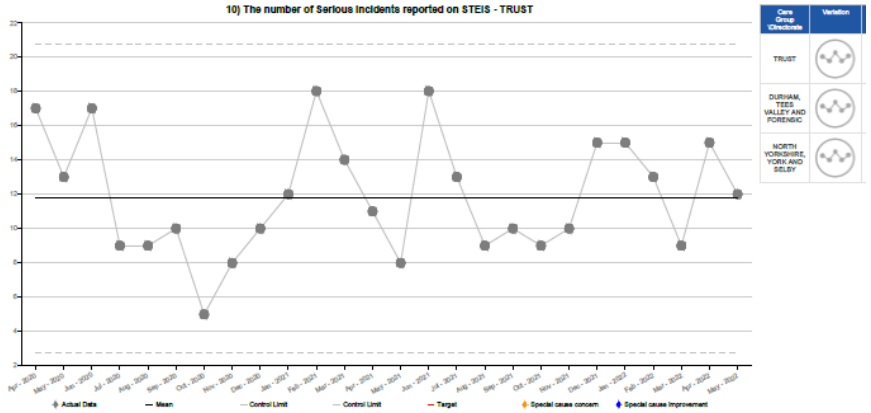
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

12 serious incidents were reported on the Strategic Executive Information System (STEIS) during May.







Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of Serious Incidents reported on STEIS, we review every Serious Incident and optimise the opportunities for learning and improvement to prevent similar incidents occurring.	Associate Director of Performance to engage with the Director of Quality Governance to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussions at the Quality Assurance & Improvement Groups.	**Completed.** Meeting held 10th June 2022. Where new or consistent themes are identified from the review of Serious Incidents these will be discussed through the appropriate governance route and highlighted to the Board including the actions we are taking to make improvements.	We would expect to see a reduction in number/themes once actions are completed and reported via the Organisational Learning Group.
As above	**New** A monthly huddle to be arranged involving the Director of Quality Governance, Associate Director of Performance and other professional leads to discuss and triangulate relevant information in order to provide assurance to the Executive Meeting. Dates to be arranged by the end of June 2022.	**Completed.** Monthly huddles in the diary from July 22 for the remainder of the financial year.	

11) The number of Service Reviews relating to incidents of moderate harm and near misses

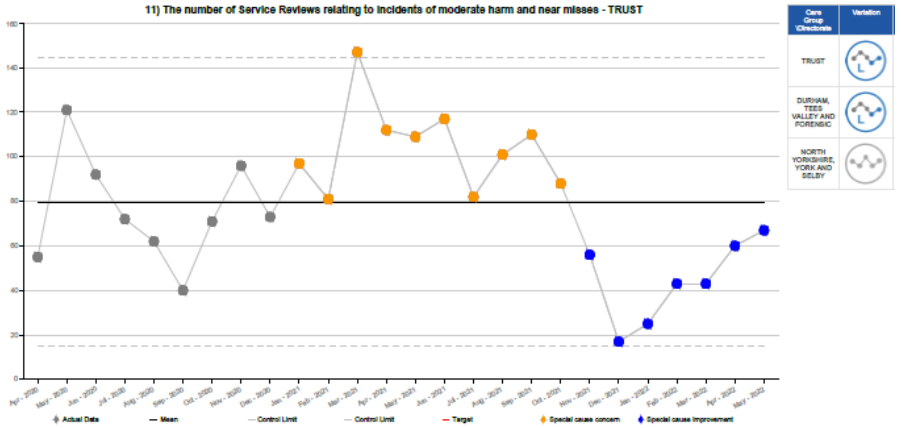
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

67 number of service reviews were undertaken in relation to incidents of moderate harm or 'near misses' during May.

We are doing well in this area and therefore no action is required

Whilst there are no specific concerns at present, we want to continuously improve in this area



Key Issue(s)	Action(s)	Progress Update	Impact
Whilst we are now indicating positive assurance in the number of Service Reviews relating to incidents of moderate harm and near misses, we review every Incident and optimise the opportunities for learning and improvement to prevent similar incidents occurring.	Associate Director of Performance to engage with the Director of Quality Governance to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussion at the Quality Assurance & Improvement Groups.	**Completed.** Meeting held 10th June 2022. Where new or consistent themes are identified from the review of Incidents these will be discussed through the appropriate governance route and highlighted to the Board including the actions we are taking to make improvements.	We would expect to see a reduction in number/themes once actions are completed and reported via the Organisational Learning Group.
As above	**New** A monthly huddle to be arranged involving the Director of Quality Governance, Associate Director of Performance and other professional leads to discuss and triangulate relevant information in order to provide assurance to the Executive Meeting. Dates to be arranged by the end of June 2022.	**Completed.** Monthly huddles in the diary from July 22 for the remainder of the financial year.	

12) The number of Restrictive Intervention Incidents

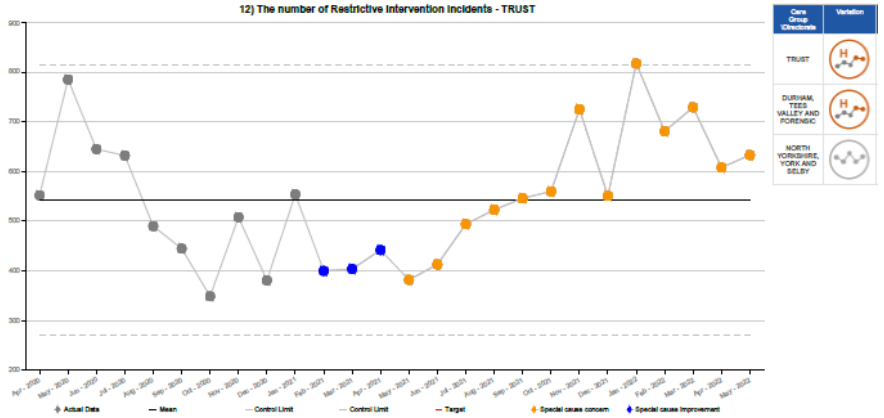
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

633 number of Restrictive Intervention Incidents took place during May.

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

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



Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that there have been a higher number of restrictive intervention incidents within our Learning Disability Services in Durham, Tees Valley & Forensics Care Group than we would like.	Associate Director of Performance to engage with the Director of Quality Governance to understand and share the learning on the work undertaken, in order to support the discussions around the measure and the key areas of concern at the Quality Assurance & Improvement Groups.	**Completed.** Meeting held 10th June 2022. This issue has already been identified in the Quality & Learning Report and there are a number of actions underway which are closely monitored by the Positive & Safe Group. We know this relates to a small number of highly complex patients and significant support continues to be provided to Learning Disabilities Services at this time.	We would expect to see a reduction in the number of restrictive intervention incidents once improvements are embedded.

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that there have been a higher number of restrictive intervention incidents within our Learning Disability Services in Durham, Tees Valley & Forensics Care Group than we would like.	**New** A number of actions have been identified within our Learning Disability Services which include: • To progress the transfer of care of some specific patients with complex needs to more appropriate provision • Delivery of bespoke training for staff within Adult Learning Disabilities services and refresher training trust-wide • Working with external partners including Merseycare to review our interim model of care and identify best practice • The development of an assurance panel to review episodes of restraint with the aim of reviewing and developing plans of care to support a reduction in restraint.	**Ongoing.** All of the actions outlined are being progressed and are being monitored through the Care Board Quality Assurance & Improvement Group . A more detailed update on each of the elements will be provided in next months' report.	
As above	**New** A Positive & Safe Group will be established within each Care Group which will meet monthly to review key information in relation to positive and safe care with the aim of reducing restrictions across inpatient areas.	**Ongoing.** The proposal to establish Positive & Safe Groups within each Care Group was agreed by the Executive Quality Assurance & Improvement Group on the 28th June 2022. A further update on the timescales for this will be provided in next month's report.	
As above	**New** The Executive Director for Nursing & Governance is going to review the resources required to ensure that we can progress our ambition to reduce the use of restrictive practices and become an Exemplar in this area. This will be completed by the end of August 22.	**Not yet started**	

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

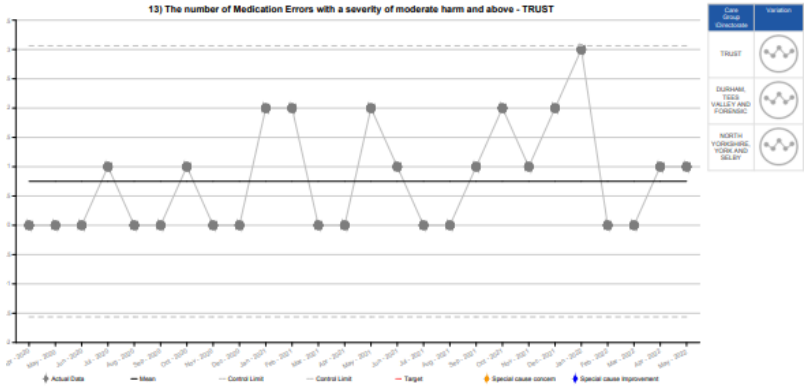
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

1 medication error has been recorded with a severity of moderate harm, severe or death during May.

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

Whilst there are no specific concerns at present, we want to continuously improve in this area



Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of Medication Errors with a severity of moderate harm and above, we review every medication error of moderate harm and above and optimise the opportunities for learning and improvement to prevent similar errors occurring.	Associate Director of Performance to engage with the Director of Quality Governance and Chief Pharmacist during June 2022 to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussions at the Quality Assurance & Improvement Groups.	**Completed.** Meeting held 21st June 2022. Chief Pharmacist outlined the current governance arrangements regarding medicines management at Care Group level and the Drug & Therapeutic Committee which reports into the Quality and Assurance Board Sub Committee.	
As above	**New** A monthly huddle to be arranged involving the Director of Quality Governance, Associate Director of Performance and other professional leads, including the Chief Pharmacist, to discuss and triangulate relevant information in order to provide assurance to the Executive Meeting. Dates to be arranged by the end of June 2022.	**Completed.** Monthly huddles in the diary from July 22 for the remainder of the financial year.	

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

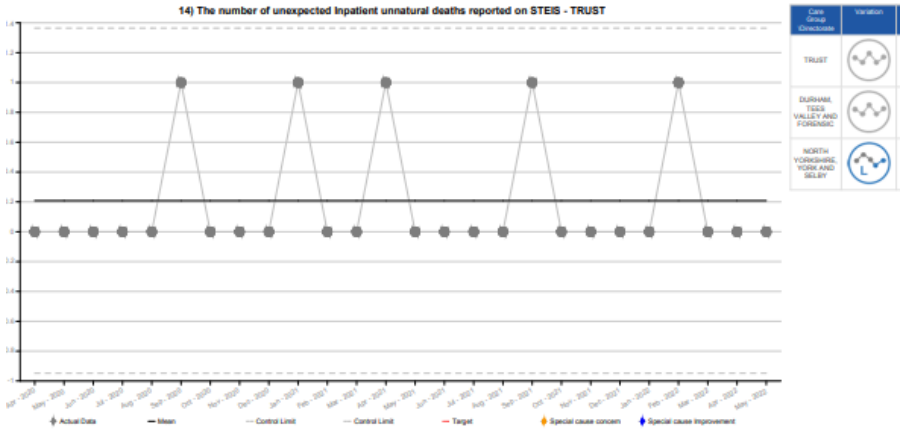
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety of our patients and to minimise the risk of any harm to them and distress to their carers and families.

0 unexpected Inpatient unnatural deaths reported on the Strategic Executive Information System (STEIS) during May.

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

Whilst there are no specific concerns at present, we want to continuously improve in this area



Key Issue(s)	Action(s)	Progress Update	Impact
Whilst there are no specific trends in the number of unexpected inpatient unnatural deaths reported on STEIS, every unexpected Inpatient unnatural death is a concern to us We review these through a Rapid Patient Safety Review to identify any immediate learning which is then followed by full Serious Incident Review.	Associate Director of Performance to engage with the Director of Quality Governance to understand the key work undertaken to date, lessons learned and ongoing actions to support the discussions at the Quality Assurance & Improvement Groups.	**Completed.** Meeting held 10th June 2022. We adhere to the Learning from Deaths policy which is based on the National Guidance on Learning from Deaths which includes a report to the Board. Where new or consistent themes are identified from the review these will be discussed through the appropriate governance route as per the Learning from Deaths policy.	We would expect to see a reduction in number/themes once actions are completed and reported via the Organisational Learning Group.
As above	New A monthly huddle to be arranged involving the Director of Quality Governance, Associate Director of Performance and other professional leads to discuss and triangulate relevant information in order to provide assurance to the Executive Meeting. Dates to be arranged by the end of June 2022.	**Completed.** Monthly huddles in the diary from July 22 for the remainder of the financial year.	

15) The number of uses of the Mental Health Act

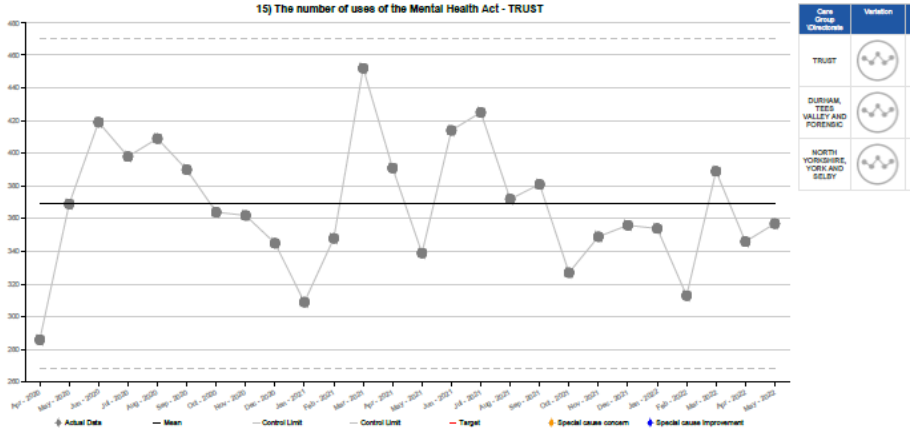
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers, friends and their community.

There were **357** uses of the Mental Health Act during May.

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

No further action is needed at this point in time



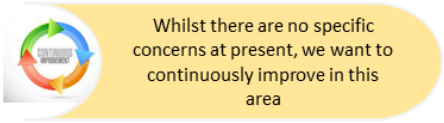
Key Issue(s)	Action(s)	Progress Update	Impact
There are currently no specific trends or areas of concern identified in the number of uses of the Mental Act; however we want to understand whether we treat our patients equally when we deploy the act	**New** The Associate Director of Performance has requested a breakdown of the uses of the Mental Health Act by ethnicity initially, with a view to widening this to the full protected characteristics in the future. This data will be analysed and discussed at the Mental Health Legislation Committee. Timescales for the provision of data to be confirmed with colleagues from Digital and Data Services by the end of July 2022.	**Not yet started.**	

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise staff recommending the Trust as a place to work is an indication of a high level of job satisfaction within our workforce which will support the provision of high quality care.

2196 staff responded to the April 2022 National Quarterly Pulse Survey question "I would recommend my organisation as a place to work" Of those, **1208 (55.01%)** responded either "Strongly Agree" or "Agree"



	Jul - 2021	Jan - 2022	Apr - 2022
TRUST	54.23%	52.54%	55.01%
ASSISTANT CHIEF EXEC	69.23%	51.61%	61.29%
DIGITAL AND DATA SERVICES	68.09%	70.13%	68.00%
DURHAM, TEES VALLEY AND FORENSIC	51.50%	50.72%	54.63%
ESTATES AND FACILITIES MANAGEMENT	57.14%	46.92%	50.38%
FINANCE	61.54%	62.22%	57.58%
MEDICAL	67.44%	68.42%	64.10%
NORTH YORKSHIRE, YORK AND SELBY	50.19%	50.48%	52.85%
NURSING AND GOVERNANCE	61.90%	53.42%	51.95%
PEOPLE AND CULTURE	69.86%	57.69%	56.99%
THERAPIES	82.35%	62.96%	54.17%

National Benchmarking – NHS Staff Survey 2021

- **59.4% of all NHS staff** would recommend their organisation as a place to work.
- The **Picker average*** was **63%** of staff would recommend their organisation as a place to work.
- **52%** of staff from **our Trust** would recommend their organisation as a place to work compared to **66%** in the 2020 NHS Staff Survey

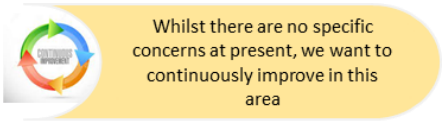
NB. *Picker carried out the NHS Staff Survey for 2021 on behalf of 24 Mental Health and Mental Health Community Trusts.

17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work, as we recognise that having the ability to suggest improvements and a high level of job satisfaction within our workforce which will support the provision of high quality care.

2221 staff responded to the April 2022 National Quarterly Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **1305 (58.76%)** responded either "Strongly Agree" or "Agree"



	Jul - 2021	Jan - 2022	Apr - 2022
TRUST	57.10%	57.50%	58.76%
ASSISTANT CHIEF EXEC	76.92%	67.74%	74.19%
DIGITAL AND DATA SERVICES	65.96%	74.03%	72.00%
DURHAM, TEES VALLEY AND FORENSIC	56.23%	57.00%	57.98%
ESTATES AND FACILITIES MANAGEMENT	55.24%	53.08%	52.67%
FINANCE	65.38%	64.44%	69.70%
MEDICAL	67.44%	81.58%	79.49%
NORTH YORKSHIRE, YORK AND SELBY	54.44%	54.35%	56.45%
NURSING AND GOVERNANCE	61.90%	65.75%	63.64%
PEOPLE AND CULTURE	78.08%	73.08%	73.12%
THERAPIES	94.12%	81.48%	70.83%

National Benchmarking – NHS Staff Survey 2021

- **53.1% of all NHS staff** feel able to make improvements happen in their area of work
- The **Picker average*** was **76%** of staff feel able to make improvements happen in their area of work
- **73%** of staff from **our Trust** feel able to make improvements happen in their area of work compared to **78%** in the 2020 NHS Staff Survey

NB. *Picker carried out the NHS Staff Survey for 2021 on behalf of 24 Mental Health and Mental Health Community Trusts.

Staff Experience: 16) Percentage of staff recommending the Trust as a place to work and 17) Percentage of staff feeling they are able to make improvements happen in their area of work

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We currently have limited data on the percentage of staff recommending the Trust as a place to work and for staff feeling they are able to make improvements happen in their area of work.	Associate Director of Performance to engage with the Director of People & Culture and Head of Business Intelligence to explore options to routinely collect staff experience during May 2022.	**Completed.** Meeting held on 11th May. It was agreed that we would explore technical solutions for the routine collection of staff experience and trial this in a small number of areas.	N/A
As above	The Head of Business Intelligence to discuss technical solutions within Digital and Data Services by 30th June 22.	**Completed.** The initial scoping conversations have taken place within Digital and Data Services and a proposed way forward is now agreed.	
As above	**New** The Head of Business Intelligence to pilot a routine survey, via Microsoft Forms in 4 areas (2 operational/2 corporate) from July 22 for a period of 3 months.	**Not yet started**	
We currently have some issues in the alignment of services/teams following the organisational change on 1st April 2022. These include a small number of operational teams and the Assistant Chief Executive Portfolio. *Please note this also impacts on the other people measures within this dashboard.*	**New** Colleagues within the Finance, Performance and Information Teams are working with services/teams to identify what changes are required.	**Completed.** A number of services/teams have now been aligned to the correct organisational structure. These changes will be reflected in the next dashboard for the period ending June 22.	

18) Staff Leaver Rate

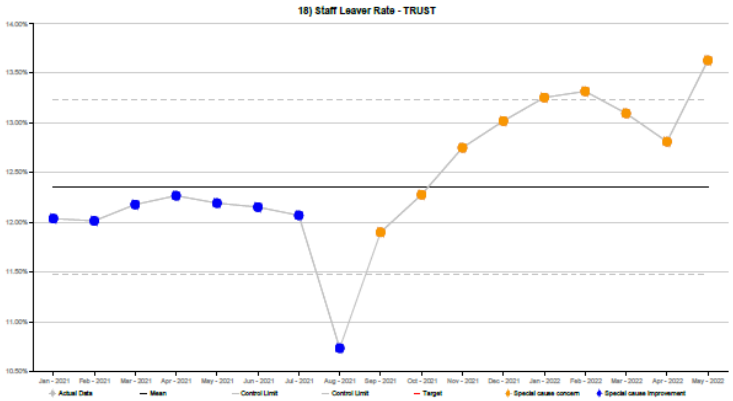
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity of care and the provision of high quality services.

From a total of **6640.76** staff in post, **904.88 (13.63%)** had left the Trust in the 12 month period ending May

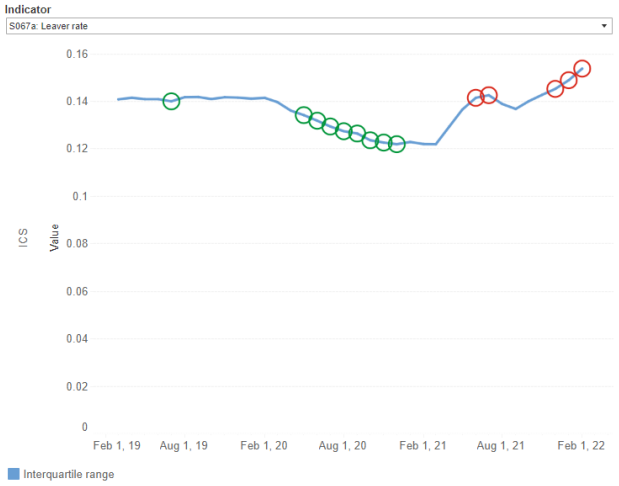
We're aiming to have low performance and we're moving in the wrong direction.

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



NHS Staff Leaver Rates - England Mental Health and Learning Disability – February 2022

NHS Staff Leaver Rates published on the Future Collaboration Platform (data for February 22) for Mental Health Providers show a similar trend (see right) to that shown for our Trust. The national mean (average) for the period shown is 15.4% compared to the Trust mean of 16%. We are ranked 19 of 72 Trusts (1 being the best with the lowest leaver rate) and are placed in the inter-quartile range.



18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We currently have limited data on Staff Leaver Rate within this report so we are unable to identify if there are any specific trends or areas of concern	Head of Business Intelligence to engage with the Workforce Information Manager by the 31st May 22, to progress a plan of work for the inclusion of historic data for this measure.	**Ongoing.** Data for the period January 21 to March 22 has now been included. Data will be provided for the period April-Dec 20 for the performance dashboard for the period ending June 21.	
We are concerned that more members of staff have left the Trust than we would like.	**New** Associate Director of Performance to engage with the Deputy Director of People & Culture to understand the key work undertaken to date and ongoing actions to support the discussions at the People, Culture & Diversity Groups.	**Completed**. Meeting held 6th July 2022. Discussions are underway to identify how we better understand why people are leaving. See new action below	
As above	**New** The Associate Director of Operational Delivery and Resourcing will facilitate a discussion at the Executive People Culture & Diversity Sub Group in July 2022 on how we better understand why people are leaving and what methods we might use to capture this with the intention of retaining staff where appropriate.	**Not yet started**	

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

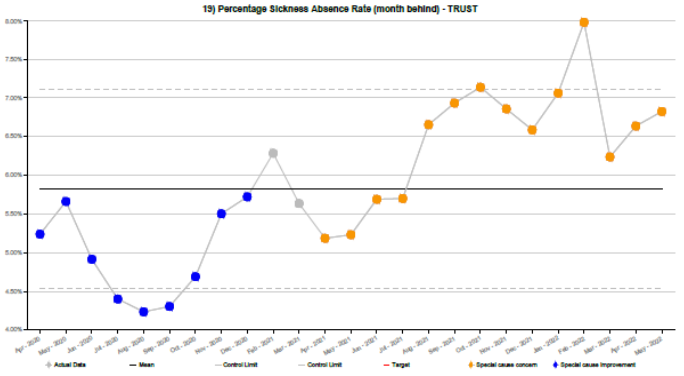
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

There were **210,157.89** working days available for all staff during April (reported month behind); of those, **14,341.77 (6.82%)** days were lost due to sickness.

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

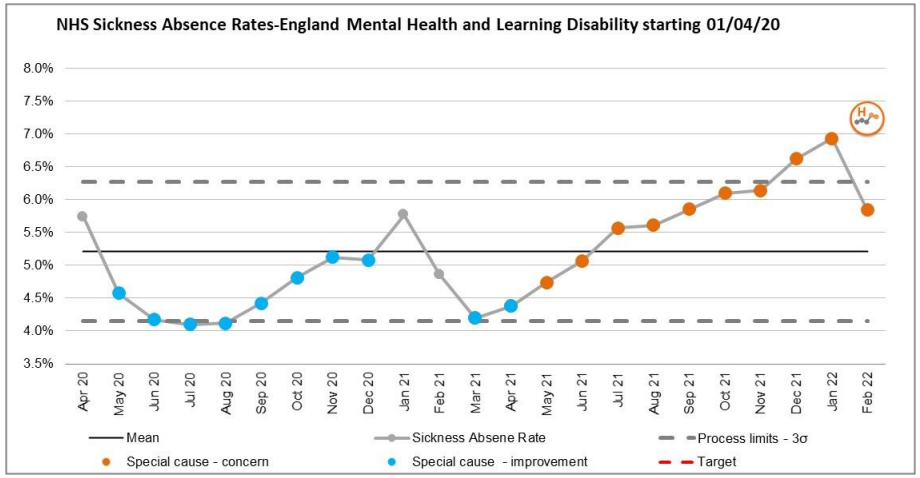
! — We need to investigate this to understand what's happened and/or take action

DQ ★ — 100%



NHS Sickness Absence Rates - England Mental Health and Learning Disability – February 2022

NHS Sickness Absence Rates published 30th June 22 (data ending February 22) for Mental Health and Learning Disability organisations show a similar trend (see below) to that shown for our Trust. The national mean (average) for the period shown is 5.2% compared to the Trust mean of 5.8%.



19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff within our North Yorkshire, York & Selby services are under increasing pressures due to current recruitment challenges.	Care Group Director of Therapies to facilitate a discussion at the June 2022 Care Group People, Culture & Diversity Sub Group to identify the key areas of concern.	**Completed.** Discussion within the People, Culture & Diversity Sub Group in June identified two specific areas of concern: • Within MHSOP work related stress as a common theme linked to sickness. This is related to reduced staffing capacity as a result of recruitment challenges. • Within, Learning Disability an increase in the number of staff on short term sick leave due to covid. See new action below	N/A
As above	**New** People Partner Lead to complete a deep dive into sickness absence rates during June to facilitate a discussion at the July 2022 Care Group People, Culture & Diversity Sub Group in order to identify actions.	**Not yet started**	
We are concerned that more members of staff within our Durham and Tees Valley services have been absent from work due to sickness than we would like.	Senior Performance Manager to engage the relevant People Partner in undertaking a team level deep dive and discussion with General Managers across CYPS, Learning Disabilities and Mental health services for older people to understand the areas of concern and document key actions in place. These will be shared for discussion in the June 2022 Care Group People, & Culture & Diversity Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** Senior Performance Manager and Principal People Partner met to discuss the process around analysis work and follow up discussions. The People Partner to lead the analysis work supported by the People and Culture Operational Managers for each speciality and linking with the General Mangers. Whilst the analysis work continues and draft report format was agreed in the June 2022 Care Group People, & Culture & Diversity Sub Group - the report with full analysis will be shared at the People, & Culture & Diversity Sub Group in July 22.	N/A

19) Percentage Sickness Absence Rate continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that more members of staff within our Durham and Tees Valley services have been absent from work due to sickness than we would like.	**New** The Principal People Partner to engage with the People and Culture Operational Managers to consolidate existing actions across CYPS, Learning Disabilities and Mental health services for older people and these will be shared for discussion at the relevant Quality Assurance and Delivery Improvement meetings in July 22. Work will start week commencing 20th June 22.	**Not yet started**	
We are concerned that more members of staff within our Secure Inpatient Services have been absent from work due to sickness than we would like.	SIS General Manager and relevant People Partner to ensure completion of the current action plan by end of June 22.	**Ongoing.** Of the 17 actions, 14 have been completed. All remaining actions are on track for completion by the end of June.	Sickness remains a concern with SIS.
We have a high number of staff absent from work due to sickness within the Oakwood Locked Rehabilitation centre.	By March 2022, relevant People Partner to meet with the team managers to obtain a background and intelligence on any staff concerns.	**Ongoing.** The People and Culture Operational Manager has met with the current team manager but further discussion with the previous manager continues to be delayed due to significant work being required in other services. A meeting is in the process of being arranged for the end of June.	
We are concerned that more members of staff within our Corporate services have been absent from work due to sickness than we would like.	Head of Performance and Senior Performance Manager to escalate with Heads of Service during May 2022, to identify areas of concern.	**Completed.** Data shared with all corporate Directors 30th May 2022. See new action below	

19) Percentage Sickness Absence Rate continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that more members of staff within our Corporate services have been absent from work due to sickness than we would like.	**New** The Associate Director of Performance/Head of Performance will meet with all Corporate Executive Directors/Senior Colleagues during July 2022, to take them through their individual dashboards which cover all of the people and finance measures within this Integrated Performance Dashboard. This is with a view to agreeing the approach for the provision of assurance and identification of best practice.	**Not yet started**	

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

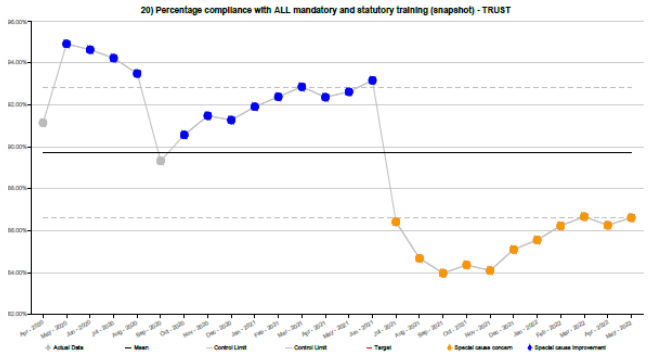
We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our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

112,586 training courses were due to be completed for all staff in post by the end of May. Of those, **97,524** (**86.62%**) courses were actually completed

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

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

DQ ★ 100%



Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff capacity and demand for our services are impacting on the ability of staff within our North Yorkshire, York & Selby services to undertake their training by the 30th June 2022 as planned.	Care Group Director of Therapies and Quality Improvement Manager to meet with the North Yorkshire, York & Selby Business Manager by the end of June 2022 to discuss potential actions that can be taken forward.	**Ongoing:** Following discussions at the People, Culture & Diversity Care Group Sub Group, it was agreed that General Managers would ask staff whose course is outstanding/due to be non compliant to book. Staff capacity and operational pressures are impacting on the ability of staff to attend planned training sessions and complete online training therefore protected time is being planned and diarised. Meeting to take place on 20th June to discuss progress.	

20) Percentage compliance with ALL mandatory and statutory training continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff capacity and demand for our services are impacting on the ability of staff within our Durham ,Tees Valley & Forensic services to undertake their training by the 30th June 2022 as planned.	Senior Performance Manager to engage the relevant People Partner in undertaking a team level deep dive and to meet with the General Managers to understand the areas of concern and document key actions in place. These will be shared for discussion in the June 2022 Care Group People, Culture & Diversity Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** Senior Performance Manager and Principal People Partner met to discuss the process around analysis work and follow up discussions. The People Partner to lead the analysis work supported by the People and Culture Operational Managers for each speciality and linking with the General Mangers. Whilst the analysis work continues and draft report format was agreed in the June 2022 Care Group People, & Culture & Diversity Sub Group - the report with full analysis will be shared at the People, & Culture & Diversity Sub Group in July 22.	
As above	**New** The Principal People Partner to engage with the People and Culture Operational Managers to consolidate existing actions across CYPS, Learning Disabilities and Mental health services for older people and these will be shared for discussion at the relevant Quality Assurance and Delivery Improvement meetings in July 22. Work will start week commencing 20th June 22.	**Not yet started**	
As above	**New** General Mangers across all specialities within the Care Group to review how they create time within the working day to enable staff to complete their outstanding training. This will be a topic for discussion at the relevant Quality Assurance and Delivery Improvement meetings in July 22 and key actions shared at the Care Group People, Culture & Diversity Sub Group. in July 22.	**Not yet started**	

20) Percentage compliance with ALL mandatory and statutory training continued

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff within a number of our corporate teams do not have up to date mandatory and statutory training.	Head of Performance and Senior Performance Manager to escalate with Heads of Service during May 2022, to identify areas of concern.	**Completed.** Data shared with all corporate Directors 30th May 2022. See new action below	
As above	New The Associate Director of Performance/Head of Performance will meet with all Corporate Executive Directors/Senior Colleagues during July 2022, to take them through their individual dashboards which cover all of the people and finance measures within this Integrated Performance Dashboard. This is with a view to agreeing the approach for the provision of assurance and identification of best practice.	**Not yet started**	

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

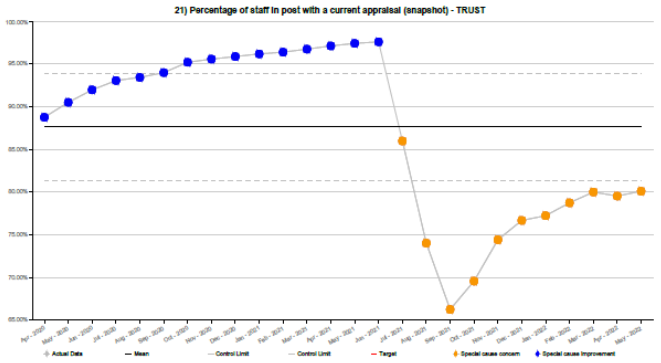
We are all committed to co creating a great experience for patients, carers families and our colleagues by ensuring colleagues feel engaged in the organisation and appraisals offer one opportunity for staff to get and give feedback on their experience of working for the Trust. We also ensure that our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

Of the **6220** eligible staff in post at the end of May; **4983** (**80.11%**) had an up to date appraisal

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

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

DQ ★ 100%



Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that a high number of staff within our Care Groups have not received a timely appraisal and that the services are not on track to deliver the trajectories agreed during 2021/22.	Head of Performance/Senior Performance Manager to engage the Care Groups' People Partners in undertaking a deep dive into the service data to support a detailed discussion at the June 2022 Care Group People, Culture & Diversity Sub Group. Work will start the week commencing 23rd May 2022.	**Completed.** The Senior Performance Manager met with the Durham, Tees Valley & Forensics People Partner to discuss the process. The People Partners for both Care Groups are leading a piece of analysis work supported by the People and Culture Operational leads for each speciality and linking with the General Mangers. Findings will be shared for discussion in the June 2022 Care Group People, & Culture & Diversity Sub Groups. *See separate updates for each Care Group below*	
We are concerned that a high number of staff within the Durham, Tees Valley & Forensics Care Group have not received a timely appraisal and that the services are not on track to deliver the trajectories agreed during 2021/22.	**New** Senior Performance Manager to engage the relevant People Partner in undertaking a team level deep dive and to meet with the Durham, Tees Valley & Forensic General Managers to understand the areas of concern and document key actions in place. These will be shared for discussion in the June 2022 Care Group People & Culture & Diversity Sub Group.	**Ongoing.** Whilst the analysis work continues and draft report format was agreed in the June 2022 Care Group People, & Culture & Diversity Sub Group - the report with full analysis will be shared at the People, & Culture & Diversity Sub Group in July 22	

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that a high number of staff within the Durham, Tees Valley & Forensics Care Group have not received a timely appraisal and that the services are not on track to deliver the trajectories agreed during 2021/22.	**New** The Principal People Partner to engage with the People and Culture Operational Managers to consolidate existing specific concerns and actions in relation to the completion of Appraisals and these will be shared for discussion at the relevant Quality Assurance and Delivery Improvement meetings in July 22. Work will start week commencing 20th June 22.	**Not yet started**	
We are concerned that a high number of staff within the North Yorkshire, York & Selby Care Group have not received a timely appraisal and that the services are not on track to deliver the trajectories agreed during 2021/22.	**New** The North Yorkshire, York and Selby People, Culture & Diversity Sub Group have identified and agreed the following actions: • For Adult Mental Health Services all outstanding appraisals will be booked by mid-July (except for staff on maternity leave or long-term sick) • Within Mental Health Services for Older People Appraiser and Appraisees are planning and diarising protected time to complete appraisals; these will be booked by end of July. • Within Learning Disabilities Team Managers are reviewing outstanding appraisals and appraisals due to expire in the 12 weeks and book these by the end of July. • Within Children & Young People's Services, the Associate Medical Director will liaise with medical staffing regarding data quality issues during June and the Service Manager will review Scarborough data quality issues during the same period	**Not yet started**	

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that staff within a number of our corporate teams have not received a timely appraisal.	Head of Performance and Senior Performance Manager to escalate with Heads of Service during May 2022, to identify areas of concern.	**Completed.** Data shared with all corporate Directors 30th May 2022. See new action below	
As above	New The Associate Director of Performance/Head of Performance will meet with all Corporate Executive Directors/Senior Colleagues during July 2022, to take them through their individual dashboards which cover all of the people and finance measures within this Integrated Performance Dashboard. This is with a view to agreeing the approach for the provision of assurance and identification of best practice.	**Not yet started**	

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

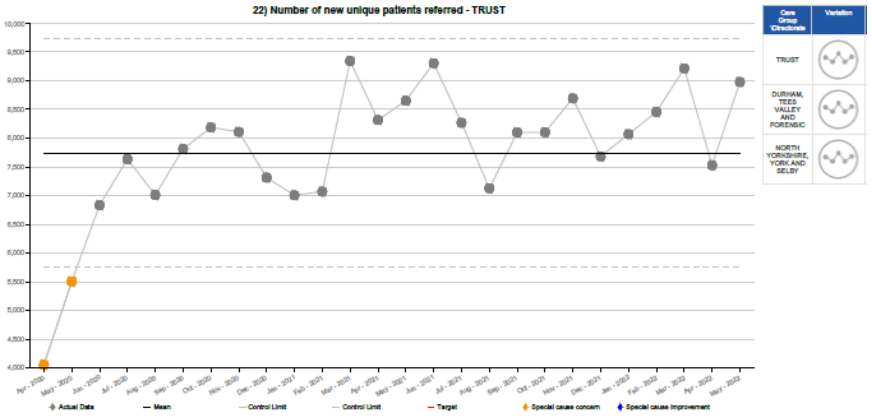
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment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

8978 patients referred in May that are not currently open to an existing Trust service

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

No further action is needed at this point in time

DQ ★ 100%



Key Issue(s)	Action(s)	Progress Update	Impact
There are currently no specific trends or areas of concern identified in the number of new unique patients referred.	N/A		

23) Unique Caseload (snapshot)

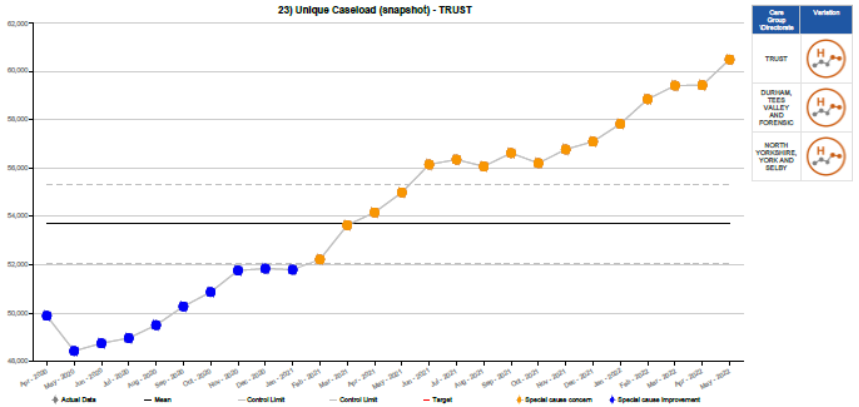
Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

60,482 cases were open, including those waiting to be seen, as at the end of May 2022.

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

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



Key Issue(s)	Action(s)	Progress Update	Impact
We are concerned that we have an extremely high caseloads within our services and that we need to build on the understanding we currently have, to identify key actions that we need to progress.	Head of Performance and Senior Performance Manager to engage the Planning Team in undertaking a deep dive into the service data to support a detailed discussion at the June 2022 Care Group Quality Assurance & Improvement Sub Group. Work will start the week commencing 23rd May 2022.	**Ongoing.** Analysis of team level data is underway and it was agreed at the Care Groups' Resource and Business Development Sub Group in June, that once initial findings had been discussed with General Managers, this would be discussed further in the July meeting.	

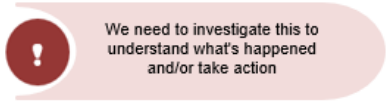
24) Financial Plan: SOCI - Final Accounts - Surplus/Deficit

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We delivered a **(£1.6m)** deficit to 31st May 2022 against a planned year to date deficit of **(£1.6m)**.

(£0.0m) variance to plan.



Summary

On the 28th April 2022 the Trust submitted, and the Trust Board approved, a final draft 2022/23 financial plan to NHSI, pending external feedback on the national financial plan position and status of individual organisation and Integrated Care System aggregate plans.

Recently £1.5bn additional funding has been allocated to Integrated Care Systems with an expectation that this will support systems to develop balanced financial plans in advance of a further final national plan submission for 2022/23 on 20th June 2022.

Due to later than normal final plan submissions, work continues to complete final detailed budget sign-off; however, this is dependant on acceptance of finalised plan.

The year to date position is an operational deficit of **£1.6m**. Whilst this is **in line with forecast expenditure** within our financial plan run rates, it means that the Trust needs to significantly reduce utilisation of independent bed capacity being used to mitigate operational bed pressures and to reduce agency expenditure and related premium pay rates from quarter two to deliver expected annual plan requirements.

Key Issue(s)	Action(s)	Progress Update	Impact
Agency expenditure is high which is impacting on our financial plan and will impact on our Use of Resources Rating when its reintroduced	CRES schemes are being developed in conjunction with the Care Groups for agency volume and rate reductions by 30th June 22	**Ongoing.** Work has commenced on the development of CRES Schemes	
Independent Sector Bed utilisation is high which is also impacting on our financial plan delivery	As above and further exploration of issues including length of stay and delayed discharges (timescales tbc)	**Ongoing.** Bed managers assessing numbers, reasons and bed days	

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Key Issue(s)	Action(s)	Progress Update	Impact
Agency expenditure and Independent Sector Bed utilisation is high which is also impacting on our financial plan delivery	Plans to re-open Scarborough beds to mitigate Locality pressures	**Ongoing.** Recruitment lead times mean re-forecast (from full capacity in May) to increase to 8 beds from June and 13 from September. The ward is currently operating with 10 beds and is on plan to increase to full capacity by September 2022.	

25) Underlying Performance - run rate movement

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

The Oversight Framework is still in consultation with the metrics used to measure this indicator yet to be defined.

26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We would be capped as a **3** for the period ending 31st May 2022 against a planned rating of **3**.

0 variance to plan.

Whilst there are no specific concerns at present, we want to continuously improve in this area

Summary

The **Use of Resources Rating** (UoRR) is impacted by Covid-19 with national monitoring suspended. However, the Trust has continued to assess the UoRR based on plan submissions and actual performance.

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity of 0.04x (can cover debt payments due 0.04 times), which is ahead of plan and is rated as a 4.
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 33.6 days; this is ahead of plan and is rated as a 1.
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover, excluding exceptional items e.g., impairments. The Trust has an I&E margin of minus 2.6%, this is in line with plan and is rated as 4.

Agency expenditure of £3.1m is £1.0m (49%) higher than planned, and is rated as a 3. The **agency expenditure metric within UoRR** is currently suspended; however, the Trust has continued to assess agency expenditure against a capped (pre-pandemic) Trust target. It is unclear, once national monitoring is reintroduced what the Trust cap will be based upon e.g. pre pandemic cap was £6.6m or 2.4% of pay bill, which would suggest a significant variance from target (184% or £2m). This is a renewed area of focus for 2022/23 Cash Releasing Efficiency Schemes. Recent regional reporting of sickness levels suggests peer mental health providers have experienced similar challenges. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence but equally to securing alternative whole system models of care for specialist packages of care.

As a result of the Trust's Capital Service Cover and I&E Margin risk ratings the **overall UORR** would be capped as a **3** for the period ending 31st May 2022 and is **in line with plan**.

Key Issue(s)	Action(s)	Progress Update	Impact
Agency expenditure is high which is impacting on our financial plan and will impact on our Use of Resources Rating when its reintroduced	2022/23 CRES plans to reduce overall utilisation and off framework / premium rate contracts to be completed by 30th June 22	**Ongoing.** Work has commenced on CRES Schemes	

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

27) CRES Performance - Recurrent

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We planned to deliver **£1.4m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£1.2m**.

£0.2m variance to plan.

Whilst there are no specific concerns at present, we want to continuously improve in this area

Summary

The Trust continues to identify and consider schemes to deliver future requirements. Activities will continue throughout Q1 2022/23 with key focus on:

- Individual scheme baseline assessment by Care Group, including identification and validation of targets.
- Quality impact assessments (QIA) to be completed for all schemes and signed off locally by relevant clinical and management leads, with final approval of schemes by Medical Director, Director of Nursing and Management Directors and Executive Director Group oversight.

Key Issue(s)	Action(s)	Progress Update	Impact
There is a risk to the commencement of plans that are phased to commence Quarter 2 which will impact on the delivery of our financial plan	CRES schemes are being developed in conjunction with the Care Groups	**Ongoing.** Work has commenced on the development of CRES Schemes	

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

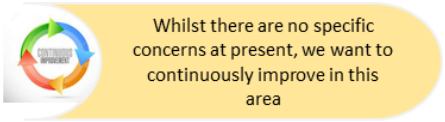
28) CRES Performance – Non-Recurrent

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We planned to deliver **£0.0m** non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£0.1m**.

(£0.1m) variance to plan.



Summary

The Trust continues to identify and consider schemes to deliver future requirements. Activities will continue throughout Q1 2022/23 with key focus on:

- Individual scheme baseline assessment by Care Group, including identification and validation of targets.
- Quality impact assessments (QIA) to be completed for all schemes and signed off locally by relevant clinical and management leads, with final approval of schemes by Medical Director, Director of Nursing and Management Directors and Executive Director Group oversight.

Key Issue(s)	Action(s)	Progress Update	Impact
There are no key issues currently identified in relation to non-recurrent CRES	N/A		

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

29) Capital Expenditure (CDEL)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

Capital expenditure at the end of May was **£1.6m** against planned expenditure of **£1.9m**.

(£0.3m) variance to plan.

Whilst there are no specific concerns at present, we want to continuously improve in this area

Summary

A final draft capital plan of £10.1m for 2022/23 was submitted on 28th April 2022, alongside revenue plans.

Capital expenditure at the end of May was £1.6m, and is £0.3m below plan (£1.9m). This is largely due to delays with anti-ligature works at Roseberry Park Hospital, Trust Lifecycle works and Community Transformation in Durham & Tees Valley. All schemes are expected to spend in line with budget for the financial year.

Key Issue(s)	Action(s)	Progress Update	Impact
There are no key issues currently identified in relation to Capital Expenditure	N/A		

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

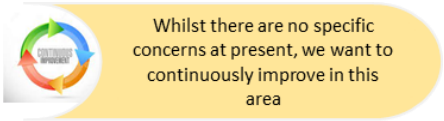
30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

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

We have an actual cash balance of **(£78.1m)** against a planned year to date cash balance of **(£76.0m).**

(£2.1m) Favourable variance from plan



Summary

Cash balances were **£78.1m** at 31st May 2022, which is **£2.1m** higher than plan **(£76.0m)**. This is linked to the slippage on the capital programme (£0.3m), and working capital movements, mainly Health Education England training funding, which has been paid in advance for quarter 1.

The Trust failed to achieve the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of both NHS and non-NHS suppliers during May, achieving 92.3%.

Conversations are ongoing with organisations to take collection of all debt over 90 days. None of the amounts outstanding are currently disputed, the delay in payment is linked to process delays within organisations e.g., purchase orders not raised, invoices mislaid, and new financial year.

Key Issue(s)	Action(s)	Progress Update	Impact
Payment of invoices is being negatively impacted by queries with purchase orders placed on Cardea.	The accounts payable team are to support those placing orders to understand best practice on Cardea, and to promote the available Cardea training dates throughout the Trust by 30 June 22.	**Ongoing**	

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Measures		Goal 1 - To co-create a great experience for our patients,	Goal 2 - To co-create a great experience for our colleagues	Goal 3 - To be a great partner
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good	√	√	
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	√	√	
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care	√	√	
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported	√		
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	√		
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported	√	√	
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	√	√	
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√	√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider	√		
BIPD_10	The number of Serious Incidents reported on STEIS	√	√	
BIPD_11	The number of Service Reviews relating to incidents of moderate harm and near misses	√		
BIPD_12	The number of Restrictive Intervention Incidents	√	√	
BIPD_13	The number of Medication Errors with a severity of moderate harm and above	√		
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS	√		
BIPD_15	The number of uses of the Mental Health Act	√		√

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Measures	Goal 1 - To co-create a great experience for our patients, carers and families	Goal 2 - To co-create a great experience for our colleagues	Goal 3 - To be a great partner
BIPD_16	Percentage of staff recommending the Trust as a place to work	√	√	√
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√
BIPD_18	Staff Leaver Rate	√	√	√
BIPD_19	Percentage Sickness Absence Rate	√	√	√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√	√	√
BIPD_21	Percentage of staff in post with a current appraisal	√	√	√
BIPD_22	Number of new unique patients referred	√	√	√
BIPD_23	Unique Caseload (snapshot)	√	√	
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit			
BIPD_25	Underlying Performance - run rate movement			
BIPD_26	Use of Resources Rating - overall score			
BIPD_27	CRES Performance - Recurrent			
BIPD_28	CRES Performance - Non-Recurrent			
BIPD_29	Capital Expenditure (CDEL)			
BIPD_30	Cash balances (actual compared to plan)			

Which risk(s) within our Board Assurance Framework does this measure support/provide assurance towards?

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

	Measures	1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Culture & Wellbeing	6. Safety	7. Infrastructure	8. Cyber Security	9. Regulatory Action	10. Influence	11. Governance & Assurance	12. Roseberry Park	13. West Lane	14. CITO	15. Financial Sustainability
BIPD_01	Percentage of Patients surveyed reporting their recent experience as very good or good			√	√	√	√			√						
BIPD_02	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for			√	√	√	√									
BIPD_03	Percentage of inpatients reporting that they feel safe whilst in our care			√	√	√	√			√						
BIPD_04	Percentage of CYP showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_05	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported			√	√		√					√				
BIPD_06	Percentage of CYP showing measurable improvement following treatment - clinician reported			√	√		√					√				
BIPD_07	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported			√	√		√					√				
BIPD_08	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	√	√		√	√	√					√				√
BIPD_09	Number of inappropriate OAP bed days for adults that are 'external' to the sending provider		√		√							√				√
BIPD_10	The number of Serious Incidents reported on STEIS			√	√		√			√						
BIPD_11	The number of Service Reviews relating to incidents of moderate harm and near misses			√	√		√			√		√				
BIPD_12	The number of Restrictive Intervention Incidents			√	√	√	√			√						
BIPD_13	The number of Medication Errors with a severity of moderate harm and above				√		√			√						
BIPD_14	The number of unexpected Inpatient unnatural deaths reported on STEIS			√	√	√	√									
BIPD_15	The number of uses of the Mental Health Act		√	√	√	√	√			√		√				

Which risk(s) within our Board Assurance Framework does this measure support/provide assurance towards?

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	Measures	1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Culture & Wellbeing	6. Safety	7. Infrastructure	8. Cyber Security	9. Regulatory Action	10. Influence	11. Governance & Assurance	12. Roseberry Park	13. West Lane	14. CITO	15. Financial Sustainability
BIPD_16	Percentage of staff recommending the Trust as a place to work	√		√	√	√	√			√	√	√				
BIPD_17	Percentage of staff feeling they are able to make improvements happen in their area of work	√	√	√	√	√	√			√	√	√				
BIPD_18	Staff Leaver Rate	√				√	√					√				√
BIPD_19	Percentage Sickness Absence Rate	√	√			√	√			√						√
BIPD_20	Percentage compliance with ALL mandatory and statutory training	√		√	√	√	√		√	√		√				√
BIPD_21	Percentage of staff in post with a current appraisal	√			√	√	√			√		√				
BIPD_22	Number of new unique patients referred		√				√					√				√
BIPD_23	Unique Caseload (snapshot)		√			√	√					√				√
BIPD_24	Financial Plan: SOCI - Final Accounts - Surplus/Deficit									√		√				√
BIPD_25	Underlying Performance - run rate movement															
BIPD_26	Use of Resources Rating - overall score									√		√				√
BIPD_27	CRES Performance - Recurrent									√		√				√
BIPD_28	CRES Performance - Non-Recurrent									√		√				√
BIPD_29	Capital Expenditure (CDEL)							√		√		√	√			√
BIPD_30	Cash balances (actual compared to plan)									√		√	√			√

ITEM NO. 11

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28 July 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 and Governors to raise any matters of importance.

2.2 From a Board perspective, the visits support a fuller understanding of the issues facing services and enable information and assurances to be triangulated, with the focus identifying actionable quick wins to support our teams.

3 **Key Issues**

3.1 Directors' visit took place face-to-face on 11 July 2022 across Early Intervention in Psychosis (EIP) and Perinatal Services as outlined below:

- Redcar EIP – Foxrush
- SWR EIP – Scarborough
- Perinatal Team Lancaster House Stockton
- YS EIP, Huntington House
- North EIP – Chester le Street
- PNMH – SWR York Cell Huntington House

3.2 Feedback from the visits is summarised below.

Strengths:

- Strong leadership and cohesive team working and dynamics across multiple teams, many demonstrating considerable transformation over the last 18 months in response to the pandemic – big focus on personal development and wellbeing – some differences notes across EIP and Perinatal Services.
- Good evidence of learning from complaints and serious case incidents and rapid reviews including sharing across multi-disciplinary teams – some work to do on sharing across localities and impact SI's have.
- Many teams reported receiving really positive service user and family feedback
- Improved position in terms of recruitment / retention of staff reported across teams, with more work required career progression.

Challenges:

- Estate issues reported across teams re space, with a lack of appropriate accommodation for staff as well as patients, carers and families to be considered eg waiting areas where they see people are seated can be triggering.
- Issues around responsiveness of the Crisis Line and the impact this has on these services (and other community) teams. Review underway.
- Sharing good practice - some teams spoke positively how Quality Improvement (QI) report outs had happened pre-Covid, and how it would be helpful to re-establish these and teams found these invaluable in terms of learning and ongoing improvement / service transformation.

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 11 July 2022.

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Item No.12

Quality Assurance Committee: Key Issues Report

Report Date to Board: 28 July 2022

Date of last meeting: 7 July 2022 **Membership:** Quoracy was met. Apologies – P Scott, Z Campbell, S Pickering, D Gardner, J Illingworth

1 **Agenda items considered:**

- Board Assurance Framework (BAF)
- Risks to Quality and Safety
- Trust status regarding the Well Led and Core Services action plans
- Trust Level Quality Assurance & Learning Report
- Care Group Board Updates (North Yorkshire, York & Selby, Durham, Darlington, Tees Valley & Forensics)
- Safe Staffing
- Reducing Suicide and Self-Harm Improvement Work
- Sexual Safety Update
- Safeguarding & Public Protection
- PALS/Complaints Annual Report 2021/22

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

Board Assurance Framework (BAF):

Members noted that some updates had been made to the Board Assurance Framework, however there are still some elements that have not been reviewed since January and March 2022.

The Committee agreed that providing assurance to the Board of Directors is therefore only "reasonable". Executive Directors were requested to re-visit and update any gaps in risk updates and review dates for further improved assurance on the health of controls and mitigating actions outlined in the BAF.

Risks relating to quality and safety:

There were 31 risks open on the Corporate Risk Register (CRR) in May 2022 that related to quality and safety. Two new risks were added, both relating to patient safety: (patients occupying NYS beds from out of the area and adult mental health patients being admitted to MHSOP wards).
One risk to patient safety was escalated to the CRR relating to the number of complex patients being cared for within temporary ward environments and being supported by agency nursing staff.

The Committee is concerned that the actions to be reviewed on the CRR have deteriorated during June 2022, and some actions had passed their review date (21 in June compared to 15 in May).

The Committee recognises that the CRR is moving in the right direction, and that the introduction of the new governance arrangements, including the newly established Risk Groups within the Care Groups governance structure and the Executive Risk Group will facilitate improved timeliness, scrutiny and management of risks. There are, however, concerns in relation to the level of capacity, capability and resources available across the organisation to oversee and manage risks. This has also been reported to Board via the Audit and Risk Committee.

The overall deteriorating position means that providing assurance to the Board of Directors is therefore "limited".

Trust Level Quality and Learning Report:

During May 2022, there were five measures of quality and safety reporting as a cause for concern. These were self-harm, seclusion, which coincides with the LD seclusion policy changes and the use of

	flexible segregation now being recorded as seclusion, mandatory training and appraisal training. A number of focused actions are being worked through to support this position. In response to feedback from Mersey Care a Positive & Safe Care Group for each Care Group has been established which is going to undertake a piece of work that will look in more granular detail behind the data in relation to restrictive interventions. **Care Group Board Updates:** The two Care Group reported in to QuAC with their key concerns, risks, mitigating actions and assurances. The messages from the Care Group Boards remained consistent with previous months, concerns about staffing levels and shortages, staff wellbeing, high demand for services and increased bed occupancy with delayed discharges due to the lack of infrastructure in the community. Members noted the broader issue of the need for there to be a shared responsibility for complex patients by key partners and stakeholders. Acuity continues to increase requiring additional nursing support with the right sets of skills, in the most appropriate environment, which is not always available. The Committee had requested an additional update on Durham and Darlington Crisis team, seeking further assurance on progress since the team has been facing challenges since 2021. The update included the outcomes and learning from a thematic review undertaken in May 2022, which has been shared at a Trust wide event. Ongoing work for the Crisis team relates to reviewing the model of care, recruiting to established vacancies, enhancing skill sets and continuing to build a positive culture. There are also ongoing concerns relating to the effectiveness of the DTVF crisis team line and there has been a reconfiguration of the telephone lines for greater oversight of call activity and to reduce the risk of calls going to unmanned telephones. The Committee is keen to increase understanding and focus on Health and Justice, in particular mitigations in place to prevent suicide in prisons. A report will be presented to the October 2022 QuAC meeting. The Care Group updates remain consistent and are clearly impacted by several key issues that Board is aware of: staffing, recruitment, retention, service demand, bed capacity, acuity and staff health and wellbeing. **Monthly Safe Staffing:** The Committee welcomed a revised format for the Safe Staffing report, with clear visual diagrams for the key pieces of information. Business Continuity Arrangements remained in place for the same areas as the previous month during June 2022 and include SIS, Durham Crisis Team, Esk Ward, CAMHS Community York, CAMHS Community Northallerton and Bankfields Court. The Care Groups are closely monitoring these areas with planned and budgeted workforce figures being reported to Executive Management Group. The impact on staff wellbeing and potential sickness continues to cause a concern with an increase in the number of shifts worked across the Trust that exceeded 13 hours from 74 to 88. With a continued marginal decrease in the use of agency and bank staff, this is still a concern. Some positive assurance can be provided with 40 offers for permanent staff and 23 for bank at the first streamlined recruitment event for HCSWs held at the Riverside Stadium in June 2022.
2b	**Assurance: The Committee assures members of the Board on the following matters:** **CQC Update on Well-led Action Plan**

	The update to the Quality Assurance Committee was retrospective as it had been presented to the Board of Directors at its meeting held on 30th June 2022. The reinspection of Secure Inpatient Services was taking place at the time of the QuAC meeting. One matter was escalated in relation to a safeguarding concern raised by a patient in SIS about allegations of bullying. The service took direct action in response to this. The CAMHS CQC inspection was closing on the day of the QuAC meeting. Initial concerns have been raised relating to the quality of some documentation, however inspectors did feedback on the positivity of staff and a greater oversight of people waiting. **PALS/Complaints Annual Report 2021/22** The Committee deferred this report to the September QuAC meeting as members had several points requiring clarity. **Proposals and Scope of work: Suicide and Self-harm** The Committee anticipates a report on this significant piece of work at the October 2022 QuAC meeting. In relation to an increase of incidents related to self-harm within in-patient services, initial meetings have taken place with a multidisciplinary team, to establish scope and purpose, which will look at all female mental health and LD wards across the Trust with one of the key aims to try to come to a deeper understanding on the levels of self-harm. Information to be reviewed will include demographic information and types of self-harm that are most prevalent as well as reviewing approaches to self-harm and incident data so that targeted support and review can be provided to areas of highest need **Sexual Safety** The Committee deferred this matter, (which was last reported at the January 2022 meeting), to the September QuAC meeting. This area of work is being picked up by the Medical Director, who being new into post will require sufficient time to prepare the update. **Safeguarding & Public Protection** The 6 monthly safeguarding report was provided with a detailed breakdown of safeguarding trends and activity. It was noted that the Trust Safeguarding Adults Policy has been approved. The CCG in North Yorkshire and York has expressed concern about assurance around safeguarding. A deep dive assurance report is currently being compiled and is due to be signed off by the Executive Director of Nursing and Governance.
2c	**Advise:** The Committee members agreed that the key issues to draw to the Boards attention are: 1. To note the consistent messages from the Care Boards, of which can be applied in other areas within the organisation at 2a. 2. Concerns remain in relation to the capacity, capability and resource across the organisation to manage risks. 3. To note the update on the CQC, which the Board will consider on the public agenda. 4. To note the update on the Durham & Darlington Crisis Team. 5. To note the proposals on the work in relation to self-harm and suicide. There will be development session held with Business Managers from the Care Group Boards to look at the content and information being provided to QuAC, with the overall aim to reduce the operational content with more focus on strategic matters and assurances in relation to key areas of concern.
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

FOR GENERAL RELEASE

BOARD OF DIRECTORS PUBLIC AGENDA

DATE:	**28th July 2022**
TITLE:	**TO RECEIVE AND OTE THE REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN**
REPORT OF:	**FREEDOM TO SPEAK UP GUARDIAN**
REPORT FOR:	**PUBLIC AGENDA**

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

Executive Summary:

This report is for information and outlines developments within the Freedom to Speak Up service over the last 6 months, from January 2022 to June 2022
It presents local, regional, and national developments, including details of numbers and types of referrals and includes reflections from some recent cases.

In Q4 (21/22) the Freedom To Speak Up Team received a total of 24 cases. In Q1 (22/23), 69 cases were received which is a welcome increase. Themes mainly centred around patient safety, staff safety, staff wellbeing and culture.

Recommendations:

To note the contents of the report and comment accordingly

MEETING OF:	**BOARD OF DIRECTORS**
DATE:	**28th July 2022**
TITLE:	**TO RECEIVE AND NOTE THE REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN**

1. INTRODUCTION & PURPOSE:

1.1 The purpose of this report is to inform the Board about the last 6 months of the Freedom to Speak Up (FTSU) role. The report will outline developments and activity to date and discuss how we intend to further develop the role in the coming year.

2. BACKGROUND INFORMATION AND CONTEXT:

2.1 The table below displays the figures for ongoing cases over the last 6 months. As these are ongoing cases there is duplication across months eg some of the people we were working with in January will also show in the figures for March.

We are managing this increase in work through the FTSU office role (in support of the FTSU Guardian) and a more flexible approach to how we respond to concerns which enables us to target a wider variety of support, matched to the concern. We would previously have gone more often to a formal investigation commissioned from someone in operational services. We now make more use of corporate support and try to triangulate with other ongoing work.

	January 2022	February 2022	March 2022	April 2022	May 2022	June 2022
Total ongoing cases	34	40	35	34	33	59
Patient safety	5	16	7	1	4	20
Staff safety	1	3	3	0	2	4
Staff Wellbeing	1	0	3	1	3	0
Allegations of bullying	1	0	0	1	1	6
Culture	4	2	0	2	28	2
Systems processes	0	0	1	0	4	
Anonymous cases	1	6	5	4	5	3
Behaviour	0	5	2	4	2	0
Resolved cases	5	2	16	7	7	2

3. KEY ISSUES:

3.1 Training

The National Guardians' Office (NGO) have released 'Follow Up' E-Learning training which is the final module developed in association with Health Education England and is available within the Health Education England E-Learning for Health Hub. This session is designed for existing and aspiring senior leaders including executive board members (and equivalents), Non-Executive Directors, and Governors.

Some technical difficulties have been encountered when accessing the 'speak up' and 'listen up' training via ESR. This issue had been escalated to colleagues within Information for resolution and recent feedback received indicates that this matter has now been resolved.

Training sessions have been delivered to those staff identified to carry out reviews of FTSU cases (investigators) to increase confidence and deliver consistency. A total of 8 staff have received this training to date.

3.2 Support networks

The continuation of the FTSU Officer role in addition to the Guardian has been beneficial for overall delivery of the service, contingency purposes and provides increased visibility of the guardian role.

Speaking Up Groups continue to meet on a monthly basis for sharing of intelligence and peer support. Information is now being used to support operational services and has highlighted three issues in the last two months.

Following the organisational restructure, it has been noted that the clarity on the collective leadership groups makes it easier to raise concerns beyond the operational leads.

NHS England (NHSE) have published its new and updated national FTSU policy, which is applicable to primary care, secondary care and integrated care systems.

Together with NHSE the National Guardian's Office has also published new and updated FTSU guidance and a FTSU reflection and planning tool.

NHSE is asking all trust boards to be able to evidence by the end of January 2024:

- An update to their local FTSU policy to reflect the new national policy template;
- Results of their organisation's assessment of its FTSU arrangements against the revised guidance; and

- Assurance that it is on track implementing its latest FTSU improvement plan.

The People and Culture Directorate will pick up these pieces of work through the executive People, Culture and Diversity group and ultimately the PC&D committee.

NHSE have also launched the redesigned 'Speaking Up Support Scheme'. The scheme provides a range of support for past and present NHS workers who have experienced a significant adverse impact on both their professional and personal lives, to move forward, following a formal speak up process.

3.3 **Development of Champions**

An event has been held for the purpose of re-launching the 'dignity at work champion' role. This role has now been renamed as 'speaking up ambassador'. Work had been carried out as follows:

- To review of the current literature that is available including posters and leaflets.
- To Identify any skill gaps for the champions and to consider how we can address these.
- To consider any ongoing support for the champions.
- To produce an action plan in relation to a new full relaunch of the champion role, recruitment to the role and training requirements.

3.4 **Feedback**

Following the closure of each FTSU case, those who have spoken up are asked to provide their feedback on their experience of accessing the FTSU service. We ask specifically, if they have encountered any demeaning treatment because they spoke up and would they speak up again in the future.

Of the feedback received since January 2022, 6 people have responded. All 6 expressed that they had encountered a positive experience of accessing the FTSU service, 1 said that they didn't experience any demeaning treatment, 4 didn't answer and 1 said that they had experienced some demeaning treatment. For the worker who said they had experienced demeaning treatment, these claims were further reviewed in collaboration with colleagues from People and Culture. Findings concluded that this was not connected as a result of the worker speaking up and subsequently the worker confirmed they felt satisfied that their concerns had been resolved.

3.5 **Learning from experience**

Case examples are now beginning to be shared with the communications team for publication on the staff intranet providing an overview of how cases were handled and the lessons that have been learnt.

3.7 **Case Examples**

The Freedom to Speak Up Team along with colleagues from Employee Support had been asked to provide rapid support to staff based within Adult

LDU at Lanchester Road Hospital in response to specific concerns raised about culture on the ward

Staff visited the site from Friday 27th May until Tuesday 31st May (including the weekend). In total 26 members of staff within this service were interviewed and subsequently findings were shared with the Director of People and Culture. Since this time, visits continue to take place at the service by FTSU and Employee Support and 2 additional staff have also spoken up. The Director of People and Culture has shared findings with Senior Leaders and through that to the CQC. This case is still ongoing.

Separately we have had a number of concerns raised in FTSU and other forums about the ways in which rosters are used. The new ways in which the Speaking up Group come together and the triangulation of other routes by which concerns are raised has enabled this to be pulled together and support sought form the central rostering team more quickly than would have been the case previously.

4. CONCLUSIONS:

We are pleased to see an increase in the use of the FTSU service after a dip at the end of the last financial year. Due to the more flexible way in which we respond to these concerns this hasn't been accompanied by a significant increase in volume of work for operational services as would have been the case.

Quality Improvement work is becoming embedded in relation to the way we identify concerns, allocate reviewers and learn / share lessons.

The publication of the updated universal Freedom to Speak Up Policy and review tools provides further opportunity for the Trust to develop the service in order to ensure a healthy and supportive Speak Up, Listen Up, Follow Up culture.

Author; Vicki Brinsley, FTSU Officer on behalf of Dewi Williams, Freedom to Speak up Guardian.

Tees, Esk and Wear Valleys
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ITEM 14

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th July 2022**
TITLE:	**Learning from Deaths Dashboard Report Q1 2022/23**
REPORT OF:	**Elizabeth Moody, Director of Nursing & Governance**
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	✓

Executive Summary:

The Learning from Deaths Dashboard Report sets out the approach the Trust is taking towards the identification, categorisation, and investigation of deaths in line with national guidance. The mortality dashboard for the period of Q1 2022/2023 financial year is included at Appendix 1 and includes 2021/2022 data for comparison.

During Q1, there were 490 deaths and 12 learning disability deaths. 22 deaths were reported on the Strategic Executive Information System (StEIS). All 22 deaths were community deaths. There was 1 expected in-patient death related to physical health. 56 deaths met the criteria for a mortality review. 13 of those cases were selected for a more detailed Part 2 Structured Judgement Review (SJR).

17 serious incident reviews were completed and discussed at Directors review panel. All cases had some actionable learning which replaces previous categories of learning including root cause and contributory causes. This language supports the Trusts approach towards a just and learning culture in line with Our Journey to Change.

The paper sets out key themes from incidents and provides current progress and assurance against these as well as the Trust approach to take this learning forward. A greater level of assurance can be seen within in-patient settings as this has been the area of most focus however improved assurance can also be noted from across our community settings. Appendix 3 details actions and learning that has been taken in relation to the identified patient safety themes and current levels of assurance.

Key to learning from incidents is the quality of the review and the experience of families within this. A designated project manager has been appointed to implement the Patient Safety Incident Response Framework (PSIRF) which will gradually be introduced in line with national requirements during 2022/23.

The Incident Reporting and Serious Incident Review policy is currently being reviewed to incorporate improvement work which has been co-produced with clinical services and bereaved families/carers. A 'Co-creating for Patient Safety' event was held on 20th May, the 70 attendees included bereaved families, clinical and corporate staff as well as commissioners.

Recommendations:
The Board of Directors is requested to note the content of this report, the dashboard and the learning points identified for assurance.

MEETING OF:	**Board of Directors**
DATE:	**28th July 2022**
TITLE:	**Learning from deaths - Dashboard Report Q1 2022/2023**

1. INTRODUCTION & PURPOSE:

1.1 The national guidance on learning from deaths requires each Trust to collect and publish specified information on a quarterly basis. This report covers the period from April to June 2022. The Board is receiving the report for information and assurance of the Trust's approach.

2. BACKGROUND INFORMATION AND CONTEXT:

It is expected when people die in our care, that the Trust reviews practice and works with families and others to understand what happened and what can be learned from the death to prevent reoccurrence where possible. All NHS Trusts are required to publish a dashboard (Appendix 1) highlighting the numbers of deaths that occur in the organisation on a quarterly basis. These are deaths which are in-scope of the Learning from Deaths policy, and which have been subject to any investigation or mortality review. It is important to note that when reviewing the data presented in the dashboard all the deaths categorised as in scope for the Learning from Deaths policy are subject to an initial review before determining if they require further investigation. Further details and the locally agreed criteria for mortality reviews and Structured Judgement Reviews (SJRs) can be found in Appendix 2.

The Learning from Deaths policy has been reviewed. The Incident Reporting and Serious Incident Review policy is currently being reviewed to reflect on-going improvement work as well as incorporating the National Standards for Patient Safety Investigation. Both are aligned to our 'Journey to Change' in that we will ensure that carers and families receive compassionate care following the loss of a loved one. We will work more closely with families and carers of patients who have died to ensure meaningful support and engagement with them at all stages, from the notification of death through to actions taken following an investigation/review.

Our staff are trained to undertake thorough reviews of deaths to ensure that learning is identified and embedded into practice to improve the services we provide. Further training will be required for reviewers as we transition to the new Patient Safety Investigation Response Framework.

We are also working collaboratively as part of the Better Tomorrow Programme to facilitate shared learning/good practice and valid comparisons with other Trusts.

3. KEY ISSUES:

3.1 Mortality Reviews and Learning

The Learning from Deaths policy has been reviewed to reflect improvement work and changes to the National Learning Disability Mortality Review Programme (LeDeR) reporting system. The LeDeR programme is now entitled 'Learning from Life and Death Reviews'. Deaths of people with a diagnosis of autism are now being reported by the Trust in line with national requirements and this is a key area of focus for learning both locally and nationally.

The Trusts mortality reviewer meets with the regional mortality reviewer to ensure that any wider learning is shared Trust wide.

The Patient Safety Team (PST) manager attends the Mortality Leads Network along with one of the Trust's Service Development Managers. The aim of the network is to provide a supportive forum to share practical ideas for developing and delivering a high-quality service and as an interested group to identify best practice and solutions to any areas of concern. It is facilitated by the 'Better Tomorrow Programme', who provide national updates and take forward any issues that may require a national solution.

Mortality Review 2022/2023

In Q1 2022/2023, 56 deaths had a part 1 mortality review. 13 of those cases were selected for a more detailed Part 2 Structured Judgement Review (SJR). Details on the locally agreed criteria for Mortality reviews and SJRs can be found in Appendix 2.

Month	Total Number of Deaths which has been reviewed under locally agreed criteria.	Total Number identified as requiring a Structured Judgement Review
April	15	6
May	21	4
June	20	3
Total	**56**	**13**

** NB due to capacity issues not all data for Q1 has been reviewed which reflects the lower numbers currently recorded. These figures will be amended when the dashboard is updated for Q2 2022/23*

Mortality Reviews

Learning and good practice from Q1 mortality review panels is identified in the table below. These learning themes largely reflect the key thematic areas of learning from Serious Incidents and will be addressed through these areas of focussed improvement work. Additionally relevant areas of learning are also being addressed through specific pieces of work in the medications management and the physical health group.

Points of learning
• Risk assessment/risk management

• Communication between Trust teams • Poor multi-agency working • Poor consideration and management of risks related to medication and obesity • Need to have a greater focus on review of service users mental state at depot clinic • Poor physical health monitoring • Poor record keeping
Points of Good Practice • Good liaison with care homes

3.2 **Learning from deaths and serious incidents**

During Q1, 22 deaths were reported on StEIS. All 22 deaths were community deaths. Emerging trends and immediate learning relating to Serious Incidents that have occurred within the period are discussed at the Quality Assurance Committee on a monthly basis.

Significant work has been undertaken over the last quarter to identify areas of learning from the thematic review of historical Serious Incidents and to determine whether the actions we are taking are making a difference to patient safety and the standard of care and services we provide. The themes have been identified as:

- **Risk Assessment and Management (Safety Summary/Plan/contingency planning)**
- **Care Planning**
- **Safeguarding**
- **Family Involvement**
- **Record Keeping**
- **Multi-agency working**
- **Records Management**

Examples of assurance provided can be seen at appendix 3.

Going forward learning from new Serious Incidents, once reviewed, will continue to be monitored against these themes and in line with standards and ambitions developed in relation to these areas.

In the reporting period there was 1 expected in-patient death related to physical health which will be reviewed under the mortality review process.

17 StEIS reportable serious incidents resulting in unexpected deaths were reviewed in this period; these related to 16 community patients and 1 in-patient who died whilst on leave (cause remains unknown). There was actionable learning identified in all cases. Recurring themes relating to harm minimisation, risk assessments/safety summaries, record keeping, lack of patient/carer involvement, and communication between teams were identified in the reviews of community cases. There were also several learning points from these cases related to the Did Not Attend/Was Not Brought policy. Although some improvement work was carried out in relation with a revised policy, the findings in Q1 indicated that the impact of this needs to be revisited. This will be further reported in in Quarter 2.

Learning in relation to the unexpected in-patient death related to contact whilst on time off the ward and the Duty of Candour post incident. In quarter 2, the Duty of Candour policy will

be reviewed to improve the response both corporately and from care groups following feedback from incident reviews and families.

When analysing themes and the impact of learning from deaths during Q1 it must be noted that the improvement work relating to risk assessment, risk mitigation, safety plans, care plans and patient/carer involvement commenced in January 2021 focussed initially on in-patient areas. There was evidence from the review of the 1 in-patient death that learning and actions from this work is more embedded into clinical practice. There was a robust risk assessment/plan in place which had been created and agreed with the MDT, the patient and family members. Improvements made in the quality of risk assessments, safety summaries/safety plans, care planning in in-patient areas. This is also supported by assurance from the Quality Assurance Programme results which are attached to this report in appendix 3.

Development work around the identified themes continues into community services; all cases reviewed in Q1 however pre-date the roll out of improvement work. Assurance that improvement work is becoming embedded in community practice is now continuously monitored by the Quality Assurance Programme tools recently introduced across community settings.

In relation to the identified themes the Trust can provide the following assurance in relation to community patients in Q1.

- The Community Quality Assurance tool provides evidence that improvements have been made to ensure that there is co-production of safety summaries/safety plans with the patient. Further work needs to be undertaken to ensure patient and carer views are included as well as clear evidence that the patient has been offered/provided with a copy of their safety plan.
- There was evidence of well written Mental State Examinations in community teams from the Community Quality Review

The work around care planning continues to be a priority and will be overseen by the Quality and Safety programme Board as well as the Clinical Strategy Board. The introduction of dialogue which will support personalised, goal focussed planning is seen as a key enabler to this work.

3.3 Structures to support and embed learning

3.3.1 Practice Development Group (PDG)

The Practice Development Practitioners (PDPs) are addressing areas of learning within their teams through compliance audits, coaching and supervision of staff. Currently these posts exist only with inpatient wards across Adult Mental Health and Secure Inpatient Services. They are now integrated into the care group Fundamental Standards group where wider learning can be shared to inform improvements in other areas.

They are also offering training in relation to risk assessment and safety summaries Trust-wide including community staff

3.3.2 Organisational Learning Group (OLG)

The Trust continues to strengthen its arrangements for organisational learning via the Organisational Learning Group. There have been 7 urgent patient safety briefings, circulated Trust wide during this reporting period.

Examples of these urgent patient safety briefings include:

- The importance of using correct seals for emergency bags to ensure easy access when required
- Accurate documentation of Observations and General Observations/Care rounds for all inpatient, respite, and residential settings
- Ensuring all staff are aware of how to access anti-barricade doors especially if there may be pressure behind the door
- the importance of bowel monitoring when patients are on high dose anti-psychotic therapy (HDAT), or any medications where constipation could cause significant issues such as Clozapine
- Delivering compassionate care and the importance of raising concerns
  Raising awareness of the importance of seamless transfers of care and service delivery when patients move between services/Trusts
- Heightening awareness of multiple suspected suicides and attempted suicides with potential connections in the same area

The briefings circulated are specific about any assurance required from services; on receipt of completed actions these are stored in the learning database.

'Learning from Serious Incidents Bulletins' are also regularly distributed across the Trust. The bulletins have shared key learning and good practice highlighted in serious incident reports presented at the Directors review panel. All briefings and bulletins are stored in the learning library on the Trust's intranet and are accessible to all Trust employees.

A quality Improvement event is being held in August 2022 to focus upon how we can further improve the communication and impact of learning in front line services.

3.3.3 Patient Safety Priorities

The Journey to Safer Care as part of the Trust's Journey to Change highlights four key patient safety priorities:

- Suicide Prevention and Self-harm Reduction
- Reducing Physical Restraint and Seclusion (Restrictive Interventions)
- Harm Free care, Psychological Safety including sexual safety and a Safe Environment
- Promoting Physical Health

Draft metrics for each of the four priorities have recently been discussed in the Quality and Safety Programme Board who will be overseeing this work.

i) Suicide Prevention – Trust's Preventing Suicide Plan

17 bespoke meetings have been held with staff, carers, and people with lived experience to help shape the Trust's Preventing Suicide Plan. The preventing suicide team also attended 12 existing Trust meetings and 6 multiagency Suicide Prevention Network/Alliance meetings.

Leadership for suicide prevention is through the Clinical Strategy Lead supported by a multi-disciplinary Preventing Suicide and Self Harm Reduction group which will monitor progress against the preventing suicide plan. All actions will be aligned to our Journey to Change.

The 3 Preventing Suicide Project Leads, with support of the wider preventing suicide group, have:

- developed and utilised processes for a rapid response where multiple suicides may be indicated; examples include potential suicide pacts, and multiple suspected suicides in the same area.
- attended daily patient safety huddles – assisting in the coordination of rapid reviews for early learning
- Met with public health leads to integrate action plans and promote multi-agency working
- developed a plan to roll out of Post Incident Peer Support meetings for staff (utilising the Critical Incident Stress Management Model) across the Trust.
- plan to develop regular virtual blogs to provide updates and share learning

ii) Harm Free Care - Safe Environment

The Environmental Risk Group receives monthly incident reports involving ligatures and other risks where environmental factors may have contributed to harm as well as progression of initiatives to reduce harm. Any urgent learning from this group is disseminated Trust wide via Patient Safety Briefings or SBards, examples for Q1 are detailed above in para 3.3.2.

Environmental surveys with a multi professional input from estates, health and safety and clinical services have been recommenced.

An update on environmental improvements to inpatient areas has been reported through to the Quality Committee. In accordance with Phase 2 of the programme, work on internal en-suite door replacement is complete and work has begun on replacement bedroom doors in accordance with plan. The group continue to review any new incidents on a monthly basis.

A recent focus has been on minimising risks around patient access to roofs and estates have undertaken risk assessments in accordance with this. A recent patient safety briefing has been developed regarding the need to consider relational and individual patient risks in relation to this risk.

iii) Promoting Physical Heath

Work continues in relation to improving the physical health of people with mental health problems in keeping with ICS priorities when learning from deaths. Improvement work includes ensuring all staff in in-patient areas attend Core Physical Skills training which will equip staff with the skills and knowledge to ensure our patients receive the best physical healthcare whilst in our services. Learning from national and local Independent Care and Treatment Reviews will also be taken forward by the group. Training is being organised for Allied Health Professionals based in inpatient services to enable them to support decision making linked to physical health and wellbeing. Medical emergency training is also planned for all in-patient clinical staff including emergency responses to ligatures. Other mental/physical health related improvement work is planned in the relation to approaches to the management of self-harm including head banging and the ingestion and insertion of foreign objects.

3.3.4 Safeguarding

Results from the Quality Assurance tool (practice development review) QA4 have demonstrated improvements in relation to identification of risk to others (96%) and from others (95%) within the safety summaries being discussed within MDT. Peer reviews (Quality Assurance tool 6) exhibited good examples of safeguarding procedures and staff knowledge. Training figures indicated that over 90% of staff are compliant with mandatory safeguarding training in both Care Groups. See appendix 3 for further detail.

3.3.5 Serious Incident Investigation Process

Preparations for the implementation of PSIRF continues with a dedicated project manager in post. Improvement work continues to identify early learning/themes from rapid reviews ensuring that clinical services embed early actions into practice. This work has been supported by Serious Incident Reviewers and the Preventing Suicide Project Leads.

The Trust's organisational restructure into 2 Care Groups has facilitated a greater understanding and response to patient safety issues by improved alignment with corporate services; this has increased accountability and simplified governance/line of sight.

3.3.6 Better Tomorrow Programme

A desk top review of the Trust's current Mortality Review systems and processes has been completed by the Better Tomorrow team to help identify and support with potential areas of development. This work is currently being refreshed by the Trust to include improvement work in learning from deaths; oversight is being provided by the multi-disciplinary Mortality Review panel. 4 Trust staff will be attending a workshop organised by the Better Tomorrow Team which will be looking at the new 'Structured Judgement Review Plus', potential for a 'community mental health dashboard' as well as a proposed national template for Learning from Death Board reports. 2 staff attend the 'Better together' network which provides an opportunity to share best practice issues and learning from deaths nationally.

3.3.7 Training

'Connecting for people' suicide awareness training - a further 8 Trust staff were trained as trainers in May 2022 bringing the total trainers up to 34. Training sessions are fully booked until the end of December 2022

The Trust's mandatory harm minimisation training has recently been updated. It continues to include updated headlines from serious incidents in relation to learning from deaths. 82% of staff have completed their mandatory harm minimisation training. This face-to-face training is fully booked until December 2022 – training dates are available up to 2024. Training has been adapted for relevant specialties, for example CAMHs. The training considers completion of documentation/record keeping, patient/carer involvement and the importance of multi-agency working. Bespoke training sessions in 'hot spot' areas are available on request (e.g., front line teams such as Crisis)

As part of the improvement work around the serious incident process and learning from deaths, several training needs for staff trust-wide have been identified. These include incident reporting, holding difficult conversations with bereaved relatives, duty of candour/culture of candour, report writing and writing smart action plans. These have been fed into the Trust-wide training needs analysis event.

3.3.8 Clinical strategy

Our newly developed draft Clinical Journey to Change (Clinical Strategy) describes our ambition to be an outward looking, modern Mental Health, Learning Disability and Autism service by providing a roadmap through co-created transformation. The purpose is to improve the overall health and wellbeing of people with mental health issues, a learning disability or autism in our region. Our approach is to consider the whole person, whole life, whole system to deliver personalised care sooner, safer, and more holistically.

3.3.10 Patient Safety Specialist

The Trust's Patient Safety Specialist continues to attend the Patient Safety Specialist Improvement Programme Webinars, arranged by the National Patient Safety Team. These interactive forums connect over 700 Specialists from around the country. There is also the opportunity to discuss any issues relating to patient safety including learning from deaths on the Patient Safety Specialists' workspace both from a national and regional perspective.

3.5 The Learning from Deaths Dashboard

The learning from deaths dashboard is attached at Appendix 1 and includes 2021/22 data for comparison.

For Q1 the dashboard highlights the following:

- A total of 490 deaths were recorded (not including LD deaths). This is all deaths (including natural expected and unexpected) in relation to people who were currently open to the Trust's caseload as recorded on datix.
- Out of the 490 deaths there was 1 in-patient death. This patient was on the end-of-life pathway due to physical health problems and care will be reviewed via the mortality review process.
- There were 12 community LD deaths. All these deaths have been/will be reviewed internally via the mortality review process. All have been reported to LeDeR.
- There were 17 StEIS reportable serious incidents resulting in death reviewed and 22 StEIS reportable serious incidents resulting in death reported.
- 56 cases within the combined number of deaths were reviewed under the mortality review criteria, 13 of these will progress to a full SJR

4.0 IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
Improvements in the learning from deaths processes outlined will support the Trust to demonstrate the delivery of high quality, safe patient care in line with CQC Fundamental standards.

4.2 **Financial/Value for Money:**
There are financial and reputational implications associated with poor standards of care. A focus on learning helps the Trust to improve the quality and safety of our care services.

4.3 **Legal and Constitutional (including the NHS Constitution):**
Adherence to Learning from Deaths provide assurance we meet CQC's Fundamental Standards in respect of Regulation 17 - Good Governance.

4.4 **Equality and Diversity:**
The Trusts learning from deaths reviews consider any issues relating to equality and diversity to ensure that any issues of discrimination are addressed.

4.5 **Other implications:**
No other implications identified.

5. RISKS:

There is a risk that if we fail to embed key learning from deaths that patient safety and quality will be compromised.

There is a risk that the data published is used or interpreted without context as there is no current national benchmarking or methodology within mental health and learning disability services for mortality.

6. CONCLUSION:

There is evidence that joint working between corporate and organisational services is positively impacting on the safety of our patients and learning from deaths. There is also evidence within our Quality Assurance Programme that actions from learning is improving the care and service delivery problems previously identified in our learning from deaths.

7. RECOMMENDATIONS:

The Board of Directors is requested to note the content of this report, the dashboard and the learning points identified for assurance.

Background Papers:

Learning From Deaths Framework
https://www.england.nhs.uk/?s=Learning+from+Deaths

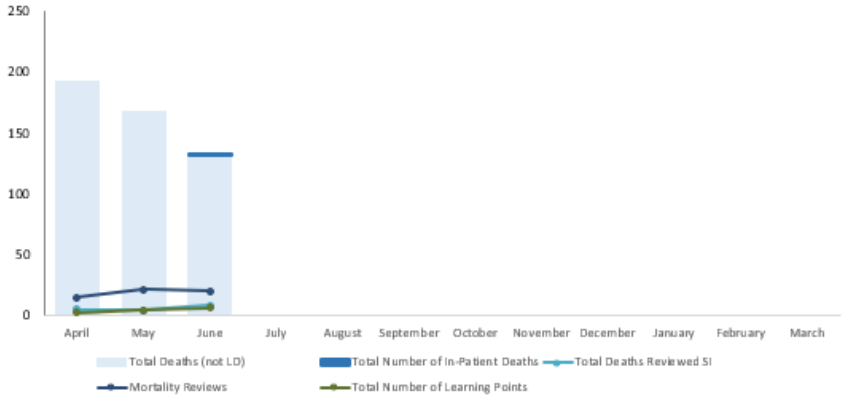
Southern Health Report
https://www.england.nhs.uk/2015/12/mazars/

Appendix 1 Learning from Deaths Dashboard

Summary of total number of deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Deaths, Deaths Reviewed (does not include patients with identified learning disabilities)

	Total Deaths (not LD)		Total Number of In-Patient Deaths		Total Deaths Reviewed SI		Mortality Reviews		Total Number of Learning Points	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
Q1	490	↗ 486	1	↘ 8	17	↘ 23	56	↘ 78	12	↘ 43
Q2		556		7		18		50		15
Q3		639		5		15		105		42
Q4		554		6		12		37		5
YTD	490	↘ 2235	1	↘ 26	17	↘ 68	56	↘ 270	12	↘ 105



Summary of total number of Learning Disability deaths and total number of cases reviewed under the SI Framework or Mortality Review

Total Number of Learning Disability Deaths, and total number reported through LeDer

	LD Deaths		Total Number of LD In-Patient Deaths		LD Deaths Reviewed Internally		LD Deaths Reported to LeDer	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
Q1	12	↘ 18	0	↔ 0	12	↘ 29	12	↘ 34
Q2		26		0		16		12
Q3		23		0		18		25
Q4		28		0		18		25
YTD	12	↘ 95	0	↔ 0	12	↘ 81	12	↘ 96

Mortality Reviews 2022/2023

Appendix 2

Mortality reviews are completed in-line with guidance from the Royal College of Psychiatrist and peer organisations across the region.
The mortality review tool used consists of a Part 1 and Part 2 review.
Part 1 is a review of the care records, if any red flags or concerns are noted a Part 2 (Structured Judgement Review) will be carried out.

The “red-flags” to be considered during the Part 1 review are as follows:

- Family, carers, or staff have raised concerns about the care provided
- Diagnosis of psychosis or eating disorders during the last episode of care
- Psychiatric in-patient at the time of death, or discharged from care within the last month (where the death does not fit into the category of a Serious Incident)
- Under Crisis Resolution and Home Treatment Team at the time of death (where the death does not fit into the category of a Serious Incident)
- Patient had a Learning Disability. These cases will also be referred to LeDeR
- Prescribed Clozapine or high doses of anti-psychotic medication

This criterion allows for greater learning from a more suitable selection of cases reviewed. To prioritise the most significant cases for learning from unexpected and expected physical health deaths throughout Q1, the following actions have been taken for those deaths reported on datix:

- All in-patient deaths have either had a Structured Judgement Review completed or are in the process of having one completed.
- All LD deaths have either been reviewed or are being reviewed under Part 1 of the mortality review process. Where any concerns are identified a Structured Judgement Review has been or will be requested. All these cases have also been referred to LeDeR for review.
- All community deaths for patients aged 64 and under have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested.
- 20% of community deaths for patients aged between 65 and 75 have been reviewed under Part 1 of the mortality review process and where any red flags/concerns have been identified a Structured Judgment Review has been requested. This 20% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.
- 10% of community deaths for patients aged between 76 onwards have been reviewed under Part 1 of the mortality review process and where any red flags/concerns are identified a Structured Judgment Review has been requested. This 10% is selected from deaths within Trust services as opposed to deaths within care homes where the Trust is not the main care provider.

Appendix 3

qa programmme aligned to learning

Theme 1: Risk assessment/ safety summaries, risk management and contingency planning

Quality Assurance

Theme 1: Risk assessment/ safety summaries, risk management and contingency planning

Where we were:

The QA2 was rolled out Trust wide for inpatients from Apr-21 and the following compliance was achieved for assessment against the minimum standards outlined by the Good Practice Guidance:

- **99%** Safety Summaries
- **99%** Patient Observation and Engagement plans (day and night)
- **96%** Safety Plans

Following further reviews of the tool since implementation to assess in greater depth key quality standards of risk documentation, high practice standards have been maintained.

Where we are:

- **99%** Incidents in the case notes have been reflected in the incident log and the safety plan; Observation and Engagement plans (day and night) were present and patient observation levels matched the paper sheets and VCB with the clinical record.
- **98%** Observation and Engagement levels are documented in the safety plan
- **97%** Safety Summaries are updated to reflect the current risks or any newly identified risks; Safety Plans reflect accurately all changes in patient need; Daily entries evidence clear rationale for patient Observation and Engagement levels
- **94%** Safety Plans reflect accurately how risks are mitigated and managed following any changes.
- **90%** Incidents in the case notes reflect in the incident log and the safety plan.
- **89%** Any incidents that have occurred since the last audit were reported through the Datix incident reporting system in line with the policy.

QA2 Assurance Self-declaration

Latest results of QA2 from 08/06/22 cycle

Theme 1: Risk assessment/ safety summaries, risk management and contingency planning

Where we were:		Where we are:
88%	Clinical records have been updated at the end of each span of patient observation.	100%
100%	Section 17 leave forms covered where the patient can go	98%
99%	Section 17 leave forms covered who the patient can go with	98%
93%	Section 17 leave forms covered the duration of leave	98%
90%	Casenotes reflect all changes made to the individual levels of observation and engagement.	97%
90%	Observation and engagement sections of the safety plan were accurate.	96%
85%	Evidence that the current prescription for leave/ time of the ward was discussed with the MDT	87%

QA3 Modern Matron Quality Review

Generally consistently high compliance is being achieved for risk assessment/ management documentation which aligns to the QA2 results.

journey to change

Latest results of QA3 from 16/05/22 cycle

Theme 1: Risk assessment/ safety summaries, risk management and contingency planning

Further key findings from latest results of the QA3 cycle which aren't comparable to QA3 results upon implementation:

100% Where the patient was on eyesight/ arms-length observation, is was clearly evidenced from the care record the responsibility of staff carrying out observation and engagement and the number of staff required.

Where the patient was on intermittent observation and engagement, is was clearly evidenced from the care record the observation and engagements required by staff. **98%**

93% The safety summaries reflect only significant dates.

Information documented was an appropriate standard that accurately reflects risks/mitigation and current presentation. **91%**

84% The NEWS2 specified the frequency of completion required for the patient.

It was clearly evidenced in the leave plan which actions should be taken should the patient not return to the ward. **80%**

77% There was evidence within the clinical record that the NEWS2 information was recorded as per prescription.

There was evidence that the patient's current mental state had been examined immediately prior to leave being taken to ensure there are no concerns regarding leave taking place. **61%**

QA3 Modern Matron Quality Review

Generally high compliance is demonstrated, however there are practice improvements required in relation to documentation of the patient's current mental state prior to inpatient leave and NEWS2 documentation.

Latest results of QA3 from 16/05/22 cycle

Theme 1: Risk assessment/ safety summaries, risk management and contingency planning

Where we were:		Where we are:
97%	When discussing the level of leave/ time away from the ward, MDTs discussed the section 17 leave ensuring that the necessary paperwork had been completed.	100%
81%	MDTs discussed the safety summary document including risk to self.	97%
100%	When discussing the observation and engagement needs of the patient, the MDT discussed the level of need during the day	97%
68%	MDTs discussed the safety summary document including other risks.	97%
70%	MDTs discussed the safety summary document including risk to others.	96%
67%	MDTs discussed the safety summary document including risk from others.	95%
88%	If new risks were identified during the MDT report out discussion, the allocated worker updated the safety summary.	92%
94%	When discussing the observation and engagement needs of the patient, the MDT discussed the risks which were required to be managed.	92%
85%	At the MDT report out, there was a clear rationale given as to how the level of observation would mitigate risk(s) identified.	86%
98%	When discussing the observation and engagement needs of the patient, the MDT discussed the level of need during the night	85%

Results from the QA4 have demonstrated improvements and consistent practice standards have been achieved overall. Improvements have been accountable to the Practice Development Practitioners supporting clinical teams directly.

Latest results of QA4 from 12/05/22 cycle

Theme 1: Risk assessment/ safety summaries, risk management and contingency planning

Where we were:	Where we are:
Staff were generally competent in completing Safety Summaries/Safety Plans with the exception of SIS where further support was needed. Staff understood that MDT members should be involved but, in some areas, care-coordinators/nurses were largely responsible for writing up plans.	Confidence has increased. In AMH services, staff have been supported through a 'back to basics' approach, intranet resources, and dedicated training from a Consultant Psychologist. However in SIS, some staff report a continued lack of formal training. Care-coordinators/ nurses remained largely responsible for writing up plans in many areas.
Staff in MHSOP were unable to locate observation plans and some relied on local processes and word of mouth rather than using formal records to identify risks. Staff in AMH and SIS knew where to find this information.	AMH, MHSOP and SIS staff are able to describe where to locate up to date information about each patient's observation plans.

QA7 MDT Walkabout

The QA7 tool reviewed a small and changing sample of inpatient or community teams, and the questions included adapted over time. This comparison is therefore not a direct demonstration of progress in individual teams, however there has been a general increase in staff confidence in completion of safety summaries and plans. Some teams reported further formal training would be helpful which has been facilitated.

journey to change

Latest results of QA7 from Feb/Apr-22 cycles

Theme 1: Risk assessment/ safety summaries, risk management and contingency planning

Where we were:

- **93%** Safety summaries were complete.
- **88%** Safety summaries were narrative based.
- **86%** All the information in the correct sections (i.e., triggers in perpetuating/ precipitating and not in historical)
- **81%** Historic incidents were summarised within the safety summary
- **80%** It was clear how the risks identified would be mitigated.
- **74%** Risk(s) identified in the safety summary were within the safety plan.
- **73%** Safety summaries identified any risks of Harm to Self from Self
- **71%** Safety summaries explicitly stated 'No recent thoughts or actions of self-harm or suicide' where no risks of harm to self from self were identified
- **46%** Safety summaries identified any risks of Harm to Self from Others

Where we are:

- **82%** Information was documented to an appropriate standard that accurately reflects risks/mitigation and current presentation (e.g., pregnancy, physical health issues etc.).
- **76%** The incidents/events section has been used appropriately and is up to date for the patient.
- **74%** The safety summaries reflect only significant dates.
- **65%** There was evidence within the PARIS records that demonstrate MDT discussion of the safety summary/plan.

Community Caseload Management Review & Community Quality Review (condensed)

The Community Caseload Management Review was introduced in response to the Section 29A warning notice received following the CQC inspection of AMH wards and PICU.
A subsequent Community Quality Review (condensed) tool was more recently implemented in May-22 focusing on 8 key questions in relation to risk management documentation therefore direct comparison is not indicated. Generally community teams have shown documentation is at an appropriate standard reflecting patient risks and presentation, however further improvements are required for ensuring consistency for safety summaries reflecting only significant dates, evidence of MDT discussion in the patient record, and incidents/events section being used.

Latest results of Community Quality Review implemented from 16/05/22, results as at 28/06/22, and community caseload management review Jun-21.

Theme 1: Risk assessment/ safety summaries, risk management and contingency planning

Peer reviews:

- Arrangements were in place for handovers and shift changes to ensure patients are safe. Mechanisms such as Safe Wards, report outs and regular safety huddles were in use.
- Teams showed that there was clear triangulation in relation to supportive observation and engagement as well as leave of absence between the electronic clinical record, paper documentation (i.e. the section 17 leave form or patient observation recording sheet) and the Visual Control Board (VCB).

Director Visits:

- The teams visited have shown staff know they are providing a high standard of patient care and that patients are safe using a range of intelligence/ processes. Some include use of patient outcomes, safety summary and co-created safety plan providing greater clarity and visibility of risks, patient and staff feedback, Greatix, team/MDT meetings, huddles, review of incidents, CQC inspections, and clinical supervision.
- Learning of incidents is shared through immediate feedback, team huddles, reviews, as well as wider sharing. Teams reported the use of Patient Safety Briefings and the Learning Library also.

journey to change

Latest QA6 Peer Review from Nov-21-Jan-22

Latest QA12 Director Visits from Apr-22-Jun-22

Theme 2: Care planning/ CPA/ interventions/ care plans

Quality Assurance

Theme 2: Care planning/ CPA/ interventions/ care plans

Where we were:		Where we are:
100%	If new patients were discussed in the MDT, the purpose of the admission was outlined.	100%
97%	When discussing the level of leave/ time away from the ward, MDTs discussed the section 17 leave ensuring that the necessary paperwork had been completed.	100%
83%	When discussing the level of leave/ time away from the ward, MDTs discussed the rationale and purpose of leave/ time away from the ward.	78%

Community:

81%	Care plans were developed that supports the patient's identified needs.
67%	CPA reviews were undertaken within timescales.
40%	Care plans were shared with the GP.

QA4 Practice Development Review

Community Caseload Management Review

Aspects from the QA4 have demonstrated high compliance and some improvement is required further in relation to ensuring MDTs consistently discuss the rationale and purpose of the patient's leave/ time away from the ward to ensure effective care planning.
Results for community teams have previously indicated requiring improvements for sharing care plans with the GP and CPA reviews to be undertaken within timescales.

Community caseload management review Jun-21.

Latest results of QA4 from 12/05/22 cycle

Theme 3: Record keeping

Quality Assurance

Theme 3: Record keeping

Where we were:		Where we are:
88%	Allocation sheets fully completed specifying the named member of staff responsible for carrying out observation and engagement for each specified time period	100%
100%	If patient's were on general observation the care rounds documentation was completed	100%
93%	The purpose of patient leave was clear	94%
98%	The patient had their rights reviewed regularly and documented on the 132a and 132b	93%
91%	The patient been referred to an IMHA (when patients lack capacity an automatic referral to IMHA has been made)	85%

97% Leave Plans met the minimum standards of the Good Practice Guidance

97% Leave plans accurately reflect the current prescription of leave/time off ward granted to the patient

QA2 and QA3 cycles have shown high practice standards were achieved for recording key documentation including patient leave, and observation and engagement.

Latest results of QA2 from 08/06/22 cycle

Latest results of QA3 from 16/05/22 cycle

journey to change

Theme 3: Record keeping

Where we were:		Where we are:
89%	New patient incidents had been logged and reported.	89%
88%	The minute taker of the MDT made a report out entry onto Paris.	88%

Peer reviews:

- Teams identified that the majority of records showed that there was clear, robust recording evidence within clinical records including accurate reflection of MDT discussions and changes in patient risk.

QA4 Practice Development Review

QA12 Director's Visit

It is acknowledged that aspects from the theme of "risk assessment, safety summaries, risk management and contingency planning" (theme 1) is also relevant to Record Keeping and appropriate documentation standards.

Standards remain high in relation to recording new patient incidents accordingly and MDT report out documentation within the patient electronic record. Peer reviews also indicate robust recording evidence observed.

Latest results of QA4 from 12/05/22 cycle

Latest QA6 Peer Review from Nov-21-Jan-22

Theme 3: Record keeping

Where we were:

Environmental audits were in place and in date where this was assessed. However, SIS staff responses regarding the location of ligatures lacked detail.

Where we are:

Some SIS and MHSOP staff require further training in relation to communicating ligature points and detailed knowledge of their environmental audits.

86%

There was evidence of a well written Mental State Examination in community teams from the Community Quality Review.

QA7 MDT Walkabout

Community Quality Review (condensed)

Community teams have shown evidence recorded for a well written Mental State Examination.
MDT walkabouts demonstrate there remain staff training requirements in relation to environmental ligature point communication and effective record keeping of the Suicide Prevention Environmental Risk survey.

journey to change

Latest results of QA7 from Feb/Apr-22 cycles

Latest results of Community Quality Review implemented as at 28/06/22.

Theme 4: Safeguarding

Quality Assurance

Theme 4: Safeguarding

Where we were:		Where we are:
70%	MDTs discussed the safety summary including risk **to** others.	96%
67%	MDTs discussed the safety summary including risk **from** others.	95%

- AMH and SIS wards included in the latest completed Peer Review reported clear systems and processes were in place to safeguard people from abuse, including liaison with the Trust Safeguarding Team, relevant Local Authority contact where required, and completion of appropriate Datix incidents.
- Staff were able to articulate safeguarding procedures and referenced staff training for safeguarding adults and children as part of mandatory training.

QA4 Practice Development Review

QA6 Peer Review

Results from the QA4 have demonstrated improvements in relation to risk to and from others within the safety summaries being discussed within MDT. Peer reviews exhibited good examples of safeguarding procedures and staff knowledge.

journey to change

Latest results of QA4 from 12/05/22 cycle

Latest QA6 Peer Review from Nov-21-Jan-22

Theme 5: Patient/carer/relative involvement

Quality Assurance

Theme 5: Patient/carer/relative involvement

Where we were:		Where we are:
58%	Patient and carer views were included in the safety summary	93%
93%	Patient/carer(s) has been given ward contact numbers when utilising leave.	90%
88%	Safety Plans were co-produced with the patient	88%
74%	Evidence that the current prescription of leave/ time off the ward was discussed, risks identified and mitigations proposed with the patient.	85%
86%	Following leave, feedback has been documented from escorting staff/ patient/carer.	76%
72%	Evidence that the current prescription of leave/ time off the ward was discussed, risks identified and mitigations proposed with carer/relatives.	73%
18%	Evidence of the patient being offered/provided with a copy of the safety plan.	58%

QA3 Modern Matron Quality Review

There is evidence of some improvements made as well as consistently high compliance in relation to patient/ carer/ relative involvement from the QA3 results. An area of focus remains to ensure evidence is documented of offering/providing a copy of the safety plan to the patient.

journey to change

Latest results of QA3 from 16/05/22 cycle

Theme 5: Patient/carer/relative involvement

Where we were:		Where we are:	
70%	Safety plans had been co-produced with the patient/advocate.	74%	The safety plans are co-produced with the patient.
47%	Patient and carer views were included in the safety summary (my view and others).	62%	Patient and carer views are included in the safety summary.
33%	The patient was provided with a copy of the safety plan.	36%	There is evidence that the patient has been offered/provided with a copy of the safety plan.
65%	Care plans were shared with the patient.		
56%	Care plans were shared with the Family/Carers.		

Community Caseload Management Review & Community Quality Review (condensed)

QA6 Peer Review

Peer reviews:

- Teams identified that patients were given enough information to make informed decisions about their care and treatment, referring to use of MCA1/2 forms, T2/T3 forms, IMHA applications, patient information leaflets including easy read versions and language adaptations.
- Patients/carers are encouraged to voice any concerns and are made aware of how to make a complaint. Examples included use of PALS, CQC contact poster and mutual help meetings.

Generally good evidence was achieved for co-production of the safety plans with the patient for community teams, however improvements remain for ensuring patient and care views are included as well as clear evidence that the patient has been offered/provided with a copy of the safety plan.

Latest QA6 Peer Review from Nov-21-Jan-22

Latest results of Community Quality Review implemented as at 28/06/22, and community caseload management review Jun-21.

Theme 6: Multi-agency working

Quality Assurance

Theme 6: Multi-agency working

Peer reviews have demonstrated:

- Good collaborative working with acute Trust's for patient care and subsequently improving patient outcomes.
- Effective MDT involvement with other agencies such as representation from the Ministry of Justice, Housing providers, Citizens Advice, and community team involvement.
- Contacts with clinical commissioners were weekly in some teams.
- Regular interface with appropriate agencies involved in the patient's discharge planning, however difficulties acknowledged sometimes for patients who are out of area.

QA6 Peer Review

Latest QA6 Peer Review from Nov-21-Jan-22

Theme 7: Medications Management

Quality Assurance

Theme 7: Medications Management

Where we were:	Where we are:
95%	96%

T Forms were evident and accurate in the patient prescription Kardex.

Peer reviews have demonstrated:

- Evidence of monitoring including daily temperature checks, and spot checks undertaken by ward managers.
- Medicines Optimisation Assessment (MOA) audits reviewed regularly and some areas have been rectified from these checks including providing relevant signatures.
- Medicines management staff training completed and monitored. Some teams reported high compliance.
- Regular controlled drugs clinical audit participation and feedback facilitated with the Pharmacy Team.
- Staff knowledge was demonstrated for escalation processes if fridge temperatures are identified as out of range.
- A few teams referred to post rapid tranquilisation monitoring having been carried out accordingly, however sometimes not recorded within the physical health case notes in Paris.

QA3 Modern Matron Quality Review

QA6 Peer Review

journey to change

High compliance has been maintained for T Forms being in place and accurate in the patient's prescription Kardex. Peer reviews show good examples of ensuring proper and safe use of medicines.

Latest results of QA3 from 16/05/22 cycle

Latest QA6 Peer Review from Nov-21-Jan-22

ITEM NO.15

Trust Board of Directors

DATE:	**20th July 2022**
TITLE:	**Guardian of Safe Working Quarterly Report - July 2022**
REPORT OF:	**Dr Jim Boylan - Guardian of Safe Working**
REPORT FOR:	**Assurance**

This report supports the achievement of the following Strategic Goals:	✓
A great experience for patients, carers and families	
A great experience for staff	✓
A great experience for partners	✓

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.

There has been a continuing major impact on working conditions by the CoVID 19 pandemic for all staff, including Junior Doctors, over the past year and the infectivity of new variants has maintained the escalation of positive cases and consequent staff absences due to self isolation or sick leave.

It is noted that it is only 2 months since the board received the GoSW annual report in May 2022, (this was delayed by a month due to a crowded agenda in the April Board Meeting), and there are no real substantial developments or additional concerns of which to inform the board since then.

The trustwide Junior Doctor Forum was held in June with good representation of Juniors from all localities. The most notable issue of discussion by Juniors were the continuing complications of communication and co-ordination of clinical information exchange between TEWV and the Leeds York Partnership. There was good representation by Leeds/York management at the meeting and a constructive discussion led to a promise to carry the matter forward. There is also a guidance handbook, which is now almost complete, to support new juniors coming into post in York and surrounding localities in this regard.

The issue of difficulties with Crisis Team cover support for Section 136 assessments in County Durham arose again during this quarter following an incident involving a Higher Trainee on call at West Park Hospital being left alone to manage an assessed patient. Following report of the incident there were constructive discussions between senior medical and crisis team management and hopefully there is now greater clarity and consistency of approach.

As can be seen in the appendices to this report there continue to be the most notable number of exception reports emanating from the York, Scarborough and also the Teesside localities, where there are Non-Residential On Call Rotas. Where it has been necessary to levy Guardian fines these continue to be largely due to the breach of the 5 hours continuous rest rule with (unusually) 2 breaches of the 13 hours maximum total shift duration rule in this past quarter.

We continue to monitor and review the process for exception reporting to try to ensure timely reporting by Junior Doctors and accurate intelligence of work intensity across all localities.

Recommendations:

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

MEETING OF:	**Trust Board**
DATE:	**28th July 2022**
TITLE:	**Quarterly 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:

- **Appendices 1 and 2** provide more details for North (Durham & Teesside) and South (York and North Yorks) sectors respectively for the quarter April to June (inclusive) 2022 with a short narrative explaining the data from the relevant medical staffing officer for each area. The relevant appendices are shared with the corresponding Health Education England body for the different sectors.

- From these appendices the data suggests that there has been some levelling off for exceptions being reported across the board in this last quarter – but this may represent, particularly in the Scarborough locality, which may be linked to the closure of the ward at Cross lane hospital. During this quarter the total numbers of exceptions are once again evenly spread across both sectors (31 North and 34 South) but there was a noticeable proportionate increase in fines levied for York and North Yorks in this period compared to the previous one. This is, as usual, primarily related to lack of continuous rest in the NROC rota there and may represent some previously reported exceptions from the last quarter effectively carried forward to this one. Nonetheless it is an indication of the continuing intensity of work across the Yorkshire patch. Up to this point there have been no reports of unmanageable levels of demand by Junior Doctors in the Scarborough locality since the re-opening of Esk ward. We obviously continue to monitor this situation.

- We continue to monitor plans and developments for the improvement of training and out of hours accommodation in the North Sector. There are no further specific developments or new concerns to report during this last period. The plans for the development of an expanded training unit on the Lanchester Road Site have been widely welcomed.

- There were no reports of concerns for the new dual middle tier NROC rotas in County Durham during this period.

- Continued monitoring and development of improved clinical / administrative communication between TEWV and LYPFT at their interface is active and apparently constructive as described in the executive summary.

- Over the past quarter we continued to witness the continuing impact of CoVID 19 and, if anything, the new Omicron variant appears to have caused an upsurge in staff absences, particularly upon nursing staff levels. This has obviously had a negative impact on work intensity for all staff still working.

- There continue to be expressed concerns about the availability of Crisis Team staff out of hours in County Durham to support the Section 136 assessments by Higher Trainees during out of hours assessments. We continue to monitor this situation in terms of working impact and safety for Senior Registrars on call, and I was recently encouraged by the prompt response and helpful intervention of the Senior Clinical Manager in County Durham to try and resolve this issue after a concerning report by a higher trainee of such an incident. There appears to have been useful communication with the Crisis Team Manager and a number of useful points of clarification and action together with an undertaking to continued monitoring. We also continue to monitor for reports by Higher Trainees of pressure to discharge patients from section 136 without an AMHP having been in attendance. I have not received any specific reports of this, however, during the last quarter.

- Over this quarter I am satisfied that all exception reports submitted by doctors on the new contract have been 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 locality forums.

- There have been no evident rota gaps of concern during this quarter and the internal locum system appear to function well with no reported use of Agency locums on Junior Doctors rotas.

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

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:

The ongoing and developing situation with Covid 19 and the recent escalation of cases resulting in staff vacancies and shortages in key areas has compromised safety for Junior Doctors in some localities for urgent out of hours assessments and it is important that monitoring of this situation continues.

In terms of promoting recruitment and retention of doctors into more senior positions within the trust it is important for the board to continue active support for the development of resources and facilities for the accommodation and educational provision of trainees. Failure to do so is likely to risk a negative influence on decisions by our high quality trainee workforce to consider a future position within the organisation.

Pressure upon Junior doctors to assess section 136 patients without the support of locality Crisis Team staff or in some instances the presence of an AMHP does not constitute best practice and may compromise the level of assurance for decisions made about these patients and pose a professional risk for Junior Doctors.

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.

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.

In the context of the current requirements for social distancing our normally robust structures for Junior Doctor Forums and meetings between senior medics are potentially more challenged, although there is continuing evolution in the availability and use of technology for remote linkage.

6. CONCLUSIONS:

The continuing challenges of the Covid19 Pandemic manifested through staff shortages have impacted upon safe working practices for Junior Doctors in acute out

of hours situations in some parts of the trust – most evidently in this last quarter in County Durham. There is a need to maintain active monitoring across all localities.

There continue to be issues around work intensity in some Non-Residential Rotas around the trust but it is encouraging to see indicators for improvement in these sectors and no evidence in the last quarter of increasing intensification. We will, of course, continue active monitoring.

Active support from the board to re-provision on call accommodation and educational facilities for Junior Doctors on the Roseberry Park site, where there is probably the highest concentration of trainees in the trust, is likely to be viewed positively and in the longer term could help with recruitment and retention.

Junior Doctors are appropriately submitting exception reports but continuing review of how to maintain and improve the efficiency of this process is important. Medical staffing are actioning exception reports in an appropriate and fair way. I am satisfied that reasonable processes continue to be in place to identify and rectify issues of safety despite the stringencies of safe distance working.

Teaching and training is starting to return face to face but appropriate alternative measures continue to be taken to provide ongoing training and support for Junior Doctors through regular webinars and video conferencing.
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7. RECOMMENDATIONS:

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

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

Background Papers:
Appendices 1 & 2: detailed information on numbers, exception reports and locum usage- North and South Sectors respectively – Second Quarter 2022.

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):	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 April up to 30th June 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	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	6	6	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	0	0	0
CT1-2 Teesside & Forensic Services Juniors	0	10	10	0
CT1-2 –North Durham	0	0	0	0
CT1-2 – South Durham	0	0	0	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	2	2	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	7	7	0
Trust Doctors - North Durham	0	0	0	0
Trust Doctors - South Durham	0	6	6	0
Trust Doctors - Teesside	0	0	0	0
Total	**0**	**31**	**31**	**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	18	18	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	6	6	0
South Durham Senior Registrars	0	3	3	0
North Durham Senior Registrars	0	4	4	0
Total	**0**	**31**	**31**	**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	0	4	14	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	0	0	0
South Durham Juniors	0	6	0	0
South Durham Senior Registrars	0	3	0	0
North Durham Senior Registrars	0	4	0	0
Total	**0**	**17**	**14**	**0**

Narrative for Exception Reports

In the Teesside area, 18 exception reports were received (3 for shadowing, 1 for missing postgrad teaching and 14 for working above work schedules as no enhanced time is included). However, the actual number of exception reports will most likely be much higher as the current NROC period has not finished meaning any claims for June haven't been reported yet.

Work schedule reviews

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

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

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	15	3	0	179	21
	CT1/2/GP	23	20	0	302	300
	CT3	0	5	0	0	61
	Trust Doctor	1	9	0	0	87
	SPR/SAS	6	6	0	112	112
North Durham	F2	5	5	0	37	37
	CT1/2/GP	19	19	0	229	229
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	SPR/SAS	28	28	0	512	512
South Durham	F2	4	4	0	24.5	24.5
	CT1/2/GP	12	12	0	107.5	107.5
	CT3	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
	SPR/SAS	59	59	0	1040	1040
Total		**172**	**170**	**0**	**2543**	**2531**

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	1	1	0	16	16
COVID isolation	13	13	0	128.5	128.5
Maternity leave	0	0	0	0	0
On call cover	113	113	0	1834.50	1834.5
Vacancy	8	8	0	98.5	98.5
Sickness	37	35	0	465.5	453.5
Extra support	0	0	0	0	0
Total	**172**	**170**	**0**	**2543**	**2531**

Vacancies

Vacancies by month						
Locality	**Grade**	**April 2022**	**May 2022**	**June 2022**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	1	1	1	1	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	1	1	1	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	1	1	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
Total		**3**	**3**	**3**	**3**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Teesside & Forensic	4	£528.20
North Durham	0	£00.00
South Durham	0	£00.00
Total	**0**	**£00.00**

Narrative – there may be more fines to be added in as the NROC period overlaps the end of this report.

Fines (cumulative)			
Balance at end of last quarter	**Fines this quarter**	**Disbursements this quarter**	**Balance at end of this quarter**
£2,091.82	**£528.20**	**£00.00**	**£2,620.02**

Purchases:

Coffee Pods - £746.58

Teaspoons - £2.40

Black Pens - £1.00

Mugs - £22.43

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 April 2022 up to 30th June 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	0	0	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	7	7	0
CT1-2 - York	0	9	9	0
CT3/ST4-6 – Northallerton	0	0	0	0
CT3/ST4-6 – Harrogate	0	0	0	0
CT3/ST4-6 – Scarborough	0	4	4	0
CT3/ST4-6 – York	0	14	14	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	0	0	0
Trust Doctors - York	0	0	0	0
Total	**0**	**34**	**34**	**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	9	9	0
Scarborough	0	11	11	0
Total	**0**	**20**	**20**	**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	0	5	4	0
Scarborough	0	5	6	0
Total	**0**	**0**	**0**	**0**

Narrative around Exception Reports

All exception reports for junior doctors on the Harrogate, Northallerton & York rota were either to claim additional payment following submission of the NROC form, or to report late finish to the normal working day.

The majority of exception reports for junior doctors on the Scarborough rota were either to claim additional payment following submission of the NROC form. There were 2 exceptions to report the inability to achieve 5 hours continuous rest between 10pm and 7am (Guardian fine) and 1 to report a late finish to the normal working day.

All exception reports from middle tier rotas were to either claim additional payment following submission of the NROC form or to report inadequate rest when on call (Guardian fines).

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	3	3	0	64	64
	CT1/2/GP	56	56	0	777.5	778
	CT3	8	8	0	130	130
	Trust Doctor	0	0	0	0	0
	ST4-6/SAS	47	47	0	872	872
Scarborough	F2	7	7	0	144	144
	CT1/2/GP	17	17	0	320	320
	CT3	2	2	0	32	32
	Trust Doctor	0	0	0	0	0
	ST4-6/ SAS	80	80	0	1496	1496
Total		**220**	**220**	**0**	**3835.5**	**3836**

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	24	24	0	448	448
Sickness	24	24	0	396	396
Other	172	172	0	2991.5	2992
Total	**220**	**220**	**0**	**3835.5**	**3836**

Vacancies

Vacancies by month						
Locality	**Grade**	**April 2022**	**May 2022**	**June 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	2.3	2.3	2.3	2.3	0
	CT3	0	0	0	0	0
	ST4 -6	3.6	3.6	3.6	3.6	0
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1/2/GP	1.2	1.2	1.2	1.2	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**7.1**	**7.1**	**7.1**	**7.1**	**0**

Fines

Fines by Locality		
Department	**Number of fines levied**	**Value of fines levied**
Scarborough	6	£834.78
North Yorkshire & York	16	£2,121.37
Total	22	£2,956.15

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£2,725.97	**£2,956.15**	**£0.00**	**£5,682.12**

Purchases

Coffee Pods - £553.32

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 16

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th July 2022**
TITLE:	**NENC Provider Collaborative Governance and Operating Model**
REPORT OF:	**NENC Provider Collaborative**
REPORT FOR:	**Tees, Esk and Wear Valley NHS Foundation Trust Board**

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

Executive Summary:

The Board is asked to approve the NENC Provider Collaborative governance arrangements including the formal Collaboration Agreement, which sets out how decisions are made, the Operating Model and its Ambitions approach. As part of the new system architecture NHS Trusts are required to be part of provider collaboratives. These are non-statutory bodies designed to bring providers together to act at scale and in the interest of the wider population. These documents:

- Establish the NENC Provider Collaborative as a collective decision and delivery mechanism for the 11 Foundation Trusts. It confirms that it will operate as a Provider Leadership Forum consisting of the Chief Executives or the nominated representatives. Final authority for decisions remains with Trust Boards

- The Operating Model sets out how the Collaborative will work, outlining the initial programmes that it will focus on noting that these will be linked to ICB objectives as well as areas where collectively the members feel joint action is required

- The Ambitions document summarises the Collaboratives purpose, function and aims primarily for an external audience.

Recommendations:

Members of the Trust Board are asked to:

1. Note the progress made on the development of the NENC Provider Collaborative
2. Note and formally approve the documents setting out the Collaboration Agreement, Operating Model and Our Ambition

NHS
North East and North Cumbria
Provider Collaborative

North East and North Cumbria Provider Collaborative Governance

Update for NHS Foundation Trust Boards

July 2022

1. Purpose

This report summarises the proposed formal work structure and governance for the North East and North Cumbria (NENC) Provider Collaborative, setting out how the 11 NHS Foundation Trusts (the Trusts) will operate, with the creation of a Provider Leadership Board (PLB), set out in the Ambition, Operating Model and Collaboration Agreement. There are separate arrangements for other collaboratives, such as those specifically for specialised mental health, learning disability and autism services.

Trust Boards are asked to note progress and confirm agreement to the proposed governance arrangements.

2. Context

National policy required that by the 1st July 2022 all NHS acute and mental health trusts are working as a provider collaborative with a requirement that they:

- Are formally convened with a focus on collaborative working to deliver local and national requirements
- Are established as a formal entity
- Have in place appropriate engagement and collective decision-making structures.

The intention of the legislation is that this supports closer system working and that it provides a basis for formal agreement between the Provider Collaborative and the Integrated Care Board (ICB) on jointly determined objectives and ways of working to deliver against those objectives.

Within NENC the 11 Foundation Trusts agreed to work together as a provider collaborative in September 2020. Since then, the Trusts have been developing working relationships, governance arrangements and determining areas for focus in the first instance. Though this work, the Provider Collaborative determined that this joint work would underpinned by four key documents:

1. A formal memorandum of agreement to be made between the Trusts, setting out how the Provider Collaborative will work, the **"Collaboration Agreement"**

2. A document setting out the aspiration and ambition that Trusts have together, as a form of prospectus, particularly designed for partners and stakeholders, in **"Our Ambition"**
3. A work programme which will need to evolve over time, setting out priorities and the mechanisms for operational delivery such as capacity, workstreams and meeting structures, the **"Operating Model"**
4. A documented agreement between the Provider Collaborative and the ICB, setting out a shared view on priorities, work areas for the Provider Collaborative to take forward on behalf of the ICB, accountabilities and resourcing, the **"Responsibility Agreement"**.

Since Summer 2021, the 11 Trusts have worked together to develop their governance model and wider approach through a series of facilitated workshops and along with specialist support from the legal firm Hill Dickinson to draft a governance structure.

3. Collaboration Agreement

The Collaborative Agreement includes as signatories all 11 Trust members of the Provider Collaborative, setting out the following key provisions:

- the overarching purpose and aims of the Collaborative and the status of the collaborative agreement;
- the proposed term of the agreement and arrangements for its regular review and updating;
- the principles of collaboration agreed between the Trusts, acknowledging each Trust's statutory duties and contractual obligations and the requirement for / ability of the Trusts to participate in other collaborative arrangements;
- the work programmes that have been agreed at the outset to be taken forward by the Collaborative and the resources the Trusts have agreed to commit (including to fund the Collaborative infrastructure (e.g. PMO)) etc;
- the governance arrangements to take forward the work programmes including the Provider Leadership Board and any sub-groups, together with terms of reference;
- a development plan setting out the key areas and priorities the Collaborative has agreed to focus on in further developing its governance and overall approach over the next 12-24 months;
- the process for resolving disagreements between the Trusts;
- the parameters of information sharing between the Trusts and dealing with conflicts of interest; and
- the process for members to terminate the arrangements, or for withdrawal of an individual Trust member and the process for admitting new members to the Collaborative.

The Collaboration Agreement sets out the governance approach, with a key vehicle for Provider Collaborative decision-making being the establishment of a 'Provider Leadership Board' (PLB). The Provider Leadership Board representation will be the Chief Executives of each of the 11 Trusts and is established as the overarching body, overseeing and directing the jointly agreed programme of work. Under this approach individual Trust boards would retain final decision-making authority with

each board giving their respective chief executive (or nominated organisational representative) delegated authority to make decisions as appropriate. Decisions would be made on a consensus basis.

A number of alternative approaches were considered that would see more formal delegation to the Provider Collaborative, but were not felt to be appropriate at this point. For reference, the key alternatives considered were Committees in Common (CiC) and Joint Committee (which are now permissible under the Health Act). In these approaches, formal decision making is delegated to organisational representatives with decisions taken in the CiC or Joint Committee binding on constituent organisations. In the provider leadership approach, final decisions rest with the individual organisations and this works on the basis that the partners trust agree formally to work together but individual trust boards retain full decision making powers.

The provider leadership model was felt to be appropriate as:

- It built from the existing model and work to date
- Allowed for a formalised decision making without becoming overly bureaucratic
- Was a flexible solution that could adjust to wider system working requirements as they evolve and emerge
- Was not restrictive, in that it would allow for growth and development into approaches which allowed for greater delegated authority, should the Trusts wish to evolve in that way over time.

The Collaboration Agreement sets out that the chair of the Provider Leadership Board would be one of the chief executives with a 24 month term of office, with a potential extension of a further 24 month term of office. The PLB Chair would be one of the two Integrated Care Board FT members and the tenure is aligned accordingly. A vice-chair would also be appointed, with the intention that the vice-chair is the successor to the chair, and a new vice-chair appointed by the Provider Leadership Board members. In January 2022, Ken Bremner was appointed as the chair and Lyn Simpson as the vice-chair.

4. Our Ambition

Our Ambition is intended to be a document that is externally facing, summarising how the Provider Collaborative seeks to deliver system priorities and how it will link, interface and work with other partners and stakeholders.

This document describes who the Provider Collaborative is, its role and what it seeks to achieve and how it will facilitate horizontal collaboration between Trusts. It highlights that the focus is at system level and therefore will complement and support work at place-level and with nested collaboratives, such as on a sub-regional basis. It recognises that there will be different partnership and collaborations at different levels in this system.

The Provider Collaborative will be one of a number of partnerships that the ICB will work with and through to deliver its overall aims and objectives. The role of the Provider Collaborative will be evolve over time in line with ICB requirements.

5. Operating Model

The Operating Model is intended to be a document that will evolve over time, setting out the key priorities for the Provider Collaborative and the way in which these will be taken forward operationally, including people, meeting and governance structures. The work programmes are structured around three broad areas of clinical, clinical support and corporate programmes, which is consistent with other, well-established provider collaboratives from around the country. The document sets out that the Provider Collaborative will have its own programmes and priorities as well as those agreed with the ICB.

The Provider Collaborative has set out to have a programme management approach with a particular focus over the next we months on:

- Clinical programmes, including
    - Elective and system recovery, reducing long waits for patients and taking forward the programme of transformation
    - Urgent and emergency care, supporting colleagues in local systems with collaborative solutions to pressures
    - Strategic approach to clinical services, tackling vulnerable services collectively such as issues with non-surgical oncology, supporting and leading clinical networks, and developing a strong model of clinical leadership
- Clinical support programmes, not least the development of the NENC Provider Collaborative Aseptics Manufacturing Hub and continuing to focus on collaborative opportunities for pathology and diagnostics
- Corporate programmes, where there are opportunities to make improvement by working together, particularly in seeking to take a more consistent, convergent approach to decisions affecting workforce and estates, while recognising the different circumstances for each organisation.

Programme reporting will be directly to the Provider Leadership Board, through Chief Executives taking on a Senior Responsible Officer role, supported by a programme management structure overseen by the Managing Director. Initial pump-priming resource to support the development of the collaborative and programme management capacity has come from NECS.

6. Integrated Care Board Working Arrangements (Responsibility Agreement)

The Collaborative Agreement, Operating Model and Our Ambition documents have been shared with the Integrated Care Board (ICB) and formally supported by the ICB Executive Team, prior to seeking final approval by FT Boards. The Provider Collaborative and the ICB are aligned on the intended priorities, governance approach and ways of working set out in these documents. However, it has not yet been possible to formally reflect this into a Responsibility Agreement, given the ICB has only been established in July 2022.

It was determined that the Collaboration Agreement, Operating Model and Our Ambition documents should be shared with Trust Boards for support and approval, whilst the Responsibility Agreement is developed. The Responsibility Agreement will be shared with Trust Boards once concluded and will document clearly shared priorities, governance, escalation, accountability and resourcing.

7. Recommendation

The FT Boards of the eleven NENC Provider Collaborative members are asked to:

- Note the progress made on the development of the NENC Provider Collaborative
- Note and formally approve the documents setting out the Collaboration Agreement, Operating Model and Our Ambition

Matt Brown

Managing Director

North East and North Cumbria Provider Collaborative

8th July 2022

Enclosures

- **Enc. A: Collaborative Agreement (MoU)**
- **Enc. B: Operating Model**
- **Enc. C: Ambitions Document**

Enclosure A

8TH JULY 2022

1. **COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST**
2. **CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST**
3. **GATESHEAD HEALTH NHS FOUNDATION TRUST**
4. **THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST**
5. **NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TUST**
6. **NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST**
7. **NORTH TEES AND HARTLEPOOL HOSPITALS NHS FOUNDATION TRUST**
8. **NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST**
9. **SOUTH TEES HOSPITALS NHS FOUNDATION TRUST**
10. **SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST**
11. **TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST**

COLLABORATION AGREEMENT

FOR THE NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE

No	Date	Version Number	Author
1	140322	1	Hill Dickinson (EV)
2	240322	2	Hill Dickinson (EV)
3	290422	3	PvCv (NS)
4	270622	4	PvCv (NS)
5	300622	5	PvCv (NS)
6	060722	6	PvCv (MB)

Contents

Overarching Note

This Collaboration Agreement is based on a memorandum of understanding approach to provide an overarching, non-legally binding, framework for collaboration between the Trust parties.

The Agreement sets out the current purpose, objectives, and initial priorities of the Collaborative. It also sets out its initial governance structure for the Trusts to come together to make aligned decisions in specific areas. The format of the Agreement is designed to work alongside existing services contracts held by the Trusts such as the NHS Standard Contract (the Services Contract), and does not affect or override any of the current Services Contracts in any way.

Some areas of the Agreement will need significant development around the nature and function of the Collaborative over time, as outlined in the Operating Model in Schedule 4. In particular, the Integrated Care Board (ICB) and Provider Collaborative have set out the need for a Responsibility Agreement, to define agreed areas of work, accountability, escalation and resourcing. This Responsibility Agreement will set out the part that the Provider Collaborative plays in the context of the wider system and will be developed throughout the Summer of 2022, following the formal establishment of the ICB.

The Integrated Care Board Executive team has supported the content of this Collaboration Agreement.

Date: **8th July 2022**

This **Collaboration Agreement** ("**Agreement"**) is made between:

1. **County Durham and Darlington NHS Foundation Trust** of Darlington Memorial Hospital Hollyhurst Road, Darlington, County Durham, DL3 6HX;

2. **Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust** of St. Nicholas Hospital, Jubilee Road, Gosforth, Newcastle upon Tyne NE3 3XT;

3. **Gateshead Health NHS Foundation Trust** of Queen Elizabeth Hospital, Sheriff Hill, Gateshead NE9 6SX;

4. **The Newcastle Upon Tyne Hospitals NHS Foundation Trust** of Freeman Hospital, Freeman Road, High Heaton, Newcastle upon Tyne, NE7 7DN;

5. **North Cumbria Integrated Care NHS Foundation Trust** of NCIC Trust HQ, Pillars Building, Cumberland Infirmary, Infirmary Street, Carlisle, CA2 7HY;

6. **North East Ambulance Service NHS Foundation Trust** of Bernicia House, Goldcrest Way Newburn Riverside, Newcastle upon Tyne, NE15 8NY;

7. **North Tees and Hartlepool Hospitals NHS Foundation Trust** of Hardwick Road, Hardwick, Stockton-on-Tees TS19 8PE;

8. **Northumbria Healthcare NHS Foundation Trust** of 7, Northumbria House, Cobalt Business Park, 8 Silver Fox Way, Newcastle upon Tyne NE27 0QJ;

9. **South Tees Hospitals NHS Foundation Trust** of The James Cook University Hospital, Marton Road, Middlesbrough, Cleveland, TS4 3BW;

10. **South Tyneside and Sunderland NHS Foundation Trust** of Sunderland Royal Hospital, Kayll Road, Sunderland, SR4 7TP;

11. **Tees, Esk and Wear Valleys NHS Foundation Trust** of Trust Headquarters, West Park Hospital, Edward Pease Way, Darlington, Durham, DL2 2TS,

together referred to in this Agreement as the "**Trusts**" and "**Trust**" shall be construed accordingly.

BACKGROUND

1. The white paper published by the Department of Health and Social Care in February 2021[1] (the "**White Paper**") builds on the NHS Long Term Plan vision of integrated care

[1] *Integration and Innovation: working together to improve health and social care for all* (Integration and Innovation:

and sets out the key components of a statutory integrated care system ("**ICS**"). One of these components is a provider collaborative, a partnership arrangement involving two or more trusts working across multiple places to realise the benefits of mutual aid and working at scale. The Health and Care Bill 2021 implements proposals from the White Paper with effect from 1 July 2022, including new mechanisms to enable provider NHS trusts to make joint decisions.

2. Guidance[2] states that provider collaboratives should have a shared purpose and effective decision-making arrangements to:

   (a) reduce unwarranted variation and inequality in health outcomes, access to services and experience;

   (b) improve resilience by, for example, providing mutual aid; and

   (c) ensure that specialisation and consolidation occur where this will provide better outcomes and value.

3. The Trusts have been working together informally as a provider collaborative since 2020 (the "**Collaborative"**). With the NHS North East & North Cumbria Integrated Care Board ("**ICB**") established on 1 July 2022 pursuant to the Health & Care Bill, there is a need for the Collaborative to formalise its governance arrangements and ways of working to ensure it can be proactive in setting its relationship with the ICB, and other stakeholders, moving forward.

4. Aligned to the Collaborative's agreed purpose, the Trusts have agreed to undertake several initial programmes of work that they will pursue through the Collaborative governance (see Schedule 3). The Trusts have also agreed a plan for the further development of the Collaborative from the Commencement Date, as detailed in the Operating Model in Schedule 4.

5. This Agreement provides an overarching governance framework for the Trusts to work and make decisions together on matters within the remit of the Collaborative. The framework set out is intended to enable, and not prevent, smaller groups of Trusts to come together on specific programmes of work where it makes sense for them to do so.

6. While, through this Agreement, the Trusts are documenting their agreed governance arrangements for the Collaborative as at the Commencement Date, the governance

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working together to improve health and social care for all (publishing.service.gov.uk)

[2] *Working together at scale: guidance on provider collaboratives* (NHS England, August 2021)

model is likely to evolve over time as the Trusts develop their working relationships further and as the ICB's operating model develops. A Responsibility Agreement will be developed to define the relationship between the ICB and the Collaborative. New governance mechanisms will become available when the Health & Care Bill becomes law, including the ability for the Trusts to form joint committees with each other, and with the ICB. The Collaborative will also need to evolve to be capable of receiving, delivering and providing assurance to the ICB on the exercise of any ICB functions delegated to or commissioned from the Collaborative, alongside any existing programmes agreed by the Trusts. It is therefore anticipated that this Agreement will be reviewed and updated regularly by agreement of the Trusts.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1 In this Agreement, capitalised words and expressions shall have the meanings given to them in Schedule 1.

1.2 In this Agreement, unless the context requires otherwise, the following rules of construction shall apply:

1.2.1 a person includes a natural person, corporate or unincorporated body (whether or not having separate legal personality);

1.2.2 a reference to a "**Trust**" includes its personal representatives, successors or permitted assigns;

1.2.3 a reference to a statute or statutory provision is a reference to such statute or provision as amended or re-enacted. A reference to a statute or statutory provision includes any subordinate legislation made under that statute or statutory provision, as amended or re-enacted;

1.2.4 any phrase introduced by the terms "**including**", "**include**", "**in particular**" or any similar expression shall be construed as illustrative and shall not limit the sense of the words preceding those terms; and

1.2.5 a reference to writing or written includes faxes and e-mails.

2. PURPOSE AND EFFECT OF THE AGREEMENT

2.1 The Trusts have agreed to work together to form a single voice and act in concert to bring further improvements to care in their combined areas of operation. The Trusts

wish to record the basis on which they will collaborate with each other in this Agreement and intend to act in accordance with its terms.

2.2 This Agreement sets out:

2.2.1 the agreed purpose, strategic objectives and principles of the Collaborative;

2.2.2 the initial Key Delivery Priorities for the Collaborative;

2.2.3 the governance structures the Trusts will put in place;

2.2.4 the programme management arrangements for the Collaborative;

2.2.5 the respective roles and responsibilities of the Trusts; and

2.2.6 a plan for the further development of the Collaborative for 2022/23, which the Trusts will work together to implement through this Agreement.

2.3 The Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this Agreement, this Agreement shall not be legally binding. The Trusts enter into this Agreement intending to honour all their obligations to each other.

3. ACTIONS TAKEN PRIOR TO AND POST THE COMMENCEMENT DATE

3.1 Each of the Trusts acknowledges and confirms that as at the date of this Agreement it has obtained all necessary authorisations to enter into this Agreement.

4. DURATION

4.1 This Agreement shall commence on the Commencement Date and will continue for the Initial Term, unless and until terminated in accordance with its terms.

4.2 On the expiry of the Initial Term this Agreement will expire automatically without notice unless, no later than 6 months before the end of the Initial Term, the Trusts agree in writing that the term of the Agreement will be extended for a further term to be agreed between the Trusts ("**Extended Term**").

4.3 The Trusts will review progress made by the Collaborative against the Key Delivery Priorities and the terms of this Agreement no later than 12 months following the Commencement Date and at such intervals thereafter as the Trusts may agree, but at least annually. The Trusts may agree to vary the Agreement to reflect developments as appropriate in accordance with Clause 16 (*Variations*).

5. THE COLLABORATIVE PURPOSE, OBJECTIVES AND PRIORITIES

5.1 The Trusts have agreed that the common purpose for the Collaborative is to bring together the Trusts in order to:

5.1.1 improve the health and wellbeing of the North East and North Cumbria population, with particular focus on improving health inequalities that exist within the region;

5.1.2 optimise the delivery, quality and efficiency of local health and care services provided by the Trusts; and

5.1.3 support the Trusts by taking the necessary collaborative, or where possible, collective, action, including mutual aid and support,

the "**Collaborative Purpose**".

5.2 The Trusts have agreed to work together to perform their obligations under this Agreement in order to achieve the Collaborative Purpose, and more specifically, have agreed the following objectives for the Collaborative:

5.2.1 development of a strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements;

5.2.2 delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets;

5.2.3 delivery of urgent care standards and requirements across providers and local systems to reduce variation and improve consistency of response;

5.2.4 building capacity and capability in clinical support services to achieve appropriate infrastructure in place to deliver strategy clinical aims; and

5.2.5 establishing and delivering appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates / capital processes and development of underpinning approaches to workforce,

(the "**Objectives**").

5.3 The Trusts have agreed a number of Key Delivery Priorities for 2022/23 in pursuit of the Objectives, as set out in Schedule 3. The Trusts will agree any changes to the Key Delivery Priorities during the NHS financial year 2022/23 if required, and will review and refresh the Key Delivery Priorities in any event in advance of each new NHS financial year.

5.4 Each programme of work within a Key Delivery Priority will be sponsored by a Trust Chief Executive as Senior Responsible Owner ("**SRO**"). SRO roles will be distributed across the Trust Chief Executives. Each SRO will be responsible to the Provider Leadership Board for the planning and delivery of their work programme and will be supported by the Programme Management Office.

5.5 The Trusts acknowledge and confirm that the success of the Collaborative will depend on the Trusts' ability to effectively co-ordinate and combine their expertise, workforce, and resources as providers in order to deliver the Key Delivery Priorities and achieve the Objectives.

5.6 Each Trust acknowledges that in order to achieve the Collaborative Purpose, it will need to collaborate with the other Trusts to provide mutual aid and solve challenges in line with the Collaborative Principles. Where practicable, the Trusts will work together to agree a joint plan for tackling such challenges which will also set out the agreed roles and responsibilities of each Trust.

5.7 The work of the Collaborative will be in the context of the Integrated Care System, in close partnership with the ICB, and will conducted in line with statutory and legislative requirements, such as the guidance on service change in the NHS[3].

6. THE COLLABORATIVE PRINCIPLES

6.1 The aim of this Clause 6 is to identify the high level collaborative principles which underpin how the Trusts will work together for the delivery of the Objectives and Key Delivery Priorities under this Agreement and to set out key factors for the success of the Collaborative.

6.2 The principles referred to in Clause 5.1 are that the Trusts will work together in good faith and, unless the provisions in their individual Services Contract(s) or this Agreement state otherwise, through the Collaborative the Trusts will:

6.2.1 look to provide mutual aid and support to each other in pursuit of the Collaborative Purpose and Objectives;

6.2.2 make collective decisions that speed up service changes and transformation, whilst ensuring that these are discussed with system partners, as relevant; and compliant with statutory and legislative requirements

[3] *Planning, assuring and delivering service change for patients* (NHS England, amended May 2022)

6.2.3 challenge and hold each other to account through agreed systems, processes and ways of working;

6.2.4 act collaboratively and in good faith with each other in accordance with Guidance, the Law and Good Practice to achieve national priorities and the Objectives having at all times regard to the welfare of the population of the North East and North Cumbria;

6.2.5 actively promote a culture that facilitates integrated working and empowers staff to work collaboratively with other Trust staff to deliver better outcomes for the population of the North East and North Cumbria;

6.2.6 ensure strong clinical leadership is built into the Collaborative governance and work programmes;

6.2.7 engage with and involve the population and wider stakeholders in the ICB area in relation to the work of the Collaborative, primarily through each Trust's membership of place-based partnerships within the ICB area;

6.2.8 support each other (informally and publicly) in taking decisions in the best interests of the North East and North Cumbria population;

6.2.9 take responsibility for and manage the risks in delivering the Key Delivery Priorities together as a Collaborative;

6.2.10 promote and develop a co-operative and high performing culture, and way of working across the Collaborative:

(i) that promotes and drives co-operation, innovation and continuous improvement;

(ii) where information is shared;

(iii) where communication is honest and respectful; and

(iv) which is founded upon ethical and responsible behaviour and decision making,

without losing sight of each Trust's corporate and statutory accountability;

together these are the "**Collaborative Principles**".

7. PROBLEM RESOLUTION AND ESCALATION

7.1 The Trusts agree to adopt a systematic approach to problem resolution between them on matters which relate to the Collaborative which recognises the Collaborative Principles, the Objectives and Key Delivery Priorities (set out in Clauses 5 and 6).

7.2 If a problem, issue, concern or complaint comes to the attention of a Trust in relation to the Key Delivery Priorities or any matter within the scope of this Agreement, such Trust shall notify the other Trusts and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion between the relevant affected Trusts.

7.3 Save as otherwise specifically provided for in this Agreement, any dispute arising between the Trusts out of or in connection with this Agreement will be resolved in accordance with Schedule 5 (*Dispute Resolution*).

7.4 If any Trust receives any formal inquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier) in relation to the Key Delivery Priorities or other work of the Collaborative, the Trust will liaise with the Provider Leadership Board as to the contents of any response before a response is issued.

8. OBLIGATIONS AND ROLES OF THE TRUSTS

8.1 Each Trust acknowledges and confirms that:

8.1.1 it remains responsible for performing its obligations and functions for delivery of services to the Commissioners in accordance with its Services Contract(s);

8.1.2 it will be separately and solely liable to the Commissioners for the provision of services under its own Services Contract; and

8.1.3 the intention of the Trusts is to work together with each other, and with the Commissioners, to achieve better use of resources and better outcomes for the population of the North East and North Cumbria initially in respect of the Key Delivery Priorities and to create a collaborative culture in, and between, their organisations.

8.2 Each Trust undertakes to co-operate in good faith with the others to facilitate the proper performance of this Agreement and in particular will:

8.2.1 use all reasonable endeavours to avoid unnecessary disputes and claims against any other Trust;

8.2.2 not interfere with the rights of any other Trust and its servants, agents, representatives, contractors or sub-contractors (of any tier) on its behalf in

performing its obligations under this Agreement nor in any other way hinder or prevent such other Trust or its servants, agents, representatives, or sub-contractors (of any tier) on its behalf from performing those obligations; and

8.2.3 (subject to Clause 8.3) assist the other Trusts (and their servants, agents, representatives, or sub-contractors (of any tier)) in performing those obligations so far as is reasonably practicable.

8.3 Nothing in Clause 8.2 shall:

8.3.1 interfere with the right of each of the Trusts to arrange its affairs in whatever manner it considers fit in order to perform its obligations under this Agreement in the manner in which it considers to be the most effective and efficient; or

8.3.2 oblige any Trust to incur any additional cost or expense or suffer any loss in excess of that required by its proper performance of its obligations under this Agreement.

8.4 Each of the Trusts severally undertakes that it shall:

8.4.1 subject to the provisions of this Agreement, comply with all Laws applicable to it which relate to the Key Delivery Priorities; and

8.4.2 inform the Provider Leadership Board as soon as reasonably practicable if at any time it becomes unable to meet any of its obligations and in such case inform, and keep the Provider Leadership Board informed, of any course of action to remedy the situation recommended or required by NHS England, the Secretary of State for Health and Social Care or other competent authority,

provided that, to avoid doubt, nothing in this Clause shall in any way fetter the discretion of the Trusts in fulfilling their statutory functions.

8.5 The Trusts have not agreed to share risk or reward between them under this Agreement and any future introduction of such provisions will require additional legally binding provisions to be agreed between the relevant Trusts.

9. COLLABORATIVE PROGRAMME MANAGEMENT RESOURCE

9.1 The Trusts have agreed that the Collaborative will be supported by a programme management office ("**PMO**"). The PMO will support each SRO in respect of the work programmes and Key Delivery Priorities. The initial PMO structure is set out in Schedule 4 (*Operating Model*).

9.2 For the financial year 2022/23, PMO costs will be met through a financial contribution to the Collaborative from the NHS North East Commissioning Support Unit. The Trusts acknowledge that the funding of the PMO and any other proposed supporting infrastructure for the Collaborative for NHS financial year 2023/24 and beyond will need to be discussed and agreed by the Trusts and may comprise or include financial or other resource contributions from the Trust members of the Collaborative.

10. REPORTING REQUIREMENTS

10.1 Each of the Trusts will during the Term:

10.1.1 promptly provide to the PMO or to any other Trust involved in the delivery of the Key Delivery Priorities, such information about their work in respect of such Key Delivery Priorities and such co-operation and access as the PMO or other Trust may reasonably require from time to time in line with the Collaborative Principles, provided that if the provision of such information, co-operation or access amounts to a change to this Agreement then it will need to be proposed as such to the Provider Leadership Board and the variation procedure set out in Clause 16 will apply; and

10.1.2 identify and obtain all consents necessary for the fulfilment of its obligations in respect of the Key Delivery Priorities,

limited in each case to the extent that such action does not cause a Trust to be in breach of any Law, its obligations under Clause 12 (*Information Sharing and Conflicts of Interest*) Clause 17 (*Confidentiality*) or any legally binding confidentiality obligations owed to a third party.

11. GOVERNANCE

11.1 The Trusts all agree to establish the Provider Leadership Board ("**PLB**"). For the avoidance of doubt the PLB shall not be a committee of any Trust or any combination of Trusts.

11.2 The PLB is the group responsible for leading and overseeing the Trusts' collaborative approach to the Key Delivery Priorities and working in accordance with the Collaborative Principles. The PLB may establish supporting and/or task and finish groups to take forward programmes in respect of the Key Delivery Priorities as appropriate, ensuring a strong clinical voice and involving input from a range of functions across the Trusts. The PLB will have other responsibilities as defined in its terms of reference set out in Schedule 2 (Provider Leadership Board – Terms of Reference).

11.3 The PLB will invite the Chairs of each Trust's board to a meeting of the PLB at 6 monthly intervals in order to brief the Chairs on the Collaborative's work and progress against the Objectives and Key Delivery Priorities.

11.4 The Trusts will communicate with each other clearly, directly and in a timely manner to ensure that the members of the PLB are able to make effective and timely decisions.

11.5 The Trusts will ensure appropriate attendance from their respective organisations at all meetings of the PLB and that their representatives act in accordance with the Collaborative Principles.

11.6 The Trusts acknowledge that they each participate in other collaborative arrangements outside of the Collaborative, including with other providers on a sector basis, and at place level. The Trusts will work together to ensure that the governance arrangements under this Agreement are streamlined and do not unnecessarily duplicate decision-making arrangements in other collaboratives.

12. INFORMATION SHARING AND CONFLICTS OF INTEREST

12.1 The Trusts will provide to each other all information that is reasonably required in order to deliver the Key Delivery Priorities and achieve the Objectives.

12.2 The Trusts have obligations to comply with competition law. The Trusts will therefore make sure that they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law and, accordingly, the PLB will ensure that the exchange of Competition Sensitive Information will be restricted to circumstances where:

12.2.1 it is essential;

12.2.2 it is not exchanged more widely than necessary;

12.2.3 it is subject to suitable non-disclosure or confidentiality agreements which include a requirement for the recipient to destroy or return it on request or on termination or expiry of the Agreement; and

12.2.4 it may not be used other than to achieve the Collaborative Purpose and Objectives under this Agreement in accordance with the Collaborative Principles.

12.3 The Trusts acknowledge that it is for each Trust to decide whether information is Competition Sensitive Information but recognise that it is normally considered to include any internal commercial information which, if it is shared between Trusts who are

providers, would allow them to forecast or co-ordinate commercial strategy or behaviour in any market.

12.4 The Trusts will make sure the PLB establishes appropriate non-disclosure or confidentiality agreements between and within the Trusts so as to ensure that Competition Sensitive Information and Confidential Information are only available to those Trusts who need to see it for the purposes of the better delivery of the Key Delivery Priorities and Objectives and for no other purpose whatsoever so that they do not breach competition law.

12.5 It is accepted that the involvement of the Trusts in this Agreement may give rise to situations where information will be generated and made available to the Trusts, which could give them an unfair advantage in competitions or which may be capable of distorting such competitions (for example, disclosure of pricing information or approach to risk may provide one Trust with a commercial advantage over a separate Trust). The Trusts therefore recognise the need to manage the information referred to in this Clause 12.5 in a way which maximises their opportunity to take part in competitions operated by the Commissioners by putting in place appropriate procedures, such as appropriate non-disclosure or confidentiality agreements in advance of the disclosure of information.

12.6 Where there are any Patient Safety Incidents or Information Governance Breaches relating to the Key Delivery Priorities, for example, the Trusts shall ensure that they each comply with their individual Services Contract and work collectively and share all relevant information for the purposes of any investigations and/or remedial plans to be put in place, as well as for the purposes of learning lessons in order to avoid such Patient Safety Incident or Information Governance Breach in the future.

12.7 The Trusts will:

12.7.1 disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this Agreement or the delivery of the Key Delivery Priorities, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Trust or any person employed or retained by them for or in connection with the delivery of the Key Delivery Priorities or Objectives;

12.7.2 not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this Agreement (without the prior consent of the other Trusts) before they participate in any decision in respect of that matter; and

12.7.3 use best endeavours to ensure that their representatives on the PLB and other Collaborative governance groups also comply with the requirements of this Clause 12 when acting in connection with this Agreement.

12.8 The Trusts shall comply with their obligations under the Data Protection Legislation.

13. TERMINATION, EXCLUSION AND WITHDRAWAL

13.1 The PLB may resolve to terminate this Agreement in whole where:

13.1.1 a Dispute cannot be resolved pursuant to the Dispute Resolution Procedure;

13.1.2 automatically and immediately where there exists just one Trust that remains party to this Agreement; or

13.1.3 where the Trusts agree for this Agreement to be replaced by a formal legally binding agreement between them.

Exclusion

13.2 A Trust may be excluded from this Agreement on written notice from all of the remaining Trusts in the event of a material or a persistent breach of the terms of this Agreement by the relevant Trust which has not been rectified within 30 calendar days of notification issued by the remaining Trusts or which is not reasonably capable of remedy. In such circumstances this Agreement shall be partially terminated in respect of the excluded Trust.

Voluntary withdrawal of a Trust

13.3 Any Trust may withdraw from this Agreement by giving at least 60 calendar days' notice in writing to the other Trusts.

Consequences of termination / exclusion / withdrawal

13.4 Where a Trust is excluded from this Agreement, or withdraws from it, the excluded Trust shall procure that all data and other material belonging to any other Trust shall be delivered back to the relevant Trust, deleted or destroyed as soon as reasonably practicable and confirm to the remaining Trusts when this has been completed.

14. INTRODUCING NEW PROVIDERS

14.1 Additional providers may become parties to this Agreement on such terms as the Trusts will jointly agree, acting at all times in accordance with the Collaborative

Principles. Any new provider will be required to agree to the terms of this Agreement before admission.

15. CHARGES AND LIABILITIES

15.1 Except as otherwise provided, the Trusts shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement, including in respect of any losses or liabilities incurred due to their own or their employees' actions.

15.2 Except as otherwise provided, no Trust intends that any other Trust shall be liable for any loss it suffers as a result of this Agreement.

16. VARIATIONS

16.1 The provisions of this Agreement may be varied at any time by a Notice of Variation signed by the Trusts in accordance with this Clause 16.

16.2 If a Trust wishes to propose a variation to this Agreement ("**Variation**"), that Trust must submit a draft notice setting out their proposals in accordance with Clause 16.3 (a "**Notice of Variation**") to the other Trusts and the Chair of the PLB to be considered at the next meeting (or when otherwise determined by the Trusts) of the PLB.

16.3 A draft Notice of Variation must set out:

16.3.1 the Variation proposed and details of the consequential amendments to be made to the provisions of this Agreement;

16.3.2 the date on which the Variation is proposed to take effect;

16.3.3 the impact of the Variation on the achievement of the Key Delivery Priorities and Objectives; and

16.3.4 any impact of the Variation on any Services Contracts.

16.4 The PLB will consider the draft Notice of Variation and either:

16.4.1 accept the draft Notice of Variation (all Trusts consenting), in which case all Trusts will sign the Notice of Variation;

16.4.2 amend the draft Notice of Variation, such that it is agreeable to all Trusts, in which case all Trusts will sign the amended Notice of Variation; or

16.4.3 not accept the draft Notice of Variation, in which case the minutes of the relevant PLB shall set out the grounds for non-acceptance.

16.5 Any Notice of Variation of this Agreement will not be binding unless set out in writing and signed by or on behalf of each of the Trusts.

17. CONFIDENTIAL INFORMATION

17.1 Each Trust shall keep in strict confidence all Confidential Information it receives from another Trust except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Trust. Each Trust shall use any Confidential Information received from another Trust solely for the purpose of delivering the Key Delivery Priorities and complying with its obligations under this Agreement in accordance with the Collaborative Principles and for no other purpose. No Trust shall use any Confidential Information received under this Agreement for any other purpose including use for their own commercial gain in services outside of the Key Delivery Priorities or to inform any competitive bid for any elements of the Key Delivery Priorities without the express written permission of the disclosing Trust.

17.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Trust or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Trust may have in respect of such Confidential Information.

17.3 The Parties agree to procure, as far as is reasonably practicable, that the terms of this Clause 17 (*Confidential Information*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Agreement.

17.4 Nothing in this Clause 17 (*Confidential Information*) will affect any of the Trusts' regulatory or statutory obligations, including but not limited to competition law.

18. INTELLECTUAL PROPERTY

18.1 In order to meet the Collaborative Purpose and Objectives each Trust grants to each of the other Trusts a fully paid up non-exclusive licence to use its existing Intellectual Property provided under this Agreement insofar as is reasonably required for the sole purpose of the fulfilment of that Trusts' respective obligations under this Agreement.

New Intellectual Property

18.2 If any Trust creates any new Intellectual Property through the operation of the Collaborative, the Trust which creates the new Intellectual Property will grant to the other Trusts a fully paid up non-exclusive licence to use the new Intellectual Property for the sole purpose of the fulfilment of that Trusts' obligations under this Agreement.

19. FREEDOM OF INFORMATION

19.1 If any Trust receives a request for information relating to this Agreement or the Integrated Services under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004, it shall consult with the other Trusts before responding to such request and, in particular, shall have due regard to any claim by any other Trust to this Agreement that the exemptions relating to commercial confidence and/or confidentiality apply to the information sought.

20. NOTICES

20.1 Any notice or other communication given to a Trust under or in connection with this Agreement shall be in writing addressed to that Trust at its principal place of business or such other address as that Trust may have specified to the other Trust in writing in accordance with this Clause, and shall be delivered personally, or sent by pre-paid first class post, recorded delivery or commercial courier.

20.2 A notice or other communication shall be deemed to have been received: if delivered personally, when left at the address referred to in Clause 20.1; if sent by pre-paid first class post or recorded delivery, at 9.00 am on the second Operational Day after posting; or, if delivered by commercial courier, on the date and at the time that the courier's delivery receipt is signed.

21. NO PARTNERSHIP

21.1 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership between any of the Trusts, constitute any Trust the agent of another Trust, nor authorise any Trust to make or enter into any commitments for or on behalf of any other Trust except as expressly provided in this Agreement.

22. COUNTERPARTS

22.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement. The expression "counterpart" shall include any executed copy of this Agreement scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment. No counterpart shall be effective until each Trust has executed at least one counterpart.

23. GOVERNING LAW AND JURISDICTION

23.1 This Agreement, and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims), shall be governed by, and construed in accordance with, English law, and, subject to Clause 6, the Trusts irrevocably submit to the exclusive jurisdiction of the courts of England.

Signed by .....

for and on behalf of **COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **CUMBRIA, NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **GATESHEAD HEALTH NHS FOUNDATION TRUST** [ ]

Signed by .....

for and on behalf of **THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST** [ ]

Signed by	.....
for and on behalf of **NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST**	[ ]
Signed by	.....
for and on behalf of **NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST**	[ ]
Signed by	.....
for and on behalf of **NORTH TEES AND HARTLEPOOL HOSPITALS NHS FOUNDATION TRUST**	[ ]
Signed by	.....
for and on behalf of **NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST**	[ ]
Signed by	.....
for and on behalf of **SOUTH TEES HOSPITALS NHS FOUNDATION TRUST**	[ ]

Signed by for and on behalf of **SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST**	..... [ ]
Signed by for and on behalf **TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST**	..... [ ]

SCHEDULE 1

Definitions and Interpretation

1 The following words and phrases have the following meanings in this Agreement:

Agreement	this collaboration agreement incorporating the Schedules
Collaborative	the provider collaborative formed by the Trusts and as detailed pursuant to this Agreement
Collaborative Principles	the collaborative principles for the Collaborative as set out in Clause 6.2
Collaborative Purpose	the common purpose for the Collaborative as set out in Clause 5.1
Commencement Date	1 April 2022
Commissioners	Pre 1 July 2022: Clinical commissioning groups in the North East and North Cumbria ICS area Post 1 July 2022: the ICB
Competition Sensitive Information	Confidential Information which is owned, produced and marked as Competition Sensitive Information by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law. Competition Sensitive Information may include, by way of illustration, trade secrets, confidential financial information and confidential commercial information, including without limitation, information relating to the terms of actual or proposed contracts or sub-contract arrangements (including bids received under competitive tendering), future pricing, business strategy and costs data, as may be utilised, produced or recorded by any Trust, the publication of which an organisation in the same business would reasonably be able to expect to protect by virtue of business confidentiality provisions

Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement, including Commercially Sensitive Information and Competition Sensitive Information;
Data Protection Legislation	all applicable Laws relating to data protection and privacy including without limitation the UK GDPR; the Data Protection Act 2018; the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426); the common law duty of confidentiality and the guidance and codes of practice issued by the Information Commissioner, relevant Government department or regulatory in relation to such applicable Laws
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it
Dispute Resolution Procedure	the procedure set out in Schedule 5 (*Dispute Resolution Procedure*) to this Agreement
Extended Term	has the meaning set out in Clause 4.2
Good Practice	has the meaning set out in the Services Contracts
Guidance	any applicable health or social care guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the Trusts have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Trust by a Commissioner and/or any relevant regulatory body
ICB	NHS North East and North Cumbria Integrated Care Board, expected to be established on 1 July 2022
IG Guidance for Serious Incidents	NHS Digital's Checklist Guidance for Information Governance Serious Incidents Requiring Investigation June 2013,

	available at Data Security and Protection Toolkit - NHS Digital
Information Governance Breach	an information governance serious incident requiring investigation, as defined in the IG Guidance for Serious Incidents
Initial Term	3 years from the Commencement Date
Intellectual Property	patents, rights to inventions, copyright and related rights, trade marks, business names and domain names, goodwill, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, Confidential Information and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world
Key Delivery Priorities	the priorities of the Collaborative, the initial priorities being those set out in Schedule 3, as may be amended from time to time by a Notice of Variation
Law	(a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (b) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (c) any applicable judgment of a relevant court of law which is a binding precedent in England; (d) Guidance; and (e) any applicable code in each case in force in England and Wales, and "Laws" shall be construed accordingly

NHS Standard Contract	the NHS Standard Contract as published by NHS England from time to time
Notice of Variation	has the meaning set out in Clause 16.2
Objectives	the objectives for the Collaborative as set out in Clause 5.2, as may be amended from time to time
Operational Days	a day other than a Saturday, Sunday or bank holiday in England
Patient Safety Incident	any unintended or unexpected incident that occurs in respect of a Service User, during and as a result of the provision of the Services, that could have led, or did lead to, harm to that Service User
Programme Management Office or PMO	the programme management office for the Collaborative, as further described in Clause 9.1 and Schedule 4 (*Operating Model*)
Operating Model	Document that describes how the Collaborative will work summarised in in Schedule 4 (*Operating Model*)
Provider Leadership Board or PLB	the group established by the Trusts pursuant to Clause 11.1, the terms of reference for which are set out in Schedule 2 (*Governance*)
Senior Responsible Owner or SRO	a Trust Chief Executive responsible for the planning and delivery of a work programme pursuant to a Key Delivery Priority
Services	the services provided, or to be provided, by a Trust to a Commissioner pursuant to its respective Services Contract which may include services which are the subject of one or more Key Delivery Priorities for the Collaborative
Services Contract	a contract entered into by one of the Commissioners and a Trust for the provision of Services, and references to a Services Contract include all or any one of those contracts as the context requires
Service User	a patient or service user for whom a Commissioner has

	statutory responsibility and who receives Services under any Services Contract
Term	the Initial Term of this Agreement plus any Extended Term(s) agreed in accordance with the terms of this Agreement
UK GDPR	has the meaning given to it in section 3(1) (as supplemented by section 205(4) of the Data Protection Act 2018
Variation	a proposed variation to this Agreement, effected in accordance with Clause 16
White Paper	has the meaning set out in Background paragraph 1.

SCHEDULE 2

Governance

Terms of Reference for the Provider Leadership Board

NORTH EAST AND NORTH CUMBRIA PROVIDER COLLABORATIVE PROVIDER LEADERSHIP BOARD Terms of Reference	
Version	**1.0**
Implementation Date	**1 April 2022**
Review Date	**1 April 2023**
Approved By	**Trust boards**
Approval Date	**8 July 2022**

REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**

1.	Purpose	The purpose of the Provider Leadership Board ("PLB") is to provide strategic leadership of the North East and North Cumbria Provider Collaborative (the "Collaborative") in setting its strategic direction and

		priorities. The PLB will oversee the delivery of the Collaborative Purpose, Objectives and Key Delivery Priorities (as set out in the Agreement and Operating Model).
2.	Status and authority	The PLB is established by the Trusts, each of which remains a sovereign organisation, to provide a governance framework for the further development of collaborative working between the Trusts in line with the Collaborative Principles. The PLB is not a separate legal entity, and as such is unable to take decisions separately from the Trusts, or bind any one of them; nor can one Trust 'overrule' any other on any matter. As a result, the PLB will operate as a place for discussion of issues with the aim of reaching consensus between the Trusts to make recommendations and proposals to statutory Trust boards as necessary. The PLB will function through engagement and discussion between its members so that each of the Trusts makes a decision in respect of, and expresses its views about, each matter considered by the PLB. The decisions of the PLB will, therefore, be the decisions of the individual Trusts, the mechanism for which shall be authority delegated by the individual Trusts to their members on the PLB. Each Trust will ensure that their designated member: - is appointed to attend and represent their Trust on the PLB with such authority as is agreed to be necessary for the PLB to function effectively in discharging its responsibilities as set out in these terms of reference which is to the extent necessary, recognised in the relevant Trust's respective scheme of delegation - has equivalent delegated authority to the designated representatives of all other Trusts comprising the PLB (as confirmed in writing and agreed between the Trusts); and - understands the status of the PLB and the limits of their responsibilities and authority.
3.	Accountability	The PLB is accountable to each of the boards of the Trusts.
4.	Responsibilities	The PLB is responsible for leading the Trusts' collaborative approach to the Collaborative Objectives and Key Delivery Priorities working in

		accordance with the Collaborative Principles, in line with the terms of the Agreement. The PLB members will make decisions together at PLB meetings in respect of the Key Delivery Priorities, including in relation to recommendations from supporting/working groups as may be established by the PLB from time to time. The PLB will also be responsible for developing the Trusts' collaborative approach across the North East and North Cumbria and beyond the initial Key Delivery Priorities. When making decisions together at PLB meetings, the PLB members will act in line with the Collaborative Principles and their respective obligations under the Agreement. The PLB may establish working groups and/or task and finish groups to support its agreed functions.
5.	Membership and attendance	The PLB will include the following members: - The Chief Executive or nominated deputy from each Trust signatory to the Agreement as notified to the PLB from time to time. It is important that members or their deputies commit to attending PLB meetings. Where a member cannot attend a meeting, the member may nominate a named deputy to attend, provided that the member gives reasonable notice of the deputy attending to the chair. Deputies must be able to contribute and make decisions on behalf of the Trust they are representing. The PLB may invite others to attend, observe and/or participate in PLB meetings, as agreed by the members from time to time. Such attendees shall not participate in decision-making or count towards the quorum.
6.	Quorum	The PLB will be quorate if eight (8) of the Trust members of the PLB, one of whom is the chair, are present.
7.	Chairing arrangements	Meetings of the PLB will be chaired by a member, initially selected by a vote of attending members at the first meeting of the PLB and thereafter on an agreed schedule where the chair is rotated to each member in turn with each carrying out the role for a twenty four (24) month period, with a potential extension for a further twenty four

		months (to align with ICB representative requirements). The successor chair in line with the agreed schedule will be the vice-chair for the preceding twenty four (24)month period to their appointment as chair.
8.	Decision making	The PLB will aim to achieve consensus wherever possible. Each member of the PLB will be representing their appointing Trust and will only make decisions at the PLB in respect of their own Trust in accordance with any delegated authority. Not all decisions within the remit of the PLB will affect all of the Trusts. Where this is the case, and the members of the PLB agree which of the Trusts are affected by a decision, then the relevant decision will be taken by the members of the affected Trusts, with the aim of achieving consensus.
9.	Conduct of business	Meetings of the PLB will be held monthly or such other frequency as may be agreed between the Trusts. Meetings may be held by telephone or video conference. Members of the PLB may participate (and count towards quorum) in a face-to-face meeting via telephone or video-conference. Any member may call extraordinary meetings of the PLB at their discretion subject to providing at least five working days' notice to PLB members. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting from the Chair. In the event members wish to add an item to the agenda they must notify the Chair. Requests made less than 7 working days before a meeting may be included on the agenda at the discretion of the Chair. The PLB will have administrative support from the Programme Management Office of the Collaborative to: - take minutes of the meetings and keep a record of matters arising and issues to be carried forward; and - maintain a register of interests of PLB members. Draft minutes of PLB meetings will be sent to the Trust's representative members within 14 days of each meeting. Approval of the minutes of the previous meeting of the PLB will be a standing

		item on each meeting agenda. It will be the members' responsibility to disseminate minutes and notes from the PLB inside their respective Trusts.
10.	Conflicts of interest	The members of the PLB must refrain from actions that are likely to create any actual or perceived conflicts of interests. PLB members must disclose all actual, potential or perceived conflicts of interest to the Chair in advance of each meeting to enable appropriate management arrangements to be put in place and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties. All members are required to uphold the Nolan Principles and all other relevant NHS requirements applicable to them. If there is any conflict between these terms of reference and the Agreement, the latter will prevail.
11.	Review	These terms of reference will be reviewed on an annual basis.

SCHEDULE 3

Key Delivery Priorities for 2022/23

The Trusts have identified the initial Key Delivery Priorities for the Collaborative (as may be agreed and amended from time to time) below.

The inclusion of any additional Key Delivery Priorities under this Schedule may only be made with the mutual written consent of all the Trusts.

NENC PvCv will:

- Optimise the resource available for healthcare (by collectively organising, managing and deploying workforce where appropriate, utilising the full NHS estate to best effect, sharing risk and gains financially to deliver an overall balanced position etc)
- Standardise pathways and interventions to reduce unwarranted clinical variation, thereby achieving improved outcomes for patients and more efficient use of the capacity available
- Leverage the assets within the PC that Trusts offer to attract inward investment (e.g. AHSC, Centre for Ageing, BRC, TREE, innovation appetite and opportunity) but this needs to be part of a coherent approach playing to the academic strengths of the member Trusts
- Facilitate data sharing to enable the NHS and care resource to be targeted more closely to need; to reduce inequalities and improve the equity of patient outcomes across the ICS and to enable prediction and prevention of health and care demand.
- Support member Trusts individually in their role as anchor institutions with the PvCV acting as a bridge aid economic recovery and the prevention agenda (through providing employment opportunities, local procurement and commitment to overall NE achievement of carbon net zero)

Given this overarching approach the PvCv will operate across four strategic objectives (underpinning work for 2022-25):

<u>Clinical Programmes</u>

1. Development of strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements

2. Delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets

3. Delivery urgent care standards and requirements across providers and local systems to reduce variation and improve consistency of response

<u>Clinical Support Programmes</u>

4. Building capacity and capability in clinical support services to achieve appropriate infrastructure in place to delivery strategic clinical aims

<u>Corporate Programmes</u>

5. Establish and deliver appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates/capital process and development of underpinning approaches in workforce.

Provider Collaborative Development

6. To continue to build capacity and capability within and across the PvCv to meet ongoing requirements.

NENC Key Delivery Priorities for 2022/23

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
Clinical Programmes				
Strategic Objective 1				
1. Strategic Approach to Clinical Services *Development of strategic approach to clinical services focusing on vulnerable services and a strategic response to clinical networks and associated cross system working arrangements*	Working with ICB to develop overarching clinical strategy/approach in line with system priorities. Focus action on agreed risk/vulnerable areas (e.g. Clinical Oncology)	Tbc	Overarching clinical aligned clinical strategy in place. Agreed action delivered for identified areas: non-surgical medical oncology revised arrangements in place with evaluation complete by q4 22/23 with view to sustainable system approach for 23/24	Range of groups support clinical strategy with ICS/B focus through Optimising Health group. Specific mechanisms targeted for work include Cancer Alliance. Clinical Networks range of responsibility/accountability arrangements linked to commissioning.
Strategic Objective 2				
2. Elective recovery *Delivery of elective recovery (covering inpatient, diagnostics and cancer) to meet or exceed national benchmarks, standards and targets*	Working through established COOs and associated mechanism formally brought under PvCv (with ICB agreement). Elective Board established	In line with national milestones	Performance in line (or exceeding) national milestones Development of elective centres, management of waiting list and associated innovations	SRO leadership from PvCv. Elective Board reporting to ICB established with operational delivery through PvCv COOs group. Requirement to establish mechanism for longer term transformation. (Note linkages to wider system groups e.g. 'Waiting Well'.
Strategic Objective 3				
3. Urgent Care *Delivery urgent care standards and requirements across providers and local systems*	Working through established locality and system groups PvCv will take overview through SRO putting in place action at system levels as necessary	In line with national milestones	Performance in line (or exceeding) national milestones	SRO lead from PvCv Established locality structure feeding through to ICP and system level group

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
to reduce variation and improve consistency of response				
Clinical Support Programmes				
Strategic Objective 4: *Building capacity and capability in clinical support services to achieve appropriate infrastructure in place to delivery strategic clinical aims*				
1.Clinical Support Services – Diagnostics & Pathology	Establish working groups under auspices of agreed SRO	Tbc	Delivery in line with plans	Program developed under Optimising Health with CEO SRO leadership for specific elements
2.Clinical Support Services – Aseptics Pharmacy	Time limited project group established to lead work	Q2 – delivery of outline business case Q4 – Full service model & plan	Agreement of approach to aseptic services across provider collaborative Plan and delivery of revised (agreed) model	Project established under auspices of PvCv with SRO leadership in place
Corporate Support Programmes				
Strategic Objective 5: *Establish and deliver appropriate corporate strategies to enhance integration and tackle variation including approaches to collective planning, rationalised and aligned estates/capital process and development of underpinning approaches in workforce.*				
1.Corporate Strategy – assessment of requirements	Review of existing mechanism to establish opportunities, requirements and potential approaches with development of agreed programme	Q2 – Delivery of proposal	Establishment of work programme with clear reporting and associated requirements	Tbc
2.Corporate strategy – Estates/finance/planning	Establishment of agreed approach to capital prioritisation, finance and planning to deliver collective	As per agreed milestones	As per agreed outcomes	SRO for Capital/Estates work established, agreed planning approach for 22/23.

Key delivery priority	How will we deliver it?	Q in which it will be achieved?	How will we know it has been achieved?	Current Delivery Mechanism
	response			
Provider Collaborative Development				
1. Establish the collaborative as a vehicle for our joint work with appropriate governance, methods of working (with CEOs leading work streams) and a resource plan	Formalisation of PvCv as a Provider Leadership Forum with associated governance arrangements	Q1 22/23	Sign off by PvCv with updates agreed via constituent Trust boards	
2. Development of appropriate programme management structures and support to deliver programmes (including reporting and associated oversight)	Identification of resource needs and requirements on a rolling basis (noting some elements will link to existing programmes, require support as part of ICS changes as well as utilisation of internal resource)	Rolling implementation based on agreed programmes and support Established reporting and associated structures	Clear, accountable SRO arrangements for programmes agreed for the PvCv delivery with agreed support implemented	

SCHEDULE 4

Operating Model

The Operating Model is the overarching document that describes what the Collaborative is, its purpose and how it works. Along with the Collaborative's Ambitions document the Operating Model has two core functions/purposes to provide:

1. A summary of what the Collaborative is, how it works and its membership in order to support discussion and agreement of the role the Collaborative will play in the NENC integrated care system as well as facilitating the agreement of the specific system objectives the Collaborative will be leading on and supporting. This is detailed in the Operating Plan but also set out in the Ambitions document.
2. Detail on the mechanism and approaches the Collaborative will use describing the programmes and detailing the specific requirements for delivery.

The Operating Model recognises that the Collaborative's role within the NENC ICS has three dimensions:

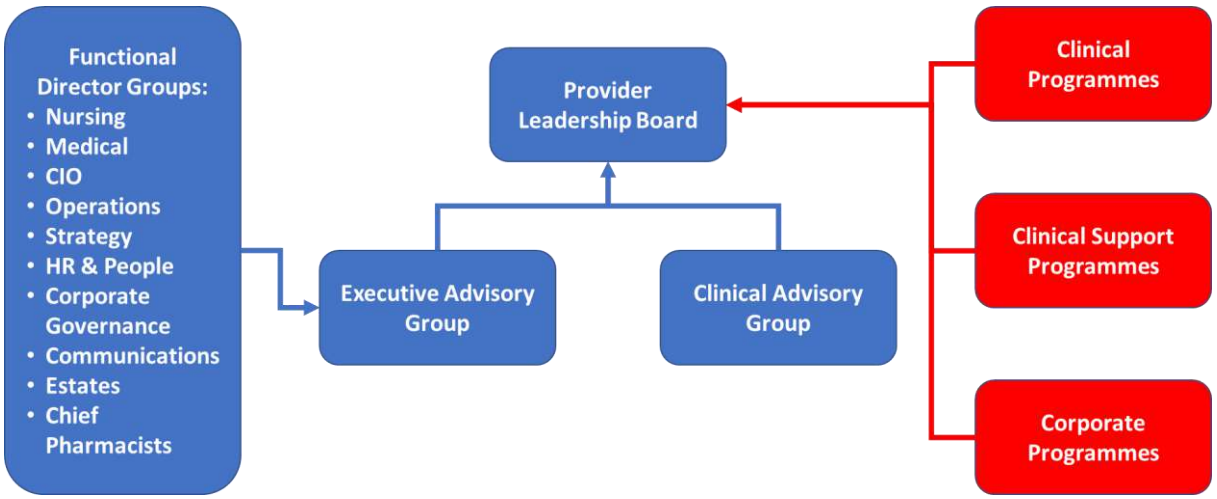
- Where the PvCv is leading on agreed objectives, with delegated authority and responsibility from the ICB
- Where the PvCv is working jointly, in partnership with ICB; working through existing mechanisms and/or groups (either leading or supporting) or as a joint committee of the ICB

It is recognised that depending on the issue, objective and requirement there may be different approaches needed for delivery

- In addition to the work to delivery ICS objectives there will be elements of the PvCv work that reflects the member's needs, requirements and priorities.

The following graphic summarises the PvCv operational model (as at April 2022), with full details found in the Operating Model and Ambitions document

Figure 1: Summary of NENC Provider Collaborative Operating Model



SCHEDULE 5

Dispute Resolution Procedure

1 Avoiding and Solving Disputes

1.1. The Trusts commit to working co-operatively to identify and resolve issues to mutual satisfaction so as to avoid so far as possible dispute or conflict in performing their obligations under this Agreement. Accordingly, the Trusts shall collaborate and resolve differences between them in accordance with Clause 7 (*Problem Resolution and Escalation*) of Agreement prior to commencing this procedure.

1.2. The Trusts believe that:

1.2.1. by focusing on the Collaborative Principles;

1.2.2. being collectively responsible for all risks; and

1.2.3. fairly sharing risk and rewards,

they will reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with the Key Delivery Priorities.

1.3. The Trusts shall promptly notify each other of any dispute or claim or any potential dispute or claim in relation to this Agreement (each a "**Dispute**") when it arises.

1.4. The Provider Leadership Board shall seek to resolve any Dispute to the mutual satisfaction of each of the Trusts involved in the Dispute.

1.5. The Provider Leadership Board shall deal proactively with any Dispute in accordance with the Collaborative Principles and this Agreement so as to seek to reach a unanimous decision. If the Provider Leadership Board reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Trusts involved in the Dispute of its decision by written notice.

1.6. The Trusts agree that the Provider Leadership Board may determine whatever action it believes is necessary including the following:

1.6.1. if the Provider Leadership Board cannot resolve a Dispute, it may select an independent facilitator to assist with resolving the Dispute; and

1.6.2. the independent facilitator shall:

1.6.2.1. subject to the provisions of this Agreement, be provided with any information they request about the Dispute;

1.6.2.2. assist the Provider Leadership Board to work towards a consensus decision in respect of the Dispute;

1.6.2.3. regulate their own procedure and, subject to the terms of this Agreement, the procedure of the Provider Leadership Board at such discussions;

1.6.2.4. determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Operational Days of the independent facilitator being appointed; and

1.6.2.5. have their costs and disbursements met by the Trusts involved in the Dispute equally or in such other proportions as the independent facilitator shall direct.

1.6.3. If the independent facilitator cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this Schedule 5 and only after such further consideration again fails to resolve the Dispute, the Provider Leadership Board may decide to:

1.6.3.1. terminate the Agreement; or

1.6.3.2. agree that the Dispute need not be resolved.

ENCLOSURE B

NHS Provider Collaborative
North East and North Cumbria ICS

North East and North Cumbria
Provider Collaborative

Operating Model

May 2022

Operating Model

The eleven FTs in North East and North Cumbria (NENC) have set out how they will work together as the NENC Provider Collaborative, along with their purpose, principles and objectives in a memorandum of understanding ("Collaboration Agreement").

This document is intended to supplement the Collaboration Agreement with some more specific operational practicalities.

Provider Leadership Board

As set out in the Memorandum of Understanding, the eleven Foundation Trusts across North East and North Cumbria have agreed to establish a Provider Leadership Board (PLB), which is the group responsible for leading and overseeing the Trusts' collaborative approach to the Key Delivery Priorities and working in accordance with the Collaborative Principles.

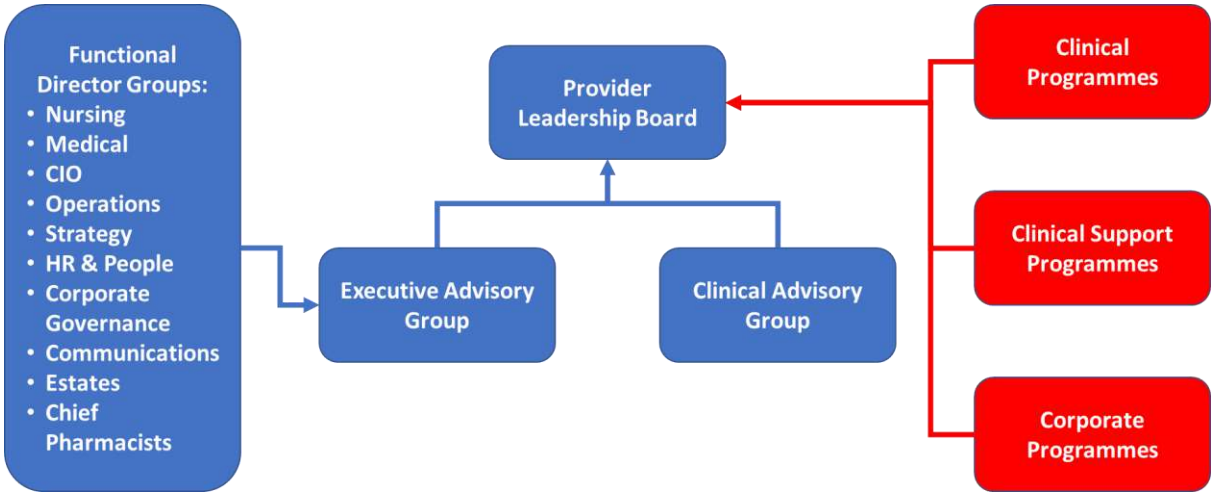
The PLB features all 11 CEOs and it is anticipated that CEOs will keep FT Boards regularly updated, supported by periodic written papers from the Provider Collaborative. The MoU sets out that Chairs of the FT Boards should be invited to meetings of the PLB at 6 monthly intervals, to discuss the work programme and progress with delivery.

The PLB may establish supporting and/or task and finish groups to take forward programmes in respect of the Key Delivery Priorities as appropriate, ensuring a strong clinical voice and involving input from a range of functions across the Trusts.

The Provider Collaborative determined that subgroups would be necessary to deliver key functions and the work programme. There is, however, a clear risk of overlap with the ICS and particularly the previous clinical advisory machinery established to support commissioning. As a consequence, this will need to be considered iteratively in the context of broader conversations with the ICB team. It was also noted that the subgroup structure should be mindful of bureaucratic burden.

For now, it is proposed that the programmes of work report directly to the Provider Leadership Board and that it is supported by an Executive Advisory Group and a Clinical Advisory Group. The Provider Leadership Board has been established, with the Executive and Clinical Advisor Groups to be put in place during Summer 2022.

In addition, the PLB will be strongly supported by nested collaboratives, such as those for mental health and at sub-regional geographies, to ensure decision making, direction and delivery take place at the right levels.



Clinical Advisory Group

The purpose of the Clinical Advisory Group is to ensure that the Provider Collaborative has strong clinical leadership and a constant focus on the key areas of collective clinical concern. The Clinical Advisory Group would draw on and provide a point of escalation for clinical networks.

Membership would need to feature clinical leads from all FTs with good medical, nursing and AHP leadership. Initial conversations with the ICB have suggested that this could be a joint body with the ICB, co-chaired by clinical leadership from within the Provider Collaborative and the ICB Medical Director, to align clinical input across the ICS. In this case, having wider clinical views, such as from general practice and community pharmacy, could support broader transformational work and enable the group to support both the Provider Collaborative and the ICB. PCN clinical leaders would be key in this.

As the ICB develops, consideration can be given as to whether it is feasible for this group to drive the strategic approach to clinical services, and the opportunity to align clinical groups generally, including the ICS Optimising Health Services Group. It should also be noted that the role and responsibility of the Provider Collaborative in the development of the ICS clinical strategy still needs to be worked through and agreed with the ICB and partners.

Executive Advisory Group

The purpose of the Executive Advisory Group is to provide a mechanism for strategic clarity across and through the Provider Collaborative FTs, making sure that a full range of functional perspectives are considered throughout the work programmes. The Executive Advisory Group will provide a sounding board and point of professional escalation for Managing Director and PMO on programmes and projects, facilitating quick access to appropriate functional expertise, in addition to being tasked with the delivery of specific projects.

This creates a mechanism to check and challenge proposals going to Provider Leadership Board, in addition to a coordinated approach to identifying risks or opportunities for collaborative work.

It is anticipated that membership of this group would be the chairs of the directors' networks, including a Director of Nursing, Medical Director, CIO, COO, Director of Finance, Director of Planning & Performance, Director of Workforce, Director of Corporate Governance, Director of Communications, Director of Estates and Chief Pharmacist.

Work Programme

Each programme of work within a Key Delivery Priority will be sponsored by a Trust Chief Executive as Senior Responsible Owner ("SRO"). SRO roles will be distributed across the Trust Chief Executives. Each SRO will be responsible to the Provider Leadership Board for the planning and delivery of their work programme and will be supported by the Programme Management Office. It is anticipated that Provider Collaborative SROs will lead some of the ICS workstreams, where appropriate.

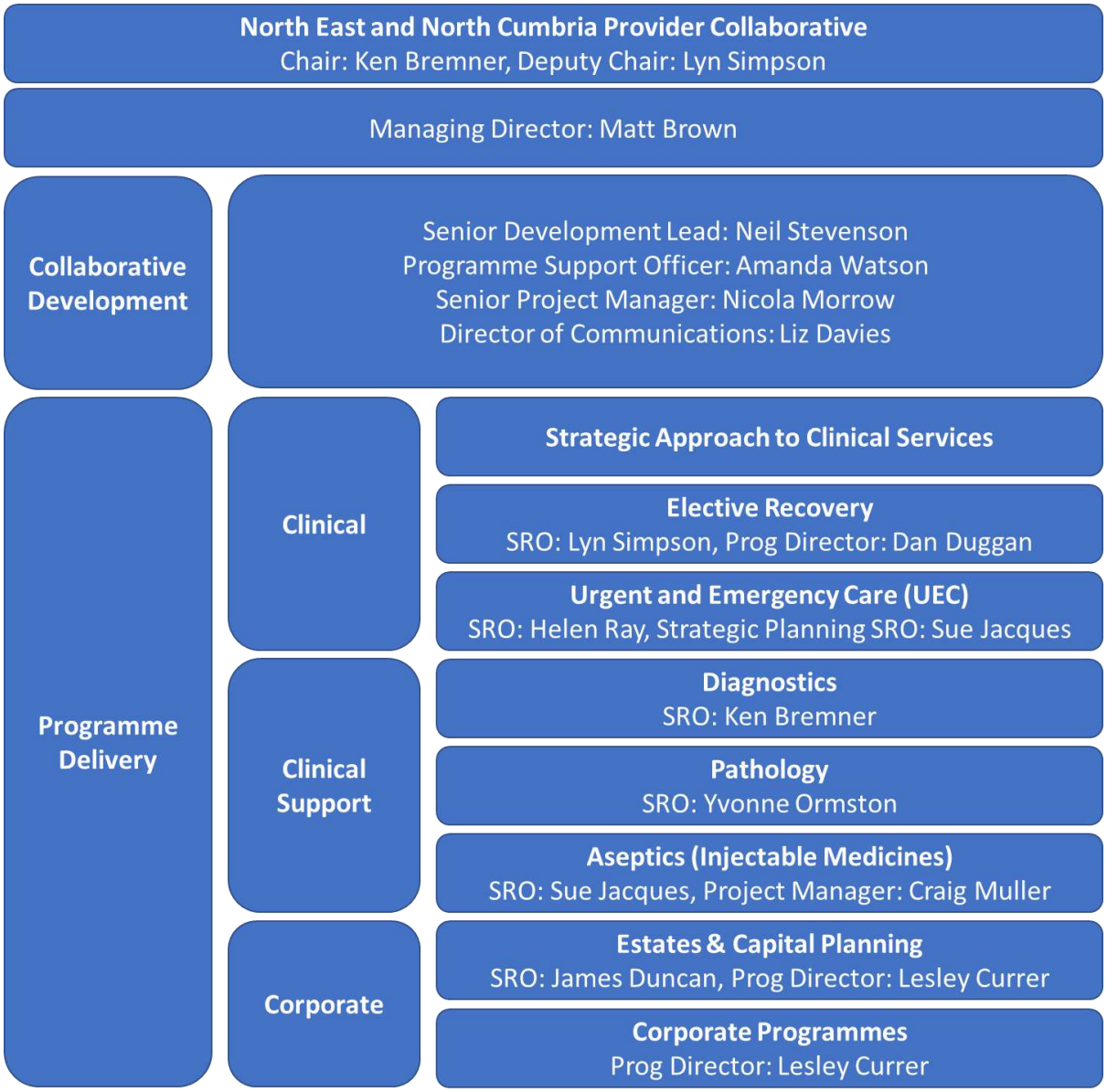
The SRO will effectively work as a Chair for the supporting programme infrastructure, with a dedicated programme management support and it is intended that there should be a designated Programme Director for each Key Delivery Priority. The Programme Director should work extremely closely with the SRO to ensure progress, direction, reporting and communication. The governance structure will be different for each Key Delivery Priority.

These teams will be supported by a general pool of project management capacity and a small core collaborative team.

Each of the five Key Delivery Priorities will report to the Provider Leadership Board on a monthly basis, using a programme highlight report, to be distributed one week before the meeting. This will focus on progress, key risks and issues for escalation. The Provider Leadership Board will ensure clear objectives and scope under each Key Delivery Priority.

The Managing Director will work closely with the SROs and Programme Directors to ensure oversight and coordination across the Key Delivery Priorities.

The following chart reflects the capacity specifically deployed by Provider Collaborative, but there are other people from the system involved in the work programmes already, such as in supporting the UEC, diagnostics and pathology ICS programmes.



Clinical Programmes – Strategic Approach to Clinical Services

It is proposed that this programme is focussed on developing a strategic approach to clinical services across North East and North Cumbria, supporting nested collaborative working. This should focus initially on tackling vulnerable services, unwarranted clinical variation and providing coordination & escalation for clinical networks. The output of this programme should be heavily informed by population health management and help guide strategic decision making on collaborative opportunities and challenges around estates, technology and workforce.

Programme infrastructure needs to be developed for this Key Delivery Priority. It is proposed that the governance for this has two forums, one clinically-led focussed on the clinical challenges and solutions through the Clinical Advisory Group, one managerially-led focussed on the corporate governance support required.

Clinical Programmes – Elective

The elective programme has a duality of focus, on the performance management aspects of elective recovery in the here and now, particularly on long waits, alongside the transformation requirements for the years ahead. In doing so, the programme seeks to tackle health inequalities, particularly of access and outcomes.

A Strategic Elective Care Board has been in established to take this work forward, with oversight of performance management, clinically-led transformation programmes, independent sector strategy, strategic productivity and collaborative opportunities (eg capitalising on GIRFT and Model Hospital) and ensuring connection to the broader programmes such as waiting well and health literacy.

Clinical Programmes – Urgent and Emergency Care

In 2022/23, the UEC Network has prioritised the long-term plan, operating guidance and national 10-point recovery plan. Specific priorities focus on UEC operating models, including community care, digital and hospital discharge.

Governance arrangements are being revised with the establishment of a UEC Board, which will provide NENC oversight, leadership on winter planning, assurance to ICB and direct connection with LADBs for place-based delivery.

Clinical Support Programmes

There are a number of key strands of work under Clinical Support programmes, particularly around diagnostics and pathology. In addition, a steering group with dedicated project management is overseeing the development of a business case for aseptics (injectable medicines) production facility for the Provider Collaborative.

The NENC Diagnostic Programme Board reports directly into the Optimising Health Services Group, then into the ICS Management Group, with a dotted line to the Provider Collaborative. The Pathology Network Board reports into the Diagnostic Programme Board.

Corporate Programmes

There are a range of active, and potential, work programmes across the Corporate Key Delivery Priority, including work on strategic planning for capital and estates. There is great potential here to make efficiencies but also to harness and maximise the many assets that exist across North East and North Cumbria. The intention is to adopt a series of evidence based programmes designed to get added value for every pound spent. These might include in the short term - redesigning and standardising care pathways, optimising sites, optimising workforce, supporting staff with cost of living pressures, adoption of innovation at pace and scale, sharing and adoption of best practice, but could also include in the longer term policies on workforce, digital innovation, back office support cost reduction, taking a rigorous approach to anchor institution development and so forth.

It is proposed that specific programme infrastructure is established for the Key Delivery Priority, with oversight, identification of opportunities and challenges through the Executive Advisory Group.

Provider Collaborative Leadership and Management Resource

The Managing Director will be accountable to the Chief Executives through the Chair of the Provider Leadership Board and will oversee the collaborative team and Programme Management Office. This team will include a secretariat function to provide administration and support across all Provider Collaborative programmes, specific programme management capacity, transformation resource, analytical capacity and communications and engagement resource. The Provider Collaborative is keen to ensure that access to, and shared leadership of, quality improvement capability.

Access to data has been determined to be a key element of being able to deliver the evidence based programmes required, in particular the use of cross system, multi sectoral data to allow benchmarking and analysis of warranted and unwarranted variation. It is anticipated that much of this will come through FTs, with analytical support from NECS and NEQOS, supported by other sources such as GIRFT and Model Hospital.

The PMO will be accountable to the Managing Director, who will have oversight across all Key Delivery Priorities.

The collaborative team will have a combination of specific staff and seconded staff, both clinical and managerial, to meet programme requirements. For the majority of collaborative programmes, the team will work with FTs to support them in delivery.

The Provider Collaborative team will need to develop over time, in line with resourcing, and alongside the Integrated Care Board (ICB).

It is expected that there will be a phased development of resources in line with increase in development and responsibilities. In the first instance, a sum of £400k has been allocated from NECS for the Provider Collaborative to draw down in 21/22, with a further £500k in 22/23.

In future years, there will need to be consideration of future funding arrangements, depending on the extent of allocated funding from either NECS or the ICB, likely to be as part of negotiation of the Responsibility Agreement. The Provider Collaborative has expressed a desire for FTs to engage collective capacity and an appetite for subscription or other contribution models.

The Development of the Provider Collaborative, including both OD and governance, will be led by the Chair and Vice-Chair. This will explicitly seek to take a strategic approach to talent management and development of a culture of collaboration.

NENC Provider Leadership Board Chair and Deputy

The Chair and Deputy Chair will act as convenors for the Collaborative, bringing together Chief Executives from the constituent FTs through the Provider Leadership Board, in line with the working arrangements set out in the Collaborative Agreement.

The Chair and Deputy will work with colleagues identifying issues for consideration and action by the Collaborative, facilitating discussion across the Collaborative to reach collective agreement on agreed action and ensuring appropriate assurance mechanisms are in place to ensure timely delivery. This will be achieved through distributed leadership, ensuring that all Chief Executives are appropriately involved in and leading Collaborative programmes. The Chair and Deputy will Provide direction, oversight and support to the Managing Director.

The position of Chair/Deputy will be elected from the constituent members and it is expected that the Chair will serve a tenure of 12-15 months. The Deputy will then step into the role of Chair, with a new Deputy nominated.

Senior Responsible Officer (SRO)

To deliver the Collaborative's work programme, a distributed leadership model will be enacted, with a Chief Executive fulfilling the Senior Responsible Officer (SRO) role in leading and facilitating delivery of agreed programmes.

The SRO will effectively act as Chair for the programme, with a designated programme director, and be responsible for ensuring that a programme or project meets its objectives and delivers the projected benefits. The SRO will act as the visible owner of the programme and the key leader in driving forward.

Managing Director

The Managing Director is responsible for leading the foundation and development of the Provider Collaborative through the establishment of governance arrangements and working infrastructure, including staffing/resourcing. The Managing Director will lead the development and delivery of the agreed work programme in line with the priorities established by the Provider Leadership Board.

The MD will ensure the leadership, development and success of the Collaborative's work programme and its contribution to the NENC ICS, coordinating the Collaborative as a membership organisation, working closely and fairly with all its constituent Trusts and ensuring it is established as a credible, robust and respected membership organisation across the North East and North Cumbria.

Programme Director

The Programme Director will work to the Programme SRO to oversee and ensure every aspect of programme delivery, from conception to implementation. Responsibilities include developing and

deploying the project team, securing appropriate resources to support delivery, developing the programme business case and milestones and ensuring that the programme meets the objectives and requirements to agreed timescales and resources. The Managing Director will have oversight of the Programme Directors.

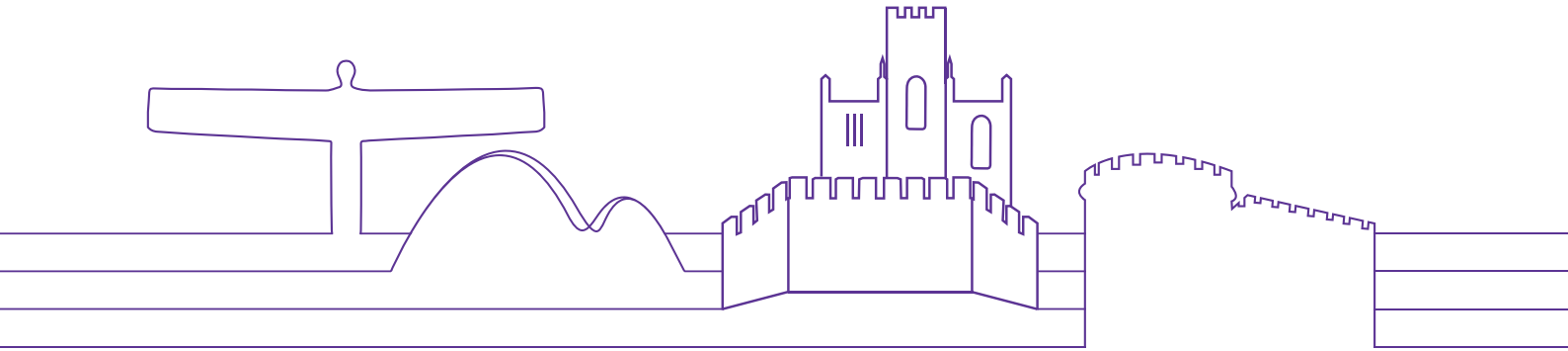
Enclosure C

North East and North Cumbria
Provider Collaborative

WORKING TOGETHER TO IMPROVE HEALTH, WEALTH AND WELLBEING

Setting out our ambitions for the future

May 2022



WHO ARE WE?

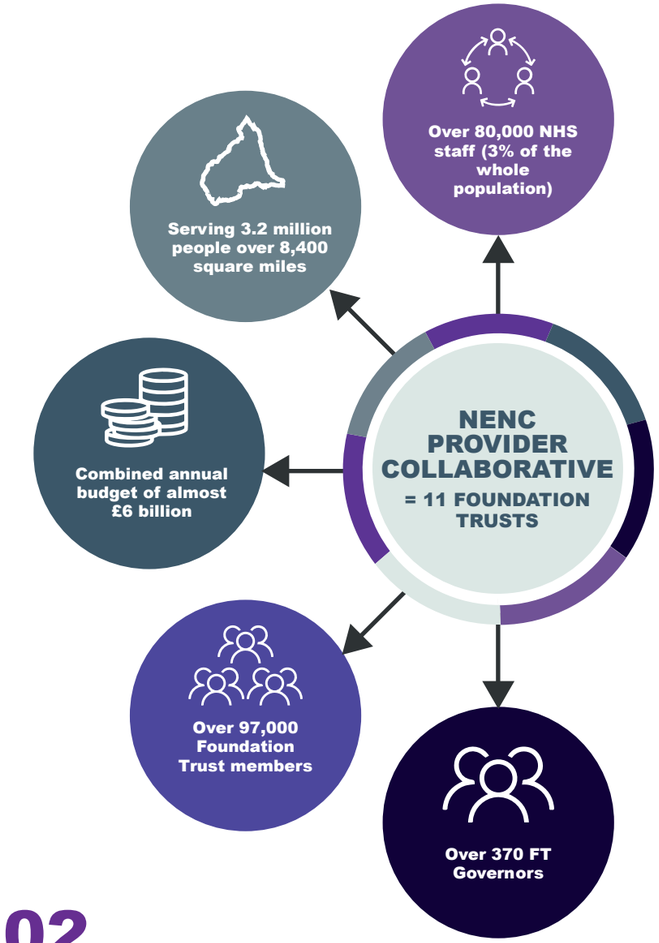
The North East and North Cumbria (NENC) Provider Collaborative is a formal partnership of all 11 NHS Foundation Trusts (FTs)* in the region. Together we cover the entire geographical footprint of the Integrated Care System and, between us, we provide the vast majority of all secondary NHS care services with millions of patient interactions every single day. This includes:

- **Community care and mental health services**
- **Acute hospital services and highly specialist care**
- **Ambulance, patient transport and emergency response services**

Our workforce is the largest in the region and we are major employers within our communities providing significant opportunities for local people. We are very proud of our strong track record, over many years, for providing some of the very best care, patient outcomes and organisational performance across the whole NHS. But we know there is more to do and especially as we recover from the impact of the pandemic.

Through the NENC Provider Collaborative our collective focus now is to ensure we consistently provide the highest quality of care right across our region and the best possible experience for our staff. Given the sheer size and scale of our organisations, we also have a significant role to play in improving the overall health, wealth and wellbeing of the local population.

OUR IMPACT



NENC Provider Collaborative Members:

- Northumbria Healthcare NHS Foundation Trust
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- Gateshead Health NHS Foundation Trust

- South Tyneside and Sunderland NHS Foundation Trust
- County Durham and Darlington NHS Foundation Trust

- North Tees and Hartlepool NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust

- North Cumbria Integrated Care NHS Foundation Trust

- North East Ambulance Service NHS Foundation Trust
- Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
- Tees, Esk and Wear Valleys NHS Foundation Trust

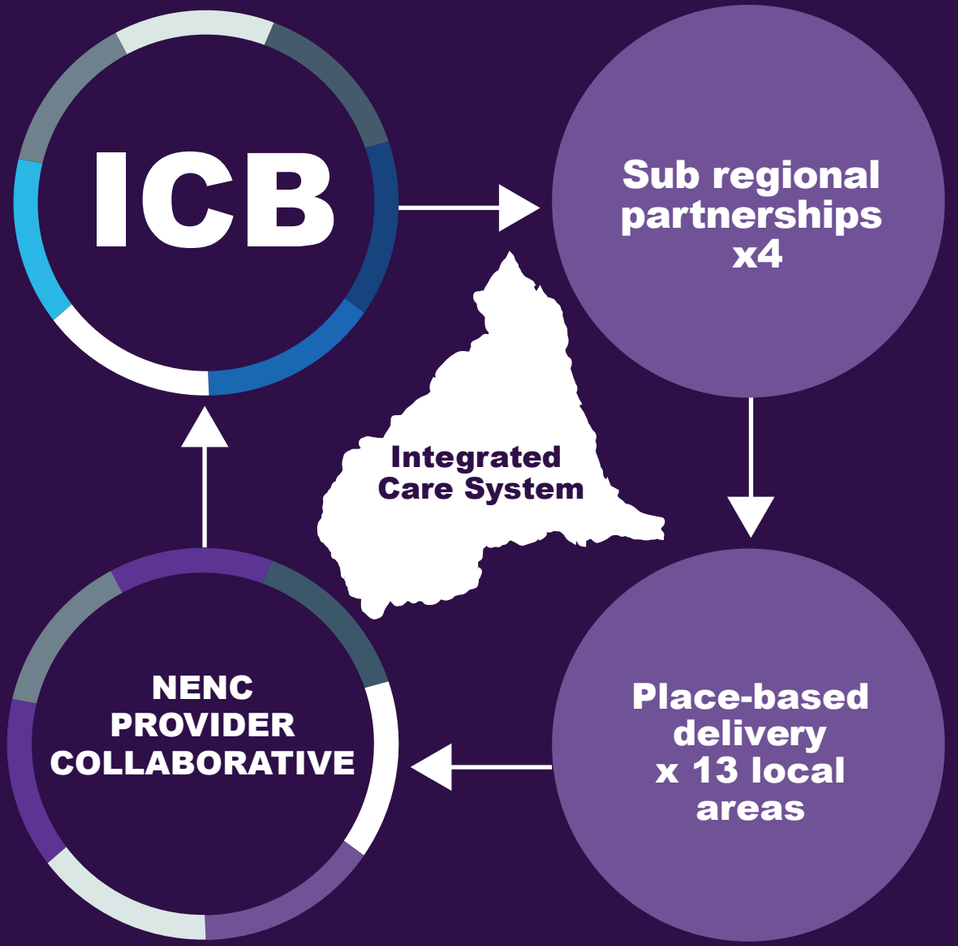
WHAT IS THE ROLE OF PROVIDER COLLABORATIVES?

Provider Collaboratives are an important part of our new system architecture. By July 2022, all NHS Foundation Trusts and NHS Trusts are expected to be part of one or more formal Provider Collaboratives, working together to agree plans for the future and deliver benefits at scale.

Our region was one of the first in England to form a Provider Collaborative ahead of national requirements. Since September 2019 all 11 of our NHS Foundation Trusts have been working together formally to discuss and address many challenges facing us all and, most importantly, to start to plan together as one for the future.

As a collective, we believe we have to continue to think differently about the way we deliver services if we want to be one step ahead and able to face the challenges, as well as the opportunities, the future presents to us.

The NENC Provider Collaborative now provides us with the formal mechanism for us to make collective decisions, to coordinate action on important issues and take forward programmes to improve health and care through collaboration. We will act on behalf of, and take decisions that represent the views of our 11 FTs collectively, rather than being a separate formal entity in our own right. We are a key component of how our new Integrated Care System will work.



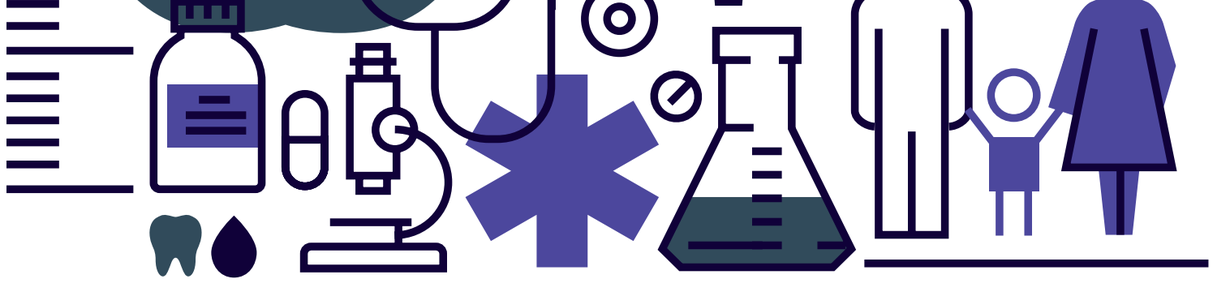
WHAT DO WE WANT TO ACHIEVE?

Our ambition as the NENC Provider Collaborative is simple:

“We want to further improve the quality of care across our Integrated Care System and use our influence to support the wider determinants of health, wealth and wellbeing across the region. We seek nothing less than for patients and the wider population within the North East and North Cumbria to have the highest possible standards of physical and mental health outcomes and positive life experiences.”

As major anchor organisations within our local communities, we recognise that we have a wider responsibility and impact across our Integrated Care System. Not only in the way we offer and deliver health and care services, but also in how we employ staff, how we procure goods and how we do business locally and achieve value for money.

As a NENC Provider Collaborative, we commit to doing all that we can to take collective action to improve health and health care services and support wider economic recovery, providing employment opportunities and local procurement.



We will work in partnership with the Integrated Care Board and share the same strategic objectives to:

Improve outcomes in population health and healthcare by focusing on improving health inequalities that exist within the region.

Tackle inequalities in outcomes, experience and access by optimising the delivery, quality and efficiency of local health and care services provided through our 11 FTs.

Enhance productivity and value for money by taking necessary collaborative. action, including mutual aid and support.

Help the NHS support broader social and economic development by providing opportunities and harnessing our collective strength to influence change.

OUR PRINCIPLES AND WAYS OF WORKING

We have ten principles which outline how we will work together. These will guide everything we do. They will help us to develop an even stronger culture of collaboration between our 11 NHS Foundation Trusts.

1.	**We will support each other and provide mutual aid in times of pressure.**
2.	**We will make shared decisions to speed up transformation and change.**
3.	**We will challenge each other and hold each other to account.**
4.	**We will always act in good faith and in the best interests of the people we serve.**
5.	**We will empower staff to work with other Trust staff to improve care.**
6.	**We will make sure there is strong clinical leadership and governance in all of our work.**
7.	**We will actively involve staff, patients, the public and wider stakeholders.**
8.	**We will show solidarity when making decisions for the local population.**
9.	**We will take responsibility for delivering on agreed priorities and manage risks together.**
10.	**We will promote a high performing culture of teamwork, innovation and continuous improvement. To do this we will share information, communicate honestly and respectfully and act ethically with responsible behaviour and decision making.**

KEY PRIORITIES

We have identified five key delivery priorities which will form the focus of our work in 2022/23 and beyond. This will be via three programmes of work:

Clinical Programmes

1. To develop a strategic approach to clinical services encompassing acute, mental health, learning disabilities and community. This will focus on vulnerable services and thinking about a strategic response to clinical networks and associated cross system working arrangements.

2. To deliver on elective recovery including all service aspects of inpatient, diagnostics and cancer care, as well as mental health and learning disabilities. Our aim is to meet or exceed national benchmarks, standards and targets.

3. To deliver urgent care standards (including ambulance standards) and requirements across all NENC providers and local systems to reduce variation and improve consistency of response.

Clinical Support Programmes

4. To build capacity and capability in clinical support services (in particular diagnostic capacity) to ensure appropriate infrastructure is in place to deliver the above clinical priorities.

Corporate Programmes

5. To support the wider ICS in sustainable transformation, establishing and delivering appropriate corporate strategies to enhance integration and tackle variation. This will include approaches to collective planning, rationalised and aligned estates/capital processes, the development of underpinning approaches in workforce and a commitment to the ICS green strategy.

WORKING AS PART OF THE WIDER ICS

In our role as the NENC Provider Collaborative we will take collective responsibility for the delivery of agreed service improvements and standards across FTS in the North East and North Cumbria. These will be agreed with the ICB.

We will facilitate horizontal collaboration between FTs, but that work will in no way reduce the primacy of place or hamper provider organisations playing full roles within their relevant place based partnerships. We recognise the crucial importance of place-based working, where our FTs work closely with local communities and partner organisations.

There will also be different collaborative arrangements (see page 12) where individual FTs will continue to work with each other on a geographical or sectoral basis All of this good work will not stop. Our role is not to cut across any of this, but to act as an enabler.

Our strength as the NENC Provider Collaborative will be through operating as a whole system collaborative when a response is best done once, together and at scale. This might be because the issue is complex, there is a need for critical mass, or requires standardisation to reduce unwarranted variation across multiple FTs.

To work effectively with the ICB we need to agree responsibilities as to how we can best contribute to the overall success of the ICS and meet the strategic objectives we all share.

We believe the NENC Provider Collaborative is best placed to lead on the priority areas identified on page 9. This includes:

- **Action to deliver recovery, specifically in tackling long waits in elective care and other services** with the development of longer term transformation solutions.
- **Addressing system level action to bring the urgent care system back to pre-pandemic levels of performance and above.**
- **Taking forward a strategic approach to clinical service development,** particularly where there are service vulnerabilities, or opportunities, that require at-scale consideration. This would include discussion and agreement around Clinical Networks and formal hosting and/or leadership arrangements.
- **Opportunities for at-scale solutions and strategic improvements to unwarranted variation or inefficiencies** within and across the 11 FTs (see page 7).

WORKING WITH HEALTH AND CARE PARTNERS

As the NENC Provider Collaborative, we are just one of a number of partnership arrangements that will work with the ICB to deliver the overall aims and objectives of the Integrated Care System. These are shown opposite.

We may interact with these other collaboratives acting as the NENC Provider Collaborative, or as individual FTs, depending on the nature of discussions taking place. However we collaborate, we want to interact and support the work of others as we collectively strive to plan, deliver and transform health and health care services for the future in our region.

DRIVING INNOVATION & IMPROVEMENT

As NENEC providers we have a high appetite for innovation and will seek a coherent approach which plays to the academic, commercial and industrial strengths of our FTs.

As part of this we will support and drive the development of research and continue our close working with vital partners. This includes working with Health Education England, education partners and professional bodies to provide high quality education and training, recruiting and retaining the workforce of today and attracting the workforce of tomorrow.

We aim to go much further than our role in directly improving health and delivering healthcare. We aim to capitalise on the substantial opportunities we have across our organisations and with our partners.

Academic Health Sciences Network	**North East Quality Observatory System**	**Biomedical Research Centre**
Academic Health Sciences Centre	**Universities of Northumbria, Newcastle, Durham, Sunderland and Teesside**	**NIHR Applied Research Collaborative**

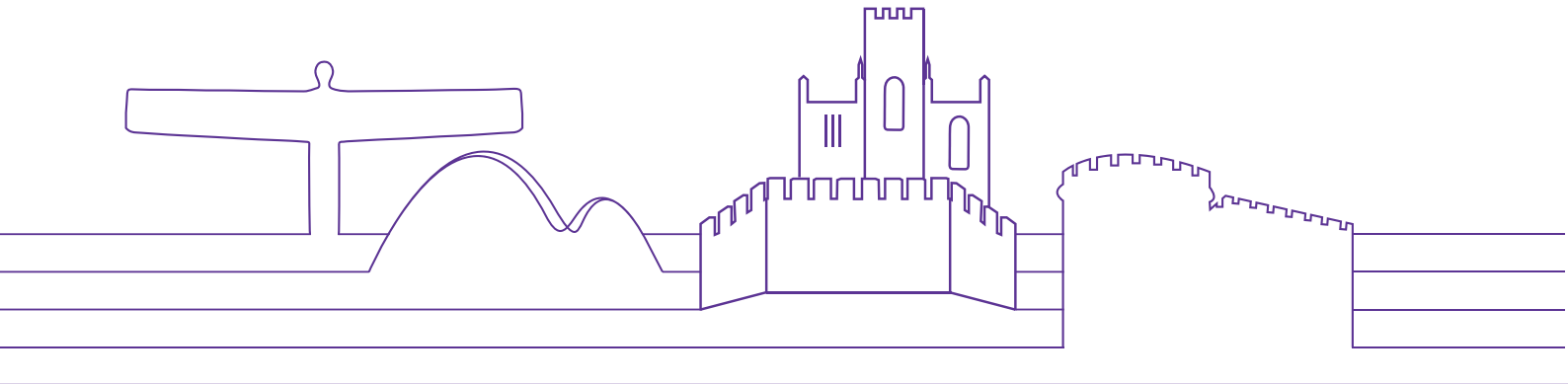
WHAT NEXT?

This document sets out our aspirations for the future and the ways of working we have developed so far as the NENC Provider Collaborative.

As work gathers pace towards our new structures and system architecture coming into place formally from July 2022, we will speak to partners about the role of the NENC Provider Collaborative and where you think we can add value to drive forward innovation and improvement.

In the coming months, we will work with the ICB to jointly agree how we can best support the delivery of ICS objectives and best use our skills and capabilities as we strive to maximise the flexibilities and freedoms of the new Health Bill when enacted. We recognise this can be achieved in several ways and we want to agree the appropriate mechanism, recognising that the basis of this working relationship will flex issue by issue.

We look forward to involving and engaging with you all along the way and building on the strengths of our relationships here in the North East and North Cumbria.



www.northeastnorthcumbria.nhs.uk/who-we-are/provider-collaborative

Tees, Esk and Wear Valleys
NHS Foundation Trust

ITEM NO. 18

FOR GENERAL RELEASE

Trust Board Meeting

DATE:	**28th July 2022**
TITLE:	**Approval of trust Risk Management Policy**
REPORT OF:	**Elizabeth Moody, Executive Director of Nursing and Governance and Phil Bellas, Trust Board secretary**
REPORT FOR:	**Ratification**

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

Executive Summary:

The GGI well-led review (2021) found weaknesses in the governance structure including that there was not yet a clear golden thread apparent in Board to ward and ward to board risk management processes. The Trust has recognised that its arrangements need to be changed to provide additional capacity, provide clear guidance and policy to staff and to ensure there are robust governance processes for risk assessment, escalation and management.

The policy describes the Trust's integrated approach to the assessment, reporting and management of risk. It sets out responsibilities, strategic systems, processes for governance and management to promote the delivery of high quality, safe, accountable healthcare, to minimise risk to patients, staff and the organisation and to maximise available resources. Approval and embedding of the policy is fundamental to the delivery of Our Journey to Care and the Trusts 3 big goals to ensure that quality drives all Trust decisions.

The policy was considered and approved at the Executive Risk Group on the 19th July 2022 subject to several minor amendments that have been made.

A new Head of Risk will commence with the Trust on 1st August 2022 and will be key to developing the understanding, delivery and compliance with the new policy however the policy clearly sets out that it is the responsibility of all staff to identify and reduce risks. Training, support from the Head of Risk and embedding of the Trusts new governance structures will all support an improved line of sight and understanding of risk management across the Trust.

Recommendations:
That the Trust Board ratify the Risk Management Policy

journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust internal and external website

Title: Risk Management Policy

Ref: CORP – 00660v2

Status: DRAFT
Document type: Policy

Policy lead responsibilities (to be deleted on completion of this document)

No.	Who	What	New documents	Amended documents
1	Policy Lead	Identify the need to develop a new policy/change and existing policy	✓	✓
2	Policy Lead	Complete a Policy Scoping Template	✓	×
3	Policy Lead	Submit completed Policy Scoping Template to Policy Manager	✓	×
4	Policy Manager	Provide the Policy Lead with feedback following EMT consideration of the Policy Scoping Document	✓	×
5	Policy Lead	Start the Equality Analysis process. Read the equality analysis policy and the equality analysis guidance which can be located on the policies page on InTouch	✓	✓
6	Policy Lead	Book yourself onto the equality analysis surgery (held weekly on Thursdays) by the EDHR team. Telephone 0191 3336267 or email tewv.eandd@nhs.net to make your appointment.	✓	✓
6	Policy Lead	Draw up a list of stakeholders/people/bodies you may need to consult for questions on legal matters, process, terminology etc.	✓	✓
7	Policy Lead	Identify who has final approval of the document	✓	✓
8	Policy Lead	Develop document using the template	✓	✓
9	Policy Lead	Complete the Equality Analysis (EA) process	✓	✓
10	Policy Lead	Submit the completed document to the Policy Manager for QA check and EA review	✓	✓
11	Policy Lead	Submit the policy to the relevant sub-group for approval (see Policies and Procedures – Guidance for Writers)	✓	✓
12	Policy Manager	After approval, submit to the EMT for ratification with a cover paper (all policies and those procedures that the responsible Director has requested have EMT approval)	✓	✓
13	Policy Manager	Publishes via intranet and, when authorised, external website	✓	✓
14	Policy Lead	Disseminate and request implementation of policy/procedure	✓	✓

Contents

1. Introduction

Tees Esk and Wear Valleys NHS Foundation Trust's (the Trust) Board of Directors is committed to ensure that the needs of patients, staff, volunteers, carers, contractors and visitors are taken seriously at every level of the organisation to provide open and transparent risk management systems to ensure that the Trust meets its principal objectives for safe, sustainable, high-quality care.

The Trust 'Journey to Change sets out why we do what we do, the kind of organisation we want to be and the three big goals we're committing to within our business plan.

The three goals are:

1 To co-create a great experience for our patients, carers and families.

2 To co-create a great experience for our colleagues.

3 To be a great partner.

The most important way we will achieve our goals is by living our values of respect, compassion, and responsibility, all the time.

Risk management involves the identification, assessment and control of risk.

Having a robust risk management system is essential in identifying where we need to focus our attention and keep on track to achieving our goals. The Trust supports a dynamic and proactive approach to risk management, identifying and managing potential threats and hazards before adverse events occur. Every risk identified and associated assessment carried out is seen as an opportunity to improve quality.

This Policy will support the delivery of our goals by:

- Improving patient experience and the delivery of safe care through the effective identification, escalation and management of risks to patients, their families and carers. It is acknowledged that some risks/residual risks will remain, but there should be a commitment to adopting best practice in the identification, evaluation and cost-effective control of risks to ensure that:
    - Quality and safety drives all our major decisions.
    - All quality and safety risks are actively mitigated, reduced to an acceptable level or eliminated; and
    - opportunities to achieve our objectives and the delivery of high-quality care is achieved
- Co creating a great experience for our colleagues through having robust systems to ensure the management of risks to staff, volunteers and others working into the Trust. It is the responsibility of all staff to identify and reduce risks. We are all responsible for the health, safety and wellbeing of patients, visitors, staff and others accessing and using our facilities and services, the delivery of services in line with the NHS Constitution and in accordance with Health and Safety legislation.
- Risks arising are inherent in all Trust activities, for example, treating patients, determining service priority, project management, record keeping, communications, staffing, service design, and setting strategies. Risk is also associated with not taking any action at all. In pursuance of our three big goals, we have a low appetite for quality and safety and regulatory risk exposure that could result in harm to patients, the public, or staff. We are willing to accept risks that may result in some financial loss or exposure to address quality, safety or cyber security concerns.

2. Why we need this policy

2.1 Purpose

This Policy describes the Trust's integrated approach to the assessment, reporting and management of risk. It sets out responsibilities, strategic systems and processes for management, to promote the delivery of high quality, safe, accountable healthcare, to minimise risk to patients, staff and the organisation and to maximise available resources.

2.2 Objectives

This Policy will:

- Ensure that risk management is an integral part of organisational culture;
- Improve safety by addressing and effectively prioritising risk treatment plans;
- Identify risk to achieve the Trust's objectives requiring intervention;
- Support compliance with legal and regulatory requirements; and
- Drive a standard and accessible approach to risk management.
- Ensure we remain on track to deliver Our Journey to Change

3. Scope

This policy is a Trust-wide document, it aligns to the Trust's values of Respect, Compassion and Responsibility, it aims to support the delivery of the Trust's Vision and Strategy articulated in "Our Journey to Change" and it applies equally to all members of staff, either permanent or temporary and to those working within, or for, the Trust under contracted services.

3.1 Culture

The Trust aims to embed an effective risk culture through the deployment of the Risk Management Policy to ensure individual staff and groups are able to take the right informed decision in line with Trust values and goals.

Embedding a risk culture in thinking, behaviours and actions around risk and risk management.

3.2 Accountability, Duties and Responsibilities

Organisational

The Board with the support of its committees have a key role in ensuring a robust risk management system is effectively maintained and to lead on a culture whereby risk management is embedded across the Trust through its strategy and plans, setting out its appetite and priorities in respect of the mitigation of risk when delivering a safe high quality service.

Committee or Group	Responsibility	Accountable Officer	RR Review & Frequency	BAF Review & Frequency

Board of Directors	Responsible for ensuring the Trust has effective systems for managing risk.	Chief Executive	Risks 15+ (Corporate Risk Register -CRR) summary Quarterly	BAF Summary monthly Reviewed in detail quarterly
Committees of the Board	Each Committee of the Board tests evidence and assurance relating to its duties and scope; and: • Reviews the management of the Board Assurance Framework/ Corporate Risk Register and the groups top risks to ensure that the board of directors receive assurance that effective controls are in place to manage corporate risks. • Reports to the board of directors on any significant risk management and assurance issues	Director of Nursing and Governance (Quality Assurance Committee)	Quality and Safety Risks 15+ each meeting and minutes of Executive Risk Group (ERG)	BAF quality and patient safety risks reviewed each meeting
		Director of Finance (Strategy and Resources Committee)	Finance, investment, estates, IT/Digital risks 15+ reviewed each meeting and minutes of ERG	BAF finance, investment, estates, IT/Digital risks reviewed each meeting
		Director of People and Culture (People, Culture and Diversity Committee)	People and culture risks 15+reviewed each meeting and minutes of ERG	BAF people and culture risks reviewed each meeting
		Medical Director (Mental Health Legislation Committee)	Mental health legislation risks 15+ reviewed each meeting and minutes of ERG	BAF Mental Health legislation risks reviewed each meeting

		Assistant Chief Executive (Commissioning Committee)	Commissioning risks 15+ reviewed each meeting and minutes of ERG	BAF commissioning risks reviewed each meeting N.B. ALL committees to review Full BAF Quarterly
Audit and Risk Committee	• Oversees the risk management system, obtaining assurances that there is an effective system operating across the Trust. • Reviews and tests the establishment and maintenance of an effective system of internal control and risk management. This process is underpinned by the internal audit function, which provides an opinion on compliance with standards.			
Executive Directors Group	Pease complete informed by TOR	CEO (Chair)		
Executive Risk Management Group	• Ensures the consistent application of risk management policies and processes within the Trust. • Provides assurance to the Board on the delivery of mitigations to reduce exposure to the strategic risks contained in the Board Assurance Framework. • Oversees operational risks contained in the corporate risk register and provides assurance (by exception) on the management of those risks to the Board. • Monitors (by exception) the management of operational risks within the Care Group Risk Registers receiving assurance from the Care Group Board.	CEO (Chair)	Risks 15+ from corporate departments monthly	BAF reviewed monthly with deep dives as programmed

	• Agrees and oversees training in relation to risk management			
Executive Subcommittee Groups (e.g. Quality Assurance and Improvement)	The committee subgroups are responsible for: • Considering wider implications of risks and themes arising, and opportunities to improve management of risk • Examining and challenge action plans developed to control risks, and assess their wider impact • Identifying new risks that are emerging related to the Sub-Group scope and duties	Executive Group Chairs	Risk 15+ aligned to scope of group monthly	
Care Group Boards And Care Group subgroups	The Care Group Board is accountable and responsible for ensuring that there is an effective process for identifying and managing risk of all types within the Care Group. The Care Group Board receives and consider reports from its Sub-Groups as necessary. The Care Group Board will: Examine and challenge the risks identified Consider wider implications of risks and themes arising, and opportunities to improve management of risk Examine and challenge action plans developed to control risks, and assess their wider impact Scrutinise completed action plans and associated metrics, and reports provided as evidence of assurance of the control of risks.	Care Group (Operational performance) Managing Directors) Care Group Sub-Groups (Care Group Senior Leadership Team including clinical and service directors)	12+ risks monthly 12+ risks aligned to Sub-Group scope and duties at each meeting	BAF received for information monthly

Care Group Risk Groups	The Care Group Risk Group Board is accountable and responsible for ensuring that there is an effective process for identifying and managing risk of all types within the Care Group. Reports to The Care Group Board. The Care Group Risk group will: Examine and challenge the risks identified Consider wider implications of risks and themes arising, and opportunities to improve management of risk Examine and challenge action plans developed to control risks, and assess their wider impact Scrutinise completed action plans and associated metrics, and reports provided as evidence of assurance of the control of risks. Identify risks to be escalated to Care Group		8+ risks	

Individual

Chief Executive Officer	• The CEO as the 'Accountable Officer' has overall accountability and responsibility for the management of risk to the safe and effective, sustainable delivery of the business of the Trust and internal controls.
Executive Directors	• Executive Directors have delegated responsibility for managing risks in accordance with their portfolios and as reflected in their job descriptions. For example, the Director of Finance has executive responsibility for financial governance and associated financial risks. • Executive Directors are responsible for ensuring effective systems for risk management, compatible with this Policy, are in place within their directorate and Care Groups. Specifically, they must ensure: (i) suitably competent staff are identified to lead on risk management in the directorate and that their role and responsibilities are clearly understood (ii) staff are familiar with the Policy and aware of their responsibility for risk (iii) staff attend appropriate risk training (including induction and mandatory training)

	(iv) risks (strategic and operational) are effectively managed i.e. identified, assessed and that action plans to mitigate risks are developed, documented and regularly reviewed. (v) service developments, business cases and capital plans are formally risk assessed
Assistant Chief Executive	• Responsible to ensure the integrated performance approach and associated systems and processes are robust in order to provide assurance on the Trust's performance and commissioning functions. Remove
Director of Quality Governance	• Responsible for the development and oversight of compliance to the Risk Management Policy.
Company Secretary	• Responsible for the maintenance of the Board Assurance Framework.
Head of Risk Management	• Supports the Executive Director of Nursing and Governance and the Director of Quality and Governance in the day-to-day management of the Trust's Risk Register. • Supports the review, development and embedding of the Risk Management Policy across the Trust to ensure that there is an effective Risk management System in place.
Care Group Directors, General Management Tier Service Management Tier	• Accountable for ensuring that risk is managed in line with this Policy within their Care Delivery Service and wider areas of responsibility. They are required to: i. Maintain a suitable local forum for the discussion of risks arising, at which, the local RR is reviewed at least monthly; ii. Ensure that risks raised by staff are fully considered, captured on local RRs, kept up to date, re-assessed, and re-graded as necessary; iii. Develop and implement action plans to ensure risks identified are appropriately treated; iv. Ensure that appropriate and effective risk management processes are in place within their designated area and scope of responsibility and that all staff are made aware of the risks within their work environment and of their personal responsibility to minimise risk; v. Monitor any risk management control measures implemented within their designated area and scope of responsibility, ensuring that they are appropriate and adequate. vi. Assurance on impact of mitigating actions
All staff	• Staff (including contractors and agency staff) must ensure they are familiar and comply with the Trust's risk-related policies and relevant professional guidelines and standards
Partnership Organisations	• Specific risks identified in the Trust will be shared with any other relevant organisation working in partnership with the Trust.

4. Definitions

Risk management at its best will radically improve the quality of services provided and provides strategic direction to the organisation by guiding staff on the appropriate level of risk they are permitted to take to enable staff to seize important opportunities.

Term	Definition
Risk	Is the threat or possibility that an action or event will adversely or beneficially affect the Trust's ability to achieve its objectives. It is measured in terms of likelihood and consequence.
Risk management	Is about the Trust's culture, processes and structures that are directed towards realising potential opportunities whilst managing adverse events. The risk management process covers all processes involved in identifying, assessing, and judging risks, assigning ownership, taking action to mitigate or anticipate them, and monitoring and reviewing progress.
Risk Assessment	Is a systematic process of assessing the likelihood of something happening (frequency or probability) and the consequence if the risk happens (impact or magnitude)
Strategic risks	Are those that represent a threat to achieving the Trust's strategic objectives or to its continued existence. They also include risks that are widespread beyond the local area and risks for which the cost of control is significantly beyond the scope of the local budget holder. Strategic risks must be reported to the Board of the Directors and should be managed at executive level, directly or by close supervision.
Operational risks	Are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, financial risk (including fraud), legal risks (arising from employment law or health and safety regulation), regulatory risk, risk of loss or damage to assets or system failures etc. Operational risks can be managed by the department or directorate which is responsible for delivering services.
Risk Appetite	Is the amount and type of risk that an organisation is willing to accept in order to meet its objectives. The Trust appreciates that: It is impossible to deliver services and achieve positive outcomes for patients and other stakeholders without risk, and these risks must be managed in a controlled way; methods of controlling risk must be balanced to support innovation, learning and the imaginative use of resources when it is to achieve substantial benefit; some high risks may be accepted.

Risk Register (RR)	Registers are repositories for electronically recording and dynamically managing risks that have been appropriately assessed. Risk Registers are available at different organisational levels across the Trust.
Board Assurance Framework (BAF)	A framework for the Board of Directors to review principle risks to meeting Trust objectives, providing opportunities to analyse assurance that those risks are being managed.
Annual Governance Statement	An annual statement signed by the Accountable Officer (Chief Executive) on behalf of the Board that forms part of the Annual Report. The Annual Governance Statement aims to provide assurance on the effectiveness of the organisation's approach to governance, risk and control.
Control	A process, policy or procedure, which is being used to manage the risk, ie to prevent, detect and correct an undesired event.
Consequence (impact)	The effect of a risk if it happened.
Gap in assurance	An area where there is insufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed are operating effectively.
Gap in control	Failure to put in place sufficient effective policies, procedures, practices or organisational structures to manage risks and achieve objectives.
Inherent risk	The assessed level of raw or untreated risk, ie the amount of risk before the application of controls.
Likelihood	The probability that risk will happen.
Mitigation/mitigating action	An action to manage or contain a risk to an acceptable level or to reduce the threat of the risk occurring, eg new or strengthened controls, improved assurance arrangements etc.
Positive assurance	Actual evidence that a risk is being reasonably managed and objectives are being achieved, eg an auditor's report.
Risk tolerance	The boundaries within which the Executive Directors group is willing to allow the true day-to- day risk profile of the organisation to fluctuate, while they are executing strategic objectives in accordance with the Board's strategy and risk appetite.
Risk grade	An expression of the seriousness of the risk based on the risk score.
Risk score	A numerical value on the quantum of a risk based on tis consequence and likelihood.

5. Risk Management System

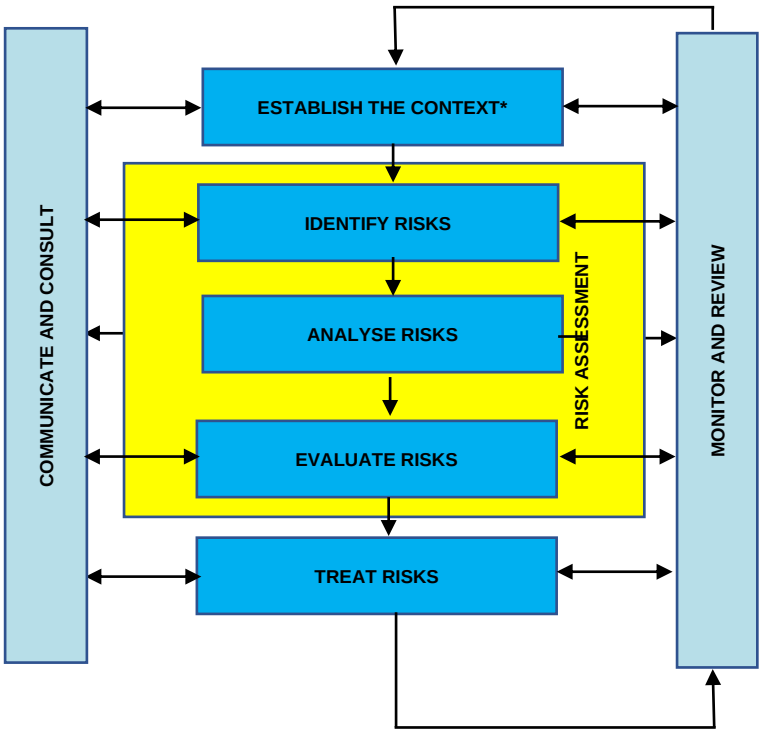
5.1 Definition of risk management

The Institute of Risk Management define Risk Management as:

"The process which aims to help organisations understand, evaluate and take action on all their risks with a view to increasing the probability of success and reducing the likelihood of failure"

Figure 1 below shows, risk management involves the identification, analysis, evaluation, and treatment of risks or more specifically recognises which events may lead to harm and therefore minimising the likelihood (how often) and consequences (how bad) of these risks occurring.

Figure 1 – Risk Management Process.



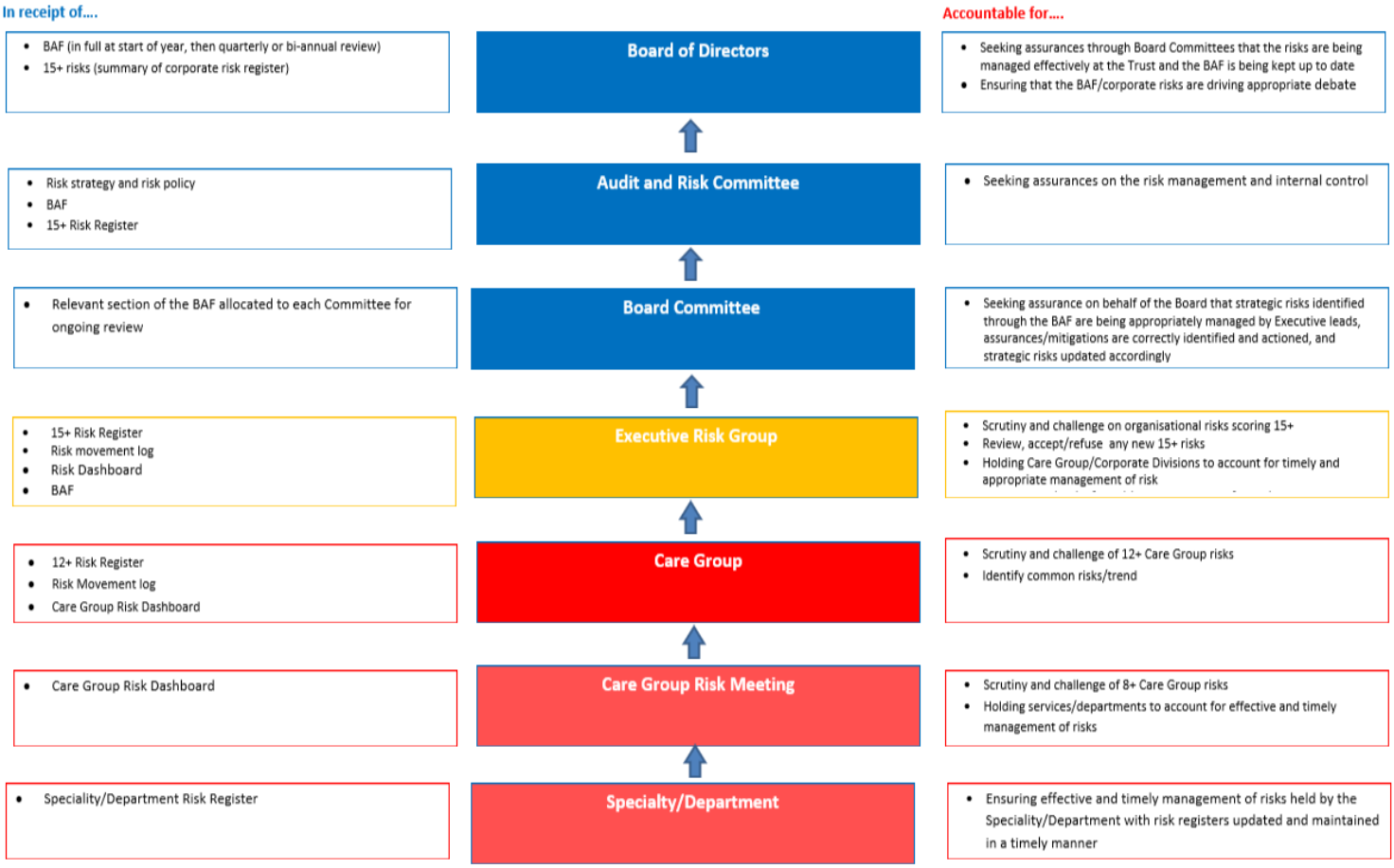
* establish the context can also be described as establish the facts.

The Trust's process for risk management is detailed in:
(i) Appendix A: Guidelines to Identify, Assess, Action and Monitor Risks
(ii) Appendix B: Guidelines for the Use of the Risk Register.

5.2 Risk Escalation Framework

Risk Review and Escalation

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



5.3 Risk Appetite

Domain	Risk Appetite		Risk Tolerance
	Level	Statement	
Quality & Safety (inc. innovation)	Minimal (1)	• We have a low appetite for quality and safety risk exposure that could result in harm or loss of life to patients, the public, or staff • Quality and safety drive all our major decisions. • All quality and safety risks must be actively mitigated • Innovations which could impact negatively on quality and safety must be subject to an impact assessment and be approved by the Director of Nursing and Governance and the Medical Director	9
Financial	Open (3)	• In the pursuit of our objectives, we are willing to accept risks that may result in some financial loss or exposure to	12

		address quality, safety or cyber security concerns. • We will not pursue additional income generation or cost saving initiatives which will have an adverse impact on quality and safety; reputation; core services or run counter to the Trust's overall Strategy 'Our Journey to Change'	
Regulation	Minimal (1)	• We will only tolerate minimal exposure to regulatory risks including to our CQC ratings • We will tolerate some exposure to risks relating to wider contractual requirements including the consequential implications of prioritising quality and safety over operational performance	5
Reputation	Cautious (2)	• In pursuance of our three strategic objectives, we are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout • The level of impact which we are willing to accept with any of our key stakeholders (patients, staff, partners and regulators) will be assessed on a case-by-case basis.	9
People	Open (3)	• We are prepared to accept the possibility of some workforce risk, as a direct result of innovation, as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff	9

- Risk 'tolerance' is the minimum and maximum risk the Trust is willing to accept as reflected in the risk appetite themes above.
- The Board agreed that all risks at level 12 and above will require executive oversight by the Executive Director Group.
- The Executive Risk Group will oversee the Board Assurance Framework and Corporate Risk Register on a bi-monthly basis.
- The Board has approved a range of Sub-Committees/Groups all charged with the responsibility of reviewing risks related to their Terms of Reference and subject matter to ensure those risks are controlled and where necessary escalated (as outlined in the Risk Escalation Framework).

5.4 Board Assurance Framework

The Board Assurance Framework (BAF) provides a range of sources of assurance that the risks to the Trust achieving its principal strategic objectives are being managed. All NHS organisations are required to sign a full Annual Governance Statement (HM Treasury requirements) and must have

the evidence to support this; the BAF brings together a significant part of this evidence. Risks to the Trust achieving its principal objectives are managed in line with the process set out below.

Additional verification of sound risk management processes is built into the Care, Fundamental Standards of Care and monitored Board Assurance Framework by the Care Quality Commission.

5.5 Board Assurance Framework Process Flow

Trust's principal objectives agreed by Board of Directors and reviewed annually

The Trust's objectives will reflect strategic ambitions, national and local commissioning intentions, and locally defined priorities. They should also take account of patient feedback, identified risks, themes relating to reported adverse events, near-misses, incidents, complaints, claims or concerns, audit findings, external recommendation s, national initiatives and directives etc.

Risks to the achievement of the objectives identified by the Board

Risks graded using Impact/Likelihood Descriptors and Risk Grading Matrix

Every risk identified is a quality improvement opportunity

Executive Directors identified as leads manage risks to principal objectives

Leads must:

Identify current and planned control mechanisms

Identify actual and potential sources of assurance on the effectiveness of the controls (e.g. key performance indicators, internal and external audits, third party reviews)

Develop mitigating action plans

Report progress on delivery of action plans via the BAF

Trust Board monitors action plans until risks resolved

Action plans devised, risks managed and monitored

Risks and action plans monitored by relevant Board Sub-Committee

As per the Risk Escalation process

Action plans implemented and monitored until required action is taken and acceptable risk grade reached

Required Action Taken

Risk managed

6. Other Proactive Risk Management Processes

6.1 Policies and supporting documentation

In addition to the Risk Management Policy there is a range of other policies that support the management of risk within the Trust, some of which, are listed and all are available on the Trust's internal website.

6.2 Resilience Management

The Trust has in place a comprehensive Business Continuity Plans, as well as a range of associated documents, designed to ensure the resilience of the Trust in a range of scenarios that would limit the operating capacity of the Trust. These plans are tested and learning from these tests is communicated to relevant staff groups and Committees/Groups to ensure that processes are refined.

The Trust has an established Emergency Planning and Resilience Group. The Group meets to discuss the Trust's progress against the EPRR core standards and its progress against the work plan.

6.3 Implementation of clinical guidance

The Trust has mechanisms in place to implement the latest guidance and recommendations from National Service Frameworks, the National Institute for Health and Care Excellence (NICE) etc. These are covered by the Trust.

6.4 Standards and accreditation

The Trust ensures that it meets (and aims to exceed) a range of standards and accreditations. Many of these are covered by the Trust's Policy for NICE guidance implementation and Audit.

6.5 Audit activity (clinical, internal and external)

There is extensive audit activity within the Trust covering a range of issues. Findings from these reviews are fed back as appropriate to staff, and reports made to the Quality Assurance Committee, Audit and Risk Committee (Internal and External audit) and the Board of Directors on a range of local forums.

6.6 Organisational learning

The Trust seeks to learn from the experiences of other organisations. For example, published reports from key regulators are reviewed, with findings compared to existing Trust practice.

6.7 Reactive risk processes

The Trust also identifies potential risks from events that have already occurred in the Trust and beyond and uses risk management techniques to address. Such reactive risk identification sources include:

6.8 Complaints

The Trust has a well-established process for the handing of complaints, ensuring that all concerns are responded to within the approved timescales, as described in detail within the Trust's Complaints Management and PALS policy.

6.9 Incidents

The Trust has a system for reporting adverse incidents, described within the Trust's Incidents and Serious Incidents Policy. All notified incidents are graded using a matrix consistent with that used for risk assessment.

6.10 Claims, Litigation and Inquests

The Trust's Legal Department works closely with the Nursing and Quality Directorate , Complaints, and Health and Safety Departments to enable the early identification of potential legal claims against the Trust. The Trust liaises with HM Coroner and clinicians in respect of the inquest process. Any concerns or recommendations raised by the Coroner are communicated appropriately to ensure that remedial action is taken. The processes associated with claims, litigation and inquests are set out in the Trust's Claims Management Policy.

6.11 Specific Clinical Risks

Clinical risks are identified through a vast range of assessments carried out at the patient/clinician interface, for example, for the prevention and management of:

Self-harm

Suicide

Vulnerability

Neglect

Violence and Aggression

6.12 Central Alert System

The Trust has robust processes in place to respond to alerts issued through national frameworks, and supplements this with its own internal alert system. These are set out in the Trust's Central Alert System (CAS) Policy.

6.13 Health and Safety Risk Assessments

The assessment of certain specific health and safety risks is required to be undertaken by the manager responsible for the service. Guidance, training and support are available for the Risk.

7. Related documents

TEWV Care Coordination/Care Programme Approach (CPA)
Ref IA-0002-v6.1

.

Harm Minimisation (Clinical Risk Assessment and Management) Policy
Ref: CLIN-0017-v8.2

All other Trust Policies are also in place to help reduce risks and can be accessed through the Trust internet site

8. How this policy will be implemented

This policy will be published on the Trust's intranet and external website.

This policy will also be communicated within the Trust's bulletins, at Induction and through supporting mandatory training.

Line managers are required to disseminate this policy to all staff through their line management briefings.

The Board of Directors will review and approve the Board Assurance Framework.

Executive Directors will consider and approve the Corporate Risk Register and have oversight of all 12+ risks.

Care Groups will monitor and have oversight of all risks within their Care Group with 12+ risks overseen by the Care Group Board level, 8+ risks overseen and scrutinised by the Care Group Sub-Groups relevant to their duties.

Specialities/Departments are required to have oversight of local risk registers.

8.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All	Trust Induction	30 minutes	Upon appointment
All	Mandatory – Risk Management Refresher	30 minutes	Annual
All	Local Induction Carried out by Line Manager to include general awareness of the risk management process, risk registers, any significant uncontrolled risks; and completion of any specific risk assessments, eg lone working, display screen equipment etc.	30 minutes to 1 hour	Upon appointment
Board members	High level risk management awareness training covering wider risk management techniques and risk appetite for all Board members and senior Directors.	1 hour	Annually
All Clinical Staff and Agenda for Change Staff 7 and above	Detailed training for all staff with responsibility for recording risks on to the Risk Register.	3 hours	

9. How the implementation of this policy will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	a) Compliance with Induction and Annual Mandatory		Executive Risk Group.

	Training standards in relation to risk management.	Annually (Director of Quality Governance) Via an Annual Audit of the risk register:	Audit and Risk Committee (Executive Directors will provide a report to the Audit and Risk Committee on the outcome of the audit). Assurance will also be provided by the annual review of the Trust's risk management arrangements in accordance with the internal audit strategy. The outcomes of the reviews by Executive Directors and the Internal Auditors will inform the Annual Governance Statement for consideration by the Audit and Risk Committee and Board. On an ongoing basis assurance will be provided on the operation of the policy through exception reporting, including progress on mitigating actions.
2	a) Risks are being appropriately assessed and graded b)Lead Risk Owners are recorded against Risks c)Initial, current and target risks are recorded d)Controls are recorded e)Mitigating actions in place f)Review of risks within appropriate timescales g)Review of actions within appropriate timescales h)Groups Receiving relevant Risk Registers in accordance with their remit		
3	Risks are being reviewed in Care Groups to identify common themes with requests for Corporate Risks made in accordance to risk score		
4	Effectiveness of risk management systems and processes against the findings and recommendations of internal and external audit reports (typically annually); External reviews, such as NHSE/I, CQC, HSE.		

10. References

Care Quality Commission Fundamental Standards

NHS England and Improvement guidance

The Healthy NHS Board: Principles for Good Governance – NHS Leadership Academy

Taking it on Trust: Questions for Boards, Health and Safety Executive, National clinical Programmes Model of Care Development, Checklist, Governance for Quality and Safety

Health and Safety at Work Act

Management of Health and Safety at Work Regulations

Health and Safety Executive

The Policy should be read in conjunction with the following Trust's policies:
Safety and Quality Strategy
Duty of Candour Policy
Claims Policy
Fire Safety Policy
Clinical Risk Assessment and Safety Planning/Risk Management Policy and Procedure
Complaints Policy
Medical Devices Management Policy
Health and Safety Policy
Incident and Serious Incident Policy
Investigation of Incidents, Complaints and Claims using Root Cause Analysis
Mandatory Training and Induction Policy
Infection, Prevention and Control Policy
Raising Concerns (Whistleblowing) Policy
Slips, Trips and Falls Policy and Procedure
Display Screen Equipment Policy
Prevention and Management of Violence and Aggression Policy
Working Alone (Personal Safety) Policy

11. Document control

Internal

To be recorded on the policy register and removed by Policy Coordinator before publication

Lead:	Name	Title
Members of working party:	Name and title	
	[Name, title], [name, title] etc.	
Equality Analysis completed by: Lead: Line Manager:	Name	Title
This document has been agreed and accepted by: (Director)	Name	Title

External

To be recorded on the policy register by Policy Coordinator

Date of approval:		
Next review date:		
This document replaces:		
This document was approved by:	Name of committee/group	Date
This document was ratified by:	Name of committee/group	Date
An equality analysis was completed on this document on:		
Document type	Private / Public* *Delete as appropriate	
FOI Clause (Private documents only)	*Delete as appropriate	

Change record

Version	Date	Amendment details	Status
1	30 January 2018	New Policy	Published
2	October 2020	Review Date Extended	Published
3	6 July 2021	Review Date Extended to 30 September 2021	Published
4	March 2022	Policy Updated	

APPENDIX A

GUIDELINES TO IDENTIFY, ASSESS, ACTION AND MONITOR RISKS

In order for the Trust to manage and control the risks it faces; it needs to identify and assess them. This document provides a step-by-step guide to help staff undertake risk management systematically and will ensure consistency of approach across the organisation.

1. Identifying a Risk

- There is no unique method for identifying risks. Risks may be identified in a number of ways and from a variety of sources, for example:
- Risk assessment of everyday operational activities, especially when there is a change in working practice or environment
- Clinical risk assessments
- Environmental / workplace risk assessments
- Risk assessment as part of Trust business – at all levels of the organisation
- Annual planning cycle
- Performance management of key performance indicators
- Internal risk assessment processes e.g. requirements to assess risks as part of development and approval of policies, procedures, strategies and plans
- Claims, incidents (including Serious Untoward Incidents) complaints and PALS enquiries
- Organisational learning e.g., assurance reviews
- External reviews, visits, inspections and accreditation e.g. Health and Safety Inspections, Fire Inspections, external consultant reports
- Information Governance Toolkit
- Staff and patient surveys
- National recommendations including Confidential Inquiries, safety alerts, NICE guidance etc
- Internal and External Audit
- Clinical audits
- Information from partner organisations
- Environment scanning of future risks (both opportunities and threats)

This list is not exhaustive. In general, the more methods that are used the more likely that all relevant risks will be identified.

There are two distinct phases to risk identification:

a) Initial Risk identification - relevant to new services, new techniques, projects

b) Continuous Risk Identification – relevant to existing services and should include new risks or changes in existing risks e.g. external changes such as new guidance, legislation etc.

2. Describing the risk

Failure to properly describe risk is a recognised problem in risk management. Common pitfalls include describing the impact of the risk and not the risk itself, defining the risk as a statement which is simply the converse of the objective, defining the risk as an absence of controls etc.

A simple tip is to consider describing the risk in terms of cause and effect.
The example below provides a useful guide to help staff define the risk accurately and precisely:

Objective: To travel from the Lanchester Road Hospital (LRH) to West Park Hospital (WPH) for a meeting at a certain time		
Risk description		Comment
Failure to get from the NGH to WPH for a meeting at a certain time	**x**	This is simply the converse of the objective
Being late and missing the meeting	**x**	This is a statement of the **impact** of the risk and not the risk itself
Eating on the shuttle bus is not allowed so I was hungry	**x**	This does not impact on the achievement of the objective
Missing the shuttle bus causes me to be late and miss the meeting	√	This is a risk that can be controlled by ensuring I allow enough time to get to the shuttle bus stop
Severe weather prevents the shuttle bus from running and me getting to the meeting	√	This is a risk that I cannot control but against which I can make a contingency plan

3. Assessing the risk

Having identified and described the risk, the next step is to assess the risk. This allows for the risk to be assigned a standard rating which determines what actions (if any) need to be taken.

Ideally, risk assessment is an objective process and wherever possible should draw on independent evidence and valid quantitative data. However, such evidence and data may not be available and assessor(s) will be required to make a subjective judgement. When facing uncertainty, the assessor(s) should take a precautionary approach.

The risk assessment should be undertaken by someone competent in the risk assessment process and should involve staff familiar with the activity being assessed. Depending on the severity of the risk, the directorate Risk/Governance lead should be notified. Trade union representatives, external assessors or experts should be involved or consulted, as appropriate.

Risks are assigned a score based on a combination of the likelihood of a risk being realised and the consequences if the risk is realised.

The Trust uses three risk scores:

- Initial Risk Score: This is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risks and is used as a benchmark against which the effect of risk management will be measured.
- Current Risk Score: This is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move toward the Target Risk Score as action plans to mitigate the risks are developed and implemented.
- Target /Residual Risk Score: This is the score that is expected after the action plan has been fully implemented. a) Scoring the consequences

Use *Table 1. Measures of Consequence*, to score the consequence, with existing controls in place: Choose the most appropriate domain(s) from the left hand column of the table. Then work along the columns in the same row and, using the descriptors as a guide, assess the severity of the consequence on the scale 1 = Insignificant, 2 = Minor, 3 = Moderate, 4 = Major and 5 = Catastrophic.

Table 1: Measures of Consequence

	Consequence ratings (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Formal complaint (stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

	Consequence ratings (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ regulatory	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

	Consequence ratings (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
	environment				
Personal Data Security	-	Potentially serious breach but risk assessed as low e.g. files were encrypted	Serious breach and risk assessed as high (e.g unencrypted data). Non-clinical data	Serious breach and risk assessed as high (e.g unencrypted data) Clinical Data	Serious breach with likelihood that the ICO will take formal action against the Trust

Scoring the likelihood

Use *Table 2. Likelihood*, to score the likelihood of the consequence(s) occurring with existing controls in place, using the frequency scale of Rare = 1, Unlikely = 2, Possible = 3, Likely = 4 and Certain =

Table 2 Likelihood

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Likelihood rating	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
Probability Chance of the risk happening	<5%	5% - 20%	20% - 50%	50-80%	.>80%

Likelihood can be scored by considering

- Frequency i.e. how many times the consequence(s) being assessed will actually be realised

or

- Probability i.e., what is the chance the consequence(s) being assessed will occur in a given period

b) Scoring the risk Calculate the risk score by multiplying the consequence score by the likelihood score. *See Table 3 Risk Score*

IMPORTANT: It may be appropriate to assess more than one domain of consequence. This may result in generating different scores. Use your judgement to decide on the overall score, however as a rule-of-thumb take the highest domain score.

Table 3: Risk Score

Likelihood	**Consequence**				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

5. Rating the Risk

Risk rating makes it easier to understand the directorate and/or Trust-wide risk profile. It provides a systematic framework to identify the level at which risks will be managed and overseen in the organisation; prioritise remedial action and availability of resources to address risks; and direct which risks should be included on the Trust's risk register.

6. Documenting the risk

It is important that identified risks are appropriately documented within the DATIX system risk register. (See Appendix B)

7. Addressing risks

Having identified, assessed, scored and rated the risk, the next stage is to decide and document an appropriate response to the risk. The response should describe how the Target Risk Score will be achieved.

In general, there are four potential responses to address a risk once it has been identified and assessed – commonly known as the 4 T's:

- Tolerate
- Treat
- Transfer
- Terminate

a) Tolerate the risk
The risk may be considered tolerable without the need for further mitigating action, for example if the risk is rated LOW or if the Trust's ability to mitigate the risk is constrained or if taking action is disproportionately costly. If the decision is to tolerate the risk, consideration should be given to develop and agree contingency arrangements for managing the consequences if the risk is realised

b) Treating the Risk
This is the most common response to managing a risk. It allows the organisation to continue with the activity giving rise to the risk while taking mitigating action to reduce the risk to an acceptable level i.e. as low as reasonably practicable. In general, action plans will reduce the risk over time but not eliminate it. It is important to ensure that mitigating actions are proportionate to the identified risk and give reasonable assurance to the Trust that the risk will be reduced to an acceptable level. Action plans must be documented on the risk assessment form, have a nominated owner and progress monitored by the appropriate risk forum.

c) Transfer the risk
Risks may be transferred for example by conventional insurance or by sub-contracting a third party to take the risk. This option is particularly suited to mitigating financial risks or risks to assets. It is important to note that reputational risk cannot be fully transferred.

d) Terminate the risk
The only response to some risks is to terminate the activity giving rise to the risk or by doing things differently. However, this option is limited in the NHS (compared to the private sector) where many activities with significant associated risks are deemed necessary for the public benefit.

8. Mitigation/ Action Plans

Mitigation plans should be developed:

- To close off any gaps in control or assurance
- To reduce the threat (likelihood and consequence) of the risk.

All mitigations must:

- Include a description of the planned action, a due date and identify an individual responsible for delivering the action.
- Be outcome focussed and directly related to the threat.
- Be approved (together with any resource implications) by the appropriate governance group for the risk (as specified in the risk escalation framework)

Monitoring of the delivery of mitigating actions will be undertaken through usual reporting arrangements.

Appendix B

GUIDELINES FOR THE USE OF THE RISK REGISTER

1. Introduction

All Trust Risk Registers

A risk register is a log of risks of all kinds that threaten the delivery of ambitions and the delivery of services. It should be a live document which is populated through the risk assessment and evaluation process.

Risk Registers operate at all levels in the trust – at local ward, department and service level, major projects and programmes, directorate, Care Group and Corporate level. Datix Risk Management System is the system used to record risks.

2. Registering a risk on Datix

As outlined in Appendix A Guidelines to Identify, Assess, Action and Monitor Risks, risks can be identified in a number of ways and from a range of sources.

Risk assessments can and should be made at any level in the organisation

Use the risk assessment matrix to assess the likelihood and consequence of the risk

Log your risk on the risk register including the following for each risk you have identified:

- Describe the risk.
- Document the source of the risk
- Identify any existing control measures in place (policies/procedures, training/physical controls) to prevent the risk occurring or reduce the potential impact if it occurred. Consider whether the controls already in place are adequate.
- Score the risk (consider what evidence you have to support how often it happens and the usual consequence).
- Describe additional action that must be taken to manage the risk and the level of resources required (if any) to manage it effectively.
- Identify the person responsible for managing the action plan (risk owner)
  If financial input is required to manage the risk, include what action is required (e.g. business case), timescales & lead personnel.

3. A Guide to developing an action plan

When identifying mitigating actions to manage identified risks there is a need to identify the most appropriate way of managing each risk. There are a number of ways to approach this which are outlined below:

REDUCTION:	taking action to reduce the likelihood or impact.
AVOIDANCE:	doing the job in a different way so that the risk does not occur.

TRANSFER: if you cannot manage the risk transfer it someone who can (with their agreement) e g. another Trust or Department

ACCEPTANCE: if the risk is small or cannot be reduced, avoided or otherwise transferred, you may have to accept the risk and prepare a contingency plan.

Document an action plan for each risk you have identified. Actions will need to be followed up on a regular basis. For each action ensure that you:

1. Identify which option you have chosen to manage the risk.
2. List any actions that are needed to manage the risk indicating the agreed time scale for each action.
3. Ensure a designated person is chosen to take responsibility for managing the risk and signs up to the action plan.
4. Re-score the risk, once the appropriate actions have been implemented.

4. Risk Escalation

Risks are managed according to the level of risk identified as set out in the risk escalation framework.

5. Review of risks

Risks registered on DATIX must specify when the current risk score, action plan and target risk score will be reviewed.

Risk Level	Review Frequency
15+	Monthly
12+	Bi-Monthly
8+	Quarterly
All risks must be reviewed at least once a year	

It is expected that as action plans are progressed the current risk score will move towards the target risk score and may be closed (if the risk has been eliminated) or tolerated (if the risk remains but all planned mitigating action has been taken). This may be achieved within one review period but it may take longer, in which case a new review date must be set

6. Quality Assurance

Quality Assurance of the Risk Registers will be secured via a number of mechanisms:

- designated risk forums have primary responsibility for their risk registers
- Executive Risk Group provides ongoing oversight of all risk registers, supplemented by random detailed reviews to assess risk scoring and treatment plans, appropriate escalation and aggregation and that all risks remain in date
- Annual Audit as detailed in
- Internal Audit will review risk registers as part of their annual review of Risk Management

Appendix 1 - Equality Analysis Screening Form

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

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Corporate					
Policy (document/service) name	Risk Management Policy					
Is the area being assessed a…	Policy/Strategy	√	Service/Business plan		Project	
	Procedure/Guidance				Code of practice	
	Other – Please state					
Geographical area covered	Trust-wide					
Aims and objectives	To support delivery of the Trust's Strategic Objectives To support compliance with legal and regulatory requirements and expectations To embed a standardised approach to the management of risk throughout the Trust To provide understanding on the Trust's risk appetite to support effective decision making					
Start date of Equality Aalysis Screening (This is the date you are asked to write or review the document/service etc.)	September 2017					
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	March 2022					

You must contact the EDHR team if you identify a negative impact - email tewv.eandd@nhs.net

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?					
Everyone – it provides a framework for assessing and responding to organisational risk					
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?					
Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Sex** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No
Yes – Please describe anticipated negative impact/s **No** – Please describe any positive impacts/s					

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	√	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Sex, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Please describe the engagement and involvement that has taken place

No – Please describe future plans that you may have to engage and involve people from different groups

Key training is planned to be arranged and supported by Induction and Mandatory Training.

5. As part of this equality analysis have any training needs/service needs been identified?					
Yes	Please describe the identified training needs/service needs below **TO BE INCLUDED FOLLOWING REVIEW BY PHIL AND AVRIL**				
A training need has been identified for;					
Trust staff	Yes	Service users	No	Contractors or other outside agencies	No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					

Appendix 2 – Approval checklist

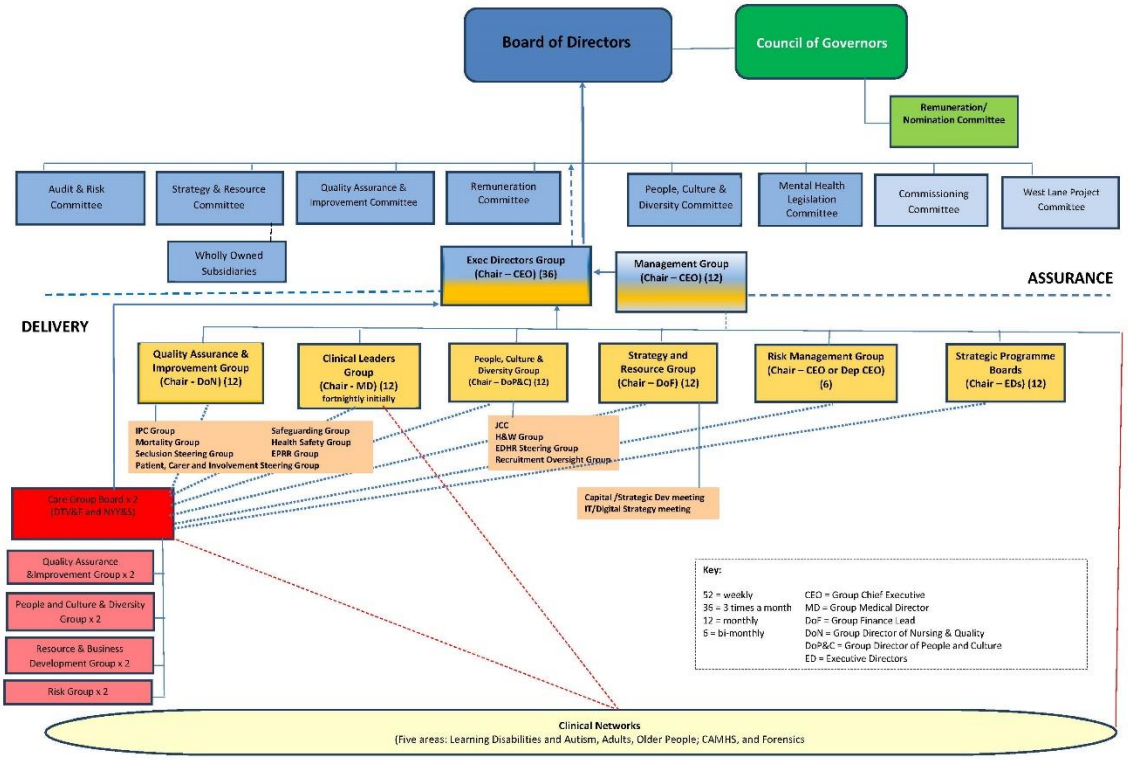
To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	Policy
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	Supports the revised corporate governance structure which was consulted with staff. Full training, including Induction and Mandatory training.
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	Datix scoring and supplementary information
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	

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

Appendix 3

Organisation Governance Structure



ITEM NO. 19

FOR GENERAL RELEASE

BOARD OF DIRECTORS

DATE:	**28th July 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
425	30.6.22	Settlement Agreement	Patrick Scott, Managing Director Phil Bellas, Company Secretary

Recommendations:

The Board is asked to receive and note this report.