MEETING OF THE BOARD OF DIRECTORS

Thursday 11 January 2024
at 1.30pm

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

AGENDA

NOTE: there will be a confidential session at 1.00pm for the Board of Directors 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	Minutes of previous meetings held on: a. 9 November 2023 b. 14 December 2023	Chair	 Minutes Minutes
5	Action Log	Chair	Report
6	Chair's Report	Chair	Report
7	Questions raised by Governors in relation to matters on the agenda *(to be received by 1pm on Tuesday 9 January 2024)*	Chair	Verbal

Strategic Items (1.50 pm – 3.00 pm)

8	Board Assurance Framework Summary Report	Co Sec	Report
9	Chief Executive's Report	CEO	Report
10	Integrated Performance Dashboard	Asst CEO	Report

Break – 10 mins

11	Corporate Risk Register	CN	Report
12	Charitable Trust Fund Annual Report and Accounts for 2023/24	EDoFI&E	Report

Goal 1: To co-create a great experience for our patients, carers and families (3.00 pm – 3.30 pm)

13	Leadership Walkabouts Report	EDoCA&I	Report
14	Report of the Chair of Quality Assurance Committee	Committee Chair (BR)	Report
15	Report of the Chair of Mental Health Legislation Committee	Committee Chair (PH)	Report

Goal 2: To co-create a great experience for our colleagues (3.30 pm – 4.00 pm)

16	Report of the Chair of People, Culture & Diversity Committee	Committee Chair (JM)	Report
17	Guardian of Safe Working, quarterly report	Int. GoSW (D Burke)	Report

Exclusion of the Public:

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

	(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.		

David Jennings
Chair
5 January 2024

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 9 NOVEMBER 2023 AT WEST PARK HOPSITAL, DARLINGTON AND VIA MS TEAMS, COMMENCING AT 1.30PM

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
B Reilly, Non-Executive Director and Deputy Chair
R Barker, Non-Executive Director
Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group
C Carpenter, Non-Executive Director
P Hungin, Non-Executive Director
J Maddison, Non-Executive Director
B Murphy, Chief Nurse
J Preston, Non-Executive Director and Senior Independent Director
L Romaniak, Executive Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
A Bridges, Executive 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, Executive Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary (minutes)
T Olusoga, Consultant Psychiatrist (on behalf of K Kale, Executive Medical Director)

Observers/members of the public:
M Bell, staff
S Double, Alder
D Longton-Worley, staff
J Wardle, Governor

23-24/108 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and commented on the staff story received prior to the formal meeting and their balanced assessment of the trust's position.

23-24/109 APOLOGIES FOR ABSENCE

Apologies for absence were received from J Murray, Non-Executive Director, K Kale, Executive Medical Director and from L Romaniak, Executive Director of Finance and Estates for lateness due to an urgent national Directors of Finance webinar.

23-24/110 MINUTES OF THE LAST MEETING ON 12 OCTOBER 2023.

The minutes were agreed as an accurate record of the meeting, subject to the following correction: '*…data collection and could have confidence in publishing the results…'* [para 23-23/106 refers].

23-24/111 BOARD ACTION LOG

In discussion the following points were raised:

1. P Bellas noted that the board would discuss the revised Board Assurance Framework risks later in the meeting, ahead of development and agreement at the board meeting in January, and related actions would then progress.

2. P Hungin undertook to circulate a briefing to the board, following the delay in progress of mental health legislation through parliament.

3. P Bellas confirmed that work had been undertaken on proposals for board meeting arrangements for 2024/25 and seminars linked to the trust's Delivery Plan.

4. J Preston noted the publication of a report by Baroness Hollins on those with a learning disability and/or autistic people and proposed a board seminar on this topic.

Action: P Bellas

He also advised that the Council of Governor's Autism Task and Finish Group would present its report to the Council of Governor's on 4 December.

The Chair welcomed the work undertaken by Governors and the contribution they had made to policy development.

23-24/112 CHAIR'S REPORT

The Chair presented the report and commented on the sense of caring and community, and the value of services, which was apparent at Ridgeway Star Awards, largely organised and presented by service users and their families.

He noted the publication of the CQC well-led inspection report and suggested that, although there remained more to do, the report demonstrated the effort and progress made by all staff across the trust and he put on record his thanks to them. In response to query, he proposed that CQC assessment methodology continued to evolve and noted that mental health trust Chairs had provided feedback on the CQC on reporting structure.

[L Romaniak joined the meeting].

The Chair provided an update on the Council of Governors' Task and Finish group on the role of a governor, which was expected to report to Council of Governors early 2024. Commenting further, A Bridges noted that work undertaken by the group would provide clarity on the role of a governor versus the role of a Non-Executive Director and examples of good practice.

23-24/113 QUESTIONS FROM GOVERNORS

None raised.

23-24/114 BOARD ASSURANCE FRAMEWORK

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

The Chair welcomed the updated report and noted the positive and negative assurances that were summarised.

B Murphy advised that Quality Assurance Committee would hold an extraordinary meeting to review the trust's response to the CQC report and current and revised BAF risks. The Chair noted that a board seminar the following week would also support further refinement of BAF risks alongside development of the 2024/25 Delivery Plan.

23-24/115 CHIEF EXECUTIVE'S REPORT

B Kilmurray presented the report, which highlighted topical issues that were of concern.

He acknowledged publication of the CQC report and thanked the communications team for their support and all staff for their hard work in implementation of Our Journey to Change. He noted that stakeholders had been supportive and were interested to hear more about the trust's journey and next steps.

In addition to the information provided in the report, he commented on:

- The Humber, North Yorkshire, Mental Health, Learning Disabilities and Autism Annual Conference and the report published by Baroness Hollins which set out a range of recommendations that the trust and partners would respond to.
- A children and young people summit held in North East North Cumbia, supported by service users and carers, which had highlighted barriers to services and the complexity in navigating systems.
- An announcement of additional national funding by NHS England, in acknowledgment of industrial action and wider system pressures.

In discussion, the following points were raised:

1. B Reilly, Chair of Quality Assurance Committee, expressed confidence that the trust would develop a robust CQC action plan.
2. B Reilly queried evidence of progress on Niche recommendations where a system wide approach was required, and B Kilmurray confirmed that partners would have the opportunity to demonstrate progress individually and collectively.
3. C Carpenter welcomed the trust's approach to communications and stakeholder engagement following publication of the CQC report and the proposed Quality Summit.
4. The Chair noted that the board had discussed a communications and stakeholder strategy to support proactive engagement across a range of areas and to ensure a balanced narrative, and he welcomed the recent Health Service Journal article.

23-24/116 CQC CORE SERVICE AND WELL-LED INSPECTION 2023

B Murphy presented the report, which outlined the outcome of the CQC core service and well-led inspection.

She added her thanks to those of the B Kilmurray and Chair, for the efforts of staff and went on to note that robust governance arrangements were in place to ensure the development and submission of the improvement plan.

In discussion the following points were raised:

1. P Hungin welcomed the improvements reported and queried if there was clarity on the rationale for the overall trust rating.

   In response and in respect of the safe domain, B Murphy suggested that the trust had been able to demonstrate improvements made and the overall rating reflected that there remained a number of challenges related to staff shortages, staff training, the backlog of serious incidents and application of related learning. She went on to note that the backlog had since reduced to below 50.

2. The Chair suggested there was not a causal link between the rating of services and positive narrative and the overall the trust rating, but the report highlighted that CQC had confidence that the trust understood its position and was in control.

3. J Preston proposed that the report was largely positive, with many services now rated as good and queried prioritisation of must and should do actions. In response, B Murphy confirmed that short and longer term priorities would be presented to Quality Assurance Committee as part of the improvement plan.

4. B Reilly advised that Quality Assurance Committee had invited the Chief Nurse and Executive Medical Director to consider how the trust demonstrated improvement and learning, including the improvement in the backlog of serious incidents.

5. B Murphy confirmed that the trust had taken a theme based approach to consideration of should and must do actions, and she noted the development of a single improvement plan that would capture the outcome of a review of learning from serious incidents over the preceding 12 months alongside any recommendations from Niche, the CQC and the Provider Collaborative.

6. J Maddison welcomed progress that had been made and proposed a focus on the safe domain, with appropriate resources to ensure that was not compromised.

7. S Dexter-Smith agreed that the focus would not be on individual goals and noted the establishment of a joint meeting between the Executive People and Culture Group and the Executive Strategy and Resources Group to support this work

8. B Kilmurray commented on the trust's confidence to deliver Our Journey to Change and to identify priorities that would support this.

Summing up, the Chair reflected that the trust's focus would not be on achievement of a higher rating, but this would be achieved through delivery of safe care. He thanked the Chief Nurse and her team for all their hard work in supporting the inspection and in development of

the improvement plan and welcomed the opportunity to link themes to the development of future priorities.

23-24/117 INTEGRATED PERFORMANCE REPORT

The board received the report, which aimed to provide oversight of the quality of services delivered and assurance on action taken to improve performance in required areas.

In presentation, M Brierley provided an overview of key changes from the previous report and drew the board's attention to the proposed reasonable level of assurance regarding the quality of services delivered, and areas highlighted in the report where there was limited performance assurance and negative controls assurance.

Z Campbell reported from North Yorkshire, York and Selby Care Group and advised that a dementia care pathway review would be completed in recognition of the limited capacity within the memory services team. She also commented on recent medical staff appointments and targeted work underway to support recruitment in older people services.

P Scott reported from Durham, Tees Valley and Forensics Care Group and advised that the previously reported deep dive on talking therapies had been completed and would report to the next care group board. He commented on work that would be undertaken by the Urgent Care Programme Board, supported by lived experience leads and also noted the reduction in staff leaver rates and a number of recent medical staff appointments.

In discussion the following points were raised:

1. B Reilly advised that Quality Assurance Committee had sought assurance in respect of patient reported outcomes and clinician reported outcomes, where concerns had been raised previously.

2. Responding to a query from B Reilly, B Murphy confirmed the trust would not wish to have service users placed away from their local area and noted the impact of high demand on staff experience and their capacity. M Brierley commented on the month on month improvement in out of area placements and suggested that wider system transformation would be required to ensure appropriate patient flow.

3. The Chair proposed that the Board would consider the issues raised as part of strategic planning for 2024/25.

4. S Dexter-Smith commented on work underway with universities on talent building and to consider what action was required to end the trust's reliance on agency staff.

5. J Preston queried the correlation between performance improvement plans and prioritisation of CQC must do actions and the safe domain and in response, M Brierley suggested that plans would be reviewed to ensure they supported those priorities, and he noted the potential to review the IPR to ensure it also had an appropriate focus.

   Commenting further, T Olusoga indicated that there would be a focus on safe staffing, which would in turn resolve a number of other challenges.

J Preston acknowledged that whilst safe staffing remained a key priority, there would be no immediate resolution and performance improvement plans would also need to be achieved.

6. P Scott suggested that, whilst he was not complacent, he was proud of the continued improvement that had been achieved, particularly in relation to use of restraint and the positive progress service users had made. He agreed that reduced occupancy would improve staff experience and provide the opportunity for teams to reflect.

7. L Romaniak commented on the financial impact of demand, use of agency staff and challenges linked to delivery of CRES proposals. She welcomed the support of staff on improved run rates and mitigation to ensure the trust was in a sustainable position at the financial year end. Reference was made to a national allocation of £800m by NHS England, funded through reprioritisation of national budgets and a reduction in the elective recovery target. Systems would be required to achieve financial balance whilst ensuring patient safety and urgent and emergency care.

8. J Maddison noted the CRES target and proposed that the board receive a summary on options to mitigate the £7m financial risk and an assessment of deliverability at the next Strategy and Resources Committee. L Romaniak confirmed this would be provided as part of the financial reforecast work. **Action: L Romaniak**

9. The Chair proposed that the board have the opportunity for a strategic discussion on the trust's financial position and L Romaniak noted that, in addition to the related agenda item at the next meeting of Strategy and Resources Committee, a strategic discussion had been included in the workshop topics currently in development by the Company Secretary. **Action: P Bellas**

10. B Kilmurray noted the underlying importance of the workforce, and that the staffing establishment and skill mix would be considered through the transformation programme.

Bringing the discussion to a close the Chair recognised that it would be essential to achieve required staffing levels and, in the interim, other priorities would need to be progressed.

The Chair varied the order of the agenda and brought forward the discussion on the Patient Safety Incident Response Framework.

23-24/118 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

D Jessop presented the report, which briefed the board on the introduction of the Patient Safety Incident Response Framework (PSIRF) and advised that reasonable assurance had been provided to Quality Assurance Committee on the delivery of the PSIRF plan and any associated risk.

In discussion the following points were raised:

1. D Jessop confirmed the trust had worked with both integrated care systems and the provider collaborative, on implementation of the framework.

2. B Reilly proposed that a briefing be provided to the next Council of Governors meeting. **Action: D Jessop**

3. P Hungin sought assurance that the framework would ensure learning continued to be captured and shared appropriately and in response D Jessop confirmed that existing reporting arrangements would continue, and staff would be supported to use the tool to identify the best approach to take, including potential for a multidisciplinary review.

4. B Murphy advised that the framework provided the opportunity to consider what arrangements were needed alongside a team – including non-clinical - to support them understand the incident and any learning that would be shared.

5. A Bridges welcomed the introduction of the framework and suggested it demonstrated the trust's commitment to co-create with families and carers, to deliver change.

6. B Kilmurray noted the framework would be a new way of working and proposed that implementation would need to be carefully considered to ensure there was sufficient staff capacity and directors were sighted on changes to their role on serious incident panels. In response, D Jessop confirmed that no changes would be made to panels, until the current serious incident backlog had been dealt with.

7. The Chair sought assurance that the framework would not remove individual accountability, whilst recognising the trust would support staff to exercise their best judgement in line with trust policy. In response, D Jessop advised that the tool still provided a focus on individual responsibility but would explore the incident in a different way with a robust follow up process, if that was required.

   The Chair proposed that this be made clear in implementation, to ensure there was a consistent approach to learning from serious incidents, under the banner of patient safety.

8. B Murphy advised that training had been held for staff across the 24 hour rota and she placed on record her thanks to the Deputy Chief Nurse for the work she had undertaken.

23-24/119 OUR JOURNEY TO CHANGE DELIVERY PLAN, UPDATE

M Brierley presented the report, which provided assurance on the delivery of projects and workstreams pertaining to Our Journey to Change 2023/24 Delivery Plan. He drew attention to those projects rated as red and amber, and those where a change in timescale or resource had been requested.

In discussion the following points were raised:

1. In response to a query on the impact of the Lived Experience Director appointments, it was proposed and agreed that Lived Experience Directors would be invited to attend a future board meeting. **Action: A Bridges**

2. H Crawford welcomed the increase and impact of peer support workers and undertook to provide an update at a future board seminar. **Action: H Crawford/P Bellas**

3. The Chair welcomed the contribution of peer support workers to development of the policy on Oxehealth implementation, and their increased visibility.

4. B Kilmurray acknowledged the roll out of Cito Connect, as a key milestone in the development of Cito.

5. B Kilmurray advised that proposals to change project milestones and resources would be robustly considered by Management Group and timeline changes would be reviewed to ensure they were achievable.

6. P Scott noted the significant impact of Lived Experience Directors and the establishment of Cocreation Boards, as a vehicle to understand performance and activity that would support feeling safe. Positive feedback had been provided by partners and a presentation would be given to Durham County Council scrutiny committee.

7. B Reilly suggested that Quality Assurance Committee could provide up to date intelligence on information outlined in the report, prior to the board and M Brierley noted that the report provided a snapshot of the position at the end of quarter 2. Commenting further, B Kilmurray advised that lead officers would be expected to provide an update on the position and reassurance on progress made.

8. Responding to a query, M Brierley advised that the report was compiled manually, but its development would continue to evolve alongside that of a central PMO tool, which would collate and share information across a number of forums.

9. The Chair welcomed the report as an opportunity for the board to be sighted on the delivery of key strategic projects and sought assurance on delivery of priorities rated as red.

   M Brierly noted that five of the eight projects marked as red were within the infrastructure workstream related to progress on the Green Plan.

   L Romaniak indicated that recruitment was underway to appoint a replacement subject matter expert, following retirement of the postholder. National restrictions on non-clinical agency assignments and consultancy had limited opportunities to increase capacity at pace. An update would be provided to the next meeting of Strategy and Resources Committee.

Summing up, the Chair thanked M Brierley and his colleagues for production of the report and all their efforts in relation to Our Journey to Change.

23-24/120 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee, presented the report and noted committee was sighted on challenges outlined in the Integrated Performance Report.

She provided an overview of the report and drew attention to an emerging risk related to use of illicit substances in and around trust sites and advised that committee had also sought assurance that there would be a focus on the use of prone and mechanical restraint.

In discussion the following points were raised:

1. T Olusoga advised that in lieu of implementing the NHS 111 service immediately, the trust had worked with voluntary sector partners to support the crisis line and calls answered had improved to 60%. He acknowledged that 40% of calls were not answered and the associated risk.

   P Scott suggested that the NHS 111 service would improve call triage, but may result in an increase in calls, and this was a key piece of work for the Urgent Care Programme Board, taking account of learning from pilots in Humber and North Yorkshire.

   J Preston expressed concern that introduction of the NHS 111 service may delay an individual from speaking to an expert and B Reilly advised that Quality Assurance Committee had sought to have oversight of the position.

2. B Murphy advised that the reduction in restrictive practice was a key element of Our Journey to Change and she expressed confidence that its use had become more unusual, and the trust would continue to focus on this area and make further improvements. She noted that resources had been identified to support the appointment of a postholder to lead on this work.

   The Chair commented on feedback from the nursing conference on progress that had been made and proposed that Governors' be updated on work undertaken.

   Action: B Murphy

23-24/121 FOR INFORMATION – MEDICAL EDUCATION REPORT

T Olusoga presented the report, which provided an overview of medical education activity during 2022-23 and outlined key priorities for the next academic year.

In discussion, the following points were raised:

1. J Preston cautioned on the lack of dedicated medical education facilities and in response he was advised that work was underway to ensure appropriate facilities were considered as part of the development of the trust's Estates Master Plan.

2. The Chair welcomed the report and proposed that provision of appropriate facilities would be a factor in attracting and retaining a highly regarded medical workforce.

3. B Reilly noted there was also related activity for other professions and B Murphy advised that a Nursing Plan, coproduced with the workforce, would be drafted by December. This would include education, learning, development and career pathways.

4. H Crawford commented on work underway through the trust's leadership academy to bring together training, development and career pathway activity.

23-24/122 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 matters, the meeting ended at 5.20pm.

Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS HELD ON 14 DECEMBER 2023 AT WEST PARK HOPSITAL, DARLINGTON AND VIA MS TEAMS, COMMENCING AT 1.30PM

Present:
D Jennings, Chair
B Kilmurray, Chief Executive
R Barker, Non-Executive Director
P Hungin, Non-Executive Director
K Kale, Executive Medical Director
J Maddison, Non-Executive Director
J Murray, Non-Executive Director
B Murphy, Chief Nurse
J Preston, Non-Executive Director and Senior Independent Director
L Romaniak, Executive Director of Finance, Information and Estates
P Scott, Managing Director, Durham, Tees Valley and Forensics Care Group
A Bridges, Executive 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, Executive Director for People and Culture (non-voting)

In attendance:
P Bellas, Company Secretary
K Christon, Deputy Company Secretary (minutes)
A Hart, DAC Beachcroft
T Olusoga, Consultant Psychiatrist (on behalf of Z Campbell)
M Pears, Ward Hadaway
J Weatherall, DAC Beachcroft

Observers:
K North, Deputy Director of People and Culture

23-24/123 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

23-24/124 APOLOGIES FOR ABSENCE

Apologies for absence were received from C Carpenter, Non-Executive Director, Z Campbell, Managing Director, North Yorkshire, York & Selby Care Group, and B Reilly, Non-Executive Director and Deputy Chair.

23-24/125 DECLARATIONS OF INTEREST

The board was reminded that J Murray had a declaration of interest in respect of a family member employed by Ward Hadaway – there was no link to the trust's legal case.

23-24/126 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 matters, the meeting ended at 3.52pm.

Board of Directors
Public Action Log

RAG Ratings:

	Action on track or 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 **09/11/2023**	22/144 22/174 23-24/06 **23-24/111** **23-24/117** **23-24/119**	Topics for board seminars	a) Mental Capacity Act b) Reported outcomes following treatment c) what transformation may mean for future services **d) Baroness Hollins' report on those with a learning disability and/or autistic people** **e) strategic discussion on the trust's financial position** **f) impact of peer support workers**	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. Oct-23: BoD invited to submit proposals for Board Seminars. It is expected that the programme will also include topics that arise during preparation of the delivery plan
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 Nov-23: BAF review to be completed in January. Risk descriptions due to be considered by the board in November - see private agenda item 7
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 Nov-23: BAF review due to conclude in Jan-24
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 Oct-23: EDG BAF workshop on 4-Oct-23 agreed next steps for Executive review Nov-23: BAF review due to conclude in Jan-24
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 Nov-23: BAF review due to conclude in Jan-24
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 Sept23: noted that a verbal update had been provided on the significant work underway to assure on safer staffing, to meet external reporting requirements and to progress steps to meet the deadline of March 2024 **Jan24: data collection is complete, there are some issues with validity, currently been analysed. CN will discuss next steps with CEO and Chair in relation to data validity**
27/06/2023	23-24/47	Annual Report and Accounts	Chair to raise with COG T&F group, governor attendance at Audit & Risk Committee when committee consider the annual report and accounts and draft annual Quality Account Report	Chair	May-24		To be progressed at 2023/24 year end - next CoG meeting 19 March 2024
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. Oct-23: HSIB overview circulated to the board of Directors by email

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	**See agenda item 9**	Sept-23: Further dates announced and an update is provided within the CEO report (item 9) Oct-23: Item 9 will be supplemented at the meeting with snapshot update of latest activity and impact **Jan-23: Further strike action during December 23 and January 24 - update to be provided at the next board meeting via CEO report**
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 MD	Nov-23	**Completed**	Sept-23: First meeting of the UCPB to be held in October - P Scott to progress the action with K Kale in the interim **Jan-24: Report provided to EDG to provide assurance on implementation of the policy and many management action required**
14/09/23	23-24/76	Board meetings	Consideration to be given to the structure of board meetings to support the move to bi-monthly meetings with additional development sessions	Co Sec	Jan-24	**Completed**	**Jan24: Board/Committee schedule to be implemented from April 2024**
12/10/23	23-24/100	Responding to issues raised by freedom to speak up arrangements	Trust to consider greater use of analytical data, alongside existing tools, to ensure all issues that arose through freedom to speak up arrangements had been captured and considered.	DfP&C	Jan-24		
09/11/23	**23-24/117**	**Financial risk**	**Assessment of deliverability of CRES targets be included for discussion at the next Strategy & Resources Committee**	**EDFI&E**	**Nov-23**	**Completed**	**Included as part of the financial reforecast work**
09/11/23	**23-24/118**	**Patient Safety Incident Response Framework**	**Presentation to be provided to Council of Governors**	**Dep CN**	**Dec-23**	**Completed**	
09/11/23	**23-24/119**	**Lived Experience Directors**	**Lived Experience Directors to attend a future board meeting**	**EDoCA&I**			**Date to be confirmed once Director has returned from leave**
09/11/23	**23-24/120**	**Use of restraint**	**Progress report to Council of Governors on action taken to reduce the use of restraint**	**CN**	**Mar-24**		**Next Council of Governors meeting is 9 March 2024**

Chair's Report: 15th November – 5th January 2024.

Headlines:

External:

- Weekly Mental Health Chairs' Network : emerging national issues.
- Meeting Yorkshire and Humberside Foundation Trust Chairs: issues of common interest.
- Annual General Meeting TEWV 2022/23.
- Our Journey to Change review and 2024/25 Business Planning event.
- TEWV 2023 Star Awards.
- Board of Directors December 2023.
- Meeting North East & North Cumbria Chairs and ICS
- Meeting with North / South Tees Chair.
- Meeting of TEWV Board and Stockton Borough Council Cabinet, and visit to Roseberry Park Hospital.

Council of Governors (CoG)

- December Council of Governors (CoG)
- CoG Task & Finish Group: role of Governor, and role of Non-Executive Directors, and role of Council of Governors, as distinct from Trust Board. Facilitated by Good Governance Institute.
- North Yorkshire York & Selby locality discussion.
- Governor meeting about a place-based concern.

Internal

- Various Living The Values Awards.
- Non-Executive Director catch-up discussions and quarterly meeting with Chief Executive.
- Meeting with Head of Co-Creation.
- Meetings regarding TEWV Constitution review.
- Meeting with Long Term Health Conditions Network.

Annual leave 25th December 2023 – 2nd January 2024.

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11 January 2024**
Title:	**Board Assurance Framework – Summary Report**
Executive Sponsor(s):	**Brent Kilmurray, Chief Executive**
Report Author:	**Phil Bellas, Company Secretary**

Report for:

Assurance		***Decision***	
Consultation		***Information***	✓

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
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 and a summary is attached.

This report seeks to provide information on the strategic risks and related key controls and positive and negative assurances relating to them, which have been identified since the last board meeting.

The board will recognise that it receives a number of reports to each meeting that are pertinent to the BAF risks, including:

- Integrated Performance Report
- Chief Executive's Report
- Board Committee Reports
- Monthly Finance Report (confidential)
- Reportable Issues Log (confidential)

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	Executive Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls and Assurance Rating	First Line of Defense	Key Controls and Assurance Ratings	Material Positive/ Negative Assurance Identified since the 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	DfP&C	PCDC	Moderate ↓	Low (Dec 23)	Good ↑	Recruiting Managers Recruitment Team	Establishment Reviews Recruitment Oversight Group Recruitment and Selection Procedure "A great place to work" ↑ Partnerships with Education and Training Providers ↑ Planning beyond the Crisis ↑	**Positive:** **Negative:** ▪ **SRC (Nov 23)** - Reasonable assurance on the oversight and establishment of workstreams to undertake the routine annual establishment review at the end of the current financial year	**Confidential Agenda Item 5** – Report of the Chair of the SRC
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 and Performance Improvement Plans Establishment reviews	**Positive:** **Negative**: ▪ **IPR** –Unique caseload - special cause concern (metric 23) ▪ **SRC (Nov 23)** - Reasonable assurance provided through the IPD regarding oversight of the quality of services delivered. High degree of volatility relating to bed occupancy and out of area placements. Reduction in assurance in relation to the number of out of area bed days, where the trajectory continues to remain higher than forecast ▪ **Leadership Walkabouts Feedback** - Caseloads / demand: high and complex caseloads were challenging to manage across both MHSOP and CYPS speciality areas, however neurodevelopmental assessment waits in CAMHS was unprecedented	**Public Agenda Item 10** – Board Integrated Performance Report as 30th November 2023 **Public Agenda Item 13** – Leadership Walkabouts **Confidential Agenda Item 5** – Report of the Chair of the SRC
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 organizational leadership structure Business plan (co-creation priorities)	**Positive:** **Negative:**	

Ref	Strategic Goals			Risk Name & Description	Executive Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls and Assurance Rating	First Line of Defense	Key Controls and Assurance Ratings	Material Positive/ Negative Assurance Identified since the last ordinary meeting	Related Agenda Items/ Reports
	1	2	3										
											Co-creation Programme Board Co-Creation Journey Lived Experience Advisory and Reference Network		
4	✓			**Experience** We might not always provide a good enough service for those who use our services, their carers and their families, in all places and all of the time	DoCA&I	QuAC	High	Moderate (Mar 23)	Reasonable	Frontline staff operating in accordance with the Trust's values and policies and procedures Peer Support Workers Patient Experience Team	Complaints Policy Friends and Family Test/ Patient Experience Survey Patient and carer engagement and involvement structures and processes Our quality and safety strategic journey	**Positive: -** ▪ **IPR –** Special cause improvement in CYP CROM and achieving standard (Metric 6) ▪ **QuAC (Dec 23)** Compliance with the 60-day target for complaint responses is on trajectory with an improved position in October 2023 to 74% ▪ **Leadership Walkabouts Feedback –** Patient-centered focus: the importance of good relationships with patients and their loved ones came through strong in teams visited, particularly in 'waiting well' and pathways. Multi-disciplinary teams (MDT): good skills mix and knowledge key to supporting patients on their journey, including movement between and across systems, and helping to navigate different pathways (different in different areas) **Negative:** ▪ **IPR –** ▪ Inpatients feeling safe - special cause concern and below standard (metric 3) ▪ AMH / MHSOP Outcomes - special cause concern and below standard for PROM and CROM (metrics 5 & 7) ▪ **QuAC (Dec 23) -** Reasonable assurance on the progress made with the quality priorities for 2023/2 in Our Journey to Change ▪ **MHLC (Nov 23)** - Concerns raised over	**Public Agenda Item 10** – Board Integrated Performance Report as 30th November 2023 **Public Agenda Item 14** – Report of the Chair of the QuAC **Public Agenda Item 13** – Leadership Walkabouts **Public Agenda Item 15** – Report of the Chair of the MHLC

Ref	Strategic Goals			Risk Name & Description	Executive Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls and Assurance Rating	First Line of Defense	Key Controls and Assurance Ratings	Material Positive/ Negative Assurance Identified since the last ordinary meeting	Related Agenda Items/ Reports
	1	2	3										
												the list of CQC findings following an inspection on Lustrum Vale and Willow Ward. Assurance given that the actions are being taken forward	
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	DfP&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 Services 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:** ▪ **IPR** – ▪ Staff leaver rate - special cause improvement (metric 18) ▪ Sickness absence – special cause improvement but increasing trend (metric 19) ▪ **Leadership Walkabouts Feedback-** Teams expressed huge pride and passion for what they do and each other, were very responsive and flexible, supportive, caring and resilient, with a big focus on wellbeing in many areas ▪ **PCDC (Dec 23)** – Good assurance on the process for the undertaking the ratings under Equality Delivery System **Negative:** ▪ **Leadership Walkabouts Feedback** - Getting, retaining and training people with the right skill mix was an area of concern. Staffing capacity / levels that reflect the local population was also reported as an issue. Medic cover also an issue	**Public Agenda Item 10** – Board Integrated Performance Report as 30th November 2023 **Public Agenda Item 13** – Leadership Walkabouts **Public Agenda Item 16** – Report of the Chair of the PCDC
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)	Incident management policies and procedures Governance arrangements at corporate, directorate and specialty levels Performance management of serious incident review	**Positive:** ▪ **QuAC (Dec 23)** ▪ Good progress on delivering the Duty of Candour compliance ▪ PSIRF milestones continue to be achieved	**Public Agenda Item 14** – Report of the Chair of the QuAC

Ref	Strategic Goals			Risk Name & Description	Executive Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls and Assurance Rating	First Line of Defense	Key Controls and Assurance Ratings	Material Positive/ Negative Assurance Identified since the last ordinary meeting	Related Agenda Items/ Reports
	1	2	3										
										Communications Team	Organisational Learning Group	**Negative:** ▪ **QuAC (Dec 23) -** Reasonable assurance that the serious incident improvement plan is progressing to eradicate most of the backlog by 31 December 2023	
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)]	DoFI&E	SRC	Moderate	Low (2025)	Good	Ward and team managers and staff Estates Directorate Management Team IT staff Digital Programme Board Digital Performance and Assurance Group Capital Project Steering Group	Estates Master Plan ERIC PLACE national annual reporting/ benchmarks and Green Plan submission and monitoring Premises Assurance Model	**Positive:** ▪ **SRC (Nov 23)** – Committee satisfied with the overall direction of travel and supported the approach for the Estates Master Plan (capacity to deliver all aspects of the proposed five year plan queried) **Negative:** ▪ **Leadership Walkabouts Feedback -** Some estates and IT issues raised in terms of suitability and availability	**Public Agenda Item 13** – Leadership Walkabouts **Confidential Agenda Item 5** – Report of the Chair of the SRC
8	✓	✓	✓	**Cyber Security** A successful cyber-attack could compromise patient safety, business continuity, systems and information integrity and cause reputational damage	DoFI&E	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	**SRC (Nov 23) -** Attention drawn to the assurance level for the delivery and oversight of aspects of cyber security	**Confidential Agenda Item 5** – Report of the Chair of the SRC
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:**	
10			✓	**Influence** Changes in the external environment, and insufficient capacity to respond or to align our objectives with those of	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	**Positive:** **Negative:**	

Ref	Strategic Goals			Risk Name & Description	Executive Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls and Assurance Rating	First Line of Defense	Key Controls and Assurance Ratings	Material Positive/ Negative Assurance Identified since the last ordinary meeting	Related Agenda Items/ Reports
	1	2	3										
				partners, might lead to loss of strategic influence and reputation							management boards Provider Collaborative Boards Monitoring of the external environment Business planning framework Executive and operational leadership and governance structure		
11	✓			**Governance & Assurance** The absence of a clear line of sight from ward to Board, due to ineffective governance 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 Clinical leaders of the Care Groups 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 organizational leadership and governance structure Quality improvement approach and team Executive Leadership Group arrangements	**Positive:** ▪ **QuAC (Dec 23) –** ▪ Good assurance on the collaborative approach and system oversight of improvement actions, which will form a component of the Trust's Integrated Oversight Plan ▪ Good assurance on progress with internal audits relating to quality and safety. All recommendations from the eight audits now fully implemented ▪ Good assurance on the oversight and progress of the quality assurance and improvement programme ▪ **MHLC (Nov 23) –** ▪ Good assurance that the requirements of section 136 are being met ▪ Substantial assurance that discharges from detention by a Tribunal or Hospital Managers are low and within normal range ▪ Substantial assurance that patients are given their rights when first detained and a robust escalation process is in place for breaches ▪ Good assurance that the Trust has followed a robust	**Public Agenda Item 14** – Report of the Chair of the QuAC **Public Agenda Item 15** – Report of the Chair of the MHLC **Public Agenda Item 16** – Report of the Chair of the PCDC **Confidential Agenda Item 5** – Report of the Chair of the SRC

Ref	Strategic Goals			Risk Name & Description	Executive Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls and Assurance Rating	First Line of Defense	Key Controls and Assurance Ratings	Material Positive/ Negative Assurance Identified since the last ordinary meeting	Related Agenda Items/ Reports
	1	2	3									process in analysing detentions under the Mental Health Act by gender and ethnicity ▪ **PCDC (Dec 23)** - Good assurance on the management of risks included in the BAF ▪ **SRC (Nov 23)** - Assurance provided on the processes in place to ensure an accurate national cost collection submission **Negative:** ▪ **MHLC (Nov 23) –** ▪ Reasonable assurance on the use of holding powers ▪ Reasonable assurance that the requirements under the MCA are being met ▪ Reasonable assurance that the use of and reporting of Deprivation of Liberty Standards (DoLS) is being carried out as required ▪ **PCDC (Dec 23) –** Limited assurance on compliance with timely risk and action review for corporate risks ▪ **SRC (Nov 23)** Six Internal Audit recommendations relating to digital and data were past their agreed due date	
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	DoFI&E	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 huddle Capital Project Steering Group	Roseberry Park Rectification Programme External technical expert support Capital Programme Legal support External Audit	**Positive:** **Negative:**	

Ref	Strategic Goals			Risk Name & Description	Executive Lead	Oversight Committee	Present Risk Grade	Target Risk Grade	Indicative Controls and Assurance Rating	First Line of Defense	Key Controls and Assurance Ratings	Material Positive/ Negative Assurance Identified since the last ordinary meeting	Related Agenda Items/ Reports
	1	2	3										
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	Information subject to legal privilege	
14	✓	✓	✓	**CITO** Failure to deliver the CITO project to its revised timescale will delay its benefits for patients and staff	Asst CEO	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:** ▪ **SRC (Nov 23) -** Good assurance on the roll out of EPMA **Negative:**	**Confidential Agenda Item 5** – Report of the Chair of the SRC
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&E	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:** ▪ **IPR**: Positive assurance on CRES performance – non- recurrent (metric 28) **Negative:** ▪ **IPR –** Issues risks relating to: ▪ Financial Plan: surplus/deficit (metric 24) ▪ Financial Plan: agency expenditure (metric 25a) ▪ Agency price cap compliance (metric 25b) ▪ CRES performance – recurrent (metric 27) ▪ Use of resources rating - overall score (metric 26)	**Public Agenda Item 10** – Board Integrated Performance Report as 30th November 2023

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of: Board of Directors
Date: 11 January 2024
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*
7	**Infrastructure**	• Information included around HQ Project.
15	**Financial Sustainability**	• NENC collaborative information

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:
- OJTC Planning Workshop
- HQ Project
- NENC Collaborative

Prior Consideration and Feedback n/a

Implications: No additional implications.

Recommendations: The Board is invited to receive and note the contents of this report.

Our Journey to Change Delivery Plan Workshop

On 29th November we ran our stakeholder workshop as part of our planning process for next year's delivery plan.

A hybrid event, held at Great North Air Ambulances building in Eaglescliffe, we had good representations from the board, governors, clinical networks staff and partner organisations.

There were presentations on our current context and the operating environment. We had input on a number of priority areas with questions and answer sessions and then group work.

The outputs from the session are being fed through into our plans. The Board will receive further updates on the development of the Delivery Plan in February and the final draft plan through in March.

Thank you to everyone who attended the session.

Headquarters Project

As part of our estate planning, we have identified an opportunity to improve the operational efficiency and effectiveness of our corporate services through co location to a single site, including to support our 'OneTeamTEWV' agenda. Currently these essential services are spread across three sites: West Park Hospital, Tarncroft and Flatts Lane Centre. The costs / benefits of this opportunity are to be formally assessed.

As part of the 2024/25 delivery plan our estates masterplan highlights the necessity to ensure we deliver services close to our communities, optimise space in clinical sites for clinical activity and teams and delivery efficiencies. We have particular clinical pinch points at our inpatient sites, including at West Park Hospital (our current formal HQ).

Implied in this is a deep review of our ways of working, our future space requirements and how this can be enabled through redesign of our workspaces and the use of technology to ensure that we are maximising the opportunities for smart working.

A site has been identified, subject to business case that would bring additional benefits from Local Authority partner colocation and related space sharing opportunities. We have been working with Stockton Borough Council who are also relocating their municipal headquarters to Dunedin House on Teesdale Park. There is an opportunity to take space within Dunedin, with the Local Authority being flexible and accommodating in terms of both scale and phasing.

Over the coming weeks we will be looking to engage with colleagues to undertake co-creation and design work, followed by consultation. We will be developing a business case where we will confirm the implications for our estate and finances and the timescales."

NENC Foundation Trust Collaborative

As Board members are aware, the Trust is part of the NENC Provider Collaborative. We will be renewing our Responsibility Agreement between the foundation trust members (all eleven trusts – including the acute, MHLDA and ambulance trusts).

The collaborative is maturing and progressing with a number of priority areas. A summary has been appended in a slide pack presented to chairs in December.

Much focus is on areas of common interest such as workforce developments, capital planning, the development of the Medium-Term Financial Plan for the ICS and developing a clinical strategy. There are also key workstreams focusing on elective recovery and diagnostics. There is also other work through clinical networks such as the urgent and emergency care network. A priority in the coming year will be the development of nested collaboratives – this will include the MHLDA and some more geographic focused alliance and other common issues emerging from the clinical strategy.

The collaborative works closely on our behalf with the ICB and provides a forum for us to work across the NHS provider network in the patch together on key issues.

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North East and North Cumbria Provider Collaborative

Provider Collaborative Priorities

Alison Marshall

Chair, Gateshead Health NHS Foundation Trust

12th December 2023

2023/24 Responsibility Agreement

Specific work programmes agreed between the ICB and the Collaborative for 2023/24:

- Delivery of a comprehensive **elective recovery** plan and programme, including leading the work of the ICS with the Getting It Right First Time Programme
- Delivery of a **diagnostics** plan and programme
- Support the development of the overarching ICB clinical strategy, as part of which, taking a lead on the **strategic approach to secondary and tertiary clinical services** to address quality and sustainability issues across the sector. This will include ad hoc clinical service improvement work and the oversight of relevant clinical networks.
- Continued implementation of the **aseptic** manufacturing hub
- Leadership of the **FT capital** programme, supported by agreed capital priorities and goals for estates, equipment and digital
- Delivery of a **strategic workforce** programme on behalf of the FT providers, linking to the ICB programme and to include action on agency spend and bank arrangements

Elective Programme

- Chief Executive SRO: Lyn Simpson
- Strategic Elective Care Board in place with oversight of elective programme inc GIRFT
- Elective recovery and transformation plan in place, focussing on Performance (eg 65+ wk patients), Pathways (eg outpatient transformation) and Productivity (eg 85% theatre utilisation, 85% day case rate)
- Mutual Support Coordination Group established with operational leads to coordinate support and assistance across NENC
- Clinical alliances established bringing clinicians together to deliver improvement across NENC inc gynae, general surgery, dermatology, urology, ENT (in addition to eye care and MSK)

Diagnostics Programme

- Chief Executive SRO: Ken Bremner (Diagnostics), Trudie Davies (Pathology)
- Diagnostics and Pathology Programme Boards in place
- CDC plans for Workington, Stockton and Metrocentre progressing well for 24/25
- Digital diagnostics programmes inc ICS Order Comms, Integrated Referral and Appointment Management, Resilient Diagnostic Network, iRefer, Histopathology Global Reporting and Imaging Global Reporting
- Pathology alliance operating model agreed

Strategic Approach to Clinical Services

- Chief Executive SRO: Ken Bremner
- Major acute service clinical co-dependency mapping in place to identify strategic vulnerabilities, using SE Clinical Senate Framework
- Facilitated meetings with FT Trust MDs and COOs to map out service strengths, vulnerabilities and opportunities for future collaboration
- CEO development session on 1st December 2023 identified key outline of joint strategic work
- Clinical service improvement work in train for areas such as repatriations, diabetes devices, OMFS, pain, neurology, non-surgical oncology, pre-hospital emergency medicine, paediatric critical care

Aseptic Manufacturing Hub

- Chief Executive SRO: Sue Jacques
- £29.7m national capital allocation to develop aseptic manufacturing hub at Seaton Delaval, overseen by Aseptics Project Board
- OBC submitted to DHSC Joint Investment Sub-Committee (JISC) for approval in January 2024
- Initial drawdown for fees approved, appointed contractor for design & build and supplier for isolators
- FBC to be submitted to JISC for approval in April 2024
- LLP operating model developed to same timescale
- Anticipated timescales for 12-month build work to commence July 2024, 6-month MHRA approval from July 2025, production from January 2026

Capital and Estates Programme

- Chief Executive SRO: James Duncan
- NENC Infrastructure Board in place, chaired by Estates SRO, including FT Estates Directors & DoFs, CIO Network Chair, ICB and NHSE colleagues to provide strategic oversight, planning and direction
- Three-year CDEL plan, formula and approach to be approved at PLB in January 2024
- Estates Framework agreed Summer 2023, informing ICS Infrastructure Strategy (covering digital, estates and major equipment)

Workforce Programme

- Chief Executive SRO: Trudie Davies
- Scaling Up Programme Board in place with oversight of eight workstreams inc payroll, job evaluation, collaborative bank, OH, policies & employee relations, recruitment, leadership development and workforce planning
- Portability Agreement to allow rotation of staff between FTs live since March 2023 and relaunched in November 2023
- Agency rates task and finish group reached agreement on pay rates for a number of consultant specialties
- Strategic workforce analysis underway to support clinical services and MTFP

2024/25

- Refresh of priorities underway with ICB colleagues, to reflect landscape for 24/25, such as MTFP
- Continuing to build on good progress in 23/24, including:
  - Harnessing strong foundations in elective and diagnostics work to continue to improve productivity, performance and pathways for our patients
  - Setting out a clear direction and strategic approach to clinical services to address quality and sustainability issues across the sector
  - Further developing the clinical support, workforce, estates and equipment frameworks, allowing coordinated decisions to underpin the strategic approach to clinical services
  - Physical development of aseptic hub and CDCs
  - Implementing tactical workforce improvement programmes
- Supporting nested collaboratives as they develop
- Further developing the culture of collaboration across FTs

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Communications Dashboard
December 2023

Tees, Esk and Wear Valleys
NHS Foundation Trust

This month we...

- Have been informed of a target date for CITO which will be 5 February
- Announced our brand new 10k running event - the TEWV 10k
- Launched our 12 days of Christmas giveaway
- Launched ‘Complaints’ which will be replacing PALS and Complaints.
- Launched our Flu vaccination prize draw
- Announced the winner of our staff survey competition

Our therapy dogs spread festive cheer

Staff, volunteers and patients at Cross Lane have written and recorded a song to raise money

Staff member from West Park launched project to keep homeless people warm this winter

Staff members at North Moor House collect presents for festive appeals

Media and Online

Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

5

Media enquiries handled by the team

3

Media releases issued

32

Total pieces of coverage across online news, TV and radio

News Stories

- **Pioneering medic knighted by King Charles III** - *Newcastle University*
- **NHS Mental Health song written and recorded in Scarborough -** *The Scarborough News and BBC Radio York*
- **Tees, Esk & Wear Valleys NHS pilot informs national guidance for ECG's in Mental Health** - *Health Tech Newspaper*
- **Nurses appeal for empty crisp packets to help homeless** - *Yahoo! News UK & Ireland*
- **Mental Health Trust launches first running event of its kind** - *York Mix*
- **3000 health, care and emergency service staff given psychological support** - *Richmondshire Today online*

Media and Online

Tees, Esk and Wear Valleys
NHS Foundation Trust

Our website

64,292

+102% YOY

Page views

Staff intranet

849,115

Page views

Top 3 visited pages

1. Vacancies
- 21,102 views
2. Suicidal thoughts support
- 2,131 views
3. Crisis advice
- 2,055 views

Top staff intranet news stories

1. Some sad news to share this morning - 2,733 views
2. 12 days of Christmas prize giveaway - 327 views
3. Cross Lane staff, patients and volunteers write and record a song - 289 views
4. Staff survey competition winners - 267 views
5. Nursing preceptor national framework policy and training - 261 views
6. Using your annual leave FAQ - 253 views

Social Media - our audience

Tees, Esk and Wear Valleys
NHS Foundation Trust

25,844

Total followers

163

New followers

207,980

People who saw our content
Impressions

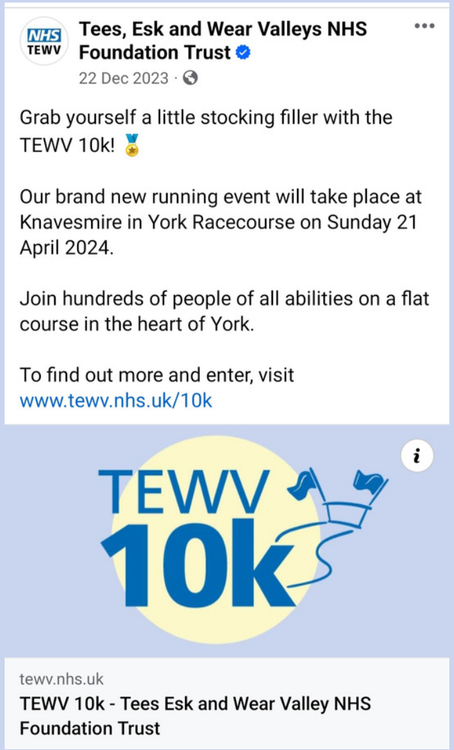
1,277

Engagements

Top posts

Tees, Esk and Wear Valleys
NHS Foundation Trust

Facebook



Impressions - 21,035

Engagement - 1475

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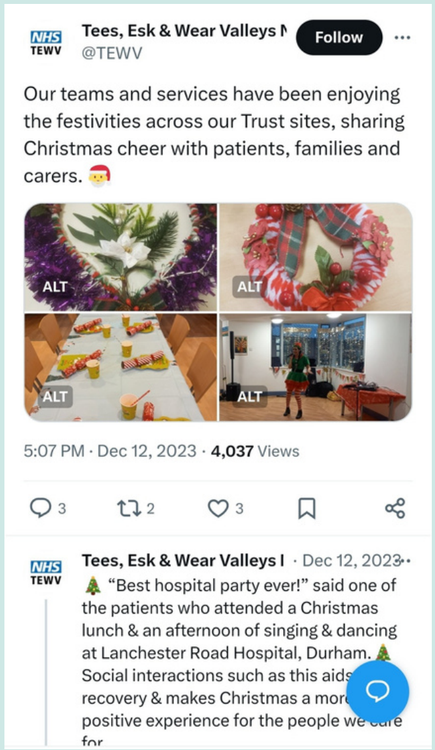
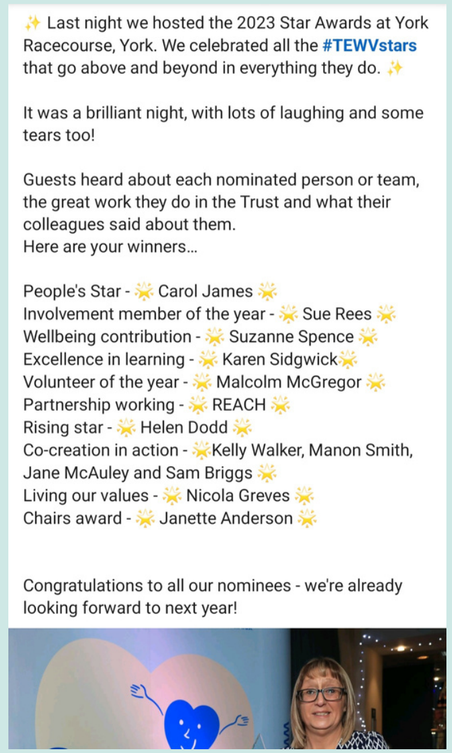


Impressions - 5259

Engagement - 5263

Linkedin



Impressions - 1587

Engagement - 547

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11th January 2024**
Title:	**Board Integrated Performance Report as 30th November 2023**
Executive Sponsor(s):	**Mike Brierley, Assistant Chief Executive**
Author(s):	**Sarah Theobald, Associate Director 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 (IPR) 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. There are three areas with **limited performance assurance** and **negative controls assurance**. Performance Improvement Plans have been established for these areas; however, these are currently being reviewed to ensure they include SMART actions that support improvement.

Overview: There are several changes to this month's report including a "Headline" summary for the Integrated Performance Dashboard (see page 5) and the National Quality Standards/Mental Health Priorities (see page 43); and revised slides focusing on the analysis of the data, underlying issues and actions in relation to the individual measures. These changes are part of our continuous improvement work and incorporate some of the feedback from NHSEI and CQC. We also moved to a new incident recording and management system (InPhase) which is referenced within the IPR for the relevant measures.

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 National Quality Standards/Mental Health Priorities. The key changes for the IPD are noted on page 6 of the IPR (change in italics).

Performance Improvement Plans (PIPs) have been established for several areas (as outlined in the IPR); however, these are currently being reviewed to ensure they include SMART actions that support improvement. It was agreed by Executive Directors Group (EDG) in January 2024, that Durham, Tees Valley & Forensic Care Group develop a PIP for the following two measures:

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

EDG also agreed that the North Yorkshire, York & Selby Care Group PIP be stood down in relation to the "percentage of CYP showing measurable improvement following treatment - clinician reported" and that any remaining actions are completed as business as usual, given their improved performance.

The Integrated Performance Report (IPR) is part of the assurance mechanism that provides assurance on a range of controls that relate to our strategic risks (see page 42 alignment of measures to the Board Assurance Framework). The two key risks currently are:

- **(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.

- **(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.

Prior Consideration and Feedback

The Integrated Performance Report was discussed by Executive Directors Group in January 2024 and the Care Group individual IPRs by the Care Group Boards in December 2023.

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 it is assured on the actions being taken to improve performance in the required areas.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Board Integrated Performance Report

As at 30th November 2023

Report produced by: Amy Walford, Performance Lead (Corporate) and Sarah Theobald, Associate Director of Performance
Date the report was produced: 19th December 2023

For any queries on the content of this report please contact: Sarah Theobald, Associate Director of Performance
Contact Details:: sarah.theobald@nhs.net

journey to change

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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 September 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

DQ ★	Data Quality Assessment Score over 90%	No actions required
DQ ✓✓	Data Quality Assessment Score 70% to 89%	No actions required; but a small number of improvements identified
DQ ✓	Data Quality Assessment Score 50% to 69%	Some actions required
DQ ✗	Data Quality Assessment Score less than 50%	Significant work is required

Action status

Positive Assurance
We are doing well in this area and no action is required at this time

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

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

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

Board Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience** no significant change, with patient experience above standard and carer experience below standard
- **Inpatients Feeling Safe** special cause concern and below standard
- **CYP Outcomes** no significant change in PROM and below standard; special cause improvement for CROM and achieving standard
- **AMH / MHSOP Outcomes** special cause concern and below standard for PROM and CROM
- **Bed Pressures** no significant change in bed occupancy and below the mean; however slight increase in OAPs
- **Patient Safety / Incidents** no significant change across all measures; however, increasing trend in incidents of moderate or severe harm
- **Staff** special cause improvement for leavers and sickness however increasing trend with sickness. No significant change in M&S training or appraisal however decreasing trend
- **Demand** no significant change in referrals; however special cause concern in caseload
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues*

Of most concern:
- Caseload
- Financial Plan: Surplus/Deficit
- Financial Plan: Agency expenditure
- Agency price cap compliance
- CRES Performance – Recurrent

Of concern:
- Inpatients feeling safe
- AMH/MHSOP PROMS
- AMH/MHSOP CROMS
- Use of Resources Rating - overall score

Positive Assurance

Significant improvement seen in:
- CYP CROMS
- Staff Leaver Rate
- Sickness Absence

Positive assurance for:
- CRES Performance – Non-Recurrent

Mitigations

We are reviewing all the Performance Improvement Plans (PIP) in the following areas to ensure they include SMART actions that support improvement (by mid-January 2024):

<u>Durham Tees Valley & Forensic Care Group</u>
- Inpatients Feeling Safe
- CYP PROM
- Bed Pressures
- Caseload (CYP, AMH & MHSOP)

<u>North Yorkshire, York & Selby</u>
- CYP CROMS
- AMH/MHSOP PROMS and CROMS
- Bed Pressures
- Caseload (AMH)

<u>Trust-wide</u>
- Mandatory Training
- Appraisal
- Safer Staffing (Financial Plan)
- Agency Reduction (Financial Plan)

It is recommended to EDG that PIPs are developed in Durham, Tees Valley & Forensic Care Group for AMH/MHSOP PROMS and CROMS

Finance – we have provided assurance to the ICB that the financial plan will be delivered (breakeven) with control totals now set. The Trust will monitor adherence to control totals to manage risk and provide mitigations.

Performance & Controls Assurance Overview

Tees, Esk and Wear Valleys NHS Foundation Trust

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

Board Integrated Performance Dashboard

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NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	92.12%	92.00%
2)	Percentage of carers reporting that they feel they are actively involved in decisions about the care and treatment of the person they care for	QAC		?	75.00%	75.44%	75.00%
3)	Percentage of inpatients reporting that they feel safe whilst in our care	QAC	L	?	75.00%	53.48%	75.00%
4)	Percentage of CYP showing measurable improvement following treatment - patient reported	QAC		F	35.00%	24.22%	35.00%
5)	Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported	QAC	L	F	55.00%	45.51%	55.00%
6)	Percentage of CYP showing measurable improvement following treatment - clinician reported	QAC	H	F	50.00%	46.07%	50.00%
7)	Percentage of Adults and Older Persons showing measurable improvement following treatment - clinician reported	QAC	L	F	30.00%	19.79%	30.00%
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				553	
10)	The number of Serious Incidents reported on STEIS	QAC				86	
11)	The number of Incidents of moderate or severe harm	QAC				493	
12)	The number of Restrictive Intervention Incidents	QAC				3,973	
13)	The number of Medication Errors with a severity of moderate harm and above	QAC				12	
14)	The number of unexpected Inpatient unnatural deaths reported on STEIS	QAC				3	
15)	The number of uses of the Mental Health Act	MHLC				2,715	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D				54.12%	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				61.95%	
18)	Staff Leaver Rate	PC&D	L			11.53%	
19)	Percentage Sickness Absence Rate (month behind)	PC&D	L			5.73%	
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D		?	85.00%	85.10%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D		?	85.00%	77.95%	85.00%

Rep Ref	Our Activity measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
22)	Number of new unique patients referred	S&RC				68,862	
23)	Unique Caseload (snapshot)	S&RC	H			65,035	

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	5,162,105	3,533,220
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	13,629,000	12,717,246
25b)	Agency price cap compliance	S&RC	100.00%	60.26%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	9,036,000	5,366,000
28)	CRES Performance - Non-Recurrent	S&RC	880,000	4,548,000
29)	Capital Expenditure (CDEL)	S&RC	10,874,000	5,680,175
30)	Cash against plan	S&RC	63,249,000	67,601,714

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

Background / Standard description:
We are aiming for 92% of patients surveyed, reporting their recent experience as very good or good

What does the chart show/context:
During November **1047** 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, **980 (93.60%)** scored "very good" or "good".

There is no significant change at Trust/Care Group level in the reporting period; however, we are showing special case improvement (an increase) in the number of patients who have responded to this question.

The latest National Benchmarking data (September 2023) shows the England average (including Independent Sector Providers) was 87% and we were ranked 20 in the list of providers. We were also ranked highest for the total number of responses received.

Underlying issues:
There are no underlying issues to report.

Actions:
- The Associate Directors of Nursing are reviewing how surveys are currently managed within the Care Groups to improve patient response rates (by end of December 2023)
- The Patient & Carer Experience Group are going to consider how a patient or carer could understand the performance of each individual team and what key 5 things they might look for (by end of April 2024)

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

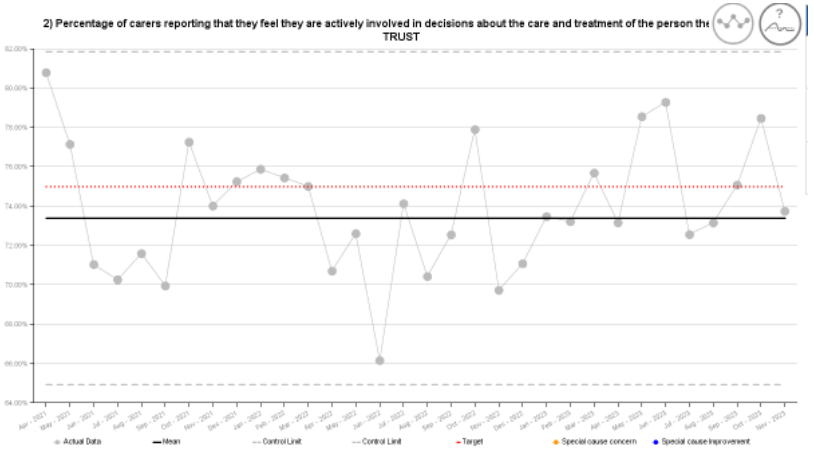
Background / standard description:
We are aiming for 75% of carers reporting, they feel they are actively involved in decisions about the care and treatment of the person they care for

What does the chart show/context:
During November, **377** 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, **278 (73.74%)** scored "yes, always".

There is no significant change at Trust/Care Group level in the reporting period; however, we are showing special case improvement (an increase) in the number of carers who have responded to the question.

Underlying issues:
Engagement with various patient groups (e.g. Secure Inpatient Services)

Actions:
- The Patient & Carer Experience Team are investigating the barriers to collecting feedback from our carers to increase response rates (by end of December 2023)
- The Patient & Carer Experience Team are working with the Recovery College to develop an e-learning package to deliver the Carer Awareness training and are continuing to deliver face to face training with an increased number of sessions



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
During November, **143** patients responded to the overall experience question in the patient survey: Question: "During your stay, did you feel safe?". Of those, **78 (54.55%)** scored "yes, always".

There is special cause concern (low performance) at Trust level and for Durham, Tees Valley & Forensic Care Group (AMH and MHSOP) in the reporting period. There is also no significant change in the number of inpatient who have responded to the question.

Underlying issues:
- There are several factors that can influence whether a patient feels safe, e.g. staffing levels, other patients, environment.
- Self Harm in inpatient settings can cause other patients to feel unsafe

Actions:
- Durham Tees Valley & Forensic Care Group are reviewing their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement (by mid-January 2024).
- The Consultant Clinical Psychologist for AMH services in Durham and Tees Valley is undertaking a self harm review/pilot work across all Trust Adult Mental Health wards including PICUs (January 2024).
- The Patient & Carer Experience Team are revisiting the benchmarking work previously undertaken to understand how we compare to other organisations and identify any key learning that can be taken forward within the Trust (by the end of January 2024).

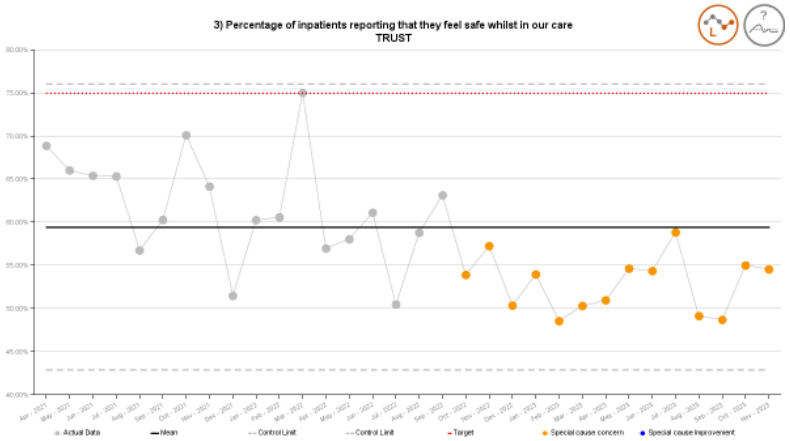
We're aiming to have high performance and we're moving in the wrong direction.

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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 35% of CYP showing measurable improvement following treatment - patient reported

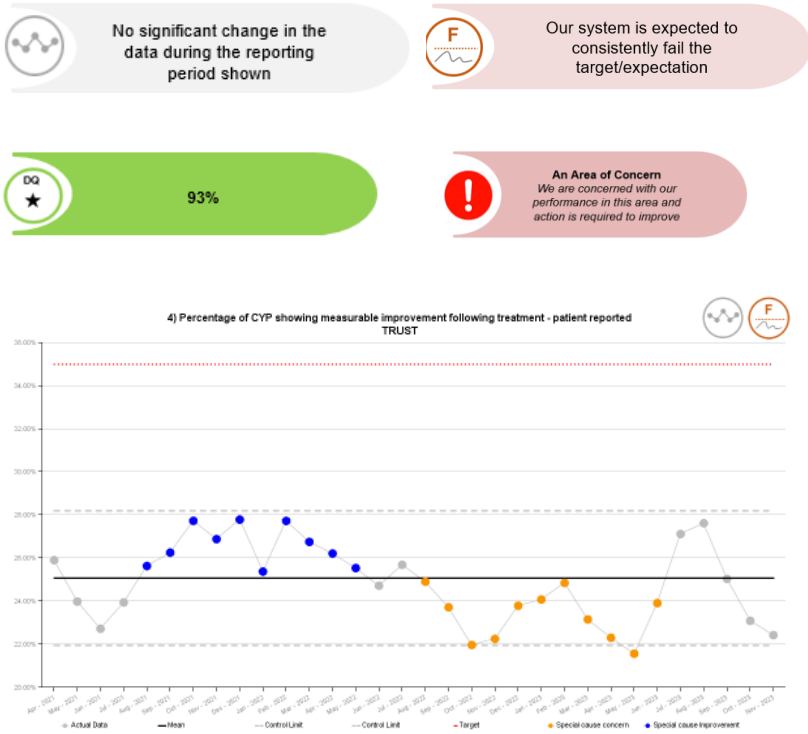
What does the chart show/context:
For the 3-month rolling period ending November **651** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 146 (22.43%)** made a measurable improvement.

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

There is no significant change at Trust level in the reporting period; however, there is special cause concern (low performance) within Durham Tees Valley and Forensic Care Group.

Underlying issues:
- No process in place to identify new starters and book them on the training
- This measure currently doesn't include Parent Rated outcomes (which is valid) or some of the newer assessment tools

Actions:
- The CYP Specialist Practitioner in Clinical Outcomes Development is providing monthly training sessions for all new starters
- Durham Tees Valley & Forensic Care Group are reviewing their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement (by mid-January 2024).
- The CYP Speciality Development Manager has submitted a paper to update the measure to the CAMHS Clinical Network Group and the Clinical Outcomes Steering Group (both approved) which will go to the Executive Review of Quality in January for final approval.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

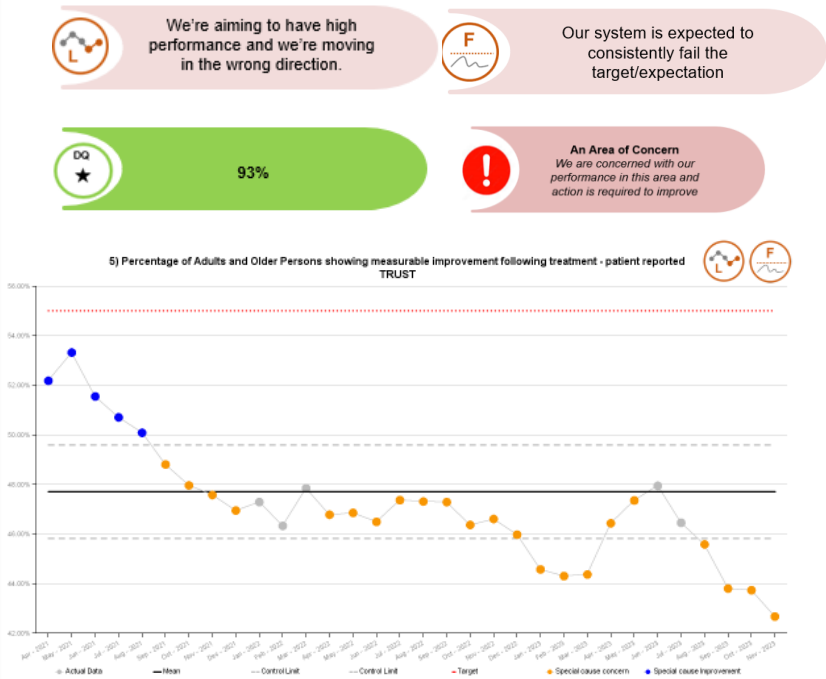
What does the chart show/context:
For the 3-month rolling period ending November **1966** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 839 (42.68%)** made a measurable improvement.

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

There is special cause concern (low performance) at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period. Special cause concern is in relation to AMH services in both Care Groups.

Underlying issues:
- Timeliness and frequency of completing outcomes is impacting

Actions:
- General Managers for Durham and Tees Valley Adults and Older Persons services to undertake a deep dive into the data by the 31st January 2024 to identify specific areas of concern and required improvement.
- North Yorkshire, York & Selby Care Group are reviewing their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement (by mid-January 2024).
- Durham, Tees Valley & Forensic Care Group are developing a Performance Improvement Plan (PIP) to support improvement in this area which will be submitted to their Care Group Board in February 2024.



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
For the 3-month rolling period ending November **751** patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 379 (50.47%)** made a measurable improvement.

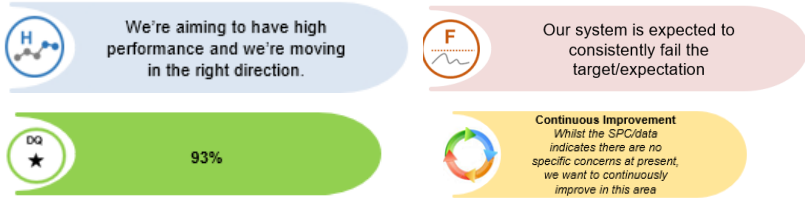
The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

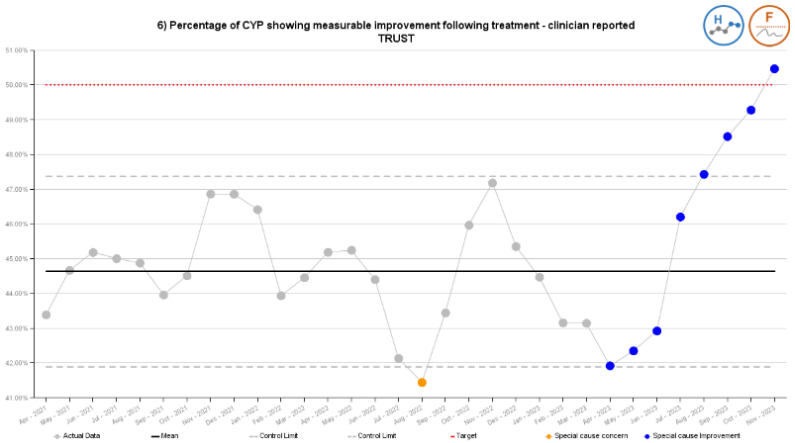
There is special cause improvement (high performance) at Trust level and for both Care Groups in the reporting period.

Underlying issues:
There are no underlying issues to report

Actions:
North Yorkshire, York & Selby Care Group are reviewing their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement (by mid-January 2024).

To note:
It was agreed by Executive Directors Group in January 2024, to stand down the North Yorkshire, York & Selby Care Group given their improvement and for any remaining actions to be completed as business as usual.





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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

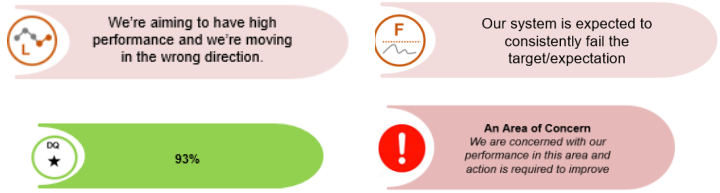
What does the chart show/context:
For the 3-month rolling period ending November **3264** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 624 (19.12%)** made a measurable improvement.

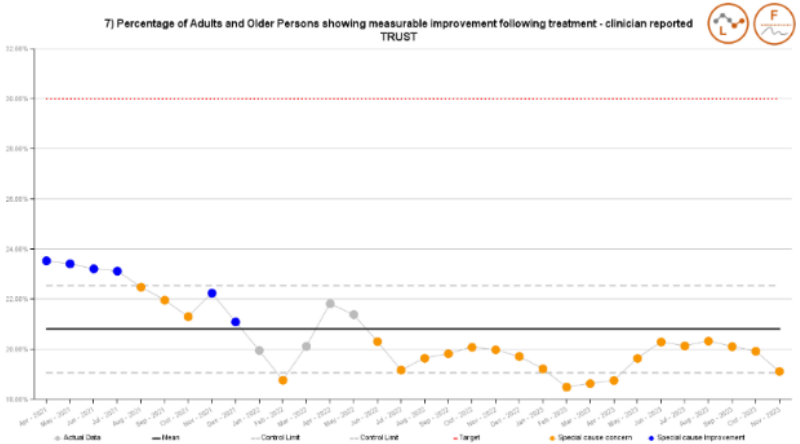
The accepted Patient Rated Outcome Measure is Health of the Nation Outcome Scales (HoNOS).

There is special cause concern (low performance) at Trust level and for Durham, Tees Valley & Forensic Care Group (AMH and MHSOP services) in the reporting period. However, it should be noted that that there is special cause improvement (high performance) for North Yorkshire, York & Selby Care Group.

Underlying issues:
- Timeliness and frequency of completing outcomes is impacting

Actions:
- General Managers for Durham and Tees Valley Adults and Older Persons services to undertake a deep dive into the data by the 31st January 2024 to identify specific areas of concern and required improvement.
- North Yorkshire, York & Selby Care Group are reviewing their Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement (by mid-January 2024).
- Durham, Tees Valley & Forensic Care Group are developing a Performance Improvement Plan (PIP) to support improvement in this area which will be submitted to their Care Group Board in February 2024.





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

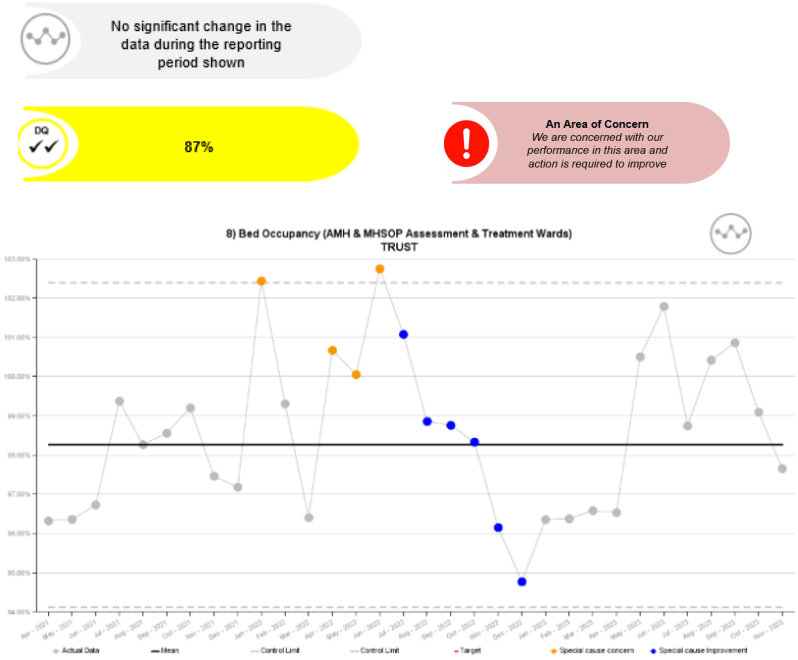
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the chart show/context:
During November, **10,500** daily beds were available for patients; of those, **10,254 (97.66%)** were occupied. Overall occupancy <u>including</u> independent sector beds was **100.25%.**

There is no significant change at Trust level in the reporting period; however, there is special cause concern (poor performance) for Durham, Tees Valley & Forensic Care Group. Special cause concern is in relation to AMH services in both Care Groups.

Underlying issues:
- Clinically Ready for Discharge – specifically around accommodation
- Patient flow and adherence to PIPA process
- Length of stay (linked to above issues)
- Greenlight admissions
- Ministry of Justice (MoJ) patients

Actions:
Both Care Groups are reviewing their Performance Improvement Plans (PIP) to ensure they include SMART actions that support improvement (by mid-January 2024)



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

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming to have no more than 153 out of area bed days by 31st December 2023 and no more than 60 by the 31st March 2024. This is also the Mental Health Priority monitored at Trust level.

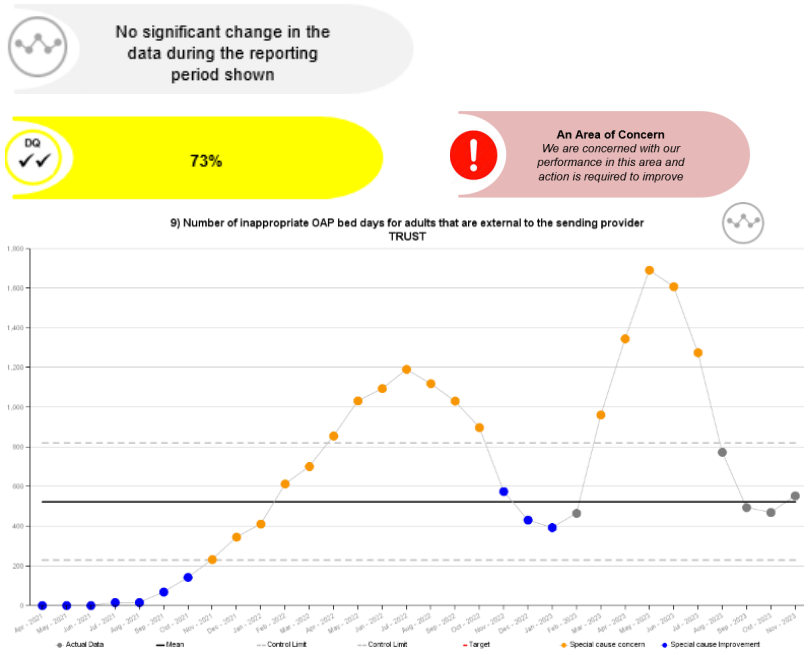
What does the chart show/context:
For the 3-month rolling period ending November **553** days were spent by patients in beds away from their closest hospital.

There is no significant change at Trust level in the reporting period; however, there is special cause concern (poor performance) for Durham, Tees Valley & Forensic Care Group. This correlates with bed occupancy for this Care Group. It should be noted, however that there is special cause improvement (good performance) in the North Yorkshire, York & Selby Care Group.

Performance against the trajectories agreed with the ICBs is shown in the **additional table below**. We are significantly exceeding the agreed number of OAP bed days.

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

Actions:
See measure 8) Bed Occupancy



ICB Trajectories versus actual performance

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		Quarter 3 23/24 (November)		Quarter 4 23/24	
	Ambition	Actual	Ambition	Actual	Ambition	Actual	Ambition	Actual
Trust	334	1608	246	494	153	553	60	
North East & North Cumbria ICB	334	1445	246	436	153	506	60	
Humber & North Yorkshire ICB	0	163	0	58	0	47	0	

10) The number of Serious Incidents reported on STEIS

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
16 serious incidents were reported on the Strategic Executive Information System (STEIS) during November; however, the chart is only showing 6. There were also 14 reported in October and the chart is only showing 12 (as reported last month).

There is no significant change at Trust/Care Group in the reporting period.

Each incident has been subject to an after-action review/early learning by services and then reviewed within the Patient Safety huddle. There were no specific themes in relation to incident details or teams.

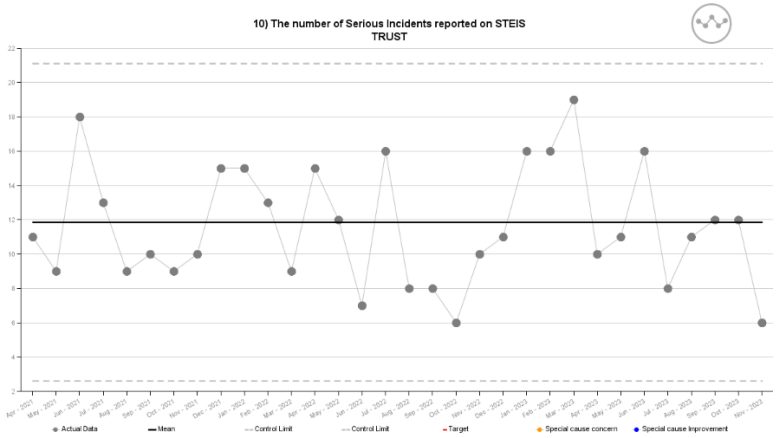
Underlying issues:
The data/charts represented in the report this month, are not an accurate reflection of the measure.

Actions:
- Standard work will be developed by the Patient Safety Team, supported by the Business Intelligence and Performance Teams, to ensure data is reported in line with the agreed requirements and therefore accurately represented in the data/charts within this report going forward.
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.

No significant change in the data during the reporting period shown

DQ 87%

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



To note:
On the 30th October 2023, the trust moved to the national LFPSE reporting system in line with national requirements, which results in all patient safety incidents reported being directly reported into the national system and subsequent reporting. To do this we replaced our incident recording and management system with InPhase (replacing Datix), therefore all incident related measures in this report have been updated to reflect this new data source from that point forwards. These measures have also been updated to remove the “finally approved” criteria as all incidents recorded are reported externally to the trust regardless of stage, so internal reporting has been aligned to this. This may mean there could be some change in the historic data previously reported, if there were any unapproved incidents remaining that pertained to the measure.

11) The number of Incidents of moderate or severe harm

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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

There is no significant change at Trust level and for Durham, Tees Valley & Forensic Care Group in the reporting period; however, there is special cause concern (high) for CYP services in this care group. It should be noted that there is special cause improvement (low) for the North Yorkshire, York & Selby Care Group (noted in AMH services).

Each incident has been subject to an after-action review/early learning by services. These incidents are then reviewed in the Patient Safety huddle where for any early learning identified, immediate actions are agreed and monitored until completion.

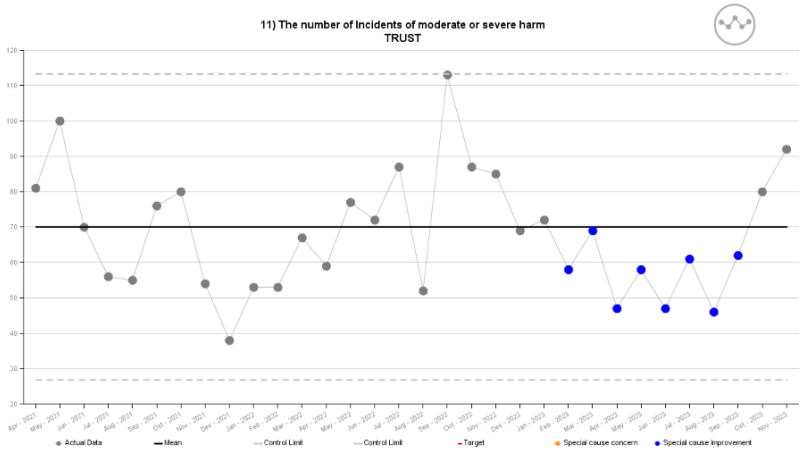
Underlying issues:
As incidents are reviewed, the severity could be reduced or increased (early indications are that severity is usually reduced) For example at the time the data is ran for inclusion in the report, there were 92 incidents and as at 11th December this had reduced to 77.

Actions:
- Work is underway with Care Groups on the process for completing after-action review/early learning via the Multi-Disciplinary Team (MDT) meetings.
- The Patient Safety Team will undertake routine detailed analysis to support their understanding of this new measure.
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.

No significant change in the data during the reporting period shown

DQ 80%

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



To note:
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Please also note this measure was previously "The number of Incidents of moderate harm and near misses" and has been changed to "The number of Incidents of moderate or severe harm" as "near miss" is not captured as a harm level within the national system.

12) The number of Restrictive Intervention Incidents

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:

Please note we have been unable to provide data this month following the move to InPhase (see note below).

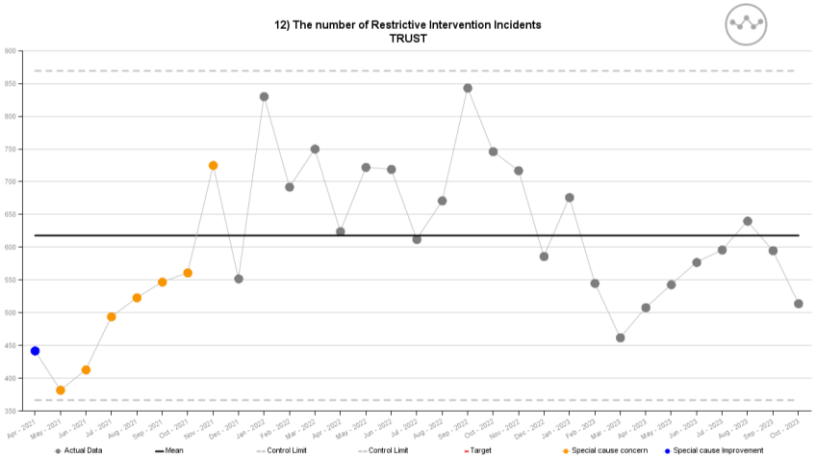
Work continues to update this measure in the Integrated Information Centre (IIC) to ensure we can report this next month.

Underlying issues:
Pending refresh of data

Actions
Pending refresh of data

No significant change in the data during the reporting period shown

DQ ★ 93%



To note:
On the 30th October 2023, the trust moved to the national LFPSE reporting system in line with national requirements, which results in all patient safety incidents reported being directly reported into the national system and subsequent reporting. To do this we replaced our incident recording and management system with InPhase (replacing Datix), therefore all incident related measures in this report have been updated to reflect this new data source from that point forwards. These measures have also been updated to remove the “finally approved” criteria as all incidents recorded are reported externally to the trust regardless of stage, so internal reporting has been aligned to this. This may mean there could be some change in the historic data previously reported, if there were any unapproved incidents remaining that pertained to the measure.

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

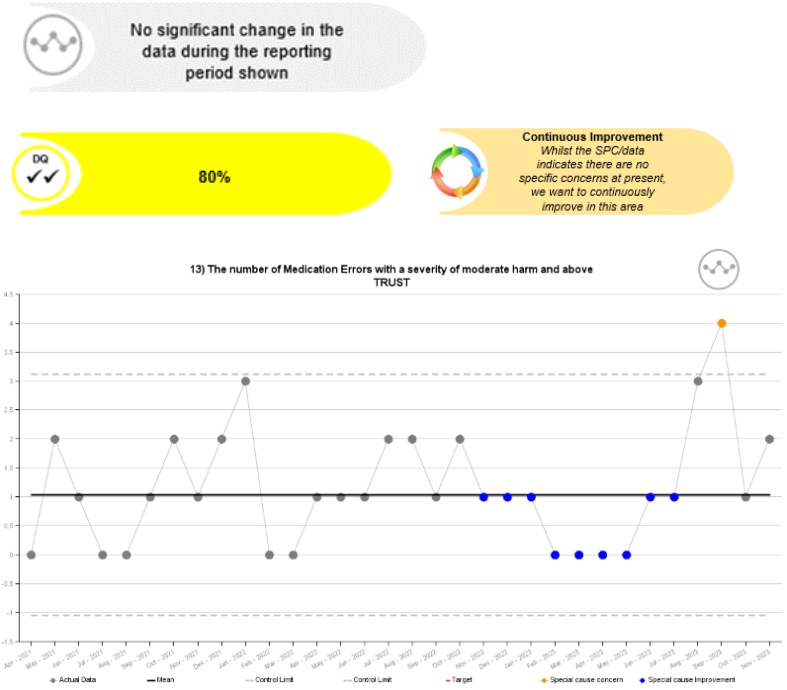
Tees, Esk and Wear Valleys NHS Foundation Trust

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

There is no significant change at Trust/Care Group in the reporting period.

Underlying issues:
EPMA (electronic prescribing & medicines administration) will enable more timely prescribing and administration of medication to patients and will reduce the risk of errors once embedded.

Actions:
To complete the roll out of EPMA for inpatients by the end of January 2024 (as at 14th December 2023 EPMA has been rolled out to 49 Inpatient units with The Orchards and Bankfields to follow in January. To note respite units are out of scope)



To note:
On the 30th October 2023, the trust moved to the national LFPSE reporting system in line with national requirements, which results in all patient safety incidents reported being directly reported into the national system and subsequent reporting. To do this we replaced our incident recording and management system with InPhase (replacing Datix), therefore all incident related measures in this report have been updated to reflect this new data source from that point forwards. These measures have also been updated to remove the “finally approved” criteria as all incidents recorded are reported externally to the trust regardless of stage, so internal reporting has been aligned to this. This may mean there could be some change in the historic data previously reported, if there were any unapproved incidents remaining that pertained to the measure.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
0 unexpected Inpatient unnatural deaths were reported on the Strategic Executive Information System (STEIS) during November.
**This has been confirmed by the Patient Safety Team based on a manual check.*

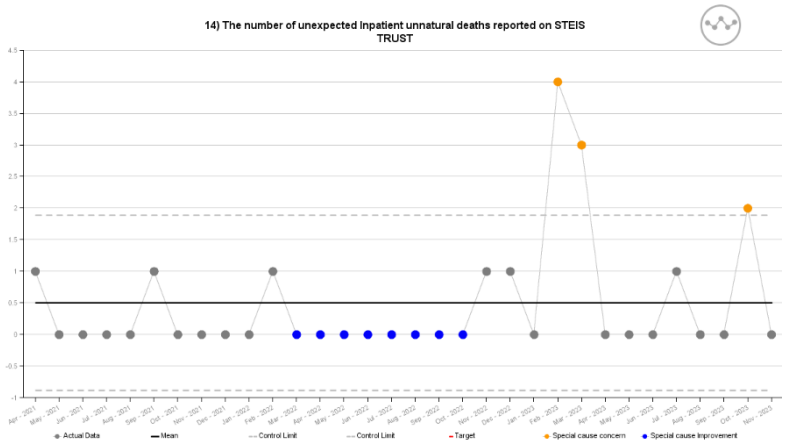
Underlying issues:
There are no underlying issues to report

Actions:
Standard work will be developed by the Patient Safety Team to ensure data is reported in line with the agreed requirements following the transfer to InPhase.

No significant change in the data during the reporting period shown

DQ 87%

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



To note:
On the 30th October 2023, the trust moved to the national LFPSE reporting system in line with national requirements, which results in all patient safety incidents reported being directly reported into the national system and subsequent reporting. To do this we replaced our incident recording and management system with InPhase (replacing Datix), therefore all incident related measures in this report have been updated to reflect this new data source from that point forwards. These measures have also been updated to remove the “finally approved” criteria as all incidents recorded are reported externally to the trust regardless of stage, so internal reporting has been aligned to this. This may mean there could be some change in the historic data previously reported, if there were any unapproved incidents remaining that pertained to the measure.

15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **328** uses of the Mental Health Act during November.

There is no significant change at Trust/Care Group in the reporting period. However, it should be noted that there is special cause improvement (a decrease) within Adult Learning Disability Services in both care groups and within Secure Inpatient Services.

To note: In agreement with the Mental Health Act Team, we have removed the renewal of sections, so only the commencement of a section is counted. The measure has also been expanded to include Community Treatment Order; Section 136.

Underlying issues:
There are no underlying issues to report

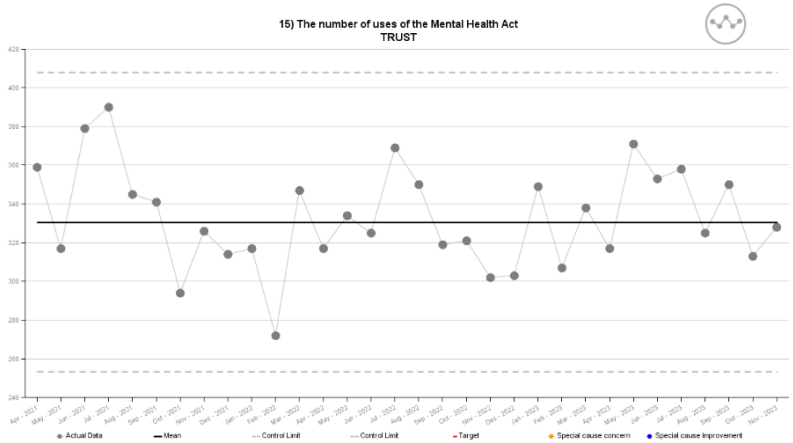
Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ

73%

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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
1276 staff responded to the July 2023 Pulse Survey question "I would recommend my organisation as a place to work" Of those, **702 (55.02%)** responded either "Strongly Agree" or "Agree".

Whilst we have limited data in this area, the line chart demonstrates there is no significant change in the reporting period.

The latest survey (October 2023) was the annual National Staff Survey undertaken by Picker. Picker will provide us with our data in December 2023; however, these results will be under embargoed until March 2024.

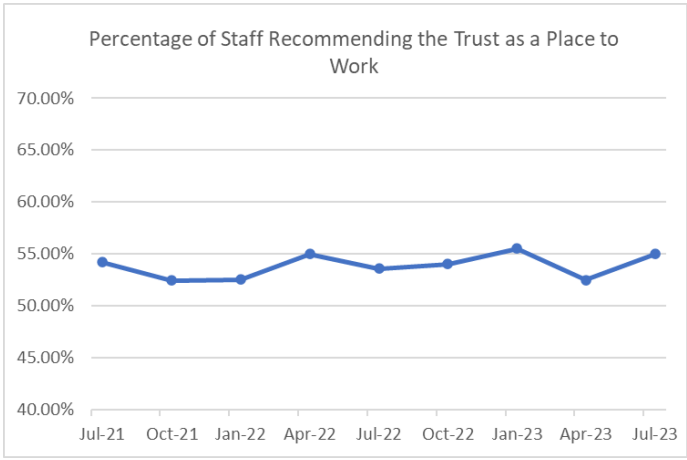
**Please note the survey is only undertaken once a quarter*

Underlying issues:
We currently have limited data on the percentage of staff recommending the Trust as a place to work.

Actions:
Whilst we don't have a specific improvement action; we do have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews/focus groups and a wide range of career development opportunities.

DQ ✓✓ 87%

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



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

What does the chart show/context:
1276 staff responded to the July 2023 Pulse Survey question "I am able to make improvements happen in my area of work" Of those, **791 (61.99%)** responded either "Strongly Agree" or "Agree".

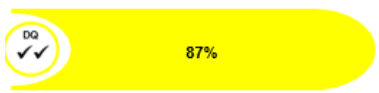
Whilst we have limited data in this area, the line chart demonstrates a slight improvement in the reporting period.

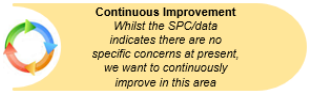
The latest survey (October 2023) was the annual National Staff Survey undertaken by Picker. Picker will provide us with our data in December 2023; however, these results will be under embargoed until March 2024.

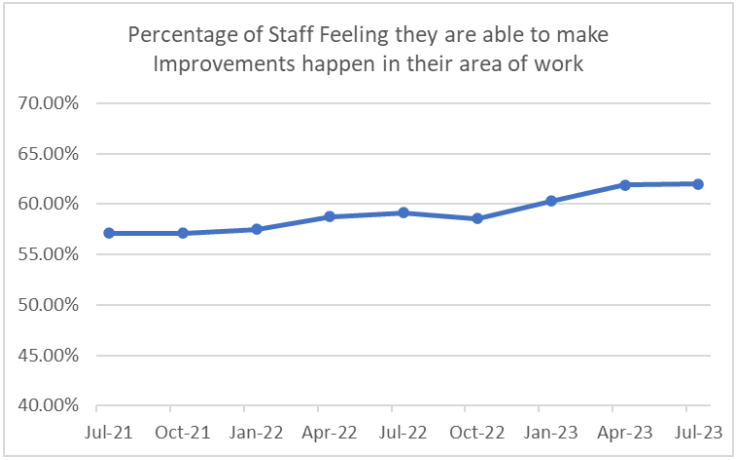
**Please note the survey is only undertaken once a quarter*

Underlying issues:
We currently have limited data on the percentage of staff feeling they are able to make improvements happen in their area of work.

Actions:
- The Trust has embarked on a 5-year (November 2027) stepped approach to Quality Improvement (QI) Training support staff to identify where improvements can be made and to feel empowered to suggest and develop those improvements.
- Our Journey To Change focuses on our cultural development through a wide range of engagement, communication and learning opportunities to enable and empower our staff to make changes in their area of work.







18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
From a total of **6,589.42** staff in post, **759.64 (11.53%)** had left the Trust in the 12-month period ending November.

There is special cause improvement (low) at Trust level and for several areas in the reporting period. However, there are 4 areas (Assistant Chief Executive, Digital and Data Services, Nursing and Governance and People and Culture) are showing special cause concern (high) in the reporting period.

The latest (August 2023) National Benchmarking for NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked 10 (previously 8) of 71 Trusts Mental Health & Learning Disability Trusts (1 being the best with the lowest leaver rate) and are placed in the highest performing quartile range.

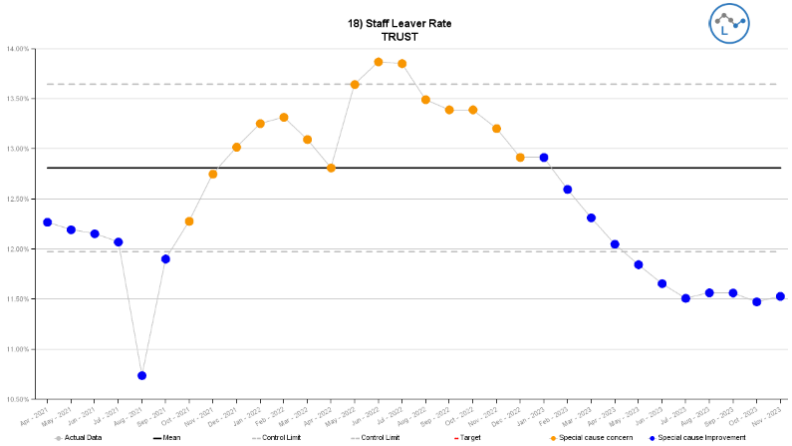
Underlying issues:
- Staff wanting a new challenge
- Role not being as expected
- Work-life balance

Actions:
- The Associate Director of Operational Delivery & Resourcing will facilitate the launch of the next Internal Transfer scheme by the end of January 2024, with a view to supporting internal transfers and reducing challenges in staff retention.
- We have a programme of work within the Safer Staffing Group which is focusing on retention. This includes flexible working opportunities; an extensive health and wellbeing offer covering Employee Support Services, Employee Psychological services, financial resilience, Intention to leave interviews and a wide range of career development opportunities.

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

DQ 80%

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



19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
There were **22,228.70** working days available for all staff during October (reported month behind); of those, 14,335.39 **(6.25%)** days were lost due to sickness.

There is special cause improvement (low) at Trust level and for most areas in the reporting period. However, Nursing and Governance are showing special cause concern (high) in the reporting period.

National Benchmarking for NHS Sickness Absence Rates published 26th October 2023 (data ending July 2023) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.29%** compared to the Trust mean of **5.89%.**

Underlying issues:
Anxiety/stress is the main reason of sickness absence

Actions:
People & Culture are focusing on the health, wellbeing and resilience of our staff. This includes flexible working opportunities, Employee Support Services, Employee Psychological services and Health & Wellbeing Champions. There is also an engagement programme including monthly health and wellbeing meetings, guest speakers and newsletters for staff.

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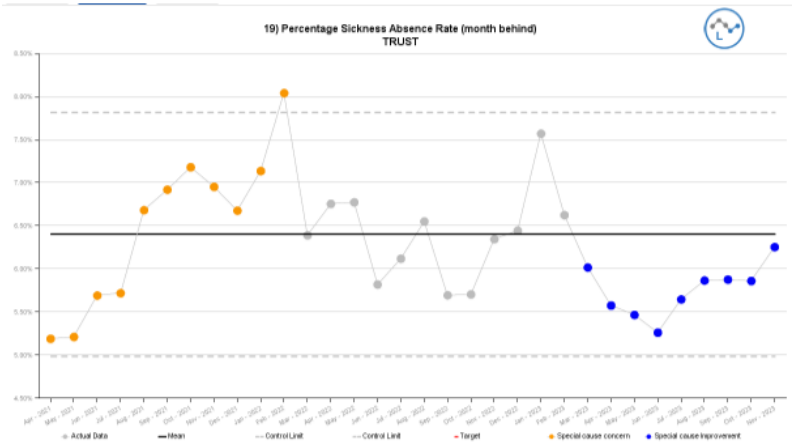
We're aiming to have low performance and we're moving in the right direction.

DQ 87%

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



20) Percentage compliance with ALL mandatory and statutory training

Tees, Esk and Wear Valleys NHS Foundation Trust

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

What does the chart show/context:
179,298 training courses were due to be completed for all staff in post by the end of November. Of those, **152,580** (**85.10%**) were completed.

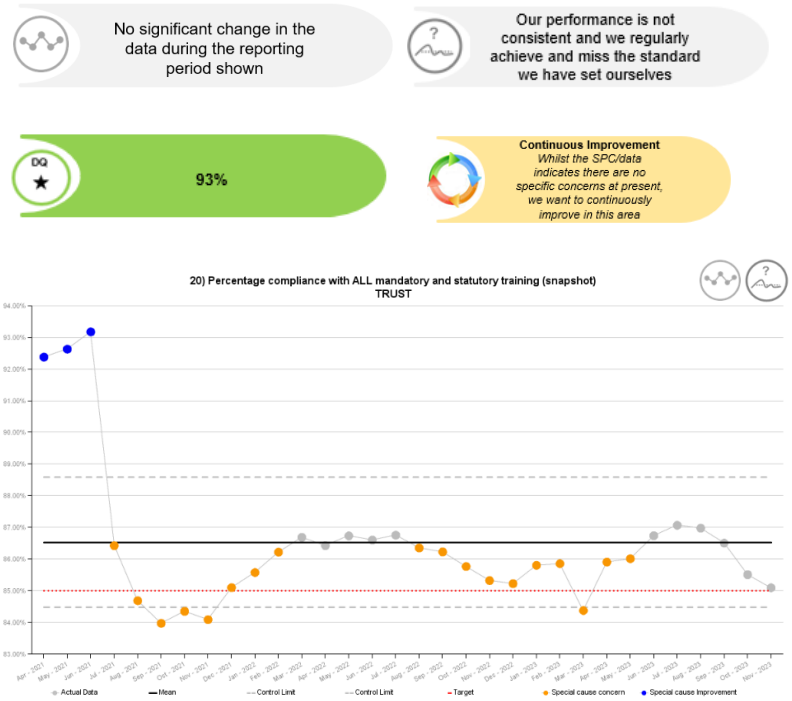
There is no significant change at Trust level and for most areas in the reporting period; however, 4 areas (Digital and Data, Estates and Facilities Management, Medical and Nursing & Governance) are showing cause for concern (low performance) in their mandatory training levels. Cause for concern is noted in AMH services in North Yorkshire, York & Selby and AMH, CYP, Health & Justice and Management within Durham, Tees Valley & Forensic Care Group.

As at the 11th December 2023, by exception, **non-compliance** by area as follows:

- Corporate Affairs & Involvement – 84.03%
- Digital & Data Services – 84.26%
- Medical – 82.62%
- North Yorkshire, York & Selby – 83.98% *(Trajectory to achieve compliance 31st March 2024)*
- Nursing & Governance – 75.60%
- Therapies – 83.85%

Underlying issues:
- Staff unable to be released to attend training (high DNA rate)
- Lack of capacity for Positive & Safe training courses
- Lack of suitable training rooms

Actions:
- People & Culture are reviewing the Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement (by mid-January 2024).
- Positive & Safe training Level 1 will change from 1st February 2024 with the requirement to be every 2 years
- The training portfolio for Positive & Safe is being reviewed currently with a potential implementation date of April 2024.
- We are constantly reviewing the availability of training rooms across trust premises.



20) Percentage compliance with ALL mandatory and statutory training – Supporting Information

Tees, Esk and Wear Valleys NHS Foundation Trust

Information Governance & Data Security Training

Background / standard description:
We are aiming for 95% compliance for Information Governance & Data Security Training (as required by the Data Security and Protection Tool Kit)

What does the data show/context:
7720 were due to be completed by the end of November. Of those, **6844 (88.65%)** were completed.

As at the 11th December 2023, by exception, **non-compliance** as follows:

- Company Secretary – 90.91%
- Corporate Affairs & Involvement –86.84%
- Digital & Data Services –84.97%
- Durham Tees Valley & Forensic –88.82%
- Estates & Facilities Management –90.70%
- Medical – 86.18%
- North Yorkshire, York & Selby – 87.60%
- Nursing & Governance – 89.91%
- People & Culture – 91.03%
- Therapies – 86.33%

Underlying issues:
- An improvement plan is in place with NHS England which includes a commitment to achieve the standard by 31st December 2023.
- Our existing measure does not include all staff which is a requirement

Actions:
- To agree with EDG a revised trajectory (December 2023)
- The Business Intelligence Team will revise an existing measure to align it to NHS England's criteria by end of January 2024

All other mandatory and statutory training

As at the 11th December 2023, by exception (below the 85% standard) are the following courses sorted by lowest performance:

1) Follow Up - 50.00%
2) Positive and Safe Care Level 1 Update- 55.00%
3) Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year - 62.08%
4) Patient Safety Level 2 - 66.97%
5) Rapid Tranquilisation 1 - 67.15%
6) Moving and Handling - Level 2 - 2 Years - 67.78%
7) Positive and Safe Care Level 2 Update - 69.86%
8) Face to Face Medication Assessment - 70.53%
9) Resuscitation - Level 1 - 1 Year - 71.02%
10) Fire Safety - 2 Years - 73.91%
11) Medicines Management Annual Module- 74.91%
12) MCA - MCA and Young People Aged 16/17 - 76.09%
13) Positive and Safe Care Level 1 - 76.44%
14) Resuscitation - Level 2 - Adult Basic Life Support - 1 Year - 77.91%
15) LD & Autism Tier 1 E-Learning - 78.04%
16) Essentials for Patient Safety for Board L1 - 80.00%
17) Safeguarding Level 3 - 80.01%
18) Observation & Engagement - 80.13%
19) Annual Medicines Optimisation Module - 80.25%
20) Rapid Tranquilisation 2 - 81.24%
21) Safe Prescribing - 81.89%
22) Infection Prevention and Control - Level 2 - 1 Yea - 82.34%
23) Mental Health Act Level 2 - 84.03%
24) Fire Safety - 1 Year - 84.33%
25) Controlled Drugs - Inpatient - 84.48%
26) Safeguarding Level 1 – Corporate -84.78%

21) Percentage of staff in post with a current appraisal

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for 85% of staff in post with a current appraisal

What does the chart show/context:
Of the **6,699** eligible staff in post at the end of November; **5,222** (**77.95%)** had an up-to-date appraisal.

Whilst there is no significant change in the data during the reporting period, 2 areas (Estates and Facilities Management and North Yorkshire, York & Selby Care Group) are showing significant cause for concern (a decrease) in their staff appraisal compliance. Finance are the only area achieving the standard.

As at the 11th December 2023, by exception, **non-compliance** by area as follows:

- Assistant Chief Executive – 84.85%
- Capital Programme – 57.14%
- Company Secretary – 55.56%
- Corporate Affairs & Involvement – 60.00%
- Digital & Data Services – 71.60%
- Durham Tees Valley & Forensic – 76.81%
- Estates & Facilities Management – 81.36% *Trajectory to achieve compliance 23rd December 2023)*
- Medical – 70.98%
- North Yorkshire, York & Selby – 78.95% *(Trajectory to achieve compliance 31st March 2024)*
- Nursing & Governance – 78.95%
- People & Culture – 84.33%
- Therapies – 66.67%
- Trust-wide roles – 66.67%

Underlying issues:
Our new structured approach to high quality appraisal conversations through WorkPal is impacting

Actions:
- People & Culture are reviewing the Performance Improvement Plan (PIP) to ensure it includes SMART actions that support improvement (by mid-January 2024).
- The new Programme Lead for WorkPal is undertaking a targeted piece of work in Estates and Facilities Management to support them using WorkPal.

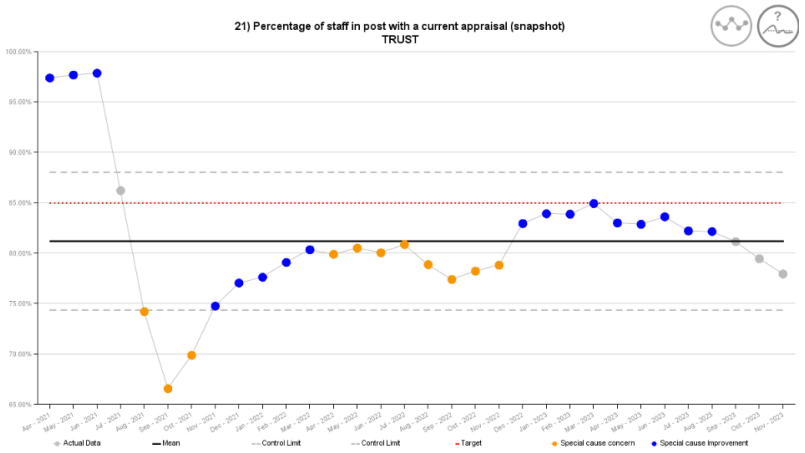
No significant change in the data during the reporting period shown

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

DQ

87%

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



Actions continued:
A plan on a page for completing appraisals is being developed (January 2024)
Appraisal training is planned for 2024 for both managers and staff (appraiser and appraisee)
A communications brief will go out to all staff not registered on WorkPal as a reminder (January)

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
8,766 patients referred in November that are not currently open to an existing Trust service.

There is no significant change at Trust/Care Group in the reporting period; however, there is special cause concern in AMH services within North Yorkshire, York & Selby Care Group(low referrals) and special cause improvement (high referrals) in AMH services within Durham, Tees Valley & Forensic Care Group.

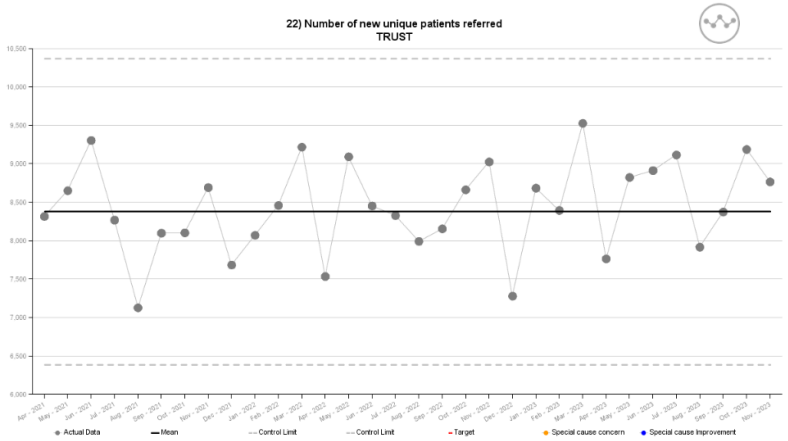
Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ ★ 93%

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



23) Unique Caseload (snapshot)

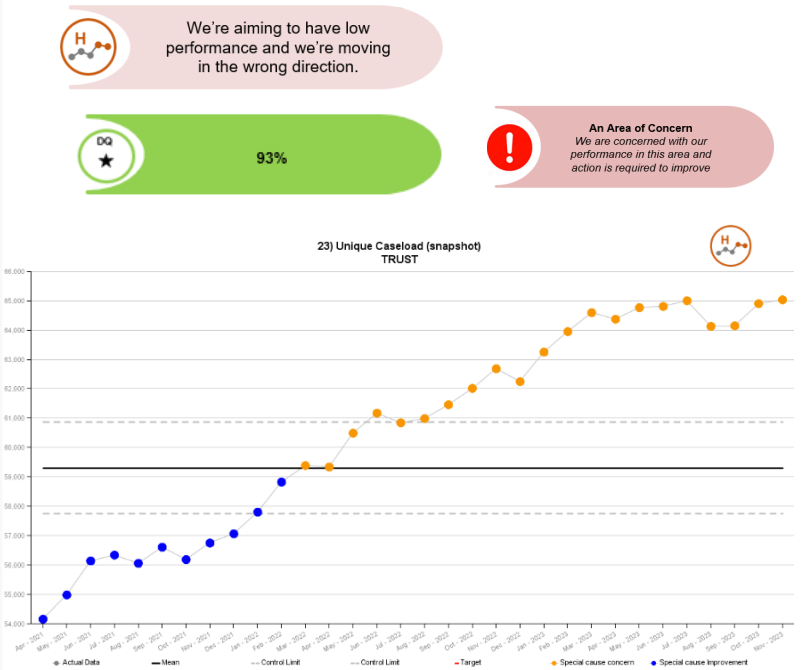
Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
65,035 cases were open, including those waiting to be seen, as at the end of November 2023.

There is special cause concern (high) at Trust and for Durham Tees Valley and Forensic Care Group (CYP and AMH services) in the reporting period. There is also special cause concern in CYP and MHSOP services within North Yorkshire, York & Selby Care Group.

Underlying issues:
- An increase in referrals in CYP services for neuro diverse patients across both Care Groups
- An increase in referrals in AMH services within DTVF for neuro diverse patients
- Increase in referrals has led to a backlog of waiters, whilst referrals have levelled, they are higher than they used to be

Actions:
- Both Care Groups are reviewing their Performance Improvement Plan (PIP) to ensure they include SMART actions that support improvement (by mid-January 2024).
- We are setting up a Task & Finish Group within Corporate Services to triangulate key measures/data that relate to caseload so we can better understand the issues and how we support improvement.



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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

What does the data show/context:
The financial position at, 30th November 2023 is an operational deficit of **£3.5m** against a planned year to date deficit of **£5.2m**, resulting in a **£1.6m** favourable plan variance, but inclusive of £2.3m national funding for 2023/24 pressures and to ensure delivery of key operational priorities in the remaining months. The Trust reforecast the position at Month 7, using this as the basis to establish 'control totals' for each month to year end, and for Care Groups / Directorates. The control total for M8 was an in month surplus run rate of (£0.95m) compared to an actual surplus run rate of (£0.66m) resulting in an adverse variance to the in-month control total of £0.29m.

- **Agency expenditure** in November 2023 was £1.30m, or £0.23m below plan in month, and £12.72m, or £0.91m below plan to date, showing an improved favourable variance to plan in month. This includes impacts from actions to exit non-clinical agency assignments. Usage includes material costs linked to inpatient occupancy and rosters, medical cover, costs within Health and Justice, and reducing costs relating to complex specialist packages of care and non-clinical assignments.
- **Independent sector beds** - the Trust used 319 non Trust bed days during November 2023 (224 in October, or a 95 bed day increase) at a cost of £0.27m (including estimates for unvalidated periods of occupancy and average observation levels pending billing). Year to date costs were £2.27m (£2.00m prior month) and £1.28m more than the £0.99m year to date plan. This remains a key area of clinical and management focus including through new arrangements for an Urgent Care Programme Board (chaired by the Managing Director for DTVF Care Group) including developing a range of forecast scenarios.
- **EFM Building & Engineering Contracts** cost £1.80m to date, or £0.47m more than planned (£0.36m prior month). Costs relate to on-call and vacancy cover (pay under spending of £0.34m YTD as of November 2023, and £0.26m prior month). Revised roles, job descriptions / bandings are in recruitment to align pay with regional peers and mitigate these pressures recurrently with structures operational from August 2023 and some run rate reductions now being seen. A review of excess inflation is in train to assess the impact on budgets from in-year contract uplifts.
- **Taxis and Secure Patient Transport** YTD cost to November 2023 was £1.89m, which was £0.81m more than plan. A quality improvement event identified grip and control recommendations as well as alternative options. The results, and need for additional Care Group action, are being closely monitored. The Chief Nurse is overseeing actions to ensure robust governance around Secure Transport and recent procurement will reduce unit costs going forward, the benefit of this is being assessed.
- **Planned CRES** are £3.27m 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, review of surge posts and actions to reduce taxi/transport costs. **Unplanned CRES of £3.27m** to date (including interest receivable) are fully mitigating adverse performance against planned schemes. Composite CRES achievement is therefore in line with plan to the end of November 2023 but with a recurrent underlying risk to delivery.

The Trust provided assurance to NHSE at the end of November that the break even financial plan will be delivered, and established control totals for Care Groups / directorates based on this forecast with recovery actions modelled centrally. Care Groups / directorates will be monitored against control totals with the requirement to manage risk and variation to control totals.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Underlying issues:

- We need to reduce Trust use of independent sector beds.
- We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan.
- We need to deliver CRES schemes to achieve our financial plan
- Understand likelihood of delivering our 2023/24 financial forecast to breakeven as per our financial plan submitted to the ICB.

Actions:

- Please see actions within measures - 08) Bed Occupancy (AMH & MHSOP A & T Wards) and 09) Number of inappropriate OAP bed days for adults that are 'external' to the sending provider.
- The Performance Improvement Plans (PIPs) for Agency and Safe Staffing are being reviewed to ensure they include SMART actions that support improvement (by mid-January 2024).
- The CRES support Team (efficiency hub) will be co-ordinated by a Programme Manager with recruitment underway. Terms of reference for the team / group will be established
- Outputs from the CRES workshop will be co-ordinated by the CRES Support Team / efficiency hub once established and terms of reference agreed.
- Monthly variance to control totals will be monitored and assessment will be made of our deliverability of the plan agreed and communicated to the ICB.

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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
Agency expenditure for the month of November 2023 was £1.30m, or £0.23m below plan, and £12.71m or £0.91m below plan to date showing an improved favourable variance to plan in month, including from actions to exit non-clinical agency assignments.

NHS planning guidance introduced Integrated Care System agency cost caps of 3.7% of pay bill. As at Month 8 Trust agency expenditure represented 4.9% of pay bill. Planned agency costs for 2023/24 were relatively in line with 2022/23 outturn and whilst levels have started to reduce from month 6 onwards, costs remain high as a percentage of overall pay and higher than the average percentage target for integrated care systems in aggregate. Reducing agency volume and premium rates is a key focus, including continued actions to exit non-clinical agency assignments with a significant reduction observed from M7.

Previous regional reporting of sickness levels suggested peer mental health providers had experienced similar challenges. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence (sustained favourable reductions now being seen) but equally to net new recruitment (including to medical, qualified nursing, inpatient, and health and justice hot spots) and securing alternative whole system models of care for specialist adult learning disability packages of care and high-cost medical assignments.

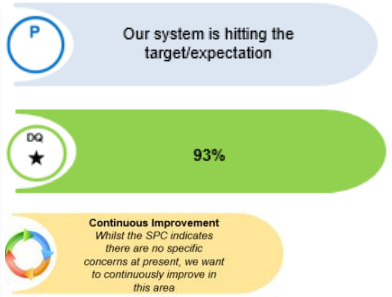
We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

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

Underlying issues:
There are no underlying issues to report

Actions:
The Executive Workforce and Resources Group have the following actions to improve rostering:

- Outline clear governance flow in Care Groups related to how rosters are overseen, including specific information on roles and responsibilities (starting January 2024)
- Look at central analysis of roster data to identify useful questions indicated by the data, with a view to providing areas of focus for discussion during live training (End of January 2024)
- Re-visit roster rules to make sure the development of rosters is equitable/fair between colleagues (end of December 2023)
- Develop roster training programme (starting January 2024)



25b) Agency price cap compliance

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
During November 2023 there were **2,886** agency shifts worked, with **1,739** shifts compliant **(60%).**

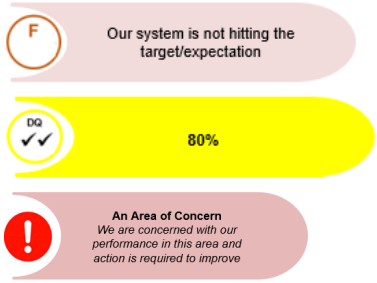
This is 456 fewer than October which is equivalent to approximately 96 shifts per day (compared to 111 per day in October).

- 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 showing sustained reductions. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to sickness absence but equally to net new recruitment (including to medical, qualified nursing, inpatient health and justice hot spots) 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 NHSE Temporary Staffing submission mid-month which may result in minor differences between reported data.
- We recognise that volume pressures and rate premia associated with agency expenditure are 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.

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

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required



26) Use of Resources Rating - overall score

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
The overall rating for the trust is a **3** for the period ending 30th November 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 0.80x, which is 0.30x better than plan and is **rated as a 4** (0.18x better than plan in October).
- 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 17.9 days; this is behind plan by 2 days and is **rated as a 1** (2.8 days behind plan in October).
- 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 -1.20%, this is better than plan by 0.52% and is **rated as 4** (0.35% better than plan in October)
- **The agency expenditure metric** assesses agency expenditure against a capped target for the Trust. Costs of £12.72m are £0.91m (6.67%) 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 M8 the agency expenditure was 4.9% of pay.

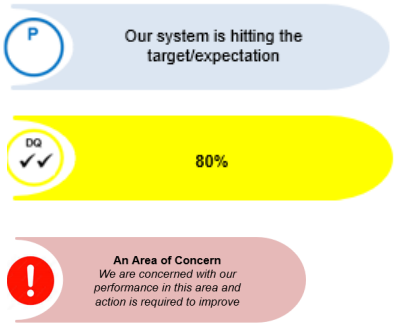
Specifically for agency please refer to **25a) Financial Plan: Agency expenditure compared to agency target & 25b) Agency price cap compliance**

The Trust's financial performance results in an **overall UORR** of **3** for the period ending 30th November and **is in line with plan.**

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

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required



27) CRES Performance - Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
We planned to deliver **£9.04m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£5.37m recurrent CRES**. This is **£3.67m adverse variance** against planned recurrent schemes.

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 8 with specific performance noted as:
- £0.99m under-delivery of CRES for OAPs Reduction in AMH (Performance Improvement Plan in place)
- £1.31m under-delivery of CRES for Surge post review (Pay)
- £0.35m CRES for Agency (Inpatient level loading of rosters – actions in train via sub group of safer staffing group)
- £0.22m CRES for Taxi spend reduction (Improvement Event and associated actions being progressed)
- £0.80m CRES for other schemes
- Recurrent CRES unachieved £3.67m to date

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

Underlying issues:
We need to deliver CRES schemes to achieve our financial plan

Actions:
Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit

F — Our system is not hitting the target/expectation

DQ — 80%

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

28) CRES Performance – Non-Recurrent

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
We planned to deliver **£0.88m** of non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£4.55m**. **(£3.67m) favourable variance** against planned non-recurrent schemes.

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 8 relating to:
Planned Schemes
- (£1.11m) Non Recurrent Grip & Control (Non Pay)
- £0.35m Unachieved CRES Non Recurrent Grip & Control Trust wide Recovery Actions / budget rebasing (Non Pay)

Unplanned Schemes
- (£1.07m) Interest Receivable
- (£0.01m) Income Contribution
- (£1.83m) LD, Medical and Long Covid contribution

Composite non-recurrent CRES **over delivery** to M8 of **(£3.67m).**

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

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required

Our system is hitting the target/expectation

80%

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

29) Capital Expenditure (Capital Allocation)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
Capital expenditure at the end of November was **£5.68m** against an allocation of **£10.87m** resulting in a **£5.19m** underspend.

- There are several favourable and adverse variances to plan; however, year to date slippage of £5.19m 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, costs relating to which are expected to be £5.0m (£0.7m year to date).

- The Trust is forecasting to outturn in line with planned performance in aggregate but notes an unplanned upside in relation to actual costs for phase 1 Teesside works. Options to utilise this are being considered, including bringing forward must do actions from 2024/25.

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

Underlying issues:
There are no underlying issues to report

Actions:
There are no specific improvement actions required

F — Our system is not hitting the target/expectation

DQ ★ — 93%

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

30) Cash balances (actual compared to plan)

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
We have an actual cash balance of **£67.60m** against a planned year to date cash balance of **£63.25m** which is **(£4.35m) positive variance** to plan.

- This is mainly due to underspending on capital budgets, and Health Education England income received in advance of the period it relates to, with partial offsets due to movements on working balances.

- The Trust has failed to achieved the 95% Better Payment Practice Code (BPPC) target compliance for the prompt payment suppliers, achieving a combined year to date BPPC of 94.7%. 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 30th November 2023 was £2.75m, with debts exceeding 90 days amounting to £0.23m (excluding amounts being paid via instalments and PIPS loan repayments).

- Of three whole government accounting organisations account for 80% of total debts greater than 90 days old (£0.18m), progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged

Underlying issues:
Please see measure - 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit

Actions:
As above

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P — Our system is hitting the target/expectation

DQ ★ — 93%

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

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

	Measure	Goal 1 - To Co-Create a great experience for our patients, carers and families	Goal 2 - To Co-Create a great Experience for our Colleagues	Goal 3 - To be a great partner
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 or severe harm	√		
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	√		
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_25b	Financial Plan: Agency expenditure compared to agency target			
BIPD_25a	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

	Measure	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 and 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 or severe harm			√	√		√			√		√				
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		√	√	√	√	√			√		√				
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_25b	Financial Plan: Agency expenditure compared to agency target									√		√				√
BIPD_25a	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)									√		√	√			√

National Quality Standards and Mental Health Priorities Headlines

Headlines

- **EIP waiting times** failing target for the second consecutive quarter (Vale of York only)
- **Child Eating Disorders waiting times** consistently failing target across all areas for urgent cases and most areas for routine cases (except Tees Valley)
- **Talking Therapies access** consistently failing target in 2 areas (County Durham and North Yorkshire) however, good/improved performance in Tees Valley and Vale of York
- **Talking Therapies 1st to 2nd treatment waits** consistently failing target in all areas however, target achieved in North Yorkshire this quarter
- **Childrens Paired Outcomes** consistently failing target
- **AMH/MHSOP 2 contacts** achieving target in most areas, except for Vale of York
- **OAP (inappropriate)** consistently failing target **This is also the MH Priority monitored at Trust level – see IPD measure 9 for further details*
- **Specialist Community PMH services** consistently achieving target in 2 areas (County Durham and Tees Valley); however, failing target in North Yorkshire and Vale of York

Risks / Issues

Of most concern:
- Child Eating Disorders
- OAP bed days (inappropriate)

Of concern:
- EIP Waiting Times (Vale of York only)
- Talking Therapies Access (County Durham and North Yorkshire)
- Talking Therapies 1st to 2nd treatment (all except for North Yorkshire)
- Childrens Paired Outcomes
- Specialist Community PMH services (North Yorkshire and Vale of York)

Positive Assurance

Consistent achievement can be seen for:
- 72hr follow up
- Talking Therapies waiting times (6 and 18 weeks)
- Talking Therapies recovery
- CYP 1 contact

Mitigations

We are reviewing all the Performance Improvement Plans (PIP) in the following areas to ensure they include SMART actions that support improvement (by mid-January 2024):

- Child Eating Disorders – both Care Groups
- OAP bed days (inappropriate) – Trust-wide
- Talking Therapies Access and Waiting Time – both Care Groups *North Yorkshire, York and Selby Access only*
- Perinatal Mental Health – North Yorkshire, York & Selby Care Group
- EIP waiting times - we are recruiting to 5 posts for the York and Selby EIP team and are reviewing the referral criteria
- Childrens Paired Outcomes – A business case is being developed for a dedicated outcomes team

Note *Talking Therapies previously known as IAPT*

National Quality Standards and Mental Health Priorities Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

National Quality Requirements																				
Measure	Agreed S-ICBL	County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD
Percentage of Service Users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric in-patient care	80%	90.91%	92.77%	89.74%		90.61%	88.66%	90.65%	85.10%		87.72%	90.12%	93.16%	88.24%		89.71%	86.43%	93.14%	86.67%		86.49%
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%	63.77%	60.38%		62.77%	73.68%	69.05%	84.44%		74.15%	85.71%	88.24%	80.00%		85.37%	73.33%	50.00%	23.81%		52.05%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait six weeks or less from referral to entering a course of NHS Talking Therapies treatment	75%	99.47%	99.86%	99.68%		99.68%	99.46%	100.00%	99.20%		99.61%	99.54%	99.70%	99.52%		99.59%	99.20%	99.81%	99.55%		99.53%
Percentage of Service Users referred to an NHS Talking Therapies programme who wait 18 weeks or less from referral to entering a course of NHS Talking Therapies treatment	95%	100.00%	99.97%	99.95%		99.97%	100.00%	100.00%	99.73%		99.93%	100.00%	100.00%	100.00%		100.00%	99.93%	100.00%	99.92%		99.95%
Child Eating Disorders: Percentage of Service Users designated as routine cases who access NICE concordant treatment within four weeks	95%	83.82%	84.13%	82.09%		82.09%	91.01%	95.12%	96.30%		96.30%	80.00%	78.05%	81.40%		81.40%	78.33%	83.05%	81.13%		81.13%
Child Eating Disorders: Percentage of Service Users designated as urgent cases who access NICE concordant treatment within one week	95%	76.67%	67.74%	63.89%		63.89%	50.00%	50.00%	50.00%		50.00%	87.50%	87.50%	83.33%		83.33%	71.43%	71.43%	71.43%		71.43%

Local Quality Requirements																				
Measure	Agreed S-ICBL	County Durham					Tees Valley					North Yorkshire					Vale of York				
		Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD	Q1	Q2	Q3	Q4	FYTD
Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy	*	2662	2899	2722		7441	557	603	569		1534	1723	1672	1786		4654	1495	1607	1859		4435
IAPT: The proportion of people who are moving to recovery	50%	51.69%	50.98%	50.40%		51.09%	54.39%	56.90%	50.93%		54.32%	51.55%	53.67%	54.29%		53.08%	54.26%	58.34%	56.78%		56.49%
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	13.92%	12.91%	13.33%		13.36%	19.76%	18.56%	23.05%		20.23%	17.57%	12.63%	6.72%		12.73%	31.15%	26.61%	25.24%		27.84%
Number of CYP aged 0-17 supported through NHS funded mental health with at least one contact	*	9978	10236	10507		10507	11654	11598	11478		11478	4319	4098	4088		4088	4545	4529	4510		4510
Percentage of CYP closed referrals, with at least two contacts, with paired outcome scores within reporting period	40%	22.46%	25.75%	21.61%		23.59%	28.53%	27.12%	24.88%		26.80%	38.24%	37.80%	32.68%		36.47%	30.38%	25.53%	24.89%		26.80%
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.	*	8193	8151	8195		8195	6824	7121	7458		7458	4161	4143	4095		4095	3341	3183	3102		3102
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider	*	1445	436	506		506	1445	436	506		506	163	58	47		47	163	58	47		47
Number of women accessing specialist community PMH services in the reporting period (cumulative)	*	207	278	324		324	233	310	374		374	77	95	117		117	37	67	91		91

NOTES ** Denotes individual plans agreed by area; Q3 is October-November (part)*

Tees, Esk and Wear Valleys NHS Foundation Trust

For General Release

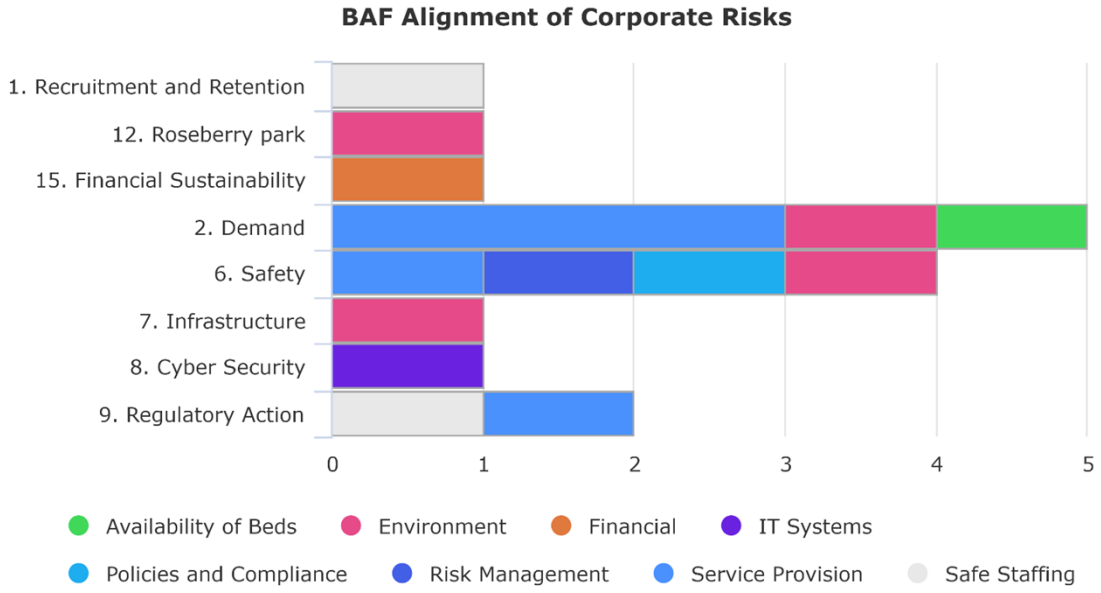
Meeting of:	Board of Directors
Date:	11 January 2024
Title:	Corporate Risk Register – January 2024
Executive Sponsor(s):	Beverley Murphy, Chief Nurse
Author(s):	Kendra Marley, Head of Risk Management

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 Committees and Executive Sub Groups have oversight of organisational wide risks that are rated as high risk in the Corporate Risk Register, and those aligned to the individual Committee's.

This is a new combined report for all of the Board Committees and their Executive Sub Groups, which will be produced on a monthly basis, covering movements and changes in the preceding month. Where any meetings are not monthly, the respective Chair can choose how to review

these in the meeting. For example, considering only the current month report unless there are specific changes to aligned risks in earlier periods.

Overview:

This paper presents to the Board the risks that are rated ≥15 on the Corporate Risk Register as of 4th January 2024, reflecting any movement and changes during December 2023.

There are currently 16 risks on the Corporate Risk Register, which reflects no change in the month as the Executive Risk Group meet bi-monthly, having last met in November.

One risk on the register has been reduced and will be reviewed at the next Executive Risk Group and a decision taken regarding removal. This risk is aligned to the Quality Assurance Committee.

- Risk 1232 (Legacy ID 1324) DTVF CAMHS - Unacceptable waits for mental health assessment and treatment, has been reduced to 12.

As some Committees/ Groups may not have met since the November meeting of the Executive Risk Group, to address any gaps reporting as a result of the report change, the following changes were made to the Risk Register at that time.

1 risk had been reduced to below 15 and agreed for removal from the Corporate Risk Register;

- Risk 1165 (Legacy ID 1257) – DTV&F- CAMHS – Risk of prolonged admission/ stay to/in inappropriate settings.

1 new risk was considered and added tot eh Corporate Risk Register;

- 1417/L1509 – Finance – DOF – there is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory breaches/interventions and /or/adversely impact quality of services.

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 Committees and Executive Sub Groups are asked to:

- Consider any changes in the risks on the register aligned to the relevant Committee and the assurance over the management of risk.

Further Information

1. Introduction and Purpose

To ensure the Board Committees and Executive Sub Groups have oversight of organisational wide risks that are rated as high risk in the Corporate Risk Register, and those aligned to the individual Committee's.

This is a new combined report for all of the Board Committees and their Executive Sub Groups, which will be produced on a monthly basis, covering movements and changes in the preceding month. Where any meetings are not monthly, the respective Chair can choose how to review these in the meeting. For example, considering only the current month report unless there are specific changes to aligned risks in earlier periods.

For Board Committees and Executive Sub Groups to consider and determine the level of assurance it can take regarding the risk management processes

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, its Committee's and Executive Sub Groups.

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, Committee's and Executive Sub Groups to easily understand the highest risks that they need to be aware of.

The Corporate Risk Register is reviewed and approved by the Executive Risk Group bi-monthly.

4. Current Reporting Period

This paper presents to the Board the ≥15 risks on the Corporate Risk Register as of 4th January 2024, reflecting any movement and changes during December 2023.

As previously receiving separate reports, the last meeting dates and as such reporting dates for individual Committees and Executive Sub Groups may have differed. As a new combined report for all Committees and the Executive Sub Groups, this report will focus on the current position and changes in December 2023, however to address any gaps in the meeting periods, the updates from November's Executive Risk Group are reflected.

A full Board report this month will cover all changes over the period since last reported to the Board in September.

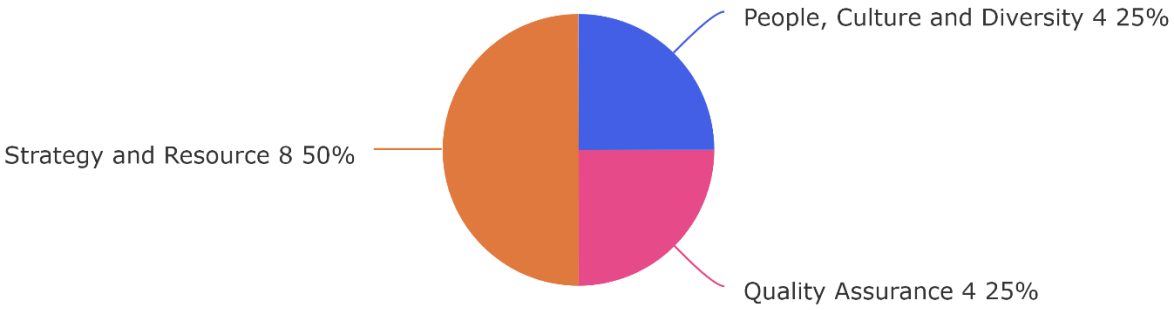
5. Corporate Risk Register

There are currently 16 risks on the Corporate Risk Register. There have been no additions or removals during December.

The Executive Risk Group last reviewed and approved additions and removals in November 2023.

The current risks on the register align to the main Board Committees as shown in the following chart.

Committee Distribution of Corporate Risks



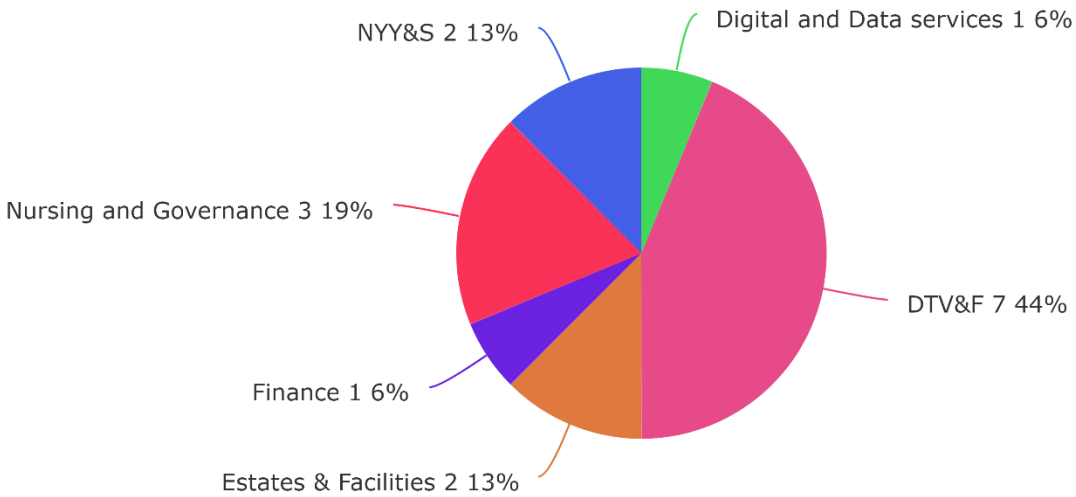
This shows that there are;

- 4 risks aligning to the Quality Assurance Committee
- 8 risks aligning to the Strategy and Resource Committee
- 4 risks aligning to the People, Culture and Diversity Committee

There are currently no risks aligning to the Mental Health Legislation Committee or the Commissioning Committee.

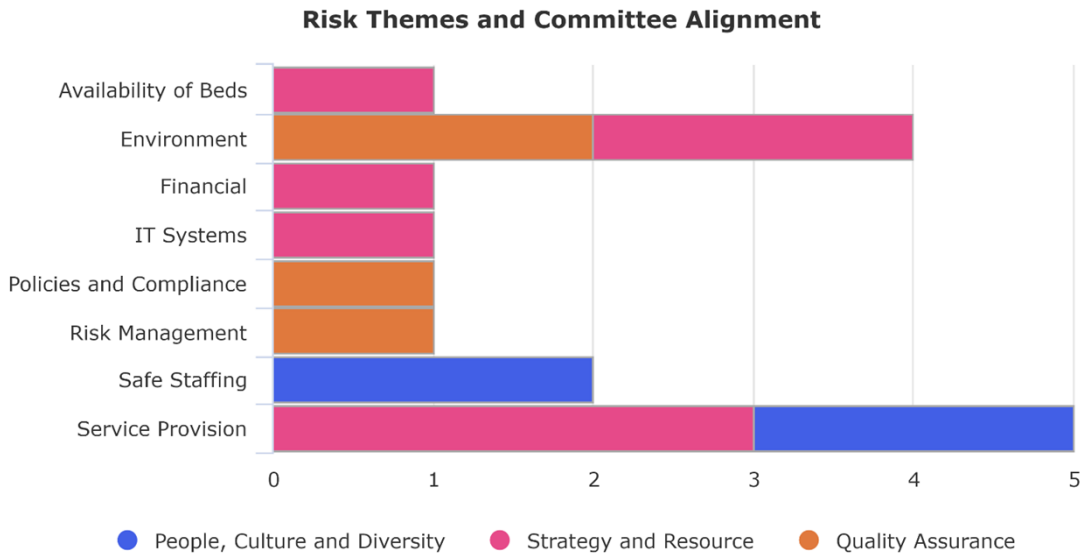
Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 44% of the current Corporate Risk Register is made up of risks from Durham Tees Valley and Forensics Care Group, with 19% Nursing and Governance, 13% North Yorkshire, York and Selby and Estates and Facilities, with Digital and Data and Finance at 6%.

Care Group/Directorate Distribution of Approved CRR Risks



5.1 Risk Themes

The 16 risks fall under the following themes within the Committee Alignment.



5.2 Risk Movements

Approved Additions and Removals

As the Executive Risk Group meet bi-monthly with no meeting taking place in December, there are no agreed additions and removals from the Corporate Risk Register during December.

Other Changes

One risk on the register has been reduced to below the 15+ threshold and will be reviewed by the Executive Risk Group to agree removal in January.

- Risk 1232 (Legacy ID 1324) DTVF CAMHS - Unacceptable waits for mental health assessment and treatment, has been reduced to 12.

  The owner has reflected - the risk score has been reduced due to progress against BCP metrics in both teams. This is notwithstanding some concerns that psychology leavers in January may lead to a deterioration in the position for SD Team - we will closely monitor and update again in February.

  The risk is aligned to People Culture and Diversity.

Changes made at the November Executive Risk Group

1 risk had been reduced to below 15 and agreed for removal from the Corporate Risk Register;

- Risk 1165 (Legacy ID 1257) – DTV&F- CAMHS – Risk of prolonged admission/ stay to/in inappropriate settings.

  The owner has reflected - the risk likelihood has been reduced due to the QA schedule now regularly being 80% or above.

  The risk was aligned to Quality Assurance.

1 new risk was added to the Corporate Risk Register;

1417/L1509 – Finance – DOF – there is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory breaches/interventions and /or/adversely impact quality of services. (20)

Full details are shown in the risk register.

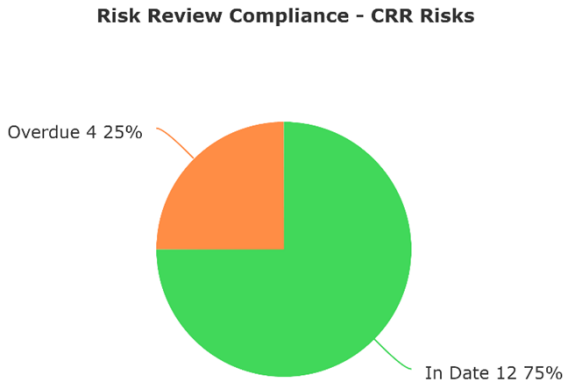
This risk is aligned to Strategy and Resources.

5.3 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

At the time of writing the paper the compliance of timely risk review for the Corporate Risk Register is 75%.



The breakdown by directorate is shown below.

6. Conclusions

The current Corporate Risk Register is provided and there is only one minor change of a reduction in risk on one of the risks, which will be reviewed at the next Executive Risk Group and any decision on removal reflected in a future paper.

Review timeliness and update on the system for Corporate Risk Register risks has fluctuated due to the change in system and staff still getting used to changes. Further work to support owners is planned.

7. Recommendations

The Board Committees and Executive Sub Groups are asked to:

- Consider any changes in the risks on the register aligned to the relevant Committee and the assurance over the management of risk.

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Committee/ Group Alignment	BAF Link	Theme	Legacy ID	Dates	Location	Ownership	Description	Rating (initial)	Controls	Details of gaps in controls	Rating (current)	Action Progress	Actions Open	Rating (Target)	Date added to CRR
Strategy and Resource	12. Roseberry park	Environment	219 295	Identified - 17/08/23 Last reviewed - 28/07/23 Next review due - 12/06/23	Estates & Facilities - EFM - 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.	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	2 in progress 9 in total">7 completed	R295 - Achieve contract resolution to the satisfaction of the TrustPhase 2 rectification works	10	31 Aug 2022
Quality Assurance	6. Safety	Environment	811 903	Identified - 17/08/23 Last reviewed - 08/01/24 Next review due - 07/12/23	Estates & Facilities - EFM - 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, due to the presence of potential ligature points and access to these, resulting in severe harm/death to patients and significant distress to families and staff, and impact on organisational reputation.	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 programme of estates work.	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	1 not started 2 in progress 10 in total">7 completed	R903 - Implement phase 2 of the ligature reduction programmeR903 - Phase 3 deliveryR903 - Roll out of Oxehealth technology to be extended for additional Inpatient Wards across the trust	10	31 Aug 2022
Strategy and Resource	8. Cyber Security	IT Systems	860 952	Identified - 17/08/23 Last reviewed - 18/12/23 Next review due - 16/11/23	Digital and Data services - DADS - It & systems - Technology Services	Owner - Mike Brierley - Manager - Steven Forster	There is a risk of a successful cyber attack on Trust, due to IT Staff having insufficient cyber security resources, and enforced cyber security policies and procedures, along with technical controls, audit and assurance, resulting in the Trust not being 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.	-The Trust has adopted a cyber strategy but has limited funding and maturity which has been highlighted in a number of areas including a Cyber Audit (Cyber Incident Response TEWV 2023/24- 10). -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 across no-Windows hosts. -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 vulnerabilities to be surfaced as they are found and risk assessment against those identified. - The Cyber/IT capability is over-stretched and cannot meet the current industry & service demands expected from operators of essential services. -There are limited tactical and strategic plans in place for planning and reacting to the myriad of inherent and systemic risks as part of a mature incident response approach. An overall Incident Response document to cover high level systems exists and is of a reasonable standard. However, further investment in time allowed to continuously improve the IT teams and senior leaders' responsiveness and awareness to scenario led incident response exercises. - Cyber risk management and effective threat modelling are not aligned to the modern-day threat. Although some controls exist, they cannot begin to keep pace with modern criminal cyber organisations. Automation and structure are needed if the Trust wishes to remain secure with strong integrity. - Awareness	20	2 in progress 4 in total">2 completed	R952 - Hire staffR952 - Purchase Cyber Software	12	22 Nov 2022
People, Culture and Diversity	1. Recruitment and Retention	Safe Staffing	909 1001	Identified - 17/08/23 Last reviewed - 13/10/23 Next review due - 14/09/23	NYY&S - 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.	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	3 in progress 7 in total">4 completed	R1001 - Develop non-medic colleague skills to ensure consistent service deliveryR1001 - Explore and encourage group job planning to increase flexibility of the workforce supportingR1001 - Putting in place a middle grade oncall rota to support medical staff retention	9	31 Aug 2022

Committee/ Group Alignment	BAF Link	Theme		Legacy ID	Dates	Location	Ownership	Description	Rating (initial)	Controls	Details of gaps in controls	Rating (current)	Action Progress	Actions Open	Rating (Target)	Date added to CRR
Strategy and Resource	9. Regulatory Action	Service Provision	925	1017	Identified - 17/08/23 Last reviewed - 30/01/24 Next review due - 30/11/23	DTV&F - DTV&F - ALD -	Owner - Jamie Todd - Manager - John Savage	There is a risk that we are unable to comply with Mixed Sex Accommodation (MSA) guidance and CQC compliance requirements, due to the layout and poor repair of the buildings, resulting in adaptations that leave us unable to meet contractual requirements and continued failure to meet MSA/CQC requirements resulting in future breaches, regulatory action and reputational damage.	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.	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	1 in progress 11 in total">10 completed	R1017 - Revisiting previous options and work with M'bro LA around Levick Court	6	22 Nov 2022
People, Culture and Diversity	2. Demand	Service Provision	1039	1131	Identified - 17/08/23 Last reviewed - 22/02/24 Next review due - 03/01/24	NYY&S - NYY&S Management -	Owner - Brian Cranna - Manager - Nicky Scott	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	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	4 in progress 16 in total">12 completed	R1131 - the requirement for a call handling system, with ability to call record to be in place for NR1131 - to be able to respond to NHS 111 mental health selection requirements and meet demandR1131 - to expand the MHS service capacity to take all calls and screen those that meet the need forR1131 - to work with NYY ICB regarding additional funding and procurement of alternative model & cap	6	31 Aug 2022
Quality Assurance	6. Safety	Policies and Compliance	1044	1136	Identified - 17/08/23 Last reviewed - 07/01/24 Next review due - 07/12/23	Nursing and Governance - N&G - Quality governance - Patient Safety Management	Owner - Dawn Jessop - Manager -	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the continuing incident backlog 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	Review of skills and roles in team undertaken and new posts JD going through JD process	15	1 in progress 1 cancelled 14 in total">12 completed	R1136 - Review team structure and recruit as required	10	22 Nov 2022
Quality Assurance	7. Infrastructure	Environment	1131	1223	Identified - 17/08/23 Last reviewed - 12/01/24 Next review due - 12/12/23	Nursing and Governance - N&G - Nursing and quality - Infection Prevention Control and Physical Health Care	Owner - Carole Rutter - Manager - 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 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 There is no central service to coordinate medical device risk, safety or lifecycle Ward staff placing own orders for new equipment, commissioning and repair - relying on form-based process to let the asset register know Inability to adhere to the requirements of DSP Data Security Standard 9.3.8 which states that 'The organisation maintains a register of medical devices connected to its network.' With the current state of the Medical Device asset database, we cannot provide any assurance or assistance to I.T in this requirement. Inability to respond to rapid Medical Device alerts, as we do not have a robust knowledge of equipment in use at TEWV. Impossible to tell if we are impacted by alerts in a timely fashion due to the status of the Medical Device estate asset register.	16	1 in progress 4 in total">3 completed	R1223 - Undertake a baseline assessment of medical devices stored within operational services to asc	3	31 Aug 2022
Strategy and Resource	2. Demand	Service Provision	1134	1226	Identified - 17/08/23 Last reviewed - 19/01/24 Next review due - 07/12/23	DTV&F - DTV&F - ALD -	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	Lack of national and local beds Potential closure of LRH further impacting bed provision Suitable alternative provision	20	8 in total">8 completed		9	31 Aug 2022
People, Culture and Diversity	6. Safety	Service Provision	1137	1229	Identified - 17/08/23 Last reviewed - 06/10/23 Next review due - 30/08/23	DTV&F - 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	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	2 in progress 6 in total">4 completed	R1229 - All ward team managers to be using the same clinical supervision recording systemR1229 - Routine performance monitoring of clinical supervision compliance to take place within all s	9	29 Mar 2023

Committee/ Group Alignment	BAF Link	Theme	Legacy ID	Dates	Location	Ownership	Description	Rating (initial)	Controls	Details of gaps in controls	Rating (current)	Action Progress	Actions Open	Rating (Target)	Date added to CRR
Strategy and Resource	2. Demand	Availability of Beds	1310	Identified - 17/08/23 Last reviewed - 31/01/24 Next review due - 04/12/23	DTV&F - DTV&F - CAMHS -	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.	Limited dietetic input within CDDFT. Inconsistent arrangements for facilitating NG feeding in the community. Need for feedback and planning meeting between TEWV CNTW case managers and ICB and NHSE case manager	16	2 in progress 3 in total">1 completed	R1310 - CDDFT/TEWV joint workplanR1310 - Working on SLA with CDDFT for dietetics provision	6	25 Jul 2023
Strategy and Resource	2. Demand	Service Provision	1311	Identified - 17/08/23 Last reviewed - 31/01/24 Next review due - 04/12/23	DTV&F - DTV&F - CAMHS -	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 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.	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	2 in progress 3 in total">1 completed	R1311 - Completion of multi agency improvement plan - see T drive for full planR1311 - SDF investment	8	17 Jan 2023
People, Culture and Diversity	9. Regulatory Action	Safe Staffing	1324	Identified - 17/08/23 Last reviewed - 28/02/24 Next review due - 04/12/23	DTV&F - DTV&F - CAMHS -	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.	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	12	1 in progress 5 in total">4 completed	R1324 - Continue to progress against Recovery Plan actions	6	17 Jan 2023
Strategy and Resource	2. Demand	Environment	1419	Identified - 17/08/23 Last reviewed - 10/01/24 Next review due - 13/12/23	DTV&F - DTV&F - SIS -	Owner - Naomi Lonergan - Manager - Richard Hand	There is a risk that the service may be required to establish more enhanced care areas (ECAs) within the existing environment and resource, due to increased clinical need, resulting in patients experience and quality of care impacted by the level of restriction, and requirement for additional staff outwith the established budgeted MDT workforce.	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.	The Cedar development is now open, the beds will be incrementally increased monthly. 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	3 in progress 4 in total">1 completed	R1419 - Clinical review of patient recordsR1419 - Review of discharge/transfer pathways for 2 patients in ECAR1419 - Through the bed management process, explore access to the medium secure male ECAs at Cedar	4	25 Jul 2023
Quality Assurance	6. Safety	Risk Management	1429	Identified - 17/08/23 Last reviewed - 08/01/24 Next review due - 07/12/23	Nursing and Governance - N&G - Quality governance - Patient Safety Management	Owner - Dawn Jessop - Manager -	There is a risk of delays in reviewing serious incidents due to ongoing backlog and low staffing resulting in avoidable harm 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	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	1 in progress 7 in total">6 completed	R1429 - Patient Safety Modern Matron Post - to be recruited	8	29 Mar 2023
Strategy and Resource	15. Financial Sustainability	Financial	1509	Identified - 05/09/23 Last reviewed - 22/01/24 Next review due - 04/01/24	Finance - FIN - Financial management - Director Of Finance	Owner - Liz Romaniak - Manager - John Chapman	There is a risk that if we do not optimise and make effective use of our annual financial resources this may result in regulatory breaches /interventions and/or adversely impact quality of services.	16	Aligned business planning and budget setting to ensure board approved jointly owned 2023/24 plan with clear assumptions, risks, issues, dependencies. Budgets loaded in ledger M2 following May national submission to ensure budget reporting minimal delays. Processes in place for in-year changes to underlying recurrent / non recurrent budget baseline to be monitored. Monthly management reporting / variances, run rate and forecast review used to assess best, worst, likely scenarios and requirement for in-year financial recovery actions Contracts and partnership investment prioritisation processes with 89% income supported by agreed NHS mandates / contracts Governance arrangements (Care Group Boards, Executive Directors Group & sub groups, Management Group, Financial Sustainability Board, Strategy & Resources Committee, and Board of Directors) improve understanding, triangulation, escalation and management of service, care group, and aggregate Truest financial position. Workforce planning, controls and monitoring in place overseen by Executive People and Culture Group (>80% costs) SFIs / SOs and scheme of delegation including approvals hierarchies and segregation of functions In-year reporting against budget and control totals (as financial recovery actions are agreed). Groups established to focus on 'hot-spots' (e.g. P&C groups for Agency Reduction, Safer Staffing and Operational Beds Oversight).	NENC ICB 2023/24 £49.9m deficit plan and minimum 4% CRES stretch all providers. YTD Position: Month 8 reported £1.6m ahead of plan, though this includes £2.3m unplanned non recurrent national income via ICB for industrial actions and 23/24 pressures. Achievement of the full year breakeven position (control total agreed at month 7) is dependent on reducing agency expenditure (and recruiting to vacancies), reducing independent sector bed use to 4 active placements by the end of March 2024 (and reducing average length of stay), addressing delayed transfers with partners and delivering CRES in line with the £20.8m target (or delivering non-recurrent mitigations to cover any shortfall). Other key assumptions relating to our forecast to deliver a breakeven plan include: PFI IFRS 16 below line. Capitalisation of schemes. Inpatient run rate is in line with probable case. ICB income of £2.3m has been transacted at month 8 but cash should follow. Provider Collaborative income agreed for share of slippage. substantially mitigate B2 to B3 HCA impact. Residual risk identified to the ICB range of £1.2m to £1.6m. Annual leave and other technical adjustments values as per probable case. Underlying Position: The opening planned underlying financial position was a deficit of £39m. More recent work to develop an NENC MTFP has included actions to refresh this. The Trust has agreed a restated vacancy factor assumption but ICB plan assumptions for income include that service development funding of £12m and £5m other currently non recurrent income is confirmed as being recurrent (currently non recurrent on mandate). £15.5m recurrent CRES delivery is assumed in this underlying position, delivery of additional recurrent CRES schemes are required to improve. Underlying accumulated underfunding of pay award including recurrent funding gap for 23/24 AfC pay award (5%). Microsoft Licence defund mitigated non-recurrently but expected recurrent pressure 24/25 (£455k). Work in underway to understand standard costs for	16	10 in progress 23 in total">13 completed	R1509 - Beds oversight group to identify actions required to eliminate OAPS by March 24R1509 - Completed PID and QIAs to deliver required 2023/24 CRES schemes and risk-assess deliveryR1509 - 23/24 Costing Transformation Plan actions to inform CRES planningR1509 - Medical Director and Chief Nurse sign off of QIAs to deliver required 2023/24 CRES schemesR1509 - Monitor delivery risk to 3 high cost planned ALD discharges and impact on CRESR1509 - Reporting and monitoring of drivers associated with Pharmacy / prescribing overspending viaR1509 - Review and propose Procurement expenditure controls to ESRGR1509 - Revisit non-commissioned posts identified as part of surge recruitment and reconfigure vacanR1509 -	12	28 Nov 2023

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Corporate Risk Register – Movements in September/ October 2023

Approved Additions and Removals in September

As the Executive Risk Group meet bi-monthly a meeting took place in September 2023 following production of the previous Corporate Risk Register reporting to the Board.

To ensure full transparency, between the September paper and now, changes made to the Corporate Risk Register as a result of the decisions made at Septembers Executive Risk Group are shown below.

Changes made at the November Executive Risk Group

6 risks were removed from the Corporate Risk Register;

- Risk 1028 (Legacy ID 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. (reduced to 12 (then 6 and closed))
    - The initial reduction and subsequent closure reflects that agency/ bank staff utilised are regular as opposed to 'one off' shift workers, therefore are familiar with the patients in a similar way to substantive staff, and quality of care is not being compromised.

- Risk 1212 (Legacy ID 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. (reduced to 12 (now 9))
    - The initial reduction was due to absence of SI's associated with the risk and a reduction in reported delays of accessing MHA assessments.

- Risk 1335 (Legacy ID 1427) Medical – Pharmacy - There 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. (reduced to 12 (now 8))
    - The initial reduction was a result of leadership capacity having been improved, with all leads in post in post with additional extra hours currently being provided from Deputy Chief (governance) and Lead Pharmacist (patient safety) to support increased governance workload.

- Risk 1487 (Legacy ID 1487) NYYS Adults – Kingsway doors not being able to be used as intended (closed)
    - This was an incorrectly stated risk that was reviewed and closed.

- Risk 1146 (Legacy ID 1238) NYYS MHSOP - 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. (closed)

  - The closure of this risk followed assessment reflecting that although we continue to have patients from DTV in NYYS beds this is not impacting on the ability to access beds for MHSOP patients from the NYYS area.

- Risk 1279 (Legacy ID 1371) DTVF Adults - Risk that compliance with level 2 positive and safe training continues to reduce across the service. (closed)
  - The closure of this risk was as a result of it being superseded by an existing risk – risk 1391 (Legacy ID 1483), while at a 16, this risk has not been added to the Corporate Risk Register as a number of Care Group and Directorate actions were underway.

Tees, Esk and Wear Valleys
NHS Foundation Trust

For General Circulation

Meeting of: Board of Directors
Date: 11th January 2024
Title: Adoption of the Charitable Trust Fund Annual Report and Accounts for 2022/23
Executive Sponsor: Liz Romaniak, Director of Finance, Estates and Facilities
Author: John Chapman, Head of Accounting and Governance

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***
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. Appropriate use of Trust funds can enhance patient and staff experience throughout the Trust.

Executive Summary:

Purpose: To support the submission of charitable Trust fund accounts and annual report in line with Charities Commission deadlines.

Proposal: The report includes the annual report and accounts for consideration, which have been subject to an independent review by Mazars.

Overview Appendix A contains the Charitable Trust Fund (CTF) annual report and accounts. In year the fund decreased by £54k in net resources mainly due to expenditure on patient welfare activities. The overall balance of the funds on 31 March 2023 was £542k.

An independent review was completed by Mazars LLP. There are no matters arising from the review (i.e., no adjustments to the accounts or annual report) and the final independent review report will be signed following the January Board of Directors meeting.

Once the independent review is approved and signed it will be included in page 9 of the accounts prior to submission to the Charities Commission (a draft from last year is included for completeness).

Prior Consideration and Feedback: The annual report and accounts were received by Audit and Risk Committee members in December 2023 (remotely as the meeting was cancelled), and the committee made the recommendation that the Board of Directors approves the submission of the Annual Report and Accounts of the Charitable Trust Fund, as shown in appendix A.

A quarterly update report on Trust Fund usage is received by the Strategy and Resources Committee. An independent review of the accounts and annual report is completed by Mazars LLP. An independent review provides a limited assurance report on the information included within the annual report and accounts. This is less intensive than an external audit but is appropriate for the size and value of transactions within the fund.

Implications: If supported, the annual report will be uploaded to the charities commission by 31st January 2024.

Recommendations: The Board of Directors is recommended to approve the submission of the Annual Report and Accounts of the Charitable Trust Fund, as shown in appendix A to the charities commission.

The Board of Directors is recommended to ensure appropriate signatures are made on the following pages of the accounts:

- Page 1 – statement of trustee responsibilities
  - Chairman and Chief Executive
- Page 3 – balance sheet
  - Chief Executive

Tees, Esk and Wear Valleys
NHS Foundation Trust

Tees, Esk and Wear Valleys NHS Trust

General Charitable Fund

Fund Number: 1061486

Annual Report 2022-23

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Appendices

1 – Incoming resources

2 – Resources expended

Tees, Esk and Wear Valleys NHS Foundation Trust

General Charitable Trust Fund

Annual Report 2022-23

1. Tees, Esk and Wear Valleys NHS Foundation Trust General Charitable Trust Fund

The Charity is administered by Tees, Esk and Wear Valleys NHS Foundation Trust and was formed as the "umbrella" Charity for the former Tees and North East Yorkshire NHS Trust and County Durham and Darlington Priority Services NHS Trust charitable funds.

2. Objectives of the Charity

The Tees, Esk and Wear Valleys NHS Foundation Trust Charitable Trust Fund Deed (which is the governing document for the charitable funds) states the Charity's principal objectives as being:

"... for any charitable purpose or purposes relating to the National Health Service".

The governing document does not place any specific restrictions on the use of the funds other than that implied by the Charity's main object. All bids are made on an ad-hoc basis with no commitment or strategic deployment from any one individual fund.

All charities must demonstrate, explicitly, that their charitable purposes are for the public benefit and adhere to the following two key principles:

Principle 1: There must be an identifiable benefit or benefits

Principle 2: Benefit must be to the public, or section of the public

The Trustee confirms that they have had regard to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the trust's aims and objective and in planning future activities and setting grant making policy for the year. It is the opinion of the Trustee that it has followed this guidance by:

- Providing additional amenities, events or equipment for service users and carers, and employees of the Trust throughout the year.

- Ensuring there is no detriment or harm that, in their view, might arise from carrying out the charity's aims.

Further details of specific activities that have been provided can be referenced in Section 4 – Achievements and performance.

3. Organisational structure and relationships

3.1 Organisation structure

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate Trustee of the charity. Delegated responsibility is allocated to the executives and non-executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board. All those with delegated responsibility of the Trustee are legally co-opted from the Foundation Trust Board and training and development

needs are addressed through the Foundation Trust appraisal process.

Those with delegated responsibility of the Trustee received no remuneration or expenses, and no remuneration or expenses have been paid to any employee.

The Strategy and Resources Committee receives and examines reports on Charitable Trust Funds at three month intervals. The membership of this committee was:

Mrs Liz Romaniak, Director of Finance, Information and Estates/Facilities
Mr Mike Brierley, Assistant Chief Executive
Mrs Ann Bridges, Director of Corporate Affairs and Involvement
Mr Paul Murphy (Interim Chair – left 31 August 2022)
Mr David Jennings, Chair (started 1 September 2022)
Mr John Maddison, Non-Executive Director (started 1 September 2022)
Dr Charlotte Carpenter, Non-Executive Director

In order to safeguard the assets of the Charity and ensure income is applied appropriately the Trustee requires charitable funds procedures to comply with the Trust's Standing Financial Instructions and Scheme of Delegation.

For day to day operational and management purposes the Charity is divided into sub funds. These are managed by Trust officers who have delegated authority to apply the funds within the objects of the Charity.

The Head of Accounting and Governance has overall responsibility for the administration of the funds, supplying regular reports to the Strategy and Resources Committee and completing the annual accounts and annual report for the charitable funds.

An administration charge is levied at the sub funds to reflect the financial and clerical work that Tees, Esk and Wear Valleys NHS Foundation Trust provides. The basis of apportionment for this charge is the value of restricted and unrestricted funds as a percentage of the total funds held.

3.2 Relationships

The Charity's principal relationship is with Tees, Esk and Wear Valleys NHS Foundation Trust.

During the year no member of the Trust's Board had any related party transactions with the Charity.

4. Achievements and performance

The following funds had material movement in balances within the year:

Chime Fund
The purpose of this fund is to manage funds for Ridgeway café and shop for the benefit of users, carers and staff and to facilitate the selling and purchasing of items with a therapeutic purpose. The trading account shows funds reducing by £4k last year.

Foss Park
The purpose of this fund is to benefit the service users of Foss Park Hospital by providing amenities, activities and events. The fund increased thanks to a legacy received for £35k.

CDDPS general fund
The purpose of this fund is to provide general funding across all services within the Durham and Darlington areas for service users / carers. The fund decreased by £93k in year due to expenditure of NHS Charities Together grants on staff and patient health and wellbeing.

Occupational Therapy
The purpose of this fund is to purchase appropriate equipment for benefit of patients receiving support from our occupational services teams. The fund increased by £12k mainly due to a legacy received.

Acomb Garth
The purpose of this fund is to benefit the service users of Acomb Garth by providing amenities, activities and events. The fund decreased by £10k due to expenditure on equipment to support patients with dementia.

5. Review of activities

There were no new funds set up, and eleven funds closed during the year. Funds are closed linked to service change or the balance becoming minimal.

An internal audit review was undertaken by Audit North in July 2019 which gave a good level of assurance. All recommendations have been implemented. Due to materiality a full internal audit review is completed every three years, however, should any process change it is reviewed by internal auditors before being implemented. The pandemic interrupted the review cycle, and we are working to reinstate established processes.

6. Financial activity

A full set of accounts for the financial year 2022-23 are included with this report. Mazars LLP undertakes an independent examination of the accounts.

6.1 General review

The year under review saw a decrease of £54k in net resources mainly due to expenditure on patient welfare activities. The overall balance of the funds as at 31 March 2023 was £542k.

Income is derived from donations, legacies, raising funds, grants and investment income. Income from raising funds is received from the shop within the learning disabilities' day centre, and the shop and café at the Ridgeway Centre at Roseberry Park.

During the period 1 April 2022 to 31 March 2023 total investment income was £2k which was a slight increase on the previous year. Investment income has continued to be less than the administration costs of the Charitable Funds – due predominantly to the current economic climate and low interest rates being available. The Trust is exploring investment accounts for charities to improve the rate of return received on cash balances.

There are a number of funds administered by the Trustee for which bids can be made for goods or services where there is no individual specific Trust Fund to draw on. There were 19 bids approved by the Trustee in 2022-23, to use grants received from NHS Charities Together from the donations raised by Captain Tom to improve service user and staff wellbeing.

Trustwide NHS Charities Together grants are included within Trustee funds balances, the full amounts received have been made available to the Health and Wellbeing committee to ensure

they are used as per grant requirements.

The funds classed as “Others” in note 8 of the accounts are further broken down as follows:

	“Others” Balance	Number Of Funds	Average Fund Balance
Restricted	£154,870	99	£1,564
Unrestricted	£45,654	41	£1,114

6.2 Incoming resources

Total income for the year was £138k, a decrease of £211k on last year. Actual figures were:

	2022-23 £000	**2021-22 £000**
Donations	18	10
Legacies	46	14
Other trading activities	161	111
Income from investments	2	0
Grants received	3	3
Total	**230**	**138**

See Appendix 1 for chart showing the split of income sources.

6.3 Material donations and legacies

The Charitable Fund received legacies totalling £46k in 2022-23 and received donations of £18k to various funds.

6.4 Resources expended

Expenditure for the year was £284k, an increase of £124k when compared with £160k spent in the previous year. Analysis of Expenditure:

	2022-23 £000	**2021-22 £000**
Purchasing goods for resale	117	97
Patients’ welfare	115	34
Staff welfare	41	18
Governance costs	11	11
Total	**284**	**160**

Expenditure has increased from the previous financial year, mainly due to the utilisation of grants received from NHS Charities Together in 2020/21 to enhance staff and patient welfare in response to the pandemic.

See Appendix 2 for chart showing the split of expenditure categories.

6.5 Management and administration costs

The administration costs include the internal audit fee, bank charges, and the Trust cost of administering the funds. Charity Commission guidelines state that if a charity does not exceed £250k gross income in a financial year and does not have aggregate value of assets of more than £3,260k, it is eligible to have an independent examination rather than a full audit of its accounts. The assets held by the fund are lower than this minimum value, and as such accounts are eligible for an independent examination.

Following discussions with the Trust's auditors, Mazars LLP, it was decided that it would be appropriate for the charitable funds to have an independent examination of the accounts. This means the overall management costs per annum are £8k, and account for 2.8% of total expenditure.

The basis of apportionment for the administration costs is the value of restricted and unrestricted funds as a percentage of the total funds held.

6.6 Material expenditure

There were two instances of material expenditure from the funds (e.g. in excess of £10k) in 2022-23 from a single fund.

Vouchers totalling £24k were given to volunteers as a thank you for their support during the pandemic, with each volunteer receiving £100 in vouchers.

Staff and patient environments were improved Trustwide using the NHS Charities together grants, with spend of £65k on furniture and equipment for clinical teams.

6.7 Going concern

The fund's activities, together with the factors likely to affect its future development, performance and position are set out in the annual accounts on pages 2-8.

The fund has maintained its level of financial resources due to its long standing policy of only funding one-off in-year applications to the fund, and has no future commitments to discharge other than creditors as disclosed in the balance sheet which reports £9k of debt compared to £551k of cash in hand.

The return on deposit account investments has been poor throughout the year due to low interest rates available on the market. The low return on investment has resulted in all funds suffering a charge to cover governance costs.

The Trustee's view is that the Charity is a going concern and can make the disclosure as recommended by the accounting standards board that:

After making enquiries, the Trustee has a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, it continues to adopt the going concern basis in preparing the annual report and accounts.

7. Funds managed for and on behalf of other NHS organisations.

Within the balances of the Funds held by the Tees, Esk and Wear Valleys NHS General Charitable Fund there were no balances relating to other NHS Organisations.

8. Policy on reserves and investments

8.1 Reserves

The Trustee considers that it should be the aim to hold sufficient reserves to be able to provide funds to meet charitable expenditure as it is incurred and to review the position on an annual basis. Access to the funds is encouraged so that cash is used often and the trust can bring the associated benefits to its patients.

There are limitations on expenditure that can be realised within restricted funds (as it must be related to the purpose of the fund), so a minimum level target is not appropriate for any fund classed as restricted. With unrestricted funds the balance is £228k; as this is not material in comparison with the Trust's turnover of £484,465k no minimum level target has yet been set.

8.2 Investments

8.2.1 Statement of policy on investments

The Charity's funds were invested in an interest bearing deposit account with Yorkshire Bank PLC at an agreed interest of 0.65%, with a minimal balance in a lower interest bearing account at Barclays Bank PLC. The Trust is exploring other investment accounts to improve this rate of return and generate additional funds.

Funds were invested in this manner, with the objective to provide maximum security and availability. This allows a flexible and prudent level of control over the charity's funds.

8.2.2 Exposure to risks

The Trustee has identified the major risks to the Charity. The main risks can be summarised as:

1. That the Charity is not operating within its objectives.
2. That accounting transactions are inappropriately or inadequately reported.
3. Expenditure is inappropriate, or inappropriately authorised or not spent for the purposes intended.
4. That income is not appropriated to specific sub-funds in accordance with the intention of the donor.
5. Investments are not properly safeguarded, resulting in loss of funds.
6. Registered fund holders do not respond to requests for actions relating to the timely and appropriate administration of funds.

The Trustee has established systems to ensure these risks are kept at a minimum. Namely:

1. The existence and compliance with Standing Financial Instructions.
2. An adequately qualified and resourced finance function.
3. The establishment of internal financial control systems which are reviewed annually by an Internal Audit Department.
4. Reporting and review of audit findings to an Audit and Risk Committee.

8.2.3 Planned future activities of the Charity

The NHS is an ever changing environment and the future direction of the Charity will be shaped by these changes. The priorities for spending charitable funds are determined primarily by the fund holders who are managers in the service. By delegating the responsibility of expending charitable funds to this level ensures that those able to make the decisions are best placed to know the exact needs of service.

9. Legal and administrative information

Registered charity number

1061486

Registered address
The Flatts Lane Centre
Flatts Lane
Normanby
Middlesbrough
TS6 OSZ

Trustee
Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate Trustee of the Charity. Delegated responsibility for Trustee duties for the period covered by this report is allocated to members of the Board of Directors. These were:

Non-executive directors:
Mr Paul Murphy (Interim Chair – left 31st August 2022)
Mr David Jennings (Chair – started 1st September 2022)
Mrs Shirley Richardson (left 31st August 2022)
Prof. Pali Hungin
Mrs Beverley Reilly
Mr John Maddison
Dr Charlotte Carpenter
Mrs Jillian Haley
Mr Jules Preston
Mrs Roberta Barker

Executive directors
Mr Brent Kilmurray
Dr Stephen Wright (left 26th June 2022)
Dr Kedar Kale (started 27th June 2022)
Mrs Elizabeth Moody
Mrs Liz Romaniak
Mrs Ann Bridges
Mrs Hannah Crawford (started 1st April 2022)

All Board of Directors appointments are made in accordance with the policy and procedures laid down in the NHS code of good practice.

The Secretary of State for Health, in line with statutory requirements approved the Chairman's appointment, and a panel comprising the minimum statutory members, including the Chairman and an expert independent assessor, made the Chief Executive's appointment.

All other executive and non-executive appointments to the Trust Board were made following external advertisement and robust and transparent selection procedures.

Independent examiners
Mazars LLP
The Corner
Bank Chambers
26 Mosley Street
Newcastle upon Tyne
NE1 1DF

Legal advisors
Ward Hadaway
Sandgate House
102 Quayside
Newcastle upon Tyne
NE1 3DX

Bankers

Yorkshire Bank PLC
7 Linthorpe Road
Middlesbrough
TS1 1RF

Barclays Commercial Bank
PO Box 190, 2 Floor,
1 Park Row,
Leeds, LS1 5WU

CHARITABLE TRUST ACCOUNT - TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST - 2022-23								
Data entered below will be used throughout the workbook:								
This year	2022-23							
Last year	2021-22							
This year ended	2023							
Last year ended	2022							
This year beginning	1 April 2022							
This year name	31 March 2023							
Last year name	31 March 2022							

10: Charitable Fund Account

Statement of trustee responsibilities

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate trustee of the fund. Delegated responsibility of the trustee is applied to executive and non executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board.

The trustee is responsible for preparing the trustees' Annual Report and financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales/Scotland/Northern Ireland requires the trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements the trustee is required to:

select suitable accounting policies and then apply them consistently;

observe the methods and principles in the Charities SORP;

make judgements and estimates that are reasonable and prudent;

state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements; and

prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed . It is also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The trustee is responsible for the maintenance and integrity of the charity and financial information included on the charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

The trustee confirms that it has met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 1-8 attached have been complied from and are in accordance with the financial records maintained by the trustee.

By Order of the trustee, and those with delegated responsibility

Chairman……..…….. Date: 11th January 2024

Executive Director …… Date: 11th January 2024

Statement of Financial Activities for the year ended 31 March 2023

	Note	31 March 2023 Unrestricted Funds £000	31 March 2023 Restricted Funds £000	31 March 2023 **Total Funds £000**	31 March 2022 Total Funds £000
Incoming resources					
Income and endowments from:					
Donations		12	6	**18**	10
Legacies		35	11	**46**	14
Grants received	5.1	3	-	**3**	3
Income from investments	5.2	1	1	**2**	-
Other trading activities	5.3	-	161	**161**	111
Total income and endowments		**51**	**179**	**230**	**138**
Resources expended					
Expenditure on:					
Raising funds	3.3	-	(117)	**(117)**	(97)
Charitable Activities	3.1	(111)	(56)	**(167)**	(63)
Total resources expended	4	**(111)**	**(173)**	**(284)**	**(160)**
Net expenditure		**(60)**	**6**	**(54)**	**(22)**
Transfers between funds	6	1	(1)	-	-
Net movement in funds	6	**(59)**	**5**	**(54)**	**(22)**
Reconciliation of funds:					
Fund balances brought forward at 31 March 2022		287	309	**596**	618
Fund balances carried forward at 31 March 2023		**228**	**314**	**542**	**596**

There were no other recognised gains or losses in the year.

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Balance Sheet as at 31 March 2023

	Notes	Unrestricted Funds £000	Restricted Funds £000	**Total at 31 March 2023 £000**	Total at 31 March 2022 £000
Current assets					
Short Term Deposit Investment		228	323	**551**	608
Total current assets		228	323	**551**	608
Current liabilities					
Creditors: Amounts falling due within one year	7	-	(9)	**(9)**	(12)
Total current liabilities		-	(9)	**(9)**	(12)
Total current assets less current liabilities		228	314	**542**	**596**
Total net assets		**228**	**314**	**542**	**596**
Funds of the Charity					
Income Funds:					
Restricted	8.1	-	314	**314**	309
Unrestricted	8.2	228	-	**228**	287
Total funds		**228**	**314**	**542**	**596**

Notes numbered 1 to 13 form part of the accounts.

Signed:

Date: 11th January 2024

Notes to the Account

Accounting policies

1 The principal accounting policies are summarised below. They have been applied consistently through out the reporting year 2022-23 and throughout the comparators shown for the previous reporting year 2021-22.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention with items recognised at cost or transaction value unless otherwise stated in the relevant note(s) to these accounts. The accounts have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued on 16 July 2014, and with the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and with the Charities Act 2011.

The charity constitutes a public benefit entity as defined by FRS 102

1.2 Incoming resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors are met:

entitlement - control over the rights or other access to the economic benefit has passed to the charity;

probable - it is more likely than not that the economic benefits associated with the transaction or gift will flow to the charity;

measurement – the monetary value or amount of the income can be measured reliably and the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.

Legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes reasonably certain. This will be once confirmation has been received from the representatives of the estate that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

Offsetting

There has been no offsetting of assets and liabilities, or income and expenses.

Grants and donations

Grants and donations are only included in the SoFA when the general income recognition criteria are met.
No performance related grants were received.

Tax reclaims on donations and gifts

Gift Aid receivable is included in income when there is a valid declaration from the donor. Any Gift Aid amount recovered on a donation is considered to be part of that gift and is treated as an addition to the same fund as the initial donation unless the donor or the terms of the appeal have specified otherwise.

1.3 Resources expended and creditors

The Charity accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party.

Cost of generating funds

The cost of generating funds are the costs associated with generating income for the funds held on trust.

Governance costs

These are accounted for on an accruals basis and are recharges of appropriate proportions of the funds administration costs from Tees, Esk and Wear Valleys NHS Foundation Trust, plus Internal and External Audit charges for 2022-23. These costs are apportioned across the funds using the appropriate classification of fund. During 2022-23 the classification split was:

Restricted 58%, Unrestricted 42%.

Creditors

The charity has creditors which are measured at settlement amounts.

1.4 Structure of funds

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified in the accounts as a restricted fund. Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are classified as unrestricted funds. Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are classified as restricted funds. The major restricted funds held within these categories are disclosed in note 8.

1.5 Realised gains and losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year end and opening market value (or date of purchase if later).

1.6 Pensions contributions

The Charity does not employ staff and does not make pension contributions.

1.7 Change in the basis of accounting

There has been no change in the accounting policy or accounting estimates in the year.

1.8 Prior year adjustments

There are no prior year adjustments in these accounts.

1.9 Going concern

After making enquiries, the Trustee have a reasonable expectation that the Charity has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Please see section 6.7 within the Annual Report for further details

1.10 Stock

A small balance of stock is held to support the activities of the Ridgeway Cafe / Shop and LD Forensic Day Services however, having reviewed the balance of stocks held over time, the Trustee has confirmed that the stocks are both stable and immaterial in value. Consequently stocks are not recognised within the financial statements rather are treated as expenditure as they are purchased.

2 Related party transactions

During the year no members with delegated responsibility for the Trustee, or members of the key management staff or parties related to them has undertaken any material transactions with the Tees, Esk and Wear Valleys NHS Trust General Charitable Fund (2021-22, £nil).

The Charitable Fund does not have the facility to pay creditors therefore, Tees, Esk and Wear Valleys NHS Foundation Trust makes the payments on the Fund's behalf and is re-imbursed on a monthly basis by the Fund.

Certain income for the Charitable Fund is initially banked through Tees, Esk and Wear Valleys NHS Foundation Trust. This income is re-imbursed to the Fund on a monthly basis.

Tees, Esk and Wear Valleys NHS Foundation Trust is the sole corporate trustee of the fund. Delegated responsibility of the trustee is applied to executive and non executive members of Tees, Esk and Wear Valleys NHS Foundation Trust Board (names listed below). All are also members of Tees Esk and Wear Valleys NHS Foundation Trust.

Mr David Jennings (started 1st September 22)
Mr Brent Kilmurray
Mrs Liz Romaniak
Dr Stephen Wright (left 26 June 22)
Dr Kedar Kale (started 27th June 22)
Mrs Elizabeth Moody
Mrs Ann Bridges
Mrs Hannah Crawford (started 1st April 2022)
Mr Paul Murphy (left 31st August 22)
Mrs Shirley Richardson (left 31st August 22)
Mr John Maddison
Mrs Beverley Reilly
Mr Pali Hungin
Mrs Charlotte Carpenter
Mrs Jilian Haley
Mr Jules Preston
Mrs Roberta Barker

3 Details of resources expended on charitable activities

3.1 Activities in furtherance of charities objectives

	Unrestricted Funds	Restricted Funds	**Total 2023**	Total 2022
	£000	£000	**£000**	£000
Patients welfare and amenities	(68)	(47)	**(115)**	(34)
Staff welfare and amenities	(36)	(5)	**(41)**	(18)
Governance costs (see 3.2 below)	(7)	(4)	**(11)**	(11)
	(111)	**(56)**	**(167)**	(63)

3.2 Analysis of governance costs

	Unrestricted Funds	Restricted Funds	**Total 2023**	Total 2022
	£000	£000	**£000**	£000
Establishment costs	(3)	(3)	**(6)**	(6)
Internal / External audit fee*	(1)	(1)	**(2)**	(2)
NHS Charities Together membership	(3)	-	**(3)**	(3)
	(7)	**(4)**	**(11)**	(11)

*Independent examination of the accounts cost £480

3.3 Details of costs incurred in raising funds

	Unrestricted Funds	Restricted Funds	**Total 2023**	Total 2022
	£000	£000	**£000**	£000
Purchasing goods for re-sale	-	(117)	**(117)**	(97)
	-	**(117)**	**(117)**	(97)

4 Analysis of total resources expended

	Costs of raising funds	Costs of activities for charitable objectives	**Total 2023**	Total 2022
	£000	£000	**£000**	£000
Internal / External audit fee	-	(2)	**(2)**	(2)
Compliance costs for Trust Funds	-	(6)	**(6)**	(6)
NHS Charities Together membership	-	(3)	**(3)**	(3)
Charitable activities	(117)	(156)	**(273)**	(149)
	(117)	**(167)**	**(284)**	(160)

5 Analysis of income

5.1 Grants received

	Unrestricted Funds	Restricted Funds	**Total 2023**	Total 2022
	£000	£000	**£000**	£000
NHS Charities Together	3	-	**3**	3
	3	**-**	**3**	-

5.2 Income from investments

Income from investments of £2k relates to interest received on individual fund balances held by the Charity. These investments are held in the UK.

5.3 Details of other trading activities

The £161k income from other trading activities was delivered from the re-sale of goods purchased at a cost of £117k.

6 Changes in resources available for charity use

	Unrestricted Funds	Restricted Funds	**Total 2023**	Total 2022
	£000	£000	**£000**	£000
Net movement in funds for the year before transfers	(60)	6	**(54)**	(22)
Internal transfers	1	(1)	**-**	-
Net increase /(decrease) in funds for the year	**(59)**	**5**	**(54)**	(22)

7 Analysis of creditors

	Balance at 31 March 2023 £000	Balance at 31 March 2022 £000
Trade creditors	(9)	(12)
Total amounts falling due within one year	**(9)**	**(12)**

8 Details of material funds

8.1 Restricted funds

	Balance 1 April 2022 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2023 £000**	**Description of the nature and purpose of each fund**
CHIME Fund	65	159	(156)	**68**	To provide funds for the well being of patients within Ridgeway
Allinson Bequest	27	-	-	**27**	To provide funds for epilepsy services in the Durham area
Lanchester Road Hospital AMH	16	-	-	**16**	To provide funds for the well being of patients within Lanchester Road Adult MH services
Learning Disabilities	14	-	-	**14**	To provide funds for activities for patients with Learning Disabilities in York and Selby
Community Team Auckland Park Hospital	1	11	-	**12**	To provide funds for activities for patients of Acomb Garth
Occupational Therapy	-	12	-	**12**	To provide funds for occupational therapy services for the patients of Tees Esk and Wear Valleys NHS FT
Epilepsy Fund, Bankfields Court	11	-	-	**11**	To provide funds for epilepsy services in the Middlesbrough area
Others (99 Funds)	175	8	(29)	**154**	
Total	309	190	(185)	**314**	

8.2 Unrestricted funds

	Balance 1 April 2022 £000	Incoming resources £000	Resources expended £000	**Balance 31 March 2023 £000**	
Foss Park Fund	111	40	(3)	**148**	To provide general purpose funds for the patients being cared for in Foss Park Hospital
CDDPS General Fund	114	9	(101)	**22**	To provide general purpose funds for the patients being cared for in the Durham area
St Mary's General Fund	12	-	-	**12**	To provide general purpose funds for the patients being cared for at St Mary's Hospital
Others (41 Funds)	50	2	(6)	**46**	
Total	**287**	**51**	**(110)**	**228**	

9 Connected organisations

	2022-23		2021-22	
	Turnover of Connected Organisation £000	Net Deficit for the Connected Organisation* £000	Turnover of Connected Organisation £000	Net Surplus for the Connected Organisation** £000
The charity is administered by Tees, Esk and Wear Valleys NHS FT	**484,465**	**(8,590)**	443,629	(4,240)

* The deficit for 2022-23 includes expenditure for unanticipated impairments of fixed assets totalling £9,394k. Excluding these non operating items would result in a surplus of £804k.

** The deficit for 2021-22 includes expenditure for unanticipated impairments of fixed assets totalling £10,698k. Excluding these non operating items would result in a surplus of £6,458k.

10 Other funds held for and on behalf of other NHS organisations

Within the balances of the Funds held by the Tees, Esk and Wear Valleys NHS General Charitable Fund there were no balances relating to other NHS Organisations.

11 Cash flow

The charity has taken advantage of the exemption available to it under section 7 of FRS102 not to produce a cash flow statement due to its size.

12 Taxation liability

As a registered charity, Tees, Esk and Wear Valleys NHS Charitable Fund is potentially exempt from taxation of income and gains falling within Part 10 of the Income Tax Act 2007 and s256 Taxation and Chargeable gains Act 1992. No tax charge has arisen in the year.

13 Post Balance Sheet events

There are no post balance sheet events to report.

INDEPENDENT EXAMINER'S REPORT TO THE TRUSTEE OF TEES, ESK AND WEAR VALLEYS NHS TRUST GENERAL CHARITABLE FUND

I report on the financial statements of Tees, Esk and Wear Valleys NHS Trust General Charitable Fund for the year ended 31 March 2021, which are set out in Section 10

Respective responsibilities of trustees and examiner

The charity's trustee is responsible for the preparation of the financial statements. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 (the 2011 Act) and that an independent examination is needed.

It is my responsibility to:

- examine the financial statements under section 145 of the 2011 Act;
- follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the 2011 Act; and
- state whether particular matters have come to my attention.

This report, including my statement, has been prepared for and only for the charity's trustee as a body. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee as a body for my examination work, for this report, or for the statements I have made.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the financial statements presented with those records. It also includes consideration of any unusual items or disclosures in the financial statements, and seeking explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit and consequently no opinion is given as to whether the financial statements present a 'true and fair view' and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, which is complete, no matters have come to my attention which give me reasonable cause to believe that in any material respect:

- accounting records were not kept in respect of Tees, Esk and Wear Valleys NHS Trust General Charitable Fund in accordance with section 130 of the 2011 Act; or
- the financial statements do not accord with those records; or
- the financial statements do not comply with the applicable requirements concerning the form and content of financial statements set out in the Charities (Accounts and Reports) Regulations 2008 other than any requirement that the financial statements give a 'true and fair' view which is not a matter considered as part of an independent examination.

I have no concerns and have come across no other matters in connection with the examination to which, in my opinion, attention should be drawn in order to enable a proper understanding of the financial statements to be reached.

Signed:

Name: Cameron Waddell (CPFA) for and on behalf of Mazars LLP
Relevant professional qualification or body: CIPFA
Address: The Corner, Bank Chambers, 26 Mosley Street, Newcastle upon Tyne, NE1 1DF
Date: 02-Dec-21

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For General Release

Meeting of:	**Board of Directors**
Date:	**11 January 2024**
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 October and November 2023 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 provide the Board with high-level feedback from leadership walkabouts that took place in October and November 2023.

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. Visits were stood down in December 2023.

1.2 Walkabouts provide an opportunity for Board to meet with teams to really understand the strengths of the service and consider the more challenging areas, and how we can work together to resolve these and co-create any potential solutions. Actions are also captured and monitored.

2 **Speciality areas visited**

2.1 Leadership walkabouts took place in October and November 2023 across MHSOP and CAMHS community services:

- Sovereign House, Hartlepool
- Sedgefield and Dales MHSOP CMH
- Darlington MHSOP, West Park Hospital
- York MHSOP, Huntington House
- Holly Unit, West Park Hospital
- Darlington CAMHS
- Redcar Getting More Help Team
- North Yorkshire Forensic Outreach and Liaison Service
- Derwentside CAMHS
- Scarborough CAMHS

3 **Key issues**

- Strengths:
    - Our people: teams expressed huge pride and passion for what they do and each other, were very responsive and flexible, supportive, caring and resilient, with a big focus on wellbeing in many areas.
    - Patient-centred focus: the importance of good relationships with patients and their loved ones came through strong in teams visited, particularly in 'waiting well' and pathways.
    - Multi-disciplinary teams (MDT): good skills mix and knowledge key to supporting patients on their journey, including movement between and across systems, and helping to navigate different pathways (different in different areas).
- Challenges:
    - Caseloads / demand: high and complex caseloads were challenging to manage across both speciality areas, however neurodevelopmental assessment waits in CAMHS was unprecedented. More streamlined pathways would be helpful.
    - Levels of deprivation / cost of living crisis: poverty and health inequalities really challenging for our teams, in terms of living conditions for our most vulnerable patients, with a direct link into referrals. Work with community mental health transformation partners was key.
    - Staffing and training: getting, retaining and training people with the right skill mix was an area of concern across our geography (that responds to complexity and updating practice). Teams reported more social workers, psychological capacity, and support staff would be helpful. Staffing capacity / levels that reflect the local population was also reported as an issue. Medic cover also an issue.
    - Infrastructure: some estates and IT issues raised in terms of suitability and availability.

3.2 For assurance, lead Directors have reviewed feedback received and agreed actions with teams visited, which will be monitored.

Recommendations: The Board is asked to:

- Receive and note the summary of feedback as outlined.
- Consider any key issues, risks or matters of concern arising from the visits held through October and November 2023.

Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 11 January 2024		
Date of last meeting: 7 December 2023		**Report of: The Quality Assurance Committee**
		Quoracy was achieved. The meeting was observed by Deloittes.
1	**Agenda**	The Committee considered the following matters: • The Board Assurance Framework • Corporate Risk Register • Executive Summary of the Executive Review of Quality Group (ERoQG) and the Integrated Performance Dashboard (IPD) • Trust Quality and Learning Report • Quality Assurance & Improvement Programme and NICE Guidance Implementation • Quality Priorities Progress 2023 • PALS/Complaints • CQC Activity • Learning from Serious Incidents • Duty of Candour • CQUIN • National Rapid Review • PSIRF • NICHE Recommendations progress and outline of the NHSE Independent review of delivery • Commissioner Safety Review Report • Update on DTVF ALD Inpatient Service • Serious Incident Improvement Plan • Internal Audit Recommendations The Committee held a confidential meeting on 7 December 2023 to approve the following: • The minutes of the confidential meeting held on 2 November 2023. • The minutes of an extraordinary meeting held on 22 November 2023. • The notes of a meeting held on 23 November 2023. The purpose of the meetings held on 22 and 23 November was primarily to agree the CQC Improvement Plan on behalf of the Board prior to formal submission to the CQC on 27 November.
2a	**Alert**	The Committee alerts the Board on the following matters: **From the Executive Review of Quality Group:** • There are concerns with the implementation of InPhase whilst staff learn how to use the new system and ensure risks are captured accurately and allocated to the right people for review. Submission of risk incidents has dropped, which is in keeping with the national trend when a risk incident system is changed. More targeted training will support improvement. • Two episodes of seclusion in NYYS occurred outside of a recognised seclusion room. Clinical leaders and the Chief Nurse are reviewing the practice. • In DTVF mechanical restraint was used on three occasions and tear proof clothing in PICU. The use of tear proof clothing is being considered.

		• The Section 136 suite was used for an admission due to lack of bed. There is a need to understand if this is an occasional event or if we have any trends of use. • Short staffing has led to business continuity in two community teams in NYYS. Lack of outcomes measures continue to need improvement. • There is a long-term seclusion in SIS since August 2022. This is being reviewed by Executive Clinical leaders to seek assurance that we are compliant with the Code of Practice and that alternative care packages have been fully considered. • There is capacity available for staff to undertake statutory/mandatory training however, compliance is not improving as anticipated.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Committee Business – Focused Priorities** • Reasonable assurance on performance controls of the Integrated Performance Dashboard. • The number of unexpected inpatient unnatural deaths reported on STEIS was discussed. Currently, there is no evidence of self harm occurring. Board to note that Confidential QAC had reviewed the incidents with the Care Group. • Three of the five CQUIN measures continue to be at risk of delivery. • The Committee reviewed progress against NICHE recommendations in its confidential session. There are no issues directly pertaining to TEWV to escalate. • The serious incident improvement plan is progressing with reasonable assurance to eradicate the of the backlog by 31 December 2023. We continue to keep the D&D fully appraised and continue to seek a meeting to discuss a range of issues including Regulation 28 notices. • Reasonable assurance was received on the learning from serious incidents work with a welcome proposal for future integrated working via multi disciplinary team events focused on themes. • There is reasonable assurance our Duty of Candour Improvement Plan. Internal Audit are also reviewing our compliance. • The CQC Improvement Plan in response to the must and should do requirements following the CQC Well Led inspection 2023 was approved at the Extraordinary QAC meeting on 22 November 2023 and subject to some amendments was submitted to the CQC on 27 November 2023. The level of assurance was agreed as good. • The Committee approved the revised BAF at the Extraordinary Meeting where controls The newly articulated BAF risks agreed by the private Board were also noted and accepted. This approach further strengthens assurance to the Board in a floor to Board understanding of the risks to quality. • A significant review of the Corporate Risk Register risks has been undertaken, with single risks aligned to Committees. QAC now has 5 as opposed to 15. The Committee will monitor closely feedback from The Executive Review of Quality Group, where risks do cut across committees. **From the Committee Business:** • Feedback from a recent audit by Cleveland Local Medical Committee (representing all Primary care colleagues in Teesside) was very positive. • The Committee approved a significant and clear workplan for 2023/24 (Appendix A). It is recommended to Board for approval. • Good assurance on the oversight and progress of the quality assurance and improvement programme, including a NICE Implementation update. Where there are gaps, the committee were assured mitigations were in place. • Reasonable assurance on the progress made with the Quality Priorities for 2023/24 in Our Journey to Change (care planning, feeling safe and PSIRF). PSIRF milestones continue to be achieved with families now working with reviewers and two family liaison officers are in post.

		• Good assurance on the Complaints, PALS, Patients and Carer Experience Report with progress demonstrable. • DTVF adult learning disability inpatient service has made significant positive progress in their improvement work and learning regarding reducing restrictive practice. This is being shared with other services. There has been no use of prone restraint since December 2022. • The Committee were delighted to hear that 3 patients had been discharged successfully from Bankfields Court. Board are aware of positive personal communication from a family. • Reasonable assurance was received on the work being undertaken with Performance Improvement Plans (PIPs) however, many actions were not expected to deliver until Q4. • Reasonable assurance was agreed for the Trust Level Quality Assurance and Learning Report. The number of unapproved incidents continues to be of concern with continued actions to improve our position. Assurance was received on vacancies within the positive and safe team. • The Committee received an increased level of confidence and assurance against the requirements of the National Rapid Review in Mental Health In Patient Settings. Currently, the Trust is confident in its position to provide full compliance against the relevant recommendations. • Good assurance was received following a series of much welcomed Commissioner Reviews from the North East and North Cumbria Mental Health, Learning Disability and Autism Partnership. • A high level of assurance was received on an QAC requested update from the DTVF Adult Learning Disability In Patient Service. The transforming care agenda remains a recognized concern. The Board should note that there are clinically led plans in place to look at a phased re opening of beds. This involves the multi disciplinary team and a quality impact assessment.
2c	**Advise**	The agenda for the Committee meeting was significant which reflects our Workplan at Appendix A which Board members should familiarize themselves with in order to appreciate the depth and breadth of our assurance and improvement journey.
2d	**Review of Risks**	From the reports presented and the matters of business discussed, the Committee considered that risks are being managed effectively with more visibility of triangulating current and emerging risks linked to delivery of quality and safety strategy.
3	**Actions to be considered by the Board**	The Board is asked to: (i) Note the report. (ii) Approve the Committee workplan for 2023/24.
4	**Report compiled by**	Bev Reilly, Chair of QuAC/ Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Chief Nurse and Donna Keeping, Corporate Governance Manage

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Quality Assurance Committee Workplan (QuAC) dated 30.11.2023

Topic	Frequency	Exec Lead	Author	7.12.23	01.02.24	07.03.24	04.04.24	02.05.24	June.24	July.24	Aug.24	Sept.24	Oct.24	Nov.24	Dec.24	Jan.25	Feb.25	Mar.25	Apr.25
Papers in				30/11/23	25/01/24	29/02/24	28/03/24	25/04/24											
Papers out				01/12/23	26/01/24	01/03/23	29/03/24	26/04/24											
Welcome and standing items: **> Apologies** **> Declarations of interest**	Monthly	Chair		*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Strategic Goal	**To co create a great experience for our patients, carers and families**																		
Quality Review: > Executive review of quality > Integrated performance dashboard	Monthly	CN & HOP	CN & HOP	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Performance Improvement Plans (PIPS)	Monthly	Care Group DoN / MD	HOP	*		*			*			*			*			*	
Trust Quality and Learning Report	Quarterly	CN	ADforCG	*		*			*			*			*			*	
Care Quality Commission: > Improvement plans > Inspection activity > Provider action statements > Enquiries > Complaints	Bi - Monthly	CN	ADforCG			*		*		*		*		*		*		*	
Mortality reviews	Quarterly	MD	AD of Patient Safety		*			*			*			*			*		
End of Life Trust Plan	Six-monthly	CN	DoN NYYS		*					*						*			
Quality Priorites Update	Six-monthly	BM	ADQG										*						
Quality Account	Annual tbc	CN	ADQG						*										
Quality Assurance Review programme	Bi-monthly	CN	AD for Clinical Governance		*		*		*		*		*		*		*		*
Safeguarding Quality report	Quarterley	CN	AD of Safeguarding			*			*			*			*			*	
Sexual safety annual statement of compliance (including EMSA)	Quarterley	MD	DCN			*		*			*			*			*		
Positive and Safe	Quarterley	CN	NC for Positive & Safe	*		*			*			*			*			*	

Quality Assurance Committee Workplan (QuAC) dated 30.11.2023

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Use of Force annual report - positive & safe	Annual	CN	NC for Positive & Safe						*										
Drugs and Therapeutic	Quarterly	MD	Chief Pharmacist	*		*			*			*			*			*	
Non Medical Prescribing	Annually	CN	Linda Johnstone						*										
Physical Healthcare	Quarterley	CN	DoN NYYS		*			*			*			*			*		
Resuscitation report	Quarterley with Annual report	CN	Carole Rutter		*						*						*		
Medical Devices	Quarterley	CN	Carole Rutter					*			*			*			*		
Infection, prevention, control	Quarterley	CN	Carole Rutter				*			*			*			*			*
Complaints and PALS Report	Quarterly	ExD of Corporate Affairs & Involvement	Head of Patient Experience	*		*			*			*			*			*	
PSIRF	Quarterly	CN	DCN	*		*			*			*			*			*	
Carers Plan	Six-monthly	An Bridges						*						*					
PCREF	Six-monthly	Hannah Crawford	Sarah Dallal		*				*						*				
Co creation	Six-monthly	Ann Bridges	Liam Corbally		*						*						*		
Safer Staffing	Annually	CN	DCN		*														
Research & Development	Six-monthly	MD	S Daniel/ Prof Ekers			*						*						*	
Clinical Outcomes	Quarterley	MD	SCD			*			*			*			*			*	
The inpatient Quality Improvement	Quarterley	DTVF, MD		*		*			*			*			*			*	
Clinical Pathways - TBC	Quarterley	MD	SCD																
Escalated Quality risks:																			
Feeling Safe	Quarterley	CN & MD	Care Group DoN & MD			*			*			*			*			*	
LD and autism provision	6 monthly	MD	Jamie Todd	*					*						*				

Quality Assurance Committee Workplan (QuAC) dated 30.11.2023

Topic	Frequency	Exec Lead	Author	7.12.23	01.02.24	07.03.24	04.04.24	02.05.24	June.24	July.24	Aug.24	Sept.24	Oct.24	Nov.24	Dec.24	Jan.25	Feb.25	Mar.25	Apr.25
Serious Incident Recovery plan	Bi monthly	CN	AD of Patient Safety		*		*		*		*		*		*		*		*
Waiting times	6 monthly	MD	Care Group Medical Director		*				*						*				
Community transformation	6 monthly	MD	Care Group Medical Director				*						*						*
Impact of short staffing	Quarterley	CN	Care Group DoN	*		*			*			*			*			*	
Crisis line performance	Quarterley	MD	Care Group Medical Director				*			*			*			*			
NICHE recommendations	Quarterley	CN	ADofQG	*		*			*			*			*			*	
Enironmental Risk Group	Quarterly	CN	S Adamson		*			*			*			*			*		
Duty of Candour progress	Quarterly	CN	DQG	*		*			*			*			*			*	
Quality Governance:																			
Annual PLACE assessment	Annual	CN	Carole Rutter																
QI Plan	Six-monthly	Sarah Dexter-Smith	Steven Bartley		*						*						*		
Annual Patient Publication of Information	Annual	Hannah Crawford	S Dallal				*												*
CQUIN	Quarterly	Mike Brierley	S Theobald	*	*			*			*			*			*		
Quality Impact Assessments	three times per year	CN	ADQG				*				*				*				*
Statement of purpose annual review and as needed	Annual	CN	ADQG					*											
Risks to Quality (verbal)	Monthly	CN	n/a	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Corporate Risk Register	Bi-monthly	CN	Head of Risk Management	*		*		*		*		*		*		*		*	
BAF	Quarterly	CoSec	Chief Nurse	*		*			*			*			*			*	

Quality Assurance Committee Workplan (QuAC) dated 30.11.2023

Topic	Frequency	Exec Lead	Author	7.12.23	01.02.24	07.03.24	04.04.24	02.05.24	June.24	July.24	Aug.24	Sept.24	Oct.24	Nov.24	Dec.24	Jan.25	Feb.25	Mar.25	Apr.25
Quality Priorities Progress	Quarterly	CN	ADQG	*		*			*			*			*			*	
Quality Assurance Review programme	Six-monthly	BM	ADQG										*						
Internal audit actions: > Reports as required > Open actions	Bi monthly	CN	ADQG	*															
National Safety Alerts	Quarterley	CN	ADforPS		*			*			*			*			*		
Annual Reports																			
Approval of the annual Quality Priorities and sign off of the Quality Account	Annual	BM	ADQG										*						
Infection, prevention, control	Annual	BM	Carole Rutter						*										
Clinical Audit Annual Report	Annual	BM	ADQG									*							
Annual Eradicating Mixed Sex Accommodation (EMSA) statement	Annual	KK																	
Drugs and Therapeutic Annual Report, Workplan & terms of Reference	Annual	MD	Chief Pharmacist									*							
Medical Devices	Annual	BM	Carole Rutter						*										
Use of Force Annual Report	Annual	BM	Stephen Davison						*										
Tissue viability annual report	Annual	BM	Carole Rutter							*									
Resuscitation Annual Report	Annual	BM	Carole Rutter							*									
Audit Annual Report	Annual																		
Safeguarding	Annual	CN	Nicki Smith									*							

Quality Assurance Committee Workplan (QuAC) dated 30.11.2023

Topic	Frequency	Exec Lead	Author	7.12.23	01.02.24	07.03.24	04.04.24	02.05.24	June.24	July.24	Aug.24	Sept.24	Oct.24	Nov.24	Dec.24	Jan.25	Feb.25	Mar.25	Apr.25
Additional Reports taken :																			
National Rapid Review	Quarterly	DTVF, MD	N D'Northwood, Programme Manager	*		*			*			*			*			*	

Key	
ADQG	Associate Director of Quality Governance
DTVF, MD	Durham Tees Valley and Forensices Managing Director
MD	Medical Director
ADofSG	Associate Director of Safeguarding
DCN	Deputy Chief Nurse
CN	Chief Nurse
ADforQG	Associate Director for Quality Governance
SCD	Specialist Clinical Director
HOP	Head of Performance
CoSec	Company Secretary
ADfPS	Associate Director for Patient Safety
HoRM	Head of Risk Management
P&S Lead	Positve and Safe Lead

Annual Reports

Where subject areas require an annual report this will be noted on the planner as and will include a 12 month report of performance, a TOR for approval and a 12 months workplan for the year ahead

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Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report		
Report Date: Dec 2023/Jan 2024	**Report of the Mental Health Legislation Committee (MHLC)**	
Date of last meeting: 13 November 2023	Full quoracy was met	
1	**Agenda: The Committee considered the following agenda items during the meeting** • CQC Mental Health Act Inspection Report • Discharges from Detention • Section 136 • Section 132b – Information to detained patients (Section 132 Mental Health Act 1983) • Section 5 MHA 1983 Holding Powers • Positive and safe Improvement Plan, including Use of Force Act Statutory compliance • Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) • Case study • Human Rights, Equality and Diversity Information • Revised policies and procedures: Mental Capacity Act Policy. Allocation of Responsible Clinician Policy	
2a	**Alert: The Committee alerts members of the Board on the following:** • The Care Groups are setting up an operational group with involvement from clinicians and the MHL team to take forward matters which need action and progress at service level. This group will meet in early 2024. • Concerns raised over the list of CQC findings following an inspection on Lustrum Vale and Willow Ward. Assurance given that the actions are being taken forward and progress will report through to the Quality Assurance Committee.	
2b	**Assurance: The Committee assures members of the Board on the following:** **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. • Steps are being taken to make S 136 data more accessible with clinical services through Fundamental Standards, as the information is currently one month behind on IIC. • In quarter two there were 170 uses of S 136, three patients did not have their rights recorded, seven were under 18 and two reached the 24-hour maximum period. • The Care Groups and Executive Review of Quality Group will monitoring the use of S 136 suite and the impact of bed pressures. Assurance was provided that there is a specific procedure in pace for anyone detained in a S 136 suite to ensure standards are similar to an inpatient environment. **Discharge from Detention** • 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. Benchmarking against national data reveals that TEWV is below, ie compares favourably with other providers. There were 4 patients discharged from 106 first-tier tribunals and none were re-detained.	

	Section 132b • There is substantial assurance that patients are given their rights when first detained and a robust escalation process is in place for any patients who have not had their rights within three days of detention. • Significant progress has been made over the last year with the processes. Next steps include working with NY Fundamental Standards lead to improve the flow of information on rights between the MHL department to clinicians, with the aim to be able to look at live data. **Section 5 MHA 1983 Holding Powers** • There is reasonable assurance on the use of holding powers. Improvements are being made to increase awareness and oversight of the process by including information on Section 5 in the Trust's Fundamental Standards groups. Data quality is good. There is work to do to standardise the use of Section 5 across services. **Equality Data on detention rates** • There is good assurance that the Trust has followed a robust process in analysing detentions under the Mental Health Act by gender and ethnicity. Next steps will include looking at numbers of restraints for those with BAME characteristics and the number of people accessing services, which will be picked up through the Care Groups and through linking in with the community transformation work.	
2c	**Advise: The Committee advises the Board on the following:** • At the time of the meeting there were no risks aligned to the MHLC. • Work continues by Business Intelligence to update the construction of the measure in the IPD "The Number of uses of the Mental Health Act". There were 357 uses of the Act during August 2023, with no significant change in the data during the reporting period and no concerns identified. • The 20203/24 Positive and Safe Improvement Plan was approved by the Quality Assurance Committee in September 2023 and the MHLC will continue to have sight of progress with the ongoing actions. Seclusion facilities are being reviewed to ensure they are fit for purpose and meet the organisation's needs. • There is reasonable assurance that the Trust is meeting its requirements under the MCA and reasonable assurance that the use of and reporting of Deprivation of Liberty Standards (DoLS) is being carried out as required. A Mental Capacity Act conference was held on 8 September to support front line clinical staff with their understanding and confidence around the MCA, with positive feedback. • The case study provides members of the Committee with the human element and background details of patients that have been in long term seclusion.	
2d	**Review of Risks**	There are no risks aligned to MHLC
Recommendation: The Committee proposes that the Board notes the report and the levels of assurance confirmed by the Committee.		
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, Kedar Kale, Executive Medical Director and Donna Keeping, Corporate Governance Manager***	

Tees, Esk and Wear Valleys NHS Foundation Trust

People, Culture and Diversity Committee: Key Issues Report		
Report Date: 11 January 2023	**Report of: People, Culture and Diversity Committee**	
Date of last meeting: 14 December 2023	The meeting was quorate, there were apologies for absence from Zoe Campbell, Managing Director NYYS Care Group	
1	**Agenda: The following agenda items were considered during the meeting:** • Committee Action Log - 22/73.4 • Corporate Risk Register • Board Assurance Framework • Integrated Performance report • Equality Delivery System • Freedom to Speak Up Guardian Report • Partnership Agreement	
2a	**Alert** None.	
2b	**Assurance** **The Committee can confirm assurance on the following matters:** **The Corporate Risk Register** • There are currently 16 risks on the Corporate Risk Register, of which 7 align to the People, Culture and Diversity Committee (22 November 2023) • Compliance with timely risk and action review has dropped to 56% and, therefore, limited assurance only is offered - staff are completing their training on InPhase which will improve the position; • Verbal updates provided in relation to: o The reducing staffing risk – 1,000 fewer Agency shifts were being used between June and November 2023 which had significantly changed the staffing risk in some areas; o The increasing capacity for Positive and Safe Level 2 training due to changes to Level 1 – ongoing issue of releasing people to attend the training – report requested for the next meeting of the Committee to identify practical ways forward; o There is an improving position for Risk reference 1324 ‘DTV&F CAMHS’ in that North Durham CAMHS has exited Business Continuity Planning (BCP), although South Durham CAMHS remains in BCP as the workforce position was not stable and unallocated cases were high. There is a risk mitigation action which remains outstanding from the February 2023 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 and it was anticipated that it would be addressed through the introduction of the ‘Inphase’ system from mid-late September 2023, the Committee lacks assurance from the report in relation to the movement of risk between Quarters. The Committee highlights the need for an ‘at a glance’ ‘RAG’ rating and a clear audit trail being provided. The purpose of this being to ensure that the report records the changes which have occurred to alter the risk score and the reason why – in the case of this report to reduce two risks and to remove one. Staff are requested to use SMART actions rather than passive language in the Risk Register. The verbal evidence at the meeting provides some mitigation for the ongoing issue with the structure of the report. Accordingly, there is some, but not sufficient, assurance, in relation to effective controls being in place to manage corporate risks. The Committee requests that this information and evidence is included in future reports so that it can support future recommendations, rather than ‘signing-off’ unsubstantiated Executive decisions, in	

	relation to providing assurance on the effectiveness of the controls in relation to the management of corporate risks (regardless of the status of the implementation of the InPhase system). **Board Assurance Framework** • There is good assurance overall: o For Recruitment (BAF ref 1) the controls are assessed as operating effectively (75% good assurance) and the risk score was reduced in line with the revised trajectory (10 with a target of 5) o For Staff Retention (BAF ref 5), the risk score has been reduced to the target of 10, with controls assurance of 60% o Additional verbal assurances were provided with regard to the following overdue actions: ▪ 'Agree with the JCC how we offer posts to candidates' – The Vacancy Control Boards took over the process for offering posts to multiple candidates during 2023. The new Executive People, Culture and Diversity and Executive Strategy and Resources which meets bi-monthly to look at cross-cutting issues will review this process early in 2024; ▪ The implementation of Integrated Performance Assurance Reporting under the heading 'A Great Place to Work' will take place from February 2024, after the 'go live' date for CITO in January 2024; and ▪ Updated information will be provided on the targets for 'Planning Beyond the Crisis' which were due for April 2023, in relation to the Workforce Plan based on 'Our Clinical Journey'. • A new BAF is being developed and will be discussed at the Committee's 'Time Out' session on 22 January 2024. This will articulate the risk more clearly than the current BAF, setting out a single targeted risk in an overarching statement. The meeting will also consider the impact of actions relating to health and wellbeing, recognising that this is also needed for assurance. **Integrated Performance Report** • There is an overall reasonable level of assurance based on the Performance & Controls Assurance Framework for the Board Integrated Performance Dashboard (IPD), with no major areas of concern; • The mandatory and statutory training review is progressing, with individuals' training profiles being mapped; • Additional project management support has been allocated for Workpal and numbers logging onto the system continue to grow; • The Occupational Health Contract is out to tender; • The staff survey has closed with a 49% response rate – the data will be available in January. • The leavers rate and recruitment and retention rates are holding which is positive within the national context of significant uncertainty; and • The appraisal position is satisfactory.
2c	**Advise** **The Committee would like to advise the Board on the following matters:** **Committee Action Log – 22/73.4** • At its meeting on 30 August 2023, 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 and escalated the proposed way forward for the recently re-commenced review of the DNC arrangements to QUAC for information/future monitoring. The outcome of the review of the DNC role concludes that no evidence had been found that wards were left un-safe because of the DNCs being pulled into general nursing staffing numbers, although there were some queries which were not linked to safety. There were some approved actions in relation to the job description and how that role featured in rotas. Task and Finish groups and a separate On Call Review were identified to pick up the outstanding issues; • The Committee notes that the quality and safety risk straddles both the People, Culture and Diversity Committee and the Quality and Assurance Committee, with the issues concerning pay, terms and conditions being relevant to the former and the safety and operational aspects falling within the remit of the latter Committee; and

- An assurance report on the pay, terms and conditions for the DNC role to be provided to a future meeting.

Equality Delivery System

- The Staff Networks and Staff-side are involved in the process supporting the Equality Delivery System, plus peer validation from CNTW;
- The outcome of the scoring process for the selected services for 2023, was to rate the Trust as 'Developing';
- The Committee agrees that there is good assurance on the process being robust and confirms the rating for EDS 2022 for 2023;
- The Committee recommends to the Board that it agrees to the publication of the EDS 2022 on the Trust website;
- The Committee 'Time Out' session in January 2024 will consider how the Trust may move from 'Developing' to 'Achieving' and include a presentation from Catherine Parker on Health Inequalities to explore how this could link to the EDS criteria;
- Hannah Crawford will have a formal lead Executive role for EDI in relation to people who access our services from January 2024, once the new Terms of Reference for the Committee are in place and will support a further strategic shift for the EDI service;
- A consultation is to commence on the EDI structure with a view to the service becoming focused more on engaging communities rather than having a data/statutory reporting-orientation;
- A priority area for focus is violence prevention and reduction work, both centrally and in the Care Groups
- EDI leads to contact leads at other Trusts to explore a potential challenge to the Equality and Diversity Council regarding how prescriptive the EDS process is and the amount of dedicated time and resource involved in making a difference, particularly for Mental Health Trusts as the framework is focused on Acute Trusts;
- Categories within InPhase are to be checked in relation to escalated issues with recording Violence and Aggression potentially indicating a reduction in discrimination from reduced reporting; and
- The report would benefit from outlining the Committee's key priorities for the forthcoming year.

Freedom to Speak Up Guardian Report

- Approximately 5% of those contacting the service believe they have experienced detriment. A revised approach for the treatment of detriment has been introduced locally and new structure adopted, whereby people will contact the Associate Director for Operations and Resourcing in People and Culture in the first instance and quarterly reviews will be provided to Roberta Barker as FTSU NED lead. To date, early indicators show the process is working well;
- Compliance with training has increased to 86-88% - Board members are encouraged to complete this (currently 50%);
- Cases are rising, with 48 in Quarter 1 and 44 in Quarter 2. October was Freedom to Speak up month, with cases potentially up to 60 following visits by Dewi Williams and Victoria Brinsley – this indicates cultural change, confidence in the process within the organisation and a level of trust;
- The refocused role of Speak Up 'Ambassador' has been launched at an event for 'Speaking Up' with the aim of recruiting 30 people – this is building on the former Dignity at Work Champion role which is no longer combined with the dual function of Bullying and Harassment role which had not been used very much. Board Members are encouraged to promote this role to people with whom they are in contact. Another event is planned to take place;
- 'Lessons learnt' is a key theme in 2023, with several people approaching the service because they felt that action was not being taken by Managers because of their 'speaking up', issues being minimised, or they felt that 'fear and futility' was an element of their decision making in approaching the service. In addition, the CQC have asked the team to demonstrate more clearly how people came to the service, lessons learnt, feedback to services, how actions plans were developed and what happened after the action plan had been put in place in terms of outcomes;
- The team is making greater use of the Regional FTSU team for support; and
- The service is reporting an ICB audit and the Reflections Tool to Board in January and February 2024 respectively. Useful feedback had been provided by the CQC on the Reflections Tool.

	Partnership Agreement • The Partnership Agreement with staffside has concluded and has led to the establishment of a Corporate Local Consultative Council, mirroring those already active in the Care Groups and Estates Department.	
2d	**Risks**	No new risks identified.

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 Committee had previously highlighted and escalated the risk in relation to the Corporate Risk Report structure not facilitating the monitoring of the movement of risks between quarters. It was recognised in August 2023, that this would be addressed through the introduction of the 'Inphase' system which was to 'go live' from mid-late September 2023. Nevertheless, this remains an ongoing issue with insufficient evidence being provided in the report regarding the changes to risk scores for assurance. However, when supplemented with verbal updates at the meeting, some but not sufficient assurance could be given in relation to the Corporate Risk Register. The Committee requests that future reports provide a clear audit trail recording the changes which have occurred to alter the risk score and the reasons why in order that it can support future recommendations, rather than 'signing-off' unsubstantiated Executive decisions, in relation to providing assurance on the effectiveness of the controls in relation to the management of corporate risks (regardless of the status of the implementation of the InPhase system). The Committee highlights that the quality and safety risk related to the DNC role straddles both the People, Culture and Diversity Committee and the Quality and Assurance Committee, with the issues concerning pay, terms and conditions being relevant to the former and the safety and operational aspects falling within the remit of the latter Committee.
4	**Report compiled by:** Deborah Miller, ***Corporate Governance Manager*** Jillian Murray, ***Non-Executive Director (Committee Chair)*** Sarah Dexter-Smith, ***Executive Director of People and Culture*** Minutes are available from: Deborah Miller	

DM/05/01/24

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11 January 2024**
Title:	**Guardian of Safe Working for Postgraduate Medical Trainees**
Executive Sponsor(s):	**Dr Kedar Kale**
Author:	**Dr David Burke – Interim Guardian of Safe Working**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
5	**Staff retention**	The experience of postgraduate doctors, and compliance with their terms and conditions of employment, is important to maintain viable training positions.
1	**Recruitment**	The experience of postgraduate doctors, and compliance with their terms and conditions of employment, is important to make TEWV an attractive place to work when they apply for substantive appointment at completion of their training.

Executive Summary:

It is the responsibility of the Guardian of Safe Working to provide quarterly reports and an annual update to the Trust Board for assurance. This report aims to provide assurance that postgraduate doctors are safely rostered and that their working hours are safe and in compliance with their terms and conditions of service.

As can be seen in the appendices to this report, there continues to be some exception reports and a narrative has been provided within the body of this report to identify any trends.

Recommendations:

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

MEETING OF:	**Trust Board**
DATE:	**11th January 2024**
TITLE:	**Quarterly Report by Interim Guardian of Safe Working for Postgraduate Doctors**

1. INTRODUCTION & PURPOSE:

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

2. BACKGROUND INFORMATION AND CONTEXT:

The 2016 national contract for postgraduate doctors encourages stronger safeguards to prevent doctors working excessive hours and, during negotiation, agreement was reached on the introduction of a 'guardian of safe working hours' in organisations that employ or host NHS doctors in training to oversee the process of ensuring doctors are properly paid for all their work and are compliant with safe working hours. It is a requirement that all doctors on the contract have an individualised schedule of work for each placement, variation from which requires them to place an exception report, based on hours of work and/or educational experience.

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

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

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

3. KEY ISSUES:

- **Appendices 1 and 2** provided by Medical Staffing, give more details for North (Durham & Teesside) and South (York and North Yorkshire) Care Groups respectively for the quarter October to December (inclusive) 2023. The relevant appendices are shared with the corresponding Health Education England body for the different sectors.

- In the North there have been 12 exception reports in Q3, which is a small increase over Q2.

- There have been 23 exception reports in the South in Q3, which is a significant decrease from Q2 (39.) The decrease is in most localities. Notwithstanding the decrease, I have this quarter emphasised the importance of exception reporting to postgraduate doctors' representatives in the postgraduate doctors' training fora (PDTFs) and at the recent induction of Foundation Doctors.

- The majority of fines in the South remains predominantly in relation to Scarborough (13) where an NROC rota remains in place. Fines levied remain in relation to not achieving 5 hours of continuous rest between 10pm – 7am.

- I am satisfied that all exception reports submitted by doctors on the 2016 contract have been actioned by Medical Staffing, though some are awaiting processing by the finance department. Some exception reports may yet be submitted by doctors in relation to the end of the quarter.

- Following my enquiries, I have been made aware by Medical Staffing that some fines are awaiting payment from Q2, and this has been flagged to the finance department which is in the process of reviewing these.

- The finance department have provided me, on 4 January 2024, with the year to date position on guardian fines as follows, with all fines being levied in the South. This includes the fines yet to be processed from Q2 (and Q3.) I am advised that there is an April to December surplus of £4,874:

	April to December
Fines Processed	-£7,160
Fines not yet processed	-£5,694
Total Fines	**-£12,854**
Expenditure	£7,980
Total Surplus	**-£4,874**

- In terms of timescales, 8% (11% in Q2) of exception reports in the North and 70% (59% in Q2) in the South were responded to within 7 days. I have liaised with the head of Medical Staffing who advises that unexpected leave in the North resulting in significant pressures, coupled with increased work in relation to industrial action, have been the reason for the decrease in response time in the North. I am informed that the deadline was missed by only a couple of days in most cases. Staffing has now improved, and the head of Medical Staffing is working to improve response times. There has however been an improvement in the South.

- The internal locum system appears to continue to function well in that there is no reported use of Agency locums on Postgraduate Doctors' rotas.

- I have chaired the PDTFs in both the North and the South of the Trust since my last update to the board. I emphasised the Trust's commitment to sexual safety, and that the trust has signed up to the NHS sexual safety charter.

4. IMPLICATIONS:

4.1 **Compliance with the CQC Fundamental Standards:**
The work of the guardian will help to inform CQC in the areas of Safety, Good Governance, Staffing and Duty of Candour. This report gives evidence of maintenance of these standards.

4.2 **Financial/Value for Money:**
The new contract is underpinned by the principle that postgraduate doctors are paid for the work they do. Implementation of the contract has cost the organisation a significant amount of money. It is necessary that the Board understands that extra costs will be incurred for additional anti-social hours worked and breaches of hours and rest agreements. It is vital that broader resources are effectively utilised to ensure work passed to postgraduate doctors is necessary and appropriate.

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

4.4 **Equality and Diversity:**
The revised 2016 terms and conditions included the responsibility of the guardian to oversee issues relating to Equality & Diversity. The Head of Equality and Diversity is therefore invited to the quarterly trustwide Postgraduate Doctor Forum.

The Champion of Less Than Full-time (LTFT) Working is a core member of the Postgraduate Doctor forum.

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

5. RISKS:

There is a potential for industrial action to impact the number of exception reports.

We continue to be mindful of the impact of Covid-19 and emerging variants. There is a risk of this impacting doctors and necessitating sick leave, but there may also be an indirect effect on the workload of doctors if other staff are sick.

6. CONCLUSIONS:

There continues to be a risk of breaches in the two non-residential rotas in the South of the Trust. Introduction of more residential rotas where possible may help to alleviate this, and my understanding is that Medical Development are in the process of reviewing this possibility. Postgraduate doctors are appropriately submitting exception reports but as mentioned above, Medical Staffing will work to improve the efficiency of this process.

7. RECOMMENDATIONS:

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

Author: Dr David Burke
Title: Interim Guardian of Safe Working hours for Postgraduate Doctors

Background Papers:
Appendices 1 & 2: detailed information on numbers, exception reports and locum usage - North and South Care Groups respectively.

Appendix 1 DTV&F (North Care Group)

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

High level data

Number of doctors / dentists in training (total): 130
Number of doctors / dentists in training on 2016 TCS (total): 118
Amount of time available in job plan for guardian to do the role: 1 PA
Admin support provided to the guardian (if any): 4 days per quarter
Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st October 2023 up to 31st December 2023

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Teesside & Forensic Services Juniors	0	0	0	0
F1 –North Durham	0	0	0	0
F1 – South Durham	0	0	0	0
F2 - Teesside & Forensic Services Juniors	0	0	0	0
F2 –North Durham	0	0	0	0
F2 – South Durham	0	1	1	0
CT1-2 Teesside & Forensic Services Juniors	0	2	2	0
CT1-2 –North Durham	0	0	0	0
CT1-2 – South Durham	0	1	1	0
CT3/ST4-6 – Teesside & Forensic Services Seniors	0	0	0	0
CT3 – North Durham	0	0	0	0
CT3 – South Durham	0	0	0	0
ST4-6 –North & South Durham Seniors	0	0	0	0
Trust Doctors - North Durham	0	8	8	0
Trust Doctors - South Durham	0	0	0	0
Trust Doctors - Teesside	0	0	0	0
Total	**0**	**12**	**12**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Teesside & Forensic Services Juniors	0	2	2	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	8	8	0
South Durham Juniors	0	2	2	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
Total	**0**	**12**	**12**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Teesside & Forensic Services Juniors	0	0	2	0
Teesside & Forensic Senior Registrars	0	0	0	0
North Durham Juniors	0	1	7	0
South Durham Juniors	0	0	2	0
South Durham Senior Registrars	0	0	0	0
North Durham Senior Registrars	0	0	0	0
Total	**0**	**1**	**11**	**0**

Hours monitoring exercises (for doctors on 2002 TCS only)					
Specialty	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**

Work schedule reviews

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

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

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Teesside & Forensics	F2	0	2	0	0	25
	CT1	38	26	0	363	274
	CT2			0		
	GP			0		
	CT3	0	0	0	0	0
	Trust Doctor	0	10	0	0	64
	SAS	9	8	0	163	139
North Durham	F2	0	0	0	0	0
	CT1	36	26	0	352	227
	CT2			0		
	GP			0		
	CT3	0	10	0	0	125
	Trust Doctor	0	0	0	0	0
	SR/SAS	40	39	0	713	697
South Durham	F2	0	0	0	0	0
	CT1	29	28	0	277	264.5
	CT2			0		
	GP			0		
	CT3	0	1	0	0	12.5
	Trust Doctor	0	0	0	0	0
	SAS	46	46	0	857	857
Total		**198**	**196**	**0**	**2725**	**2685**

There are 2 less shifts worked due to the middle tier locum not being taken up. Middle tier shift is not required every night. This accounts for the difference in shifts/hours requested versus shifts/hours worked.

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Vacancy	4	4	0	33	33
Sickness	0	0	0	0	0
On call cover	194	192	0	2692	2652
Total	**198**	**196**	**0**	**2725**	**2685**

Vacancies

Vacancies by month						
Locality	**Grade**	**Month 1**	**Month 2**	**Month 3**	**Total gaps (average)**	**Number of shifts uncovered**
Teesside & Forensics	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	2	2	2	2	0
	ST4 -6	0	0	0	0	0
	GP	1	1	1	1	0
	Trust Doctor	0	0	0	0	0
North Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	1	1	1	1	0
	CT2	0	0	0	0	0
	CT3	0	0	1	0.3	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
South Durham	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1	0	0	0	0	0
	CT2	0	0	0	0	0
	CT3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
Total		**4**	**4**	**5**	**4.3**	**0**

Appendix 2 NYY&S (South Care Group)

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

High level data

Number of doctors / dentists in training (total): 85
Number of doctors / dentists in training on 2016 TCS (total): 75
Amount of time available in job plan for guardian to do the role: 1 PA
Admin support provided to the guardian (if any): 4 days per quarter
Amount of job-planned time for educational supervisors: 0.125 PAs per trainee

Exception reports (with regard to working hours) from 1st October 2023 up to 31st December 2023

Exception reports by grade				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
F1 - Northallerton	0	0	0	0
F1 - Harrogate	0	0	0	0
F2 - Scarborough	0	7	7	0
F1 - York	0	0	0	0
CT1-2 - Northallerton	0	0	0	0
CT1-2 - Harrogate	0	0	0	0
CT1-2 - Scarborough	0	3	3	0
CT1-2 - York	0	2	2	0
CT3/ST4-6 – Northallerton	0	1	1	0
CT3/ST4-6 – Harrogate	0	2	2	0
CT3/ST4-6 – Scarborough	0	3	3	0
CT3/ST4-6 – York	0	5	5	0
Trust Doctors - Northallerton	0	0	0	0
Trust Doctors - Harrogate	0	0	0	0
Trust Doctors - Scarborough	0	0	0	0
Trust Doctors - York	0	0	0	0
Total	**0**	**23**	**23**	**0**

Exception reports by rota				
Specialty	**No. exceptions carried over from last report**	**No. exceptions raised**	**No. exceptions closed**	**No. exceptions outstanding**
Northallerton	0	1	1	0
Harrogate	0	2	2	0
Scarborough	0	13	13	0
York	0	7	7	0
Total	**0**	**23**	**23**	**0**

Exception reports (response time)				
Specialty	**Addressed within 48 hours**	**Addressed within 7 days**	**Addressed in longer than 7 days**	**Still open**
Northallerton	0	0	1	0
Harrogate	2	0	0	0
Scarborough	4	5	4	0
York	3	2	2	0

Work Schedule reviews

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

Work schedule reviews by locality	
Northallerton	0
Harrogate	0
Scarborough	0
York	0

Locum bookings

Locum bookings by Locality & Grade						
Locality	**Grade**	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
Harrogate, Northallerton, Selby & York	F2	8	6	0	86.5	74
	CT1/CT2/GP	31	29	0	399.5	327.5
	CT3	2	6	0	12	82.5
	Trust Doctor	0	0	0	0	0
	SAS	2	2	0	32	46
Scarborough	F2	1	1	0	16	24
	CT1/CT2/GP	7	6	0	128	96
	CT3	0	1	0	0	24
	Trust Doctor	0	0	0	0	0
	SAS	86	86	0	1553	1553
Total	**0**	**137**	**137**	**0**	**2227**	**2227**

Locum bookings by reason					
Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts given to agency**	**Number of hours requested**	**Number of hours worked**
On call cover	47	47	0	822.5	822.5
Vacancy	77	77	0	1263.5	1263.5
Sickness	13	13	0	141	141
Increase in workload	0	0	0	0	0
Total	137	137	0	2227	2227

Vacancies

Vacancies by month						
Locality	**Grade**	**Month 1**	**Month 2**	**Month 3**	**Total gaps (average)**	**Number of shifts uncovered**
Northallerton	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	1	1	1	1	0
	ST4 -6	2	2	2	2	0
	GP	1	1	1	1	0
	Trust Doctor	0	0	0	0	0
Harrogate	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	1	1	1	1	0
	ST4 -6	1	1	1	1	0
	GP	1	1	1	1	0
	Trust Doctor	0	0	0	0	0
Scarborough	F1	0	0	0	0	0
	F2	0	0	1	0.33	0
	CT1-3	0	0	0	0	0
	ST4 -6	0	0	0	0	0
	GP	0	0	0	0	0
	Trust Doctor	0	0	0	0	0
York	F1	0	0	0	0	0
	F2	0	0	0	0	0
	CT1-3	1	1	1	1	0
	ST4 -6	3	3	3	3	0
	GP	3	3	3	3	0
	Trust Doctor	0	0	0	0	0
Total		**14**	**14**	**15**	**14.33**	**0**

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