MEETING OF THE BOARD OF DIRECTORS

14 September 2023

The Boardroom, West Park Hospital, Edward Pease Way, Darlington, DL2 2TS and via MS Teams at 1.30 pm

AGENDA

Note: there will be a confidential session at 1.00 pm for the board to receive a patient story.

Standard Items (1.30 pm – 1.50 pm)

1	Chair's welcome and introduction	Chair	Verbal
2	Apologies for absence	Chair	Verbal
3	Declarations of interest	All	Verbal
4	To approve the minutes of the meeting held on 13 July 2023	Chair	Draft Minutes
5	To receive the Board Action Log	Chair	Report
6	To receive the Chair's report	Chair	Report
7	To note any questions raised by Governors in relation to matters on the agenda *To be received by 1pm on 12 September 2023*	Chair	Verbal

Strategic Items (1.50 pm – 3.00 pm)

8	To receive the Board Assurance Framework summary report	Co Sec	Report
9	To receive the Chief Executive's report	CEO	Report
10	Our Journey to Change Delivery Plan, update	Asst CEO	Report
11	To consider the Integrated Performance Dashboard	Asst CEO	Report
12	To consider the Corporate Risk Register	CN	Report
13	To receive a report on winter emergency preparedness, resilience and response	MD, DTVF & MD, NYYS	Report

BREAK – 10 minutes

Goal 1: To co-create a great experience for our patients, carers and families (3.10 pm – 3.35 pm)

14	To consider the Leadership Walkabouts report	DoCA&I	Report
15	To consider the report of the Chair of Quality Assurance Committee	Committee Chair (BR)	Report
16	To consider the report of the Chair of Mental Health Legislation Committee	Committee Chair (PH)	Report

Goal 2: To co-create a great experience for our colleagues (3.35 pm – 3.50 pm)

17	To receive the report from the Chair of People, Culture and Diversity Committee	Committee Chair (JH)	Report
18	To receive a report on the appraisal and revalidation of doctors – Board report and Statement of Compliance 2022-23	MD	Report

For Information:

19	The NExT Director Scheme	Chair	Report

Exclusion of the Public:

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

David Jennings
Chair
8 September 2023

Contact: Karen Christon, Deputy Company Secretary
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Tees, Esk and Wear Valleys NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 13 JULY 2023 AT WEST PARK HOPSITAL, DARLINGTON AND VIA MS TEAMS, COMMENCING AT 1.30 PM

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
B Reilly, Non-Executive Director and Deputy Chair
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
J Haley, Non-Executive Director
P Hungin, Non-Executive Director
K Kale, Medical Director
J Maddison, Non-Executive Director
B Murphy, Chief Nurse
J Preston, Non-Executive Director and Senior Independent Director
L Romaniak, Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
A Bridges, Director of Corporate Affairs and Involvement (non-voting)
M Brierley, Assistant Chief Executive (non-voting)
H Crawford, Director of Therapies (non-voting)
S Dexter-Smith, Director for People and Culture (non-voting)

In attendance:
K Christon, Deputy Company Secretary (minutes)
V Brinsley, Freedom to Speak Up Officer (agenda item 14)

Observers/members of the public:
L Alexander, Governor
H Griffiths, Governor
S Paxton, Head of Communications
Member of the public

23-24/52 CHAIR'S WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and noted that the board had the opportunity to receive an inspirational patient story, prior to the meeting.

23-24/53 APOLOGIES FOR ABSENCE

Apologies for absence were received from C Carpenter, Non-Executive Director and R Barker, Non-Executive Director. Apologies were also noted from J Preston who would need to leave the meeting early.

The Chair placed on record his thanks to J Preston for all the work he does as a Non-Executive Director for the trust and for the work that he also does in his local community.

23-24/54 DECLARATIONS OF INTEREST

None.

23-24/55 MINUTES OF THE MEETING HELD ON 25 MAY 2023

The minutes of the meeting were agreed as an accurate record for signature by the Chair.

23-24/56 MINUTES OF THE MEETING HELD ON 8 JUNE 2023

The minutes of the meeting were agreed as an accurate record for signature by the Chair, subject to the correction 'H *Crawford* noted that targets….' [page 5, para 2 refers]

23-24/57 MINUTES OF THE MEETING HELD ON 27 JUNE 2023

The minutes of the meeting were agreed as an accurate record for signature by the Chair, subject to the inclusion of J Maddison, Non-Executive Director and J Haley, Non-Executive Director, who had been present at the meeting.

23-24/58 BOARD ACTION LOG

The Chair welcomed the update provided and the following was noted:

1) In respect of the Establishment Review, B Murphy advised that significant work had taken place to understand the current position and those actions that were required to make progress [action: 23-24/17].

2) Responding to a query, B Reilly advised that Quality Assurance Committee (QuAC) had received assurance on the revised mortality process and would receive a report in September 2023. It was proposed that the narrative in the action log be updated accordingly. [action: 23-24/15]. **Action: K Kale**

3) The board agreed to defer the report of the Guardian of Safe Working to September 2023 [action: 23-24/16].

4) The Chair welcomed the update provided in relation to feeling safe and requested that the action log provide further details on action proposed/taken and related timescales [actions: 23-24/28 and 23-24/39]. **Action: B Murphy/P Scott**

5) The Chair requested that the minutes of the meeting include an update in relation to progress on the Annual Report and Accounts, following the special board meeting held on 27 June 2023 [action: 23-24/47]. **Action: L Romaniak**

   Addendum to the minutes: Mazars have formally concluded their work on the trust's annual report and accounts and have provided the audit completion certificate to the Council of Governors. This was received on 21 August 2023. The trust will lay its annual report and accounts before Parliament week commencing 4 September 2023.

6) As there was no scheduled board meeting in August, it was proposed and agreed that actions due in August would be moved to the following meeting in September. **Action: K Christon**

23-24/59 CHAIRS REPORT

The Chair introduced his report and commented on a recent meeting with the Police, Fire and Crime Commissioner for North Yorkshire and her commitment to work with the trust on the introduction of the Right Care, right Person Policy, and he welcomed the opportunity for a similar

meeting in Teesside and Durham. He went on to note the Living the Values Awards held recently and his attendance at HMP Durham, where the values held by staff had shone through.

B Kilmurray advised that the meeting with the Dean of Teesside University to sign the Memorandum of Understanding had been deferred at their request and would be re-arranged.

The Chair noted the receipt of a letter from the Secretary of State to congratulate staff on their hard work, on the 75th anniversary of the NHS.

23-24/60 MATTERS RAISED BY GOVERNORS

No matters had been raised.

23-24/61 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT

The board received and noted the report which provided a reminder of the strategic risks for consideration during the meeting.

23-24/62 CHIEF EXECUTIVE'S REPORT

B Kilmurray introduced the report, which aimed to highlight topical issues that were of concern. He referenced the 75th anniversary of the NHS and thanked A Bridges and those involved who had ensured the celebration was a success. Attention was then drawn to:

1) The announcement of a statutory independent inquiry into mental health inpatient deaths across trusts in Essex.

   Responding to a query, B Kilmurray confirmed that the trust expected to contribute to the national investigation into mental health inpatient care settings, by the Health Services Safety Investigations Body later in the year, alongside other trusts and he undertook to provide further information once the terms of reference were available. **Action: B Kilmurray**

2) The findings of the rapid review into data on mental health inpatient settings, which would be considered by the Integrated Care Board (ICB) and a report would be presented to QuAC in September 2023.

3) The themes of the NHS Long Term Workforce Plan and S Dexter-Smith suggested that the report provided clarity to support long term workforce planning, albeit that there remained some significant challenges.

   The proposal to work with higher educational institutions and universities was welcomed and L Romaniak advised that of the £2.5bn funding available to support training costs, the majority was back end loaded in year five.

4) Arrangements that would be in place during the period of industrial action by junior doctors and consultants in July and B Kilmurray undertook to report retrospectively on the management of this at the next meeting including on the trajectory for recovery.
   Action: B Kilmurray

   K Kale advised that there were no related issues to bring to the attention of the board and he welcomed the willingness of staff to be redeployed to ensure cover was available.

Z Campbell advised that any activity that had been stood down would be monitored closely and attention paid to areas where there had already been an impact from previous industrial action. The trust continued to engage with the wider system and would attend meetings and provide information in a timely way.

Responding to a query, B Kilmurray suggested there was no intelligence to indicate there would be an imminent resolution to the position.

The Chair welcomed the update and proposed that a report be provided to the next Council of Governors meeting to outline the position and controls that the trust had established.
Action: Z Campbell

In respect of industrial action by consultants, Z Campbell confirmed that 18 BMA members had indicated they would participate from a total of 140, with 30 to be confirmed. The position was monitored daily to ensure appropriate cover was in place.

5) P Scott welcomed early engagement by Cleveland Police on the Right Care, Right Person Policy, which had included the identification of a key contact in order to minimise risk. He noted that Durham Constabulary would meet with urgent care partners once the national toolkit had been made available.

Z Campbell indicated that North Yorkshire Police had taken a staged approach to implementation, and she highlighted the escalation and oversight processes already in place and examples of operational and tactical interventions, as outlined in the report.

The Chair welcomed the update and recognised that there would be local differences to how the policy was implemented. He proposed that the next report provide assurance that inconsistencies in approach were appropriate. **ACTION: B Kilmurray/P Scott/ Z Campbell**

Responding to a query from J Maddison, B Kilmurray agreed that the position should be reflected on the Corporate Risk Register. **ACTION: B Kilmurray/P Scott/Z Campbell**

23-24/63 INTEGRATED PERFORMANCE REPORT

M Brierley presented the Integrated Performance Report (IPR), which aimed to provide oversight of the quality of services delivered and provide assurance to the board on action taken to improve performance in required areas.

In presentation, he drew the board's attention to areas that were a priority where performance improvement plans (PIPs) had been developed and performance clinics held, in order to review proposed actions. The impact of the PIPs were expected to be reflected in the July performance report, and oversight and assurance was provided by the care groups.

He commented on the current position in relation to bed occupancy and out of area placements, challenges in respect of the national model for Talking Therapies and cautioned on the reported in month deterioration in performance for restrictive intervention incidents, where there had been an overall improvement.

In respect of the crisis line, he advised that work had taken place on the business case to support the transition to NHS 111 in Durham, Tees Valley and Forensics (DTVF) Care Group area and that immediate work had taken place to increase short term capacity.

Z Campbell provided an update from North Yorkshire, York and Selby (NYYS) Care Group and commented on: the mitigation in place beneath the IPR; the overall increase in staff training and the clarity on services below target due to capacity; monitoring of the national quality requirement in respect of follow-up 72 hours after discharge; and successful recruitment to learning disability services, where only 2.5FTE vacant posts remained. She also went on to note that proposals had been brought forward to work with the voluntary sector to triage calls to the crisis line and this was expected to improve response rates.

In response to a query, she confirmed that there was shared learning across the care groups.

In discussion the following queries or points of clarification were raised:

1) S Dexter-Smith welcomed the reported improvement in staff absence and retention and suggested that the positive action taken in relation to staff wellbeing and high workloads underpinned the change and provided confidence that this was a genuine improvement.

   She noted an error in the report and advised that year to date retention data showed a marked difference in care groups, with 15 more staff leaving in Durham, Tees Valley and Forensics Care Group than recruited, and 16 more staff recruited in North Yorkshire, York and Selby Care Group than had left.

2) P Hungin suggested that staff sickness data would be skewed by a small number of staff on long term sick and S Dexter-Smith advised that this information was understood, and she noted there had been an overall reduction in long term and recurrent sickness.

3) B Murphy welcomed the use of care group IPR information by the Executive Quality Assurance and Improvement Sub-group to review performance and risks and identify assurance, as a positive new way of working.

4) B Murphy advised that there had been planned use of mechanical restraint during the month and that this had been reported to QuAC and was clinically appropriate.

5) Responding to a point raised by B Reilly in relation to contact with service users placed in out of area beds, P Scott advised that, whilst contact was maintained, this could be strengthened, and he noted that a proposal on this would be presented to QuAC.

6) B Reilly queried how the board would be assured that the actions in place would deliver the improvement required and the Chair noted that whilst the board would not wish to review the PIPs it would wish to be assured that they had made difference.

7) J Maddison suggested that there was greater risk for service users in the community, where the trust was not commissioned at the level required to be able to respond immediately to those waiting for services, and that this would have a detrimental impact on the trust's reputation.

   M Brierley advised that whilst commissioners would hold the trust to account for delivery, they acknowledged the difficult financial position and the gap between demand and the level of services commissioned. The Chair proposed the report include this strategic context and the outcome of conversations with commissioners. **ACTION: M Brierley**

   B Kilmurray acknowledged that there were pressures on some services and advised that the trust would do what it could to ensure patient experience, whilst transformational changes were made.

8) In respect of the target 72 hour follow up following discharge, K Kale advised that recent research supported a 24 hour approach and he welcomed a change in the system to support this.

9) P Scott advised that a proposal had been agreed by Management Group for a revised approach to oversight of bed occupancy, that would support the robust oversight and monitoring of multiple pieces of work across the urgent care pathway. This proposal would change the remit of the existing Bed Oversight Group into an Urgent Care Programme Board.

10) J Haley welcomed the improvement in staff retention, recruitment and sickness and the reduction in agency expenditure.

11) J Haley queried delivery against target for children and young people showing measurable improvement following treatment, and K Kale advised that a preferred approach was to measure goal based outcomes and recovery focused on quality of life outcomes, rather than improvement noted only by a reduction or change in symptoms, and this would be measured from 1 July 2023 onwards.

M Brierly noted that the query had risen previously and agreed to outline the position in the next report. He also undertook to provide clarity where acronyms had been used in the report. **ACTION: M Brierley**

12) In response to a query from J Haley on staff training levels, S Dexter-Smith advised that the trust had mapped all positive and safe care, as leavers and sickness rates had reduced and training levels had continued to improve.

She also advised that the level of completed appraisals had begun to increase following the introduction of WorkPal and care groups would be supported to ensure their quality. In respect of compliance at a 'trust' level she noted that posts within this cohort had begun to be moved into the right category and the group was now compliant.

13) J Maddison queried the timescale for oversight of all medical devices and B Murphy advised that a report would be presented to QuAC on a proposed way forward.

14) B Kilmurray advised that the IPR had been nominated for a national award as one of the best among its peers and the Chair thanked M Brierley and his team for their hard work.

23-24/64 LEADERSHIP WALKABOUTS REPORT

The board received the report which provided high level feedback from the leadership walkabouts to services who had experienced challenges with staff recruitment and services where information had been provided via PALs and complaints.

A Bridges presented the report and welcomed the positive feedback received from service users, that they had been listened to and heard. She noted the recruitment challenges faced by the estates team and commented on the opportunity that had arisen for the team to appoint a service user. She also advised that work was underway on the visit programme for the next year.

In discussion, the following queries or points of clarification were raised:

a) The Chair welcomed the attendance of governors on visits and reflected on his visit to Willow Ward, where staff had noted an increased prevalence of autism, which had

impacted on the service. Whilst they had welcomed the autism training provided, they had acknowledged that they were not autism specialists.

b) L Romaniak advised that work had been undertaken on the estates team structure, pay rates and apprenticeships, in order to make the service more competitive and to promote opportunities for the female workforce.

23-24/65 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee, thanked staff for the prompt report following the committee meeting and advised that she was able to provide reasonable assurance to the board.

She drew attention to committee concerns about the backlog of serious incidents and the mortality process, where reasonable assurance had been provided on actions proposed. She noted that committee had requested a review of BAF risks in order that it would be assured that risks adequately reflected the current position and she welcomed the improvement in risk review compliance.

She provided an overview of the committee development session, the revised work plan and proposed changes to the terms of reference and welcomed participation from members at the last meeting and clarity that had been provided in reports.

Summing up she confirmed that committee had delivered on its commitment to Victor's parents that it would have oversight of the improvement plan, that his name would be heard at board meetings and his legacy would be recognised.

Commenting on the backlog of serious incidents, B Murphy noted correspondence from the coroner and advised that she received twice weekly reports on progress against what was an aggressive improvement trajectory and would escalate to the Chair of QuAC if she considered the risk had increased.

23-24/66 REPORT OF THE CHAIR OF MENTAL HEALTH LEGISLATION COMMITTEE

P Hungin, Chair of Mental Health Legislation Committee, presented the report and advised that there were no areas of concern to bring to the board's attention.

He noted that the trust had introduced changes in how detentions were recorded, as a result of work undertaken by the committee on data accuracy, and he went on to express concern about the impact of the Right Care, Right Person Policy.

He welcomed the input and commitment from staff to the committee and advised that committee had proposed changes to its terms of reference and membership.

In discussion, the following queries or points of clarification were raised:

a) In response to a query, P Hungin advised that committee had noted a geographical variation in use of the Section 136 Act, with a greater prevalence in areas of deprivation.

b) Z Campbell advised that the NYYS rights lead would ensure a timely response to any escalations, and that this was not an additional post.

c) B Reilly sought assurance that a standard operating procedure and forms were in place for Section 17 leave and P Hungin confirmed that was the case. He noted the scale of this work and the compliance role of the MHL team.

P Scott acknowledged that there was a variance in how the act was used and advised that the urgent care programme board would consider if this indicated the pathway was not working effectively.

The Chair requested that feedback be provided to the board at a future meeting.

Action: P Scott

23-24/67 REPORT OF THE FREEDOM TO SPEAK UP GUARDIAN

V Brinsley, Freedom to Speak up Officer presented the report, on behalf of D Williams, which provided an overview of activity during the previous six months.

In presentation she drew attention to the reported increase in contacts, and the themes that had emerged, and she suggested that the increase may be due to improved awareness and timely resolution of concerns, which provided assurance that staff felt able to speak up on any matter.

She noted the National Guardian's Office document 'Fear and Futility' and advised that, whilst the region had scored well in the staff survey on questions related to speaking up, nationally there had been a deterioration in staff confidence over the last two years.

She concluded by inviting board members to complete the freedom to speak up training.

In discussion, the following queries or points of clarification were raised:

a) J Preston proposed that the increase in contacts indicated an open culture, which was welcomed. He went on to suggest that some individuals may not be able to clearly express their concern and queried how the service would respond.

V Brinsley advised that the service would seek further evidence or information to support their concern and S Dexter-Smith also noted that where a matter was escalated to the People and Culture Directorate, they would provide support to help the individual shape their concern.

b) B Reilly expressed concern at the reported increase in cases related to patient safety/ quality between quarter 4 2022 and quarter 1 2023 and V Brinsley advised that a questionnaire had been circulated on the categorisation of concerns, which may have resulted in an increase. S Dexter-Smith also noted that any concern raised that related to a patient safety issue would immediately be prioritised.

23-24/68 RESPONSE TO THE STAFF SURVEY

The board received the report, which responded to a query raised at a previous meeting on why the score for staff who would recommend the trust as a place to work had not increased, despite the trust reported as been the most improved mental health/learning disability trust.

S Dexter-Smith presented the report and drew attention to areas of reported improvement from the previous year and areas where there had been a deterioration in score. These included satisfaction with pay, the quality of appraisals and high workloads, which she suggested would impact on staff morale and the overall recommendation score. She noted actions in place to

respond to these concerns and proposed that there would be a lag before an improvement in score was noted.

In discussion, the following queries or points of clarification were raised:

a) The Chair queried how visible the actions were to staff and how the trust provided feedback following a survey. In response, S Dexter-Smith acknowledged that actions may not be as visible as the trust would wish and a pulse survey was underway to support this continued work.
b) A Bridges welcomed the opportunity to make action plans more visible to staff and easier to understand and she noted that this had been discussed by executive directors in the lead up to the next staff survey in October.

23-24/69 ENGAGEMENT STRATEGY

A Bridges presented the report, which provided an overview of the proposed draft stakeholder communications strategy.

In presentation, she commented on the insight and benchmarking provided through the targeted stakeholder audit and the feedback provided by partners, which had shaped the strategy. She noted the influence that stakeholders may have and the opportunity to harness that support as advocates for the trust and went on to acknowledge the collective and individual role of board in delivery of the strategy.

In discussion, the following queries or points of clarification were raised:

a) M Brierley welcomed the opportunity the strategy provided for focused engagement, to support key conversations, and noted links to care group work on engagement and development of the 2024 - 2025 delivery plan. He suggested that the trust would not start from scratch, but the strategy provided an opportunity to focus resources on the delivery of key priorities.

b) P Scott proposed that the strategy would help to inform conversations with the community and partners on the trust's journey to change, and that it provided an opportunity to strengthen the voice of service users and carers, who would also be advocates for the trust.

c) J Preston welcomed the work completed and the opportunity it provided to make a positive step forward in respect of the trust's reputation.

d) The Chair welcomed the report, which alongside the Communications Strategy, provided an opportunity for the trust to be proactive in its approach, and he suggested that the strategy would be reviewed regularly to be responsive to emerging issues.

23-24/70 ANNUAL REVIEW OF THE BOARD OF DIRECTORS REGISTERS OF INTERESTS

The board received the report, which presented the updated Register of Interests for the Board of Directors.

K Christon presented the report and reminded board members that they had a duty to identify any conflict of interest, or where there may be perceived to be a conflict of interest.

J Preston, Non-Executive Director, advised that he had provided a further update in respect of his position as Chair of Boroughbridge Primary School, which was attended by children with special educational needs, who may receive an autism diagnosis.

The Chair noted that the need to declare an interest had also been discussed as part of the governor induction programme and he invited board members to contact the Company Secretary if there were any queries on what should be declared.

Agreed: *that the Register of Interests be approved for publication on the trust website, subject to the inclusion of an additional interest highlighted by J Preston.*

23-24/71 EXCLUSION OF THE PUBLIC

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 conclusion of confidential business, the meeting ended at 5.31pm.

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

Updates since the last board meeting are provided in bold

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
29/09/2022 22/10/2022 27/04/2023	22/144 22/174 23-24/06	Topics for board seminars	a) Mental Capacity Act b) Reported outcomes following treatment c) what transformation may mean for future services	MD CEO Co Sec	Jun-23		Apr-23: proposed board & committee dates circulated w/c 24 April for consultation May-23: the seminar programme will be developed to take account of topics identified by the board during the year.
26/01/2023	23/215 23-24/5	BAF	Format to be reviewed to consider potential for a table detailing the target level of risk, actual risk and gap	Co Sec	Sep-23		Apr-23: timescale changed to August 2023 to align with the outcome of the full review of the BAF due commence in May-23 **Sept-23: BAF Review to conclude in Oct-23**
26/01/2023	23/215		Risk tolerance - Executive Directors and committees to scrutinise the position to understand how long high risks had remained at their current level and what related action was proposed.	Exec Directors, Committee Chairs	Jun-23		Mar-23: Discussed by QuAC in March-23 Next cycle of committee meetings will be May 2023 **Sept-23: BAF Review to conclude in Oct-23**
27/04/2023	23-24/11		BAF report to reflect the impact of the financial position on delivery of priorities for 2023/24	Co Sec DoFI&E	Sep-23		May23: Linked to full review of the BAF due to commence in May-23 **Sept-23: BAF Review to conclude in Oct-23**
25/05/2023			Board discussion to be held on areas of the BAF where the IPR had reported there is limited performance assurance and negative controls assurance, and where the target date has passed.	Co Sec	Sep-23		Linked to the review of the BAF **Sept-23: BAF Review to conclude in Oct-23**
27/04/2023	23-24/11	Our Journey to Change Delivery Plan	Quarterly report to the board to include an assessment of the financial impact on delivery of proposals.	ACEO	Sep-23		**See Item 10 for OJTC Delivery Plan quarterly update**
27/04/2023	23-24/13	Serious Incidents	Proposal to come to the board on how it can close the loop on reported incidents.	CN	Jul-23		CN to discuss with QuAC chair to agree content of the learning report to QuAC within a revised work plan. Change to reporting anticipated July 23. Jul-23: CN is working on a review of incidents to report to the Q Board in August the themes of learning, the proposal is that we move to an integrated improvement plan based on themes. The themes will relate to our QA process in order that we continually monitor delivery of actions, the QA review is underway. The outcome of this work will be reported to QuAC and onto the Board. **August 23: The QuAC will receive a progress report on the revised QA schedule in September 23, the outcome of the schedule which is directly linked to serious incidents will be regulalry reported to QuAC. It is proposed that this will close the loop. In addition once the backlog of serious incidents is dealt with it is suggested that the AD of Nursing for Patient safety convene a group to review all learning over the previous 12 months and that the outcome is triangulated with issues raised from complaints and with the CQC inspection findings and that QuAC receive a proposal about an integrted improvement plan to be implemented for Q1 24 - 25.**
27/04/2023	23-24/15	Learning from Deaths	Report to provide narrative on what action had been taken since the previous report	KK	Jul-23		Jul-23: Item deferred to Sept-23 **Sept-23: Report deferred to October 2023**

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
27/04/2023	23-24/16	Guardian of Safe Working	Next report to provide an update on the introduction of residential on call rotas and senior medical workforce staffing levels.	J Boylan	Jul-23		Jul-23: Agreed to defer the report to September 23 **Sept-23: Next report deferred - date to be confirmed**
27/04/2023	23-24/17	Establishment Review	Format of the report to be revised, to include summarised actions proposed to mitigate risks highlighted and to outline the level of assurance provided to the board.	CN	Mar-24		Next report to the board due March 2024
25/05/2023	23-24/27	Third party risks	Executive Directors to ensure that risks related to the supply chain and third party delivery are considered.	CEO	Jul-23		Jul-23: BK to provide verbal update at the meeting **Sept-23: will be considered by Executive Risk Group on an ongoing basis**
25/05/2023	23-24/28	Feeling safe	Briefing to be circulated in repsect of the various elements that contribute to feeling safe	CN	**Oct-23**		Jul-23: An MDT has been brought together across care groups to develop a trustwide approach to this. To be reported back to QuAC. **Sept-23: This action has been delayed, the Director of Quality Governance is progressing.**
08/06/2023	23-24/39		Update to be provided from assurance work underway by DTVF Care Group.	MD DTVF	Sep-23		**Sept23: Assurance work underway by DTVF Care Group Board and the Outcome Steering Group.**
25/05/2023	23-24/28	IPR	Out of area placements - narrative to be included in the IPR on why the slippage had occurred	ACEO	Aug-23		**Sept-23: Completed: Further detail will be provided in the October board report**
			Narrative in the IPR to provide clarity on where an external agency or factor has impacted on delivery.	ACEO	Aug-23		**Sept-23: Completed: Further detail will be provided in the October board report**
08/06/2023	23-24/39		Report narrative to be reviewed to ensure that the areas of concern outlined in the cover report are appropriately reflected in the IPR.	ACEO	Aug-23		**Sept-23: Completed: Future reports will address this**
			Board to receive an update on progress on PIPs and related timelines.	ACEO	Aug-23		Jul-23: To be incorporated into the next quarterly update in August 2023 **Sept-23: further information provided in September report and a more detailed overview of the impact will be provided in October.**
13/07/2023	**23-24/63**		**Report to include narrative on the strategic context (commissioned services/demand) and the outcome of conversations with commissioners**	**ACEO**	**Nov-23**		**Sept-23: Will be included in the next Quarterley report due Nov-23**
13/07/2023	**23-24/63**		**Report to include clarification in respect of the target for children and young people showing measurable improvement following treatment.**	**ACEO**	**Oct-23**		**Sept-23: confirmation of the position to be provided in the next report in October 2023.**
25/05/2023	23-24/28	Memory assessment services - NYYS	Memory assessment services - Information and data on delays in scans and access to results to be provided to P Hungin	MD NYYS	14-Jul-23		Jul-23: Information is currently being collected and will be shared with PH by the due date. A decision will then be taken as to whether any further action is required or not and if so, what form the action will take.
26/05/2023	23-24/28	Advocacy for older people	The issue of advocacy for older people to be considered once the new I&E facilitator is in post	DoCA&I	Sep-23		Jul-23: action amended to join up previous two related actions related to a) review of advocacy services for older people and b) the issue of advocacy for older people be considered once the new I&E Facilitator was in post **Sept-23: this is included in the faciliator job description due to be advertised and recruitment is expected in Q3 2023.**
25/05/2023	23-24/29	Corporate Risk Register (CRR)	In resepct to the graph on committee alignment of risks - narrative be included to indcate the scope and range of services provided by the NYYS care group.	CN	Sep-23		Next CRR report due August 2023 Jul-23: the issue was considered at Quac on 6-Jul and the MD confirmed confidence about risk management and that the DTVF resource is sufficient. **Sept-23: Following previous update, this action is for closure.**
08/06/2023	23-24/38	Right Care, Right Person model	Executive Directors to consider if the position is appropriately reflected in the CRR and BAF and a report to be provided to MHLC.	CEO	Sep-23		Jul-23: update provided with CEO report (agenda item 6). Next meeting of MHLC on 31 August 2023

Date	Ref No.	Subject	Action	Owner(s)	Timescale	Status	Comments
13/07/2023	**23-24/62**		**Board update to provide assurance that inconsistencies in how the policy is implemented, is appropriate.**	**CEO, MD DTVF, MD NYYS**	**Oct-23**		
			Position to be reflected on the Corporate Risk Register	**CEO, MD DTVF, MD NYYS**	**Sep-23**		
08/06/2023	23-24/39	Safety Summit	Sumary from the event to be circulated.	MD	Sep-23		Sept-23: Information circulated 8-Sept-23
08/06/2023	23-24/40	International Recruitment	Update to be provided on the policies and procedures in place to support international recruitment and subsequent retention.	DfP&C	Sep-23		
27/06/2023	23-24/47	Annual Report and Accounts	Chair to raise with COG T&F group, governor attendance at ARC when committee consider the annual report and accounts and draft Quality Report	Chair	Sep-23		
27/06/2023			Proposed amendments to be actioned prior to publication of the final report	Co Sec	Sep-23		**Completed**
13/07/23	**23-24/58**		**Minutes of the meeting on 13 July to include an update on progress to finalise the annual report and accounts**	**Dep Co Sec**	**Sep-23**		**Completed**
13/07/23	**23-24/62**	**National Investigation into MH inpatient care settings**	**CEO to provide further information once ToR are available**	**CEO**	**Autum 23**		**Sept-23: the HSIB website reports that the investigation will be launched in Autumn 2023.**
13/07/23	**23-24/62**	**Industrial Action**	**CEO to update retrospectively on management of industrial action and the trajectory for recovery**	**CEO**	**Nov-23**		**Sept-23: Further dates announced and an update is provided within the CEO report (item 9)**
			Report to be provided to Council of Governors to outline the position and controls the trust had established	**MD NYYS**	**Nov-23**		**Sept-23: next Council of Governors meeting is November 2023**
13/07/23	**23-24/66**	**Section 17 leave**	**Board to receive feedback from the Urgent Care Programme Board in relation to variance in how the act is used.**	**MD DTVF**	**tbc**		

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Chair's Report: 14th July – 13th September.

Headlines:

External:

- Weekly MH Chairs' Network
- Meeting NHS FT Chair North & South Tees NHSFT: areas of common interest and role of our organisations as anchor institutions in Tees Valley.
- Meeting North East & North Cumbria ICS Chair, Executive and FT Chairs including update on NHS priorities and finance, and Lucy Letby
- Meeting Yorkshire and Humberside FT Chairs
- Meeting NHS NEDs
- Mentor meeting for DJ
- Durham Police & Crime Commissioner. Cleveland Police & Crime Commissioner - mental health, blue light services, and joint working.
- Stockton MBC Chief Executive.
- Meetings Yorkshire Ambulance Chair and CX; and also NEAS Char & CX : areas of common interest including Right Care, Right Person.
- National NHS Chairs Meeting with NHSE Chair London
- Chair meetings with Yorkshire & Scarborough Trust Chair, and Greater Manchester Mental Health Trust Chair.
- Meeting with Leadership Group of York / North Yorkshire Community Mental Health Transformation.

Council of Governors (CoG)

- CoG Task & Finish Group
- 2 x Council of Governors
- Various ongoing issues from Governors
- Governor induction (wash-up session).

Internal

- Various Living The Values Awards (Elm Ward, ADHD Team Stockton, Bankfields Court)
- Non-Executive Director appraisals.
- Non-Executive Director catch-up discussions.
- Mandatory Training.
- Chief Executive Appraisal.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

ITEM NO. 8

For General Release

Meeting of:	**Board of Directors**
Date:	**14th September 2023**
Title:	**Board Assurance Framework – Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Author(s):	**Phil Bellas, Company Secretary**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
11	Governance & Assurance	The Board Assurance Framework supports the Board discharge its overall responsibility for internal control.

Executive Summary:

Purpose: The purpose of this report is to support discussions at the meeting by providing information on the risks included in the Board Assurance Framework (BAF).

Proposal: Board Members are asked to take the strategic risks, included in the BAF, into account during discussions at the meeting.

Overview: The BAF brings together all relevant information about risks to the delivery of the Trust's Strategic Goals.

A summary of the BAF is attached. This includes information on the strategic risks and related key controls and positive and negative assurances relating to them which have been identified since the last meeting.

Prior Consideration and Feedback None relating to this report.

Implications: None relating to this report.

Recommendations: The Board is asked to take the strategic risks into account during its discussions at the meeting.

BAF Summary

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Related Agenda Items/Reports
	1	2	3										
1	✓	✓		**Recruitment** Inability to recruit sufficient qualified and skilled staff might jeopardise our ability to provide high quality/safe services	**DoP&C**	**PCDC**	**Moderate** ↓	**Low (Dec 23)**	**Good** ↑	Recruiting Managers Recruitment Team	Establishment Reviews Recruitment Oversight Group Recruitment & Selection Procedure "A great place to work" ↑ Partnerships with Education and Training Providers ↑ Planning beyond the Crisis ↑	**Positive: -** **PCDC –** ▪ Good assurance that the Trust has followed a robust process in recruiting, training, and inducting volunteers ▪ Good assurance of progress in delivering the employment elements of Our Journey to Change **Negative: -**	Public Agenda Item 16 – PCDC Key Issues Report
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)**	**QuAC**	**Moderate**	**Moderate (Mar 23)**	**Good**	Ward and team managers Bed Management function Daily Lean Management Huddles Daily staffing calls Daily bed management calls	Partnership Arrangements Surge Modelling Operational Escalation Arrangements Integrated Performance Reporting Establishment Reviews	**Positive: -** **IPD –** Bed occupancy (AMH and MHSOP A&T Wards (Metric 8) – Improvement in performance **Negative**: -	Public Agenda Item 10 – Integrated Performance Dashboard
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**	**QuAC**	**Moderate**	**Moderate (Mar 23)**	**Good**	I&E Team Lived Experience Directors Service managers	Revised Executive and Organisational Leadership Structure Business Plan (Co-creation priorities) Co-creation Programme Board Co-creation Journey (new) Lived Experience Advisory and Reference Network (new)	**Positive: -** **Negative: -**	
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 6 (Learning))	**DoCA&I**	**QuAC**	**High**	**Moderate** (Mar 23)	**Reasonable**	Frontline staff operating in accordance with the Trust's values and policies and procedures Peer Support	Complaints Policy Friends and Family Test/Patient Experience Survey Patient and carer engagement and involvement structures and processes	**Positive**: - **IPD** – Percentage of CYP showing measurable improvement following treatment – patient reported (Metric 4) – Improvement in performance and improved	Public Agenda Item 10 – Integrated Performance Dashboard Public Agenda Item 12 – "Winter Planning 2023/20/24" Public Agenda Item 14 – QuAC

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Related Agenda Items/Reports
	1	2	3							Workers Patient Experience Team	Our Quality and Safety Strategic Journey	assurance **QuAC** - Assurance on the contents of Positive & Safe Improvement Plan **MHLC** – Substantial assurance from Internal Audit on the reporting of rights and discharge information **Negative**: Reasonable assurance on the operation of controls to maintain delivery of services due to winter pressures **QuAC** – NICHE: limited assurance with significant risk to delivery that children with autism receive care in line with NICE guidance, due to capacity and/or complex multi-agency approaches all of which are needed to fully address the issues	Key Issues Report
5	✓	✓		**Staff Retention** Multiple factors could contribute to staff not choosing to stay with the Trust. This will undermine the provision of safe and sustainable services as well as putting individual staff and patients at risk of harm.	DoP&C	PCDC	**Moderate** ↓	**Moderate (Dec 23)**	**Good** ↑	Ward and team managers Guardian of Safe Working Freedom to Speak Up Guardian Organisational Development Team EDI Team Communications Team Employee Support Service Trust Health and Wellbeing Leads	Understanding the cultures that exist across the organisation ↑ Health and Wellbeing Group and offers Ensuring staff are able to raise concerns in a safe and constructive way Work with services to resolve problems in relationships and culture, based on ABC model of wellbeing ↑ Ensure that we provide multiple spaces where staff can explore difficult and complex situations with each other safely and in line with our Trust values Cultural embeddedness in communities we serve Understanding why people choose to leave the trust or move roles	**Positive: -** **PCDC** – ▪ Good assurances that the Trust has followed a robust process in analysing its staff data by protected group and is meeting its NHS Standard Contract requirements and Equality Act duties ▪ Good assurance that the right actions are being taken during Quarter 1 of 2023-24, to maintain the Trust's Apprenticeship workforce **Internal Audit** – Good assurance from the IA Review of Whistleblowing/Freedom to Speak Up Guardian Follow Up Review **Responsible Officer** – Good assurance on compliance with the Framework of Quality Assurance for Responsible Officers and Revalidation (FQA) **Negative:** **IPD –** Percentage Staff Absence Rate (Metric 19) –	Public Agenda Item 10 – Integrated Performance Dashboard Public Agenda Item 16 – PCDC Key Issues Report Public Agenda Item 17 – Report on the Appraisal and Revalidation of Doctors

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Related Agenda Items/Reports
	1	2	3									Reduced assurance **PCDC** – Reasonable assurance in relation to health and wellbeing actions	
6	✓			**Safety** Failure to effectively undertake and embed learning could result in repeated serious incidents	**CN**	**QuAC**	**High**	**Low (Mar 23)**	**Good**	All frontline staff Patient Safety Team Complaints and PALS team Legal Services Team (claims) Communications Team	Incident management policies and procedures Governance arrangements at corporate, directorate and specialty levels Performance Management of Serious Incident Review Organisational Learning Group (OLG)	**Positive: -** **IPD-** ▪ The number of incidents of moderate harm and near misses (Metric 11) – Improvement in performance and improved assurance ▪ The number of Restrictive Intervention Incidents (Metric 12) – Positive Stabilising in performance **QuAC** - Good assurance that the organisation is underway with the key themes identified against the recommendations from the Safeguarding Adults Review on Whorlton Hall (commissioned by Durham Safeguarding Adults Partnership), published in May 2023 **MHLC** – ▪ Good assurance that the legislative requirements for patients held in the Trust on section 136 are being met ▪ Substantial assurance that the CQC have been notified of those patients who were absent without leave under the stipulated definition **Negative** **QuAC** – ▪ Reasonable assurance on the delivery of the Patient Safety Incident Response Plan (PSIRP) ▪ Partial assurance on compliance and the position against the recommendations described in the Rapid Review of Data into MH Inpatient settings DHSC June 2023	Public Agenda Item 10 – Integrated Performance Dashboard Public Agenda Item 14 – QuAC Key Issues Report Public Agenda Item 15 – MHLC Key Issues Report

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Related Agenda Items/Reports
	1	2	3										
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	SRC	**Moderate**	**Low (2025)**	**Good**	Ward and team managers and staff Estates Directorate Management Team IT staff Digital Programme Board Digital Performance & Assurance Group Capital Project Steering Group	Estates Master Plan (EMP) ERIC PLACE national annual reporting / benchmarks and Green Plan submission and monitoring Premises Assurance Model	**Positive:** **CEO Report** - Surveys of the estate have found no use of Reinforced Aerated Autoclaved Concrete (RAAC) in Trust buildings and no concerns have been flagged by the landlords of leased properties **Negative:**	Public Agenda Item 9 – Chief Executive's Report
8	✓	✓	✓	**Cyber Security** A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage	DoF&I	SRC	**High**	**High (Mar 24)**	**Reasonable**	All staff trained and acting in compliance with Trust IG policies CIO and Deputy CIO Technical Delivery Manager and technical team Communications Team Digital Programme Board Digital Performance & Assurance Group	Controls information not provided due to security concerns	**Positive: -** **Negative: -**	
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	QuAC	**High**	**Moderate (Mar 23)**	**Good**	All staff delivering services in line with approved governance policies Policy authors ensuring compliance with best practice Ward and team managers ensuring awareness of regulatory requirements amongst staff	Senior secondments and interim appointments Relationship Management Arrangements with the CQC CQC Action Plan	**Positive: -** **Negative: -**	

Ref	Strategic Goals			Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Related Agenda Items/Reports
	1	2	3										
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	SRC	Low	Low (Mar 23)	Substantial	Trust representatives on partnership bodies and groups	ICS level governance arrangements Specific Local Partnership Boards and Contact Management Boards Provider Collaborative Boards (PCB) Monitoring of the External Environment Business Planning framework Executive and Operational Organisational Leadership and Governance Structure	**Positive: -** **Negative: -**	
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	QuAC	Moderate	Moderate (Mar 23)	Good	Executive Directors Co Sec Dept Members of the tiers of governance in the Trust All staff re compliance with policies and procedures including escalations Head of Risk Management	GGI Well-Led Implementation Plan Executive and Operational Organisational Leadership and Governance Structure Quality Improvement Approach and Team Executive Leadership Group Arrangements	**Positive: -** **PCDC** - Good assurance that the BAF risks continue to be managed effectively **Negative**: **IPD** - Reasonable assurance regarding the oversight of the quality of services being delivered **PCDC** – Limited assurance in relation to the Corporate Risk Register due to a reduction in compliance on the timeliness of risk and action reviews **Commissioning Committee** - No assurance on the data for Adult Secure Services as it was unavailable	Public Agenda Item 10 – Integrated Performance Dashboard Public Agenda Item 16 – PCDC Key Issues Report Private Agenda Item 10 – Commissioning Committee Key Issues 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	Board	High	Moderate (Jan 26)	Good	Director of Finance, Information and Estates/Facilities Management Programme Director, Programme Manager and team re rectification programme RPH weekly	Roseberry Park Rectification Programme External Technical Expert Support Capital Programme Legal Support External Audit	**Positive:** **Negative:**	Private Agenda Item 6 – Chief Executive's Report

Ref	Strategic Goals 1	2	3	Risk Name & Description	Exec Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls Assurance Rating	First Line of Defence	Key Controls and Assurance Ratings	Material Positive/Negative Assurance identified since last ordinary meeting	Related Agenda Items/Reports
										Huddle Capital Project Steering Group			
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**	**WLPC**	**High**	**20 (Jan 26)**	**Good**	Director of Nursing and Governance West Lane Project Director Communications Team Clinical network	Controls information subject to legal privilege	**Positive: -** **Negative: -**	Private Agenda Item 3 – Update Briefing
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	**DoFI**	**SRC**	**High**	**Moderate (Summer 2024)**	**Good**	CITO Delivery Team CITO Clinical Sub-Group CITO Project Board Digital Programme Board	Project Governance Staff CITO Awareness and Training Clinical Safety Clinical Capacity to support the development and implementation of CITO CiTO supplier Clinical and Technical Support	**Positive: -** Assurance that there is a robust plan in place for the CITO project which is on track **Negative**:	Private Agenda Item 4 – CITO Update Report
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**	**SRC**	**High**	**Moderate (2025 – review)**	**Good**	Financial Sustainability Board Budget Managers	Mental Health Partnership Boards ICP/ICB Funding Arrangements Provider Collaboratives Business Planning and Budget Setting Framework Financial Sustainability Board	**Positive:** **SRC -** Assurance in relation to cash management **Negative**: **IPD –** ▪ Financial Plan: Agency expenditure compared to target – Reduced assurance ▪ Cash balances (actual compared to plan) – reduced assurance	Public Agenda Item 10 – Integrated Performance Dashboard Private Agenda Item 7 – SRC Key Issues Report Private Agenda Item 8 – Month 4 Finance Report

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: **Board of Directors**
Date: **14 September 2023**
Title: **Chief Executive's Public Report**
Executive Sponsor(s): **Brent Kilmurray, Chief Executive**
Author(s): **Brent Kilmurray**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
9	**Regulatory Action**	• A key part of the context we operate in is the ongoing legal cases the CQC has brought.

Executive Summary:

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

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

Overview: This report covers an update on the following:

- The recent CQC inspection, what was covered and the current position with factual accuracy and publication.
- Changes to the Fit and Proper Persons Test for new board members and the upcoming publication of a Leadership Competency Framework for all Executive and Non-Executive Directors
- An update on our assurance work following the outcome of the Lucy Letby trial.
- An update on our assurance work following correspondence from NHS England on RAAC
- News on the commissioning of the review of the MHLDA collaborative arrangements in Humber North Yorkshire.
- Update on Industrial Action

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

Care Quality Commission Inspection

The CQC inspected the Trust during May and June 2023. This included the inspection of six of our eleven core services as well as a well led inspection. The CQC visited 42 wards, 14 community teams and spoke to 292 staff. The inspection consisted of unannounced visits to ward areas and short notice inspections of community teams. The well led covered a presentation, interviews, focus groups, meeting observation, clinical visits and document review. The whole process has been supplemented by over 300 data requests.
The services visited were:

- Adult acute wards and psychiatric intensive care
- Adult Learning Disability Wards
- Older Adults Wards
- Secure inpatient services
- Community teams for adults of working age.
- Community teams for people with learning disabilities.

The draft report has been received and we have submitted factual accuracy comments. We are currently awaiting confirmation from the CQC on plans for finalising the report and the date of publication. The team is drawing up plans to support the publication process with briefings to staff, patients and stakeholders.

Fit and Proper Persons Test

NHS England has published a new Fit and Proper Person Test ("FPPT") Framework which has been developed in response to the Kark review on professional standards (2019).
The Framework is designed to assess the appropriateness of an individual to discharge their duties effectively in their capacity as a board member whilst being fair and proportionate and avoiding unnecessary bureaucratic burden on NHS organisations. However, NHS England considers that ensuring high standards of leadership in the NHS is crucial and the Framework will help board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit board members will be prevented from moving between NHS organisations.

From 30 September 2023, NHS organisations are required:

- To use a new board member reference template for references for all new board appointments.
- Complete and retain locally the new board member reference for any board member who leaves their position for whatever reason, and record whether or not a reference has been requested.

NHS England is also working to finalise a new NHS Leadership Competency Framework (LCF) for board level roles. This should be available during September so that it can be implemented alongside the FPPT Framework.
The LCF will help inform the 'fitness' assessment in the FPPT in line with the recommendation in the Kark Review. It takes account of the NHS Long Term Workforce Plan, NHS People Promise and ICB formation, and will support the developments of a

diverse range of skilled and proficient leaders to deliver the best outcomes for our patients, workforce and wider communities.

A new board appraisal framework will also be published, incorporating the LCF, by March 2024 for use for all annual appraisals of all board directors for 2023/24.
Further information on the FPPT Framework is available at:
www.england.nhs.uk/leaders/leaders

Lucy Letby
Following the outcome of the Lucy Letby trail the NHS is understandably taking the opportunity to review the learning from the terrible events at the Countess of Chester Neonatal unit. One of the key considerations has been the need for us to seek assurance that colleagues have unfettered opportunities to raise concerns, that these concerns are welcome and that whistle-blowers are treated well.
NHS England has written to Trust to ensure that Boards are briefed on the arrangements in place against these criteria. This work is being completed and will be initially discussed at the People and Culture Sub-Committee, prior to a paper coming to our Board meeting in October.
It is important that no organisation becomes complacent about these matters. TEWV has been working on this agenda for a little while with a review ongoing regarding our Freedom to Speak Up approach. In the meantime, there have been developments on our communication strategy, a proactive programme of team visits has been developed by our Guardian, we have increased the resource in the speaking up function pending the outcome of the review, there has been a recent review of our policy, the board receives regular reports from the Freedom to Speak Up Guardian and this often includes a commentary on any possible detriment arising for anyone having raised a concern, we have visible executive and non-executive leadership on this agenda.
We are clear we need to keep going at this work. It is critical in embedding the cultural change we have been seeking to achieve over the past 3 years.
Another aspect of the debate based on the learning associated with the Letby case has been the role of managers in taking concerns seriously and an implication that reputational matters have trumped the safety agenda. Linked to the item above on the Fit and Proper Person test we understand that further communications are likely on the introduction of standards for managers and possible regulation. This may be linked to the Leadership Competency Framework mentioned above or could go further. We expect more information imminently.

Reinforced Aerated Autoclaved Concrete (RAAC)
Trusts have been asked to undertake some review and assurance work regarding our estate following the recent news about the risks associated with RAAC in school buildings. This has been a live agenda within the NHS for many years, with surveys happening service wide during 2019/20.
TEWV completed surveys of our estate at this point and found there was no RAAC used in our buildings. We also lease a number of properties and landlords have not flagged any concerns to us. We are undertaking a desktop check of our own surveys to ensure that they are as complete as possible and reflect our current estate and we are seeking positive assurances from landlords of leasehold buildings as opposed to relying on exception reports. I will include a statement of our position in my report to the October board.

Humber North Yorkshire Integrated Care Board Review of the Mental Health Learning Disability and Autism Collaborative

The executive of the ICB has commissioned a review of the collaborative arrangements for MHLDA in the patch.

The purpose of the review is to undertake a rapid look at how to further build on existing collaboration and innovation, NHS Humber and North Yorkshire Integrated Care Board on behalf of the HNY Health and Care Partnership and MH Collaborative has engaged external advice, from Carnall Farrar Consulting to consider new approaches to commissioning and provider collaboration to bring about closer integration across health and social care and exploit opportunities to work more effectively across 'Place' and organisational boundaries.

In undertaking this work, the HNY Health and Care Partnership are seeking a new collaborative model that reflects best practice and achieves the following objectives:

- reducing unwarranted variation, ensuring we provide accessible, high-quality, evidence-based services to meet local population needs.
- increasing the spread and pace of service innovation and integration.
- simplifying the contracting process for both commissioners and providers, with a focus on longer term outcome-based contracts.
- delivery of financial efficiencies

The Trust is a key player within this collaborative and will fully engage with the review. It is expected that an interim report will be prepared for a collaborative event at the end of October/early November.

Industrial Action

You will have seen the notification from the BMA that they have successfully re-balloted to extend their mandate for junior doctor strike action in England and have announced new strike dates in September and October including joint action with consultants. On Tuesday 19 September, consultants will deliver Christmas Day levels of staffing only, while junior doctors will work as usual. On Wednesday 20th September, both junior doctors and consultants will deliver Christmas day levels of staffing only and this will be followed by a full walkout of junior doctors on Thursday 21st and Friday 22nd September with consultants returning to work. In October, both consultants and junior doctors will provide Christmas Day levels of staffing from 2nd – 4th October inclusive.

The Trust Contingency Planning Group has continued to meet over the last few months to oversee the plans to mitigate this action. As we move forward, the work of our stakeholders is becoming more regular and business as usual. Through the deployment of doctors not taking action, the other grades of medical staff available to re-deploy and the support from other clinical staff groups, I'm pleased to report that the action taken to date has not had a significant impact on our services. That said, we are conscious of the standing down of some clinical activity and have put in place measures to ensure patients who had booked appointments that were later cancelled, are re-booked as soon as possible, To date we have seen approximately a third of junior doctors taking part in action and a fifth of consultants, although quite a number of doctors were on annual leave during the action over the Summer and so we don't fully understand their intentions when back at work. We continue to work with colleagues from LNC and junior doctor representatives and have good engagement.

It is clear that the periods of action in September and October will need to be more closely monitored because this is the first time both junior doctors and consultants have taken combined action. As we make plans for these dates, we are seeing less

feedback from colleagues about their intentions of taking action which makes planning more difficult. Medical management are working with clinical leads and medical staffing to ensure there will be sufficient medical cover and we are discussing the impact of Christmas day cover on the normal running of services. We have also made the difficult decision to stand down routine clinical work on the periods of joint action and will make a decision on planned educational activity in and around industrial action on Monday next, with the inevitability that this will be postponed.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Meeting of:	Board of Directors
Date:	14th September 2023
Title:	Trust OJTC Delivery Plan Q1 progress update
Executive Sponsor(s):	Mike Brierley, Assistant Chief Executive
Author(s):	Chris Lanigan, Gail Johnston, Sarah Smith & Louise Swinburne

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

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

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

Strategic Risks relating to this report:
The *Our Journey to Change Delivery Plan 2023/24* is informed by an understanding of all of the BAF risks and the differential levels of risk appetite for each of the risks within it.

Executive Summary:

Purpose:

This report has been produced to enable Board of Directors (BoD) to gain assurance on projects and workstreams pertaining to the current *OJTC* 23/24 Delivery Plan. The report aims to succinctly capture project/workstream progress against key milestones over the year, highlighting those that are completed, work that is on track, and work that is deemed at risk and/or facing significant issues. Where progress is not on track, the report gives BoD assurance on the mitigations being put in place or escalates issues/decisions that require BoD attention.

This is the first time, that the new style delivery plan has been monitored. This report was presented to Executive Directors Group in July 2023.

Proposal:

The current delivery plan was produced when the Trust's new governance systems were still maturing. Monitoring and escalation of the delivery plan is not fully embedded within the organisation due to this. While the planning framework for the new plan will resolve many of these issues for 2024/25, it is proposed that BoD take account of the variable levels of assurance that the Strategy team is able to give across the 17 priorities within this plan and identify where their own intelligence can improve the accuracy of the information in this report.

Overview:

The updates to this report were provided from either:

- One to one discussion between priority leads and Strategy team members.
- Care Group governance meetings (by the planning team).

- Intelligence gathered by the Planning and Strategy team from attendance of other meetings (e.g. Commissioning groups).
- Existing reports where information could be extracted.

As many of the plan priorities have several initiatives/projects contributing to their overall goal, the strategy team have RAG rated the main projects and initiatives contributing to each priority. Blue has been used for milestones completed, to differentiate from on-track, but yet to be completed (Green).

The legend outlining RAG categories is below.

Key	
Complete	
On track	
Some targets missed, but overall end date is not at risk	
Some targets missed & overall end date is at risk	
Not started/project paused	

This report includes:

- **Appendix One - Priority RAG status** for each of the 17 priorities.
- **Appendix Two - 23/24 Our Journey to Change delivery overview** summarising RAG ratings by project.
- **Appendix Three - Project RAG rating** summarising project RAG rating.
- **Appendix Four – Milestone Plan**

Prior Consideration and Feedback Where appropriate, progress and issues have been discussed within Care Group or Executive Directors Group meetings.

Implications: Impact on delivery of key milestones caused the postponement of the go-live date for CITO has been assessed and it has had a direct impact on the roll out of Dialog+, InPhase & the development of committee level IPR metrics. There may also be indirect impacts, but these are still being ascertained.

Recommendations: BoD members are asked to:

a) Note the information and analysis given in this report.
b) Raise any issues where information or intelligence contradicts the assurance given in this report.
c) Discuss any views about the current format of the report.

Appendix One - Priority RAG status

Clinical Journey priorities	Project RAG status					Total projects per priority
Community Transformation		5	5			10
CITO			1			1
Autism		5	1		1	7
						18

Q&S Journey priorities	Project RAG status					
Reducing In-patient pressures			4			4
Patient Safety		2	1			3
Harm Free Care		2	2			4
Personalising Care Planning			1			1
						12

Co-creation Journey priorities	Project RAG status					
Expand/develop Lived experience posts		1				1
Data collection & Learning		2				2
Diversify/expand Involvement		1				1
						4

People Journey priorities	Project RAG status					
More people		2	1			3
Inclusive & compassionate culture			2			2
Working differently			1		1	2
						7

Infrastructure Journey priorities	Project RAG status					
One Team TEWV	1	2	1			4
Digital & Data		2	2	1	1	6
Green Plan				5		5
Estates Masterplan		5				5
						20

Overall number	1	29	22	6	3	61

Appendix Two - 23/24 Our Journey to Change delivery overview

	Projects potentially at risk
Clinical	CITO: project go live delayed until Q4 2024. Autism: Whilst the Autism service has maintained recurrent funding and continues to deliver against set milestones, the Adult Neurodevelopmental Service DTV has a risk to delivery by Q2.
Q&S	Inpatient Flow DTV MHSOP: project is delayed due to the absence of a service manager, interim arrangements have been put in place re. who is picking up this action. Timescale to be extended from June 2023 to December 2023
Co-Creation	
People	More People: significant progress made 2 out of 3 projects; workforce planning project may need an extension to the end date.
Infrastructure	Digital & data: substantial progress to date with key milestones being met for most of the D&D projects. Potentially some milestones delayed due to the CITO implementation delay.1 project currently paused (IIC) until a recovery plan is agreed with the lead supplier. Additionally, the D&D programme board have RAG rated the Improving Connectivity project as red, although significant progress has been made with 27 further sites being migrated and the 2 blockers to starting our inpatient roll out have been resolved. Now that work can resume, next month a new plan with revised dates will be submitted for all 3 workstreams:-WiFi replacement, LAN refresh, PATTI replacement. Green plan: significant issues requiring escalation for decision over resources required to take this work forward as Sustainability officer, responsible for actions to date with crucial technical expertise, is now retired. Additionally, no project management expertise is allocated. Several mitigations are in place to recruit to this post, including: liaising with other Estates Directors, raised the issue with the Tees Valley council's via the One Public Estate network and the setting up of a OPE Task and Finance Group (yet to be established).

	Projects on Track
Clinical	Community MH Transformation: 5 projects are green and 5 are reporting amber. At this stage no significant risks to achieving agreed end dates.
Q&S	Patient Safety: 2 of 3 projects on track. Some delay to LFPSE due to CITO but expected to remain within timescales. Personalised Care Planning: significant progress made. The CITO delay has impacted on timescales however is expected to be delivered by the agreed end date.
Co-Creation	Expand & develop lived experience roles: progress being made to expand LE roles. Data Collection and Learning: substantial progress made on both projects. Improve & accurately capture patient experience data - re-procurement of Meridian system on hold due to the number of change programmes and planned implementation of CITO currently ongoing in 2023. Impact currently unknown. Diversify & expand involvement: substantial progress has been made in respect of milestones for this priority.
People	Inclusive/compassionate culture: some minor delay by one quarter to one of the projects, but not requiring escalation. Working differently: some issues with implementation of WorkPal but mitigation in place.
Infrastructure	One Team TEWV: progressing on track; one project due to finish by June now will complete in July. Estates masterplan: All actions green for this priority. Specific updates: Assistive Technology / Sensor Doors: Phase 1 is now complete. Phase 2 is in progress and due to complete in December 2023. Phase 3 was approved at Strategy and Resource Committee but approval for the combined phases 3 & 4 must be approved by Board due to approval limits. Oxehealth:The PMO assigned a Senior Project Manager to oversee the Oxehealth project. Following business case approval and contracts signed, 403 Oxevision units across 30 wards are to be installed in 4 phases between now and stage 4 commencing before 31st December 2024. This is in addition to the existing 22 wards who have already successfully had Oxevision installed. The project SRO is Deputy Chief Nurse, Dawn Jessop. There is a monthly Steering Group and bi-weekly sub groups for installation and clinical work. Estates have appointed a Project Manager working into this, overseeing the cabling and server installation. The project aims to minimise disruption to wards by aligning installation with the anti-ligature magnetic doors install, also being managed by the same PM in estates.

Appendix Three - Project RAG rating

	Priority	Individual Project	End RAG date
Clinical	Community Transformation	Adult/older people comm. mental health team transformation-DTV	Mar-24
		Crisis - DTV	Jun-23
		i-Thrive - DTV	Mar-24
		Adult LD - DTV	Sep-24
		Forensics – Establishing a community	Sep-24
		Health and Justice – Reconnect, North Yorkshire	Jul-23
		Older People's community mental health team transformation-NYYS	Mar-24
		Adult community mental health team transformation – NYYS	Mar-24
		Crisis - NYY	Mar-24
		I-Thrive - NYY	Jun-24
	CITO	CITO	Jun-24
	Autism	Autism Training	Mar-24
		Autism Reasonable Adjustment support and coordination	Mar-24
		Complex Autism case work	Mar-24
		Children and Young People Neurodevelopmental Assessment Service - DTV	Sep-23
		Adult Neurodevelopmental Service - DTV	Sep-23
		Children & Young People Neurodevelopmental Ass. Service NYY	Sep-23
		Adult Neurodevelopmental Service - NYY	Sep-23

Q&S	Reducing inpatient pressures	Inpatient Flow – DTV AMH and MHSOP wards	Mar-24
		Older adults pathway (NYYS) Ensure 7 day availability for Assessment & Treatment	Mar-24
		Reducing pressure on inpatient beds programme	Mar-24
		Implement bed configuration in line with NE&NC SSs Provider Collaborative Review	Oct-25
	Patient Safety	Patient Safety Incident Response Framework (PSIRF)	Apr-24
		Learning from patient safety events (national system) (LFPSE)	Dec-23
		Serious Incident backlog recovery/Local management of incidents	TBC
	Harm Free Care	Reducing the Use of Restrictive Interventions	Mar-24
		Safeguarding / Parental/Carer Mental ill Health impact on children (PAMIC)	Mar-24
		Reducing in Sexual Safety Incidents	Mar-24
		Reducing suicide / misadventure	Mar-24
	Personalising Care Planning	DIALOG+ full implementation through CITO	Jul-23

Infrastructure	**One TEWV**	Full review of Corp service staff lists & reconciliation of data on Oracle/ESR	Jun 23
		Develop digital and data service standards	Jan-24
		Set up a new Corporate Services Leadership Group	Jul-23
		Voluntary and Community Sector provider grants scheme	TBC
	Digital & Data	Electronic Prescribing and Medicines Administration (EPMA)	Mar-25
		Improving Connectivity	Jul-23
		IIC re-procurement and migration	Jul-23
		Robotic Process Automation	Oct-23
		Enhancing collaboration	Jun-23
		Asset Management	Mar-24
	Green Plan	Embedding the Green Plan and Carbon reduction	May-23
		Heat Decarbonisation Plan	Sep-23
		Installation of additional electric charging points at trust properties	Dec-23
		Trust Environmental Pledge - 'Pledge for Greener'	Dec23
		Look to address the carbon footprint from supplier to door when procuring goods	Mar 24
	Estate Masterplan	Assistive Technology Installations	Rolling
		New base for Stockton AMH services	Sep-23
		Medical Education Facilities	Mar-24
		One Public Estate participation	Ongoing
		Strategic Estates Planning	Mar-24

People	**More People**	New Starters and Onboarding	TBC
		International Recruitment	Dec-23
		Workforce Planning	Sep-23
	Inclusive & Compassionate Culture	Leadership Development programme	Ongoing
		Health and Wellbeing Council	Mar-23
	Working Differently	Workpal	Feb-24
		Smarter Working	TBC

Co-Creation	**Lived experience posts**	Expand and develop lived experience roles and leadership, including peer support workers	Dec-23
	Data collection & learning	Improve & accurately capture patient experience data	ongoing
		Review/transform PALS and complaints pathways with co-creation principles	31/12/23
	Diversity & expand involvement	Embed and grow co-creation across the organisation	Oct 23

Appendix Four – Milestone plan

Projects and Milestones									
	Individual Projects	Milestone	Q1	Q2	Q3	Q4	Q1	Q2
Clinical Journey Priorities									
Community Transformation	Adult/older people's community mental health team transformation - DTV	New Transformed models for adults & older adults in place across geography, in line with national roadmap				Mar-24		
	Crisis - DTV	New access model in place with NEAS & demonstrable improvement in call answer rate, responsiveness, signposting and assessment processes			Dec-23			
	Adult LD - DTV	Working with partners/ regulators on future respite service model						Sep-24
	Older People's community mental health team transformation - NYYS	Review memory serivce offer to support development of a consistent offer across the care group with medical and leadership provision		Sep-23				
	Adult community mental health team transformation - NYYS	Progress development of the community hubs across place-based settings				Mar-24		
	Crisis - NYY	Improve All Age Crisis Telephone service & addressing service response rates & call retention (LTP funding proposal submitted)				Mar-24		
CITO Implementation	Implementation of the CITO EPR	Phase 1 go live					Mar-24	
Autism	Adult neurodevelopmental service - DTV	Using improvement methodology and events to implement a single pathway to manage ADHD and ASD referrals		Sep-23				
Q&S Journey Priorities									
Reducing in-patient pressures	Impatient flow -DTV AMH and MHSOP wards	A central bed management policy implemented, supported by refreshed PIPA (Purposeful Inpatient Admission) processes	Jun-23					
	Implement bed configuration in line with NE & NC secure services provider collaborative review	Bed model agreed	Jun-23					
Patient Safety	Learning from patient safety events; national system (LFPSE)	Implementation of fit for purpose Risk & Quality management system			Dec-23			
Personalising care planning	DIALOG+ full implementation through Cito	CITO module goes live		03-Jul-23				
Co-Creation Journey Priorities									
Expand & develop Lived experience posts	Expand and develop lived experience roles and leadership, including peer support workers	Enhance and develop peer support operational and training infrastructure & agree banding for leads, training & development roles			Dec-23			
Data Collection and Learning	Improve & accurately capture patient experience data	Further QI work/refinement from consultation/proposals/policy development			Nov-23			
	Review/transform PALS and complaints pathways with co-creation principles	Policy refreshed/launched				Jan-24		
Diversify & expand involvement	Embed and grow co-creation across the organisation	Develop shadow governance mechanism to work interdependently with new TEWV governance structures		Jul-23				
People Journey Priorities									
More people	International recruitment	Delivery on cohorts of healthcare professionals, as per implementation plan			Dec-23	Mar-24		
	Workforce planning	Implement new workforce planning processes		Sep-23				
Inclusive & compassionate culture	Health and Wellbeing Council	Health and Wellbeing Council in place	Apr-23					
Working differently	Workpal	Scope and set up implementation plan for the transfer of supervision recording onto workpal	Jun-23					
Infrastructure Journey Priorities									
One Team TEWV	Voluntary and community sector provider grants scheme	New scheme in place and ready to be used by TEWV budget managers		Jul-23				
Digital & data journey	Electronic prescribing and medicines administration (EPMA)	Go live inpatient services		Sep-23				
	Improving connectivity	Wifi replacement of new controllers (all sites)		Jul-23				
	RPA (Robotics)	Delivery into live environment of six processes			Oct-23			
Green plan	Embedding the Green plan and carbon reduction	Establish green plan 'community of interest' to lead and scope workstreams and co-produce a phased implementation plan which will work towards NHS Net zero by 2040		Sep-23				
	Installation of additional electric charging points at trust properties	Carry out installations (three months lead time)			Dec-23			
Estates masterplan	Health, safety and assistive technology	Complete installation of next phase of assistive technology including sensor doors and Oxehealth installations				Mar-24		
	Medical Education Facilities	Business case completed. Complete interim scheme at Roseberry Park	Jun-23			Mar-24		

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14th September 2023**
Title:	**Board Integrated Performance Report as at 31st July 2023**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Ashleigh Lyons, Head of Performance**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1. 2. 3. 4. 5. 6. 9. 11. 15.	Recruitment & Retention Demand Involvement and Engagement Experience Staff Retention Safety Regulatory Action Governance & Assurance Financial Sustainability	The Integrated Performance Report is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks.

Executive Summary:

Purpose: The Board Integrated Performance Report aims to provide oversight of the quality of services being delivered and to provide assurance to the Board of Directors on the actions being taken to improve performance in the required areas.

Proposal: It is proposed that the Board of Directors receives this report with **reasonable** assurance regarding the oversight of the quality of services being delivered. Whilst there are a small number of areas with **limited** assurance, Performance Improvement Plans have been developed for some of the issues that are impacting on performance and are in the process of being developed for others.

Overview: The overall **reasonable** level of assurance has been determined based on the Performance & Controls Assurance Framework for the Board Integrated Performance Dashboard (IPD) and progress against the Mental Health Priorities, including National Quality Standards. (*See Appendix A highlighting key changes from previous months report.)*

IPD Areas of Concern

The **areas of concern** within the IPD where we have limited performance assurance and negative controls assurance are:

- Unique Caseload
- *Financial Plan: SOCI - Final Accounts - Surplus/Deficit
- Financial Plan: Agency expenditure compared to agency target
- Financial plan: Agency price cap compliance
- CRES Performance Recurrent

(*See Appendix A for detail*)

Performance Improvement Plans

As part of our ongoing improvement journey around reporting for assurance and developing SMART actions for any areas where our performance is not where we want it to be; we have introduced Performance Improvement Plans (PIP) to demonstrate to the Board, that we are focussed on the right things and in a timely manner. PIPs have been developed and shared with Executive Directors for approval for the following issues that are impacting on performance and/or have negative controls assurance i.e. limited actions to affect any improvement:

- Percentage of inpatients reporting they feel safe whilst in our care (Durham, Tees Valley & Forensic)
- Percentage of CYP showing measurable improvement following treatment - patient reported (Durham, Tees Valley & Forensic)
- Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported (North Yorkshire, York & Selby)
- Percentage of CYP showing measurable improvement following treatment - clinician reported (North Yorkshire, York & Selby)
- Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported (North Yorkshire, York & Selby)
- Bed Pressures including OAPs (Trust-wide)
- Percentage compliance with ALL mandatory and statutory training (Trust-wide)
- Percentage of staff in post with a current appraisal (Trust-wide)
- Caseload (Care Groups)
- Agency Expenditure (Trust-wide)
- Safe Staffing (Trust-wide)

Mental Health Priorities including National Quality Standards

There are 1 Trust and 7 commissioner priorities currently at risk of achievement (*See Appendix A*). PIPs have been developed by the Care Groups and have been shared with Executive Directors for approval.

Broader Key Issues

Broader key issues/work in relation to Workforce, Inpatient Pressures and Finance this month are:

- Serious Incident Backlog
- Staff Training
- Crisis Lines

- Commissioning for Quality Improvement & Innovation
- Out of Area Placements
- Bed Occupancy
- Pulse Survey
- Leavers
- Appraisals
- Agenda for Change and other pay awards

(*See Appendix B for detail, including the Care Group Summaries)*

Overall, there is good assurance on the quality of data supporting the information provided in the Board Integrated Performance Dashboard.

Summary of Key Risks

The Integrated Performance Report is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks.

(BAF Risk 15) Financial Sustainability & (CRR risk 1260) There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory interventions and/or adversely impact quality

- Failure to reduce inpatient staffing costs and Trust wide agency (in particular Medical and LD premium rate) utilisation (volume and rate reductions to reduce related premium costs)
- Failure to reduce lengths of stay, including through work with system partners, to reduce adult A&T and PICU bed occupancy and eliminate unfunded adult Independent Sector bed placements, maintain nil older adult Independent Sector bed placements and reduce safer staffing requirements for inpatient wards
- Failure to negotiate equitable recurrent funding mechanism for in-year and accumulated prior year AFC pay deal and nationally negotiated 2023/24 pay deals (tariff-based) pressures
- Failure to retain permanent staffing, including as a consequence of acute cost of living pressures
- Failure to deliver a challenging back-end loaded CRES plan and trust-level vacancy factor
- Failure to manage the financial impact of excess inflation (compared to tariff)

(BAF Risks 1 and 5) Recruitment and Staff Retention There is a risk that our inability to recruit and retain sufficient qualified and skilled staff (a common risk shared by all providers) might jeopardise our ability to provide high quality/safe services. In addition, there are multiple factors that could contribute to staff not choosing to stay with the Trust once we have recruited them. This will undermine the provision of safe and sustainable services as well as putting individual staff and patients at risk of harm. Oversight and escalation processes are well embedded to maintain safe staffing levels.

Prior Consideration and Feedback The monthly Integrated Performance Report is discussed by Executive Directors Group and by the Care Group Boards (the latter at Care Group level)

Implications: There are no identified implications in relation to receipt of this report to the Board of Directors.

Recommendations: The Board of Directors is asked to:

1. Note the information contained within the report.
2. Note the actions in place to manage any areas where performance is not where we would want it to be.
3. Confirm if it is assured on the actions being taken to improve performance in the required areas.

Appendix A

IPD Key Changes from the Previous Report

Measure	Key Change
Percentage of CYP showing measurable improvement following treatment - patient reported	Improvement in performance Improved assurance
Bed Occupancy (AMH & MHSOP A & T Wards)	Improvement in performance
The number of Incidents of moderate harm and near misses	Improvement in performance Improved assurance
The number of Restrictive Intervention Incidents	Positive stabilising of performance
Percentage Sickness Absence Rate	Reduced assurance
Financial Plan: Agency expenditure compared to agency target	Reduced assurance
Cash balances (actual compared to plan)	Reduced assurance

IPD Areas of Concern

There are 5 measures where we have limited performance assurance and negative controls assurance, for which Performance Improvement Plans have been developed for the issues that are impacting on performance to support improvement and increased assurance.

Measure	Comments
Unique Caseload	We continue to have special cause concern at Trust level and in both Care Groups. Performance Improvement Plans, identifying the key issues and improvement actions that will be undertaken have been developed by both Care Groups; however, there is currently limited assurance pending the actions within those plans being progressed.
*Financial Plan: SOCI - Final Accounts - Surplus/Deficit	As at 31st July 2023 the Trust has a deficit to plan of £4.70m compared to its planned deficit of £4.05m. Two national pressures fully account for the year-to-date variance: • Adverse recurrent financial impacts have been assumed following the nationally negotiated pay award for Agenda for Change staff (increase from 2.1% plan to 5% pay uplift). With underfunding of the increase through a 1.6% additional tariff uplift, this is contributing £0.50m to the deficit as at 31st July 2023 (£1.50m projected 2023/24). • Defunding of providers in relation to national Microsoft Licensing arrangements (with no equivalent opportunity to reduce locally contracted Microsoft licences) is contributing £0.15m to the year-to-date deficit (£0.5m projected 2023/24) There continue to be three consistent key operational drivers of financial performance: elevated bed occupancy/delayed transfers of care, independent sector bed utilisation and elevated agency staffing pressures/premia. The Trust has recommenced the financial recovery measures introduced during 2022/23 and actions including vacancy control, task and finish activities for beds oversight, agency reduction and will tighten controls around discretionary spending to improve financial performance, and CRES delivery that is back end loaded in the plan.

Measure	Comments
Financial Plan: Agency expenditure compared to agency target	The Trust agency expenditure is £0.10m lower than planned costs up to 31st July 2023 (1.30% lower than plan, previous month 13.74% lower than plan, reduction due to re-categorisation of previous balances), albeit that plan levels reflected elevated 2022/23 run rates. Monthly run rates for agency staff costs remain high, and the financial plan included additional stepped CRES targets from July. There is limited assurance with elevated levels of agency expenditure being a cause of ongoing concern, both from a volume and a rate perspective. Key usage includes cover for increased medical vacancies, staffing needed for patient observations, backfill for sickness, and vacancies, most notably for inpatient rosters, as well as support for complex packages of care for Adults with a Learning Disability. High inpatient bed occupancy, including due to longer lengths of stay, is continuing to exacerbate impacts on safe staffing and therefore elevating temporary staffing requirements. There are modest positive signs of improvement, including from significant progress to eliminate off-framework agencies, expenditure reductions in Adult Learning Disability Services (and with future reductions forecast from planned discharge of individuals with a complex care package), and impacts anticipated following success of international recruitment of both nursing and medical staffing. Medical locum assignment rates are subject to review, with actions to pursue substantive recruitment status, and/or conversion to substantive and non-direct engagements. Agency Reduction and safe staffing subgroups of the Executive People and Culture Group have been established to deliver optimal e-rostering and target agency reductions. However, despite wider discussions, including through regional Quality Board, progress is slow to enact system plans for the discharge of a small number of individuals supported through complex Trust Care Packages.
Financial plan: Agency price cap compliance	Agency usage includes shifts fulfilled on hourly rates above the price cap or off framework (albeit minimal residual off-framework – digital only). There is limited assurance due to the pressures highlighted at measure 24 and 25a) above driving staffing pressures. However, the flexible staffing team have obtained reduced rates above cap and continue to challenge agency suppliers on meeting framework terms and conditions. There has been a consistent level of compliance (based on average per day) for quarter 1 2023, compliance at 102 shifts per day. However, in June 2023 32% of shifts were non-compliant with price cap or framework rules (of which 769 and 17% were medical locums, all price cap breaches).
CRES Performance Recurrent	The Trust is not achieving its recurrent CRES savings target. Non-delivery of cost reductions predominantly relates to Independent Sector bed placements. As at 31st July 2023 £3.18m CRES has been achieved, £1.78m recurrently (£1.69m behind plan measure 27) and £1.40m non-recurrently (£1.22m ahead of plan measure 28). Planning of a trust wide CRES event is in train to take place during quarter 2. Composite CRES delivery of £3.18m is £0.46m behind plan, with out of area placements accounting for £0.59m under achievement.

Mental Health Priorities including National Quality Standards
We are at risk of not achieving our planned reduction in out of area placements and the agreed trajectories in the following areas:

Measure	Sub-ICB Location
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	County Durham
CED: Percentage of Service Users designated as routine cases who access NICE concordant treatment within 4 weeks	all Sub-ICB Location areas
CED: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within 1 week	all Sub-ICB Location areas
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	all Sub-ICB Location areas
IAPT: Percentage of people who have waited more than 90 days between first and second appointments	all Sub-ICB Location areas
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scored within the reporting period	all Sub-ICB Location areas
Number of women accessing specialist community PMH services	North Yorkshire and Vale of York

Appendix B

Broader Key Issues/Work

Quality

Serious Incident Backlog
As at 17.07.2023 there were 154 open Serious Incidents. Of the 47 incidents in Cohort 1, those cases reported up to the 1st February 2023 and not allocated, 33 are being completed through either a North of England Commissioning Support Unit contract, other external contractors or Trust-based reviewers, 1 is completed and closed, and the remaining 13 will have investigations underway by the end of September 2023. A trajectory has been established to complete and close the majority of investigations into these cases by the end of December 2023. Work is ongoing to improve our investigation process and by the end of November 2023 it is anticipated that with ongoing support from bank, external and service reviewers, we will have capacity to allocate investigations within one month of an incident occurring. Integral to this process will be a keeping-in-touch procedure for those families impacted by serious incidents.

Staff Training
Access to face-to-face Positive & Safe, Intermediate Life Support and Basic Life Support training continues to impact on the compliance of our staff with manual & statutory training requirements, and potentially the safety of our staff and people in our care. Our Care Group Directors of Nursing & Governance are to produce a joint paper with training and research officers outlining the key issues that are impacting on our training compliance.

Crisis Lines
Work is continuing within the Care Groups to support the answer rates for our crisis lines; however, capacity within both Care Groups remains a concern. Some additional staff have been provided to increase the resources available to respond to the crisis lines, including the use of support staff within North Yorkshire, York & Selby and the reallocation/realignment of staff within Durham & Tees Valley. In addition, within Durham & Tees Valley the Familiar Faces Team is reviewing all repeat callers daily and liaising with the community mental health teams and/or proactively contacting people to offer support and review care plans.

Commissioning for Quality Improvement & Innovation
There are two schemes currently a concern from a quality perspective, both of which are at high risk of delivery:

- The next flu vaccination campaign will commence in October and having not achieved the Flu Vaccinations for frontline healthcare workers CQUIN in past years, we will require a sustained focus on improvement work and engagement to support achievement this year. The Programme Plan for the 2023/24 flu vaccination campaign was approved at the Executive People, Culture and Diversity Group in June and work is now progressing.
- Routine outcome monitoring remains a concern in Children & Young People's Services with all areas significantly below the national quality standard and notable variance across the services. The Associate Director of Performance will facilitate a workshop with senior leaders from CYP services, Business Intelligence colleagues, and the Performance Team before the end of October 2023, to identify the key issues impacting on this quality standard and the short to medium terms actions that will improve performance.

Inpatient Pressures

Out of Area Placements (OAP)
There is continued focus on reducing expenditure on the use of Independent Sector beds as quickly as possible through the various schemes that are in place and the immediate work being undertaken that has formed the performance improvement plan.

Whilst the position in Q1 had shown a significant deviation from agreed targets, the data continues to show an improved position at the start of Q2. Out of Area Placements continue to be in single figures (as of 10th August: 5 OAPs for Durham & Tees Valley, 1 OAP for North Yorkshire, York & Selby).

Whilst a significant incremental reduction has been demonstrated in Q1, slight fluctuations in the number OAPs can occasionally be seen, it is possible that we are now seeing a plateauing.

Bed Occupancy
Bed occupancy still remains high (≥100%) however we continue to see a sustained reduction in Patient Length of Stay over 60 days.

Work continues within the Care Groups to implement their bed occupancy reduction plans and the Performance Improvement Plan (PIP) which has been developed to aid the rapid improvement in performance. Whilst the plan has been approved in its current state, a closer and more detailed analysis of the data is to be undertaken to help identify if there is any further action that can be taken to address any operational issues that are contributing to an OAP. A request for further data and its analysis has been made.

Minimising any barriers to discharge continues to be the focus of this specific piece of work, however it is important to acknowledge that there are other enabling schemes and programmes of work not mentioned here, that will also play a role in sustainably reducing bed occupancy and OAPs.

Progress on key schemes being taken forward to address Out of Area Placements are below:

Progress to date with key schemes that are in implementation:

- PIPA development plans continue to be implemented by the modern matrons and service managers across Adult Mental Health wards.
- A workshop is being planned to undertake a review of the discharge policy and processes. This will incorporate the homeless / no fixed abode issue.

New schemes:

- OPTICA pilot: A workshop was held to agree the data specification. Arrangements to be made to undertake a diagnostic assessment to determine what data can be obtained from the existing systems and look to stress test the system.
- Active support on wards showing highest level of patients with a length of stay over 60 days.
- Implementation of lead psychiatrists focused on patient flow for a period of 3 month (Durham Tees Valley).
- Targeted work to be undertaken with the Darlington, Hambleton & Richmondshire community teams to explore why admission rates are higher than expected per weighted population.
- Weekly interface meetings continue to take place with Senior Local Authority representatives to escalate barriers / address people identified as Clinically Ready for Discharge.
- Weekly Greenlights meetings are in place to escalate and progress issues in relations to patients with an identified Learning Disability.
- Work ongoing to increase substantive Registered Clinician/Associate Clinician post and nursing positions (particularly in Tees).

A proposal to develop an “Urgent Care programme” that will redefine and expand the remit of the existing Beds Oversight Group has now been approved. Preparations are underway to hold a workshop with key stakeholders to work through the programme purpose before the first meeting of the Urgent Care Programme Board which is anticipated to be November 2023.

<u>Workforce</u>

Pulse Survey
The Organisational Development team have delivered a structured programme of engagement over July, attending sites across the Trust to encourage staff to complete the quarterly Pulse Survey. This approach has proved highly successful with figures doubling, moving from 10.72% (872 people) in April 23 to 20.87% (1697) in July 23. The team will continue with this approach as they start engagement for the Annual Staff Survey, which opens in October 2023.

Leavers
The number of staff leaving the Trust continues to show a consistent downwards trend with July 23 showing 11.5% in comparison to 13.85% in July 22, and 9th out of 71 similar Trusts nationally (1 being the best with the lowest leaver rate). A number of factors have contributed to this improvement including the new "Thinking of Leaving" process and relaunching the Transfer Scheme which has seen over 90 people register. Whilst this Scheme was originally opened on a time limited basis, this has since been reviewed following its success and will be offered on an ongoing basis with staff confirming on a quarterly basis should they wish to remain on the scheme.

Appraisals
The appraisal figures across a number of services have dipped below compliance targets. The People & Culture teams are actively working with services to identify issues and areas of non-compliance. It is acknowledged that the implementation of Workpal could have impacted upon the figures, highlighting areas where there may have previously been over reporting, whereas this is no longer possible using Workpal as the appraisal recording tool. Timescales are also being reviewed to ensure effective and efficient data flow from Workpal through to Integrated Information Centre and Electronic Staff Record for recording.

Finance

Agenda for Change (AFC) and Other Pay Awards
The Trust has an existing accumulated funding shortfall up to 2023/24 plan 2022/23 relating to impacts of prior year and current year plan Agenda for Change pay awards of around £11.5m due to the disproportionate impacts from funding via national annual 'tariff' uplifts applied to provider contract values. A further impact of the outcome of the 2023/24 revised Agenda for Change Pay Review Body which awarded 5% uplift versus 2.1% included at plan is c.£1.5m full year (£1.7m recurrently) or £0.50m at 31st July 2023, resulting in a recurrent cumulative impact of £13.2m. Tariff inflation at a flat percentage uplift of 1.6% has generated an additional in-year pressure for the Trust due to our higher (than acute providers') pay cost weight. Both mental health providers in the North East & North Cumbria (NENC) Integrated Care Board (ICB) patch have requested a review of the tariff funding methodology, due to precedents established in 2022/23, where funding was allocated relative to actual cost. The impacts of non-Agenda for Change pay negotiations remain unclear, and present the risk of further financial exposure, even if tariff funded. Without additional support the Trust would need to find further mitigations in order to deliver its financial plan.

Care Group Summaries

Durham Tees Valley and Forensic Care Group

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

- Pressures on our inpatient services are continuing; our bed occupancy remains high within our adult wards although we are starting to see increased discharges, reduced lengths of stay on some wards and a sustained reduction in the use of Independent Sector beds across July and into August. Discussions and progress continue with partners in Tees around supporting us to improve patient flow and with the implementation the Optica bed management system. A workshop for the newly established Urgent Care programme has been arranged for October 23 to scope out the role and purpose of the Board and we have an agreement with the Head of Quality Transformation, NHS England for TEWV to be an early adopter on a number of the initiatives linked to the national inpatient quality improvement programme.
- We continue to be below where we would like in terms of our compliance with mandatory and statutory training and appraisals and continue our weekly oversight of compliance trajectories. Concern around moving and handling, Positive and Safe and Immediate Life support, mitigations are in place at team and service level and further actions are in place at Trust level. We are starting to see some improvements to our Appraisal compliance across all specialities with most now on or above the standard with the exception of Adult Mental Health. This remains a key focus. A Trust wide Performance Improvement Plan for both areas are included in this report.

- Whilst generally a strong position, we have seen a deterioration for the second month in compliance with the standard for Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommenced package of care within our County Durham Sub-Integrated Care Board, there is an operational rationale for this in terms of key service staff having been away from work in one team during June and actions were put in place during July to mitigate risk going forward. Actions are taking time to embed within the team but it is envisaged we will see an improvement from next month.

The areas of positive assurance identified within the IPD

- We continue to see a reduction in the number of Restrictive Interventions used across the Care Group in all specialities but particularly in relation to Adult Learning Disabilities and Secure Inpatient Services. This is as a result of focused work and key actions in all areas.
- Our staff leaver rate continues to reduce across the last 9 months and improvement is demonstrated in most specialities. This will continue to be monitored.
- Within our Talking Therapies services we have achieved the local access standards in both sub ICB areas and we continue to achieve the standard for patients achieving recovery and to have excellent waiting times, achieving the 6 and 18 week standards for accessing our services. We continue to exceed standards consistently for The Number of people who receive two or more contacts from NHS or NHS-commissioned community mental health services for adults and older adults with severe mental illnesses and the Number of CYP aged under 18 supported through NHS-funded mental health with at least one contact. Following the implementation of key actions, we are also achieving the standard for patients discharged from our services, followed up within 72 hours.

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

- Within our Crisis services, the 4-hour measure continues to be monitored closely to understand any areas of under-performance with particular attention focused on the North Durham area where an improvement plan in now in place. We have a received the letter of intent and continued discussions with the Integrated Care Board regarding investment to support all age crisis access service that will be co-located with the North East Ambulance Service. We are now working through issues regarding co-location and agreeing clinical processes. The earliest we will be able to go live is October 23. Within the Care Group, we have agreed to work at a stronger alignment of the screening function of the 3 crisis services (Adult Mental Health, Mental Health Service for Older People and Children & Young People) to maximise the capacity of the call pick rate and this commenced on 14th August in the Tees area and 21st August in Durham and Darlington.
- The current answer rates (1st – 16h August) are 51% in Durham and Darlington team and 62% in Tees team.

North Yorkshire, York & Selby Care Group

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

- Bed occupancy is improving, although Adult wards are still high, we are reporting 98.07% for July, an improving position since April 102.74%. Within Mental Health Services for Older People, we are reporting 83.58% for July, an improving position from April 89.88%.
- Delayed Transfers of Care is improving, mainly within Adult Mental Health, although a slight improvement has been seen in Mental Health Services for Older People. Both are due to complex needs and patients waiting for identified placements, due to the nature of their presentation, which is being monitored.
- There were 2 independent sector beds at the end of July 23.
- Appraisals is declining, however there is a significant amount of work being done to resolve the Workpal issues, this is being picked up within the workforce development subgroup.
- Child & Adolescent Mental Health Service Managers are continuing to complete appraisals in the absence of team managers, however in York, handover meetings are taking place with the new Team Managers to move the responsibility for supervision and appraisals now they have completed their induction process.

- Memory waiting times demand and capacity exercise is ongoing and due for completion at the end of September to report to Commissioners on 3rd October.

The areas of positive assurance identified within the IPD
We are achieving an excellent standard on the following measures within both North Yorkshire and York Sub-Integrated Care Board:

- Talking Therapies Recovery
- CYP supported through NHS funded MH with at least one contact
- Adults and Older Adults with severe mental illness who receive 2 or more contacts from NHS or NHS commissioned community MH Services
- Number of women accessing specialist community PMH Services
- Percentage of Service users under AMH specialties who were followed up within 72 hours of discharge.
- Patients waiting less than 2 weeks for first episode of Psychosis
- Talking therapies 6- & 18-week standards for accessing our services
- AMH patients seen by crisis within 4 hours for York Sub ICB
- CYP patients seen by suitably trained practitioner within 4 hours for York Sub-Integrated Care Board
- CYP patients aged 17 years and 6 months with a transition plan for NY Sub-Integrated Care Board

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

- Lack of medical workforce across all Service areas. Adult Mental Health & Mental Health Services for Older People has agency and mind the gap arrangements in place. Child & Adolescent Mental Health Services Scarborough and Selby continues to be of significant concern. Scarborough has a locum identified, but there is lack of clarity with commencement. Mitigation is in place with a covering rota to support teams, but this is not equivalent to having a substantive post holder in post
- Mental Health Services for Older People Therapies vacancies continue to have an adverse impact on service delivery. Scarborough, Whitby & Ryedale inpatient psychology post is out to advert. Dietetics and Speech & Language remain a pressure as both leads are due to go on maternity leave, along with the team experiencing long term sickness, therefore the resource is stretched across community and inpatients.

Appendix C

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 31st July 2023

Report Produced by: Ashleigh Lyons, Head of Performance
Date the report was produced: 29th August 2023

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

journey to change

CONTENTS

Chapter 1

Integrated Performance Dashboard (IPD)

Our Guide To Our Statistical Process Control Charts

Tees, Esk and Wear Valleys NHS Foundation Trust

Within our Board Integrated Performance Dashboard we use Statistical Process Control Charts to determine whether we have any underlying causes for concern. 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	No significant change in the data during the reporting period shown
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/plan is achievable is now included for a number of measures. Standards for the remaining ones will be progressed this year.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS Foundation Trust

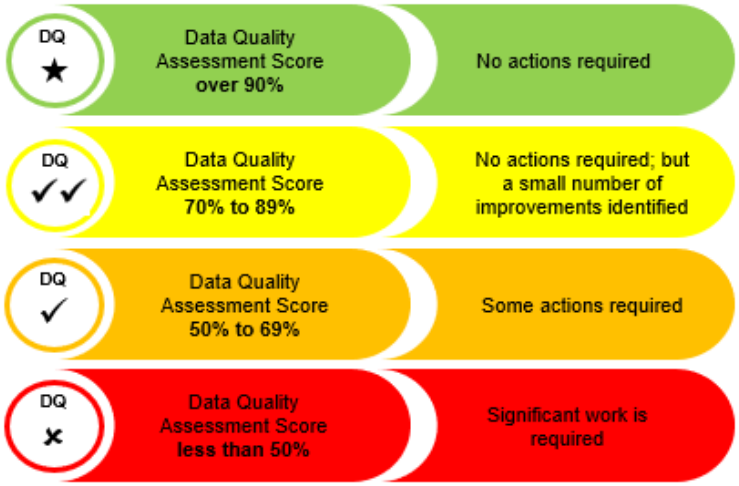
Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The latest assessment on all measures has been completed during February 2023 and the results incorporated within this report.

Note: The development of the local audit/assurance framework to support the assessment will be completed in quarter 4 2023/24, with a view to undertaking the first assessments in quarter 1 2024/25. This element has, therefore, been omitted from the latest assessment.

Action Status
Our action status is informed by a combination of current performance, performance over time (including trends) and general intelligence.

When we interpret a Statistical Process Control chart we look at the current variation depicted within the chart, how our performance is compared to what we are trying to achieve, whether we have assurance that we will achieve the standard (if applicable) and whether our performance over time is improving.

Data Quality Assessment status



Action status

Performance & Controls Assurance Overview

Tees, Esk and Wear Valleys NHS Foundation Trust

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

***NOTE**: green and white text indicates changes in assurance to the previous month's report.*

Board Integrated Performance Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC	H	?	92.00%	91.82%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC		?	75.00%	75.76%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	54.92%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	23.71%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC		F	55.00%	46.93%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC		F	50.00%	43.39%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	19.64%
8)	Bed Occupancy (AMH & MHSOP Assessment & Treatment Wards)	S&RC				99.45%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			1,275
10)	The number of Serious Incidents reported on STEIS	QAC				45
11)	The number of Incidents of moderate harm and near misses	QAC	L			611
12)	The number of Restrictive Intervention Incidents	QAC				1,933
13)	The number of Medication Errors with a severity of moderate harm and above	QAC	L			1
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				1
15)	The number of uses of the Mental Health Act	MHLC				1,512

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
16)	Percentage of staff recommending the Trust as a place to work	PC&D				54.48%
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				59.08%
18)	Staff Leaver Rate	PC&D	L			11.51%
19)	Percentage Sickness Absence Rate (month behind)	PC&D				5.47%
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D		?	85.00%	87.07%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D	H	?	85.00%	82.21%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)
22)	Number of new unique patients referred	S&RC				34,558
23)	Unique Caseload (snapshot)	S&RC	H			64,974

Our Finance Measures	Committee Responsible for Assurance	Assurance	Plan (FYTD)	Actual (FYTD)
Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	F	4,047,537	4,701,720
Financial Plan: Agency expenditure compared to agency target	S&RC	P	7,166,749	7,112,898
Agency price cap compliance	S&RC	F	100%	66%
Use of Resources Rating - overall score	S&RC	P	3	3
CRES Performance - Recurrent	S&RC	F	3,469,000	1,781,000
CRES Performance - Non-Recurrent	S&RC	P	176,000	1,399,000
Capital Expenditure (Capital Allocation)	S&RC	F	5,710,000	2,790,000
Cash balances (actual compared to plan)	S&RC	F	68,914,000	69,922,922

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

Tees, Esk and Wear Valleys 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.

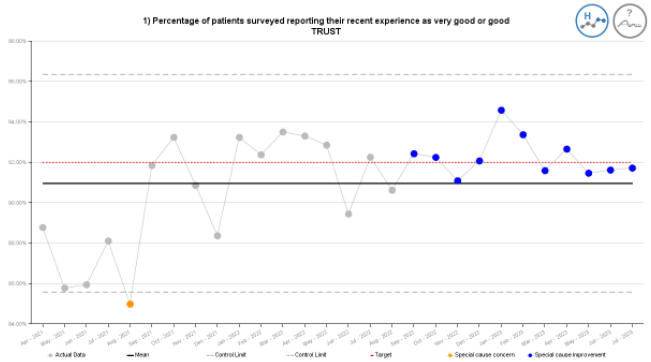
During July, **1,195** patients responded to the overall experience question in the patient survey: Question: "Thinking about your recent appointment or stay overall how was your experience of our service?". Of those, **1096 (91.82%)** scored "very good" or "good".

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

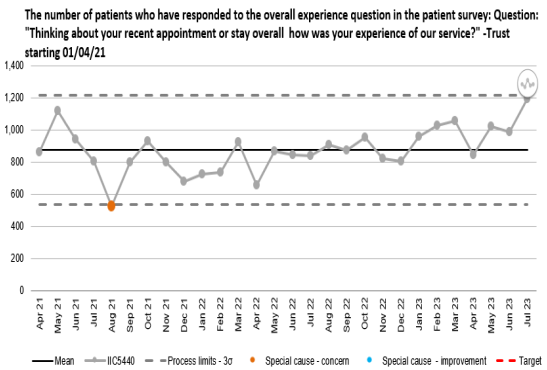
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

93%

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



Care Group/Directorate	Variation	Assurance
TRUST	H	?
DURHAM, TEES VALLEY AND FORENSIC		?
NORTH YORKSHIRE, YORK AND SELBY	H	?



Analysis at service level for July shows:

- Crisis Services **92.2%** reported their recent experience of our services as very good or good
- Learning Disability Services **96.7%** reported their recent experience of our services as very good or good
- Adult Mental Health Services **91.3%** reported their recent experience of our services as very good or good
- Younger People Services **86.8%** reported their recent experience of our services as very good or good
- Older Person Services **96.7%** reported their recent experience of our services as very good or good

Patients are encouraged to provide additional information when completing the survey. A total of 2,138 comments were received in July of which 1,650 (77%) were positive and 434 (20%) were negative; the highest number of negative comments were in relation to "*Quality of care and treatment*" followed by "*Personalised care*".

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
A cohesive programme of work is required to improve our understanding of the experience our patients are having, improve survey response rates, identify key themes and hotspot areas, and develop a set of clearly defined improvement actions.	*Enabling action:* Executive Director of Corporate Affairs to establish a Trust-wide Patient & Carer Experience Group by the end of ~~May~~ July 2023 to improve patient and carer experience. The group will report into the Executive Quality Assurance & Improvement Group and membership will include Patient Safety, service users, carers and representation from the Care Groups.	**Complete.** The group has been established and held its first meeting in July 2023. Reports from the group will be shared routinely with the Executive Quality Assurance & Improvement Group.	
	Enabling action: The Trust-wide Patient & Carer Experience Group to undertake a deep dive of the Friends & Family Test data in order to develop actions to improve our response rates. This work will be completed by September 2023.		

Additional Intelligence in support of continuous improvement

The national benchmarking data for the month of June 2023 reported the Trust as the **highest** nationally for mental health trusts in relation to the total number of responses received.

The Trust has established the Co-creation Board and our Lived Experience Directors are supporting the employment of support workers and other key posts. Work has been undertaken to review carer information packs and further actions are in development. The next key area of focus is Adult Mental Health Planned Care and meetings are being arranged to support this work.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

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 July, **368** 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, **267 (75.76%)** scored "yes, always".

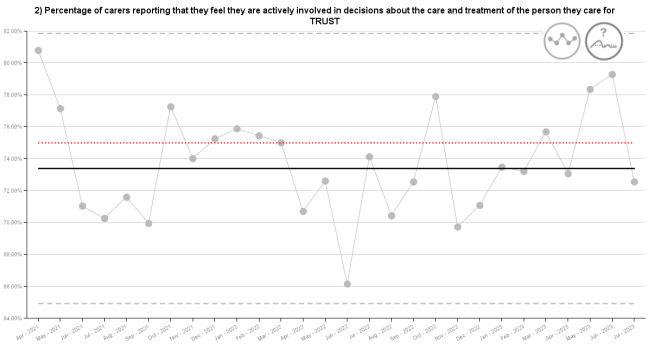
No significant change in the data during the reporting period shown

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

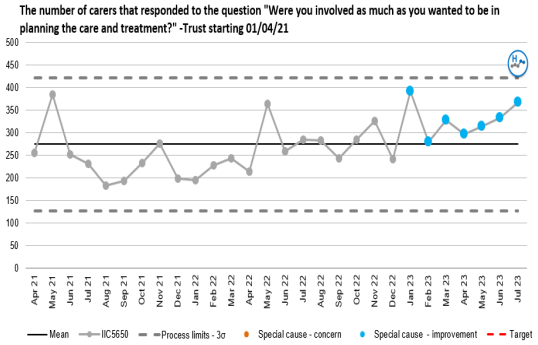
DQ

87%

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



Care Group /Directorate	Variation	Assurance
TRUST		
DURHAM, TEES VALLEY AND FORENSIC		
NORTH YORKSHIRE, YORK AND SELBY		



Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
An emerging theme is that staff are not engaging with carers on the grounds of patient confidentiality.	*Enabling action:* Patient & Carer Experience Group to conduct a deep dive into the involvement of carers by the end of ~~June~~ ~~July~~ August 2023, triangulating data from multiple sources, including Patient & Carer Experience, Patient Advice & Liaison Service, Complaints and Patient Safety, with a view to identifying any improvement actions.	Work is underway to identify early learning; however, the deep dive will continue throughout August. Initial learning indicates that although there is a perceived shortage of required staff, carers consider our workforce to be pleasant, compassionate, professional and knowledgeable. However, whilst 79% of patients report their carer has been involved in their care as much as they want, the indication is that 21% want their carers to be more involved than they currently are.	

Additional Intelligence in support of continuous improvement

In the July 2023 Friends & Family Test, 95.6% of responding carers said that their recent experience of our services was very good or good.

Carer awareness training is available for all staff; 2,500 people have been trained in total with 140 members of staff trained this year to date.

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

NHS
Tees, Esk and Wear Valleys
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.

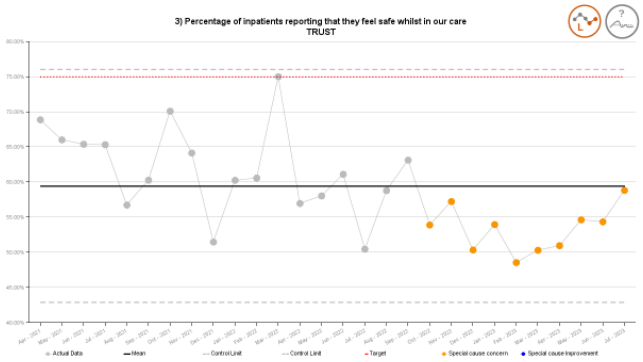
During July, **153** patients responded to the overall experience question in the patient survey: Question: “During your stay, did you feel safe?”. Of those, **90 (58.82%)** scored “yes, always"

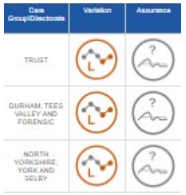
We're aiming to have high performance and we're moving in the wrong direction.

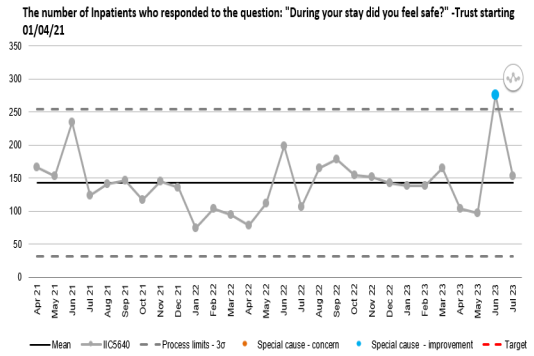
Our performance is not consistent and we regularly achieve and miss the standard we have set ourselves

DQ
87%

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







Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Patients within our North Yorkshire, York & Selby Care Group have told us that their sense of feeling safe is impacted by staffing numbers and the lack on consistent staff on wards.	Care Group Associate Directors of Nursing and Assistant Locality Manager to develop a robust workforce plan, which will include recruitment and retention, by the end of June 2023, with a view to increasing the number of inpatient staff available and to ensure consistency on rosters.	**Complete.** The plans were shared by the Associate Director of Nursing with the Quality Assurance & Improvement Group in July and will be reported into the Executive Quality Assurance & Improvement Group on a monthly basis.	No impact to date; improvements can be expected as the plan is progressed.
Patients within our North Yorkshire, York & Selby Care Group have told us that their sense of feeling safe is impacted by incidents involving other patients.	Care Group Director of Nursing to develop a workplan focusing on the ‘Safe Wards’ programme by the end of June 2023, with a view to increasing the safety of our inpatient wards. This will be progressed through the Positive & Safe Care Groups and Fundamental Standards.	**Complete.** The plans were shared by the Associate Director of Nursing with the Quality Assurance & Improvement Group in July and will be reported into the Executive Quality Assurance & Improvement Group on a monthly basis.	No impact to date; improvements can be expected as the plan is progressed.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
A cohesive programme of work is required to improve our understanding of the experience our patients are having, improve survey response rates, identify key themes and hotspot areas, and develop a set of clearly defined improvement actions.	*Enabling action:* The Patient Experience Team to revisit the focus groups in Adult Mental Health Services and Secure Inpatient Services by the end of ~~June~~ August 2023, to revisit the findings and progress from previous groups, with a view to learning from successes and identifying any further improvement actions. Findings will be reported to the Executive Quality Assurance & Improvement Group.	The SIS focus groups have been completed and findings shared with services and Care Boards. Staffing levels continue to be the primary concern for both patients and staff and several actions have been undertaken to address this, including recruitment drives and the protection of roles such as activity coordinators (although this can be difficult due to staffing pressures). There were noted improvements from both patients and staff in terms of accessing the leave team. Ward cultures are to be continuously reviewed to ensure they encourage supportive engagement in positive interactions and activities, which could prevent situations that contribute to our patients feeling unsafe. Findings and learning should be included within all Service Improvement Plans. The AMH focus groups are ongoing; initial findings indicate concerns regarding low/changes to staffing and patient involvement. Analysis continues and reports will be completed by the end of August and shared with care groups in September.	

We strive to ensure that our patients receive safe care and treatment, and we are concerned that our patients within our Durham, Tees Valley & Forensic services do not always feel safe and secure within our inpatient wards. To address this the Care Group has developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. There are 9 actions currently included within the plan; 7 actions are due to be completed by the end of September 2023, of which 0 have been completed to date.

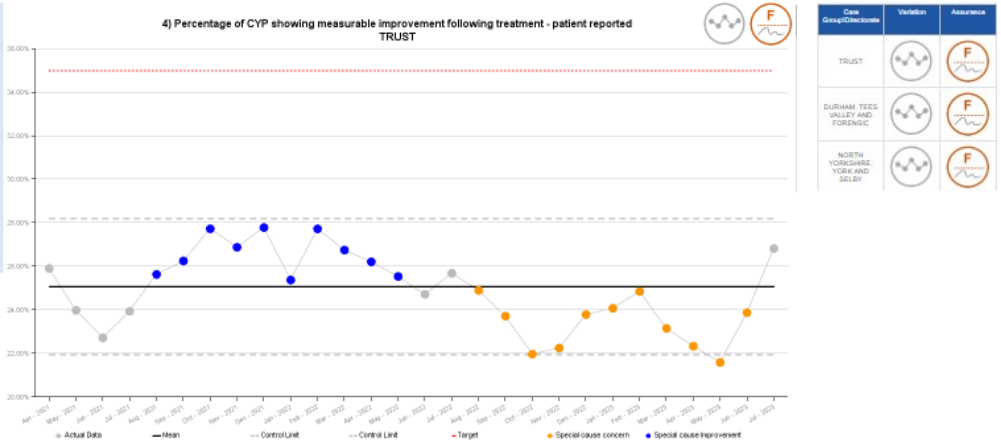
04) Percentage of CYP showing measurable improvement following treatment - patient reported

NHS
Tees, Esk and Wear Valleys
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 July, **768** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 206 (26.82%)** made a measurable improvement.

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



No significant change in the data during the reporting period shown

Our system is expected to consistently fail the target/expectation

93%

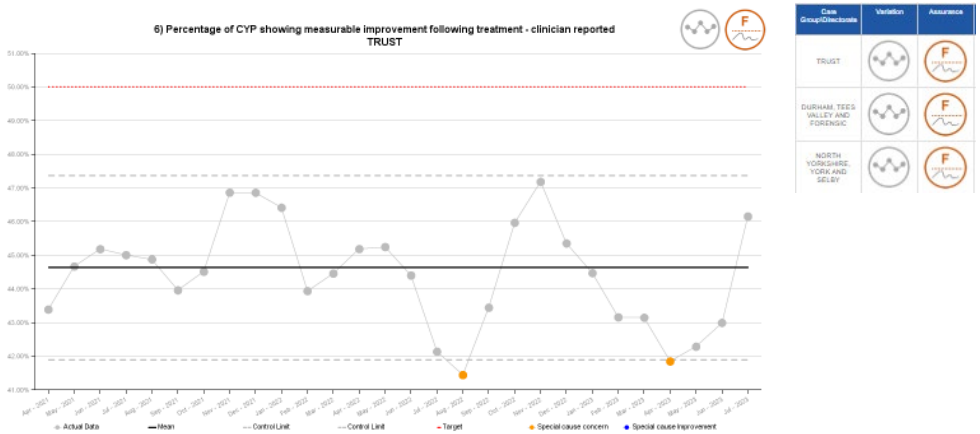
An Area of Concern
We are concerned with our performance in this area and action is required to improve

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

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 July, **897** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 414 (46.15%)** 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)



No significant change in the data during the reporting period shown

Our system is expected to consistently fail the target/expectation

93%

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to ensure outcomes training is provided for both new and existing staff to ensure clinical outcomes is fully embedded into clinical practice	*Enabling action:* The CYP Specialist Practitioner in Clinical Outcomes Development will provide a monthly training session for all new starters	In July, 2 staff attended the monthly training sessions (out of 2) from Durham & Tees Valley and 1 (out of 2) for North Yorkshire, York & Selby. The services are currently reviewing a list of new starters since February 2023 to ensure that all have attended or are booked onto relevant outcomes training. Any staff that have not attended, will be booked onto the next available training session.	
We are concerned that our patients' improvement is not being captured by ROMs due to the timeliness of their completion in the patient journey.	*Enabling action*: Specialist Practitioner in CYP Outcomes Development to facilitate bespoke half day training sessions in October 2023 and January 2024, focusing on themes identified in discussions with teams, Team Managers and ROMs Leads, with the aim of improving the timely completion of ROMs.		

We are concerned that a significant number of patient-reported outcome measures within our Durham & Tees Valley services and clinician-reported outcome measures within our North Yorkshire, York & Selby services are not reflecting measurable improvements in our patients. To address this the Care Groups have developed **Performance Improvement Plans** that define the actions that are being taken to support improvement and increased assurance. There are 5 actions currently included within the plans; 3 were to be completed by the end of June 2023, of which 1 has been completed:

- The development of a Durham & Tees Valley service-wide register and training plan to ensure that all lead professionals and clinicians are trained to complete paired rated outcome measures.

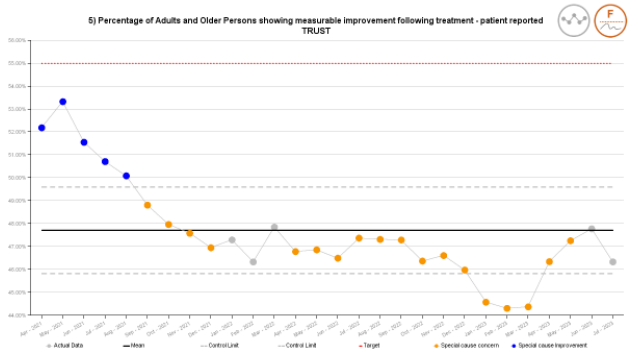
05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

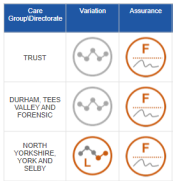
Tees, Esk and Wear Valleys NHS Foundation Trust

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 July, **2100** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 973 (46.33%)** made a measurable improvement.

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





No significant change in the data during the reporting period shown

Our system is expected to consistently fail the target/expectation

93%

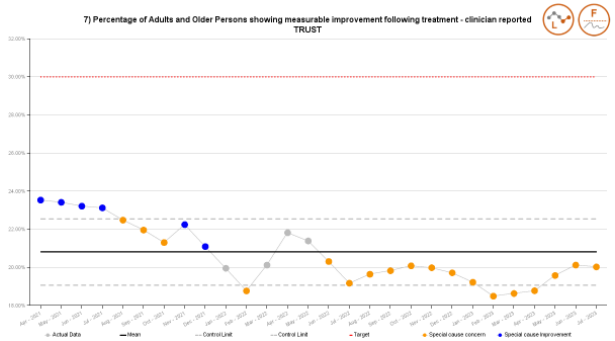
An Area of Concern
We are concerned with our performance in this area and action is required to improve

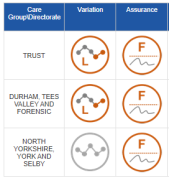
07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

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 July, **3251** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 651 (20.02%)** made a measurable improvement.

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





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

Our system is expected to consistently fail the target/expectation

93%

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

Outcomes: 05) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported and 07) Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported

Tees, Esk and Wear Valleys NHS Foundation Trust

We are concerned that a significant number of patient-reported and clinician-reported outcome measures within our North Yorkshire, York & Selby services are not reflecting measurable improvements in our patients. To address this the Care Group has developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. There are 3 actions currently included within the plan; 2 have been completed to date, both supporting enhanced monitoring of the use of outcomes measures in clinical practice through clinical supervision and caseload management supervision.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

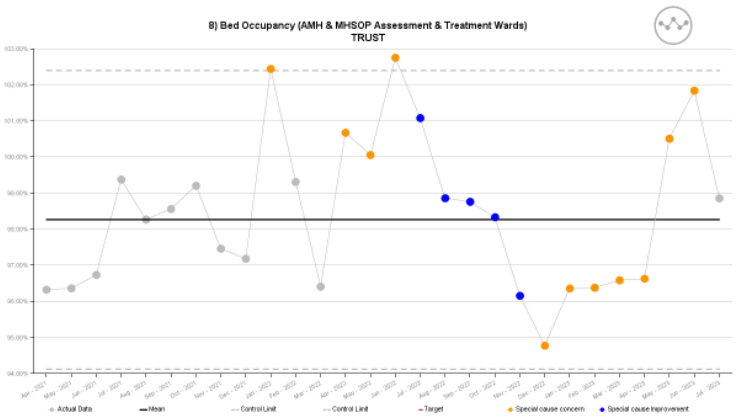
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community. It is important 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 July, **10,850** daily beds were available for patients; of those, **10,726 (98.86%)** were occupied.

No significant change in the data during the reporting period shown

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

DQ 73%



Care Group/Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

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

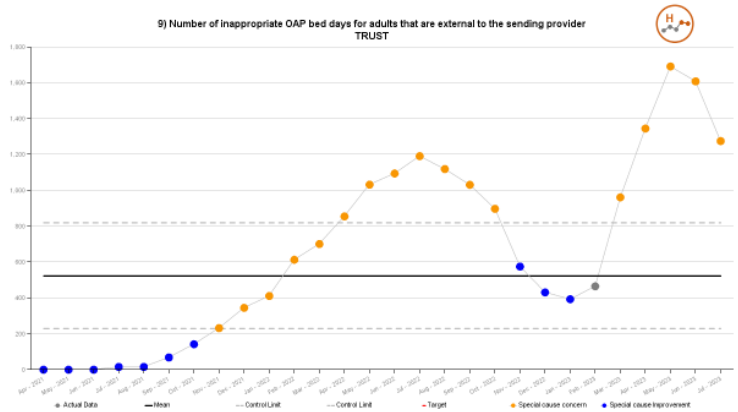
We want to ensure that we use our inpatient beds as effectively as possible to meet the needs of our patients. We are committed to co creating a great experience by ensuring all patients are treated in a hospital that helps retain contact with family, carers, friends and their community.

For the 3 month rolling period ending July, **1275** 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.

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

DQ 73%



Care Group/Directorate	Variation
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DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

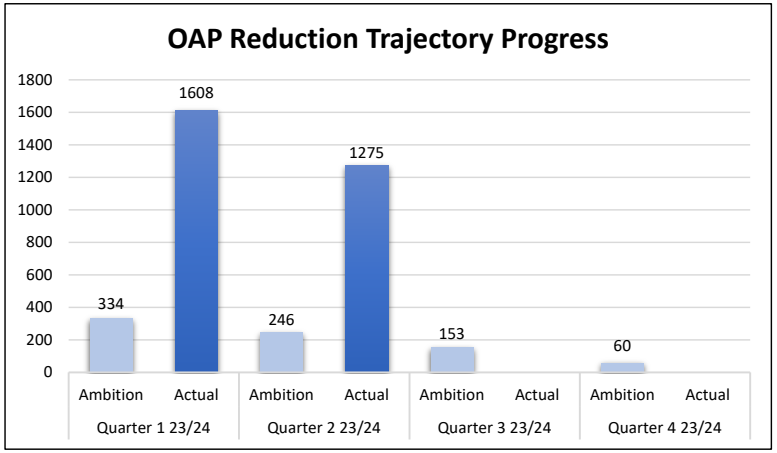
Bed Pressures: 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Supporting Measures

		2023 - 2024				
		Apr	May	Jun	Jul	FYTD
Overall Occupancy including Trust and independent sector bed usage	Number of occupied bed days	10,633	11,533	11,212	10,950	**44,328**
	Number of available bed days	10,740	10,866	10,500	10,850	**42,956**
	Percentage Bed Occupancy	**99.00%**	**106.14%**	**106.78%**	**100.92%**	**103.19%**

Number of inappropriate OAP bed days for adults that are either 'internal' or 'external' to the sending provider	Quarter 1 23/24		Quarter 2 23/24	
	Ambition	Actual	Ambition	Actual
Trust	334	1608	246	1275
North East & North Cumbria ICB	334	1445	246	1175
Humber & North Yorkshire ICB	0	163	0	100



We recognise that occupancy of our assessment & treatment beds within Adult and Older People Services is an area of concern and is impacting on our ability to meet the needs of our patients. To address this, we have developed **Performance Improvement Plans** for both Care Groups that define the actions being taken to support improvement and increased assurance. There are 13 actions currently included within the plan; 7 are due for completion by the end of September, of which 5 have been completed. Those completed include:

- A review all appropriate cases on a weekly basis with local authority colleagues (in both Care Group patches) to develop plans to expedite the timely discharge of those patients requiring local authority residence.
- A review of alternative options for Approved Clinicians and Responsible Clinician cover within North Yorkshire, York & Selby. MPAC (multi-professional approved and responsible clinician) posts support all four assessment and treatment wards.
- The implementation of daily escalation processes on our Durham & Tees Valley adult mental health wards to ensure immediate response from service management to help address any operational and/or clinical barriers to discharge.

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

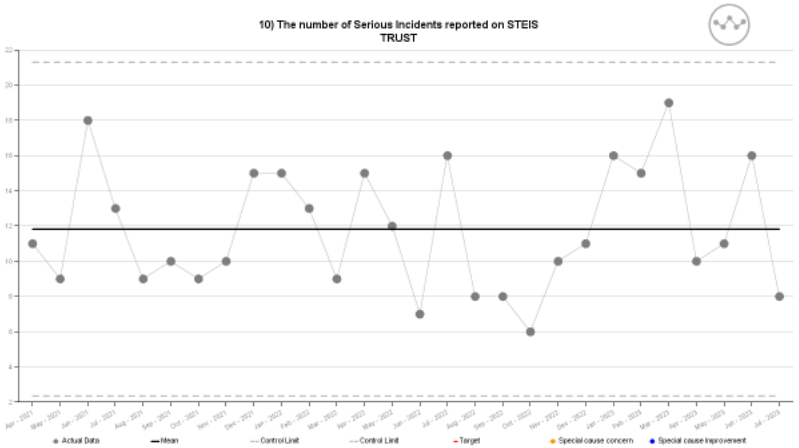
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

8 serious incidents were reported on the Strategic Executive Information System (STEIS) during July.

No significant change in the data during the reporting period shown

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

DQ
87%



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

8 Serious Incidents are reported for July; however, there were 11 serious incidents reported on STEIS. The additional 3 incidents were approved on Datix after data had been extracted for the report.

Each incident has been subject to an early learning review within the patient safety huddle and there are no specific themes in relation to incident details or teams. Two cases indicated that safety summary/safety plans had not been updated to reflect the current risk/need and two cases highlighted gaps in clinical records, specifically around recording of Multi-Disciplinary Team discussions.

11) The number of Incidents of moderate harm and near misses

Tees, Esk and Wear Valleys NHS Foundation Trust

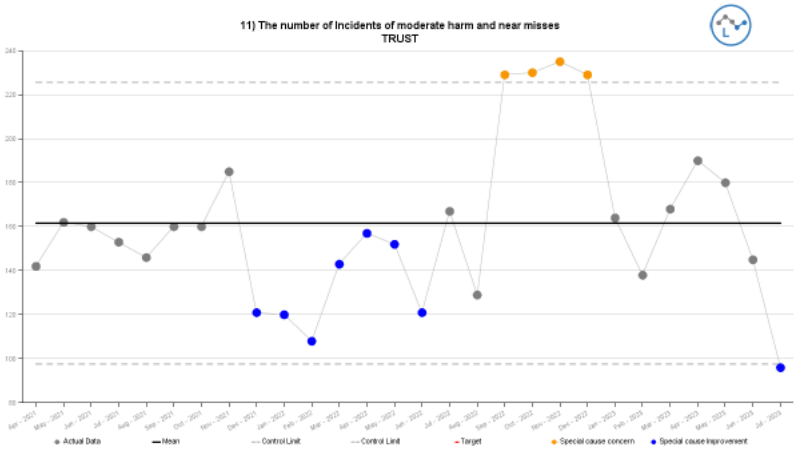
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When serious incidents occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

96 incidents of moderate harm or near misses were reported during July.

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

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

DQ
80%



There are no new emerging themes within the 96 incidents of moderate harm or near miss reported in July. Where any early learning is identified immediate actions are agreed and monitored until completion.

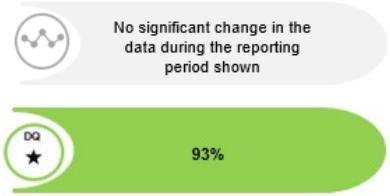
Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
When incidents are centrally approved, the patient safety team request an Early Learning Review (ELR) be undertaken by the services; when services approve their own incidents, they initiate they ELR. Clinical services are not always undertaking a timely ELR due to confusion regarding the process.	*Enabling action:* Patient Safety Team to link in with the care groups by the end of August to ensure that where moderate harm incidents have occurred there is an ELR with appropriate oversight and approval, undertaken in a timely manner.		
There is a concern that a number of incidents are being incorrectly recorded and approved as moderate harm within the clinical services when the severity should have been reduced at the review/approval stage.	*Enabling action*: Patient Safety Team to link in with the care groups by the end of August to ensure that reviewers and approvers correctly understand their responsibilities to ensure incident severity is being correctly coded.		

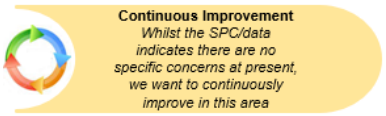
12) The number of Restrictive Intervention Incidents

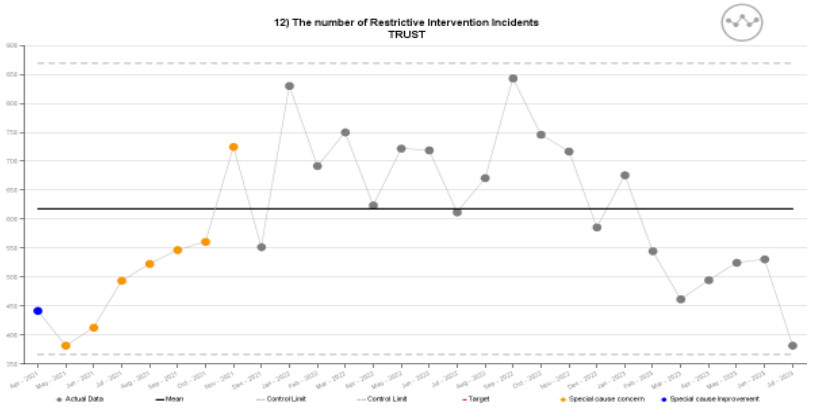
Tees, Esk and Wear Valleys NHS Foundation Trust

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.

382 Restrictive Intervention Incidents took place during July.







Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We require greater assurance locally from Care Boards on the implementation of the Restraint Reduction Plan	*Enabling action:* Care Boards to ensure delivery of the Restraint Reduction Plan by ~~31st March~~ 31st October 2023.	The Restraint Reduction Plan has not been developed as the away day identified further work required to ensure the Lived Experience voice is at the centre of the plan. Three workstreams have been identified to: • co-produce the Positive & Safe Care Policy, • review the positive and safe carer information and carer pack • agree key priorities for reducing restrictive interventions over the next 12 months. Task and finish groups have been established to complete the work over the next 3 months.	
	Enabling action: The Nurse Consultant for Positive and Safe Care to lead the development of a Positive & Safe Care Policy. The proposed Policy will be completed by the ~~30th June~~ 31st October 2023 for pubic consultation.		

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We require additional resource to support Care Boards with reduction of restrictive practices	*Enabling action:* The Nurse Consultant for Positive and Safe Care to share the business case for additional resources with the Care Groups during January and February 2023 to agree the next steps prior to submitting for approval.	Agreement is still to be confirmed for 2 Advanced Practitioners, 2 Peer Workers and 2 Clinical Skills Trainers that will be aligned to the Care Groups. The Nurse Consultant for Positive & Safe Care is to liaise with Care Group Directors to agree the next steps.	

Additional Intelligence in support of continuous improvement

Since October 2022, a decreasing (improving) trend in the use of restrictive practices has been visible within our Adult Learning Disabilities; a trend that has been seen across all types of restraint. Of note, we have not physically restrained any patients in a prone (chest down) position since November 2022 and the use of rapid tranquilisation stopped in May 2023.

We have developed a full training programme, which includes Positive & Safe training accredited by the UK Restraint Reduction Network, Positive Behaviour Support training, HOPEs awareness training developed by Mersey Care NHS Foundation Trust and SPELL – Structure, Positive (approaches and expectations), Empathy, Low Arousal, Links - training.

An environmental de-escalation model is now being used, by which the physical & social environment is used to:

- help the person feel physically & emotionally safe,
- help them process information that helps them to calm, and
- provide the right type of support at the right time.

The Positive Support Strategy has been developed, focusing on the quality of life for patients with a learning disability. Co-produced with patients, carers, social workers, social care providers, and staff, it provides a developmental framework to ensure that specialist Learning Disability services can deliver high quality support that will improve the lives of people with learning disabilities who are at increased risk of presenting behaviours of concern in our area.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

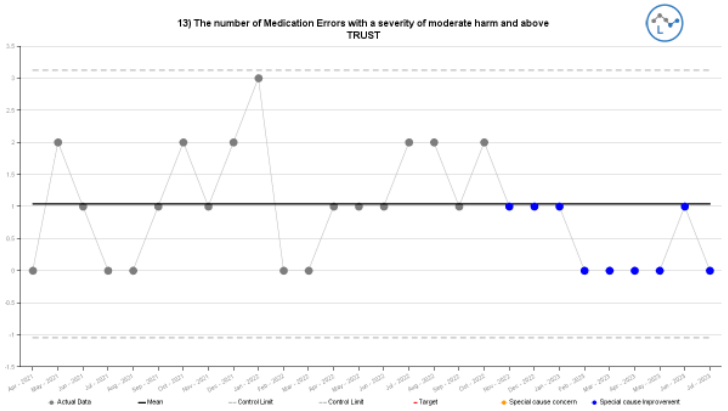
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When medication errors occur, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements are identified and implemented to maintain the safety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

0 medication errors have been recorded with a severity of moderate harm, severe or death during July.

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

DQ
93%

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



Care Group/Directorate	Variation
TRUST	L
DURHAM, TEES VALLEY AND FORENSIC	L
NORTH YORKSHIRE, YORK AND SELBY	

Additional Intelligence in support of continuous improvement

The Trust successfully launched a pilot on Moor Croft Ward at Foss Park for electronic prescribing & medicines administration (EPMA) in June 2023. EPMA will enable more timely prescribing of medication to patients and reduce the risk of errors. The pilot has been well received by the ward team (prescribers and nursing staff). A revised roll out plan for EPMA is in development for the next ward (yet to be confirmed), the first subsequent to Moor Croft, which is expected to go live in September.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

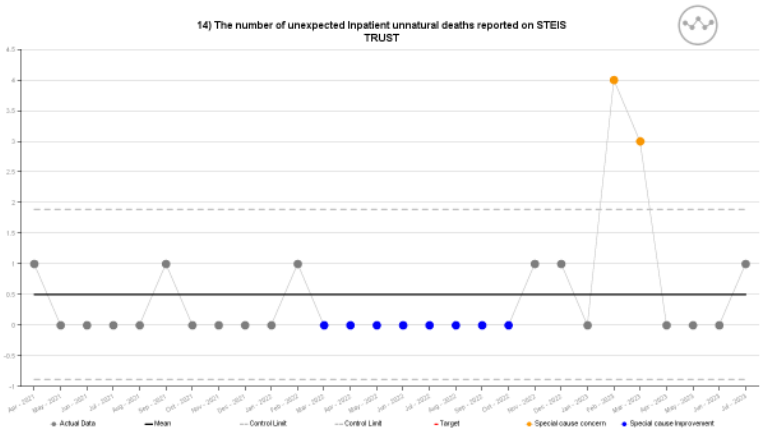
We are committed to ensuring that all our patients are cared for in a safe and secure environment. When any deaths occur within our services that are not attributable to natural causes, it is important to understand why and how they have occurred so that we can learn from them, ensuring that any improvements 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.

1 unexpected Inpatient unnatural deaths was reported on the Strategic Executive Information System (STEIS) during July.

No significant change in the data during the reporting period shown

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

DQ ★ 93%



Care Group/Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

NOTE: We have not had any unexpected unnatural inpatient deaths during July. Whilst one unexpected death has been reported, which is being investigated as a serious incident, every indication is that this was attributable to physical health causation.

15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

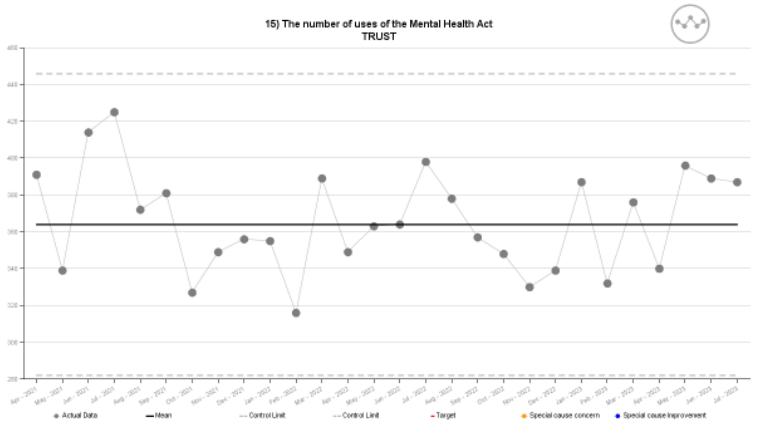
We are committed to co creating a great experience by ensuring all patients that are admitted to our beds feel secure, supported and safe within our services. It is important that we support all patients that are treated within our hospitals equally and support them to retain contact with family, carers,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

There were **387** uses of the Mental Health Act during July.

No significant change in the data during the reporting period shown

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

DQ
73%



Care Group\Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
As a result of monitoring and analysing this measure, we have identified through the IPA process, that some refinement is required.	The Head of Performance to work with the Business Intelligence Operational Manager – PLICS & MHMDS to develop a KPI change by the end of March 2023, with a view to amending the measure for the ~~April~~ August 2023 report.	Following the delay of Cito it has been recommended that we now progress the change request by the end of August 2023.	

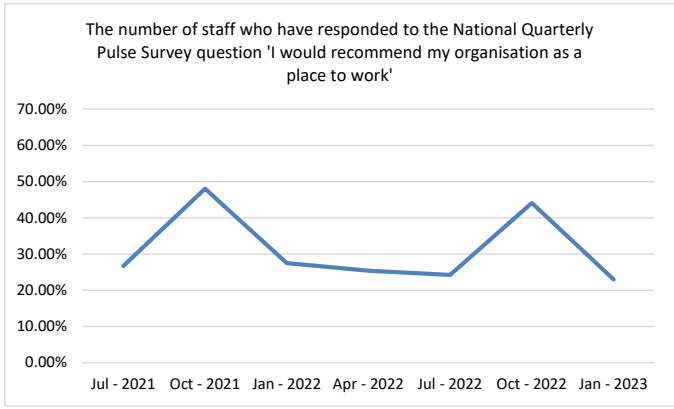
16) Percentage of staff recommending the Trust as a place to work

NHS
Tees, Esk and Wear Valleys
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.

1988 staff responded to the January 2023 Pulse Survey question "I would recommend my organisation as a place to work" Of those, **1104 (55.53%)** responded either "Strongly Agree" or "Agree". ***Please note this is not "new" data as survey is only undertaken once a quarter***

	Jul - 2021	Oct - 2021	Jan - 2022	Apr - 2022	Jul - 2022	Oct - 2022	Jan - 2023
TRUST	54.23%	52.46%	52.54%	55.01%	53.60%	54.05%	55.53%
ASSISTANT CHIEF EXEC	69.23%	60.94%	51.61%	61.29%	47.83%	62.86%	56.00%
DIGITAL AND DATA SERVICES	68.09%	60.50%	70.13%	68.00%	57.65%	60.50%	57.50%
DURHAM, TEES VALLEY AND FORENSIC	51.50%	50.76%	50.72%	54.63%	54.64%	53.42%	55.92%
ESTATES AND FACILITIES MANAGEMENT	57.14%	52.43%	46.92%	50.38%	50.76%	41.95%	46.00%
FINANCE	61.54%	57.41%	62.22%	57.58%	61.54%	46.30%	47.37%
MEDICAL	67.44%	78.95%	68.42%	64.10%	65.71%	63.64%	61.36%
NORTH YORKSHIRE, YORK AND SELBY	50.19%	47.92%	50.48%	52.85%	49.89%	55.21%	55.60%
NURSING AND GOVERNANCE	61.90%	56.31%	53.42%	51.95%	35.14%	49.14%	43.53%
PEOPLE AND CULTURE	69.86%	68.00%	57.69%	56.99%	61.05%	61.34%	52.17%
THERAPIES	82.35%	61.54%	62.96%	54.17%	53.85%	47.06%	67.86%



DQ ✓✓ 87%

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

Response rates for the Quarter 2 2223 NHS Pulse Survey ranged between 0.10% and 52.08%.
Note: October 2021 and October 2022 in the chart reflects the annual Staff Survey that is undertaken by Picker

National Benchmarking – NHS Staff Survey 2022

The national overall response rate for the 2022 Staff Survey was 46; TEWV was 44% and were the most improved Mental Health & Learning Disabilities trust nationally; ranked 1 out of 25 in overall positive change score.

- The **Picker average*** was **61%** of staff would recommend their organisation as a place to work.
- **54%** of staff from **our Trust** would recommend their organisation as a place to work (compared to **52%** in the 2021 NHS Staff Survey)
- National benchmarking data shows that we are ranked 47 out of 51 Mental Health & Learning Disability Trusts (1 being the best with the highest rating). Whilst we are placed at the lowest end of the inter-quartile range, this is a slight improvement to our ranking in 2021 (48 our of 51).

NB. *Picker carried out the NHS Staff Survey for 2022 on behalf of 25 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 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.

2013 staff responded to the January 2023 Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **1214 (60.31%)** responded either "Strongly Agree" or "Agree". ***Please note this is not "new" data as survey is only undertaken once a quarter***

	Jul - 2021	Oct - 2021	Jan - 2022	Apr - 2022	Jul - 2022	Oct - 2022	Jan - 2023
TRUST	57.10%	57.11%	57.50%	58.76%	59.12%	58.53%	60.31%
ASSISTANT CHIEF EXEC	76.92%	67.19%	67.74%	74.19%	65.22%	80.00%	88.00%
DIGITAL AND DATA SERVICES	65.96%	72.27%	74.03%	72.00%	65.88%	66.39%	65.00%
DURHAM, TEES VALLEY AND FORENSIC	56.23%	54.59%	57.00%	57.98%	58.94%	57.60%	57.35%
ESTATES AND FACILITIES MANAGEMENT	55.24%	26.04%	53.08%	52.67%	51.52%	46.55%	61.00%
FINANCE	65.38%	61.11%	64.44%	69.70%	71.79%	53.70%	57.89%
MEDICAL	67.44%	73.68%	81.58%	79.49%	68.57%	65.45%	70.45%
NORTH YORKSHIRE, YORK AND SELBY	54.44%	56.48%	54.35%	56.45%	55.77%	57.26%	59.12%
NURSING AND GOVERNANCE	61.90%	66.99%	65.75%	63.64%	59.46%	59.48%	69.41%
PEOPLE AND CULTURE	78.08%	77.60%	73.08%	73.12%	69.47%	77.31%	71.74%
THERAPIES	94.12%	58.97%	81.48%	70.83%	69.23%	47.06%	67.86%

87%

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

Response rates for the Quarter 2 2223 NHS Pulse Survey ranged between 0.10% and 52.08%.
Note: October 2021 and October 2022 in the chart reflects the annual Staff Survey that is undertaken by Picker

National Benchmarking – NHS Staff Survey 2022

The national overall response rate for the 2022 Staff Survey was 46; TEWV was 44% and were the most improved Mental Health & Learning Disabilities trust nationally; ranked 1 out of 25 in overall positive change score.

- The **Picker average*** was **60%** of staff feel able to make improvements happen in their area of work
- **59%** of staff from **our Trust** feel able to make improvements happen in their area of work (compared to **57%** in the 2021 NHS Staff Survey)
- National benchmarking data shows that we are ranked 38 out of 51 Mental Health & Learning Disability Trusts (1 being the best with the highest rating) and are placed in the inter-quartile range. This is lower than our ranking in 2021 (34 out of 51).

NB. *Picker carried out the NHS Staff Survey for 2022 on behalf of 25 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 Foundation Trust

TO NOTE: From April 2023 we have changed the provider that undertakes the Pulse surveys on behalf of the Trust; this has resulted in a delay to reporting the April data. The data has been provided to our Organisational Development team and work is currently underway by our Integrated Information Centre team to establish the required processes that will facilitate reporting; timescales for completion of this work are currently being assessed.

Current Focus	Current Improvement Action(s)	Progress Update	Actual 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.	*Enabling action*: Associate Director of Leadership & Development to evaluate the information received from York University and the options for engaging with staff more frequently and to develop a detailed plan by the end of September 2023, with a view to increasing staff participation in the survey.	A proposal to use the tool developed by colleagues at York University has been agreed at Executive People Culture & Diversity Group. Plans will now be developed to roll out usage of the tool.	
We need to increase participation within the Staff Survey to ensure our results reflect a wider number of our staff.	*Enabling action:* Organisational Development to explore ideas shared by the North East Ambulance Service, North Tees & Hartlepool NHS Foundation Trust, South Tyneside & Sunderland NHS Foundation Trust and North East & North Cumbria Integrated Care Board for progressing within the Trust. This work will be completed by the 31st August 2023.	Terms of Reference have been agreed and a meeting has been established for the end of August 2023 to progress this work.	

Additional Intelligence in support of continuous improvement

The Organisational Development Team has undertaken a series of Trust-wide focused visits throughout July to raise awareness of the Pulse Survey and to encourage participation. This has included the design and production of new banners that are being used at each event, to reinforce the message to staff that their voice counts and that the Pulse and Staff Surveys provide the Trust with a learning opportunity, to identify how we can be better. The key message to staff is our People Promise to work together to improve the experience of working in the NHS for everyone. This has resulted in an increase in response rate since the last quarter (April) from 10.72% (872 staff) to 20.87% (1697 staff).

The team are now starting work on the annual 2023 Staff Survey, which will be undertaken in October.

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 Foundation Trust

Additional Intelligence in support of continuous improvement

The Trust has embarked on a 5-year stepped approach to Quality Improvement (QI) Training until November 2027 to support staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements.

Programme Aim	Position as at 01.08.2023	
Enable **100%** of staff to access Foundation training	**15%**	(1139 out of 7603 members of staff)
To have trained **50%** of staff at Intermediate level	**11%**	(861 out of 7603 members of staff)
To have **15%** of staff trained at Leader level	**4%**	(323 out of 7603 members of staff)
To have **1%** of staff trained at Expert level	**0.51%**	(39 out of 7603 members of staff)

It should be noted that the rollout of CITO is expected to have an impact on the training numbers as staff prioritise Cito training between June and October 2023.

18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

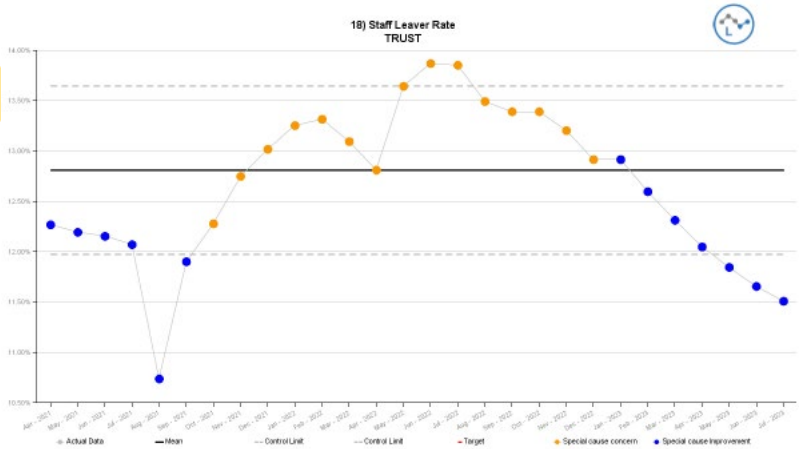
We are all committed to co creating a great experience for our colleagues so that they will feel they can continue to develop their careers within the organisation. By ensuring that we do not have an excessively high staff leaver rate, we will be retaining experienced staff helping us to ensure continuity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

From a total of **6,683. 17** staff in post, **769.16 (11.51%)** had left the Trust in the 12 month period ending July.

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

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

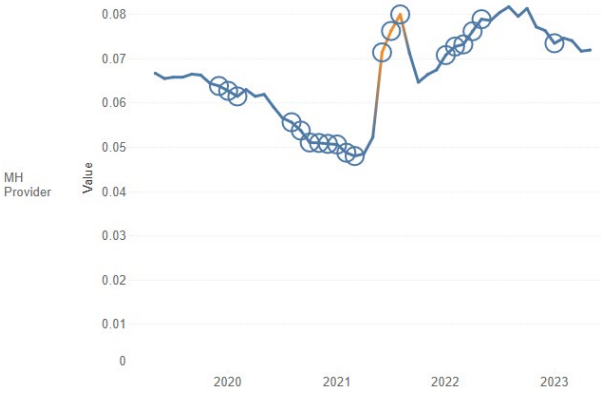
DQ 80%



Care Group/Directorate	Variation	Care Group/Directorate	Variation
TRUST	L	FINANCE	
ASSISTANT CHIEF EXEC	H	MEDICAL	
COMPANY SECRETARY	L	NORTH YORKSHIRE, YORK AND SELBY	L
CORPORATE AFFAIRS AND INVOLVEMENT	L	NURSING AND GOVERNANCE	
DIGITAL AND DATA SERVICES	H	PEOPLE AND CULTURE	
DURHAM, TEES VALLEY AND FORENSIC	L	THERAPIES	L
ESTATES AND FACILITIES MANAGEMENT			

National Benchmarking: NHS Staff Leaver Rate - England Mental Health and Learning Disability – April 2023 (latest published data)

The NHS Staff Leaver Rate published on the Future Collaboration Platform for Mental Health Providers shows a similar trend to that shown for our Trust. We were ranked 9 of 71 Trusts (1 being the best with the lowest leaver rate) and are placed in the highest performing quartile range.



18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to understand the workforce profile of our leavers - professions, age groups, team, reasons – to better inform improvement actions.	*Enabling action:* Deputy Director of People & Culture to develop (with our Principle People Partners) an action plan based on the profile of our leavers by the end of ~~July~~ Aug 2023, with a view to improving our staff retention.	This work is underway. Monitoring and performance against the plan will be reported into the Safer Staffing Strategy Group.	

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

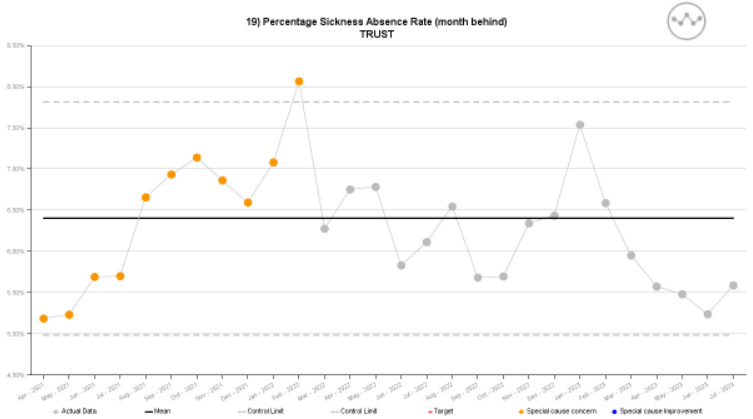
We are all committed to co creating a great experience our colleagues. We want to ensure that we support all our staff to maximise their health and wellbeing and enjoy coming to work as we know this also impacts on the quality of care we provide to our patients.

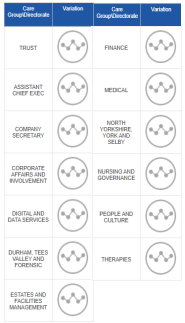
There were **219,170.07** working days available for all staff during June (reported month behind); of those, **12,248.85 (5.59%)** days were lost due to sickness.

No significant change in the data during the reporting period shown

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

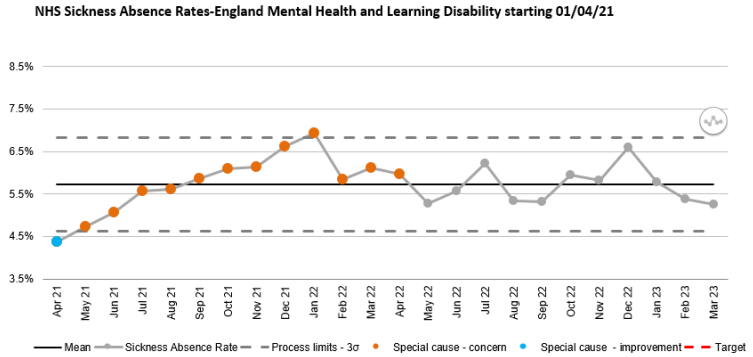
DQ 73%





National Benchmarking: NHS Sickness Absence Rates - England Mental Health and Learning Disability – March 2023.

NHS Sickness Absence Rates published 27th July 2023 (data ending March 2023 for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is 5.73% compared to the Trust mean of 6.40%.



Update

As at the 13th August 2023, sickness absence is 5.76% for August 2023.

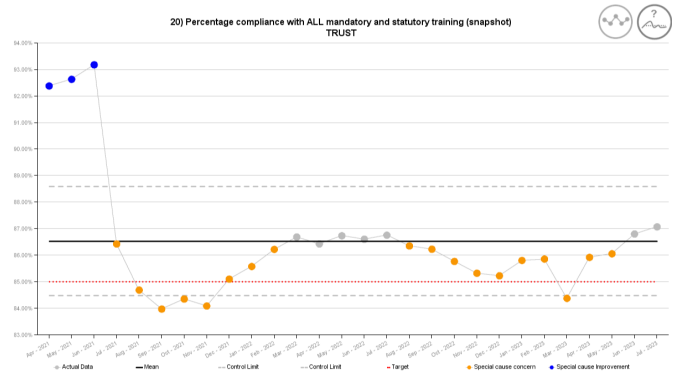
20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys 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.

136,902 training courses were due to be completed for all staff in post by the end of July. Of those, **119,204** (**87.07%**) courses were actually completed.

Percentage Compliance with Information Governance & Data Security Training. As required by the Information Governance Tool Kit the Trust must achieve 95% staff compliance. As at end of July, **6936** were due for completion, **7568 (91.65%)** were actually completed.



No significant change in the data during the reporting period shown

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

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

DQ

93%

We recognise that the levels of compliance with our mandatory and statutory training may be impacting on our ability to provide high quality and safe services. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. There are 28 actions currently included within the plan; 13 are due to be completed by the end of September 2023, of which 5 have been completed. Those completed include:

- The recruitment of 2 additional Positive & Safe Care trainers; however, there remains concern that capacity is still insufficient to meet demand.
- The upskilling of 8 Positive & Safe Care trainers to be able to provide Basic Life Support (Resus) training.
- A capacity & demand exercise completed to provide assurance that we have sufficient capacity to deliver Moving & Handling training.

20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Information

As at the 13th August 2023, compliance for each of the Trust directorates is as follows:

Directorate	Mandatory & Statutory Training Compliance	
	Trajectory to achieve 85% compliance:	Data as at 13th August
Trust	Achieving	87.30%
Assistant Chief Executive	Achieving	96.01%
Capital Programme	Trajectory required	84.72%
Company Secretary	Achieving	87.65%
Corporate Affairs & Involvement	Achieving	94.79%
Digital & Data Services	Achieving	88.67%
Durham, Tees Valley & Forensic	Achieving	87.30%
Estates & Facilities Management	Achieving	92.46%
Finance	Achieving	91.68%
Medical	Achieving	86.49%
North Yorkshire, York & Selby	Achieving	86.19%
Nursing & Governance	Achieving	88.24%
People & Culture	Achieving	89.89%
Therapies	Achieving	87.23%
Trust-wide roles	Trajectory required	77.78%

Work is being undertaken as a matter or priority to understand the underlying reasons for the reduction in compliance for those directorates not achieving standard.

21) Percentage of staff in post with a current appraisal

NHS
Tees, Esk and Wear Valleys
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.

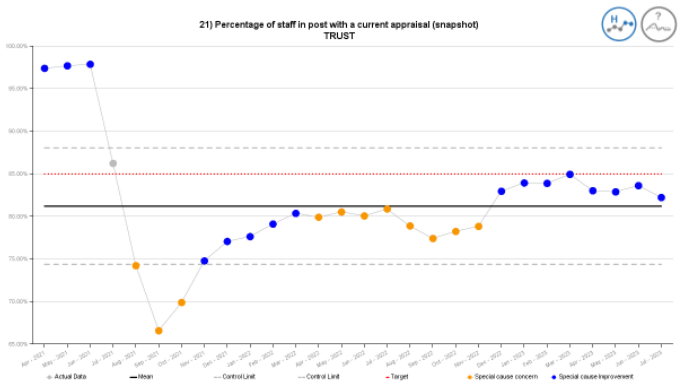
Of the **6561** eligible staff in post at the end of July; **5394** (**82.21%**) had an up to date appraisal

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

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

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

DQ
93%



Care Group/Directorate	Variation	Assurance	Care Group/Directorate	Variation	Assurance
TRUST	H	?	FINANCE	H	?
ASSISTANT CHIEF EXEC	?	?	MEDICAL	H	?
COMPANY SECRETARY	H	F	NORTH YORKSHIRE, YORK AND SELBY	?	?
CORPORATE AFFAIRS AND INVOLVEMENT	?	?	NURSING AND GOVERNANCE	H	F
DIGITAL AND DATA SERVICES	?	?	PEOPLE AND CULTURE	H	F
DURHAM, TEES VALLEY AND FORENSIC	H	?	THERAPIES	H	F
ESTATES AND FACILITIES MANAGEMENT	?	?			

We recognise that we have a significant number of staff within the Trust that have not received a timely appraisal and that this may be impacting on our ability to provide high quality and safe services. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance. There are 13 actions currently included within the plan; 6 are due to be completed by the end of September 2023, of which 2 have been completed and will be continued monthly, these are:

- The running of twice-monthly coffee break sessions to raise awareness and understanding of Workpal.
- Monthly reviews within the Safer Staffing Group to ensure that the Care Groups are supported to release staff for their appraisals.

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

Supporting Information

As at the 13th August 2023, compliance for each of the Trust directorates is as follows:

Directorate	Appraisal Compliance	
	Trajectory to achieve 85% compliance:	Data as at 13th August
Trust	Not achieving	81.94%
Assistant Chief Executive	Achieving	88.24%
Capital Programme	Trajectory required	83.33%
Company Secretary	Achieving	100.00%
Corporate Affairs & Involvement	Trajectory required	72.73%
Digital & Data Services	Trajectory required	71.86%
Durham, Tees Valley & Forensic	Trajectory required	83.21%
Estates & Facilities Management	26th August 2023	82.09%
Finance	31st July 2023	80.49%
Medical	Trajectory required	83.51%
North Yorkshire, York & Selby	31st May 2023	78.86%
Nursing & Governance	Achieving	89.80%
People & Culture	Achieving	85.19%
Therapies	Achieving	86.84%
Trust-wide roles	Trajectory required	42.86%

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

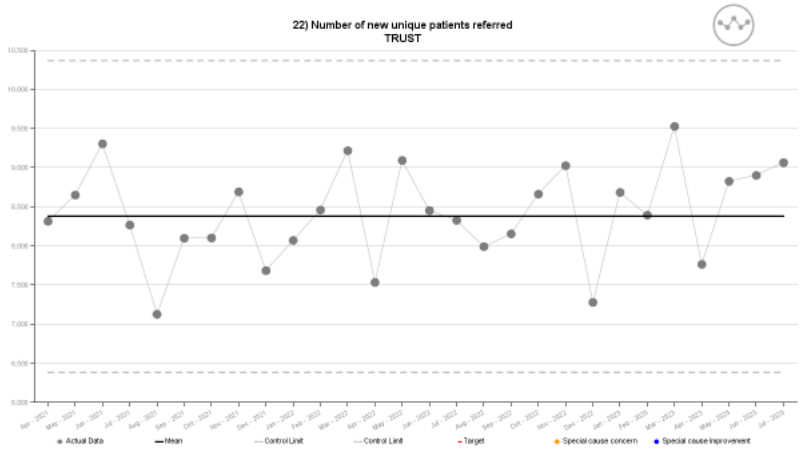
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment 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.

9065 patients referred in July that are not currently open to an existing Trust service

No significant change in the data during the reporting period shown

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

DQ ★ 93%



Care Group \Directorate	Variation
TRUST	
DURHAM, TEES VALLEY AND FORENSIC	
NORTH YORKSHIRE, YORK AND SELBY	

There are currently no specific trends or areas of concern identified within this measure.

23) Unique Caseload (snapshot)

Tees, Esk and Wear Valleys NHS Foundation Trust

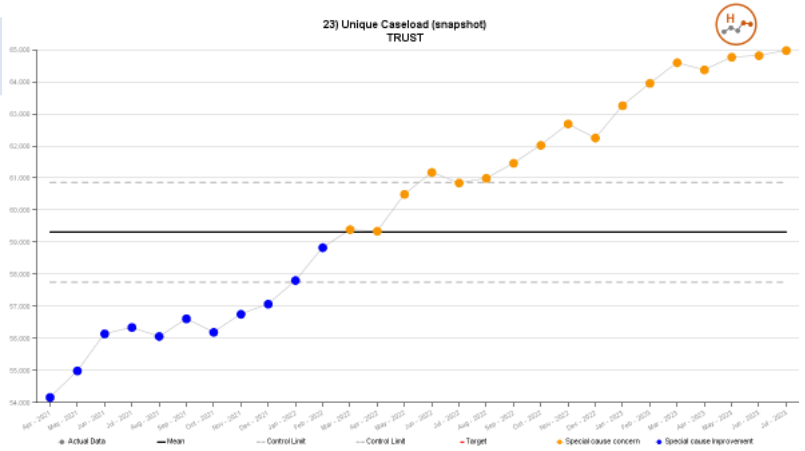
We are all committed to co creating a great experience for patients, and carers and families by ensuring that they experience support to achieve their goals and care that is right for each individual. Understanding the levels of patients that are referred to our services, assessed and taken on for treatment 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.

64,974 cases were open, including those waiting to be seen, as at the end of July 2023.

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

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

DQ ★ 100%



Care Group \Directorate	Variation
TRUST	H
DURHAM, TEES VALLEY AND FORENSIC	H
NORTH YORKSHIRE, YORK AND SELBY	H

We recognise that the size of caseloads in a number of our services is an area of concern and may be impacting on the delivery of care and may affect our patients' recovery and staff wellbeing. To address this, our care groups have developed **Performance Improvement Plans** that define the actions that are being taken to support improvement and increased assurance. There are 34 actions currently included within the plans; 20 are to be completed by the end of September 2023, of which 11 have been completed. Those completed include:

- The recruitment of two additional assessment posts within Durham & Tees Valley Adult Mental Health Planned Care to support patients waiting for and Attention Deficit Hyperactivity Disorder assessment.
- The development of an automated patient tracker list to support the waiting list for patients with an Autism Spectrum Disorder; this is currently being validated.
- The increase of our medic complement within the Ripon Adult Community Team.
- The increase of nursing capacity within our York Memory Team.
- The undertaking of a caseload review within our Harrogate Vanguard Community Care Team.

Some improvements are starting to be observed. A decreasing trend is now visible across some Durham & Tees Valley Adult Learning Disability community teams and a number of our Children & Younger People Learning Disability teams within the Care Group are no longer showing concern. There has been a visible reduction within our Tees Mental Health Services for Older People community teams, particularly within Redcar & Cleveland, Stockton and Hartlepool. Some decreasing trends are also visible within a number of teams within North Yorkshire, York & Selby, primarily as a result of improvement work. Of note, this has included the York Care Home and Dementia, which has recently completed a caseload review.

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

Tees, Esk and Wear Valleys 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 **£4.70m deficit** (to break even) to 31st July 2023 against a planned year to date deficit of **£4.05m,** resulting in a **£0.65m adverse** plan variance.

Summary

The financial position at 31st July 2023 is an operational deficit of £4.70m against a planned year to date deficit of £4.05m, resulting in a £0.65m adverse plan variance. Two national pressures fully account for the year to date variance i) Underfunding of the nationally negotiated pay award for **Agenda for Change** staff is contributing £0.53m to the year to date position (£1.6m projected 2023/24). ii) Defunding of providers for national **Microsoft Licensing** arrangements (with no equivalent compensating cost reduction) is contributing £0.15m to the year to date position (£0.5m projected 2023/24).

• **Agency expenditure** within July 2023 was £2.34m, which was £0.68m over plan, and £7.11m to date, or £0.05m below plan to date. Usage includes material costs linked to inpatient occupancy and rosters, medical cover and reducing costs relating to complex specialist packages of care.

• **Independent sector beds** - the Trust required 232 bed days during July 2023 (493 in June, a 261 bed day reduction) at a cost of £0.22m (including estimates for unvalidated periods of occupancy and average observation levels pending billing). Year to date costs were £1.50m, or £0.89m more than the £0.61m year to date plan. This remains a key area of clinical and management focus including through the Beds Oversight Group.

• **EFM Building & Engineering Contracts** cost £1.06m to date, or £0.64m more than planned. Costs relate to on-call and vacancy cover (pay surplus of £0.21m YTD as of July 2023). Revised roles, job descriptions / bandings are in recruitment to align pay with regional peers and mitigate these pressures recurrently with structures planned to be operational from August 2023.

• **Taxis and Secure Patient Transport** YTD cost to July 2023 was £1.01m, which was £0.49m more than plan. A recent quality improvement event was held which included grip and control recommendations as well as alternative options. The results of this will be monitored over the coming months.

• **Planned CRES** are £1.11m behind plan to date. Key variances relate to independent sector bed pressures for Adult Mental Health, level loading of Inpatient roster to reduce agency costs, and actions to reduce taxi/transport costs. Under achievement of planned CRES is being partly off-set by unplanned CRES delivery of £0.65m to date (including interest receivable). Composite under-achievement of CRES is £0.46m to the end of July 2023.

To deliver the 2023/24 financial plan of breakeven the Trust needs to achieve planned CRES financial targets and operate within the planning assumptions contained within the submitted plan. Variation from this will be monitored in year with any necessary recovery actions developed and implemented. Key new risks relate to pay award (including ongoing non Agenda for Change impacts as well as Agenda for change funding gap) and defunding for Microsoft.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to reduce Trust use of independent sector beds.	*Please refer to progress for measures - 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider.* *A bed pressures **Performance Improvement Plan** that defines the actions that are being taken to support improvement has been developed and shared with Executive Directors for approval.*		
We need to deliver CRES schemes to achieve our financial plan	Relevant Care Groups / Directorates to ensure that all CRES schemes have an appropriate QIA and delivery plan by the end of June 2023	Care Group Boards have had oversight and signed off QIA's for relevant CRES schemes with delivery plans in progress.	Greater understanding of differences between Care Group / directorate schemes and schemes from Trust plan.
EFM building & engineering contracts are over planned expenditure levels	The EFM DMT to establish an expenditure reduction plan by the end of June 2023 to bring expenditure in line with planning assumptions	**Complete** The expenditure reduction plan has been agreed, and is being implemented.	New roles advertised and in the process of recruitment. Review of non-pay costs being undertaken at Month 4. Structures operational from August.

We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan . To address this, we have developed **Performance Improvement Plans** that define the actions that are being taken to support improvement and increased assurance.

There are 34 actions within the current Safer Staffing PIP; 11 are due for completion by the end of September, of which 0 have been completed to date. There are 22 actions within the current Agency PIP; 14 are due for completion by September, of which 5 have been completed. Those completed include:

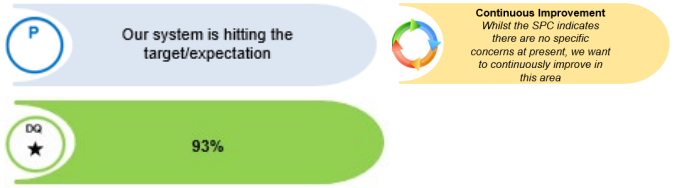
- A review of the timeframes for when shifts are outsourced to agencies. This has resulted in a reduction from up to 48 hours to 24-36 hours for Healthcare Assistants and from 7 days to 4-5 days for registered nurses.
- The development of a translation matrix of clinical competencies to support the shortlisting process to reduce delays in recruitment.
- The alignment of new student nurses to clinical need via the central recruitment programmes. The next student cohort is due in January 2024.

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

Tees, Esk and Wear Valleys 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.

YTD Agency expenditure of £7.11m is **£0.05m (0.75%) below plan**, however NHS planning guidance suggested that ICS agency expenditure should be no more than 3.7% of pay bill, as at M4 the Trust's agency expenditure represented 5.5% of pay bill.



Summary

Agency expenditure for the month of July 2023 was £2.34m, or £0.68m over plan, and £7.11m year to date, or £0.05m below year to date plan. NHS planning guidance suggested that ICS agency expenditure should be no more than 3.7% of their pay bill. As at Month 4 Trust agency expenditure represented 5.5% of pay bill. Planned agency costs for 2023/24 were relatively in line with 2022/23 outturn and remain slightly below plan for quarter 1 of 2023/24, but are high as a percentage of overall pay and higher than the average percentage target for integrated care systems in aggregate. Reducing agency volume and rates is a key focus.

Previous 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 (favourable reductions now being seen) but equally to net new recruitment and securing alternative whole system models of care for specialist adult learning disability packages of care and high cost medical assignments.

We recognise that agency expenditure is significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

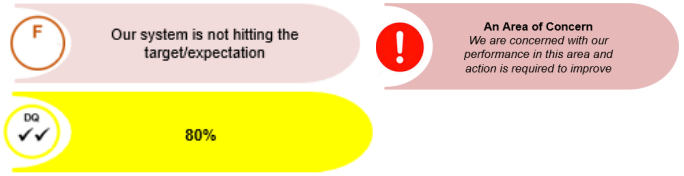
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

25b) Agency price cap compliance

Tees, Esk and Wear Valleys 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.

During July 2023 there were 4,516 agency shifts worked, with **2,977 shifts compliant (66%).**



Summary

During July 2023 4,516 agency shifts were worked (6 fewer than June). This is equivalent to approximately 146 shifts per day, compared to 152 per day in June.

Of these, 2,977 or 66% shifts were compliant (3,054 compliant shifts or 68% compliance prior month). This is equivalent to approximately 96 compliant shifts per day in July, compared to 102 compliant shifts per day in June.

Of the non-compliant shifts 1,444 or 32% breached price caps (compared to 1,375 shifts and 30% prior month). This is equivalent to approximately 47 price cap breaches per day in July, compared to 46 price cap breaches per day in June.

95 or 2% breached framework and price cap compliance (compared to 93 shifts and 2% prior month). This is equivalent to approximately 3 framework breaches per day in July and June.

Regional reporting of sickness levels suggests peer mental health providers have experienced similar challenges, albeit that the most recent absence reports for Durham, Tees Valley and North Yorkshire, York & Selby are reducing. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence but equally to net new recruitment and securing alternative whole system models of care for specialist adult learning disability packages of care and high cost medical assignments. Other key areas of focus include actions to ensure optimal roster efficiency.

Further refinement of shift data relating to the above takes place up to the NHSI Temporary Staffing submission mid-month which may result in minor differences between reported data.

We recognise that agency expenditure is significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

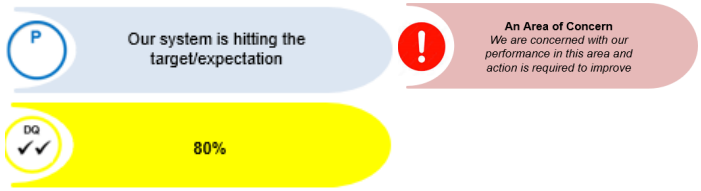
NOTE Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.

26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys 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 overall rating for the trust is a **3** for the period ending 31st July against a planned rating of 3.



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

- The **capital service capacity metric** assesses the level of operating surplus generated, to ensure Trusts can cover all debt repayments due in the reporting period. The Trust has a capital service capacity of -0.39x, which is 0.28x or £0.66m worse plan and is **rated as a 4** (£0.35m worse than plan in June).
- 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 18.5 days; this is behind plan by 3.9 days and is **rated as a 1** (4.2 days behind plan in June).
- The Income and Expenditure **(I&E) margin metric** assesses the level of surplus or deficit against turnover. The Trust has an I&E margin of -3.02%, this is worse than plan by £0.51m and is **rated as 4** (£0.26m behind plan in June)
- **The agency expenditure metric** assesses agency expenditure against a capped target for the Trust. Costs of £7.11m are £0.05m (0.75%) less than plan, and would be **rated as a 1.** (The agency metric assesses performance against plan) NHS planning guidance suggested that providers agency expenditure should be no more than 3.7% of their pay bill, as at M4 the agency expenditure was 5.5% of pay.

Specifically for agency please refer to **25a) Financial Plan: Agency expenditure compared to agency target & 25b) Agency price cap compliance**

The Trust's financial performance results in an **overall UORR** of **3** for the period ending 31st July and **is in line with plan.**

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

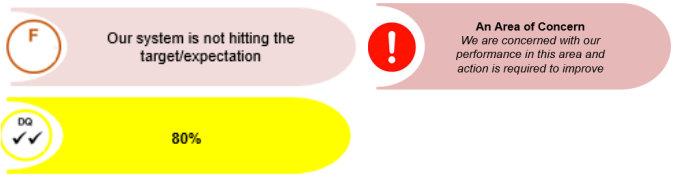
27) CRES Performance - Recurrent

Tees, Esk and Wear Valleys NHS 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 **£3.47m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£1.78m**.

£1.69m deficit to plan.



Summary

The Trust planned to deliver **£3.47m** recurrent Cash-Releasing Efficiency Savings (CRES) to July 2023 but delivered **£1.78m** resulting in **under performance of £1.69m**. Following the submission of our financial plan, which includes £15.5m recurrent CRES, key areas of focus are:

- Individual scheme baseline assessment by Care Group, including actions to support delivery.
- 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.

Recurrent CRES delivery for the year is behind plan at Month 4 with specific performance noted as:

- £0.59m under-delivery of CRES for OAPs Reduction in AMH (Performance Improvement Plan in place)
- £0.56m under-delivery of CRES for Surge post review (Pay)
- £0.15m CRES for Agency (Inpatient level loading of rosters – actions in train via sub group of safer staffing group)
- £0.11m CRES for Taxi spend reduction (Improvement Event and associated actions being progressed)
- £0.36m CRES for other schemes
- Recurrent CRES Unachieved £1.77m to date mitigated in part by:
- £0.08m CRES delivered (unplanned) Pay Review
- Composite recurrent CRES **under delivery** to M4 of **£1.69m**.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
We need to deliver CRES schemes to achieve our financial plan	*Please refer to progress for measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit*	Performance Improvement Plans in place for Agency and OAPs cost reductions. Improvement Event progressed for Taxis. Non recurrent mitigations identified to mitigate in-year slippage.	OAPs reduced from 21 (peak) to 9 currently. £0.08m recurrent CRES mitigation Measure 27.

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 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 **£0.18m** of non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£1.40m**.

(£1.22m) surplus to plan.

Summary

The Trust planned to deliver **£0.18m** non-recurrent Cash-Releasing Efficiency Savings (CRES) to July 2023 but delivered **£1.40m** resulting in **over performance of (£1.22m)**. The Trust planned to deliver non-recurrent Cash-Releasing Efficiency Savings (CRES) of **£5.38m** for the year with key areas of focus being:

- Individual scheme baseline assessment by Care Group and Directorate, including actions to support delivery.
- 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.

Non-Recurrent CRES delivery for the year is ahead of plan at Month 4 relating to:

- £0.57m Interest Receivable
- £0.83m Non Recurrent Grip & Control (Non Pay)

Unplanned CRES delivery of (£1.40m) offset by planned under-delivery of CRES:

- £0.18m Non Rec Grip & Control Trust wide Recovery Actions / budget rebasing (Non Pay)

Composite non-recurrent CRES **over delivery** to M4 of **(£1.22m).**

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

29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys 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 July was **£2.79m** against allocation of **£5.71m** resulting in a **£2.92m** underspend against allocation.

Summary

Capital expenditure at the end of July was £2.79m, and is **£2.92m below** allocated costs of £5.71m.

There are several favourable and adverse variances to allocation; however, year to date slippage of £2.92m is mainly linked to previously anticipated costs of 2023/24 schemes which completed in the 2022/23 financial year and reprofiling of the implementation plan for additional assistive technologies. The Trust is forecasting to outturn in line with plan at the end of the financial year.

Any delays to planned schemes are communicated to the Environmental Risk Group to manage any associated risks.

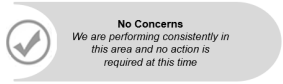
30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS Foundation Trust

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 **£69.92m** against a planned year to date cash balance of **£68.91m.**

£1.01m higher than plan.



Summary

Cash balances were **£69.92m** at 31st July 2023, which is £1.01m higher than planned **£68.91m** balance**.** This is mainly due to slippage on the capital programme and higher interest received than planned.

The Trust did not achieve the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment of Non NHS suppliers, but has met the target for NHS suppliers, achieving a combined BPPC of 94.4%. We continue to support the use of Cardea to make processes as efficient as possible, and ensure suppliers are paid promptly.

The value of debt outstanding at 31st July 2023 was £3.55m, with debts exceeding 90 days amounting to £0.85m (excluding amounts being paid via instalments and PIPS loan repayments).

Four whole government accounting organisations account for 68% of total debts greater than 90 days old (£0.58m), progress continues to be made to receive payment for older debts.

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Please refer to progress for measure – 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit			

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	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_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 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?

NHS
Tees, Esk and Wear Valleys
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_25a	Financial Plan: Agency expenditure compared to agency target			
BIPD_25b	Agency price cap compliance			
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?

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Measures		1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Staff Retention	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 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?

Tees, Esk and Wear Valleys NHS Foundation Trust

Measures		1. Recruitment and Retention	2. Demand	3. Involvement and Engagement	4. Experience	5. Staff Retention	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_25a	Financial Plan: Agency expenditure compared to agency target									√		√				√
BIPD_25b	Agency price cap compliance									√		√				√
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)									√		√	√			√

Chapter 2

Mental Health Priorities including National Quality Standards

Mental Health Priorities including National Quality Standards

Tees, Esk and Wear Valleys NHS Foundation Trust

There are 6 National Quality Standards for 2023/24 and 4 Mental Health priorities for which we have agreed local plans for delivery. Of the Mental Health Priorities, one measure is monitored at Trust level with the remainder (3) monitored at ICB sub location.

Mental Health Priorities

Our performance against the Trust level plans are provided in the table below.

Mental Health Contract Trust Standards	Agreed Standard for 2023/24	Q1 (Apr - May)	Q2
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	Q1 334 Q2 246 Q3 153 Q4 60 (North East & North Cumbria only)	1608	1275

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

The remaining 6 National Quality Standards and 3 Mental Health priorities are monitored at Sub-ICB Location (S-ICBLs) level. Whilst the National Quality Standards have nationally applied targets, the Trust has agreed trajectories for the Mental Health priorities with our commissioning S-ICBLs, agreeing to improved trajectories where there was either 2022/23 investment that had not fully worked through into improved performance or where quality improvement work held out the prospect of increased performance.

There are several areas that are at risk of achieving the national quality standards or local priority trajectories; these are outlined in the following pages, with accompanying narrative by exception. As part of the new Accountability Framework, we have developed **Performance Improvement Plans** for a number of measures that have consistently failed to achieve the national standard or commissioning plan. These plans define the actions that are being taken to support improvement and increased assurance.

There are 23 actions currently included within the plans; of those 19 are due to be completed by the end of September 2023, of which 9 have been completed.

Actions completed to improve our National Quality Standards include:

- The establishment of a standard DNA (Did Not Attend) process within our Durham & Tees Valley Childrens Eating Disorders Teams to facilitate effective and timely discharge.
- The development of a standard operating procedure within our Durham & Tees Valley Childrens Eating Disorder Service to ensure that any young person requiring psychoeducation, is provided this immediately.

Actions completed to improve our Local Quality Priorities completed include:

- Team huddles have been converted into additional appointment slots within our Durham & Darlington Single Point of Access Team with a view to increasing access rates to Talking Therapies.
- The use of the new Choose & Book system within Durham & Darlington Talking Therapies has been reviewed, with a view to reducing the number of patients that do not attend their appointment.
- A training plan has been developed within our Durham & Darlington Talking Therapies Services, which utilises Step 3 vacancies to employ Interpersonal Therapy and Eye movement desensitization and reprocessing (EMDR) trained therapists, to reduce our in-treatment waits.
- North Yorkshire & York Talking Therapies have rebranded their marketing material with a view to improving access rates, and have released videos promoting the service on Trust social media.

County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **3** national quality standards at risk of delivery for quarter 2 (**2** at risk for the financial year) and **2** local priorities at risk of delivery for quarter 2 (**3** for the financial year).

NATIONAL QUALITY REQUIREMENTS				
Measure	Agreed S-ICBL Ambition	Q1	Q2 July	FYTD
Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care	60%	63.64%	51.85%	60.22%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	83.82%	84.85%	84.85%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	75.86%	75.00%	75.00%

LOCAL QUALITY REQUIREMENTS				
Measure	Agreed S-ICBL Ambition	Q1	Q2 July	FYTD
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 12448 Monthly 1037	2662	1092	3754
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	13.92%	11.35%	13.24%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	19.81%	27.98%	22.71%

County Durham Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

Percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait less than two weeks to start a NICE-recommended package of care

Current Focus	Current Improvement Action(s)	Progress Update	Actual Impact
Staff shortages and changes to patient assessors and administration staff within our North Durham Early Intervention in Psychosis (EIP) team have been experienced, which have impacted on the number of patients waiting less than 2 weeks to start a NICE-recommended package of care.	Team Manager to implement a plan to manage the assessment process, including timely monitoring of the patient tracker list, by the end of July 23 with a view to improving the timeliness of patients entering treatment.	**Complete.** Process in place to review the tracker 3 times weekly and a visual flow chart is being developed for staff as a prompt around completion timeframes.	No change to date; improvement expected to be visible by the end of September 2023.

Tees Valley Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **2** national quality standards at risk of delivery for quarter 2 and the financial year, and **2** local priorities at risk of delivery for quarter 2 (**3** for the financial year).

NATIONAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 July**	**FYTD**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	91.01%	93.02%	93.02%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	50.00%	60.00%	60.00%

LOCAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 July**	**FYTD**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 2260 Monthly 188	557	206	763
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	19.76%	20.77%	20.04%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	25.33%	21.03%	23.71%

There are **2** national quality standards and **4** local priorities at risk of delivery for quarter 2 and the financial year.

NATIONAL QUALITY REQUIREMENTS				
Measure	Agreed S-ICBL Ambition	Q1	Q2 July	FYTD
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	80.00%	80.00%	80.00%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	87.50%	88.89%	88.89%

LOCAL QUALITY REQUIREMENTS				
Measure	Agreed S-ICBL Ambition	Q1	Q2 July	FYTD
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 8627 Monthly 719	1723	607	2330
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	17.66%	17.63%	17.65%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	36.55%	31.85%	34.68%
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 71 Q2 142 Q3 213 Q4 284	78	88	88

Vale of York Sub-ICB Location

Tees, Esk and Wear Valleys NHS Foundation Trust

There are **2** national quality standards and **4** local priorities at risk of delivery for quarter 2 and the financial year.

NATIONAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 July**	**FYTD**
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	79.66%	82.46%	82.46%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	71.43%	71.43%	71.43%

LOCAL QUALITY REQUIREMENTS				
Measure	**Agreed S-ICBL Ambition**	**Q1**	**Q2 July**	**FYTD**
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	Annual 7096 Monthly 591	1493	520	2013
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	30.88%	34.09%	31.75%
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	28.99%	23.44%	27.05%
Number of women accessing specialist community PMH services in the reporting period (cumulative)	Q1 60 Q2 120 Q3 180 Q4 240	37	43	43

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For General Release

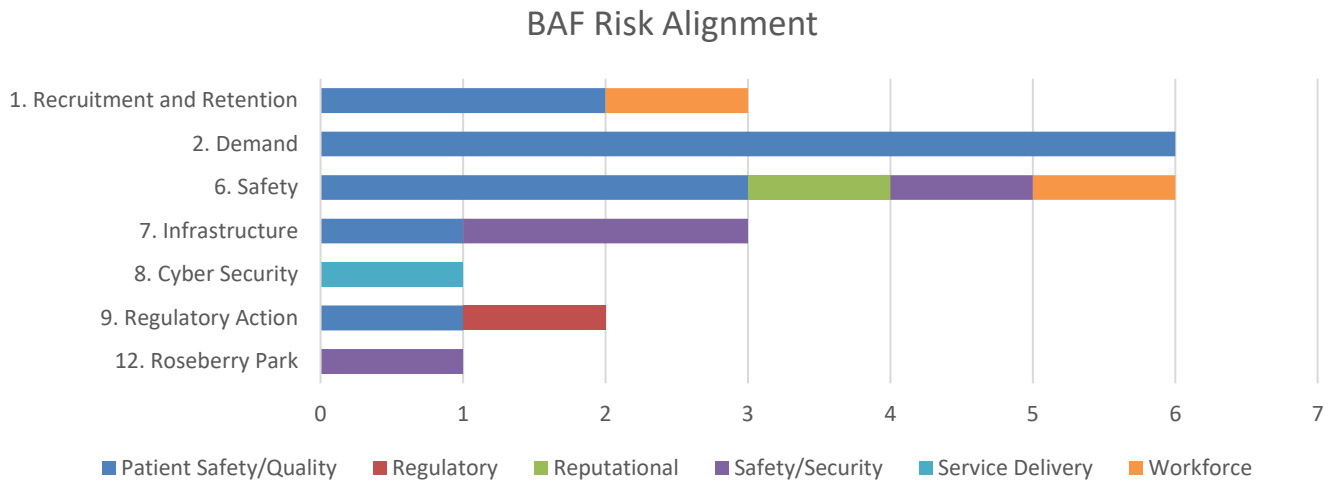
Meeting of:	Board of Directors
Date:	14th September 2023
Title:	Corporate Risk Register
Executive Sponsor(s):	Beverley Murphy, Chief Nurse
Author(s):	Kendra Marley, Head of Risk Management

Report for:				
	Assurance	✓	Decision	
	Consultation		Information	✓

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

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

Strategic Risks relating to this report:



Executive Summary:

Purpose: To ensure the Board has oversight of organisational wide risks that are rated as high risk in the Corporate Risk Register.

For Board consideration to determine level of assurance it can take regarding the risk management processes.

Overview: This paper presents to the Board the risks that are rated ≥15 on the Corporate Risk Register as of 1st September 2023.

There are currently 22 risks on the Corporate Risk Register.

3 risks were added following review at the Executive Risk Group In July 2023.

- Risk 1310 – DTVF – CAMHS – Risk of prolonged admission/stay to/in inappropriate settings due to shortage of CAMHS national tier 4 beds nationally (16)
- Risk 1419 – DTVF – SIS – Risk that we may need to establish more enhanced care areas due to increased clinical need (16)
- Risk 1487 – NYYS – Adults – There is an increased risk of ligatures in bedrooms for patients on Esk Ward due to the weight of the replacement Kingsway doors

3 risks on the register have also reduced below the =>15 threshold and will be consider by the Executive Risk Group in September for removal from the register.

- Risk 1120 – DTVF – LD - Risk - There is a risk that patient safety and quality of care will be compromised due to an increased usage of bank and agency staff across both ALD inpatient sites. This results from high levels of patient acuity and complexity which can only be managed by a higher staffing ratio which include familiar and trained staff. (12)
- Risk 1304 – DTVF – MHSOP - Risk - AMH Tees Liaison Risk - Delays in MHA being completed in a timely manner along with a suitable bed being identified for admissions poses a risk to the patient safety and is impacting on level of recorded incidents in the ED department. Risk also to relationship and reputation of TEWV. (12)
- Risk 11427 – Medical – Pharmacy - Risk - The is a risk of compromised patient safety, due to reduced capacity within the pharmacy leadership team, resulting in; reduced service management, reduced governance, reduced response times, reduced oversight. (12)

Prior Consideration and Feedback

All risks are considered at service level governance.

All risks are considered by the Care Group Risk Group/ Directorate.

The Trust Executive Risk Group consider all risks rated as ≥15.

Implications:

Risks may impact on the delivery of individual services, patient safety and quality of care, and overall impact the achievement of the Trust strategic aims and objectives.

Recommendations:

The Board is asked to:

- Review the risks and actions and consider if the risk management sufficient.
- Determine level of assurance it can take regarding the risk management processes.

MEETING OF:	**Board of Directors**
DATE:	**14th September 2023**
TITLE:	**Corporate Risk Register**

1. Introduction and Purpose

To ensure the Board has timely information to enable oversight of those high risks that potentially have an organisational wide impact reflected in the Corporate Risk Register.

The Corporate Risk Register is reviewed and approved by the Executive Risk Group. This paper presents to the Board the ≥15 risks on the Corporate Risk Register as of 1st September 2023.

2. Background Information and Context

The Trusts Organisational Risk Management Policy was approved by the Board in July 2022 and sets out the responsibilities of the Trust Board.

- Responsible for ensuring the Trust has effective systems for managing risk.
- Receipt of the Corporate Risk Register for consideration.

3. Purpose of the Corporate Risk Register

The Corporate Risk Register should be reflective of the highest risks affecting the organisation in the delivery of its objectives. It should also enable the Board to easily understand the highest risks that they need to be aware of.

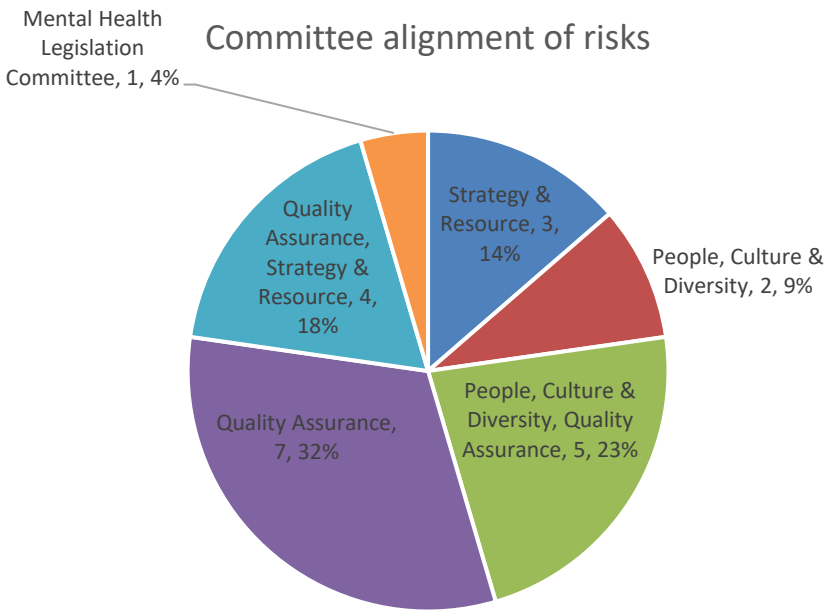
4. Current Corporate Risk Register

As of 1st September 2023, there were a total of 22 risks on the Corporate Risk Register. These form the main register that is reported to the Board and Committees.

The Executive Risk Group last reviewed and approved additions and removals in July 2023. There has been 1 removal, risk 1289, from DTVF relating to Service delivery in HMP Hull and HMP Humber This had been reduced below the ≥15 threshold as progress had been made in reducing waiting times. 3 additions were also made following the July meeting;

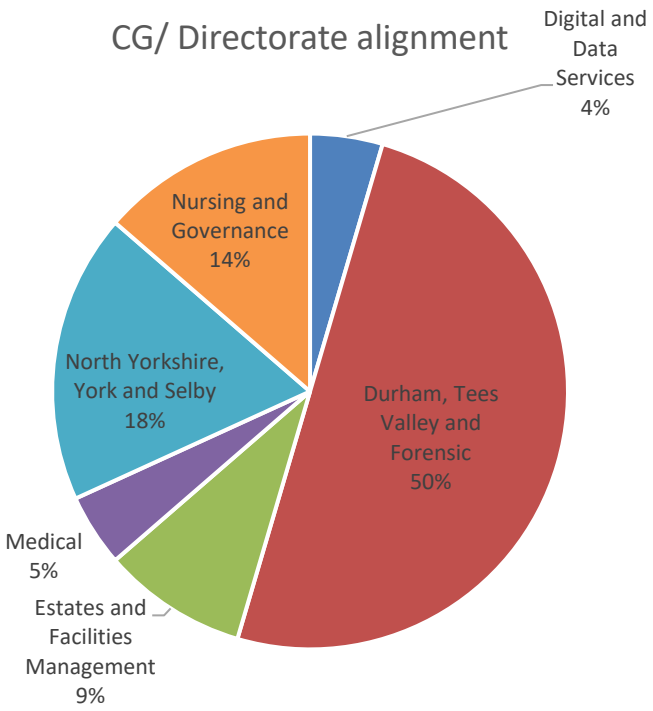
- Risk 1310 – DTVF – CAMHS – Risk of prolonged admission/stay to/in inappropriate settings due to shortage of CAMHS national tier 4 beds nationally (16)
- Risk 1419 – DTVF – SIS – Risk that we may need to establish more enhanced care areas due to increased clinical need (16)
- Risk 1487 – NYYS – Adults – There is an increased risk of ligatures in bedrooms for patients on Esk Ward due to the weight of the replacement Kingsway doors. (16)

The current risks on the register align to the main Board Committees as shown in the following chart. It should be noted that they may align to more than one Committee.



This shows that there are;

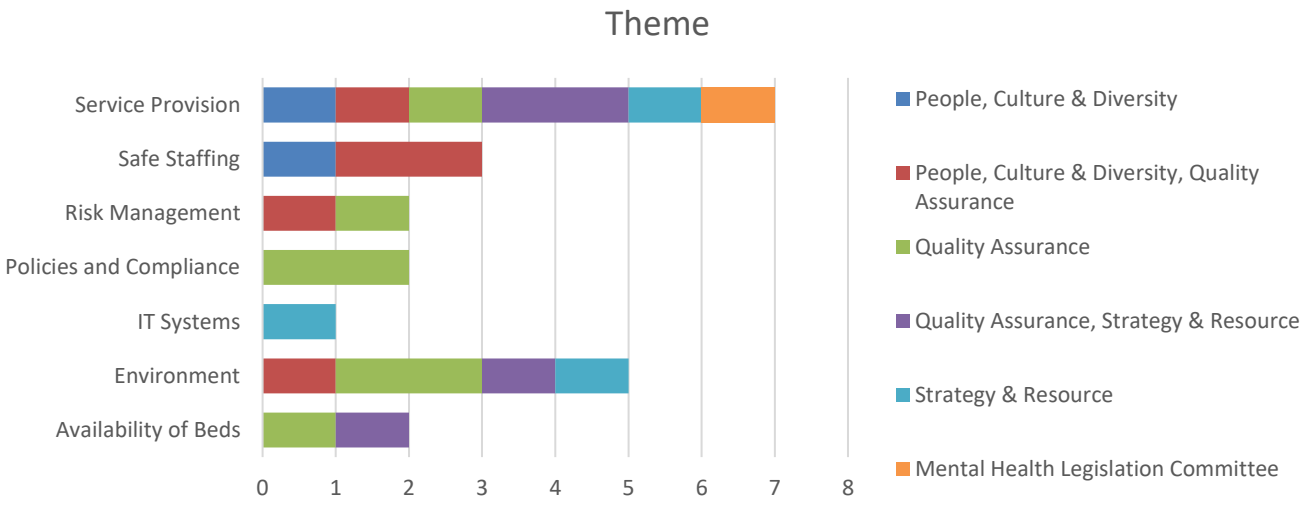
- 16 risks that align to the Quality Assurance Committee (increase of 3), 4 of which also align to Strategy and Resource, and 4 to People, Culture and Diversity, making up over 50% of risk on the Corporate Risk Register.
- 7 risks align to the Strategy and Resource Committee (increase of 2), 4 of which also align to Quality Assurance.
- 7 risks align to the People, Culture and Diversity Committee (increase of 1), 4 of which also align to Quality Assurance.
- 1 risk that aligns to Mental Health Legislation Committee.



Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 50% of the current Corporate Risk Register is made up of risks from Durham Tees Valley and Forensics Care Group, with 18% North Yorkshire York & Selby Care Group and Corporate Directorates making up the other 34%.

4.1 Risk Themes

The 22 risks fall under the following themes within the Committee Alignment.



4.2 Risk Movements

The Executive Risk Group reviewed ≥15 risks and the risks already on the Corporate Risk Register in July 2023, agreeing additions and removals.

Additions

The Executive Risk Group reviewed and approved the following 3 additions in July 2023.

Risk	Committee Alignment	Date Identified	Locality & Service	Risk	IRR	CRR	TRR
1310	Quality Assurance, Strategy & Resource	Identified - 16/09/22 Last reviewed - 04/07/23 Next review due - 31/08/23	Durham, Tees Valley and Forensic - DTV&F Child and YP -	There is a significant shortage of CAMHS tier 4 beds nationally. This is placing significant pressure on the CNTW bed management system - nearest inpatient unit is Ferndene. The pressure is across all bed types but is particularly acute with regards to young people with eating disorders in County Durham. This is resulting in increased risk of prolonged admission/stay to/in inappropriate settings with insufficient care arrangements including: adult mental health beds, 136 suites, crisis assessment suites, paediatric inpatient beds and police custody.	20	16	6
1419	Quality Assurance, People,	Identified - 02/02/23 Last	Durham, Tees Valley and	It is a risk that in response to clinical need the service may be required to establish more enhanced care areas (ECAs) within the existing environment and resource. The Ridgeway estate	20	16	4

Risk	Committee Alignment	Date Identified	Locality & Service	Risk	IRR	CRR	TRR
	Culture & Diversity	reviewed - 13/07/23 Next review due - 17/08/23	Forensic - Secure Inpatient Service (SIS) -	is not suitable for this even with considerable rectification, it also offers limited opportunity for step down. Any enhanced care areas requires additional staff outwith the established budgeted MDT workforce. It is also a risk that the patients experience and quality of care is impacted by the level of restriction.			
1487	Quality Assurance, Strategy & Resource	Identified - 03/04/23 Last reviewed - 28/06/23 Next review due - 31/07/23	North Yorkshire, York and Selby - NYY&S Adults -	There is an increased risk of ligatures in bedrooms for patients on Esk Ward due to the weight of the replacement Kingsway doors which can't be fully used as intended, resulting patients being placed on additional restrictive interventions impacting their wellbeing and dignity.	25	16	4

Reduced Risks

Three risks on the register have been reduced below the =>15 threshold. These will be review at September's Executive Risk Group and their removal from this register approved.

Risk 1120 – DTVF – LD - Risk - There is a risk that patient safety and quality of care will be compromised due to an increased usage of bank and agency staff across both ALD inpatient sites. This results from high levels of patient acuity and complexity which can only be managed by a higher staffing ratio which include familiar and trained staff. (12)

Risk 1304 – DTVF – MHSOP - Risk - AMH Tees Liaison Risk - Delays in MHA being completed in a timely manner along with a suitable bed being identified for admissions poses a risk to the patient safety and is impacting on level of recorded incidents in the ED department. Risk also to relationship and reputation of TEWV. (12)

Risk 11427 – Medical – Pharmacy - Risk - The is a risk of compromised patient safety, due to reduced capacity within the pharmacy leadership team, resulting in; reduced service management, reduced governance, reduced response times, reduced oversight. (12)

4.3 Risk and Action Review Compliance

The policy includes appendices that outline the process in more detail, including the timing of risk review. This is shown below:

Risk Level	Review Frequency
15 or above	Monthly
12	Bi-Monthly
8 to 10	Quarterly

Of the risks on the Corporate Risk Register at 1st September 2023, 5 of the 22 are overdue review, indicating that review compliance is 77%. Review compliance has ranged from 100% to 63% at monthly assessments.

5. Risks and Mitigations

Timely risk and action review is not consistent and we have not maintained progress made early in 2023.

There are two actions underway/proposed to address this in the medium/ longer term;

- A reliable and consistent 'reminder' process -
    - This will be addressed by the design and implementation of the new risk system, InPhase, which will enable reminder notifications and escalation where they go unaddressed. (Due for implementation September 2023).
- Improved individual and local processes -
    - The improved reminder process will also be a significant help to risk owners, managers and actions owners to aid with routine individual management.
    - Although we can evidence that risks are discussed and reviewed in governance meetings there is a lag in updating these on the register. Development of the new system will encourage the use of the dashboard reports in local meetings and direct updating of risks, reflection of the discussion and any queries that may arise. The target date for implementation is 31st December 2023.
    - Local staff involved in risk registers to undertake system training delivered from September 2023.

6. Conclusions

The current Corporate Risk Register as at 1st September 2023 is provided and there are 3 new additions and 3 reductions shown.

Review timeliness and update on the system for Corporate Risk Register risks has fluctuated in the period, system and process changes are hoped to aid further improvement.

7. Recommendations

The Trust Board are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Determine the level of assurance that there is active management of risk.

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Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Strategy & Resource	12. Roseberry Park	Regulation	295	Identified - 08/09/16 Last reviewed - 12/06/23 Next review due - 28/07/23	Estates and Facilities Management - Estates -	Owner - Liz Romaniak - Manager - Simon Adamson	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	15	MIST system now installed into roof voids of all in patient areas to safeguard and reduce fire load and spread of flame until rectification works complete. Block 16 (decant) construction now complete. Phase 1 practical completion achieved, commissioning underway (blocks 5 & 10). Week. Phase 2 programming and procurement options are in train.	Weekly huddles take place to oversee progress of rectification works. RPH sub-group of the board convened as needed to oversee progress with regular CEO briefings to the board.	Agreed programme of works which resolve all the defects in the design and construction of Roseberry Park Hospital. Unknown quantum and type of defects in individual occupied blocks.	15	Achieve contract resolution to the satisfaction of the Trust Gain commitment to the programme of work to address fire stopping issues across the whole site Gain commitment to the programme of works, where possible to be co-ordinated with fire stopping works, to resolve 19 outstanding construction defects requiring mitigation Agreement of recourse to legal processes should commitment to works and commercial settlement not be appropriate Review of Capitec (independent consultants) report Full condition survey of Roseberry Park Establish facilities management special purpose vehicle Determine most appropriate route to defect rectification (complete phase 1 and identify phase 2 programme).	30/06/2023 31/12/2016 31/12/2016 31/12/2016 31/12/2016 30/04/2017 28/11/2017 12/07/2023	Simon Adamson Brent Kilmurray Brent Kilmurray Brent Kilmurray Brent Kilmurray Brent Kilmurray Brent Kilmurray Simon Adamson	 31/01/2017 31/01/2017 31/01/2017 31/01/2017 02/01/2018 28/11/2017	10
Quality Assurance	7. Infrastructure	Quality & Safety	903	Identified - 01/06/20 Last reviewed - 30/06/23 Next review due - 28/07/23	Estates and Facilities Management - Estates -	Owner - Simon Adamson - Manager - Simon Adamson	There is a risk that patients may attempt suicide using potential ligature points within clinical areas across the organisation, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation. The Trusts ligature data suggests that the highest self harm risks to patients is in their own bedroom environment and recent serious incidents have highlighted bedroom doors as a specific risk	20	Suicide Prevention and Environmental Risk Assessment Procedure Supportive Engagement and Observation Policy and practice Harm Minimisation Policy (Risk Assessment and Management) Environmental Risk Group Care Rounds assistive technology in some areas (door sensors) Oxehealth (extension of installation on further wards agreed) Significant investment in staffing MDT Report Out Ward 'drills' ensuring all staff aware of ward environmental/ligature risks and individual patient risks Individual Safety Summaries Team Risk Logs Estates Work Log System Capital Work Programme Capital Investments Group Capital Planning Group Harm Minimisation Training Programme Safety summary and safety plan patient documentation and guides for staff Monthly review of ligature incidents at environmental risk group and actions taken Sharing learning with staff around ligatures through patient safety bulletins, webinars, ward handovers Monthly reporting to the Quality Assurance and Improvement Group Contractual meetings with contractors to monitor the	1.Harm minimisation training show high levels of compliance. 2.Suicide prevention survey and risk assessment procedure log demonstrates that the majority of individual teams have been reviewing their surveys and they include risk mitigation. 3.Responded and compliance with NPSA ligature alert released in March 2020 and the ESA low lying ligature alert released in 2019. 4.Remedial action taken within 24hr by PFI providers following near miss incidents being identified. 5.Ligature Programme of works is reviewed at the Environmental Risk Group. 6.Phase one of the ligature works programme completed 2021/22 at a cost of £2.8m. 7.Phase 2 programme of ligature reduction works have been agreed and finances allocated in 2022/23 capital plan. Evaluation of Oxehealth shows that a high % of staff feel it	Known risks within clinical services have been assessed and mitigating actions are in place. However, there remains the possibility that patients may create ligatures without an anchor point which could cause severe harm and or unexpected death. Limitations have been identified in relation to detailed knowledge of all ligature points amongst some staff. CQC inspections of Acute AMH and PICU wards undertaken in January 2021 highlighted gaps in relation to risk assessment documentation and management. Assistive technology such as Oxehealth and Door sensors is not available on all wards. Recent patient safety serious incidents have taken place with ligatures over bedroom doors	15	Complete phase 1 of the ligature reduction programme of estates works to remove exsiting ligature points particularly in en-suites Undertake a clinical audit to gain assurance from clinical areas regarding the awareness and appropriate management of ligature risks. Estates to undertake a review of ward/department environmental risk logs to determine if recently identified risks within the clinical area have been logged within estates for action. A standard specification for each speciality to be developed in regards to anti-ligature equipment. Put in place a system of procurement to ensure clinical services order goods from a pre-approved list. Agree phase 2 of the ligature reduction programme (this will focus on bedroom doors) Implement phase 2 of the ligature reduction programme Roll out of Oxehealth technology to be extended for additional Inpatient Wards across the trust. Roll out of the Body Camera pilot to additional inpatient wards Phase 3 delivery	31/07/2021 17/06/2020 31/08/2020 31/03/2022 31/03/2022 31/03/2022 31/07/2023 31/07/2023 31/10/2021 31/07/2024	Simon Adamson Elizabeth Moody Simon Adamson Elizabeth Moody Elizabeth Moody Paul Foxton Simon Adamson Elizabeth Moody Elizabeth Moody Simon Adamson	29/11/2021 03/03/2021 03/03/2021 11/08/2022 21/09/2022 07/03/2022 29/11/2021	10

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Strategy & Resource	8. Cyber Security	Regulation	952	Identified - 10/06/20 Last reviewed - 25/07/23 Next review due - 28/08/23	Digital and Data Services - IT& Systems -	Owner - Chris Reynolds - Manager - Steven Forster	Cause: IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical controls, audit and assurance. Event: Cyber attack on Trust Impact: Trust is not able to identify, isolate and rectify the source of attack to prevent loss of data and or access to trust systems	25	Microsoft Defender Endpoint Manager is a tool which can manage a number of alerts being able to both identify and isolate devices. The tool has proven invaluable in identifying incidents and potential cyber breaches.	There is a Cyber Security Group setup to monitor Cyber security and risks. Alerts are provided by CAN to TEWV along with monthly reports from NHSD. A quarterly Cyber Board Assurance Framework update is submitted to report on current progress.	-The Trust has adopted a cyber strategy but has limited maturity which has been highlighted in a number of areas. -Technical deficit grows year on year as digital technologies and threats advance. -No Network Detection and response system in place to understand if cyber attack/infection occur across the network. -There are limited security tools for monitoring and providing higher levels of observability. A consequence of this means breaches could go undetected for months or years while malicious individuals could potentially be operating with the network. The Technical teams are making some use of the national Microsoft Defender for Endpoint tenancy and score in the top 20% of equivalent size NHS Trusts/bodies when comparing secure score (A risk assessment of computers across the estate in relation to patching). -Penetration testing/Vulnerability assessments are carried out annually. Requires automated approach to enable	20	Develop and implement cyber strategy Confirm funding and advise on impact of less funding Purchase Cyber Software Hire staff	28/02/2023 28/05/2023 25/10/2023 25/11/2023	Chris Reynolds Chris Reynolds Steven Forster Steven Forster	21/03/2023 25/05/2023	12
People, Culture & Diversity	Recruitme nt and retention	People	1001	Identified - 20/10/20 Last reviewed - 09/08/23 Next review due - 11/09/23	North Yorkshire, York and Selby - NYY&S Management -	Owner - Tolulope Olusoga - Manager - Tolulope Olusoga	There is a risk due to difficulties in recruitment to vacant posts in the consultant workforce across NYYS due to local and national shortages, resulting in the potential impact on; safe care delivery, teaching and training of junior staff and students, OOH on call rota, research, existing staff morale and wellbeing, finances.	20	Mitigation is all via locums and mind the gaps though there are increasing pressures with the mind the gap arrangements. Promoting the Trust at Royal College of Psychiatrists events, Trust recruitment event in London and York in January 2022 and Feb 2022. The Trust has also recently completed a recruitment programme internationally recruiting 11 doctors who have commenced the process of relocation to the UK likely due in late spring 2023. Trust-organised Leadership Programme for Aspiring New Consultants in 2022. Actively reaching out to colleagues and existing networks promoting TEWV. Redesigning job descriptions to be more flexible to support LTFT colleagues. Participate in teaching sessions to higher trainees in Yorkshire Deanery promoting benefits of working in TEWV. Regular touch points to engage with existing medical workforce to support retention (bimonthly visits to bases/local meetings – impacted by Covid but alternative arrangements via MS Teams) and ensure leadership visibility. Ensuring our consultant trainers maintain capacity to train core trainees and higher trainees (to ensure supply route into consultant posts). Addressing place based service issues to improve attractiveness of locations/teams as a good place to work. Engaging with local high schools via careers events promoting psychiatry and TEWV. Developing well being programmes to support retention of medical staff including flexible working and remote working and work-life balance.	Expressions of interest in posts through promotion of TEWV and engagement with trainees through teaching. Reduction of costs for agency through monthly budget reports Monitoring staff wellbeing through sickness levels of medical staff. We have recruited 2 new substantive consultants in the last 12months. Monitor long-term sickness absence Exit interviews to understand why people leave.	At the time the risk was identified, there were 12.5 WTE vacant Consultant posts (out of 63 total across AMH, MHSOP, CAMHS and LD services), covered by 11 agency locum medical staff in addition to our local staff mind the gap arrangements. It results in an annual agency spend in excess of 1.4 million pounds. Failure to recruit to these vacancies will pose further significant risks to Trust reputation from impact on safe care delivery and will make it more difficult to attract and recruit new staff. We need to identify and implement recruitment options to attract medical staff to NYY eg use of recruitment premium, recruitment of doctors from overseas, review sessional job plans to support working across the locality, implement a middle grade on call rota, propose additional SpR posts. Develop skills across other professions such as non-medical ACs and Physician Associates	16	Recruiting CESR/SAS doctors from overseas Develop non-medic colleague skills to ensure consistent service delivery Sessional job plans to support working across the locality (utilising technology where possible) Explore and encourage group job planning to increase flexibility of the workforce supporting interests of the consultant workforce Putting in place a middle grade oncall rota to support medical staff retention proposal to get approval for 8 additional funded Higher Trainee posts (SpRs) in NYY to increase number of front line clinicians and improve pipeline for consultant posts Approval for the use of recruitment premium	09/02/2022 28/02/2024 09/02/2022 31/07/2024 31/07/2024 09/02/2023 01/10/2020	Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga Dr Tolulope Olusoga	07/04/2022 07/04/2022 09/08/2023 10/12/2021	9

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Strategy & Resource	9. Regulatory Action	Regulation	1017	Identified - 21/10/20 Last reviewed - 16/08/23 Next review due - 29/09/23	Durham, Tees Valley and Forensic - DTV&F Learning Disabilities Services -	Owner - Jamie Todd - Manager - John Savage	In 2019, a CQC inspection identified that the only two units in the trust that offer adult respite provision (BFC Unit 2 and Aysgarth) do not meet Mixed Sex Accommodation (MSA) guidance and we were issued with an action to comply. The layout of the buildings presented challenges and both buildings are in poor repair. As an interim measure, the service adapted how clients were allocated respite stays but this meant we have been unable to meet our contractual requirements. Families are passionate and extremely vocal about the need for the service and some feel strongly that this should be NHS-led. The future of the service is highly political - historically, complaints have triggered a Secretary of State review and issues have been highlighted by local councillors. There is a risk that any proposed changes will reignite concerns from families, carers and other	20	Revised service model in place offering family a reduction in nights. Project group for respite services established in 2020 and meets regularly, aiming to establish an estates solution for existing service users and a secondary goal of establishing a future clinical model for new referrals. CCG involved in project group and receive regular reports and reviews re plans for an estate solution.	As above. 22/12/20 presented to LMGB. No MSA breaches as COVID 19 restrictions remain in place however this reduces occupancy to below normal service provision. 26/1/20 no MSA breaches reported. Carer concerns re service provision to provided to monitor effectiveness of controls 23/2/21 Continue to operate at reduced capacity no MSA accommodation breaches. 23/3/21 continue to operate at reduced capacity therefore no MSA breach, no formal complaints received, informal concerns raised b carers as to the continued lack of resolution. 27/4/21 Reviewed at LMGB continue to operate at reduced capacity therefore 0 MSA Breaches 0 complaints Regular meetings with Carer Rep to manage and contain anxieties/concerns.	Lack of estates solution to enable the service to increase to pre-covid capacity. lack of assurance that the services are correctly registered with CQC given the nature and type of service in comparison to the registration details.	15	Discussion with CQC re registration of the respite service to be facilitated Review and revise the outreach function to mitigate the risk associated for those service users not being able to access the phsyical health monitoring and interventions as they usually would one to one consultation sessions with families and carers Discuss new service model proposal with the commissioners Paper for SLG describing current CQC registration challenges, estates challenge, actions taken to date and potential future options. Revalidation of the work undertaken in 2020 confirming the impact of the CQC instruction on the delivery of the service due to current accomodation congifuration review the current booking process to ensure current estates and places can be optimised in line with family carer wishes. Review of the estates options appraisal for updating the current buildings to be MSA compliant. review the current IPC arrangements in place for respite and explore if these could be revised to increase service provision now. Update on current position John Savage started in post 15/05 and is arranging to meet with Judith Brown to reinigorate this work	26/02/2021 26/02/2021 11/06/2021 26/02/2021 31/12/2020 18/03/2021 13/05/2022 30/09/2022 30/04/2021 09/01/2023 31/10/2023	Sarah Gill Tracy Whitelock Sarah Gill Dominic Gardner Sarah Gill Sarah Gill Joseph Walker Sarah Gill Tracy Whitelock Sarah Gill John Savage John Savage	18/03/2021 18/03/2021 11/06/2021 18/03/2021 04/01/2021 06/04/2021 26/04/2022 28/02/2023 14/05/2021 28/02/2023 04/07/2023	6
People, Culture & Diversity, Quality Assurance	6. Safety	Quality & Safety	1120	Identified - 29/06/21 Last reviewed - 16/08/23 Next review due - 29/09/23	Durham, Tees Valley and Forensic - DTV&F Learning Disabilities Services -	Owner - Jamie Todd - Manager - Tracy Whitelock	There is a risk that patient safety and quality of care will be compromised due to an increased usage of bank and agency staff across both ALD inpatient sites. This results from high levels of patient acuity and complexity which can only be managed by a higher staffing ratio which include familiar and trained staff.	20	Formal business continuity invoked 29th June 2021 which includes a minimum of daily reporting and action log. safe staffing escalation protocol for inpatients daily staffing reports 3 x per week meetings with the other localities in relation to bed management across LD inpatient and also staffing support. this includes review of DToCs stop admissions that require additional staff to the current numbers development of recruitment plans and step down of other activity to create capacity two packages have identified agency with regular staff is in place. rapid induction plans developed for agency and bank workers	daily business continuity meetings to review action log progress and mitigations for short term, medium term and long term goals health roster Datix reports recently introduced daily staffing calls across the DTV&F care group.		12	additional recruitment review service spec for NYY commisoned beds and explore opportunties for recovering aditional expenditure Alignment of agreed workforce model, health rosters and budgets establish formal process for BC To develop a clear framework that supports coming out of business continuity Developed and implementing s31 action plan Weekly meeting with Commissioners, chaired by ICB, continues Weekly meeting with Commissioners, chaired by ICB, to look at transitions and all options available to this patient nationally Continue to try to reduce patient JH's (BFC) reliance on IM medication as he will not be accepted to his community placement whilst still in receipt of IM Discharge of patient WS from LRH in March 2023 Weekly update to Trust Executive Board Weekly update to CQC Plan to hold a further dedicated recruitment event Mapping of establishments against vacant posts and leavers	30/11/2022 08/04/2022 30/09/2022 30/09/2021 12/07/2021 29/12/2023 28/04/2023 02/06/2023 21/03/2023 30/06/2023 30/06/2023 28/07/2023 28/02/2023	Tracy Whitelock Sarah Gill Sarah Gill Sarah Gill Sarah Gill Sarah Gill Jamie Todd Karla Sharif Karla Sharif Dr Jo Nadkarni Sheila Halpin Sheila Halpin Tracy Whitelock Kathryn Ord	28/02/2023 09/08/2022 03/11/2022 08/10/2021 16/08/2021 09/08/2022 25/04/2023 04/07/2023 25/04/2023 04/07/2023 24/05/2023 24/05/2023 28/02/2023	6

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Quality Assurance	2. Demand	Quality & Safety	1131	Identified - 26/07/21 Last reviewed - 23/08/23 Next review due - 29/09/23	North Yorkshire, York and Selby - NYY&S Management -	Owner - Brian Cranna - Manager - Liz Herring	There is a risk that people will have a long waits for their calls to the NYY&S all age crisis/mental health support line to be answered due due to current staff capacity available to support the volume of calls, resulting in our inability to filter and assess the level of need of each call stream people to the right level of need.	20	Trust wide crisis & urgent response policy Crisis operating standard for a 4hours response for face to face assessment call handling information to reflect % call answered; Number of call handlers required per team	% of call answered each month MHS calls responded to CRT call responded to volume of calls each day - increase to 150 number of vacant posts across the crisis teams	Level of service funding & Workforce capacity to meet demands ability to recruit into vacant posts & availability of temp staffing time lost creating record for each call	16	the requirement for a call handling system, with ability to call record to be in place for NHS 111 mental health selection to maintain current MHS selection on the 0800 line to be able to respond to NHS 111 mental health selection requirements and meet demand to address the staffing gaps to rating the right level of crisis call handlers 24/7 to expand the MHS service capacity to take all calls and screen those that meet the need for crisis triage the introduction of a listening service as part of the NYYS IVR choice to understand the measured impact of the mental health support IVR choice Trust-wide improvement group - call filtering and HAP roles to the line requirement for creating safety summary (SS) & safety plan (SP) for non-crisis calls the alignment of staff resource to meet service demand to increase service capacity through the use of support workers alognside registerd professional to align call to staffed capacity Divert function divert function shared rota across crisis teams potential for link with third sector phome responses to work with NYY ICB regarding additional funding and	29/12/2023 31/05/2023 31/10/2023 31/08/2023 29/09/2023 13/01/2023 31/03/2022 28/02/2023 31/08/2022 30/09/2022 30/09/2021 31/08/2021 31/08/2021 31/08/2021 17/09/2021 30/09/2021 29/09/2023	Rachael Hill Liz Herring Liz Herring Rachael Hill Liz Herring Liz Herring Rachael Hill Liz Herring Andrew Knox Rachael Hill Andrew Knox Andrew Knox Andrew Knox Andrew Knox Andrew Knox Andrew Knox Liz Herring	08/06/2023 24/08/2023 28/12/2022 28/02/2023 28/02/2023 07/09/2022 12/06/2022 05/11/2021 05/11/2021 05/11/2021 25/08/2021 07/12/2021 05/11/2021	6
Quality Assurance	1. Safety	Quality & Safety	1136	Identified - 08/08/22 Last reviewed - 30/06/23 Next review due - 31/07/23	Nursing and Governance - Nursing -	Owner - Lesley Munshi - Manager - Lesley Munshi	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the incident backlog and reduced staffing capacity resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	20	Incident reporting policy and timescales for review. Central approval team of reviewers (1 lead, 4 team reviewers and 2 admin support) Temporary staffing used to mitigate some gaps in team. Training given to those assisting in the review of incidents 2-step process implemented so CG reviewing own incidents in step 1. Assistance obtained from wider N&G Corporate Teams Prioritisation of incidents to ensure those of a more serious nature are reviewed over and above those of low harm.(but miss any categorised incorrectly) Robust scrutiny of all deaths and hot spot areas, EMSA breaches, anchored ligatures. IIC report in place	Weekly monitoring of those incidents that are in the holding area awaiting review to be reported to the Executive Quality Assurance and Improvement Group & Executive Director Group. IIC reports to give services/ CG overview of position. A report has been built within the IIC to view those accessing the Incidents Dashboard. Weekly check audit on stage 1 review and those outside this process. Weekly report to Exec team	Gaps in staffing - vacancies - posts advertised twice, unable to recruit Review of skills and roles in team undertaken and new posts JD going through JD process	15	Recruitment of temporary staffing to assist in the backlog of incidents Recruitment of a B5 Datix Reviewer (permanent) Training to be given to Corporate Staff assisting in the reviewing of incidents Weekly report out at QAIG Datix Incident training (recording and Reporting) to be delivered trust wide SOP to be developed on how to review incident data within the IIC Monitoring of the IIC incident Dashboard Notification of Incidents Expand existing system to include a 2 stage approval process Auditing of those incidents being approved outside of the CAT team The recording and reporting of incidents to be included as mandatory training Communicate trustwide of the inclusion of datix incidents recording and reporting within the mandatory training criteria Review team structure and recruit as required External support being brought in to reduce the backlog	30/11/2021 30/09/2021 30/11/2021 30/11/2021 30/09/2021 30/09/2021 31/12/2022 30/11/2021 30/09/2023 30/11/2021 30/09/2022 30/11/2021 28/07/2023 30/06/2023	Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi Lesley Munshi	08/08/2022 08/08/2022 08/08/2022 08/08/2022 08/08/2022 08/08/2022 28/02/2023 08/08/2022 08/08/2022 08/08/2022 08/08/2022 08/08/2022 01/07/2023	10

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Quality Assurance	7. Infrastructure	Quality & Safety	1223	Identified - 16/02/22 Last reviewed - 30/08/23 Next review due - 29/09/23	Nursing and Governance - Nursing -	Owner - Nurse Carole Rutter - Manager - Nurse Carole Rutter	There is a risk that medical devices may not be available/ or safe to use due to the potential for devices being obsolete, out of date, poor working condition etc. when needed most i.e. emergency situation, resulting in patient harm.	16	Medical device policy clearly states the roles and responsibilities of the wards in relation to medical devices. Central asset register held in the Estates Department National Safety Alerts actioned Medical devices group Medical devices safety Officer appointed 5/12/22	The number of SI's that have a root cause or contributory finding in relation to medical devices. The number of incidents citing medical devices Monitoring of works to be undertaken around medical devices via the medical devices group	The current MD systems do not allow the Trust to fully satisfy its obligations and requirements under CQC Premises and Equipment regulations 2014: Regulation 15, MHRA Managing Medical Devices (2021) or NHS Digital Data Security & Protection (DSP) Toolkit (2022-23). The Excel system (asset log) does not allow for effective Field Safety Notice tracking (an MHRA requirement), manufacturer update tracking and application or Freedom of Information request data provision. It does not have the capability to record Medical Device software revision numbers, or online connectivity status as required by DSP regulations and therefore gives no true lifecycle data for the asset. The current Medical Device Management processes do not allow a centralised oversight of risk management across the Trust and allow several opportunities for bad practice to arise There is no assurance over removal of obsolete equipment from areas Service records on the T drive are not comprehensive No plan for asset aging/replacement, reactionary only	16	All equipment used in two ECT suites to be serviced immediately Appointment of a Medical Devices Safety Officer Re-establishment of the Medical Devices Group with appropriate representation across the trust Undertake a baseline assessment of medical devices stored within operational services to ascertain working condition of device Carry out a review of the current Medical Devices Policy	31/03/2023 30/04/2022 31/03/2023 31/03/2023	Nurse Carole Rutter Nurse Carole Rutter Nurse Carole Rutter Nurse Carole Rutter Nurse Carole Rutter	30/08/2023 24/02/2023 12/08/2022 25/04/2023	3
Quality Assurance, Strategy & Resource	2. Demand	Quality & Safety	1226	Identified - 07/03/22 Last reviewed - 16/08/23 Next review due - 29/09/23	Durham, Tees Valley and Forensic - DTV&F Learning Disabilities Services -	Owner - Patrick Scott - Manager - Jamie Todd	There is a risk that LD patients may not be placed in the best environment to support their care due to a local and national shortage of LD beds, this results from a national reduction in bed availability post Transforming Care, a high level of inpatient acuity (many of whom currently require single-occupancy care), and a lack of community providers to facilitate discharge. resulting in complex patients cared for within temporary ward environments/ inappropriate beds, supported by agency nursing staff and potential adverse patient safety and quality outcomes. This also includes Green Light admissions to AMH and MHSOP beds, including to PICU.	20	Informal escalation arrangements with system partners, both to find beds and gain resources for staffing	Regular meetings with system partners during these situations CE advised	Lack of national and local beds Potential closure of LRH further impacting bed provision Suitable alternative provision	20	Weekly system-wide meetings with ICB taking lead Fortnightly Chief Exec Commissioning meeting from February 2023 Support for discussions with commissioners (esp. Yorkshire) to identify and fund appropriate non-hospital placement New matron supporting staff training, resilience and formulation Architects floor plans signed off for reconfiguration of Ramsey into 3 single occupancy flats Assess and Monitor the temporary staffing usage Investigate suitable alternative provisions Monitor the bed management position within the Trust	29/12/2023 29/12/2023 31/08/2022 31/08/2022 30/12/2022 30/12/2022 31/08/2022 30/12/2022	Jamie Todd Jamie Todd Janet Telford Jemma Hill Janet Telford Sarah Gill Rob Berry Tracy Whitelock	04/07/2023 04/07/2023 08/11/2022 08/11/2022 27/02/2023 08/11/2022 08/11/2022 08/11/2022	20
People, Culture & Diversity	6. Safety	Quality & Safety	1229	Identified - 22/03/22 Last reviewed - 30/08/23 Next review due - 06/10/23	Durham, Tees Valley and Forensic - DTV&F Management -	Owner - Elspeth Devanney - Manager - Sharon Salvin	Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. Current system unable to provide assurance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered.	15	Supervision compliance monitoring spreadsheets Supervision Policy Clinical Supervision Kaizen event outputs Brief situational reflection	Monthly supervision compliance monitoring at overall specialty level with exception reporting of teams below 70%	Monitoring of supervision compliance as part of routine performance reporting Single unified system of monitoring due to difficulties with Foundry and potential additional systems being introduced to bridge gap Loss of knowledge and standard process from original Kaizen	15	All ward team managers to be using the same clinical supervision recording system Routine performance monitoring of clinical supervision compliance to take place within all specialities LMGB to be provided with a monthly specialty position in relation to clinical supervision compliance and exceptions of teams/wards below 70% compliance Outputs of clinical supervision kaizen event to be reviewed and plan to restablish process to be completed Awaiting update in relation the supervision app to ensure visibility of compliance Escalation of communication issues regarding current supervision recording processes	27/10/2023 09/06/2023 31/08/2022 31/05/2022 09/06/2023 03/03/2023	Elspeth Devanney Elspeth Devanney Elspeth Devanney Sharon Salvin Elspeth Devanney Elspeth Devanney	 30/01/2023 15/03/2023 30/08/2023 15/03/2023	9

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Quality Assurance	2. Demand	Quality & Safety	1238	Identified - 19/05/22 Last reviewed - 17/08/23 Next review due - 21/09/23	North Yorkshire, York and Selby - NYY&S MHSOP -	Owner - Bridget Lentell - Manager - Bridget Lentell	There is a risk to being able to provide quality of care and patient experience for North Yorkshire & York patients need admission due to admission of out of locality and out of specialty patients into NYY MHSOP beds. There is high demand from out of locality and out of specialty, variable control process across the trust, resulting in increased work and pressure on teams, communication difficulties with community teams, increased LOS, impact on patients and families for visiting.	15	Matrons screening and gatekeeping during the day to ensure admissions are safe, and asking for assurance that risk assessments have been complete. 1045 sitrep - identify current situation and flow with bed managers. 30, 60, 90 day process implemented across 4 wards. Strategic S177, TOC lead for NYYS (fixed term) takes the lead on liaising with Local Authorities for OOA patients. Fortnightly meeting with Service manager in DTV to look at repatriation.	Risk assessment for each inpatient admission.	None	15	DTOC/S117 lead nurse post is contacting OOA local authorities os they are part f the NY S117 process to try and enable earlier discharges Bed Oversight group led by Kedar Kale with 100 day challenge to reduce length of stay. Review daily in sitrep and bed capacity call feeding into bed oversight meeting Bed management policy event 7 December	16/03/2023 16/02/2023 27/10/2022 09/12/2022	Emma Williams Kedar Kale Bridget Lentell Rachel Hogarth	20/04/2023 16/02/2023 20/10/2022 14/12/2022	9
Quality Assurance	6. Safety	Quality & Safety	1257	Identified - 25/04/22 Last reviewed - 09/08/23 Next review due - 13/09/23	Durham, Tees Valley and Forensic - Secure Inpatient Service (SIS) -	Owner - Naomi Lonergan - Manager - Alison McIntyre	There is a risk that patient care documents do not accurately reflect risks, risk management plans, risk of incidents and risk of harm due to lack of training or understanding, and workload pressure, resulting in potential for patient or staff harm.	20	Quality assurance schedule is in place	- Audit demonstrates that safety summaries and plans are in place and that they effectively identify the appropriate risks and mitigations - Increase in clinical leadership to support quality assurance processes - Validation audits to strengthen quality assurance processes - Audits and risk management plans - Quality assurance schedule	Need to identify the roles of the SDM and PDPs in this process Quality assurance schedule is self assessed instead of peer review	16	Taking into account the improvement work already undertaken, ensure that the Trust wide work in relation to safety summaries and plans is embedded and consideration of further quality improvement work Produce a CITO training plan in conjunction with IT to enable CITO rollout PDPs to roll out a service-level induction	12/10/2023 01/06/2023 04/05/2023	Richard Hand Jane Keenan John Savage	 03/05/2023 04/05/2023	4
Mental Health Legislation Committee	6. Safety	Quality & Safety	1304	Identified - 01/07/22 Last reviewed - 05/07/23 Next review due - 05/09/23	Durham, Tees Valley and Forensic - DTV&F MHSOP -	Owner - Thomas Hurst - Manager - Judith Ann Brown	AMH Tees Liaison Risk - Delays in MHA being completed in a timely manner along with a suitable bed being identified for admissions poses a risk to the patient safety and is impacting on level of recorded incidents in the ED department. Risk also to relationship and reputation of TEWV.	20	Acute trust has added delays to the risk register for monitoring. TEWV Daily bed management huddles in place. Liaison to attend P&Qs and V&A task and finish group within the acute trust. Training offered on MHA/DOLs. EDT central log now in place recorded at daily sitrep.	Regular meetings with ED - to maintain positive relationship General manager to oversee log and meet with EDT to look at improving relationship and response. Feedback on training offered. Trust-wide bed management on going work.	EDT sits within social care outside of TEWV.	12	EDT delays	13/01/2023	Thomas Hurst	03/04/2023	6
Quality Assurance, Strategy & Resource	2. Demand	Quality & Safety	1310	Identified - 16/09/22 Last reviewed - 17/08/23 Next review due - 29/09/23	Durham, Tees Valley and Forensic - DTV&F Child and YP -	Owner - Jamie Todd - Manager - James Graham	There is a significant shortage of CAMHS tier 4 beds nationally. This is placing significant pressure on the CNTW bed management system - nearest inpt unit is Ferndene. The pressure is across all bed types but is particularly acute with regards to young people with eating disorders in County Durham. This is resulting in increased risk of prolonged admission/stay to/in inappropriate settings with insufficient care arrangements including: adult mental health beds, 136 suites, crisis assessment suites, paediatric inpatient beds and police custody.	20	To note: Mitigations relate to ED beds as this is the area where we face delays in admissions - Ferndene (nearest inpt unit - have 4 ED beds. Effective links and relationships with CNTW bed management and North and South Tees acute trusts. SLA for Paediatric input into Tees CEDS. Effective crisis and IHT practices and further developments (YIPP). Working groups and strategic alliance between TEWV and CDDFT; looking at pathways, alternatives to admission, increasing community-based eating disorders interventions, avoidable admissions, improved environment, training, supervision and joint working practices. This work is at an early stage as of September 2022. SLA with CDDFT now also in place to cover current practice.	CDDFT performance reports and progress with joint workplan are shared at the CDDFT/TEWV MH alliance board. Inpatient bed use, blockages, DTOC's, and daily bed management issues are monitored jointly between TEWV and CNTWW at daily huddles and monthly provider collaborative meetings.	Limited dietetic input within CDDFT. Inconsistent arrangements for facilitating NG feeding in the community. Need for feedback and planning meeting between TEWW CNTW case managers and ICB and NHSE case manager	16	Community NG feeding CDDFT/TEWV joint workplan Working on SLA with CDDFT for dietetics provision	30/09/2022 29/09/2023 29/09/2023	Tracy Storey Michelle Trainer James Graham	03/11/2022	6

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
Quality Assurance, Strategy & Resource	2. Demand	Quality & Safety	1311	Identified - 01/04/21 Last reviewed - 17/08/23 Next review due - 29/09/23	Durham, Tees Valley and Forensic - DTV&F Child and YP -	Owner - Jamie Todd - Manager - James Graham	There is a risk that young people being referred for specialist neurodevelopmental assessment face unacceptable waits for commencement and conclusion. This is due to a significant increase in referral demand post-pandemic and exacerbated by the backlogs created during the national lockdowns; resulting in a dissatisfactory experience for families, complaints, knock on effect of long waits for diagnosis-specific support, & reputational damage for TEWV.	20	Openness and transparency of position and issues with all key stakeholders. Improvement plan, codeveloped with key stakeholders including patients/carers, to try to reduce demands on pathway. Commissioning of needs-led autism or 'suspected autism' support services to meet need while families are waiting for assessments. Any co-existing mental health needs are picked up by separate CAMHS teams who are performing well in relation to waits for assessment and treatment. Keeping in Touch process in place Working with Commissioners on an options appraisal for recovery.	Performance reports monitored at monthly partnership forums and improvement and delivery groups.	Demand far outstrips capacity currently. Teams are delivering the expected number of assessments as was originally commissioned. Recruitment challenges with regards to new and existing posts. Plan to pull an action plan together with the ICB which allows ongoing risk to be monitored.	15	Completion of multi agency improvement plan - see T drive for full plan Options appraisal paper being drafted to agree next steps SDF investment	29/09/2023 29/09/2023 29/09/2023	Mita Saha Mita Saha James Graham		8
People, Culture & Diversity, Quality Assurance	9. Regulatory Action	Regulation	1324	Identified - 01/04/22 Last reviewed - 17/08/23 Next review due - 29/09/23	Durham, Tees Valley and Forensic - DTV&F Child and YP -	Owner - Jamie Todd - Manager - James Graham	There is a risk that some children and families in North and South Durham will be subjected to unacceptable waits for mental health assessment and treatment, caused by significant staffing pressures in those teams (particular issues with medic, nursing and psychology workforce) in addition to lack of alternatives in community provision, resulting in patient deterioration/risk, patient dissatisfaction, complaints and reputational damage and potential CQC breaches.	20	Keeping in touch process. Overtime is being offered. Caseload deep dive to free up team capacity. Alternative roles being recruited to and agency utilised. BCP invoked and recovery action plan in place.	Waiters dashboard (assessment and treatment) in IIC monitored through improvement and delivery groups and reported to care group board.	Some team functions are role specific and effect of controls are limited. Lack of alternatives in community provision in Durham area. unable to recruit into some vacant posts. retention of current staffing	15	Progress all actions in relation to the CQC s29 action plan - see T drive for plan Continue to progress against Recovery Plan actions We are invoking the BCP and developing a recovery plan Capacity and demand review Waiters data validation	28/04/2023 29/12/2023 29/09/2023 28/04/2023 28/04/2023	James Graham Gillian Leckenby Gillian Leckenby James Graham James Graham	25/04/2023 19/06/2023 25/04/2023 25/04/2023	6
People, Culture & Diversity, Quality Assurance	16. Safety	Quality & Safety	1371	Identified - 17/11/22 Last reviewed - 31/08/23 Next review due - 27/09/23	Durham, Tees Valley and Forensic - DTV&F Adults -	Owner - Thomas Hurst - Manager - Sarah Kuster	Due to the length of time current level 2 positive and safe training takes staff away from clinical work, there is a risk that compliance continues to reduce across the service which may also result in reduced ability to respond correctly to incidents.	20	Booking onto training going forward from July 2023 Performance Framework	Oversight on training booked Weekly monitoring of compliance. Monitor incident trends 9th Feb-23 overall Level 2 compliance is currently at 17% which is a reduction on previous months. No incidents have been raised as an impact of this risk. 8th Mar-23 overall level 2 compliance is currently is at 25% which is a slight increase on last month. 31st Aug-23: Current IIC data shows compliance at 44% for level 2 update which is an increase since last risk review.	Lack of available training dates for staff to book onto training.	20	Service manager will liaise with RPH inpatients service manager regarding bespoke training options and dates Escalation to General Manager for further escalation and discussion with People and Culture group Update requried from People and Culture Directorate in relation to availability of PAS level 2 training courses Liaison with Urgent Care General Manager regarding updates on training proposal to allow service to consider trajectory moving forwards.	31/03/2023 28/02/2023 31/05/2023 13/01/2023	RMN Sarah Kuster RMN Sarah Kuster Thomas Hurst RMN Sarah Kuster	24/05/2023 08/03/2023 05/07/2023 08/03/2023	9

Committee / Group Alignment	BAF Link	Theme	ID	Dates	Location	Ownership	Description	Rating (initial)	What mitigating controls already in place	Assurances to monitor effectiveness of controls	Details of gaps in controls	Rating (current)	Description	Due date	Person Responsible	Done date	Rating (Target)
People, Culture & Diversity, Quality Assurance	2. Demand	Quality & Safety	1419	Identified - 02/02/23 Last reviewed - 09/08/23 Next review due - 13/09/23	Durham, Tees Valley and Forensic - Secure Inpatient Service (SIS) -	Owner - Naomi Lonergan - Manager - Richard Hand	It is a risk that in response to clinical need the service may be required to establish more enhanced care areas (ECAs) within the existing environment and resource. The Ridgeway estate is not suitable for this even with considerable rectification, it also offers limited opportunity for step down. Any enhanced care areas requires additional staff outwith the established budgeted MDT workforce. It is also a risk that the patients experience and quality of care is impacted by the level of restriction.	20	North East North Cumbria (NENC) Provider Collaborative bed management process we will explore access to the CNTW ECAs. Oversight of impact of restrictions and shared learning / best practice cross specialty in this area, including use of ECA areas within the speciality positive and safe group from which concerns or issues are escalated via the appropriate governance group to Care Group Board.	Within the medium secure male CNTW planned estate there is provision for purpose built ECA accommodation	The Cedar development is delayed until at least mid September 2023. It is unknown at this point whether or not there will be sufficient workforce to open the ECAs. Also, the dedicated ECA provision in Boothall is not commissioned as yet.	16	Through the bed management process, explore access to the medium secure male ECAs at Cedar Review of current ECAs within Ridgeway Clinical review of patient records Review of discharge/transfer pathways for 2 patients in ECA	14/09/2023 05/04/2023 14/09/2023 12/10/2023	Richard Hand Naomi Lonergan Naomi Lonergan Naomi Lonergan	13/06/2023	4
People, Culture & Diversity, Quality Assurance	1. Recruitment and Retention	Quality & Safety	1427	Identified - 26/01/23 Last reviewed - 06/08/23 Next review due - 02/10/23	Medical - Pharmacy -	Owner - Christopher Williams - Manager - Christopher Williams	The is a risk of compromised patient safety, due to reduced capacity within the pharmacy leadership team, resulting in; reduced service management, reduced governance, reduced response times, reduced oversight.	16	The structure of the pharmacy leadership team at baseline is less than it should be to manage the size of the directorate. This was identified in the organisational restructure. The structure should have the Chief Pharmacist, 2 deputy chief pharmacists, 4 lead pharmacists, a lead medicines management nurse and 7 lead pharmacy technicians.	Proactive service planning and management. Compliance with mandatory training and appraisals. Sickness / absence levels in the team.	1 lead pharmacist is on maternity leave. 1 lead pharmacist has just joined the team so is under a period of induction. Another of the lead pharmacists is heading up the EPMA project which further reduces leadership capacity.	12	Manage return from LTS Lead Pharmacst CDD to start Create capacity with MSO Appoint Chief Pharmacy Techncian Appoint Acting Lead Pharmacist (D&D)	06/04/2023 02/05/2023 01/04/2023 01/02/2023 01/02/2023	Christopher Williams Christopher Williams Christopher Williams Christopher Williams Christopher Williams	10/05/2023 10/05/2023 10/05/2023 10/05/2023 10/05/2023	4
Quality Assurance	1. Recruitment and Retention	Quality & Safety	1429	Identified - 27/01/23 Last reviewed - 30/06/23 Next review due - 28/07/23	Nursing and Governance - Nursing and Quality -	Owner - Avril Lowery - Manager - Avril Lowery	There is a risk of delays in reviewing serious incidents due to ongoing backlog and low staffing resulting in avoidable hard to service users and staff, delayed or lost learning, poor patient or carer experience and resultant phycological harm.	20	Proactive Delays - Processes outlined in SI policy, including review timescale Staff levels to support - Agreed staff cohort Reactive patient/ carer experience - communication plan, correspondence	Delays - reporting data on total SIs, allocated, unallocated, new SI's, no of S's reviewed at DP, and review timescales achieved. Weekly report on new SI's (detail) to CG PSM/ EDG. Current assurance - Negative - confirming that review timescales not being achieved, backlog not reducing Staff levels to support - monitoring of staff vacancies/ sickness/ wellbeing Current assurance - Negative - gaps in team (see gaps in controls) Patient/ carer experience - monitoring of PALs, complaints, feedback to patient safety team. current assurance - moderate - not a persistent level of complaints	Staff levels to support - understaffed with outstanding vacancies, team sickness patient/ carer experience - communication plan, correspondence - due to low staffing and lack of FLO	16	Recruit cohort of staff FLO recruitment NECS staff external support for backlog Root and Branch review - external support appointed Root and branch review to be completed Patient Safety Specialist Post - to be recruited Patient Safety Modern Matron Post - to be recruited	31/07/2023 30/04/2023 31/05/2023 31/05/2023 31/07/2023 30/09/2023 30/09/2023	Amy Taylor Amy Taylor Avril Lowery Avril Lowery Avril Lowery Avril Lowery Avril Lowery	31/05/2023 31/05/2023 31/05/2023	8
Quality Assurance, Strategy & Resource	7. Infrastructure	Quality & Safety	1487	Identified - 03/04/23 Last reviewed - 23/08/23 Next review due - 29/09/23	North Yorkshire, York and Selby - NYY&S Adults -	Owner - Liz Herring - Manager - Nicky Scott	There is an increased risk of ligatures in bedrooms for patients on Esk Ward due to the weight of the replacement Kingsway doors which can't be fully used as intended, resulting patients being placed on additional restrictive interventions impacting their wellbeing and dignity.	25	Harm minimisation policy Environmental risk survey Observation and engagement policy PiPA process	Patient safety related ligature incidents Incidents related to room access Levels of observations and engagement Patients reporting not feeling safe PALS and Complaints adverse alarm sounding reported as incidents	Ward safety process to reflective environmental risk changes Safety drill for the ward Individual patient safety planning to mitigate risk Changes to the operability of the Kingsway doors & site response to alarm management of the Kingsway doors unable to roll out doors to Danby ward	16	To resolve the operability of the Kingsway doors & use of alarms by the wards Ward safety drills to be amended Safety planning for patients on the ward environmental risk survey to be updated	29/09/2023 31/08/2023 29/09/2023 31/05/2023	Nicky Scott Lee Bradley Lee Bradley Lee Bradley	25/08/2023 20/06/2023	4

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14th September 2023**
Title:	**Winter Planning 2023/2024**
Executive Sponsor(s):	**Patrick Scott, Managing Director, DTVF** **Zoe Campbell, Managing Director, NYY**
Author(s):	**Lorna Moore, Business Manager, DTVF**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***

Executive Summary:

Purpose: The aim of this report is to provide an insight into the DTVF and NYY Care Groups position and to seek assurance measured against the standards and suggested requirements set down in the NHS (2023/2024) "Delivering operational resilience across the NHS this winter" report and to appraise the Board of the actions and potential mitigations in place where any standards are not met.

Proposal: This report provides assurance that controls are in place within DTVF and NYY Care Group to maintain delivery of services and that where standards cannot be maintained, appropriate escalation and mitigation is in place to ensure consistency to deliver by ensuring interventions are in place.

Overview: The NHS continues to experience significant levels of pressure and recognising the importance of planning for multiple scenarios, NHS are asking systems to identify how they will mobilise additional capacity across all parts of the NHS should it be required to respond to peaks in demand driven by external factors eg, very high rates of influenza or COVID-19, potential further industrial action.

Trust board members are collectively responsible for workforce planning, practice and safeguards. Whilst the actuality of winter pressures is more significantly experienced in the acute medical

and ambulance services, the principles of the NHS (2023) paper remain of equal importance regarding pressures seen in the Trust. As such the Trust needs to be assured that systems and controls are in place for managing and supporting services in the delivery of care for patients and identify any gaps which need further attention. A robust programme of workforce scenario-based resilience testing will be concluded by the end of October and reviewed within EQUAIG

Prior Consideration and Feedback: Paper was reviewed at Exec Directors Group on 6th September 2023, feedback received and incorporated within this paper.

Implications: There are no implications identified. Assurance is offered to lead and support the delivery of high-impact interventions 3, 4 and 9 across mental health provider pathways as described on page 13 of 'Working together to deliver a resilient winter' in Appendix B.

Recommendations: For the Trust Board to confirm the level of assurance as reasonable.

For the Trust Board to review and comment on the report and agree any further actions or potential mitigations needed where the standards are not met in support of the above decision.

The Trust Board to consider any additional scrutiny of resilience plans required at board or committee level.

Appendix 1

Detail	Lead	Controls - DTVF	Controls - NYY	Further Action Needed	Issues currently escalated	Ongoing monitoring/review
Ensure plans are in place so that individuals know how to access mental health services with access to effective assessment and help in a timely manner and that crisis alternatives are in place to help reduce reliance on A&E (recognising that A&E is still an appropriate way of seeking help and people presenting with mental health issues also may have urgent physical health care needs). This should include making reasonable adjustments to pathways and therapeutic interventions for people with a learning disability and autistic people who seek mental health support.	DTV F - Tom Hurst/Claire Farley NYY - Liz Herring / Bridget Lentell	Maintenance of alternative to crisis/hospital initiatives. These include: Tees: Together in a Crisis (ETMH) providing practical support to address issues impacting their MH – expanded from IHT to Crisis/Assessment Pilot of co-located drug and alcohol support service with CAS Walk in provision available for all Tees Service Users as alternative to presenting through ED's Pilot of c-located urgent care services out of hours between Liaison, AMH and CAMHS Crisis. Allowing for more flexible response to areas of greater demand (including acute hospitals) and to support resilience of workforce out of hours when they are likely to feel more isolated. D+D: Pioneering Care Partnership Community Pop up Hubs – offering signposting to appropriate MH support services, targeting areas with high deprivation and high referrals to crisis. Together in a crisis also working into D+D Hub DTV-Wide: Staffing – All services using safe staffing escalation procedures and daily lean management to respond to periods of	Staffing – All services using safe staffing escalation procedures and regular management / clinical review to respond to periods of surge or adversity. Core services prioritised include crisis, treatment and psychiatric liaison to prevent admission or facilitate alternatives to admission, alongside maintaining staffing levels within inpatient areas. Working with communications colleagues to ensure people in NYYS have information about sources of support and how to access services when in crisis. Website and social media to be updated when new model is launched. Support available to teams from the Trustwide Autism Team on an individual case basis to support reasonable adjustments to pathways and interventions. **NYYS MHSOP wide:** First Contact Mental Health Practitioners located in several PCN's across NYYS offering a Primary care level of access to mental health assessment with support to access other services according to need. Positive approaches to care training provided to care home staff to support them to be more resilient and prevent unnecessary	D&D Service redesign implementation – plans to disaggregate team into two place-based crisis teams, aim to improve responsiveness to very urgent assessments and integrate more consistently into local system. DTV Wide 111(2) crisis access projects. All service users should be able to access support in a crisis through 111. Local project group in place, working with ICB and NEAS to aim for a Q4 implementation of new screening team, expected to release capacity from all age crisis teams and improve response times. NYY Improving all age crisis line offer through working in partnership with VCSE. Expected improvement to call answer rates with new model of service delivery being implemented prior to linking into NHS 111 option All calls will be routed through the mental		York and Selby MHSOP Pilot of CMHT physical health lead joining the MDT of the city of York frailty hub weekly to help reduce anticipated crisis. Pilot of Community Hub working in partnership with Local Authority and Third Sector ensuring people are signposted effectively.

		surge or adversity and ensure core assessment and IHT offer can be maintained. Communications – working with the internal comms teams team to reiterate crisis offers locally and how to access these – rolling comms. Crisis line support project – working across specialty to bolster capacity on the AMH crisis line. Additional resource is being allocated from CAMHS and MHSOP to support with screening calls until 111(2) team in place DTV-wide listening service in situ – some additional roles being appointed into to improve call answer rate, also exploring flexible use of local resource to bolster lines during periods of high demand	admissions. All age Crisis Team across NYYS All Age Crisis Line Provision Across all services, during core working hours, urgent and crisis contacts with patients are committed to being completed by the Service providing primary involvement with an individual before additional requests for support from other services is requested Staffing – All services using safe staffing escalation procedures and daily lean management to respond to periods of surge or adversity and ensure core assessment and IHT offer can be maintained. Communication with GP's around provision of Crisis Line contact information to any person referred to mental health services (supporting waiting well approach). **<u>York and Selby:</u>** **<u>MHSOP</u>** Care Home and Dementia Team in York supporting care homes with individuals in crisis. Positive approaches to care training provided to care home staff to support them to be more resilient and prevent unnecessary admissions. Liaison team signpost to the Haven and Community hub to reduce	health support line with escalation in line with national guidance to crisis clinicians where this is appropriate. It is anticipated this will improve access and people's experience of contact the all age crisis line.		

			people representing in A&E **<u>Scarborough Whitby & Ryedale MHSOP</u>** All CMHT and Memory Team offer support to Care Homes as part of standard offer with increased support available for people in crisis and/or at risk of admission. Scarborough Survivors are contracted to provide an A&E Support Worker service. Support Workers offer interim contact and support to people with mental health needs whilst waiting in the A&E Department. The Scarborough Acute Hospital Liaison Service work closely with Scarborough Survivors staff to ensure that people are offered ongoing help by the right service. **<u>Harrogate, Hambleton and Richmondshire:</u>** **<u>MHSOP</u>** In Harrogate there is a dedicated Crisis Team for older people (Monday to Sunday, but not nights) who work to prevent unnecessary admissions and support timely discharges. The H&R CMHT operates a 7-day service and will provide intensive support to patients at home/in care homes as an alternative to mental			

			health inpatient admission.			
Where individuals do seek help for mental health issues via A&E, ensure processes are in place for assessment and onward support, including adjustments to meet the needs of autistic people and people with a learning disability. Ensure there are clear escalation processes for A&E where there is considerable delay in receiving specialist support.	DTVF - Tom Hurst/Judith Brown and Emma Scarr NYY – Bridget Lentell/ Liz Herring	• All Liaison services across DTV are complaint with core 24 standards, work 24 hours and have clearly defined pathways and assessment frameworks. • Assessment pathways and training support making adjustment for people with Autism and LD • Escalation processes are in place through Service Management (in-hours) and tactical and strategic on-call out of hours.	• All Liaison services across NYYS where there is an A&E are complaint with core 24 standards, work 24 hours and have clearly defined pathways and assessment frameworks. • Greenlight processes are in place • Escalation processes are in place through Service Management (in-hours) and tactical and strategic on-call out of hours. • Business Continuity Plan for Liaison Services across NYYS to provide cover for triage and assessment where extenuating staffing issues impacting service delivery arise during peak times (night shifts where just x 1 staff member is on shift). • Assessment pathways and training support making adjustment for people with Autism and Learning Disability. • Support available to teams from the Trustwide Autism Team on an individual case basis to support reasonable adjustments to pathways and interventions. • Escalation processes are in place through Service Management (in-hours) and tactical and strategic on-call out of hours.	DTV Liaison teams are exploring the possibility of introducing face to face triage similar to crisis services. This may improve capacity within the team to respond to urgent referrals. First stage is to understand any implications relating to Core 24 standards and then make recommendation to clinical networks and QAIG's		DTV Plans to co-locate urgent care services in Tees (as a pilot) is expected to improve response times out of hours to urgent referrals from ED's – pilot will be reviewed and possible extended into D+D dependant on findings. Trust plans to refresh greenlight procedure in Oct 23 with support of clinical networks in the context of new guidance. Recommendations will be actioned accordingly.
Mental health, learning disability and autism services should ensure maximum uptake of	DTVF Richard Morris	As in previous years, the Trust will offer seasonal influenza vaccinations and Covid-19 booster vaccinations to all frontline staff and eligible inpatients in line with national guidance for the 2023-24 immunisation programme				

vaccinations for their populations, both inpatient and community. This is vital given the high incidence of COPD and other co-existing long-term conditions such as diabetes which can compromise response to flu and Covid-19.	NYY Brian Cranna	Patients using Trust services in the community who are eligible for seasonal influenza and Covid-19 booster vaccinations will be directed to their GP, community pharmacy or other provider to access these vaccinations (they will not be provided directly by the Trust) Our Health Facilitation Team/Enhanced Physical Health Team support our Adult Learning Disability client group to attend their local GP practices for any required vaccinations. This can include bespoke arrangements to meet individual client needs. Flu and Vaccination Champions are appointed with local clinics booked for staff to attend.				
Ensure tools are in place to understand demand, activity, workforce and capacity in mental health provider pathways. This should be shared across the system to give a comprehensive view of mental health pressures and where support may be required that could alleviate pressure on both mental health and UEC pathways.	DTVF - Tom Hurst NYY - Bridget Lentell / Liz Herring / Mel Woodcock	Local demand and activity monitoring in place, supported by dashboards and IIC and reviewed as part of daily lean management and monthly governance processes. Activity reports developed by LADB's and supported by information and additional narrative from service. Senior Manager attendance at LADB's and system pressures calls	Local demand and activity monitoring in place, supported by data reporting and reported through local and trust governance processes. Patient flow and capacity calls daily across trust including staffing pressures. Service level escalation calls ensuring minimum staffing levels maintained and mitigating actions identified where required. Daily monitoring and authorisation regarding out of area placements and current pressures across MH system nationally. Attendance at local system monitoring calls and urgent escalation calls with partners. MHSOP – Daily workload and resource management in place across teams (Report Outs, Ward Safety Drills, Huddles and MDT's). Daily staffing review and escalation process supported by HealthRoster			

			and SafeCare on inpatient units. Local demand and activity monitoring in place, supported by dashboards and IIC and reviewed as part of daily lean management and monthly governance processes. Safe Staffing Protocol in place Trustwide. Care Group Business Manager attends OPEL Meetings with Acute Trust and Social Care and escalates local issues to Service Managers. High Intensity User Group (HIUG) meetings in place chaired by Ambulance Service and including local key partners.			
Ensure access to emergency housing funds to enable discharge of patients with no fixed abode (NFA) to ensure that they can be supported with follow up crisis / community care and support. – Partnership lead	John Stamp/Jo Murray	Individuals who are homeless are referred to the local authority housing scheme under the duty to refer. Where individuals cannot be housed through this process, other options are progressed through the Mental Health Hospital Discharge team and other partners. All processes for follow up care, crisis support etc would apply in the same way as for the rest of the population	Local arrangements in place with local authority colleagues to support access to housing support and registration of those who are homeless to ensure support is in place to facilitate discharge from hospital.			
Lead delivery of actions from the NHS Long Term Plan and Delivery Plan for Recovering Urgent and Emergency Care Services that support winter pressures, particularly: 1. Strengthen ambulance response to	DTVF - Tom Hurst/Helen Embleton NYY - Liz Herring / Bridget	1.Working with ICB, NEAS and CNTW to review options available to expand support offers through ambulance EOC. RPIW has taken place and will explore options to progress following 111(2) team implementations. 2.Bed occupancy reduction plan and PIP in place to improve patient flow. Planned deep dive with North Tees LA's and NTUH for September 23, recommendations to be actioned accordingly. ICB supporting	1.Working with YAS around the soft launch of the mental health response vehicle, and effective interaction with crisis services, alternative to crisis services and places of safety. Continued provision of Mental Health Clinicians within the force control room to support police officers where mental health concerns have been identified and facilitate appropriate access to services.			NYY MHSOP - Weekly DTOC call in place with Lead Practitioner S117 and Community Care, Wards, Local Authority and Continuing Healthcare. 30, 60, 90 day check

mental health by deploying multidisciplinary professionals to support 999 mental health demand and preparing for the rollout of mental health response vehicles. 2. Optimising flow through mental health inpatient settings through system-wide focus on reducing delayed discharges and avoidably long length of stay in mental health inpatient settings. Work collaboratively with social care and other system partners who play a key role in timely discharge. 3. Continuing to raise profile of all-age 24/7 urgent mental health helplines and other complementary crisis support services – including those for people with a learning disability and autistic people, such as intensive support	Lentell / Mel Woodcock	discussions with system partners to support roll out of recommendations. 3.See first section of action plan. 4.Project group in place to implement 111(2) screening team – planned implementation Q4	Monthly right care, right person group in place with all agencies working together to support appropriate mental health response. 2.Urgent and Emergency Care Pathway Project in place pulling together existing internal work around improving patient flow. Second stage of the project is to work with partners including those who use services to identify good practice, challenges and gaps in provision across crisis, alternatives to admission, inpatient admission and discharge. The first meeting is planned for October. Daily monitoring of patient flow in place including out of area bed use and current / expected demand. Current escalation processes in place and operating well where delayed transfers of care occur to seek solutions for the most appropriate ongoing care and support upon discharge. 3.See reference to all age crisis line above. 4.Project group in place to implement NHS 111, option 2, service in place for test connection in September 2023 with further development of the telephony system in coming months to improve call handling, reporting and introduce additional functionality going forward to meet NHS 111 specifications.			and challenge meetings in place and to be attended by Community Service Manager to give objective challenge. MHSOP Wards implementing outreach support interventions to complex patients testing placements as part of discharge pathway; this intervention has been evidenced to increase the likelihood of successful placement and hospital discharge.

teams, ensuring delivery of 4. NHS 111 'select mental health option' and working towards crisis text line implementation.						
Supporting children and young people with mental health needs in acute paediatric settings by adopting the new integration framework for systems to support children and young people with mental health needs within acute paediatric settings, and to take up NHS England (Workforce, Training and Education directorate) commissioned CYP crisis telephone training to support crisis mental healthcare staff.	DTVF - James Graham NYY - Mel Woodcock,	Any non-recurrent funds could be used on additional staffing through agency to support YP in beds with complex MH needs; to minimise pull on paediatric staff and the impact on other YP care. Could also be used to supply a stock of 'self sooth' boxes to help support any YP with MH needs in a paediatric bed. We have worked with CDDFT, our acute provider who we have the highest demand with (in terms of YP with MH needs in their care), to benchmark our joint practice against the integration framework. This has formed the baseline/basis for our wider work plan on this agenda. Actions include: 1. SLA between organisations to help facilitate joint working practices for YP with eating disorders in acute beds. 2. Provision of in-reach support by community eating disorders and crisis/IHT teams onto paediatric wards. 3. Agreement of escalation procedures when challenges and delayed transfers of care arise. The crisis training has been made available to all TEWV CAMHS crisis staff.	24 / 7 access to crisis services for children and young and young people, accessed through planned intervention with existing community services and / or through the all age crisis line. Increase in capacity of children and young person expertise within crisis services currently moving into recruitment stage.			

Maximise the uptake of training on learning disability and autism appropriate to their role, to ensure preparedness to be able to meet the needs of autistic people and people with a learning disability. John Savage	DTVF - John Savage NYY –Mel Woodcock / Bridget Lentell / Liz Herring	The service has an LD presentation on staff induction and the Trust have rolled out the Oliver McGowan (modules on e-learning, soon to be followed by a face-to-face session up to 6 months after they have completed e-learning), Autism training (face to face), Environmental de-escalation (face to face), SPELL (face to face). Awareness raising sessions in Acute Trust during the last 12-months and also in GP practices where space allows (this is ongoing). Also sessions delivered to local University to cohorts of paramedic trainees on LD awareness.	Monitoring in place re uptake of available training regarding autism and learning disabilities across services.	Subject to non-recurrent funding being available, we could develop and deliver a range of bespoke training packages for providers and for other non-LD services to help to understand the needs of complex individuals. We are exploring opportunities with the Education Alliance to extend our training offer into care homes. STOMP – subject to non-recurrent funding being available, we could extend our offer to include more GP practices. Quality of Life Passport – subject to non-recurrent funding being available, we could widen our offer of training to non-LD services and partners.		NYY Review of teams use of trustwide autism team for support and advice regarding support with care planning an providing reasonable adjustments to ensure good access to, and receipt of effective care and positive patient experience. Targeted communication activity where use is low. Access route for support and guidance from learning disability services to other trust services to be reviewed and communicated across services.
Additional Staffing for Winter - Increasing capacity with larger multidisciplinary teams, including over the Christmas period - Ensure that robust workforce plans are in place to respond to an increase in demand over the winter period,	John Savage	If consideration of increasing capacity for ALD over winter months with primary focus being the covering of inpatients e.g. over-establishment of posts currently out to advert and retire and return opportunities, flexible contracts for students This would protect our already stretched resource in community teams as would reduce the risk of the pull from community resource. Equally if resource is not required there is		Focus Groups to be set up to enable work on scenario's based events with focus of looking at BCP. Helen Day and Dawn Jessop		

including planning annual leave to maintain a continuous physician presence throughout the Christmas/New Year period. This should include planning for a possible increase in staff sickness associated with an increase in winter illness, including Covid-19 and influenza. - Implement flexible mechanisms for staff pooling and utilisation of resources across organisational boundaries, including increasing use of staffing banks to onboard both health and care workers to the right part of the pathway utilising 'mutual aid' arrangements where needed and supplemented by digital solutions.		enough demand across the ALD system to level load. Appreciate recruitment is difficult but looking staffing processes during the pandemic eg the recent retired staff on short term contracts was a big help in MHSOP at the height of covid – not sure how successful this was in ALD. Waiting list initiative for ALD Community for therapies – subject to non-recurrent funding. Assurance that there is a reduction in referrals in December from SPC charts.				

Appendix B

- NHS England – delivering operational resilience
- System roles and responsibilities

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To:
- ICB:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- NHS acute, community and mental health trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- Primary care networks

cc.
- NHS England regional directors

NHS England
Wellington House
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27 July 2023

Dear Colleagues,

Delivering operational resilience across the NHS this winter

This letter sets out our national approach to 2023/24 winter planning, and the key steps we must take together across all parts of the system to meet the challenges ahead.

In January, we published our delivery plan for recovering Urgent and Emergency Care (UEC) services: an ambitious two-year plan to deliver improvements for patients across the integrated Urgent and Emergency Care (iUEC) pathway. This plan, along with the Primary Care Recovery Plan, Elective Recovery Plan and the broader strategic and operational plans and priorities for the NHS, provides a strong basis to prepare for this winter.

The publication of the UEC Recovery Plan followed an incredibly challenging winter – with high rates of infectious disease, industrial action, and capacity constraints due to challenges discharging patients, especially to social and community care. We know these challenges have continued but want to thank you for the work you have done in the face of this to ensure that there have nonetheless been significant improvements in performance. Thanks

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to these improvements, we are in a significantly better place compared to last summer. Compared to last June, A&E performance has improved and Category 2 performance is 14 minutes faster.

This progress and the plan we are today setting out for winter preparedness are key steps in helping us achieve our two key ambitions for UEC recovery of:

- 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25.

To help achieve these ambitions, we have ensured that systems have had clarity over finances well before winter to allow them to plan effectively and further roll-out the measures that we know will improve services for patients. We have invested extensively in this, including:

- £1 billion of dedicated funding to support capacity in urgent and emergency services, building on the £500 million used last winter.
- £250 million worth of capital investment to deliver additional capacity.
- £200 million for ambulance services to increase the number of ambulance hours on the road.
- Together with DHSC, an additional £1.6 billion of discharge funding over 2023/24 and 2024/25, building on the £500 million Adult Social Care Discharge Fund.

While we are making good progress towards achieving our overall ambitions, we want to encourage providers to achieve even better performance over the second half of the year. We will therefore be launching an **incentive scheme** for those providers with a Type 1 A&E department to overachieve on their planned performance in return for receiving a share of a £150 million capital fund in 2024/25. We are asking providers to meet two thresholds to secure a share of this money:

- Achieving an average of 80% A&E 4-hour performance over Q4 of 2023/24.
- Completing at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

We recognise that these are stretching targets but know that many providers will be able to achieve these to help the NHS as a whole make greater headway towards improving care for patients. Providers should already be putting measures in place which will contribute towards reaching these, including a greater focus on the longest times in department, particularly those spending longer than 12-hours, and wider system flow. We will communicate more details on this shortly, including how we will be working with you to improve data quality.

Turning to our wider planning for winter, we are clear that the challenges are not just in ambulance services or emergency departments, and recovery requires all types of providers to work together to provide joined-up care for patients. ICBs will play a vital role in system leadership but the actions we take need to extend across the wider health and care system including mental health services, services for children and young people, community health services, primary care and the voluntary, community and social enterprise (VCSE) sector.

We are therefore setting out four areas of focus for systems to help prepare for winter:

1. Continue to deliver on the UEC Recovery Plan by **ensuring high-impact interventions are in place**

Together with systems, providers, and clinical and operational experts we have identified 10 evidence-based high-impact interventions. These are focused around reducing waiting times for patients and crowding in A&E departments, improving flow and reducing length of stay in hospital settings. Delivering on these will be key to improving resilience in winter. We have recently written to all systems to ask that they assess their maturity against these areas as part of the universal improvement offer for the UEC Recovery Plan. Systems will then receive dedicated support on the four areas they choose to focus their improvement for winter.

More detail on these areas can be found at Appendix A and on the NHS IMPACT website.

2. **Completing operational and surge planning** to prepare for different winter scenarios

We have already collectively carried out a detailed operational planning round for 2023/24 but we are now asking each system to review their operational plans, including whether the assumptions regarding demand and capacity remain accurate. Although this will cover surge planning for the whole winter, specific plans should be made for the Christmas/New Year/early-January period which we know is often the most challenging time of the entire year.

In addition to this, and recognising the importance of planning for multiple scenarios, we are asking systems to identify how they will mobilise additional capacity across all parts of the NHS should it be required to respond to peaks in demand driven by external factors eg, very high rates of influenza or COVID-19, potential further industrial action.

This planning is essential to ensure winter plans protect and deliver elective and cancer recovery objectives, as well as deliver the primary care access programme, and proactive care for those most at risk of hospital admission (guidance on proactive care will be published shortly).

Next week, we will be issuing each ICB with a template to capture their surge plan and overall winter plan. We will work with those areas that are facing the greatest challenges across the UEC pathway via our tiering programme to support them in completing these returns. If you think you require additional support, please contact england.uec-operations@nhs.net.

All returns should be sent to england.uec-operations@nhs.net by **11 September 2023**.

3. **ICBs should ensure effective system working across all parts of the system**, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.

ICBs will play a vital role in system leadership and co-ordination but it is important that all parts of the system play their role. The NHS England operating framework describes the roles that NHS England, ICBs and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

To help systems plan, we have developed a set of recommended winter roles and responsibilities (**Appendix B**) to ensure clarity on what actions should be undertaken by each part of the system. These will require broad clinical leadership to implement, and systems should be using these to develop their winter planning return, reflecting how these relate to the circumstances within their individual system.

DHSC is also writing to local authorities and the adult social care sector shortly to set out priority actions for improving winter resilience and encouraging cross-system working with the NHS on winter planning.

To assist system working this winter, next week, we will also be publishing an updated specification for System Co-Ordination Centres and an updated Operational Pressures Escalation (OPEL) Framework to ensure we are taking a consistent and co-ordinated approach to managing pressures across all systems.

4. **Supporting our workforce** to deliver over winter

This year colleagues have continued to work incredibly hard in the face of increased demand. We know how much supporting your workforce matters to you, and it is crucial that employers ensure that they take steps to protect and improve the wellbeing of the workforce.

Last winter, we saw flu return at scale. It is vitally important that we protect the public and the health and care workforce against flu and other infectious diseases, and the best way of doing this is to ensure they are vaccinated. Providers should also ensure that they have an

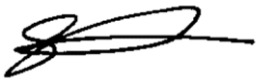
established pathway for identifying patients at-risk of COVID-19 and flu in their care, including those who are immunosuppressed.

Systems and providers should also continue to improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise, as set out in 2023/24 priorities and operational planning guidance and more recently in the NHS Long Term Workforce Plan, and ensure continued supply through maintaining education and training.

We want to thank you and everyone across the NHS for your continued hard work this year, we have again faced some unprecedented challenges but through strong partnership working we have once again risen to these.

The coming months will undoubtably be difficult, but we will continue to support you to ensure that we collectively deliver a high-quality of health service to patients and support our workforce. Thank you again for all your efforts as we work to build a more resilient NHS ahead of winter.

Yours sincerely,



Sarah-Jane Marsh
National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Julian Kelly
Chief Financial Officer
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Appendix A: 10 High-Impact Interventions

Action	
1.	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2.	**Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3.	**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4.	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5.	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6.	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8.	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.
9.	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment
10.	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Working together to deliver a resilient winter

System roles and responsibilities

The NHS England operating framework describes the roles that NHS England, integrated care boards (ICBs) and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

As we continue planning for winter it is important that we are clear on the actions that each part of the NHS system must now take to ensure that we are collectively pulling in the right direction to deliver for patients.

To support this, we have developed a set of recommended winter roles and responsibilities for each part of the system, which are included in this document, largely taken from existing guidance and recovery plans. These build on the core objectives outlined in the winter letter and provide a platform for systems to be clear on how actions are taken in all areas to deliver a resilient winter period.

The roles and responsibilities are designed to be supportive and provide clarity but are by no means exhaustive – each system should use these to develop their winter planning return and consider how these relate to the circumstances within their individual system.

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Integrated care boards

- Ensure that the system winter operating plan incorporates all the high-impact interventions and actions for the entire health and social care economy. This should include specific operating actions for all system partners across acute, community, mental health, primary care aa well as links with local authority services. Systems should ensure that plans reflect the needs of all age groups, including services for children and young people.
- Facilitate partnership working – ensuring that all system partners are pulling in the same direction to deliver a resilient system this winter, and appropriately manage risk to ensure that it is balanced across the entire system, ensuring all parts of the system are held to account for delivery of their responsibilities.
- Be accountable for the delivery of capacity in line with agreed 2023/24 ICB Operating Plan – including additional capacity identified via the winter planning exercise.
- Ensure that arrangements are in place to lead the system through winter – including:
- maintaining 24/7 oversight of system pressures through the System Co-ordination Centre (SCC)
- implementing the revised SCC specification to ensure appropriate structures, systems and process are in place to maintain operational oversight and delivery
- implementing the revised Operating Pressures Escalation Levels (OPEL) Framework in a consistent manner across all acute sites as the key clinical safety indicator of system pressure
- leading the development of a comprehensive winter operating plan underpinned by a locally agreed operating model.
- Ensure infection prevention and control (IPC) colleagues are involved in winter planning and that they continue to be involved in responding to winter.
- Lead the liaison and engagement with the voluntary, community and social enterprise partners to ensure that they are fully engaged in winter planning and their support maximised.
- Ensure the continued workforce supply through early planning of actions to mitigate any loss of education and training during the periods of greatest winter service pressures.

Lead the delivery of high-impact interventions 5-10

- **Care transfer hubs**: In partnership with local authorities, implement a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and reablement

services and prevent unnecessary re-admission to a hospital bed. Improve the operation of current care transfer hubs from the baseline assessment, including operation throughout the winter holiday period.

- **Intermediate care demand and capacity**: With local authorities, commission sufficient capacity to meet projected demand for step-down care, including both home-based and bed-based care, to facilitate the timely discharge of patients from across acute and community hospitals and services.

  Make effective use of the Better Care Fund, including the Discharge Fund, to support patients to leave hospital with a package of care where needed.

  Ensure that capacity and resource gaps are escalated, and actions progressed; all data is submitted for all commissioned beds to the Community Discharge and Acute Discharge SitReps and the Capacity Tracker.

  Ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services and to streamline pathways and reduce duplication.

  Embed mechanisms to enable monitoring of the impact of intermediate care interventions on people's functional outcomes and their long-term care needs.

- **Virtual wards**: Be accountable for the delivery of virtual ward capacity and maximising virtual ward use, ensuring 80% occupancy across VWs is maintained over the winter period. Systems should ensure appropriate step-up and down capacity is in place at scale for frailty, respiratory and for heart failure, ensuring capacity is tightly aligned to winter flow priorities. This includes:

  - All step-up virtual wards should be accepting admission alternative referrals from care homes, ambulance trusts, primary care, and urgent community response ahead of winter and should ensure there are clear agreed processes in place between partners.

  - **Urgent Community Response (UCR)**: Ensure full geographical coverage with a minimum of 7 days a week and 08.00-20.00 operating times – going beyond the 9 clinical conditions/needs set out in the national specification to meet all appropriate community-based demand. Ensure, through working with the ambulance service, that plans are in place for most clinically appropriate Cat 3 or 4 calls to be diverted to UCR or community-based falls services.

  - **Advanced clinical support**: You should also ensure that care homes have access to advanced clinical decision-making support outside of UCR operational hours (eg 8pm to 8am) to ensure residents receive treatment and care in the right setting, and to enable clinical risk sharing across the system.

  - **Single point of access**: driving standardisation of urgent integrated care co-ordination which will support whole system management of patients into the right care setting, with the right clinician or team, at the right time. This includes

increasing the number and breadth of services profiled on the directory of services (DoS) and ensure steps are in place to maximise the use of the DoS.

- **Acute respiratory infection (ARI) hubs**: support consistent roll out of services for adults and children and young people, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in emergency departments and general practice to support system pressures.
- Through commissioning actions, ensure that **NHS 111** clinical input is prioritised where it will have most impact – in particular, maximising the assessment of NHS 111 Category 3 or 4 ambulance dispositions. Ensure that robust workforce plans are in place for NHS 111 service advisors, health advisors and clinical advisors. This should include using home working opportunities to the full.
- Support the delivery of key actions from the **Primary Care Recovery Plan** that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly:
- Increasing support for self-directed care
- Expanding community pharmacy services
- Implementing modern general practice by:
- engaging and nominating their practices and PCNs to join the national general practice improvement programme
- supporting practices to move to cloud-based digital telephony and to access the right digital tools
- improving online patient journeys, including practice websites
- understanding general practice transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to continue improvement:
- to make online channels easy to use
- to enhance navigation and triage processes
- to improve the experience of access
- to understand and better match demand and capacity.

Increasing capacity with larger multidisciplinary teams, including over the Christmas period

Improving the primary-secondary care interface.

Acute and specialist NHS trusts

Lead the delivery of high-impact interventions 1-4

1. **Same day emergency care (SDEC)**: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2. **Frailty**: Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3. **Inpatient flow and length of stay**: Reducing variation in inpatient care and length of stay for key integrated urgent and emergency care (iUEC) pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients. This includes through:
    a. Delivering improvements in ambulance handover times

    b. Ensure documented internal professional standards are in place for rapid specialty in-reach to urgent and emergency care pathways 24/7 – ensuring that patients requiring admission are moved from the emergency department in line with these standards. Put in place mechanisms to monitor performance against these standards and take action to course correct delivery where required.
4. **Community bed productivity and flow**: Reducing variation in inpatient care and length of stay by maximising therapeutic interventions to reduce deconditioning and bringing forward discharge processes.

    - Ensure that general and acute beds are available and open in line with the agreed 2023/24 ICB Operating Plan – including escalating the number of beds as needed in line with the winter addendum to this plan. This includes monitoring and reducing occupancy in the run up to Christmas.
    - Focus on improving performance against the four-hour standard for type one attendances, to contribute to the overall A&E performance target of 76%.
    - Continue focused efforts on patients attending A&E who spend more than 12 hours in department from arrival to discharge, admission or transfer.
    - Ensure clear arrangements for early referral to care transfer hubs where patients are likely to require step-down care following hospital discharge. Align processes and protocols with standard operating procedures for care transfer hubs to reduce variation, minimise discharge delays, maximise access to community rehabilitation and reablement and optimise 7-day working. Provide timely data where needed by care transfer hubs to support governance,

operational grip and decision-making and to support intermediate care capacity and demand planning.

- Ensure that sufficient capacity is in place to protect the elective pathway for both adults and children and young people – with clear triggers in place to open additional non-elective capacity in line with the winter addendum to the 2023/24 Operating Plan.
- Ensure actions to improve the primary and secondary care interface set out in the Primary Care Access Recovery Plan are implemented with system wide understanding of pressures across the totality of the UEC pathway including primary care.
- Ensure that robust workforce plans are in place to respond to an increase in demand over the winter period, including planning annual leave to maintain a continuous physician presence throughout the Christmas/New Year period. This should include planning for a possible increase in staff sickness associated with an increase in winter illness, including Covid-19 and influenza.
- Implement flexible mechanisms for staff pooling and utilisation of resources across organisational boundaries, including increasing use of staffing banks to onboard both health and care workers to the right part of the pathway utilising ‘mutual aid’ arrangements where needed and supplemented by digital solutions.
- Ensure that a robust plan is in place for the vaccination of staff, volunteers and patients against influenza and that plans are in place to rapidly respond to any other vaccination programme recommended by the Joint Committee on Vaccination and Immunisation (JCVI)

Primary care

Ensure plans are in place to maintain access to primary care services between 18 December 2023 and 8 January 2024, including ensuring Bank Holiday cover in line with primary care national contracts is in place, so that patients can access services in primary care settings over the Christmas and New Year period.

- Ensure tools are in place to understand demand, activity and capacity in primary care, eg operational pressures escalation levels (OPEL) reporting. This should be shared across the system to give a comprehensive view of primary care pressures and where support may be required that could alleviate pressure on primary care and on the UEC pathway.
- Through working with the ICB and other system providers, ensure additional capacity is in place to respond to a surge in demand for primary care services – including through the development and provision of hot hubs and/ or acute respiratory infection hubs.
- Ensure proactive identification and management of people with complex needs and long-term conditions, so care is optimised ahead of winter and that people are supported to better manage their health, to reduce demand on primary and secondary care.
- Work with the ICB to develop system plans and communication strategies to maximise the role of general practice and community pharmacy.
- Lead delivery of actions from the Primary Care Recovery Plan that will support winter pressures, particularly:
- Support the delivery of key actions from the **Primary Care Recovery Plan** that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly:
- Increasing support for self-directed care
- Expanding community pharmacy services
- Implementing modern general practice by:
- engaging and nominating their practices and PCNs to join the national general practice improvement programme
- supporting practices to move to cloud-based digital telephony and to access the right digital tools
- improving online patient journeys, including practice websites
- understanding general practice transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to continue improvement:
- to make online channels easy to use

- to enhance navigation and triage processes
- to improve the experience of access
- to understand and better match demand and capacity.

Increasing capacity with larger multidisciplinary teams, including over the Christmas period

Improving the primary-secondary care interface.

Children and young people (CYP) services

Winter plans should reflect the needs of the local children and young people's population, with actions in place to manage pressures in paediatric services.

- **High-impact interventions for children and young people**: ICBs should ensure commissioning arrangements are in place to support scaling of age-appropriate virtual ward models and ARI hubs; building on pilots and plans and targeting areas of greatest needs to effectively manage winter pressures and increases in respiratory infections.
- **Whole-system planning**: embed whole-system approaches to winter planning for paediatric services, linking to paediatric critical care surge planning and Level 2 bed provision expansion, led by operational delivery networks (ODNs) with paediatric ARI hubs and virtual ward development. Disaggregate datasets should be available at ICB level to permit monitoring of CYP data, pressures across paediatric services, as well as the wider system and patient pathway, including primary care, acute and mental health services, immunisation, and school attendance.
- **Paediatric critical care surge planning**: ICBs and ODNs should work in partnership to co-ordinate, implement and oversee robust winter and surge planning, including mitigations to manage the impact of surges in paediatric respiratory infections on CYP services. This should include mutual aid arrangements at regional and national level, particularly for Level 3 paediatric intensive care unit (PICU) bed provision and for children on long term ventilation.
- **Mutual aid**: ensure local winter plans include mutual aid considerations across paediatric and adult teams, between providers within the system, and across systems.
- **Protecting elective capacity for children and young people**: ensure preservation of the standard clinical pathway for CYP elective surgery, critically ill children, emergency, general and specialist services and continue to reduce disparity in elective recovery between adults and CYP. Ensuring close monitoring of paediatric surgery cancellations.
- **Vaccination uptake**: ensure that a robust plan is in place to maximise uptake of childhood and flu vaccinations as part of winter preparedness.
- **Supporting self-care and management of minor illness**: ensure targeted communication and paediatric advice is available to parents/carers. Ensure collaborative approaches with VCSE partners, embedding preventative approaches to support parents/carers in management of minor illness and navigating NHS services, particularly across areas with high attendances and communities that experience the greatest health inequalities.

Community trusts and integrated care providers

Lead and support the delivery of high-impact interventions 4-6

- **Community bed productivity and flow**: reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes. This includes:
    - ensuring actions from daily ward and board rounds have been implemented and are being recorded or escalated in the day
    - discharge planning takes place early on in admission and in conversation with the person and/or next of kin
    - screening, assessment and rehabilitation plans are in place and communicated to the person and/or their next of kin
    - protocols for mobilisation of the individual are in place
    - workforce planning to ensure rehabilitation needs are met with minimum delays.
- Ensure clear arrangements for early referral to **care transfer hubs** where patients are likely to require step-down care following hospital discharge. Align processes and protocols with standard operating procedures for care transfer hubs to reduce variation, minimise discharge delays, maximise access to community rehabilitation and reablement and optimise 7-day working. Provide timely data where needed by care transfer hubs to support governance, operational grip and decision-making and to support intermediate care capacity and demand planning.
- Ensure focus on **admission avoidance**, ensuring 24h access to palliative care services and enhanced join-up between primary, community and social care services through enhanced care in care homes.
- **Data sharing and submission**: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.
    - Submit data for all commissioned community beds to the Community Discharge SitRep.
    - Ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services and to streamline pathways and reduce duplication.
- Ensure there are joint executive leadership and system agreements in place across partner organisations, to ensure shared decision making and governance arrangements.
- Ensure multi-professional teamworking and a partnership approach to discharge, and multi-agency working with local authority partners and the

independent and voluntary sector to review availability of resource, provide access to reablement/pathway services for ongoing recovery support at home, and ensure timely discharge from intermediate care for a person's ongoing and longer-term needs.

- Implement flexible mechanisms for staff pooling and use of resources across organisational boundaries, including increasing use of staffing banks to onboard health and care workers and deployment of therapy capacity to the right part of the pathway using 'mutual aid' arrangements where needed and supported by digital solutions.
- Implement solutions to release therapist time and increase rehabilitation capacity, including through use of digital solutions, admin capacity, streamlining referral processes and utilising support workers to undertake tasks where appropriate.
- Implement data and operational dashboards, including daily oversight of capacity and demand and blocks in the pathway including:
    - demand for therapy workforce to deliver rehabilitation assessment and interventions
    - working with acute hospitals to proactively plan for demand, support timely discharge and enable flexible resource utilisation plans across partners and organisations
    - working with systems to undertake the self-assessment exercise as part of the system maturity evaluation and progress agreed actions to maximise delivery of services through winter.

Ambulance trusts

- Ensure a greater number of deployed hours on the road over winter in line with agreed recruitment and resourcing plans.
- Increase the clinical assessment of calls in every emergency operations centre to deliver the navigation and validation of Cat 2 calls, as well as increasing clinical input to Cat 3 and 4 calls.
- Ensure efficient electronic processes are in place for the transfer of patients who do not need a face-to-face response to services more appropriate for their needs, including urgent community response, urgent treatment centres and SDEC. Note the responsibility for other parts of the system to maximise the number of cat 3 and 4 calls responded to by UCR and falls services.
- Establish sufficient call handling capacity and finalise arrangements for the use of the ‘Intelligent Routing Platform’ in times of surge.
- Ensure mental health professionals are embedded in all emergency operation centres ahead of winter.
- Use the ambulance auxiliary service when needed.

Mental health provider pathways

Lead and support the delivery of high-impact interventions 3, 4 and 9 across mental health provider pathways

- Ensure plans are in place so that individuals know how to access mental health services with access to effective assessment and help in a timely manner and that crisis alternatives are in place to help reduce reliance on A&E (recognising that A&E is still an appropriate way of seeking help and people presenting with mental health issues also may have urgent physical health care needs). This should include making reasonable adjustments to pathways and therapeutic interventions for people with a learning disability and autistic people who seek mental health support.

- Where individuals do seek help for mental health issues via A&E, ensure processes are in place for assessment and onward support, including adjustments to meet the needs of autistic people and people with a learning disability. Ensure there are clear escalation processes for A&E where there is considerable delay in receiving specialist support.

- Mental health, learning disability and autism services should ensure maximum uptake of vaccinations for their populations, both inpatient and community. This is vital given the high incidence of COPD and other co-existing long-term conditions such as diabetes which can compromise response to flu and Covid-19.

- Ensure tools are in place to understand demand, activity, workforce and capacity in mental health provider pathways. This should be shared across the system to give a comprehensive view of mental health pressures and where support may be required that could alleviate pressure on both mental health and UEC pathways.

- Ensure access to emergency housing funds to enable discharge of patients with no fixed abode (NFA) to ensure that they can be supported with follow up crisis / community care and support.

- Lead delivery of actions from the NHS Long Term Plan and Delivery Plan for Recovering Urgent and Emergency Care Services that support winter pressures, particularly:

- Strengthen ambulance response to mental health by deploying multidisciplinary professionals to support 999 mental health demand and preparing for the rollout of mental health response vehicles.
- Optimising flow through mental health inpatient settings through system-wide focus on reducing delayed discharges and avoidably long length of stay in mental health inpatient settings. Work collaboratively with social care and other system partners who play a key role in timely discharge.
- Continuing to raise profile of all-age 24/7 urgent mental health helplines and other complementary crisis support services – including those for people with a learning disability and autistic people, such as intensive support teams, ensuring delivery of

NHS 111 ‘select mental health option’ and working towards crisis text line implementation.

- Supporting children and young people with mental health needs in acute paediatric settings by adopting the new integration framework for systems to support children and young people with mental health needs within acute paediatric settings, and to take up NHS England (Workforce, Training and Education directorate) commissioned CYP crisis telephone training to support crisis mental healthcare staff.

- Maximise the uptake of training on learning disability and autism appropriate to their role, to ensure preparedness to be able to meet the needs of autistic people and people with a learning disability.

Local authorities and social care

Local authorities should continue to work with ICBs to ensure an integrated approach across health and social care.

This includes:

- commissioning intermediate care services that help keep people well at home, prevent avoidable hospital admissions and support timely and effective hospital discharge.
- areas keeping under review their Better Care Fund (BCF) capacity and demand plans for intermediate care, in line with the BCF Policy Framework and planning requirements, considering trends in demand.
- improving data flows where the BCF capacity and demand plans showed limited data or insights available to support local areas' ability to accurately forecast demand for these services throughout the year.
- supporting NHS winter surge planning, including considering contingency arrangements for a significant flu or COVID-19 wave.
- deploying this year's Discharge Fund in ways that have greatest impact in patient safety and experience and in reducing delayed discharges, both to improve outcomes following hospital admission and help prevent avoidable A&E and ambulance delays for patients who need emergency care, alongside planning how to deploy next year's discharge funding.
- systematically embedding good practice in the use of care transfer hubs to manage discharges for patients with more complex needs, focusing on nine priority areas that will be set out as part of the upcoming support offer for the UEC Recovery Plan.
- ensuring systematic involvement of social care and community health providers in planning discharge services and in improving the operation of care transfer hubs.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**14 September 2023**
Title:	**Feedback from Leadership Walkabouts**
Executive Sponsor(s):	**A Bridges, Director of Corporate Affairs & Involvement**
Author(s):	**A Bridges**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	***Risk Title***	***Context***
All	1 – Recruitment 2 – Demand 5 – Staff retention 6 - Safety	The report highlights summarised feedback from the June leadership walkabouts, which can contribute to the Board's understanding of strategic risks and the operation of key controls.

Executive Summary:

Purpose: The purpose of this report is to enable the Board to consider high-level feedback from the July 2023 leadership walkabouts.

Overview:

1 **Background**

1.1 The Trust undertakes a monthly programme of regular leadership walkabouts 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.

1.2 From a Board perspective, the walkabouts provide an opportunity to meet with team members to really understand the strengths of the service and consider the more challenging areas and how we can collectively work together to resolve these.

2 **Speciality areas visited**

2.1 The Leadership Walkabouts took place on Monday 3 July 2023 and followed a series of themed visits to targeted teams who have had issues recruiting staff, which had been triangulated with PALS and complaints themes, and included:

- York CAMHS
- Easington North / South– Affective Disorders Team
- Ripon Integrated Community Team
- Perinatal Services, York

3 **Key issues**

- Strengths:
  - Cocreating shared understanding and interventions through collaborative formulations, facilitating support and being responsive to local priorities.
  - Creating meaningful connections with patients and their loved ones whose needs can be hard to meet through responding to the needs of our patients.
  - Embedding multi-agency processes working with partners across agencies and the benefits this brings.
  - Knowledgeable staff, with good skills mix, who worked well together and supported each other.

- Challenges:
  - Staffing was an issue across all teams visited, in terms recruitment and retention, with some concern raised over HR systems and processes, in terms of navigating these and timeliness.
  - Caseload and waiting times highlighted as a concern, and teams actively reviewing these to try to affect positive change.
  - Private neuro assessments highlighted in CAMHS as challenging in terms of integration with our pathway.
  - Some estates issues were highlighted.

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

Prior Consideration and Feedback A further strengthened approach to leadership walkabouts is being developed, including an 18-month forward plan, better cocreation with teams on addressing main challenges, and improved reporting and tracking processes being implemented.

Implications: No additional implications.

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 visits held on 3 July 2023.

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 14 September 2023		
Date of last meeting: 7 September 2023		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda**	The Committee considered the following matters: • The management of relevant risks included in the BAF • Executive Summary of EQAIG, Integrated Performance Dashboard (IPD), including NYYS and DTVF QAIGs • Serious Incident Improvement Plan • Duty of Candour • Positive & Safe Improvement Plan • Self- Assessment against the Rapid Review of data in Mental Health Inpatient Settings Recommendations • CQC Report • Whorlton Hall – review of the learning and relevance to TEWV • Verbal update on the plans for the Trust wide Themes of Learning Report • IPC Annual Report • IPC Board Assurance Framework • Patient Safety Incident Response Framework • NICHE Recommendations Update Report • Received for information: Healthwatch Darlington Annual Report
2a	**Alert**	The Committee alerts the Board on the following matters: **Executive Summary of Quality, Assurance & Improvement Group (EQAIG), including DTVF and NYYS QAIGs and the Integrated Performance Dashboard** The Executive QAIG met on 29 August 2023 and considered the assurance, alerts and matters for escalation from the Care Group's Quality, Assurance & Improvement Groups The top areas of risk reporting from the DTVF and NYYS Quality Assurance and Improvement Groups are the backlog of serious incidents, staffing, compliance with positive and safe training and basic and immediate life support training, access to dietetics in LD services, provision of office space at York District Hospital for the AHLS team, continued glitches while the assisted technology doors are fixed. There was an inappropriate incident of restraint on Wold view relating to a patient with dementia who required rapid tranquilisation. There are 3 wards (Esk, Minster and Ebor) in staffing escalation due to high agency use. There are ongoing concerns with the answer rate to the crisis lines, which are being considered in liaison with the ICB and how it might link with the 111 service. It is noted that the quality of the triage process is stronger than 12 months ago. When an individual rings back to the crisis line they can get the option of speaking to a mental health support worker. It was recognised though that there was a risk that a caller could come to harm if calls remained unanswered. A PIPs is in place within CYPS, DTVF relating to the PROM with improvement in month however there is limited oversight at care group of outcome measures and this is being explored further.

		There are emerging concerns at West Park Hospital, with various strands over the last 6-8 weeks relating to whistleblowing, culture and implementation of actions following MHA visits. This is being reviewed. Some immediate action has been taken with operational changes made and QuAC will be updated following the full review. **Patient Safety Incident Response Framework (PSIRF) and Patient Safety Incident Response Plan (PSIRP)** The Committee agreed that there is reasonable assurance on the delivery of the plan. The plan sets out how the organisation will respond to and learn from patient safety incidents and the plan is a working document that sits alongside the PSIRF. The action plan is currently being reviewed with the ICB. PSIRF is essentially a cultural shift away from SIs looking at the root causes and more towards system learning and just culture. The care groups will be supported to gain the skills and confidence to operate in a different way. The risks associated with the plan include the inability to identify early learning from serious incidents due to the backlog, there may be poor external and system confidence in the implementation of PSIRF regarding patient safety, knowledge and learning delays which may hinder the ability to fully implement the intention of PSIRF. There remains a current Regulation 28 notice relating to the backlog. The patient safety team has limited capacity to implement the new approach to PSIRF while focusing on reducing the backlog. As the new approach requires a shift in culture and thinking from staff this will require the whole system to adapt. TEWV is ahead nationally in terms of engagement with families - which is a positive step and a communications plan is being developed to ensure better awareness and learning.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **1. Board Assurance Framework (BAF)** Reflecting on the strategic risks during the discussions at the meeting, there are no new risks considered that should be added to the BAF. It is recognised that following the last review of the BAF by the Board it is determined that there is only reasonable assurance on the progress being made to mitigate against the risks and bring scores down to target. PSIRF will require work as the new plan is implemented and the Board should be mindful of the impact on increased communications and embeddedness. This should be considered in more detail once developments are further along, at a Board Seminar. The Council of Governors might also welcome an update on PSIRF. **Duty of Candour** Significant progress has been made with implementation of 9 of the 11 actions. One of the key areas is the ratification of the policy, which was approved by the EQAIG on 29 August 2023 and will go to Management Group in September 2023. Extensive engagement has taken place. Strengthened governance arrangements to ensure that the policy is effective and applied will be monitored through QuAC and externally in line with contractual and regulatory requirements. A dedicated duty of candour page is now available on the Trust intranet page. Training needs will be incorporated into PSIRF and other incident management training The Committee sought further assurance on how it will be evident that improvements are being made and what the impact will be of the completed action plan, so that assurance can be given to Board. The Fundamental Standards Group will monitor progress and duty of candour will be included in the quality assurance schedule. Implementation of CiTo will provide a measurement and also Inphase. Daily monitoring of duty of candour takes place in huddles at service level. **Delivery of the CQC Action Plans** There are 4 must do actions from the CQC core service and well led inspection 2021. (1 Trust wide and 3 SIS). The Trust wide action relates to commissioning a further external review, due for completion on 30 March 2024. The SIS actions due for completion relate to

		a review of the seclusion procedure, for a Trust wide long-term segregation and prolonged seclusion group to monitor the use of seclusion and to increase training capacity for statutory and mandatory training courses for the service where this is required. The publication of the CQC inspection report, which is being checked for accuracy is likely to be published before the end of September 2023. **Self-Assessment against the Rapid Review of data in MH Inpatient Settings Recommendations** From the information presented the Committee agreed that there is partial assurance following the self-assessment of the Trust's compliance and position against a set of recommendations described in the Rapid Review of Data into MH Inpatient settings DHSC June 2023. A more robust and detailed assessment will be undertaken to fully understand the gaps and ensure robust plans are made. There are five out of thirteen recommendations that directly apply to TEWV and the Committee queried whether any independent challenge might be worthwhile. However, the Medical Director noted that he was confident that the organisation could undertake the baseline assessment and that a presentation would be made to NHSE quality board in the coming month who would have oversight of this across the ICB. **Whorlton Hall** Good assurance can be evidenced that the organisation is underway with the key themes identified against the recommendations from the Safeguarding Adults Review on Whorlton Hall (commissioned by Durham Safeguarding Adults Partnership), published in May 2023. Further consideration will be given to knowledge and training around LD and autism and closed cultures and next steps will include exploring whether the Trust wants to participate in the NHSE founded National Autism Trainer Programme (NATP) and to look at training for closed cultures to support staff within safeguarding, PALS and patient safety to recognise closed cultures. (Current compliance with Oliver McGowan LD and autism training is 46% following its launch in June 2023). Since the beginning of Our Journey to Change the organisation has gone through a significant transformation relating to culture, including the development of a cultures dashboard and culture included in the new peer review tool, which will be piloted during October 2023. Soft intelligence backs up the themes with examples of work in Positive and Safe and reducing restrictive practice and how we engage in communication. Peer review visits are a strong element of that with the ability to walk on wards and gain a feeling of how things are going. **Annual Infection, Prevention and Control Report** The Committee received the annual report. **IPC Board Assurance Framework** The overall RAG status for TEWV across the 10 criteria has revealed that the Trust is fully compliant with 6 key lines of enquiry, 3 of the criteria are partially compliant and 2 non-compliant. The areas of non-compliance relate to all identified staff being recorded as fit-tested as per health and safety executive requirements and that the Board receives a formal annual report on antimicrobial stewardship activities, which includes progress with achieving the UK AMR National Action Plan goals. Fit testing is being addressed through a task and finish group and Pharmacy will produce the antimicrobial report for Board. **Positive & Safe Improvement Plan** Following consideration of the proposed plan for positive and safe, the requirement to have a strategy focused on reducing the use of restrictive practices, the Committee was assured

		that following significant consultation of the draft plan, which was presented to QuAC in May 2023, it is content to approve the final version. The plan will reflect evidence-based practice for reducing restrictive practice, workstreams will include preventative clinical approaches and learning lessons from incidents. Agreed outcome measures are identified in the plan, which will be reviewed in local positive and safe groups. Progress on implementation and any matters for escalation will be to the Executive Quality, Learning & Improvement Group and the plan will be reviewed annually. The Committee questioned whether the plan is still contemporary and whether there are sufficient resources to deliver the ask. It is welcome news that a full-time post is being worked up to support the Lead for Positive and Safe. **NICHE** The Committee received information on levels of assurance and actions proposed relating to the 4 independent investigations undertaken by Niche (Health and Social Care Consulting), on behalf of NHSE, (3 independent patient SI reports and a system wide independent review into concerns relating to quality and safety of CAMHS provision at West Lane Hospital – referred to as the governance review). The recommendations within the 3 independent patient reports are themed into risk assessment and management, collaborative care planning, transfers of care and governance. There is limited assurance with significant risk to delivery that children with autism receive care in line with NICE guidance, due to capacity and/or complex multi-agency approaches all of which are needed to fully address the issues. There is risk to delivery of implementing PSIRF – already referenced in this report. Good progress is being made with ligature reduction and QuAC will receive an Environmental Risk Group report going forward on a quarterly basis, from October 2023. Further work is needed to strengthen Board oversight and effective learning and an assurance review is planned during September 2023 by the Deputy Chief Nurse.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **Serious Incident Improvement Plan** Reasonable assurance can be provided on the delivery of the serious incident recovery plan although there is a changeable position week to week based on newly allocated and concluded SIs. Based on the current trajectory the aim is that all SIs dated before 1 February 2023 will be concluded by 31 December 2023, excluding external SIs (1 inpatient death, 2 homicides). Slippage may happen due to family anniversaries and other families' circumstances. It is recognised that delays in reviews might be associated with a reduced level of learning and embedding of improved practice. It was noted that there is wide engagement and support for completing the backlog from numerous sources both externally and internally, with services and buy in from the care groups and there is confidence that whilst resources are dedicated to catching up, a new backlog of SIs will not be created. There are also mitigating plans being pursued with 'Spectrum', a prison-based service who are commissioned by NHSE to undertake clinical reviews of deaths. **Quarterly Report on Trust Wide Themes of Learning** There are plans to combine the previous Trust Quality and Learning report into a quarterly report demonstrating Trust wide themes of learning. This is expected to be completed in around three months' time to allow time to triangulate all of the information. **Accountability of Cross Cutting risks across Board Committees** At a recent meeting with Chairs of Committees and the Head of Risk Management it was agreed that it was very challenging for every Committee to hold cross cutting risks to

		account. It was agreed that a proposal would go to the Audit & Risk Committee on 29 September 2023.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considered that risks were being managed effectively with firm plans to triangulate current and emerging risks. The Committee received satisfactory information to be informed and briefed on the oversight of risks.
3	**Actions to be considered by the Board**	There are no specific actions to be considered by the Board.
4	**Report compiled by**	Pali Hungin, Deputy Chair of QuAC/ Non-Executive Director, K Kale, Medical Director, Beverley Murphy, Chief Nurse and Donna Keeping, Corporate Governance Manager

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report		
Report Date: 14 September 2023	**Report of the Mental Health Legislation Committee (MHLC)**	
Date of last meeting: 31 August 2023	Full quoracy was met	
1	**Agenda: The Committee considered the following agenda items during the meeting** • Scheme of Delegation • Risks aligned to Mental Health Legislation Committee • Internal Audit (Audit One) Update • Integrated Performance Dashboard, (position) • CQC Mental Health Act Monitoring Activity • Discharges from Detention • Section 136 • Section 132b – Information to detained patients (Section 132 Mental Health Act 1983) • Section 18: Absent without leave • Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) • Case study • Use of Force Act	
2a	**Alert: The Committee alerts members of the Board on the following:** **CQC Mental Health Act Monitoring Activity** During May to July 2023, there were four CQC MHA inspections undertaken on Kestrel/Kite ward, SIS Roseberry Park, Talbot ward, ALD, Lanchester Road, Hawthorn/Runswick ward, Roseberry Park and Birch Ward, AMH Eating disorders, West Park Hospital. In seeking to monitor progress against compliance with legislation, the Committee requested at its May 2023 meeting, more information on the key emerging themes identified from the inspections, which were: Discharge planning – lack of clear discharge plans for two patients, feedback after the visit was that staff were liaising with the community team. Staffing issues – where a ward was short staffed and the CQC heard patients being asked to wait on several occasions to have their requests met as the ward was busy. MHA Patients' rights, where one patient told the CQC he found it distressing to have his section 132 rights explained. There was no system in place for ensuring the patient understood their rights under section 132. One patient detained under the MHA had not had their rights explained to them. The Committee has sought further assurance on the status of outstanding actions, some of which have been active for a long period. Work is being undertaken to look at strengthening the processes to ensure patients have access to the independent mental health advocacy service (IMHAR). The Trust operates an "opt out" system, where patients should be automatically referred unless they decide not to access the service. From the numbers of referrals, it has become apparent that the policy is not being followed. Meetings are taking place with all ward managers and matrons to reinforce policy compliance. **Section 136** That there is a good level of assurance that the legislative requirements for patients held in the Trust on section 136 are being met.	

	There is concern over the growing numbers of people being detained in a 136-suite due to a lack of beds, with 35 incidences in the last quarter, where individuals were detained for over 24 hours. The Trust has also been notified that it is not just people being brought in on a section 136 who are being detained to the suite, but others who are having a MHA assessment in the community when there are no beds being detained straight to the suite without having been placed on a section136. In recognition of this growing concern, the DTVF care group have introduced standards for using the 136 suite and a process is being followed by clinical teams. Despite these measures, the Committee, recognises that the care provided to the 35 individuals who were detained for more than 24 hours is not acceptable level and would like this matter escalating to the Board. The Committee requested that checks be made to ensure that this risk sits appropriately on the Corporate Risk Register and whether there is any impact on the Board Assurance Framework. Reassurance can be provided that the bed oversight group is discussing this matter and it is included in the transformation work, which is being considered locally, regionally and at ICB level. The MDs of the Care Group Boards, in liaison with the Head of the MHL team, will initiate a Mental Health Act operational group where such matters and operational issues will be discussed.
2b	**Assurance: The Committee assures members of the Board on the following:** **Audit One: Data Quality, Mental Health Legislation Committee Reports** Following an independent audit by Audit One on the rights and discharge information reported to the MHL Committee the outcome was that "governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place". Two low priority recommendations are now complete, which relate to capturing the discharge date for a patient discharged before their rights are read and to establish a standing operating procedure. The MHL team have taken the latter recommendation further by setting out to develop SOPs for all areas on which they report. **Integrated Performance Report (IPR)** The IPR for the MHL Committee continues to contain one measure: "The number of uses of the Mental Health Act". This continues to report "reasonable performance assurance and neutral controls assurance". Work is underway by the information department to cleanse the data relating to detentions, where previously renewals of detentions were also being counted. The development of this measure has progressed significantly. An additional data item which identifies renewals was not previously feeding into the IIC from Paris. This field is now flowing through from Paris into the IIC and the logic used within the measure has been updated. Once the IPR measure is updated and approved, the Business Intelligence team will then focus on bringing the national data set logic (the MHSDS) in line with the IPR measure to ensure our position externally exactly matches our internal viewpoint. Following the update to the MHSDS, the focus will be to align the logic within the new IIC Mental Health Act dashboard. However, this is likely to be delayed until towards December 2023. TEWV has reached out to several other Trusts who have also been inaccurately recording detentions, which is raising the profile of this issue at a national level. **Discharge from Detention** There are no exceptions in the data related to discharges from detention and there is substantial assurance that the number of times detained patients are discharged by the tribunal or Hospital Managers is low and within normal range.

	Absent without Leave There is substantial assurance that the CQC have been notified of those patients who were absent without leave under the stipulated definition. The Committee sought assurance on where the operational discussions take place to address patterns and themes of AWOL patients, which is through the Patient Safety, Learning and Experience Forum and if necessary up to Care Group Boards. **Section 132b** There have been significant improvements made over the last year with patients being given their rights. From the 795 (696 previous) new detentions, the escalation process was used for 12% of patients (8% in previous quarter) and there were four patients discharged with no evidence of being given their rights. The escalation process continues to ensure that ward Managers are contacted for those areas that continue to have high numbers of escalations. The information on the escalation process has been uploaded to an IIC dashboard and is shared with care group general Managers. The outcome of the independent audit on the process and reporting of section 132 rights provides "substantial assurance" with the two low priority recommendations completed and implemented (as mentioned above). **Use of Force Act** The Committee noted the proposed next steps to improve compliance with the statutory requirements of the Use of Forces Act. (Statutory guidance came into effect in December 2021). This report, which is also presented to the Quality Assurance Committee provides a line of sight for awareness that work is ongoing across the organisation to ensure compliance, which is closely monitored via regulatory frameworks. The proposed actions from the Gap analysis are included in the restrictive intervention reduction plan for 2023/24. Quarterly updates will continue to report into MHLC.
2c	**Advise: The Committee advises the Board on the following:** **Scheme of Delegation** The Committee reviewed and approved the Scheme of Delegation, which had not changed as there have been no changes to the delegated functions of the Mental Health Act or the Code of Practice. NHS Trusts and Foundation Trusts manage NHS hospitals and the Trusts themselves are defined as the 'hospital managers' for the purpose of the Mental Health Act. The Scheme of Delegation sets out the key responsibilities and functions placed on the Hospital Managers of the detaining authority and who is authorized to exercise those functions that are delegated down to individuals, or groups of individuals on their behalf. **Risks relating to MH Legislation** The Committee noted the ongoing management and monitoring of risk 1304: DTVF: "delays in Mental Health Act being completed in a timely manner, along with a suitable bed being identified for admissions which poses a risk to patient safety and is impacting on the level of recorded incidents in the emergency department". The risk was due to be reviewed on 5 September 2023 and assurance was provided that regular meetings were in place to maintain positive relationships with the acute emergency department, TEWV daily huddles and training offered on MHA and DoLs. **Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)** There is reasonable assurance that the Trust is meeting its requirements under the MCA and reasonable assurance that the use of and reporting of DoLS is being carried out as required. Whilst the government has put on hold the plans for implementing Liberty Protection Safeguards, the MHL team continues to focus on strengthening MCA and DoLS processes and awareness. Following a Trust wide audit in December 2022 of inpatient records and the completion of capacity assessments a question has been added to the QA tool to identify if a capacity assessment was completed for consent to treatment where applicable. The monthly audit completed by inpatient areas will bring additional oversight to the recording of the Mental Capacity Act.

	Section 17 Leave Since the introduction of a standard operating procedure (SOP) and meeting with responsible clinicians for checking that section 17 leave forms are being completed in clinical areas, improvement have been made, however the issue continues of incomplete forms being submitted to the MHL team. This will need reinforcing at ward level and the MD of DTVF care group board is going to consider some quality improvement work to address this. **Case Study** – the case study provides members of the Committee with the human element and background details of patients that have been in long term seclusion. From the evaluation of the meeting, in future, reports will detail where matters are being considered outside the MHL Committee, which will give triangulation of information and mapping of governance.	
2d	**Review of Risks**	The Committee wishes to escalate the risks to non-compliance with the detention of individuals in the section 136 suites over the 24-hour period. This is also impacting on resources as there is the need for staff to take care of these individuals.
Recommendation: The Committee proposes that the Board: *i)* *Note the positive levels of assurance confirmed by the Committee.* *ii)* *Consider the escalating risk of people being detained over the 24-hour time period in section 136 suites due to lack of beds.* *iii)* *Note the progress with recording detentions, following the work of the Business Intelligence team to bring the national data set logic (the MHSDS) in line with the IPR measure to ensure our position externally exactly matches our internal viewpoint.* iv) *Note the plans to establish a Mental Health Act Operational Group to bring together compliance with legislation, sharing of data and addressing any emerging concerns or themes.*		
3	**Actions to be considered by the Board:** There are no actions for the Board to consider.	
4	Report prepared by*:* ***Pali Hungin, Chair of the Committee/Non-Executive Director, Donna Keeping, Corporate Governance Manager***	

Tees, Esk and Wear Valleys
NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 14 September 2023	**Report of: People, Culture and Diversity Committee**	
Date of last meeting: 30 August 2023	The meeting was quorate, there were apologies for absence from Ann Bridges, Executive Director of Corporate Affairs and Involvement	
1	**Agenda: The following agenda items were considered during the meeting:** • Committee Action Log - 22/73.4 • Colleague Story • Corporate Risk Register • Board Assurance Framework • Integrated Performance report • Voluntary Services' Annual Update • Delivering the People Journey – Update from the Executive People, Culture and Diversity Sub-Group • WRES WDES SOWES & Publication of Staff Equality Information • Quarterly Apprenticeship Data • Health and Wellbeing Update • Review of Workplan • HR-0017-v9 Freedom to Speak Up Policy (Whistleblowing/ Raising concerns) – revisions based on National template	
2a	**Alert** None	
2b	**Assurance** **The Committee assures members of the Board of the following:** **The Corporate Risk Register** The Committee notes that there are currently 19 risks on the Corporate Risk Register, of which 6 align to the People, Culture and Diversity Committee (1 July 2023). Compliance with timely risk and action review has dropped significantly to 63% and, therefore, offers limited assurance. However, it was reported verbally at the Committee, that the DTVF Care Group had recently reviewed all their risks and there was significantly reduced Agency spend. The Committee notes that a risk mitigation action remains outstanding from the February meeting in relation to the report structure not facilitating the monitoring of the movement of risks between Quarters. Whilst this risk has previously been escalated, the Committee recognises that this will now be addressed through the introduction of the 'Inphase' system which will 'go live' from mid-late September 2023 for incident work, following data transfer. **Board Assurance Framework** The Committee considers that there is "good" assurance that the BAF risks continue to be managed effectively based on: (1) all the risks having been recently reviewed by their Executive Leads; (2) all the controls for BAF ref 1 (Recruitment) now being assessed as operating effectively (good assurance) and the risk score having been reduced in line with the revised trajectory, and now at 10; (3) for BAF ref 5 (Staff Retention), the risk score reducing, and now being at target (10), in response to there being greater assurance in the operation of two controls. The Committee notes that there is now a Workforce Planner in post who is representing TEWV at NENC networks and reviewing the approaches used by other Trusts. NYYS reported that the Care Group are aware of their hotspots and reviewing actions on a regular basis. **Integrated Performance Report** The Committee notes an overall reasonable level of assurance based on the Performance & Controls Assurance Framework for the Board Integrated Performance Dashboard (IPD), with no areas of concern and the key change in the IPD this month being a rise in the percentage sickness absence rate during the reported month, although this is still low at 5.47% FYTD . There are Trust-wide PIPs supporting the PCDC KPIs: percentage compliance with ALL mandatory and statutory training; percentage of staff in post with a current appraisal; and finance measure PIPs for agency expenditure and safe staffing. With	

regard to staff leavers, the Committee notes the consistent downward trend from 13.85% in July 2022 to 11.5% in July 2023 with the Trust now being ranked 9th out of 71 similar Trusts nationally for this metric. Factors contributing to this include our new "Thinking of Leaving" process and the relaunch of the Transfer Scheme (with 90 people registering to date). The Committee notes that the appraisal figures have dipped below compliance targets from 85% to 82%. The extent to which the introduction of 'Workpal' may be a contributing factor to this is being explored. The Committee welcomes the doubling of responses to the Pulse Survey - increasing from 10.72% (872 people) in April 2023 to 20.87% (1697 people) in July 2023 and suggests that this should be built on for the annual staff survey in October, via promotion through the Staff Networks and offering incentives/prizes to encourage returns.

Voluntary Services' Annual Update

The Committee confirms that it has good assurance that the Trust has followed a robust process in recruiting, training, and inducting volunteers. The work of the Team and the Volunteers support the Trust's 'Journey to Change' through improving patient experience, improving staff wellbeing and the future supply of new people joining the Trust. In addition, the NHS Long Term Workforce Plan 2023 is supported as volunteering improves people's mental and physical health and gives them the opportunity to acquire skills that enhance their ability to gain employment. The Committee was pleased to learn that the team successfully won 'Non-clinical team of the year' at the Positive Practice Awards'. It was suggested that consideration could be given to encouraging more managers to take on volunteers as it was a good investment in 'grow your own staff', as they often stayed on following a good experience with TEWV.

There are a total of 223 volunteers in the Trust, with 164 being registered (84% DTVF;16% NYYS) and 59% being processed (80% DTVF;20% NYYS). The Committee considers the rurality of NYYS may prohibit volunteering, although, more was required to understand why the figure was so much lower and how learning might be shared from other parts of the Trust eg the Peer Workforce. The demographics for volunteers indicates that they are far more diverse than the paid workforce, for example: Volunteers are 70% Female and 30% Male compared with a staff workforce 80% female and 20% Male; 95% heterosexual, 5% LGB/other compared with a staff workforce 86% heterosexual, 4% LGB, 10% not declared; 80% White, 20% BAME compared with a staff workforce 93% White, 6% BAME, 1% unknown; and 75% non-disability, 25% with a disability compared with a staff workforce comprising 77% non-disability, 8% with a disability, 15% not declared. The Committee notes that there is learning from the ways in which volunteers are recruited eg via Social Media and the Mela which has resulted in a more diverse demographic.

Significant work has been undertaken on training compliance with volunteers with 100% being achieved across all measures (100% of volunteers have completed initial training; 100% of volunteers have a DBS check when role requires this; volunteers have occupational health clearance; 100% of volunteers have two satisfactory references; and 100% of volunteers have had a volunteer induction).

The Committee noted that a total of 46 people attended the Step Toward Employment Programme (STEP) in 2022/23 which was evaluated positively at 4.7 for the usefulness of the programme and 4.6 for how prepared respondents felt to apply for a post, where the rating scales were 1-5, with 5 as the highest. Other programmes completed by the team include: 19 therapy pet volunteers visiting Trust sites; partnerships with Silver Talk and Durham Age UK to provide check and chat calls to isolated people; delivery of 16 additional training course for volunteers, including boundaries, dementia awareness and autism awareness; and completion of the 3rd 'Volunteer to Career programme', aimed at helping people from the BAME community to apply for HCA roles, with participants successfully achieving paid employment.

Delivering the People Journey – Update from the Executive People, Culture and Diversity Sub-Group

The Committee notes that there has been significant progress in strengthening the governance of workforce issues in the last quarter which provides good assurance of progress in delivering the employment elements of Our Journey to Change. Examples include: the intake of newly qualified nurses is 27% higher for September 2023 compared with September 2022; work on reducing violence and

aggression towards staff has included a development session with staff from Broadmoor on introducing restorative practice and updates to the verbal aggression policy to include physical violence and a review of all related policies by a Task and Finish Group to bring them together into one overarching policy; and over 90 people registered in the first month of the relaunched Transfer Scheme (which enables people to move to another role at the same band, where they meet the essential criteria without going through the full application process), with 3 securing new jobs in the first week.

WRES WDES SOWES & PUBLICATION OF STAFF EQUALITY INFORMATION

The Committee confirms that there is good assurance that the Trust has followed a robust process in analysing its staff data by protected group and that in doing so it is meeting its NHS Standard Contract requirements and Equality Act duties. The Committee notes that there have been many areas of progress including: BAME staff and staff with disabilities are no more likely to enter the Trust's formal disciplinary and capability processes than their colleagues; the percentage of staff from a BAME background, those declaring having a disability and LGB staff have increased this year (BAME staff 5.9% compared to 5.1% last year, staff with disabilities 7.9% compared to 6.6% last year, LGB staff 4.2% compared to 3.9% last year); the pilot centralised reasonable adjustments team has commenced; the first long term health conditions reverse mentoring programme has been delivered successfully; the first mid-career programme was evaluated to have a positive impact on participants from protected characteristic groups; the staff networks continue to grow and members report that these are a positive way to engage with the organisation and the completeness of the Board's demographic data has improved.

The Committee highlights the need to closely monitor the following concerns: firstly, white people are 1.83 times more likely to be appointed from shortlisting compared to BAME people - this is higher than in previous years; and secondly, whilst the Trust is meeting its Model Employer trajectory targets for Bands 8a and above in terms of representation, it is not achieving them for Band 8c where the target is two BAME staff members. At the current time there is only one BAME Band 8c staff member. A further concern is that BAME staff, staff with disabilities and LGB staff all report higher levels of bullying, harassment, abuse and discrimination compared to other colleagues.

A total of 15% of staff have not declared if they have a disability or not and 10% of staff have not declared their sexual orientation. There is an improvement of 3.8% in the percentage of staff with a disability saying that their employer has made adequate adjustment(s) to enable them to carry out their work to 75.8%, however, the data continues to show that 24.2% of people who require workplace adjustments do not have these in place. Staff with disabilities report they are less likely than non-disabled staff to believe they have equal opportunities for career progression or promotion, are less satisfied with the extent that the organisation values their work and are less engaged than non-disabled staff. In addition, LGB staff, male staff and staff aged 16-20 are more likely to enter disciplinary processes than other staff. This year, 11 staff members responded to the staff survey identifying as 'sex not the same as assigned at birth' and the data showed that they were more likely to report higher levels of abuse, harassment, or discrimination than others with protected characteristics.

In addition, the Committee acknowledges that the proposed actions provide a clear response to the concerns raised. These include: the pilot of the virtual interview platform (SAMMI), which aims to reduce the bias in the recruitment process; developing a Trust Violence Reduction Strategy; the planned 'Stand up to bullying' campaign in February 2024; the proposed localised action plans in the Care Group Boards EDHR subgroups to address harassment, bullying, abuse and discrimination; the planned updates to EDI training to include upstanding, understanding biases, how to address discrimination; and the piloting of the 'Kind Life' programme to create a kinder and safer culture.

Quarterly Apprenticeship Data

The Committee confirms that it has good assurance that the right actions are being taken during Quarter 1 of 2023-24, to maintain the Trust's Apprenticeship workforce, including meeting its responsibilities in relation to monitoring Apprenticeship provision, safeguarding and making best use of the apprenticeship levy funding. The Committee notes that there are 510 apprentices enrolled currently onto 29 different Apprenticeships with 22 providers. It acknowledges that not being able to take on under 18s remains a strategic risk for the service and that a report is in preparation for consideration during Quarter 4.

	Health and Wellbeing Update The Committee notes that there is a reasonable level of assurance in relation to health and well-being actions. Completed actions include the following: development of a self-evaluation framework which could be extended to other initiatives, completion of data collection as evidence of the Trust working towards silver accreditation for the Better Health at Work Awards, implementation of NICE guidance about Mental Health at work and the NHS Health and wellbeing framework and; 32 people from a variety of roles across the Trust have joined the Health and wellbeing staff-led Council which will raise and allocate TEWV charitable funds on a range of initiatives. The Committee welcomes the commencement of monthly health and wellbeing training sessions commenced from September 2023 and the pilot for volunteering in staff time which has had a positive impact in IAPT services in North Yorkshire and led to an improved appreciation of the Trust, including some members of the Executive Board who also participated. In addition, the Committee supports the work which has been undertaken in respect of the risk assessment containing all the information relevant to an individual such as Health and Safety Executive, reasonable adjustments and Covid. **HR-0017-v9 Freedom to Speak Up Policy (Whistleblowing/ Raising concerns) – revisions based on National template** The Committee assures that the Freedom to Speak Up (Whistleblowing/Raising Concerns) Policy has been revised to adopt the National Guardian's Office policy template as developed with NHSE&I. All NHS providers are to adopt this policy and include their local information in any revision. The policy attached at Appendix 1 includes the Trust's local information.	
2c	**Advise** **The Committee advises the Board that:** **Committee Action Log – 22/73.4** The Committee re-opened a previously closed action from 7 November 2022 relating to the review of the DNC role and links with the On-Call function. This had commenced earlier in 2023, however, the review had paused pending the arrival of the new Deputy Chief Nurse which was seen as having an integral oversight role for this process. The review has now recommenced with the arrival of the postholder and leads from each Care Group have been identified. The Committee notes that a commitment has been given by the lead for the review to co-production/engagement with staff side and Care Group delivery. In addition, a deadline for the conclusion of the work will be agreed within a short timescale and the work will be progressed in a timely and robust manner, given its importance as a quality and safety matter. **Colleague Story** The menopause affects women in their 40's-50's, however, the peri-menopause can begin up to 10-12 years prior to this. A Menopause Champion and colleague from a Community Team in Durham provided insight into the impact of the menopause on women's working lives in terms of their experience of the working environment, and the effect on their mental and physical health. They recognised that the Menopause Café was a good source of support, as well as GPs. However, anecdotal evidence indicated many women passed over promotions, 'downgraded' themselves or even gave up work due to the impact of the menopause on their perception of their ability to successfully fulfil their role. The Committee notes the need for a supportive network and the importance of raising awareness across all staff as people often did not recognise physical health symptoms such as migraines and 'brain fog' as being linked to the menopause. The Committee notes that the Trust does not yet have a Menopause Policy and has not signed the Menopause Pledge to date nor been independently accredited as an 'Menopause Friendly Employer'. The Committee supports adopting this approach and will take this forward as a future action.	
2d	**Risks**	No new risks identified. The Committee has previously highlighted and escalated the risk in relation to the report structure not facilitating the monitoring of the movement of risks between quarters. It now recognises that this will be addressed through the introduction of the 'Inphase' system which will 'go live' from mid-late September 2023 for incident work, following data transfer.

Recommendation: The Board is asked to note the contents of this report.		
3	**Any Items to be Escalated to another Board Sub-Committee/Board of Directors**	The proposed way forward for the review of the DNC arrangements are escalated to QUAC for information/future monitoring
4	**Report compiled by:** Deborah Miller, ***Corporate Governance Manager*** Jillian Haley, ***Non-Executive Director/Interim Deputy Chair (Committee Chair)*** Kate North, ***Deputy Director of People and Culture*** Minutes are available from: Deborah Miller	

DM/8/09/2023

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Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

Meeting of:	**Executive Management Team**
Date:	**14 September 2023**
Title:	**Revalidation/Appraisal Annual Report**
Author(s):	**Kedar Kale, Lenny Cornwall, Elaine Corbyn, Chloe Casson**

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

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

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

Strategic Risks relating to this report:

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

Executive Summary:

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

It highlights compliance rates for appraisal and revalidation amongst our doctors for the previous appraisal year (2022-23) and the supporting narrative explains the processes we have in place. The report also shows the number of doctors who were managed under 'Responding to Concerns' and demographic information relating to such concerns during the reporting period.

Proposal:

All Responsible Officers are asked to present an annual report to their Board or equivalent management team along with the statement of compliance in order to provide a substantial level of assurance that our doctors are fit to practice. The statement of compliance should be signed off by the Chief Executive or Chairman of the Designated Body's Board or management team and submitted to NHS England by 31st October 2023.

Overview:

The purpose of revalidation is to provide **assurance** to patients and the public, employers and other healthcare professionals that licensed doctors are up-to-date and fit to practise. This aim will be achieved through annual appraisal and processes supporting revalidation.

By presenting our appraisal and revalidation data within this report which shows we have strong compliance in these areas as we had no 'unapproved' missed appraisals in 2022-23, it is hoped this will give **good assurance** that we uphold a strong system for appraising and revalidating our doctors.

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

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

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

REVALIDATION / APPRAISAL ANNUAL REPORT
1st April 2022 – 31st March 2023

Management of Appraisal and Revalidation

Responsible Officer:	Dr Kedar Kale
Associate Responsible Officer:	Dr Lenny Cornwall
Medical Development and	Mr Bryan O'Leary
Medical Management:	Mrs Elaine Corbyn
	Mrs Chloe Casson
	Dr Tolu Olusoga (GMD – South Care Group)
	Dr Suresh Babu (GMD – North Care Group)
	Dr Kirsty Passmore (GMD – North Care Group)
	Dr Hany El Sayeh (Director of Medical Education)

Activity Levels

Number of doctors that TEWV are responsible body	Consultant		SAS		Trust Doctors/MTI	
	2021–22	2022–23	2021-22	2022–23	2021-22	2022–23
Adult Mental Health	64	62	26	28	11	5
Mental Health Services for Older People	31	30	17	19	1	4
Child and Young Person's Services	35	33	7	8	0	0
Learning Disabilities	11	12	2	3	0	0
Forensic Services	16	15	2	2	3	1
Total:	**157**	**152**	**54**	**60**	**15**	**10**

Comments:
A total of 222 doctors had a prescribed connection with TEWV as at 31st March 2023.

Number of doctors who were due for an appraisal	Consultant		SAS		Trust Doctors/MTI	
	2021-22	2022–23	2021-22	2022–23	2020-21	2022–23
Adult Mental Health	61	59	22	20	8	4
Mental Health Services for Older People	28	28	13	15	0	3
Child and Young Person's Services	34	32	7	6	0	0
Learning Disabilities	11	12	2	3	0	0
Forensic Services	15	15	2	1	2	1
Total	**149**	**146**	**46**	**45**	**10**	**8**

Comments:
The table above illustrates the number of doctors that were due an appraisal in the last appraisal year between 1st April 2022-31st March 2023.

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

These account for the difference of 6 in the consultant figure as there were 6 new consultants who commenced employment with the Trust during the last year and therefore were not due an appraisal as of 31st March 2023. In addition, there were 15 new SAS doctors who were not due an appraisal at this time. There were also 2 Trust doctors who were not due a 'priming appraisal' at 31st March 2023 as they joined in February 2023 and are due their priming appraisal 2 months after joining.

Number of doctors who have had an appraisal in the appraisal year	Consultant		SAS		Trust Doctors/MTI	
	2021-22	2022–23	2021-22	2022–23	2021-22	2022–23
Adult Mental Health	59	58	19	19	7	4
Mental Health Services for Older People	28	28	13	13	0	2
Child and Young Person's Services	33	29	6	4	0	0
Learning Disabilities	11	12	2	3	0	0
Forensic Services	14	15	2	1	2	1
Total	**145 (97%)**	**142 (97%)**	**42 (91%)**	**40 (89%)**	**9 (90%)**	**7 (88%)**

Comments:
The figures in the table above show the number of doctors that have had an appraisal between 1st April 2022 - 31st March 2023. The overall compliance rate for appraisals in 2022-23 was 95%.

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

Exceptions

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

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

Number of 'approved missed or incomplete appraisals'	Consultant	SAS	Trust Doctors/MTI
Adult Mental Health	1	1	0
Mental Health Services for Older People	0	2	1
Child and Young Person's Services	3	2	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	**4**	**5**	**1**

Comment:
The consultant exceptions are due to 3 consultants being on long term sick and 1 consultant retiring for a significant part of the year and then returning to work. This resulted in the doctor not being able to do an appraisal before 31st March 2023.

The SAS doctor exceptions are all due to long term sickness.

The Trust doctor exception is due to 1 'priming appraisal' which was booked for March 2023 that was re-scheduled after 31st March 2023 due to the meeting being unable to go ahead because of IT connectivity issues.

The table below illustrates the 'unapproved missed or incomplete appraisals'. This group of doctors have not completed their appraisal in the appraisal year, neither have they sought any agreement of this from the Associate Responsible Officer. As you can see, none of our doctors fall into this category.

Number of 'unapproved missed or incomplete appraisals'	Consultant	SAS	Trust Doctors/MTI
Adult Mental Health	0	0	0
Mental Health Services for Older People	0	0	0
Child and Young Person's Services	0	0	0
Learning Disabilities	0	0	0
Forensic Services	0	0	0
Total	**0**	**0**	**0**
Comments:			

Revalidation

Number of doctors completing revalidation cycle	Consultant		SAS		Trust Doctors	
	2021-22	2022–23	2021-22	2022–23	2021-22	2022–23
Adult Mental Health	10	12	9	3	1	1
Mental Health Services for Older People	6	2	3	4	0	0
Child and Young Person's Services	6	4	2	1	0	0
Learning Disabilities	3	2	0	2	0	0
Forensic Services	3	1	0	1	0	0
Other	0	0	0	0	0	0
Total	**28**	**21**	**14**	**11**	**1**	**1**

Number of doctors receiving revalidation recommendations	Consultant		SAS		Trust Doctors	
	2021-22	2022–23	2021-22	2022–23	2021-22	2022–23
Adult Mental Health	9	12	7	2	0	0
Mental Health Services for Older People	6	2	3	3	0	0
Child and Young Person's Services	5	4	2	1	0	0
Learning Disabilities	3	2	0	2	0	0
Forensic Services	3	1	0	1	0	0
Other	0	0	0	0	0	0
Total	**26**	**21**	**12**	**9**	**0**	**0**
Comments: Of the 33 doctors that were due for revalidation between 1st April 2022-31st March 2023, the Trust revalidated 30. This meant 3 doctors had their recommendation deferred. This was a result of 2 doctors on sick leave and the other doctor was in a Trust doctor role who had insufficient evidence from his previous employment for us to make a recommendation for revalidation at the time.						

Performance Review, Support and Development of Appraisers

Training of Appraisers

	Consultant		SAS	
	2021-22	2022-23	2021-22	2022-23
Number of enhanced appraisers	54	48	6	7
Number of enhanced appraisers carrying out appraisals in appraisal year	54	48	6	7
The Trust trained one new appraiser in March 2022. They were ready to start the role in April 2022.				

Support and Development of Appraisers

Update/Support Sessions	**Update/Support Sessions**
18th May 2022	16th November 2022
28th September 2022	8th February 2023
Comment: There are two different training sessions held each year and these are both repeated once, providing greater opportunity for colleagues to attend. The sessions in May and November are face to face, whilst September and February are operated on MS Teams virtually. This provides appraisers with options of how they wish to attend. As part of the session, the Trust provides appraisers with an opportunity to share feedback and/or issues that they may have experienced.	

Performance Review of Appraisers

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

Quality Assurance of Appraisals

The Trust took 38 appraisal summaries from doctors who were revalidated in the previous year 2021/22. These summaries were anonymised and ten volunteer appraisers were selected to rate 7 or 8 summaries each as part of a quality improvement exercise.

Each summary was rated by two different appraisers, with feedback provided to the appraisers at the appraiser update sessions in November and February. This will be repeated in Summer 2023 for the doctors who were revalidated throughout 2022/23.

Responding to Concerns about doctors in TEWV

Total Number of All doctors who were managed under 'Responding to Concerns' (includes 'Low Level' and 'Investigations')	Consultant				SAS				Trust Doctors/MTI			
	2021/22		2022/23		2021/22		2022/23		2021/22		2022/23	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	1	1	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	3	0	1	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	1	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	1	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	1	0	0	0	1	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**4**	**0**	**2**	**0**	**3**	**1**	**0**	**0**	**0**	**0**	**0**	**0**

Comments: The following is the demographic information relating to all doctors detailed above.

Code	Ethnicity	No. of Doctors 2022/23Only
SE	Other Specified	
C	White – Any other white background	2
CQ	CQ White ex USSR	
N	Black or Black British – African	
L	Asian or Asian British – Any other Asian background	
H	Asian or Asian British - Indian	

Age Range of All Doctors – 2021/22				
	Aged 30-40	Aged 41-50	Aged 51-60	Aged 61-70
Male Consultants		1		1
Female Consultants				
Male SAS Doctor				
Female SAS Doctor				
Male Trust Doctor				
Female Trust Doctor				

Total Number of doctors spoken to under 'Low Level Concerns'	Consultant				SAS				Trust Doctors/MTI			
	2021/22		2022/23		2021/22		2022/23		2021/22		2022/23	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	1	1	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	1	0	1	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	1	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	1	0	0	0	1	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2**	**0**	**1**	**0**	**3**	**1**	**0**	**0**	**0**	**0**	**0**	**0**

Comments:

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

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

This year there has only been one low level concern form submitted compared to five in 2021/22. Whilst there is no evidence to suggest the reason for this, Medical Development work closely with managers at a very early stage and this may prevent the need to formally document an issue or concern and more likely it will have been dealt with through discussion at a supervision meeting. A training session was held with Wardhadaway and Medical Development in 2022, where 'Dealing with Concerns affecting Medical Staff' was discussed in detail, including within was when to complete a Low Level Concern form. It is expected that further awareness sessions will run during 2023/24.

Total Number of doctors where investigation was necessary 'More Serious Concerns'	Consultant				SAS				Trust Doctors/MTI			
	2021/22		2022/23		2021/22		2022/23		2021/22		2022/23	
	M	F	M	F	M	F	M	F	M	F	M	F
Adult Mental Health:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	2	0	0	0	0	0	0	0	0	0	0	0
Mental Health Services for Older People:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Child and Young Person's Services:												
Teesside	0	0	1	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Learning Disabilities:												
Teesside	0	0	0	0	0	0	0	0	0	0	0	0
Durham & Darlington	0	0	0	0	0	0	0	0	0	0	0	0
North Yorkshire & York	0	0	0	0	0	0	0	0	0	0	0	0
Forensic Services:												
Forensics	0	0	0	0	0	0	0	0	0	0	0	0
Forensics LD	0	0	0	0	0	0	0	0	0	0	0	0
Total	**2**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Comments:
In 2022/23 there was only one investigation. Following the investigation, it was decided that a formal action plan would be put in place which would be monitored by the doctor's line manager.

One of the actions was to ensure that the situation that led to the investigation was thoroughly reflected upon in writing and discussed in their annual appraisal. The Trust can confirm that all actions have subsequently been addressed and the action plan is now signed off.

Ongoing Actions

Responding to Concerns – Remediation/Disciplinary

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

The Policy followed in relation to Trust doctors is called 'Dealing with concerns affecting medical staff policy'.

Electronic IT System

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

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

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

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

The Trust held five job plan consistency panels for each specialty which began in May 2022 and these meetings helped to identify areas where further training was required. This was subsequently delivered in December 2022 before the 2023 job planning round began.

The contract with SARD JV was therefore renewed in October 2019 on a contractual model of 3+1+1 years.

Learning from Revalidation

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

The third cycle of revalidation is now underway for a number of doctors, despite revalidation being postponed by the GMC during most of the 2020/21 year.

Other Information:

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

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

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

The Trust has reviewed the Academy of Medical Royal College's (AOMRC) medical appraisal guide 2022 so that it could compare and contrast its own approach to that outlined and determine if any change to the process was necessary. The Trust is not making any immediate changes for April 2023 but will consult doctors about potential changes.

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Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Tees Esk and Wear Valleys NHS Foundation Trust can confirm that:

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

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

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

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

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: N/A Comments: Yes, this is done by the Medical Development team under the management of Dr Kedar Kale. Names are recorded via GMC Connect. Action for next year: This process remains ongoing as described above.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: N/A Comments: Yes, our policy & procedure is reviewed every 3 years. They were last updated August 2022. Action for next year: N/A

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: N/A

Comments: This exercise is currently in its fifth year of being carried out and last took place between July-September 2022. We use the appraisal summaries for those doctors who were revalidated in the last year. Whilst we don't have the results for this year just yet, we have seen an improvement in the quality of our appraisal summaries in the previous years. We provide feedback of the results of this exercise at our appraiser networks which we run 4 times a year.

Action for next year: To continue to undertake a peer review of a selection of appraisal summaries to review their quality.

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

Action from last year: N/A

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

Action for next year: To continue with the above.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

[1] For organisations that have adopted the Appraisal 2020 model (recently updated by the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those

Action from last year: N/A

Comments: As a Trust we decided not to use the Appraisal 2020 model, we continued with our normal process for collecting evidence for appraisal.

Action for next year: To continue as above.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: N/A

Comments: We have an appraisal policy and procedure in place which is followed in this instance.

Action for next year: No action identified.

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

Action from last year: N/A

Comments: Yes. Our Trust appraisal policy and procedure were last updated in August 2022 and were approved at the Medical Directorate management meeting. The policy and procedure follows national guidance.

Action for next year: None - next policy review due 2025.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: N/A

Comments: Yes. There were 55 appraisers for 222 doctors in 2022/23.

Action for next year: To continue to monitor the number of appraisers to ensure we always have enough to cover the appraisal cycle.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal

organisations that have not yet moved to the revised model may want to describe their plans in this respect.

network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: N/A Comments: Yes, there are normally four training sessions a year, of which appraisers must attend at least two. These were ran in May, September, November 2022 and February 2023. We also provide feedback to appraisers from appraises and these are discussed at the appraisers own appraisal. Action for next year: To continue to run these training sessions.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

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

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	**222**
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**212**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**10**
Total number of agreed exceptions	**10**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: N/A

Comments: Yes. Good communications exist with no concerns raised from either side. In addition regular meetings occur between the Responsible Officer and the GMC's ELA which are minuted – these allow for ongoing concerns and low level concerns to be regularly reviewed.

Action for next year:

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: N/A

Comments: Yes, letters are sent to doctors following recommendations from the RO and if unable to make recommendation the doctor is contacted immediately.

Action for next year:

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: N/A

Comments: There are effective and well established processes in place for pre-employment checks, medical appraisal and revalidation, and responding to concerns. Within this, roles and responsibilities are clearly defined. The medical directorate has dedicated expertise and is adequately resourced to carry out its function.

Action for next year:

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: N/A

Comments: There is a disciplinary policy for maintaining high professional standards. Issues around conduct and performance can be identified from

multiple sources, including formal complaints, SUIs, Guardian of Safe Working, and the Freedom to Speak up Guardian, Monitoring of any conduct and performance issue is undertaken within the medical development team. Processes are in place to allow this to be done under a variety of different formats, depending on the seriousness of the concern e.g. low level concerns and disciplinary investigations. The department receives PALS/Complaints and SUI reports each month and this is documented on the supporting information which is sent to doctors ahead of their appraisal. All doctors have a line manager who monitors performance.

Action for next year:

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:

Comments: We have a medical remediation and disciplinary procedure for dealing with all concerns, including low level concerns, which is monitored.

Action for next year:

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year:

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

Action for next year:

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

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

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

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

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

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

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following:

- **General review of actions since last Board report**

In the last year we have reviewed the recommendations by the Academy of Royal Medical Colleges to consider changes for the 2023-24 appraisal year.

- **Actions still outstanding –** None
- **Current Issues -** We acknowledge that the electronic system which we use for appraisal and Job planning 'SARD' has its limitations at times, which can impact on our processes. Our contract for this is due for tender in October 2024.
- **New Actions:**

Overall conclusion:

Our governance arrangements and assurance processes for doctors employed within TEWV remain robust and fit for purpose.

Section 7 – Statement of Compliance:

The Board of Tees Esk and Wear Valleys NHS Foundation has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

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

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

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

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The NExT Director scheme - supporting tomorrow's non-executives

A practical guide for NHS host trusts and placements

1. Introduction

1.1. Two of NHS England's (NHSE) key strategic objectives are to *'develop, maintain and enhance effective boards'* and to expect the board of every NHS provider *'to reflect the diversity of the people it serves'*. To help meet these objectives, we have developed the NExT Director scheme to support the creation of a pipeline of strong and diverse candidates for future non-executive director roles in the NHS.

2. What is the NExT Director scheme?

2.1. The NExT Director scheme provides support to senior people from groups who are currently under-represented on trust boards with the skills and expertise necessary to take that final step into the NHS board room. Following success in London, the Midlands and East the scheme is being expanded. The focus of the scheme will be on supporting women, people from BAME communities or with disabilities into NHS board roles. People with other protected characteristics that are under-represented on boards may also be considered for inclusion in the scheme.

2.2. The NExT Director scheme will give participants a unique insight into the role and responsibilities of being an NHS non-executive director by helping them to bridge gaps in their own experience such as:

- Operating at board level
- Transition from executive to non-executive roles
- Board level exposure in organisations of huge size and complexity
- Gain knowledge of NHS structures and accountability, how the money flows, who the key partners are, where all the regulators fit and the board's role in quality and safety.

2.3. Individual NExT Directors will be offered a placement with an NHS healthcare provider in their area, over a 12 month period and will give them the opportunity to learn first-hand about the challenges and opportunities associated with being a non-executive director (NED) in the NHS today. Each placement will be shaped to meet the individual needs of participants but will include a range of support such as:

- Access to board and committee meetings and papers, including an opportunity to review and analyse meetings to learn with board members, as appropriate;
- The assignment of an experienced NED mentor for the period is critical to help shape the NExT Director's personal programme and provide regular feedback and advice;
- Access to training and networking opportunities available to substantive non-executive directors.

3. The NExT Directors

3.1. The NExT Directors were identified from a range of sources and have been through a selection process by NHSE's Non-executive Talent and Appointments Team to ensure that they have the attributes needed to be a NED one day and that they are willing and able to make the most of the opportunity provided by the scheme. They were then "matched" with participating trusts based on their geography and any service area preferences before being introduced to the trust chair, to ensure they were a good fit for that organisation.

3.2. All NExT Directors have been subject to due diligence checks and have signed the NExT Director Placement Agreement at Annex A before their placement was confirmed.

4. A strong starting point

4.1. There will be a short planning period before any placement starts to give both the NExT Director and their host trust the opportunity to prepare so that the placement gets off to a strong start. Each placement will be different but before starting NExT Directors and their trust should have a high level, shared understanding of what it will offer and the level of commitment the NExT Director will be able to make.

4.2. In this planning period, and before the placement starts, the trust chair should:

- Ensure there is "buy-in" from the whole board and establish some basic rules of engagement that wherever possible are inclusive – ie will the NExT Director have access to confidential sections of board meetings, or be invited to participate in discussions? NB – individuals will have different levels of experience and these arrangement can always be changed as the relationship between the NExT Director and trust develops over the placement;

- Identify an experienced NED from within the trust to act as mentor to the NExT Director – some host trusts identified more than one mentor but it is important everyone understands who is responsible for what;

- Ensure the NED Mentor meets their NExT Director to explain the rules of engagement and agree the first set of high level outcome based development objectives. The NExT Director should confirm the time commitment they are able to give to the placement, we estimate a minimum of two days a month, whether they have the support of their employer (where appropriate), and confirm their availability for key board / committee dates which for many trusts will be during the day;

- Ensure administrative arrangements to allow NExT Directors to have access to board and committee meetings and papers, as required and to claim travel expenses if required;

- Ask the NExT Director to sign a confidentiality agreement if he / she will have access to confidential board meetings and sub-committees or other sensitive information. Depending on the level of contributions envisaged by individual NExT Directors consider whether indemnity arrangements would be appropriate;

- Ensure that NExT Directors who will receive sensitive information know how to and are able to protect it properly. This may mean creating a secure email address, providing access to the same IT as NEDs and providing the appropriate Information Governance training;

- Develop a comprehensive local induction programme for the NExT Director. Individual trusts should determine what this will be and how this is delivered, depending on local circumstances, but it could be based on the induction provided to new substantive NEDs, and include information about the key policies and procedures that may be relevant during the NExT Director's placement; and

- Provide the NExT Director with a tour of the major sites of the trust and an opportunity to meet key members of staff. It is important that he / she is introduced to both the executive and NED team, as well as key members of the trust's wider management team.

5. NED mentors

5.1. NED mentors are experienced non-executives responsible for making sure their NExT Director is provided with the support they need during their placement and are therefore critical to its success. It is not expected that it will be too time consuming but should include:

- Regular diarised meetings with the NExT Director before and after each board meeting to discuss key issues and observations and answer any questions they may have;

- Regular and timely feedback between mentors and NExT Directors including honest reviews of development objectives. Regularly refresh these objectives and consider establishing a deliverable project - this will ensure the learning experience is targeted and productive. Experiences and exposures need to be tailored to the development needs of each individual and their journey to step into a NED role on an NHS board;

- Arranging opportunities to learn from other board members and key staff, as appropriate.

6. Maximising the placement

6.1. Any programme should be customised to the development needs of each NExT Director (see above). This paragraph provides a list of ideas that will help the trust and the NExT Director get the most from the placement:

- NExT Directors should take responsibility for their own learning and development by documenting experiences and learning outcomes, and identify areas the trust can help them develop further;

- Arrangements should be made to provide NExT Directors with a full briefing on the NHS, the trust and its stakeholders – internal and external - as part of or soon after the induction programme;

- NExT Directors should be encouraged to feel part of the team and depending on individuals experience could be invited to take part in board discussions. If this isn't possible then participating in committee debate may be more appropriate;

- Consider inviting NExT Directors to participate in any organised programme of NED ward and / or site visits, or allocate a senior member of staff who could accompany them on such visits;

- Opportunities for the NExT Director to shadow key senior staff should be offered, and meetings with representatives from staff and patient groups, HealthWatch, volunteers and hospital charities should be considered.

- Consider whether the NExT Director should observe public board meetings of other trusts in the area to gain an insight into other leadership styles and approaches to governance as well as other types of providers;

- NExT Directors will be strongly encouraged to network with and learn from other NExT Directors. NHSE will be able to support them in this (see below).

7. Support from NHSE

7.1. Workshops, networking events and webinars will take place throughout the year, the agendas for which will be largely driven by the NExT Directors and will give them exposure to subjects of wider interest both within and without the NHS. They will also provide an opportunity to reinforce connections between NExT Directors and allow them to share experience and learn from each other.

7.2. Regular tracker conversations with providers and NExT Directors will enable NHSE to track progress, quickly identify any potential issues and offer advice / guidance to ensure that the scheme provides the best possible experience and outcomes.

7.3. Access to the NExT Director network and useful reading materials.

8. Moving towards the end of a placement

8.1. Placements with a trust can be for any period of up to twelve months, and NExT Directors can opt to rotate to a placement on a different trust if this matches their development needs. For example, an individual may wish to increase understanding of challenges faced by other service providers or exposure to different approaches to governance. If after six months it is felt that a NExT Director would benefit from such a move they and their current trust should contact NHSE to discuss options before the current arrangement comes to an end.

8.2. At the end of any placement, the trust should provide their NExT Directors with a structured appraisal, including an honest assessment of their progress and how close they are to being “board ready”. The NExT Directors should also be clear about

any further development needs and be given guidance on how they might fill any gaps in their knowledge and experience going forward, particularly if the NExT Director is moving on to another placement.

8.3. At the end of the scheme, NHSE will offer NExT Directors additional support in applying for NHS NED roles in the future, including help preparing CVs and applications: independent panel assessment with a mock interview, summing up session, introductions to head-hunters, and scheme evaluation questionnaire.

Annex A

NExT DIRECTOR PLACEMENT AGREEMENT

This is important information about your placement as part of the NHS England (NHSE) NExT Director Scheme. Please read it carefully and contact the NHSE Non-executive Talent and Appointments Team if you have any queries.

1. **The NExT Director Scheme** – provides you with an opportunity to gain first-hand experience of an NHS board through a placement with an NHS trust or NHS Foundation Trust. Although this will give you access to board and committee meetings, you will have no formal board role. This is not a public appointment or employment and does not entitle you to a position with the host Trust or any other Trust at the end of your placement.

2. **Principles of public life** - Public service values are at the heart of the NHS and Trust boards play a critical role in shaping and exemplifying an organisational culture that is open, accountable, compassionate, and puts patients first. Respect, compassion and care are at the centre of good leadership and governance in the NHS, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful with patients and the public. You are therefore expected to:
    - understand and commit to the personal behaviours, values, technical competence and business practices outlined in "The standards for members of NHS boards and clinical commissioning group governing bodies in England" produced by the Professional Standards Authority;
    - reflect the standards of selflessness, integrity, objectivity, accountability, openness, honesty and leadership set out in the Seven Principles of Public Life;
    - uphold the policies and procedures adopted by the host Trust;
    - treat any information that is gained during the course of your placement with the Trust in the strictest confidence.

3. **Time commitment** – To get the most from your experience, you should attend all of the board, committee and other meetings you have agreed as with your mentor that you should attend as part of your development. You should confirm the time commitment you are able to give to the placement with your Trust, a minimum of two days a month, and whether you have the support of your employer (where appropriate).

4. **Public speaking** – You should not make political speeches or engage in other political activities relating to the work of the Trust during your placement.

5. **Conflicts of interest** – At the beginning of your placement you should declare to the Trust any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services that may be relevant to the Trust.

6. **Visiting guidelines** - Visits to wards or other areas with access to patients must always be accompanied and planned beforehand, identifying where you are going and who you will speak to. Senior staff should be notified well in advance and always be clear about who you are and why you are there.

7. **Change in circumstances** - You should also notify the Trust and NHSE if there is any change to your situation or connections during the period of your placement. Any failure to do so could jeopardise the reputation of the Trust and / or NHSE and result in an end to your placement.

8. **Allowances** – Your Trust can reimburse you for reasonable and receipted travel and expenses incurred during your placement if necessary.

9. **Length of placement** – Your placement will last for a period of up to 12 months. You may leave the scheme at any time by giving notice to your Trust and NHSE. Where possible, you should first speak with the chair of your host Trust.

10. **Ending your placement** - When your placement comes to an end, for whatever reason, you will immediately return any Trust property in your possession or under your control, and irretrievably delete or destroy any electronic or other information you hold that is relating to the business of the Trust and if requested, provide a signed statement that you have complied with this obligation.

I have read and understand the information above:

SIGNED…….. Date……..

PRINT NAME…….

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