Tees, Esk and Wear Valleys
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

11 April 2024

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

AGENDA

NOTE: there will be a confidential session at 1.00pm for the Board of Directors to receive a patient/staff story.

Standard Items

1	Chair's welcome and introduction (verbal)	Chair	1.30pm
2	Apologies for absence (verbal)	Chair	
3	Declarations of interest (verbal)	All	
4	Minutes of the last ordinary meeting held on 14 March 2024	Chair	
5	Board Action Log	Chair	
6	Chair's report	Chair	
7	Questions raised by Governors in relation to matters on the agenda (verbal) *(to be received by 1pm on Tuesday 9 April 2024)*	Board	

Strategic Items

8	Board Assurance Framework Summary Report	Co Sec	1.45pm
9	Chief Executive's Report	CEO	1.55pm
10	Integrated Performance Report	Asst CEO	2.15pm
11	Corporate Risk Register	ECN	2.55pm

BREAK (3.10pm - 3.20pm)

BAF RISK 1: Safe Staffing

12	Staff Survey	EDfP&C	3.20pm

BAF RISK 3: Co-creation

13	Update from Lived Experience Directors	C Morton C Nosiri	3.40pm

BAF RISK 4: Quality of Care

14	Report of the Chair of the Quality Assurance Committee	Committee Chair (BR)	4.00pm

BAF RISK 10: Regulatory Compliance

15	Report of the Chair of Mental Health Legislation Committee	EMD	4.10pm

Governance Items

16	Reservation of Powers to the Board and Scheme of Delegation	Co Sec	4.15pm
17	Board Assurance Framework (verbal)	Chair	4.20pm

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* *(c) would otherwise prejudice, or would be likely otherwise to prejudice, the effective conduct of public affairs.*	Chair	4.40pm

BREAK (4.40pm - 4.50pm)

Standard Items

19	Confidential minutes of the last ordinary meeting held on 14 March 2024	Chair	4.50pm
20	Confidential Action Log	Chair	

Strategic Items

21	Chief Executive's Confidential report	CEO	5.00pm
22	Reportable Issues Log	CEO	5.20pm

BAF RISK 12: Financial Sustainability

23	Report of the Chair of Strategy & Resources Committee	Committee Chair (CC)	5.35pm
24	Month 11 2023-24 Finance update	EDoFI&E	5.40pm
25	2024-25 Financial Plan	EDoFI&E	5.55pm

BAF RISK 13: Public Confidence

26	Trust-wide Communications Strategy, outline	HoC	6.15pm

Evaluation

27	Meeting evaluation *In particular, have we, as a board of directors:* • *Via the agenda, papers and our discussions, fulfilled our objectives of supporting our communities, staff and stakeholders?* • *Fulfilled our statutory roles?* • *Held the organisation to account for the delivery of the strategy and services we provide?*	Chair	6.30pm

Matters for information

28	Minutes of the meetings of the following committees: a. Quality Assurance Committee, 7 March 2024	Co Sec	n/a

David Jennings
Chair
5 April 2024

Contact: Karen Christon, Deputy Company Secretary
Tel: 01325 552307
Email: karen.christon@nhs.net

Tees, Esk and Wear Valleys
NHS Foundation Trust

MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS HELD ON 14 MARCH 2024 AT WEST PARK HOSPITAL, DARLINGTON AND VIA MS TEAMS

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

Observers:
P Coombs, Governor
S Double, Alder
K North, Deputy Director for People and Culture
G Restall, Governor
A Sayeed, Senior Registrar
S Theobald, Associate Director of Performance

23-24/159 CHAIR'S WELCOME AND INTRODUCTION

The Chair welcomed everyone to the meeting. He commented on the inspiring patient story that the board had heard prior to the meeting and recognised the valuable contribution of the voluntary and community sector to mental health services.

Reference was made to the outcome of the CQC prosecution, where the trust had been found not guilty, and he noted that the trust would continue to show understanding and empathy for the family involved.

The Chair invited executive directors to identify in advance, where additional time may be required to prepare a board report or where an item may need to be deferred to the next meeting.

23-24/160 APOLOGIES FOR ABSENCE

Apologies for absence were received from K Kale, Executive Medical Director.

23-24/161 DECLARATIONS OF INTEREST

None.

23-24/162 MINUTES OF THE LAST ORDINARY MEETING HELD ON 8 FEBRUARY 2024

Agreed: *minutes be approved as an accurate record of the meeting.*

23-24/163 BOARD ACTION LOG

The following points were noted:

1. To clarify use of consequence and likelihood in the Board Assurance Framework (BAF) the report had been updated to provide risk scores where they were not considered to be confidential [action 23-24/152].

2. Reference was made to the development of the seminar programme for 2024/25, which would include an early session on patient outcomes, subject to staff availability.

   It was noted that patient reported outcomes and clinical reported outcomes would be captured and managed through Cito, and the board was advised that Quality Assurance Committee had held a discussion on performance outcomes as part of the development of the Quality Dashboard.

3. The Establishment Review report was included on the agenda and, subject to agreement on the revised content, the action would be closed [action 23-24/17].

23-24/164 CHAIR'S REPORT

Noted.

23-24/165 QUESTIONS RAISED BY GOVERNORS IN RELATION TO MATTERS ON THE AGENDA

None received.

23-24/166 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT (BAF)

P Bellas introduced the report, which provided information on strategic risks to support the board's discussions at the meeting. He noted the inclusion of risk scores and ratings, the development of narrative on the first line of defence, and further work that would be undertaken to complete all risk profiles to the required level.

In discussion the following points were raised:

1. B Reilly, Chair of Quality Assurance Committee, confirmed that the committee had considered and supported the proposed trajectories for relevant BAF risks. She noted the high standard of information provided in relation to co-creation and welcomed the inclusion of similar detail across other risks.

2. It was noted that limited information would be provided in the public report in relation to cyber security and Roseberry Park Hospital.

3. The chair proposed that the BAF be reviewed to ensure information provided was not too historic. **Action: P Bellas**

Bringing the discussion to a close the Chair noted his intention to return to the BAF risks on conclusion of the strategic items on the agenda, in order to identify if any changes were subsequently required.

23-24/167 CEO REPORT

B Kilmurray presented the report, which provided a briefing on important topical issues that were of concern to the Chief Executive.

He noted the outcome of the CQC prosecution, where the District Judge had determined there had been overwhelming evidence that the care and treatment provided by the trust was safe, compassionate and had focused on the patient's needs as understood at that time. He went on to acknowledge how difficult the process had been for family and friends.

In discussion the following points were noted:

1. S Dexter-Smith suggested that the trust had made steady progress across the majority of areas in the staff survey and advised that headline results had been considered at an informal meeting of People, Culture and Diversity Committee and a full board report would be provided at the next meeting.

2. B Reilly noted the introduction of a NHS England performance metric on staffing and B Kilmurray confirmed that NHS Providers would contribute to its development.

3. In respect of the announcement of £3.4bn capital national funding to support technology and digital investment, B Kilmurray suggested this would be a competitive process judged on innovation and ability to share results, for schemes starting in 2025/26.

   L Romaniak noted that the funding included no associated revenue budget, and trusts would therefore incur an additional cost.

4. J Maddison referenced the requirement to achieve a 1.9% average productivity growth target between 2025/26 and the challenge the trust would have to balance the target against provision of labour intensive services, where there was high demand and existing waiting times.

   B Kilmurray acknowledged that the target would be a difficult balance for all NHS organisations and there would be difficult decisions to make during the year. He suggested that whilst there may be some changes to staffing across services, there would be no overall reduction in the workforce and the trust would seek to fully understand the quality impact of any changes it sought to make through transformation proposals.

   L Romaniak commented on a number of productivity challenges, related to: provision of a small number of complex learning disability packages, equivalent to the operation of two wards; agency costs of £3-5m, equivalent to 44 bed days; and additional staffing and out of area placement costs due to higher occupancy rates as a result of increased lengths of stay.

23-24/168 INTEGRATED PERFORMANCE REPORT (IPR)

The board received the report, which provided reasonable assurance on the oversight of the quality of services delivered and actions undertaken to improve performance in required areas.

M Brierley provided an overview of the report and noted the current level of out of area placements at 12. He advised that, due to the roll out of Cito, several metrics would not be reported the following month, with additional data used to provide assurance on performance.

Z Campbell reported from North Yorkshire, York and Selby Care Group and commented on a series of deep dives undertaken by the care group to provide greater clarity on areas of focus and to identify where a broader system discussion was required. She also noted work in progress to complete performance improvement plans with SMART objectives.

P Scott reported from Durham, Tees Valley and Forensic Care Group and noted the opportunity for trust involvement in the national Culture of Care Programme alongside the Getting it Right First Time Programme, to support further work as part of the transformation programme. He also noted: implementation of a new telephony system for the Crisis Line, call pick up rates at 97% and further that work that would be undertaken to provide assurance on the triage model; improvements in restrictive interventions, driven by Adult Learning Disability and Secure Inpatient Services, and concerns about Adult Mental Health Services; agreed changes to the children and young people assessment pathway to respond to the increase in referrals to services for neuro diverse patients; the significant improvement in caseloads at Children and Adolescent Mental Health Services South Durham, which was expected to exit business continuity; focused work undertaken on Birch Ward; and the significant improvement in agency expenditure on nursing over the last six months.

In discussion the following points were raised:

1. B Murphy commented on the aim to achieve a trust wide reduction in restrictive practice and noted that completion of the new strategy had been delayed to ensure it was cocreated with service users. She went on to suggest that management of over occupancy of acute mental health beds was a key driver of change, with changes harder to achieve in services with high occupancy, acuity and reliance on temporary staff.

2. In respect of new standards proposed by People, Culture and Diversity Committee for people measures, J Murray advised that the targets were stretching but considered to be achievable and committee would maintain oversight throughout the year.

3. T Olusoga advised that an improvement was expected in Mental Health Services for Older People outcome measures, following the introduction of Cito.

4. B Reilly confirmed that Quality Assurance Committee was sighted on short term reporting issues due to implementation of InPhase. Commenting further, M Brierley noted the trust had introduced two major systems – Cito and InPhase – and further work would be undertaken to consider any concerns related to data quality and risk mitigation. The introduction of the Electronic Prescribing and Medicines Administration system was also noted.

5. In respect of bed pressures and out of area placements, B Reilly sought assurance on delivery of related performance improvement plans. In response, M Brierley suggested the metric was complex and whilst limited improvement was expected by

the end of March 2024, the focus on SMART actions would provide greater clarity on performance.

6. P Scott advised that in Durham, Tees Valley and Forensic Care Group, performance improvement plans had been rigorously reworked, with oversight by a weekly performance management group, and targets identified for April would provide assurance on progress.

   M Brierley confirmed that performance against key milestones outlined in performance improvement plans would be tracked.

   Commenting further, B Kilmurray noted the findings of the governance review by Deloitte, which had highlighted the role of the accountability framework in performance arrangements and its connection to the financial framework.

7. B Murphy advised that the trust was working with NHS England to identify and evidence the criteria for transition from SOF3 to SOF2 and a further opportunity for discussion was expected at the next Quality Board. B Kilmurray also noted the potential for a further board to board meeting.

8. C Carpenter queried the potential to include contextual information in the report, for example national benchmarking data, and in response M Brierley advised that there was often no clear standard for each measure and information or learning from other areas had been provided where available.

   C Carpenter also noted the potential to use contextual information to evidence where a performance improvement plan had led to a position that contrasted positively against national trends.

9. Responding to a query, P Scott advised there was no clear evidence for the reported change in performance for inpatients feeling safe in Durham, Tees Valley and Forensic Care Group.

10. In respect of bed occupancy in North Yorkshire, York and Selby Care Group, Z Campbell advised that the performance improvement plan had been stood down, as bed occupancy had been zero/one for some time and there were no additional actions beyond those included in the Durham, Tees Valley and Forensic Care Group performance improvement plan or via the Urgent Care Programme Board.

11. L Romaniak suggested there would be a number of factors that would impact on performance and reflected on the need to triangulate a range of intelligence to understand what impact a performance improvement plan had, and if that was the desired outcome.

12. The Chair acknowledged the points raised by C Carpenter and L Romaniak and welcomed the opportunity to build related narrative into the report.

13. J Maddison welcomed the inclusion of overall numbers in the report alongside percentage data, to provide context.

14. In respect of the reduction in the percentage of adults and older persons showing measurable improvement following treatment – patient reported, T Olusoga advised that the measure would also reflect patient experience of waiting times.

15. R Barker noted the need to report on milestones at an appropriate interval to identify progress. She went on to query if the trust was able to meet the waiting time expectations of children and young people in order to improve the patient reported metric and if the trust was able to collect sufficient data to report statistically significant outcomes.

    Commenting further, the Chair proposed that the trust would wish to identify a metric that reported on the outcome for the patient and their family, and he noted that the patient reported outcome would not necessarily correlate with the clinician reported outcome.

16. M Brierley expressed caution on an increase in the level of detail provided in the board report and noted that the development of committee dashboards provided an opportunity for detailed scrutiny and assurance to the board.

Bringing the discussion to a close, the Chair noted the report aimed to provide headline narrative on context, analysis and mitigation, and he welcomed the opportunity for care group managing directors to provide assurance on delivery of results.

Agreed: *that the proposed standards recommended by the People, Culture and Diversity Committee be approved.*

23-24/169 FEEDBACK FROM LEADERSHIP WALKABOUTS

A Bridges presented the report, which provided high level feedback from leadership walkabouts that took place on 26 February 2024 across Mental Health Services for Older People and Children and Adolescent Mental Health Services.

In discussion the following points were raised:

1. B Reilly commented on the worthwhile visit to Forensic Children and Adolescent Mental Health Services and noted that key performance indicators for the service were not captured by the Integrated Performance Report. B Kilmurray acknowledged that specialist services may not be represented in the report and proposed that this would be reviewed through the development of the accountability framework.

2. J Preston commented on the impact that a remote location had on staff, who may feel isolated as a result, and expressed concern about the environment at Whitby Mental Health Services for Older People. L Romaniak confirmed the trust was aware of concerns raised and was ambitious to find a more appropriate venue, recognising financial constraints. Z Campbell also noted the aim to make best use of the service, as part of a wider holistic conversation about new ways of working.

23-24/170 REPORT OF THE CHAIR OF QUALITY ASSURANCE COMMITTEE

B Reilly, Chair of Quality Assurance Committee, presented the report and advised that committee was sighted on: immediate actions to ensure safety and provide leadership support on Birch Ward; short term reporting issues caused by InPhase and agreement to invest in additional team capacity; an episode of seclusion in Secure Inpatient Services, where advocacy and a care plan had been put in place; and work commissioned by the Chief Nurse into use of restrictive practice. She also welcomed the opportunity for Council of Governors to receive an update on the Crisis Line at their next meeting.

Commenting further, B Murphy noted there had been episodes of use of mechanical and prone restraint and advised that a lead practitioner had been employed in each care group

area to lead on this agenda. She referenced work she had commissioned to understand nuances in restrictive practices, risk and the impact on patient experience. This work will report back to Quality Assurance Committee.

In discussion the following points were raised:

1. Z Campbell advised that proposals were in place to ensure a high number of call handlers were available at any time to respond to calls to the Crisis Line.

2. In respect of the instance of seclusion on Ebor Ward, B Murphy advised that whilst the individual waited to be transferred, the ward would continue to explore opportunities every day to improve their experience.

3. The Chair welcomed the depth of conversation at the committee meeting and the level of assurance this had provided, and he proposed that analysis included in the quality dashboard would provide early indication of when intervention was needed. He went on to note a tendency in all organisations to promote competent clinical staff into leadership positions that they may not have all the necessary skills to do, and this may have contributed to the position on Birch Ward.

23-24/171 REPORT OF THE CHAIR OF MENTAL HEALTH ASSURANCE COMMITTEE

Report deferred to the next meeting.

23-24/172 REPORT OF THE CHAIR OF PEOPLE, CULTURE & DIVERSITY COMMITTEE

J Murray, Chair of People, Culture and Diversity Committee presented the report, drawing attention to items considered at the last meeting and alerting the board to the limited assurance in respect of three risks on the Corporate Risk Register, which were aligned to the committee and would be considered in depth at the next meeting.

Commenting further, S Dexter-Smith confirmed that executive directors had discussed the concerns raised by committee and a change in the format of the report had been proposed, in order that committee would be more assured.

23-24/173 ESTABLISHMENT REVIEW REPORT

The board received the report, which provided assurance that an annual establishment review had been conducted in line with national regulatory requirements and advised the board on the risks to quality and recommendations that had been taken forward to address the risks.

In presentation, B Murphy noted the revised format, to reflect feedback received on the previous report and drew attention to the position in respect of board approved investments 2022-23 and the key areas of focus outlined in the report.

In discussion, the following points were raised:

1. The Chair welcomed the revised format of the report and noted its alignment to risks included in the Board Assurance Framework.

2. J Preston noted that the care hours per patient day would provide clarity on staffing pressures, including when due to complex cases. He went on to query the flexibility to respond to increased bed occupancy and B Murphy confirmed that where the roster suggested there was high acuity/dependency, additional staff would be allocated if needed, and this would be reviewed each day.

3. L Romaniak noted that, whilst the establishment review had not highlighted the need for further investment at that time, trust expenditure on staffing had been approx. £10m per annum more than budget, in order to ensure the trust provided high quality safe services.

4. B Murphy commented on the development of a business case for international recruitment and changes through student nursing, which may suggest a more positive recruitment position. She advised that of 48 international nurses appointed to date, 13 had completed the OSCE and 35 were working with the trust to progress into full practice.

   She went on to note that the Mental Health Optimal Staffing Tool provided a means of calculating staffing requirements based on acuity and dependency and to make adjustments for speciality areas, but there were limits to its reliability and a range of other evidence would also be considered. She noted a query in relation to the data for acute and Psychiatric Intensive Care Units, which would be reviewed.

5. B Kilmurray proposed that discipline was required in the development of rosters, and he noted that the Registered Nurse vacancy rate was broadly in line with national average, albeit there were variances across services. He proposed that the trust would consider all opportunities to reduce the reliance on agency staff and noted the potential to benchmark against other disciplines to understand performance against establishment and any hot spot areas.

6. J Murray commented on the impact that factors such as the environment and violence and aggression, would have on patient experience, which remained a key performance indicator for the trust.

   B Murphy noted the reduction in teams with a red rating from the previous report and suggested that where there was over occupancy and staff vacancies, there would be an impact on patient experience and she referenced further work that would be undertaken to consider alternative staffing models. She went on to note that the majority of agency staff had worked for the trust for some time and would not be unfamiliar to patients.

   Commenting further, L Romaniak acknowledged the role the environment had on patient experience and noted the challenge in providing a comfortable and welcoming environment in some settings. A Bridges also noted that the environment was a theme that had arisen at the Patient and Carer Experience Group and advised that peer support workers had contributed to development of the performance improvement plan for feeling safe.

7. J Maddison welcomed the improved format of the report. He noted the trust was overstaffed in comparison to budgeted establishment and proposed that any recommendations on future investment would follow once the establishment had been reset at an appropriate level to reflect the real levels of demand and occupancy. This should enable headroom to be effectively managed and for staff to be confident about staffing levels.

8. S Dexter-Smith advised that there was close oversight of staffing levels each month and noted work underway to respond to concerns that there may not be enough headroom in inpatient services to respond to increased mandatory and statutory training.

9. H Crawford commented on the contribution of other professional groups to address staffing challenges and how innovation and identification of roles such as Chaplains and social workers, would impact positively on staffing, outcomes and patient experience, and she spoke about a recent experience of music therapy.

10. P Scott reflected on the trust's ability to influence acuity and commented on the contribution the Getting It Right First Time Programme would make to reducing acuity levels.

The Chair brought the discussion to a close and proposed that the next iteration of the report include a table of those areas of focus, the route by which they would be dealt with and when an outcome was expected.

23-24/174 LEADERSHIP ACADEMY

S Dexter-Smith presented the report, which appraised the board on development of the trust's leadership academy, its purpose and timelines for its development and launch.

In discussion the following points were raised:

1. B Kilmurray welcomed the opportunity to establish a consistent approach to the development of current and future leaders, to provide them with core skills and tools to carry out their job effectively and support the organisation as it progressed.

2. S Dexter-Smith noted that some programmes would provide stretch opportunities for participants, working in a cohort with their peers, including from the wider system.

3. B Reilly welcomed the opportunity to brief Council of Governors at a future meeting.
Action: S Dexter-Smith

4. J Murray welcomed the proposal and proposed that reference be made to inclusion and the six traits of leadership.

5. R Barker welcomed the proposal and potential for the trust to grow its own talent. She proposed a robust evaluation on the return of investment and benefit to patients and staff.

6. The Chair welcomed the opportunity to work with partners, and he queried if the programme was open to clinical leaders and how staff who would benefit from taking part, would be encouraged to participate.

7. S Dexter-Smith confirmed that the trust would wish to see a demonstratable impact, for example, a thesis that supported the trust in dealing with a challenging issue, and she noted that individuals would be supported to participate by the Organisational Development Team.

Agree: *to support the continued development of the Leadership Academy noting the comments raised in discussion.*

23-24/175 PAY GAPS (GENDER AND ETHNICITY)

S Dexter-Smith presented the report, which provided good assurance that the trust had adhered to the statutory requirements of the gender pay gap reporting legislation, along with further context to explain any gender differences to demonstrate the trust's commitment to equality.

Commenting further, J Murray, Chair of People, Culture and Diversity Committee, confirmed that the committee had taken good assurance from the report, which equated well to other public sector organisations and noted that committee had requested additional illustration in the next iteration.

In discussion K North advised that no issues related to a gender pay gap in posts 8a and below had been identified and this would be kept under constant review. She also noted that changes at senior grades may appear to be more significant, due to the smaller cohort of staff.

Agreed:

i. There is good assurance that a robust process has been undertaken when completing the pay gap reports, including the proposed actions.

ii. The publication of gender pay gap data on the trust and government website by 30 March 2024.

23-24/166 BOARD ASSURANCE FRAMEWORK SUMMARY REPORT (continued)

The Chair returned to the Board Assurance Framework and invited Executive Director risk leads to comment on the assurance they had that key controls would respond to the risk described.

In discussion the following points were raised:

1. Quality Governance – B Murphy proposed that there was good assurance on quality governance and no material changes to note following discussion during the meeting.

2. Demand – Z Campbell proposed that care group Managing Directors had a good understanding of the drivers of demand and impact across community and inpatient services, and overall, there was good assurance on the first line of defence.

3. Quality of Care – B Murphy noted that Quality Assurance Committee had raised a query in respect of crisis service staffing and the impact on care and would review the position at a future meeting.

4. The Chair proposed that the framework provide assurance in respect of highlighted pressures in Adult Mental Health and Psychiatric Intensive Care Units.
Action: P Scott/Z Campbell

5. Digital and Cyber – the Chair recognised that limited information would be provided in the public report and requested that narrative be included on the overall level of assurance. **Action: M Brierley**

6. Financial Sustainability – L Romaniak proposed there was increased confidence in the outturn position for 2023/24 and noted that the draft plan for 2024/25 would be challenging both regionally and at a trust level.

The Chair welcomed the update and proposed that risk leads provide a view on how assured they are on the risk, mitigation and trajectory, following discussion at the meeting.

23-24/176 CONSTITUTIONAL CHANGE

The board received the report, which sought approval to proposed amendments to the trust's constitution, prior to the agreement of Council of Governors'. In presentation, P Bellas advised that the scheme of delegation would be provided as a separate report for ratification at a future meeting and he referenced work underway in respect of proposed changes to financial instructions and board committee terms of reference. He also drew attention to a proposed change to appointed governors, to include an appointed governor to represent voluntary sector organisations in each care group area, subject to agreement by Council of Governors.

In discussion the following points were raised:

1. B Kilmurray proposed that the trust may wish to reflect on its health inequality and net zero obligations.

2. A Bridges noted that a number of current governors were also active members of the voluntary sector in their local area and the chair suggested there would be a number of interested organisations.

The Chair placed on record his thanks to P Bellas for work undertaken on development of the Constitution, including consultation sessions held with governors.

***Agreed**: that –*

i. The amendments to the Constitution, as set out in annex 1 to the report be approved, subject to:
- *'Trust Secretary' be amended to 'Company Secretary' [para 35.2 refers]*
- *Content to be gender neutral.*

ii. The amendments be recommended to Council of Governors' for approval.

23-24/177 USE OF THE TRUST'S SEAL

Noted.

23-24/178 EXCLUSION OF THE PUBLIC

***Agreed:** that representatives of the press and other members of the public be excluded from the remainder of the 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.*

On conclusion of the confidential session, the meeting ended at 6.15 pm.

This page is intentionally left blank

Board of Directors
Public Action Log

RAG Ratings:

	Action on track
Completed	Action completed
	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 Jan-24: Board invited to propose topics Feb-24: Draft programme to be shared with Chair/CEO in Feb
27/04/2023	23-24/11	BAF	BAF report to reflect the impact of the financial position on delivery of priorities for 2023/24	Co Sec EDoFI&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 Mar24: redrafts considered at SRC.
14/03/2024	**23-24/166**	**BAF**	**Historical information to be removed.**	**Co Sec**	**Apr-24**	**See agenda item 8**	
14/03/2024	**23-24/166**	**BAF**	**BAF to be updated to provide assurance in respect of highlighted pressures in AMH and PICU, and to comment on the overall level of assurance related to digital and cyber security**	**Co Sec MD DTVF MD NYYS Asst CEO**	**Apr-24**	**See agenda item 8**	
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 NYYS	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 - agreed that a report would be provided to QAC or MHLC on implementation Feb24: the group nurse/medical directors will bring an update to MHLC in February 2024. **Apr24: discussed at MHLC**
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	**Completed**	**Apr24: Report received by CoG on 19 March 2024**
11/01/24	23-24/131	Lived Experience	Lived Experience Directors be invited to attend the board in March 2024. Executive Directors to consider how the board could take advantage of lived experience input at all board meetings.	CEO	Apr-24	**See agenda item 13**	Lived Experience Directors invited to attend the Board in April 2024 (Note: LE Directors report into Care Group MD's)
11/01/24	23-24/135	ToR - Commissioning Committee	Executive Directors to consider most appropriate arrangements for responsibilities previously held by Commissioning Committee	CEO	Mar-24		

Board of Directors
Public Action Log

RAG Ratings:

	Action on track
Completed	Action completed
	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
11/01/24	23-24/136	Patient outcomes	Timescales to be provided for completion of current work to improve the reporting of patient outcomes.	EMD	**Jul-24**		**Linked to board seminar session to be held on 11 July 2024**
11/01/24	23-24/137	Corporate Risk Register	Report to provide an 'at a glance' summary of risk movement across the year.	CN	Q2 2024/25		
11/01/24	23-24/137	Corporate Risk Register	Report to include timescales to indicate when a target rating would be achieved.	CN	Apr-24	**See agenda item 11**	Next report due April 2024
11/01/24	23-24/138	Charitable Funds	LR to consider how governance arrangements could reflect independent assurance provided by Non-Executive Directors	EDoFI&E	Apr-24		Discussing establishment of a new Charitables Committee formed from ARC NED membership supplemented by other colleagues, e.g. potentially staff wellbeing council / Lived Experience with SRC and ARC chair / Trust secretariat. Propose might meet 6-monthly (for example for 30 minutes following ARC). Trust secretary considering alongside scheduling of 2024/25 Board and Committee Meetings
11/01/24	23-24/144	Staff Survey	Report to be provided on the results of the Staff Survey	EDfP&C	Apr-24	**See agenda item 12**	Results shared at PCDC time out and people journey delivery plan reviewed and agreed in light of the results. Implications to be reported to the board in March/April 2024 Mar24: overview provided in CEO report
08/02/24	23-24/151	Our Journey to Change	Update on delivery of the Autism Adult Neurodevelopmental Service in DTVF to be provided at the next meeting	P Scott	Mar-24		Mar24: Proposed for discussion in April 2024 - in order that the care group can provide a more meaningful report (delay in IIC waiters report due to migration to Cito) **Apr24: report delayed to June 2024**
14/03/2024	**23-24/174**	**Leadership Academy**	**Council of Governors to be briefed on proposals, at a future meeting**	**EDfP&C**	**Jun-24**		**Next CoG 3 June 2024**

Chair's Report: 14th March – 11th April 2024.

Headlines:

External:

- Weekly Mental Health Chairs' Network : Discussion with national Mental Health Policy Lead covering waiting times, demand and increase in autism / ADHD, efficiency and productivity, recent CQC legal result.
- Meeting Yorkshire and Humberside Foundation Trust Chairs: issues of common interest & also H&NY Provider Chairs meeting reflections on recent H&NY event.
- Board of Directors March 2024.
- CQC Legal Case and outcome.
- Norton Community Group, on TEWV and our Journey to Change.
- Suicide Memorial and memorial Quilt : Newcastle Cathedral : Speak Their Names.
- Meeting with County Durham & Darlington, North Tees and South Tees Trust Chairs and Chief Executives, to discuss areas of common purpose.
- Meeting Darlington Borough Council : to discuss areas of common purpose.

Council of Governors (CoG)

- Public and Private meetings of CoG.
- Conclusion of Task & Finish Group, and briefing on Constitution changes.

Internal

- Monthly Chair and Non-Executive Meeting.
- Community Mentla Health Transformation Learning Network : initial scoping discussions.

Annual Leave : 25/3/24 to 3/4/24.

This page is intentionally left blank

Communications Dashboard

March 2024

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

This month we...

- Raised awareness of eating disorders at an open day at Imperial Avenue in Stockton-on-Tees
- Celebrated International Womens Day, and Neurodiversity week
- Announced actor Richard Hawley as our official starter of the TEWV 10k
- Received the results of our National Staff Survey results
- Updated staff on the NHS 111 service for anyone experiencing a mental health crisis

Highlights

Beth Leighton is running the TEWV 10k to raise awareness of a condition she experienced during pregnancy

World Delirium Awareness Day event, hosted by our Teesside liaison psychiatry service

An Easter Fayre at Foss Park raised £280 for the hospital's charitable fund

Eating Disorders Week event at Imperial Avenue, featuring tours and interviews with service users

Media and online

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

In the media

6
Media enquiries handled by the team

4
Media releases issued

32
Total pieces of coverage across online news, TV, and radio

News stories

- **TEWV found not guilty in connection with Emily Moore's death -** *The Northern Echo Online*
- **Nursing Times Awards Highlights: Nursing in the Community -** *Nursing Times Online*
- **Distress Intervention service expands into County Durham following regional success -** *Business Mondays Online*
- **Hartlepool Mental Health nurse signs up for new 10k run at York Racecourse to raise awareness of severe pregnancy sickness** - *Hartlepool Mail online*

Our website

70,190
page views

Top three visited pages

1. Careers
2. Services
3. Locations

Staff intranet

1,089,880
page views

Top staff intranet news stories

1. CQC prosecution verdict
2. Beth's 10k fundraising story
3. Beginning of Ramadan
4. Electric vehicle charging changes
5. 111 mental health option
6. Easy expenses overview

Social Media

Tees, Esk and Wear Valleys
NHS Foundation Trust

Our audience

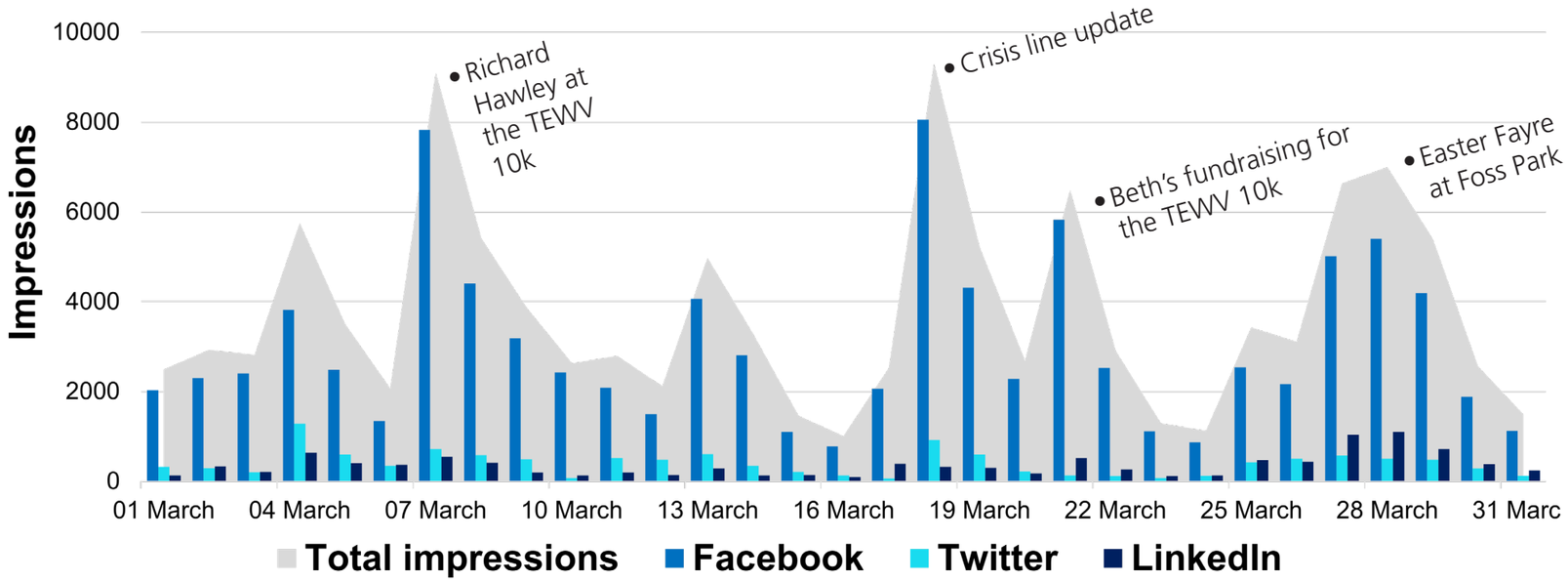
26,345
Total followers

325
New followers

112,857
People who saw our content - impressions

1,864
Engagements

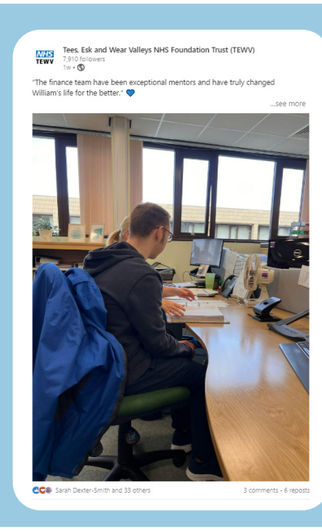
Daily impressions



Top posts

Impressions 16,850 - Engagement 111

Impressions 978 - Engagement 28



Impressions 1,356 - Engagement 50

This page is intentionally left blank

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11th April 2024**
Title:	**Board Integrated Performance Report as 29th February 2024**
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: Despite the absence of data to support the patient measures within the IPR, 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 five areas within the Integrated Performance Dashboard (IPD) with **limited performance assurance** and **negative controls assurance;** in addition, there are **several areas of concern** within the National Quality Standards/Mental Health Priorities. There are mitigations within each of the Headlines which summarise the improvement actions and the impact expected.

Overview: There are several points to note in this month's IPR which are as follows:

- On the 5th February 2024, we went live with our new mental health and learning disability electronic patient record (CITO). Whilst we had planned for there to be no gaps in our reporting during the implementation, we encountered some issues which impacted the data feeding into our Business Intelligence solution, the Integrated Information Centre (IIC). Unfortunately, these issues have impacted

our ability to provide our usual high-quality reports and means we are not able to report patient-based measures in our IPR this month. We expect to resolve these issues before the next IPR

- We are continuing to work on improving the quality of incident data recorded, following the transfer to InPhase, and have identified several actions to support this. These actions are described in full on page 5 of the IPR.
- We have identified several measures where we are currently validating some of the data following some concerns over consistency. If we find anything pertinent following investigation the detail will be updated in next month's report. These are noted against the relevant measures.
- We have included the new standards for the People measures that were agreed in March. These will be deployed into the SPC charts next month as these require some development work.

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.

There are "Headlines" for each of the sections: the Integrated Performance Dashboard (page 6) and the National Quality Standards/Mental Health Priorities (page 48). These headlines include mitigations which describe how we intend to improve performance, the impact of the actions and when we expected to see the impact. We are continuing to use the Performance Improvement Plans (PIPs) as a tool to support improvement; however, the improvement actions are within the IPR (where completed). The key changes for the IPD are shown in italics on page 11 within the Performance & Controls Assurance Overview.

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 47 alignment of measures to the Board Assurance Framework). This will be updated in next month's report to reflect the recent changes to the Board Assurance Framework risks.

Prior Consideration and Feedback

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

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 29th February 2024

Report produced by: Amy Walford, Performance Lead (Corporate) and Sarah Theobald, Associate Director of Performance
Date the report was produced: 28th March 2024

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

CONTENTS

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.
Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	We're currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.
Special cause variation of a decreasing nature where DOWN is not necessarily improving nor concerning.	We're currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.

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, where required.

Our Approach to Data Quality and Action

Tees, Esk and Wear Valleys NHS Foundation Trust

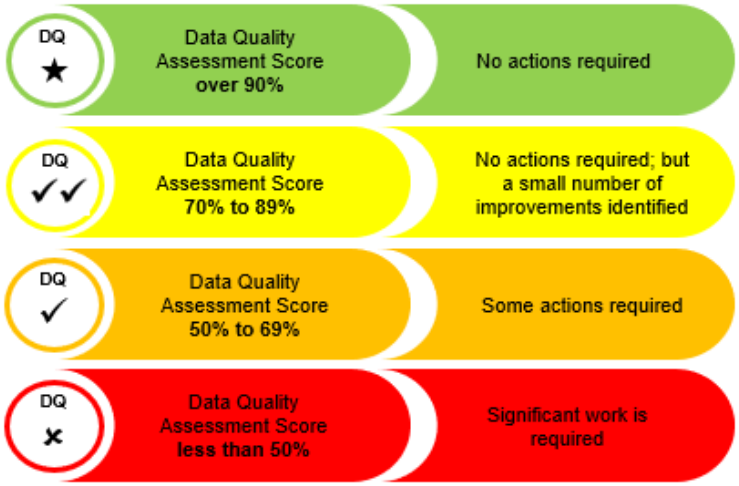
Data Quality
On a bi-annual basis we undertake a data quality assessment on our Board measures as part of our assurance to the Board. Our data quality assessment focuses on 4 key elements: robustness of the measure, data source, data reliability and audit. The latest assessment on all measures has been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



Action status

Key Points to Note

CITO implementation

On the 5th February 2024, we went live with our new mental health and learning disability electronic patient record (CITO). Whilst we had planned for there to be no gaps in our reporting during the implementation, we encountered some issues which impacted the data feeding into our Business Intelligence solution, the Integrated Information Centre (IIC). Unfortunately, these issues have impacted our ability to provide our usual high-quality reports and means we are not able to report patient-based measures in our Integrated Performance Reports (IPR) this month. We expect to resolve these issues before the next IPR.

InPhase implementation

Whilst we know the incident data recorded in InPhase is accurately reported through IIC, there are areas where data quality can be improved, which is to be expected following a transfer to a new recording system. With InPhase the visibility of some of the areas of poor quality in incident records has become more visible, therefore we have agreed several actions to support improvement in the quality of the incident data recorded:

- Additional communications are continuing to be sent via the weekly briefing and included in the weekly InPhase Weekly Newsletter circulated to key staff groups of common errors and changes.
- The full roll-out of local incident review is now in place; however, as this process is new to some areas, additional support is being provided. We expect the quality of data to improve as the new processes of review are fully embedded, although improvements in data quality are already being seen where common errors were being made, but with subsequent communication and discussion across teams has now improved. It is anticipated the new review processes will be fully embedded by September 2024, acknowledging that in some area's reviewers are regular users and will have processes fully embedded much sooner (some already have), while others may not review regularly due to low incident occurrence and as such need further support. In addition, as part of the ongoing review of incidents, the relevant specialists and Central Team will continue to pick up areas of poor-quality reporting, and these will be addressed on an ongoing basis. and more
- Additional 'expert training' on the incident system has been delivered to several key staff, with excellent feedback. As a result of this, Level 2 review training is being revised to include the key aspects of the 'expert' training that attendees highlighted as beneficial, this will be relaunched in April and run weekly.
- The 'Navigating and using reports on InPhase' part of the 'expert' training will be delivered as a separate training package for managers and senior leaders from April, as the analysis of local data in the reports will highlight local quality concerns and enable managers to address these.
- A weekly meeting of key corporate stakeholders who are best placed to identify any key areas of concerns and identify the actions needed to improve the quality of data continues.
- Funding for a new post within the Risk management team has been agreed. The postholder will lead on the proactive planning, coordination and ongoing development of the InPhase system, key to which will be the change management in terms of system use, leading the development of tools and resources to aid staff at ward level and above to fully use the system and improve the quality of data entered. This post will be out to advert shortly although we expect at least a 3-month period before someone is in post. Further support is being sought in the interim.

Board Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience** no significant change however, both measures achieving standard in February. There is also no significant change in the number of responses to each measure.
- **Inpatients Feeling Safe** no significant change however there is special cause improvement (an increase) in the number of responses to this measure.
- **Bed Pressures** special cause concern (an increase) in the number of inappropriate out of area bed days and significantly exceeding the agreed trajectory.
- **Patient Safety / Incidents** for the number of Patient Safety Incident Investigations reported on STEIS there is special cause improvement however, this is not necessarily an actual improvement, as there was a change in process at the end of January 2024 when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations. For the remainder of measures there is no significant change. There was 1 unexpected Inpatient unnatural death reported on the Strategic Executive Information System (STEIS) during February.
- **Staff** The annual NHS Staff Survey results have now been published. For recommending the Trust as a place to work we achieved 57.23%; the "best result" was 75.43% and the "average result" was 65.59% for similar organisations therefore we are lower. For staff feeling able to make improvements we achieved 60.73%; the "best result" as 67.81% and the "average result" as 61.37% therefore we are slightly lower. Whilst there is no significant change for sickness an increasing trend is visible. There is also no significant change for mandatory training or appraisal; however, we are achieving standard in February for mandatory training.
- **Finance** significant recurrent underlying pressures but improved performance relative to in-year control totals and increasing confidence of ability to deliver 2023/24 break even plan.

Risks / Issues

Of most concern:

- *Adults and Older Persons Patient reported Outcome Measure
- Inappropriate OAP bed days
- *Caseload
- Financial Plan: Agency expenditure
- Agency price cap compliance
- CRES Performance – Recurrent

Of concern:

- *Adults and Older Persons Clinician Reported Outcome Measure

Positive Assurance

Significant improvement seen in:

- *Children and Young Persons Clinician Reported Outcome Measure

Positive assurance for:

- CRES Performance – Non-Recurrent

NOTE We have rolled forward the Risks/Issues, Positive Assurance and Mitigations for the patient-based measures* from last month (see Key Points to Note).

Mitigations

AMH/MHSOP Patient reported Outcome Measure and Clinician Reported Outcome Measure
DTVFCG have a PIP and the actions are for Adult services (specifically EIP and Treatment and intervention teams) to focus greater discussion and challenge utilising the team and service level dashboards; for Older Persons services to add this measure to the team and service level governance dashboards and for both Adult and Older Persons services clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. It is anticipated that the impact of these improvement actions should be seen in May 2024 with a 5% increase in Adults and Older Persons showing measurable improvement. North Yorkshire, York & Selby Care Group (NYYSCG) have developed a PIP for AMH services which focuses on completion rates within caseload supervision and monitoring of outcomes within service leadership huddles. It is anticipated that the impact of these improvement actions will be seen in June 2024 with a 5% increase in Adults. Within MHSOP a deep dive is needed to understand the root cause to support the development of a PIP. This work is expected to be completed by the end of April 2024.

Inappropriate Out of Area Placements
DTVFCG have a PIP and the actions are to ensure report out agendas are more action focused; Care Group Board members and Urgent Care supercell members to attend ward 'Report out' meetings and provide feedback and leadership support; and to develop a standard process for monitoring of patients clinically ready for discharge across urgent care wards. It is anticipated that the impact of these improvement actions should be seen in April 2024 with a 50% reduction of patients with a length of stay over 60 days. To review the discharge policy in line with best practice and implement by end of April 2024. It is anticipated that the impact of this action should be a reduction in length of stay to an average of 30 days. To identify patients that are clinically ready for discharge and offer support to address the barriers; to ensure standard approach is taken across Local Authority Meetings to address delays; to identify patients they require additional support from senior leadership team and arrange stop the line meeting; and to review/update Stop the line processes and share with clinical teams. It is anticipated that the impact of these actions should be seen in April 2024, with a 50% reduction in the number of patients clinically ready for discharge.

Caseload
DTVFCG have a PIP and have identified several actions to address the back log of waiters within CYPS neurodevelopmental teams which includes implementing a revised neuro assessment protocol and a refresh of the Patient Tracker meetings. It is anticipated these actions will eliminate over 3 year waits by the end of Q1. AMH services will pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues. It is anticipated this action will increase assessment and reduce 80% of referrals coming into intervention teams by June 2024. NYYSCG are continuing to work on their PIP for CYP services to ensure it includes SMART actions that support improvement.

Finance
Improved performance relative to control totals set in year to support financial recovery provide increased assurance that the Trust will deliver our 2023/24 breakeven plan, based on a mid-case scenario. A small number of external factors have potential to impact the financial outturn however these are currently projected as being manageable within the overall position.

NOTE: See individual pages for full details of the improvement actions and expected impact/timescales

Page 27 of 89

Integrated Performance Dashboard Headlines – Durham, Tees Valley & Forensic Care Group

Headlines

- **Patient and Carer Experience** no significant change with patient and carer experience however we see special cause improvement (an increase) in the number of responses from carers
- **Inpatients Feeling Safe** special cause concern
- **Bed Pressures** special cause concern (an increase) in the number of inappropriate out of area bed days and significantly exceeding the agreed trajectory.
- **Patient Safety / Incidents / Mental Health Act** no significant change across all measures. There was a change in process at the end of January 2024 when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations.
- **Staff.** The annual NHS Staff Survey results have now been published. For recommending the Trust as a place to work we achieved 56.47%; the "best result" was 75.43% and the "average result" was 65.59% for similar organisations therefore we are lower. For staff feeling able to make improvements we achieved 59.74%; the "best result" as 67.81% and the "average result" as 61.37% therefore we are slightly lower. No significant change in mandatory training and appraisal or sickness however an upward trend in sickness is noticed.
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year.

Risks / Issues*

Of most concern:
- AMH/MHSOP PROMS and CROMs
- Unique Caseload
- Financial Plan: Surplus/Deficit

Of concern:
- Inpatients feeling safe
- CYP PROM
- OAPs
- Agency price cap compliance
- Agency Spend

Positive Assurance

Significant improvement seen in:
- CYP CROM

NOTE *We have rolled forward the Risks/Issues and Positive Assurance for the patient-based measures (see Key Points to Note).

Mitigations

AMH/MHSOP Patient reported Outcome Measure and Clinician Reported Outcome Measure
A PIP is in place and the actions are for Adult services (specifically EIP and Treatment and intervention teams) to focus greater discussion and challenge utilising the team and service level dashboards; for Older Persons services to add this measure to the team and service level governance dashboards and for both Adult and Older Persons services clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. It is anticipated that the impact of these improvement actions should be seen in May 2024 with a 5% increase in Adults and Older Persons showing measurable improvement.

Inappropriate Out of Area Placements
A PIP is in place and the actions are to ensure report out agendas are more action focused; Care Group Board members and Urgent Care supercell members to attend ward 'Report out' meetings and provide feedback and leadership support; and to develop a standard process for monitoring of patients clinically ready for discharge across urgent care wards. It is anticipated that the impact of these improvement actions should be seen in April 2024 with a 50% reduction of patients with a length of stay over 60 days. To review the discharge policy in line with best practice and implement by end of April 2024. It is anticipated that the impact of this action should be a reduction in length of stay to an average of 30 days. To identify patients that are clinically ready for discharge and offer support to address the barriers; to ensure standard approach is taken across Local Authority Meetings to address delays; to identify patients they require additional support from senior leadership team and arrange stop the line meeting; and to review/update Stop the line processes and share with clinical teams. It is anticipated that the impact of these actions should be seen in April 2024, with a 50% reduction in the number of patients clinically ready for discharge.

Caseload
A PIP is in place with several actions to address the back log of waiters within CYPS neurodevelopmental teams which includes implementing a revised neuro assessment protocol and a refresh of the Patient Tracker meetings. It is anticipated these actions will eliminate over 3 year waits by the end of Q1. AMH services will pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues. It is anticipated this action will increase assessment and reduce 80% of referrals coming into intervention teams by June 2024.

Finance
Improved performance relative to control totals set in year to support financial recovery provide increased assurance that the Trust will deliver our 2023/24 breakeven plan. A small number of external factors have potential to impact the financial outturn however these are currently projected as being manageable within the overall position.

NOTE: See individual pages for full details of the improvement actions and expected impact/timescales

North Yorkshire, York and Selby, Integrated Performance Dashboard Headlines

Headlines

- **Patient and Carer Experience** no significant change, with patient and carer experience above standard
- **Inpatients Feeling Safe** no significant change.
- **Bed Pressures** no significant change in bed occupancy and below the mean; OAPs special cause improvement
- **Patient Safety / Incidents** no significant change across all measures, however, for the number of patient safety incident investigations, there was a change in process at the end of January 2024 when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations.
- **Staff** The annual NHS Staff Survey results have now been published. For recommending the Trust as a place to work we achieved 57.23%; the "best result" was 75.43% and the "average result" was 65.59% for similar organisations therefore we are lower. For staff feeling able to make improvements we achieved 60.73%; the "best result" as 67.81% and the "average result" as 61.37% therefore we are slightly lower. **Sickness and Appraisals** no significant change however decreasing trend. **Mandatory Training** no significant change with an increasing trend.
- **Finance** significant challenges in relation to financial recovery to achieve breakeven by the end of the year

Risks / Issues*

Of most concern:

- *Adults and Older Persons Patient reported Outcome Measure

Of concern:

- Restrictive Interventions
- Appraisals
- Financial Plan: Surplus/Deficit
- Financial Plan: Agency expenditure
- Agency price cap compliance

Positive Assurance

Improvement seen in:

- *Children and Young Persons Clinician AND Patient Reported Outcome Measures
- *Adults and Older Persons Clinician reported Outcome Measure
- Inappropriate OAP
- Incidents of moderate or severe harm

Mitigations

We are continuing to work on the Performance Improvement Plans (PIP) in the following areas to ensure they include SMART actions that support improvement:

- AMH/MHSOP PROMS

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.

.

NOTE * We have rolled forward the Risks/Issues, Positive Assurance and Mitigations for the patient-based measures* from last month (see Key Points to Note).

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 • 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 • Patient Safety Incident Investigations Incidents of moderate or severe harm • Medication Errors with a severity of moderate harm and above • Unexpected Inpatient unnatural deaths reported on STEIS • *Uses of the Mental Health Act • Compliance with ALL mandatory and statutory training ***improved performance assurance*** • *New unique patients referred	• Inpatients reporting that they feel safe whilst in our care ***improved controls assurance*** • CYP showing measurable improvement following treatment - patient reported • *Bed Occupancy (AMH & MHSOP A & T Wards) • Restrictive Intervention Incidents Used • Staff recommending the Trust as a place to work • Staff feeling they are able to make improvements happen in their area of work • Percentage Sickness Absence Rate • Staff in post with a current appraisal	
Negative		• Financial Plan: SOCI - Final Accounts - Surplus/Deficit • Financial Plan: Agency expenditure compared to agency target • Use of Resources Rating - overall score	• *Adults and Older Persons showing measurable improvement following treatment - clinician reported • Capital Expenditure (Capital Allocation) • Cash balances (actual compared to plan)	• *Adults and Older Persons showing measurable improvement following treatment - patient reported • Inappropriate OAP bed days for adults that are 'external' to the sending provider ***reduced performance and controls assurance*** • *Unique Caseload • Agency price cap compliance • CRES Performance - Recurrent

NOTES Measures 4-8, 15 and 22-23 are patient-based measures* therefore ratings are based on last month's review (as per Key Points to Note). Measure 18 (Staff Leaver Rate) is not included in the above overview – see individual page for further details

Board Integrated Performance Dashboard

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Rep Ref	Our Quality measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
1)	Percentage of patients surveyed reporting their recent experience as very good or good	QAC		?	92.00%	92.24%	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		?	75.00%	78.51%	75.00%
9)	Number of inappropriate OAP bed days for adults that are external to the sending provider	S&RC	H			839	
10)	The number of Serious Incidents reported on STEIS	QAC	L			126	
11)	The number of Incidents of moderate or severe harm	QAC				605	
12)	The number of Restrictive Interventions Used	QAC				9,558	
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				5	

Rep Ref	Our People measures	Committee Responsible for Assurance	Variation	Assurance	Standard (FYTD)	Actual (FYTD)	Annual Standard
16)	Percentage of staff recommending the Trust as a place to work	PC&D				55.98% (Oct - 2023)	
17)	Percentage of staff feeling they are able to make improvements happen in their area of work	PC&D				61.10% (Oct - 2023)	
19)	Percentage Sickness Absence Rate (month behind)	PC&D				5.98%	
20)	Percentage compliance with ALL mandatory and statutory training (snapshot)	PC&D		?	85.00%	86.70%	85.00%
21)	Percentage of staff in post with a current appraisal (snapshot)	PC&D		?	85.00%	80.17%	85.00%

Rep Ref	Our Finance measures	Committee Responsible for Assurance	Plan (FYTD)	Actual (FYTD)
24)	Financial Plan: SOCI - Final Accounts - (Surplus)/Deficit	S&RC	5,072,514	2,335,180
25a)	Financial Plan: Agency expenditure compared to agency target	S&RC	18,200,000	16,070,771
25b)	Agency price cap compliance	S&RC	100.00%	61.91%
26)	Use of Resources Rating - overall score	S&RC	3	3
27)	CRES Performance - Recurrent	S&RC	13,834,000	7,751,000
28)	CRES Performance - Non-Recurrent	S&RC	3,940,000	10,019,151
29)	Capital Expenditure (CDEL)	S&RC	13,348,000	8,969,000
30)	Cash against plan	S&RC	61,284,000	63,678,833

NOTES Measures 4-8, 15 and 22-23 are patient-based measures therefore are not included in this month's dashboard (see Key Points to Note). Measure 18 (Staff Leaver Rate) is also not included – see individual page for further details

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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 February **990** 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, **92.53% (916)** scored "very good" or "good".

There is no significant change at Trust/Care Group level in the reporting period and we are also now showing no significant change in the number of patients who have responded to this question.

Health & Justice and Secure Inpatient Services within Durham, Tees Valley & Forensic Care Group are both showing special cause improvement for patients reporting their recent experience as very good or good.

The latest National Benchmarking data (December 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.

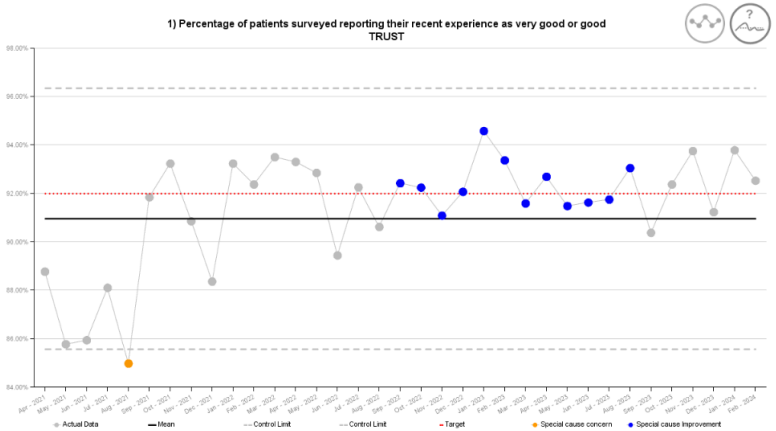
Actions:
- The Patient & Carer Experience Group are going to consider how a patient or carer could understand the performance of each individual team and what key 5 things they might look for (by end of April 2024)

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 ★ 93%

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



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

Tees, Esk and Wear Valleys NHS Foundation Trust

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

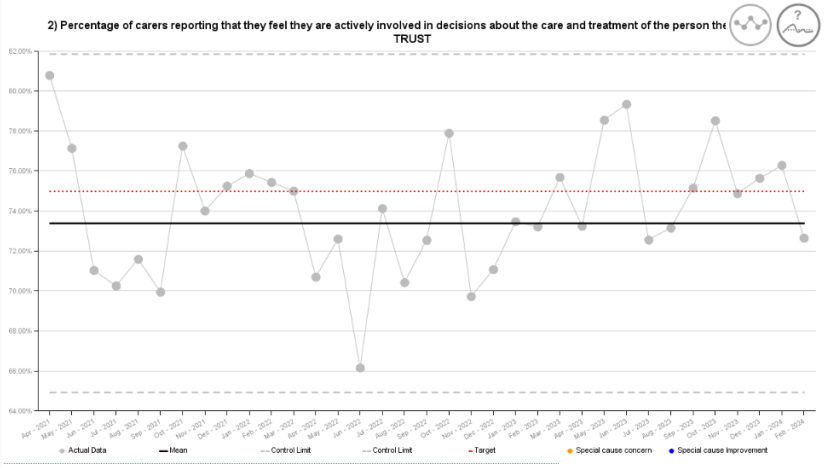
What does the chart show/context:
During February, **329** carers responded to the question in the carer survey: Question: "Do you feel that you are actively involved in decisions about the care and treatment of the person you care for?". Of those, **239 (72.64%)** scored "yes, always".

There is no significant change at Trust/Care Group level in the reporting period; however, we are continuing to show special cause improvement in the number of carers who have responded to the question.

Adult Learning Disabilities within Durham, Tees Valley & Forensic Care Group are showing special cause improvement for carers reporting they feel actively involved in decisions about the care and treatment of the person they care for.

Underlying issues:
- Engagement with various patient groups
- Barriers to collecting feedback include:
    - Access to and up to date surveys through the various mechanisms
    - Up to date carer and team information
    - Lack of feedback including display of feedback

Actions:
- 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 February, **148** patients responded to the overall experience question in the patient survey: Question: "During your stay, did you feel safe?". Of those, 121 **(81.76%)** scored "yes, always" and "quite a lot".

There is no significant change at Trust level and for North Yorkshire, York & Selby Care Group in the reporting period. However, there is special cause concern for Durham, Tees Valley & Forensic Care Group (Mental Health Services for Older People). There is no significant change in the number of inpatients 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

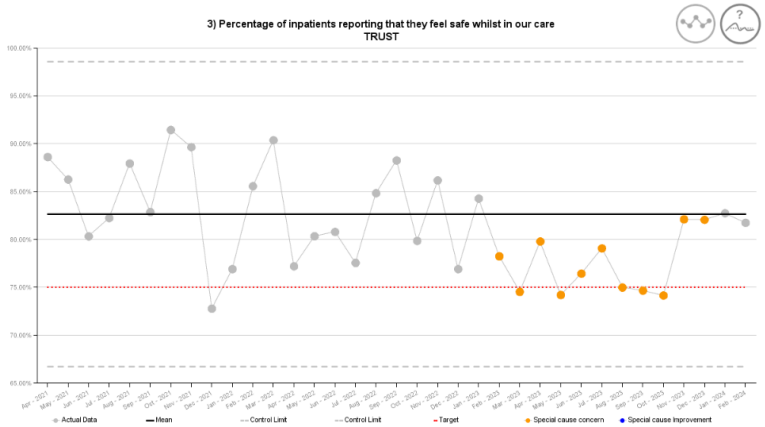
Actions:
- Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP). Actions are for Peer Workers and Patients to create their own Leaflets outlining, what would they want other patients to know when they arrive, what would help them feel safe; Suggestion boxes on wards to support people to raise questions or concerns about feeling safe in an anonymous/less intrusive way and a monthly checklist to explore how many patients attended the Mutual Help, Activities, and psycho-social sessions etc so activities can be tailored to suit the cohort of patients. It is anticipated that the impact of these improvement actions should be seen by May 2024 with a 5% increase in inpatients reporting they feel safe.
- 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. This will now be completed by the end of February 2024. ***(Completed)***
- The Patient & Carer Experience Team have revisited the benchmarking work previously undertaken to understand how we compare to other organisations and are now looking to identify any key learning that can be taken forward within the Trust (by the end of March 2024). ***(Completed)***

No significant change in the data during the reporting period shown

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

DQ 87%

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



Actions continued:
- The Patient & Carer Experience Team in collaboration with the Lived Experience Directors will review the "standard" for this measure following the expansion to include "quite a lot". A proposal will go to the Executive Review of Quality in April 2024.

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:

Please note the data and analysis contained in this slide pertains to the previously reported position ending January 2024.

For the 3-month rolling period ending January **680** patients were discharged from our CYP service with a patient rated paired outcome score. Of those**, 158 (23.24%)** made a measurable improvement.

There is no significant change at Trust level in the reporting period; however, there is special cause concern within Durham Tees Valley and Forensic Care Group. It should be noted there is special cause improvement in North Yorkshire, York & Selby Care Group.

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

Underlying issues:
- This measure currently doesn't include Parent Rated outcomes (which is valid) or some of the newer assessment tools

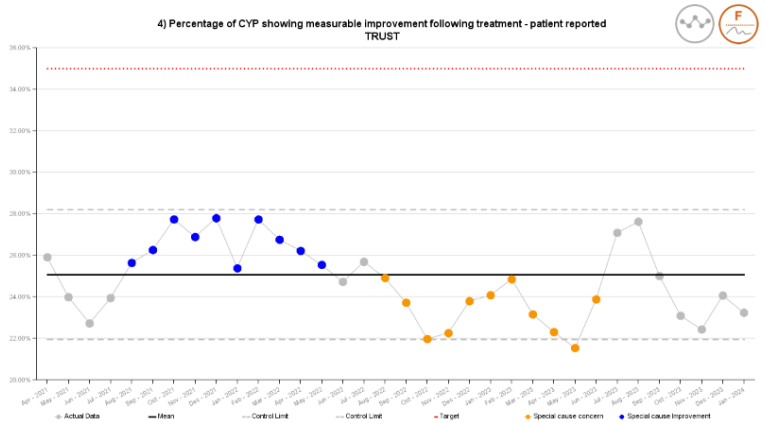
Actions:
- Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP). Actions are to add this measure to the team and service level governance dashboards and begin reporting against this and for clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. ***(Completed).*** It is anticipated that the impact of these improvement actions should be seen in April 2024 with a 5% increase in CYP showing measurable improvement.
- Management Group have now approved the updates to the measure to include Parent Rated outcomes and the new assessment tools. This will be actioned by the Business Intelligence Team post CITO.

No significant change in the data during the reporting period shown

Our system is expected to consistently fail the target/expectation

93%

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



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

NHS
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:

Please note the data and analysis contained in this slide pertains to the previously reported position ending January 2024.

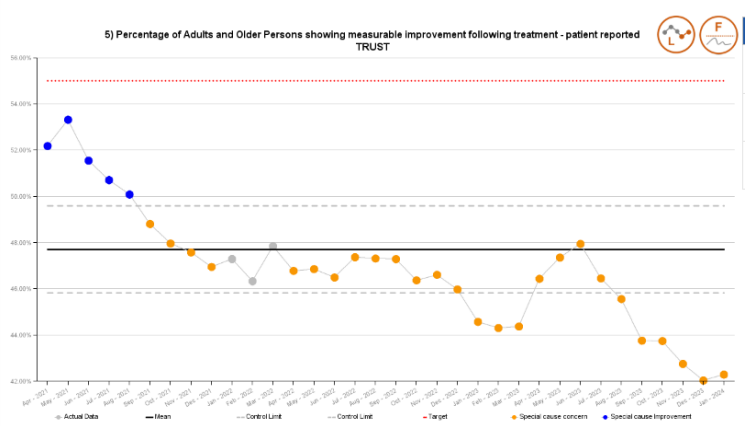
For the 3-month rolling period ending January **1927** patients were discharged from our Adults and Older Persons services with a patient rated paired outcome score. Of those**, 815 (42.29%)** made a measurable improvement.

There is special cause concern at Trust level and for both Care Groups in the reporting period. Special cause concern is in relation to AMH services in both Care Groups. Whilst there is no significant change in MHSOP services, performance is consistently low and is therefore a concern.

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

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

Actions:
- Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP). Actions are for Adult services (specifically EIP and Treatment and intervention teams) to focus greater discussion and challenge by utilising the team and service level dashboards including details of discharges and paired numbers; and for clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. For Older Persons services actions are to add this measure to the team and service level governance dashboards and begin reporting against this measure; and for clinical supervision and caseload management agendas/processes to be updated to include support and discussion around completion of outcomes and reviews of patients not making an improvement. It is anticipated that the impact of these improvement actions should be seen in May 2024 with a 5% increase in Adults and Older Persons showing measurable improvement.



Actions continued:
- North Yorkshire, York & Selby Care Group (NYYSCG) have developed a PIP for AMH services which focuses on completion rates within caseload supervision and monitoring of outcomes within service leadership huddles. It is anticipated that the impact of these improvement actions will be seen in June 2024 with a 5% increase in Adults showing measurable improvement. Within MHSOP a deep dive is needed to understand the root cause to support the development of a PIP. This work is expected to be completed by the end of April 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:

Please note the data and analysis contained in this slide pertains to the previously reported position ending January 2024.

For the 3-month rolling period ending January 762 patients were discharged from our CYP service with a clinician rated paired outcome score. Of those**, 356 (46.27%)** made a measurable improvement.

There is special cause improvement at Trust level and for both Care Groups.

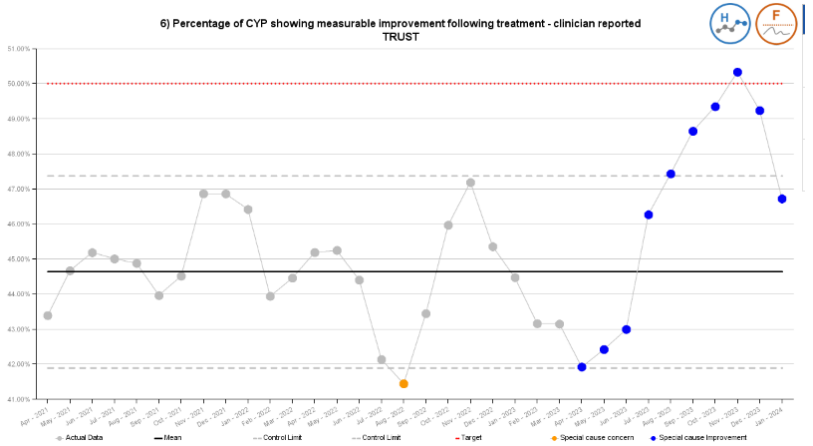
The accepted Clinician Rated Outcome Measures are Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) and Children's Global Assessment Scale (CGAS)

Underlying issues:
The decline in performance has been investigated as part of a high-level deep dive by the Performance Team which has identified the following teams as the main drivers within each Care Group:

- Durham Tees Valley & Forensic Care Group - Hartlepool Community, Mental Health Support Team East and Community Eating Disorder Teams are showing a concern and Durham & Darlington Eating disorders and showing common cause but are contributing to the decline.
- North Yorkshire, York & Selby Care Group - Harrogate Community is showing as a concern and whilst Harrogate and Selby Mental Health Support Teams and York East and Central Community Team are showing common cause, they have also contributed towards the decline in performance.

Actions:

- Durham Tees Valley & Forensic teams are undertaking a patient level review of a sample of patients form each of the teams about who did not show measurable improvement to understand in more detail reasons for this. This will be completed by the end of April 24.
- North Yorkshire teams are now undertaking a deeper investigation to understand the root cause of the decline which will be completed by the end of April 2024.



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:

Please note the data and analysis contained in this slide pertains to the previously reported position ending January 2024.

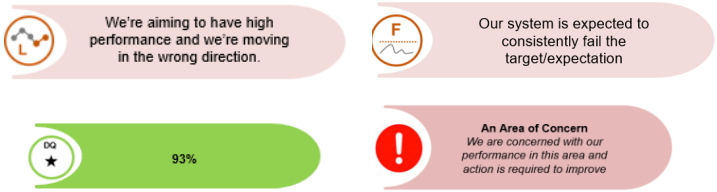
For the 3-month rolling period ending January **3281** patients were discharged from our Adults and Older Persons services with a clinician rated paired outcome score. Of those**, 636 (19.38%)** made a measurable improvement.

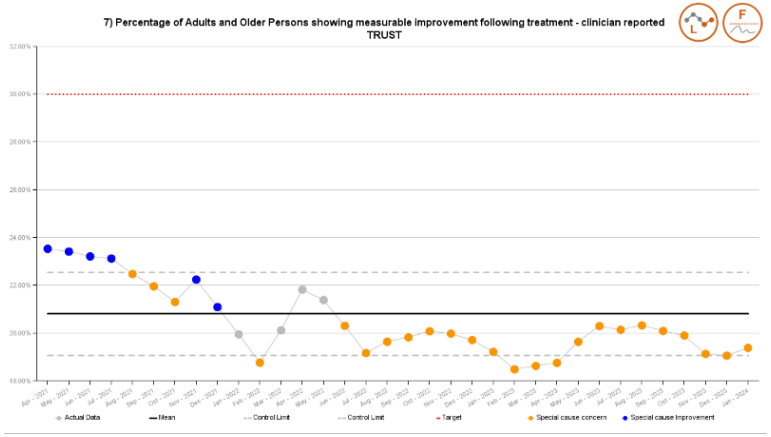
There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group (AMH and MHSOP services) in the reporting period. However, it should be noted that that there is special cause improvement for North Yorkshire, York & Selby Care Group.

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

Underlying issues:
Please see issues against measure 5) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported

Actions:
Please see actions against measure 5) Percentage of Adults and Older Persons showing measurable improvement following treatment - patient reported





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

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:

Please note the data and analysis contained in this slide pertains to the previously reported position ending January 2024.

During January, **10,850** daily beds were available for patients; of those, **10,452 (96.33%)** were occupied. Overall occupancy including independent sector beds was **98.01%**

There is no significant change at Trust level or for both Care Groups in the reporting period; however, there is special cause concern in AMH services within Durham, Tees Valley & Forensic Care Group. Special cause improvement is noted in MHSOP within Durham, Tees Valley & Forensic Care Group

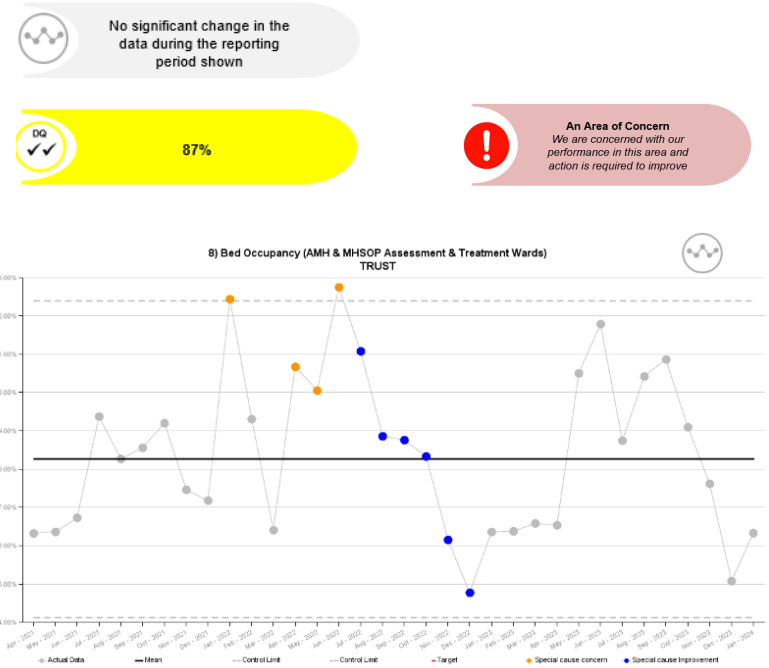
Underlying issues:

- Clinically Ready for Discharge – specifically around accommodation. There is special cause concern in relation to delayed transfers of care (DTOC) for AMH services within Durham, Tees Valley & Forensic Care Group (approximately 10% DTOC during January).
- Patient flow and adherence to PIPA process
- Length of stay (linked to above issues)
- Greenlight admissions
- Ministry of Justice (MoJ) patients

Actions:

Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP). Actions are to:

- Review the 30/60/90 day report out agendas to ensure they are more action focused; Care Group Board members and Urgent Care supercell members to attend ward 'Report out' meeting across AMH services and provide feedback and leadership support to ensure standards are met and to develop a standard process for monitoring of patients clinically ready for discharge across urgent care wards. It is anticipated that the impact of these improvement actions should be seen in April 2024 with a 50% reduction of patients with a length of stay over 60 days.
- Identify best practice across other NHS trusts to support the review of our discharge policy. Policy expected to be implemented by end of April 2024. It is anticipated that the impact of this action should be a reduction in length of stay to an average of 30 days.



Actions continued:

- Identify patients that are clinically ready for discharge where there are delays and offer support to clinical teams to address the barriers; to ensure standard approach is taken across Local Authority Meetings to address these delays; to identify patients they require additional support from senior leadership team and arrange stop the line meeting; and to review/update Stop the line processes and share with clinical teams. It is anticipated that the impact of these actions should be seen in April 2024, with a 50% reduction in the number of patients clinically ready for discharge.

Executive Directors Group have agreed to stand down the development of a North Yorkshire, York & Selby Care Group PIP for this measure, as this is no longer a specific area of concern in this Care Group.

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

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Background / standard description:
We are aiming to have no more than 60 out of area bed days by 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 February **839 days** were spent by patients in beds away from their closest hospital.

There is special cause concern at Trust level and for Durham, Tees Valley & Forensic Care Group (AMH services) in the reporting period. This correlates with bed occupancy in AMH services for this Care Group. It should be noted there is special cause improvement 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.

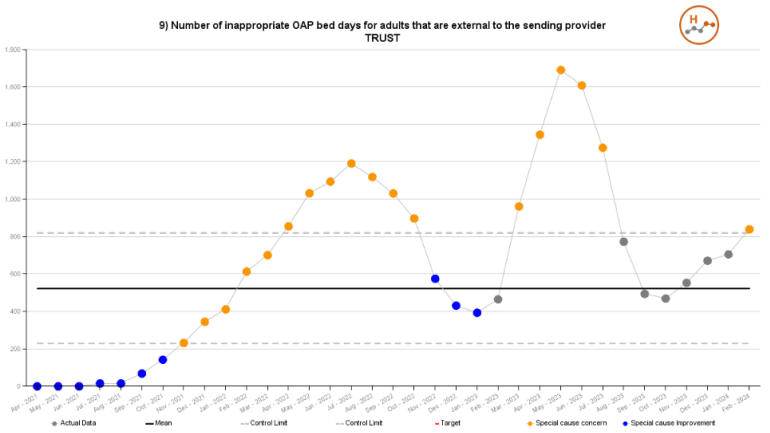
Underlying issues:
Bed Occupancy is impacting on our ability to admit patients to our beds

Actions:
See measure 8) Bed Occupancy

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

DQ 73%

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



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		Quarter 4 23/24	
	Ambition	Actual	Ambition	Actual	Ambition	Actual	Ambition	Actual
Trust	334	1608	246	494	153	671	60	839
North East & North Cumbria ICB	334	1445	246	436	153	608	60	722
Humber & North Yorkshire ICB	0	163	0	58	0	63	0	117

10) The number of Patient Safety Incident Investigations reported on STEIS
previously the number of Serious Incidents

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:
2 Patient Safety Incident Investigations (PSII) were reported on the Strategic Executive Information System (STEIS) during February.

Whilst the SPC chart indicates special cause improvement at Trust level, this is not necessarily an actual improvement, as there was a change in process late January 2024, when we Trust transitioned to the National Patient Safety Incident Framework (PSIRF). This new framework advocates a more proportionate approach to investigations.

Each incident has been subject to a multi-disciplinary after-action review by services and then reviewed within the Patient Safety huddle.

Update:
The full investigations (closest equivalent to Serious Incidents previously reported) are now referred to as Patient Safety Incident Investigations (PSII).

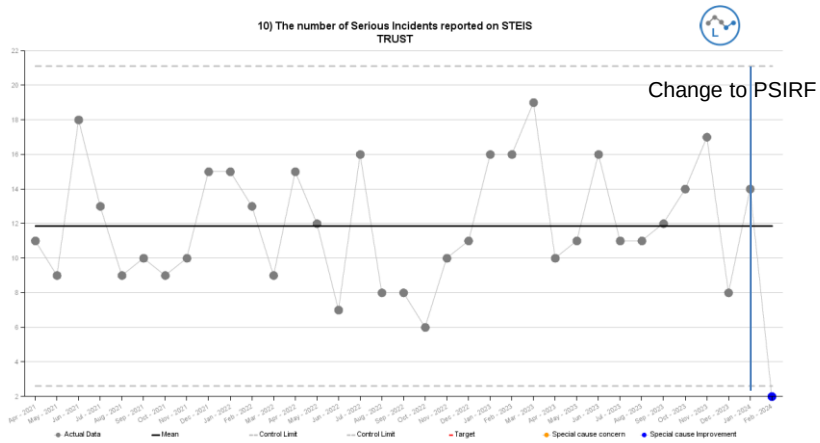
Underlying issues:
There are no underlying issues to report

Actions:
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.
- The Head of Performance will work with the Patient Safety Team and Business Intelligence Team to action the name change to reflect the transition to the new National Patient Safety Incident Framework (PSIRF) by end of March 2024.

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



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:

44 incidents of moderate or severe harm were reported during February.

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

Each incident is subject to a multi-disciplinary after-action review by services. These reviews are then considered in the Patient Safety huddle to determine if any further investigation is required.

Underlying issues:

- As incidents are reviewed, the severity could be reduced or increased (early indications are that severity is usually reduced).
- See Key Points to Note in relation to InPhase Implementation

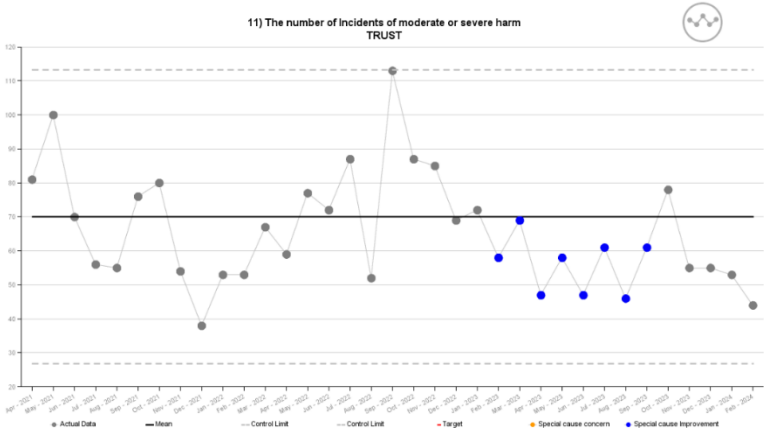
Actions:

- The learning from all incidents will be pulled together and themed by the Patient Safety Team and shared monthly with the Organisational learning Group
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.
- See Key Points to Note in relation to InPhase Implementation

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



12) The number of Restrictive Intervention Used

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:

We are currently validating some of the data following some concerns over consistency. If we find anything pertinent following investigation the detail will be updated in next month's report.

1022 types of Restrictive Interventions were used during February.

There is no significant change at Trust level and for Durham Tees Valley & Forensic Care Group in the reporting period. However, North Yorkshire, York & Selby Care Group are showing special cause concern (high) which is mainly attributable to MHSOP services. It should be noted that AMH services within Durham Tees Valley & Forensic Care Group are also showing special cause concern (high).

Underlying issues:

- Concerns within Wold View (one complex patient) and Springwood within MHSOP services in North Yorkshire, York & Selby Care Group
- Concerns in Elm and Overdale (latter small number of complex female patients) and high number on Cedar (PICU) within AMH services in Durham Tees Valley & Forensic Care Group
- See Key Points to Note in relation to InPhase Implementation

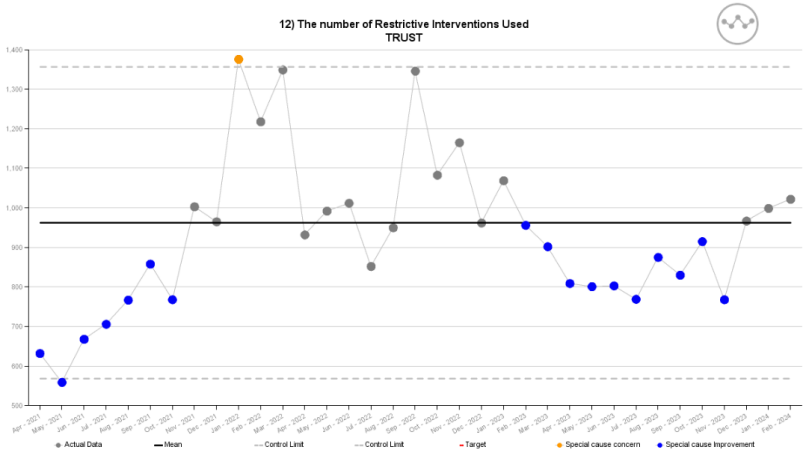
Actions

- Deep dives to be undertaken within both services to better understand the issues and actions required (by end of March 2024)
- Increased support is being given into AMH female wards by Inpatient Lead Psychologist and additional leadership support into Elm Ward as part of a wider action plan
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.
- See Key Points to Note in relation to InPhase Implementation

No significant change in the data during the reporting period shown

Data Quality: pending assessment

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



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:

We are currently validating some of the data following some concerns over consistency. If we find anything pertinent following investigation the detail will be updated in next month's report.

0 medication errors were recorded with a severity of moderate harm, severe or death during February.

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.
- As incidents are reviewed, the severity could be reduced or increased (early indications are that severity is usually reduced).
- See Key Points to Note in relation to InPhase Implementation

Actions:

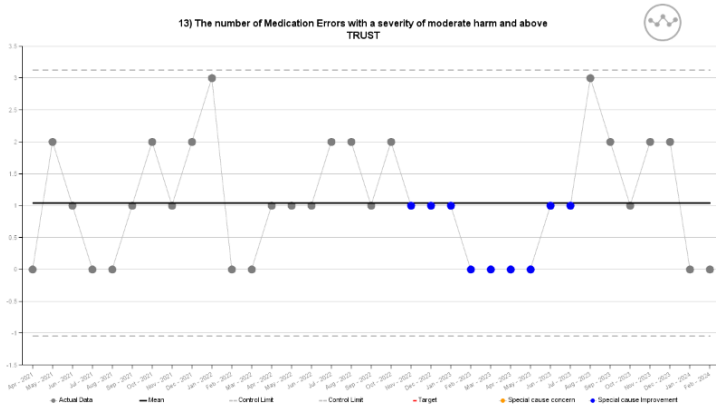
- During Q4 23/24 we will complete the Project Initiation Document for the community roll out which will begin early 24/25.
- The Chief Pharmacist is undertaking a review of the incidents reported for this measure to ensure they are an accurate representation. This will be completed by the end of February 2024. ***(Completed)***
- The Data Quality Assessment will be reviewed by the Business Intelligence and Performance Teams working with the Process Owner in Q4 23/24.
- See Key Points to Note in relation to InPhase Implementation

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



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:
1 unexpected Inpatient unnatural deaths were reported on the Strategic Executive Information System (STEIS) during February. This death occurred whilst the patient was on planned unescorted leave from the ward.

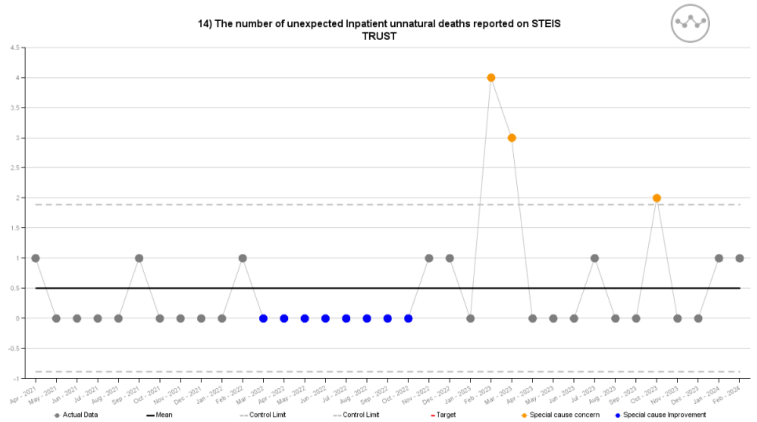
Underlying issues:
There are no underlying issues to report

Actions:
A comprehensive multi-disciplinary after-action review has been completed and in line with the National Patient Safety Incident Framework, a full Patient Safety Incident Investigation will be completed.

No significant change in the data during the reporting period shown

DQ

87%



15) The number of uses of the Mental Health Act

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:

Please note the data contained in this slide pertains to the previously reported position ending January 2024.

There were **331** uses of the Mental Health Act during January .

There is no significant change at Trust/Care Group in the reporting period. However, it should be noted that special cause improvement (low) is showing for Secure Inpatient Services within Durham Tees Valley and Forensic Care Group and for Adult Learning Disability Services within North Yorkshire, York & Selby Care Group.

Underlying issues:
There are no underlying issues to report

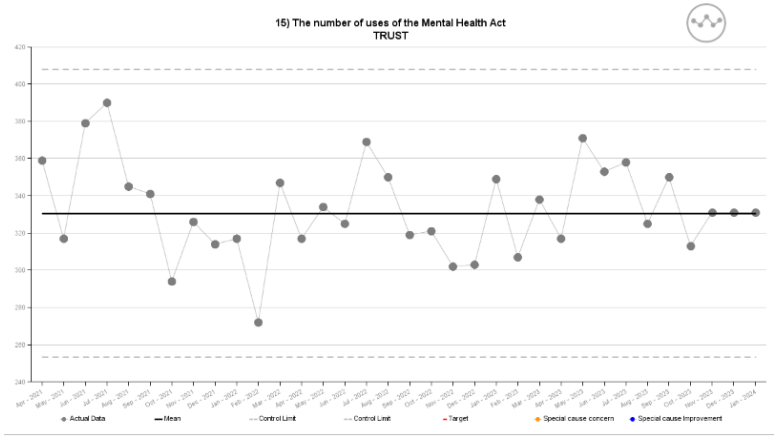
Actions:
There are no specific improvement actions required

No significant change in the data during the reporting period shown

DQ

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

Background / standard description:
We are aiming for 60% of staff to recommend the Trust as a place to work (agreed March 2024)

What does the chart show/context:

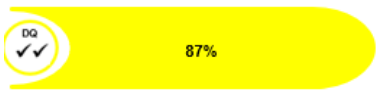
We are currently validating some of the data following some concerns over consistency. If we find anything pertinent following investigation the detail will be updated in next month's report.

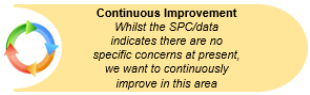
3,782 staff responded to the October 2023 Survey. In relation to the question "I would recommend my organisation as a place to work", **2,154 (56.95%)** responded either "Strongly Agree" or "Agree".

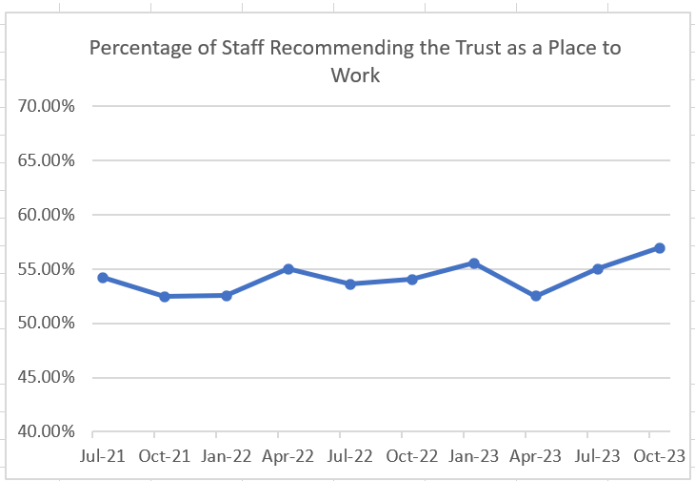
Whilst we have limited data in this area, the line chart demonstrates there is no significant change in the reporting period. The recent NHS Staff Survey Benchmarking report 2023, shows the "best result" was 75.43% and the "average result" was 65.59% for similar organisations.

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

Actions:
- 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/focus groups and a wide range of career development opportunities including development posts.
- In addition to the programme of work, People and Culture triangulate various data sources including staff survey, Organisational Development interventions, Freedom to Speak Up, to identify key themes for targeted action plans.







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

Actions continued:
The latest Staff Survey results will be shared with Care Groups and Corporate Services to both disseminate information to staff and to identify key themes and trends. The Organisational Development Team and People Partners will work with Services to develop targeted action plans over the next 6 months (Sept 24) and report into Executive People Culture and Diversity and People Culture and Diversity Committee. Engagement events will then take place over Sept/Oct 24 to update staff on what we have heard and what action is being taken.

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

Background / standard description:
We are aiming for 65% of staff to feel they are able to make improvements happen in their area of work (agreed March 2024)

What does the chart show/context:

We are currently validating some of the data following some concerns over consistency. If we find anything pertinent following investigation the detail will be updated in next month's report.

3,782 staff responded to the October 2023 Survey. In relation to the question "I am able to make improvements happen in my area of work", **2,294 (60.66%)** responded either "Strongly Agree" or "Agree".

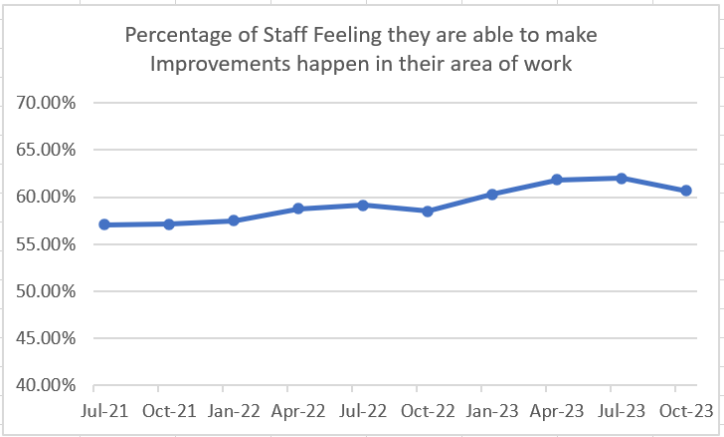
Whilst we have limited data in this area, the line chart demonstrates a slight improvement in the reporting period. The recent NHS Staff Survey Benchmarking report 2023, shows the "best result" as 67.81% and the "average result" as 61.37% for similar organisations.

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.
- The latest Staff Survey results will be shared with Care Groups and Corporate Services to both disseminate information to staff and to identify key themes and trends. The Organisational Development Team and People Partners will work with Services to develop targeted action plans over the next 6 months (Sept 24) and report into Executive People Culture and Diversity and People Culture and Diversity Committee. Engagement events will then take place over Sept/Oct 24 to update staff on what we have heard and what action is being taken.

DQ
87%

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



*Please note the survey is only undertaken once a quarter

18) Staff Leaver Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Update:

We have temporarily removed the data and chart for staff leaver rate as we have some concerns that the data may not be an accurate representation which was identified during routine analysis. Work has been undertaken to understand the issue(s) and rectify this however, this has taken longer than anticipated. It is anticipated the data and chart will now be re-introduced in next month's report with a level of assurance as to the data accuracy.

The latest (November 2023) National Benchmarking for NHS Staff Leaver Rate published on NHS England NHS Oversight Framework Dashboard shows we were ranked 11 (previously ranked 10) 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 (*for those who do leave and tell us why):

- Staff wanting a new challenge
- Promotion
- Role not being as expected
- Work-life balance

Actions:

- 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. A report on the reasons people stay will now be provided to Executive People Culture Diversity Group in April.
- We have developed a Performance Improvement Plan focusing on E Roster effectiveness which includes actions on publishing rotas in a timely manner and improving level loading of annual leave in line with Trust guidance both of which support staff wellbeing and should have a positive impact.

19) Percentage Sickness Absence Rate

Tees, Esk and Wear Valleys NHS Foundation Trust

Background / standard description:
We are aiming for sickness absence to be no more than 5.5% (agreed March 2024)

What does the chart show/context:
There were **229,947.09** working days available for all staff during December (reported month behind); of those, 14,892.32 **(6.48%)** days were lost due to sickness.

Whilst there is no significant change at Trust level and for most areas in the reporting period there is a visible increase in sickness absence as shown in the SPC chart displayed. The areas showing special cause concern are Company Secretary, Finance, Children and Young Peoples Services and Management within Durham, Tees Valley & Forensic Care Group and Adult Mental Health Services within North Yorkshire, York & Selby Care Group.

There are several areas however, showing special cause improvement which are Corporate Affairs and Involvement, Adult Learning Disabilities and Secure Inpatient Services within Durham, Tees Valley & Forensic Care Group and Management within North Yorkshire, York & Selby Care Group.

National Benchmarking for NHS Sickness Absence Rates published 29th February 2024 (data ending October 2023) for Mental Health and Learning Disability organisations reports the national mean (average) for the period shown is **5.86%** compared to the Trust mean of **6.33%** and special cause concern displayed.

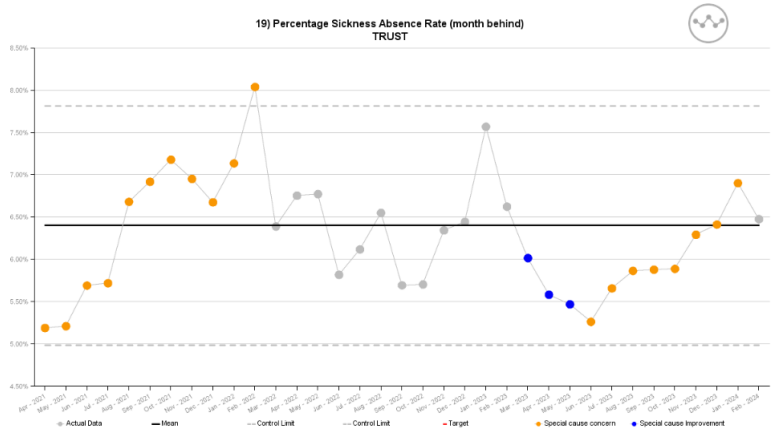
Underlying issues:
- Anxiety/stress/depression is the main reason of sickness absence

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.
- Sickness audits are now being undertaken by People & Culture colleagues to understand whether sickness absence is being managed in line with procedures. Early indications show there is limited assurance.

No significant change in the data during the reporting period shown

DQ 87%

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



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:
177,238 training courses were due to be completed for all staff in post by the end of February. Of those, **156,665** (**86.70%**) were completed.

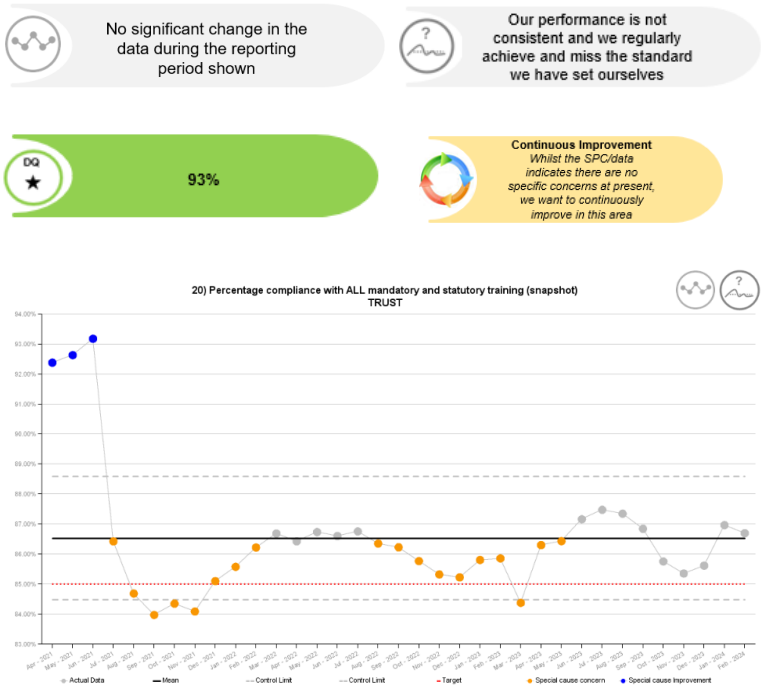
There is no significant change at Trust level and for most areas in the reporting period. However, there are several areas showing special cause concern which are Estates and Facilities Management, Adult Mental Health and Management within Durham Tees Valley & Forensic Care Group and Adult Mental Health Services within North Yorkshire, York & Selby Care Group. To note there are several areas showing special cause improvement which are Adult Learning Disabilities, Mental Health Services for Older People and Secure Inpatient Services within Durham, Tees Valley & Forensic Care Group and Adult Learning Disabilities, Children and Young People's Services and Mental Health Services for Older People within North Yorkshire, York & Selby Care Group.

As at the 7th March 2024 , by exception compliance levels below 85% are as follows:

	Number Compliant	Total Number	% Compliant
1) TRUST BOARD	70	104	67.31%
2) NURSING AND GOVERNANCE	1618	1983	81.59%

Underlying issues:
- Staff unable to be released to attend training (high DNA rate)
- Staff double booking courses which reduces availability
- Lack of capacity for Positive & Safe training courses
- Lack of suitable training rooms
- Misalignment of competencies and staff on ESR

Actions:
- Training Department are actively following up all staff who DNA and identifying and rectifying where staff double book on courses to increase availability
- Positive & Safe training Level 1 changed from 1st February 2024 with the requirement to be every 2 years ***(Completed)***
- The training portfolio for Positive & Safe has been reviewed in line with capacity and demand and the Trust Welcome. Implementation date September 2024.



Actions continued:

- We are constantly reviewing the availability of training rooms across trust premises.
- A Quality Improvement Event is planned for March 2024 to review mandatory training requirements for all staff including how/where this is delivered.
- We have a Performance Improvement Plan which consolidates actions across all the areas of concern. The actions include ensuring alignment of staff competencies correctly on ESR and following up all staffing information not correctly recorded on ESR. It is anticipated that the impact of these actions should be the achievement of 85% by the end of March 2024 and thereafter.

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 were aiming for 95% compliance for Information Governance & Data Security Training (as required by the Data Security and Protection Tool Kit) by the end of March 2024; however, NHS England have now allowed some flexibility with the required standard.

What does the data show/context:
7711 were due to be completed by the end of February. Of those, **6921 (89.75%)** were completed.

As at the 7th March 2024 , by exception compliance levels below 95% are as follows:

	Number Compliant	Total Number	% Compliant
1) CORPORATE AFFAIRS AND INVOLVEMENT	31	37	83.78%
2) NORTH YORKSHIRE, YORK AND SELBY	1606	1842	87.19%
3) THERAPIES	128	144	88.89%
4) DURHAM, TEES VALLEY AND FORENSIC	4080	4553	89.61%
5) TRUST BOARD	9	10	90.00%
6) COMPANY SECRETARY	11	12	91.67%
7) NURSING AND GOVERNANCE	107	114	93.86%
8) MEDICAL	206	219	94.06%

Underlying issues:
- Staff Sickness
- Staff capacity
- Misalignment of staff on ESR

Actions:
- All new starters are being contacted to ensure training is completed as part of the Trust Welcome/Induction
- A new standard of 85% has been proposed and agreed by Executive People Culture & Diversity and now agreed by Executive Directors Group. This will be updated in next month's report.

All other mandatory and statutory training

As at the 7th March 2024 , by exception compliance levels below 85% are as follows for the following courses sorted by lowest performance:

	Number Compliant	Total Number	% Compliant
1) Positive & Safe Care Level 1*	2730	4373	62.43%
2) Rapid Tranquilisation 1	176	280	62.86%
3) Follow Up	12	19	63.16%
4) Positive and Safe Care Level 2 Update*	1062	1638	64.84%
5) Resuscitation - Level 1 - 1 Year*	1710	2525	67.72%
6) Resuscitation - Level 3 - Adult Immediate Life Support - 1 Year*	201	292	68.84%
7) Face to Face Medication Assessment	1533	2218	69.12%
8) Moving and Handling - Level 2 - 2 Years*	665	918	72.44%
9) Medicines Management Annual Module	435	585	74.36%
10) Fire Safety - 2 Years**	5903	7897	74.75%
11) Resuscitation - Level 2 - Adult Basic Life Support - 1 Year*	1956	2611	74.91%
12) Annual Medicines Optimisation Module	1726	2200	78.45%
13) Safe Prescribing	203	257	78.99%
14) Safeguarding Level 3**	3064	3876	79.05%
15) Patient Safety Level 2	4094	5160	79.34%
16) Infection Prevention and Control - Level 2 - 1 Year	4827	6083	79.35%
17) MCA - MCA and Young People Aged 16/17	700	864	81.02%
18) Rapid Tranquilisation 2	430	527	81.59%
19) Observation & Engagement	1388	1699	81.70%
20) Controlled Drugs - Inpatient	407	496	82.06%
21) Fire Safety - 1 Year	6641	7891	84.16%
22) Mental Health Act Level 2	3202	3802	84.22%
23) MCA - Restraint	3454	4069	84.89%

*Indicates face to face learning ** face or face via MST

Actions continued for Information Governance & Data Security Training**:**
- We have a Performance Improvement Plan which consolidates actions across all the areas of concern. The actions include validating outstanding staff lists and following up with individuals; monitoring compliance in weekly huddles and ensuring they are booked in diaries in advance; following up all information not correctly recorded on ESR. It is anticipated that the impact of these actions should be the achievement of 95% by the end of March 2024 and thereafter.

21) Percentage of staff in post with a current appraisal

NHS
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 **6814** eligible staff in post at the end of February; **5463** (80.17**%)** had an up-to-date appraisal.

There is no significant change at Trust level and for several areas in the reporting period. However, there are several areas showing special cause concern which are Children and young Peoples Services within Durham, Tees Valley & Forensic Care Group and North Yorkshire, York & Selby Care Group/Adult Mental Health Services. To note there are several areas showing special cause improvement which are Company Secretary, Finance, Nursing & Governance and People & Culture and Adult Learning Disabilities within Durham, Tees Valley & Forensic Care Group.

As at the 7th March 2024, by exception compliance levels below 85% are as follows:

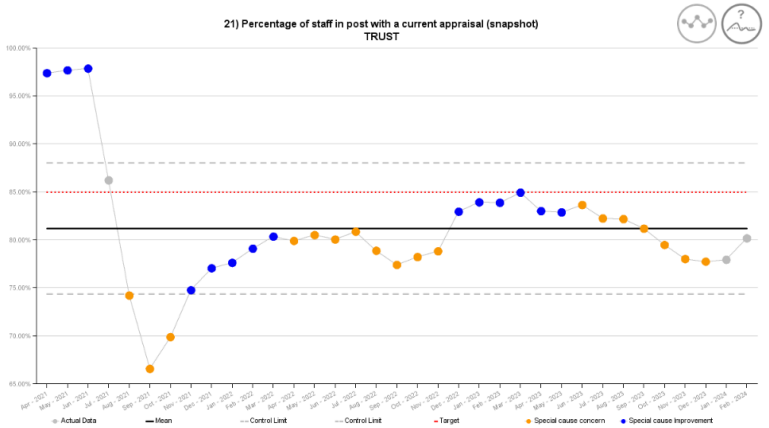
	Number Compliant	Total Number	% Compliant
1) THERAPIES	27	44	61.36%
2) NURSING AND GOVERNANCE	72	98	73.47%
3) DURHAM, TEES VALLEY AND FORENSIC	3207	4058	79.03%
4) NORTH YORKSHIRE, YORK AND SELBY	1246	1568	79.46%
5) COMPANY SECRETARY	8	10	80.00%
6) CORPORATE AFFAIRS AND INVOLVEMENT	27	33	81.82%
7) DIGITAL AND DATA SERVICES	138	164	84.15%
8) MEDICAL	165	195	84.62%

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



Underlying issues:
- Some completed appraisals from WorkPal have not transferred onto ESR and some supervisors are not correctly recording appraisals on ESR
- Staff Sickness of both staff and managers
- Staff not being aligned correctly on ESR
- Lack of monitoring process by services

Actions:
- Appraisal training is currently planned from March 2024 (post CITO) until July 2024 for both managers and staff (appraiser and appraisee).

Actions continued:
- We have a Performance Improvement Plan which consolidates actions across all the areas of concern. The actions include booking all outstanding appraisals; validating outstanding staff lists; monitoring compliance in weekly huddles and ensuring they are booked in diaries in advance; following up all information not correctly recorded on ESR and training for supervisors. It is anticipated that the impact of these actions should be the achievement of 85% by the end of March 2024 and thereafter.

22) Number of new unique patients referred

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the chart show/context:

Please note the data contained in this slide pertains to the previously reported position ending January 2024.

8,628 patients referred in January that are not currently open to an existing Trust service.

There is no significant change at Trust/Care Group in the reporting period; however, we are showing an unexpected level of variation – a continued shift of low referrals for AMH services within North Yorkshire, York & Selby Care Group.

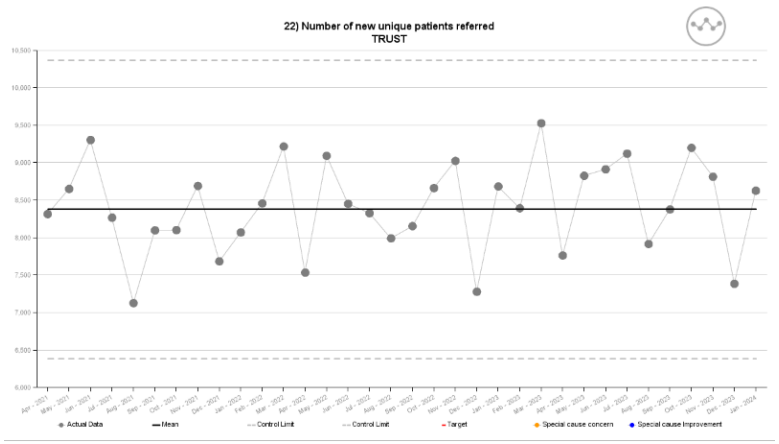
Underlying issues:
There are no underlying issues to report

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:

Please note the data contained in this slide pertains to the previously reported position ending January 2024.

65,270 cases were open, including those waiting to be seen, as at the end of January 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 and an increase in AMH services within Durham Tees Valley Forensic Care Group. We have approximately 20k neuro diverse patients waiting to be seen which equates to 30% of the caseload. There has been an increase in caseload of 10% since March 2022 (start of special cause concern) and we know from internal waiting time information that in CYP services, there has been an increase of 9% in neuro diverse patients waiting for the same time-period. We are unable to compare the increase in AMH services as we do not have historic data.
- An increase in referrals in MHSOP services for memory patients in North Yorkshire, York & Selby Care Group
- An increase in referrals has led to a backlog of waiters, whilst referrals have levelled, they are higher than they used to be. More detailed analysis is required to better understand whether an increase in waiters, particularly for neuro diverse patients is the main reason for the increase in caseload.

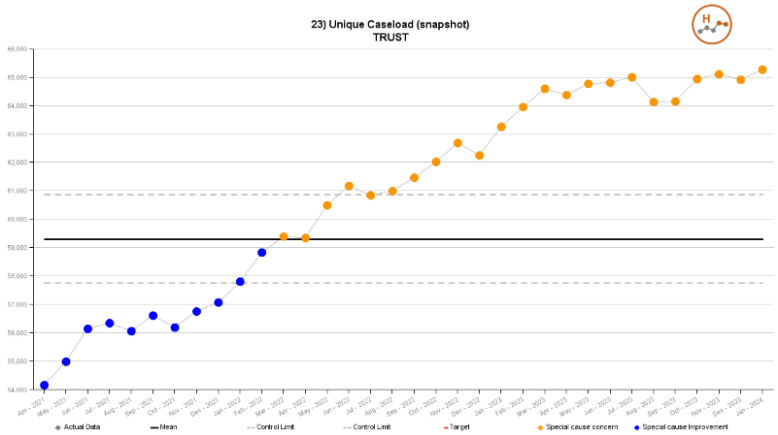
Actions:

- Durham Tees Valley & Forensic Care Group have a Performance Improvement Plan (PIP) and have identified several actions to address the back log of waiters within CYPS neurodevelopmental teams which includes implementing a revised neuro assessment protocol and a refresh of the Patient Tracker meetings. It is anticipated these actions will eliminate over 3 year waits by the end of Q1. AMH services will pilot work within Sedgefield teams to implement a revised assessment process for ADHD and ASD pathways working with Primary Care colleagues It is anticipated this action will increase assessment and reduce 80% of referrals coming into intervention teams by June 2024.

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

DQ 93%

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



Actions continued:

- NYYSCG are continuing to work on their PIP for CYP services to ensure it includes SMART actions that support improvement; however, EDG have agreed to stand down the development of a PIP for AMH/MHSOP services. AMH is no longer a specific area of concern and following completion of demand and capacity work in MHSOP services for memory patients, the ICB had agreed to lead an event across the system in April, however further confirmation is required following recent communication from the ICB.
- The Task & Finish Group within Corporate Services met in February 2024 and agreed a core data set to support improvement. The core measures will be shared with both Care Groups by end of March 2024, to ensure these are suitable. In addition, the Business Intelligence Team are reviewing timescales for the measures that require development and will feedback by end of March 2024. The Business Intelligence Team will also explore whether we can use a proxy measure in the interim to aid further analysis.

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 to 29th February 2024 is an operational deficit of **£2.34m** against a planned year to date deficit of **£5.07m**, or a **(£2.74m) favourable** plan variance. This includes the benefit from a £2.3m national allocation which was accounted for in Month 8 and provided to support in-year pressures including Industrial Action and the delivery of key operational priorities in the remaining months. The Trust reforecast the position at Month 7 and used this as the basis to establish 'control totals' for Care Groups and Directorates for each month to the financial year end. The control total for M11 was a projected in-month deficit of £0.25m compared to an actual surplus of (£1.14m), or a (£1.39m) favourable variance to control total in month. The cumulative favourable variance to control total at Month 11 is (£2.45m) largely owing to receipt of unplanned NHS England Education funding.

- **Agency expenditure** in February 2024 was £1.12m, or £0.39m below plan in month, and £16.08m YTD, or £1.97m below plan to date, showing an improved favourable variance trend. This includes impacts from actions to exit non-clinical agency assignments and reducing costs relating to complex care packages. Ongoing usage includes material costs linked to inpatient occupancy and rosters, medical cover and costs within Health and Justice. The trust had **no off-framework agency assignments** in month.
- **Independent sector beds** - the Trust used 344 non-Trust bed days in month (355 in January, a reduction of 11 bed days) at a cost of £0.43m (including estimates for unvalidated periods of occupancy and average observation levels pending billing). Year to date costs were £3.12m (£2.70m prior month) and **£1.97m more than the £1.11m year to date plan**. This remains a key area of clinical and management focus including through the new Urgent Care Programme Board (chaired by the Managing Director for DTVF).
- **Taxis and Secure Patient Transport** cost £2.42m to date, or **£1.5m 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, but demonstrate around a 50% reduction in taxi utilisation compared to quarter 1. The Chief Nurse is overseeing actions to ensure robust governance around Secure Transport and a recently approved procurement will reduce unit costs from mid Quarter 1 in 2024/25.
- **Planned CRES** are **£7.63m behind plan** to date. Key adverse 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. Delivery of **unplanned CRES of £7.63m** to date (including interest receivable, with an interest rate at 5.2% for the past two months) is fully mitigating adverse performance against planned schemes**. Composite CRES achievement** is therefore **in line with plan** to date but with a recurrent underlying risk to delivery.
- **Improved performance relative to control totals** set in year to support financial recovery provide increased assurance that the Trust will deliver our 2023/24 breakeven plan, based on a mid-case scenario. A small number of external factors have potential to impact the financial outturn however these are currently projected as being manageable within the overall position.

Page 59

P
Our system is hitting the target/expectation

DQ
93%

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

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

Tees, Esk and Wear Valleys NHS Foundation Trust

Underlying issues:

- We need to reduce bed occupancy including through reduced lengths of stay to reduce reliance on independent sector beds.
- We recognise that agency expenditure and safe staffing levels are significantly impacting our financial plan including due to agency premia rates above price cap.
- We need to deliver CRES schemes to achieve our financial plan and deliver recurrent programmes to address our underlying financial pressures.
- We need to continue to track delivery of our 2023/24 breakeven financial plan, including compared to the reforecast and control totals agreed in late November 2023.

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.
- Leads have revised their Performance Improvement Plans (PIP) for E Roster Effectiveness and Agency Reduction and the new actions are shown below with additional scrutiny at the new joint bi-monthly Executive Workforce and Resources Group:

  E Roster Effectiveness

  - To publish rotas in a timely manner to ensure effective planning with the expected outcome that 50% of rotas are published within the Trust target of 42 days prior to the commencement of the roster period by April 2024.
  - To improve the level loading of annual leave to within Trust guidelines (11% to 17%) of contracted staff per week with the expected outcome that 50% of teams achieving target for annual leave level loading, by Grade Type (Registered Nurse / Unregistered Nurses) and to consistently achieve this target by April 2024.

  Agency Reduction

  - To re-negotiate rates of pay with framework agencies for Registered Nurses (RNs) and all new RNs onboarded will be within cap rates with the expected outcome to be zero by beginning of March 2024. ***(Update: Inpatient position of zero was achieved; however, Community position remains at 1 worker over cap, revised target date 1st April 2024)***
  - To continue recruitment in areas with high demand with a Trust wide rolling RN advert and a HCA advert targeting specific areas with the expected outcome of increasing bank fill rates to 60%, reduction in agency fill rates to 18% and increasing the number of bank workers by 5%. It is expected the impact of these actions will be seen by the end of March 2024.
  - Increased engagement with agency workers in hard to fill areas to encourage movement from agency to bank with the expected outcome of transitioning 15% of agency workers to bank workers. It is expected that the impact of these actions will be seen by the beginning of April 2024.
  - Review the current timeframes for when shifts are outsourced to agencies and reduce these where possible (specific to NYYS as DTVF completed). Expected impact increase in bank fill rate and reduction in agency use as per above.
- The efficiency hub will be co-ordinated by a Programme Manager with recruitment of the post now completing. Terms of reference for the team / group are being established.
- The efficiency hub will provide support to enable focus on key strategic financial recovery actions including to manage and reduce over-establishments (including relating to Surge posts), ensure the efficient rostering of inpatient staffing, and linked to inpatient occupancy, flow and Out of Area Placements moving ahead to 2024/25.
- Variances to monthly control totals are monitored, with a re-assessment made of the continued deliverability of our breakeven plan, including with reference to worst and best case, as well as the mid case scenario assumed.

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 February 2024 was £1.12m, or £0.39m below plan, and £16.07m YTD, or £1.97m below plan to date. This represents **an improved favourable variance** in month, including from actions to exit non-clinical agency and off-framework assignments.

NHS planning guidance for 2023/24 introduced system agency cost caps of 3.70% pay bill. Agency expenditure represents 4.55% pay bill for the year to date which remains above system cost cap but has reduced from around 6% prior year. Planned agency costs for 2023/24 were relatively in line with 2022/23 outturn. Reducing agency shifts and premia above price cap remains a key focus, including from actions to exit non-clinical assignments (with a significant reduction from October onwards). The Trust has achieved agency reductions equivalent to 117 WTE from April 2023 to February 2024, and the related annualised premia has reduced from £4.9m in March 2023 to £3.8m in January 2024 (£1.1m reduction), demonstrating a positive impact from actions taken to date.

The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to management of sickness absence, 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.

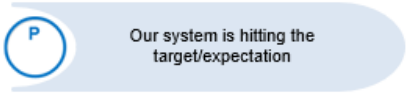
We recognise that volume pressures and rate premia associated with agency expenditure are significantly impacting our financial plan. To address this, we have developed a **Performance Improvement Plan** that defines the actions that are being taken to support improvement and increased assurance.

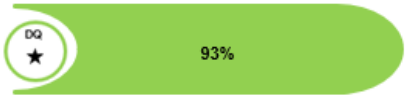
**Financial values with brackets indicate a (Surplus) or (Favourable) position, financial values without brackets indicate a deficit or adverse position.*

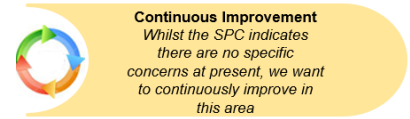
Underlying issues:
We need to continue to ensure a sustainable permanent workforce, including in key shortage professions including medical and nursing, and to use temporary staffing more optimally including through improved rostering and regularly reviewing our safer staffing levels relative to clinical need.

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

- Re-visit roster rules to ensure optimal rosters and equity for colleagues: This work is ongoing and is reviewed in the monthly safe staffing meeting. Training is being provided for teams in order to optimise their use of the roster. Care Groups are being asked to hold monthly governance meetings reviewing the roster KPIs such as timely publications of rotas.
- Develop roster training programme (running 3 x weekly January to March 2024)







25b) Agency price cap compliance

Tees, Esk and Wear Valleys NHS Foundation Trust

What does the data show/context:
2,518 agency shifts were worked in February 2024, with **1,559** shifts compliant **(62%)** and 959 non-compliant (38%) (prior month 1,728 shifts compliant or 2% and 1,052 non-compliant or 38%).

This is 261 fewer overall shifts than January and is equivalent to approximately 87 shifts per day (90 per day in January).

- Regional reporting of sickness levels suggested peer mental health providers have experienced similar challenges. The Trust's ability to reduce temporary (including agency) staffing reliance will in part link to management of 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 point that NHSE Temporary Staffing data is submitted 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:
Particular persistent challenges relate to levels of medical staffing vacancies requiring cover from premia rate locum assignments which breach price caps.

Actions:
In addition to actions from 25a) supporting improved compliance, the Trust is also progressing a second phase of International Recruitment to aim to recruit a more sustainable medical and nursing workforce and reduce reliance on agency costs. Medical assignments attract the highest value and percentage premia rates.

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

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 29th February 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 1.24x, which is 0.55x better than plan and is **rated as a 4** (0.13x better than plan in January).
- The **liquidity metric** assesses the number of days' operating expenditure held in working capital (current assets less current liabilities). The Trust's liquidity metric is 18.7 days; this is on plan and is **rated as a 1** (2.6 days behind plan in January).
- 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 -0.54%, this is better than plan by 0.68% and is **rated as 3** (0.55% better than plan in January).
- **The agency expenditure metric** assesses agency expenditure against planned costs for the Trust. Costs of £16.19m are £1.85m (10.27%) less than plan and would be **rated as a 1.** (The agency metric assesses performance against plan). NHS planning guidance suggested that providers' (and aggregate system level) agency expenditure should not exceed 3.7% pay bill. As at Month 11 agency expenditure was 4.6% pay bill.

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 29th February 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. As recovery actions to support delivery of the Trust's planned breakeven position are achieved, confidence levels relating to achievement of the planned 2023/24 UoRR have increased as compared to the mid-year financial risk assessment.

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 **£13.83m** recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and has delivered **£7.75m recurrent** CRES, a **£6.08m adverse variance** against planned recurrent schemes.

Following the submission of our financial plan, which included £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 11 with specific performance noted as:

- £1.58m under-delivery of CRES for OAPs Reduction in AMH (Performance Improvement Plan in place)
- £1.79m under-delivery of CRES for Surge post review (Pay)
- £0.50m CRES for Agency (Inpatient level loading of rosters – actions in train via sub group of safer staffing group)
- £0.29m CRES for Taxi spend reduction (Improvement Event and associated actions being progressed, but with notably reduced taxi run rates)
- £1.99m CRES for other schemes
- Recurrent CRES unachieved £6.08m to date

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 **£3.94m** of non-recurrent Cash-Releasing Efficiency Savings (CRES) for the year to date and have delivered **£10.02m, a (£6.08m) favourable variance** against planned non-recurrent schemes.

The Trust planned to deliver full year non-recurrent Cash-Releasing Efficiency Savings (CRES) of **£5.38m** for 2023/24 with key areas of focus including interest receivable and operational grip and control measures to be identified in-year.

Non-Recurrent CRES delivery for the year is ahead of plan at Month 11 relating to:

Planned Schemes:

- £0.94m Unachieved CRES Non Recurrent Grip & Control (Non Pay)
- (£0.23m) Non Recurrent Grip & Control Trust wide Recovery Actions / budget rebasing (Non Pay)

Unplanned Schemes:

- (£1.48m) Interest Receivable (interest rate has been 5.2% for the last two months)
- (£4.37m) Largely relating to Learning Disability and Medical run rate reductions

Composite year to date non-recurrent CRES **over delivery** of **(£6.01m).**

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:
Financial Planning activities will confirm the extent to which the same actions can be delivered recurrently (or non-recurrently) and any other scope to deliver new non-recurrent CRES in 2024/25 to mitigate underlying financial pressures.

Page 95

P — Our system is hitting the target/expectation

DQ — 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)

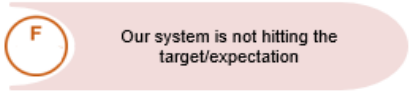
Tees, Esk and Wear Valleys NHS Foundation Trust

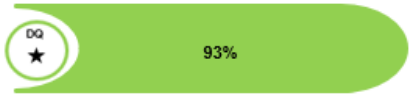
What does the data show/context:
Capital expenditure was **£8.97m** at the end of February against a year to date plan of **£13.35m** resulting in a **£4.38m** underspend.

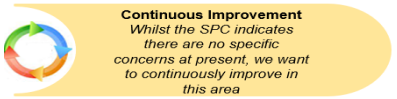
- Whilst several favourable and adverse variances contribute to the current position key areas include previously anticipated costs of 2023/24 schemes which completed in the 2022/23 financial year, slippage against start dates for lifecycle schemes and a change to plan for medical education centre development at Lanchester Road.
- 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 patient safety works Tees. Must do actions for the 2024/25 financial year have been brought forward to aim to ensure outturn spend in line with capital allocation. Material lifecycle schemes with a delayed start are supported by purchase orders and milestone plans.
- Any delays to planned inpatient environment schemes are communicated to the Environmental Risk Group to manage any associated risks. There is a delay in the start to Phase 3 sensor door works due to inability to secure escorts for contractors. Actions are being fast tracked to secure appropriate staffing.

Underlying issues:
There are no underlying issues to report.

Actions:
Work is continuing to review progress against milestone plans for lifecycle works and to progress schemes that are being brought forward to utilise under spending, including from Phase 1 Teesside works. A key focus is on the recruitment of escorts to enable sensor door installation.







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 **£63.68** against a planned year to date cash balance of **£61.28m** which is **£2.40m positive variance** to plan.

- This is mainly due to the current positive I&E variance against plan and underspend against the capital programme. This is partially offset by movements on working balances, including as the Trust has increased the speed of supplier payments.
- The Trust has narrowly failed to achieve the 95.0% Better Payment Practice Code (BPPC) target compliance for the prompt payment suppliers, achieving a combined year to date BPPC of 94.4%. We continue to support the use of Cardea to make processes as efficient as possible, and ensure suppliers are paid promptly.
- The value of debt outstanding at 29th February 2024 was £2.51m, with debts exceeding 90 days amounting to £0.69m (excluding amounts being paid via instalments and PIPS loan repayments). Two whole of government accounting (WGA) organisations account for 50% of total debts greater than 90 days old (£0.35m), progress continues to be made to receive payment for older debts. No outstanding debts have been formally challenged

Underlying issues:
In additional to information at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit, the Trust needs to expend significantly more via its annual capital programme budget than is generated internally from depreciation, meaning the Trust's annual cash reserves are gradually reducing.

Actions:
In addition to actions at measure 24) Financial Plan: SOCI - Final Accounts – (Surplus)/Deficit, the Trust has recently secured national capital funding for Frontline Digitisation (£1.67m), LED lighting (£0.79m), Future connectivity (£0.16m),MH Liaison Accommodation York (£0.07m) and Cyber (£0.06m). These schemes would otherwise have further depleted Trust cash balances.

F — Our system is not hitting the target/expectation

DQ ★ — 93%

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

Page 45 of 51

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)									√		√	√			√

NOTE: To be updated in next month's report to reflect change to BAF risks

National Quality Standards and Mental Health Priorities Headlines

Headlines

- **Talking Therapies waiting times (6 and 18 weeks)** consistently achieving target
- **Talking Therapies Access –** failing target in all areas except for Tees Valley, however, please note achievement in County Durham for latest quarter to date
- **Talking Therapies Recovery -** achieving target
- **Talking Therapies 1st to 2nd treatment waits** - failing target in all areas however, target achieved in North Yorkshire in Q3 and latest quarter to date.
- **OAP bed days (inappropriate)** consistently failing target **This is also the MH Priority monitored at Trust level – see IPD measure 9 for further details*

Page 70

Risks / Issues

Of most concern:

- *Child Eating Disorders Waiting Times (except Tees Valley routine cases and North Yorkshire urgent cases)
- Talking Therapies Access (except Tees Valley)
- Talking Therapies 1st to 2nd treatment (except North Yorkshire)
- *Childrens Paired Outcomes
- OAP bed days (inappropriate)
- *Specialist Community PMH services (except Tees Valley)

Of concern:

- *EIP Waiting Times Vale of York only
- *Adults/Older Persons 2 contacts Vale of York only

Positive Assurance

- *72 hour follow up
- Talking Therapies waiting times (6 and 18 weeks)
- Talking Therapies Recovery
- *CYP 1 contact

NOTE We have rolled forward the Risks/Issues, Positive Assurance and Mitigations for the patient-based measures* from last month (see Key Points to Note).

Mitigations

Child Eating Disorders waiting times
Durham Tees Valley & Forensic Care Group (DTVFCG) have a Performance Improvement Plan (PIP) and the actions are to consider appropriate use of therapy codes for young people presenting with ARFID; exploring dietetic consultation to the treatment team and to ensure assessing practitioner is treatment lead ***(all actions completed)***. It is anticipated these actions should eliminate any further breaches by the end of March 2024. Executive Directors Group have agreed to stand down the development of a North Yorkshire, York & Selby Care Group (NYSCG) PIP for this measure, as the underlying issues were Did Not Attend and Patient Choice. Non-attendance is managed through engagement with patients/families in line with the DNA policy.

Talking Therapies Access
DTVFCG have a PIP and the actions are to promote suitability criteria/referral routes ***(completed)***; Therapy Support Workers contacting patients prior to their assessment; formulation of SPA dashboard to track capacity and demand to maximise capacity. It is anticipated these actions will improve the number of referrals and reduce DNAs from 20% to 12% by the end of May 2024. NYYSCG have developed a PIP and the actions are for admin to contact all patients to remind them of their appointment. It is anticipated this action will reduce DNAs to 16% by end of April 2024. They are also going to combine both services' attendance polices into one including reasonable adjustments to improve patient choice. Is it anticipated this action will further reduce DNAs to 15% by the end of May 2024.

Talking Therapies 1st to 2nd treatment waits
DTVFCG have a PIP and the actions are to implement a gatekeeping process for low intensity step ups; review demand and align capacity to ensure availability of slots; develop a standardised VCB for the Leadership Teams so resources and demand can be aligned; amend the report out process and attendance to include monitoring the outcome of assessments and use of CCBT importance and workshops will be prioritised. It is anticipated these actions will improve waiting times by 5-10% by May 2024.

Childrens Paired Outcomes
A business case was developed for a dedicated outcomes team however, a more comprehensive options appraisals, risk and quality impact assessment is required prior this going to Care Group Boards in April.

OAP bed days (inappropriate) - *Please see Board Integrated Performance Dashboard Headlines for mitigations*

Specialist Perinatal Mental Health
NYYSCG have developed a PIP and the actions are to recruit to the vacant posts and to develop standardised triage criteria to ensure all appropriate woman are accepted onto caseload. It is anticipated the impact of these actions will increase the number of women being assessed with a high proportion then being accepted onto caseload starting from April through to August 2024 (expected end of recruitment).

EIP waiting times
North Yorkshire, York & Selby Care Group have recruited to 3 posts, one of which is a preceptorship role, and have one remaining post to recruit to. The service is continuing to recruit temporary staff in the interim to support improvement in waiting times.

Adult/Older Persons 2 contacts
North Yorkshire, York & Selby Care Group have identified that one of the main underlying issues in the reduction of contacts is the York and Selby EIP team, as outlined above, recruitment is under way to improve staff capacity.

National Quality Standards and Mental Health Priorities Dashboard

Tees, Esk and Wear Valleys NHS Foundation Trust

National Quality Requirements

Measure	Agreed S-ICBL Ambition	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 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%	99.57%	99.38%	99.59%	99.46%	100.00%	99.65%	99.55%	99.68%	99.54%	99.70%	99.52%	100.00%	99.67%	99.20%	99.81%	99.62%	99.92%	99.62%
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%	99.96%	99.96%	99.97%	100.00%	100.00%	99.83%	100.00%	99.95%	100.00%	100.00%	100.00%	100.00%	100.00%	99.93%	100.00%	99.95%	99.92%	99.95%

Local Quality Requirements

Measure	Agreed S-ICBL Ambition	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 service and signposting or start a course of NICE psychological therapy	*	2662	2899	2780	2275	10616	557	603	575	442	2177	1723	1672	1879	1326	6600	1495	1607	1838	1185	6125
IAPT: The proportion of people who are moving to recovery	50.00%	51.69%	51.01%	48.57%	51.42%	50.56%	54.39%	56.75%	48.42%	50.75%	52.72%	51.55%	53.67%	53.71%	52.01%	52.82%	54.26%	58.34%	56.95%	59.28%	57.13%
IAPT:Percentage of people who have waited more than 90 days between first and second appointments	<10%	13.92%	12.91%	13.05%	15.91%	13.80%	19.76%	18.56%	23.47%	27.18%	22.08%	17.57%	12.63%	6.13%	3.97%	10.34%	31.15%	26.61%	25.66%	29.38%	28.06%
Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider (rolling 3 months)	*	1445	436	608	722	722	1445	436	608	722	722	163	58	63	117	117	163	58	63	117	117

Page 170

NOTES ** Denotes individual plans agreed by area; Q4 is January & February (part)*

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

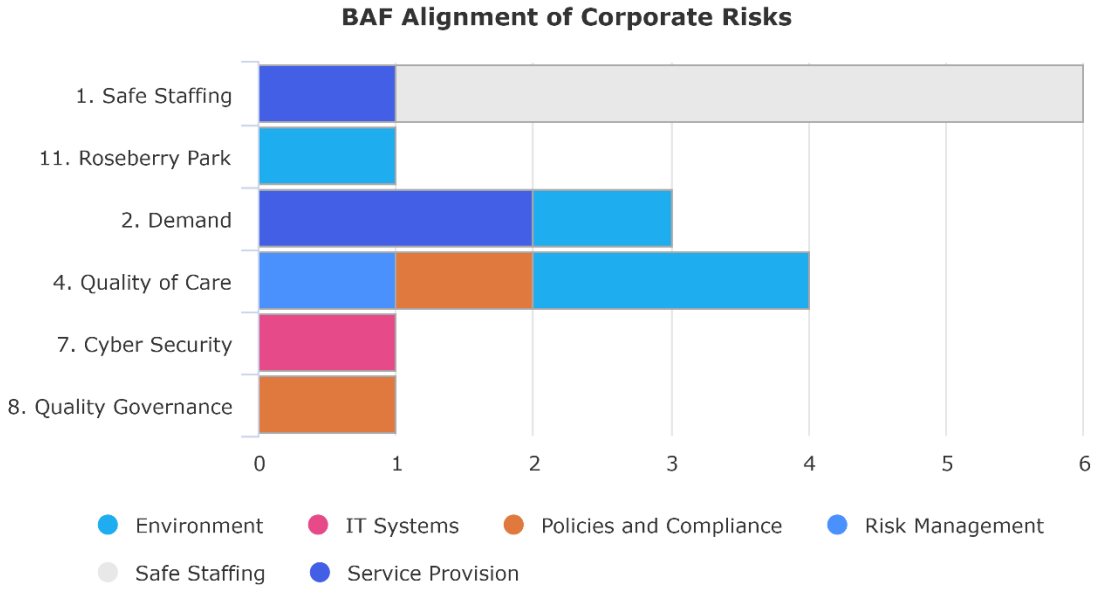
Meeting of:	**Board of Directors**
Date:	**11 April 2024**
Title:	**Corporate Risk Register**
Executive Sponsor(s):	**Beverley Murphy, Chief Nurse**
Author(s):	**Kendra Marley, Head of Risk Management**

Report for:				
	Assurance	✓	Decision	
	Consultation		Information	

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

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

Strategic Risks relating to this report:



Note: provisional realignment of corporate risks to BAF risks has been undertaken but has yet to be fully reviewed and agreed.

Executive Summary:

Purpose: To provide assurance to the Board over the management of risk and ensure oversight of organisational wide risks that are rated as high risk in the Corporate Risk Register.

Overview:

This paper presents to the Board the risks that are rated ≥15 on the Corporate Risk Register as of 3rd April 2024, reflecting any movement and changes since last report in January 2024.

There are currently 16 risks on the Corporate Risk Register. While there is no change in number of risks, there has been movement as outlined below.

5 risks have been removed from the Corporate Risk Register following being reduced below the ≥15 threshold and agreed by the executive Risk Group. These are;

Risks previously aligned to aligned to Strategy and Resource Committee.

- Risk 925 - DTVF ALD - Risk of service failure due to multiple issues at BFC Unit 2 and Aysgarth, including that we are unable to comply with Mixed Sex Accommodation (MSA) guidance and CQC compliance requirements. (Reduced from 15 to 8)
- Risk 1218 – DTVF CAMHS - 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 due to shortage of CAMHS Tier 4 beds. (Reduced from 16 to 9)
- Risk 1417 – Finance – Financial Management - 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. (Reduced from 16 to 12)

Risks previously aligned to People, Culture and Diversity Committee.

- Risk 1039 – NYYS Management - 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 to current staff capacity available to support the volume of calls. (Reduced from 16 to 12)
- Risk 1232 - DTVF CAMHS - Unacceptable waits for mental health assessment and treatment. (Reduced from 15 to 12)

5 new risks have also been added to the Corporate Risk Register following review by the Executive Risk Group, and have been provisionally allocated to the following Committees, including;

Risks aligned to People, Culture and Diversity Committee.

- Risk 998 - DTV&F H&J - Run services with less than minimum staffing levels at HMP Northumberland (This is an increased risk, which was 12 and was raised to 15).
- Risk 1311 - NYYS CAMHS – CAMHS CRISIS Recovery plan for workforce (16)
- Risk 1361 - NYYS AMH – unable to give assurance that all calls to the crisis team will be answered in a timely manner or that urgent assessments can be taken within 4 hours (16).

- Risk 1464 - PCD Health & Wellbeing - Occupational Health Provision (16)

Risks provisionally aligned to Quality Assurance Committee.

- Risk 1495 - N&G – Patient Safety - Risk of increased public interest and FOIs (15)

Current risk review compliance for corporate risks is currently at 88%, an improvement since January.

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 are asked to take good assurance over the risk management processes in place, the consideration of risks for addition to the Corporate Risk Register and the ongoing management of these risks.

Further Information

1. Introduction and Purpose

To provide assurance to the Board over the management of risk and ensure oversight of organisational wide risks that are rated as high risk in the Corporate Risk Register

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. Corporate risks are aligned to strategic risks reflected on the Board Assurance Framework.

The Corporate Risk Register is reviewed and approved by the Executive Risk Group bi-monthly. The group review any new ≥15 risk or any risk deteriorating into this ≥15 level and consider for addition, as well as reviewing risks reduced (improving), seeking assurance to support this before agreeing local management and removal from the Corporate Risk Register.

4. Current Reporting Period

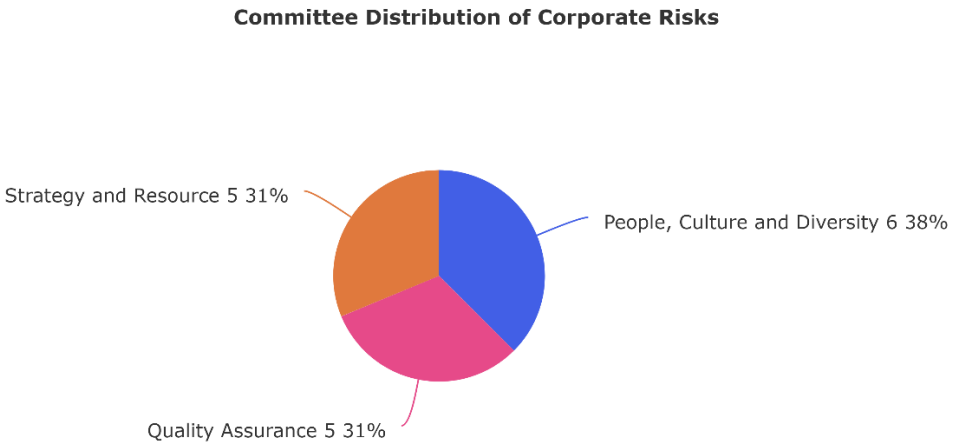
This paper presents to the Board the ≥15 risks on the Corporate Risk Register as of 3rd April 2024, reflecting any movement and changes since January 2024.

5. Corporate Risk Register

There are currently 16 risks on the Corporate Risk Register. While there is no change in number of risks, there have been 5 removals and 5 additions.

5.1 Committee & Care Group Alignment

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



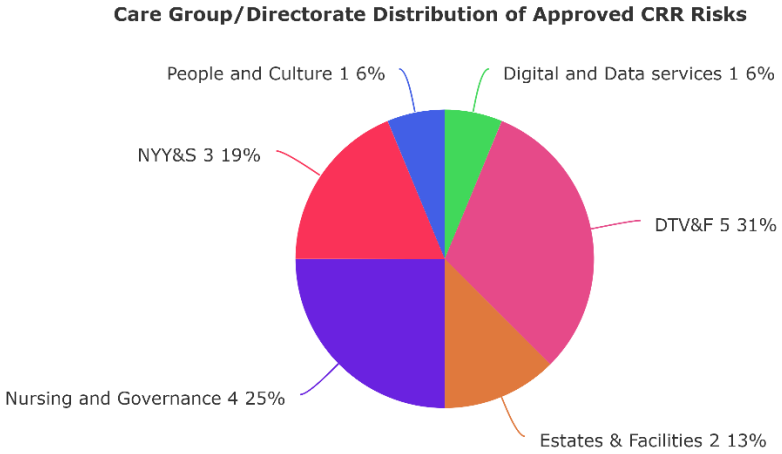
This shows that there are;

- 5 risks aligning to the Quality Assurance Committee
- 5 risks aligning to the Strategy and Resource Committee

- 6 risks aligning to the People, Culture and Diversity Committee

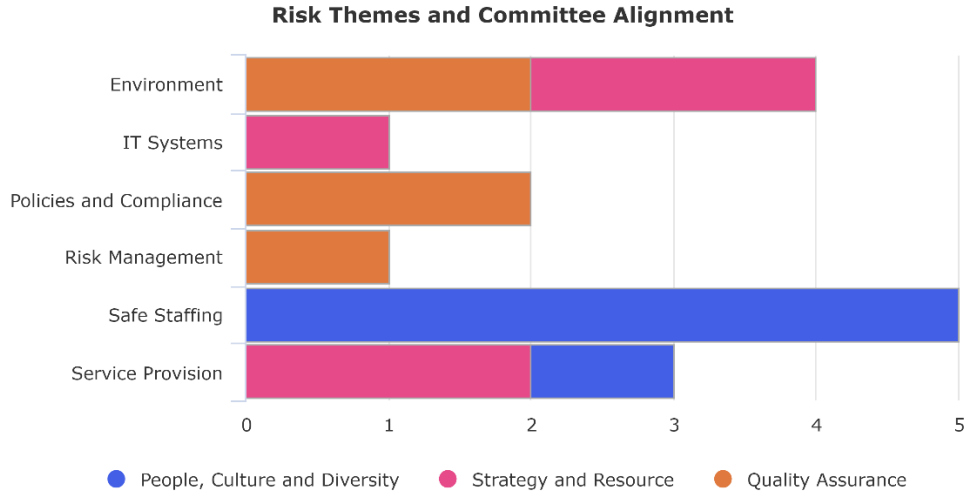
There are currently no risks aligning to the Mental Health Legislation Committee or the Commissioning Committee.

Focussing on the Care Group and Directorate breakdown of the Corporate Risk Register shows us that 31% of the current Corporate Risk Register is made up of risks from Durham Tees Valley and Forensics Care Group, with 25% Nursing and Governance, 19% North Yorkshire, York and Selby, 13% Estates and Facilities, with Digital and Data and People and Culture at 6%.



5.2 Risk Themes

The 16 risks fall under the following themes within the Committee Alignment, with higher numbers of risks relating to Safe Staffing.



5.3 Risk Movements

The overall position of risks on the Corporate Risk Register is shown on the following Matricies.

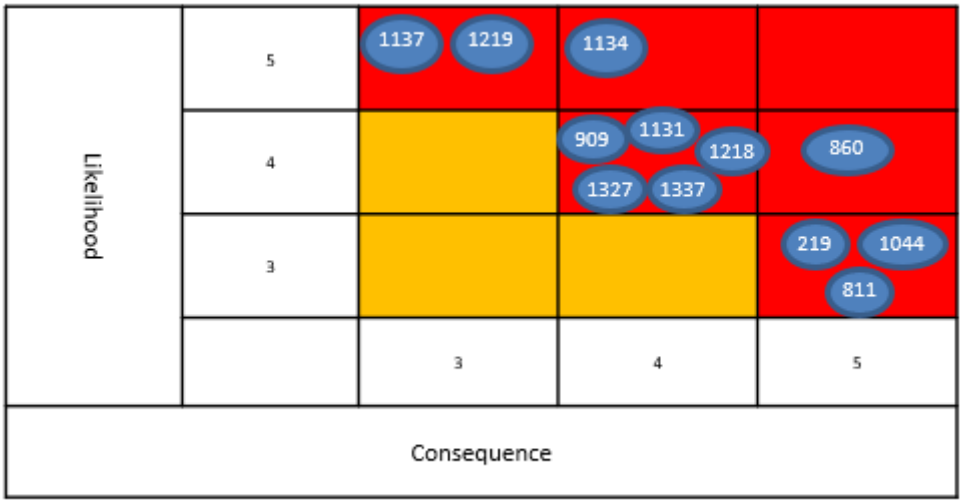
There has been some successful mitigation of risks and removal from the Corporate Risk Register, combined with ongoing identification and inclusion of new risks. While this is positive we do have some static risks that may take time to mitigate.

Timelines for mitigation to the target levels are being sought from leads and where received are shown on the attached risk register. While some have clear timelines, others are harder to determine and further discussion and review with leads will be undertaken. As a result of this dates should be considered indicative and may change as further discussion takes place.

Risks with no movement in the period

The 11 risks shown on the following matrix have had no movement in the period of reporting, however review of position across the year shows there has been no movement in 12 months.

Corporate risks remaining static in period



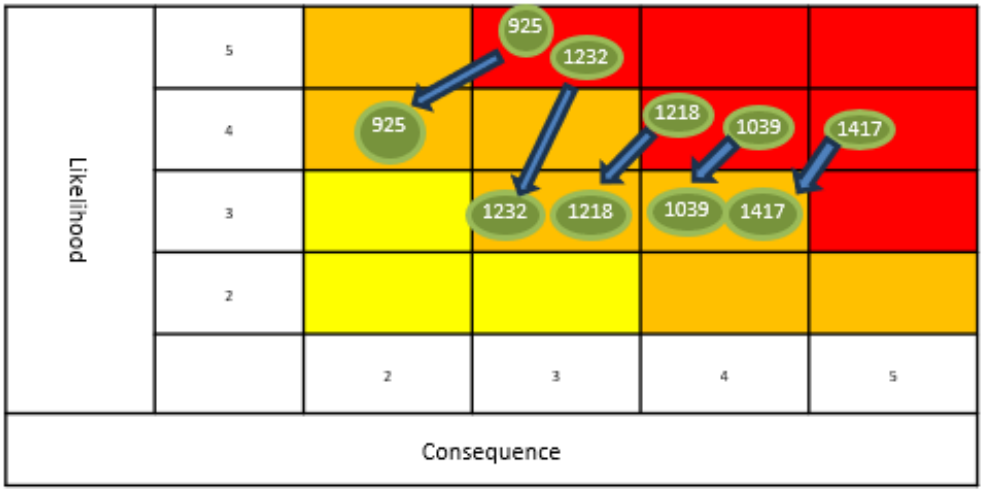
Risks are shown based on current risk rating

Further review of these risks is to be undertaken with leads to determine timelines for mitigation to target risk levels.

Risks reduced and removed

The 5 risks reduced and removed are shown on the matrix below;

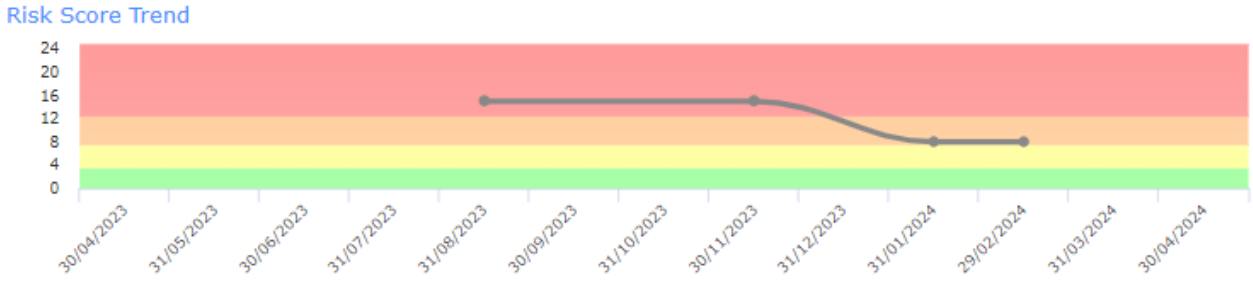
Corporate risk movement



5 risks have been reduced below the ≥15 threshold and removed from the Corporate Risk register. These risks are outlined below with an explanation for the change, and assurances agreed by the Executive Risk Group during their review.

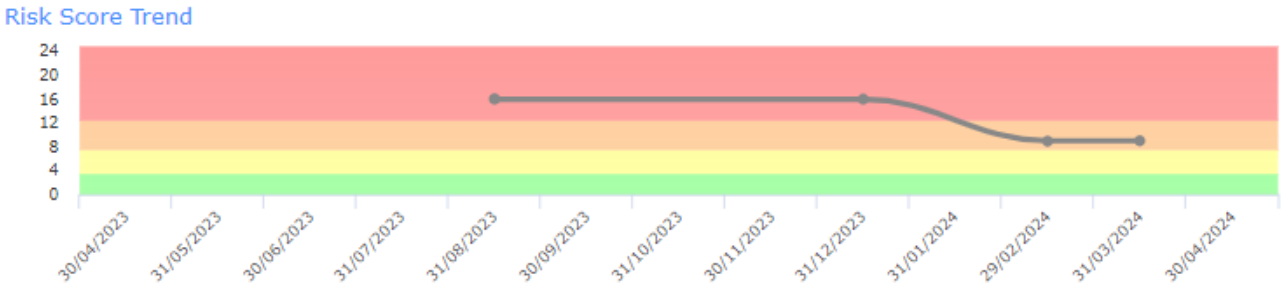
Risks aligned to the Strategy and Resource Committee.

- Risk 925 DTVF ALD - Risk of service failure due to multiple issues at BFC Unit 2 and Aysgarth, including that we are unable to comply with Mixed Sex Accommodation (MSA) guidance and CQC compliance requirements. (Reduced from 15 to 8)



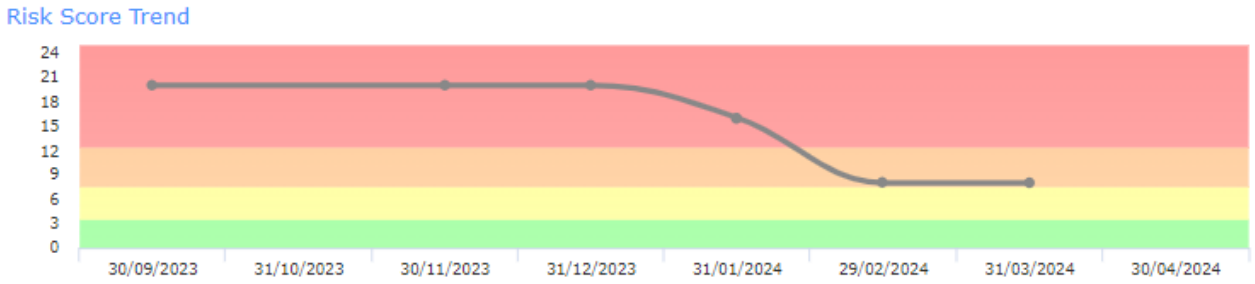
  Rationale for change - The part of the risk which relates to MSA is now managed by having split weeks for service users. There remains a risk relating to the poor condition of the properties and also to maintaining the service across two sites - this is being managed by the BCP process now in place.

- Risk 1218 - DTVF CAMHS - There is a significant shortage of CAMHS tier 4 beds nationally. This is placing significant pressure on the CNTW bed management system - nearest inpatient unit is Ferndene. The pressure is across all bed types but is particularly acute with regards to young people with eating disorders in County Durham. This is resulting in increased risk of prolonged admission/stay to/in inappropriate settings with insufficient care arrangements including: adult mental health beds, 136 suites, crisis assessment suites, paediatric inpatient beds and police custody. (reduced from 16 in January to 9 in February)



  Rationale for change - We have had a sustained period of over 24 months whereby the numbers of incidents of YP people being placed in unsuitable environments as a consequence of limited CAMHS tier 4 bed availability has been very low (2 incidents). It is debatable as to whether availability was the primary cause in these, as clinical decision making and adherence to operational processes have been factors in these incidents.
  We have further cause for optimism in that we are set to contribute to work within the provider collaborative that is looking to expand the scope of Lotus ward to be able to offer beds to young people with eating disorder needs.

- Risk 1417– Finance – Financial Management - 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. (Reduced from 16 to 12)

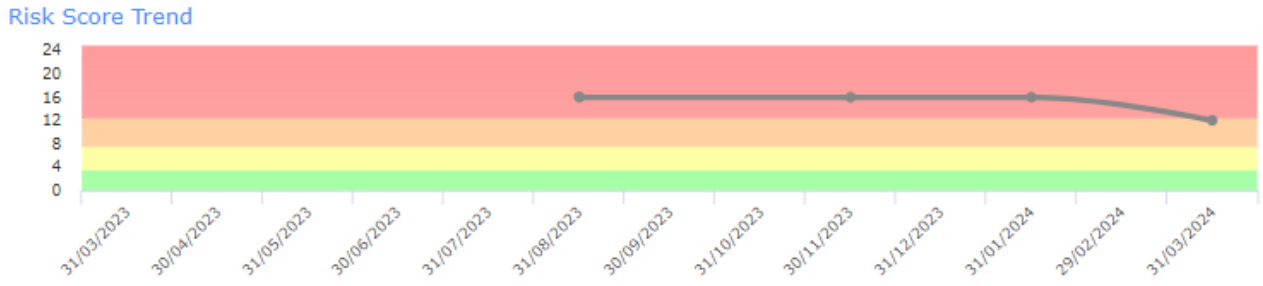


Rationale for change - The risk of not achieving financial plan in the 2023/24 financial year has been downgraded in likelihood due to the current revenue run rate position and detailed forecast actions that support the trust delivering its plan. Underlying problems remain, as the Trust has need to support under delivery of recurrent CRES requirements with non-recurrent mitigating items (£11.6m). Work is ongoing to understand the 2024/25 plan requirements, and it is expected that the risk of non-delivery will be high until recurrent CRES schemes are identified to bridge the shortfall on delivery, or mitigating items are identified from non-recurrent expenditure reductions next financial year.

Note – while this risk has reduced and been removed, a replacement risk for the 2024/2025 financial year will be assessed and as this is likely to be ≥15 will be reviewed for addition to the Corporate Risk Register.

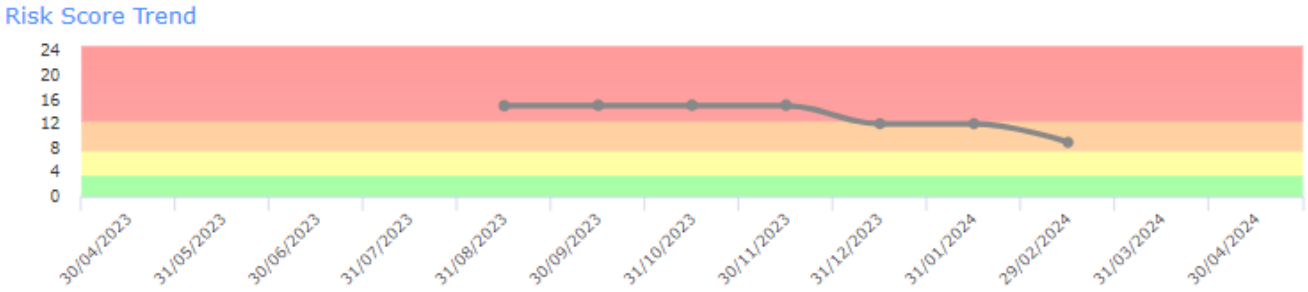
Risks aligned to People, Culture and Diversity Committee.

- Risk 1039 (legacy ID 1131) NYY management - 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 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.



Rationale for change - While there are high vacancy rates amongst all crisis teams, the Scarborough team manager has returned to post. The BT line is now in place allowing greater oversight of the calls, wait times and gaps in service.

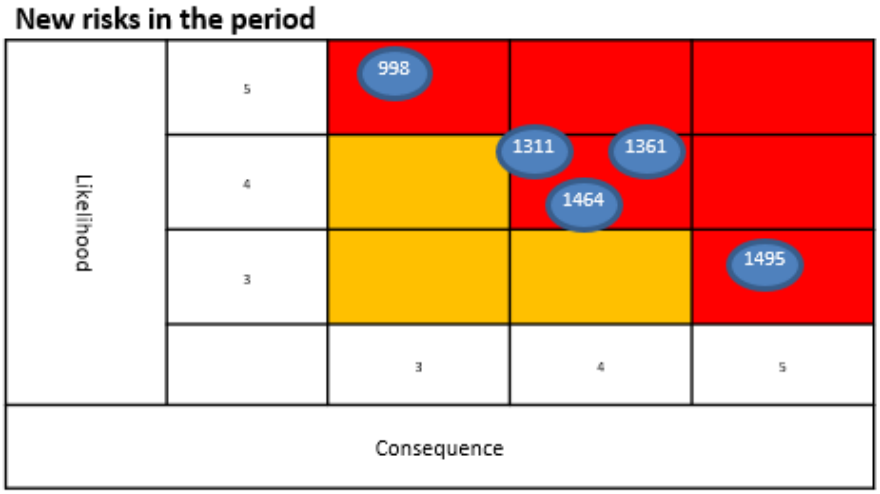
- Risk 1232 - DTVF CAMHS - There is a risk that some children and families in North and South Durham will be subjected to unacceptable waits for mental health assessment and treatment, caused by significant staffing pressures in those teams (particular issues with medic, nursing and psychology workforce) in addition to lack of alternatives in community provision, resulting in patient deterioration/risk, patient dissatisfaction, complaints and reputational damage and potential CQC breaches. Also risk of burn out for staff. (Reduced from 15 to 12)



Rationale for change – North Durham have successfully exited BCP arrangements.

Risks added to Corporate Risk Register

5 new risks have also been added to the Corporate Risk Register following review by the Executive Risk Group and are shown on the matrix below.

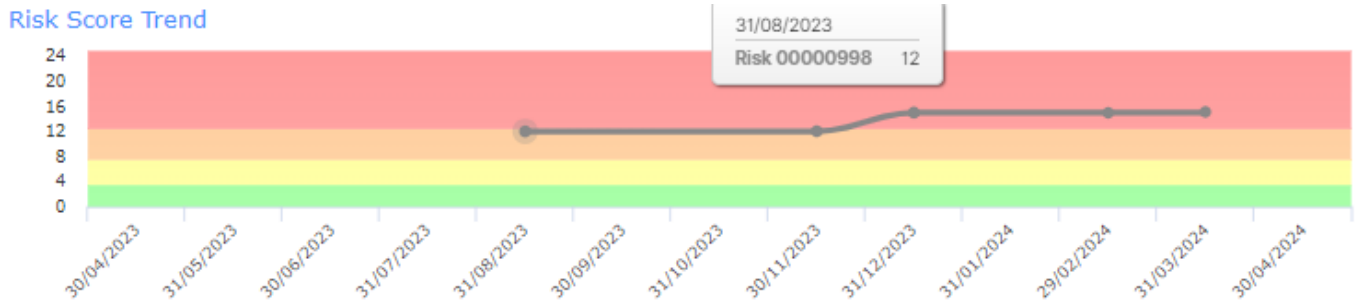


These have been provisionally aligned to the following Committees;

Risks aligned to People, Culture and Diversity Committee.

Increased risk

- Risk 998 - DTV&F H&J - There is a risk that we may have to run services with less than minimum staffing levels at HMP Northumberland. This is due to reduced staff availability as a result of being unable to recruit to clinical lead vacancies. This results in an increased potential for patient and staff safety issues, reduced quality, poor experience, and impact on staff wellbeing. (This is an increased risk, which was 12 and was raised to 15).



Rationale for increase – HMP Northumberland have needed to instigate their formal Business Continuity Plans.

New risks

- Risk 1311 - NYYS CAMHS – There is a risk that the NY & Y Crisis team are not always able to cover the rota with enough staff 24/7 (especially at night) to ensure good cover across the whole NYYS geography due to low staffing (as a result of vacancies), especially for night shifts there may only be one qualified and 1 HCA on duty across the whole county. This may result in service users waiting longer to be seen and if presenting at A&E can result in a breach of the 4 hour response time. Due to long waits there is a risk that some young people and families do not wait to be seen. There is also an impact on staff as the pressure in the team is impacting on workload staff morale due to the pressure to cover shifts and staff working overtime to cover these in the absence of vacancies being filled. (16)

- Risk 1361 - NYYS AMH – There is a risk of delayed access to telephone crisis triage, very urgent assessments (crisis 4hour response) and limited support through home based treatment across the NYYS AMH crisis response home based treatment teams due to the inability to recruit into vacant posts or secure temp staffing for the teams, resulting in the inability to mitigate against risk presentations and support alternative to admissions that supports treatment and promote patient safety and family/carer wellbeing. (16).

- Risk 1464 - PCD Health & Wellbeing - There is a risk that OH / physiotherapy services would be suspended due to current contract disputes, resulting in wider impact on staff, their availability and capability to work, their overall health & wellbeing, timely clearance for new staff to commence work, and impact on small number of staff applying for ill health retirement. (16)

Risks aligned to Quality Assurance Committee.

New risk

- Risk 1495 - N&G – There is a risk of increased public interest, and FOIs, as a result of a new public facing dashboard potentially resulting in adverse publicity and increased FOI's. (15)

5.4 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 88% (previously 75%).

The breakdown by directorate is shown below.

6. Conclusions

Governance meetings are being undertaken in line with policy and risks reviewed and there has been some successful mitigation of risks and removal from the Corporate Risk Register, combined with ongoing identification and inclusion of new risks. While this is positive, we do have some static risks that may take time to mitigate. Timelines are being discussed and reflected on the risk register.

7. Recommendations

The Board are asked to take good assurance over the risk management processes in place, the consideration of risks for addition or removal to/from the Corporate Risk Register and the ongoing management of these risks.

This page is intentionally left blank

Risk ID(s)	BAF Risk Alignment	Theme	Dates	Location	Ownership	Description	Rating (Initial)	Legacy Controls	Legacy Assurances	Controls (New ones added)	Gaps in controls or assurance	Rating (Current)	Action Summary	Actions Closed	Actions open	Rating (Target)	Date Added to CRR	Estimated date to reach target rating	Committee Alignment	Secondary Committee Alignment (Impact)
219 (295)	11. Roseberry Park	Environment	Opened 08/09/2016 - Last reviewed 02/04/2024 - Next due review 02/05/2024 - In Date	Estates & Facilities - EFM - Estates -	Risk Owner - Liz Romaniak - Risk Manager - Simon Adamson	There is a Health & Safety risk to staff, service users and members of the public due to defects in the design and construction of Roseberry Park Hospital.	15	MIST system now installed into roof voids of all in patient areas to safeguard and reduce fire load and spread of flame until rectification works complete. Block 16 (decant) construction now complete. Phase 1 practical completion achieved, commissioning underway (blocks 5 & 10). Week. Phase 2 programming and procurement options are in train.	Weekly huddles take place to oversee progress of rectification works. RPH sub-group of the board convened as needed to oversee progress with regular CEO briefings to the board.		Agreed programme of works which resolve all the defects in the design and construction of Roseberry Park Hospital. Unknown quantum and type of defects in individual occupied blocks.	15	7 completed 2 in progress 9 in total	R295 - Agreement of recourse to legal processes should commitment to works and commercial settlement R295 - Determine most appropriate route to defect rectification (complete phase 1 and identify phase R295 - Establish facilities management special purpose vehicle R295 - Full condition survey of Roseberry Park R295 - Gain commitment to the programme of work to address fire stopping issues across the whole sitR295 - Gain commitment to the programme of works, where possible to be co-ordinated with fire stoppiR295 - Review of Capitec (independent consultants) report	R295 - Achieve contract resolution to the satisfaction of the Trust Phase 2 rectification works	10	31 Aug 2022	31 Mar 2030	Strategy and Resource	
811 (903)	4. Quality of Care	Environment	Opened 01/06/2020 - Last reviewed 02/04/2024 - Next due review 02/05/2024 - In Date	Estates & Facilities - EFM - Estates -	Risk Owner - Simon Adamson - Risk 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	1.Harm minimisation training show high levels of compliance. 2.Suicide prevention survey and risk assessment procedure log demonstrates that the majority of individual teams have been reviewing their surveys and they include risk mitigation. 3.Responded and compliance with NPSA ligature alert released in March 2020 and the ESA low lying ligature alert released in 2019. 4.Remedial action taken within 24hr by PFI providers following near miss incidents being identified. 5.Ligature Programme of works is reviewed at the Environmental Risk Group. 6.Phase one of the		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	15	7 completed 1 not started 1 in progress 1 parked 10 in total	R903 - A standard specification for each speciality to be developed in regards to anti-ligature equiR903 - Agree phase 2 of the ligature reduction programme (this will focus on bedroom doors)R903 - Complete phase 1 of the ligature reduction programme of estates works to remove exsiting liga R903 - Estates to undertake a review of ward/department environmental risk logs to determine if rece R903 - Put in place a system of procurement to ensure clinical services order goods from a pre-appro R903 - Roll out of the Body Camera pilot to additional inpatient wards R903 - Undertake a clinical audit to gain assurance from	R903 - Implement phase 2 of the ligature reduction programme R903 - Phase 3 delivery	10	31 Aug 2022	TBD	Quality Assurance	
860 (952)	7. Cyber Security	IT Systems	Opened 10/06/2020 - Last reviewed 31/01/2024 - Next due review 04/02/2024 - Overdue	Digital and Data services - DADS - It & systems - Technology Services	Risk Owner - Mike Brierley - Risk 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.	There is a Cyber Security Group setup to monitor Cyber security and risks. Alerts are provided by CAN to TEWV along with monthly reports from NHSD. A quarterly Cyber Board Assurance Framework update is submitted to report on current progress.		-The Trust has adopted a cyber strategy but has limited 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	20	2 completed 2 in progress 4 in total	R952 - Confirm funding and advise on impact of less funding R952 - Develop and implement cyber strategy	R952 - Hire staff R952 - Purchase Cyber Software	12	22 Nov 2022	TBD	Strategy and Resource	

Risk ID(s)	BAF Risk Alignment	Theme	Dates	Location	Ownership	Description	Rating (Initial)	Legacy Controls	Legacy Assurances	Controls (New ones added)	Gaps in controls or assurance	Rating (Current)	Action Summary	Actions Closed	Actions open	Rating (Target)	Date Added to CRR	Estimated date to reach target rating	Committee Alignment	Secondary Committee Alignment (Impact)
909 (1001)	1. Safe Staffing	Safe Staffing	Opened 20/10/2020 - Last reviewed 11/03/2024 - Next due review 22/04/2024 - In Date	NYY&S - NYY&S Management - North Yorkshire and York Management	Risk Owner - Tolulope Olusoga - Risk 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	Expressions of interest in posts through promotion of TEWV and engagement with trainees through teaching. Reduction of costs for agency through monthly budget reports Monitoring staff wellbeing through sickness levels of medical staff. We have recruited 2 new substantive consultants in the last 12months. Monitor long-term sickness absence Exit interviews to understand why people leave.		There are 14 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 2 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	16	4 completed 3 in progress 7 in total	R1001 - Approval for the use of recruitment premium R1001 - proposal to get approval for 8 additional funded Higher Trainee posts (SpRs) in NYY to incre R1001 - Recruiting CESR/SAS doctors from overseas R1001 - Sessional job plans to support working across the locality (utilising technology where possi	R1001 - Develop non-medic colleague skills to ensure consistent service delivery R1001 - Explore and encourage group job planning to increase flexibility of the workforce supporting R1001 - Putting in place a middle grade oncall rota to support medical staff retention	9	31 Aug 2022	TBD	People, Culture and Diversity	Quality Assurance
998 (1090)	1. Safe Staffing	Safe Staffing	Opened 26/04/2021 - Last reviewed 27/03/2024 - Next due review 12/04/2024 - In Date	DTV&F - DTV&F - H&J - H&J Hmp Northumberland Prison	Risk Owner - Lisa Taylor - Risk Manager - Kayleigh Parris	There is a risk that we may have to run services with less than minimum staffing levels at HMP Northumberland. This is due to reduced staff availability as a result of being unable to recruit to clinical lead vacancies. This results in an increased potential for patient and staff safety issues, reduced quality, poor experience, and impact on staff wellbeing.	20	-RAG review of caseloads to ensure patients are managed on clinical risk presentations - Using social media to adverts to target candidates. - Advertisement review -Support from wider regional prison teams (where available) -Use of agency staff - Review of processes from referral to caseload - Use of regular phone support for patients - Request to CNTW for secondment - unsuccessful - An temporary R&R incentive payment has been put in place for all staff recruited within a specific three month window. - finished 2023 - Additional leadership support from 9/5/23 - admin support to be provided for 1 week to establish processes.	Waiting times monitored through Service IDG and Quality and Safety meeting.	Business Continuity Leadership Support Recruitment Fayre Recruitment Incentive Support for Workload	The service continue to work with recruitment to attract applicants to posts and continue to use agency staff.	15	10 completed 4 in progress 14 in total	R1090 - B5-6 development roles R1090 - Development of team action plan R1090 - OD support to the team R1090 - Recruitment of B7 ANP and B8a Psychologist R1090 - Request to CNTW for secondment opportunity R1090 - Review of RRP paper for ongoing recruitment issues R1090 - RRP paper R1090 - Successfully engage agency staff R1090 - SUpport from wider prison teams R1090 - Team Process review	R1090 - Recruit x 5.4 wte B6 Nurses R1090 - To recruit into 2 psychology posts. Northumberland to be included in the Health and Justice Recruitment and Retention paper Liaison with University	9	26 Mar 2024	TBD	People, Culture and Diversity	Strategy and Resource
1044 (1136)	4. Quality of Care	Policies and Compliance	Opened 08/08/2022 - Last reviewed 02/04/2024 - Next due review 02/05/2024 - In Date	Nursing and Governance - N&G - Quality governance - Patient Safety Management	Risk Owner - Rachel Weddle - Risk Manager -	There is a risk that incidents that may be more serious than initially reported are not identified within appropriate timescales due to the lack of a timely initial review resulting in failure to quickly identify learning, and mitigate patient safety and quality risks, affecting regulator confidence in services and trust reputation.	20		INC - Patient Safety Huddle Daily - reviews moderate and above incidents Staff understand the initial review process and timelines	Local processes of monitoring, review and governance not fully established. System glitch to address re visibility of listings.	15	14 completed 2 in progress 1 cancelled 17 in total	R1136 - Auditing of those incidents being approved outside of the CAT teamR1136 - Communicate trustwide of the inclusion of datix incidents recording and reporting within theR1136 - Datix Incident training (recording and Reporting) to be delivered trust wideR1136 - External support being brought in to reduce the backlogR1136 - Monitoring of the IIC incident Dashboard R1136 - Notification of Incidents R1136 - Recruitment of a B5 Datix Reviewer (permanent)R1136 - Recruitment of temporary staffing to assist in the backlog of incidents R1136 - Review team structure and recruit as required	INC - Transition to PSIRF INC - Local incident review processes	10	22 Nov 2022	30 Sep 2024	Quality Assurance

Risk ID(s)	BAF Risk Alignment	Theme	Dates	Location	Ownership	Description	Rating (Initial)	Legacy Controls	Legacy Assurances	Controls (New ones added)	Gaps in controls or assurance	Rating (Current)	Action Summary	Actions Closed	Actions open	Rating (Target)	Date Added to CRR	Estimated date to reach target rating	Committee Alignment	Secondary Committee Alignment (Impact)
1131 (1223)	4. Quality of Care	Environment	Opened 16/02/2022 - Last reviewed 02/04/2024 - Next due review 02/05/2024 - In Date	Nursing and Governance - N&G - Nursing and quality - Infection Prevention Control and Physical Health Care	Risk Owner - Carole Rutter - Risk 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 number of SI's that have a root cause or contributory finding in relation to medical devices. The number of incidents citing medical devices Monitoring of works to be undertaken around medical devices via the medical devices group		The current MD systems do not allow the Trust to fully satisfy its obligations and requirements under CQC Premises and Equipment regulations 2014: Regulation 15, MHRA Managing Medical Devices (2021) or NHS Digital Data Security & Protection (DSP) Toolkit (2022-23). The Excel system (asset log) does not allow for effective Field Safety Notice tracking (an MHRA requirement), manufacturer update tracking and application or Freedom of Information request data provision. It does not have the capability	16	3 completed 1 in progress 4 in total	R1223 - Appointment of a Medical Devices Safety Officer R1223 - Carry out a review of the current Medical Devices Policy R1223 - Re-establishment of the Medical Devices Group with appropriate representation across the tru	R1223 - Undertake a baseline assessment of medical devices stored within operational services to asc	3	31 Aug 2022	30 Sep 2025	Quality Assurance	Quality Assurance
1134 (1226)	2. Demand	Service Provision	Opened 07/03/2022 - Last reviewed 27/03/2024 - Next due review 30/04/2024 - In Date	DTV&F - DTV&F - ALD -	Risk Owner - Patrick Scott - Risk Manager - Jamie Todd	There is a risk that LD patients may not be placed in the best environment to support their care due to a local and national shortage of LD beds, this results from a national reduction in bed availability post Transforming Care, a high level of inpatient acuity (many of whom currently require single-occupancy care), and a lack of community providers to facilitate discharge. resulting in complex patients cared for within temporary ward environments/ inappropriate beds, supported by agency nursing staff and potential adverse patient safety and quality outcomes. This also includes Green Light admissions to AMH and MHSOP beds, including to PICU.	20	Informal escalation arrangements with system partners, both to find beds and gain resources for staffing	Regular meetings with system partners during these situations CE advised	Immediate Response Group	Lack of national and local beds Potential closure of LRH further impacting bed provision Suitable alternative provision	20	8 completed 1 in progress 9 in total	R1226 - Architects floor plans signed off for reconfiguration of Ramsey into 3 single occupancy flat R1226 - Assess and Monitor the temporary staffing usage R1226 - Fortnightly Chief Exec Commissioning meeting from February 2023 R1226 - Investigate suitable alternative provisions R1226 - Monitor the bed management position within the Trust R1226 - New matron supporting staff training, resilience and formulation R1226 - Support for discussions with commissioners (esp. Yorkshire) to identify and fund appropriate R1226 - Weekly system-wide meetings with ICB taking lead	Plan to re-open to admissions	9	31 Aug 2022	30 Apr 2025	Strategy and Resource	Quality Assurance
1137 (1229)	1. Safe Staffing	Service Provision	Opened 22/03/2022 - Last reviewed 06/03/2024 - Next due review 06/04/2024 - In Date	DTV&F - DTV&F - Management -	Risk Owner - Elspeth Devanney - Risk Manager - Sharon Salvin	Due to vacancies, staff absence and clinical activity compliance with the clinical supervision of Registered and unregistered nursing staff is below the desired compliance. Current system unable to provide assurance. The lack of opportunity to discuss clinical cases and reflect on the care delivered reduces opportunities for staff development and support of their wellbeing and in turn potentially impacts on the quality and effectiveness of care delivered.	15	Supervision compliance monitoring spreadsheets Supervision Policy Clinical Supervision Kaizen event outputs Brief situational reflection	Monthly supervision compliance monitoring at overall specialty level with exception reporting of teams below 70%		Monitoring of supervision compliance as part of routine performance reporting Single unified system of monitoring due to difficulties with Foundry and potential additional systems being introduced to bridge gap Loss of knowledge and standard process from original Kaizen	15	4 completed 2 in progress 6 in total	R1229 - Awaiting update in relation the supervision app to ensure visibility of compliance R1229 - Escalation of communication issues regarding current supervision recording processes R1229 - LMGB to be provided with a monthly specialty position in relation to clinical supervision co R1229 - Outputs of clinical supervision kaizen event to be reviewed and plan to restablish process t	R1229 - All ward team managers to be using the same clinical supervision recording system R1229 - Routine performance monitoring of clinical supervision compliance to take place within all s	9	29 Mar 2023	TBD	People, Culture and Diversity	Quality Assurance

Risk ID(s)	BAF Risk Alignment	Theme	Dates	Location	Ownership	Description	Rating (Initial)	Legacy Controls	Legacy Assurances	Controls (New ones added)	Gaps in controls or assurance	Rating (Current)	Action Summary	Actions Closed	Actions open	Rating (Target)	Date Added to CRR	Estimated date to reach target rating	Committee Alignment	Secondary Committee Alignment (Impact)
1219 (1311)	2. Demand	Service Provision	Opened 01/04/2021 - Last reviewed 11/03/2024 - Next due review 30/04/2024 - In Date	DTV&F - DTV&F - CAMHS -	Risk Owner - Jamie Todd - Risk 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.	Performance reports monitored at monthly partnership forums and improvement and delivery groups.		Demand far outstrips capacity currently. Teams are delivering the expected number of assessments as was originally commissioned. Recruitment challenges with regards to new and existing posts. Plan to pull an action plan together with the ICB which allows ongoing risk to be monitored.	15	3 completed 1 in progress 4 in total	R1311 - Completion of multi agency improvement plan - see T drive for full plan R1311 - Options appraisal paper being drafted to agree next steps R1311 - SDF investment	Revised clinical protocol to improve efficiency.	8	17 Jan 2023	30 Apr 2025	Strategy and Resource	Quality Assurance
1311 (1403)	1. Safe Staffing	Safe Staffing	Opened 19/12/2022 - Last reviewed 01/02/2024 - Next due review 01/03/2024 - Overdue	NYY&S - NYY&S CAMHS - CAMHS Ny and Y Crisis Team	Risk Owner - Melanie Woodcock - Risk Manager - Nicola Everett	There is a risk that the NY & Y Crisis team are not always able to cover the rota with enough staff 24/7 (especially at night) to ensure good cover across the whole NYYS geography due to low staffing (as a result of vacancies), especially for night shifts there may only be one qualified and 1 HCA on duty across the whole county. This may result in service users waiting longer to be seen and if presenting at A&E can result in a breech of the 4 hour response time. Due to long waits there is a risk that some young people and families do not wait to be seen. There is also an impact on staff as the pressure in the team is impacting on workload staff morale due to the pressure to cover shifts and staff working overtime to	20	Daily Team Huddles to support staff Team are on e-roster to support shift planning Team and Service Manager increased support and oversight to team Recruitment is up to date with adverts out for all vacancies Agency request to support the vacancies has been agreed and has been used when we can source appropriate staff Staff in Team carrying out overtime to fill vacant shifts Support from other TEWV teams where possible for 16+ cases from adult crisis and liaison teams when the wait to see a CAMHS clinician is impacted by reduced staffing Any young person who decides not to wait to be seen is recorded as a Datix with the reason for the delay and followed up by the team for review.	Increased Supervision - Team Manager and Service Manager Routine monitoring of 4 hour waits working with Performance to drill into each case delayed to ensure the reasons for delay are understood Monitoring amount of overtime in the team to ensure adequate breaks and downtime is being taken by staff Support to the team via CAMHS Supercell and with regular away days/team time to ensure consideration has been given to any alternative actions		Other teams in the Trust may have there own staffing concerns and unable to support the CAMHS Crisis Team when needed. Continuing to advertise posts is necessary but may not result in successfully recruiting to vacancies especially as we are competing with the incentives on offer in other organisations.	16	1 in progress 1 in total		R1403 - Continue to proactively advertise for staff	12	26 Mar 2024	30 Sep 2025	People, Culture and Diversity	Quality Assurance
1327 (1419)	2. Demand	Environment	Opened 02/02/2023 - Last reviewed 14/02/2024 - Next due review 13/03/2024 - Overdue	DTV&F - DTV&F - SIS -	Risk Owner - Naomi Lonergan - Risk 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.	Within the medium secure male CNTW planned estate there is provision for purpose built ECA accommodation		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	2 completed 2 in progress 4 in total	R1419 - Clinical review of patient records R1419 - Review of current ECAs within Ridgeway	R1419 - Review of discharge/transfer pathways for 2 patients in ECA R1419 - Through the bed management process, explore access to the medium secure male ECAs at Cedar	4	25 Jul 2023	31 May 2024	Strategy and Resource	Quality Assurance

Risk ID(s)	BAF Risk Alignment	Theme	Dates	Location	Ownership	Description	Rating (Initial)	Legacy Controls	Legacy Assurances	Controls (New ones added)	Gaps in controls or assurance	Rating (Current)	Action Summary	Actions Closed	Actions open	Rating (Target)	Date Added to CRR	Estimated date to reach target rating	Committee Alignment	Secondary Committee Alignment (Impact)
1337 (1429)	4. Quality of Care	Risk Management	Opened 27/01/2023 - Last reviewed 05/03/2024 - Next due review 05/04/2024 - In Date	Nursing and Governance - N&G - Quality governance - Patient Safety Management	Risk Owner - Dawn Jessop - Risk 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	Delays - reporting data on total SIs, allocated, unallocated, new SI's, no of S's reviewed at DP, and review timescales achieved. Weekly report on new SI's (detail) to CG PSM/ EDG. Current assurance - Negative - confirming that review timescales not being achieved, backlog not reducing Staff levels to support - monitoring of staff vacancies/ sickness/ wellbeing Current assurance - Negative - gaps in team (see gaps in controls) Patient/ carer experience - monitoring of PALs, complaints, feedback to patient safety team. current assurance - moderate - not a persistent level of complaints	Si/PSII - review timeliness tracking SI/PSII - allocation process SI/PSII - Panel arrangements, attendance and coverage SI/PSII - Quality of reporting - training	timely sign off due to panel availability alignment to new PSIRF process	16	7 completed 2 in progress 9 in total	R1429 - FLO recruitment R1429 - NECS staff external support for backlog R1429 - Patient Safety Modern Matron Post - to be recruited R1429 - Patient Safety Specialist Post - to be recruited R1429 - Recruit cohort of staff R1429 - Root and Branch review - external support appointed R1429 - Root and branch review to be completed	SI/PSII - backlog action plan SI/PSII - inPhase development	8	29 Mar 2023	31 Jul 2024	Quality Assurance	
1361 (1453)	1. Safe Staffing	Safe Staffing	Opened 03/04/2023 - Last reviewed 14/03/2024 - Next due review 15/04/2024 - In Date	NYY&S - NYY&S AMH -	Risk Owner - Billie Cameron - Risk Manager - Nicky Scott	There is a risk of delayed access to telephone crisis triage, very urgent assessments (crisis 4hour response) and limited support through home based treatment across the NYYS AMH crisis response home based treatment teams due to the inability to recruit into vacant posts or secure temp staffing for the teams, resulting in the inability to mitigate against risk presentations and support alternative to admissions that supports treatment and promote patient safety and family/carer wellbeing.	20	Daily crisis team team staffing reports weekly Service report out monthly recruitment tracking Service governance meeting & assurance reporting	all age crisis telephone triage rate compliance with 4 hours standard Gatekeeping compliance prior to admission HBT caseload numbers team sickness levels Vacancy wte Patient safety incident reporting Patient experience: PALS and complaints 72 hour post hospital discharge rate		the inability to recruit into vacant posts Gaps in crisis consultant posts access to temporary staffing or agency staff	16	1 completed 4 in progress 5 in total	R1453 - To secure temp support workers staff to screening calls on the all age line	R1453 - ability to reatin a night time offer across HHR R1453 - Offer of overtime to core staff across services R1453 - to secure locum medics for York, Harrogate and Ham Rich crisis R1453 - to secure student/newly qualified placements into crisis team capacity	4	26 Mar 2024	31 Oct 2024	People, Culture and Diversity	Quality Assurance
1464 ()	1. Safe Staffing	Safe Staffing	Opened 01/11/2023 - Last reviewed 03/04/2024 - Next due review 03/05/2024 - In Date	People and Culture - PCD - Health and wellbeing - Health and Wellbeing	Risk Owner - Helen Cooke - Risk Manager -	There is a risk that OH / physiotherapy services would be suspended due to current contract disputes, resulting in wider impact on staff, their availability and capability to work, their overall health & wellbeing, timely clearance for new staff to commence work, and impact on small number of staff applying for ill health retirement.	16			Contract in place	Currently do not have a finalised business continuity plan for any element of the contract.	16	1 completed 1 in progress 2 in total	EDG paper	1464- Develop BCP	8	26 Mar 2024	30 Nov 2024	People, Culture and Diversity	

Risk ID(s)	BAF Risk Alignment	Theme	Dates	Location	Ownership	Description	Rating (Initial)	Legacy Controls	Legacy Assurances	Controls (New ones added)	Gaps in controls or assurance	Rating (Current)	Action Summary	Actions Closed	Actions open	Rating (Target)	Date Added to CRR	Estimated date to reach target rating	Committee Alignment	Secondary Committee Alignment (Impact)
1495 ()	8. Quality Governance	Policies and Compliance	Opened 12/02/2024 - Last reviewed 06/03/2024 - Next due review 05/04/2024 - In Date	Nursing and Governance - N&G - Quality governance - Patient Safety Management	Risk Owner - Beverley Murphy - Risk Manager - Kendra Marley	There is a risk of increased public interest, and FOIs, as a result of a new public facing dashboard potentially resulting in adverse publicity and increased FOI's.	15			Expected deaths recorded as OutcomesSafeguarding referrals recorded as outcomes	Currently unknown what will be published - will be communications nearer the time (although lead did indicate if could be soon) Expected deaths and safeguarding referrals that are not PSI's being recorded as PSIs - new processes in place and review of expected deaths to move to new process backdating of deaths (underway) Need to gain assurance that new processes working i.e. death and safeguarding accurately recorded. We know the quality of records submitted needs to improve and this needs to be addressed. Rejected	15	1 completed 1 not started 6 in progress 8 in total	1495 - Set up Outcomes option for expected deaths and safeguarding referrals	1495 - Expected deaths already recorded to be changed to outcomes 1495 - safeguarding referrals identfied and changed to outcomes 1495 - Review LFPSE dashboard with a view to identifying any areas we may need to address. Ongoing process to ensure deaths are recorded correctly as incidents or outcomes. Ongoing process to ensure safeguarding incidents and referrrals are correctly recorded R1495 - Rejected records process to be established R1495 - Expected Deaths Process to be established in Outcomes	2	26 Mar 2024	31 Dec 2024	Quality Assurance	

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11th April 2024**
Title:	**Staff Survey**
Executive Sponsor(s):	**Sarah Dexter-Smith**
Author(s):	**People and Culture team**

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

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

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

Strategic Risks relating to this report:

BAF ref no.	*Risk Title*	*Context*
1	**Safe Staffing**	The annual staff survey is a key element of the way in which we are able to hear from colleagues across our workforce about a broad range of experiences working in the Trust. It provides us with national benchmarks and guides us on future priorities in the people journey delivery plan as well as providing feedback on whether previous work has had the intended impact.

Executive Summary:

Purpose: This paper provides information on the staff survey undertaken in autumn 23. The paper describes the key results, the routes for consideration to date and the work proposed by committee and executive directors to address remaining concerns.

Proposal: It is proposed that the latest staff survey provides ongoing assurance of progress since the 'most improved' mental health and learning disability outcome the year previously. The board are asked to consider whether the proposed areas of focus will increase the opportunities for further progress against the people journey.

Overview:

Background

Autumn 2023 saw the 21st annual staff satisfaction survey. All TEWV staff were invited to participate via email.

The results were provided to the trust in early 24 and then released for public dissemination in March 24.

Our response rate increased by 4% to 48% which reflected a good return rate nationally. 3782 staff responded, an increase of 452 staff from 2022. We are ranked #14 against 23 Mental Health (MH) Trusts for final response rate, who commission Picker for the survey. This is compared to #15 in 2022 (against 25 MH Trusts).

Results

We maintained progress or improved in 100 of the 103 areas. We are ranked #10 in overall positive score change.

Ongoing progress is noted in

- the experience of staff in relation to harassment and discrimination,
- work hours/ time pressures,
- experience after a near miss/ incident.

In relation to the people promise elements / themes we improved significantly on:

- we are recognised and rewarded
- we are always learning
- staff engagement
- and morale.

We did not deteriorate on the remaining four (one was unreportable nationally for all organisations).

Results indicate that we have work to do on

- the feedback to teams after an incident and what changes have been made to clinical practice as a result
- Staff experience of their team/ team manager.

Actions in response

Key Trustwide areas of focus are:

- Support for colleagues in management roles or carrying out management activities in their leadership role. Although we have invested a lot of resource into supporting leaders from service management level and up as a planned stage of implementing the new Trustwide structure and continued to run new managers courses and managers' bitesize programmes, we need to refocus on the team / ward level. We plan to do this by:
  - Integrating new leaders into the current 'new managers' development programme so that all senior staff are supported to develop a foundation level of management skill
  - Integrating the national 'expectations of people managers into this and the managers' bitesize programmes
  - Tracking the training profiles of all manager and leaders at team level in the same way that we now do for colleagues at service management level and above
  - Beginning to oversee the uptake of these programmes for all new leaders are team level (operational, clinical and corporate) and integrate the new national resources 'expectations of people managers'.
- Continuation of the central reasonable adjustments team for another year.
- Flexible working – feedback from various trials reporting into executive People Culture and Diversity Group in May

- Sharing changes to clinical practice and the outcome/ experience data from people accessing our services to ensure that all colleagues are aware of the developments in clinical services.

For the first time this year, the communications and organisational development teams have worked together to provide teams with a template and guide to using the local results at team level which has received positive feedback.

Prior Consideration and Feedback

Due to the way the meetings fell, the staff survey was discussed in detail in the January People Culture and Diversity time out in order to set the priorities for 24/5 and evaluate impact against the people journey. The group concluded that, to date, the people journey had made good impact and that the plan of work for the next six months was appropriate.

The results have also been discussed and endorsed at EDG.

Implications:

It is not proposed to amend the BAF risk scoring at this stage as the results had already been considered by committee and the implications incorporated into the BAF when it was recently reviewed. The people delivery plan has not fundamentally changed but the focus on supporting team and ward managers/ leaders has been given significantly greater focus.

Recommendations:

Board members are requested to note the improvements in the staff survey and comment on the proposed areas of focus for 24/5. It is proposed that, overall, the staff survey results give good assurance of continued progress following the significant improvement in 2022 when the trust was the most improved MHLDA trust in the country.

This page is intentionally left blank

Tees, Esk and Wear Valleys
NHS Foundation Trust

TEWV staff survey 22-23

Background

Tees, Esk and Wear Valleys
NHS Foundation Trust

- 2023 saw the 21st annual staff satisfaction survey.
- All TEWV staff were invited to participate via email.
- The final response rate was 48% compared to 44% in 2022.
- 3782 participants in total – an increase of 452 staff from 2022.
- We are ranked #14 against 23 Mental Health (MH) Trusts for final response rate, who commission Picker for the survey. This is compared to #15 in 2022 (against 25 MH Trusts).
- We are ranked #10 in overall positive score change.

Breakdown of professional groups

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Occupational Group Respondents	Actual Respondents	Response rate by Directorate	Percent of Trust response rate (based on 3782 participants who completed survey)
Assistant Chief Exec	32	82.05%	0.85%
Corporate Affairs and Involvement	26	76.47%	0.69%
Digital and Data Services	135	76.27%	3.57%
Director of Therapies	78	53.06%	2.06%
Durham Tees Valley & Forensic Care Group	2002	45.56%	52.90%
Estates & Facilities Management Directorate	189	39.54%	4.99%
Finance Directorate	52	70.27%	1.37%
Medical Directorate	179	63.25%	4.73%
North Yorkshire York & Selby Care Group	852	45.46%	22.50%
Nursing & Governance Directorate	89	74.17%	2.35%
People & Culture Directorate	119	81.51%	3.15%
Teesside Directorate	Data cleanse exercise carried out since original data pull. This directorate is no longer on ESR since the restructure, only staff on legacy cost codes are currently showing (less than 5 responses)		
Trustwide roles	14	51.85%	0.37%

This report summarises the findings from the core NHS Staff Survey 2023* carried out by Picker, on behalf of Tees, Esk and Wear Valleys NHS Foundation Trust. Picker was commissioned by 23 Mental Health and Mental Health Community Trusts organisations to run their survey – this report presents your results in comparison to those organisations.

A total of 118 questions were asked in the 2023 survey, of these, 113 can be compared to 2022 and 100 can be positively scored. Your results include every question where your organisation received at least 10 responses (the minimum required).

8012	7870	48%	52%	44%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (3782)	Average response rate for similar organisations	Your previous response rate

57%	q25c. Would recommend organisation as place to work
55%	q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation
78%	q25a. Care of patients/service users is organisation's top priority

Comparison to 2022**

Comparison with average**

*Bank worker survey results are presented via separate reports for those organisations who took part
**Chart shows the number of questions that are better, worse, or show no significant difference

Most Improved Scores

Tees, Esk and Wear Valleys NHS Foundation Trust

Most improved scores	Org 2023	Org 2022	Org 2021
Q4c. Satisfied with level of pay	38%	31%	38%
Q14d. Last experience of harassment/bullying/abuse reported	63%	58%	57%
Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours.	44%	40%	42%
Q19c. Staff involved in an error/near miss/incident treated fairly	55%	50%	No results *
Q5a. Have realistic time pressures	29%	25%	25%

* 2021 question was Q18a.

Most declined scores

Tees, Esk and Wear Valleys NHS Foundation Trust

Most declined scores	Org 2023	Org 2022
Q19d. Feedback given on changes made following errors/near misses/accidents	63%	65%
Q20b. Would feel confident that organisation would address concerns about unsafe clinical practice.	59%	61%
Q31b. Disability: Organisation made reasonable adjustments(s) to enable me to carry out work.	74%	76%
Q19c. Organisation ensure errors/near misses/incidents do not repeat	68%	70%
Q7i. Feel a strong personal attachment to my team	65%	66%

NB. We will not be putting undue focus on any changes that are less than 3% in either direction

Top 5 scores where the organisation compares nationally *(out of 23 Trusts that chose Picker)*

Tees, Esk and Wear Valleys NHS Foundation Trust

Top 5 scores vs Organisation Average	Org	Picker Avg
q15. Organisation acts fairly: career progression	64%	58%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	82%	77%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	95%	91%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	44%	41%
q16b. Not experienced discrimination from manager/team leader or other colleagues	95%	92%

Bottom 5 scores vs organisation average

Tees, Esk and Wear Valleys NHS Foundation Trust

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	55%	62%
q25c. Would recommend organisation as place to work	57%	64%
q6b. Organisation is committed to helping balance work and home life	52%	58%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	74%	80%
q4d. Satisfied with opportunities for flexible working patterns	63%	68%

YOUR JOB (part 1 of 3)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q2a	Often/always look forward to going to work	59%	59%	52%	55%	57%	58%	57%
q2b	Often/always enthusiastic about my job	75%	73%	67%	69%	71%	71%	71%
q2c	Time often/always passes quickly when I am working	78%	78%	74%	75%	75%	75%	75%
q3a	Always know what work responsibilities are	83%	83%	82%	82%	83%	84%	83%
q3b	Feel trusted to do my job	89%	89%	90%	90%	91%	91%	91%
q3c	Opportunities to show initiative frequently in my role	75%	75%	74%	76%	77%	78%	77%
q3d	Able to make suggestions to improve the work of my team/dept	77%	78%	73%	75%	76%	78%	76%
q3e	Involved in deciding changes that affect work	57%	57%	52%	55%	57%	55%	57%

YOUR JOB (part 2 of 3)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q3f	Able to make improvements happen in my area of work	60%	63%	57%	59%	61%	61%	61%
q3g	Able to meet conflicting demands on my time at work	46%	50%	44%	44%	48%	47%	48%
q3h	Have adequate materials, supplies and equipment to do my work	64%	69%	65%	62%	64%	63%	64%
q3i	Enough staff at organisation to do my job properly	35%	42%	28%	28%	32%	35%	32%
q4a	Satisfied with recognition for good work	63%	63%	54%	58%	59%	63%	59%
q4b	Satisfied with extent organisation values my work	52%	53%	43%	47%	49%	52%	49%
q4c	Satisfied with level of pay	45%	45%	38%	31%	38%	35%	38%
q4d	Satisfied with opportunities for flexible working patterns	60%	63%	59%	63%	63%	68%	63%

Your job continued

Tees, Esk and Wear Valleys NHS Foundation Trust

YOUR JOB (part 3 of 3)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q5a	Have realistic time pressures	23%	26%	25%	25%	29%	29%	29%
q5b	Have a choice in deciding how to do my work	61%	62%	59%	61%	61%	63%	61%
q5c	Relationships at work are unstrained	49%	52%	49%	51%	53%	56%	53%
q6a	Feel my role makes a difference to patients/service users	87%	86%	84%	84%	85%	88%	85%
q6b	Organisation is committed to helping balance work and home life	-	*	47%	51%	52%	58%	52%
q6c	Achieve a good balance between work and home life	-	*	54%	56%	58%	61%	58%
q6d	Can approach immediate manager to talk openly about flexible working	-	*	71%	74%	76%	79%	76%

YOUR TEAM & PEOPLE IN YOUR ORGANISATION (part 1 of 2)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q7a	Team members have a set of shared objectives	74%	74%	73%	74%	74%	77%	74%
q7b	Team members often meet to discuss the team's effectiveness	70%	68%	65%	69%	70%	72%	70%
q7c	Receive the respect I deserve from my colleagues at work	75%	75%	73%	76%	75%	77%	75%
q7d	Team members understand each other's roles	-	*	69%	69%	69%	71%	69%
q7e	Enjoy working with colleagues in team	-	*	82%	84%	84%	85%	84%
q7f	Team has enough freedom in how to do its work	-	*	55%	58%	60%	63%	60%
q7g	Team deals with disagreements constructively	-	*	59%	61%	60%	62%	60%

YOUR TEAM & PEOPLE IN YOUR ORGANISATION (part 2 of 2)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q7h	Feel valued by my team	-	*	70%	73%	73%	76%	73%
q7i	Feel a strong personal attachment to my team	-	*	63%	66%	65%	67%	65%
q8a	Teams within the organisation work well together to achieve objectives	-	*	47%	48%	49%	54%	49%
q8b	Colleagues are understanding and kind to one another	-	*	74%	77%	76%	77%	76%
q8c	Colleagues are polite and treat each other with respect	-	*	76%	78%	78%	79%	78%
q8d	Colleagues show appreciation to one another	-	*	72%	74%	75%	75%	75%

YOUR MANAGERS

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q9a	Immediate manager encourages me at work	74%	76%	74%	76%	78%	80%	78%
q9b	Immediate manager gives clear feedback on my work	68%	67%	66%	69%	71%	74%	71%
q9c	Immediate manager asks for my opinion before making decisions that affect my work	59%	61%	62%	63%	64%	68%	64%
q9d	Immediate manager takes a positive interest in my health & well-being	74%	75%	73%	75%	75%	79%	75%
q9e	Immediate manager values my work	75%	76%	74%	76%	76%	80%	76%
q9f	Immediate manager works with me to understand problems	-	*	71%	73%	73%	77%	73%
q9g	Immediate manager listens to challenges I face	-	*	73%	75%	75%	79%	75%
q9h	Immediate manager cares about my concerns	-	*	72%	75%	75%	78%	75%
q9i	Immediate manager helps me with problems I face	-	*	68%	71%	71%	74%	71%

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (part 1 of 4)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q10b	Don't work any additional paid hours per week for this organisation, over and above contracted hours	75%	78%	71%	72%	74%	75%	74%
q10c	Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	40%	40%	42%	40%	44%	41%	44%
q11a	Organisation takes positive action on health and well-being	-	*	58%	60%	60%	62%	60%
q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	81%	78%	77%	80%	82%	77%	82%
q11c	In last 12 months, have not felt unwell due to work related stress	57%	57%	53%	55%	58%	60%	58%
q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	44%	55%	45%	45%	45%	47%	45%
q11e	Not felt pressure from manager to come to work when not feeling well enough	80%	78%	82%	84%	84%	84%	84%
q12a	Never/rarely find work emotionally exhausting	-	*	19%	19%	20%	20%	20%
q12b	Never/rarely feel burnt out because of work	-	*	31%	33%	35%	34%	35%

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (part 2 of 4)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q12c	Never/rarely frustrated by work	-	*	20%	20%	22%	23%	22%
q12d	Never/rarely exhausted by the thought of another day/shift at work	-	*	37%	40%	41%	42%	41%
q12e	Never/rarely worn out at the end of work	-	*	19%	19%	20%	21%	20%
q12f	Never/rarely feel every working hour is tiring	-	*	54%	55%	58%	58%	58%
q12g	Never/rarely lack energy for family and friends	-	*	37%	37%	38%	38%	38%
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	77%	83%	81%	85%	85%	86%	85%
q13b	Not experienced physical violence from managers	100%	100%	100%	99%	100%	99%	100%
q13c	Not experienced physical violence from other colleagues	99%	99%	99%	99%	99%	99%	99%
q13d	Last experience of physical violence reported	89%	87%	92%	90%	91%	88%	91%

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (part 3 of 4)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	70%	76%	75%	77%	77%	75%	77%
q14b	Not experienced harassment, bullying or abuse from managers	90%	90%	92%	93%	93%	91%	93%
q14c	Not experienced harassment, bullying or abuse from other colleagues	84%	84%	86%	86%	86%	85%	86%
q14d	Last experience of harassment/bullying/abuse reported	58%	57%	59%	58%	63%	62%	63%
q15	Organisation acts fairly: career progression	62%	63%	61%	63%	64%	58%	64%
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	95%	96%	95%	95%	95%	91%	95%
q16b	Not experienced discrimination from manager/team leader or other colleagues	94%	93%	94%	95%	95%	92%	95%
q17a	Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public	-	-	-	-	92%	90%	92%
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	-	-	-	-	97%	97%	97%

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK (part 4 of 4)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q18	Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	-	-	-	74%	75%	73%	75%
q19a	Staff involved in an error/near miss/incident treated fairly	-	-	-	50%	55%	59%	55%
q19b	Encouraged to report errors/near misses/incidents	-	-	-	89%	89%	88%	89%
q19c	Organisation ensure errors/near misses/incidents do not repeat	-	-	-	70%	68%	69%	68%
q19d	Feedback given on changes made following errors/near misses/incidents	-	-	-	65%	63%	63%	63%
q20a	Would feel secure raising concerns about unsafe clinical practice	76%	76%	77%	76%	76%	75%	76%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	63%	65%	62%	61%	59%	60%	59%
q21	Feel organisation respects individual differences	-	*	69%	74%	73%	74%	73%
q22	I can eat nutritious and affordable food at work	-	-	-	-	58%	57%	58%

YOUR PERSONAL DEVELOPMENT & YOUR ORGANISATION (part 1 of 2)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q23a	Received appraisal in the past 12 months	-	*	79%	84%	84%	85%	84%
q23b	Appraisal helped me improve how I do my job	-	*	18%	19%	22%	26%	22%
q23c	Appraisal helped me agree clear objectives for my work	-	*	30%	31%	34%	37%	34%
q23d	Appraisal left me feeling organisation values my work	-	*	28%	31%	33%	37%	33%
q24a	Organisation offers me challenging work	-	*	75%	76%	76%	76%	76%
q24b	There are opportunities for me to develop my career in this organisation	-	*	56%	57%	58%	57%	58%
q24c	Have opportunities to improve my knowledge and skills	-	*	72%	74%	75%	75%	75%
q24d	Feel supported to develop my potential	-	*	57%	62%	62%	63%	62%
q24e	Able to access the right learning and development opportunities when I need to	-	*	59%	61%	63%	64%	63%

Your personal development

Tees, Esk and Wear Valleys NHS Foundation Trust

YOUR PERSONAL DEVELOPMENT & YOUR ORGANISATION (part 2 of 2)

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q25a	Care of patients/service users is organisation's top priority	76%	79%	74%	75%	78%	78%	78%
q25b	Organisation acts on concerns raised by patients/service users	79%	78%	76%	74%	75%	74%	75%
q25c	Would recommend organisation as place to work	62%	66%	52%	54%	57%	64%	57%
q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	65%	65%	54%	51%	55%	62%	55%
q25e	Feel safe to speak up about anything that concerns me in this organisation	*	71%	65%	67%	68%	66%	68%
q25f	Feel organisation would address any concerns I raised	-	*	52%	54%	55%	54%	55%
q26a	I don't often think about leaving this organisation	48%	51%	43%	42%	44%	47%	44%
q26b	I am unlikely to look for a job at a new organisation in the next 12 months	56%	59%	50%	51%	52%	52%	52%
q26c	I am not planning on leaving this organisation	62%	65%	59%	59%	60%	60%	60%

Background information

BACKGROUND INFORMATION

		Historical					External	
		2019	2020	2021	2022	2023	Average	Organisation
q31b	Disability: organisation made reasonable adjustment(s) to enable me to carry out work	*	81%	72%	76%	74%	80%	74%

Bank Staff Returns 2023

Tees, Esk and Wear Valleys
NHS Foundation Trust

- A total of 115 responses were received.
- Results were taken from 98 responses due to <10 responses in some areas.

Tees, Esk and Wear Valleys NHS Foundation Trust
NSS23 RAG report - RAG Table Report
Breakdown: Historic Comparison
Suppression Threshold: 10

Key:
100.0%
>3 ppt above
<3 ppt below
In between

People Promise Elements

Your Job

q4a	Often/always look forward to going to work	50.0%	62.9%
q4b	Often/always enthusiastic about my job	75.2%	80.0%
q4c	Time often/always passes quickly when I am working	55.8%	69.5%
q5a	Always know what work responsibilities are	87.0%	86.5%
q5b	Feel trusted to do my job	95.6%	94.2%
q5c	Opportunities to show initiative frequently in my role	66.1%	68.6%
q5d	Able to make suggestions to improve the work we do	55.7%	58.1%
q5e	Involved in deciding changes that affect work	27.8%	36.2%
q5f	Able to make improvements happen at work	40.9%	43.8%
q5g	Able to meet conflicting demands on my time at work	58.3%	59.0%
q5h	Have adequate materials, supplies and equipment to do my work	63.5%	65.7%
q5i	Enough staff at organisation to do my job properly	23.7%	26.7%
q6a	Satisfied with recognition for good work	41.6%	51.9%
q6b	Satisfied with extent organisation values my work	36.0%	40.0%
q6c	Satisfied with level of pay	23.0%	15.2%
q7a	Have realistic time pressures	31.3%	26.9%
q7b	Have a choice in deciding how to do my work	25.2%	44.2%
q7c	Relationships at work are unstrained	42.6%	50.0%
q8a	Feel my role makes a difference to patients/service users	84.3%	89.3%
q8b	Organisation is committed to helping balance work and home life	37.7%	46.7%
q8c	Achieve a good balance between work and home life	65.2%	69.5%
q9	I decide the hours/shifts I work as a bank worker	79.4%	*

People Promise Elements

Tees, Esk and Wear Valleys NHS Foundation Trust

Your Team

q11b	Team members understand each other's roles	73.0%	72.4%
q11c	Enjoy working with colleagues in team	83.5%	81.9%
q11d	Team has enough freedom in how to do its work	44.7%	50.5%
q11e	Team deals with disagreements constructively	54.4%	59.0%
q11f	Feel valued by my team	68.4%	72.4%
q11g	Feel a strong personal attachment to my team	54.4%	51.4%

People Promise Elements

Tees, Esk and Wear Valleys NHS Foundation Trust

People in your organisation

q12a	Teams within the organisation work well together to achieve objectives	58.3%	67.6%
q12b	Colleagues are understanding and kind to one another	72.2%	77.1%
q12c	Colleagues are polite and treat each other with respect	73.0%	71.4%
q12d	Colleagues show appreciation to one another	67.8%	65.7%

People Promise Elements

Tees, Esk and Wear Valleys NHS Foundation Trust

Your managers

q14a	Immediate manager encourages me at work	65.2%	62.9%
q14b	Immediate manager gives clear feedback on my work	51.3%	52.4%
q14c	Immediate manager asks for my opinion before making decisions that affect my work	36.5%	44.8%
q14d	Immediate manager takes a positive interest in my health & well-being	47.0%	53.3%
q14e	Immediate manager values my work	61.7%	63.8%
q14f	Immediate manager works with me to understand problems	51.3%	55.2%
q14g	Immediate manager listens to challenges I face	56.5%	58.1%
q14h	Immediate manager cares about my concerns	59.1%	59.0%
q14i	Immediate manager helps me with problems I face	55.7%	57.1%

People Promise Elements

Your health, safety & wellbeing at work, Part 1

q16a	Organisation takes positive action on health and well-being	43.9%	48.1%
q16b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	82.5%	83.8%
q16c	In last 12 months, have not felt unwell due to work related stress	54.9%	64.8%
q16d	In last 3 months, have not come to work when not feeling well enough to perform duties	53.1%	51.4%
q16e	Not felt pressure from the organisation to come to work when not feeling well enough	37.7%	51.0%
q17a	Never/rarely find work emotionally exhausting	21.7%	23.3%
q17b	Never/rarely feel burnt out because of work	32.2%	35.6%
q17c	Never/rarely frustrated by work	28.7%	32.7%
q17d	Never/rarely exhausted by the thought of another day/shift at work	37.4%	39.4%
q17e	Never/rarely worn out at the end of work	24.3%	24.0%
q17f	Never/rarely feel every working hour is tiring	53.0%	59.6%
q17g	Never/rarely lack energy for family and friends	39.1%	40.4%
q18a	Not experienced physical violence from patients/service users, their relatives or other members of the public	38.1%	41.9%
q18b	Not experienced physical violence from managers	98.9%	99.0%
q18c	Not experienced physical violence from other colleagues	94.6%	98.1%
q18d	Last experience of physical violence reported	96.2%	91.2%
q19a	Not experienced harassment from patients/service users, their relatives or other members of the public	47.8%	54.8%
q19b	Not experienced harassment from managers	93.8%	94.2%
q19c	Not experienced harassment from other colleagues	81.4%	82.4%
q19d	Last experience of harassment/bullying/abuse reported	75.9%	65.9%
q20	Organisation acts fairly: career progression/development opportunities	70.2%	72.4%

People Promise Elements

Your health, safety & wellbeing at work, Part 2

q21a	Not experienced discrimination from patients/service users, their relatives or other members of the public	74.8%	84.8%
q21b	Not experienced discrimination from manager/team leader or other colleagues	89.9%	91.4%
q22a	Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or other members of the public	65.8%	*
q22b	Not experienced unwanted behaviour of a sexual nature from staff/colleagues	95.7%	*
q23	Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	49.5%	62.9%
q24a	Staff involved in an error/near miss/incident treated fairly	45.1%	48.9%
q24b	Encouraged to report errors/near misses/incidents	85.0%	93.0%
q24c	Organisation ensure errors/near misses/incidents do not repeat	59.6%	67.4%
q24d	Feedback given on changes made following errors/near misses/incidents	52.4%	60.6%
q25a	Would feel secure raising concerns about unsafe clinical practice	73.0%	78.1%
q25b	Would feel confident that organisation would address concerns about unsafe clinical practice	51.3%	61.9%
q26	Feel organisation respects individual differences	70.4%	76.2%
q27	I can eat nutritious and affordable food at work	44.3%	*

People Promise Elements

Your personal development

q28	Received appraisal in the past 12 months	19.3%	22.9%
q29a	Organisation offers me challenging work	68.7%	79.0%
q29b	There are opportunities for me to develop my career in this organisation	56.1%	60.0%
q29c	Have opportunities to improve my knowledge and skills	67.8%	71.4%
q29d	Feel supported to develop my potential	53.0%	55.2%
q29e	Able to access the right learning and development opportunities when I need to	60.5%	62.9%
q29f	I get the help and support needed if I have questions when at work	69.6%	*
q30a	Care of patients/service users is organisation's top priority	83.5%	82.9%
q30b	Organisation acts on concerns raised by patients/service users	78.3%	77.1%
q30c	Would recommend organisation as place to work	51.3%	58.1%
q30d	If friend/relative needed treatment would be happy with standard of care provided by organisation	50.4%	51.4%
q30e	Feel safe to speak up about anything that concerns me in this organisation	59.1%	69.5%
q30f	Feel organisation would address any concerns I raised	48.2%	50.5%

People Promise Elements

Tees, Esk and Wear Valleys NHS Foundation Trust

Bank work at this organisation

q32a	Easy to get hold of the bank team if I have a query	68.4%	63.1%
q32b	Quickly get answers I need from the bank team	69.3%	58.3%
q32c	I feel supported by the bank team	51.8%	*

People Promise Elements

Tees, Esk and Wear Valleys NHS Foundation Trust

Background Information

q40b	Disability: organisation made reasonable adjustment(s) to enable me to carry out work	40.0%	53.3%

This page is intentionally left blank

Tees, Esk and Wear Valleys
NHS Foundation Trust

Committee Key Issues Report		
Report Date to Board of Directors – 11 April 2024		
Date of last meeting: 4 April 2024		**Report of: The Quality Assurance Committee**
		Quoracy was achieved.
1	**Agenda**	The Committee considered the following matters: • Summary of Executive Review of Quality Group • Integrated Performance Dashboard (IPD) • Proposed changes to measures for the new quality dashboard • CQC Improvement Plans • Quality Assurance Improvement Programme • Quality Impact Assessments • Quality Priorities • Infection, Prevention and Control • Serious Incident Improvement Plan • Development of NYY Community Mental Health Transformation • DTV Community Mental Health Transformation • Learning from Edenfield Review in Greater Manchester MH FT • Section 17 Leave progress on actions for the Care Groups • Research and Development Performance • Safeguarding Performance • BAF • Draft Internal Audit Report: TEWV 2023-24/16 NICHE Complaints Review: Action Plans The Committee held a confidential meeting on 4 April 2024 to: • Approve the minutes of the confidential meeting held on 7 March 2024
2a	**Alert**	The Committee alerts the Board on the following matters: **From the NYYS and DTVF Care Groups:** • There are a number of community services in DTV and NYYS in business continuity measures including one child and adolescent team in NYYS. • A small number of wards in DTVF are overly representative in restrictive practices, specifically restraint. There is a focus on this. • On two occasions patients have been admitted to areas with higher levels of restriction, i.e.. PICU due to lack of AMH beds. • Although improvements have been made, limited assurance was taken on the ability to consistently manage Section 17 leave and time 'away from the ward' arrangements for inpatients. • Restrictive Practice – there was one incident of mechanical restraint (soft cuffs), two instances of the use of tear proof clothing. • The Head of Risk Management is working with care groups to specify the ongoing concerns related to InPhase to ensure improvements are made. **Other business matters:** • Three CQC must do actions are behind schedule, with approval given to extend deadlines: 1. Delays with the Assistive Technology Programme, due to the inability to recruit escorts. 2. Monitoring physical health after rapid tranquilisation. The action requires revision to have the desired impact and will be completed by the end of April.

		3. Cedar ward environment to maximise privacy and dignity. The Care Group will present the options appraisal in May 24, the risk to us being able to meet our ambitions was discussed. • Two CQC improvement actions were presented for extension that were not agreed: 1. External governance review. The review has been completed however the resulting recommendations have not been actioned. Committee urged that this be completed before July 2024 and extension not approved. 2. Board Sub committees. The ToRs for all Sub Committees require review and ratification and the BAF risks need to be correctly aligned to all committees. Committee did not agree to the extension of time and are alerting the Board of the need to complete this work. • Three CQC actions that are made up of a number of parts are dependent on CITO actions before they can be marked as complete. CITO actions need to be programmed over time and delivered one at a time in order that system stability is maintained. These actions are therefore running behind and a schedule is required about which action will be delivered by when. The actions are summarised as: 1. Recording of seclusion reviews in CITO. 2. New physical health pathway for patients via CiTo. 3. T2 and T3 forms audited directly from CITO.
2b	**Assurance**	The Committee wishes to draw the following assurances to the attention of the Board: **From the Care Groups:** • We are reporting a reduction in missed doses of medication since the introduction of the Electronic Prescribing and Medication Administration system. • Roseberry Park Hospital AMH services will come out of business continuity due to improved staffing levels. • The piloting of a bladder scanner has led to the avoidance of 11 transfers for patients who would have required treatment in an acute setting in NYYS MHSOP services. • No breaches of mixed sex accommodation. **Other business matters:** • Good assurance demonstrated that the Trust's Quality Account Priorities for 2024/25 have been developed with people who have experience of our services. • Substantial assurance on delivery of the historically backlogged SI reviews. There are now no historical serious incident reviews that have not been reviewed with a small number in the final stages of QA prior to submission to the ICS. • Good assurance was taken about our management of infection prevention and control. • Good assurance on the delivery of the clinical audit schedule. • Reasonable assurance in NYY on the MH transformation work for community services – the risk being the lack of available funding. • Good assurance taken about the transformation of community mental health services and partnership working in DTVF. • Good assurance on the performance of the research and delivery programme of work. We are within the top five mental health trusts for mental health research activity including the national work on early detection of the risk of dementia. • Good assurance demonstrated in the quarterly report from Safeguarding and Public protection that progress is being made against priorities.

		• The AuditOne internal audit report gives substantial assurance that within the NICHE recommendations we have delivered the complaints review and the associated improvements.
2c	**Advise**	The Committee wishes to advise on the following matters to the attention of the Board: **From the Care Groups:** • The increased waiting times in HM Prison services is being monitored closely. • The Care Groups are sighted on the number of teams not offering patient experience measures. **Other business matters:** • Committee approved proposed changes to the quality dashboard, further consideration will be given to quality measures for community services in a future iteration. • Equality impact assessments will be brought together with quality impact assessments both for service changes and policy development to ensure good governance. • Committee has requested a briefing on the impact of the introduction of Martha's law. • Learning from the Edenfield Review of services at Greater Manchester MH FT have been considered and shared with the Committee. The Executive Clinical Leaders group and Strategic Fundamental Standards Group will undertake further review in advance of a presentation being made to Board.
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 the quality and safety strategy.
3	**Actions to be considered by the Board**	The Board is asked to note the report.
4	**Report compiled by**	Bev Reilly, Chair of the Quality Assurance Committee, Deputy Chair of Trust/Non-Executive Director, Beverley Murphy, Chief Nurse and Donna Keeping, Corporate Governance Manager

This page is intentionally left blank

Tees, Esk and Wear Valleys NHS Foundation Trust

Mental Health Legislation Committee (MHLC): Key Issues Report	
Report Date:	14 March 2024
Date of last meeting:	27 February 2024 – committee was quorate

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 15 MHA 1983 Holding Powers
- Section 17 Leave
- Section 18 Absent without leave
- Positive and safe Improvement Plan
- Mental Capacity Act/Deprivation of Liberty Safeguards
- Case study
- Equality data on detention rates
- Revised policy: Community Treatment Orders Policy

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

- **CQC MHA inspections** – of the six site based inspections in the period (Nov23-Jan24) themes continue to arise in relation to care planning – some patients not aware they had a plan or felt they were not involved in its development; and carer concerns in relation to difficulty in communicating with the ward and updates not being provided on the patients' mental health, progress or discharge plans. Due to staffing shortages on occasions Section 17 leave could not be facilitated.
- **Section 17 and Time away from Ward-** recent audits indicate some wards are not complying adequately to the Sec 17 leave and time away from ward policies. The Care group Board are doing focussed work on wards with low compliance**.**
- **Positive and Safe Improvement Plan** – there continue to be concerns with reporting of restrictive interventions via the recently introduced InPhase system. Mechanisms for data analysis remain limited and the accuracy of the data lacks validity, this has led to delays in the production of reports and identification of patients requiring RRI assurance panels.

2b Assurance: The Committee assures members of the Board on the following:

- Committee received assurance on a patient who had complained their drug had been reduced without consultation or awareness (as highlighted in the last MHLC report to the board).
- **CQC MHA inspections** – there is good assurance regarding the oversight of inspection activity and completion of actions.
- **Discharge from detention -** There is substantial assurance that the number of times detained patients are discharged by the tribunal or hospital mangers is within a normal range. In the reported quarter, 6 patients were discharged from 116 first-tier tribunals and 1 patient was discharged from 119 hospital mangers meetings, against clinical team advice. None of the patients have been re-detained or re-admitted.
- **Section 136 –** There is a good level of assurance that the legislative requirements for patients held in the trust on a s136, are being met in all areas. There was one occurrence in the quarter where a patient's s136 had been extended to 36 hours, due to their physical ill health and transfer to an acute trust for treatment, and one instance where a patient had reached 24 hours, following a stay in police custody, transfer to TEWV and a delay in the AMHP attending. Committee was provided with a progress update on establishing the internal MHL operational groups and the inter-agency operational groups with partners. Committee noted that the

	recording of information collected when a patient is brought to a trust place of safety, is a manual process and therefore subject to potential of human error and there is no way to validate if any occurrences have been missed. The MHL Team are exploring ways to reduce errors and improve data validation and share information with clinical services. • **Section 136b –** 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 withing three days of detention. Of new detentions (750), 15% required escalation (same as the previous quarter) and 1.6% (12) were discharged with no evidence of rights being given (8 in the previous quarter). Eight of these were discharged on/prior to day three of detention, meaning the escalation process had not started. Actions have been implemented to review and address any shortfall in practice. • **Scrutiny of MHA documentation (annual report) –** There is good assurance that the administrative and medical scrutiny processes take place. It was reported that, due to system limitations, there may be some omissions in the data when sections fail scrutiny. If processes did not take place there is a risk that detentions will be invalid. The MHL Team are exploring the viability of refining the recording of filed documents within electronic patient records and will undertake internal checks to provide further assurance that processes have taken place and failures have been recorded appropriately. • **Section 18 Absence without leave –** there is substantial assurance that the CQC have been notified of every instance of absence without leave, that the trust is required to notify them of. Committee has sought information on the context of absences ie if a proportion have just returned slightly later than expected, and how other instances are investigated to support organisational learning. • **Positive and Safe Improvement Plan –** there have been delays to implementation of the plan (agreed by QAC in September 2023) and therefore reasonable assurance is provided on progress. Progress has been made in relation to the appointment of a specialist practitioner by each care group; rebuilding the positive and safe dashboard for completion in March 2024; and recertification of the positive and safe care, due to completion in March. The trust continues to report an improving trend in the numbers of restrictive interventions used, which is largely attributed to reductions in ALD services over the last 12 months. • **Mental Health Act/Deprivation of Liberty Standards –** there is reasonable assurance that the trust is meeting its requirements under the MCA and a reasonable level of assurance that the use and reporting of DoLS is being carried out as required. • **Section 17 leave** – Committee received reasonable assurance from the care groups that their quality assurance programme via the fundamental standards group is actively monitoring section 17 leave and time away from the ward arrangements and care groups are providing dedicated focus to wards that haven't performed well and learning from the ones that have. • **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 and comparing these to national figures to understand differences between the numbers of anticipated and actual detentions. The report indicated that the trust is detaining more patients than the national rate suggests would be detained and further information has been sought to understand if the information can be weighted to take account of local demographics. It was also noted that, as the numbers are low overall, they may not be statistically significant.
2c	**Advise: The Committee advises the Board on the following:** • Committee approved minor changes to the Community Treatment Orders Policy, to reflect change in terminology and updated template. It was noted that the new policy would be provided to coroners alongside any previous versions requested.	
2d	**Review of Risks**	There are no BAF risks currently 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***: Kedar Kale, Executive Medical Director and Karen Christon, Deputy Company Secretary*

This page is intentionally left blank

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust

For General Release

Meeting of:	**Board of Directors**
Date:	**11 April 2024**
Title:	**Reservation of Powers to the Board and Scheme of Delegation**
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*
10	Regulatory Compliance	The Trust must have a legally binding Constitution in accordance with para. 1 (1) of the NHS Act 2006 (as amended).

Executive Summary:

Purpose: The purpose of this report is to seek the approval of the Reservation of Powers to the Board and Scheme of Delegation.

Proposal: The Board is asked to approve the Reservation of Powers and Scheme of Delegation (attached to this report).

Overview: The Reservation of Powers to the Board and Scheme of Delegation were removed from the revised Constitution.

This approach was taken in order to remove the need for them to be subject to the Constitutional change process and make it easier to maintain alignment between them and other governance documents (e.g. the Standing Financial Instructions).

The removal of the provisions from the Constitution means that, in effect, there are no reservation of powers or scheme of delegation in place.

The document attached includes the previous reservation of powers of the Board (as amended to reflect the changes to the Constitution); the present delegated powers of the Board's Committees, the Executive Directors' Group and the Care Group Boards; the scheme of delegation implicit in Standing Orders and Standing Financial Instructions.

It is recognised that further work is required on the contents of the

document in the light of the continuing development of the Trust's governance arrangements; however, it is necessary for the document to be approved to ensure proper and safe decision making.

Prior Consideration and Feedback The Reservation of Powers to the Board and Scheme of Delegation have been subject to consultation with the Executive Directors. No material issues were raised.

Implications: The Reservation of Powers to the Board and Scheme of Delegation are required to ensure the Trust's governance arrangements operate effectively and safely.

Recommendations: The Board is asked to approve the Reservation of Powers and Scheme of Delegation attached to this report.

Scheme of Decisions Reserved to the Board and Scheme of Delegation

1. Introduction

Standing Order 5.5 of the Board of Directors provides that the Chief Executive shall prepare a Scheme of Decisions Reserved to the Board and Schedule of Decision/Duties Delegated by the Board, identifying his/her proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion.

The purpose of this document is to provide details of those powers which are reserved to the Board, while at the same time detailing those delegated to the appropriate level. However, the Board remains accountable for all of its functions, even those delegated to the Chair, individual Directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.1 Role of the Chief Executive

All powers of the Trust which have not been retained as reserved by the Board or delegated to a committee or sub-committee or an executive committee, sub-committee or group shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he shall perform personally, and which functions have been delegated to other Directors and officers.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting Officer, the Chief Executive is accountable for the funds entrusted to the Trust.

1.2 Caution over the Use of Delegated Powers

Powers are delegated to Directors and officers on the understanding that they would not exercise delegated powers in any matters which in their judgment was likely to be a cause for public concern.

1.3 Directors' Ability to Delegate their own Delegated Powers

The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the Trust's Budgetary Control Framework and other established procedures within the Trust.

1.4 Absence of Directors or Officer to Whom Powers have been Delegated

In the absence of a Director or officer to whom powers have been delegated those powers shall be exercised by that Director or officer's superior unless alternative arrangements have been approved by the Board. It may be fitting for the Chair to take advice from the designated Deputy Chief Executive (where such a designation exists) or the most appropriate Director, depending on the particular issue.

2. Matters Reserved to the Board

2.1 It is for the Board to determine those matters on which decision are reserved unto itself. These reserved matters are set out in paragraphs 2.2 to 2.12 below:

2.2 General Enabling Provision

The Board may determine any matter it wishes in full session within its statutory powers.

2.3 Internal Control

2.3.1 Approval of changes to the Constitution (in conjunction with the Council of Governors)

2.3.2 Approval of the Standing Orders (SOs), a schedule of matters reserved to the Board, the Scheme of Delegation and Standing Financial Instructions for the regulation of its proceedings and business and the suspension or variation or amendment of them

2.3.3 Ratification or otherwise, of instances of failure to comply with Standing Orders brought to the Chief Executives' or Company Secretary's attention.

2.3.4 Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.

2.3.5 Approval and monitoring of the Board Assurance Framework.

2.3.6 Approval of a programme of risk management.

2.3.7 Determination of routine security practices in relation to NHS property as may be determined by the Board.

2.3.8 The receipt of notification of any losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial.

2.3.9 Approval of arrangements for dealing with complaints.

2.3.10 Approval of arrangements relating to the discharge of the Trust's responsibilities as a bailee for patients' property.

2.4 Committees

2.4.1 Establishment and dismissal of committees of the Board.

2.4.2 Approval of terms of reference and reporting arrangements of all committees and other formal groups established by the Board.

2.4.3 Appointment of members of any committee of the Board of Directors.

2.4.4 Receipt of reports from committees including those which the Trust is required by regulation to establish and to take appropriate action thereon.

2.4.5 Determination of recommendations received from committees where they do not have delegated powers.

2.5 People and Culture

2.5.1 Approval of the Trust's Values.

2.5.2 Appointment of the Chief Executive (subject to the approval of the Council of Governors) and other Executive Directors

2.5.3 The approval of the remuneration and terms of service of Executive Directors and other senior employees (i.e., those employees not covered by Agenda for Change or Medical Staffing Terms and Conditions of Service)

2.5.4 Setting the remuneration (including commencing pay rates) and conditions of service for those employees not covered by the Nomination and Remuneration Committee

2.5.5 Appointment and approval of the terms and conditions of service including the responsibilities of Associate Non-Executive Directors.

2.5.6 Appointment of the Senior Independent Director taking into account the views of the Council of Governors.

2.5.7 Appointment, appraisal, discipline and dismissal of the Company Secretary.

2.5.8 Approval of the form of the contract of employment.

2.5.9 Nomination of persons to be directors or senior officers of a subsidiary.

2.5.10 Appointment of a person or persons to act on the Trust's behalf in relation to its shareholding in any Subsidiary including representing the Trust at meetings of the Subsidiary and executing any notices received from the Subsidiary.

2.6 Policy Determination

2.6.1 Approval and monitoring of the Trust's policies and procedures for the management of risk.

2.6.2 Approval of Trust policies in relation to investments.

2.6.3 Approval of Trust policies and procedures relating to business standards including codes of conduct, the disciplinary procedure; personal accountability framework; and conflicts of interest policy and procedure.

2.6.4 Approval of Trust policy on litigation against or on behalf of the Trust.

2.6.5 Approval of Trust policy on complaints.

2.6.6 Approval of the Trust's valuation policy.

2.7 Strategy and Business Plans and Budgets

2.7.1 Definition of the strategic aims and objectives of the Trust.

2.7.2 Approval of the Trust's Forward Plan, business plan and/or delivery plan subject to:

- Consultation with the Council of Governors.
- The approval of the Council of Governors if, in any year, it is proposed to increase by more than 5% the proportion of its total income attributable to non-NHS services.

2.7.3 Overall approval of programmes of investment to guide the letting of contracts for the supply of clinical services.

2.7.4 Approval of individual proposals for making write-offs and special payments above the limits of delegation (£50,000) previously delegated to the Chief Executive and Director of Finance by the Board.

2.7.5 The approval of any merger, acquisition, separation, dissolution or significant transaction (as defined in paragraph 45 of the Constitution) in conjunction with the Council of Governors.

2.8 Direct Operational Decisions

2.8.1 Approval of the acquisition of land and/or buildings in excess of £5,000,000.

2.8.2 Approval of the disposal (including relinquishing control) or change of use of land or/and buildings in excess of £2,500,000 or (subject to the consent of NHS England) where the said land and/or buildings is a "relevant asset" as detailed in the Trust's Licence.

2.8.3 The introduction or discontinuance of any significant activity or operation where the transaction is reportable to NHS England.

2.8.4 Approval of individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £2,500,000 over a 3-year period or the period of the contract if longer.

2.8.5 Determination of whether inhouse services should be subject to competitive tendering.

2.8.6 Approval of arrangements to enable functions to be exercised on behalf of the Trust by, or jointly with a relevant body.

2.8.7 The approval of arrangements to enable the Trust to carry out the functions of another relevant body, whether jointly or otherwise.

2.9 Finance and Performance

2.9.1 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from Directors, committees, members and officers of the Trust as set out in management policy statements including but not limited:

(a) All monitoring returns required by NHS England, or an Integrated Care Board and the Charity Commission shall be reported, at least in summary.

(b) The performance of investments.

(c) The position on loans and overdrafts.

2.9.2 Approval of the opening or closing of any bank or investment account, excluding individual patient accounts,

2.9.3 Receipt of reports on arrangements with the Trust's bankers for accounts to be overdrawn.

2.9.4 Receipt of reports on the outcome of competitive tendering of the Trust's banking arrangements.

2.9.5 The agreement of the use of private finance (subject to any authorisations required from HM Treasury, NHS England, or an Integrated Care Board).

2.9.6 Receipt and approval of a schedule of NHS contracts signed in accordance with arrangements approved by the Chief Executive.

2.9.7 Receipt of information on any pricing of contracts at marginal cost undertaken by the Director of Finance, Information and Estates.

2.9.8 Setting of budgetary total or virement limits.

2.9.9 Approval of any likely overspending or reduction of income which cannot be met by virement or otherwise mitigated across Care Group or departmental overall budgets.

2.9.10 Approval of individual compensation payments over £25,000.

2.9.11 Approval of grants in excess of £5,001.

2.10 Charitable Funds

2.10.1 Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

2.10.2 Approval of proposals for the potential rationalisation of funds held in trust within statutory guidelines

2.10.3 Adoption of the governing document for new funds held in trust

2.10.4 Agreement to charge all costs directly incurred in the administration of funds held on trust to the appropriate trust accounts.

2.10 Statutory Reporting

2.10.1 Approval of any certificates, notices or other information required to be provided to NHS England under the conditions of the Licence.

2.10.2 Consideration and approval of the Trust's Annual Report including the Annual Accounts.

2.10.3 Consideration and approval of the Trust's Quality Account.

2.10.4 Receipt and approval of the Annual Report for funds held on trust.

2.11 Audit Arrangements

2.11.1 Approve of audit arrangements (including arrangements for the separate audit of funds held in trust) and the receipt of reports of the Audit and Risk Committee and the approval of appropriate action in response to them.

2.11.2 Receipt of the annual audit letter received from the external auditor (or other document prepared by the external auditors in lieu of an annual audit letter) and agreement of action on the recommendation where appropriate of the Audit and Risk Committee.

2.11.3 Receipt of the Annual Audit Letter or its equivalent for funds held in trust.

3. Delegation of Powers to Committees

The Board may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board from time to time taking into account where necessary the requirements of NHS England and/or the Charity Commissioners (including the need to appoint an audit and committee and a remuneration committee). The Board shall determine the reporting requirements in respect of these committees. In accordance with SO 5.3 committees may not delegate executive powers to sub-committees unless expressly authorised by the Board.

3.1 Audit and Risk Committee

3.1.1 Approval of any administrative actions as may be necessary to facilitate the delivery of the Committee's purpose and functions.

3.1.2 Authority to investigate any activity within its terms of reference.

3.1.3 Authority to seek any information it requires from any employee. All employees are directed to co-operate with any request made by the Committee.

3.1.4 Authority to obtain external legal or other independent professional advice and to secure the attendance of external experts with relevant experience at its meetings if it considers this necessary.

3.1.5 Authority to commission value for money and other studies.

3.1.6 Approval of the Internal Audit Strategy and Operational Plan.

3.1.7 Approval of the annual Counter Fraud Plan.

3.1.8 Appointment and dismissal of the Internal Audit provider.

3.1.9 Approval of the External Audit Strategy.

3.1.10 Authority to write off losses within the limits set by HM Treasury and NHS England/Improvement.

3.2 Nomination and Remuneration Committee of the Board of Directors

3.2.1 Agreement of all matters relating to the appointment of the Chief Executive, the Medical Director and Directors covered by Very Senior Manager (VSM) contracts including the role description and person specification for the position subject to:

- All appointments being advertised externally to the Trust unless the organisational change policy applies.
- Suitable controls being established to ensure all candidates are considered on merit against objective criteria.
- Suitable controls being established to ensure candidates meet all statutory and regulatory requirements for appointment as directors of the Trust, including the "Fit and Proper Person" requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Provider Licence and the Constitution.
- Due regard being given to equality and diversity.

(Note: the appointment of the Chief Executive requires the approval of the Council of Governors)

3.2.2 The establishment of appointment panels including their membership and delegated powers.

3.2.3 Approval of the remuneration and terms and conditions of service of the Chief Executive, the Medical Director and Directors covered by VSM contracts (except where these are determined nationally).

3.2.4 Approval of any annual uplifts in Trust determined pay structures.

3.2.5 Approval of any termination payments to the Chief Executive, the Medical Director and Directors covered by VSM contracts (except where these are determined nationally), ensuring they are properly calculated and are reasonable with regard to their probity and value for money.

3.2.6 Approval of locally determined terms and conditions of service for all Trust staff employed on national medical terms and conditions and all staff paid at, or above, AFC Band 8.

3.2.7 Agreement of the annual objectives of the Chief Executive and the Executive Directors.

3.2.8 Approval of applications to NHS England and HM Treasury for permission to make a special severance payment to an employee or former employee.

3.2.9 Engagement of external and independent advice relating to any matter within the Committee's functions.

3.2.10 Agreement of clinical excellence awards.

3.3 Mental Health Legislation Committee

3.3.1 Approval of any administrative actions as may be necessary to facilitate the delivery of the Committee's functions.

3.3.2 Authority to investigate any activity within the Committee's purpose and functions.
(Note: All employees are directed to cooperate with any request made by the Committee)

3.3.3 Approval of metrics to support the monitoring of compliance with mental health legislation.

3.4 People Culture and Diversity Committee

3.4.1 Approval of any administrative actions as may be necessary to facilitate the delivery of the Committee's functions.

3.4.2 Authority to investigate any activity within the Committee's functions.

(Note: All employees are directed to cooperate with any request made by the Committee)

3.4.3 Authority to commission external support and advice relating to its purpose and functions.

3.4.4 Approval of action plans in response to staff surveys and other feedback.

3.4.5 Approval of the publication of information under The Equalities Act 2021 (Specific Duties) Regulations 2011.

3.4.6 Approval of workforce, cultural and behavioural metrics.

3.5 Quality Assurance Committee

3.5.1 Approval of any administrative actions as may be necessary to facilitate the delivery of the Committee's functions.

3.5.2 Authority to investigate any activity within the Committee's functions.
(Note: All employees are directed to cooperate with any request made by the Committee)

3.5.3 Authority to commission external support and advice relating to its purpose and functions.

3.5.4 Approval of an annual programme of clinical audit subject to consultation with the Audit and Risk Committee.

3.5.5 Approval of action plans in response to the findings and recommendations of external reviews and investigations into the provision of healthcare services

by the Trust except in cases where the Board expressly states that it wishes to retain these powers.

3.5.6 Approval of quality and safety metrics.

3.5.7 Authority to commission projects/programmes of work to assist the Trust to maintain CQC registration and/or discharge its duty of quality and safety.

3.5.8 Authority to sign off the completion of CQC Action Plans.

3.5.9 Approval of responses to Section 28 letters.

3.6 Roseberry Park Sub-Group

3.6.1 Approval of plans for the delivery of the Sub-Group's purpose and functions, and any changes to them, so long as they support the delivery of the vision approved by the Board.

3.6.2 Approval of the communications and engagement strategies and plans to support the delivery of its purpose and functions.

3.6.3 Approval of expert, legal and other adviser costs as necessary within agreed limits set out in the Trust's Standing Financial Instructions.

3.6.4 Approval of any material changes to the Global Programme for rectification works and associated cost changes.

3.6.5 [Confidential].

3.6.6 Approval of the establishment of the Roseberry Park Hospital Huddle including its scope, functions, membership and reporting arrangement.

3.6.7 Approval of the commissioning of any work, both internally and externally to the Trust, as may be necessary for the delivery of its purpose and functions except where such activity falls within the terms and reference of other committees/groups.

3.6.8 Power to do anything which appears to be reasonably necessary or expedient for the purposes of or in connection with its purpose and functions except where such activity falls within the terms of reference of other committees/groups.

3.7 Strategy and Resources Committee

3.7.1 Approval of any administrative actions as may be necessary to facilitate the delivery of the Committee's functions.

3.7.2 Authority to investigate any activity within the Committee's functions.
(Note: All employees are directed to co-operate with any request made by the Committee)

3.7.3 Authority to commission external independent advice and support relating to the Committee's purpose and functions.

3.7.4 Approval of business cases and investments within the delegated limits set out in the Constitution and Standing Financial Instructions:

3.7.5 Approval of changes to the Business Plan/Delivery Plan priorities subject to them not impacting on the overall delivery of the Trust Strategy.

3.7.6 Approval of documentation relating to statutory consultations for major service changes.

3.7.7 Approval of the disposal of property which is surplus to requirements and within delegated limits.

3.7.8 Approval of the submission of national cost collection information to the Department of Health and Social Care.

3.7.9 The provision of guidance on any matter related to the Trust's interest in a subsidiary to:

(i) The nominee(s) on the Board or equivalent of that Subsidiary.

(ii) If relevant, a person or persons appointed under Section 323 of the Companies Act 2006 to act as the Trust's representative or representatives at any meeting of the Subsidiary.

3.7.10 Approval of metrics to support the monitoring of the Committee's purpose and functions.

3.8 Executive Directors Group

3.8.1 Responsible for the day-to-day management of an effective system of integrated governance, risk management and internal control across the whole Trusts' activities (both clinical and non-clinical), which also supports the achievement of the Trust's objectives. In particular:

- Ensure ongoing delivery of OJTC through review of performance against key targets, programmes, and other objectives within the Business Plan, and any legal/regulatory requirements etc.

- Review and approve draft Board agenda following release from the Chair and recommend any suggested changes. Draft Board papers to be reviewed as and when required.

- Review and approve topics for Board Seminars and Development Days prior to sign off by the Trust's Chair.

- Provide a corporate view on Trustwide issues of current concern ensuring co-ordination.

- Consider and determine/recommend business cases for service developments in accordance with the delegated arrangements set out in Standing Financial Instructions (see section 6.0).

- Ensure staff are kept up to date on Trustwide issues.

- Receive updates from Managing Directors on the Care Group's operational issues, including any risks and mitigations in place.

- Review the Board Assurance Framework and Corporate Risk Register following review by the Executive Risk Group to agree any required changes/actions or make recommendations to the Board accordingly.

- Monitor regulatory compliance and any associated Action Plans, included but not limited to CQC, NHSI/E, HSE, and determine any mitigations where risks of non-compliance are identified.

- Receive weekly Patient Safety Reports for information and agree any required actions for escalation.

- Approve Terms of Reference and membership of any Sub/Groups and/or Task and Finish Groups reporting directly to the Executive Directors Meeting;

- Debate strategic issues affecting the Trust and the wider health economy and agree any communication plans as required.

3.09 Care Group Boards

3.9.1 Responsible for the day-to-day management of an effective system of integrated governance, risk management and internal control across the whole Care Group's activities (both clinical and non-clinical. In particular the CGB will:

- Consider the Care Group's performance against key targets, divisional business plans, CQC outcomes and relevant corporate and site objectives.

- Consider the Integrated Performance Report for the Care Group and gain assurance that mitigations to improve performance are in place.

- Monitor the effectiveness of the management of significant risks and recommend any additional risks for consideration/acceptance by the Executive Directors.

- Provide a corporate view on Care Group issues of current concern ensuring co-ordination between both Care Groups.

- Advise on planning, service level agreements and change management initiatives.

- Ensure staff are kept up to date on Care Group and Trust wide issues.

- Monitor the Care Group's Business Plans.

- Produce a Care Group Annual Report to include a summary of overall performance.

- Review Terms of Reference and membership of Sub-Groups that report to the CGB prior to submission to Executive Directors for formal ratification.

- Debate strategic issues affecting the Care Group, the Trust and the wider health economy.

3.10 Management Group

- Receive updates on key external meetings including those relating to ICS, Commissioning, national networks etc and discuss implications in the delivery of OJTC and agree actions required to mitigate or optimise implications;

- Consider progress on the delivery of the Business Plan and agree any mitigating actions to ensure progress remains on track;

- Provide a corporate view on Site wide issues of current concern ensuring co-ordination between Care Groups;

- Ensure staff are kept up to date on Trust wide issues;

- Receive legal and regulatory updates including guidance that covers the Trust's current and potential future business including any recommended actions required;

- Debate strategic issues affecting the Trust and the wider health economy including but not limited to business of Partnership Boards and ICS Boards;

- Receive an update from the Care Board(s) Managing Directors on operational issues impacting on the delivering of high-quality services;

- Receive updates on progress and any associated risks against the Trust's financial strategy;

- Receive updates from Corporate departments performance such as fire safety, maintenance of medical devices and agree any necessary course of action;

- Receive update reports following each Director visit to understand any common themes to identify any areas to celebrate and communicate more widely Trust-wide;

- Approve Terms of Reference and membership of any Sub-Groups/Task and Finish Groups that report to Management Group for ratification by Executive Team

- Receive updates on progress and any associated risks against the Trust's financial strategy.

- Approval of policies and procedures unless such approval is reserved to the Board.

4.0 Delegation to Officers

4.1 Delegation implied by Standing Orders

SO, 4.2	Chief Executive	Grant permission to disclose the contents of papers or minutes marked “Confidential” for Board meetings.
SO 4.21	Company Secretary	Provide advice to the Chair on the interpretation of Standing Orders.
SO 4.21	Director of Finance	Provide advice to the Chair on the interpretation of Standing Financial instructions.
SO 5.2	Chief Executive (Jointly with the Chair)	Exercise the powers of the Board in an emergency and report thereon to the next Board meeting.
SO 5.4	Chief Executive	Determine which functions to be performed personally and nominate officers to undertake the remaining functions whilst retaining accountability to the Board.
SO 5.5	Chief Executive	Prepare a Scheme of Decisions Reserved to the Board and Schedule of Decision/Duties Delegated by the Board.
SO 5.8	Chief Executive and Company Secretary	Receive discloses of any non-compliance with Standing Orders.
SO 8.3	Chief Executive	Receive declarations from officers on any other employment or business or other relationship of him/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.
SO 8.8	Chief Executive (or nominated Director)	Report on disclosures of any candidature for appointment made by a relative of the Chair or a Director.
SO 13.1	Chief Executive (or nominated officer)	Keep the Trust seal in a safe place.

SO 13.3 Directors and Company Secretary

Attestation of the affixing of the Trust Seal.

SO 13.4 Director of Finance

Approval and signature of any building, engineering, property or capital document before it is sealed.

SO 14.1 Chief Executive (or other officer authorised by the Board)

Signature of any document as a necessary step in legal proceedings involving the Trust.

SO 14.2 Chief Executive (or other officer authorised by the Board)

Signature, on behalf of the Trust, of any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

SO 15 Chief Executive

Responsible for ensuring all existing Directors and officers, and all new appointees are notified of, an understand their responsibility within the Standing Orders.

4.2 Delegation implied by Standing Financial Instructions

General

SFI 1.3.3 Chief Executive

Ultimate accountability to the Board for ensuring that the Board meets its obligation to perform its functions within the available financial resources.

SFI 1.3.3 Chief Executive

Overall executive responsibility for the Trust's activities and responsibility to the Board for ensuring that its financial obligations and targets are met.

SFI 1.3.4 The Chief Executive and Director of Finance, Information and Estates

Delegation, as far as possible, of their detailed responsibilities whilst remaining accountable for financial control.

SFI 1.3.5 Chief Executive

Notification and ensuring understanding of responsibilities within Standing Financial Instructions.

SFI 1.3.6 (a) Director of Finance, Information and Estates

Implementation of financial policies and co-ordination of any corrective action necessary to further these policies.

SFI 1.3.6 (b) Director of Finance, Information and Estates

Ensure that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement Standing Financial Instructions.

SFI 1.3.6 (c) Director of Finance, Information and Estates

Ensure sufficient records are maintained to show and explain transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

SFI 1.3.6 (d) Director of Finance, Information and Estates

Provision of financial advice to the Trust and its Directors and employees.

SFI 1.3.6 (e) Director of Finance, Information and Estates

The design, implementation and supervision of systems of financial control.

SFI 1.3.6 (f) Director of Finance, Information and Estates

Preparation and maintenance of such accounts, certificates, estimates, records and reports as they may require for the purpose of carrying out the Trust's statutory duties.

SFI 1.3.7 All Directors and employees

Duties relating to:
(a) the security of the property of the Trust.
(b) avoiding loss, including those consequential to cyber threats.
(c) exercising economy and efficiency in the use of resources.
(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

SFI 1.3.8 Chief Executive

Ensure contractors or employees of a contractor are aware that they are covered by the Standing Financial Instructions.

Audit

SFI 2.1.2 Chair of the Audit and Risk Committee

Ensure any ultra vires transactions, evidence of improper acts, or any other important matters the Audit and Risk Committee wish to raise, are reported to the Board.

SFI 2.1.3 Director of Finance, Information and Estates

Ensure the provision of an adequate Internal Audit Service.

Fraud and Corruption

SFI 2.2.1 Chief Executive and Director of Finance Information and Estates

Monitor and ensure compliance with Service Condition 24 of the NHS Standard Contract.

SFI 2.2.1 Chief Executive

Nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist.

SFI 2.2.3 Local Counter Fraud Specialist

Report to the Director of Finance, Information and Estates and regularly liaise on all matters of fraud and corruption.

SFI 2.2.4 Local Counter Fraud Specialist

Investigate all cases of suspected fraud and corruption.

SFI 2.2.5 Local Counter Fraud Specialist

Work with the Director of Finance, Information and Estates to ensure compliance with the Bribery Act 2010 is embedded into Trust policies and procedures.

SFI 2.2.6 Local Counter Fraud Specialist

Work with the Director of Finance, Information and Estates to ensure compliance with the Managing Conflicts of Interest in the NHS (NHS England 2017) is embedded into Trust policies and procedures

Director of Finance, Information and Estates

SFI 2.3.1 (a) Director of Finance, Information and Estates

Ensure there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function.

SFI 2.3.1 (b) Director of Finance, Information and Estates

Ensure that the internal audit is adequate and meets the NHS mandatory audit standards.

SFI 2.3.1 (c) Director of Finance, Information and Estates

Decide at what stage to involve the police in cases of misappropriation, and other irregularities.

SFI 2.3.1 (d) Director of Finance, Information and Estates

Ensure that an annual internal audit report is prepared for the consideration of the Audit and Risk Committee and the Board.

SFI 2.3.2 Director of Finance, Information and Estates and designated auditors

Require and receive without prior notice:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) access at all reasonable times to any land, premises or employee of the Trust;
(c) the production of any cash, stores or other property of the Trust under an employee's control; and
(d) explanations concerning any matter under investigation.

Role of Internal Audit

SFI 2.4.2 All staff and Internal auditors

Report immediately any matter arising which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature to the Director of Finance, Information and Estates.

SFI 2.4.3 Chief Executive

Designate officers to receive audit reports.

SFI 2.4.3 Designated Officers

Report to the Chief Executive where there is failure to take any necessary remedial action in response to Internal Audit recommendations within a reasonable period.

SFI 2.4.3 Head of Internal Audit

Directly report to the Trust Chair or Senior Independent Director where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit.

External Audit

SFI 2.5.2 Audit and Risk Committee

Approve the “Policy on the Engagement of the External Auditor for Non-Audit Services”.

Preparation and Approval of Business Plans and Budgets

SFI 3.1.1 Chief Executive

Compile and submit a business plan to the Board.

SFI 3.1.2 Director of Finance, Information and Estates

On behalf of the Chief Executive, prepare and submit budgets for approval by the Board.

SFI 3.1.3 Director of Finance Information and Estates

Monitor financial performance against budget and business plans, periodically review them, and report to the Board.

SFI 3.1.4 All budget holders

Provide information as required by the Director of Finance, Information and Estates to enable budgets to be compiled.

SFI 3.1.5 Director of Finance, Information and Estates

Ensure delivery of training to budget holders.

Budgetary Delegation

SFI 3.2.1 Chief Executive

Delegate management of budgets.

SFI 3.2.2 Chief Executive and Designated Budget Holders

Not to exceed budgetary total or virement limits set by the Board.

SFI 3.2.4 Chief Executive

Approval of use of non-recurring budgets to finance recurring expenditure.

Budgetary Control and Reporting

SFI 3.3.2 (a) Budget holders

Ensure that any likely overspending or reduction of income which cannot be met by virement or otherwise mitigated across their overall budgets is not incurred without the prior consent of the Board.

SFI 3.3.2 (b) Budget holders

Ensure that the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised, subject to the rules of virement.

SFI 3.3.2 (c) Chief Executive

Approval to appoint permanent employees in addition to the budgeted establishment.

SFI 3.3.3 Chief Executive

Identify and implement cost improvement and income generation initiatives.

Monitoring Returns

SFI 3.5.1 Chief Executive

Ensure external monitoring forms are submitted to the requisite monitoring organisation.

Annual Report and Accounts

SFI 4.1 (a) Director of Finance Information and Estates

Prepare financial returns in accordance with the guidance given by NHS England and the Treasury, the Trust's accounting policies, and international financial reporting standards.

SFI 4.1 (b) Director of Finance Information and Estates

Prepare, certify and submit financial reports and returns to NHS England.

SFI 4.1 (c) Director of Finance Information and Estates

Submit financial returns to NHS England for each financial year in accordance with its prescribed timetable.

Bank and GBS Accounts

SFI 5.1.1 Director of Finance Information and Estates

Responsible for managing the Trust's banking arrangements.

SFI 5.2.1 Director of Finance Information and Estates

Responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;
(b) establishing separate bank accounts for the Trust's non-exchequer funds;
(c) ensuring payments made from bank or Government Banking Service (GBS) accounts do not exceed the amount credited to the account except where arrangements have been made; and
(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

Banking Procedures

SFI 5.3.1 Director of Finance Information and Estates

Prepare detailed instructions on the operation of bank and Government Banking Service (GBS) accounts.

SFI 5.3.2 Director of Finance Information and Estates

Advise the Trust's bankers in writing of the conditions under which each account will be operated.

Banking – Tendering and Review

SFI 5.4.1 Director of Finance Information and Estates

Seeking competitive tenders for the Trust's banking business at regular intervals to ensure they reflect best practice and represent best value for money by periodically.

Income Systems

SFI 6.1.1 Director of Finance Information and Estates

Designing, maintain and ensure compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

SFI 6.1.2 Director of Finance Information and Estates

Responsible for the prompt banking of all monies received.

Fees and Charges

SFI 6.2.2 Director of Finance Information and Estates

Responsible for approving and regularly reviewing the level of all fees and charges

SFI 6.2.3 All Employees

Inform the Director of Finance, Information and Estates promptly of money due arising from transactions

Debt Recovery

SFI 6.3.1 Director of Finance Information and Estates

Responsible for the appropriate recovery action on all outstanding debts.

SFI 6.4.1 (a) Director of Finance Information and Estates

Approve the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

SFI 6.4.1 (b) Director of Finance Information and Estates

Ordering and securely control receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable.

SFI 6.4.1 (c) Director of Finance Information and Estates

Provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.

SFI 6.4.1 (d) Director of Finance Information and Estates

Prescribe systems and procedures for handling cash and negotiable securities on behalf of the Trust.

SFI 6.4.3 Director of Finance Information and Estates

Approval of arrangements for the disbursements made from cash received,

Contracting for the Provision of Services

SFI 7.1 Chief Executive or designated officer

Responsible for negotiating contracts for the provision of services to patients taking into account advice received from the Director of Finance Information and Estates.

SFI 7.3 Director of Finance Information and Estates

Produce regular reports detailing actual and forecast contract income.

Remuneration

SFI 8.1.2 (a) Board Nomination and Remuneration Committee

Advise the Board on:
(a) Appropriate remuneration and terms of service for the Chief Executive and other executive directors (and other senior employees) including all aspects of salary; the provision of bonuses; arrangements for the termination of employment and other contractual terms; and the approval of Clinical Excellence Awards for Consultant Medical Staff.

SFI 8.1.2 (b) Board Nomination and Remuneration Committee

Recommend the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the

provisions of any national arrangements for such staff where appropriate.

SFI 8.1.2 (c) Board Nomination and Remuneration Committee

Monitor and evaluate the performance of individual executive directors (and other senior employees as may be determined by the Board).

SFI 8.1.2 (d) Board Nomination and Remuneration Committee

Advise on and oversee appropriate contractual arrangements for executive directors (and other senior employees as may be determined) including the proper calculation and scrutiny of termination payments.

SFI 8.1.4 Chief Executive

Propose arrangements for the setting of remuneration and conditions of service for those employees not covered by the Board Nomination and Remuneration Committee.

Staff Appointments

SFI 8.3.1 Chief Executive

Authorise (or delegate authority to) Directors and employees to engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration within the limits of their approved budget and the funded establishment.

SFI 8.3.2 Chief Executive

Present procedures for the determination of commencing pay rates, condition of service, etc., for employees.

Processing of Payroll

SFI 8.4.1 Director of Finance Information and Estates

Responsible for matters relating to the processing of the payroll.

SFI 8.4.2 Director of Finance Information and Estates

Responsible for issuing instructions relating to the processing of the payroll.

SFI 8.4.3 (a) Nominated Managers

Submit staff variation details and other notifications in accordance with agreed timetables.

SFI 8.4.3 (b) Nominated Managers

Complete staff variation details and other notifications in accordance with the Director of Finance, Information and Estates instructions and in the form prescribed by the Director of Finance, Information and Estates.

SFI 8.4.3 (c) Nominated Managers

Terminate employee contracts (using Manager Self Service) immediately upon knowing the effective date of an employee's resignation, termination or retirement.

SFI 8.4.3 (c) Nominated Managers

Inform the Director of Finance, Information and Estates where an employee fails to report for duty in circumstances that suggest they have left without notice.

SFI 8.4.4 Director of Finance Information and Estates

Ensure that the payroll service is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and make suitable arrangements for the collection of payroll deductions and payment of them to appropriate bodies.

SFI 8.4.5 Director of Finance Information and Estates

Verify that the rate of pay and relevant conditions of service are in accordance with current agreements and that proper compilation of the payroll and payments have been made.

SFI 8.4.5 Director of People and Culture

Resolve disputes arising from the interpretation of conditions of service.

SFI 8.4.6 Director of Finance Information and Estates

Agree exceptions to the payment of employees monthly by bank credit.

Contract of Employment

SFI 8.5.1 Director of People and Culture

Ensure all employees have a contract of employment and deal with variations to, or termination of, contracts of employment.

Non-pay Expenditure

SFI 9.1.1 Chief Executive

Determine the level of delegation to Budget Managers.

SFI 9.1.2 Chief Executive

Establish a list of managers authorised to place requisitions for the supply of goods and services; the maximum level of each requisition; and the system for authorisation above that level.

SFI 9.1.3 Chief Executive

Set out procedures on the seeking of professional advice regarding the supply of goods and services.

Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

SFI 9.2.1 Relevant Director or General Manager

To be consulted where a requisitioner does not accept advice from the Trust advisor on supply.

SFI 9.2.2 Director of Finance, Information and Estates

Determine the appropriate approach where it is considered not possible for goods and services to be procured through the Trust's electronic purchasing system

SFI 9.2.3 Director of Finance, Information and Estates

Responsible for the prompt payment of accounts and claims.

SFI 9.2.4 Director of Finance, Information and Estates

Responsible for the provision of advice on the thresholds for quotations and formal tenders; preparing procedural instructions on the obtaining of goods, works and services; the prompt payment of all properly authorised accounts and claims; designing and maintaining a system of verification, recording and payment of all amounts payable; and ensuring that payment for goods and services is only made once the goods and services are received.

SFI 9.2.5 Officers certifying accounts

Ensure separation of duties between those officers placed the order and negotiated the prices and terms and those checking delivery or execution of works.

SFI 9.2.5 Director of Finance, Information and Estates

Authority to make payment on receipt of a certificate in the appropriate form for contracts for building and engineering works which require payment to be made on account.

SFI 9.2.8 (a) Director or General Manager

Demonstrate and document the business need and financial benefits versus risk where prepayments are required.

SFI 9.2.8 (b) Director of Finance, Information and Estates

To be satisfied with the proposed arrangements before contractual arrangements for prepayments proceed.

SFI 9.2.8 (c) Budget Holders

Responsible for ensuring that all items due under a prepayment contract are received and for informing the appropriate Director/Head of Service or Chief Executive if problems are encountered.

SFI 9.2.9 Director of Finance, Information and Estates

Approval of the form for official orders.

SFI 9.2.9 Chief Executive

Authorise employees to use official orders.

SFI 9.2.10 (a) Managers

Ensure compliance with guidance and limits specified by the Director of Finance, Information and Estates regarding all contracts, leases, tenancy agreements and other commitments.

SFI 9.2.10 (e) Director of Finance, Information and Estates (on behalf of the Chief Executive)

Authorisation for requisitions/orders to be placed where there is no budget provision.

SFI 9.2.10 (g) Chief Executive

Designation of officers to place verbal orders.

SFI 9.2.10 (j) Managers

Notify the Director of Finance Information and Estates of any changes to the list of directors/employees authorised to certify invoices.

SFI 9.2.10 (k) Director of Finance, Information and Estates

Issue instructions on making purchases from petty cash.

SFI 9.2.10 (l) Director of Finance, Information and Estates

Determine form of petty cash records.

SFI 9.2.11 Chief Executive

Ensure Standing Orders are compatible with the requirements of the Trust and consistent with the provisions of its Licence.

Grants to Other Bodies

SFI 9.3.1 Relevant Director

Approval of grants to other bodies up to £1,001.

SFI 9.3.1 Chief Executive

Approval of grants to outside bodies up to £5,001.

Proof on Concept (Trials and Pilots)

SFI 10.2 Director of Finance, Information and Estates (for goods and services) and the Chief Pharmacist (for medicines)

Approval of all 'proof of concept' trials or pilot projects that may lead to a contractual relationship within the Trust.

Formal Competitive Tendering

SFI 10.5 Nominated Officers

Consult and jointly undertake tendering with the Procurement Department for contracts with a value in excess of £50,000 (excluding VAT).

SFI 10.5 Director of Finance, Information and Estates

Authority to waive competitive tendering procedures for proposed tenders below the Public Procurement thresholds.

SFI 10.5.4 Director of Finance, Information and Estates

Agree a 'permitted list' of items the supply of which does not require the application of formal tendering procedures.

SFI 10.5.4 Director of Finance, Information and Estates

Authority to approve the waiver of formal tendering procedures.

Contracting / Tendering Procedure

SFI 10.6.5 (i) Chief Executive

Approval of award of contract in cases where the designated officers are of the opinion that the tenders received are not strictly competitive.

SFI 10.6.5 (ii) Chief Executive and Director of Finance Information and Estates

Determine whether the price to be paid is fair and reasonable and ensures value for money for the Trust where only one tender is sought and / or received.

SFI 10.6.6 Chief Executive or nominated officer

Determine whether applications from bidders to submit tenders after the due time and date may be considered or whether retendering should be undertaken.

SFI 10.6.7 Chief Executive or Director of Finance Information and Estates

Authority to accept tenders which will commit expenditure in excess of that which has been allocated by the Trust and not in accordance with Standing Financial Instructions.

SFI 10.6.9 Director of Finance Information and Estates

During the period of a contract, make or institute any enquiries they deem appropriate concerning the financial standing, financial suitability and technical competence of contracted suppliers.

SFI 10.6.9 Chief Nurse

During the period of a contract may make or institute any enquiries they deem appropriate to be satisfied as to the suppliers technical / medical competence.

Quotations

SFI 10.7.3 Chief Executive or Director of Finance, Information and Estates.

Authorise acceptance of a quotation which will commit expenditure in excess of that which has been allocated by the Trust and not in accordance with Standing Financial Instructions.

SFI 10.7.4 Director of Finance, Information and Estates

Approval of waivers from quotation procedures.

SFI 10.7.4 Director of Finance, Information and Estates

Ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

Authorisation of Tenders and Competitive Quotations

SFI 10.8 Chief Executive or an Executive Director.

Authorisation to sign contacts.

SFI 10.10 Director of Finance, Information and Estates

Oversight and management of each contract on behalf of the Trust.

SFI 10.11 Chief Executive

Delegate authority to nominated officers to enter into contracts of employment, regarding employees, and temporary worker arrangements for agency staff or bank workers.

Disposals

SFI 10.13 Chief Executive and Nominated Officer

Determine, in the case of whether competitive tendering or quotation procedures shall not apply to disposals, any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve).

Inhouse Services

SFI 10.14 Chief Executive

Responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.

Declaration of Interests

SFI 10.16 Director of Finance, Information and Estates.

Advise individuals on a recommended course of action where they have a conflict of interest and direct influence over the Trust's purchasing decisions or are privy to information that would provide an unfair advantage to the organisation or company.

External Borrowing

SFI 11.1.1 Director of Finance, Information and Estates

Advise the Board of Directors concerning the Trust's ability to pay dividend on, and repay, both the Public Dividend Capital and any proposed new borrowing.

SFI11.1.1 Director of Finance, Information and Estates

Responsible for reporting periodically to the Board concerning loans and overdrafts where relevant.

SFI 11.1.2 Director of Finance, Information and Estates or nominated employee

Authority to make an application for a loan or overdraft.

SFI 11.1.3 Director of Finance, Information and Estates

Prepare detailed procedural instructions concerning applications for loans and overdrafts.

SFI 11.1.4 Director of Finance, Information and Estates

Authorise any short-term borrowing requirement in excess of one month.

Investments

SFI 11.2.2 Director of Finance, Information and Estates

Responsible for advising the Board on investments and reporting periodically to the Board concerning the performance of investments held.

SFI 11.2.3 Director of Finance, Information and Estates

Prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

Capital Investment

SFI 12.1.1 (a) Chief Executive:

Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

SFI 12.1.1 (b) Chief Executive:

Responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost.

SFI 12.1.1 (c) Chief Executive:

Ensure that the capital investment is not undertaken without confirmation of relevant commissioner(s) support and the availability of resources to finance all revenue consequences, including capital charges.

SFI 12.1.1 Chief Executive:

Ensure that all business cases meet the requirements of the NHS capital regime, as advised by NHS England.

.

SFI 12.1.2 (a) Chief Executive

Ensure that a business case is produced for every capital expenditure proposal.

SFI 12.1.2 (b) Director of Finance Information and Estates

Professionally certify the costs and revenue consequences of business cases involving capital expenditure proposal.

SFI 12.1.3 Chief Executive:

Issue procedures for capital schemes where the contracts stipulate staged payments.

SFI 12.1.3 Director of Finance Information and Estates

Issue procedures for the regular reporting of expenditure and commitment against authorised expenditure for capital schemes where the contracts stipulate staged payments.

SFI 12.1.4 Chief Executive

Issue authorisations to the manager responsible for any capital scheme

SFI 12.1.4 Chief Executive

Issue a scheme of delegation for capital investment management.

SFI 12.1.5 Director of Finance Information and Estates

Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

Private Finance

SFI 12.2.1 Director of Finance Information and Estates

Demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

Asset Registers

SFI 12.3.1 Chief Executive

Responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance, Information and Estates on the form, updating and annual physical check of assets.

SFI 12.3.5 Director of Finance, Information and Estates

Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

Security of Assets

SFI 12.4.1 Chief Executive

Responsible for the overall control of fixed assets.

SFI 12.4.1 Each Employee

Responsible for exercising a duty of care over the assets of the Trust.

SFI 12.4.2 Directors and senior employees

Apply such appropriate routine security practices in relation to NHS property as may be determined by the Board and report any breaches.

SFI 12.4.3 Director of Finance, Information and Estates.

Approve asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets).

SFI 12.4.4 Director of Finance, Information and Estates.

Receive notifications of all discrepancies revealed by verification of physical assets to fixed asset registers.

SFI 12.4.5 All Directors and employees

Report any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies.

Stores and Receipt of Goods

SFI 13.2 Chief Executive

Delegation of arrangements for the overall responsibility for the control of stores subject to the responsibility of the Director of Finance, Information and Estates for the systems of control.

SFI 13.2 Designated Pharmaceutical Officer

Responsible for the control of pharmaceutical stocks.

SFI 13.2 Designated Estates Manager

Responsibility for the control of fuel oil

SFI 13.3 Designated Manager/Pharmaceutical Officer

Define in writing the responsibility for security arrangements and the custody of keys for all stores and locations.

SFI 13.4 Director of Finance, Information and Estate

Set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

SFI 13.5 Director of Finance, Information and Estate

Agree stocktaking arrangements.

SFI 13.6 Director of Finance, Information and Estate

Approve alternative arrangements where a complete system of stores control is not justified,

SFI 13.7 Designated Manager/Pharmaceutical Officer

Responsible for a system approved by the Director of Finance, Information and Estates for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles.

SFI 13.7 Designated Manager/Pharmaceutical Officer

Report to the Director of Finance, Information and Estates any evidence of significant overstocking and of any negligence or malpractice.

Disposals and Condemnations

SFI 14.1.1 Director of Finance, Information and Estates

Prepare detailed procedures for the disposal of assets including condemnations and ensure that they are notified to managers.

SFI 14.1.2 Head of Department or authorised Deputy

Advise the Director of Finance, Information and Estates of the estimated market value of the item, taking account of professional advice where appropriate, when a disposal is decided.

SFI 14.1.4 Supplies Department

Report any evidence of negligence of an item due for disposal or condemnation to the Director of Finance, Information and Estates who will take the appropriate action.

Losses and Special Payments

SFI 14.2.1 Director of Finance, Information and Estates

Preparation of procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

SFI 14.2.1 Director of Finance, Information and Estates

Preparation of a “fraud response plan” that sets out the action to be taken both by persons detecting fraud and those persons responsible for investigating it.

SFI 14.2.2 All Employees

Immediately inform their Head of Department upon discovering or suspecting a loss of any kind.

SFI 14.2.2 Head of Department

Immediately inform the Chief Executive and the Director of Finance, Information and Estates, or inform an officer charged with responsibility for responding to concerns involving loss or fraud confidentially.

SFI 14.2.2 Director of Finance, Information and Estates

Immediately inform the police if theft or arson is involved in a loss

14.2.3 Director of Finance, Information and Estates

Notify the Board and NHS England in regard to non-trivial losses apparently caused by theft, arson, neglect of duty or gross carelessness,

SFI 14.2.5 Director of Finance, Information and Estates

Authority to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

SFI 14.2.6 Director of Finance, Information and Estates

Consider whether any insurance claim can be made for any loss.

SFI 14.2.7 Director of Finance, Information and Estates

Maintain a Losses and Special Payments Register in which write-off action is recorded.

Information Technology

SFI 15.1 Director of Finance, Information and Estates,

Responsible for the accuracy and security of the computerised financial data of the Trust.

SFI 15.1 (a) Director of Finance, Information and Estates,

Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware.

SFI 15.1 (b) Director of Finance, Information and Estates,

Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

SFI 15.1 (c) Director of Finance, Information and Estates,

Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment.

SFI 15.1 (d) Director of Finance, Information and Estates,

Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he/she may consider necessary are being carried out.

SFI 15.1 (e) Director of Finance, Information and Estates,

To be satisfied that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation.

SFI 15.2 Responsible directors and employees

Provide information to be sent to the Director of Finance, Information and Estates in regard to computer systems which are proposed General Applications.

SFI 15.3 Director of Finance, Information and Estates

Ensure that contracts for computer services for financial applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage.

SFI 15.3 Director of Finance, Information and Estates

Seek assurance that adequate controls are in operation where another health organisation or any other agency provides a computer service for financial applications.

SFI 15.5 Director of Finance, Information and Estates

Ensure adequate controls are in place for computer systems which have an impact on corporate financial systems.

SFI 15.6 Director of Finance, Information and Estates

Responsible for the adequacy of controls as the Senior Information Risk Owner.

Patients' Property

SFI 16.2 Chief Executive

Responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission of arrangements for patients' properties.

SFI 16.3 Director of Finance, Information and Estates

Provide detailed written instructions in regard to the administration of patients' property.

SFI 16.4 Director of Finance, Information and Estates

Agree arrangement where Department of Health instructions require the opening of separate accounts for patients' moneys,

SFI 16.6 Appropriate departmental or senior manager

To inform staff, on appointment, of their responsibilities and duties for the administration of the property of patients.

Funds held in Trust

SFI 17.1.3 Director of Finance, Information and Estates

Primary responsibility to the Board, in close liaison with the Board's Legal Adviser, for ensuring that standing financial instructions are applied for funds held in trust.

Existing Trusts

SFI 17.2.1 Director of Finance, Information and Estates (in conjunction with the Legal Adviser)

Arrange for the administration of all existing trusts including ensuring governing instruments exist and detailed codes of practice are produced.

SFI 17.2.2 Director of Finance, Information and Estates

Make recommendations to the Board regarding the potential for rationalisation of existing funds within statutory guidelines.

SFI 17.2.3 Director of Finance, Information and Estates

Recommend an increase in the number of funds where this is consistent with this Body's policy for ensuring the safe and appropriate management of restricted funds.

New Trusts

SFI 17.3.1 Director of Finance, Information and Estates (in conjunction with the Legal Adviser)

Arrange for the creation of a new trust where funds and/or other assets, received in accordance with this Body's policies, cannot adequately be managed as part of an existing trust.

SFI 17.3.2 Legal Adviser

Present the governing document for a new fund to the Board for adoption.

Sources of New Funds

17.4.1 Director of Finance, Information and Estates

Produce guidelines to officers on how to proceed when offered donations and provide secure and appropriate receipting arrangements for those received.

17.4.2 (a) Director of Finance, Information and Estates

Provide guidelines to officers on Legacies And Bequests

17.4.2 (b) Director of Finance, Information and Estates

Where necessary, obtain grant of probate, or make application for grant of letters of administration, where this Trust is the beneficiary;

17.4.2 (c) Director of Finance, Information and Estates

Empowered, on behalf of this Body, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty.

17.4.2 (d) Director of Finance, Information and Estates (in conjunction with the Legal Adviser)

Directly responsible, for the appropriate treatment of all legacies and bequests

SFI 17.4.3 (a) Director of Finance, Information and Estates

After consultation with the Legal Adviser, deal with all arrangements for fund-raising by and/or on behalf of this Trust and ensure compliance with all statutes and regulations.

SFI 17.4.3 (b) Director of Finance, Information and Estates

Empowered to liaise with other organisations/persons raising funds for this Trust and provide them with an adequate discharge.

SFI 17.4.3 (c) Director of Finance, Information and Estates

Responsible, along with the Legal Adviser, for alerting the Board to any irregularities regarding the use of this Trust's name or its registration numbers; and

SFI 17.4.3 (d) Director of Finance, Information and Estates

Be responsible, after due consultation with the Legal Adviser, for the appropriate treatment of all resources received from fund raising.

SFI 17.4.4 (a) Director of Finance, Information and Estates (along with the Legal Adviser and other designated officers)

Responsible for any trading undertaken by this Trust as corporate trustee.

SFI 17.4.4 (b) Director of Finance, Information and Estates (along with the Legal Adviser)

Responsible for the appropriate treatment of all funds received from investment income.

SFI 17.4.5 Director of Finance, Information and Estates

Responsible for the appropriate treatment of all dividends, interest and other receipts from investment income.

SFI 17.5.1 Director of Finance, Information and Estates

Responsible for all aspects of the management of the investment of funds held on trust including providing advice to the Board on formulation of investment policy (in conjunction with the legal adviser); appointment of advisers, brokers, and, where appropriate, fund managers; the pooling of investment resources; participation by this Trust in common investment funds; the review of the performance of brokers and fund managers; and the reporting of investment performance

Disposition Management

SFI 17.6.1 Director of Finance, Information and Estates

Manage the exercise of the Trust's dispositive discretion in conjunction with the Board.

Banking Services

SFI 17.7.1 Director of Finance, Information and Estates

Advise and ensure, with the approval of the Board, that appropriate banking services are available to this Trust as corporate trustee.

Asset Management

SFI 17.8.1 (a) Director of Finance, Information and Estates (in conjunction with the Legal Adviser)

Ensure appropriate records of all assets owned by this Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account.

SFI 17.8.1 (b) Director of Finance, Information and Estates

Ensure that appropriate measures are taken to protect and/or to replace assets.

SFI 17.8.1 (c) Director of Finance, Information and Estates

Ensure that donated assets received on trust, rather than into the ownership of the Secretary of State, are accounted for appropriately;

SFI 17.8.1 (d) Director of Finance, Information and Estates

Ensure that all assets acquired from funds held on trust which are intended to be retained within the trust funds are appropriately accounted for, and that all other assets so acquired are brought to account in the name of the Secretary of State.

Reporting

SFI 17.9.1 (a) Director of Finance, Information and Estates

Ensure that regular reports are made to the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources.

SFI 17.9.2 (b) Director of Finance, Information and Estates

Prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

SFI17.9.3 (d) Director of Finance, Information and Estates (in conjunction with the Legal Adviser)

Prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Board.

Accounting and Audit

SFI 17.10.1 Director of Finance, Information and Estates

Maintain all financial records to enable the production of reports to the satisfaction of internal and external audit.

SFI 17.10.2 Director of Finance, Information and Estates

Ensure that the records, accounts and returns receive adequate scrutiny by internal audit and liaise with external audit and provide them with all necessary information.

SFI 17.10.3 Director of Finance, Information and Estates

Advise the Board on the outcome of the annual audit.

SFI 17.10.3 Chief Executive

Ensure that the Annual Audit Letter or its equivalent is considered by the Audit and Risk Committee prior to submitting it to the Board.

Administration Costs

SFI 17.11.1 Director of Finance, Information and Estates

Identification of all costs directly incurred in the administration of funds held on trust and, in agreement with the Board, charge such costs to the appropriate trust accounts.

Taxation and Excise Duty

SFI 17.12.1 Director of Finance, Information and Estates

Ensure that this Body's liability to taxation and excise duty is managed appropriately.

Retention of Documents

SFI 18.1 Chief Executive

Responsible for maintaining archives for all documents

Risk Management and Insurance

SFI 19.1 Chief Executive

Ensure that the Trust has a programme of risk management which will be approved and monitored by the Board.

SFI 19.3 Director of Finance, Information and Estates

Ensure insurance arrangements exist in accordance with the risk management programme.

5.0 Budgetary Delegation (Appendix 1 to Standing Financial Instructions)

Revenue expenditure limits for existing budget / contracted expenditure

Level	Signatories	Limit
L1	Chief Executive and Director of Finance, Information and Estates **BOTH** signed	Above £750,000
L2	Chief Executive, Director of Finance, Information and Estate	Up to £750,000
L3	Executive Director (Board members) / Managing Director / Company Secretary	Up to £500,000
L4	Care Group Directors / Director of Estates / Chief Information Office	Up to £300,000
L5	Clinical Director / Deputy Director / Associate Director / General Manager	Up to £100,000
L6	Operational Service Manager / Head of Department	Up to £50,000
L7	Team / Ward Managers	Up to £10,000 (can be lower on request)

Capital Expenditure Limits (approved schemes)

Level	Signatories	Limit
L1	Chief Executive, Director of Finance, Information and Estates	Above £1,000,000
L2	Managing Director, Deputy Directors of Finance and Information, Director Estates, Chief Information Officer	Up to £1,000,000
L3	Head of Financial Planning and Investment, Head of Capital Development Head of Information Services Head of Digital Transformation	Up to £250,000
L4	Capital Project Leads	Up to £100,000

6.0 Delegation of investment Decisions (Appendix 2 to Standing Financial Instructions)

A description of what is included in each investment decision heading is below the table. Limit is per annum for all apart from capital items, which are one off transactions.

Meeting	Investment Decision	Limit £000s	Comment
Board of Directors	Tender for new services Capital expenditure Capital disposal Expenditure requiring additional budget Expenditure within existing budget	Unlimited Unlimited Unlimited Unlimited Unlimited	Material investment decisions are subject to NHSE approval Advice should be sought from the Finance Department
Strategy and Resources Committee	Tender for new services Capital expenditure Capital disposal Expenditure requiring additional budget Expenditure within existing budget	2,500 5,000 2,500 2,500 5,000	
Executive Directors Group	Tender for new services Capital expenditure Capital disposal Expenditure requiring additional budget Expenditure within existing budget	1,000 2,000 1,000 1,000 2,000	
Care Group Board	Tender for new services Capital expenditure Capital disposal Expenditure requiring additional budget Expenditure within existing budget	nil nil nil nil 750	
Care Croup Senior Management Team	Tender for new services Capital expenditure Capital disposal Expenditure requiring additional budget Expenditure within existing budget	Nil Nil Nil	Decisions taken cannot increase agreed care group forecast expenditure position if overspending. If underspending, increase is

		nil 500	capped at the lower of £500k, and residual underspend. Any service change (e.g., outsourcing) must be agreed by Executive Directors Group

Tender for new services
All decisions regarding tendering to provide new services (clinical and non-clinical). This includes additions to existing service scope.

Capital expenditure
The purchase of any property, plant or equipment that will be capitalised in the Trust's financial statements.

Capital disposal
The sale of any property, plant or equipment that was previously capitalised, and held on the trust's asset register.

Expenditure requiring additional budget
All expenditure for which new budget allocation is required.

Expenditure within existing budget
This includes all amendments to expenditure for which budget exists within teams. For example, an IT system contract renewal is for a reduced value and creates surplus budget. This surplus budget is subject to the above restrictions. Where IT purchasing has been centralised, all orders must be placed using the established process. Local procurement is not permitted. The budget virement process must be adhered to at all times.

NHSI reporting requirements / approval
In line with NHSE's Transactions Guidance (link), all significant transactions that meet the review thresholds should be reported to the Trust's NHSI regional team for assessment and approval. Advice should be taken from the Finance Department.

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank

Document is Restricted

This page is intentionally left blank